TOWN HALL MEETING
MEDICAL TREATMENT GUIDELINES

Held on Friday, September 30, 2016
At the Louisiana Department of Insurance
Plaza Hearing Room
1702 N. 3rd Street
Baton Rouge, Louisiana

REPORTED BY: KELLY S. PERRIN, C.C.R.

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JUDGE DIANE LUNDEEN

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FREDA CHAUCER, MEDICAL SERVICES SECTION

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DANIELLE JAFFEE, INJURED WORKERS PHARMACY

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P R O C E E D I N G S

JUDGE KELLAR:

Good afternoon. I'm Sheral Kellar. I'm the Director of the Office of Workers' Compensation. I hope everybody signed in. If you did not, please do so.

I want to thank you all for coming. I was recently appointed Director of the Office of Workers' Compensation after having served as the Workers' Compensation Chief Judge for 17 years. And it had not been unnoticed during my tenure as Chief Judge, nor as the Director that the medical treatment guidelines need some work. And so we have been going around the state for the last couple of weeks to hear from the folks who deal with the medical treatment guidelines who do the 1010s, the 1010As, and 1009s, the 1008 appeals to try to find out what problems you're having with navigating that system.

We want to make it work for you. We understand that some things are broken, and we want to fix them. But you're the guys who are in the trenches. And so we want you to have an opportunity to tell us what you think we

might be able to do better, what you think we might throw out, what you think we might just tweak. I have some staff from the Office of Workers' Compensation and from District 5, the Workers' Compensation Court here with me today who are going to listen to your grievances. And we will maybe not be able to give you the answers that you like, but maybe we can give you some direction of how to navigate the system better.

I have on my immediate left the Chief Judge, Diane Lundeen. To her left is the Medical Director, Dr. Jason Picard. Then, we have Pam Laramore, the judge in District 5, the Baton Rouge office. Next to Judge Laramore is Denise Lee, the Mediator in the District 5 Office. And next to her is Freda, who is a member of the Medical Services section in the Baton Rouge office.

Freda actually sees your documents when you file a 1009 appeal to the Medical Director. So as we proceed through this afternoon, she's going to tell you some of the things that she sees that would help her; that she sees and does not see that would help her

to put those files together better before they are sent to the Medical Director for his review.

On that table, we also have some statistics from the medical services section from March 2016 to date. We chose March 2016 because that's the date that Dr. Picard became the full-time Medical Director. And as you can see, he has a 70 percent approval rate. When you file a 1009 appeal with him, he approves 70 percent of the requests for appeal that he receives and 30 percent of those he denies.

I'm going to give him an opportunity to address you as well. And he will tell you some of the things that he sees that cause those denials and some of the things that he sees which assists him in approving your request for medical treatment.

As you can see, we have a court reporter here today. Throughout the state, we have been taking recorded statements of these Town Hall Meetings, because what we want to do is at the conclusion of this one, our last one, we're going to go back to the office and read

all of the comments that you've made about the problems you're having with the medical treatment guidelines process and use those comments to try to make it better for you. We want the medical treatment guidelines to be user-friendly. We do know that there are problems.

So we have a court reporter who is going to take your comments. And we have Michael Pippins, who is an IT guy in the back of the room. Michael has a handheld mic. And when you speak, I'm going to ask you to first identify yourself, tell us who you represent, and then speak slowly and clearly so that the court reporter can get your comments down.

If you have cell phones, I'm going to ask you to put them on silent, vibrate, or stun, whichever you prefer. In deference to everyone in the room who may want to make a comment, I'm going to ask you to keep your comments to three minutes, but you may speak multiple times.

But just don't hog the mic, just three minutes and then let's move on to the next person, and then we can come back to you.

We're not going to necessarily answer all of your questions today. And if we do answer some, there may be some answers that you don't like. But this is not an opportunity for us to -- this is an opportunity for you to talk. You guys are in the trenches. You do this every day. I see some attorneys in the room. I see some health care providers. You're dealing with the 1010 process every day, so you know things from your perspective that we don't know.

It's amazing that throughout these Town Hall Meetings, some of the problems have been repeated. And I'm sure we're going to hear some of the same things that we've heard in other cities. But we've also heard new things as well.

So this is your opportunity to talk to us. Some of you call us individually, but now you have our undivided attention. And you will not get this always, so I ask you to take advantage of this opportunity.

So with that, I will open up the floor. Yes, sir? Mic?

DR. ZIMMERMAN:

My name is Peter Zimmerman. I'm a practicing physician in Baton Rouge. I've got a number of questions. But the first one that I'd like to address is, when carriers check off the under box and list as their reason that they're still investigating whether or not claims are job related or not, these investigations seem to go on for months and months in an attempt, at least in my understanding, to starve the patients into settling. I'm wondering what recourse we have and how best to address that situation?

JUDGE KELLAR:

This is on the 1010 form, and you have, I think, three boxes. One says, for causation. Are there --

DR. ZIMMERMAN:

Not in accordance with the medical guidelines, not job related, not compensable, and other.

JUDGE KELLAR:

Okay. If -- and you submit it to the UR; right?

DR. ZIMMERMAN:

We submit a 1010 form. The check off box

comes back, other; the investigating -- still investigating compensability of the claim, and that goes on for months in an attempt to get to a 1008 without ever having to address medical guideline issues.

JUDGE KELLAR:

So is your request for treatment denied at that point, because other is checked off?

DR. ZIMMERMAN:

Other takes it out of the medical treatment guidelines and into a 1008 issue. And but it's -- it's not that they've challenged compensability. They have said, we are still looking into this. But it goes on forever.

JUDGE KELLAR:

Well, what we've heard around the state is that not that specific scenario, but we've heard the scenario where the 1010 moves through the process to approval by the Medical Director.

DR. ZIMMERMAN:

No, ma'am.

JUDGE KELLAR:

By the Medical Director.

DR. ZIMMERMAN:

It's not allowed to.

JUDGE KELLAR:

I have no -- I understand.

DR. ZIMMERMAN:

We don't get an --

JUDGE KELLAR:

I understand.

DR. ZIMMERMAN:

Okay.

JUDGE KELLAR:

I understand. It moves through the process to approval by the Medical Director, and then the payor raises the issue of causation. I'm not aware that the office is receiving those that say other.

Have you seen that, Freda?

MS. FREDA CHAUCER:

In the past.

JUDGE KELLAR:

Use the mic.

MS. FREDA CHAUCER:

Not recently since the people have been investigating the Medical Director have we seen under investigation. If so, the front

desk, who receives the 1009, if it's being sent back so that they're rejecting it on the front end, have you gotten that rejection recently on that?

DR. ZIMMERMAN:

Within the last two months, yes, ma'am.

MS. FREDA CHAUCER:

I think it is --

DR. ZIMMERMAN:

I can identify the individual carriers if you'd like. I know exactly who they are. LUBA does that and LCI does that. So it's very specific and it's a very clear tactic that they take.

JUDGE KELLAR:

I was not aware that when the box other is checked that it's sent back to you, because we have a system now where if the 1009 appeal -- because I'm assuming that's what you mean, the appeal?

DR. ZIMMERMAN:

No, ma'am. I mean the 1010.

JUDGE KELLAR:

Okay. See, yeah, it's --

DR. ZIMMERMAN:

We're not allowed to get to a 1009 at that point because it's not --

JUDGE KELLAR:

Okay. Then --

DR. ZIMMERMAN:

It's not within the medical guidelines. It's taken out of the medical guidelines by checking other. And the prior director viewed that as -- viewed that as non-compensable or putting compensability at issue.

JUDGE KELLAR:

I don't know what that means, I really don't. But at that point, I think your only recourse would probably be to file a 1008 with The Court.

DR. ZIMMERMAN:

But that defeats the purpose of the --

JUDGE KELLAR:

It does.

DR. ZIMMERMAN:

-- expedited nature of the process.

JUDGE KELLAR:

I think it does defeat the process, but we don't even see that is what you're telling me?

DR. ZIMMERMAN:

Yes, ma'am.

JUDGE KELLAR:

So --

DR. ZIMMERMAN:

So what I'm wondering is, is there any way to time limit investigations of compensability?

JUDGE KELLAR:

I don't know that, an answer to that question, but it is an issue that we can take under advisement. Okay?

DR. ZIMMERMAN:

(Nods head.)

JUDGE KELLAR:

Thank you for bringing that to my attention. Now, that is the first time we've heard that one. Thank you.

DR. ZIMMERMAN:

(Nods head.)

JUDGE KELLAR:

Dr. Zimmerman, can you tell us what your field of specialty is?

DR. ZIMMERMAN:

Pain management. I work at Louisiana

Medical Clinic in Baton Rouge.

JUDGE KELLAR:

Thank you. Anybody else?

MR. PROCELL:

My name is Paul Procell from Shreveport, Louisiana, occupational therapist. Is there any other therapists in the room? Raise your hand. Okay. I represent all the therapists in Louisiana.

