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MINNESOTA DEPARTMENT OF LABOR & INDUSTRY

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Workers' Compensation Advisory Council
Feb. 24, 2016 – Meeting minutes

Members attended
Jason Bartlett
Janice Draxler
Walter Fredrickson
Russell Hess
Glen Johnson
Douglas Loon
Robert Lux
Bill McCarthy
Bobbi Pearson
Ed Reynoso
Robert Ryan
Gary Thaden

Nonvoting members attended
Rep. Tim Mahoney
Rep. Tony Albright

DLI staff members attended
Commissioner Ken Peterson
Assistant Commissioner Chris Leifeld
Sandy Barnes
Kate Berger
David Berry
Jon Brothen
Tom Hanson
Ralph Hapness
Sonya Herr
Mike Hill
Lorelei Hoyer
Karen Kask-Meinke
Mark McCrea
David Musielwicz
Donna Olson
John Rajkowski
Jessica Stimac
Jeanne Vogel
Lisa Wichterman
Laura Zajac

Visitors attended
JoAnn Aiken – TCO
Bill Blazar – MCC
Scott Brener – SFM
Nancy Conley – Minnesota Legislature
Eric Dick – MMA
Jason Fountain
Susan Gigiere – MAPS
Britt Graupner – Department of Human Services
James Heer – WCRA
Erin Huppert – Allina
Bob Johnson – Insurance MN
John Kavanagh – Almeida PA
Brad Lehto – Minnesota AFL-CIO
Bob Lund – SFM
Cody Marks – CorVel
Bill Marshall – Office of Administrative Hearings
Brian Martinson – Minnesota Senate
James McClean – Health Partners
Phil Moosbrugger – Department of Commerce
Carol Norris – QRC
Kim Olson – CorVel
Liz Owens – Department of Human Services
Tom Poul – MNASCA/TCO
Dean Salita – MNAJ
Joe Schindler – MHA
Joe Twomey – MDLA

I. Call to order and roll call
Commissioner Ken Peterson called the meeting to order at 9:45 a.m.

Roll call was taken and a quorum was present.

II. Approval of the agenda

Peterson asked to add two items to the agenda. The first item would be a change in the language to the remodeling statute, Minnesota Statutes § 176.137. This statute deals with remodeling or altering a home of a worker who is disabled because of a work-related injury. The second item to add is an update about the hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Centers Payment System (ASPCS) negotiations. Robert Ryan moved to approve the agenda with changes and Gary Thaden seconded the motion. All voted in favor and the agenda was approved.

III. Approval of the minutes

Thaden moved to make a correction to the minutes from the Jan. 13, 2016 meeting. He asked that on page 4, paragraph 5, the first sentence should read, "Thaden spoke and indicated he does not believe government agencies should be exempt from attending these proceedings if private parties are required to attend." The motion was seconded and all voted in favor to make the change and approve the minutes from the Jan. 13, 2016 meeting.

IV. Agenda items

a. Legislative proposal

Addressing issues related to Sumner decision

The commissioner introduced the first item on the agenda. This proposal addresses issues related to the Sumner decision, which has to do with the rights of intervenors during proceedings before the Office of Administrative Hearings (OAH). Current law requires intervenors to attend hearings, though that has not been the practice. The Supreme Court decision last year required that intervenors must now follow the letter of the law. The intent of the Workers' Compensation Advisory Council (WCAC) proposal is to clarify exactly when intervenors have to attend. The Department of Labor and Industry (DLI) had numerous discussions with various parties that may be affected by this decision – OAH, attorney defense bar, lawyers representing intervenors and also hospitals, and lawyers representing the state, especially the Department of Employment and Economic Development (DEED) and the Department of Human Services (DHS). Both DEED and DHS have substantial amounts of these cases with OAH. As a result of these discussions, DLI has drafted language that addresses the issues that are problematic to the parties in these proceedings. The commissioner introduced Kate Berger, DLI Office of General Counsel, to review those changes and recite the terms of the proposal.

