

Medical Advisory Committee

September 7, 2016

Location: Tennessee Room, 1-A, 220 French Landing Drive, Nashville, TN. 37243

Attendees:

David Tutor, MD, Occupational Medicine, Committee Chair
Abbie Hudgens, Administrator, Bureau of Workers' Compensation
Keith Graves, DC, Chiropractor
Rob Behnke, Cracker Barrel
John Brophy, MD, Neurosurgeon
Misty Williams, Travelers Ins.
Ginny Howard, Zurich Ins.
James Talmage, MD, Assistant Medical Director, Bureau of Workers' Compensation
Jeffrey Hazlewood, MD, Assistant Medical Director, Bureau of Workers' Compensation
Greg Kyser, MD, Psychiatrist
Robert Snyder, MD, Medical Director, Bureau of Workers' Compensation
Suzanne Gaines, Bureau of Workers' Compensation
John Benitez, M.D., Department of Health
Lisa Bellner, M.D. Pain Management
Cerisia Cummings, D.O.
Suzy Douglas, Bureau of Workers' Compensation
Troy Haley, Bureau of Workers' Compensation
Mark Finks, Bureau of Workers' Compensation

On telephone:

Randall Holcomb, M.D. Orthopaedics
Sushil Mankani, M.D. Liberty Mutual
Robin Smith, Neurospine Committee
Jesse Parnell

Guests:

David Broe	Mary Ryan	John Williams
Tony Parker	Treva Overstreet	Katherine Moffat
Yarnell Beatty	David White	Toni McCaslin
David Price	Lou Alsobrooks	Tom Farrell
Tonya Cain	Faith Parrish	Tiffany Stevens
David DiPetro	Adam Jaynes	
Terry Parker	Susan Stewart	

Reed Group: Carlos Luna, Joe Guerriero, David Roberts

CALL TO ORDER

Call to order and by Dr. Tutor at 1:00 PM

Introductions

Quorum determined

Minutes for May were approved as circulated.

Each member was asked to complete the attestation of conflict of interest for this new (state) fiscal year. At the end of the meeting, members were asked to turn in their travel reimbursement requests.

OLD BUSINESS

Treatment Guidelines and Drug Formulary:

Dr. Snyder announced that the Drug Formulary was implemented on August 28 for the 6 month notification period. Updates are posted monthly on website. He asked for comments. He noted that there have been no expedited requests yet. There are a number of approaches that the insurers and other have recommended:

1. Proactive approach to patients from both adjusters and providers on long acting opioids or medications.
2. Identify clearly what is covered under open medical for these patients?
3. Know how to get prior approval for medications.
4. Physicians must keep track of medications and work patients through them to correct dosage.
5. Pre-screen the day's patients, know what meds they are on and cross reference the list with the formulary (cheat sheet).

Dr. Hazlewood noted that it does and will take a lot of work and counseling. He has to work aggressively to get the prior approvals. The restriction on the Butrans patch is not appropriate. Dr. Brophy stated that the Memphis pain groups are upset that they can't use Duragesic patches.

Other comments:

The role of the adjuster in this situation is difficult since adjusters can approve medications over denials but are very uncomfortable with this. They can waive UR denial. It was observed that the adjusters do not know that they do have the power to approve and don't know the processes. Most UR doctors will deny medications. They must be educated on documentation of pain management. UR doctors will not approve hydrocodone.

There is a need to separate legacy patients from new patients during this entire process. The best that can be hoped for realistically is to get the legacy patient down to lower doses.

Abbie Hudgens asked if it would it make sense for a supplemental group? The Committee agreed and Dr. Snyder has been charged with forming and implementing the group. Dr. Bellner and Dr. Hazlewood agree to serve. Dr. Autry Parker of Memphis was suggested. Misty Williams will serve. Adding a PBM was suggested. The group will take a look at the Butrans patch and other sustained release formulas to replace morphine. Why are some drugs moved from "Y" to "N"?

Dr. Bellner brought five letters where the information and her attempt to reach someone who could make a decision ended in a “run around.” There is a lot of confusion between the adjusters, the PBMs and who can do what. When a medication is approved, overriding a UR, often another UR is opened soon afterwards to deny it.

Dr. Snyder said that, in the new fee schedules and UR rules, once an appeal is determined that another UR may not occur for 6 months unless some other medical development in the case warrants it.

UR doctors tend to deny these (meaning long acting) drugs even though there is documentation for drugs’ effectiveness.

Dr. Snyder tried to explain the difference between prior approval and utilization review: “Prior approval”—drug is appropriate for person’s injury. “Utilization Review”—drug is appropriate for long term treatment and is medically necessary.

Doctor’s should gradually wean the patient and lower the doses. Oftentimes, they don’t and panic when the patient is denied the drug. There is a need to justify medications to UR doctors and there are problems with coding. A treatment may be denied just because it is coded incorrectly.