First question I have is, as a therapist, I'm getting some feedback from certain attorneys in my area that I cannot fill out a 1010 on behalf of a patient unless the patient gives me their consent. So a doctor refers a patient to me, the insurance carrier, nurse case manager, insurance adjustor, and they want me to fill out a 1010 and submit it to them. And is it legal for someone to fill out a 1010 without the patient's consent? Have y'all heard this one before?

The background of this would be that certain attorneys are trying to manipulate where the people go for functional capacity evaluation. And if you force it to receive approval or consent by the patient, then you

can somehow direct or manipulate the course of where these functional capacities are being performed. So my question is, do I need a consent from the patient to fill out a 1010?

JUDGE LUNDEEN:

So you have two questions here. You have two issues. But first, let me address the second issue, and this may or may not be the answer. But medical treatment guidelines are designed to be mandatory for any workers' comp patients. So if you are treating a workers' comp patient, you have to use this form.

So it's not about the consent of the patient. This is the legal mandate created by our legislature that is a tool that you have to use to get medical care for them, if they are there because they've had an occupational injury and are filing under workers' compensation.

You may have a different answer if they come to you. It's undetermined if they have had an occupational injury or claiming a workers' compensation compensable claim, and they present to you under a private insurance company. That's a very different scenario.

MR. PROCELL:

That would be the case with me. I would not get the referral unless it came from the treating physician and they provided me the contact information, work comp information and so forth. So every patient I'm discussing is a workman's comp claim with a claim number that's been processed.

JUDGE LUNDEEN:

You're legally obligated to use this form.

MR. PROCELL:

I understand. I got that part.

JUDGE LUNDEEN:

There's nothing in the statute that indicates, at least that I am aware of, that indicates that you have to have the patient's consent to do what the legislature has told you have to do.

MR. PROCELL:

Thank you. Second thing is, since I do functional capacity evaluations, I've been having issues with a certain insurance carrier in the state, and I've mentioned LUBA, that a functional capacity evaluation is usually 24

units. Before the state went to units, they were doing it by the hours. I've been in business since 1989, so six hours. Once the state went to units, four units -- a unit is 15 minutes, so basically 24 units.

Now, LUBA is saying they're only going to approve 14 units. You do the 1009, you appeal it. It goes to you guys. And the next thing I know is that it gets denied, and that a 14-unit functional capacity evaluation is acceptable.

What I would like to discuss with the panel is that there's no such thing as a partial functional capacity evaluation. When a patient goes to an orthopedic and does the evaluation and they have an assigned body part, they're doing a full evaluation of that injured body part. When they come to me for a functional capacity evaluation, I have to do a full evaluation.

So I'm wondering or maybe to educate, because I'm not sure if there is a therapist on your Board to determine partial and full functional capacity evaluations. Is there a therapist that that information has been

shared with? Is there a therapist?

JUDGE KELLAR:

The Medical Director makes the decisions on all 1009 appeals, regardless of what field of specialty there is.

MR. PROCELL:

So there's no such thing as a functional function capacity evaluation. You have a functional capacity evaluation and a work screening tolerance. A functional capacity evaluation is, once a patient has achieved maximum medical improvement, they've achieved maximum rehab potential, then you do a functional capacity evaluation.

A work screening tolerance is done in the process of them achieving MMI, achieving maximum rehab potential that you're trying to determine that they can return to work at some capacity, but that is a partial -- a work screening tolerance. That is not a functional capacity evaluation. So I would suggest cleaning up the definition of a partial FCE.

JUDGE KELLAR:

Yes, sir?

DR. PICARD:

The guidelines don't specify partial versus full FCE. So if you're addressing an FCE and it is appropriate and it was denied due to what you're describing, it would be approved by me or back to me. We can't do anything about what the insurance companies do on the front end about things like that. I can only look towards what to do when it gets to me.

And I look at what the guidelines say. And there is no delineation between those two things. You either do an FCE or you don't. And if it's appropriate, then you would approve it and we would consider limiting the amount of hours and things of that nature.

MR. PROCELL:

The previous medical director has approved partial functional capacity evaluations, so ...

DR. PICARD:

That's kind of --

MR. PROCELL:

I just got stuck with one this past week so I would submit that.

JUDGE KELLAR:

Have you received the partial functional capacity evaluation since March?

MR. PROCELL:

Last week, yes, ma'am.

JUDGE KELLAR:

From Dr. Picard?

MR. PROCELL:

I didn't appeal it. I just went ahead and did the evaluation because it was on a timing basis, because previous ones I had -- I was unaware of the new medical director -- in the past when you submit them, it's denied. So in the future, I'm going to try it again. And but I would just ask you to consider, there's no such thing as a partial functional capacity evaluation.

And in the guidelines with LUBA, they're asking that you only reimburse 14 units versus 24 units. And there's no way you could do a full functional capacity evaluation in that short a period of time. Because when I go through depositions, my findings are going to be shot out of the water.

DR. PICARD:

If it's not specified in the guidelines,

then I wouldn't deny it on that basis. If it's not specified that there is such a thing as a partial functional capacity evaluation to specify functional capacity evaluation and you make a decision on what that entails, then I would approve it.

MR. PROCELL:

Well, the referring physician would write on the script, functional capacity evaluation.

DR. PICARD:

Right.

MR. PROCELL:

So they don't need to put full or anything. A functional capacity evaluation has its own definition.

DR. PICARD:

I agree.

MR. PROCELL:

Thank you.

JUDGE KELLAR:

Let me go back to Dr. Zimmerman for a minute. I've been looking at the 1010 form and in Section III, Responsive Care and Self-Insured Employed for Authorization. And what it says is the requested treatment or

testing is denied because, other.

DR. ZIMMERMAN:

Yes.

JUDGE KELLAR:

That's a denial, which means that at that point, you're required to appeal to the Medical Director --

DR. ZIMMERMAN:

No, ma'am. The only way you can get to the Medical Director is if it's denied based on not consistent with the medical guidelines, the first check off box. Boxes two, three, and four do not allow you to get to the Medical Director. They take you to a 1008.

Boxes two, three, and four are non-compensable, not job related, or other. So they're not inconsistent with the medical guidelines and they don't get to a 1009.

JUDGE KELLAR:

The four boxes are not in accordance with the medical treatment schedule. The second one is the request for a portion thereof is not related to the on-the-job injury. The third is the claim is being denied as non-compensable. And the fourth one is other.

And it says, attach brief explanation.

DR. ZIMMERMAN:

And then, if you check off boxes two, three, or four, you do not get to a 1009. The only way you get to a 1009 is if you check off box number one.

JUDGE KELLAR:

Okay.

MS. FREDA CHAUCER:

I'm -- I guess I'm not sure what he was referring to what -- it says, a brief explanation, because other, other has been checked on the 1010, and it does go to the Medical Director.

DR. ZIMMERMAN:

Not if they put compensability at issue.

JUDGE KELLAR:

If compensability is at issue --

MS. FREDA CHAUCER:

Well, that's --

JUDGE KELLAR:

-- no, it does not give them medical.

DR. ZIMMERMAN:

So but the point is to not allow them to fudge and say, we don't know whether

compensability is an issue or not. My preference would be that if compensability is the issue, that they check off non-compensable. They don't.

What they do is, they check off other and they say, we're still investigating whether compensability is at issue or not. And then, they go on and take months to make that determination.

JUDGE LUNDEEN:

So what you're saying, Doctor, is that they've actually created a new category of non-compensable by checking off other and saying we're investigating its compensability, when they should have checked off non-compensable or undetermined as compensable?

DR. ZIMMERMAN:

They haven't been -- their feet haven't been forced to the fire --

JUDGE LUNDEEN:

Right.

DR. ZIMMERMAN:

-- by taking and saying we have placed compensability at issue. They have simply

said, we are investigating and it takes -- and they go on and on and on until they finally get to a 1008. They depose and they try and investigate the patients over time. And they use that to not have to pay for medicals in the meanwhile. And they use that to not have to pay for benefits in the meanwhile when they haven't determined whether compensability is at issue or not.

JUDGE KELLAR:

Has anybody in the audience seen a 1010? Yes? Yes, ma'am? Can you stand up and identify yourself, please, ma'am?

MS. ROBERTSON:

I'm Melinda Robertson.

JUDGE KELLAR:

Hold on just a minute.

MS. ROBERTSON:

Melinda Robertson, I'm the Workers' Comp Coordinator for the NeuroMedical Center. And we do a lot and I see that a lot, and that's just to stop the process where we can't do anything and the patient is sitting waiting for treatment, but they're not making any decisions. So we can't send a 1009 because

they're going to reject it for being -- for compensability.

JUDGE KELLAR:

"Compensability"?

MS. ROBERTSON:

Yeah. We're stuck.

JUDGE KELLAR:

So you get the 1010 back from the payor and it says, other?

MS. ROBERTSON:

And it says, claim under investigation. And we're waiting months to -- and we can send it again and they'll keep over and over, and the patient is not getting the care they need because they're investigating.

