LOUISIANA WORKFORCE COMMISSION

WORKERS' COMPENSATION TOWN HALL MEETING

MONROE CITY COUNCIL CHAMBERS – MONROE, LA

SEPTEMBER 16, 2016

Director Sheral Kellar: Okay. Uh, thank you guys for coming this morning, because we thought we were going to be only ones here. (Laughter.) But, we're happy that you showed up. Uh, I'm Sheral Kellar. I'm the Director of the Office of Workers' Compensation. Uh, I'm the former Chief Judge of the office for 17 years, before being appointed by Governor Edwards to the position of Director. And, uh, we're here today to hear what you think about the medical treatment guidelines and the 1010, 1010A, and the 1009 process, uh, that we use to request medical treatment for injured workers. Uh, we know that we have some challenges and we hope that you have some rewards. But, we want to hear from you, the guys who work in the trenches, uh, to see if you can help us to be part of the solution to some of the difficulties we are aware that we have. Uh, I'm going to introduce you to some of my staff, and then, we're gonna hear from the Mayor, uh, and then, we will, uh, get started with hearing from you. But, we ask you that if you have cell phones, to turn them off. And, we would appreciate if you will not use any real cases, but, give us some hypothetical generalities. Uh, and, uh, we may not give you answers that you'd like today, but, we will hear you and take all of your comments into consideration when we're trying to refine the medical treatment guideline process. Okay?

Uh, today, I have with me, Dr. Picard, a Medical Director. He is the gentleman that makes all those decisions on the 1009 appeals. I have Pauline Williams. She's the Deputy Director of the Office of Workers' Compensation. And, next to her is

Cathy Chesson. She's one of the nurses of the medical services section. And, I think you guys know the D1-E Monroe Staff, Tekisha Smith, here, is the mediator. And we have Sophie Brice in the back, who is the Judge's secretary. Kimberly Buck is the Public Relations Director for the agency in the Louisiana Workforce Commission. And, Michael Pittman is the, uh, IT guy for the Office of Workers' Compensation Administration.

Uh, I'm gonna ask Mayor Mayo to come up and say a few words. We're so happy to have him with us this afternoon and we're so grateful that he has allow us to use his lovely facility. Thank you. Mayor?

Mayor Jamie Mayo: Thank you, Madam Director. Let me say good afternoon to everyone.

Director Sheral Kellar: Good afternoon.

Mayor Jamie Mayo: Let me, first and foremost take this opportunity to welcome all of you here, Madam Director. Good to have you here. Good to have all of you here today at Monroe City Council Chambers. We welcome some of you to the City of Monroe if you've never been here before. Uh, very quickly, we are the birthplace of Delta Airlines and also the home of the University of Louisiana-Monroe; as well as the largest corporate headquarters in the State of Louisiana Centurylink, among others that we are very, very proud of. Judge Jones had called maybe a week ago and asked to have this facility to meet and, anytime a judge calls you (laughter from audience), you'll answer. But, we do appreciate that. But we do appreciate the hard work that you and professionals are putting forth, having to address some of the issues of Workers' Comp. and others. And, so, it's good to be here. I may have to step out, but, anything that you need while you're here, don't hesitate to let us know. And, we'll see if we can help you with that. Thank you again, for being here. And, we do appreciate all of the work that you're doing.

Director Sheral Kellar: Thank you. Thank you very much (handclapping). Okay. We have some folks who've walked in since, uh, I was at the podium earlier. And, uh, what we're talking about is the medical treatment guidelines of the Office of Workers' Compensation, uh, in reference to other participants in the room. I had asked you guys to keep your comments to three minutes. But, there is so many of us that you can just ramble if you'd like to take the time (laughter). Uh, so, if you would like to ask a question of the staff, or me, we will try our best to address those for you. Would anybody like to start? This always happens. Nobody wants to be the first person to speak.

Judge Brenza Irving Jones: And, Mr., Mr. Edwards is never quiet (laughter from audience). Attorney Edwards is never quiet.

Speaker: Before today.

Director Sheral Kellar: Okay. Can I ask you to, we have a court reporter who is going to transcribe everything we say because I want to take it back home and review it. Uh, so that I will remember what you say and hopefully use it to help us solve some of the problems. So, when you begin to speak, give us your name and who you represent.

Attorney Jimmy Edwards: All right. First of all, I want to say that if Judge Jones wants me to be quiet, just put a microphone in front of me (laughter from floor), I won't say anything. Anyway, uh, what I was going to ask --- I'm Jimmy Edwards. I'm a Workers' Compensation attorney here in Monroe and I do just about 100% defense work for LAC claims and some affiliated clients of theirs. And I wanted to know before today --- I know this meeting was held in many of the different parts of the State for a reason. And, I wanted to know what the Workers' Compensation Administration is thinking at this time in

order to call these meetings. Is there any kind of a preconceived notion about how well the guidelines are working, or aren't working? It would help me to know that.

Director Sheral Kellar: Well, we know that, uh, several things. Uh, the good news is that the guidelines are working in the sense that it is doing what it was intended to do. And, that is to get, uh, the treatment injured workers need quicker. Before the medical treatment guidelines, it could have taken up to approximately a year to get requested medical treatment because you had to go to a trial on merits with medical depositions, uh, second medical opinion depositions, independent medical evaluation depositions, and then you had to wait for the judge to make a decision. The medical treatment guidelines were designed to get a response to a request for recommended treatment in less than 90 days. And, to a great extent, it is working. The vast majority of requests for medical treatment receive a decision, uh, within that 90-day period. And, if a 1009 is filed with the medical director, he responds within 30 days. So, that's how it is intended to work. We know that there are some hiccups in the system, because we have heard from you individually. Some of you have called us to ask us specific questions about, uh, things that, uh, we have not been able to address up to this point. And so, my purpose in having the, uh, town hall meetings in the various cities is to allow you an opportunity to address the staff. Because you all generally don't get a chance to do this. We don't put ourselves out here very often. But, we're putting ourselves out here to hear what your grievances are with respect to the medical treatment guidelines. We know that tacit denial is a problem. We know that getting, uh, copies of the, uh, file is a problem. We know that people have complained that once the, uh, appeal gets to the judge, there is no opportunity to, uh, present further

evidence to the judge. So, we know there are some problems. But, we don't know all of it, because we haven't heard from you. But, in the two cities that we have been in, thus far, uh, New Orleans and Shreveport, we have a long list of issues that we had never considered before. Uh, we're very close to the process because we do this every day. But, you guys are in the trenches. You do it every day as well. And, so, you have a better --- a different perspective, I'll say. Not a better, but a different perspective of how things are going than we do. And, that's why we want to hear from you. Now, I want to say one other thing. The medical treatment guidelines also work because it has taken medical treatment issues out of the trial pipeline. So, if you were to have a trial before Judge Jones today, you could get a final resolution of your issue, uh, within seven months, as opposed to, uh, 400 days. Which is what it took five or six years ago. That's because those medical treatment issues are not in the pipeline. So, it does work. There are hiccups. We know what they are, some of them. But, you know some that we don't. So, we want you to tell us what those are.

Attorney Jimmy Edwards: I hope I am speaking for my client. This is a client representative of mine. When I say that overall, the guideline process has help in the administration of determination of medical issues. Uh, because, before when a dispute would arise, they were given SMOs which is costly. Litigation would commence. Which is costly and a much slower process with some issues. And, now, although in some form I'm sure to do 1010s, 1010As and 1009s, and all that, it does seem to expedite the process and I think that's where we've gotten. As far as the 1010 process was designed to do and I think it's working, do you agree?

Speaker: Yeah, I agree fully.

Director Sheral Kellar: Can you state your name for me, please?

Speaker: Tommy Green. Uh, I'm claims manager for LAC claims. And, I kinda have to reiterate what Jimmy has said. Before, the 1010 process was pretty labor intensive and it really didn't provide, you know, expedient treatment for the, uh, for claimant as far as the way the process was set up. I think with the 1010 process now, you know, once we do the request from the writer, it turns out well weekly; actually within the five days. I don't see as much of a problem --- we're on the other side. I don't see as much of a problem with tacit denial, maybe from our standpoint, because we are supposed to, you know, turn that around quickly whether approved or denied, so there may be some concerns that I am not aware of from that perspective. But, as far as the entire process, it's a whole lot more efficient than it used to be, from our standpoint.

