

## **MEDICAL ADVISORY COMMITTEE MEETING**

November 12, 2015

### **ATTENDEES:**

David Tutor, MD, Committee Chair

Robert Snyder, MD, Medical Director, Bureau of Workers' Compensation

Abbie Hudgens, Administrator, Bureau of Workers' Compensation

Troy Haley, Esq., Bureau of Workers' Compensation

Keith Graves, DC, Chiropractor

Rob Behnke, Cracker Barrel

John Brophy, MD, Neurosurgeon

Gregory Kyser, MD, Psychiatrist

Misty Williams, Travelers Ins.

Ginny Howard, Zurich Ins.

Jim Talmage, MD, Assistant Medical Director, Bureau of Workers' Compensation

Jeff Hazlewood, MD, Assistant Medical Director, Bureau of Workers' Compensation

Suzy Douglas, Bureau of Workers' Compensation

Cris Gonzalez, Bureau of Workers' Compensation

Suzanne Gaines, Bureau of Workers' Compensation

### **ON PHONE:**

Randall Holcomb, MD, Orthopedic Surgeon

Tina Rankin, My Matrixx

Ken Eichler, Work Loss Data

Martha Nerenhausen, Healthcare Solutions

Cassandra Frediksen, Healthesystems

Sushil Mankani, MD, Liberty Mutual

### **GUESTS:**

Cara Campbell, AHCS

Adam Jaynes, Baker Donelson

Yarnell Beatty, Tennessee Medical Association

John Williams, TN Chiropractic Association

Dave Broemel, AIA

Terry Parker, Vanderbilt

Leann Lewis, Coventry  
Jim Schmidt, Schmidt Govt. Solutions  
Robin Smith, NSC  
Desiree Anderson, Schmidt Gov. Solutions  
Mary Ryan, MedTronic  
Paula Niemi, Eckman Freeman  
Tracy Bustin, Eckman Freeman  
Tammy Crafton, TOA  
Chris Scoma, Results Physiotherapy  
Elizabeth Millsaps, One Call  
Katherine Moffat, TN Academy of PA's  
Lou Alsobrooks, AHCS

A quorum was determined.

Introductions were concluded.

**APPROVAL OF MINUTES:**

Minutes were later approved as circulated.

**OLD BUSINESS:**

The Supplemental Spine Study Group report and the ODG Contributors responses had been forwarded to the committee members and those on the invitation list. The floor was then opened for comments and Dr. Snyder also requested that any written responses be forwarded to him.

1. It was acknowledged that "incapacitating pain" was vague but that "spinal disc pathology" might be clear enough if there was better definition of what that might entail. Altered proposed wording: **Incapacitating acute radicular pain from spinal disc pathology may be considered a valid reason to accelerate surgical intervention, if the diagnostic studies and the nerve root physical examination deficits correlate. Incapacitating pain may include an inability to perform sedentary and/or personal care activities, inability to stand for over 5 minutes, interference with minimal functional activities despite**

**treatment with higher doses of opioids, and Emergency Room visits for pain control.**

2. The accuracy of the diagnosis is what would determine the treatment. There was general agreement that treatment for a lumbar strain or sprain would not require treatment for longer than 12 weeks unless there were other diagnoses. Dr. Hazlewood brought up the diagnosis of facet disease but that diagnosis once made accurately would not be a “lumbar strain/sprain”. Consensus continues to try to restrict back pain treatment as compensable in the absence of evidence to the contrary. Changes in the language: **Surgical fusion and/or other treatments for cervical and lumbar degenerative disc disease longer than 12 weeks from the date of the first medical evaluation are not most likely work related.**

3. Although judged to be too vague, the committee felt that the wording was satisfactory as written. **The decision regarding a multilevel cervical fusion is multifactorial involving the distribution of pain, which could include more than one nerve root, as well as the severity of the radiographic findings at adjacent levels. If the radiographic findings demonstrate compression of nerves or the spinal cord at an adjacent level, the decision concerning a one or two level procedure should be left to the discretion of the operative surgeon.**

4. The response from ODG seemed not to take into account the word choices for this statement. “Acute discogenic lumbar radiculopathy clearly specifies the time (acute-less than or equal to 6 weeks), the source (discogenic-attributable by studies to the level where the spondylolisthesis is present), location (lumbar-L1 to S1), and nerve involvement (radiculopathy-a set of symptoms and physical signs that include specific dermatomal distribution, motor involvement, reflex changes and nerve stretch signs). The addition of “at the same level”. **In a patient with spondylolisthesis and acute discogenic lumbar radiculopathy at the same level (who is otherwise a candidate for surgery), fusion may be considered by the surgeon in addition to addressing the disc pathology.**

5. No comments, seemed fine as is. Add some clarity. **Diagnostic criteria for C-4 (no motor or reflex) and C-8 (no reflex) are limited. After appropriate conservative treatment, surgical indications will primarily be related to**

**correlation with the radicular pain distribution in a clear corresponding dermatomal distribution and the appropriate radiographic findings.**

6. Reference to Colorado to be removed and incorporate the reviewer's suggestion. **The option to use BMP in selected lumbar fusions should be restricted to the use only in complicated or re-fusions.**

Troy Haley advised the committee and guests of the rules process. Once notified of leaving the AG's office and posting on the Secretary of State's website, we will then know when it is to be put on the agenda for the GOV/OPS Committee. We would likely have about 60 days before they became effective to announce and educate further.

Dr. Snyder announced the attendance for the ODG Webinar (88 registrant venues but many had multiple viewers), and the VU-ODG sessions (59 and a video). The link was passed out to the committee and the guests.

Abbie offered and received participation responses to the DFWP revision group of Rob Bencke and Dr. Talmage. An expansion of the drug testing is to be included.

No other old business.

#### **NEW BUSINESS:**

Abbie presented a list the Bureau compiled on why physicians resist treating WC. Although unable to give Tennessee specific examples, Rob Bencke of Cracker Barrel said that their experience in Texas indicates that given the opportunity to individually contract for services separate from a fee schedule and relief from some of the burdens of depositions, that their opt out position in Texas has been positive.

Dr. Brophy suggested that the imposition of the fee schedule reducing physician's payments from full fee was a factor. Although the present fee schedule is generous.

Dr. Kyser observed that ½ of the US psychiatrists take no insurance at all and subsequently, the pool of those available is significantly reduced. The “dirty tricks” of bill review companies, using false identification of participating networks (Silent PPO’s) has continued to be a problem.

Other comments:

1. Physicians dislike confrontation with angry unappreciative patients.
2. Treating older workers creates the potential of having to deal with long term disabilities.
3. The fear of extra attorney requests and correspondence after the visit.
4. The view that the guidelines will be an extra burden.
5. The risk that now seems to be escalating: physicians being asked personal and financial information during expert witness depositions.

No further business.

**NEXT MEETING:**

January 20, 2016.

**MEETING ADJOURNED.**