WORKERS COMPENSATION
ADVISORY COUNCIL MEETING

Members Present:
Patrick Robinson (Chair)
Joe Shine
Denis Juge
Michael Morris
Troy Prevot
Clark Cossé, III
Dr. Dan Gallagher
Bob Israel

Members Absent:
Mark Kruse
Eddie Crawford
Dr. Jim Quillen
Ray Peters
Greg Hubachek
Dr. Hank Eiserloh
Joesph Jolissaint
Chuck Davoli
Julie Cherry

AGENDA

- Call to Order at 9:35am

- Michael Morris moved to update agenda. "Agency Update" prior to "Draft Formulary Proposal" due to technical difficulties.

- Agency Update [time stamp 9:58:00]
  - New Second Injury Fund Executive Director
    - Dan LaStrapes replaced Pauline Williams
  - Status of Medical Director Review Process
    - Judge Johnson issued injunction in July. Currently under suspensive appeal. Hearing scheduled for Monday to discuss plaintiff's request to convert to devolutive appeal.
  - LWC Educational Conference- January 21-22, 2016

- Announcements [time stamp 10:00:50]
  - Nov. 10th "Ethics, Professionalism and all that Jazz" CLE provided by WC section of Baton Rouge Bar. Reception afterwards.
  - 1st week of November declared Kids' Chance week. Business asked to recognize and do something to support it like blue jean day, etc to collect donations. They can be sent to liaison, Michelle Sorrells, at Louisiana State Bar Association.

- Draft Formulary Proposal [time stamp 10:03:10]
  - Need to address problem of workers' being out of work longer than anyone else. Benefits to getting back to work faster:
    - Employees- back on job and recovered from injury
    - Employers- have their employees back
    - Insurance Carriers- resolve claims faster

- Number to look at is amount of narcotics prescribed. LA & NY listed as worst.
- Formularies currently in other states: TX, OK, WA, OH
- Speaker, Ken Eichler with Work Loss Data Institute [time stamp 10:07:00]
    - TN & AZ have adopted formularies and are currently going through promulgation of regulations. TN goes live in January.
    - Center for Disease Control (CDC) stands behind evidence-based medicine.
    - Goal: improve patient outcome. Cost saving is by-product.
    - Group health defined coverage with defined benefits. Coverage limited. Workers Compensation bound to provide any treatment which includes meds that benefits injured worker.
    - Y and N category. "N" means "needs authorization". Y does include narcotics and opioids but for short term use. If something outside guidelines, doctor has to prove necessity.
    - Blind to cost except generic vs. brand. If patient allergic to generic, doc can document to get patient brand.
    - **Slide 9**
    - **Slide 10:** TX had a 62% drop in prescribing meds after implementation of guidelines. Normally, it would have taken longer to say no than to say yes to a patient. This due to patient would argue and give a dissatisfaction review. This affects pay, etc.
    - Payor- cost more to fight authorization.
    - U.S. consumes over 90% of oxycontin in the world.
    - **Slide 12**: against compounds unless medically substantiated. It will address active ingredient.
    - **Slide 23:** Cases- Son overdoses on fentanyl patches and pills; infant dies from contact with mother's hands that possibly had residue from topical compounds with narcotics.
    - **Slide 24:** Only one insurance company sends a safe to patients on narcotics for more than 3 months. Dangerous parties where people take meds from a bowl of random pills and shot it down with vodka or beer. Real Estate broker in CA arrested from stealing meds at open houses.

- Formulary addresses drugs by class, generic/brand, and NDC codes. NDC code doesn't mean FDA approved it.

- Compounds not always topical. Compound pills tend to be a pain med, anti-inflammatory and vitamin mix. Only a need if it can be substantiated that patient can only swallow 1 pill versus 3.

- MEDs (morphine equivalence). Low, Mid, and high levels

- MSAs- all drugs prescribed in a 2 year period have to be included

- Chart can go on state website with no charge. You can click the link straight to the evidence. Publisher doesn't determine recommendation.

- Advisory Board reviews studies.

- **Slides 13-17**

- **Slide 19-21**

- **Slide 26:** Also, problem with pharmacy monitoring programs is not real time. Drug seeker can go to 4-6 doctors and fill all prescripts at independent pharmacies. It won't hit until 24hrs to 7 days later.

- **Slide 27**

- **Slide 29:** complementary access setup. Can be integrated into claims systems, EMR systems or physician systems.

- In California, AB-1124 hit {Senate} floor in 2 weeks, so they can adopt the formulary. NY is also working on a formulary; will be meeting in September.

o Commentary: [time stamp 10:31:17]

- **Trey Mustian** [*audience*] - How much does it cost the state?
  - Response by **Ken E.** - cost the state nothing. State would get free access. Most payors in state already have subscriptions to ODG. Payor community would have minimal costs. Physicians would be about $50/year subscription. Similar to use of Lexis Nexis or Westlaw. What it cost in a year saves that much time a year.
  - **Trey M.** [*audience*] - what about license fees?
    - Response by **Ken E.** - free license to post chart on website like all states.
- *Audience Member*- What about patients that have been on medicine for years?

