**Meeting with the Doctor, the second visit**

Ideas on starting and continuing a productive working relationship with Attending Providers

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Financial statement & bias: no financial conflicts of interest. I think VRC’s are vital part of successful RTW. Cooperation betw AP’s & VRC’s helps everyone.

Attending Providers don’t come trained in dealing with VRC’s. The VRC’s need to train the AP’s, many of whom are learning work comp on the fly.

Docs are afraid of malpractice.

Docs often don’t understand L&I jargon

Doctors worried about satisfaction surveys. Determine bonuses & salaries.

Doctors are concerned with pt privacy & HIPPA.

What do AP’s need to know?

For whom are you working?

What does a VRC do? VRC’s should talk about modified duty, not: it’s all or nothing. (Review this JA….)

How do we work together? Why are asking me this question? Should I know the answer? Can I share it with you? Didn’t I already say that in my notes? How is this not a waste of my time?

What was your role compared to the new era post Vocational Recovery Pilot? For experienced (jaded, frustrated, adversarial) docs, this will be important to explain. Important for some patients, too.

stress

Docs don’t have time to answer lengthy generic questionnaires.

Docs don’t always understand their role in RTW planning.

Docs are more inclined to allow a worker to remain off work due to pain. Could be addressed with gradually increasing a work schedule.”

Employers #1 obstacle to RTW.

VRC’s can help reduce anxiety

* + Find out how the AP’s want to be contacted?
  + “Who’s on my team?”
  + Project Help
  + Offer to brainstorm solutions with doc to avoid workers getting stuck or to help them get un-stuck.

What can you do for them?

* + Reduce everyone’s stress. Focus on stages. RTW doesn’t have to wait until MMI. Help with Light duty, Transition schedules.
  + Explain claim process to AP & to Patient. Where is the pt in the voc process? Put the paperwork in context. We’re doing this now because… We’re in the phase which means…. This helps move pt forwards in recovery AND return to work because…

What have you already told the pt or what will you be telling the pt?

* + How does a JA or Physical/Functional Capacity Exam help (or not help)? Why present a JA that on the face if it doesn’t make any sense? Eg. 1 armed security guard.
  + Provide resources & information about resources. Offer up brainstorming ideas such as ID ergo changes, job mods, graduated RTW. “Would this worker’s situation be improved by different equipment at work? Claims will sometimes pay for changes ….”
  + PGAP, Worksource, ID barriers <https://lni.wa.gov/patient-care/advisory-committees/_docs/2018DocFuncImprovfunctionalscales.pdf>
  + Coordinate with OT/PT/Rehab
  + Communicate with Employer, Stay at Work (How does this benefit the worker to encourage return to work $?). The VRC can explore options with the employer, help do the leg work after discussing stages of functional recovery with doc. ID work options.

How can a VRC & AP work as a team?

* + Encourage worker with same message
  + Take advantage of COHE (COHE Advisor consults rather than IME’s, HSC’s, encourage providers to join COHE networks).
  + Explaining things to worker/patient so the AP doesn’t have to.
  + Explaining things to both the worker & the AP at the same time.
  + Benefits of ruling in/out job of injury early before permanent restrictions.
  + Discuss stages of recovery/function.
  + Move the claim forwards.
  + Provide info to CM, explain PGAP.
  + Early Return to work doesn’t mean stopping treatment.
  + Explaining things to CM/employer so the AP doesn’t have to.
  + Discuss different kinds of rehab, RTW, financial benefits to worker/employer of each.
  + Save time.
  + AP can request a second opinion & not need an IME. Faster, cheaper, doesn’t require pre-auth, often more useful. <https://lni.wa.gov/patient-care/authorizations-referrals/referrals-to-specialists>

What don’t AP’s know?

* + That they can bill for their time with you.
  + Focus on function
  + There might be limited light duty available. What qualifies for light duty vs graduated RTW?
  + What if pt believes or tells AP there isn’t light duty?
  + Stay at Work program
  + How to phrase things so that they make sense to the CM?
  + Staying active speeds recovery & helps prevent disability. Decreases chronic pain.
  + What are Job Mods?
  + Reasonable Accommodations? & Reasonable Accommodations process? How is that different from ADA?
  + How to do an APF usefully? Change the objective findings? Show progression of recovery? Plain & useful language? Attending Provider’s Return to Work Desk Reference <https://lni.wa.gov/forms-publications/F200-002-000.pdf> Pages 20-22. Approximate Weights of Common Objects
  + Not waiting until MMI before determining whether able to RTW at JOI.
  + The utility – or lack thereof – of an FCE?
  + What to expect from quality Work Conditioning or rehab? L&I Physical Medicine Best practices Quick ref card <https://www.lni.wa.gov/forms-publications/F245-464-000.pdf>
  + Graduated RTW vs Work Conditioning or Work hardening?
  + LEP options & advantages? Combining LEP & Work Conditioning?
  + Treating Barriers to Recovery vs adding Psychiatric diagnoses to claim
  + Using behavioral health codes – same as PGAP.

