LOUISIANA WORKFORCE COMMISSION

DEPARTMENT OF LABOR

STATE OF LOUISIANA

TOWN HALL MEETING, held at Willis-Knighton North Eye Clinic, on September 15, 2016. Director Sheral 'C. Kellar, Office of Workers' Compensation Administration, presiding.

Reported By:
Donna B. Crenshaw
Certified Court Reporter

DIRECTOR KELLAR: Okay. I'm Sheral Kellar. I'm the Director of the Office of Workers' Compensation.

If you have not signed in yet, I would ask you to please do so. We want to keep a record of all of our attendees. So that, if we have any follow-up correspondence, we'll know how to reach you.

I am the former Chief Judge for 17 years before being appointed as Director of the Office of Workers' Compensation in the Edwards administration. So, as a former Chief Judge, I am uniquely aware of the difficulties you're having and the difficulties we have, as a matter of' fact, with the medical treatment guidelines and its process.

Some of you have problems with the forms that we use; the 1010, 1010A, 1009, and then the 1008. And then some of you have problems with the process by which we implement the medical treatment guidelines.

So, in an effort to allow you to be a part of the solution to some of the problems we've seen, we wanted to hear from you. We're taking this show on the road, as you might have noticed.

We started in New Orleans on Tuesday, we're in Shreveport today, Monroe tomorrow. Then we're going to take break for a week, and then the following

week we'll be in Lafayette, Lake Charles, Alexandria, and Baton Rouge.

You are welcome to come to multiple Town Hall meetings. As a matter of fact, there's some folks here today who were at the Town Hall meeting on -- in New Orleans.

They have found that the questions and answers between the Office of Workers' between the Office of Workers' Compensation staff and you guys has been informative, to say the least. So they're coming to hear questions from and answers from everybody.

Today I have with me some of my staff from OWC. I don't think this is working. My voice is very soft, but I can speak loudly.

Okay. I have my staff here, some of the staff, from the Office of Workers' Compensation that I'd like to introduce to you.

First, we have Pauline Williams, who is the Deputy Director. We have Dr. Jason Picard, who is the medical director. Cathy Chesson is a nurse in the medical services section. We have Diane Lundeen, the Chief Judge. We have Rosa Whitlock from District 1W in Shreveport, the mediator. We have the Judge in district 1W, Linda Smith. And we have Kimberly Buck, who is a public relations person for the agency. And

the gentleman who just left is Mike Pippins, who is the IT guy for the Office of Workers' Compensation.

We have a few rules for you this afternoon. We have a court reporter who will be recording this session. We will have court reporters in all of the cities to record the sessions, and that's for us to go back and see what comments you've made and to see if we can use those comments to address some of the issues I know you have.

So, first of all, I'm going to ask you to put your telephones on silent or vibrate. Then the next thing I'm going to ask you to do is to speak loudly, clearly, and slowly so that the court reporter can record what your comments or questions or answers are. You should identify yourself and the company that you represent.

And, Mikal, is the microphone working?

MR. PIPPINS: They've got somebody coming to work on it.

DIRECTOR KELLAR: Okay. So, until we can get a microphone, you're going to have to speak extra loudly. When we get a microphone, Mikal is going to bring it around to you to assist the court reporter in hearing you.

So, if you can't hear someone, will you just

ask them to speak up, please.

COURT REPORTER: Sure.

DIRECTOR KELLAR: Very good. Okay. So we will get started.

This is for you, and it's for us. So, if you have any comments or questions regarding the medical treatment guidelines or the process, we would like to hear from you.

One other thing, I would ask you to keep your comments to three minutes in deference to other members of the audience that may want to speak. You may speak multiple times, but each time you do so please limit your comments or your questions to three minutes.

So who wants to go first? It's always an ice breaker. Nobody wants to be the first person to speak.

Okay. Why don't we do this. Mike, while we're waiting for someone to come for the microphone, why don't you show them an example of some of the problems we see in the office that they may be able to fix for us.

MR. PIPPINS: We have in the medical services department currently five employees. That's it.

COURT REPORTER: I'm sorry, I can't hear you very well.

MR. PIPPINS: Medical services currently has five employees. That's it. Two of them are here.

We get our -- we get our 1009s mainly in through a fax line. That fax line -- that fax line goes to a -- great. I guess I won't show my slide show. The fax line goes to an e-mail box and puts the puts an e-mail message in the e-mail box with the same subject line for each one. It says fax forward from a fax number.

So we get multiple instances of filing, and with five people doing date entry it's a bit chaotic. This was not a problem prior to the flood because we'd stay pretty well caught it. Since the flood, we're not so caught up. We have a lot of people working, but not able to --

DIRECTOR KELLAR: Mikal, can you speak up, please.

MR. PIPPINS: Yeah. We have probably more people working on data entry right now than is good for us given the cumbersomeness of our system. We're working on that, too.

What I was going to show you was an example of a 1009 that came in. The healthcare provider who

submitted it did not give us the name of the employee, did not give us the name of the insurance company, did give us his name, and he had a file for the data entry person to try to comb through to enter the -- enter the record in the computer. And there's just not time.

DIRECTOR KELLAR: You can't get it up on the screen?

MR. PIPPINS: It I don't know what the problem is. I can see it on my screen, but it's not --

DIRECTOR KELLAR: Okay. It may be the whole system seems to be down, because we had it up earlier.

JUDGE LUNDEEN: That just makes it more interesting.

DIRECTOR KELLAR: Well, why don't we take a break, because the acoustics in the room are not very good. So, if we have some people who are speaking way in the corner, the court reporter is not going to be able to hear them. So let's just take like a five-minute break and try to get the microphone or the system working.

Okay? We're in recess.

(Whereupon, there was a break taken)

DIRECTOR KELLAR: We have someone coming to work with the projector; but, meanwhile, we have microphones working. So, if you will identify yourselves, you can begin to make your comments on the record.

Okay. Go ahead. Mikal, there's a lady in the corner back there.

MS. CANNATELLA: My question is as far as the medical guidelines, they were set up in 2012, I believe.

MS. KELLAR: Okay. Did you identify yourself?

MS. CANNATELLA: Oh, sorry. Joanne Cannatella with York Risk Services. The medical guidelines and the process were set up 2011, 2012.

Things are revolving in that -- and, I mean, this is an example, drug screens for pain management. The drug screens allow medical guidelines. There's no listing of which ones.

We've gone from regular small, normal drug screens to extensive drug screens with multiple CPT codes that are thousands and thousands of dollars.

And is there a plan to upgrade either the guidelines at an interval; so that, as things like that come up, they can be addressed?

DIRECTOR KELLAR: The statute provides that the medical treatment guidelines be updated at periodic intervals.

MS. CANNATELLA: Is it just periodic, that word, or is it a specific?

DIRECTOR KELLAR: No, it's two years. We have a medical advisory council.

If you will go to our website at Laworks.net, you can see who the members of the medical advisory council are for the four guidelines that we currently have.

MS. CANNATELLA: Okay.

DIRECTOR KELLAR: Also, one other thing I need to ask you guys is, if you are asking a question, please don't be specific about the litigants or the parties. Give us hypothets or generalities.

Did that answer your question?

MS. CANNATELLA: Yes. Thank you.

MS. SALLEY: I'm Mary Lou Salley. I actually have a comment about that, because that's a good question Joanna asked.

The current DHH, Department of Health and Hospitals, statutory Louisiana law has guidelines for pain clinics on drug testing. And that is -- that's what's -- I think, she is talking about.

The problem is the pain clinics are filing 1010s for the urine drug screen that is required under already existing Louisiana law.

I think they're -- aren't they quarterly, Joanne?

MS. CANNATELLA: Yes.

MS. SALLEY: Yes, they're quarterly testing. And our guidelines don't address that, and our guidelines are kind of vague as to how often. It just says if the doctor thinks it's necessary.

And, unfortunately, already existing Louisiana law requires a pain clinic to drug test them quarterly whether they suspect anything is going on or not.

And so what you're having is the pain clinic is saying well, I can't treat the patient; because, if I don't comply with already existing DHH rules, they're out.

So I think we -- actually, what's going on is it's not that we don't have any guidelines. We have a conflicting statutory Louisiana duty on behalf of the pain clinics versus qur guidelines, and I think Joanne is asking the question which one are we going to use.

DIRECTOR KELLAR: Do you want to respond?

DR. PICARD: I would agree with you.

can just talk. I'm Dr. Picard. I would agree with you that that does need to be dealt with, does need to be addressed.

At the current time, I'm not denying any drug screens that are being ordered because the guidelines do not specify the type of drug screen or how often that they are allowed. So what the physician deems as necessary is what we're approving.

So, if you get rejections and you send them, since the guidelines don't specify that, it says what the physician wants, then that's what we're allowing right now.

You might just have to go through the 1009 process more than you would want to until that guideline is updated.

Does that answer your question?

MS. SALLEY: Yes. Thank you.

MS. PANTHER: I'm Terianne Panther of the Spine Institute.

Our main question that we have is, in ordering radiology, MRis, CTs, they get approved, but then the insurance company wants to say you can't do it at the facility that you indicated on the 1010. It has to be done at a different facility, and the reason behind it is because it's being scheduled through a

separate scheduling company at a lower than the fee schedule rate.

How is that okay?

JUDGE LUNDEEN: All right. I'm just going to stand so that you guys can hear me. Can you hear me in the back? Okay. So my name is Diane Lundeen. I'm the Chief Judge.

And what you've asked is really a legal question. So in Louisiana the employee has the right to choose his or her own medical provider.

Right now in North Louisiana whether they get to choose where they go to their FCE is up in the air based on a new case. But, arguably, the 1009 process isn't designed to determine which medical facility someone can go treat at. It's to determine whether or not that CT scan is appropriate or whether or not that MRI is appropriate. It is then the plaintiff's or the injured worker's choice to select where they want to have that procedure done.

