PUBLIC TOWN HALL MEETING

OFFICE OF WORKERS' COMPENSATION

MEDICAL TREATMENT GUIDELINES

MONDAY, SEPTEMBER 26, 2016

CECIL J. PICARD CENTER

200 E DEVALCOURT STREET

LAFAYETTE, LA 70506

INCLUDING:

JUDGE SHERAL KELLAR
DIRECTOR OF OFFICE OF WORKERS' COMPENSATION ADMINISTRATION

JUDGE ADAM JOHNSON
LAFAYETTE OFFICE

JUDGE ANTHONY PALERMO
LAFAYETTE OFFICE

CHIEF JUDGE DIANE LUNDEEN
BATON ROUGE OFFICE

DR. PICARD
MEDICAL DIRECTOR

MICHAEL PIPPINS
IT, BATON ROUGE

FREDA CHARLESTON
MEDICAL SERVICES, BATON ROUGE

REPORTED BY: KRISTA ACKAL, CCR

JUDGE KELLAR:

I'll go ahead and make my introduction. I'm Sheral Kellar, the director of the Office of Workers' Compensation Administration, newly appointed by Governor John Bel Edwards. Prior thereto, I was the chief Workers' Compensation judge for 17 years. And prior to that, I actually, was the Workers' Compensation judge here in Lafayette for about eight or nine years. I have with me this afternoon some members of the Office Of Workers' Compensation, both from the Baton Rouge Administrative Office, and from the Lafayette office. Immediately to my right, and your left, is Adam Johnson -- Judge Johnson in the Lafayette office. Next to him is our Chief Judge, Diane Lundeen. She's in the Baton Rouge office. Then we have Judge Anthony Palermo from the Lafayette office. We have Freda Charleston. Freda is from the Medical Service's section in the Baton Rouge office. Dr. Picard is the Medical Director. You've seen his name. That's probably why you're here, some of you. And then last, but not least of all, we have Michael Pippins, who is the IT guy at the main office in Baton Rouge.

We're here this afternoon -- I'd like to thank you, first of all, for accepting my invitation to come and talk to us about the Medical Treatment Guidelines. Thank you for coming this afternoon and accepting our invitation to talk about the Medical Treatment Guidelines. We are not unaware that there are numerous problems with the guidelines, both in terms of how we process the 1010/1009, and the 1008 appeals. We want to hear from you. We want you to be part of the solution to help us to solve the problems as you see them. You are the guys who are working in the trenches and have difficulties navigating

the system every day.

We have been to three cities already. We've been to New Orleans, to Shreveport, and to Monroe. We've heard some constructive criticism, some of the same things repeatedly. And then at other times, we've heard things that we were unaware of. So we're hoping to hear from you some new things. I'm sure that we're going to hear some of the old complaints that have been repeated throughout the state. From here, we'll be in Lake Charles tomorrow, we'll be in Alexandria on Wednesday, and our final stop on this town hall meeting train will be Baton Rouge on Friday, September 30th. You are invited to attend the remaining town hall meetings, all of them, or any of them, as you would like. And there's a list of them on the back table, but only a few. If you miss getting a sheet of the remaining town hall meetings, you can look on our website at laworks.net under the town hall meetings, and you'll see them listed there.

We probably will not solve any problems this afternoon, but we do want to hear from you what you think we might do better, what you think we might eliminate, or what you think we might just tweak. Because, after all, the Medical Treatment Guidelines are intended to make the process of securing treatment for injured workers quicker and faster. We know that that does not always happen, and to the extent that it doesn't, we want to hear from you what you think we might do better.

I would ask you, in deference to everybody in the room, that when you speak, to first give us your name, what company you represent, and to only speak for three minutes. You may speak multiple times, but at each occasion, speak only three minutes, in deference to other

participants in the room who may wish to speak as well. We have a court reporter, as you can see, as we've had in all of the cities. She is going to record your comments so that after the conclusion of all of our town hall meetings, we can go back and review what you've told us your problems are, and we're going to try to address those issues.

I'm going to ask you, in deference to privacy laws, not to talk about any particular cases, and please don't use the names of any patients that you might see. You can give us hypothets, or talk in generalities. If you have questions, we will try to answer them to the best of our ability. But we really want to hear from you what we can do to make things better. If you have cell phones, please silence them, or put them on vibrate, or if you're tricky, you can put them on stop. There's water, and tea, and coffee, I believe, if you are interested.

We also have on the back table a handout that we used at the Louisiana Association of Business and Industry conference early -- well, last week, and those are just some statistics about the Medical Treatment Guidelines, the number of guidelines requests that have been submitted to our office during this year from January to September. It's a graph of how well we are processing those Medical Treatment Guidelines. And I think there is a graph of how many of the guidelines are approved and how many are denied. Dr. Picard -- Jason Picard has been with us since March. So the graph that you see on the approvals and denials is probably only from March 2016. Okay. So Michael has a microphone, so if you raise your hand, we will recognize you. Please, again, state your name, and what company you represent, and keep your comments,

questions, criticisms, beefs, limited to three minutes. So who wants to start?

Yes, ma'am?

MS. PHOEBE:

I'm Phoebe. I work at Lafayette Bone and Joint Clinic. It's a group of orthopedic surgeons. Two medical treatment guideline directed questions. The first one is orthopedic surgery, as you all know, is very subspecialty, and we want to know, from our practices, how do we ensure that the person who does a peer review on a very innate and difficult orthopedic procedure is, actually, orthopedically trained and/or educated to make that decision. We oftentimes get physiatrists or nonpracticing sports medicine doctors reviewing for a revision TLIF at three levels. That's usually where our first problem comes into play, because they don't understand it.

Secondly, we've been getting denials on radiofrequency ablasions, indicating that they need and require a psychological evaluation prior to that, but it's not recommended for the medial branch block, which is the precursor procedure to the RFA. And statistically, we try to get those scheduled very quickly, because they are related procedures. And if we have to get a psychological evaluation, that takes four weeks to schedule and six weeks to get a report, it's delaying care for the patient between the two procedures.

DR. PICARD:

On the first question, that's something that we, on our end, probably can't control, because we don't have control over the insurance companies and who they hire to review -- to look at your case and determine whether they think it's appropriate or that it meets the guidelines.

However -- Can everybody hear me? Any problems hearing? So there's probably nothing, and correct me if I'm wrong, Judge, in the law now, that's going to prevent you -- or require an orthopedic evaluation from the insurance company. However, if that does get denied, then we can certainly take care of it, on our end, with the 1008 process and overturn that, if what you're asking for is appropriate and within the guidelines. So that's where we can help you.

In terms of your second question, a psychological evaluation shouldn't need to be required for the RFA. So I would normally just approve that for you. I've not seen denials based on that. So I don't know -- Do you know if you sent --

MS. PHOEBE:

I've had two recently, and the Medical Treatment Guidelines were quoted, and to the best of my familiarity with it, it did stipulate and look like it was saying such. There was a time when the Medical Treatment Guidelines did not address RFAs, specifically. It was kind of included in other injections. They then revised and now, specifically, address radiofrequency ablation and even once I read it -- the quotation that they sent back to us -- it appeared that it was required.

DR. PICARD:

I see a lot of quotations from the guidelines, and I don't look at those. I look at my actual copy of the guidelines, because sometimes I'm not sure where they're getting it from, but have you sent any of those to the Medical Director? I'm not talking about specific cases. Obviously, you can't do that. But just in general, do you --

MS. PHOEBE:

They've both been fairly recently, and we have not made our decision yet as to whether or not we were going to, because we wanted to clarify whether it was, in fact, a correct quote from the guideline, or if that was --

DR. PICARD:

I have not seen that, and I look at it every day. There are certain ones that do require that. Discography is very commonly one that's rejected for that reason --

MS. PHOEBE:

And fusion surgery.

DR. PICARD:

And fusion surgery. But not RFA.

MS. PHOEBE:

Thank you.

JUDGE KELLAR:

The gentleman in front of this young lady. Go ahead, sir, tell us your name and who you represent.

MR. PATRICK JOHNSON:

A bunch of them know me. Patrick Johnson with Allen and Gooch, Judge. And this is something that we had spoken about on Thursday, Doc. I think there needs to be attention given, Judge, to variances and how they're handled. And I believe it would apply to both sides. A lot of doctors -- they, you know, like, for the defense doctors, the peer reviews, they're used to having to go to ODG, which covers everything, whereas Louisiana Medical Treatment Guidelines are very specific. And so they tend to default to ODG, when it's my understanding that they should go to the variance process. The treating physicians oftentimes just are used to, for having done it for years and for doing it in non-comp situations, just

making a recommendation without having to go back and provide recommendations for why do they need a variance. So if we do have to wind up doing some tweaking with regards to the process of how it's handled, I think we need to give some attention to either clarifying it for the doctors as to what's needed for a variance, and when it's needed, or make it a more streamlined procedure for the reviewing doctors as to when they can look outside of the guidelines, and where they can look. Because there's a lot of times that our doctor makes a recommendation and it then becomes an issue: Although that's not a proper variance, you didn't do anything. Or it'll come up -- I haven't had it with Dr. Picard. I had it with Dr. Rich. So that's just one of the problems I'm seeing that we can take away a lot of frustration by having that process streamed. More of a comment than a question.

JUDGE KELLAR:

Thank you.

Someone back there. Yes, sir. Go ahead.

DR. MITCHELL:

I'm Dr. Matthew Mitchell. I practice here in town at Louisiana Pain Management. We have some guidelines that we've been following for the State, and I can give you all a copy of them. It's the Louisiana State regulations. It, basically, tells us that the Medical Director of the clinic is responsible for ensuring that a urine drug screen of each patient is obtained, at least, in part -- at least, quarterly. Let me give y'all a copy of that. And it's, basically -- tells us that we're supposed to do no less than four of these urine drug screens a year, and then unannounced urine drug screens.

But what we've been running into is problems in

getting them approved. Some of the insurance companies will say that they will allow us to do a urine dip, like, something you buy at the grocery store or Walgreens. Well, that's -- as y'all know, that's very inconsistent, has a lot of errors. We could end up accusing the patient of something. So we have a liquid chromatography screen, and then we do a gas chromatography confirmation on those that need confirmation. But we can't get the workers' comp insurance companies to always approve even the screen. They'll say: Well, we'll approve one a year. But the State guidelines from the Legislature tells us we have to do no less than four a year.

JUDGE KELLAR:

Before Dr. Picard responds, let me make sure that I understand what you're saying. The guideline that you're, actually, referring to is the one that's used by the Department of Health?

DR. MITCHELL:

That's correct.

JUDGE KELLAR:

We are aware that the guideline followed by the Department of Health is different from the one that we use, and we are trying to reconcile the two. But having said that, I'll let Dr. Picard address your issue, if he can.

DR. PICARD:

So, basically, there's nothing we can do about the denial from the insurance company on the front end. However, the Louisiana State guidelines, basically, allows you, at your discretion, to decide the frequency and the amount of drug testing that you want to do. So I can't recall one that I denied when it got to me. You just have

to go through the extra process of filing a 1009 with us. Because at this time, we don't have anything to tell the insurance company, you know: You can't deny this. They denied it based on what they think is the appropriate thing to do, but not based on what the guidelines say.

JUDGE KELLAR:

Yes, ma'am? Right here in front.

MS. VALERIE LANDRY:

My name is Valerie Landry. I'm with Dr. George Willims. We're an orthopedic spine surgeon, as well. We're also having trouble with the urine drug screens with the guidelines, but our denials are being stated that we have to think they're not complying or that they're thinking was -- So they're denying because they're saying we have to have reason that they're noncompliant. So how do you know that they're complying, if you don't?

DR. PICARD:

You don't have to have reason to -- Excuse me. According to the guidelines, you don't have to have reason to believe that they're noncompliant to order your drug screens. Now, that might change. There might be some revisions to the Medical Treatment Guidelines, but as of now, it's up to you, or your office, to decide when you want and need drug testing, and how often you need to do it. So I do see that very frequently. And when it comes to me, I just approve it. Because the guidelines don't state that you have to have that.

JUDGE KELLAR:

Let's go back this way and then come back to the front. This young lady right here.

MS. EDIE DUHON:

Hi. My name is Edie Duhon. I work for Dr. Jayme

Trahan. He's a neurosurgeon. Where do we get a decent copy of those guidelines? Because I don't have a copy of the guidelines in our office at all.

JUDGE KELLAR:

They're online.

UNIDENTIFIED SPEAKER:

The Louisiana Admin Code. The Louisiana Admin Code. You look up Louisiana Administrative Regulations, and you can download as a PDF or a Word document.

JUDGE LUNDEEN:

Also, if you go to Louisiana -- to laworks.net, and they have a search function, and type in "Medical Treatment Guidelines," and it will give you a link. And then there's a username and password that they provide to you, and you can get in that way. So you get the most current form, hopefully, on our website. Or you can, again, go to the administrative code.

JUDGE KELLAR:

The young lady back there.