Director Sheral Kellar: Thank you.

Attorney Jimmy Edwards: And, I know we have other people here, now. Thank goodness.

Director Sheral Kellar: Okay.

Attorney Jimmy Edwards: But, what I was gonna say is that there are some issues that --- and I haven't spoken to my client about this. This is just my free talk here. Uh, when there's an issue that's more complex, like a surgery, a back surgery, a neck surgery, I personally would like to see there'd be more than five days for that kind of determination. Cause sometimes it's hard for my client to get to an UR professional, get an opinion, have it properly evaluated, and turn that around in five days. Now, if it's for MRI or CT Scan, or physical therapy, that's easy. But, some of the surgeries are a little more complex. So, that's one issue. And, the other thing is,

and maybe I'm kinda of speaking now for folks on the plaintiff's end --- it does seem like there might be some initial time to respond. Not the period of time that's in effect now but I think there's already been some, some, uh, some complaints or feedback for having a long period of time to respond to the 1010 denial, to file the 1009.

Director Sheral Kellar: I think, uh, some attorneys, on the other side, claims attorneys, have requested, uh, 30 days to respond as opposed to the 15 as it is now. So, we are aware of that issue and we'll be looking at it.

Attorney Jimmy Edwards: Okay. Now, I'm giving up this microphone.

Director Sheral Kellar: Thank you.

Attorney Jimmy Edwards: I've done my part.

Director Sheral Kellar: Okay. Thank you.

Attorney Jimmy Edwards: Thank you.

Director Sheral Kellar: Uh, we're here to talk about the 1010, 1010A, 1009 process, medical treatment guidelines. If you have any questions, concerns, complaints, criticisms, please speak up and, uh, I'll recognize you. Give your name, uh, who you represent before you begin. So, who's next?

Speaker: I have a question.

Director Sheral Kellar: Okay.

Speaker: Hi. I'm Connie of Louisiana Pain Care. The biggest problem that I see is that, in a urine drug screen test for, let's just say 17 components. So each component has a CPT code. The biggest thing I'm finding is that they're being denied because the adjusters are not reviewing it correctly. They say it's an exhausted list. When they are not reviewing the attached explanation letter that explains why we're requesting the CPT code times 17. And the problem is, we are prescribing medication to patients. We have to be compliant in

making sure that they're, they're doing their medication regimen correctly. So, if we don't get those through, then I have to wait, I have to appeal it. So, that process goes from a possibly ten-day timeframe to –-- I have some right now that I am still waiting from the July.

Director Sheral Kellar: So, are you submitting 1010s to...

Connie: Um hum. I submit a 1010. I have an explanation letter that explains the CPT codes of my work requesting, what we're requesting. I send the records. I send the past hearing drug screen and I still get back denials that state the patient doesn't show abusive behavior. The patient lists an exhaustive list of CPT codes. When I've explained why we're doing it. And all at once they call me, like, before they deny, they call me and say, "Hey, can you explain this?" When I explain to them on the phone, they completely understand it. I don't know what else to do to make it easier. But, I mean, I have honestly, that I know of right now, over 17 that have been denied. And, those are patients that we're still prescribing medications. We are prescribing medications and are not able to do the urine drug screens unless we just don't get paid for it. And, that's something that's new. It's come across with, you know, the State of Louisiana where it says in the documents that we are able to do that on a quarterly basis. The adjusters are not, they're not abiding by that.

Director Sheral Kellar: Dr. Picard, do you see the requests for this?

Dr. Jason Picard: Yes, very frequently. And, there's nothing that we can probably do about your 1010 denials other than tell you to file a 1009. I don't think I can recall a time that I've denied one of the urine drug screens.

Connie: All right. You don't.

Dr. Jason Picard: It's...

Connie: It’s just the timeframe. You know, it’s just a long process.

Dr. Jason Picard: Yes. Cause it’s taking more time with that.

Connie: Right.

Dr. Jason Picard: Hopefully, they’re gonna to get to the point at some point if we keep approving them because the guidelines do not specify the amount of drugs you can do, or how often you can do it. So, when you send it to me, it’s gonna be approved.

Connie: Okay.

Director Sheral Kellar: Go ahead, sir. (Pause). We’ll come back to you, ma’am.

Speaker: Okay.

Speaker: I want to kinda add to that with the urine drug screen.

Director Sheral Kellar: Your name, please, sir?

Speaker: Matt Davis, Case expert: Uh, with the urine drug screens, what we are seeing from the medical case management side...

Director Sheral Kellar: Who did you say you were?

Matt Davis: Case Expert, I’m a case manager in UR. What we’re seeing is that the guidelines do state they should be done randomly, and they’re not being done randomly. They are being done every time they come in. Which is not random based on they know their appointment is coming up. They know they’re gonna be seen and they are doing the tests. So, they know that if they come in, the test is gonna be done. On top of that, we’re seeing also that even though in some instances, that the quality of urine drug screen was a negative, that we still would do a quantitative on top of the qualitative drug screen. So, we’re doing the qualitative up front and then we doing the

confirmation on the back end when the qualitative was "consistent with what the medication was." I do understand that in some instances, drugs like tramadol cannot be tested on a qualitative drug screen. But, we feel as though when the qualitative is within what they're taking, and we've done quantitative confirmations in the past and it also showed that they were taking the medications properly, then why are we continuing to request confirmation over and over and over again? Which is running a slew of medications from things that, some things I've never even heard of. I have had to do numerous searches on. Mainly, there needs to be some more specification on what can be done. I wanna kinda add to it. But it's a little bit over. Just a latitude guideline on the fee schedule. Per Medicare, 80101 allows for one K of $65.00 for Medicare. But we don't address it or respond for fee schedule. When we take 80101, it's done 12 times, 16 times, 18 times. However many times they are addressing that medication. So, a doctor who's doing the drug screen at Medicare is being paid $65.00 for reimbursement for doing that drug screen, whereas with Workers' Comp. they're being reimbursed at $650.00, $750.00, $800.00, because we're not addressing that on a fee schedule because Medicare, they took the initiative to made that change. We did not, you know, respond. So, they're being compensated no less than 12 to 15, 18 times more for Medicare's reimbursement.

By Director Sheral Kellar: So, is it your suggestion that one, that, uh, the medical treatment guidelines be revised so as not to require so many, uh, urine drug screens?

By Matt Davis: Correct.

By Director Sheral Kellar: And then, two, uh, regardless of the 1059...

By Matt Davis: Of the fee schedule.

Director Sheral Kellar:...the fee schedule should be adjusted to make the, uh, costs for that?

Matt Davis: It's not cost effective a lot of times, for whatever it may be, because what we see is not only they bring some many drug screens, but we see situations where it's inconsistent and then nothing is done. Well, if nothing is done, why are we even doing the drug screen?

Director Sheral Kellar: So, if a CPT Code 80101 is not in the Workers' Comp. Medical Fee Reimbursement Schedule, what is the $650.00 for?

Matt Davis: It is in the fee schedule.

Director Sheral Kellar: It is?

Matt Davis: It allows a charge for each medication you try to keep a run. So, if you run for THC, or whatever, say you charge for each lab, each unit, instead of with Medicare, it's the whole thing. The whole drug screen is 8001. In Workers' Comp. it 80101 per line. So, you're charging 12 units for that one drug screen that you did. So, like I said, being reimbursed at almost 1200 to 1500, 1800% versus what Medicare is reimbursing at.

Director Sheral Kellar: Okay. I understand. Thank you.

Matt Davis: But, as from the medical side, there's two things. Why is it being doing every time? When it's inconsistent, why is it not being addressed every time? And, then if it says in the treatment guidelines to be done as a random screen, if they know they're gonna be screened every time they come in, it's not random. It's being done every time they come in. They know it's gonna happen.

