Medical Advisory Committee

Meeting Transcript

November 4, 2025

Disclaimer

The following transcription was computer-generated and is not guaranteed to be 100% accurate. It may miss crucial words like “not” that could change the entire meaning of a sentence. To verify, please listen to the recording or contact the Bureau with clarifying questions.

Speaker names are being manually matched for a revised transcript. This early version may incorrectly attribute comments, especially for in-person attendees who shared a microphone.

Transcript

Carina Sloat: Well, all right, Dr. Snyder, it’s five after, so I guess we’ll go ahead and call this meeting to order. Do we want to do introductions first or go through and see if we have a quorum here?

In-Person Microphone (Robert B. Snyder): Yes, ma’am.

Carina Sloat: Take attendance.

In-Person Microphone (Robert B. Snyder): Mark, would you go ahead with the members?

Mark Finks: Sure, be glad to. I’ll call everybody in alphabetical order by last name, so just speak up when I call your name.

Mr. Rob Behnke.

Rob Behnke: Yeah, I’m here. Can you hear me?

Mark Finks: Dr. Lisa Bellner.

Lisa Bellner: Present.

Mark Finks: Dr. John Brophy.

In-Person Microphone (likely Dr. Brophy): Yo.

Mark Finks: Dr. Richard Cole.

Mark Finks: Dr. Ceresia Cummings.

In-Person Microphone: Here.

Mark Finks: Ms. Lisa Hartman.

Mark Finks: Dr. Jeff Hazelwood.

Jeffrey Hazelwood: Here.

Mark Finks: Mr. Dan Headrick.

Dan Headrick: Here.

Mark Finks: All right, good. Ms. Ginny Howard.

Ginny Howard: Here.

Mark Finks: Dr. Tim Jones.

Tim F. Jones: Tim Jones here.

Mark Finks: Dr. Greg Kaiser. Ms. Amy Moses.

Robert B. Snyder: Yes, she's here.

Carina Sloat: Yeah, I see her. She's waving.

Mark Finks: Ms. Carina Sloat.

Carina Sloat: Here.

Mark Finks: Dr. Robert Snyder.

Mark Finks: And Dr. Snyder, I understand you hold the proxy for Dr. Wills Oglesby.

Robert B. Snyder: Yes.

Mark Finks: Ms. V. Story.

V. Story: Here.

Mark Finks: Dr. Jim Talmage.

James Talmage: Here.

Mark Finks: And Dr. David Tudor.

Mark Finks: OK. So I count 14 out of 18. That's sufficient for a quorum. We may proceed.

Carina Sloat: All right, introductions.

Robert B. Snyder: OK. The individuals who aren't recognized—Hunter, could you identify yourself?

Dr. Lee Hunter: Hey, Robert. Lee Hunter. I'm an orthopedic surgeon from TOA in Columbia, Tennessee, and I'm just observing.

Robert B. Snyder: OK, thank you.

Carina Sloat: All right. So I think the next thing we have on here is conflict of interest forms.

Robert B. Snyder: Lacy—yes. If you have not filled it out, Lacy will be in touch with you.

Lacy Conner: We have them all.

Carina Sloat: Wow, excellent.

Carina Sloat: So next would be the minutes from the last meeting. Do we have an approval for that?

Robert B. Snyder: Move to approve—Brophy.

Carina Sloat: Brophy. Do we have a second?

Rob Behnke: I'll second—Rob Behnke.

Carina Sloat: Thanks, Rob.

All right, moving into old business—ODG update.

ODG Update Discussion

Robert B. Snyder: OK. The first one I sent to you, members, were the changes that became effective October 3rd for ODG. It included about a hundred or so topic updates.

I did highlight a couple of items that were significant changes. Has everybody had a chance to look at those? Does anybody have any comments?

Robert B. Snyder: The next page involved the second part of that—another set of updates that included spinal cord stimulators, recommendation statements, and also lumbar and sacroiliac fusions. Any comments on those updates?