JUDGE KELLAR:

And when you've sent those in to the Office of Workers' Compensation Medical Director, they've been rejected?

MS. ROBERTSON:

Well, when we first started doing it, we were doing it that way when the guidelines came around. But once we realized it wasn't going to get through, we don't waste our time.

JUDGE KELLAR:

Okay. Thank you. Thank you, ma'am.

MS. LEE:

I've seen instances where insurers will pay for claims, even though they are being investigated; maybe not everybody, but some of them will. And, of course, it's unfortunate if there's something they learn that would make them cut off the benefits, but I would give it a shot. There are a few who will pay for claims while they are being investigated.

JUDGE KELLAR:

Yes, sir?

DR. ZIMMERMAN:

My second issue that I'd like to chat about is when carriers create rules not in the guidelines; specifically when they impose requirements not in the guidelines. For instance, if I get denied as not in accordance with the medical guidelines and I call in and I ask for a voluntary reconsideration, Carrier A may say, we will only allow you voluntary reconsideration if you provide additional medical documentation. Carrier B may say, we will not consider any additional medical documentation when we have -- when you have

voluntary reconsideration.

So there are inconsistent rules amongst carriers for the right to have voluntary reconsideration when neither of those requirements are part of 2715I. So they impose rules not in the guidelines and they are inconsistent so that LWCC will say X, and Novare will say Y, and it depends on the carrier as to whether or not, I guess, how we respond.

JUDGE KELLAR:

Thank you. There are also inconsistent rules imposed by carriers on things that are not required by the medical treatment guidelines, so 2715 in other areas as well, but we were not aware of that one.

DR. ZIMMERMAN:

Additionally, and I'm curious particularly with LWCC as to their ability to impose a formulary when no formulary within the guidelines exist; so that if I write for a branded medication, I receive a denial from Dr. Beau -- or Dr. Clark, I should say, advising me that they will only pay for generics and that they will -- I will either

need to submit a 1010.

So I write a prescription, that gets turned down. I then submit a 1010, that gets turned down. I have voluntary reconsideration, that gets turned down. And then I finally go to a 1009 where the Medical Director approves it. But by then, the patient has waited in excess of 30 days for the medication, when in fact, there is no formulary that they can hang their hat on.

JUDGE KELLAR:

Thank you. Yes, ma'am?

MS. ROBERTSON:

I have a question about the 1009 after it's approved. It states that the 1009 is not a guarantee of payment. So what we do is we go back to the carrier, send them the 1009 approval, along with a new 1010 so that they can send us the approval. However, we're waiting upwards of months to get those back.

Is there a certain amount of time they have to respond to us after getting the 1009 approval?

JUDGE KELLAR:

There is currently no period of time

written into the rules regarding how long it is they have to approve the procedure once it's been approved by the Medical Director. We've heard this question in other cities. And our response has been to file a 1008 appeal.

Yes? Go ahead.

JUDGE LUNDEEN:

Under the Workers' Compensation Act, an employer or its insurer has 60 days' written demand to pay for medical bills. We don't -- we don't have any cases yet that have tried that, but we are getting cases where the Medical Director -- and we're hearing some of the state -- the Medical Director approves something and then people sit around waiting for the insurer to actually provide that medical care.

Arguably, you could file a motion to -- a 1008 with a motion to enforce in that 60-day rule, potentially applying for either penalties and attorneys' fees depending upon the circumstances of the case to enforce that decision. But I don't think that they can circumvent that 60-day certainty and that

doesn't help the patients in need, because that's 60 more days after the medical treatment guideline process. But it is sort of a finite window. It's not clear yet though how to do this.

JUDGE KELLAR:

Well, you see, the first time we've heard that complaint is during these Town Hall Meetings. And we had no clue that the Medical Director would approve a treatment and then the payor would not pay it. I personally don't feel that you need to send another 1010, together with the 1009 approval to get them to authorize the treatment. But as I said, one of the reasons we're here is to find out what your issues are and try to fix them.

These Town Hall Meetings have revealed to us that our medical treatment guidelines lack enforcement power. And so that's one of the things that needs to be written into the rules to enforce once the Medical Director gives an approval, that needs to be enforced so that you don't have to file a 1008.

Because as Dr. Zimmerman pointed out and as we all here know, the medical treatment

guidelines are intended to be quicker, faster to get the treatment to the injured worker. So if you're having to file a 1008 to enforce what we intended to happen in the first place, then we're failing. You know, we're failing. So thank you. We've heard that one numerous times.

Yes? Yes, ma'am?

MS. TARKINGTON:

Hi. I'm --

JUDGE KELLAR:

Just a minute.

MS. TARKINGTON:

Hi. I'm Cris from Capital City Chiropractic. I have a question. When you fill out the 1010 form, we send it in. It gets approved. The Code that I'm using is a 97124, which is a massage therapy code.

For every 15 minutes is one unit. And I put four units on the side of that code. It gets approved, then the payor doesn't pay it. It's just denied. It doesn't have a medical explanation by it or anything.

So, therefore, by the time I get that denial back, that could be two months, and

they've had ten massages by then. And so they're all getting denied. What do I do in that circumstance?

JUDGE KELLAR:

So the Medical Director is approving the requests?

MS. TARKINGTON:

Yes, ma'am.

JUDGE KELLAR:

And then the payor denies --

MS. TARKINGTON:

Just that code, yes, ma'am.

JUDGE KELLAR:

Well, again, you're in the same position where you have to enforce the Medical Director's approval through the 1008 process. Because, currently, there's nothing in the rules which allow you to do anything further. There's nothing in the rules that say, once the approval is received from the Medical Director, the payor has 60 days to approve or they'll be assessed a penalty and attorneys' fees. There's nothing in the rule that says that. So that is an issue that we will be addressing so that when the Medical Director

gives an approval, it can be enforced.

MS. TARKINGTON:

Okay. Also, I have a question when the patient has an attorney and it's a workman's comp case, everything goes through the workman's comp process. If a workman's comp carrier keeps denying that claim and I cannot get it paid, is the attorney or the patient responsible for that care that didn't get paid?

JUDGE LUNDEEN:

No.

MS. TARKINGTON:

No? Okay. That's what I thought. I just wanted to --

JUDGE KELLAR:

I -- somebody over here said no, but they need to say it verbally.

JUDGE LUNDEEN:

No. In fact, Tulane Medical Center in New Orleans got dinged for doing that because you can't go beyond the fee schedule of the Workers' Comp Act. And while a claim, even if it's compensability is being denied, you can't seek payment from both sources and charge the

whole in excess of the fee schedule to the injured worker or if he's been guaranteed by somebody else like an attorney to the attorney.

MS. TARKINGTON:

Yeah, I just wanted to --

JUDGE LUNDEEN:

Be careful of that. You can actually get penalized for that as a medical provider.

MS. TARKINGTON:

Okay. I thought so, but I just wanted to make sure that I was understanding it correctly. Thank you.

JUDGE KELLAR:

Thank you, ma'am.

DR. ZIMMERMAN:

I have another.

JUDGE KELLAR:

Please, Dr. Zimmerman, go ahead.

DR. ZIMMERMAN:

So, recently, I had a case where I called seeking voluntary reconsideration after being denied on a 1010. I called and spoke to the nurse case manager and the adjustor who claimed that, because the patient was

represented by counsel that they were not able to speak with me to allow for or deny a voluntary reconsideration. I'm curious whether that's a reasonable response.

JUDGE KELLAR:

Generally, if someone is represented by an attorney, you speak through their attorney. That's generally.

DR. ZIMMERMAN:

The nurse case manager -- so the patient's attorney needs to request voluntary reconsideration in order to allow me to then speak to the adjustor or the nurse case manager?

JUDGE KELLAR:

I can't make the rule generally about that at this time. But, generally, if someone has an attorney, you need to speak to their attorney. We're finding that there's a lot of gamesmanship going on with the implementation of the medical treatment guidelines. And so what we need to do is we need to tighten up our rules for that purpose so that these sorts of things don't happen. But thank you for bringing it to our attention.

DR. ZIMMERMAN:

While I've got the mic, I want to try one other way, which is more aspirational than anything. I find myself asking for the same things for different reasons for different patients repeatedly and redundantly to the same carrier. If I ask for Amrix because the patient has found that Flexeril is too sedating, I will get a denied by the prescription level, denied at the 1010 level, and then authorized by the Medical Director routinely.

I'm wondering whether there is any way to allow for precedential value of Medical Director's decisions so that if the same carrier has been asked the same question for the same reasons in the past, we need not go through the process redundantly.

JUDGE KELLAR:

That's a suggestion?

DR. ZIMMERMAN:

I'm wondering whether that is in fact something that I already have the right to request or whether that is something that needs to be added because I don't know what

the panel thinks about that, but I'd be curious to hear.

JUDGE KELLAR:

Okay. First of all, this panel doesn't make decisions on your request. Only one person does.

