COMMONWEALTH OF KENTUCKY

DEPARTMENT OF WORKERS' CLAIMS

SECOND REPORT TO INTERIM JOINT COMMITTEE ON ECONOMIC DEVELOPMENT AND WORKFORCE INVESTMENT

AUDIT OF PHYSICIANS PERFORMING EVALUATIONS PURSUANT TO KRS 342.316 (3)(b)4.c

July 1, 2020

Robert L. Swisher, Commissioner

Introduction

Upon the filing of an application for resolution of claim for occupational disease (Form 102) with the Department of Workers' Claims ("DWC"), the DWC Commissioner shall assign the claim to an administrative law judge and promptly refer the employee to a duly qualified "B" reader physician who is licensed in the Commonwealth and is a board-certified pulmonary specialist for a medical examination.[1]

As amended in 2018 by House Bill 2 ("HB 2"), KRS 342.316(3)(b)4.c. provides that the Commissioner shall develop a procedure to audit annually the performance of physicians and facilities selected to perform such examinations. The audit shall include an evaluation of the timeliness and completeness of examination reports and the frequency at which the physician's classification of an X-ray differs from those of the other physicians "of that X-ray."[2] The statute further requires the Commissioner to remove a physician from selection consideration if the physician consistently renders incomplete or untimely reports or "if the physician's interpretations of X-rays are not in conformity with the readings of other physicians of record at least fifty percent (50%) of the time."[3] The report "required under this subdivision" shall be provided to the Interim Joint Committee on Economic Development on or before July 1, 2019, and on or before July 1 of each year thereafter.[4] This report is submitted in compliance with the statutory mandate. Claims data reflect activity from June 1, 2019 through May 31, 2020.

Chest Radiography and "B" Readers

Income and retraining benefits for occupational disease resulting from exposure to coal dust are payable based on radiographic evidence (chest X-ray) demonstrating the presence of coal workers' pneumoconiosis.[5] The level of income benefits or qualification for retraining benefits is determined by reference to the radiographic classification of the disease and may be further impacted by spirometric evidence of respiratory impairment.

Radiographic classification of coal workers' pneumoconiosis is provided by a physician ("reader") interpreting a chest X-ray by comparison to a standard set of X-rays developed by the International Labour Organization, a specialized agency of the United Nations. The International Labour Office ("ILO"), the research arm of the International Labour Organization, publishes guidelines on how to classify radiographs for pneumoconiosis in order to describe and codify radiographic abnormalities of pneumoconiosis in a simple, systematic, and reproducible manner.[6]

The classification system categorizes opacities as either small (up to 10 mm) or large (greater than 1 cm). Small opacities are further subdivided by size, shape (round or irregular), and profusion (frequency). Profusion of small opacities (so-called "simple" coal workers' pneumoconiosis) is classified on a 4-point

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[1] KRS 342.316(3)(b)4.b. (2019).
[2] KRS 342.316(3)(b)4.c. (2019).
[3] *Id.*
[4] *Id.*
[5] KRS 342.732(1) (2019).
[6] *See* U.S. Centers for Disease Control and Prevention, The National Institute for Occupational Safety and Health, *Chest Radiography: ILO Classification*, https://www.cdc.gov/niosh/topics/chestradiography/ilo.html (last visited June 26, 2019).

major scale (0-3) with each major category divided into three, giving a 12-point scale between 0/- and 3/+.[7] The 12-point scale is depicted in the following chart:

0/-	0/0	0/1
1/0	1/1	1/2
2/1	2/2	2/3
3/2	3/3	3/+

Large opacities (so-called "complicated" coal workers' pneumoconiosis or progressive massive fibrosis) are classified as category A (for one or more large opacities the combined dimension of which does not exceed 5 cm), category B (for one or more large opacities the combined dimension of which exceeds 5 cm but does not exceed the equivalent area of the right upper lung zone), or category C (size is greater than category B).[8]

The intent of the ILO in promulgating a standard classification system for systematically describing and recording the radiographic appearances of abnormalities created by the inhalation of dusts was to achieve uniformity among readers interpreting chest X-rays. Initially, however, readers disagreed with each other to such an extent that The National Institute of Occupational Safety and Health ("NIOSH") established the "B" reader program to identify and certify physicians who demonstrate the skill and expertise to provide accurate ILO classifications.[9] Physicians wishing to become certified "B" readers must pass an examination demonstrating technical capability and must re-test every four years to maintain the certification.[10]