MS. ASHLEY MARTIN:

Hi. I'm Ashley Martin, laboratory supervisor with Anesthesiology and Pain Consultants. A problem that we're having is, actually, during drug screening and the confirmation testing is some of our workers' comp companies want to pay 80101 times one. They'll let me choose one test. I've even talked to adjusters. I've explained to them: I don't know if you think that we're doing a dip stick. We're not. We're doing immunoassay for it. And Medicare, we do a 2479, which groups together an immunoassay and gives us like $97. 80101 times one is less than what Medicare would pay.

So for some reason they will only pay one and then I

asked them: Well, which one do you want me to pay? Because that's virtually impossible. And then, basically, the same thing as Bone and Joint had, whenever I'm discussing with adjusters about confirmation, liquid chromatography versus screening, they have no clue as to what I'm exactly talking about. And then by the time we get to the end of the conversation, they're, like: What do you want? Just tell me what you want. They don't know the cutoffs, reference ranges, absolutely nothing.

JUDGE KELLAR:

Thank you. This gentleman in the front of Mike. Go ahead, sir.

MR. BRUCE DAVIS:

My name is Bruce Davis from CaseExperts, a nurse case management company. Talking about the urine drug screens, I'm looking at it from a different standpoint from a nurse case management standpoint is we're getting the drug screens, we're seeing that they tested positive for drugs that were not prescribed, and then we're seeing the physician not address those issues, which is a patient safety concern, not only for that physician, but also for the patient and everybody else involved. And if we're going to perform drug screens, we need to have some process to hold the patient accountable for compliance, whether they're taking the medicine, you know, if they're testing negative for a drug, then why do we keep on ordering a drug if they're not taking it. Or if they test positive for illicit drugs, why aren't the physicians addressing those to where we don't have the patient who's addicted?

JUDGE KELLAR:

Thank you. Yes, ma'am?

MS. VALERIE:

Hi. My name is Valerie, and I work for Dr. Darrell Henderson. He's a plastic surgeon, certified hand specialists. We've been having a lot of denials lately. My question is clarifying the days until we have to file a 1009, and how long does the workers' comp have to give an answer on a 1009? Because I've been in touch with adjusters that say: We'll approve anything after 30 days if we haven't heard anything from the State. By law we have to hear from the State. Meanwhile the patient's still waiting, kind of in limbo to get approved for surgery. So just a clarification on the days after the 1009 is filed and after a 1010, before we file a 1009.

DR. PICARD:

If your 1010 is denied by the insurance company initially, you have five days to file a 1009 appeal with the Office of Workers' Comp.

UNIDENTIFIED SPEAKER:

And just to clarify that, so on --

DR. PICARD:

Did I say that right?

MS. CHARLESTON:

No. Because if she waits five -- well, it sounds like she's not getting a response. So she only has to wait five days before she sends it in to --

DR. PICARD:

I might have misunderstood. Are you getting a denial to your 1010 initially? Is that what you're asking about?

MS. VALERIE:

Well, sometimes we do, sometimes we don't.

DR. PICARD:

Sometimes you get nothing?

JUDGE KELLAR:

So once you submit the 1010 to the payor, or the UR, you have five days to get a response, and if you receive an actual response, if it's a denial, you have 15 days from that date in order to file your 1009 appeal. But if you do not receive a response from the payor, or the UR company, within the five days -- Well, listen it's considered a tacit denial, if you've received no response at all, but you still have to count an artificial five days before -- to give them to respond and then 15 days after that.

We know that's a problem. Because you don't have any idea when they received it, or you don't have any idea of when to start counting the five days, when the five days ends, or anything like that. So your 15 days may have long passed, and you have no clue. Tacit denial we understand is a problem, and we are trying to address that problem. Because it requires you to count an artificial number before you file your appeal, and that's just not the way we should be doing things.

So we're trying to come up with a trigger for your five days, either it being the actual notice that the 1010 has been denied, or written notice, something like that. But we do know it's a problem. Does that help you?

MS. VALERIE:

It does. As far as the 1009, how many days after that's filed should you get a response, and should there be a written response?

JUDGE KELLAR:

To the 1010 -- the 1009? Because the 1009 goes to Dr. Picard.

DR. PICARD:

It's 30 days. We have 30 days to give you an answer.

JUDGE KELLAR:

And there should be a written response, always. If not, let me know.

MS. VALERIE:

Okay.

JUDGE KELLAR:

Yes, ma'am?

MS. DAWN MORRIS:

Dawn Morris. I'm an attorney. I'm working with a healthcare provider. So we have a situation where we are submitting 1010s to get approval for follow-up visits, and the issue is with a particular code that's being put on the 1010. Our office codes 99215, which is a level 5, because, of course, we don't know what level the visit's going to be because it's prospective, the visit hasn't happened yet.

The carrier, however, will do one of two things. They'll either deny the visit, saying there's no support for that level of care, or they will approve it with modification and down code it before the patient has ever been seen. So it seems to me that since the visit hasn't happened yet, we should put the upper level of the code and then it can be down coded later. It's going to be much easier to down code it during the time of reconsideration of the bill rather than trying to up code it later. I don't know if that's an issue that's been coming to the Medical Director, because by using the 1010 to direct the healthcare provider as to what particular level to code, before the visit's ever happened, doesn't seem like a Medical Treatment Guidelines issue. But that's how the carrier is trying to fit it into the

procedure or the process.

UNIDENTIFIED SPEAKER:

Dr. Picard, we have --

JUDGE KELLAR:

Just a minute. Hold on. This young lady right here. Thank you, ma'am. Did you want to respond?

UNIDENTIFIED SPEAKER:

I want to add a little something.

JUDGE KELLAR:

Hold on just a second. Remember we have a court reporter, and she can only hear one of you at a time.

DR. PICARD:

Most of the ones I see do not have a code. They just have a procedure that is being requested without any numbers behind it. So I don't know if it might be easier for you to not put that upfront and see if that works better.

MS. DAWN MORRIS:

The same carrier, if there's no code, refuses to do anything with it without every single code that --

DR. PICARD:

Is it just that carrier?

MS. DAWN MORRIS:

I think it's just that one primarily.

DR. PICARD:

Just that insurance company? It's not in the guidelines, so we can't really -- All I can do is when it comes to me in a 1009, I ignore that part of it, because that's not really in the guidelines. And I'm just looking at the procedure, whether it's approved or not.

JUDGE KELLAR:

Why don't I give you my card, and we can talk

afterwards, okay?

MS. DAWN MORRIS:

Sure.

JUDGE KELLAR:

Okay. This young lady right here in the front of me.

UNIDENTIFIED SPEAKER:

I want to add a little to that. She's saying she's upgrading that code, so that, you know, if they use a lesser code, you know, it may be approved. We're having problems where it's not getting paid if it's not that exact code that is approved. Not only that, when we are submitting 1010s for follow-up visits, they have a minimum of four visits that they have to approve for follow-ups, and they're only approving one at a time, which causes a problem in a large clinic. I mean, it doesn't matter if I submit two or not, they tend to ignore it.

JUDGE LUNDEEN:

That's a case where you really probably should be using the 1009 process to your advantage, because at some point, even though it's cumbersome and not necessarily related directly to the guidelines, since the guidelines are telling you that you get four visits or that's at least the protocol for your type of clinic, then the doctor can do what's appropriate in accordance with the guidelines. And at some point, these people will hopefully change the culture of how they're conducting business.

UNIDENTIFIED SPEAKER:

Another thing with those four visits, sometimes they're putting a limit to 10 days, 15 days for us to use the four visits. They're kind of trying to get around being -- approving those visits.

JUDGE LUNDEEN:

But that's what the whole purpose of the Medical Treatment Guidelines is. It's to provide people appropriate access to good care in a timely fashion, so we can help them to get them back to work. So use that 1009 process to your advantage, and don't be bullied by someone who's not following those guidelines.

JUDGE KELLAR:

This young lady right here.

UNIDENTIFIED SPEAKER:

I'm, actually, going to help both you guys out because we had that trouble last year. On your 1010, we do 90212-90215, so it gives them a span of codes. And in the documentation, where you put how many office visits you're asking for, I put "4 OV routine follow-up, documentation to support level billed." That way, they know that we're going to bill according to what we document for that particular day, no problems getting them approved. Medical Treatment Guidelines, actually, give us a max of four, not a minimum of four, so they can approve just one at a time, or two at a time. They sometimes give us two weeks, sometimes they give you a year, and there's no stipulation that says they can or can't do that.

JUDGE KELLAR:

Thank you.

JUDGE LUNDEEN:

If there's not a prohibition -- If there's not something that says that they have to do something one way or the other, then you have, again, the right to file that 1009. Because if they're artificially limiting something saying: Well, it's the guidelines. Send it to the doctor, because if it's not in the guidelines saying that

it's limited, then the legislature has not found it appropriate or the people enacting this part of the administrative code to limit it in that fashion.

JUDGE KELLAR:

Yes, ma'am?

MS. FAY GIROIR:

Fay Giroir with Terrebonne Parish Government. I, actually, adjust claims for Terrebonne Parish Government. Some of the issues that I'm seeing with the 1010 process is, basically, a lack of understanding how the 1010 process flows. I think it would be much more helpful for a lot of medical providers if there were some type of flowchart that they could follow, because I'll get 1010s in that may get denied, but they'll never go to the 1009 process. Then a month or so later, they'll file another 1010. Or if I have a 1010 that they send in without any medical documentation, and I pend it for lack of documentation, instead of them just submitting it with that same 1010 request, they're submitting whole new 1010s. So it's -- you get bombarded with the 1010s, when they should be filing a (inaudible), an exchange of information (inaudible). So I think it would be much helpful for everyone if they had some type of flowchart for them, you know, to follow how the process works, and what's their next step, what they can do. And everybody would understand it.

JUDGE KELLAR:

Thank you.

Joe, did you want to respond?

MR. JOE:

It used to be, in the old system, when a 1010 came through or when the request came through, and there wasn't

enough documentation attached, they didn't know if they had conservative treatment. The adjuster had all the information. They could look and see they approved conservative treatment for -- They could answer that. Now, they put the burden upon the doctors to go back through the file. Where in the old days, the adjuster had all the information, and they could look at their file quickly. They don't do that anymore. They now deny it, send it back. Not my problem. And so that would clear up and prevent a lot of new 1010s coming back. If you go over the 1010s, look through the file, you can know if you've approved conservative treatment or not, and answer your question.

UNIDENTIFIED SPEAKER:

Hopefully that's not my issue.

MR. JOE:

That's the issue we --

MR. PATRICK JOHNSON:

It's not uncommon for medical records -- I'm sorry, Judge.

JUDGE KELLAR:

No, go ahead.

MR. PATRICK JOHNSON:

It's not uncommon to get requests, now still in this day and age, without a medical record. I mean, for the doctors and the nurses here, as someone who deals with the adjusters every day, we've got to get those records, because we have that situation: Well, Patrick, why didn't you approve this? I'm, like: I haven't had a medical record for six months now, but I've got a lot of 1010s. So, I mean, that's one small problem that can be fixed. Make sure the records, and the documentation, all the

things that you need for a level 5 are in their records. And I know it is, for the doctors, a new way of doing things. Whereas they may not have done it before, and for the staff, but it is the game we have to learn. That has to be in there. It has to be provided. Now, if it's a situation where my adjusters had these records for six months and hasn't done anything, well, then hopefully there's a method it can get back to me, so that I can help you. But it's a situation where both sides still aren't meeting in the middle for whatever reason.

JUDGE KELLAR:

When the Medical Treatment Guidelines were first implemented, we went around the state trying to teach healthcare providers how to use the 1010, the 1010(A) and the 1009. That has been five years now, and so it may be time, once we are able to tweak the process of which we implement the Medical Treatment Guidelines, to go back and do that again, because we do understand that some healthcare providers are having problems. Some adjusters are not doing the things that the rules require them to do, as well.

But if you find that your difficulty is with a particular doctor, if you're always having a problem with a particular doctor, then you should let us know, because we can contact the doctor and see if there's something we can do to assist him, so that his 1010s will at least have the proper documentation, so that they can be approved if they're within the Medical Treatment Guidelines. I'll give you -- We all have cards, and we'll give you our cards at the end of this.

Yes, ma'am?

UNIDENTIFIED SPEAKER:

This question is probably more directed towards the judges. First, with the goal of workers' comp getting the injured workers back to work, I've seen many healthcare providers on their work restrictions use the language, "Unable to work, pending treatment." What are your thoughts on that particular work restriction? Is it sufficient? Does it need more detail? Or when you're looking at it from a judge's point of view, is that an adequate work restriction?

JUDGE JOHNSON:

It's all the circumstances, not just one thing. There's all the medical records, all the testimony. So just to say "yes" to that, I mean, I don't think anybody could.

