Meeting Transcript

Medical Advisory Committee Meeting

September 23, 2025

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Transcript

Dr. Snyder:
OK, we're ready.
Good afternoon, everyone.
Thank you for participating.
Dr. Tudor, I'm going to turn the meeting over to you, please.

Dr. David Tudor:
Thank you, sir.
Welcome, everyone.
We will go ahead and get the meeting called to order.
And I guess we'll go through introductions first.
Who's going to call the roll today?

Mark Finks:
Dr. Tudor, I'll be glad to call the roll.
Thanks, Mark.
This is Mark Finks.
So let me start with—I'm going to call the roll of the committee members, and please speak up if I call your name to note that you're present:

- Mr. Rob Binky
- Ms. Lisa Hartman
- Ms. Corina Sloat?
    - **Corina Sloat:** Here.

- Ms. Jenny Howard
- Dr. David Tudor
    - **Dr. Tudor:** Here.
- Dr. Richard Cole
- Dr. John Brophy
    - **Dr. Brophy:** Yo.
- Dr. Gregory Kaiser
    - **Dr. Kaiser:** Here.
- Dr. Robert Snyder
    - **Dr. Snyder:** Here.
- Dr. James Talmage
    - **Dr. Talmage:** Here.
- Dr. John Oglesby
- Dr. Tim Jones
    - **Dr. Jones:** Here.
- Dr. Jeffrey Hazelwood
    - **Dr. Hazelwood:** Here.
- Dr. Lisa Bellner
    - **Dr. Bellner:** Here.
- Dr. Ceresia Cummings
    - **Dr. Cummings:** Here.
- Mr. Dan Hedrick

Mark Finks:
Does anybody hold proxies for any of the other members that didn't respond?
OK. I count—let's see—12 out of 18.
That's enough to establish a quorum, so we're free to proceed, Dr. Tudor.

Dr. Tudor:
Excellent. Thanks, Mark.
Could whoever is on the telephone, 615-***-4188, identify themselves, please?

Tommy Castleberry:
Sure. This is Tommy Castleberry with Concentra.

Dr. Tudor:
OK. Emma Winters, could you identify your organization, please?

Emma Winters:
I'm with Butler Snow.

Dr. Tudor:
OK. And Steven Peters, could you identify your organization, please?

Steven Peters:
[Possibly said “Enlight” — please verify.]

Dr. Tudor:
OK. I think we recognize everyone else.
So thank you, Dr. Tudor.

Dr. Tudor:
Thank you, guys.
Appreciate everyone joining in and participating today.
So we have a quorum, so we will move on to approval of minutes from the last meeting on May 20th.
Everyone should have received those in their packet and hopefully had a chance to review them.
They were a lengthy set of minutes, so—

Dr. Brophy:
Good. Yes, it was fine.

Dr. Tudor:
OK, very good.
Do we have a second?

[Unidentified Speaker]:
I'll second.

Dr. Tudor:
Thank you.
Any opposed?

Very good.
We will accept the minutes as written.

Dr. Tudor:
Conflict of interest forms — new fiscal year, so new form.
Laci, we send the conflict of interest forms to Lacey?

[Unidentified Speaker]:
I believe so.
We'll be sure to have everyone complete those forms.
She will pester you if you haven't.

Dr. Tudor:
Yes, yes, yes. I promise.
It's AI.
I think it's a built-in part of our agenda now.
All right.
So any other preliminaries?
If not, we'll move into old business.
Which I think we'll pick up our discussion on—
Our big discussion from last meeting was spine.
So, Dr. Talmage?

Dr. James Talmage:
Yes, sir.
Emma is with the Official Disability Guidelines
Or should we switch to Washington State?
Or ACOM's guidelines? ACOM is used in New York, and I think Nevada.
ODG is used in a majority of the states.
Washington State is its own system — they're the Canadian model of workers' compensation.
So state government is the insurer, not private insurance companies.

But Washington has published 2021 surgical guidelines for the back and neck.
They haven't been updated since then.
ODG has published smoking guidelines prior to July of 2024, then new guidelines in July 2024 that the committee did not like.
Revised guidelines in November 2024, and revised again in April 2025.
ODG revised well over 100 items in 2025, but apparently did not change spine from April 2025.
So at least they've been stable for five months.