Evaluation Process Prior to *Vision Mining, Inc. v. Gardner*[11]

Prior to the Kentucky Supreme Court's decision in *Vision Mining, Inc. v. Gardner*, an employee filing a claim for coal-related occupational pneumoconiosis was required to submit, with the application, a chest X-ray and report containing the interpretation of that X-ray by a NIOSH-certified "B" reader.[12] In interpreting the X-ray, the "B" reader was required to use the latest ILO classification system and complete an ILO classification report.[13] The employer was granted forty-five (45) days from the date the claim was assigned to an administrative law judge to have the employee examined by a physician of the employer's choice and file with the Commissioner an X-ray interpretation by a "B" reader.[14] If the readings were not in consensus, the Commissioner sent both X-rays to a panel of three "B" readers (many of whom were licensed outside the Commonwealth of Kentucky) selected randomly from a list maintained for that purpose. "Consensus" was reached between two chest X-ray interpreters when their classification met one of two criteria: each found either category A, B, or C progressive massive fibrosis, or findings with

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[7] *Id.*

[8] *Id.*

[9] *See* U.S. Centers for Disease Control and Prevention, The National Institute for Occupational Safety and Health, *Chest Radiography: The NIOSH B Reader Program*, https://www.cdc.gov/niosh/topics/chestradiography/breader.html (last visited June 26, 2019).

[10] *Id.*

[11] 364 S.W.3d 455 (Ky. 2011).

[12] *See* KRS 342.316(3)(a)1. (2017).

[13] KRS 342.316(3)(b)1. (2017).

[14] KRS 342.316(3)(b)4.d. (2017).

regard to simple pneumoconiosis were both in the same major category and within one minor category (on the ILO 12-point scale) of each other.[15] Each of the panel members selected the higher quality film and reported the interpretation of that film. The Commissioner determined if two of the X-ray interpretations filed by the "B" reader panel were in consensus. If consensus was reached, the Commissioner forwarded copies of the report to all parties as well as notice of the consensus reading which was considered as evidence. The consensus classification was presumed to be the correct classification of the employee's condition unless overcome by "clear and convincing evidence."[16] If consensus was not reached, an administrative law judge decided the claim on the evidence submitted.[17]

The so-called "consensus process" of KRS 342.316 was declared unconstitutional by the Kentucky Supreme Court in *Vision Mining*. The Court found that the evidentiary procedure (the consensus panel process) and standard for adjudicating coal workers' pneumoconiosis claims violated the Equal Protection guarantees of both the U.S. and Kentucky Constitutions.

Evaluation Process Subsequent to *Vision Mining*

Following the issuance of the *Vision Mining* opinion in December 2011, there was initial uncertainty about the process by which statutorily required[18] occupational disease evaluations/examinations would be conducted in coal workers' pneumoconiosis claims. The DWC had existing memoranda of agreement with the University of Kentucky Medical Center and the University of Louisville School of Medicine to perform medical evaluations of workers who had been injured or were affected by occupational diseases covered by KRS Chapter 342. The DWC experienced significant delays in dealing with both of those facilities, particularly when attempting to schedule evaluations for coal workers' pneumoconiosis claimants and receive the evaluation reports. As of January 2014, there was a backlog of more than seven hundred (700) coal workers' pneumoconiosis claims awaiting evaluation examinations. As a result, the DWC entered into agreements with Coal Miners' Respiratory Clinic of Greenville (Muhlenberg County Hospital)/ Muhlenberg Community Hospital, Inc., and B.T. Westerfield, M.D./Commonwealth Respiratory Consultants to perform medical evaluations of workers affected by occupational diseases pursuant to KRS 432.315 and KRS 342.316(3)4.b. The agreements provided that "for occupational lung disease claims, X-ray reading shall be performed by evaluators having current 'B-reader' certification." From 2014 through July 14, 2018, the Coal Miners' Respiratory Clinic and Commonwealth Respiratory Consultants performed the vast majority of DWC-referred evaluations with the University of Louisville performing relatively few and the University of Kentucky performing none.

Because the consensus panel process of having three appointed physicians review the same X-ray was no longer valid, the DWC no longer required the parties to file their own original X-rays into evidence as part of the claim adjudication process. Instead, the parties and administrative law judges relied on the medical reports of the physicians, which included the ILO form and classification. The physicians conducting evaluations on referral by the DWC performed their own X-rays and based their expert opinions on those X-rays without reviewing the X-rays of the litigants.

