Emergency Responders Health Center

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July 9, 2018

Idaho Industrial Commission
Attn: Kamerron Monroe, Commission Secretary
PO Box 32720
Boise, ID 83720-0041

re: Response to Annual Fee Schedule Review

Dear Commission Secretary Monroe,

As the Founder, Medical Director, and lead practicing physician of an independent primary care clinic, I am writing in support of increasing the Workers' Compensation (WC) medical fee reimbursement for primary treating providers.

Our Clinic, Emergency Responders Health Center (ERHC), was founded in 2004 to provide specialized primary care and occupational medicine services to first responders. ERHC provides comprehensive annual wellness examinations, continuity care, mental health services, and Workers' Compensation injury care for active-duty members of fire departments, law enforcement agencies, and paramedic/EMS agencies. We currently serve a population of more than 1,500 patients representing 20 first responder departments across the Treasure Valley and throughout Idaho. Based on occupational risks and exposures, our patients present an elevated likelihood of experiencing an injury or condition covered by WC. Because our patients are public servants who place their health at risk to protect others, their injury exposure and medical care is a matter of public concern.

In providing WC care on a weekly basis, I can personally attest to the increased time devoted both to patient care and administrative follow-up in these cases, for musculoskeletal injuries as well as acute medical events. During each new evaluation, clinicians must be extremely thorough and capture information for medical, WC insurance, *and* employment purposes. Our engagement includes:

✓Obtaining and recording a detailed history of the event;
✓Performing an in-depth medical examination and workup to assure an accurate and complete diagnosis;
✓Providing in-depth patient education regarding the nature of the injury/condition and the importance of prescribed rehabilitation;
✓Providing referrals to physical therapy or medical specialists;
✓Providing treatment and follow-up, and/or coordination of care among specialists and therapists;
✓Providing detailed progress notes to the respective Workers' Compensation agency (i.e. Idaho State Insurance Fund or Intermountain Claims), following each initial evaluation and every follow-up appointment. (Administrative burden unique to WC cases.)
✓Communicating with the patient's Department/employer on an ongoing basis regarding patient progress, recommended work status, restrictions/special accommodations and anticipated 'return to duty' date. (Administrative burden unique to WC cases.)

Our primary care practice has incurred unreimbursed administrative burdens, as well as unbillable provider labor, in the management of WC cases. We rely on medical reimbursement fees for billable WC office visits to offset these expenses; the current rate structure has been inadequate to cover costs. For example:

- The additional administrative/paperwork burden for managing a WC encounter, compared with a non-WC encounter, ranges from 20-30 minutes for simple cases to several hours for complex cases. This burden is shared by our medical providers, Medical Assistants, and Front Office personnel.
- When a primary care practice serves as a true medical home, the patient's provider may continue to coordinate WC care among all specialists and therapists engaged in a patient's case, even when the course of treatment does not require the primary provider to see the patient. In these cases, the provider's continued engagement is not billable, representing unreimbursed medical expenses.

Workers' Compensation cases require the completion of a medical release form to be submitted to the patient's employer the *same day of their appointment*. (This is not a requirement in non-WC cases, and therefore represents a unique administrative burden.) ERHC collaborates with more than 20 fire, police, and EMS agencies, each of whom has specific requirements for form content, presenting significant challenges in managing multiple forms in the care of multiple patients. Recently, ERHC invested in the development of a universal, software-based release form that interacts with our Electronic Medical Record (EMR) system, which can be readily auto-populated by the provider following a WC appointment. This *Release to Return to Duty* form, along with a companion *Patient Authorization to Release Information* form, was vetted through key first responder agencies for approval. This form will allow ERHC to expedite communications to Departments/employers who rely on us for patient progress updates, and was developed by a tech specialist at a cost to our Clinic. (Please refer to draft attached; the final form will be deployed within 3 to 4 weeks.)

I have attached case studies which further illustrate the process, level of time/engagement, and long-term efforts to provide high-quality medical care for patients involved in WC cases. These examples include a Simple Case (typical ankle injury) and a Complex Case (compounded injuries). I would be happy to discuss these cases in more detail, or provide additional case studies.

ERHC is honored to provide WC care to our first responder patients. We thank you for your consideration of our concerns and perspective as the Commission completes its Fee Schedule Review. Please feel free to contact me directly with any additional questions.

Sincerely,

Rob Hilvers, MD
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Family Medicine, Sports Medicine, Emergency Medicine

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Case #1 | Simple WC Case | Ankle Injury, Typical Example

Patient presents with acute ankle injury. Components of this case include:

a. Detailed History of Injury: Document description of emergency response/training drill scenario, specific mechanism of injury, and any post-injury care provided prior to medical visit.
b. Physical Examination: Thorough examination and diagnostic workup to establish early correct diagnosis, which is the most important factor in determining appropriate treatment course, avoiding delayed complications, and providing patient's Department/employer with estimated 'return to duty' timeframe.
c. Treatment Course. Early referral for physical therapy (deep tissue myofascial modalities, therapeutic exercises), advanced imaging modalities (as indicated) or specialty referral.
d. Follow-Up. Define follow-up timeline to assure patient is making appropriate progress.
e. Communication with Patient: In-depth conversation during initial evaluation and follow-up appointments to assure patient understanding of injury and the importance of rehabilitation and compliance with follow-up.
f. Communication with Department: During initial evaluation and each follow-up office visit, an updated Department-specific medical release form is completed by the provider, recommending work status (active duty, modified light duty or off-duty), outlining any restrictions or special accommodations, and providing estimated date of medical release to active-duty status.

Case #2 | Complex WC Case | Severe Low Back and Hip Injury (based on an actual, ongoing case):

Brief Description: First responder suffered high-impact incident 22 months ago, resulting in significant injury to the lumbosacral spine and hip. Patient attempted to manage injuries (self-care) for 6 months, but became progressively disabled and eventually unable to perform essential job tasks. Patient was seen by Dr. Hilvers 6 months after initial date of injury for first medical evaluation. An appropriate and detailed workup demonstrated severe low back and hip injuries. The patient's condition failed to respond to conservative treatment modalities including extensive physical therapy and injectional therapy modalities, and eventually required lumbosacral spine fusion and hip arthroscopic debridement. Following referral to a subspecialist, ERHC did not see this patient in Clinic between June 2017 and June 2018, and is no longer considered the primary provider for the WC case. However, as the Department physician of choice, Dr. Hilvers has been asked to continue to manage the patient's case, and has continued to coordinate care between surgical offices, physical therapy, and the patient's Department/employer. ERHC has spent extensive time communicating with the patient's spine surgeon, hip surgeon, physical therapy provider, and Department chief, toward enabling the patient to resume active-duty status following extensive rehabilitation. The case is currently ongoing, with anticipated return to duty Fall 2018.

Comments: In more difficult cases, I often spend considerable time as a primary care provider coordinating care between subspecialists and therapists, and communicating information between the patient and his/her employer in a manner that is both HIPAA-compliant as well as responsive to the unique first responder culture. In cases referred to specialists, I am typically no longer considered to be the treating physician; therefore it is difficult for our Clinic to bill for additional coordination of care and follow-up office visits, which are often required by Departments before final medical release to return to duty. This unreimbursed labor could be offset by medical fee reimbursement for in-office WC visits.