Dr. Brophy and I have looked at ODG's guidelines and Washington State's.
I did not see ACOM's.
Dr. Snyder got us access — only ACOM sent the email: "Here's your way to get a password."
Last week, Dr. Snyder and Dr. Oglesby were on vacation, and I didn't deal with the password since I was it.
And the password link expired in 24 hours.
So we haven't really seen ACOM.

What I like about Washington:
Their guidelines cover not only workers' compensation, but state Medicaid and the state medical insurance for all state employees.
So the people who write the guidelines have to live with those same guidelines being applied to their case or their family member's case — because they're employees of the state of Washington.

And Washington comes out and just flatly says:
Not covered.
You can get it if you want it, but we won't pay for it.

For:

- Lumbar disc replacement
- Joint fusion
- Lumbar fusion for back pain or degenerative disc disease
- Discography
- Implants

Washington also says:
You have to, as a surgeon, have seen the patient at least once in the office.
You can't have a mid-level commit the patient to surgery and the surgeon meet the patient in the pre-anesthesia area in the hospital.

But what I like about Washington — we are familiar with ODG.
And I'll let Dr. Brophy speak.
He doubts me.
He thinks he can live with ODG.

So, Dr. Brophy?

Dr. John Brophy:
It is a big phone call standpoint with ODG — this requirement to wait three months.

With a few simple proposed changes to their guidelines, they dropped it to six weeks, which is consistent with ACOM and with Washington State.

They have other issues that I'm hoping they're going to address — sort of out in the weeds. These kinds of things: fusion first, second disc recurrence — I won't bore you with.

But according to Dr. Snyder a few minutes ago, their proposals — if you go on their website right now — they have not changed it from three months to six weeks.
And that change was supposed to occur in early October.

I propose that we see what they've actually decided on and then make a judgment at the next meeting in November.

Dr. Talmage:
You had some other issues. Do you want to just give me a list?

Dr. Brophy:
Sure.
Under normal fusion, they talk about using an adjacent level with criteria — basically subject to back pain. That's not standard.
They talk about fusion for lumbar stenosis — that's not standard.
If you fuse, it should be for instability. They should say that.

They talk about fusion not being authorized for disc herniation [original: "discrimination"] or first recurrence — but they don't address second recurrence.

And then the issue is for lumbar fusion:
Three months of conservative management — I think that's reasonable.
But in the rare occurrence of a second recurrence, they frequently have incapacitating leg pain and it all needs to get done.
So that should be well under three months.

Then they still have this physical therapy thing — this arbitrary number of treatments, the duration of treatment that makes no sense.
It should be determined by the patient-specific diagnosis, not a general term like they have in the guide — and how they are responding to treatment.
Meaning more or maybe less depending on how they're doing.

Troy Prevo:
Yes, sir. I was waiting for everybody to finish.
And to Dr. Brophy's last point — Dr. Brophy, I think they tried to address the PT concerns.
And if they didn't, any language would be helpful for the editors to consider.
I think Dr. Snyder just documented that too.

So, regarding duration — I think one of the things ODG tried to do is make the PT visit durations more of a guide.
They're designed to be a guide for the adjusters to look at as they follow their claimant patients.

There was language actually being put in that would allow functional improvement to guide physical therapy.
Now, if that didn't fit the way you think it needs to fit, I would absolutely want feedback on that to get back to them.

If y'all reviewed the October 3rd changes that are coming up —
Y'all, through Dr. Snyder, it sounds like you've had opportunities to review those.
There isn't, at this point — I had sent those a month ago — but at this point, it'll be hard to make changes this round from feedback.
But we could definitely look at considering them for the next cycle, which would be a January cycle probably.

I'm just going to be straight honest with you — it's hard to make interim changes unless it's something very small.
But I'll let them stand on their own where they are on those.

There was a lot of input back to the ODG editors on that information.
Some went back to the drawing board with the librarians on looking at evidence and considering specifically Tennessee's concerns.
So, I'll leave it at that.

Dr. Talmage:
Troy, if you're making a list—

Troy Prevo:
Yes, sir.

Dr. Talmage:
Many of the back surgery sections have a requirement for a psychological evaluation.

Troy Prevo:
Yes, sir.

Dr. Talmage:
Which is logical.
But if you look at what is actually required, it's:

- Assess motivation for recovery and return to work — not that it be favorable, just that it be assessed.
  So you could assess that it's terrible, but still recommend the patient for surgery.