- Response via **Ken E.** - doesn't cut people off. There's a chapter on weaning and tampering. It's not just narcotics and opioids that need weaning; it also covers psychotropics and steroids.
    - *Audience Member*- after you wean, then what?
        - Response via **Ken E.** - hopefully physician will look into what is needed. Biggest denials come from lack of documentation from physician to payor.
        - Response via **Will Green** [*audience member*]- it's all about education

- *Audience Member*- If giving to state for free, who's paying? Where's loyalty?
    - Response via **Ken E.** - Loyalty in creating objective guidelines substantiated by evidence. Payors don't mind state getting it posted in the website. Louisiana regulations allow application of evidence-based guidelines where the current guidelines are silent or out of date so majority of payors already have subscription. They don't mind docs getting it cheaper since it facilitates the process.
      Currently only commercial formulary. Differences from PBMs is standardization. PBMs is more clinical focus.
- *Audience Member*- What is maximum recommend morphine levels?
    - Response via **Ken E.** – yellow, red, or black flag. Yellow is 60-80mg. This is when it should be looked at. Red is 100mg. Black is 120mg and really needs to be looked at.
      Drugs.com gives an extensive list on drug interactions. Can enter 15-20 drugs to see possible interactions.
- **Dr. Dan Gallagher**- Have any states that have used this, been able to change from Y to N? If so, did they have to go through your board or can the state use theirs?
    - Response by **Patrick Robinson**- Proposal has provision for MAC to look at the drug changes.
    - Response by **Ken E**. – when state accepts plan, we engage with the medical advisory board. Viewers not allowed to communicate with those that submit evidence. Changes have been made based on feedback and way guidelines are written have changed. California recently requested a section on "risk vs benefit".
- *Audience member*- What other states are using ODG formulary?
    - Response by **Ken E**. – TX, OK, AZ, TN. Ohio wrote their own. WA has their own. WA is a monopolistic state which state fund is carrier. WA adopted a formulary that is not exclusive to workers' comp. It is for all prescribing. It is a very short list and overly restrictive for any other state workers' comp.
- *Audience member*- What didn't Ohio go with ODG?
    - Response by **Ken E.** – Ohio decided to go with a short list.
        - **Patrick**- isn't OH and WA more restrictive than ODG?
            - **Response by Ken** E. - Yes. OH is also a monopolistic state.

- *Audience member*- How is short term vs. long term distinguished in formulary.
    - **Response by Ken E**. - It's in the recommendations. You have to look at evidence behind list. This is why narcotics, opioids, and muscle relaxers listed under Y. To get long term, you have to substantiate with documentation as indicted.
- *Audience member*- How do you get a variance?
    - Response via **Dr. Roy Lee** [*audience*] – No. You can get variance just most doctors don't submit documentation with request. Current evidence disagrees with doctor's request. No good long-term evidence based studies (other than cancer) for opioids in workers compensation. Code does allow for variances.
    - Response via **Ken E.** – docs normally submit answer that's just "I said so". When doc clicks on drug then the studies will show support.
    - *Audience member* – IWP says it's almost impossible under ODG in TX to get a variance.
- **Dr. Roy Lee** [*audience*] - most opioids should be proven necessary after a month of usage.
- *Audience member*- is weaning addressed in guidelines.
    - Response by **Patrick**- if not in guidelines, submit evidence or peer review literature.
    - *Audience member*- how is an adjuster supposed to know? Most just cut off if not on list.
    - **Dr. Roy Lee** [*audience*] – this issue isn't only in workers' comp.
    - **Dr. Dan Gallagher**- not as easy as it seems**.** Can never wean in 2 months.
    - **Ken E.** – AHRQ may be going away in 2 years due to federal possibly pulling funding.
- **Ken E. -** Depending on jurisdiction, legacy claims may be given up to 2 years after implementation to address the issue. Data shows transitions usually happen within the last 6 months of period no matter how long given.
- **Patrick**- Why so many opioids? ODG can update while we lack the staff to keep updating.
    - **Ken E. -** don't write; simply review and rank evidence. Update quarterly.
- **Dr. Dan Gallagher**- formulary then have MAC review
    - Response by **Patrick**- We need to add pharmacists to MAC. Statute does protect MAC from lawsuits.
- **Jan Barber** [*audience*] - clarification on long term study for opioids
    - Response by **Dr. Roy Lee** [*audience*] – just go through certain steps as listed in guidelines before you make them an addict.
- **Jan Barber** [*audience*] - What's number of people that die from an overdose in LA? Is it even a problem?
    - **Patrick**- is the problem that they die or that we medicate so much they can't function.
- Priority should be on retraining→ Voc. Rehab
- **Patrick**- drafted the rules

- **Dr**. **Roy Lee** [*audience*] - opioid is cheap in generic form.
- **Brian Allen [***audience***]** - spoke about PBM in TX with regard to legacy claims.
- **Troy Prevot**- guidelines need to be updated if go to universal formulary.
    - **Response by Patrick**- currently allow drugs N which people use PBMs that have their own formularies and they differ.

- *Wilson vs. Broadmoor, LLC* (La. App. 4 Cir. 2015)/Utilization Review [time stamp 11:26:52]
    - Deferred to September meeting
    - Denis Juge motioned; Dr. Gallagher second

- Public Comment

- Adjourn at 11:30am
    - *Motion*- Clarke Cossé ;*Second*- Troy Prevot

* Call in Option - **(888)278-0296,** code number **4203265**. **Please mute your telephone to avoid any interruptions**.