DR. ZIMMERMAN:

Okay.

JUDGE KELLAR:

And that's Dr. Picard.

DR. ZIMMERMAN:

Precedential value --

JUDGE KELLAR:

I understand what you're saying. It's like when the judges render decisions, if you know what treatment a judge has given to a particular issue, you don't need to appeal it because you know what's going to happen in that case. I think that the Medical Director's decisions ought to be instructed.

But insofar as asking for the same thing, receiving the same answer is concerned, I would say each patient is different. So it might be a little bit difficult. That's my response. Dr. Picard might think something

differently.

DR. PICARD:

Yeah, I understand your question. The only problem with it would be the amount of variability from person to person, and the insurance company is going to want to look at that case and its mentality to determine what, you know, they want to do. And if they're basically rejecting that particular thing every time, regardless of what the circumstances are, I think the only thing you can do is file a 1009. I know it's more difficult, but there's nothing in the guidelines that would allow what you're asking for.

DR. ZIMMERMAN:

Understood. I guess my issue is if it's something that you've already said yes to and it's the same fact pattern routinely as it is, it seems to me that they're denying it solely to delay. And so at that point, it becomes again a vital issue of the spirit of the notion that our rules exist to expedite things.

JUDGE KELLAR:

But it's a different patient; right?

DR. ZIMMERMAN:

Different patient with the exact same fact pattern.

MR. PROCELL:

Same carrier?

DR. ZIMMERMAN:

Yes.

JUDGE KELLAR:

Thank you. Anybody else? Yes, sir?

MR. PROCELL:

Is there any way as far as the medical professionals and rehab professionals to gain more information on the 1010 as far as what insurance carriers are receiving the most 1009s or does that data exist? Because if there are certain carriers that continually deny, I think we should be made aware? Your thoughts?

JUDGE KELLAR:

The only information that we are currently keeping is information that actually comes into our office. We are not privy to the information that is received at the various payors.

MR. PROCELL:

But the work comp carrier is on the 1009; right?

JUDGE KELLAR:

The payor?

MR. PROCELL:

Yes.

JUDGE KELLAR:

Yes.

MR. PROCELL:

So that data is there?

JUDGE KELLAR:

So you're asking --

MR. PROCELL:

I'm asking to --

JUDGE KELLAR:

Let you know the names of the carriers that are denying --

MR. PROCELL:

At a higher rate than the average of the state that there's normative empirical data that shows that, here's the average; we've received Medical Director approval, but which insurance carriers out there are going above the average that you're having to file 1009s?

DR. ZIMMERMAN:

You're not aware of the 1010s.

JUDGE KELLAR:

Yeah, I don't -- I mean I would not be willing to release that information. It may be useful for internally in the office, but I don't -- I don't see where we should be, you know, giving that information to the public.

DR. ZIMMERMAN:

Right.

JUDGE LUNDEEN:

Also, the data you would collect would be inaccurate as a whole for reasons that the Director stated earlier. Because the only information that we would have would be the cases that came to us. There might be tons of other cases or no other cases internally that never made it to the 1009 process. So it would be a skewed and incorrect statistic.

JUDGE KELLAR:

Yes, ma'am?

MS. KRUMHOLT:

Robin Krumholt with Davoli and Krumholt. I represent injured workers. We have clients that are permanently, totally disabled, so

they can't get treatment under the medical treatment guidelines because it's not giving them 50 percent functional improvement for returning them to work.

So my question is, how do we ask for a variance for these long-term patients and what type of medical evidence do we need to try to get a variance from the medical treatment guidelines? Thank you.

DR. PICARD:

I don't know how to answer that one, Judge.

JUDGE KELLAR:

You don't know how to answer that one?

DR. PICARD:

I mean you're asking -- typically, if you're asking for a variance from the guidelines, what it's intended to do is allow you to have a particular procedure or something that might be new that didn't make it to the guidelines yet or some variation on a surgical therapy, something of that nature.

You're talking about a whole spectrum of care that you're looking at providing now that's different from what is in the

guidelines. So that's why I'm not sure how to answer that question. She's talking about somebody that completely falls outside of the guidelines.

And now, do we have a variance to allow them to now comply with the guidelines? I'm not sure how to answer that.

JUDGE KELLAR:

Well, the medical treatment guidelines provide for a listing of criteria to be used to submit to the Medical Director if you want a variance. We are aware that the requirements for the kinds of evidence or literature you submit is stated differently in the guidelines and in the rule, 2715. And so it has caused a conflict and it needs to be cleaned up.

But if we look at 1203.1, it directs you back to the section to tell you specifically what it is you need to submit to the Medical Director to support the request for variance.

MS. KRUMHOLT:

Yes, ma'am. And the problem we're encountering is these are patients, say for instance, that have had multiple back

surgeries that have failed back syndrome. And before the medical treatment guidelines are strictly palliative care, they could get, say, epidural steroid injections or trigger point injections, but they're not being allowed to have this necessary treatment under the medical treatment guidelines and they're not able to return to work or ...

DR. PICARD:

Okay. Now, I understand what you're asking a little bit better, I think. In that case, if you have a specific case that you just discussed, if the patient has what's required for an ESI, they have radiculopathy and pain, you know, if they've failed nonconservative treatment, that I would typically approve that particular procedure.

Return to work is not in the guidelines as required for that procedure. So I think it's still worth going through the 1009 process and to let us take a look at it, because it might be that some cases do meet the guidelines.

MS. KRUMHOLT:

Thank you.

JUDGE KELLAR:

Yes, sir?

UNKNOWN:

Judge Kellar, Members, thank y'all. Today, I'm here with several pharmacies who would like to express their concerns and their -- basically the 1010 forms. And I have IWP, I have the AHCS and GEM drugs and they would like to maybe suggest some ideas of how they can -- how we can address these issues that they're facing on the pharmacy side.

MR. MIRE:

Thank you, guys. So my name is Randy Mire and I own four pharmacies in Louisiana. I'm a pharmacist as well. And one thing that we find very difficult is with the role of the $750 for approval for medication. Many of times, you know, with the costs of generic drugs being more cost effective and so forth, they will lump all of the patients' meds on an office visit together.

So a patient gets four generic medications, they exceed 750. Then they say, you should have filled out a 1010 and got authorization. We find that very difficult.

You know, it slows up the process for the care of the patient.

They'll go out without meds for many days while you wait for an adjustor to get back with the pharmacy. And patients, when we have them sometimes in the pharmacy, you know, are begging for their meds. And it's just generic meds that are price efficient.

I understand that there needs to be a rule in place for some sort of threshold, but it needs to be defined better. And a single medication, if it's a branded med that's over a certain dollar amount, that you need authorization for that specific medication, but not lump them all together like that. And we find it very, very difficult to deal with when we're trying to get patients the care they need.

JUDGE KELLAR:

Thank you.

MR. GROVES:

And just to weigh in on that, we've basically come to a decision --

JUDGE KELLAR:

Your name?

MR. GROVES:

I'm sorry. It's Brett. Sorry.

JUDGE KELLAR:

Okay.

MR. GROVES:

Yes, we've come to a decision that we could either wait to give the patients their medications and try to obtain a 1010 form or we can go ahead and risk, go ahead and give the patient their medications and hopefully that we collect on the back end. But so many times, we're denied for the reason of authorization wasn't given because you exceed the 750, so that's their denial. So at that point in business, we're out of pocket on that just because we want to make sure that the patient is serviced in a timely fashion.

JUDGE KELLAR:

Would either of the judges like to address the 1010 and the prescription issue?

Judge Laramore?

JUDGE LARAMORE:

I don't know that you want me to get into this.

UNKNOWN:

We also have IWP --

JUDGE KELLAR:

Well, you can tell them what the First Circuit's treatment is on that issue.

JUDGE LARAMORE:

There's a case out there, it's Ms. Krumholt's case, it's the Mire case, I have made the decision that the medical treatment guidelines do not apply to pharmaceutical drugs; that there's nothing in the medical treatment guidelines that says, you get this drug at this amount for this length of time for this condition. That's not in there. There is no formulary for drugs in the medical treatment guidelines.

There's been a lot of talk for many, many years about doing one, but it's not there. And I said that the medical treatment guidelines do not apply to pharmaceutical drugs. And I've been upheld to the First Circuit. It's on its way to the Supreme Court now.

It's, like I said, Ms. Krumholt could give you more specifics about what the actual case is, but it's a gentleman who is

permanently, totaled disabled and this is all he's got is pain management drugs and it's expensive. But that's -- that's where the issue stands now.

Denise, if you want to cite the -- did we bring it here? She can give you the cite --

MS. LEE:

For the First Circuit.

JUDGE LARAMORE:

-- for the First Circuit. It's up on writs. And I have not received whether or not the Supreme Court's accepted the writ yet or denied it. But Phil did take it up; didn't he? Denise -- I mean, Robin, or do you know? Have they accepted it?