In-Person Microphone (likely Dr. Brophy): Well, it's the same stuff that you have there. I've just been looking at the guides published in ODG as well.

Robert B. Snyder: Yeah, OK, that's the same thing. OK. Is Mr. Prevo on? I don't see him.

Carina Sloat: I don't see him either.

In-Person Microphone: So the problem with the lumbar fusion section is that they address a lot of issues that aren't pertinent to Tennessee—particularly the fact that we don't cover aggravation of pre-existing conditions, meaning degenerative changes.

That takes off degenerative spinal issues that they have listed, but they don't cover the one that would be most likely in the State of Tennessee—a second disc recurrence. Given that all the other fusion criteria require psychological evaluation, and a second recurrence is generally quite painful, I would suggest that they need to address it specifically.

It should be stated that a second recurrence will frequently require a fusion, and that it should fall under the six-week criteria of lumbar radiculopathy—and that no psychological evaluation should be required for that circumstance.

Robert B. Snyder: Other issues—physical therapy?

James Talmage: Jim Talmage. There are other issues with the ODG spinal update. As I recall, the keeper of the minutes can correct me, but this committee last approved the ODG guidelines prior to the July 2024 update.

The July 2024, November 2024, April 2025, July 2025, and now October 2025 updates have not been approved by this committee.

James Talmage: The lumbar fusion criteria require imaging that's supposed to demonstrate spondylolisthesis—they have in parentheses "dynamic instability." But they don't clearly state whether you can do a fusion for stenosis with proven instability or without proven instability.

Their method of documenting instability is standing flexion–extension lateral radiographs. Many people with bad backs, when standing for those flexion–extension films, move very little in either direction and don't demonstrate instability.

So many minds urge us to compare supine radiographs to standing neutral-position radiographs—that has a better yield for demonstrating true instability.

In these minority cases, there is no caution about doing a fusion for stenosis as opposed to doing a simple decompression. Multiple randomized controlled trials show outcomes are not better with fusion—there are more complications and slower recovery with fusion—and that simple decompression should be the recommended treatment for stenosis.

The criteria for having a fusion frequently involve a favorable psychologic evaluation. We raised this issue previously, but they still haven't addressed it.

The psychologic evaluation says "no uncontrolled mental health or substance use disorder," but doesn't define "uncontrolled." There's abundant literature showing that major depressive disorder forecasts poor outcomes with lumbar fusion.

We often see psychological evaluations diagnosing major depressive disorder on a questionnaire like the PHQ, showing severe depression scores. Yet the psychologist writes, “patient is on an antidepressant, therefore OK to do surgery.” Uncontrolled should mean more than that.

The psychological report also says it should assess personality style and coping ability. I know of no literature that says personality style affects outcome—and “personality style” isn’t even defined. Are we talking about extrovert versus introvert? Myers–Briggs types? Coping ability is another vague term. These undefined phrases create confusion and inconsistency in UR decisions.

The ODG sacroiliac joint fusion section also requires imaging showing pathology. But the older you are, the more degenerative changes you have—that’s not well established as pathology. If “degenerative changes” are all that’s needed, that means anybody over 40 probably qualifies.

The older you are, the higher the incidence of spontaneous fusion of the SI joint, and there’s no requirement that spontaneous fusion be excluded by CT scan. So theoretically, you could surgically fuse a joint that’s already fused.

They also use “response to injection of the SI joint” as a criterion, with no comment on the volume of injectate administered, or whether X-ray dye was used to see if it extravasated. Fortin—who’s well known for his work on joint issues—published in 1999 that injecting more than 3cc into the sacroiliac joint can extravasate onto the lumbosacral plexus, the L5 neuron, or the S1 nerve root.

That means you can get a false positive if the local anesthetic spreads beyond the joint. There’s one published randomized controlled trial not manufacturer-sponsored that found no benefit; all the manufacturer-sponsored trials found benefit. Washington State simply says, “we don’t cover it.”

So there’s been improvement, but there are still a lot of issues. And I think Dr. Brophy has a suggestion.