JUDGE LUNDEEN:

Everything is on a case-by-case basis, once it makes it into the court system. And so we need as much information as we can get. When we talk about restrictions, we get into vocational rehabilitation and DOT guidelines, so that we can determine what the patient's limitations and restrictions are for rehab purposes and return to work purposes. It is, certainly, helpful to know, you know, what specifically the doctor thinks the patient can or can't do. If there's specific things the doctor knows that the patient can't do, that's wonderful. But I also understand, I think, why some doctors write that. Because if you have someone coming in with, for example, a possible torn rotator cuff, and you don't have that MRI yet, it's probably terrifying from a malpractice perspective to say: I think you can do something sedentary when you probably shouldn't be using this at all and should, to the best of everybody's

ability, have surgery as quickly as possible to repair it before it freezes and it's permanent.

So that's kind of a tough question. That's really a medical legal question, but the more information doctors can give, I think the more helpful it is to us as a court, but also probably to the adjusters making the decisions to approve treatment. You have anything else to add?

JUDGE PALERMO:

I think the most baffling situation that we have is when the doctor puts that the person is "unable to work, pending treatment." And then in the body of the report, he takes a history from him, and the person says that he's doing stuff around the house, you know, cutting the grass, or, you know, doing other things. And then he says "No work." Basically, no work, pending treatment.

We're caught in a situation where what do we do with that. I mean, he's, obviously, capable of something, but the doctor's saying no work. I mean, if it's the treating physician and he hasn't seen any other doctor, we don't really have much of a choice in that case. You know, so it kind of goes to what are the totality of the circumstances in the particular case.

JUDGE KELLAR:

Yes, ma'am?

UNIDENTIFIED SPEAKER:

For the 1009 process, once we have submitted the 1009 to your office, and we've gotten no response saying it's approved, how long does the carrier have -- or is there an amount of time the carrier has to then enforce that approval you said, and send us a 1010 to acknowledge that they agree and that they are going to pay for those services?

And the other question is for 1010s, when we submit for something as complex as like a psychosocial evaluation, recently -- it's been going on for a long, long time, but recently they've come up with a new idea that they want to demand that we provide them with a code for the psychosocial evaluation. And as the office, we're not providing the treatment, we're making the recommendation to be in compliance, and each psychiatrist stipulates what they're going to do, because they may get through the first three tests and not need anything else, but yet they may need the fourth and fifth. So now they're wanting me to give them codes from a psychological office that, of course, I didn't have, and had to hunt. And now our fear is I'm going to code the most possible, and then we're going to get that denial saying that that's $4,000, we're not paying for that. So do we, as the provider asking for the surgery, have to provide the coding for the psychological evaluation required by the treatment guidelines?

DR. PICARD:

No. I can't tell you that the insurance company doesn't require that, and that's their policy; however, if it came to me, I would approve it and say: No, that is not required, per the guidelines. To answer your first question, how long does the insurance company have to respond.

JUDGE KELLAR:

Judge Lundeen?

JUDGE LUNDEEN:

The defense -- I think the defense --

DR. PICARD:

After I approve --

JUDGE LUNDEEN:

Oh, after you, they have --

JUDGE KELLAR:

The question is after Dr. Picard approves the 1009, how long afterwards does the carrier have to --

JUDGE LUNDEEN:

I think it's ten. I think it's ten days.

UNIDENTIFIED SPEAKER:

Ten business days? Not ten calendar?

JUDGE LUNDEEN:

I don't think it specifies business, so I think it's ten calendar.

JUDGE PALERMO:

I don't think it says.

UNIDENTIFIED SPEAKER:

I never found it, that's why I'm asking.

JUDGE KELLAR:

What she's asking is once Dr. Picard approved the treatment, how long should she wait before the payor says: Okay, go on with the treatment?

JUDGE LUNDEEN:

I understand what you're saying. So what you're getting is you're getting the tacit denial all over again, after it's been approved. You're getting no action.

UNIDENTIFIED SPEAKER:

Correct. Because, typically, what I'll do is make contact with the adjuster, and say: Hey, I got Dr. Picard's 1009. He's saying approved. Can you send me my 1010? Sometimes, they make me send in a new one, which I do just to get it over with, but it -- the last two that I've had, it took over two months for them to get me a 1010 with an approval signature.

JUDGE KELLAR:

So, wait, let me make sure that I understand. So you get Dr. Picard's approval, then you call the adjuster, and they're asking you --

UNIDENTIFIED SPEAKER:

I'm asking them to give me their 1010 with their signature.

JUDGE LUNDEEN:

So it seems to me that at that point, they're not in compliance with the statute. And at that point, you would treat it -- I think you would have to come to the court with a 1008.

MR. PATRICK JOHNSON:

Judge, I mean, there would be other issues, perhaps of causation or accident course and scope that are depending upon the ultimate approval and payment issue, so --

JUDGE PALERMO:

To solve her problem, she's got to file a 1008.

MR. PATRICK JOHNSON:

That's what I'm saying. That's why if someone gets me involved: Hey, Patrick, your client's not approving us. Okay, let me make a phone call. But, again, there's no mechanism for that to flow back to us, or to be able to meet with our insurers, our clients, our peer reviews --

JUDGE KELLAR:

But the statute that Judge Lundeen is talking about is 1201(G)?

JUDGE LUNDEEN:

No, that's when you have a judgment -- an enforceable, non-appealable judgment. But I would think that if somebody is refusing or failing to timely respond,

and we don't know what that timely is exactly. We know that it's been approved at the 1009 level, and at that point, the parties have a certain number of days if they don't like that decision to file a 1008. I believe that that is ten days. I'm looking it up for you in the statute right now, so I can, actually, be accurate, but it's -- if somebody is aggrieved by the Medical Director's decision, there's a specific amount of time in which they have to file a 1009 appeal. If someone has failed to act within that time, arguably you are aggrieved, because you haven't gotten what you were supposed to get. So you're not -- you're not contesting. This is a very interesting legal question as I'm a sitting up here, so I'm going to look --

UNIDENTIFIED SPEAKER:

It's happened on three separate cases.

JUDGE LUNDEEN:

-- at my colleagues. But the best way to enforce something is to file the 1008, because you've been approved, you can't use 1201(G), because there's not an enforceable, non-appealable final judgment.

JUDGE KELLAR:

It depends on what complexion you give to Dr. Picard's decision. You've been through the Medical Treatment Guidelines, as the statute requires you to do to get your recommended treatment approved, and your treatment has been approved, so what happens next is I think you have to file the 1008 to enforce his approval. That's for sure.

But what complexion we give to the approval is the issue that you're having. Now, 1201.1(G) says that if any award payable under the terms of a final non-appealable

judgment is not paid within 30 days after it becomes due, then you add certain penalties. So I understand what you're saying. Actually, it's in the context of these town hall meetings that we first heard that the approvals were not being given the attention that they're due. We didn't know that before, and so what we're going to have to do is come up with some manner in which we say that once you have an approval from Dr. Picard, then the payor has so many days to act. Because that is a gap in the 2715 that's not in there now. And so we have heard this before, and so it's incumbent upon us to try to fix that.

JUDGE LUNDEEN:

And we've just found -- it doesn't directly answer your question, but under Title 23, Section 1203.1, which is the (inaudible) that gets everyone to the Medical Treatment Guidelines, under section J(1), and again, you're not exactly aggrieved by the Medical Treatment Guidelines, but it says (Reading): "Any aggrieved party shall file, within 15 calendar days, an appeal." And that may be the way that you -- it may be the tool -- the best tool for now to try and enforce this opinion.

UNIDENTIFIED SPEAKER:

And we have had a situation that this gentleman was speaking about earlier where you gave us an -- you gave us an approval, I came back to the adjuster, and she said: Well, we have litigation. We're addressing causation. So we let it lie until they were able to address that. But, we had two other cases that it was just simply very long periods of time between the time we got your approval, and when they were able to -- when they were compliant to send us a signature to say that they agreed with you and that they were going to move forward with payment on treatment.

So thank you.

JUDGE KELLAR:

The statute does say that you can appeal the 1009 within 15 days, but that's a separate issue, because the 15 days really is off the table after a Supreme Court decision. So we need to come up with some kind of way to make your approval enforceable with the payor. Thank you for bringing that to our attention.

Yes, sir?

UNIDENTIFIED SPEAKER:

One of the problems that we've been having recently -- with two patients that I can think of in particular -- these patients have been on medicines for years, anti-depressants, medicines for nerve pain, and opiates, and what we've been having is the insurance companies will send the patient records for a pharmacists review, or physician reviews. Basically, it says the patient needs to get off all the medicines. It's becoming more and more frequent that this happens. So they, basically, quit paying for any of the medicines. And what happens is the patients go into withdrawal, they get depressed because they're off their anti-depressants, they have a lot of pain, they can't get out of bed. And what we've been doing is we've been having to find something generic that they can pay for out-of-pocket.

They list the reasons that they're denying this, the guidelines. But if you look at the guidelines, they say: Yes, the medicines are appropriate. One thing that some of them have been doing is saying: Okay, well, we'll approve it, but you have to send in a 1010 every month for every medicine they're on. A 1010 for Cymbalta, a 1010 for Lyrica, a 1010 for an opiate. So it's becoming very

difficult to treat the patients, when they're using the 1010 as a way to keep from paying for things.

JUDGE KELLAR:

The circuit courts -- the appellate courts that rendered decisions advising our workers' compensation judges whether they made the right decision or not are split on the issue of whether or not prescription drugs are subject to the Medical Treatment Guidelines. I think the First, the Second, and the Fifth have said that prescription drugs are not subject to the Medical Treatment Guidelines. The Third and the Fourth have not spoken.

What that means for you is that if you are in a parish served by the First Circuit, the Second Circuit, or the Fifth Circuit, you are not constrained to submit requests for prescription medications to your payor. But if you're in a circuit that is controlled by the Third and Fourth, then you have to. And what we're doing is the office is silent on this issue, because we know there's a split in the circuits, and we're hoping that it will eventually go to the Supreme Court, and they will make a decision as to whether or not prescription drugs are subject to the Medical Treatment Guidelines. But until that happens, you will have to follow the circuit in your location.

Now, the way you do that is you go on our website, laworks.net, and we have a map of the state, and the state is divided into the ten district offices, one here in Lafayette, and then the map also shows which appellate jurisdiction you're in. In Lafayette, you're in the Third Circuit Court of Appeals. The Third Circuit Court of Appeal has not spoken on this issue.

JUDGE JOHNSON:

The Third Circuit has spoken with 1142(B) saying that prescription meds are under there, they're the same languages, underneath there -- I don't want to go -- I halfway have the issue before me, so I don't know how appropriate it is for me to comment on it, but --

JUDGE KELLAR:

Not if it's before you, but if you have a previous decision, you can talk about that one.

JUDGE JOHNSON:

The 1142(B) with the Rebel Distributors' case, basically, states that prescription meds are not, specifically, in the statue, but had no problem with the way that the judge interpreted 1142(B) to apply to prescription medications. If you take the statute -- it's the same language under 1142(B) as it is in another statue. So the analogy would be that the Third Circuit would say that prescription meds are --

JUDGE KELLAR:

Are subject to the Medical Treatment Guidelines.

JUDGE JOHNSON:

Right. Right.

JUDGE KELLAR:

So that's still -- that's a split in the circuit. Some of the circuits say "Yes," and some of the circuits say "No." So right now what we're doing, as workers' compensation judges, are following the law in the circuits which have spoken, whatever it is that they have said.

Yes, ma'am?

MS. KAREN WINFREY:

I'm Karen Winfrey, and I'm representing the Louisiana Restaurant Association today. I want to go back to the

comments you made about appeal time and the amount of time for the carrier to authorize the treatment once it's been approved by the Director. And I think what is important from the employer's standpoint and from a carrier's standpoint is you do have the 15 days to appeal. And while all the courts have made their comments on that time, we still need to take into account the time that we have for appeal, if we don't agree with Dr. Picard. And you also have the time frames, and Judge Lundeen referenced it, the amount of time the carrier has to pay before penalties are imposed.

So I didn't want it to go on and have more comments before we talk about when you're addressing the time frame that gives the employer the -- the set time when they have to authorize or when they have to sign off on the 1010. You have to keep those two in line. Because the first thing we're going to ask for and the first thing that's going to be filed in a 1008 is penalties and attorney's fees. So we've got to give them enough time, and they need to be given enough time, if they want to appeal a decision.

I had one recently where Dr. Picard agreed with us. So are we to just stop everything and not be given the 15 days to appeal? They need their 15 days, but we need our 15 days, plus the amount of time we are allowed by statute to make payment or to authorize the treatment.

JUDGE KELLAR:

Well, and I agree with you. It's kind of murky, because the 15 days is really not 15 days, but the statute does say l5 days, and so what Ms. Winfrey is saying is you need it to become final, kind of give them some time. Although, 15 days is not really 15 days. But that's

another issue we can talk about it afterwards. Thank you.

Yes, ma'am?

MS. GENIE VALOT:

Genie Valot. I represent the injured workers. We just have a few basic access problems. One of them would be we would ask that the agency please put the treatment guidelines under the link for workers on the website. Because right now it's under the employer's link, and nobody's going to look for it. None of my people are looking for it. That's the last place they're going to look on the website. So I think that would be an easy functional fix.