MS. KRUMHOLT:

Yes, Your Honor. I filed an objection to the writ. He's filed a reply. But it all happened at the time of --

JUDGE LARAMORE:

The flood?

MS. KRUMHOLT:

-- the flood, so we have not heard if they've accepted the writ or not.

JUDGE LARAMORE:

So we don't know if the Supreme's going to address it or not, but the First Circuit has agreed with me.

DR. ZIMMERMAN:

Can I just ask for clarification? If the guidelines don't apply, there's nothing that the carrier is -- or what does that imply?

JUDGE KELLAR:

No, that's not what that means at all.

JUDGE LARAMORE:

You mean as far as I'm concerned? And it's just me. It's just me. Every judge has got their own way of looking at things. And, believe me, Director Kellar will tell you that my way of looking at things ain't always the way everybody else does it.

DR. ZIMMERMAN:

Sure.

JUDGE LARAMORE:

But --

DR. ZIMMERMAN:

Well, what's your opinion?

JUDGE LARAMORE:

My opinion on this issue is there is no medical treatment guidelines for how to handle

the drugs in general. And until they do that and give specifics, then it's reasonable and necessary medical treatment. If it's reasonable and necessary medical treatment, then I'm going to agree with it.

So what you do is you have -- present me that it's -- carrier present to me that it's not reasonable and necessary medical treatment until I get the decision from the Supreme Court that says, gee, Judge, stop that, you know, or okay. I don't know.

JUDGE KELLAR:

And it is the First, the Fifth, and the -- is it the Third -- the Second?

JUDGE LARAMORE:

I lose count, Dear.

JUDGE KELLAR:

All right. I know it's the First and the Fifth and there's one other circuit?

MS. FONTENOT:

First, Second, and Fifth.

JUDGE KELLAR:

First, Second, and Fifth?

MS. FONTENOT:

As per the meeting in Lafayette.

JUDGE KELLAR:

Okay. That has decided that prescription medication is not subject to the approval and the appeal process authorized by 23 -- 1203.1.

JUDGE LARAMORE:

Now Brian has got his hand up, and I'll tell you that Brian has got that same issue with me too, and they -- on the exception of prematurity. And we -- I've ruled the same way on it. And I know, Brian, you're taking that up too; aren't you?

MR. BLACKWOOD:

Yes. Brian Blackwood, State of Louisiana. So the Mire case that you're talking about with Robin and Phil Foco and then myself for the State, we've got several cases, they're all going up at the same times. The writs were due at the same day. So --

JUDGE LARAMORE:

We're just waiting.

MR. BLACKWOOD:

-- The Court will likely consolidate them if they accept it. But the point I was going to bring out is the Second Circuit in dictum says that it does go through the treatment

guidelines, and that's my opinion at least according to in dictum in court. And I don't recall the Fifth making comment.

The First clearly said that, you know, upheld the judge and overturned Judge Thompson, who in the District Court level had said that the drugs would go through the guidelines. So that was overturned.

JUDGE KELLAR:

Okay. So I have the decision from the First and the Fifth, and I know there's one other circuit. I'm not sure which one that is. But what that means is for the lawyers in the room, they know that they are to follow the Appellate Court in their jurisdiction.

To the extent that the Appellate Court has made a different decision in the other jurisdictions, then you do something differently until the Supreme Court renders a decision. And since we have a split in the circuits, we're hoping that they will tell us whether or not statewide pharmaceuticals are subject to the medical treatment guidelines.

UNKNOWN:

We have one more client here at the LWP.

They would like to say -- express their concerns and what they've had going on and suggests their opinions on what -- how we can fix it.

MS. JAFFEE:

Hi, I'm Danielle Jaffee, IWP, Injured Workers Pharmacy. We share the concerns with the other pharmacists and pharmacies. But our model is a little different, so we've seen a lot more of this problem.

We're a home delivery pharmacy. We deliver the prescriptions to the injured workers in our area. We had to fill that gap. I think some of the providers have seen where when there's an issue at hand, a patient can't go into a pharmacy and get the prescription without paying out of pocket, paying out of a health care plan or just walking out without it. So we try to fill that gap.

We have a staff that works with adjustors and insurance claims. We pay and we take that risk. And it works for us. It's our model. We work in all 50 states.

But here in Louisiana, the problem we're seeing is so much confusion, as you say, on

the court level as to if we need to be filling it out. And that confusion comes from insurers. Some insurance companies want us to fill it out. Some want the doctors to fill it out. You know, some want us to fill it out for a prescription. Some say that once they've approved it once, it carries through the end of the prescription.

And on top of that confusion that we're getting back, we do still have the 1010s. We're covering ourself. So, for example, in August, we filed -- we filled 700 prescriptions in Louisiana. We filed 700 1010 forms. We got replies from insurance companies, only 78 replies.

And so for us, if they don't reply within five days, it's a denial. And you can appeal it, but that would be, like, over 600 decisions every month. And so for us, the system is just not working as it should be.

And we're doing everything we're told we're supposed to do, even when the attorney is like he doesn't think we should be doing it and we're still getting nothing from them and that's apparently a denial for us. So we have

to take on the decision, do we keep going or do we cut off this service that we're providing for these injured workers that already have no where else to go. So we kind of agree with them.

You have to value the system whether it's pharmacies filling out the 1010 forms or give pharmacies a clearer idea of when they need to fill out a 1010 form, whether there are certain drugs that require that pre-authorization because they're less -- maybe they're less effective, they're not as common in the workplace injuries, or, you know, generic drugs are available.

You have to give us some certainty. Otherwise, I mean, I'm assuming you don't want us to file 650 some-odd 1009 forms.

JUDGE KELLAR:

So what you do is you get a prescription from the physician, the health care physician, and you fill it out. You send it to the injured worker. And then, you submit a 1010 to the payor to see if they will pay for the script that's already gone to the injured worker?

MS. JAFFEE:

That's how we do initial prescriptions. Because, again, we cover that half. We'll take on the risk that they're going to say no. That's initial prescriptions. But we present our 1010 forms as soon as we exceed the prescription and start our work.

So we bill the next day. They're getting the 1010 forms immediately and they have five days to respond. They're not responding and it's a confusion of what are we supposed to do?

We're filling out the form. You're telling us sometimes we don't need to fill out the form and sometimes we need to, and you don't reply. So you're going to deny us without even evaluating the request we've made.

JUDGE KELLAR:

Okay. Thank you.

MR. MIRE:

If there was a clearer role that there was no 1010s for medications on the pharmacy level or if it was just for branded medications or it was just some type of role

laid out, because you've all been in the pharmacies. It's impossible for us to fill out all of the 1010 forms, give the quality of care to the patient and make sure they get the meds, and then hope we get paid.

It's -- the carriers look for any reason to deny. So they use this as their way to be able to deny. And, personally, all the generic meds are very cheap. It seems like a good fix would be just to save the brand medications.

JUDGE KELLAR:

The problem, as I said previously, is there that there is a split in the circuits, so it would be inappropriate for the agency to make a decision one way or the other as to whether or not pharmaceuticals are subject to the medical treatment guidelines. And as Judge Laramore says, the issue has gone up to the Supreme Court. We don't know whether they've accepted writs or not. But if they do, then the Supreme Court will settle the issue statewide, and then you'll have your answer.

Until then, you only can do what the

Appellate Courts and the jurisdiction in which you're working has ruled. Whichever way they've ruled is the way you --

MR. MIRE:

And that prevents us from appealing through you as well with a 1008 or anything; right?

JUDGE KELLAR:

No, it does not.

MR. MIRE:

So in the meantime, we could just say if they deny for that reason, we can appeal with a 1009?

JUDGE KELLAR:

That's correct. In those circumstances where pharmaceuticals are subject to the medical treatment guidelines, yes.

MS. JAFFEE:

So part of our problem comes with we submit the 1010s, as I said, and they take that out in the rules where if they don't reply in five days, it's denied. And some of that could be just administratively not feasible for them to approve every prescription 1010 form.

But the problem is, if they don't rule on it, they don't make a judgment on any part of it, but they deny it by not responding. And then, if we continue to fill or if anything happens, they can come back and say, you didn't get a prior authorization. Well, we've tried.

And if you don't give us anything to appeal on, we -- we're just -- we're banging our heads against the wall because you're just choosing to not respond basically. I'm not saying they're doing it intentionally. Part of it is, if you're submitting a prescription, a 1010 form on every prescription, any provider can tell you, Workers' Comp patient can receive a lot of prescriptions, it might not be feasible for the insurance company to go through each and every one.

JUDGE KELLAR:

If they don't respond, that's a denial.

MS. JAFFEE:

So then it's considered not prior auth, and then what are we supposed to do?

JUDGE KELLAR:

It's considered what?

MS. JAFFEE:

Yeah, I know it's a denial.

JUDGE KELLAR:

That's a denial.

MS. JAFFEE:

Yeah, but we -- yeah, I know and I agree with you, but our 1009s would be double to the Medical Director. It would be 650 1009s in August.

