Medical Advisory Committee

Meeting Minutes
March 7, 2023
via Teams

Tennessee Room
220 French Landing Drive
Nashville, TN 37243

The meeting was held in the BWC Large Conference Room with telephone and virtual options available. All attended via TEAMS. The use of the virtual platform is a benefit to the public, allowing participation of out-of-state stakeholders and others interested in the subjects of this meeting. It is necessary for establishment of a quorum that the members have the virtual option available. The committee rules provide for the members to be counted as present for the determination of a quorum (see rule **0800-02-23-.04 (2-3)**).

Members:

Misty D. Williams, Travelers
Lisa Hartman, RN, AFL-CIO
Ginny Howard, Zurich
David Tutor, MD, Occupational Medicine Chair
John Brophy, MD, Neurosurgery (tele)
James G. Kyser, MD, Psychiatry
Richard L. Cole, D.C., DACNB, DAAPM, FICCN, FICC(H)
Jeff Hazlewood, MD, PM&R, Pain Management
Lisa Bellner, MD, PM&R Pain Management
Cerisia Cummings, DO, Bridgestone
Amy Moses, McKee Foods Corporation
John Benitez, MD, TN Department of Health
Dan Headrick, PT, CEASIII, ASTYM, BS
Veatrice Storey, Zurich Insurance (tele)

Guests:

Carla Townsend, NCCI
Faith Parrish, Vanderbilt
Tiffany Gryzbowski, HealtheSystems
Larry Brinton, Accuro Solutions
Alex O'Neil, Arbitech
Fran Sweatt, Vanderbilt
David Price, Preferred Medical

Staff:

Troy Haley, Administrator, BWC
Robert Snyder, MD, Medical Director BWC
James Talmage, MD, Asst. Medical Director BWC
Wills Oglesby, MD, Asst. Medical director BWC
Suzy Douglas, BWC
Mark Finks, BWC
Anne Zimmerman, BWC
Suzanne Gaines, BWC
Kyle Jones, BWC

Via telephone:
Veatrice Storey, Zurich Insurance
John Brophy, MD

Call to Order

Dr. Tutor called the meeting to order at 1:05 PM.

Introductions were made of committee members, staff, and guests.

This is the first hybrid meeting of the Medical Advisory Committee.

Quorum

Mr. Finks took roll of the members, and a quorum was confirmed as present: 14 of 16 members present (1/3 members needed for a quorum).

Approval of Minutes

Dr. Cole motioned to accept the minutes of the December 13, 2022, meeting, and Dr. Oglesby seconded. The minutes of the December 13, 2022, meeting were approved as written with no dissent.

Conflict of Interest

Ms. Douglas reported that all forms were in.

Old Business

ODG Update

Dr. Snyder reported that he received no new updates.

Medical Fee Schedule

The three new medical fee schedules are being analyzed by the Attorney General's office. They gave an update approximately two weeks ago. The fee schedules were reassigned to another attorney due to workload issues. There will be an update as to when the fee schedules become effective once they have been approved.

Medicare Update

The conversion factor dropped retroactive to the first of the year. It was done with the Budget Reconciliation Act that passed at the end of December 2022, so the final figure for Medicare came out before the first of the year. As of the first of this year, Medicare reduced the Conversion Factor from $35.00 to $34.06. The BWC will try address this change in the Tennessee Fee Schedule and do as much as possible to keep providers seeing injured workers and maintain access to care. This includes doing everything possible from a reimbursement mechanism to establish access to care for very difficult subspecialists.

Changes to the Tennessee Fee Schedule included an increase in the percentages of the Tennessee specific percentages for occupational medicine and physical medicine. These were instituted with last year's changes to the medical fee schedule and will increase to 180% as of this January.

For 2023, the conversion factor dropped 3%; there was a 15% increase for occupational medicine and physical medicine. This ended up being much less of the drop for these two groups of physicians.

Internal medicine includes no PM&R physicians and only for E/M codes**.**

Rules and Legislative Update

Mr. Haley reported that the present legislative session has been very busy. There is an administration bill, HB 82 by Lamberth, SB 263 by Johnson. Currently, the uninsured employer fund has a $20,000 benefit and 10 benefits, $20,000 in medical maximum for injured workers who get injured while working for an uninsured employer or an employer who broke the law and did not carry workers' comp insurance. Until now, there was no statutory authority to pay death benefits. This bill has gone through the Senate and the House as amended. When it has finished the process, it will provide a $20,000 death benefit from the uninsured employer fund. It will give the Bureau rulemaking authority for the Certified Physician Program which is high priority for the Bureau and administration.

The Firefighter PTSD Presumption (SB856, Bailey) bill has come back. Previously, it did not get through the process before because of the fiscal impact on local governments. This year, they are trying something different with the state grant program that would be administered by the Department of Labor, Bureau of Workers' Compensation. This is a very popular bill with all 33 senators and most of the House signing as sponsors. The fiscal impact will have to clear the budget process.