The other problem we have, and I think we've said this before, is that we are not getting copies of things. And that sounds like it's not a big deal, but when I tell you I'm getting copies of denials that don't have 1010s, so I can't file a 1009. I'm getting them 12 days after the date that's stamped. I've got 3 days. I'm calling the doctors like a maniac begging them for copies. They're busy. I'm calling adjusters who have everything and give me nothing, ever, and we have a problem with that.

We would suggest that the agency to please shift the burden of providing. Right now our rules don't state -- there is never a place in the rules that says the claimant should get anything until there's an actual written denial. So I have nothing. All we've been talking about right now, back and forth with the 1010, we never get that. It's not in the rules. We would ask that that please be put in the rules, and to shift the burden to the adjusters to provide what the medical providers provide to them for certification. So the 1010 and the records that

are provided to the adjuster, if they're going to deny it, make the adjuster send that to the claimant and the claimant's lawyer.

So we can take a little bit of this extra burden we put on the doctors, and get -- you know, spread the burden around a little bit and make sure that the claimants and the claimant's attorney are getting what they need. Because today, right now, I'm fighting over a surgery, where the doctor filed a 1009 -- which I had to do a handstand because I was so excited -- except that they did it before I got the denial. And they didn't copy me, and they didn't put me on the 1009, and now I can't get it from your office, because I'm not on the 1009. So we have a massive communication hole with the claimants in the system, and we don't know what to do about it. So we're looking for solutions on that.

JUDGE KELLAR:

Thank you, ma'am.

We do understand that that is a big problem, and that's one we've heard repeatedly that the 1010 is sent to the UR or to the adjuster, but never to the claimant or the claimant's representative, and so once Dr. Picard makes the decision, the 15 days has already passed to file the appeal.

So we're aware that there needs to be some -- some teeth in the Medical Treatment Guidelines to make people accountable for sending records where they should go. I think sending it by the adjuster may be the answer we need. Thank you, ma'am.

Yes, ma'am?

UNIDENTIFIED SPEAKER:

I'm glad that you brought up frustrating interaction

with adjusters. But I'm curious as to whether or not there's anything for us to do at the provider's office when we have a particular adjuster who is repeatedly completely defiant to any requests? Doesn't return phone calls, doesn't return e-mails, doesn't respond to a 1010. When you finally get them, they say: Well, I never got it. Can you send it again? Or you talk to the supervisor, which is a voice mail, and you never get that call back. And then finally the adjuster calls you back and, again, says: I didn't get that. Can you send it again? Do we have anyone that we can alert to the -- that, so that disciplinary action can be taken with the adjusters?

JUDGE KELLAR:

You can alert our office, but one of the things that we have become aware of through these town hall meetings, also, is that many of the numbers -- fax numbers that are listed on our websites for the UR or your adjusters to send your 1010s, they are incorrect. And we think the onerous needs to be on the adjusters or the UR company to give us good numbers. When -- The judges, when they send notices of conferences to claimants, if those notices are returned unclaimed, because the claimant has not given us a correct address, we dismiss their case. We make them accountable for giving us proper information. And I think, likewise, adjusters and UR companies need to be held accountable for giving us good information, as well. You do know that those fax numbers are listed on the website?

UNIDENTIFIED SPEAKER:

Yes, ma'am. I don't have an issue with having correct numbers. I get confirmations. I'm getting

everything I can humanly possibly get to prove that it was sent. There's just that other person on the: Well, I don't know what happened. You know, whatever their case may be. I've resulted to, on those particular adjusters, not just faxing them to them, not just to the patient's attorney, and not just to the UR, but e-mailing it to them, and sending a confirmation receipt, so that I have an e-mail that says it was opened.

JUDGE KELLAR:

Two things. One, on that list, all you're going to see is fax numbers, but we're going to require telephone numbers, as well. And, also, you can give me that information to the recalcitrant adjuster, or recalcitrant payor, recalcitrant employer, who seems to deliberately -- fails to comply with the rules.

JUDGE LUNDEEN:

So this is also another opportunity to, I think, where you could file a 1009. Because if you have confirmation at the posted, public number to which this person is connected, then it is not your problem that they have lost it, that the dog ate it, that, you know, the fairies took it away. And their timeline, according to these guidelines, has started ticking once you have that confirmation. So that falls into that category of tacit denial, and so you can treat it that way.

UNIDENTIFIED SPEAKER:

Our issue with doing things that way is, typically, I find that if I put a push on an adjuster, I'll get a response. And that way, I can treat my patient. If I go through the process and send Dr. Picard every office visit that they're not responding to me, and I know he's swamped, and there's, you know, major medical issues that

need to be made, and I'm over here fighting for an office visit, it's just a bit ridiculous, and I'm sure we all agree with that. So I just wish there was something that we could do that would be disciplinary action on an adjuster who is defiant to work the process.

JUDGE KELLAR:

I don't think there's anything in the rule, at the moment, regarding disciplinary action, but I would certainly be willing to make a telephone call, if it's repeated. So just let me know.

UNIDENTIFIED SPEAKER:

Thank you. Absolutely.

JUDGE KELLAR:

Thank you, ma'am.

Yes, ma'am?

MS. MARIE SEGURA:

My name is Marie.

JUDGE KELLAR:

Stand up, Maureen. Maureen, what's your last name?

MS. MARIE SEGURA:

My name is Marie Segura, and I have a corollary to that. It's great that the doctors are held accountable, that there's all these rules, and the attorneys are held accountable when they submit their forms. But why isn't the carrier utilization review departments accountable as well? In our office, there's one reviewer who -- we look at the name of the response first, before we look to see if it's approved or not, and then predict the outcome. So if there are repetitive people on the carrier utilization review department that aren't following the guidelines, sure, we file a 1009, and sure, Dr. Picard is going to approve it, and sure, we get another 1010, but it seems

like a lot of unnecessary work. Is there anything to address those issues? We can do all that forever, and it just seems so unnecessary.

JUDGE KELLAR:

I understand, and currently there is nothing in the rule, at this time, to address the issues of UR reviewers, or adjusters, who might be deliberately violating the rules by denying repeatedly things that aren't in the Medical Treatment Guidelines. But as I said, one of the problems we've noticed with the Medical Treatment Guidelines, based upon the responses from the town hall meetings and from just working with them every day, is that there's no teeth, there are no penalties, in the Medical Treatment Guidelines for persons who deliberately try to circumvent the rules. So that will be an issue that we'll be looking at, as well. Thank you, ma'am.

Yes, ma'am, back here, and then the gentleman way in the back.

MS. TRICIA:

Hello, Tricia with Anesthesiology and Pain. I just need clarification on the 750 rule, which states if the fee is going to be more than $750, you need to file a 1010. Some adjusters will say it's not needed, and the ones that do require it, all have their own interpretation of it. Some of them will say it's per visit, others will say it's for the lifetime of the patient.

JUDGE KELLAR:

It's per visit, or it's for the lifetime of a claim?

MS. TRICIA:

Yes, which means by the second visit, the patient will never be over $750.

JUDGE KELLAR:

Have you ever heard anybody say it's per HCFA?

MS. TRICIA:

Per what?

JUDGE KELLAR:

HCFA.

MS. TRICIA:

Huh-uh (Negative response).

JUDGE KELLAR:

The form?

MS. TRICIA:

No.

JUDGE KELLAR:

No?

Does anybody want to address that? We have heard that one, as well, that the 750 threshold that you fall into, you don't need approval from anybody, but once you go over 750, then you need to get approval. So we've heard that some adjusters have said it's per claim, some have said its per visit, and some have even said that it's per HCFA, the form that you submit with request for payment, I believe.

And we are aware that it is an issue that we need to address, and it has not been thus far, but hopefully we'll do so as we are trying to come up with fixes for 2715.

JUDGE LUNDEEN:

We can answer it.

JUDGE JOHNSON:

It's per provider.

JUDGE LUNDEEN:

It's per provider.

JUDGE KELLAR:

Where is it?

JUDGE JOHNSON:

1142(B).

JUDGE LUNDEEN:

Title 23. You can find this either on our website, or you can also go to the Louisiana Legislature's website. If you look in Title 23, Section 1142(B), nonemergency care (Reading): "Except as provided herein each healthcare provider" -- so each healthcare provider -- "may not incur more than a total of $750 in nonemergency diagnostic testing, or treatment, without the mutual consent of the payor and the employee as provided by regulation."

And then they go on to talk about other -- (Reading): "Except as provided herein, the portion of the fees for nonemergency services of each healthcare provider, in excess of $750, shall not be an enforceable obligation against the employer or the employer's workers' compensation insurer, unless the employee and payor have agreed upon the diagnostic testing or treatment by the healthcare provider." It's pretty clear the statute says it's healthcare provider.

JUDGE KELLAR:

Does that help?

JUDGE LUNDEEN:

And that's helpful, too, because that way, you don't have to know that the person has already been to a pain management person, or that the person's already been to their primary care doctor, emergency room, when you guys are seeking that medical care under 750.

MS. TRICIA:

So are we to interpret it as per visit?

JUDGE LUNDEEN:

Per provider. So for whomever your doctor is -- If you're Dr. Smith, then Dr. Smith has up to that 750 cap. It's, certainly, always good to seek permission for care. You're not always going to have that opportunity in an emergency situation, and that's what this statute is designed to address. But be prepared to explain and justify to somebody who wanted to get paid, that it was an emergency situation, and it wasn't feeling like an emergency to you, because we want our healthcare providers to get paid for the services that they're providing to injured workers.

JUDGE KELLAR:

There was a gentleman in the back.

DR. HENDERSON:

Yes, I'm Darrell Henderson. I'm a plastic surgeon. I do mostly very, very complex hand surgery. Of course, there's no guidelines except just the routine carpal --

JUDGE KELLAR:

Just a minute. Sir? Dr. Henderson? Can you start over, please? The court reporter couldn't hear your.

DR. HENDERSON:

Yes. I'm sorry. I'm Darrell Henderson. I'm a plastic surgeon, and I do mostly hand surgeries. We do very complex hand surgeries. A very few is just routine carpal tunnel. And, of courses, there's no guidelines for anything that I do. In the last four or five months, we've gotten more and more requests for what's called "peer-to-peer reviews." And this is some doctor, usually in California, it's a different time zone, that calls our office, and we have to talk to him within the next 36 to 48 hours or they -- claim not gets entered. It's automatically disproved.

My secretary tells them the days that I'll be in surgery, tells them what time our office closes, the fact that we're in a different time zone, and 80 percent of the time, the calls are called after our office closes, while we're in surgery, or when we're not there. And, of course, it's disapproved. And it really hurts the patient, because the patient still has this bad injury, that he -- we can't operate. And then 20 percent of the time I talk to this doctor and invariably it's a board certified orthopedist or plastic surgeon. Usually, they've never heard of the surgical procedure I'm going to do on the hand, and then kind of remember maybe back in residency he might have seen one. Then I'll ask him what records do they have for my chart, and I usually write l5 to 30 pages of reports about the patients when I initially see them. He says: Well, I don't have your report. He says: All I have is the 1010, and I have a denial form that the insurance company gave me to sign by the time that, of course, it's denied.

Is that going to -- The peer review doctors, is that something that's going to get bigger and bigger and what -- does it twice. It doesn't really work, because 80 percent of the time you can't even talk to the doctors, and when we do talk to them, he has no clue what type of procedure you're talking about doing on the patient.

DR. PICARD:

I'm not sure that I can address that, because that's an insurance company policy, and it's not something that -- and I don't know the law like the judges do, but I don't think there's any regulations in the law that can stipulate requirements for that type of interaction that you're talking about. What type of, you know, person do

you have to have, what type of certification do you have to have? There are no requirements for that. So that's something that the insurance company decides that we don't have anything that we can do about it, at this point. Am I wrong about that?

JUDGE KELLAR:

We've heard from other doctors' offices that some utilization review companies outside of this state do a peer-to-peer review, where they want to talk to the treating physician -- the physician who has submitted the 1010, and either the doctor's office will give them a specific time to call to talk to the treating physician, and they never call during that time. So they end up denying the request for treatment.

The utilization review rules are in Title 40. And so in some cases, those utilization review rules are inconsistent with Title 23. And so that needs to be refined, as well. So that is another issue that has been raised, and one we will be looking at.

DR. HENDERSON:

And usually these doctors are board certified orthopedists, or board certified plastic surgeons. But those are huge, huge fields, they're not -- it wasn't hard for any of them to do the complex hand surgery. So this kind of leaves us out -- either not talking to anybody, or talking to somebody and they don't have a clue what you're talking about.

JUDGE KELLAR:

Thank you.

Yes, ma'am?

MS. JENNY VALOIS:

Jenny Valois. I have a question just on a

logistical -- the way that I see things in our office. We have a lot of carriers, and, of course, we do litigation, so we don't see everything so, you know, we're seeing some things that are in litigation, and some that aren't. But we have carriers who like to use the Medical Treatment Guidelines when it works for them but mostly ODG, and then they also want to use the SMO system. And we're using both systems in all the cases, and it's getting a little bit crazy. And I'm wondering if the agency is going to address that or how we handle that.