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[15] *See* KRS 342.316(3)(b)4.f. (2017).
[16] KRS 342.794(2) (2017).
[17] KRS 342.316(3)(b)4.e. (2017).
[18] KRS 342.315(1) (2017).

HB 2

On March 30, 2018, Governor Matt Bevin signed HB 2 into law. HB 2 amended KRS Chapter 342 regarding the performance of DWC-referred medical evaluations in occupational disease claims. Effective July 14, 2018, the Commissioner is required to refer the employee to a duly qualified "B" reader physician who is licensed in the Commonwealth and is a board-certified pulmonary specialist pursuant to KRS 342.315 and 342.794(1).[19] Of the evaluators to whom the DWC referred claims prior to HB 2, only Dr. Westerfield had the requisite qualifications. As a result, the DWC terminated the memorandum of agreement with Miners' Respiratory Clinic. The Commissioner then reviewed directory information published by NIOSH to identify Kentucky-based certified "B" readers and compared that list to the list of physicians certified by the American Board of Internal Medicine in the subspecialty of pulmonary medicine to identify physicians meeting those qualifications. The resulting list of physicians was cross-referenced against records published by the Kentucky Board of Medical Licensure to confirm licensure in Kentucky. Five (5) individuals with the necessary qualifications were identified.[20] On April 10, 2018, the Commissioner wrote to each of those physicians to determine their willingness in participating in the DWC referral/evaluation program. Initially, only Dr. Byron Westerfield was willing to participate. Later, Dr. Bruce Broudy agreed to participate. Subsequently, the Commissioner was informed of two (2) other physicians who, though not Kentucky residents, nonetheless met all three (3) qualifications.[21] Neither of those two (2) physicians, however, responded to a July 3, 2018 written inquiry from the Commissioner regarding their willingness to participate in the referral/evaluation program. In April 2020, Dr. Srinivas Ammisetty informed the Commissioner that he was willing to participate in the CWP referral/evaluation program and that he had the requisite qualifications for doing so. The Commissioner confirmed Dr. Ammisetty's qualifications and entered into a Memorandum of Understanding with Dr. Ammisetty regarding his participation in the referral/evaluation program. As of June 2020, the DWC has begun to refer claimants to Dr. Ammisetty.

Evaluator Performance Audit

As mentioned above, the Commissioner is required to audit annually the performance of physicians/facilities performing occupational disease evaluations on referral from the DWC. Three (3) areas are to be monitored: (1) completeness of reports; (2) timeliness of reports; and (3) the frequency with which a physician's interpretation of an X-ray are not in conformity with that of other physicians interpreting that X-ray. In order to assess the performance of the evaluators, the DWC reviewed each report upon receipt and maintained a database/spreadsheet for this purpose. With respect to the completeness, both evaluators submitted reports deemed complete in <u>every</u> referral.

With respect to timeliness, reports are to be filed within fifteen (15) days after the examination. From June 1, 2019, through May 31, 2020, Dr. Westerfield submitted sixty-four (64) reports, ninety-four percent (94%) of which were filed within fifteen (15) days of the examination. The reports filed after fifteen (15) days were submitted, on average, twenty (20) days after the examination. For the same period, Dr. Broudy submitted seventy-seven (77) reports, seventy-six percent (76%) of which were filed within fifteen (15) days of the examination. The reports filed after fifteen (15) days were submitted, on average, twenty-

[19] KRS 342.316(3)(b)4.b. (2019).

[20] Those five (5) individuals are Glen Ray Baker, M.D., Bruce Charles Broudy, M.D., Thomas McElroy Jarboe, M.D., Jeff W. Selby, M.D., and Byron Thomas Westerfield, M.D.