Berger indicated the changes to M.S. § 176.011, subd. 7(a), lines 1 through 8, were requested by OAH. This is a housekeeping matter that clarifies the meaning of "compensation judge." In 1998, compensation judges were moved from DLI to OAH and the statute was never changed to reflect that move. The changes in lines 18 and 19 are also requested by OAH. This deals with the situation where an answer is not filed as required by law and lines 17 through 19 say that if a party fails to file an answer, they can appear at the hearing. They can question witnesses and present evidence, but they are not allowed a continuance of the hearing for any reason. Because the question of unanticipated circumstances arises, and the party cannot attend the proceeding, OAH requesed that the language be added "except upon a showing of good cause."

The major proposed changes are in M.S. § 176.361. This new language is a response to the Sumner case, which interpreted existing language to require intervenors to attend every proceeding. OAH has issued a standing order to try to make that work and allow parties to appear by telephone, but it is still a concern for many intervenors that they need to be available even by telephone. The changes in subdivision 1 are primarily administrative, so lines 49 through 52 update the terminology. It clarifies that the attendance requirements do not apply to administrative conferences at either agency. This section refers to pre-hearing conferences and hearings at OAH. DLI no longer has a unit called Mediation or Rehabilitation and Medical Services, therefore lines 49 through 52 update the terminology. Also, on line 43, this clarifies the difference between "attend" and "appear" at proceedings. The Supreme Court said in this context there really is not a difference. "Appear" is struck here and throughout the proposal and replaced with "attend."

Berger further explained some changes to subdivision 2. These are changing all the instances referring to "application or motion" to simply "motion" for the sake of consistency. Line 59 currently states the motion must be served on all parties. The change now states "except for other intervenors." This change is necessary because some cases have many intervenors and it would require every intervenor to serve every other

intervenor with private medical information. This change clarifies that motions must be served on the primary parties, but not all intervenors. This language is also reflected on lines 89 and 90.

In subdivision 3, the changes are on lines 107 through 109, where OAH may establish procedures for filing objections if a timely motion to intervene is filed fewer than 30 days before a scheduled hearing. Normally, they are required to do that, but sometimes the intervenor does not receive notice that they have the right to intervene until late in the proceeding. Perhaps this intervenor was just discovered and OAH was not aware of them until now. What this change does is that OAH can say that if somebody files a timely motion to intervene fewer than 30 days before the hearing and another party wants to object to that, OAH can establish procedures for filing those objections.

Berger explained the proposed changes to subdivision 4. What this new language provides is that an intervenor does not need to attend a pre-hearing conference or a hearing unless a judge orders them to do so pursuant to a motion filed by a party or the judge's discretion that the intervenor needs to be there. What this also provides is that the intervenor must be given at least 10 days notice and if not given a 10-day notice, they cannot be required to attend. This also provides that if attendance is ordered, failure of the intervenor to attend either in person or, if approved by the judge, by telephone or other electronic medium, shall result in the denial of the claim. Again, in this language, good cause is added because unanticipated situations arise. The last section clarifies that even though the intervenor has not been ordered to attend, they can always attend as a party at any time and any case.

Subdivision 5 deals with objections and it requires that objections be specific in detail so that the intervenor knows why someone is objecting to their intervention. It says the intervenor, if they have not been ordered to attend, can file a response to the motion in writing and submit that into evidence in writing before the hearing.

Subdivision 6 addresses the presentation of evidence by the intervenor when they have not been ordered to attend or where they have been allowed to attend the hearing by telephone. OAH can establish a procedure for submission of this evidence and their response to objections. It also clarifies that if the intervenor chooses not to submit something in writing, it is that party's risk. If they choose not to attend and they choose not to submit anything in writing, the judge can only consider what the judge has before them. It will be considered a matter of discretion by the judge.

Subdivision 8 gives the chief administrative law judge authority to issue standing orders in lieu of each judge issuing a separate procedure. The commissioner said some clarification is needed in the second sentence where it begins: "The chief administrative law judge has the authority to issue standing orders instead of, or in addition to, the authority granted to the office ..." A concern was raised about what the scope of this language involves. The commissioner indicated DLI will work with the chief administrative law judge to clarify this language. The intent is not to allow the replacement of a statute by an order and DLI will work on this language with OAH.