- Assess any uncontrolled mental health or substance use disorder — again, you could document that it's present and a bad prognostic sign, but as long as you assess it, you've complied with the criterion.
- Evaluate personality style and coping ability — undefined.
  What is personality style? What is coping ability?

So we can get in arguments about what those words mean, but they're undefined.

And then buried in the text — not up in the criteria, but in the text — it says:
Part of the psych evaluation should be standardized, well-known psychological tests, at least two of which have built-in symptom validity checks.

There are people who lie.
There are people who lie to their doctor or therapist.
And they usually fail symptom validity testing in psychological tests — well-constructed, psychometric, well-known instruments.

But that criterion is buried in the text and not up in the bullet points, where it really should be.

And then the criterion is six months of CBT — that's cognitive behavioral therapy — which has been well documented to be effective for chronic pain.
Or psychotherapy — it's well documented that supportive psychotherapy doesn't help these people.

And yet, with the "or" in there, six months of seeing a psychiatrist or psychologist for "Oh, poor John, it's bad, isn't it?" — that sort of supportive therapy that we see not uncommonly in records — meets the criterion.

So the criteria listed in multiple surgical sections for a psych evaluation need to be relooked at.

Troy Prevo:
Yes, sir. I will make sure that happens.
And I can't argue those points with you at all.
Yeah, I've got those notes down.

Dr. Snyder:
So, Dr. Brophy, do you have your folks go through psychological evaluation before you fuse them?

Dr. Brophy:
I do not.
We do that for those called simulators, but not for fusion.

Dr. Snyder:
Yeah, I was going to say — if they had quite a few workers' compensation spinal surgeries, then I think probably would have benefited better than that.
But I haven't seen it. I haven't seen it happen.

Dr. Snyder:
I guess one of my concerns with spine surgery is:
Do our guidelines protect our patients?

And here's what I mean —
It gets harder and harder to find neurosurgeons.
I'm in Knoxville.
And we have to send our folks sometimes to Jackson, to Chattanooga, to Nashville, to Tri-Cities.
And they end up with a lot of surgeons I don't know.

And sometimes — I just had a surgeon in Chattanooga do a multi-level thoracic fusion.
It was a case you and I looked at.
This guy's a lot worse now.
And I'm thinking — but he wasn't going to stop until he got a surgery.
But I don't think that should have been—

Dr. Talmage:
Hopefully by the adjuster, based on the ODG requirements?

Dr. Snyder:
No. He had it done.
Could be the adjuster.
That should have gotten a second opinion.

Yeah. I asked the adjuster to get a second opinion, and they just wanted to push the case through.
Frankly, they were tired of dealing with the guy.
And they just said, "OK, you want it? Be careful what you ask for — you're going to get it."
And he did.

So he's a 49-year-old fellow who's going to end up on full permanent total disability, is my guess.
Of course, it's still playing now, but—

Dr. Talmage:
So, OK — you feel like ODG will protect, as long as the rules are applied?
They will protect us from the surgeons who maybe are a little too aggressive?

Dr. Brophy:
Yes. In fact, it supplements my guidelines that we agreed to 10 years ago.
The biggest problem I see is the patient that comes in with degenerative changes, and they do a fusion, and they do poorly.
And it never should have been approved because it's all pre-existing.
The State of Tennessee is not required to be governed by that.
And that's what we tell the adjusters when they ask for a discussion about the criteria.
But many don't know or haven't had a bad experience enough to make an impression.

But the whole cost of the whole thing could have been avoided with a good decision up front.

Dr. Talmage:
Well, I think it's a very valid question — do the guidelines protect the patients, and do they provide the patients with appropriate treatment?
And I think that's what we're trying to get ODG to do in the long run — to do both of those things:
Make sure that what's approved is appropriate, and make sure that it protects them against inappropriate things.

Dr. Snyder:
You can take that back, Troy, as well.

Troy Prevo:
Yep. Yes, sir.
I think the idea that the guidelines are supposed to do both of those — and I think you heard, there are some gamesmanship outside of guidelines on the part of carriers and maybe providers too, depending — specifically the psych evals.

I've seen the plaintiff bar do a lot of doctor shopping on that end to get the kind of psych result they need, so that can be problematic.
So yeah, I think we're trying to do both of those things — show what's appropriate and prevent what's not.
So yeah, I will take that back. Yes, sir.

