

Medical Advisory Committee

March 26, 2019

Tennessee Room, 1st FL, Side A
220 French Landing Drive
Nashville, TN 37243

Members:

Rob Behnke, Cracker Barrel
Misty D. Williams, RN, Travelers
Ginny Howard, Zurich
David Tutor, MD, Occupational Medicine, Chair
John Brophy, MD, Neurosurgery
Keith Graves, DC.
Jeff Hazlewood, MD, PM&R, Pain Management
Lisa Bellner, MD, PM&R, Pain Management
Cerisia Cummings, DO, Bridgestone
James Gregory Kyser, MD
Marlin L. Blane, Pharm D, JD
Robert Snyder, MD, Medical Director
Abbie Hudgens, Administrator, BWC
Mark Finks, Attorney, BWC
Suzy Douglas, RN, BWC
Suzanne Gaines, BWC

Guests:

Toni McCaslin, HealthTrac Inc.
Terry Horn, Vanderbilt
Faith Parrish, Vanderbilt
Jeri Vincent, Certified Case Manager
Adam Jaynes, MNA GR
Carter Phillips, MNA GR
John K. Jones, Hankook
Everett Sinor, Brentwood Services,
Stan Jackson, Vertos Medical
Thom Mudrick, Vanderbilt University
Faith Parrish, Vanderbilt

Via telephone:

David Price, Preferred Medical
Laura Roberts, CorVel
Hanna Erkkila, HealtheSystems

Call to Order

The meeting was called to order by the Chair, Dr. Tutor at 1:00 PM.
Introductions were made.

Quorum

A quorum was confirmed as present (11/20 members, 1/3 of the members needed).

Approval of Minutes

The minutes of 12-11-2018 meeting accepted and approved.

Old Business

ODG Updates:

The monthly updates were distributed. Of most notable, there was an update on ultrasound treatments for the neck and other body parts. On top of a number of minor fixes, Dr. Snyder announced that the ODG had made changes regarding work hardening/conditioning and functional capacity evaluations. This was in response to this committee's recommendations that he forwarded to ODG.

For compound drug prescription counts, a graph was presented showing the savings before and after the drug formulary was instituted. The guidelines, "N" status, were included in the rules after discussion with Texas. FDA studies show that compound topicals have not been proven to be effective.

ODG recently included the same change in status in their drug formulary. Dr. Snyder made some notes that he had forwarded to ODG. Response has been gratifying. In the ODG initial proposal, the delivery method of compound drugs is not defined. They do use the FDA definition: compound medication is the combination of two drugs into a new formulation. There are some issues with the delivery method, such as epidural steroid injection. The ODG was advised that they may need to be more specific about the delivery method.

Concerning epidural steroid injections, Dr. Snyder observed that this area needs improvement and should likely be addressed in the future. What determines an appropriate compound for an epidural steroid injection? Presently compounds are not specified and it is unknown what is in them. Multiple injections can cause problems with bone density. It also raises the issue of how much is given in injections. Dr. Talmage and Dr. Hazlewood discussed dosages of steroids as observations.

When physicians consistently show 80% pain relief for months, Dr. Talmage explained that this may be the use of a technique called "foreshadowing" and may explain the effect on patients given these injections. The doses are discretionary, there is no maximum dose.

The motion to accept ODG changes approving them to be used in state regulations on guidelines, was accepted, no dissenting votes.

E-billing update: Almost all of the larger payers have activated e-billing for Tennessee. Fewer smaller payers have done so, some asking for continued exemptions. Providers who have less than 10 employees are automatically exempted; only the largest providers use e-billing. Those who have tried e-billing have found that it requires extra steps, which can be difficult. However, those that are successful have benefited from a reduction in delayed payments and greater ease in processing worker's comp bills-less staff time.

Access to Care Forum: A copy of survey questions was attached to the handouts. Physicians' resistance to treating worker's comp cases was briefly discussed. The floor was opened for comments.

1. **Physician participation and younger doctors.** Dr. Brophy repeated his observation about the lack of participation by his younger partners and extending to others as well. With enough business without the "WC hassles", the payment differential is just not sufficient.
2. **Telemedicine/telehealth.** Dr. Tutor pointed out that telemedicine increases patient access to healthcare. It is available 24/7 and appropriate as long as the health issue is non-urgent care.

A challenge for telemedicine is good internet access and EMR integrated into a virtual video system. 60% to 90% of "injuries" are appropriate for telemedicine. Injuries and employees have to be screened to make sure telemedicine is an appropriate match.

There is a broad reimbursement profile. At the beginning, it is important to triage patients appropriately.

Ginny Howard said that she had a good personal experience with telemedicine, but it was a minor incident.

Mr. Behnke said that cost is a problem. Every time a worker calls telemedicine, it costs and the costs could easily get out of control.

Misty Williams described a nurse line in which patients can talk to a nurse triage line as needed. This service has not extended to visual.

Dr. Tutor pointed out that most information about telemedicine is anecdotal. Dr. Snyder and Dr. Tutor discussed licensing of telemedicine. It must be licensed in the state where it is being practiced, both patient and provider.

Abbie Hudgens and Dr. Tutor discussed which cases would be appropriate for telemedicine. This would have to be determined by the severity of the case. Dr. Brophy said that anything that would require surgical expertise would not be appropriate for telemedicine. An example of an inappropriate condition would be a spinal condition. Post-ops and follow-ups can be telemedicine. A significant injury would be referred to a physician.