Rep. Tim Mahoney asked if the department changes the language to subdivision 8, will that new language be presented to WCAC before the bill is drafted and written. The commissioner asked that WCAC members approve this proposal and the new language will be added. WCAC members will be notified when the new language is drafted to make certain there is agreement. The commissioner indicated another meeting of WCAC would not be called to approve the additional changes. Thaden confirmed this type of procedure has been done successfully in the past.

Douglas Loon proposed the following language be added to the end of subdivision 8 after the word "section": "providing that any and all such standing orders must be consistent with this section."

Mahoney asked that the language be sent to both him and Rep. Tony Albright for the purpose of routing it through the House legal staff to ensure it is appropriate for the bill. The commissioner agreed. He confirmed that the motion before the council presently is to approve the proposal, along with the language proposed by Loon. Thaden added that the final copy should be sent to the heads of the two caucuses, Bill McCarthy and Loon.

Glen Johnson moved to approve, it was seconded by Thaden and the language as amended was approved by the council.

b. Legislative proposal

Remodeling of residence for disabled employees, Minnesota Statutes § 176.137

The commissioner introduced the proposal to correct some technical issues about this matter. DLI is proposing to remover "or Workers' Compensation Court of Appeals" in the three places that are stricken and add a new subdivision 6 that states any disputes under this section will be decided by OAH.

Berger added that the current language that includes WCAC in this statute was drafted prior to OAH hearing workers' compensation cases. In the 1998 legislative session, a law was passed that gave OAH the authority to hear cases. But what happens in practice is that the DLI attorney works with all the parties and, if there is agreement, issues the remodeling award based on the agreement. If the parties disagree, it goes to OAH as a dispute and appeals go to WCCA. This proposal corrects the language.

The commissioner indicated this has not yet been discussed with the Workers' Compensation Court of Appeals chief judge, Judge Patty Milun. DLI will be in contact with the judge to confirm the language. WCAC members will be notified if Judge Milum does not agree to the proposed language. WCAC can withdraw this change if Judge Milun is not in agreement. The commissioner asked WCAC to approve the amending language so this matter can be included in Albright's workers' compensation legislation. Thaden moved to approve the language, Ryan seconded and the motion was approved by the members.

c. Update: Negotiations with hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Centers Payment System (ASCPS) negotiations

The commissioner explained DLI has been negotiating for some time with insurers, hospitals and ambulatory surgery centers (ASCs) about drafting a new fee schedule similar to what occurred last year with the inpatient hospital fee schedule. He indicated there is no written agreement, but there is a verbal agreement that was reached on Monday between the ASCs and insurance companies. The commissioner introduced two parties to the agreement, Scott Brener from SFM – the insurance industry – and Tom Poul, representing the ASCs.

Brener spoke to the council and indicated there has been a meeting of the minds with respect to the payment structure as it relates to the ASCs and payor relationship. As a bit of background to the issue, Brener explained that in the early 1990s, the Legislature instituted a series of medical reforms to assist in containing spending within this environment. At that point, a provider fee schedule was put in place as it relates to doctors, physical therapists and chiropractors. At the same time, treatment guidelines were put into law to control the demands of the utilization side of the equation, referring to appropriate treatment guidelines. The indemnity benefits or wage-loss benefits in the early 1990s probably constituted about 60 to 70 percent of the equation. The other 30 to 40 percent were medical benefit dollars. In 1999 or 2000, in the state of Minnesota and elsewhere in the country, that dynamic flipped so the medical component outweighed the indemnity component. In today's workers' compensation environment in national norms and state norms, the spending is about 70/30 to medical/indemnity. About 70 cents in the benefit dollar is spent on medical benefits and about 30 cents on the indemnity benefits. Medical spend has been the focus of much discussion lately and how to contain it. Minnesota was an early adopter of fee schedule and treatment guidelines. What was not adopted at that time was any significant cost containment vehicle as it relates to the hospital component. Hospital spend has traditionally been paid out at 80 percent (large hospital) usual and customary. Small hospitals – fewer than 100 beds – were paid at 100 percent usual and customary. The way most of the states – or half the country at this point – has gone about controlling that hospital spend is through the institution of fee schedules. There are primarily three fee schedules. There is the inpatient hospital fee schedule that was adopted by the Legislature in the last session and went into effect Jan. 1, 2016. That left two remaining fee schedules to close the loop. One was addressing ASCs and the other, and by far the most significant piece, relates to outpatient hospital spend. There has been no agreement about the outpatient hospital side of the equation, but have come to agreement with the ASCs.