Don’t just take my word for it – check out L&I resources. My L&I.

Filing claims, APF’s, Guidelines, PGAP (Activity Coaching), Provider Handbook. https://lni.wa.gov/patient-care/workshops-training/attending-provider-resource-center/

Referral forms for consults & rehab available on L&I website that focus on function. Rehab referral form link <https://lni.wa.gov/patient-care/health-care-incentive-programs/physical-medicine-best-practices-project#best-practices>

How can AP’s bill so VRC adds to the bottom line – doesn’t detract from it?

Billing for time spent with the VRC via phone, email, or in person

Billing for any form completed, including forms the VRC is trying to get AP to do that the CM has requested.

<https://lni.wa.gov/patient-care/_docs/COHEFeeScheduleJuly2019Final.pdf>

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For fees and policies on billable services related to COHE best practices and available to all providers (not exclusive to COHE), please refer to L&I’s Medical Aid Rules & Fee Schedule (MARFS)for fees and policies.

These codes include:

<https://www.lni.wa.gov/forms-publications/F245-414-000_2019.pdf>:

•Medical conference to coordinate care, patient NOT present:

* 99367 $159.44 (physician)
* 99366 $79.63, 99368 $68.62 (ARNP, PA, psychologist)

•Medical conference to coordinate care, patient Present:

* 992XX (physician) Appropriate E&M code, 25 min = $201.34, 40 min $271.26
* 99366 (ARNP, PA, psychologist) $79.63

•Telephone call consultation regarding care of injured worker (COHE use modifier -32 for calls to employers):

* 99441 $26.54, 99442 $49.85, 99443 $73.80 (physician, based on time)
* 98966, 98967, 98968 (ARNP, PA, psychologist, same $)

•Secure online communication (COHE use modifier -32 for secure communication to employers):

* 99421 = $28.49, 99422 = $56.32, 99423 = $91.28 (physician)
* G2061 = $22.01, G0262 = $39.49, G2063 = $61.50 (ARNP, PA, psychologist)

* Activity Prescription Form (APF): 1073M $53.41
* Review Functional Capacity exam report 1097M $53.41
* Review first JA or job description1038M $53.41
* Review subsequent JA’s 1028M $40.07
* Review IME report 1063M $41.09
* Written response to a return to work request, up to 1/day 1074M $32.87

ROA for COHE provider (code 1040M) within 2 business days (standard rate x 150%) = $61.63. ($20 more than standard rate)

online filing via FileFast provides an additional $10 incentive.

COHE Center of Occupational Health & Education

Check “Find a doc”for \* marking COHE providers. Or ask.

info from L&I **Core COHE services**

* Coordinate worker care for the first year of treatment.
* Engage with employers about return to work options.
* Train providers on best practices.
* Help providers implement best practices in their office(s).

<https://lni.wa.gov/patient-care/health-care-incentive-programs/centers-of-occupational-health-education-cohe>

[https://lni.wa.gov/patient-care/docs/COHEFeeScheduleJuly2019Final.pdf](https://lni.wa.gov/patient-care/_docs/COHEFeeScheduleJuly2019Final.pdf)

If you treat workers and would like access to core COHE services, reach out to the appropriate COHE:

[COHE at UW Medicine Valley Medical Center of the Puget Sound](https://www.valleymed.org/cohe/) enrolls providers in UW Medicine Valley Medical Center, and parts of King and Pierce counties.

[COHE Community of Eastern Washington](https://www.gocohe.com/)**enrolls providers in all of central and eastern Washington.**

[COHE at UW Medicine Harborview Medical Center](https://www.uwmedicine.org/locations/occupational-and-environmental-harborview) enrolls providers in UW Medicine Harborview.

[COHE at The Everett Clinic](https://www.everettclinic.com/medical-departments/occupational-medicine) enrolls providers in The Everett Clinic.

[COHE Alliance of Western Washington](https://www.chifranciscan.org/health-care-services/cohe.html)**enrolls providers in all western Washington counties.**

[COHE at Kaiser Permanente](https://wa.kaiserpermanente.org/html/public/specialties/occupational-health) enrolls providers in Kaiser Permanente of Washington.