By Connie: I have a comment. It's not being done every time they come in. But, the only way that I can make it somewhat random, is to request it and on the 1010, put a date range. I have no control over the fact that the adjusters or

the carrier, they copy the patient on everything I send out. So, if they send in an approval, their patient is getting a copy of that approval. I can't help that, you know. I mean, they're gonna know that document, the urine drug screen, approved through Workers' Comp. There's a 90-day date range on those 1010 forms for that range if its recent. It's not done every time they come. Uh, as far as being inconsistent, we address that in the clinic sometimes. I mean, it depends on the patient. I see what he's saying, especially about the 80101. I agree with him. That's my biggest issue. And he sees it as much as I do that I send him a request and it says times 17 because that's the way we bill it. We don't get paid for that much but that's the way we bill it. The randomness, that's the only way I know how to make it random, is a good date range. I don't know how else to make it random. Because if I do it further than 90 days --- I've done it six months before and the adjusters hit me back with that like, Hum, why so long? So, the 90 days seems to be the easier way for me to get it random. I mean, we don't have anything to do with that next visit because most of the time it's not approved that quickly. But that's the only way that I can make it somewhat random. Again, he's right. The patient is still aware that they are gonna have a drug screen at some point because there's no way for me to stop them from knowing because they're getting that information in to them.

Director Sheral Kellar: That's, that's an issue that we could take a look at and see if we might be able to address it. I think all of you who deal with the medical treatment guidelines are aware that we have a medical advisory consult that is required to update the medical treatment guidelines. So, we can report that issue to them and see if there's something they can do to address your concerns.

Matt Davis: My concern is, is it okay if I speak?

Director Sheral Kellar: Yes. Go ahead, yes.

Matt Davis: My concern is for the patient safety. I mean if we, if we have a drug screen that is inconsistent and we're not addressing it, and they continue to say they are taking medication on top of what they're supposed to, that's not safe for an injured worker and they're out driving, they are currently working at the time, that's not safe for whoever they're with. There needs to be something in the guidelines that not only supports when the drug screen should be done, but how they should address the, the negative --- the inconsistency, I'm sorry, not negative, an inconsistent reading in the drug screen, how the doctor should move forth with that. Cause right now, it's, it's really just left in the hands of the physicians. And this is threat. We do all over the State of Louisiana. This is obvious all over the State. They're doing the same thing. They're doing, a lot of the problems, more so in certain areas. But, I just wanted to throw that out there.

Director Sheral Kellar: Thank you.

Connie: It should be left to the physician. The physician is the one who is prescribing the medication. It's in the license that, that you screen four or five prescribers' medications. We do drug screens. We do pill counts. We discharge patients. We wean medications. I mean, we more than make up for what we should do on patients. I mean I, without the physicians speaking, I'm speaking for them, and that's in our clinic, those are the things we do when administer drug screens. A lot of times if they will get sick, which is what we do in clinic, it shows a very limited amount of drugs. A lot of times it's illicit drugs. Possibly Norco, Percocet, the toxic drugs. If those are inconsistent, then we request the qualitative. Which is what Matt's talking about. If that's

inconsistent, then we request quantitative, which is confirmatory, which we send out. The confirmatory is the only test that shows dreaminol, uh, duragesic patches. It shows if they're positive for methamphetamine. It will tell us if it is illicit. That is the only way for us to know if they're on methamphetamine. That's the only way for us to be able to be 100% positive that we're tracking what they're doing.

Director Sheral Kellar: And, I appreciate what both of you are doing and what you're talking about. But, I think that you know that uh, the, the drug use, overuse, over-prescribed, is a big, big issue in Louisiana. Uh, and it's not just the Workers' Compensation issue. It's a general healthcare issue. Uh, it is one that our Governor is aware of. Uh, this past legislative session, he, uh, convened an open door commission to look at the use of drugs, uh, in our State. And, I think we are one of the, uh, highest, uh, the state with the highest number of abuse of opioids in the country. As we always are. We're always number one on the bad list at the bottom of the good list. But, we are aware that you're having these problems. Uh, it is a general healthcare problem but it does affect Workers' Compensation patients. And I'm glad you're bringing it to the forefront and that we know about it. And, we will address it in the context of the opioid condition and the context of the meds as well. Thank you very much.

Speaker: Do you have access to the opioid commission at all? Because as far as what I've seen...

Director Sheral Kellar: Okay. Uh, tell me who you are.

Speaker: Bernie Davis. I'm case manager. Bernie Davis. What I've seen kinda with doing the utilization review, is there's different standards out there for the pain management and the drug tests. American Medical Association for the pain management sets out rules that's put it in tiers. Tier one is a

patient who is at no risk, should have referral once a year. Tier two, they say is a patient who has the potential of a risk. And Tier three is people who have shown risks or are addicted to drugs or have history of that and they're in that tier, which I see them anywhere from six to eight drug screens a year. So, maybe that may be something that they can kinda take a look at whenever they're reviewing that. Cause what I've seeing is, it's not just one doctor in an area. But they're running drug screens monthly, and not just monthly but they're either in the confirmatories and they're doing 52 point drug screens on things most people never even heard about. And, they are not addressing it. And if they do get responses back, it's like, for instance, I had a gentleman who had tested positive for meths four times. Four pieces of drug screen. Positive for meth all four times. And when I discussed it with the doctor, it's coldness. Well, okay, give us a little more information before we can, you know, help us out here because, you know, what we're seeing is although we will uphold our end of the bargain, it's not being upheld over there. So, we're having, there's a disconnect between physicians and carrier, to kinda- We all need to be held to the facts, basically. If the patient is not doing what they're supposed to and they are going off their treatment regime, they'll get back in there. Help us out. Let's figure out what we need to get them the treatment that they need but continually give them that medication. I mean, that's we're seeing. We're seeing nothing is being doing for positive drug screens or negative drug screens. And, so that's a lot of the plight right now. And maybe if the opioid were cancelled or denied, they could look at something like that and figure out some kind of rule to set.

Dr. Jason Picard: We just need a happy medium that, that helps, that's in the best interest of the patient where the

doctor feels that he, he or she, is giving the medication with all the information they're being given. They're not going to determine denials for urine screens but also the carrier, and there's a nurse involved, or whoever feels as though that things aren't being over-utilized and overdone so there's just a happy medium so that everybody is, I guess, appeased and, uh, I think that would be the best.

Director Sheral Kellar: I think, uh, that when we all take a look at the opioid issue, overuse, abuse, overprescribing, uh, I'm hoping that the commission will come up with a balanced approach to pain management. Because in my opinion, just on pills and pain, or pills and pain should not necessarily be used in the same conversation. There are all kinds of, uh, different modalities you can use to adjust pain rather than a pill. You can do behavior modification. You can do topical medication. Uh, you can do physical therapy. There are a lot of things that, that, have not been, that are not being considered by our physicians. The easiest thing to do is to throw a pill. But, that's not the best way. We know, because it causes the general population and our Workers' Compensation workers to become addicted to overdose. And again, if you throw them of, then they go out into the street and get illicit drugs and that drives up the heroin overdoses that we have in this state. We're number one for that, as well. So, it is a good discussion that is being had by many people. We're not unaware of the problem and so as we address your drug screen issue and the random test taking and that sort of thing, we will consider all those issues, as well. Okay?

Bernie Davis: Thank you.

Director Sheral Kellar: Thank you. Anybody else? Would you like, you had a comment, ma'am? Do you have a comment? No? Okay. Anybody else?

Attorney Jimmy Edwards: May I have the microphone?

Director Shiral Kellar: Yes, go ahead.

Attorney Jimmy Edwards: Jimmy Edwards, and I just had a question, it's just a curiosity of mine. How the feedback is now from the medical community. They're the ones that have to do these Form 1010 submissions. Is it negative, positive, a little of both, or, are you getting feedback?

Director Sheral Kellar: Uh, in Shreveport the meeting was at the Louis-Knighten Medical Center. So, we had an opportunity for lots of healthcare professionals to come and speak with us. And, it was a very lively conversation. Uh, they're having lots of problems that we were not aware of prior to the meeting yesterday. Uh, a lot of their problems are regarding tacit denials. Uh, you don't have that problem with it, but when they send 1010s, they get lost in a blackhole and nobody ever responds. So, they don't know when the five days begin to start the 15-day process to file the 1009. They, uh, might get, uh, uh, a denial from a UR person and an approval from, the adjuster, and then they don't know which one they're supposed to rely on. Things like that. Uh, but because the people that work in Shreveport were the guys who do the 1010s for the doctors. There, in New Orleans, there was a doctor represented. The doctor wasn't there but his representative was there. So, things are not good out in 1010 land. And, uh, we're finding that...

Bernie Davis: Can I ask this? When you said they were having some issues as far as 1010s, some were denied and some were approved, did they did they specify where those are coming from? Were those from outside the State of Louisiana that they're getting most of the, uh, most of those adjusters that really don't know what's going on in the State or is that, are

they seeing that with, you know, adjusters that are licensed and practice in the State of Louisiana?