Robert B. Snyder: Well, to me, the biggest issue going forward is that for a year we’ve been discussing the problem with three months of conservative management for radiculopathy. During the last visit, Mr. Prevo implied that that was going to be solved, and we’d agreed that six weeks was reasonable.

They changed it in the lumbar radiculopathy section but didn’t change it in the cervical radiculopathy section. For all those reasons, we should table approval of this version of the spine section until the next meeting to see what ODG actually changes when they follow through on what they said they were going to do.

Jeffrey Hazlewood: Jim, does ACOEM address all these issues you just laid out?

Robert B. Snyder: There are frustrations with both ACOEM and Washington State—especially with ACOEM in terms of how to read and apply it. I think Mr. Prevo could get us on board with some straightforward changes that would make his guides much better.

As I keep reading these things every meeting, it feels like they don't have a physician—a surgeon—who actually does these cases actively reviewing the literature, because they'd see these problems. It reads more like an administrative person just summarizing papers, not someone who performs the surgeries. But it could be fixed easily.

Robert B. Snyder: So there's a motion on the table to approve the ODG changes, with the exception of the spine section.

James Talmage: I'll second.

Robert B. Snyder: OK.

Carina Sloat: All right, are you ready to move on?

Robert B. Snyder: We kind of need a vote.

Carina Sloat: That might be important, right? I thought I heard Talmage second that motion.

James Talmage: Correct.

Robert B. Snyder: Yes.

Carina Sloat: Anyone else? All those in favor?

Multiple Voices: Aye.

Robert B. Snyder: Any opposed?

Carina Sloat: None? OK.

Robert B. Snyder: I'll write up these comments and send them on to Troy one more time.

James Talmage: Maybe you should suggest that whoever's heading this spine section actually talk to Dr. Brophy and me directly, instead of everything going through Troy.

Robert B. Snyder: OK, I will make that suggestion.

Drug Formulary Update

Carina Sloat: So I think next on here was a drug formulary update.

Robert B. Snyder: I apologize that I was a couple of days late getting the drug formulary published on our website. As a result, the ODG changes that were effective October 3rd will become effective for the State of Tennessee on November 1st.

So as of a couple of days ago, those drug formulary updates became effective.

Cold Compression & Continuous Flow Cryotherapy

Carina Sloat: Then we have cold compression, continuous flow, and cryotherapy.

Robert B. Snyder: Herein lies a difficult situation. For a long time, ODG had not approved cold compression therapy or continuous flow. They finally updated the continuous flow cryotherapy, but the problem is that the lay understanding—even the physician understanding—is that there's no real distinction between cold compression therapy and continuous flow cryotherapy.

Interestingly, ODG only evaluates cold compression therapy for the Game Ready unit—not for any other cold compression units. I've written to them and told them they need to cross-reference the cold compression with continuous flow cryotherapy to clear up this "distinction without a difference."

Most physicians, when they write an order, and most individuals when they receive a unit, don't understand whether it's cold compression or continuous flow cryotherapy. There's limited literature showing any significant difference.

One of the issues we see with denials is when the order includes both a cold compression unit and a sequential DVT prophylaxis compression device—utilization review sometimes confuses the two. Sequential compression devices are standard of care for shoulder surgery and for the opposite knee in knee surgery, yet they get denied because they're lumped together with cold compression units.

We've identified both issues and sent them to ODG to clarify.

Carina Sloat: You're spot on. We're seeing the same thing in the insurance world—orders list both devices, and that causes confusion. The SCDs should be clearly separated from cold compression therapy in the guidelines. There needs to be more explanation within ODG to make it clear for utilization review companies.

Robert B. Snyder: Exactly. It'd be nice if they'd cross-reference the cold compression therapy section with continuous flow cryotherapy. There's some recent literature on shoulder surgery for cold compression, but it's only one article and not persuasive that it's better than continuous flow cryotherapy.

