

# Medical Advisory Committee

## Meeting Minutes

September 24, 2019

Tennessee Room  
220 French Landing Drive  
Nashville, TN 37243

### **Members:**

Rob Behnke, Cracker Barrel  
Misty D. Williams, R.N. Travelers  
Lisa Bellner, MD PM&R  
Cerisia Cummings, DO Bridgestone Clinic  
Ginny Howard, Zurich  
David Tutor, MD Occ Med  
Keith Graves, DC  
John Brophy, MD Neurosurgeon  
James Gregory Kyser, MD Psychiatrist  
Jeffrey Hazlewood, MD PM&R  
Robert Snyder, MD, Medical Director  
Troy Haley, Attorney, BWC  
Mark Finks, Attorney, BWC  
Suzy Douglas, RN BWC  
Jennifer Schneider, BWC  
Suzanne Gaines, BWC

### **Guests:**

Everett Sinor, Brentwood Services  
Judy Bobbitt, Tennessee Orthopedic Alliance  
Roy Johnson, MD Occ Med  
Melissa Clark, MTOEMC  
Nancy Kelly, Averitt  
Theresa Schnebel, Averitt  
Desiree Anderson, SGS  
Carter Phillips, MNA GR  
Jeri Vincent, Certified Medical Case Manager  
Faith Parrish, RN Vanderbilt  
Terry Horn, RN Vanderbilt  
Katherine Moffat, TNAPA  
Toni McCaslin, HealthTrac  
Susan Stewart, Aetna  
Luis Garcia, \_\_\_\_\_

### **Via telephone:**

James Talmage, M.D.  
David Price, Preferred Medical  
Jonathan May, Morgan & Morgan

## Call to Order

The meeting was called to order at 1:03 PM by the Chair, Dr. Tutor.

## Quorum

A quorum was confirmed as present (1/3 of the members needed, 12/16 members present).

## Approval of Minutes

Dr. Brophy said that some of the language in the 7/16/2019 minutes needed to be changed. Action: *The minutes of the 7/16/2019 meeting were accepted with revisions and approved.* Correction will be posted.

There was a reminder for members to complete the Conflict of Interest forms.

## Old Business

### **ODG:**

Dr. Snyder said that the ODG was very active over the last six months. He distributed via e-mail to the members handouts showing changes in April, May and June. There were no comments upon the changes at that time.

Dr. Brophy observed that the specifics of screw fixation for posterior cervical fusion are now the standard of care. Using 20 year old data does not reflect current information or complication rates. Drs. Talmage, Brophy and Snyder will communicate to get specific language to send to ODG.

In a separate issue, Dr. Hazlewood reported on the findings of nerve radiculopathy and the definition of pain in impairment ratings and that its exclusion understates the analysis of the impairment.

Dr. Hazlewood said that pain should also be a determining factor, not just objective damage. Dr. Snyder and Dr. Hazlewood discussed issues of the correlation of pain to damage and weakness. Dr. Hazlewood said the pain pattern should be consistent to the anatomic radiculopathy.

Turning to a different but related topic, Dr. Hazlewood said that there should be an option in acute or sub-acute cases for an initial epidural even if there is no objective radiculopathy. Dr. Brophy and Dr. Bellner concurred. Dr. Bellner observed that there was a need for more precise definitions. Other questions that were raised about the ODG guidelines for epidurals:

If after an epidural, pain cessation does not last six months, can another epidural be given?

If pain keeps coming back, how often could/should an epidural be done?

Dr. Tutor questioned if there had been any challenges (UR Appeals). Drs. Talmage and Snyder said yes with mixed determinations based upon the record. At the last meeting a summary of those determinations was presented confirming the mixed results of the appeals.

April, May, June, July and August updates were accept except for post cervical infusions and epidural questions to be worked on by Dr. Snyder. Action: *There were no dissenting voice votes.*

### **Access to Medical Care:**

Out of the Conference in August came 13 observations for discussions. The first eight have been previously discussed.

In-house and other clinics: Are there better outcomes with In-house/employer clinics and emergency clinics as opposed to more conventional medical settings? The general agreement was, that properly run, they are an important, effective, cost-effective and efficient way of treating many employee conditions. Observations:

In-house clinics are for minor injuries do not necessarily require a panel. Beyond first aid treatment, the patient needs a panel.

The injured worker should always be given a choice without coercion.

Pressure on employer clinics to keep the employee for treatment would be hard to regulate but is a risk.

Employees who choose to be treated outside of the employer/company clinic should be free to do so.

Is there anything the Bureau can do to enhance access?

Injured workers should always be encouraged to report injuries.

Urgent care clinics might treat longer than they should when the patient really needs specialized care.

The panel can be the safety net and should be considered and/or given if treatment is extended since the three day rule places restriction on the employer/insurer. Some insurer policy is that the patient must have a panel. This policy protects the chosen physician and carrier if the treating physician does not give an answer that patient wanted regarding causation or treatment.

Alternate providers: with the new fee schedule increases, encouragement of these extenders has some financial incentives. As of September 10, 2019: Psychologists—85% to 130% of Medicare allowable. PAs and APNs—160% Medicare allowable. Per the statutes, the authorized treating physician *must* be a physician (DO, MD, or DC), as the primary caregiver responsible for the treatment under the claim.

There are access limitations in specialty care for the state was raised again. (This is a corollary to the use of extenders in many practice settings). There is a need for practitioners of such specialties as neurology and pulmonology to participate in worker's compensation. There is fear of depositions and questions about causation. Mr. Behnke noted that litigation has declined in the past years. There could be financial incentives but silent PPO's are still a problem.