JUDGE KELLAR:

Okay. Yes, Dr. Zimmerman?

DR. ZIMMERMAN:

Sorry. Last one, I promise. In the circumstance where we file a 1010 and we get denied or we have tacit denial, there are several carriers will then give us exactly the same person who has denied us the first time to have the discussion regarding voluntary reconsideration. That seems like a system set up for failure. If you've already made up your mind, it's unlikely that I'm going to change your mind.

Often times, the more reasonable carriers will provide us with an alternant decision maker for the voluntary reconsideration

discussion. I don't know whether they have any obligation under 2715 currently, but it would be a great help if the rules insisted that a different person provide voluntary reconsideration than the one who provided the original decision.

JUDGE KELLAR:

Thank you. The Chief Judge was just pointing out to me that the 1009 process is not available for retrospective treatment. Which means, if you render it and are seeking our approval afterwards, we're not going to take the 1009 to the pharmacy guys in the back.

Your request for treatment is supposed to be made before you render the treatment. So I don't know what we do with pharmacy benefit managers like our LWP people, but we hear you.

MR. FERRIS:

Jason Ferris, also of LWP. Just a question, I guess, regarding what you said. If we then dispense the medication prior to actually sending the 1010 -- no, 1009, however for refills and stuff like that, we generally know they're coming up, so we'll file the 1010

first. In those cases, even though we file a 1010, no response to fill the med. Is the 1009 available to us then? Is it your understanding or is that --

JUDGE KELLAR:

The 1010 is available -- process is available before the treatment is rendered, before the meds are given or filled or whatever.

Freda, is that right?

MS. FREDA CHAUCER:

Yes.

JUDGE KELLAR:

If they've already rendered the treatment or whatever, then we send the 1010 back because we don't approve the procedure, treatment, medicine after it's already been given.

MR. FERRIS:

Okay. You said the 1010, but the 1009.

JUDGE KELLAR:

The 1009, same thing.

MR. FERRIS:

So once the medication has been dispensed, we are not able to file a 1009?

JUDGE KELLAR:

At presently, that is correct. Presently, the 1009 process is not available to you if you've already dispensed the medication.

MR. FERRIS:

All right. So I think we can all see the issue with that; right?

JUDGE KELLAR:

Yes. Absolutely.

MR. FERRIS:

All right. And then the only other thing I wanted to just add is you mentioned, yeah, this is going to the Supremes and we're going to have some, hopefully, indication one way or another across the state eventually. I'm just thinking, in terms of if they say, yes, this is required for pharmaceuticals, we still -- a company like IWP is going to have issues forever with this because we don't have access to a lot of the -- for instance, there's a spot right on the 1010 for the physician's signature, for instance, or provider's signature, or I think something like that, right, and we don't have a lot of the

information that's provided.

So I guess my suggestion would be, in lieu of waiting for the Supremes, perhaps even now start thinking about, if they come back saying that the medical treatment guidelines apply to pharmacy, there should probably be a different form or something different that a pharmacy would provide to the carrier versus what an actual physician. It's just a thought, something to put in your head. I don't know if there's any way to do that practically, but ...

JUDGE KELLAR:

Thank you. Anyone else?

MS. ROBERTSON:

I have a question about the 1010A forms. I get a lot of denials because they don't have enough information, but they're not utilizing the 1010A form. Is that still in place?

I have, like, two carriers that actually use it. And I think a lot could be done, because they give us a extra ten days to get it through, you know, get it back through to you instead of denying it and we have to go through the appeal process and wait up to 30

days.

JUDGE KELLAR:

Freda, would you like to respond?

MS. FREDA CHAUCER:

Yes. The 1010A is still a form that should be used. If the carriers are not using that particular form, if you know the particular carriers, so you can call them or let us go ask and we can, you know, contact them and remind them to use that form. If they don't use it --

MS. ROBERTSON:

Its like, it's only about two carriers that I know of that actually do use them. All the rest of them don't use it. They'll just outright deny it. Like, is there is way that when it does get denied, can we use that as some kind of fact that they didn't use the 1010A form and just outright denied it? We don't get phone calls.

Like, we'll do a peer to peer, but my doctors are in clinic all day. And they'll call on that fourth or fifth day and my doctors can't get to their peer to peer in time. So, like, we're doing -- we're sending

out a 1010, and they'll wait until the fourth or fifth day to try to get in touch with the doctor. They're not even sending 1010As where the doctor can respond, and then we're sending out 1009s.

JUDGE KELLAR:

And so the request for treatment is being denied? All right. So the only recourse at that point is to appeal.

DR. ZIMMERMAN:

You can also file a new 1010.

JUDGE KELLAR:

Well, you can file a new 1010, but I mean why should she expect that her experience is going to be different. The Utilization Review Company or the payor is requesting peer to peer review with her physician, who is in clinic and never gets to talk to them, so they're going to deny it again.

DR. ZIMMERMAN:

Perhaps get another five days and be able to facilitate in light of the additional forms during that five-day period.

JUDGE KELLAR:

Well, that's one way to do it. I mean

and another way to do it is to file a 1009.

MS. FREDA CHAUCER:

File the 1009.

JUDGE KELLAR:

Yes, sir?

UNKNOWN:

Just a point of clarification. We were just discussing something back here and I might have misunderstood you. You said that after something is -- a prescription is dispensed and a 1010 form is denied, they cannot submit a 1009 form; correct?

JUDGE KELLAR:

The medication is dispensed, you submit a 1010 afterwards, it's denied; right?

UNKNOWN:

Yes.

JUDGE KELLAR:

The 1010 process is intended to come before the treatment to get approval before the treatment.

UNKNOWN:

And that's the primary issue for these people here. These companies here are doing the right thing. They're providing services

to injured workers. They're giving them the medication. And then they take this risk. And what happens is these forms are denied, because after a five-day period, they're not responding to these forms and it's getting denied and they get stuck with the bill.

So how -- you're telling me that they need to submit 1009 forms, but they can't submit a 1009 form because they're doing the right thing and providing care. So what's the next course of action for them? What -- how do they -- I mean they're trying to take care of injured workers.

They're trying to get people back to work. They're giving them the medicines they need, but they can't follow the protocols in place because there -- it's not working out for their companies and their business models. So what's their course of action?

What can they do right now until the Supreme Court has ruled and y'all can change the rule? Because it is a rule that's written by the Department and by Workforce Commission. What can they do in the meantime to recoup some of this money or try to address these

issues properly?

JUDGE KELLAR:

Well, I understand what you're saying and you've explained your business model to us, but the rule is such that approval is supposed to be received before the medication is dispensed or the treatment is given or whatever. And I understand, because of your business model, that puts you in a severe disadvantage because you've taken the risk to get injured workers the medication that has been prescribed for them.

At this time, the only thing I can do is tell you that we will consider what you are saying, but no answers are going to be given to you today. I do understand what you're saying, but we have no answer for you at this time.

DR. ZIMMERMAN:

But if -- regardless of which way the Supremes rule, the best case scenario for different pharmacies is that the formulary requirement or the 1010 process applies that they can get perspective authorization. And if the 1010 process doesn't apply, then

they're going to have to go to a 1008, which will take months which will mean the patients will have care delayed even more. So either way, patients are going to suffer regardless of which way the Supreme Court rules.

JUDGE KELLAR:

But what the gentleman is saying is that manner in which they do business is they don't ask for perspective approval. They're asking for retrospective approval.

DR. ZIMMERMAN:

Which is clearly not how the rules work.

JUDGE KELLAR:

Which is not how the rules were intended to apply. And I understand in this case, there's a different business model for them. But, unfortunately, the medical treatment guidelines have not carved out something special for pharmacy benefit managers. And maybe we should.

I don't -- I'm not saying that we won't. I'm not saying that we should not. But at this current time, we do not. But I hear you and I will -- it will be taken into consideration.

UNKNOWN:

Thank you.

MR. MIRE:

And with all due respect, it's not so much the business model, ma'am, it's the patient needing the care because they won't reply in a timely fashion. And if you want to be in business, exist as a health care, you have to worry about the patient. And they can't wait that timeline --

JUDGE KELLAR:

I agree.

MR. MIRE:

-- even the initial five or ten or anything.

JUDGE KELLAR:

I agree.

MR. MIRE:

So the new rules would be very beneficial.

JUDGE KELLAR:

And that's why we're all here is because --

MR. MIRE:

I appreciate it.

JUDGE KELLAR:

-- because we want the injured workers to get the treatment that they need quicker, faster so that they can return to work in a timely fashion.

MR. MIRE:

Thank you.

JUDGE KELLAR:

Remember, we're the Department of Labor, we put people to work. So to the extent that we can get them the treatment that they need and get them back in the workforce, that's what we're here for.

UNKNOWN:

I just want to thank you all very much for trying to address these issues. I know it's a lot to deal with and it's a complicated process. But thank y'all for trying to address this and taking our concerns today.