There's a series of old cases that used to talk about surgery where people would get frustrated on the employer's side because the injured worker would need surgery to reach maximum medical improvement and function.

What the Court said is we can't force people

to accept medical care; but, if they choose to, then they get to pick. If they choose not to, that is their right and we call them as functionally improved as they're going to be without the surgery.

So this is sort of the same type of thing where the claimant, the injured worker, has the right to choose what facility. That's not the function of the 1010 or the 1009 process. It's directed to figuring out whether the medical care is appropriate pursuant to the guidelines.

MS. HARRIS: Good evening, everyone. My name is Latasha. In response to --

DIRECTOR KELLAR: What's your last name, Latasha?

MS. HARRIS: Harris. Latasha Harris.

DIRECTOR KELLAR: Thank you.

MS. HARRIS: Orthopedic Clinic. In response to her question, if I'm understanding you correctly, it's a great question.

She's indicating when we, the provider, submit a 1010 for a particular diagnostic test, okay, MRI lumbar spine, we submit it to the carrier. It returns approved.

On the 1010, there is no indication hey, this test needs to be scheduled with One Call, Aden, or

whatever the carrier is.

So what is happening, we as the provider, we are-- what she's saying, we're receiving the 1010, approved 1010, of the diagnostic. We're going ahead and scheduling it, and then moments later we're receiving a telephone call from One Call Medical, Aden Healthcare, or whomever asking, you know, hey, let's schedule it. We have to schedule through that particular third party.

And it really holds a delay; because, once we receive the 1010 back, we're ready to schedule. You know, I think that's her question.

So how do we handle the third party diagnostic carriers which the work comp carrier is contracting?

I mean, that' a really huge problem. You know, can the provider not just go ahead and schedule with whatever diagnostic team we are selecting. If the patient needs open air, for example, Northwest Imaging, Advanced Diagnostics. But we're being told we need to schedule through this third party carrier, and it causes a delay.

JUDGE LUNDEEN: I don't know if you're going to disagree with me on this having been the Chief Judge for a long time, but my opinion is this.

Once it's approved, you're outside of that 1009 process because there is nothing to fight about. What you're fighting about is where the procedure is done, and that is when you get to come to court. And you can file a 1008 claim form.

If you go onto Laworks.net and you go under the workers' compensation section under forms, you'll see something called a Form 1008, and that is the gatekeeping form to get into the court system.

If you have a 1010 that's been denied, then your procedure is to go the route of the 1009 process. And then, if you don't like the result of that, then you come to the court with the 1008.

But, in this particular factual pattern, I would say that you can come to the court with a 1008. At that point, unfortunately, because you're probably an incorporated entity or an LLC or if you're an insurer, you then have to have a lawyer help you to file that and proceed forward and you have all kinds of remedies under the Workers' Compensation Act.

Do you have anything different to add, Director?

DIRECTOR KELLAR: No, ma'am.

JUDGE LUNDEEN: All right.

MS. HARRIS: I mean, and I just want to

add I agree with you, because they are -- the 1010s are being approved. So, therefore, we would not have to file a 1009.

JUDGE LUNDEEN: Right.

MS. HARRIS: No 1009 is needed.

JUDGE LUNDEEN: You wouldn't be able to.

MS. HARRIS: Right. But I guess the question would be: What do we do as a provider to avoid the third party? There's nothing?

JUDGE LUNDEEN: You can't you can't control the conduct of somebody else, but what you can do is use the tools in the tool box that you have to get them to do the right thing. And sometimes you need a judge to tell someone what the right thing is.

MS. HARRIS: Okay.

JUDGE LUNDEEN: And, hopefully, it changes the culture with that particular provider or carrier, so that you can accomplish what you need.

Ultimately, the goal of the medical treatment guidelines was to expedite medical care and to make sure that we were getting legitimately injured workers back to work and to provide the appropriate medical care, so that they could get back to some occupation and have a real life. So things like that obstruct the goal of the system.

MS. HARRIS: Okay.

JUDGE LUNDEEN: And you all have to realize that you have to bring these things to us. Otherwise, they will continue to go on.

Now, we're not encouraging litigation, but what we are encouraging is people working together to get these people appropriate medical care as fast as possible. Because the faster you treat people, the better the outcome.

DIRECTOR KELLAR: Let me see, Mike. Hold on a minute. The question you're posting is, as Judge Lundeen said, it's outside of the 1009 process. But the question really is who gets the choose the diagnostic facilities.

And we are aware that this is an issue, because what frequently happens is we'll get a 1010 for a diagnostic procedure and it has a particular facility on it; and, when it comes to us for an appeal, that facility has been scratched through and another facility has been placed on it.

We're not certain that that is an appropriate thing for carriers and healthcare providers to do, but we do recognize that it is an issue. And I'm glad that you guys have mentioned it, because we know that it is one that needs to be addressed.

I think --

MS. SALLEY: It is a problem.

DIRECTOR KELLAR: ultimately, the forms is a problem. But more to your point, choice of diagnostic facility, because the inquiry is between the healthcare provider and the carrier.

So I don't know that that issue has been addressed by the Courts; and, as Judge Lundeen said, we don't want to address it until it comes before us. But we do recognize that it is a problem.

MS. ELIE: My name is Keashia Elie. I'm one of the managers for pain management at River Cities Interventional Pain. At this time we are not seeing any workers' comp, but we're reconsidering.

After the last guidelines concerning the 1010 is required for narcotics to issue with the patient with the prescription, is that one of the guidelines that's still in effect?

MS. SALLEY: I think she's asking if y'all are taking the position that she's got to file a 1010 for prescription drugs?

DIRECTOR KELLAR: Okay.

MS. SALLEY: I think that's what she's asking.

MS. ELIE: Yes.

DIRECTOR KELLAR: This question came up in New Orleans. And we pointed out that the First and the -- is it Third, Diane?

JUDGE LUNDEEN: I don't recall.

DIRECTOR KELLAR: There's two circuits. Two circuits have determined that medication should not be submitted to the medical treatment guidelines process.

In one case in Baton Rouge before Judge Ourso the claimant brought the issue regarding medication to him for the necessity of the prescriptions, and he ruled that the claim was premature because it had not been filed with the medical director first.

And the First Circuit ruled that medication was not subject to the medical treatment guidelines. There are two circuits that have ruled that. I think it's the First and the Third. But the Second and the Fourth and the Fifth have not made any pronouncement on that issue. We're watching it to see if it will go to the Supreme Court.

So the answer to your question is, if you're in the circuits where the courts have determined that prescription medication is not subject to the medical treatment guidelines, you do not have to submit a 1010.

MS. ELIE: Okay. How can you determine whether or not you're in that circuit?

DIRECTOR KELLAR: You'll need to know the jurisdiction. You'll need to know the jurisdiction of those various circuits.

JUDGE LUNDEEN: You're in the Second Circuit.

DIRECTOR KELLAR: If you'll go on our website at Laworks.net, we have a map of all the parishes in the state and they're broken down not only by the district courts, and there are 10 of them, but they're also broken down according to appellate jurisdictions, as well. And that will tell you which parishes are subject to which appellate jurisdiction.

MS. ROBERTS: Hi, I'm Connie, and I work for Center for Hand Surgery.

And getting back to the diagnostic tests, I've had to fight with One Call Medical because there's a certain ultrasound that my doctor requires for certain people to check compressed nerves in their arms and their hands, and there's only one doctor that does this test.

And I have had to fight and fight and fight and fight, but I finally got One Call to put this doctor in their system and now they will schedule with

this doctor. But it took me months of calling every day to try to get these people to put this doctor in their system. But they were willing to work with me. It was just a big ordeal to try to get them in.

JUDGE LUNDEEN: If you're having problems with an injured worker having the ability to choose, not what with the procedure itself, but the ability to choose where to have it, you can speed up that process tremendously by having that injured worker make a demand, which you've done for him, and then file the 1008, if necessary, to get his choice of physician.

The hearing, and this is separate from the medical treatment guidelines, but it goes back to the original question that you had, the hearing to get an injured worker's choice of physician by law is an expedited hearing that has to be heard I believe within 30 days of filing.

So what might have been three months to get a diagnostic test so that you could determine what was next could have been taken care of in 40 days with a judgment rendered.

So it's just, again, use the tools in your tool box. That's why we're having these meetings so you guys can ask us these questions, so we can help you to do what you need so that you can do your jobs.

MS. GLADNEY: Hi, my name is Cheryl Gladney, and I'm a patient. I don't know any of the legal jargon that y'all are talking about.

Only thing I know is I'm in continuous pain day and night. And the waiting and the waiting and the waiting and the waiting while everybody in this room talks to this person; that's not legal; that's right; that's wrong; I can't do this; and I couldn't do that.

What about us? I don't know if it's another patient in here. I'm a patient, and my accident at work was on 9/29/15. 9/29/16 is coming up. And I heard you say as soon as possible. I don't know what your as soon as possible is, but it's not my as soon as possible.

This is ridiculous. I need injections for my back. The orthopedic clinic has put that in twice. It's still not approved. I don't understand that. I don't understand the waiting and the right or wrong.

Every patient is not lying on workman's comp. I can barely sit in this chair. I can't leave town. I can't drive my car because right side back, I have to sit on a pillow. He has to drive me everywhere I go. I'm an independent person that has became dependent everywhere.

Now, if anybody thinks that's cute and somebody wants to get two dollars in the mail from workman's camp to sit at the house, and have no reason to get up in the morning time, because a job is a reason. It gives you communication with the public. It gives you money to pay bills. It gives you an out. It gives you a life.

I want my life back, and I would rather have my life back while I'm waiting on everybody to do what they need to do for the patients than to sit at home. And then you sitting there, and then you can't get the medical treatment that you need.

I don't understand that. I don't understand what the holdup. If you're trying to save money, I think you should go ahead, give the doctors what they need, so the doctors can give the patient what they need. Then the patient gets back to work.