Dr. Snyder:
So, do we need to take an action on this?

Dr. Talmage:
That action would be a motion that we delay action until we can read the final copy of ODG that comes out October 3rd and discuss it at the November meeting.

Dr. Brophy:
Is there a second?

Dr. Talmage:
Second.

Dr. Snyder:
Who was the second?

Dr. Talmage:
Second — Jim Talmage.

Dr. Snyder:
OK. Any opposed?
So we will delay that vote until the next meeting.

Dr. Talmage:
Any other discussion there?

Dr. Snyder:
Good.

Dr. Talmage:
OK. I have one other thing I want to add.
I sent to ODG a very good article on cryotherapy — cryo-compression therapy — in shoulder and knee surgery.
Troy, it is my understanding that they are going to make that change in October as well, and I commend ODG for that.

Troy Prevo:
Yes, sir. That's going to limit a lot of those — must be six or eight appeals that we see a month — for the denial of the cryotherapy.
So hopefully that change is going to make a big difference.

Dr. Snyder:
I sent you the draft, Dr. Snyder. If you didn't get to see it, I can send it again.

Dr. Snyder:
No, yes — no, I got it. I did get it. That's why I'm noting that.

Troy Prevo:
Thank you for the article.
Those are the kinds of things we love to get — good literature like that that we can grade at that level.

Dr. Talmage:
Is that using the dry chamber?

Dr. Brophy:
No — CryoThermic, CryoCuff, or CryoNomatic [original: “cryonomatic”].
Cold compression device.

Dr. Snyder:
Yeah. Different names for it.

Dr. Talmage:
Can always make things more difficult by labeling them differently.

Dr. Brophy:
Say — a bag of ice.

Dr. Snyder:
Yeah. With a nice wrap.

Dr. Talmage:
It always worked.
Back in the day — the good old ice bath.

Dr. Snyder:
All right.
We’ll move on to a simpler topic, I think — the drug formulary with the July update.
I think that was in our packet also.
So that’s another — I don’t know — 15-page document of changes they made, of which very few were substantial.
Most of them were topic changes.

I highlighted the ones on top — the first seven — which had to do with recommendation and conditional recommendation for mental health and pain management for psychoactive drugs.

So if you have any comments on those, please send them to me and I will forward them to ODG.

The next update is due in October, and I have that and will publish that hopefully within the next week.
So it will become effective then — 1st of October.

Dr. Talmage:
Dr. Snyder, can I add a comment to that?
If everybody will pay attention — ibuprofen 300 has been addressed in the new formulary because we had several requests on it.
It’s got a new NDC, and yeah — not a real cost-effective drug in a 300 mg form.
So just so you know, that is one of the highlights of the update coming in October.

Pay attention to that.
Any feedback would be helpful.
We're already getting some feedback on some of it.

Dr. Snyder:
Well, we — in the past — we've had trouble with Flexeril putting an NDC number on a 7.5 mg tablet when the standard had been 5 and 10.
So it's just another way to try to — I don't know — save some money on the amount of drug you put in.

Any other discussion regarding the medication changes — in particular, the highlighted?

[No response]

If not, we're ready to move to the motion for the formulary.
Do we have a motion to accept the changes?

Dr. Richard Cole:
So moved — Rick Cole.

Dr. Talmage:
Second.

Dr. Snyder:
OK. Good deal.
So we got a first and a second.
Any opposed?

[No response]

No? All right.
We will accept the formulary changes as written.

Dr. Snyder:
Moving on — next order of business: AMA Guides to the 6th Edition.
Any updates there?

The digital version has been published and supposedly finalized.
The people that would be involved in evaluating that have been busy with ODG, so at this point in time, we have no update on that one.
It'll be an agenda item again in November.
So no risks at this time.

Troy Prevo:
Dr. Snyder, this is Troy. Can I make a comment real quick on that?

Dr. Snyder:
Yes.

Troy Prevo:
ODG will — sometime before the end of the year — be able to deliver the digital guidelines through the web version of ODG.
If somebody is a subscriber, they'll be able to access it through the web.
We've got an agreement with AMA to deliver those, so that'll be available on the ODG website.

Dr. Snyder:
Congratulations. That's great.