Dr. Talmage asked if there should be a category for egregious UR, a penalty for poor UR that delays a patient’s care? Decisions in UR have implications for quality of patient care and recovery. Why subject patient to more severe effects from injury by delaying or denying treatment? Better outcomes occur from sooner treatment. Should Dr. Snyder be able to identify egregious UR’s, sending them back to the insurers and outline behaviors not acceptable for doctors? He already polices violations for not requesting necessary information and when the UR reviewer is not licensed or is not of the same or similar specialty.

Not doing UR does generate more expense and there are recommended treatments that are clearly not medically necessary or appropriate. Sometimes physicians are unavailable or unprepared.

Dr. Mankani asked if the reviewer not communicating? Do we need to know which reviewers are guilty of this?

It was observed that there are penalties. A UR company can be sanctioned or suspended. There are also \$100 to \$1000 penalties but the new rules penalties (based upon new law) is \$50-\$5000.

The three Medical Directors will try to develop criteria to identify “bad UR.” Dr. Tutor suggested naming 5 doctors that have “bad behavior.” Dr. Mankani noted that Liberty Mutual already has a auditing process that gives reviewers scores based upon criteria and have gotten rid of some from feedback.

Abbie questioned the impact of severity on delays in care due to UR. The Medical Directors already factor in the foreseeable consequences of further delays on the potential outcomes for the patients. They are sensitive to the patients' needs in reaching some resolution when UR is being appealed. If it will adversely affect the outcome and it is medically appropriate and necessary, it is approved.

Case Management Rules:

Dr. Snyder outlined the new rules for case management that became effective August 29, 2016:

1. Most provisions go into effect January 1, 2016.
2. Two years conversion for CMA to CM.
3. Four hours of Tennessee specific continuing education per year.
4. Face to face meeting time frames between CM and patient.
5. Five elements that qualify as case management, patient contact.

FAQs are posted on the web site with more to follow.

Dr. Tutor questioned RN's onsite health clinics. Are they case managers?

Dr. Snyder responded that it depends upon the services provided, the situation must be studied.

MIRR:

New rules are effective tomorrow. The new provisions may help with impairment ratings, by allowing access to the registry in a third situation regarding a "dispute":

1. Two physician give different rating and the parties cannot agree.
2. Permanent medical or mental restrictions are given but a zero permanent impairment.
3. Both parties agree that the one PI given by the ATP is not correct.

There is an increase in the fees that are effective for applications after today (\$1500 for regular and \$2000 for psychiatric). The rules for a cancellation or "no-show" fee and recovery by the insurer are also included.

Peer to Peer:

There were no further comments.

Fee Schedules:

State variations in fee schedules were discussed. Which state's fee schedule applies when out-of-state employee is hurt? An employee can live, be hired, be injured, receive treatment, etc. in different states. There are many cross state rules. Presentation of the different methodologies would be valuable.

Before reform, there was a \$10,000 fine for paying above and for keeping the payment above the Tennessee Fee Schedule. No penalties have ever been assessed. There is a mechanism to provide waivers within as well as outside Tennessee when either proper care cannot be obtained at the fee schedule or when other good reasons exist. Dr. Snyder pointed out that in general, Tennessee uses a Medicare based fee schedule.

NEW BUSINESS

Brochures:

A question from Abbie: How much information should the Bureau of Worker's Compensation provide to injured workers? Florida provides injured workers brochures and website information, most about the process and their rights. Some states including, Washington State, provide information concerning outcomes, risks and complications from individual procedures. Should Tennessee provide the same type of information to employee and employers?

Abbie made some suggestions:

1. Warn people not to see opioids as long term solutions? There is very little doctor/patient conversation about this. Could we get information to the patients with the first prescription? Should we use mass mailings like the Federal CDC sent to all pain management physicians?

2. Fusions are not done for degenerative disc disease. Minnesota has specific information.

3. Idaho (Dr. Mankani) and some other states provide it.

It was noted that the website provides some information.

Maine and Massachusetts have legislated limits on opioid prescriptions to 7 days.

If the patient is angry or confused, should he/she have something available to cushion the blow of a UR denial or to trust the doctor without further information?

There was not much enthusiasm but a generic brochure and links to the website or other information might be helpful. It might be too confusing for the Bureau to be providing the specific medical information.

NEXT MEETING:

Dates:

Will get consensus on some dates for the next meeting (November 8 is Election Day, and December 15 may be too long).

Adjourn: at 2:50 PM.

Afterwards:

Reed Group-MD Guidelines presented their treatment, return-to-work (disability) and drug formulary guidelines. Development, philosophy, methodology, and other questions were discussed. Regular updates occur but take about 18 months from the start to publication. They can be integrated into settings beyond WC. there are ICD cross walks, search features, diagnosis related treatments, mapped by body part and condition. The recommendations are followed by an assessment of the strength of that recommendation. The drug formulary is diagnosis/condition specific (is the drug recommended for this condition, acute, sub-acute or chronic?). Drugs can be referenced by a number of different pathways (condition, name, NDC, etc.). ACOEM is working on new E/M rules

for WC. There was a discussion about what California is doing presently with their formulary. Reed Group graciously offered three months free to any interested committee members.