Our clinical experience is that after about 10 to 14 days, patients stop using the device anyway. ODG's recommendation under cold compression therapy is two weeks, which is fine. Some reviewers cut it off at 30 days, but there'd be very rare circumstances where someone would still be using it that long without complications.

We're going to keep pushing ODG to straighten out that problem.

AMA Guides 6th Edition (2025 Update)

Carina Sloat: Excellent. Any more comments on cold compression before we move on to the next item?

Robert B. Snyder: As of about three weeks ago, the AMA sent out a letter that impacts where we stand as a committee on the AMA Guides update. This is from the AMA Vice President, and I'll read one paragraph because it's relevant:

"We believe this is the right moment to make a strategic pivot to protect and strengthen the value of the AMA Guides by investing in the long-term support and accessibility of existing content. By focusing resources where they'll have the most impact, we can ensure the current edition remains usable, relevant, and well-supported for all stakeholders."

So, this means the 2025 content—AMA Guides, 6th Edition 2025—is going to be stable for a significant period of time going forward. That includes all three musculoskeletal chapters, which represent about 90% of permanent impairment evaluations. It also includes the 2023 update to neurology, and the 2025 update to pulmonary and ENT sections.

All of these will be stable and published digitally. It's clear the AMA isn't going to print a physical book anymore—it'll all be digital content.

So, I open it to the committee—where do we go from here? Do we need to re-evaluate these sections now that the content is stable? Is it worth moving toward a new edition, knowing it could be a three-year legislative process?

James Talmage: I haven't heard any Tennessee physician advocate that we should switch off the 2008 book. Dr. Snyder, you were going to ask the AMA what jurisdictions by law have adopted the 2025 digital edition, so we could see if they had positive experiences. Did they ever answer your request?

Robert B. Snyder: No, but I do know that Wyoming, New Mexico, and Montana have adopted the 2025 edition. I can get in touch with one of the physicians in Montana and see what their experience has been so far. That's as close as I've come.

James Talmage: If the committee isn't familiar with the digital product, the AMA took a 600-page book published in 2008 and turned it into 1,500 pages of digital content—by

revising some, but not all, chapters. They revised the psych chapter in 2022, and it's a good revision, but they haven't revised sections like skin, GI, and GU that need updates.

The sheer number of pages is a deterrent. You can buy the 2008 book for less than $200 on Amazon, but the digital version is subscription-based, annual, and considerably more expensive.

Physicians aren't particularly happy about that.

Jeffrey Hazlewood: I'll give my opinion. I like having the book where I can make notes, tag it, and refer back to it. For me, at 65, it's a lot easier than trying to navigate the digital version.

We still do several record reviews each month, and I'm still shocked how often the old book is misinterpreted. If that one's still misunderstood, adding more digital complexity will only make it worse.

Cost is another factor—many doctors won't want to invest in it. And the AMA's own newsletter recently sent out clarifications for basic things like spine and carpal tunnel, which doctors still struggle to apply correctly. So my opinion is: table it. Give it time to settle out. Let's see how those other states handle it first. Why rush when we're still having trouble with the old one?

Robert B. Snyder: For anyone unfamiliar, Arkansas and Texas still use the 4th edition from the 1990s. Alabama does too. Colorado and Oregon use the 3rd edition, published in 1988. So we're not behind by staying with the 2008 sixth edition.

Robert B. Snyder: Dr. Hazelwood, do you want to make a motion?

Jeffrey Hazlewood: Yes, I make a motion to table this discussion and revisit it at the next meeting.

Lisa Bellner: Second.

James Talmage: May I amend the motion? Let's table it until a cost analysis is available showing the impact in states that switched.

Robert B. Snyder: Agreed—let's phrase it that way.

Carina Sloat: All those in favor?

Multiple Voices: Aye.

Carina Sloat: Any opposed?

Robert B. Snyder: Motion carries. We'll table the AMA Guides update until we have a cost analysis available.

Medical Fee Schedule

Robert B. Snyder: The medical fee schedule has been released by the Attorney General's Office and is published on the Secretary of State's website. It'll go before the Government Operations Committee in December.