But the waiting and the waiting and the waiting, and that's all I heard, the waiting, this form, that form. Somebody is hurt. You need one form. That's from the patient who do not know the legal part.

DIRECTOR KELLAR: Mikal. What's your name again, ma'am?

MS. GLADNEY: Cheryl Gladney.

DIRECTOR KELLAR: I'm really sorry that you're having so much difficulty getting the medical treatment that you need.

I want to tell you that, when the 1009 process for medical treatment guidelines was implemented, it was intended to be a fast process. And we're here this afternoon because we realize that there are some challenges with the process by which we try to get injured workers the medical treatment that they need.

Do you have an attorney?

MS. SALLEY: I am her lawyer. I'm her lawyer. And if you want me to talk in the microphone and tell you what's going on, I will.

DIRECTOR KELLAR: Okay. But let me say this. You know, I'm really sorry for the problems that you're having. You have an excellent attorney who has been working in the system for a very long time.

MS. GLADNEY: But I need medical treatment.

DIRECTOR KELLAR: I understand that. I understand that. There's a process by which you get medical treatment, and it can be delayed. And as I said, that's one of the reasons why we're here to try

to ferret out what those reasons are, so that we can take care of them.

When you get a denial from a carrier, they're supposed to give you a response within five days.

MS. GLADNEY: Huh-uh.

DIRECTOR KELLAR: They're supposed to give you a response within five days. If you don't get the response in five days, you have 15 days to go to the medical director for an approval or denial.

If the medical director denies the request for the recommended treatment, then you go to the Courts and the Courts have a limited amount of time within which they make a decision on the treatment that you have requested.

But, you know, we're not here because everything is perfect and, you know, well with the world. We're here because we understand that there are problems.

And I'm glad you're here because we want to hear, as I said in the notice for this Town Hall meeting, we want to hear from employees, employers, health care providers, third party administrators, utilization review people, about what your challenges are so that we can try to make the system better for you.

Because if not for you, we would not be here. We are public servants, and you're our job security. If we didn't have injured workers, then Dr. Picard wouldn't be here, Cathy wouldn't be here. Neither of us would be here if it were not for you guys.

So we want to make this work for you, and that is why I have initiated these Town Hall meetings all over the state for the next two weeks to hear from you about what your problems and concerns are.

Mary Lou, if you would like to elaborate, you can.

MS. SALLEY: Well, I don't want to talk about anybody's case specifically.

DIRECTOR KELLAR: Please don't.

MS. SALLEY: I'm not. But one of the things that I see that's going on is a doctor submits a 1010 and checks the box and says these records are attached, and then you get an out-of-state utilization review physician who says such and such and such and such wasn't documented.

And the healthcare provider says bull, yes, it was. We sent this. No, you didn't. No, you didn't. There's no way for the healthcare provider to document what specifically was sent to Dr. Chin, family practice, San Francisco. Because what you're

seeing come back on those URs is not this is not contained within the guidelines. It is you didn't document X.

And the physician says yes, we did document X. And there's no penalty for Dr. Chin, family practice, San Francisco, if he lies and says we didn't get it.

Because, if my client lied in writing and said I didn't receive that or I wasn't working, that's fraud. And I'm not a conspiracy theorist, but my opinion is those UR physicians have got to be held to some kind of standard or it's going to continue to go on.

And I know Latasha sees it. You know what, we know how to handle when someone says it's not contained within the guidelines, y'all. It's not provided for. We know what to do.

But this back and forth yay-yaying you didn't document this, you didn't document that, they're not court reporters. Healthcare --they're not court reporters. And I think that something has got to be done when the healthcare provider sends the 1010.

The burden is on the UR and the insurance company to say they didn't. The burden can't be on the healthcare providers. They're not lawyers.

They're not court reporters. And I hear a thousand times a day, Ms. Salley, we sent that to them. They have it.

And one more thing. We've got to have a database on where to send 1010s. These healthcare providers keep saying I'm sending it; I'm getting no answer. Well, they moved to Cheyenne, Wyoming, last week.

We've got to have a statewide database that, if you're going to provide insurance in the State of Louisiana, this is the address and the fax number that the 1010 goes.

MS. HARRIS: Yes, it should be universal.

DIRECTOR KELLAR: Can I have the mic, Mike?

MR. PIPPINS: Sure enough.

DIRECTOR KELLAR: One of the issues that we've heard continuously and we are aware of is that healthcare providers send their information, well, in this case to the medical director without sending it to the attorney or the claimant. So nobody knows what was sent.

And, also, we are aware that the fax numbers that you use to send your 1010s to the utilization review companies or the third party administrators are

not being kept up.

In fact, one of the documents that Mikal wanted to show you this afternoon was a 1010 that was faxed twice to a utilization review company, and it failed twice because the fax numbers -- fax number was incorrect.

In court, we require injured workers to keep us apprised of any address changes; because, if we send them a notice of a conference, a trial or a hearing, and it is returned to us because their address is incorrect, we dismiss their claim.

So I think, likewise, we need to put the burden on the utilization review companies to keep us apprised of their fax numbers and/or their addresses for the same reason. And if they do not keep us apprised of that information, then they need to be penalized. I don't disagree with Mary Lou on that issue.

MS. HARRIS: I agree also, but I think it should be on the carrier to notify the provider of their utilization company; because what's happening currently, which I'm aware of currently, there's three pairs.

LWCC, they have their own dedicated 1010 fax number. Summit has their own dedicated fax number for

1010s. And I want to say LUBA, but I know LWCC and Summit. I think from a provider's point of view, if the carrier could notify us of their utilization review company from the initial intake process would be great. I know in our office we try to obtain from the beginning the UR info, attorney info because it helps.

Now, in response to Mary Lou's response, we do have a lot of issues with utilization companies response.

Number one, we submit the 1010. The carrier submits it to UR. The UR determination returns without the 1010. But the UR -- the utilization company makes their response. And, you know, we disagree with it.

But what I'm really trying to say, I think the company should tell us who is the UR company so we will know who to send it to, to send a claim to.

So I don't know, but you guys are doing a good job, but it's just a lot of work for the providers. I'm sorry. When they implemented this rule and it changes from 2012, it has just been extra work. I just think it's extra, unnecessary work.

MS. KEEN: Hi, I'm (i_naudible). I work at the Spine & Pain Specialists.

COURT REPORTER: I'm sorry, I didn't get your name.

MS. KEEN: Liz.

COURT REPORTER: Liz, what's your last name?

MS. I\:EEN: Keen. One of the issues that we have is we'll do a 1010, but then we get a peer-to-peer review call and they give a phone number, usually a cell phone number, for the reviewer and the doctor has like two days to respond, but they call on like a Friday and our doctor is in surgery.

Then it just kind of auto denies, because they were never able to do the peer-to-peer review because they kind of felt unrealistic expectations of being able to call them back with the UR people, companies. Just a comment to add to the UR review issues.

MS. HARRIS: And that's true. We are told at one point that the utilization process we did not have to do.

So some of these peer reviewers, physician reviewers, are calling. They're giving us a time limit. They're placing a time limit on the provider to respond to a particular request.

And the reason the peer review is set up is

because either lack of information was not included on the 1010. As a matter of fact, we had one yesterday.

DIRECTOR KELLAR: Generalities. Hypothets.

MS. HARRIS: Well, just it was a diagnostic physician reviewer called. They needed us to call back. We couldn't ever reach them. Well, we called 15 times. No answer. The good news is it was approved without a peer review.

DIRECTOR KELLAR: But, generally, if you don't -- if your doctor doesn't talk to the peer reviewer, it's an auto denial?

MS. HARRIS: It will be a denial most of the times. Majority is denial. Automatically -- it will be an automatic denial.

MS. KEEN: I have something to add to that. I find at our office that, when they're calling for the peer reviews, they're calling and asking the physicians questions about stuff that they already have in their hands in the records. They're asking specific questions that all they had to do was look at the notes and read them.

They're not wanting to read all the notes. I don't know why they're not wanting to read all the notes, but they're not. They're just not seeking out

the time to follow through with all of the information that they're given.

DIRECTOR KELLAR: Thank you.

MS. ELIE: And, also, to add to that, that's one reason our facility had an issue with the peer-to-peer because I would even circle the main point. I would note that as the guideline. I would circle it on the office note and they would still deny it, still want a peer-to-peer.

I would even give them the time that our provider was available, and they still call on the outside timeframe of that and then we would still get a denial.

So it's things like that that-- you know, that cause a hardship concerning our workers' comp patients, and our provider just felt like, you know, he was doing more harm for the patients than we were helping the patients. And if we can't actually provide a service for the patient, then, I mean, what are we here for.

So, I mean, those are some of the things. You know, that's the reason why we just had to just you know, we had to just cut our load. We just couldn't do it. And especially when they were saying that we had to do a 1010 for certain narcotics and

that's what we do.

I mean, that's I mean, we do --we're a specialist, and we provide procedures. And, of course, unfortunately, some patients may have to have narcotics.

So that's in our every day, that's every patient that we come in contact with. So it was just very -- it was just very overwhelming and so we hated to make that decision, but that was just, you know, what we had to do.

She's sitting beside Mary Lou.

DIRECTOR KELLAR: Thank you, ma'am. It's the First and the Fifth that have ruled that prescription medication is not subject to the approval process of the medical treatment guidelines.

MS. PATE: I'm sorry, could you repeat those two districts?

MS. LUNDEEN: First and Fifth, which is not you all.

DIRECTOR KELLAR: The First and Fifth said prescription medication is not subject to the approval and the appeal process authorized by 23:1203.1.

COURT REPORTER: Can I get her name?

DIRECTOR KELLAR: Can I get your name, the lady who just asked the question?

MS. PATE: Oh, Shelley Pate.

DIRECTOR KELLAR: Thank you. Thank you, ma'am.

MS. SALLEY: I can elaborate a little bit on that for you, Sheral.