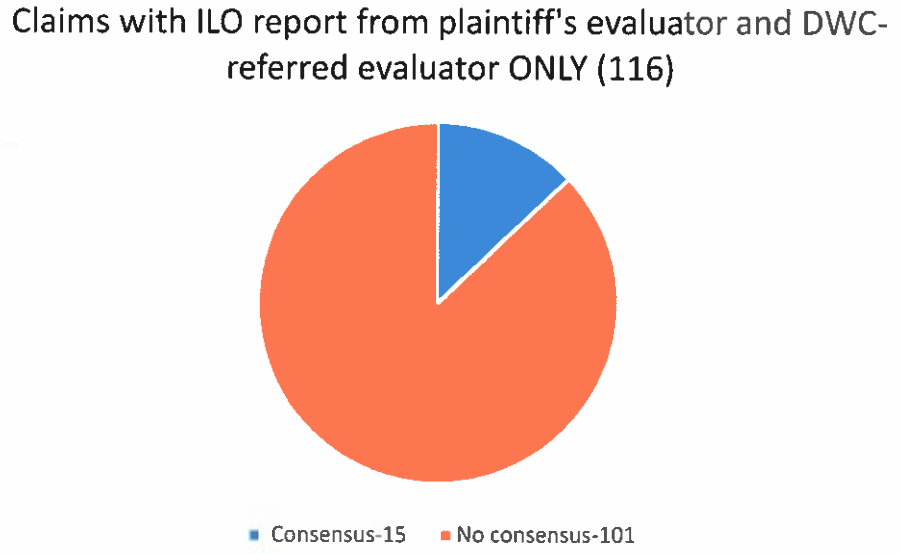
[21] Those two (2) individuals are James E. Lockey, M.D., and David M. Rosenberg, M.D.

one (21) days after the examination. The receipt of evaluation reports beyond fifteen (15) days from the date of examination has not materially delayed the resolution of any claims. Both evaluators, therefore, have substantially complied with the completeness and timeliness requirements.

As set forth above, the evaluating physicians do not review and interpret X-rays other than their own. Therefore, a factual basis for determining the frequency with which an evaluator's interpretation of an X-ray differs from that of the interpretation of other physicians "of that X-ray" does not exist. In amending KRS 342.316(3)(b)4.c. to require comparison of X-ray interpretations, the General Assembly essentially imported the same provision from the pre-HB 2 version of KRS 342.794.[22] While such analysis was possible when three (3) members of a consensus panel were reading the same X-ray, once the practice of each physician (parties' experts and DWC-referred evaluators) reviewing and interpreting only his/her own X-ray was implemented post-*Vision Mining*, this provision was essentially nullified. That process has not changed post-HB 2. The frequency with which an evaluator's interpretation of an X-ray differs from that of other physicians reviewing that X-ray cannot be determined.