JUDGE KELLAR:

Thank you for coming.

Yes, ma'am?

MS. FONTENOT:

I don't know if I want to -- I'm Terri Fontenot. Hi, Dr. Zimmerman.

DR. ZIMMERMAN:

Hi. Be careful.

MS. FONTENOT:

This was brought up in the meeting in Lafayette. The rules that I read, and that's why I didn't talk about it in the meeting in Lafayette, but the Louisiana medical treatment guidelines in the Rule R.S.23 blah, blah, blah, it says that if a procedure is not covered under Louisiana treatment guidelines, you would revert to another state's guidelines. Is that still so?

JUDGE KELLAR:

It does -- it does say that.

MS. FONTENOT:

Because we're seeing denials from Dr. Picard because it's not covered under the medical treatment guidelines.

DR. PICARD:

So we prefer to use the Louisiana State guidelines as much as possible. When a procedure is not within the guidelines, I sometimes use now, and we've just recently figured this out, that we can do that, what you're discussing, because we've looked that

up, we use OBG guidelines and other guidelines when they're available. We don't have access to all of that where I can keep up with everybody's guidelines.

So, normally, what I rely on would be the insurance company or somebody to provide that part. And a lot of them do, they provide that part of the guideline of another state or an OBG for me to look at. And we previously had not been using that, but now we are. And when they are both provided to me when it's in the state guidelines or another guideline there, I don't view the other guideline, I use the state's guideline.

MS. FONTENOT:

Right.

DR. PICARD:

But we are looking more now towards other guidelines when they are sent to us to look at.

MS. FONTENOT:

And I have other concerns. Drug screenings, I know y'all are looking into --

JUDGE KELLAR:

Yeah, we're trying to reconcile what is

in the medical treatment guidelines with regard to urine drug screens and what the Department of Hospitals requires.

MS. FONTENOT:

And I totally understand it because that's licensure for physicians and practicing (inaudible). My concern is the physicians who are doing urine drug screens monthly, and the urine drug screens are all normal monthly, and they're still doing them monthly. We also send off for a conformation monthly.

So in y'all looking into maybe updating the guidelines, if both types of drug screens can be addressed, because confirmations, when they're looking on a patient who has never had an abnormal drug screen and they're looking for conformation on synthetic marijuana and heroin and cocaine, and it's kind of, on a 78-year-old patient, it's kind of --

JUDGE KELLAR:

Counterproductive?

MS. FONTENOT:

-- counterproductive. If a patient has never had an abnormal drug screen, I don't know why you would do a confirmation of 30

drugs.

DR. ZIMMERMAN:

Well, let me tell you why. Urine drug screens do not test for all medications. And so if the patient is on Usenta, if the patient is on synthetic marijuana, if the patient is on medications that -- (inaudible) is another one that is not typically within a cup, then confirmatory tests monthly are perfectly reasonable.

Additionally, if the patient has had a history even in the distant past of drug abuse, specifically cocaine or drugs other than pot, I personally think it's perfectly reasonable to test them monthly.

Quarterly testing is reasonable for the average patient, but carriers aren't aware necessarily of whether the patient is an average patient or a high risk patient. And so the notion that we should have to provide a cookie cutter approach for all patients is not a reasonable thing to ask us to do. We need to customize our care to the risks of an individual patient, not to the cost structure of the carriers.

JUDGE KELLAR:

Thank you.

Yes, ma'am?

MS. ROBERTSON:

I have a question about the 1010s. When we first started doing 1010s, there was a list for every carrier where you should, like, a dedicated 1010 line. And as the years go on, there's either the adjustor say, send it straight to me, or we have to send it to a UR company or even a number that's not on this list that's on the website. So we get a lot of nonresponses and we are doing tacit denials.

Is there going to be a list put up that we can just send those to this 1010 dedicated line; therefore, we know it's there and they can't say we haven't received it, you were supposed to send it here, or you were supposed to send it to me? We need a dedicated line for these 1010s so that we know that they're getting to the correct place.

JUDGE KELLAR:

One of the things we've noticed is that the numbers that are contained on our website

for the dedicated fax lines, they're also not up to date. And many of the tacit denials result from those numbers not being up to date. And so one of the things that we've decided to write into the rules as a responsibility of the carriers to give us a good number, good fax number and a good telephone number.

In the Workers' Compensation courts, we require injured workers to keep us updated with a good address for them. If we send them a dually noticed date for a hearing or trial and they don't receive it because the address is incorrect, we penalize the injured worker by dismissing his case, but we don't do anything like that to recalcitrant TPAs or URs or payors who don't keep us apprized of a good number for them.

And so one of the things that we have already considered is writing in the rule a penalty for their failure to keep us apprized of a good number so that we won't get so many tacit denials as a result of the numbers not being in there. Thank you for bringing that up.

DR. ZIMMERMAN:

With regard to the tacit denials for one second, the Medical Advisory Committee had at one stage discussed the possibility of reversing courts and having the five-day period lead to tacit approvals. I wonder whether that ever was considered and whether that is still under consideration.

JUDGE KELLAR:

There's a member of the Advisory Council back here and I think he was one of the proponents of tacit approvals. So why don't we let Mr. Davoli tell us why we don't have that.

MR. DAVOLI:

That's still under consideration.

JUDGE KELLAR:

Tell us who you are, please.

MR. DAVOLI:

Excuse me?

JUDGE KELLAR:

Tell us who you are. Who are you?

MR. DAVOLI:

Oh, Chuck Davoli. I'm a past member of the Advisory Council and apparently will be on

the new one. I'm a claimant attorney. That was an issue early on that was intended to follow what was the jurisprudential rule at the time when we had problems with -- there used to be a time when we didn't have a time limit at all as approving the treatment.

And then, there was always a time limit for payment of medical bills. That, even in and of itself, did not happen. So the jurisprudential rule was, if they don't approve it within a reasonable period of time, and that was at the time, it's considered a tacit denial and then you proceed with a 1008. That's the history, I think, of how we got the tacit denial.

We were kind of trying to maintain that rule of thumb. And so, basically, arbitrarily, it was set at five business days, I think, and the time receipt to consider the tacit denial. But the original intent was that you can go to a 1008 without interjected step -- interim step with, you know, the 1010A which is actually her suggestion is very good if the carriers would use it. But most carriers and payors, and this is my bias, are

in a cause for mitigation, not in a utilization, reasonable utilization mode.

There are some carriers, you know, Mike Morris left. I consider (inaudible) one of the more responsible administrators out there. Why argue about the necessity of an MRI when you've got evidence there or it isn't there, and the costs that that prohibited causes.

And so it depends on the philosophy out there of whose basically approving. Now, you know, somebody mentioned a business model of IWP. They take the risks. I mean I -- frankly, you know, the rules shouldn't be any different for them than they are for any other health care provider. You want to take the risks, take the risks with the $750, do it. You want to take the risks beyond that, I mean there are some claims out there that are non-compensable.

And in my opinion, even though I come from the claimant's side, why should an employer in a non-compensable claim necessarily get stuck with that? So it's checks and balancing.

But to answer your question, the whole

intent was that that's how it came about. It used to be a rule of thumb. Well, they haven't -- you know, what's a reasonable period of time? Sixty days? Ninety days? I mean it's still going on. So we just arbitrarily said five days.

Now tacit approval, what would that mean? I mean from a legal standpoint, that would just mean that you now, Doctor, can take the risk and treat. But even -- now, hold on. Hold on. You could take the risk and treat. Because even if they authorize, it's not a guaranteed payment; correct? I mean that's my understanding. I mean they could authorize the treatment, but it's no guarantee of payment.

So, you know, we've talked about this and talked about this and talked about this. You know, I was a tacit denial advocate. At this point, I mean we've gotten away from, and I appreciate what the Workforce Commission and particularly Director Kellar is doing in trying to -- and we've been in some pretty serious deliberations on revising the 2715 rule, because the intent of the guidelines,

and I'm a guideline advocate, was to make medical treatment for the providers and for the claimants more predictable, more timely, more efficient.

And, unfortunately, the bureaucratic process and the manipulation and the games that are played are delaying that process, and it's unfair to the system. But I don't know if that answers your question, but that's the history of the tacit denial. And I'm not sure I'm an advocate for either anymore.

DR. ZIMMERMAN:

(Inaudible.)

JUDGE KELLAR:

I can't hear you, Dr. Zimmerman.

DR. ZIMMERMAN:

I'm sorry. The manipulation that's taking place now is more to the carriers. And the way that they're doing is by not responding. And so if there were a cost to not responding, it would encourage them to actually give us a decision as opposed to giving us nothing. So if there were an incentive for them to actually respond, instead of hoping that we'll go away, it might

actually make this process more predictable and more expeditious.

JUDGE KELLAR:

I don't disagree with you, but I think there's some adjustors in the room who would say that the gamesmanship is not just on their side. I think some of them, I've heard said, the gamesmanship is on the health care physician side as well. So, you know, we're not really here to point fingers.