The Second Circuit, you know, we do things our own way in North Louisiana. But the Second Circuit takes the position that prescription drugs under the comp act are a claim of reimbursement. I don't know where they got that, but that's what they think.

So the Second Circuit takes the position that it's the injured worker's job to go buy the prescription and send it in for reimbursement. So I would say that the Second Circuit says there are no guidelines that apply, because they believe the injured worker should just go buy the prescription and send in the reimbursement claim.

So that's the --do you agree with me, Kris?

I mean, probably not. That's just --that's the only case we have from the Second Circuit is that prescriptions are a claim of reimbursement.

It was a case about choice of pharmacy, wasn't it?

MR. JACKSON: Was that an IWP case?

MS. SALLEY: Yeah. Yeah. There's some-- that IWP case and they said prescriptions are a claim of reimbursement and it shouldn't matter which pharmacy you use.

So they take the position the injured worker, there doesn't have to be a pre approval because the injured worker should just go pay cash for the prescription and send it in. That is what we have.

And I'm just telling, y'all, I would take the position that the Second Circuit would probably say, if they've already held what they want the injured worker to do is send in their reimbursement from Kroger or whatever pharmacy, that there's no 1010 involved in prescription drugs until the legislature says these are our guidelines and file a 1010.

MR. JACKSON: Kris Jackson. I normally represent insurance carriers and employers in workers' comp cases.

I think Mary Lou is mostly right on that. That case, I think that case is a little distinguishable, though, because they found that IWP as an out-of-state provider is not reasonable and necessary within the State of Louisiana.

I have another question, though. One, has there been a plan to implement any type of electronic

filing?

DIRECTOR KELLAR: For?

MR. JACKSON: For, well, we'll start with 1010 -- 1009s. I'd like to see it for the whole system, but for 1009s, essentially, I think the fax machines seem to be an antiquated system. That might eliminate some of the multiple filing issues.

DIRECTOR KELLAR: Electronic filing for everything is on the table, and we're moving toward that.

I think the first step, however, will be the Troy, which is the 1002, Pauline, and then we'll move forward with that. And, of course, the 1008 will be in line for electronic filing, as well.

MS. WILLIAMS: Uh-huh.

MR. JACKSON: Also a question I have along with treatment guidelines and everything that it provides about what is reasonable and necessary, it also provides guidelines for doctors in preparing reports and how they treat claimants.

And it states that they're supposed to every time a doctor sees a claimant, prepares a report, make a statement regarding return to work ability and a plan of action towards getting a claimant to return to work, because that is one of the stated goals of the

system.

It's primarily an issue I see with pain management doctors. After everything orthopedic has been done, the pain management doctor is just prescribing medications or giving injections and there's no comment at all in the report about what they're trying to do to get the claimant back to work.

From a defense attorney perspective and an insurance carrier perspective, is there anything that can be done to compel the doctors to comment on return to work ability and restrictions because I think that's important to know where a claimant is in trying to get them back to work.

DIRECTOR KELLAR: I think that issue can be addressed in the hearing rules. We do address the components of a narrative report when it comes to the IME physician to prevent him from being subjected to a deposition.

So I certainly think that that might be one thing that we can address in the hearing rules that Judge Lundeen is dealing with.

MR. JACKSON: You can address that with regard to the treating physician?

JUDGE LUNDEEN: So what we're trying to do, Director Kellar has spearheaded our analysis of

all these rules and it's something that's important to me as well as a leader in the system.

There are a lot of hearing rules that make no sense in light of the medical treatment guidelines. There's a lot of hearing rules that just make no sense.

So we are forming statewide committees to review both Title 23 as well as the hearing rules, and you're welcome to join if you'd like to give me your name and card afterwards. We want, you know, both sides of the bar to participate. We want folks that are dealing with the hearing rules and with Title 23.

And for that matter, any enabling statutes that we might find in the Code of Civil Procedure or Civil Code. And, hopefully, we will have something put together that we can present to correct certain problems.

So we would love to have your participation. It sounds like you're interested.

MR. JACKSON: I am.

JUDGE LUNDEEN: So welcome aboard.

MR. JACKSON: Can I expound on that real quick, too. The FCE choice issue I actually argued before the Supreme Court last week out of a Third Circuit case with Mike Miller.

JUDGE LUNDEEN: Okay.

MR. JACKSON: So that's before them now. So we're going to get some guidance from that maybe. They didn't seem to grasp it very well, but they gave me a lot of commentary about how they're disgruntled with our act and the hearing officer rules and the ambiguous nature of it and that they don't feel like they're getting guidance on what the law is because the law is quiet to certain issues.

And that was a big issue that they had with the FCE issue was that an FCE is never mentioned one time anywhere in the Workers' Camp Act or the Hearing Officer Rules.

I know it's now in the treatment guidelines to a certain extent. But that was an issue that the Supreme Court has. So I think what you're working on will be great to give some guidance.

DIRECTOR KELLAR: And, of course, Mr. Miller thinks he has choice of FCE.

Right?

MR. JACKSON: Oh, Mr. Miller was totally right about everything. You can imagine.

DIRECTOR KELLAR: Okay. Any other comments, questions?

Yes, sir.

MR. MANNO: Thank you. My name is Mark Manno from Fischer & Manno. I represent injured workers.

And in response to the issues raised by choice of diagnostic, I know we have Terianne raised that and Connie and Latasha.

What Judge Lundeen's response was is to file a 1008, which is a lawsuit. But the problem is, the reality is Dr. Mody is not going to go and file a 1008 on that issue.

So, when you run into that kind of road block, it has to be the injured person's lawyer that takes it up and files a lawsuit. And if the patient, you know, doesn't have a lawyer, then we have to think about getting one to resolve that issue.

Like Judge Lundeen explained, the 1009, 1010 process resolves, do they get that care, yes or no. And so, once that is decided, the choice or the issue needs to be fought out by that injured worker's lawyer in the Court system.

So that's what I think you need-- I think that's the answer to that. I think'that ties into what Judge Lundeen was saying.

The problem with, you know, the 1009, 1010 process, it's an extra step for doctors and their

staff to complete. And so what the nightmare is we have Keashia, when I see you here, I know that River City has stopped seeing workers' comp patients.

And that's what we don't want to have happen. I don't want, you know, Pierce Nunley and Euby Kerr to wake up one day and say, you know what, we just don't want to do this paperwork, we're not going to see any people that were injured on the job anymore.

So what we don't want to do is have the process run doctors away from treating people that were hurt on the job. So the issue is why do we have this extra step.

So I look at it is what did we have before. And before on choice of medical care, before this process came in in 2011 and '12, a doctor would recommend a procedure.

Well, then the insurance company gets a second medical opinion, which we call an SMO for short, and that doctor is almost always going to side with the insurance company and say they don't need this. That's at least my perception. I could be wrong, but that's what's happening with my clients.

So then, in response to that, either side can ask for an IME, which is an independent medical exam. So you have a third doctor. Well, that process takes

months and thousands of dollars to work itself out. So I'm assuming that this 1009, 1010 process was supposed to get medical care approved or denied quicker.

And I probably have a rosier outlook on this than Mary Lou does. I think that a 1009, 1010 process, I think generally it works. And I wasn't happy with it when I first came on board, but I think now we're all kind of used to it and we kind of know what it is and we know what to do with it.

The problem that I had with the SMO and IME system before, you know, I felt like especially with spine surgeries that some of the doctors that were doing the SMOs and IMEs, even though they were orthopedic physicians, they weren't doctors that were practicing day-to-day in that specialty.

And I felt like their reports were not always fair to the injured worker, and I could be wrong. That's my perception. So, therefore, I wasn't in love with the SMO and IME process.

But I think that this 1009, 1010 process I think it's better overall. Having seen this evolution over the last few years, I think it's a little bit better than what we had before.

But I hope that the 1010 step that the

doctor's office has to take, I just hope it doesn't run out more doctors like River Cities and I hope that River Cities would reconsider and come back and see injured workers.

DIRECTOR KELLAR: Mic. Thank you, Mark. That's the best thing anybody has said about the medical treatment guidelines since we've been having the Town Hall meetings.

And I think that a vast majority of the recommendations for medical treatment are approved. It's those that are not approved where we have the difficulty.

From January, 2016, to date, we've received approximately 1,600 requests for-- the doctor has received appeals for 1,600 medical treatment guidelines requests, and generally he makes a decision within 30 days.

What happened in the past was the request for medical treatment was based upon reasonable necessity, and it had to be decided by a judge. It was a full blown trial on the merits, and it could take sometimes up to a year before the judge made a decision because it had to go through a pipeline.

You had to get your depositions of your IME doctor, your treating physician, your second medical

opinion physician, and as Mr. Manno said, it did cost thousands of dollars. This way it's supposed to be quick and fast, and the vast majority of times it is.

Unfortunately, in your case, it has not been your experience. And, again, I say that's why we're here.

Generally, the carriers will make a decision. If it's approved, that's good. If it's not, the denial comes to the doctor within 15 days. He makes a decision within 30 days. So you'll know whether or not you get the treatment that has been recommended within 60 days as opposed to 365 days, which is what it took sometimes before.

The good thing for the system as a whole is that medical treatment guidelines are based upon evidence based medicine. And so what that means is, if you have a knee injury in South Louisiana and a knee injury in North Louisiana, they get the same treatment because it's based on the medical treatment guidelines as opposed to what a doctor thinks .that treatment ought to be. Of course, you take into consideration the patients.

But the other good thing about the medical treatment guidelines for the system is that because we've taken medical treatment issues out of the trial

pipeline, we've been able to reduce the number of days it takes to resolve other issues by almost seven months, which is a reduction by half of what it was, say, five or six years ago. We don't have as many disputed claims, because the medical treatment issues are not in the trial pipeline. And all of these things are good things.

So, while we work through these issues with the medical treatment guidelines, we would ask that you be patient with us. We're here because we're not unaware that there are problems. And we want you to help us to first identify what those problems are; and, if you have some solutions for how we might fix it, that's what we want to hear. That's why we're making a recording.