Dr. Kyser pointed out that there was no consistency in practice. He does not know anybody who does telemedicine in psychiatry. There is not much use of telemedicine in psychiatry. Prisons do tele-psychiatry; they are one of the underserved areas of psychiatry.

Dr. Kyser remarked that pain management apps for non-urgent primary care might be good.

Related to electronic transmissions, in 2020, all prescriptions will need to be submitted electronically. Mr. Blane added that 20% of controlled substance prescriptions use electronic means. Dr. Bellner explained difficulties of paying the fees and using codes with a telephone or beeper. Mr. Blane agreed that the two process verification is becoming more complicated. He also talked about the difficulty of implementing codes for prescriptions and surgery.

Does the adoption of new technology create resistance? How to incentivize doctors to use telemedicine?

3. **Payment delays and discounts.** Dr. Snyder gave an example of how an insurance company could not get the records that a doctor had released and faxed to the company months ago. This delayed the doctor's payment. As it turned out, the insurance company had received the records but failed to match the records to the patient. This type of incident makes physicians hesitate to take new cases. Dr. Snyder asked why insurance companies need medical records; the answer is to make sure that the correct physician is seeing the correct patient for the correct illness.

There are no contracts for physicians in worker's comp treatment. The "silent PPO" are discounts that payers apply that shortchange the provider. The provider does not agree to these discounts. Dr. Snyder said that very few cases have come forth to be investigated in spite of the legislation. It appears to be a matter of not knowing on the part of the providers.

Dr. Graves said that silent PPO's render the state fee schedule irrelevant. This is an obstacle keeping providers out of worker's comp. Committee members discussed the frustration of trying to negotiate with the silent PPO.

Dr. Snyder pointed out that the fee schedule is meant to cap the providers' fee and allow for negotiations between providers and payers below the cap. (The silent PPO does away with negotiations.)

Misty Williams observed that doctors that are not in networks are not likely to be put on panels. Would the system have less friction if the fee schedule were a mandate (fixed) rather than a cap? Would this save money and improve access?

4. **Lack of response from adjusters and outdated contact information.** Do the general rules for claims handling say that the insurance companies must tell doctor and patient when

there is a change in adjuster? Dr. Snyder is going to send the General Rules to the committee members.

Dr. Hazlewood added that insurers also need to tell physicians when they buy out a case. Physicians are not the only ones that have problems reaching adjusters.

5. **Third Party Schedulers/Consolidators.** Dr. Hazlewood noted that when a third party schedules therapy, the physician is unable to direct where the patients go.

Physical therapists are automatically paid when a third party schedules appointments but take substantial discounts.

Both Dr. Bellner and Dr. Hazlewood noted the reduced quality of physical therapy since third party scheduling has been in place. Dr. Snyder added that that is also true for diagnostic exams (MRIs, etc.) and for other tests such as EMGs.

6. **Expand access to the MIRR.** Legislation broadening access to MIRR (the expertise for the impairment rating) for patients and insurers. This would save money and time. The accuracy of the ATP ratings has always been an issue.

There will be more specific points at the next meeting.

Legislative Update:

Mark Finks, Bureau Attorney, gave the report. 1500 bills filed.

Two bills involved: 1) certain cancer conditions in firefighters were presumed to be caused by employment and 2) that PTSD would be compensable in first responders. Neither are yet "on the calendar" meaning not yet to be heard in the respective committees.

SB0312 involved Drug Free Workplace Program determining test results of employees with valid prescriptions. It set a 6 month limit on what was considered valid. Some additional definitions were forthcoming.

SB0456 was a twenty factor test used by the IRS to determine whether an individual was an employee or an independent contract. WC was removed as it already has a specific 7 factor test.

SB0486 was filed early and involves legalizing medical cannabis.

SB1062/HB0919 is called the "Agricultural Medicine Act" and has a 68 page amendment and is not yet on the calendar. It, too, is about legalizing medical cannabis.

Misty Williams pointed out that the cases of post-traumatic stress disorder were often concerning the attempted rescues of children. The insurance companies argue that the firefighters know there is a possibility of being involved in these situations when they take the job; insurance companies are also aware that they can be responsible for taking care of them as well.

Cannabis in WC:

Following up on the previous meeting, Dr. Snyder gave additional information concerning medical cannabis and the impact on chronic pain management and worker's_comp.

It is important to know the cut off levels of positive drug tests. Dr. Bellner's example of a "positive" was where the patient was 6ng/ml and the lab cutoff was 5. This is below the DOT cutoff of 15 and below Aegis lab of 25. It is conceivable that an individual using only "hemp oil" might truly test positive at these low thresholds. To support this, Dr. Talmage referenced a study where hemp oils obtained from internet sources were mislabeled as to content 68% of the time, 46% more CBD than labelled and 20% containing THC (above the TN limit of 0.3%) that was not even on the label. Both Drs. Bellner and Hazlewood noted some good results in patients using hemp oils. There is difficulty judging a positive result and whether to continue opioids.

New Business

Kid's Chance:

The Golf Tournament is scheduled for April 18 and is going well. The Auction will take place at the Annual Conference in June.

Peer to Peer Problems:

Dr. Dreskin sent two complaints concerning failure of the UR peer to respond. Dr.'s Hazlewood and Bellner agree that the present system does not work. Every insurance company is different and handles peer to peer differently and has varying success. Per the statute, Dr Snyder noted that every insurance company or employer can set up their own "peer" system. It is not clear that it is cost effective in most circumstances.

Next Meeting

No meeting date for next MAC meeting was set. A Google poll will be sent.

Adjournment

Adjournment at 2:35 PM.