Director Sheral Kellar: You want to answer, Dr. Picard?

Judge Brenza Irving Jones: I don't think that was discussed.

Director Sheral Kellar: Well, well...

Dr. Picard: We do get a lot of out-of-state denials, out-of-state carriers in your reviews. But, I can't say specifically the tacit denials, where they're coming from.

Bernie Davis: Okay.

Dr. Jason Picard: They do it as a tacit denial and from the carrier.

Bernie Davis: I understand there's a lot of...

Connie: I mean, it's like day-by-day, the drug changes.

Director Sheral Kellar: Are these tacit denials or denials?

Connie: Denials.

Director Sheral Kellar. Denials.

Connie: Or, I don't hear anything. I have one right now, that's actually a drug procedure. And, I actually faxed it in today. It's the third time I faxed it. I put on there "Today. This is delaying patient treatment for the third time I have been faxing it in to you." So, at that point, it's too late for me to send it to you. When it's too late for me to send it to you, you know, when I wasn't getting a response and I've gotten one response and the girl said, "Oh, a judge just changed such and such." That's the biggest issue I have. I don't have a problem doing the 1010s at all. I have a problem with the process.

Cathy Chesson: Right. And, then, that's why we, a lot of times it was (Indistinguishable) before it gets to us.

Connie: Right.

Cathy Chesson: So, so, this has really made us aware of a lot of those issues. Uh, and, we've gotten some complaints about making the way some of the, what we call domestic original carriers, are handling their responses. But, they are responding. A lot of what we're hearing about, uh, the tacits, or, you know, these, who's supposed to be getting the answer. It's a lot of the national carriers that are, you know, some of them don't even have people here and some of them large, you know, large TPAs a lot of them, needs to be little smaller and kinda reachable out around the State, and, you know, it's become a lot of national TPAs and so I think that's what we want to sum up, uh, with the working relationships we've had in the past. And, that's something that we're gonna have to do.

Tommy Green: To follow your concept, I'd like to interject something here as well. I don't think, when this first came out, the learning curve was pretty steep for us and I think it was pretty steep for providers as well, just to learn an entirely new process as far getting it processed caused it concerned us. I think that since we've learned it and since we know it, at least with our TPA, I don't see us having a real issues with the process, itself. I think it works really well from our prospective and I hate to see us throw the baby out with the bath water because, you know, and I know we have to deal with those companies anyway, regardless of where they're at. But, I hate to see you change the entire process back to where it was or completely changed because companies aren't complying with, you know, how the process is supposed to work. And, you know, what I said earlier, I think it's the best process and I'm real hesitate, and Jimmy can, I think you can agree with it. We were real hesitate about going into this 1010 process because you're used to the old way of doing things. But, now that we've learned it, and I think it expedites on the

treatment. I think it's a good process that both, you know, the insurance company or the employer and the provider working together, you're getting the treatment that's necessary for that injured employee quicker. So, I encourage you, please, you know, let's not completely change what we're doing because we have some third-party administrators or insurance companies that just don't know the process or they're not complying with the process.

Director Sheral Kellar: It's, it's not our intent to throw the baby out with the bath water. (Laughter.) Our medical treatment guidelines work. The vast majority of time, they do exactly what they're intended to do. It's the injured worker, the medical treatment that he or she needs quickly. And, as I said, it has also reduced the time for, uh, making decisions on other kinds of things because we don't have the medical treatment decision in the pipeline. So, we're not getting rid of the medical treatment guidelines. But, we are aware that there are problems with the, with the manner in which we process, uh, 1010s, 1010As, and 1009s. So, we want to try to rectify those problems. But, you guys do it every day. We deal with the paperwork but we don't deal with the process. So, we want to know what your problems are. We've heard a lot that we hope to go back home and try to fix. But, no, we're not getting rid of the medical treatment guidelines.

Speaker: And some of it may just be educational as a matter of identifying, you know, who cost task the ones that needs to be processed.

Director Sheral Kellar: Cathy?

Cathy Chesson: Yes. I wanted to address the young lady in administration. You said for the third you sent it in, and you haven't gotten a response from the carrier?

Connie: Right.

Cathy Chesson: So, I guess a suggestion, if I'm understanding you correctly, would be when you filed that first 1010 and you've waited those five business days and got no response, given when you send it in is of tacit to us. If you have everything in that chart that you need and it's timely, it's going on to Dr. Picard and he'll have to give a decision.

Connie: I understand. I honestly just forget to do it, but I have so many that, you know, that I set it to remind me in five days and I guess I just need to start doing that on those.

Cathy Chesson: Right. As soon as you do a TPA, or whatever works for you, as soon as it passes that mark, you'd want to send it on in here to us and you know, we're a little behind right now because of the flood but we're gonna catch up and he's gonna kick out those decisions fairly quickly at some point in the future.

Director Sheral Kellar: Judge, let me ask you a question. Uh, as a result of the flood, right now it's only in the affected parishes, but prior thereto, it was in all of the State. The Governor suspended time delays. So, with regard to the five days tacit denials, that 15 days to file, wouldn't that have been suspended as well?

Judge Brenza Irving Jones: Correct.

Director Sheral Kellar: Okay.

Judge Brenza Irving Jones: That's correct. Cause it was very clear that it was all delays.

Director Sheral Kellar: Okay.

Judge Brenza Irving Jones: Yes.

Director Sheral Kellar: So, so, the new executive order came out this week?

Judge Brenza Irving Jones: In the earlier part of this week or the end of last week.

Director Sheral Kellar: Okay. Do you guys understand what, what I'm talking about? Okay. So, uh, the carrier has five days to render a decision on your 1010. If they don't render a decision, then you have 15 days to get the 1009 to the medical director. As a result of the flood, which was August 11 through September 8, the Governor issued an executive order suspending all prescriptive periods and specifically named Workers' Compensation. So, that meant that if you filed a 1009 outside the 15-day period, we would have accepted it because your delays were suspended. Now, those delays were suspended until September 9th.

Judge Brenza Irving Jones: Ninth.

Director Sheral Kellar: But, last week, he issued a new executive order to suspend delays in the affected parishes, and there were 23 parishes. So, and, it also specified that you had to say, certify, how you were affected. How the flood affected your inability to get something to us in a timely fashion. So, you might want to go to, uh, I think it's the Secretary of State's website to look at those executive orders from the Governor, and, uh, see how it might apply to you with respect to delays for filing 1009s. And, I don't think this last one has any end date on it.

Speaker: Uh, maybe the 30th of August?

Judge Brenza Irving Jones: I thought it was the end of September.

Director Sheral Kellar: The end of September?

(Simultaneously speaking): The end of September.

Director Sheral Kellar: Yeah. You might want to go to their website and look at their executive order and see how it might apply to you. Yes, ma'am?

Speaker: I also work for...

Director Sheral Kellar: State your name.

Speaker: My name is Angie. I also work with Connie at Louisiana Pain Care. And, once Connie gets the approval for any treatment, uh, with her 1010, she faxes it in and is given authorizations for any pain management procedures. The procedures are performed and the claims are submitted with documentation. We do not schedule or perform any procedure without authorization. Once the claim is submitted, we wait, and wait, and wait, for response. When we finally get response after repeated phone calls, faxes, then we get denials. And, the denials state “no 1010s are on file. When they deny it’s stated “not medically necessary.” When those adjusters already have every visit that that patient has already been seen: office visits, drug screens, every type of report that they need on that patient, they have it already for review and then they’ll ask for additional records. They have referring doctors’ records. They have everything they need. And, we still get repeated denials.

Director Sheral Kellar: Okay. I need to make sure I understand what you’re saying. So, you submitted a 1010. The 1010 was approved by the utilization review company?

Angie: Yes.

Director Sheral Kellar: And, then you send that approval along with the appropriate documentation to the adjuster?

Angie: To the Workers’ Comp. Company.

Director Sheral Kellar: To the Workers’ Comp. Company.

Angie: To the adjuster, right.

Director Sheral Kellar: And, then they denied your request, saying that the treatment is not medically necessary?

Angie: Yes, ma’am.

Director Sheral Kellar: Judge, would you like to address that issue?

Judge Brenza Irving Jones: Well, the adjuster is not responding once...