I've noticed that the SMOs never really address the medical guidelines themselves. They render the opinion. So with the treating physician talking about the guidelines, and then we have an SMO who never mentions the guidelines, then we get a Medical Director, who mentions the guidelines. It's just -- it's kind of everywhere. And we're using both systems in a lot of our cases, and I'm not really sure that was the intent. I'm not really sure how to stop it. We sometimes file a motion for protection, we sometimes don't, because there's not enough time. I just -- I thought I would just put that out there that I hear this from a lot of defense lawyers, too.

JUDGE KELLAR:

Is the SMO used to support the denial of the 1010? Is that what you're saying?

MS. JENNY VALOIS:

It's, actually, not really done in time to support the denial of a 1010. It's typically done when we see the surgery coming down the line. We usually -- they get the SMO right about the psychological evaluation time, you know, or right when you get that diagnostic that's positive, which I don't really have a problem. You know,

they're statutory. They're allowing SMO, but I'm wondering why we're not requiring SMOs to apply the guidelines. If we're going to have statutory allowed SMOs, they should have to apply the guidelines -- our Louisiana Guidelines so that the treating doctors have to use, because the opinions never apply to us, and then it's really apples and oranges at that point. It's a problem.

JUDGE PALERMO:

There's usually more than -- When the SMO that I've seen -- When they're using an SMO, and they're also going through the medical guidelines, what I've been seeing is that there's more an issue of just medical treatment. And so the SMO is asked to address certain things, or certain aspects of the case. And then they have the Medical Treatment Guidelines, which goes just to the treatment.

And then I'm also having -- from the other side I'm getting the argument from the plaintiff's behalf that if all they do is go through the Medical Treatment Guidelines, that that's not competent medical evidence, and therefore, they are entitled to penalties and attorney fees, because treatment's being denied without competent medical evidence. So they're saying: Okay, well, I'm going to get an SMO, so that argument can't be made. And as far as I know, that hasn't been presented to the Court of Appeals yet, so I don't know what's going to happen. But that's the situation. There may be a causation question, there may be some other question besides just whether is this treatment necessary or not. So I don't know if there's much we can do, because we have the separate issues.

JUDGE JOHNSON:

I'll take that a little bit further. I don't have

the answer to this question, but the issue is is whether UR's competent medical advice, where you got the Perrin versus St. Landry aspect of it, and then following reliance on the process, which calls for it to be UR. It's either going to be penalty and attorney fees, or it's not. I don't know the answer to that question.

JUDGE KELLAR:

Anything further?

Yes, sir?

MR. DAVID BANKSTON:

My name is David Bankston, and I represent the injured workers. And one of the problems that I've seen, that this lady referenced, is the system seems to have been currently designed to improve or speed up is the goal -- speed up the medical review process between the doctors and the adjusters, but it has taken the injured worker and his representative, basically, out of the process for all intents and purposes.

I rarely know that there's even a problem, because when I call my client, after I haven't heard from him for two months, and he's sitting at home waiting on his three month follow-up visit, he doesn't know what's going on. And by then all the delays for appealing or pursuing some sort of remedy had expired. So there needs to be some mechanism, whether it's notice to the employee -- yes, the employee or his representatives, but even at that point, what is -- what is my role in that process? It seems like it's, basically, down to the burden of being on the medical staff to fight these fights and then taking us out of it.

And I think all of the major providers in this arena -- the orthopedists, neurosurgeons, and all these people,

have now dedicated staff, and probably have full-time employees just to deal with these forms, but you get a lot of smaller providers, like a GP -- you sending a guy to his family physician for a first visit, they may not know how to do this, or they probably don't want to do this. I've got a psychiatrist in Lake Charles, they don't want to have anything to do with this, refuse to file a 1010. So, basically, I'm precluded, as far as I see, from even raising that issue with the Court. I can't file it as a disputed medical treatment, because the provider cannot, or will not, choose to engage in a fray. So I can't protect my client's interests in pursuing something that hasn't been through the mechanics of this process.

So that's -- Is that solely now the medical provider's burden to fight that fight, or is the claimant and his attorney or representative have any options in getting involved in that fight?

JUDGE KELLAR:

The Medical Treatment Guidelines, or the manner in which injured workers receive medical treatment after the implementation, and the system is flawed. We do understand that, but we think overall it is a better system than the previous one, because the majority of cases employees are able to get the medical treatment recommended by the healthcare provider in a much shorter time than they did under the previous system. And it would appear that this system is less costly than the previous system, because you don't have to do your treating physician, employer physician, the IME, the depositions, the medical costs, or wait sometimes a year before you can have a trial on the merits as to whether or not the recommended treatment was reasonable and

necessary.

In the vast majority of the cases, even though the system is flawed, the injured worker gets the medical treatment that his physician has recommended. So the answer to your question is 1) yes, this is the system that a doctor has to use, 2) this is the system that is a mainstay of Louisiana Workers' Compensation system, and there's no intent, at this time, but though it may be just a wash, but we're here at these town hall meetings so that we can learn from you guys in the trenches what the problems are and try to address those problems to make it easier, not harder.

We don't want doctors to leave the Workers' Compensation system. We have had many to leave already. We don't want more to leave. But we want to make it easier for them to practice, using the Medical Treatment Guidelines.

Yes, ma'am?

MS. JAN BARBER:

Jan Barber from Barber Law Firm. We represent only injured workers. And, Your Honor -- or sorry, Director Kellar, while the intent of the guidelines may originally have been to provide faster medical care, even medical care without litigation, I just want you to know that in our office, right now, every single surgery that Dr. Picard has approved is now being scheduled for an SMO, based on causation. The claims are five years old, some of them. And so while your intent of the guidelines is noble, as we in the trenches are trying to apply and use them, they are not having that intended effect.

So unless and until we together cause the -- close the causation issue, or define which system we're all to

operate under, then your intent cannot be met. And who is suffering is our people who need multiple level surgeries, Your Honor -- Director. So when we go forward, please understand that your system is being hijacked.

JUDGE KELLAR:

I appreciate your comment, but I think one of the reasons we're here is to hear from you how you believe the system is being hijacked. As we said, there's some things that you guys see that we were never aware of, and through these town hall meetings we're becoming aware of problems that you're having that we had never envisioned before. So thank you for your comment.

Let's go over this side and then around. Mark?

MR. MARK:

Yes, ma'am. I'm going to follow up on her comment. You know, the 1010 forms have a line that says it's "Denied for causation" and they have a line that says it's "Denied for not being within the guidelines." And repeatedly I'm getting cases where it's denied for not being in the guidelines. We file a 1009, we get it approved, and then they tell us: Oh, well, no, now they're challenging it for causation. And the rules seem to allow that, and that does lead to horrible delays that I don't think were contemplated in the system. I would suggest that the guidelines should require carriers to make a decision on that, and if they don't put causation on their 1010, then they shouldn't be able to raise causation six months later, after we finally get the thing approved.

JUDGE KELLAR:

Thank you. Go that way, Mike.

MS. KAREN:

Hi, I'm Karen. I'm on the reverse side of what you're talking about who should --

JUDGE KELLAR:

Karen, can you speak up?

MS. KAREN:

Oh, sorry. Who should push this process? Should it be the doctor, or should it be the attorneys that are representing the injured workers? From the carrier side, we believe it should be the doctors. It's supposed to be a medical decision. It is not supposed to be a litigation decision. And I will tell you that I have had situations where a doctor puts in a 1010 for surgery A, we deny, then he will send a request for a different surgery, surgery B, and we were told by the doctor's office that the plaintiff's attorney has told them to hold off.

Now, surgery B is approved, surgery A is denied. Who's moving the process? Is it the plaintiff's attorney who say: Wait a minute, I'm going to schedule this medical decision doctor, even though you requested surgery A, it was denied, and now you changed your mind, and you requested surgery B, which has been approved. Surgery is not being scheduled. Why? Because the plaintiff's attorney is telling the doctor: Hold off until we finish the process on surgery A. What do we do as the insurance carrier? At what point in time is surgery A off the table? Or can we force him to do surgery B, since they asked for it, and we approved it. Again, it's putting non-medical people in the process, and that's not the way it should work. It should be medically necessary, and then move on.

JUDGE KELLAR:

Thank you. The back, Mike.

MR. STEVE REESE:

My name is Steve Reese. I'm a local physiatrist. I've been dealing with the workers' comp system for 25 years, and probably at least 25 times a day, I tell myself I'm not going to deal with the workers' comp system anymore. And looking at -- kind of piggybacking on some of what Mark was saying, part of the problem that I see was one time during a deposition I was being asked by an attorney: Don't your litigation patients take much longer to get better? I said: Yes, they do. But if I had a private insurance patient, they'd come in to my office, and I'd order an MRI -- Unfortunately, then you need another private insurance injury attorney -- but this was a few years back, I said: I will have an MRI in a week, and then I will make a decision on that MRI. And then I will say: Well, maybe I want to get them some physical therapy. And I will get the physical therapy, and, you know, in a few weeks I'll have them back and I'll look and see how they've improved. From that, I will say: Well, possibly they might need an injection, and I will do the injection.

So within a two-month period of time, I have gone through a treatment plan. I have an idea of whether or not this diagnostic and therapeutic treatment plan is going to lead us in the direction we want, or do we need to reevaluate what's going on. When I have the same patient come in from workers comp, and I order an MRI, in two months I might get the MRI completed. And then I will say: Okay, I've looked at the MRI, and now I want to get physical therapy. But it might be another two months before the physical therapy is approved. And now at the end of that time -- so now we take a process that could be

done in a short period of time and we're now at a six to nine month period of time. And we think of that as due process, and we turn it into a chronic process. And it isn't because of anything the patient particularly has done. It's because of something the system has done.

And another issue dealing with the guidelines, I was in the mid-90s, and I was part of -- when they first started talking about let's come up with some workers' comp guidelines. That was part of what we do was looking at this and doing this, and it was never the intention the guidelines were the difficult laws of nature. They're not like gravity. That's okay. They were guidelines. And to have somebody come into your office and have a ten-year-old process -- those guidelines, they don't fit anymore. People try to act like: Okay, you got hurt, you know, last -- you know, three months ago. So it's the exact same situation as if you got hurt ten years ago. And it's just not the same process, and it doesn't appear to be any common sense. It's how the system works, because it's not designed to, at least from a practitioner's standpoint, to get somebody back to work in a timely fashion, which is really what your goal should be, to return them to whatever maximum level of function, whether it's back to work or not.

Sometimes, they're not going to get back to work. You have somebody that they, you know, they come in and they're now a quadraplegic. Their chances of returning to their previous job are not really very high, but we should try to get them to whatever maximal level of function that we can get them to. And I think the focus is gone away from -- because of the system it's gone away from the person who is in the center of whole processes, you know,

who probably didn't want to break his leg in a car wreck, but he did, and now let's see what we can do to make the world best for him, not what we can do to drag him on and treat him like he's some sort of criminal. And that really is what it seems like a lot of times, from the practitioners standpoint. And so if there is a way that we can say: Okay, good we're going to use these guidelines at least in a streamlined fashion, we will get people to whatever level of function we can.

We get a conclusion of cases much bigger, which is what everybody really wants, but the system drags it on and then, of course, the patient then by this time is getting frustrated. And so now they say: Well, you know what I didn't do it before, but now, I'm going to get an attorney. And as we all know, once that happens, then, you don't know -- nothing -- there's nothing against my -- my attorney rathered it in this -- in this group -- but once that happens it throws everything into a new level of confusion.

And so, you know, I know that this group may not have the answers to this, but I can tell you, I've watched it happen and it hasn't gotten better with the implementation of these guidelines. It just got worse. It's a way for people to hide behind reasonable and rational decisions.

JUDGE KELLAR:

Thank you.

Yes, ma'am?

UNIDENTIFIED SPEAKER:

This is my last comment. One thing I think would help is -- I know, Director Kellar, you and I have worked on -- I had a 1009 rejected, and I swore up and down, and even put in my 1009 that my office did not receive the

fax. The UR denial said that it was faxed to my office, and we checked both physical offices -- scrambled, checked, we never received it. We received it on the date -- we stamp our mail, and it's, basically, an affidavit, attached to the 1009 and said this is the date you received it. Our filing of the 1009 should be within 15 days of the day we received it. And there was an issue that it was rejected, and we had to get everybody on the phone with LWCC and work out all of those facts.

My suggestion would be that regularly, when we go to court, the prescription issues and the filing issues are factual issues. And I took a little bit of umbrage with the fact that the Office of Workers' Comp absolutely took the adjuster's word, or the UR person's word, that they faxed it, over my same exact words saying I never received it. That's a factual decision. And I think that the office maybe shouldn't be making those. If there's going to be an issue, you know, or whoever is taking in those initial 1009s and doing that initial screening, if that -- they're making factual determinations that are going to impact where my clients, you know, when their treatment's going to occur. Also, whether or not I've met my legal obligations to my clients.