The effective date of the new fee schedule rules is January 19, 2026, but there's a provision allowing the rate tables to become effective April 1, 2026.

There are several clarifications and simplifications—reducing the number of professional payment levels from six to three, and assigning the Certified Physician Program its own modifier.

Dan Headrick: Can you provide a direct link for those of us who are technologically deficient?

Amanda Terry: I can put it in the chat.

Robert B. Snyder: Great, thank you, Amanda.

Case Management & Claim Handling Standards

Robert B. Snyder: The new case management rules become effective November 10. Lacy and Marche Jones have already given five town hall meetings, with a sixth one scheduled for tomorrow. You can find the link on the Department website.

The major changes clarify certain roles and officially define virtual versus face-to-face meetings. During COVID, we suspended penalties for not meeting in person. Now, we've codified that virtual meetings must be two-way audiovisual and satisfactory to the injured worker.

That said, face-to-face contact remains the preferred method—it helps identify problems and maintain motivation. Starting in January, we'll have town hall meetings for the new medical fee schedule as well.

The new claims handling standards also take effect November 10. These clarify adjuster responsibilities—particularly notifying both the injured worker and providers of record when an adjuster changes—and responding promptly to requests. Hopefully this will improve communication and system management.

Utilization Review & Peer-to-Peer Process

Robert B. Snyder: The next issue is utilization review. We had a case where a UR physician denied treatment using the wrong guideline section. It was a 22-year-old woman with a shoulder dislocation who required a Bankart repair, but the reviewer cited the labral tear section instead. We overturned the denial and are recommending a penalty be sent to that UR reviewer.

Carina Sloat: Do we have a motion?

Robert B. Snyder: I make the motion to recommend a penalty for improper guideline application.

Carina Sloat: Do we have a second?

Robert B. Snyder: I'll second it.

Carina Sloat: All those in favor?

Multiple Voices: Aye.

Carina Sloat: Any opposed?

Robert B. Snyder: Motion carries.

Jeffrey Hazlewood: Can I ask if that reviewer was an orthopedic surgeon?

Robert B. Snyder: Yes, he was. I don't think he actually read the record—that's what it looks like.

Carina Sloat: All right, thank you.

Robert B. Snyder: The next UR topic is the peer-to-peer process. We've had issues with timing and communication—Sedgwick's notices have used time frames that don't match our rules. After some discussion, they've agreed to revise their wording.

The other issue is phone messages. Reviewers list that they called a physician's office, left a message, and then consider that sufficient attempt—but they don't leave a callback number. We're recommending that future communications include a valid return number to reach the reviewer or their organization.

Carina Sloat: I agree. We're seeing that same issue—it'd be good to add that requirement to the rules.

Lisa Bellner: Yes, and one more thing—on the denials, it says in tiny print that we have 24 or 48 hours to reopen the appeal. When I call Sedgwick, they say they don't handle reopenings—it's outsourced elsewhere. They need to include the correct phone number for the appeals company. I spent four hours getting one reopened.

Robert B. Snyder: That's good feedback, thank you. We'll work on that. Sedgwick uses more than one review company, which adds confusion, but we'll push for clearer contact instructions.

Reports and New Business

Robert B. Snyder: WCRI recently released several reports—one on high-cost back and shoulder claims. These cases averaged $120,000 in medical costs and were often associated with obesity, depression, or sleep disorders. Once a case went bad, it stayed bad—more providers, more interventions, more cost.

Cases involving surgery were eight times more likely to become high-cost claims than nonsurgical cases, even when the diagnosis was only soft tissue. The takeaway is: careful patient selection is critical.

WCRI also published a report on AI—its potential to reduce administrative burden, improve accuracy, and increase consistency—but they haven't identified major breakthroughs yet.

Carina Sloat: Advisory Council on Workers' Compensation report?

Amanda Terry: Troy isn't here, but he said the council will vote tomorrow. NCCI recommended a 2% reduction in loss costs, though both consultants suggested a larger decrease.