Senate Bill 1263 by Akbari is presently moving forward. It will change the law in which the employer or workers' comp insurance carrier must provide the injured worker with a panel of three or more physicians. SB 1263 would allow injured employees to choose any doctor they wanted, and the treatment would be paid.

Mr. Haley went on to explain that there was not a significant fiscal difference in states with panels versus non-panel states. There would be an impact in Tennessee on utilization review numbers and MIRR

program numbers. There doesn't appear to be enough support to get the bill through the committee process, but it's progress is being monitored.

Senate Bill 97 by Senator Walley will also be monitored. Mr. Haley and Ms. Terry both had a limited involvement.

There were two deaths in a manufacturing plant in Senator Walley's district, one in 2014 and one in 2021. Both widows contacted his office about making some dramatic changes in the workers compensation law. After several meetings with the business community and doctor, Senator Walley worked out an amendment that would basically make a small change to the payment of death benefits to a single beneficiary. If the surviving spouse remarries, the benefits automatically terminate. There would be a payment of a lump sum of 25% of the average weekly wage for 100 weeks. That is the most significant change, but there are other changes such as removing the exclusive remedy and global gross negligence cases. That part of it did not make if to the original bill or the final amended version.

There are other bills moving at various stages through the legislative process that are scope of practice bills for PA's and NP's and physical therapy. They are complicated and being amended.

There is a final point about medical cannabis in general. It does not seem to be moving forward this year. There are maybe 6 or 8 of these bills that were filed and some of them are still languishing. The main bill that proceeded to a committee vote and failed was Senator Bowling's annual medical cannabis bill. It does not have sufficient support to make it through the committee process.

The delta 8, delta 10 regulatory bill is still moving forward. It might pass this year.

There is a bill that is moving forward that changes the makeup of the Medical Cannabis Commission by adding a patient who has suffered from one of the covered conditions to the commission. It looks like it will pass.

The recreational cannabis does not seem to have the votes to be able to move through the process, but it looks like medical cannabis for the most part is going to be next year at the earliest.
Mr. Haley offered to help with any questions about the legislation.

Dr. Tutor asked what is the driving factor behind getting rid of panels?
Mr. Haley answered that he had heard that it is the general access to care concerns. For such a change from current law to happen, there will have to be a very serious problem in Tennessee that gets the attention of the business stakeholders, insurance stakeholders, and the legislature.

Ms. Hartman asked for a synopsis of the bills to understand their intent and how it impacts the committee, providers, and employees on workers' comp.

Mr. Haley offered to email a list of bills with the links to the General Assembly website for more information. He explained that after the legislative session is done, bills that are approved go to the governor to be signed or not. A year end update is prepared to be posted on the website. During the legislative session itself, analyzing or taking positions is prohibited since the Bureau is an Executive

Branch entity and work sthrough the Governor's office. These things are in a "confidential status" until the process is completed.

Mr. Headrick had questions about a bill concerning physical therapy. Mr. Haley explained that SB72 would allow the practice of physical therapy to be done under the written or oral referral by a nurse practitioner or physician's assistant. It also addresses some aspects of education requirements. The bill has passed in the Senate but not in the House.

Dr. Kyser asked if the regulations of the Bureau of Workers' Compensation have to be done legislatively or does the committee have anything to with it? Mr. Haley answered that legislation that requires statutory change limits the Bureau to making a presentation to the governor's legislative team in May or June. The proposal is submitted in writing and a face-to-face presentation. In the fall, the Bureau would be notified as to which part or parts were approved to be included in the governor's package for the following January.

Rules and regulations, such as the fee schedule rules, utilization review rules or case management, are on a year-round basis and can be sent to Dr. Snyder or Mr. Haley to be included in the yearly review. The process is a public rule-making hearing, and a notice is filed with the Secretary of State which is a preliminary copy or draft of the proposed rules. This is filed at least 50 days prior to the date of the rule-making hearing. After the rule-making hearing, the comment period is open for 14 days. The final version is sent to the Attorney General's Office where it undergoes a lengthy review. When it is approved and returned from the Attorney General's Office, the final version is filed with the Secretary of State. It appears before the joint Government Operations Committee within a 30- or 60-day period, and the effective date is 90 days from the date the final version was filed with the Secretary of State. This process is lengthy but more fluid; it is not on a June to January schedule like legislation.

Dr. Kyser asked for guidance with two issues. The first was the proper way to introduce a regulation or law that would state that the workers' compensation carrier is required to give written notice to the treating physician that benefits have been terminated. The carrier has not always been forthcoming with notification when a claim has been denied or benefits settled.