And so I just -- I hope that we -- going forward can work on those issues. And I would say that I think most clerk's offices do not raise prescription defenses, we leave that to the other party. And I think maybe we should just -- it would be a decent solution to just do that. Let the employer say: You know what, that's too late filed. And take the State out of that mess that we kind of created.

JUDGE KELLAR:

Thank you.

Joe?

MR. JOE:

I had a similar issue that's come up. I think I have it worked out with the adjuster, but the case is with an attorney, and I'm sure it's going to be a different issue. A 1009 appeal was filed by my office, by an e-mail. It was filed on a Thursday. I get a letter on the next Wednesday stating: We've received your 1009 appeal. And it's got the date. Well, the date that the office issued the letter was outside of 15 days. The adjuster immediately called me and says: Hey, you didn't appeal the 1009 within 15 days. I said: No, go back and check your e-mail. I e-mailed it, and I copied you. And she pulled it up and goes: Yeah, I see, you're right.

But the problem is what came from your office, on its face, shows that when you look at that letter compared to the UR denial, I didn't have it filed on time. But I did. But the letter that you sent out doesn't say: We received your 1009 filed on such-and-such a date. It just says: We received your 1009 filing -- I think it says this day. Or we received your 1009 filed. And it just has the date of the letter, it doesn't say when. Used to be, when I filed it by e-mail, I'd get a fax within four or five hours, maybe a day. Now, I'm getting it by regular mail quite a few days later, so I can see that being an issue further on down the line.

JUDGE KELLAR:

Michael, didn't we just address this issue?

MR. MICHAEL PIPPINS:

We did -- If you're talking about the rejection letter, it's now --

MR. JOE:

No, this wasn't a rejection -- This was just showing: Hey, it's been filed. We'll get you your response at the end of 30 days. The Notice of Receipt has no date filed.

JUDGE KELLAR:

I think we just addressed that issue. Just put the date in there that we actually received it, instead of just saying that we received it. But it's a change we just made.

MR. MICHAEL PIPPINS:

I'm pretty sure I changed it, but I will double check it as soon as I get back tomorrow -- (inaudible)

JUDGE KELLAR:

Court Reporter, can you hear Michael?

Michael, she couldn't hear you.

MR. MICHAEL PIPPINS:

Oh, I'm sorry. I believe that I did change that date on that letter, but I will double check that as soon as I can get back on our network PCs at home.

JUDGE KELLAR:

Thank you.

Yes, ma'am?

UNIDENTIFIED SPEAKER:

Speaking of that response to the receiving of the 1009, it would be helpful if we could also have what the 1009 was for. Because on some patients we may be submitting multiple 1009s for multiple things. And so when we get that thing that says: We've received it. We're going to review it. It doesn't say what. And sometimes, the attorney may have filed the 1009 on behalf of the patient, and so I get it because we're the provider, and I'm, like: Oh, which one -- What are they

filing the 1009 for? So it's not super clear on that letter what 1009 you've received, or at least what you're going to review, as per that particular 1009. And the other thing -- I'll think of it again.

UNIDENTIFIED SPEAKER:

Just a few issues from somebody's that's handling the defense side, and dealing with this daily. I think most people who work with me on the law side would say that I tend to be pretty reasonable. Some things that we see a lot of -- we still, like I mentioned earlier, receive requests without medical records. You need to provide that. And I know 95 percent of y'all do it, and I'm sure do it in your sleep now. But we still occasionally get it.

And another problem, whenever the peer review denies something, quite often, it's not just a tacit denial, like: We're not going to approve it. Or sometimes it's more then just: It's not covered under the guidelines. On occasion, it's: We don't have this record, or we don't have test results. Please take the opportunity to review it, and make sure it's not simply a situation where some information that the peer review doctor needed, didn't have it. That's something that can usually get resolved. You can call the doctor, you can call the adjuster and say: Look, the doctor said he didn't have the EMG results. Here are the EMG results. Now, again, it does cause a little confusion with the timing issue. But giving the doctor the EMG results that he can review is a lot faster than filing a 1009 to Dr. Picard, who's going to ultimately say: I don't have the 1009 that's on file. That's just a small fraction, but if the care of your patient is that important, that small fraction is

incredibly important to that particular patient.

There is always -- and I know it's frustrating, and I don't want to talk about causation. As the case develops, we may well see a case from one perspective as an attorney, that may be entirely different from how we see it six months or a year from now. You're doctors, you're nurses, you're treatment facilitators -- and God knows I've probably been in front of most of you at some point for my own issues -- but at the end of the day, you're dedicated to getting that person the care that they need. My job is to find out whether they need it or not, because of the accident. Our physicians aren't, or shouldn't be, adversarial. We're both trying to find the same thing. Is this person entitled to this medical care because of this accident. And, unfortunately, we don't have enough adjusters here, we don't have peer review physicians here.

But take the time to get to know most of these adjusters. A lot of them are overworked, and I know there are some who do engage in the little games of: I didn't receive that. So you know what you do? You send them a fax. Why? You send it in an e-mail -- Whenever we subpoena medical records, or whenever your attorney subpoenas the medical records, unless you're willing to print out all your e-mails, that attorney -- your attorney does have confirmation as we discussed. Send them a fax. That way I can go to my adjuster and go: Hey, there's a fax. You said you didn't receive the fax from the doc of -- Yeah, here's the fax. You need to go over there and mark an entry for doc. I will do that. Will a lot of defense attorneys do it, I'd like to believe so. But you need to be able to give me something that I can go to my

adjuster and go: Look, the doctor says here is what he sent you, and here is when he sent you. Count those dates, he's timely.

Now, as for the other billing issues, I know we aren't -- there's a lot of level four, level five. Ladies and Gentlemen, you know we need to go into the medical records to get billed out level four, level five. I still get routine follow-up, no additional care requested, same complaints, same problems, same limitations, here's the treatment. And there's going to be requirements for a level four and level five. There are other issues, which I'm sure are our fault or our adjuster's fault. That's just one issue we've been seeing a lot of. If you could have the documents correct that. It's just one little issue we don't have to deal with on a daily basis, and that's really all I have to say today.

JUDGE KELLAR:

Thank you.

Why don't we start with this young lady right here.

Yes, ma'am?

MS. PAULA JENKINS:

Hi. I'm Paula Jenkins, I work for Our Lady of Lourdes. It's a self-insured employer, and I'm the adjuster for our workers' comp, professional liability, and general liability. So with that being said, that's a lot. So when I get a 1010, and I look at those medical records -- and for me, for a small employer, I actually, know my injured workers quite well. Many of them have been with us for decades. There's nothing more important to me than getting them diagnosed quickly and treated appropriately. If they need surgery, well, then I want them to have it. I want them back at work. They have

many years invested in their education, and in their careers, and I want them back to work. I don't want anybody to lose their career.

That said, I'm looking at that 1010, underneath those medical records. Occasionally, I do have to send it out for peer review, because I'm not a physician. If something is quite complex -- I had one not too long ago, it was a triple level fusion and the Medical Treatment Guidelines don't really call for that, but still I wanted to send it out. But when I send it out, all I'm sending is the medical records that were, actually, attached to that 1010. I used to, when I had a second adjuster, we would, actually, go back through our records, and attach additional things to either -- in support or whatever, but now I don't have time for that. I send whatever was attached. That's going out for the peer review. So if it's not all there -- it's not all there. I count the pages. If you send me a fax that says: I'm sending ten pages, the first thing we do is go through and count that I get ten pages. If I didn't, I'm calling the office: I only got eight pages.

So I'm really trying hard to work with our providers. We have personal relationships with most of our providers. They work at Lourdes. They do surgeries at Lourdes. I really want to do what's best for my employees. I do want to comment on this 1009 process that she brought up, is I'll get the 1009 back. They usually denied something, not often, just denied three out of four things because of the appropriate documentation wasn't there. When I get a 1009 back, I really do need to know what's being appealed. Which of those three things. So that would be super important, just like you said, to know what is being

1009'ed. What precisely. Because we don't know that. All I get is something that says: Hey, it's going -- and I'm like: Well, which one? Which thing is going? Is it the pharmaceuticals? Is it the procedure? What is it?

And I guess that's the only other thing I wanted to say is I appreciate all these providers that are here, and I can't even imagine how complex and difficult your work is. Just know that if you have a workers' comp claim for Lourdes, call me. I want to do what's right. I know that employee. I know them well. I want to get them back to work. So don't think I'm not trying to do it. I pray about these people every day. Please, God, help them. Get them back to where they need to be. So let me help you. If I'm not doing it, it's not on purpose. I really may not have gotten that fax. Honestly. Thank you.

JUDGE KELLAR:

Thank you, ma'am.

Let's go to the gentleman in the back, and then we'll come forward again, Mike.

DR. MATHIS:

Dr. Mathis, hello again. I just wanted to address the psychological evaluations before some of our pain procedures, and before spinal surgery. One of the problems that we've gotten into is there's nobody that wants to do that psychological evaluation. I just heard this week that there's one doc that's new here in town that's willing to take a few, but that's been an ongoing problem over the years, trying to get the patients in to see a psychologist. And then having to do a 1010 to get that patient to see the psychologist, and having it denied when it's in the guidelines that they're supposed to see a psychologist. It becomes real difficult to move on with

the treatment of the patient when the -- when there's no psychologists and then when a psychology evaluation is being denied.

One of the things that I would suggest in the future is just removing that from the guidelines -- for future guidelines, because as I said, nobody wants to see these patients. I asked one of them one time why they didn't want to see the patient. They said: Well, there's a lot of paperwork involved, and also, we'll make all these recommendations, and then the recommendations aren't being approved, such as further counseling, coping techniques, biofeedback. They're not getting approved, so we just quit seeing those patients.

JUDGE KELLAR:

Thank you.

This lady right here, and then the gentleman in the front.

UNIDENTIFIED SPEAKER:

So my question would be -- and I think I know what the purpose was of the psychosocial eval prior to fusion surgery, was to stipulate whether or not the patient's aware of what that is, aware of what's going to be required after, you know. The problem that we're having, and that I had on two different occasions, is that we have patients that are not literate, and so going for the psychosocial evals, they were not able to complete some of the testing that was required, some of the paperwork that was required, so the psychologist could not make a determination whether they felt that they were or were not a candidate for surgery. And then that patient's care kind of stops. So how do we -- What do we do as the provider to address that. I know it doesn't happen often,

but unfortunately, it's happened twice lately in our practice.

And the other thing was they were talking about work statuses earlier, and that whole stipulation of "Unable to work, pending treatment." I think it would help us, and what I started to do is request a job description, either from the adjuster or the employer, so that our physician can be more specific. Because sometimes, the patient's, like: Well, I'm a cashier. You know, or: Well, I'm a this. And we don't really know what that entails for that particular employer. So we get the specifics of what's required, and then we can address it more specifically. So if the adjustors would be more readily -- have access to job descriptions. Because sometimes they don't have them. And so to get to an employer is even more difficult. And to make it the burden of the patient, I just fell like, you know, it can be kind of unfair.

So if we could get job descriptions at the beginning of the claim, I think it would be helpful. And then, again, with the psychosocial eval, how do we address a patient that just is incapable of making it through that interview?

JUDGE LUNDEEN:

On the psychosocial eval, because I've heard this from some of my friends, from medical providers, if there is an attorney involved, a lot of the times the attorney -- and I know it's probably the last thing most of you want as doctors -- but you can get the attorney to go in there and read the documents to the individual, and hopefully write exactly, like a translator, what the injured worker is stating.

An alternative is to have a family member, who is

literate, which is probably a better option, at least from the standpoint of bias, is to have a family member who is willing to help that person and come in and be their patient advocate, to the extent that they're going to read whatever it is you need read, and fill out the questionnaires. And it's something you all should be asking ahead of time. And it's an uncomfortable question, so sometimes what I find works better, at least in the courtroom setting, so that we don't embarrass people, is we'll ask not the question: Can you read or write? But we'll ask: I know that sometimes these forms can be long. Would it be helpful to have someone come with you, who can help you read them and write all of this information?

And that can be beneficial for you guys. Or if you guys are a big enough facility that you can dedicate, you know, the four hours, instead of the two hours, to sit there and help the person through it. Now, obviously, it wouldn't be you guys because you're orthopedist, but for the pain management person. But that's something that maybe the pain management person needs to know when you're -- or the psychosocial or the neuropsych needs to know before you guys are sending them over is, this person may have either a language barrier -- Because that's another thing that comes up. If all the forms are in English and you don't have an English speaking patient, then you can get all kinds of crazy stuff that comes out there, because the person's trying their best to navigate the system, but literally can't.

So I think that those are all alternatives, and they're something that you all should explore. Also, please remember that if you are going to have someone who's going to have to have someone read something to them

or translate something for them, that you're actually going to need to give that person extra time before the scheduled evaluation.

DR. PICARD:

Also, just one other thing to say. The guidelines specify a psychosocial evaluation, and they don't specify a specific type of psychosocial evaluation, or what form that evaluation should have. So if the evaluator is comfortable doing it without any type of written materials, but doing it by questioning the patient, then that's fine. That would depend on the provider, though.