Angie: The adjuster --- once the claim gets to the adjuster, she has to then approve, uh, for that claim to be paid.

Judge Brenza Irving Jones: Right.

Angie: Then, she, she stops everything. She or he stops, and states that that treatment was not medically necessary and it’s already been...

Director Sheral Kellar: Approved by that utilization review committee.

Angie: ...already been approved and it still gets repeated denials.

Connie: On top of everything, I’ve already done.

Director Sheral Kellar: Who do you, do --- the procedure has been...

Angie: The procedure has been performed by the physician.

Director Sheral Kellar: At this point, I think a 1010 --- 1008 would be appropriate.

Judge Brenza Irving Jones: Yeah. I would think so. I think that’s the only thing that’s left to do.

Speaker: Sue. (Laughter.)

Angie: Once you get a denial, then you need to send a 1008?

Judge Brenza Irving Jones: Yeah.

Director Sheral Kellar: Uh, yeah. If you have an approval of the utilization.

Cathy Chesson: We don’t do anything without that 1010.

Director Sheral Kellar: The 1010 has been approved?

Angie: Yes, ma’am.

Director Sheral Kellar: The procedure has been performed?

Angie: Yes.

Director Sheral Kellar: Then you've submitted the appropriate documentation for payment. Uh, I think, that, uh, a 1008 would be appropriate.

Judge Brenza Irving Jones: Yeah. That's the only thing left.

Director Sheral Kellar: You have 60 days from that date to, uh, pay, uh, the bill before, uh, and, what that also means that you're going to need to get an attorney to file that.

Judge Brenza Irving Jones: Right.

Angie: Okay.

Angie: To file a 1008?

Director Sheral Kellar: Yes, ma'am.

Judge Brenza Irving Jones: To file a 1008.

Angie: Okay.

Judge Brenza Irving Jones: Yes.

Angie: So, what's the timeframe, though, after, after we've repeatedly made our phone calls for the follow up, after, and we look at 30-45 days for that claim to be paid, we look at 30-45 days for the patient. We're going into from 90 to 120 days before we can even get someone to answer our phone call.

Judge Brenza Irving Jones: Well, I'm not familiar with any deadline that you will have to file the 1008. I guess it'll just depend on what level you all set if it's, if after 30 days there's no response, then you could create a policy that said then you'll go on and file the 1008.

Angie: Okay.

Attorney Jimmy Edwards: Or, you can notify the plaintiff's attorney and they'll file the 1008.

Judge Brenza Irving Jones: That's true. That's true. Uh, I do see a plaintiff's attorney in the audience. Mr. Bruscato?

Attorney John Bruscato: Hello.

Judge Brenza Irving Jones: Do you have any, I think before you came, she indicated that we were just looking at the process, seeing what we can do to, uh, change it, adjust it, make it better. Uh, from your prospective, do you have any suggestions or ideas?

Attorney John Bruscato: John Bruscato from Bruscato Law Firm. From my standpoint, by the time the treatment has already been requested and denied, the deadline is over with by the time I find out, usually. So, if we ever get into litigation, that's the only time that I'm looking to see if there's been any 1010s that's been denied. But we try to do in my office is request any and all 1010s that have been denied. When we send out a letter of rep, and ask the provider to refile the 1010 and see if they'll deny it again. Uh, from the medical provider's standpoint, to be honest with you, I don't have very many litigations involving that particular issue. Although I think I did have one with Mr. Edwards (Laughter). And, we very amicably settled that matter.

Judge Brenza Irving Jones: Very good.

Attorney John Bruscato: But, uh, (Very indistinguishable), I'd be happy to talk to him (Laughter).

Director Sheral Kellar: The denials, especially the tacit denial, faces that problem because it, it creates an artificial date; a five-day date. And, so, you have to figure out what that artificial date is and start counting from there. And, many times, the claimant's attorney doesn't even know that it was submitted.

Judge Brenza Irving Jones: Right.

Director Sheral Kellar: And, so, he doesn't know that it was, that there was no response and that there will be a denial, to key him into you know, the 15-day delay. So, uh, we're aware that those are problems that, and will we would look at.

Bernie Davis: My understanding is that if it's denied, and I know that uh, we advise whoever you are, it should always be sent to, if the patient is not represented, at least the patient information representatative absolutely needs to be sent to the attorney. So, if he's not receiving that denied 1010, then they're not doing what they're supposed to be doing on uh, denials. Cause it's supposed to go to that claims representative.

Cathy Chesson: Yeah. (Indistinguishable – others simultaneously speaking.)

Judge Brenza Irving Jones: Yes.

Director Sheral Kellar: One at a time, please. You're one of the good guys. Because one of the biggest complaints we've heard is that the healthcare provider will send the 1010 to the UR company and will not send in a copy of it to the plaintiff or the plaintiff's representative. So, they have no idea that their request for medical treatment has been requested. And, so, they don't know when the five days begin. As a matter fact, the first notification that the plaintiff's attorney might get that a 1010 has been filed is when they receive a notice from our office saying we have received a notice that we have filed your request for recommended treatment. But, at that time, the 15 days are up.

Bernie Davis: Well, I've been sending --- they're not required to re-sending the 1010. For one, they'd be inundated with 1010s. They're really not going to worry themselves for something that was approved. They're gonna worry themselves for something that was denied. So, if it was denied, then that carrier's whoever is doing it should, the UR company, should be ceasing that denial to that plaintiff's attorney. I mean, that, if I'm not mistaken, that was required in the 1010 process.

Director Sheral Kellar: The medical treatment...

Attorney John Bruscato: (Indistinguishable.)

Director Sheral Kellar: The medical treatment process requires that when they...

Various Speakers in background: (Indistinguishable.)

Director Sheral Kellar: Listen. The medical treatment process requires that when the healthcare provider sends the 1010 to the UR company, it is also sent to the claimant's attorney. And, that is not happening.

Bernie Davis: Prior to a decision being made?

Director Sheral Kellar: Prior to the decision being made. As soon as you send it to the, uh, UR company, you need to send it to the claimant or his representative. The claimant or his representative doesn't know about it until you send him a notification from our office saying that it has been filed. By that time, the 15 days have run.

Attorney John Bruscato: I going along with Mr. Davis. I'm not sure that I want to be inundated for every 1010 for every one of my clients, but if it's denied, I feel like I need to know that. And, I need to know the day it's denied.

Judge Brenza Irving Jones: Absolutely.

Attorney John Bruscato: And, if I don't, I'm unable to properly address that medical concern for my client and my clients certainly, in 99 cases out of 100, isn't even gonna have a clue about this process or what could or should be done to get it through.

Director Sheral Kellar: Cathy, is that right? That every time a 1010 is filed with the UR, they're supposed to send a copy to the uh, claimant and his attorney?

Cathy Chesson: I'd need to look at the 1010, but I thought that was correct. (various comments – indistinguishable.) I'd have to look at the 1010 and see.

Dr. Jason Picard: I think it's the response. The approval or denial has to be sent to the (Indistinguishable – simultaneous responses and comments.)

Cathy Chesson: But I will say, also, what we see on the 1009 when they come in --- and this happens quite often --- is that plaintiff's attorney is not listed anywhere on the 1009. So, there's a lot of cases where the attorneys have been given revocations that we aren't aware of it. And, even though if Mary Jones is the patient, she sent in a 1010 before, we don't have the time to date her reference and the facts we needed. So, that's part of the issue too, why the claimant's attorney is not getting notice. Cause they're not even listed on the 1009. Then we get calls. Then we have to get a letter of representation. Then, we can release everything at that point.

Director Sheral Kellar: This is a letter from --- I was mistaken. This is a letter from an attorney about a 1009. He says, "Once again, I'm having to object to the filing of a 1009 because this medical provider did not provide my client with a copy of the 1009 and the accompanying documents. The first we heard of this was the notification by your office that the 1009 was filed by the healthcare provider." So, that means then that the, uh, employer doesn't have an opportunity to respond to the 1009 appeal, uh, before Dr. Picard renders a decision. I get these all the time.

Attorney Jimmy Edwards: Has there been any discussion about doing something about those tacit denials to remove or lengthen that delay period...

Director Sheral Kellar: Uh...

Attorney Jimmy Edwards: ...to appeal? Cause if somebody's doing a tacit denial, then why should there be a 15-day delay to appeal that? It might encourage more real denials.