The second is the issue of presumption of being part of a PPO network and having to send in the treatment contract with every bill to show that they are not part of a PPO. The presumption should be that if there is no agreement with the discounted network, payment should be made according to the Tennessee Fee Schedule.

Mr. Haley answered that the first issue is already on the list of possible amendments to the insurance claims handling standards. All the rules are under a mandatory department review that occurs every eight years to update rules or repeal rules that are not necessary. Ms. Terry is working with all the directors and is halfway through the process.

Dr. Snyder said that he would email Dr. Kyser about the PPO network presumption and get more specific information. This would fall under the settled PPO Statute. This recommendation would be beneficial when it comes to clarity of reimbursement. Dr. Kyser said he will forward the email he received to Dr. Snyder and Ms. Douglas.

Mr. Headrick asked about the adjuster treatment approval time which was extended from three days to four days. Dr. Snyder said the date that the provider ordered treatment and the date that utilization review was instituted is being more closely monitored.

As part of Dr. Snyder's report, two of those had been sent to penalty since the first of the year for failure of timely response from the adjuster. One provider submitted the problem to the Bureau, and the other one was picked up from a utilization review appeal.

Dr. Tutor had questions about Dr. Kyser's first point about provider notification when the claim has been terminated or denied, and the payment of visits that take place during the interim of denial and provider notification. The provider should get notification in writing; and any visits that occur between the termination/denial date and notification date should be paid.

Dr. Snyder said that the wording of the recommendation of the claims handling standard must be worked out as well as how the notification occurs. The timing for that and what payments are due will be part of the language.

Claims handling standards specify that the adjuster must notify the injured worker within two days of the change of the adjuster status. Right now, that is the only thing to do with claims adjuster notification in the claims handling standards. It will be added that they must notify the other parties to the claim, including the providers, when there's a change in the adjuster status as well as change in the claim status.

Dr. Tutor commented that this is an access of care issue.

Not only the authorized treating physicians will have to be notified, but other providers of record.

For claim closure, the injured employees must agree to a settlement with the court so they can close the claim whether for open medicals or closed. If there is a settlement that the injured worker has agreed to and they are not notified, it's because the attorney is not notified. The other is claims denial and providers are not notified.

Ms. Williams stated that when a claim is denied for compensability, the providers are to be notified by C-23, just the same as the employee and the insured. All parties are to be notified of a denial of compensability.

Mr. Haley added that the physician, the injured worker, and their counsel are supposed to get a paper copy of the notice of denial.

Ms. Williams said that the notification was usually sent out the day of the denial or within one business day of the denial. The adjusters are instructed that it is necessary to provide the verbal notification of the denial to the employee or attorney immediately, even before the letters are sent.

Dr. Bellner added that the treating physician does not always get all the information they need even when they are notified. They need the telephone number, fax, email, and new claim numbers. If there is

a new carrier involved or if companies have merged, all the information changes and it is very difficult to get adjuster contact information or locate patients within the system.

Dr. Bellner also said that physicians never know when the Medicare set aside is done. Formerly, the patients would tell the physician that they did the Medicare set aside and didn't have workers' comp anymore. The physician would still be paid at Tennessee fee schedule rate. Some of the companies are not using the Tennessee fee schedule rate anymore; they are using the Medicare rate and there is a disclaimer telling physicians they can bill the remainder to the patient. The treating physicians do not have any information on what the patients signed. The patients tell them that they settled their claim and have a new card that will pay, but it pays the Medicare fee schedule.

Mr. Headrick said that the networks should have a requirement to communicate to the adjuster and case manager and to all stakeholders. They don't do that for rehabilitation professionals. Some of them do, but some of them do not. It needs to be a requirement. They do not give the information, nor do they share it when called. It is not on the referral forms.

They only get physician orders from the networks about half the time. When the physician orders are received from the networks, the referrals are sometimes incorrect. Now, they call the doctors to get them. The networks have a purpose and need to help and fulfill the purpose.

Dr. Tutor agreed that if he has specific goals or requests, they seldom get passed on. Many times, he does not know where they are going until he is called. Many do not call.

Ms. Hartman asked whether it would be prudent to notify patients and all other involved parties by registered mail or certified mail. The letters could be tracked. Can the committee decide to do it?

Dr. Snyder said that he would look at the present statute and present regulations and report back at the next committee meeting.

Mr. Headrick explained about communication from the insurance companies to the providers. There is a difference between rehabilitation providers and the medical providers. The networks are responsible for giving rehabilitation providers information from the insurance companies which they are not doing in a timely fashion or at all. If only the insurance companies are addressed, the networks won't be addressed, and the rehabilitation professionals continue to be exposed to the same risk of not knowing if the case is closed.

Ms. Hartman answered that when she suggested all involved parties be informed, she was including rehabilitation specialists.