UNIDENTIFIED SPEAKER:

And I agree with that. The problem is because the guidelines don't stipulate what is required to satisfy the requirements, the psychologists are doing as much as they possibly can. So maybe if the guidelines were more clear as to exactly what is a sufficient psychological evaluation, then perhaps maybe that would eliminate the in-depth interview that's being done at this time.

DR. PICARD:

Actually, it would be better to keep it as it is, because the more you specify they have to do, that means that is required to be done. If it's not specified, that means it's up to you, the provider, to make a decision of what's appropriate, and then that's what we accept.

UNIDENTIFIED SPEAKER:

Okay.

UNIDENTIFIED SPEAKER:

But from the defense side, I would tend to agree with her that there needs to be some sort of limitations. Because we oftentimes see that psychosocial evaluation as an opportunity to give them an end with regards to

psychological treatment. So if it could be simply something directed to: Are you comfortable with a surgery? Do you understand the potential outcome, negative, positive? Do they have the psychological ability to make that determination? That would, to me, satisfy, 1) her not needing to find a doctor who could conduct a three-day examination, but would allow us to then not be so fearful of: Now, they're going to try to make a case out of psych.

DR. PICARD:

I would agree with you that everybody doesn't need to see a psychiatrist. So if it would be more specified that the provider can ask particular questions and make that determination, and that psychosocial evaluation can be done by the provider. The question is is an orthopedic doctor capable of doing that? Do they want to do it? That's very complex. It's going to vary from provider to provider.

JUDGE KELLAR:

Well, maybe we can define the parameters of the psychosocial evaluation?

UNIDENTIFIED SPEAKER:

Right. That's kind of where I was going with that. It's just that it's so kind of general and the psychiatrists that are willing to do them --

DR. PICARD:

They're very detailed.

UNIDENTIFIED SPEAKER:

They're very detailed, and they're requiring two payments from the carriers. And the carriers are not super happy, and I don't blame them, for getting a prebill for $4000.

MR. MICHAEL PIPPINS:

Yeah. I disagree with that. I think it's definitely overkill. It's way more than is necessary in most cases. So we could certainly consider doing something when the guidelines are revised on that particular issue, and that is one of the things that is going to be discussed.

UNIDENTIFIED SPEAKER:

Thank you.

MR. CASEY:

My first name is Casey. As a registered nurse, we're seeing a troubling trend that could affect numerous things. And what we're seeing is that medical conferences are very important for that registered nurse who assisted with, you know, the patient, and that kind of rare-like liaison between the insurance carrier and the injured worker. And so we want to do a medical conference, and what we're seeing in certain areas that we do throughout the state is some of the physicians are requiring, I don't say outrageous, but I hate to say it, but outrageous fees for a medical conference.

For the most part, forever it's been $250, $300, has kind of been the norm. Now, it's going to $100 per question, or $1500, or $100 per minute. I mean, it's all these outrageous -- and what we've been talking about all day here is communication. And communication is critical and if there's nothing in their fee schedule -- it says "by report," so pretty much they can charge whatever they want to charge, and some of them are seeing the hit that Obamacare and private insurance are doing, so: Well, I can make this money up here.

But it's detrimental to our patients, because that physician sitting in front of the, you know, registered

nurse talking about -- because we know more about what's going on with that patient than a physician does, you know. Because they see that patient for this little bit of time, where we talk to that patient sometimes two or three times a day. We know what's working and what doesn't work. And when we're not able to be in front of that physician, because a lot of physicians refuse to answer letters or take phone calls or whatever, so we're, like: This is our avenue to be face-to-face.

So what I would like to do is try to -- when we start looking at, you know, adjusting the fee schedule, basically, is to set a fee for the medical conference. There's a reasonable -- where the physicians feel like they're getting their money's worth, but also where the carriers feel like they're not getting --

UNIDENTIFIED SPEAKER:

Raped.

MR. CASEY:

Right. Thank you. I didn't want to say that, but --

JUDGE KELLAR:

Thank you.

Yes, ma'am? Chandler?

MS. CHANDLER:

I was going to let Dr. Henderson go first.

DR. HENDERSON:

Darrell Henderson, again. I have a question about how do you change your codes for surgery. You thought you needed surgery codes for this surgery and you find something else. Surgery medicine, of course, as you know is not an exact science. And we see, at least I do, patients that have badly crushed injuries of the forearm, -- forearm, wrist, hand, and having problems where the

fingers aren't moving. And I try to make the best decision that I can without forcing the wrong -- the way that I can. I know it's going to need surgery. Then you wouldn't need to repair the tendons that I -- I gave the CPT codes for that and got approved. And at the time of surgery, it turns out that those tendons have been crushed so bad, or in the wrong spot, where you if you repair it, you're going to get a terrible result. And now you need to do tendon transfers, transfer one tendon over another. Rob from Peter to save Paul. We do that all the time in surgery. That doesn't particularly add any extra time for the surgery. It's a different type of surgery. Basically, the postop, the rehab and outpatient are totally different. What's happened, we're faced with the fact that now we have to get it working again, because we did this different operation, but we don't get paid for it because we presented a CPT code for this case what needed to be done, now it turns out the surgery -- We had to do a different type of procedure to get a good result. I have no idea how we can correct that. How do we do per hour, or what do we do, or do we just keep it kind of like we've been doing?

JUDGE KELLAR:

That's a medical fee reimbursement issue, because before the surgery you submit one code and then during the course of the surgery, you determined that you need to do something differently --

Dr. Henderson

That's correct --

JUDGE KELLAR:

And so the question is --

DR. HENDERSON:

Stuff was being cut. It was crushed and fell apart about over an inch and a half. You can't repair that. You've got to move another tendon over to take the place. It's just kind of a disaster when we run into that.

JUDGE KELLAR:

And so the question is do you refile using the CPT code for the surgery that you ended up doing?

DR. HENDERSON:

Yes, I go ahead and enter the correct CPT codes in the operative report, is what I did. But, of course, we don't get paid for those codes, because we weren't clever enough to know what they were before. But that's a small percentage of the time. Most of the time -- you know, I've been doing this over 45 years. Usually I know what we need to do. We don't always know. Sometimes, things are different when we get in there. I would think other specialities would have a similar sort of thing, such as -- of course, it may happen, and I have a pretty good idea about diagnostics studies, but it's not a hundred percent. A lot of circumstances. So is there any way to try to file for what you did after you've done it?

JUDGE KELLAR:

Dr. Henderson, Freda said something. You can talk to the doctor about it after we finish?

MS. CHARLESTON:

Actually, once you contact the insurer with all the information explaining why you had to do a different procedure, are they not responding?

JUDGE KELLAR:

They won't pay, because that's not what he --

DR. HENDERSON:

They won't pay. That code wasn't presented before.

Usually, the surgery time is about the same. The follow-up care is about the same. Everything is about the same. The fees are about the same, but it just turned out you had to do a different type of procedure on that tendon or on that nerve than what you thought you did.

(Inaudible)

MS. CHARLESTON:

Usually, those -- yeah, the only other thing you can do is file a 1008 in court for the --

DR. HENDERSON:

File a what?

JUDGE KELLAR:

A 1008. A Disputed Claim for Compensation to seek payment for the treatment that you -- the surgery that you actually performed.

MS. CHARLESTON:

With all the supporting documentation --

UNIDENTIFIED SPEAKER:

Would the outlier reimbursement request be appropriate in that situation?

JUDGE KELLAR:

An outlier is just for the certain, specific thing, so it wouldn't be outlier.

UNIDENTIFIED SPEAKER:

Outlier wouldn't change the code?

JUDGE KELLAR:

No.

JUDGE KELLAR:

No. It would probably be the 1008. Dr. Henderson, we can talk to you about it some more after we finish with the treatment guidelines. Thank you, sir.

Shannon?

MS. SHANNON DARTEZ

Shannon Dartez. This is an administrative question for Dr. Picard. I know that the 1009S can be, you know, denied for not having a 1010, and not being filed within 15 days, incomplete 1009, et cetera, but if it's something administrative, such that you're reading -- you get the documentation in and a page just maybe got folded over in the fax machine or something so it's not readable. Why is there no mechanism for someone to just pick up the phone and say: Can you refax this to us? If it's been timely filed and all the attachments were there. We recently had a 1009 kicked back for not being readable. But, otherwise, everything was attached, and it was filed timely. If the purpose of medical treatment -- these treatment guidelines is to get efficient, you know, medical care for injured workers that -- just having it kickback for that reason seems like it flies into the face of the purpose of the Medical Treatment Guidelines and the 1009 process. Because what happens is that, because I was told by the office that what I would need to do is tell the doctor's office that they have to refile their 1010 request and start the process all over again.

This just delays the treatment for the injured worker. So why is there not a process in place for a simple phone call to be made. And I know you guys get lots of 1009 filings, and having it denied for one of the reasons listed, that's understandable because the process is set in place, and you should be able to have everything attached to it when you send it in, but if it's simply that maybe a couple of pages weren't readable. Why are they not calling you and saying: Can you just refax it to us? Or can you e-mail it instead?

DR. PICARD:

Once it gets to me -- Once it gets to my level -- there are some front end rejections for inappropriately filled out forms, documentation not being sent. I don't see that. Once it gets to me, everything's there, and it's ready to be looked at and make a decision. So on the front end, to answer her question, I'm going to ask Freda, who deals with this more than me. What would you do with something like that when there's a page that's not readable or something, but everything else is there?

MS. CHARLESTON:

That one normally will be rejected, and sent back. But it's sent back -- when it's sent back, you have the option to call and explain the reason, you know: I have another copy. Can I, you know, send it back? Have you tried that? Who did you speak with?

MS. SHANNON DARTEZ

I was told I had to follow -- I have it here. I was told that I had to follow the process under 1203.1(J), which meant I had to have the doctor's office resubmit the pages. It didn't appear that I had that option to call and say: Can I refax it to you?

DR. PICARD:

Yeah. There should be a person who's working the case -- Freda would be one of them, for example. Their name should be on there, and that would be the person to contact. You might have talked to somebody at the front desk, or somebody who misunderstood something, but the specific person, once it gets to that 1009, it has been assigned to somebody. You can speak to that person. Am I correct?

MS. CHARLESTON:

Yes. And explain --

MS. SHANNON DARTEZ:

And the only person listed here is Director Kellar, and --

JUDGE KELLAR:

In the last paragraph, it doesn't say, "If you need further information call..." --

MS SHANNON DARTEZ:

It says, "Call medical services." And that's what I did. I called medical services --

MS. CHARLESTON:

There's probably some initials on the --

MS. SHANNON DARTEZ:

-- and I was abruptly told I had to follow the process. In other words, I had to have a 1010. I'm just wondering why in that situation there wasn't a phone call to say: Can you refax it?

JUDGE KELLAR:

I don't know, but can we talk about it --

MS. Shannon Dartez:

Sure.

JUDGE KELLAR:

-- more specifically afterwards. I want to look at the letter.

DR. PICARD:

Yes. Because we do need to take care of that. You should be able to call the person who's handling and who's been assigned to the case where they can help you deal with a minor issue like that without having to refile that. That's not necessary. So we can work that out with you.

JUDGE KELLAR:

It appears -- And I haven't looked at the letter, but it appears that it was a rejection on the front end -- from the front desk reception. It never got to a nurse. I don't think -- it doesn't sound like it was ever assigned to a nurse.

MS. SHANNON DARTEZ:

That's the way it looks. It just says, "Asterisk, asterisk, cannot read the submitted copy."

MS. CHARLESTON:

It says, "Notice of Rejection" on the top?

MS. SHANNON DARTEZ:

Yes.

MS. CHARLESTON:

So it probably came from the front. When it came in, it didn't get to the back where we could have, actually, saw the file, and it would have had a specific person on there for you to call and speak with.

DR. PICARD:

We do have front end rejections, and many of them, because we get large amounts of forms that are just completely not filled out, no documentation with them, and we can't do anything with that. So apparently, you ended up with one of those, and I'm not sure what the specifics are.

JUDGE KELLAR:

Anything further?

Okay. If you guys don't have any further comments at this time, what I'd like Dr. Picard to do is to tell you some things that he would like to see when he receives a 1009 filed that would help him in his decision-making process.

DR. PICARD:

So there's just a few things that we see very frequently, that have come up, that I've been discussing at these meetings. So, basically, the 1009 is a dispute between an insurance company and a patient -- patient's representative provider. And one of those two is going to prevail in that dispute. You can't have both of them be approved.

So typically, when an insurance company denies a particular procedure or therapy and it comes to us in the 1009 process, we have to make a decision based on the Medical Treatment Guidelines, whether the procedure or therapy that's requested, meets those guidelines. In which case, we would overturn that insurance company denial and approve it. If it doesn't meet the guidelines, then we would deny it. So people ask me, from an insurance company standpoint, what are the things that you see, that we are saying, that we could do better in regards to our denials to help us to prevail, if we think it's appropriate.

So, basically, a couple things I see frequently. One of them is what we call "tacit denials," which is where the provider or patient's representative has sent a 1010 form in requesting a particular procedure or therapy, and they did not get a response back from the insurance company. So they filed the 1009 with me to look at it to see if their treatment, their therapy, meets the Medical Treatment Guidelines.