I saw some hands.

MS. PANTHER: The other issue that I've noticed major is the 1010 needing for any office visits from the very start.

And I understand these are guidelines, but there are certain companies, I'll say 95 percent of the companies, don't abide by that particular guideline.

There's one in particular that is hard nosed about that particular guideline. And if you don't

have an office visit approved and the patient slips in on you, you didn't know they came in, they're not going to pay for that visit and they're not going to give you a retro authorization for it, either.

And that means the doctor's office, in turn, is seeing the patient for free, and we're having to write off treatment that's being done when they're coming in to see the physician.

MS. SALLEY: Yeah, they want documentation. They'll deny treatment and say you need to document this. She gets them back in to document that, and they go oh, you didn't file a 1010 for the office visit.

MS. PANTHER: Right, that, or we'll see them and they'll say we're not going to pay for that office visit.

But the doctor ordered something. They'll approve something off of that doctor visit, but they won't pay for the office visit because a 1010 wasn't done.

You know, when you work in larger offices, you've got people who answer the phones. The patients call in, make an appointment. Us in the work comp department, we may or may not know that that patient is coming in and it gets slipped -- I mean, things

happen. They get slipped through.

So I just don't understand the purpose for that particular rule. Why is that rule even in the guidelines?

DIRECTOR KELLAR: And that's the rule that you have to submit a 1010 for an office visit?

MS. PANTHER: For office visits, yes, ma'am.

MS. HARRIS: It was -- I'm trying to find it. It was implemented just a few years ago.

The reason, from my understanding, there were some providers -- there were some providers providing diagnostic care in their facility along with the office visit, and the diagnostic care was not being approved.

So, therefore, work-- Louisiana Workers' Comp has implemented a $750 clause. It's like any office visits leading up to $750 has to be approved.

JUDGE LUNDEEN: Right. That's the law.

MS. HARRIS: So, in response to what she's saying is LWCC and LUBA, those are the two, if your office visit is not approved, the provider will not be paid. We have to obtain prior authorization or return visits for an office visit.

DIRECTOR I\:ELLAR: Do you see requests for

office visits, Dr. Picard?

DR. PICARD: Very uncommon.

MS. HARRIS: Well, we've been submitting ours for the last two years.

(Several speaking at once)

DIRECTOR KELLAR: Okay. Court reporter is going crazy because too many people are speaking at one time.

Dr. Picard said -- he can say it himself.

DR. PICARD: The only thing I have to comment is that I rarely see those. So it doesn't get to my level. Every once in a while I do, and there's not a lot in the guidelines that I see regarding approval of office visits and how often a patient can be seen.

There are a few specific instances of that; but, at the 1009 process, I'm just not seeing it. So you're seeing something that's not getting to my level.

MS. HARRIS: We wouldn't apply for 1009s. That's true. It's just a 1010 issue.

DR. PICARD: Right.

MS. HARRIS: 1010 initial submit issue.

DR. PICARD: Are you sending 1009s for those sometimes when they're denied?

MS. HARRIS: You know, no. But I've fought them by calling the carrier. Because, see, with the 1009 process, you have to first submit the initial 1010, have all of that covered, then your 1009, so.

DR. PICARD: Okay.

DIRECTOR KELLAR: Anybody else?

MS. SALLEY: I have just a small response to her. I know what the guidelines say, but I think it intertwines with the actual act. I think a denial of an office visit is actually a denial of choice of physician.

So, again, that might be one of those instances where the patient and their lawyer needs to be informed; because, if you don't have an office visit, you don't have a doctor, so.

MS. HARRIS: Well, that's -- you know, you're right. And I'm really trying really hard to submit those denials to the attorneys, because the attorneys really help. They're actually denying our office visits, and that's placing a limbo on the patient.

MS. SALLEY: To me, that's a denial of choice of physician to not even have an office visit.

So that's one of those -- I'm not giving

anybody any legal advice. I'm just -- I interpret the act that, if you can't even have an office visit, you don't have your choice.

MS. HARRIS: I had to turn a patient away.

DIRECTOR KELLAR: Any further comments, questions?

Okay. Why don't we let Dr. Picard tell you some of the things that he sees that are problematic for him and that if were done differently could help in the process.

DR. PICARD: The most common thing that I see, or common things that I see, basically, you're looking at two sides. You're looking at the provider and the patient, and the insurance company.

And in the 1009 process, I'm looking at whether or not I'm going to approve a particular treatment or service that the provider is requesting and the insurance company has denied.

So I look through the documentation to see if the medical treatment guidelines are being met and the criteria are there for that procedure; and, if they are, I approve it.

If the criteria are not there, then I have no choice but deny it because it's not based on my opinion, it's based on what the treatment guidelines

say.

So, if the provider has not documented specific things that they need to document, specific criteria that are required for a certain procedure, for example, then that procedure by the guidelines cannot be approved.

And then I would make a statement in the denial about what is missing from that documentation to allow the provider to then either submit that documentation or do the therapy that needs to be done or whatever criteria needs to be taken care of, so that the process can occur or the procedure can occur and they can submit another 1009 in that instance to allow their procedure to occur.

The biggest thing I see on the carrier side is, number one, lack of a response. We see very many tacit denials whereby the carrier has not responded to the provider or the patient's attorney, in which case I'm looking at only documentation from the provider.

And if the documentation is such that the procedure should be approved based on the guidelines, then it is approved and the carrier has not sent me anything.

So anybody that represents insurance carriers, that would be the most common problem that I

see, most frequent thing, that could be improved from their standpoint.

The other standpoint, this was commented on earlier by somebody, is that sometimes the insurance carrier is not getting all of the information from the provider. So, in their response and the insurance carrier's denial, they might state that certain criteria have not been documented when I'm looking at the provider's documentation and it's clearly there. And I approve it based on that and state that in the approval, these things were documented.

So I don't know if the carriers are not getting that documentation that I'm seeing, or if they're ignoring it. I have no idea how that is happening. But the carriers have to be aware of what has been done and use that information appropriately to see if the guidelines criteria are there. So that's from a carrier standpoint.

From the provider standpoint, the biggest things I see why I deny something would be lack of documentation. If they don't document that they did certain things that are required for a certain procedure.

Some procedures have certain things that you have to show that you have done prior to approval of

that procedure. If you want a spine surgery, you have to say that you've done physical therapy, you've had a psychosocial evaluation. There's certain criteria you have to have in your documentation.

As long as those are there, then I'm going to approve the procedure to be done. If those are not there, then the criteria for the guidelines are not in the documentation and it's going to be denied.

We do approve the vast majority of what comes to me. It's less than a third are being denied, and it's usually due to that fact. It's usually due to some criteria are not being documented that should or are required to be documented to allow that procedure to take place.

So are there any questions specific that I might be able to answer, insurance carriers, providers, anybody who have something with regard to the guidelines decision?

MR. JACKSON: Kris Jackson. Do you see it as a problem or do you have a problem with the peer review doctors who are doing -- are reviewing for the UR, that they're misapplying the guidelines?

DR. PICARD: Yes, every day.

MR. JACKSON: Okay. Can you -- I really don't know how --

DR. PICARD: I can see -- the most frequent thing I see is that they're saying that patient does not have a particular symptom or has not had a particular procedure or therapy, and I'm looking at the documentation and I clearly see that it's there. So I do see that very frequently.

DIRECTOR KELLAR: Yes, ma'am.

MS. KEEN: When you submit the 1010 and like you give them the information and they still want to do the peer review and they ask the same questions that's in the information, I just don't see the point of the peer-to-peer review when the documentation is there.

DIRECTOR KELLAR: That's before it comes to us, but I understand it's a problem for you. To the extent that we can address it, we'll, you know, look at it.

This is the first time we've heard some critique of the peer-to-peer review during the utilization review process. So, now that we're aware of it, we'll just keep that on our antenna radar.

Yes, ma'am.

MS. BREWER: Amanda Brewer. I'm a physical therapist.

Who is completing the peer review for

physical therapy?

DIRECTOR KELLAR: We don't do peer reviews.

DR. PICARD: We don't do that.

DIRECTOR KELLAR: You send your 1010 to your carrier or their utilization review company or the third party administrator.

If it comes back denied, then you send it to the medical services section and Dr. Picard reviews it. We don't do peer-to-peer review.

MS. BREWER: Okay. Previously, I've spoken to a physician on other end of the line about notes that we send in requesting additional visits, or something like that.

And so I guess you have, no physical therapists that are actually reviewing physical therapy notes or no occupational therapists who are reviewing occupation therapy notes, but you have just a physician determining if they need to continue treatment or receive treatment.

DR. PICARD: That is correct.

MS. BREWER: That is correct?

DR. PICARD: That's me. I review every document that comes into our office on the 1009 if you get a denial of service, and it's very unusual for me

to deny continuation of physical therapy as long as the documentation is there.

MS. BREWER: Right. No, this was not you that I spoke to.

DR. PICARD: Okay.

MS. BREWER: It was a different physician, so.

DIRECTOR KELLAR: We only have one at LWC.

MS. BREWER: This was in years past. This was ln years past.

So I just was -- I just was wondering because it just seems like, you know, I've had physicians tell me prior that they're a physician or they're a surgeon, they are not a physical therapist. And, you know, they can't make that determination.

DR. PICARD: It's not that complicated. To continue physical therapy, you need two things and that's usually what you're asking for.

MS. BREWER: Right.

DR. PICARD: You're asking to continue physical therapy.

MS. BREWER: Right.

DR. PICARD: You need to demonstrate that it has been improvement in condition and that the guideline criteria for the amount of therapy has not

been exceeded. If those two things are there, I'm going to approve it.

MS. BREWER: All right. Okay.

MS. HARRIS: Can you repeat those last two?

I need those. Improvement and the condition.

DR. PICARD: You need to show that the patient is improving from therapy and that the guidelines criteria have not been exceeded.