Director Sheral Kellar: There has been, uh, conversations, a lawsuit, about the tacit denials and, uh, there have been suggestions about the delay. You know, there have been a lot of suggestions. And, of course, we're looking at that. Uh, because one of the things that we want to do is to resolve that litigation before it goes to a trial on merits. And, this is an opportunity to hear what you guys think that might be helpful that we might suggest to the plaintiffs in the spirit of compromise.

Attorney Jimmy Edwards: Well, is the plaintiff's bar still pushing for the tacit approval? That was happening.

Director Sheral Kellar: Some. Yeah. Yes. Yes, sir?

Matt Davis: I have a question that's kinda, uh, I guess, switching gears a little bit. But, with epidural steroid injections, or any injection for that matter, we had this nice, little, if they 50% or reasonably better, and, uh, at first, doctors were like, okay, they got better, they got better. A lot of denials occurred because of that. Well, of course, some doctors, you know, they began addressing that. But it also refers to functional improvement. And, I understand it addresses 50% improvement, but, isn't anyone gonna have 50% improvement when they got injected with a lidocaine substance and it's deadened that nerve for at least the time that's in? Which, I know it addresses that. But, their addressing, saying there in their note that, you know, they got a 65-75% improvement for this, you know, two days, or whatever. Well, and then they want another injection. Well, you know, it doesn't really address to us, what's, what's truly a good timeframe.

Doctor Jason Picard: What's considered improvement?

Matt Davis: Well, a lot of them, many of them, don't address functional improvement at all.

Doctor Jason Picard: The guidelines state that you should discuss functional improvement. There are some things that are very specific in the guidelines and they are asking you to require, for instance, if you want to do a spinal infusion, you can't do it more than two levels. There's no ambiguity in that. And, there are other parts of the guidelines that suggest that you should do something. Functional improvement is one of the indicators for a positive response to the injection. But, they also discuss pain response in the appropriate setting as another indicator. So, you can't necessarily hold the provider to a specific, uh, gain for improvement that's not absolutely specified. It has to occur. And, there are some specifications in terms of when you can relieve. Those are very specific in the guidelines in terms of how long it has to last, and how many you can do per year. And those are adhered to. But, again, when something says 'should,' that's much different than when something says 'it must' be done a certain way.

Connie: Can I respond to that, as well? In regards to what Matt said about the length of time that they had their pain relieved because they've been injected with lidocaine. They have post-op appointments between 7 and 14 days. By that timeframe, that lidocaine has worn off. And, you're already in, long-term steroids is what's active. So, if they're still having pain relief at that level, then means that the injection helps.

Matt Davis: That's, that's my point.

Connie: Right. I know what your point is, and I agree with you. And I've spoken the doctors about the functional gains thing.

Matt Davis: The doctors are implying that they've have improvement during the timeframe of which...

Connie: Right.

Matt Davis:... the lidocaine was...

Dr. Jason Picard: They're documenting...(Indistinguishable – all speaking simultaneously.)

Director Sheral Kellar: Hold on. One at a time, so the court reporter can hear what you saying.

Connie: I know what you are saying. Because they're given, and I've spoken them about. I don't know, I didn't know that was an issue for ya'll. But I have spoken to them about their post-op pain level versus their post-op pain level the day of the post-op appointment. It should be based on lidocaine level and not the post-op pain level right after the injection.

Matt Davis: Right. That's my point.

Connie: And, I've spoken to them about that --- with post-its. We've been addressing that in the office visit. So, hopefully you're gonna see a change. Cause I've put post-its on everybody's desk.

Dr. Jason Picard: We do, we do try to use the guidelines for that. But, sometimes, the fact is, it's not well documented. In which case, there are injections. So, I don't know how much denial you see versus approval of this specific group. You use so many different cases involving different things about that procedure that you're discussing. But, we try to adhere to the guidelines and make sure that providers are documenting what the guidelines are requiring.

Director Sheral Keller: Yes, ma'am?

Speaker: I am Bridget Strange (Company name indistinguishable.) One thing that I've seen is, uh, they'll rate the pain scale on their previous appointment as a nine, and they'll come back after an injection and they'll have their pain scale as an eight. But the doctor will say there's been a 60% improvement. Well, what are we supposed to go by? The percent that the doctor says, or the pain scale the patient gives?

Dr. Jason Picard: I would say accept what the provider, uh, puts in the documentation. Cause that is what the guidelines call for. What percentage improvement do you have? You know, you can look at the guidelines in different ways, depending on what your prospective is. And, I've seen many times, uh, people are looking at quantitative in the guidelines to find a reason to make a denial. And that is not what we're to do in the 1009 process. We trying to look to see if the provider has the documentation that is required in the guidelines to allow a procedure to occur.

Bernie Davis: I've seen, uh, situations where the guidelines are not clear about, uh, basically --- I want to address the situation where the gentleman had a herniated --- Hypothetical situation --- had a person had herniated disc, uh, two levels above, one level below where age related degenerative, uh, congenital issues. The doctor requested the whole four-levels. The carrier denied it, stating that we would pay for the one level that's herniated, but we're not gonna pay for the above and below levels because they're pre-existing and congenital. A cost appeal process went to the 1009 desk. 1009 had permanently been approved the total four-level infusion. I think the biggest concern that I have, --- hypothetically, so that laughter) --- was that we're starting to see a lot now that we're starting to pay for a lot of pre-existing issues. They're not necessarily related to the work claim at all. Only, because it'd be easier on the surgery at the time. And, because they of medical treatment guidelines. They said, you know, the original infusion, yes, it's approved by medical treatment guidelines. But, I don't think we're going deep enough in the records to say this is congenital. A four-level infusion is not to be paid by this carrier because it's a one-level injury. That's my opinion of the situation.

Dr. Jason Picard: We do not address causations in any form in a 1009 process. I don't look at anything to determine whether it was work-related. Everything that comes to me is assumed to be work-related.

Bernie Davis: What would be the best thing that we can provide to you in order to prove that to you? Or, is it just kinda of the way it's gonna be because --- technically, it's gotta come to you cause part of it is responsible, the insurance company is responsible for it. But the other parts are not. So, it's kinda without...

Dr. Jason Picard: I'm not --- this is the first. And, I am not aware of the cases discussed. Cause there'd be so many I don't recall it. But, this is th first I've heard of a case like what you're talking about where partially the injury which is in the same area is work-related and partially not. Do you have a suggestion on that, Judge?

Director Sheral Kellar: Uh, the, on the 1010 there is a place to check for causation. Uh, and, I think this is what is important for the claimant and/or his attorney to be involved. Uh, because if it's causation, then you have to go to the judge for them to make a decision.

Bernie Davis: So, what, well in this case, for an hypothetical, he and I was certain it had overturned. We had to take care of it. So...

Director Sheral Kellar: So, on the front-end...

Bernie Davis: ...how do you get pass the...

Director Sheral Kellar: On the front-end on the 1010, you did not check causation?

Bernie Davis: It had done got pass the 1010. It was denied. It was approved partially.

Director Sheral Kellar: Okay. But, what I'm saying is, when you did the 1010, the 1010 was for a four-level infusion.

Bernie Davis: That's right.

Director Sheral Kellar: Okay. But, you didn't check?

Bernie Davis: It was approved with modification.

Speakers: Approved with modification --- indistinguishable (various individuals speaking simultaneously) approved with one level that was herniated. Denied for the other three levels as pre-existing as related to the 1009 process.

Dr. Jason Picard: Were the providers in agreement that it was, the causation issue, was not all work-related?

Bernie Davis: The provider had said that it was already there previously. But, because of the injury, he's now compliant.

Dr. Jason Picard: But, is the provider requesting the services? Judge Jones?

Judge Brenza Irving Jones. And, a lot of times, you know, once it gets to the point of the provider making a decision, it's out of our hands because you can't step in the shoe of the doctor. Neither can I. And, so, logically, we could look at it and say, "that's illogical" because he only injured one level. But, if there is a medical report that says, this is what's needed, then, I, I mean, the medical treatment guidelines, will not give us the authority to overrule what the doctor has recommended.

Bernie Davis: Um hum. So, the question, would, well, I guess, so, you're saying we should go with the second opinion, or something?

Judge Brenza Irving Jones: Well, if it, again, if it's, if you're --- cause it sounds like, still, what you're saying is causation.

Bernie Davis: Yeah.