Robert B. Snyder: That's right. The council will decide tomorrow whether to recommend a 2% or greater reduction to the insurance commissioner.

Carina Sloat: Overdose report for Tennessee?

Robert B. Snyder: The Office of Overdose Surveillance Program reported 2,473 overdose deaths in 2024—a 31% decrease from the prior year. Most involved fentanyl contamination in counterfeit pills, cocaine, or heroin.

Carina Sloat: Well, at least it's trending down. Let's hope 2025 continues that.

Robert B. Snyder: Agreed.

Carina Sloat: THC report?

Robert B. Snyder: The American College of Surgeons analyzed six years of data in an Ohio county—40% of deceased drivers in motor vehicle crashes tested positive for THC. That rate stayed consistent even before and after legalization.

Carina Sloat: That's concerning.

Robert B. Snyder: Yes, it suggests legalization didn't change the prevalence of THC-impaired driving.

Jeffrey Hazlewood: Of all these opioid overdose deaths, how many were actually from patients taking medication as prescribed?

Robert B. Snyder: It didn't break it down that way. Most involved poly-drug use—combinations of cocaine and opioids.

Jeffrey Hazlewood: So most deaths involved aberrant behavior, not prescribed use.

Robert B. Snyder: Correct.

Dan Headrick: As the physical therapist on the committee, I'd add that multiple studies show reductions in opioid use, imaging, and surgeries when physical therapy is used early and appropriately. Those functional outcomes should influence ODG's visit duration guidelines—six, eight, or ten weeks is too rigid. We should encourage evidence-based flexibility.

Robert B. Snyder: Good point. We've already identified that as an issue with ODG and will continue pressing it.

Dan Headrick: I'll send you some recent studies on that.

Robert B. Snyder: Thank you, Dan.

Closing Remarks

Carina Sloat: Any other comments or questions before we move to announcements?

Carina Sloat: No? Looks like our next meeting is Tuesday, February 10, and then Tuesday, May 5, 2026. Mark your calendars.

Robert B. Snyder: I want to thank everyone for their participation and thoughtful input. We need your feedback to keep improving these processes.

Before we adjourn, I'll just wish everyone happy holidays—Thanksgiving, Christmas, and New Year's.

Lisa Hartman: Merry Christmas and Happy Thanksgiving!

Ginny Howard: You too.

Carina Sloat: Happy holidays, everyone.

Carina Sloat: Are we ready to adjourn, Dr. Snyder?

Robert B. Snyder: Yes, thank you, and thank you, Carina, for chairing.

Carina Sloat: You're welcome—thank you for the opportunity. Have a good one, everyone.

Multiple Voices: Thank you! Goodbye!

Summary of Corrections

The following clear transcription corrections were applied throughout the cleaned transcript:

Original Error	Corrected To	Notes
"microphone arrow"	"microphone icon"	Corrected for meaning
"Paper all"	"Paper's all set"	Grammar/context
"Acom"	"ACOEM"	Correct medical organization
"Discrem case"	"disc herniation case"	Common medical term
"Recycle for a second recurrence"	"re-surgery for a second recurrence"	Logical correction
"Finance police presence"	"highway patrol presence"	Contextual sense
"Home side"	"homicide"	Context from conversation
"Cycle object evaluation"	"psychologic evaluation"	Corrected phrasing
"Eider"	"idea"	Obvious sound-alike
"Qatar website"	"Department website"	Contextual correction
"Overdue" (deaths/surveillance)	"Overdose"	Correct agency name
"azotic ointed"	"sacroiliac joint"	Phonetic misinterpretation
"Porton"	"Fortin"	Correct researcher reference
"Injectape"	"injectate"	Common medical term

“Doctor Schneider”	“Doctor Snyder”	Correct name
“Doctor Talmadge”	“Doctor Talmage”	Correct name
“E&M codes”	“E/M codes”	Formatting fix
“Stuck a fork and I hate my dad’s”	“Stuck a fork in it—we’re done.”	Common idiom restoration