Brener indicated that, for a variety of reasons – mostly because the new fee schedules are freshened up every July 1 – it was decided the implementation date be moved from Jan. 1, 2017, to July 1, 2017, to give the parties a little more time to adapt and work with new codes. He indicated both parties have worked with DLI to work on this new language. He emphasized there is no differing intent on behalf of the parties, but a matter of crafting the correct language.

Poul, of Messerli & Kramer, and representing the state ASCS association and Twin City Orthopedics, spoke to the group regarding the negotiations. He indicated he believes it a fair agreement for ASCs although there have been some trade-offs for the industry he represents. He felt the proposals will result in cost reduction for the ASCs and there will be uniformity in the reimbursement process. The hope is to reduce or eliminate bill scrubbing or bill review, which is certainly a challenge for the ASCs. It is the ultimate goal to develop a system that has stronger enforcement for problem insurers.

The commissioner asked Brener and Poul if the prompt payment issue was in the agreement, since that has been problematic. Since the ASCs have agreed to some cuts, they are hoping prompt payment and less bill scrubbing will assist their efforts. Brener explained there is a 30-day pay or denial period and a one-year look back with a 60-day appeal period.

Mahoney commented his concern was regarding the prompt pay component of the agreement. He indicated there were implied promises last year when he and Albright worked on this matter for the legislative session. There were also implied promises that bill scrubbing or bill review was getting eliminated. He questioned whether the two items, prompt payment and bill scrubbing, were a part of the ASCs piece agreement.

Brener said timely payment requirements have been tightened up to some degree. The principal payment remains at 30 days and the vast majority of time it is met within that 30-day period. There is no longer a look back after a year. The window to address issues has been tightened up. As far as bill review or bill scrubbing, Brener indicated he cannot promise the elimination of bill review. There will be detailed bill review done in certain situations, but less of it under this arrangement because this is going to a fee schedule. If it is not in the fee schedule, under this agreement, then it would be considered at 75 percent usual and customary. Those would be items that rarely occur, but are currently not in the fee schedule. There would be no other way of addressing it, other than by review. Those cases are relatively rare. He said there will be far less bill review or bill scrubbing.

Poul stated that with this implementation, the fee schedules are pretty clear about what is paid for each procedure. If not on the ASC schedule, this it moves to the OPPS fee schedule, so there is a process to eliminate some bill scrubbing. He indicated bill review should be significantly reduced and almost eliminated, but could not guarantee 100 percent elimination of that process.

Brener stated the vast majority of claims would run through this ASCPS bill review methodology or coding. If there is no code as developed by Medicare, it then goes under the OPPS, which is the outpatient fee schedule.

Mahoney stated his concern is that by leaving just a little opening for bill review in this agreement, this will lead to more bill review. He indicated there continue to be delays in payments because of this issue. His expectation, and that of Albright, was that the bill reviewing would be almost non-existent, that the electronic billing would be done within 30 days and that attorney costs would go down for both insurers and hospitals. He explained the added time and cost by excessive bill review and delays takes away from an injured worker and a business. The goal is to give businesses the best cost and get workers back to work. Mahoney asked that both organizations be aware that this process will be closely monitored for compliance with the law. The commissioner also stated that violations will have consequenses from DLI.

Thaden asked if the inpatient piece had a certain process and timeline for payment and is it the same as ASCs. Brener answered that the ASCs wanted a 60-day appeal period, rather than 30 days.

Albright said he felt the workers' compensation bill last session that he and Mahoney carried was successful and beneficial for all parties in the process. He asked Brener and Poul if all parties of interest to this agreement are on board with the proposed changes.