Troy Prevo:
It's been a long process, but we're getting close.
I just wanted to give that ahead of time in case anybody needed to finalize that.

Dr. Snyder:
Would you let me know when that's finalized?
Because I can notify Pat and the committee.

Troy Prevo:
Absolutely. Yes, sir.
You'll be first to know.

Dr. Snyder:
So again — we'll be able to access the AMA Guides through ODG without subscribing to the AMA Guides — just go?

Troy Prevo:
The 6th Edition digital, yes.
It'll be part of your ODG subscription.

Dr. Snyder:
Awesome. OK. Thank you.

Dr. Snyder:
Any other discussion?

If not, we'll move on to the legislative update.
Amanda, do you have that for us today?

Amanda Terry:
I do. Thank you so much.
Just a few quick notes.

We will have legislation coming up next year.
We're sworn to secrecy by the Governor's Office until after January, so I'll discuss those into next year when we get there.

The things that I think you're probably most interested in are:

- The **medical fee schedule**, which is at the Attorney General's Office.
  I have requested an update from them and was just sent back some information, so I'll continue working on that until we get that to their liking.
  Hopefully it will wrap up quickly and soon.
- **Claims handling and case management rules** — we will be headed to Gov OPS on, we think, October the 15th.
  So we are on our way there as well.

And that's it for the legislative update.

Dr. Snyder:
So the changes in the fee schedule have to do with increasing the fees paid to physicians in three categories to meet inflation.
That's the biggest change.

The case management — the biggest change is going to be the ability to use virtual communications, such as secure audio-video, for some face-to-face meetings.

And the claims handling standards — the biggest change in that is identifying contact individuals at the insurance companies and at the carriers and at the employers, requiring them to update that every six months.
So that if there's a problem with an adjuster or a claim, then we will have not only the adjuster's information, but also contact information with the carriers.

Dr. Snyder:
All right. Well, thank you.

Dr. Talmage:
Thanks, Ms. Terry. Appreciate that.

Dr. Snyder:
Well, medical fee schedule — so I guess we've covered that.
Any other discussion around the fee schedule?

Dr. Talmage:
It's published on the Secretary of State's website.
There you can see what has gone to the Attorney General's Office.

Dr. Snyder:
So we'll move on to the utilization review report and the fiscal year stats.

The first one — I included the utilization review organization annual reports, and we compiled those.
We were very successful in getting, I believe, 34 out of 37 organizations to respond with accurate information concerning utilization review.

The numbers are pretty stable — that is, between 11,000 and 15,000 utilization reviews are done on Tennessee patients, Tennessee injured workers, every year.

And the breakdown in that data also is by the utilization review physicians.
We have separated them so that physicians that have had over 20 utilization reviews in the state are broken into a separate worksheet so that you can see the numbers.

Some are pretty big — we've got three physicians that are, I think, in the area of 200 reviews that they do.
And it also lists the number of companies that each one of those physicians works for.
There are some physicians that are doing work for up to 13 companies.

So it's very interesting.
I think it's valuable information to evaluate what utilization review is occurring in the state.

Dr. Talmage:
I think the report said Dr. Alpert was the number one.
So she — how many did she do?

Dr. Snyder:
As I recall, it was 380. Don't quote me on that number — I haven't looked at it in a couple weeks.

Dr. Talmage:
And that's just for Tennessee?

Dr. Snyder:
Yeah.

Dr. Talmage:
If I recall, I think she's based in New York?

Dr. Snyder:
Well, we just got — there are three of the physicians that actually worked under the label of Gotham Orthopedics.

Dr. Talmage:
OK.

Dr. Snyder:
That's her.
But they've got — according to their website — six or seven different addresses in New Jersey and New York.

Dr. Talmage:
Yeah.

Dr. Snyder:
So — that's what it is.

Dr. Talmage:
Yeah, yeah, yeah. Good for them.
Hopefully that's good for us.

Dr. Snyder:
All right.
Any discussion around UR review or the report itself?

Let's move on to penalties.
We've got the second one — the fiscal year stats for our utilization review.

So I am very proud of our staff.
There were a couple of months in this fiscal year where we were able to send out every appeal determination the same day that we could legally send it out.

Essentially what happens is — once an appeal is filed, there's a minimum of five days to let the adjusters either reconsider or let the appeal go through.
So we were sending reports out — there were two months in that fiscal year where we sent the reports out on that fifth day.

