Medical Advisory Committee

December 1, 2020
Via Webex

Members:
Rob Behnke, Cracker Barrel
Misty D. Williams, Travelers
Lisa Hartman, RN, AFL-CIO
David Tutor, MD, Occ Med
John Brophy, MD, Neurosurgery
James G. Kyser, MD, Psychiatry
Ginny Howard, Zurich
Keith Graves, DC, Chiropractic
Jeffery Hazlewood, MD, PM&R
Lisa Bellner, MD, PM&R
Cerisia Cummings, DO, Bridgestone

Staff:

Abbie Hudgens, BWC Administrator
Robert Snyder, MD, Medical Director
James Talmage, MD, Assistant Medical Director
Suzy Douglas, RN, BWC
Troy Haley, BWC
Mark Finks, BWC
Kyle Jones, BWC
Suzanne Gaines, BWC

Guests:
Toni McCaslin, Health Trac
Faith Parrish, Vanderbilt
Adam Jaynes, MNA GR
Jennifer Clark, MTOEM
Alex O'Neal, Arbicare
Carter Phillips, MNA GR
Tiffany Grzbowski, Health Systems
Jonathan May, Attorney
David Price, Preferred Medical
Tracy Wall, Eckman/Freeman
Christopher Chappell
Jim Schmidt, Schmidt GR
Roy Johnson, MD, MTOEM

Call to Order

The meeting was called to order at 1:04 PM by the Chair, Dr. Tutor.

Quorum

A quorum was confirmed as present (11 of 16, 8 needed).

Approval of Minutes

Minutes from the 9-15-2020 meeting were approved as circulated.

Called for any delinquent Conflict of Interest forms to be completed and returned to Suzy Douglas.

Old Business

ODG Updates:
June and July had lots of updates. ODG updates for August and September were few.
The update for August was for Chapter Pain, H-Wave® device stimulation.
September's updates were Neck, Manipulation; Low Back, H-Wave® device stimulation.
ODG changes were accepted, no dissent.

Telemedicine and Telehealth:
The public hearing for rules is in January (delayed until Friday February 19, 2021). The entire process takes eight months. The draft rules have not been sent out yet but may be available to anyone who e-mails Dr. Snyder.

Legislative/Rules:
The Medical Fee Schedule rules are in the process of going to the Governor's office and there will be a public hearing. The rules have already gone through the Medical Payment Committee. Clarification of billing and payment rules have a minor change in language. The rules are pretty much the same.

UR Working Group:
Research of last spring has been completed; the index of cases will be sent, by request, to carriers.

Update on UR and UR appeals:
The COVID-19 report showed (without a presumption) 3858 claims, 1603 denied (42%), 577 accepted (15%), remainder not reviewed yet. This is 15% of this year's claims which are down 18% from the year prior. Jane Salem has published a review of proof in the **Ad*MIR*able Review**.

UR and UR Appeals are down about 10% for the year. A noticeable shift has occurred where 40% of the appeals are coming from attorneys, replacing physicians. An explanation for this trend is that plaintiff attorneys are aware of this avenue to get their clients treatment. Jonathan May noted that the attorneys are looking for better outcomes for client/patients. Attorneys have reached out to physicians and go ahead with an appeal if the physicians don't. They try to get physicians to appeal because the physicians know what is going on medically. Why physicians don't appeal is likely due to the fact that it takes resources and time.

Dr. Bellner asked if there were any incentives for attorneys to get involved? Mr. May responded that an element of the services attorney's provide is a part of advocacy for clients.

Dr. Talmage observed that files sometimes don't contain the latest treatment notes.

Attorneys often rely on adjusters to supply the latest medical records received. Dr. Talmage observed that files sometimes don't contain the latest treatment notes. It was suggested that the appealing party could be copied on submissions.

BWC has only one potential COVID-19 claim determination that has been filed with court, so far. Many cases have been mediated or are being mediated.

Dr. Snyder observed that claims were down because of fewer hours and less high-risk work. Possibly, there is more attention to safety.

Mr. Behnke observed that, for his company, claims were lower than they have been in fifteen years.

New Business

WCRI Report—Reoperation & Readmission Rates for Workers' Compensation Patients Undergoing Lumbar Surgery:

Dr. Talmage gave the report on lumbar surgery captures operation changes but didn't have outcomes regarding pain. The outcomes of surgery should be looked at in the future.

Indications for lumbar fusions are confusing mixing trauma and third time herniated discs **in this study**. Minimum 2-year follow-up from 2016. Rates, readmissions and re-operations were reviewed from the handout.

Observations:
The overall medical training and oversight of adjusters is limited.
It is hard to focus on any specific company or company policies.
Misty Williams stated that any complicated surgery should be put through UR for patient safety.
Is it recommended that all lumbar fusions be put through utilization review? Dr. Brophy disagreed.
Dr. Hazlewood suggested psychological evaluation before getting spinal fusion.
The effect of depression on the potential of pain should be assessed in patient.
Patients' lack of specific, competent and complete conservative care before surgery could prevent them from going on to fusion.
Dr. Talmage suggested psychological tests to screen out people who shouldn't have lumbar fusion.

Question posed by Committee without a consensus:

- Should all lumbar fusions go through UR?
- Should all lumbar patients go through opioid weaning before procedure?

Dr. Brophy said that adjusters need to be educated.
Dr. Tutor asked Dr. Brophy, what group should approve fusions?

How many fusions a year does Tennessee average? There's not enough for follow-up data.
For Tennessee, there are 7000 claims for low back, 25% of the musculoskeletal injury claims.
Fusions average about 300/year.

There are no more than 30 cases a year of fusions appealed.

Dr. Snyder will check lumbar appeals for data.

50% of fusions are for chronic low back pain, likely an aggravation of pre-existing disease that is not likely (more likely than not) work related. Was there a structural change with the injury? Or is it pain?

It is suggested to catch it at the beginning before surgery and try to find something else that might help the patients. If conservative measures fail, next thing is usually surgery. The success rate of the fusions in improving the condition is in question. Outcomes of fusions for trauma, third disc herniation, or degenerative spinal disease vary widely.

Educating adjusters might help.

A study in Vanderbilt spine surgery and opioids predicts pain relief does not improve and medications continue. Although incapacitating back pain will need some medication until surgery.

Dr. Snyder will summarize these suggestions for the next meeting.

Dr. Tutor asked for any other comments.

Announcements

The state is moving towards Microsoft TEAMS and away from Webex.

Next Meeting

Tuesday, March 9, 2021, 1:00-3:00 PM CST.

Adjournment

Dr. Tutor adjourned meeting at 2:16 PM.

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