There are certain amounts of therapy visits that are allowed for each particular condition, and those are in the guidelines.

And you can go beyond those, but there's a criteria for that, too. You have to demonstrate that there's a specific need and a reason why you're going beyond the normal limitations set forth in the guidelines for how much therapy is allowable.

MS. GLADNEY: Okay. You said you would -- you go -- you approve by what they send you and what you read?

DR. PICARD: Right.

MS. GLADNEY: Okay. Well, I can't understand why my injections haven't been approved.

I have family out of town. I have kids out of town. I have sisters out of town. The church that

I go to, home church, that has been in our family for 164 years is out of town. I haven't been able to attend that church. Haven't been able to go out of town. This is the farthest I have ridden in a car since September the 29th of '15.

The reason why I'm standing, I'm not trying to be rude, I wouldn't want to be rude anywhere. I cannot sit down for a long period of time at all. It has -- and then I'm having pain that's coming from the back shooting down this leg. I have numbness.

So, if they writing up all of that that I'm experiencing, why wouldn't anybody approve what the patient needs?

I hear all -- I've been listening. I hear all of this legal stuff. I don't know what y'all are talking about. I'm trying. I'm really trying. I'm trying to keep from crying because I want to understand it. I really, really want to understand what's going on.

DIRECTOR KELLAR: Let me say something.

MS. GLADNEY: My question is: Why wouldn't they approve that?

DIRECTOR KELLAR: Listen.

DR. PICARD: I can answer it.

DIRECTOR KELLAR: No, I don't want you to

answer that because we have the judge of this jurisdiction in the room, and she is really hearing ex parte communication about your case that she may hear later and it would prejudice her.

So, when ■ started, ■ said let's not talk about particular cases. ■ understand your situation, but the judge who will hear cases in Shreveport is sitting here and this is information that she really should not be hearing.

MS. GLADNEY: Okay.

DIRECTOR KELLAR: These are things that you should discuss with your attorney.

MS. GLADNEY: No, but my question was to him. He said he takes what he reads and --

DIRECTOR KELLAR: The problem, ma'am, is that you don't even know if he has it.

MS. GLADNEY: No. ■ was just asking him if they -- if a particular person wrote down -- the doctor wrote down all of that, what would stop that person-- it's more than me in chronic pain.

What would stop that person -- what would stop that person from saying, hey, we need to try to help. I mean help, that's a small word. And that's all I was asking, ma'am.

JUDGE LUNDEEN: So the medical treatment

guidelines, when director gets a claim on a 1010 form or actually on a 1009 form, so it's been denied by the insurance carrier that you're dealing with or whomever is dealing with.

Then he looks at a statute, at a series of rules that tell him that are based on medical guidelines from other states, as well as ours, of what is the accepted treatment.

And your doctor will have put down how he or she thinks you fit into that guideline, and that is what the doctor bases all of his judgments on in determining whether or not the denial was appropriate.

DIRECTOR KELLAR: Anybody else?

Yes, ma'am.

MS. BREWER: Who are the medical professions on the advisory council?

DIRECTOR KELLAR: If you go to Laworks.net, you will see the members of the MAC, the Medical Advisory Council. Go up under workers' compensation, and it has the members of the MAC.

JUDGE LUNDEEN: Also, if you look at Title 23 Section 1294, it will tell you who the legislature has stated should be on the advisory council. It tells you, you know.

DIRECTOR KELLAR: It tells you --

MS. BREWER: That's what I need, the workers' camp advisory council.

DIRECTOR KELLAR: It tells you the various disciplines that should be on the medical advisory council.

If you will go to Laworks.net under workers' compensation, you will find the names of the physicians who are representative on the medical advisory council.

MS. BREWER: Okay. I think I'm talking about just the workers' compensation advisory council.

You said it's Louisiana statute what?

DIRECTOR KELLAR: Do you want the MAC, or do you want the workers' camp advisory council?

MS. BREWER: Not the --

DIRECTOR KELLAR: Because there are two.

MS. BREWER: Not the medical advisory council.

DIRECTOR KELLAR: The workers' camp advisory council is by statute. Those members are appointed by the governor. It's Title 23:1294, and the representatives of the workers' camp advisory council are listed in that statute.

The particular members of the workers' camp advisory council, their names are listed in

legis.state.la.gov. If you'll look under boards and commissions, you'll see the names of the eight members that were recently appointed and then the other members who are still on the workers' comp advisory council.

MS. BREWER: Okay. So is it -- on the workers' comp advisory council, is it attorneys, is it medical providers, is it --

DIRECTOR KELLAR: The workers' comp advisory council is made up of stakeholders in the workers' compensation communities.

There are attorneys who represent employees, attorneys who represent employers. There's a laborer representative. There's a business representative. There's an orthopedist representative, a representative from Louisiana State Medical Society.

The director is the Chair. And there are five at large members, one from each of the public service commissioned districts.

MS. BREWER: Okay. Thank you.

DIRECTOR KELLAR: You're welcome.

MS. HARRIS: So the panel here today, you all represent the 1009 department?

DIRECTOR KELLAR: I'm sorry, say it again.

MS. HARRIS: The panel present today, each

one of you represent the 1009 department?

DIRECTOR KELLAR: The people that we have here are the management and staff of the Office of Workers' Compensation. Dr. Picard and Cathy Chesson work in the medical services.

MS. HARRIS: Oh, okay. Nice to meet you.

DIRECTOR KELLAR: They deal directly with the 1009s.

Judge Lundeen is the Chief Judge for the hearing section of Office of Workers' Compensation. So she will deal with 1009s, 1008s, 1002s, 1003s, 1007s, and all of those things.

You have Judge Linda Smith is the judge in District 1W Shreveport. Rosa Whitlock is the mediator in District 1W Shreveport.

Pauline Williams is the deputy director right here, deputy director of the Office of Workers' Compensation. So these two deal directly with the 1009s and the rest of us indirectly.

MS. HARRIS: Okay. I understand now.

MS. WILKINSON: Christy Wilkinson at Musculoskeletal Institute.

Okay. I received a 1010 -- actually, I received a UR denial, and then the adjuster gives me a 1010 approval.

Which one takes

MS. HARRIS: The adjuster.

MS. WILKINSON: Then she e-mails me back and says oh, no. No. No. UR --

(Several speaking at once)

DIRECTOR KELLAR: Okay. Hold on. Hold on.

Let me make sure we have the facts straight. So you sent in a 1010, and it was returned because it

MS. WILKINSON: It wasn't returned. I submitted a 1010. I received a letter from the UR with a denial. Maybe a day later the approval 1010 came in from the adjuster.

So I responded with an e-mail to confirm clarification was she overriding the UR and she was giving approval. She said no, they have to do whatever. It's denied and

MS. SALLEY: That's a judicial confession.

DIRECTOR KELLAR: The UR denied, and the adjuster approved?

It never got to us. It never got to us.

(Several speaking at once)

MS. WILKINSON: So we -- even though

DIRECTOR KELLAR: I can't -- I don't know

the answer to your question.

MS. SALLEY: I do. I know the answer.

DIRECTOR KELLAR: It never got to us.

MS. WILKINSON: Well, I do have a 1009 issue. Received the 1009 approval, submitted it to the carrier, and we get nothing back.

DIRECTOR KELLAR: Okay. So you submitted a 1009 to the doctor. The doctor approved it.

You submitted it to the carrier, and nothing happened?

MS. WILKINSON: Correct.

DIRECTOR KELLAR: We had this issue before.

Diane, do you want to address it?

JUDGE LUNDEEN: Sure. So the 1010 is going to trump, because by statute that's the method that the legislature has prescribed for how this system will work.

When you get nothing back from -- and we call that a -- it's not even a tacit denial. When they don't send -- when they don't -- you've got it approved, but then they don't cooperate with you, again, unfortunately, that's where you end up getting into litigation because it's an approved 1010. So you can't file a 1009, because you have nothing to

dispute.

So then that's when, as Mr. Manno suggested, you talk to the claimant. You determine who, if anyone, should pursue the treatment through the use of the 1008 form.

DIRECTOR KELLAR: Why don't we have this gentleman over here.

MR. MILEY: I don't know if I need that. I think I can talk loud enough. My name is John Miley -- excuse me, John Miley from Level Solutions.

As I sit here and listen -- well, let me explain where I sit. I'm not a provider, and I'm not a payer. I just actually walked in here for a free lunch, but they're not serving. No, I'm joking.

I kind of sit between the facilities and the payers most of the day trying to make sense of bills and negotiating the best outcomes on medical bills.

Unfortunately, a lot of times I'm stuck with a situation that we've touched on today, but I don't hear a clear resolution other than it's probably a 1008 issue.

I'll try to make this a simple question. When a provider -- and I'm going to use a back surgery as an example. When a provider gets an approved 1010 for a back surgery, who and what is included under

that approval?

I think, again, that gets to an issue of, you know, you have a 1010 from a doctor saying here's your surgery. That to me from I have an old UR background that that's --we've approved that as medically necessary. And then to me there's a separate approval that says, okay, I'm approving you to do the surgery.

MS. SALLEY: That's not the way it works.

MR. MILEY: This issue I have -- and that may be right or wrong. I'm just saying the issue I see now is -- and don't throw stuff at me when I say this, but it seems to be a blanket or a blank canvas and maybe even an open checkbook with some, once they get an approval of a 1010 procedure where then everything is done from the facility to implants to every third party that's involved, they throw that 1010 at you and say it was approved.

MS. SALLEY: That doesn't even make any sense. You have to get each procedure approved on the 1010. That doesn't even make any sense.

MR. MILEY: Do you want -- let me explain. A doctor gets a 1010 for a back surgery.

Okay. Does the facility fall under that 1010 meaning

(Several speaking at once)

DIRECTOR KELLAR: Okay. Hold on.

(Several speaking at once)

JUDGE LUNDEEN: One person at a time.