So congratulations to my staff, to Dr. Oglesby, and to Dr. Talmage for their hard work.
That's a high bar to keep managing every day — everything — especially if I take vacation.
Those poor guys suffer.
But I'm very proud of that report.

Interestingly enough, if you compare our statistics with California's IMR process — They're within 30 days on average of issuing their reports.
And so I think that we're doing very well.

The other thing is that the IMR process in California upholds the denials 90% of the time. Our statistics are more like 40% of the time.
So I believe that we are protecting the patients a little bit more through a less administrative process.
So I'm very proud of those numbers.

In this last period, since our last meeting, there have been 9 referrals to penalty.
Of them:

- Two of those were peer violations — in other words, they were not same or similar specialty or were not Tennessee licensed.
- Five of them were for record violations — I'm not very happy when I get 750 pages of records with duplicates, so that goes to penalty.
- And then there were two penalty referrals where the peer-to-peer contact was not carried through by the reviewing person.

Dr. Talmage:
On that last category — was that when the treating provider attempted to contact them back, but they didn't communicate back to them?

Dr. Snyder:
Correct.
The number was either not answered or not answered in time, or sent to voicemail.

Dr. Talmage:
OK.

Dr. Brophy:
I would like to see more of those, because I think a lot of those occur.
But it's difficult to get the documentation.

Dr. Snyder:
That's the biggest thing — documenting when the first call was made, when the second call was made.
When we get enough documentation, we send it on.

Dr. Brophy:
So should we be documenting that in our appeal?
Because I've not been doing that, and we do come into that a lot.

Dr. Snyder:
If you can document that you made a certain call at a certain time and that you received a voicemail or did not get a contact — please send that to us.

Dr. Brophy:
OK. Thank you.

Dr. Talmage:
So if that part of the evaluation isn't met, is that a reason that you would overturn that denial?

Dr. Snyder:
No.
We look only at the medical evidence.

Dr. Talmage:
OK.

Dr. Snyder:
So a lot of times we will see a denial — because that's what usually happens if you don't make the peer — most of the time it's a denial.
But we look at the medical facts.
We don't take that into consideration.

Dr. Talmage:
OK.

Dr. Snyder:
If not, we will move on to new business — the WCIR reports.
I have four reports I'm going to summarize, and if anybody wants a copy of those reports, please email me.

The first one was **hospital outpatient payments**.
Tennessee, for their outpatient payments, ranked well below the median state, and they pay about 62% of Medicare.
The range for most states is about 110% of Medicare, but the growth rate in outpatient payments is between 10% and 40%.
Tennessee has one of the lowest increases for all the states.

The second report is on **advanced practitioners** in workers' compensation claims and how they affect outcomes.
Advanced practitioners make up, according to WCRI, on average 30% of all initial non-ER appointments.
It's higher than 37% for specialists.

They do provide quicker availability and shorten the time for first diagnostics and first treatments.
They have slightly higher medical costs, but interestingly enough, lower indemnity payments.
And they have slightly longer out-of-work or restricted duty than physicians.
But ultimately, the claims outcomes are very close to the same.
So I thought that was interesting.

For **medical fee schedules**, Tennessee is approximately 50% above Medicare, which is slightly less than most states.
This was based on 2023 data, so it would not reflect what we're doing now.
Interestingly enough, **emergency room visits and radiology services** are higher in Tennessee than average, but **E&M services and EMG services** are significantly below — at 62%.
Physical therapy and physical medicine is about 25% above the median state.
Surgery comes in at about 100% above the median state because we have that multiplier for orthopedics and neurosurgery.

Then the **inflation report from 2020 to 2025** — how did it affect workers' compensation?
In spite of attempts to increase the physician and provider reimbursements, Tennessee providers have cumulatively lost 2% over that period of time — per year — at the same time that medical inflation went up 13%.
So physicians are essentially 11% down over the course of those five years.
Tennessee ranks on the lowest side for increased rates of payments over that period of time, in spite of all we've tried to do to increase them.
So hopefully this new fee schedule will help address as many of those issues as we can.

Dr. Talmage:
Is there an explanation over the hospital outpatient payments?

Dr. Snyder:
There was no explanation as to why it occurred, but it's just that we were significantly below — in spite of the fact that we're 50% above Medicare.
Yeah, but that's less than other states.