Judge Brenza Irving Jones: Then, that's something that you need to emphasize on the front-end so that it can go through an additional process before the, uh, the procedure is done.

Director Sheral Kellar: Before the procedure is approved.

Judge Brenza Irving Jones: Yeah. Before it's approved.

Dr. Jason Picard: I think that once you get the response back from the 1009 in that situation, the only direction you can go as far as a carrier is concerned, is not approve it.

Judge Jones. Yeah.

Dr. Jason Picard: Cause, then you go, then you have to wait on the 1008 process...

Judge Brenza Irving Jones: Exactly.

Dr. Jason Picard:...to determine whether there's causality between the other levels.

Judge Brenza Irving Jones: Exactly.

Dr. Jason Picard: So, I mean, it's, and that's not the best way to do that because...

Bernie Davis: There's a lot of pre-existing issues out there.

(Indistinguishable – various speakers simultaneously.)

Director Sheral Kellar: But, your only alternative in such case is to get an approval for a part that's caused by work injury and a part that's not. So, the only recourse you have is on the front-end to just check causations.

Judge Brenza Irving Jones: Exactly.

Director Sheral Kellar: And, send it to the judge and when you get to the judge, make her or him understand that we're only talking about this first level as opposed to the four levels. Cause, otherwise, it can get approved. And, then you're stuck with it.

Attorney John Bruscato: Just because they have a pre-existing condition doesn't mean that it wasn't aggravated by whatever caused the...

Director Sheral Kellar: This sounds like a claims attorney (laughter).

Attorney John Bruscato: (Laughter.) Obviously, there is some problems.

Director Sheral Kellar: Obviously.

Judge Brenza Irving Jones: And, the jurisprudence will emphasize disabled. If they were okay even with the degenerative condition, but they can't disable it as a result of the additional injury.

Director Sheral Kellar: But, again, that's a decision for the judge to make. But, if you don't check causation...

Judge Jones: Right.

Director Sheral Kellar:...on the front-end, it's never going to get to her.

Judge Brenza Irving Jones: Exactly.

Director Sheral Kellar: Okay? Any further questions? Comments?

Judge Brenza Irving Jones: He has one. I can see it (laughter).

Bernie Davis: I just wanna to re-clarify something. So, if on the BAS scale, if they say eight out of ten in pain and the previous said nine, ten, we need to go by percentage.

Dr. Jason Picard: If the provider documents percentage, then that's what is specified in the guidelines. It's specified percentage. If it's a discrepancy in there that the BAS scale is also percentage documented, I don't know if that was inadvertently done, you know? But, if the guidelines specify percentage, the provider is doing it with respect to the guidelines, they know what they need to say.

Bernie Davis: That's my point.

Dr. Jason Picard: Yeah.

Bernie Davis: If, if, cause, I mean, we all know that going down one point on BAS from nine to eight is not 75%.

Dr. Jason Picard: Exactly.

Bernie Davis: So, I mean, I guess I'm asking like how, I guess a 1010A is in order at that point?

Director Sheral Kellar: A 1010A is the request for additional information.

Bernie Davis: For the doctor to say, you know, you say 75%, but the BAS scale says eight out of ten.

Various speakers – (Indistinguishable.)

Director Sheral Kellar: Okay. Mr. Edwards? Nothing?

Attorney Jimmy Edwards: This, this is one of those hypothetical situations. And, really it's for Dr. Picard. Let's just say in this hypothetical situation where there's a multi-level infusion at issue, and a 1009 process, the director approves. Says, it's okay. This should be done.

Dr. Jason Picard: Okay.

Attorney Jimmy Edwards: A hypothetical question.

Dr. Jason Picard: Okay.

Attorney Jimmy Edwards: Anyway, and then the person goes in for surgical clearance, and the next thing that comes is a 1010 from a cardiologist saying there's an abnormal EKG. So, the cardiologist wants to do a nuclear stress test, an echocardiogram, a calcium score CT --- what else in a hypothetical situation?

Dr. Jason Picard: I don't know, sir.

Director Sheral Kellar: (Laughter, also from audience.)

Dr. Jason Picard: It's your hypothetical.

Attorney Jimmy Edward: A whole lot of very expensive things because the person couldn't be cleared for surgery

because of an abnormal EKG. The hypothetical person. And, that presents a problem. What, how does that, is that to stay within the 1009 process, because, of course there's a denial because it's diagnostic test that has nothing to do with the back issue. It has to do with the problem that was found that is not related to the accident. But, I didn't know --- but it is referred to as diagnostic testing, should that stay within the 1009 process or is it we are we off to 1008 petition land? If you can follow?

Dr. Jason Picard: So, your question would be, this is a separate issue being filed for the drug procedures?

Attorney Jimmy Edwards: That's correct. By a cardiologist.

Dr. Jason Picard: That would not be able to be approved. Those types of tests are not within the medical treatment guidelines. It's mostly orthopedic. That's an extensive guideline issue But, there are some things that are not in the guidelines and you have to ask for a variance for those specific things. Typically, a variance wouldn't be used for a procedure that is not within the guideline; and you submitting medical literature to, uh, document the need for that procedure and why it should be removed. So, this is a situation I have not had yet. But, you discussed it specifically. So, I would not be able to approve it because it is not a type of procedure that is covered within the guidelines. So, what recourse can you have? Would that be the carrier?

Director Sheral Kellar: I think so.

Attorney Jimmy Edwards: My hypothetical situation for the 1008 was biased.

Dr. Jason Picard: I think that would be the most appropriate thing I would suggest.

Judge Brenza Irving Jones: In that hypothetical situation, is it pending, now? (Laughter and comments from audience.) Was a decision already made in that hypothetical situation?

Attorney Jimmy Edwards: No. Not in this one.

Judge Jones: Oh, somebody else?

Attorney Jimmy Edwards: Yeah.

Judge Brenza Irving Jones: Ooh.

Attorney Jimmy Edwards: All right. I'm sorry. That's why I didn't want to ask the question.

Speaker: Dr. Picard, if that gets to you, how does that come back to the carrier?

Dr. Jason Picard: If that gets denied, it would have stated that this is not covered in the medical treatment guidelines.

Speaker: Okay.

Dr. Jason Picard: Or, this is now allowed by the medical treatment guidelines, something to that effect.

Director Sheral Kellar: Yes, sir?

Attorney John Bruscato: Can the plaintiff's attorney or client ask for a reconsideration for a variance from the medical guidelines?

Dr. Jason Picard: Again, that is not what a variance is used for. It is described as used for a specific related, let's say spinal surgery, a new procedure, or a new type of device or something that's being used that basically would involve being discussed in the guidelines but it's not been added to them yet. So, this is totally a different area that's outside of what medical treatment guidelines cover. So a variance wouldn't apply. I would say the 1008 process would be the best way to deal, to address that problem.

Attorney John Bruscato: Okay. Do you think there is any interest on the verizon to amend the medical guidelines to

include ancillary but necessary procedures that would allow someone to continue their treatment, uh, despite the fact they might suffer from a heart problem or some other type of problem?

Dr. Jason Picard: We've not discussed that. This is the first time this specific issue has been discussed. This is why we're having these meetings, you know, to, to start thinking about those things. So, that's not something that's come up yet but it's something we're making note right now and could possibly be discussed. The question too, is it always going to come up, how frequently does it come up, and does this area change in guidelines when it's something that's such an unusual type case. We're not being made aware of it because it just doesn't get to us. It's not covered in the guidelines. So, that's why we're trying to get this information.

Attorney John Bruscato: I'm putting in my two cents. It seems to me that if a person needs the treatment in order to receive the surgery...

Dr. Jason Picard: It would make sense to me that it should follow the guidelines, because it's testing that is required for that surgical procedure. But, that's beyond my legal medical understanding how that should work.

Director Sheral Kellar: Anything further? Okay. Uh, why don't we let Dr. Picard and Cathy tell you some of the things that, uh, they have seen, uh, that you might do differently that could help them to perform their jobs better. Dr. Picard?