Information and communications: Although an access to care issue, there was not any particular action item brought by the committee members. Telehealth is being addressed elsewhere.

Statistical outcomes: Mr. Sinor observed that there is this gap between group health and worker's compensation but it has many facets, not easily to address in this review.

Fairness: What is wanted is overall fairness in the system processes but the committee did not come up with any noteworthy solutions.

## **Medical Fee Schedule**

As of 9-10-2019 updates to the Medical Fee Schedule are in effect. The Bureau website reports this.

## **Medical Marijuana/ CBD:**

The handout was noted. In response to a question, no case has been known to come before the courts regarding medical necessity of medical marijuana or CBD oil. Some cases have come to the Utilization Review. Denials were upheld for requests for Marinol since the FDA does not approve it for use outside of AIDs and cancer. A patient initiated appeal for CBD oil, not recommended or "prescribed" by the

physician, was also denied. The medical notes on that case stated that the patient was taking it. Medical necessity is hard to judge if there is no algorithm, dosage guidelines or established medical indications.

### **UR "bad":**

Dr. Snyder reported that over the last month, letters of warning were sent out in these cases:

- 1) A UR physician ignored treatment guidelines.
- 2) Physician misquoted the treatment notes of the physical examination letter in making his decision.
- 3) A physician used wrong section of guidelines to deny treatment.

### **UR Analysis:**

In the summary report for four years, no trends or patterns can be ascertained.

A question about a pattern of denials was raised. Can the Medical Directors investigate as to whether there patterns by reviewing physician or others when they overturn denials?

### **UR Denials Analysis:**

Dr. Snyder and Dr. Talmage did a two month study. Could they categorize the reasons for overturning denials?

In 125 assessments in May and June of 2019:

- 1) 8% were for UR or other technical criteria.
- 2) 26% were for errors in documentation.
- 3) 66% of cases were iatrogenic:
  - a) No current medical evidence for the treatments being recommended.
  - b) The physician was over prescribing, duplicating, or ordering medicine without stopping current medication.
  - c) Patients had reached plateaus with no additional improvement from treatments already rendered; ordering further treatment would seem to do no good.

Dr. Snyder made some further observations. One cannot generalize Utilization Review, but some treatments are not appropriate. Data will come to UR group in more detail. The group is also looking at insurance. Internal data estimates that there are over 15,000 URs done for TN claims yearly. Fifty percent of referrals to UR end up denied ("non-certified"). 1,500 appeals are file with the Bureau. That means that there are roughly 6,500 treatments not received; does this harm the patient?

Others made further observations. When physician/patient and insurer/employer disagree, it can become a legal issue. There needs to be enough separation between the company and the URO to not seem like a conflict. The patient must have enough knowledge and be relatively easy to appeal a decision.

This data will be further looked at by the UR Working Group.

### **Emergencies and Drugs:**

Dr. Snyder made points about Emergency Medical Services and drug tests involving the Drug Free Workplace injuries or actually any employer. If a person gets a serious injury with large medical bills, trauma centers do not want to test for drug use because if drugs are found, the insurer won't pay. This

situation is being looked at. What are the possible implications? It is a question of fairness. Who should pay in this situation? Further discussion may follow at a later date.

### **NCCI Report:**

The summary of the Drug Formulary Report was included for the members' review in the e-mails that had been sent.

### **Mental Illness in WC:**

Injured workers have a significant incidence of mental illness before injury. The carrier does not want to take on the burden of psychiatric diagnosis and ongoing treatment. Dr. Kertay has suggested a method and coding that was distributed. It raised questions for which each individual insurer and patient will have to address. How should patients be supported who need psychological treatment in a way that will improve the patient's outcome? There are also not enough psychologists who treat Worker's Comp patients.

### **UR Working Group:**

The first meeting was August 30 with recommendations for obtaining additional information, 14 of the 16 members in attended in person or by phone. They asked for further research, with the next meeting to be scheduled by "Doodle Poll."

### **Telehealth Working Group:**

Mark Finks reported on Telehealth and the August 19<sup>th</sup> meeting. Twenty-nine people attended in person and on the telephone. The next meeting will be October 4th at 10:00 AM in the Tennessee Room.

## **New Business:**

### **Meetings:**

The House Government Operations Committee Chair has written to all departments and agencies to insure transparency and openness as much as possible. Below is the response that was presented to this committee:

*For our committees, MPC and MAC, there are no limits to attendance or speaking. We do ask for prior notification of attendance because the security guards at the entrance want a list. No one has been turned away even if they have not replied in advance. Future meeting times are announced at the end of the prior meeting. Changes as well as notifications are communicated to all on our e-mail notification lists. In addition, all meetings are posted on our website and on the state's website as soon as we have confirmed the location and time of the meeting. This is no later than seven days in advance and usually more than four weeks. Call-in arrangements are available for all of these meeting. Because of limits on the line, we ask to know the week prior to the meeting who will be using the telephone line. So far, we have not had to limit this option because of the available ports on the bridge line. Web-ex services have been used in some circumstances where we know that the volume of call-ins will exceed the bridge line capabilities. Agendas are sent to the members and the contact lists prior to the meeting.*

In addition, any subgroup (by whatever name) that comprises two or more members of the committee must be open to the public by announcement and by a physical location. The Bureau will post these on its website and the state meeting site, making every effort to do so more than one week in advance. Some form of discussion summary or minutes will be available to the committees.

### **Next Meeting:**

The next MAC meeting will be 11-5-2019.

### **Adjournment:**

Meeting adjourned at 2:40 PM.