Dr. Talmage:
It's interesting.

Dr. Snyder:
We aren't the lowest.
The lowest was 20% over Medicare.

Dr. Talmage:
Wow. Which state?

Dr. Snyder:
I don't remember.
If you want the report, I'll send it to you.
You can go through all the graphs.

Dr. Brophy:
I think they've done several reports now on advanced practitioners and workers' comp.
And I think they've all come up that the cost is not significantly different, and outcomes are very similar — if not the same.
So it may be that the fact that they can get quicker treatment makes up for some errors in overtreatment — maybe, if that's a word you want to use.
But I think that appropriate and earlier treatment should affect the outcomes.

Dr. Talmage:
You think the indemnity payments are lower because they're nicer to the patient?

Dr. Brophy (laughing):
Well, it's interesting that there's a slightly longer period of out-of-work and restricted duty, but you would think that would affect the indemnity payments.
But it just may be that the quicker treatment they get to begin with makes up for that little bit longer period of restricted duty or out-of-work.

Dr. Snyder:
Well, I think in this research — I bet ERs are the same.
I mean, probably 75–80% of the injuries I see are just very minor musculoskeletal things.
I think most of them — if they didn't occur at work — they wouldn't have even seen a provider at all.
So I wonder if a lot of the advanced practitioners are actually getting that selected group of more minor conditions — perhaps easier-to-treat conditions — and then the more complex cases go to the physicians.

Dr. Richard Cole:
Well, interestingly—

Dr. Kanban [likely misheard; possibly Dr. Hammond or another member]:
Just an unusual observation — but there's also some data out there that shows that patients who are waiting for a physician encounter can develop inappropriate behaviors that complicate their process.
And that earlier evaluation by a provider — getting them on the right track — seems to

have a lower overall outcome as far as cost.
There's some nice data published on that.

Dr. Brophy:
Yes, I would totally agree.

Dr. Snyder:
All right.
Any other questions or discussions over those?
Those are always interesting studies — or reports — to peruse.

Dr. Talmage:
Well—

Dr. Snyder:
Any other new business?
Well, we do have one announcement.

The **National Work Comp Meeting**, which is a fairly large organization, is going to be at the Music City Center here in Nashville on **November 11th and 12th**.
It'll be good to look that up and see what their program is.
It's a national organization that usually meets in Las Vegas.
So now it's meeting in Nash-Vegas.

Dr. Talmage:
That's November of this year?

Dr. Snyder:
November of this year — November 11th and 12th.

Dr. Talmage:
And what's the name of that group again?

Dr. Snyder:
National Work Comp.

Dr. Talmage:
Thank you, sir.
Are they an entity unto themselves, or an organization?

Dr. Snyder:
An entity unto themselves, yes.

Dr. Snyder:
All right. That's good information.
I guess otherwise, our next meeting will be **Tuesday, November 4th**, and then looking toward next year — **February 10th of 2026**.
So please put it on your calendars.

Any other announcements or discussion?

Dr. Brophy:
Just doesn't seem right — it's not even 2:00 yet.

Dr. Snyder:
There's a lot of information, and I appreciate everybody's attention.
I appreciate the work that the committee does in going through these things — your attention and your input.
So please let me know what I can do to help you.

Dr. Talmage:
No, thank you.
The information that you and Dr. Talmage and everyone brings to the meetings is very, very helpful.
Useful. Beneficial.

Dr. Snyder:
Yeah. Thank you, guys.

Troy Haley (joking):
We can't let this meeting end without somebody making a comment about Dr. Snyder's beard.
He came back from vacation with a very nice beard, which I like a lot.
He kind of let it come in while he was out in the wilderness.
So hopefully everybody appreciates that — give him a thumbs up if you like it.

Dr. Talmage:
That's impressive for one week's growth — very impressive.
Very distinguished.

Dr. Snyder:
It's three weeks now — three weeks.

Dr. Talmage:
Oh wow.

Dr. Snyder:
Wow, that was a vacation.
Well, I wasn't gone that long. I've been back for 10 days.

Dr. Talmage (joking):
Tell me — Dr. Talmage would have assassinated me if I had stayed away that long.

Dr. Snyder:
Thanks, everyone.
Enjoy the rest of your day, and we'll see you in November.

All:
Thanks, everybody.
Thank you.
Thank you.