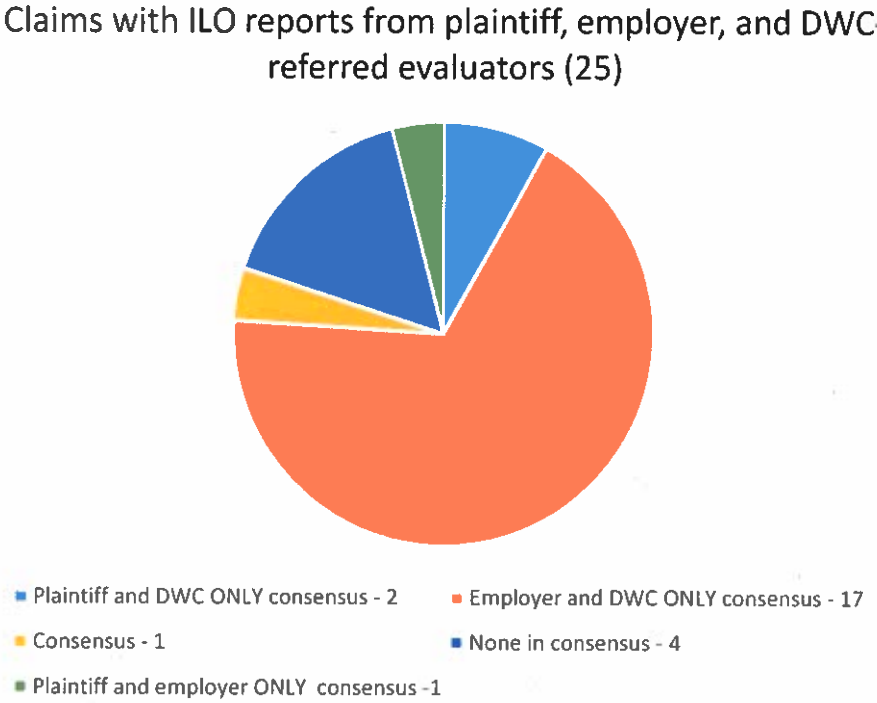
Statistical Analysis

Although the Commissioner is unable to report on the frequency with which an evaluator's interpretation of an X-ray differs from the interpretation of that X-ray by other physicians, it is possible to provide statistical analysis of post-HB 2 coal workers' pneumoconiosis claims activity. From June 1, 2019 through May 31, 2020, Drs. Westerfield and Broudy submitted one-hundred forty-one (141) reports (collectively) in claims referred by the DWC for examination/evaluation. In one-hundred sixteen (116) of those claims, only the plaintiff's evaluator and the DWC-referred evaluator filed ILO reports. Of that group, the evaluators' interpretations were in consensus (*i.e.*, positive for complicated coal workers' pneumoconiosis or in the same major category and within one minor category for simple coal workers' pneumoconiosis) in fifteen (15) claims. In the remaining one-hundred one (101) claims, there was no consensus.



[22] See KRS 342.794(4) (2017).

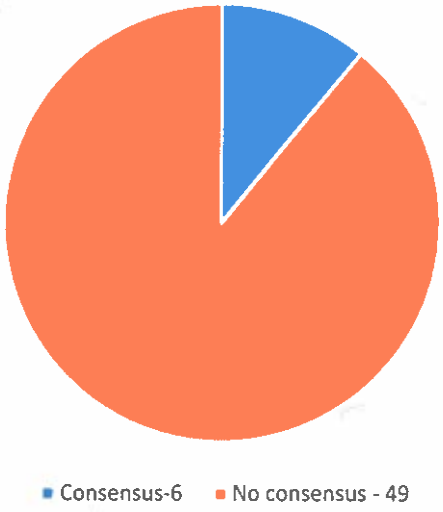
In twenty-five (25) claims, the plaintiff's evaluator, the employer's evaluator, and the DWC-referred evaluator filed ILO reports/interpretations. In two (2) claims, the DWC evaluator was in consensus with only the plaintiff's evaluator. In seventeen (17) claims, the DWC evaluator was in consensus with only the employer's evaluator. In one (1) claim, only the plaintiff and employer interpretations were in consensus, in one (1) claim, all were in consensus, and in four (4) claims, no interpretations were in consensus.



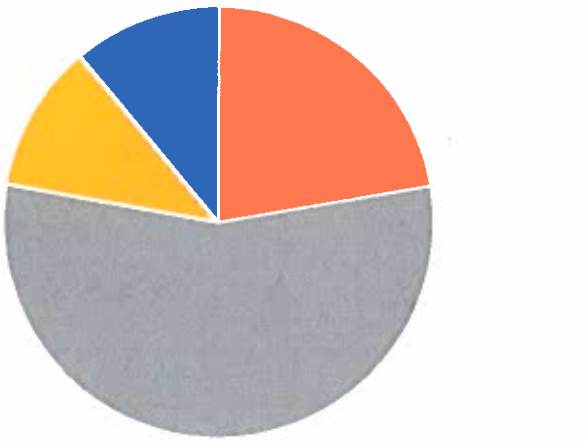
In twenty- two (22) of the one-hundred forty-one (141) claims referred for evaluation since June 1, 2019, the plaintiff's evaluator interpreted an X-ray or CT scan as positive for complicated coal workers' pneumoconiosis or progressive massive fibrosis. In nine (9) of those claims the DWC evaluator's interpretation was in consensus, while in ten (10) the DWC evaluator's interpretation was positive for simple coal workers' pneumoconiosis.

Individual Evaluator Metrics

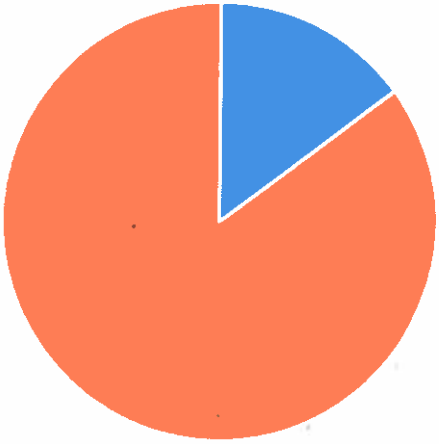
Dr. Westerfield's evaluations with only plaintiff filing ILO report (55)



Dr. Westerfield's evaluations with both parties filing ILO reports (9)



Dr. Broudy's evaluations with only plaintiff filing ILO report (61)



Dr. Broudy's evaluations with both parties filing ILO reports (16)