DIRECTOR KELLAR: The court reporter can't hear everybody at once.

MR. MILEY: Okay. I'm sorry.

DIRECTOR KELLAR: You have to speak first, and then let the next person speak.

Okay. Go ahead.

MR. MILEY: Okay. So, when I'm reviewing a bill and there's --and I'll try to come from this angle. When I'm reviewing a bill and there's a first and foremost a third party provider of implants, okay, there was nowhere listed, and actually implants, it may have said implants, you know, with surgical implants on the 1010, but when you have questions about the implants that were, you know, used or if you have -- there's issues when you're trying to question that, you know, first of all, you're having to go to a third party who is not named on the 1010 as providing the implants.

Is this starting to make sense?

DIRECTOR KELLAR: Yes, it does make sense.

MR. MILEY: Okay.

DIRECTOR KELLAR: Because what you're saying is you submit a 1010 for a back surgery; and then, when you get the bill, you have an invoice for an anesthesiologist, the facility, the physician, the da, da, da, da, da.

Right?

MR. MILEY: And then, again, another unnamed entity getting a bill

DIRECTOR KELLAR: Okay. First of all, the 1010 is not a guarantee of payment.

MR. MILEY: Right. I agree.

DIRECTOR KELLAR: Okay. So, when the 1010 is approved by the carrier for the treatment that was recommended, all those other things are ancillary and should be communicated or worked out between the healthcare provider and the carrier somewhere.

MR. MILEY: Well, I guess that's my question.

Where?

DIRECTOR KELLAR: I have no idea.

MR. MILEY: I don't know if that makes sense to you guys.

MS. HARRIS: It makes sense.

MR. MILEY: Because the question I've always heard was, you know, and I've been in

conversations with facilities, and I've said, listen, what we're arguing about wasn't even approved.

And they say oh, yeah, it was approved, the doctor approved it. I said, he made no mention that you were going to do this. And so they're looking at me like wait, what are you talking about.

So I always say the last thing I want to do is ding a facility because the doctor didn't approve -- get the right thing on the 1010.

And so to me it's almost like, okay, at what point does it get to a point where now facilities will have to get a 1010?

But that's not really what the 1010 is about. It's more or less an approval to use this facility or an approval to use this third party that's going to supply these implants that necessarily isn't a third party. It's just by name it's a third party, and they're billing it separately and all that good stuff.

So my question, you know, and I heard that earlier when someone said, well, the choice of diagnostics is a choice of physician or choice of -- I don't remember exactly. But that to me that muddies the water even more, because that's not necessarily --

JUDGE LUNDEEN: So would a solution -- I understand what you're saying. So the question, then,

is what's the solution so that in a surgery where you know certain things have to happen, you know you have to have a facility to do it in, you know you have to have an anesthesiologist who is going to put this person under a general anesthesia, you know that there's certain things that are always going to happen in that type of surgery.

So would you propose as a solution, then, that the medical treatment guidelines be modified to say standard surgery under general anesthesia covers the following modalities?

MR. MILEY: Well, I'll say it this way. I've even seen before where the UR company, because the customer, their customer, asked them, hey, get the facility name.

And so they'll approve the 1010 and say, hey, let us know where, you know, where you're going to schedule it. Well, they never hear back. And so it's an empty blank, the facility.

And so, again, it wouldn't be that big of deal, but what's creeping in right now is -- and you saw that with the recent decision in the LUBA case or not LUBA yeah, it was LUBA. The choice of

MS. SALLEY: The physician?

MR. MILEY: -- prescription, the

prescription stuff. Where you get to you can go to this facility and get a surgery for $15,000, but this facility is $115,000 --

MS. SALLEY: You can't --

MR. MILEY: And it's the same

JUDGE LUNDEEN: So your question -- that goes back to what we talked about earlier. It's choice of that is the choice of the injured worker where they -- with whom they seek treatment and where that treatment is performed, with the exception of the split -- the circuits that, hopefully, the Supreme Court will rule on now related to certain things such as FCEs.

MR. MILEY: I thought that was choice of physician.

Isn't that what we're talking about?

JUDGE LUNDEEN: You're entitled to be treated by whom and where, with the exception of FCE under certain circumstances --

MR. MILEY: Right. Right.

JUDGE LUNDEEN: you want. Because, when you undergo an invasive procedure, the theory is that you are supposed to be comfortable with the people and the places that are providing that.

Now, the underlying question that you're

asking is what is a reasonable and customary charge.

MR. MILEY: Actually, it's a second -- a whole separate thing.

JUDGE LUNDEEN: That's a whole separate issue.

MR. MILEY: And that's a whole 'nother Town Hall.

JUDGE LUNDEEN: Right. And that is regulated by the fee schedule as to what is appropriate. So that's a whole separate issue that's handled by a different part of the Workers' Compensation Act.

But I do think that you've raised an interesting point as to what is the scope --

MR. MILEY: Right. What's covered?

JUDGE LUNDEEN: of this 1010 related specifically to surgery that requires general anesthesia.

And that's why I'm asking you would it help you in UR to approve or deny these things if there were some type of guideline that related to what the scope of a typical general surgery is, so that anything that's not covered in that guideline would then have to be requested separately?

MR. MILEY: Right.

JUDGE LUNDEEN: Would that assist you?

MR. MILEY: Well, it would assist me; but, again, I'm not trying to suggest that I'm making these-- again, I'm not the party that's making these determinations. So I want to make sure and make that clear.

I'm seeing it on the back end. So I'm trying to make sense of, okay, there's this implant system that they chose is not approved for the surgery that they do and so you start going well, goodness, this is odd. But you go back to the 1010 and nowhere is it mentioned.

So you're kind of at a position of, okay, well, it's a really, really expensive implant device that was chosen to be used, and it was never -- it was never discussed on a 1010 or approved by anyone; and so, therefore, you know, it just kind of leaves a big question mark as far as I'm concerned.

I appreciate it. I didn't mean to muddy the waters even more.

DIRECTOR KELLAR: Thank you.

MS. BREWER: Okay. Now I have more information for my question.

So I'm looking at the members of the workers' compensation advisory council, and I guess that my

concern as a patient advocate is that our goal is to return these workers to work. A large portion of that can be provided by physical therapy, a benefit of physical therapy or even nccupational therapy.

So I see on here that the members of the workers' comp advisory council are a chiropractic association member, a psychological association, a psychology association member, attorneys, a claimants' attorney, an employer attorney, Louisiana State Medical Society, five members of the general public, a representative from the LOA among others, but there is no physical therapy association or physical therapist on that council.

Is that going to be considered in the future?

DIRECTOR KELLAR: Joe Shine, a physical therapist, was on the workers' comp advisory council for a very long time.

The makeup of the council is legislative. So, if you think that a physical therapist should be on the committee, then that's probably something you need to address with your legislator.

We can appoint well, we can't, but the Governor has the option to appoint a physical therapist as one of the at large members and I think Joe Shine was one of the at large members from one of

the public service commissioned districts.

So the Governor has not appointed 17 people yet. I think he's only recently appointed eight. So, I mean, he could appoint a physical therapist. But, if you are interested in having a physical therapist represented all the time, that's probably something you should take up with your legislator.

MS. BREWER: Okay. So the LPTA would have to file a bill to request that physical therapy be added to the workers' camp advisory council?

MS. SALLEY: Yes, ma'am.

MS. BREWER: That's the only way? Okay. Or to be appointed by the Governor as a member at large?

DIRECTOR KELLAR: You can appeal to the Governor, who makes the appointments.

MS. BREWER: Okay. Just wanted to check. Thanks.

DIRECTOR KELLAR: Any further questions or comments?

MS. HARRIS: I did want to comment on the nice young lady which addressed the question about submitting a 1010.

If I'm understanding correctly, utilization review deemed that as medically necessary and then

approved it -- no.

Did they deny it, ma'am?

MS. WILKINSON: UR denied it, and then --

MS. HARRIS: UR denied it, and then the adjuster approved it.

So I've had that to happen before several times, and I was told by Office of Workers' Comp that it depends on the carrier because some adjusters have the capability to override.

However, Louisiana is a state where everything is conducted by a utilization review due to any services over $750, anything, it has to be processed through UR.

So that's a great question. What do we do when utilization review denies and the adjuster overrides? Which party is correct? Do we go with the adjuster for final say or utilization review?

Also, on the 1009s, once we submit the 1009s, as you all know, there's a notice on the 1009 that final approval must come from the adjuster. So we have to take -- for example, if the 1009 department medical reviewer deems the service medical approved, we take that decision, file the 1009 back to the carrier.

I have some carriers, as she stated, they

will not respond and I've probably had at least one carrier to deny or go against what the medical director advised, which is rare, and that ended up in court.

So my question is if you all can clarify this for me, because I've had some adjusters and maybe a few attorneys tell me oh, you do not have to send that 10 --your 1010 back to your adjuster; and it's right there on the 1009, determination, final determination must be received from your adjuster.

So that's two questions in one. I'm sorry.

DIRECTOR KELLAR: Mary Lou wanted to respond.

MS. SALLEY: Well, okay. You're specifically talking about the situation where the adjuster approves it on the 1010 form --

MS. HARRIS: Yes.

MS. SALLEY: -- but the UR had denied it?

MS. HARRIS: Yes.

MS. SALLEY: Okay. Y'all, I think that is a judicial confession. I'm sorry, that is an approval. Because under the administrative code, technically, the insurance company is an aggrieved party, and they would have to take the 1009 to undue their own approval.

I mean, that's, to me I'm not giving anybody legal advice, but that is the promise to pay the debt of a third party in writing. I'm sorry. That's judicial confession. You approve it on the 1010 form, honey, you're done.

Otherwise, to say otherwise renders the whole process null and void. I think, if you approve it, you have to appeal your own approval, which Dr. Picard I would assume you would lose.

But I don't -- I do not see how the 1010 form, the approval on it, is not a promise to pay. If you -- to say otherwise, why do we even have the procedure. If an insurance company is not held to what they approved in writing, I don't know why we even have this.