Brener answered that those he represents in the insurance industry are in agreement. Poul answered that his organization represents most of the ASCs in Minnesota, but not all. His organization has provided this information and distributed it as widely as possible in requesting feedback from the others. He could not say 100 percent that there is no opposition, but has not heard of any opposition at this point. He indicated the comments that were received have been incorporated in the agreement. Poul said his organization reached a consensus, but there are some ASCs that are not members of the association that may not be in this process.

Albright asked the commissioner if his expectation was to begin implementation of the changes July 1, 2017. The commissioner answered that the law currently authorizes DLI to implement rules Jan. 1, 2017, but that could be pushed out to July 1, 2017, to accommodate the parties. Albright indicated the commissioner still has authority, from the rulemaking standpoint, that he could impose this on parties if they did not come to the agreement. Albright asked if this option is still on the table if there is not a timely agreement. The commissioner replied that the option has been negated for the ASCs, but not for the outpatient hospital piece. That authority still exists. The commissioner's intent is to move ahead, failing an agreement with the hospitals. He said he remains optimistic that something still can be worked out with the hospitals, but is prepared to use rulemaking to comply with the law. Any rulemaking by DLI would be after the session is over because of the time challenges. The commissioner also cautioned that expedited rulemaking procedures can be changed by 100 signatures presented to OAH. OAH can make it a full-blown administrative hearing that would take a lot longer. Any rulemaking by DLI could still be used as a forum to continue the negotiations with the hospitals.

Albright reiterated his concern, along with Mahoney, that the law as passed last session be implemented. They both expressed that the effort and work involved in the last session should not go in vain. The commissioner agreed and also indicated there is a sense of urgency, but the process still needs to be fair so it avoids litigation by interested parties.

Mahoney said one of his concerns is that when you get into rulemaking and have a 120-day comment period, it can stretch out a couple of years. He asked of the possibility that WCAC put a motion on the floor that the 120-day period be suspended and make it an expedited process.

Thaden thanked the representatives for their input and suggestions. His concern is that an agreement with the ASCs alone, and without the hospitals, will accomplish little. Also, he said the rulemaking process will send this to a couple of more legislative committees for discussion and approval.

Mahoney also indicated that with the passage of last year's legislation, the committee number has increased to three, regardless of whether we have more rulemaking.

The commissioner proposed a solution that would include working with the two parties and drafting language agreeable to the parties. WCAC would convene again in two weeks and DLI could propose the new language then. At the same time, the agreement between the insurers and the ASCs does not mean passage, it has to be signed upon by this council and it is composed of both labor and management. There may be negotiations that go on between these two parties during the next two weeks. If they cannot agree, then the meeting will be canceled. It would take our next meeting to March 9.

Loon asked both parties, Brener and Poul, if this gives them enough time to develop the language and give WCAC adequate time to review it. He also expressed he would like to see the other piece of this, which is the outpatient hospital component. Is this a possibility yet this year? If the answer is no, then we have to ask ourselves if we want to proceed on the ASCs independently and without the outpatient piece.

The commissioner said the hospitals have indicated they do not want to proceed this year. He indicated he and DLI will make every effort to see if the hospital representatives will come back to the table, but is uncertain

they will do so. Loon said the hospitals' concerns will be reviewed and carefully considered to make certain they are represented.

Mahoney commented the agreement has been moving forward and all parties have worked very hard to get to this point. His wish for expedited rulemaking is really geared toward last year's legislation, where there is still bill scrubbing, electronic billing not being used enough and attorneys still being dragged into court to recoup their clients' funds. He would like to see that last year's legislation is working and some of the issues it addressed be implemented. He felt the commissioner has been very fair and has been trying hard to get the parties to an agreement. The commissioner commented that the hospital inpatient provision went into effect Jan. 1 and, as far as DLI has heard, no violations have been reported. He assured the members that penalties would be enforced for violators who are paying late or not paying.

The commissioner asked for any other questions or topics of discussion. No other questions or topics were brought for discussion. WCAC will plan a meeting two weeks from today, March 9. If there is no agreement, he will cancel the meeting.

V. Adjournment

Ryan moved to adjourn the meeting and Robert Lux seconded. The motion carried and the meeting was adjourned at 11:05 a.m.

Respectfully submitted,
Patty Rutz
Executive secretary