Dr. Jason Picard: The two sides to the 1009 process are of course the UR representative and the insurance company. And, uh, in terms of what could be done better on the side of the injured worker or their, or rather their representative --- because it's not the injured worker that's making the claim --- is to make sure that the correct documentation is there and that it does meet the guidelines. That's mostly by way of the

provider, uh, putting in their appropriate documentation versus if they're in the surgical procedure, the guidelines state that there are certain criteria that has got to be there, got to be documented in order to approve that surgical procedure. And, again, the provider that routinely do it and routinely deal with this, know what they have to have. Sometimes, I see cases where certain information is requested, and there is no apparent reason, there is no conservative treatment, uh, involved. In which case we have to deny because they meet the guidelines criteria. That's not happening as often. That's less than a third of the cases that we get that are denied. But, that is the most likely reason that they're gonna be denied because the documentation is not there to support a procedure or injection. Uh, so that's on the provider's side, or their representative. From the insurance company's standpoint, uh, the most common reason, most frequent reason denied, or returned, their denial is gonna be kinda what I said before. If you're looking at the guidelines just to try to find a reason to deny a procedure, that's not appropriate. If the documentation from the provider is not there and the criteria is not being documented, that is appropriate. So, basically, what I often see is medical opinions from UR companies, from the insurance companies, where the provider or the person that is giving that medical opinion is doing it not based on the guidelines but based on even another guideline, like EG guidelines, or they're doing it based on what they think is the appropriate, uh, procedure, not what the guideline states. So, uh, that's the documentation that needs to be there. It needs to show where the guidelines state that this is not approved. And when they do so, and their decision to denial is apparent.

Speaker: In that situation where you, the medical treatment guidelines, do not, uh, go into detail at all on a

conditional request, is it appropriate for us at that time, medical treatment guidelines, the burden of proof falls on the UR company to notify and to find another source? Is the OBG an appropriate source for you to bounce that off of?

Dr.Jason Picard: No.

Speaker: It says in the, in the statute that it is.

Director Sheral Kellar: For the 1203.1?

Speaker: Yes. It says if it's not in the medical treatment guidelines, you refer to another state's guideline.

Director Sheral Kellar: If it's not in the guidelines?

Speaker: If it's not in our guidelines, you refer to another state's guidelines for...

Director Sheral Kellar: That's just one of the things to look at.

Speaker: Or, you can refer to the occupational disability guidelines or any other evidence-based medicine. It's five...

Director Sheral Kellar: Yeah. Under 1201.---

Speaker: 1201.3...

Director Sheral Kellar: 1201.J.

Speaker: E, and then M. It goes to M where you can refer to that.

Director Sheral Kellar: One of the things...

Speaker: So, we're within, right?

Director Sheral Kellar: One of the things that, uh, we're considering, uh, is reconciling the statute with the rule. The rule is 2715.

Speaker: Um huh.

Director Sheral Keller: And the statute is 1203.1. But, what they require are different. I think the rule is more volumious than the statute. So, we need to rectify that because it's evidence based medicine. They talk about the literature, and so forth and so on. But, they're different. Uh, so, that's

one of the problems that we're aware of that we need to work out.

Speaker: So, we can or cannot refer to...

Director Sheral Kellar: It does, the statute...

Speaker: The statute reads that.

Director Sheral Kellar: The statute does say you can refer to it, if, because you have three, uh, areas in the guidelines. It's in the guidelines, it's not in the guidelines, or a variance from the guidelines because of some mobility that the patient has means something different. So, if it's not in the guidelines, you go to, uh, Section D? Is that what it says?

Speaker: 1203.1D and then, I think M.

Director Kellar: Yeah. And that has a list of things that you're to look at.

Speaker: Um huh.

Director Sheral Kellar: And, that was the criteria that we used in coming up with our guidelines?

Speaker: Yeah.

Director Sheral Kellar: And, so you're supposed to use that same criteria to present to the doctor to support whatever treatment it is that you want. But, that ought to come from the healthcare provider. Not from the UR or the...

Speaker: Let's be honest. We're, that's asking a lot, in some instances, from the provider to not only send us that request but then provide information outside of what's in the guidelines. So, I think the UR company is going the extra mile whether or not they're approving or denying. Cause we've done both based on if it's not in the guidelines, we've done both whether denied or approved, based on what OBG said or what another state's guidelines says. So, but I mean, I guess my question is, if we're denying something based on OBG and you

just said you wouldn't take what we said what the OBG is. Am I misunderstanding?

Dr. Jason Picard: No. Normally, uh, we have medical treatment guidelines for what we are looking for, for guidance in terms of making a decision. If a procedure is being asked for that is not within the guidelines whatsoever, you know. For something that's just not in the guidelines. I'm gonna deny it because it's not in the guidelines. Unless, there's either a second opinion or some literature, or something from a variance that's very compelling that the procedure should occur. Cause I'm likely to make a determination of what I think is the right thing to do without the guidelines being consulted.

Speaker: Okay.

Dr. Jason Picard: You know, I'd like someone to look it in terms of the case. I am not the provider that's treating the patient. I'm not gonna look at this and say, 'this is what I think.'

Speaker: Okay.

Dr. Jason Picard: You know, if there's no guideline on that, I'm not gonna make a decision. Until they process his problem is the best way to deal with that.

Speaker: Okay. Thanks. So, this is a bad situation, a 1009 would not be a good...

Director Sheral Keller: Well, I, I looked at that. It's not in the guidelines. It would be the healthcare provider who would be submitting additional evidence...

Speaker: That's what the statute reads. Correct.

Director Sheral Kellar: I wouldn't think it would be the UR guys who would use additional evidence to deny it.

Speaker: Yeah. But also, if they don't, if they do give us information...

Director Sheral Kellar: Then, you can respond with it.

Speaker: We can respond by referring to...

Director Sheral Kellar: Exactly. Exactly. And, I think that's what the medical treatment guidelines division, in cases where guidelines don't speak to a particular treatment that something comes from the healthcare provider and something comes from you which shows that that's what he is requesting is not the best evidence-based medicine for this particular procedure. And, then you base your denial on that.

Speaker: Okay.

Director Sheral Kellar: It goes to the medical director that he has what both of you have submitted and can make a decision based on those things. Anything else? Cathy?

Cathy Chesson: I'm Cathy. I'm one of the RNs in medical services. I've seen your names on a lot of the papers. It's nice to put faces to some of those names. Uh, I deal on the front-end, sometimes inputting the 1009s into the system and also prepping the 1009s in order to see if they're appropriate; if they're complete enough to send to Dr. Picard. One of the issues we've had, and it's been an ongoing issue, is that whoever is submitting those 1009s to us, is not sending in a complete 1009. Uh, it may be missing the 1010. So, we've implemented something on our end called the up frontend projection. So, if I get that file and I look at it and there's no 1010, I'm going ahead and send it right back to you cause there is no 1010. But, then may find out three hours later that that same party is now sending the 1010 and some medical documentation. And, there could be 20 other submissions in between that. So, we're not gonna know that you're sending in some more later on unless you specify. So, we ask, to try an expedite the whole process for those of you who are submitting the 1009s, to please submit the 1009 with the signature, with

the 1010, and the medical records so that we can move along in the process and avoid those frontend rejections.

Director Sheral Kellar: Thank you, Cathy.

Cathy Chasson: Uh hum.

Director Sheral Kellar: Is there anything further from anyone? Any comments? Okay. If there's nothing further, then I think that will conclude our Town Hall Meeting. Thank you all very much for coming and for your comments, uh, and as I said, with medical records. And, we will review, we're reviewing, uh, those records after we complete all of the, uh, Town Hall Meetings at the end of this month and hopefully we will incorporate some of your suggestions into revision of 2715. We're not, we're now throwing the medical treatment guidelines out. (Laughter from audience.) We're going to revise them to make it easier for you to deal with. Thank you very much. You are free to go.

Judge Brenza Irving Jones: In previous meetings, Judge Kellar always presents them with a gift. And, she doesn't present them with a gift as payment. She just presents them with a gift just to show appreciation for their taking out their time to come and speak with us. And, so, I'd like to give her the same courtesy. And, I want to say that I'm not, this is not from me. It's from the Workers' Compensation community because that's what we are. We're the Workers' Compensation community. Any one of us that's dealing with anything dealing with an injured worker, that's what we are. And, I always say as a Workers' Comp. Judge, that, uh, it's my desire to just have resolution. And, I think through all of us working together and her taking out her time to come and speak, how to make things better, I think that's what we're headed toward, more and greater resolutions. So, just from the Workers' Compensation community in Northeast Louisiana, thank you.

Director Sheral Kellar: Thank you. (Handclapping). Thank you, guys.

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