And, Director, you may want to comment on that, but I don't see how if you approve something on the form you get to go oh, I shouldn't have done that. When they deny it, that triggers my requirement to appeal it. If they approve it and then change their mind, they need to file the 1009 appeal. I don't see how they're not bound by that.

And somebody else may have a difference of opinion. But that's-- you're done. You've approved it on the state sponsored form where you are legally

required to either approve or deny it.

DIRECTOR KELLAR: Judge Smith, did you have a comment?

JUDGE SMITH: No.

MR. MILEY: This is John Miley again. My response to that would be, again, if -- and I have seen this.

I know you guys may not believe this, but I've seen when a procedure was disallowed-- not disallowed, but not approved in UR and the insurance company, for whatever reason, extenuating circumstances, approved it.

So, if that to me, that makes the distinction, because they don't have to go through with it because UR said yes or no or you know what I mean.

So, to me, it really, again, has to be evaluated for medical necessity. That's what the medical treatment guidelines are for. It defines what is appropriate per medical guidelines and evidence. And then there's an approval. So I don't

MS. SALLEY: The 1010 form -- the statute doesn't even provide for UR. The statute doesn't even provide for UR. It's not required. None of these people have to participate in this peer-to-peer junk.

It's not even required.

What is required is that the provider file the form. What's required is a yes or no or I don't know. What's required is an appeal of a denial or I don't know. That's all that's required. I don't -- there's nothing in the statute or the administrative code that an additional approval from the adjuster has to be obtained.

And I think what Latasha is asking is why on the 1009 when the medical director says yes, I believe this is contained within the guidelines, why is this statement on there that the healthcare provider has to get an additional approval? Is that your question, Latasha?

MS. HARRIS: Yes.

MS. SALLEY: I think that's her question. Because I think some of these adjusters are confused, and you've got two different situations going on.

MS. HARRIS: Yes, but that's definitely one of my questions.

MS. SALLEY: You've got the situation where an adjuster approves it on the 1010 form, but now says she's not going to pay for it. That's number one.

And then the question of, if you win the

appeal, why is this statement on a 1009 that you have to get an additional approval. I think those are two separate questions.

DIRECTOR KELLAR: I'm looking for the 1009.

MS. SALLEY: I think what Latasha is asking is okay, so you win the 1009. The director says yes, it's contained within the guidelines, but you have to get additional approval.

I think what she's asking is now do I have to go back and file a new 1010 and get the yes or no on the 1010 form.

MS. HARRIS: Because there's --

MS. SALLEY: What document -- what document do you get from whomever as the promise to pay?

MR. JACKSON: Mary Lou, I think you have to get a new 1010, because the employer and the carrier have the right to appeal.

MS. SALLEY: Right. But what do you do if that time delay-- let's say you don't. The 15 days expires.

Where are you legally? Are they bound by at that point is it res judicata? Is your client bound by what the director finds, or does Latasha

there are two separate questions, but they're intertwined. What document are we going to say binds the insurance company to pay?

It's a good question. It's a great question.

MR. JACKSON: Between the medical director's ruling and the 1010 form?

MS. SALLEY: Well, she's talking-- we've got two different factual situations here.

MR. JACKSON: Right. Well, I'm going off your second factual situation.

MS. SALLEY: Yeah. Okay. So let's say Dr. Picard says no, it's contained within the guidelines. This is my ruling. We know what's going to happen if you appeal it to the owe.

MR. JACKSON: Within 15 days?

MS. SALLEY: Right. We know what happens. I think what she is saying is let's say your client doesn't appeal it.

At that point is Liberty Mutual bound to pay for the surgery? Does she have to get additional authorization or something in writing?

MS. HARRIS: Because it's indicated to obtain --

MS. SALLEY: Right, because his 1010 -- this 1009 says yes, I think it's contained within the

guideline, but you have to obtain additional approval from Liberty Mutual.

MR. JACKSON: I understand that. And I'm not going to answer that question on the record.

MS. SALLEY: I know. I understand. It's a great question. It's that's

JUDGE LUNDEEN: Mary Lou, If you're using legal words, because we have a lot of doctors in the room, would you please explain what they mean.

MS. SALLEY: Res judicata?

JUDGE LUNDEEN: Yeah, res judicata.

MS. SALLEY: It means the parties are bounds by the decision. It means you don't get another appeal. You don't --

So the question on the floor, even though it's two different situations, is what document are we all going to say binds someone to pay?

You know, my personal opinion is you approve that on that 1010 form, that's a judicial confession. That means you say I did it, you know. That's what that means. You have now bound yourself by your own admissions.

The 1009 is a little bit different, because that's like a ruling from a Court. That is the director saying we believe it is contained within the

guidelines. That's different. So I think that's a really good question.

DIRECTOR KELLAR: You know, we'll look at it. I was looking for a decision letter, but I don't have one. I do have the 1009 with me, but not a decision. I think it is a good question.

MS. SALLEY: It is.

DIRECTOR KELLAR: It's something that we'll take a look at.

MS. SALLEY: But I do think, when an adjuster approves something on that form, they're bound by it because the administrative rules say any aggrieved party. So that would be an insurance company, an adjuster.

She would at that point have to file the 1009 appeal, or she's bound by it just like I'm bound by if it's a no.

DIRECTO KELLAR: Okay. Thank you.

Anybody else? Cathy, do you want to make any comments?

MS. CHESSON: Let me make a few.

DIRECTOR I\:ELLAR: Sure.

MS. CHESSON: I'm Cathy Chesson, one of the nurses in medical services, and the 1009s come to our department.

I want to kind of revisit what Mikal said at the beginning. Since the flood, we were inundated with 1009s. When we came back, we had a huge amount. So, in order to expedite the process, there are now five of us trying to data entry those 1009s.

So some of the problems we're seeing is that a 1009 is submitted on the facts but not in its entirety, and I'll give you an example. I pulled up one, and right up front it did not have a 1010 on it.

So you are all probably familiar with the front desk rejections. So it's not going to go any further than that. It's not going to come back to the nurses and wait for a rejection for a week later. So the clerical staff up front will send out a front end rejection.

Prior to the flood, there were only two people doing those data entries. So the two of them were going back and forth; and, if they did Mary Smith and then five down on that, here comes Mary Smith again, well, then, they see oh, they did it in two submission so there's the 1010 down there. They would catch it on the front end.

What's happening now is we have five of us putting in. So I grab one, go to look at it, no 1010. I'll send out my front end rejection. Well, then the

next four people do the next four. Then I'll pull up this next one and guess what, there's a second submission with just a 1010.

Now I got it, so I was able to reverse that front end rejection and go ahead and work the 1009. If Mikal would have gotten it, you would have gotten two rejections; one from me, then one from your other submission.

So it's really important and helpful and it expedites the process if you can send the 1009 in its entirety to us. These multiple and bits and pieces with as many as we're getting, you could submit it 15, 20 minutes later, an hour later, submit the rest of it, and guess what, there might be 15 more ahead of you. And we're not going to see it until sometimes the next day.

So please try and submit the filing in its entirety would be very helpful and expedite the process, because I know y'all get frustrated with the front end rejections and the back end rejections. So we don't want to reject, either. So, if you send in everything you need, we'll try and move those files along.

DIRECTOR KELLAR: Is there anything else from anyone else? Okay.

MS. HARRIS: Can you please -- I'm sorry.

DIRECTOR KELLAR: Go ahead.

MS. HARRIS: Can you all please address that compensability is not a -- not addressed in 1009 department.

DIRECTOR KELLAR: Causation.

MS. HARRIS: Yes.

DIRECTOR KELLAR: It's not addressed.

MS. HARRIS: It's not addressed.

DIRECTOR KELLAR: At the 1009 process.

MS. HARRIS: I just -- thank you.

DIRECTOR KELLAR: All right. Listen, thank you all very much for coming, and thank you for your comments.

As I said, we're going throughout the state having these Town Hall meetings to give providers and employees and employers, TPAs, URs an opportunity to tell us about their experiences with the medical treatment guidelines and the process.

We hear you. We're not unaware that there are problems. But you guys are in the trenches, and so we have experiences that we are not aware of. As a matter of fact, we've heard many of them here today and we thank you for your candor.

We have a court reporter who has recorded

everything that you've said; and, when we finish with these Town Hall meetings, we intend to go back and review the comments that you've made and to make some corrections to the 2715 process, which is the rule that implements the medical treatmerit guidelines.

If you think of anything or have any questions after today, we have other Town Hall meetings in your area, the one in Monroe is tomorrow. There's a list of the Town Hall meetings on the table. You're welcome to come to multiple Town Hall meetings.

There's a gentleman in here who was in New Orleans yesterday who promised me he would ask his questions today because he didn't ask them on Tuesday, but he didn't ask them today, either. So maybe he'll come to Monroe and ask them there.

But, if you are unable to come to any of the other Town Hall meetings, and you do have questions or comments, please feel free to contact us.

Again, if you go to Laworks.net, you can find a number or an e-mail address for each of us and please feel free to contact us and give us more insight into your challenges and regards with the medical treatment guidelines and its process.

Thank you. Thank you all very much for attending.

(Whereupon, this proceeding was concluded for the day)

* * *

C E R T I F I C A T E

STATE OF LOUISIANA:

PARISH OF CADDO:

I, Donna B. Crenshaw, Certified Court Reporter in and for the State of Louisiana, as the Officer before whom this proceeding was taken, do hereby certify that the proceedings were reported by me in the stenotype method, was prepared and transcribed by me or under my personal direction and supervision, and is a true and correct transcript to the best of my ability and understanding; that I am not related to the parties herein, nor am I otherwise interested in the outcome of this matter.

SUBSCRIBED AND SWORN TO on this the 26th day of September, 2016.

C\ JJ \JNJ

Q,onna B. Crenshaw
Certified Court Reporter

(318) 425-1323

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