In that case, that is a tacit denial, because I have information only from the provider or patient's representative to go by, and I have nothing from the insurance company saying why they denied the particular procedure. Therefore, that is more likely to be approved,

because if everything I see there meets the guidelines and there's nothing to explain why it's being denied, then it's more likely to be approved. So it's important for the insurance company to get their information -- their denial in to us in a timely fashion, so that we can look at their side of the dispute, also.

Sometimes, it has been brought to my attention that they're not sending anything because they were not made aware of the claim, and they never got the 1010. And there are things that we are talking about doing to see how we can improve upon that process. So that's one thing, the tacit denials. Reduction in tacit denials would be very helpful from the insurance company's standpoint.

The other thing is making sure that the people who look at -- the medical professionals who are looking at the case are given appropriate information in their denials. And that would be that they're not just giving a personal opinion, based on their expertise, but rather that they're giving an opinion based on whether or not the therapy or procedure meets the guidelines, which is how we make our decisions. Not on what they think they would do, but what the guidelines say are appropriate for this particular injured worker.

Also, oftentimes, there is incorrect information in there. It might say that something wasn't documented, when clearly I'm looking at the provider's documentation, and it is documented. So those are the things, from the insurance company's standpoint, that could be improved upon, could be done better, to better their case. From the provider or patient's representative's standpoint, the biggest thing I see is lack of documentation.

If you are requiring or asking for a particular therapy or particular procedure, there are certain criteria that are set forth in the guidelines that mandate what you have to have documented to allow that procedure to be approved. And if that documentation is not there, then we can't approve the procedure. You're requesting a surgery, where you haven't done conservative care, you haven't done therapy, you haven't -- you know, had everything documented within the guideline requirements for that procedure, then it can be approved. So it would behoove the providers and patient's representatives to familiarize themselves with the guidelines for the types of therapies and procedures that they typically do, so that they know what is required for it to be documented prior to submitting those 1009s. So that's just a summary of what I commonly, frequently see from both sides of it.

UNIDENTIFIED SPEAKER:

Is there such thing as too much documentation?

DR. PICARD:

No. I mean, I get large amounts of notes, sometimes the documentation is very useful, sometimes it's not very useful. I just look at what I need to look at -- I look at everything. Of course, but I don't need to see every therapy note if the most recent one has the amount of therapy the patient's had, how much improvement they've had, what positive gains they've made. So it's very variable, but we look at everything, but you can't send too much documentation.

MR. MICHAEL PIPPINS:

May I address that. This is not a philosophical answer, but it is a technical answer. In the past, we've gotten several hundred page filings, and all this stuff

gets scanned into our database, which operates on a storage -- storage area network -- operates through and is stored in an area network. And when the storage fills up, it quits. It just stops. And it's not a matter of simply resizing this particular -- the whole thing has to be rebuilt by somebody. And it's not a terrific task, and there is a limit, I'm told, as to how much we can expand it. So at some point, barring technical advances, we'll just be out of luck. So to the extent that you can reduce the problem, it's greatly appreciated.

DR. PICARD:

Let me just say one other thing -- I mean, the documentation that is required to show what is needed in the guidelines is what I need. Whether that's one page or several pages is not important. Because sometimes, I have to look through several pages to pick out the things I need in the guidelines. Sometimes there's one page that the doctor -- people who know what they're doing and have dealt with it a lot know what they need to write down, they have everything right there in one -- you know, one document.

UNIDENTIFIED SPEAKER:

I think the challenge is when the plaintiff's attorney's doing it on behalf of the claimant, and we're not doctors, and we're not as well versed. And we want to make sure that all the documentation is attached. Sometimes doctors will tell us: We don't file 1009s. We'll send you what you need, and you have to do it. It puts me at a disadvantage and it puts my client at a disadvantage if I have to pick and choose what I think should be in there as great documentation.

So that's why I asked, because one time I did send

quite a bit, and was asked not to ever do that again. So I just wanted to make sure that I'm doing the best job for my client. But I don't want to burden the office either. So that's why I asked what is too much.

JUDGE LUNDEEN:

Dr. Picard, would it be helpful if somebody is -- does have that concern that you have a complete record to look at, if perhaps they highlighted certain parts of it to call your attention to those parts, and say, you know: Here are the doctor's visits from this doctor that say that I get cervical fusion. Would that be helpful?

DR. PICARD:

It is. It is sometimes done already. I do get providers that do it that way. Again, it's the ones that are familiar with the guidelines, and they know what I need to see, and they specifically do that.

JUDGE KELLAR:

Freda, would you like to add anything?

MS. CHARLESTON:

Please make sure when you submit a 1009 that you put the claimant's current address, and if she has a representative, make sure that you add him, as well, so we can inform him. Otherwise, we won't be able to inform all parties. I think someone stated that they don't get a notice. Make sure that you list the physician that's requesting the treatment. We've discussed medical records. Submit the medical records. Make sure the 1009 has been signed. We send a Notice of Receipt and Filing out to all parties listed on the 1009, and currently we don't have what the requested procedure is on that Notice of Receipt and Filing. But we get calls, and we get e-mails all the time from the parties who receive them,

asking us what particular procedure is being requested. So please continue to do that. Like, if you have a question, in regard to what procedure is being requested, we can inform you. Make sure that you submit the 1010 with the 1009. Make sure that is included. I think that's about it. Does anybody have any questions regarding the 1009 or 1010, and completing it?

JUDGE KELLAR:

Yes, ma'am?

UNIDENTIFIED SPEAKER:

Can more information that was sent with the 1010 --

JUDGE KELLAR:

Can you speak up and say it again?

UNIDENTIFIED SPEAKER:

Can more information that was sent with the 1010 -- you know, the information that was sent with the 1010 is sent with the 1009, can more documents be added?

MS. CHARLESTON:

Yes, we get that all the time. Many people will say -- you know, send us an e-mail or fax it. But make sure you note the log number that was on that Notice of Receipt and Filing, so we can put it in with that file.

UNIDENTIFIED SPEAKER:

No. We will send them a 1010 and it's denied, the copy of that entire 1010 that we, actually, send them with the 1009's, can more documents be added to that, the original 1010?

MS. CHARLESTON:

Oh, when you send it to our office, yes.

DR. PICARD:

Yes.

MS. CHARLESTON:

Yes, you're saying once it's submitted to our office?

UNIDENTIFIED SPEAKER:

When the 1010 is denied, now we are going to file a 1009, can we add documents to that 1010 package to go with the 1009?

DR. PICARD:

You can, but for instance, if your 1010 is denied, because you didn't demonstrate therapy or something, it might be easier to call the carrier and say: Look, I do have these documents that show this therapy, where you could possibly get it approved through the insurance company without having to go through a 1009. But to answer your question, yes, you can add information.

JUDGE KELLAR:

Is that it? Would you guys like to add anything? The OWCA representatives? Judges?

JUDGE LUNDEEN:

Sure. I think when we're dealing -- and there is a split in circuits now, so your question -- Are you also a Dr. McDonald? I'm sorry. In response to your question, so we have your situation, but then I think with a lot of lawyers -- and there's a split in our circuits -- what can you add once you get to the court system. And that depends on the jurisdiction in which you're filing. Because there's an argument that if you get to add things at our level, that you're now circumventing the whole point of the Medical Treatment Guidelines.

So the Supreme Court resolves that, we don't have a great answer for you. But what I can tell you is, as a judge, trying to understand your 1009 -- or really any case, we need as much information and we need succinct direction from you why you believe you should have this

particular procedure, and why it falls within the guidelines, and why you think that Dr. Picard missed the boat, so that we can then determine whether or not, according to our standard, the clear and convincing standard, with which you're charged, why we should overturn or uphold that decision at the appellate level

So the more succinct, the more you can point to: Look, here's the guideline. Here's how my case falls in it, based on this evidence, not just: My person really, really deserves this medical care, because they're a great person, and we really think that the doctor is right. We, actually, need you to really explain it, because we aren't doctors. So we need your help, lawyers, and we need the doctors help in helping the lawyers to make sure that we can understand, as lay people, interpreting these records, why someone is entitled to have an appeal upheld or overturned.

JUDGE PALERMO:

Yeah, I think another thing to remember is -- I run into the issue sometimes where the healthcare provider is appealing the decision of the Medical Director, where the Medical Director has denied some treatment and they file a 1008, they come before me, and they start arguing their case. And in the middle of their argument, I realize that what the doctor really wants is a variance, but they didn't ask for it. So I'm presented with a situation where the Medical Director has denied a procedure, based on the medical guidelines. That decision is correct. So I have a choice, either I overrule, or I affirm them. I mean, those are the choices that I have.

And so in this situation, the Medical Director was correct, based on the guidelines, but what the doctor

wanted was a variance. So at the end of the hearing, that's what I told the attorney who was representing the doctor. I said: I think your doctor wants a variance, but the Medical Director was correct, so I'm denying the appeal.

So I think sometimes if you do get a denial, I don't know -- I know it makes it more complicated. I have to go back to the doctor and say: Look, this is the denial we've got. Is this really what you were asking for, or is there a variance? You know, is there something that maybe there, that maybe you can present it back to the Medical Director. Because I'll tell you, if it is a variance, presenting it back to the Medical Director is probably going to be quicker than doing the 1008 process.

JUDGE LUNDEEN:

And less costly.

JUDGE KELLAR:

Jan?

MS. JAN:

I just want to say to the medical providers -- and I thank the panel for pointing it out to them -- I don't think the medical community understands the importance of the 1009 or what it is. Basically, it is what the lawyer or the claimant or any aggrieved party uses to maintain treatment. So if your treatment is denied, and somebody files a 1009, that 1009 is going to become evidence in a court proceeding. When the 1008 is filed, should the Medical Director deny the 1009.

So if everything that we need to prevail on the treatment you're asking for is not in the 1009, in some jurisdictions, you cannot get in any other evidence. That is a problem, because now our system has set the medical

community up to have to know what is enough evidence. So just -- I would ask, for my clients, I would rather error on the side of too much information than not enough. Because our print's left on it, your record, that goes to the Medical Director. And if my office doesn't have any knowledge that the medical community that is treating my client has filed a 1009, I can't supplement that to the Medical Director.

So we have put ourselves together where we have doctors filing pleadings and the burden of proof is clear and convincing. I'm pretty sure I can't explain how to do a back surgery, but I don't if the doctor knows the meaning of clear and convincing. So that is the system we work in. So from a claimant's representative, anybody working with my office, we need data. We need your help in knowing what you need, so we can supplement that record, in case we find ourselves in front of Judge Johnson or Judge Palermo.

JUDGE KELLAR:

Thank you, Jan.

Karen?

MS. KAREN:

We, actually, agree on this issue, because what we're seeing, on the defense side, is when a 1009 or a 1010 comes in to our adjusters, it doesn't say: I want a variance, check, or I want to do a procedure that's outside of the guidelines, check. On our side, we deny based on what's not in the guidelines, or we don't approve that variance, assuming your adjuster catches it, that that's what was being asked for.

And in those circuits where we can not introduce any more evidence when it gets to the 1008 stage, our hands

are tied too, from the defense side, because if the provider is truly asking for a variance, or for something that's outside the guidelines, we want to address that with the Medical Director. We want him to make the decision by a preponderance of the evidence. Can the variance be approved? Can it be outside the guidelines? And when the provider doesn't give that information in the 1010, a lot of times -- we're in the same boat on this one -- we get our hands tied, because we cannot introduce anymore, or the decision from the Medical Director probably would have been different, had at the 1010 level we would -- had we known at the 1010 level that you were asking for a variance, or that you were asking to go outside the guidelines.

JUDGE KELLAR:

Thank you. Is there anything further?

Okay. Well, thank you guys. Thank you very much for attending. I appreciate all of your comments, and they will be taken into consideration when we make modifications to the process by which we implement the Medical Treatment Guidelines.

-- END OF MEETING --

C E R T I F I C A T E

This certificate is valid only for a transcript accompanied by my original signature and original required seal on this page.

I, Krista Ackal, Certified Court Reporter, in and for the State of Louisiana, employed as an official court reporter by the Office of Workers' Compensation, District 04, for the State of Louisiana, Department of labor, as the officer before whom the proceedings were held, do hereby certify that the foregoing 86 pages of typewritten matter constitute a true and correct transcription of the proceedings held before me on the 26 day of September 2016, at Cecil J. Picard Center, Lafayette, Louisiana; that these proceedings were reported by me in the stenomask reporting method, was prepared and transcribed by me or under my personal supervision, and is true and correct to the best of my ability and understanding; that the transcript has been prepared in compliance with transcript format guidelines required by statute, or by rules of the board or by the Supreme Court of Louisiana, that I am not related to counsel, I am in no manner associated with counsel for any of the interested parties to this litigation, and I am in no way concerned with the outcome thereof.

Lafayette, Louisiana, this _____ day of _____, 2016.

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Krista Ackal, #2013005

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