Ms. Williams pointed out that there is not a requirement on the state forms that the ancillary providers be notified, only the primary provider. Some companies may not notify the other providers.

Dr. Snyder thanked everyone for their input.

Utilization Review Report

Dr. Snyder reported on the utilization review appeals for calendar year 2022. The Bureau of Workers' Comp completed and resolved 1,099 utilization review appeals, which is down from 1,400, two years ago.

Fifty percent (50%) of the utilization review appeals sent to the Bureau as denials were upheld.
Thirty-one (31%) percent were overturned.
Nineteen (19%) were closed for administratively. The administrative purposes can be for causation, which cannot be ruled on, or the adjuster approves the treatment after notification of the appeal.

It takes an average of 21 days to get the complete records, which has been a problem. The Bureau is in the process of speeding up the process by issuing penalties. Once all the records have been received, on average it takes less than two days to complete an appeal and send out the determination. The staff continues to work on medical records issues.

The Utilization Review Appeals Unit has sent 10 requests for penalties to the Penalty Unit in the last 2.5 months.
One (1) was notification that the reviewing physician had used the wrong diagnosis and the wrong guideline to issue a denial.
Two (2) of them were filed because the authorized treating physician failed to respond to requests for information from the utilization review organization.
Two (2) of them were filed for an untimely response from the adjuster for request for treatment.
Two (2) were sent for violations of peer-to-peer recommendations. The physician requested a peer-to-peer contact, and the reviewing peer never responded.
There were 3 requests for medical records that the adjusters did not respond to and so were sent to penalties.

Dr. Snyder said if there is a problem as far as providers are concerned, if there is a failure to respond, let him know and it will be acted upon. Some problems are picked up by complaints from providers and some come from patients and others are picked up from utilization review appeals

Covid Update

Dr. Snyder presented the covid update. There has been very little change in the total number of applications. Since the start of January 2020, there have been 14,000 first reports of injury. Benefits were paid to 1,636. Of those, 52 fatalities have been reported under the COVID codes. Of those, 15 of those have been accepted and payments made.

Presently, there are two cases pending in the courts. One had to do with a reaction to a COVID vaccine. The second is a dispute over a death claim. Neither case has been settled. Twelve (12) other cases made it through mediation and were accepted as a dispute and have been dismissed. Most of these were dismissed because the claimant did not properly complete what was necessary to continue the case. They did not respond to the court orders or to requests for information.

There have been very few court cases concerning COVID in Tennessee with no other decisions have been made by the courts on COVID claims.

Dr. Tutor asked if there was any information on the severity of the reaction to the vaccine.

Dr. Snyder said no, it is still in pending for the court. There are some figures from NCCI and from Workers' Compensation Insurance rating. During the first 6 months of medical treatment, COVID claims are around $6,800.00 on average, compared to all other claims being approximately $2,500.00 in the medical payments. Hospitalization raises the cost of COVID claims. The average non-COVID claim medical benefits is $22,000.00, but the hospitalized patients with COVID is $77,000.00. NCCI has reported $630 million in COVID incurred losses over 80,000 claims with an average of approximately $7,800.00 in total claims cost for a non-hospital COVID claim. This is higher than the average cost for other claims. When COVID claims are accepted, they cost more.

Dr. Snyder observed that there has, at the present time, not been any activity in the courts, ombudsman or the mediation program concerning long COVID claims. These claims could arise at any time.

Dr. Tutor asked for questions or comments.

New Business

Contract Issues and PPOs

Dr. Snyder notified the committee that since before the first of the year, the Bureau has been working with the Department of Commerce and Insurance concerning issues with contracts and workers compensation. These issues concern applicability of contracts and access to PPO networks through merged entities. There have been a lot of merged entities when it comes to bill review agencies and utilization review agencies. The Bureau has been working with the Department of Commerce and Insurance concerning these contracts.

Authorized Treating Physician

The Bureau has received a request to expand the definition of authorized treating physician to include psychologists. This would require a statutory change and a lot of background information. If the PTSD and/or presumption bills move forward, it would require an investigation by the Bureau as to how to provide these services within workers' compensation.

Utilization Review Organization Annual Report

As of the new rule effective September, 2022, the Bureau requires the utilization review organizations to issue an annual report. The Bureau has received approximately 15 utilization review reports with

significant numbers. Those annual reports will be reported next meeting. It includes the total numbers of utilization reviews that were done in the state of Tennessee during the year 2022.

The number is broken down by denials, modifications, and by approvals (certifications, authorizations). The number and types of physicians that made those reviews are broken down by physician and their activity concerning denials, modifications, or approvals. This will provide information about potential issues with the utilization review activities in the state.

Next Meeting:

June 6, 2023.

Adjournment:

Dr. Tutor adjourned the meeting at 2:07 PM.