DR. ZIMMERMAN:

I'd love to hear them speak.

JUDGE KELLAR:

We want to try to solve whatever problems we have because I think there is gamesmanship in the system period, regardless of whose side that's on. But I think that is a very good suggestion that there should be some teeth in the system if they fail to respond. Some of that is delivery. Some of it's because they don't have good numbers, but they should be held accountable for that. Just like we hold injured workers accountable, the adjustors, payors, and TPAs or whomever should be held accountable as well.

DR. ZIMMERMAN:

Chuck said five days was the arbitrary number for Texas. (Inaudible) three days. So the notion that 60 days was reasonable is believed by the fact that Texas believes that we give too much time.

JUDGE KELLAR:

And Texas has tacit approval.

DR. ZIMMERMAN:

Yes, ma'am. Yes, ma'am.

JUDGE KELLAR:

Anyone else? Yes, sir?

MR. MITCHELL:

Yeah. I'd just like to comment because one of the first things that I thought as well with the five-day period was, what about tacit approvals? Jonathan Mitchell, deGravelles, Palmintier, Holthaus & Fruge'. And I mainly represent plaintiffs.

We have to remember that the purpose of these rules is for the benefit of the worker. And there are rules that must also say that we need to assess intelligently whether or not this worker deserves the treatment and whether or not the treatment is compensable. But the

insurers, the compensation system, we've all imposed ourselves into a relationship.

And the relationship that we've imposed ourself into is a relationship between the patient and its physician. And if you think about it, that's the purest relationship that we have in the system.

When the attorney becomes involved and when the adjustor becomes involved and has some sort of skin in the game other than just the treatment and well being of the patient -- so since we've chosen to impose ourselves into this system, shouldn't the impetus and the costs be on the insurer to say, look, if you're going to deny this person what his doctor is saying he necessarily needs, then you need to do it expeditiously. And if you don't do it expeditiously, then this person who is at home suffering is going to have their claim approved, their treatment approved.

And I think if you get back to the, like I said, the basis of these rules which is to make sure that these injured workers get the treatment that they need that their physicians

are recommending, that I would certainly advocate a reversal to a tacit approval as opposed to a tacit denial.

JUDGE KELLAR:

You would suggest a tacit approval instead of a tacit denial?

MR. MITCHELL:

Yes.

JUDGE KELLAR:

Okay. Thank you.

Anyone else? Yes, sir?

MR. PRICE:

Hello, I'm Brad Price. I represent injured workers. What I want to address as well as the information is one of the issues I'm having in my practice is the doctor submits the 1010 and I don't intend to know what the UR procedure is, but the information is sent to the UR doctor and the UR doctor comes back and he says, you know, meet criteria A, B, C, but you lack approval of conservative care. And that's because, I guess, the treating physician has not sent in whatever documentation he feels is required.

But the issue that I have is the carrier

has approved all of that treatment and is in possession of all of those records. So it's putting the illness on me or the doctor to run around and scramble around and try to find out where his PT, where his therapy was or whatever the conservative care was, and then try to submit it in time for the 1009 to get it before the Medical Director.

And I think there needs to be some kind of -- some kind of mechanism in place that when the submission is made and the carrier is in possession -- I had one that I looked at today. They said, we did not have a discogram. Well, 45 days ago, they approved a discogram. It was done. And I know they had the report, but the UR is denying and that they don't have the information, which is all being in the possession of the carrier.

I don't think there's -- assuming that I even get notice of the UR denial, you know, there needs to be some kind of mechanism or some kind of stick that, you know, I as an attorney can say, hey, look, you have this information and you're denying it solely because you're saying you don't have it. And

that's just a practical problem that I face once, twice a week.

JUDGE KELLAR:

Thank you.

MS. ROBERTSON:

I have a question about the 1010 for office visit. At one point, they was saying we didn't need a 1010 for referrals. Some people want it. Some people won't approve without it. Some carriers won't take a patient without an approved 1010. And then we have this office visit situation, I think it's the first year, they approve up to 12 visits. And every year after, then it's four to six.

And it's confusing because I don't know whether to send a 1010 for a office visit or to -- because some does -- some don't want it. They'll say 1010 is not required for office visits or 1010 is not required for referrals. But a lot of carriers don't take a patient without the 1010 approving them to see their doctor.

JUDGE LUNDEEN:

Okay. So this is a repeating issue that we're having. The law does not require a 1010

for a referral. The doctor says it's his patient or her patient and makes a referral to another doctor of a different specialty. Under the Workers' Compensation law, you have the right to choose a specialist in each field as the injured worker.

Now as the medical provider, which is the question that you're asking, you don't need the 1010 for the referral. But if you are the receiving doctor or medical provider, then you probably need to put in your 1010 for the visits that you intend to have. Now what is the scope of that visit?

You don't know, but you know you have your initial evaluation. Is it a level five? Is it a level four? What a lot of providers are suggesting to us that they have done, and I'm not saying that this is the answer, but it is what we are hearing across the state, is they're putting in for the highest level for their initial evaluation appointment and then putting in for the subsequent appointments and putting things in like up to level five depending on what the patient's needs are or if there's extra tests that you're going to

need.

Maybe, typically, you're a type of provider that normally does X-rays on the first visit or certain other tests, but you're not going to do need those, but maybe you will need those on followup, you can put it in as your regular general request. But then say, and patient may need, but will determine at visit.

And those seem to be getting through the system a little bit better. So your referral MD doesn't put the 1010 in for the referral. The referral MD simply makes the referral, but the recipient MD is going to make the request for the office visits for his or her practice.

MS. ROBERTSON:

Okay.

DR. ZIMMERMAN:

I apparently have an opinion on every subject. The problem is that carriers will sometimes suggest that certain specialties are not medically necessary and denied the referral based on the tact that they're determining that patient X, who has been seen by a primary care doesn't need to see an

orthopedist or doesn't need to see a pain management specialist and are imposing themselves in between the referring physician and the referral and the patient -- and the physician who is receiving the referral.

JUDGE KELLAR:

Well --

JUDGE LUNDEEN:

As -- go ahead.

JUDGE KELLAR:

I was just going to say that all patient care is under the umbrella of reasonable and necessary and work related.

DR. ZIMMERMAN:

Yes, ma'am. But for a carrier to render the determination as to whether a referral is reasonable and necessary has them serving in the role as provider.

JUDGE KELLAR:

Well, the statute provides that the injured worker has the right to a physician in a different field of specialty. And we've had referral issues before the medical treatment guidelines, and I thought this issue would have been laid to rest.

JUDGE LARAMORE:

It's called a Motion to Compel Choice of Physician.

DR. ZIMMERMAN:

It's an individual, not a specialty.

JUDGE LARAMORE:

Not a specialty. What I'm saying is when you make the referral, if the carrier is decided that they don't think that that's reasonable, that that referral is reasonable, then the claimant files a 1008 and attaches a Motion to Compel Choice of Physician in this Specialty.

And their evidence is here is the prescription. I've been to see my doctor. Here's the prescription on pain management. I saw my ortho. He says I now need pain management. And let the adjustor come forward and explain why they think that that specialty is not needed.

And you -- the Act provides for an expedited process for that. You could get on the docket in two weeks if you file. But don't just file a 1008 and say, I want Choice of Physician. They need to file with it a

motion and order so we can set it on the rule docket.

And you'll get on the rule docket within two weeks. And you'll get a decision yeah, yeah or no, no. But there's an expedited process applied in the Act for Choice of Physician issue.

JUDGE KELLAR:

Yes, ma'am?

MS. TARKINGTON:

I have a question for that lady right there.

JUDGE KELLAR:

Ma'am?

MS. TARKINGTON:

I had a question for the lady walking out. Sorry.

JUDGE LARAMORE:

I can wait.

MS. TARKINGTON:

No, I can wait.

JUDGE LARAMORE:

Go ahead.

MS. TARKINGTON:

What you were just saying, can you

explain that to me one more time what you were saying, because I'm not an attorney and I don't understand documents, stuff like that. Because I -- what I understood what you were saying is I -- I'm a physician's office and I refer to another physician's office, I don't have to do a 1010 form or anything like that; is that correct?

JUDGE LARAMORE:

That's correct.

MS. TARKINGTON:

Okay. So --

JUDGE LARAMORE:

You're -- you work for a chiropractor; correct?

MS. TARKINGTON:

Yes, ma'am.

JUDGE LARAMORE:

You're supplying chiropractic treatment. And now, your chiropractor has decided that you need an orthopedic surgeon?

MS. TARKINGTON:

Correct.

JUDGE LARAMORE:

And your chiropractor has written a

prescription -- referral for an orthopedic surgeon?

MS. TARKINGTON:

Right.

JUDGE LARAMORE:

And you've contacted the carrier and the carrier says, we need to send him to Prime Medical or to doc in the box. Before he came to you or while he was coming to you and our doc in the box does not say he needs an orthopedic.

MS. TARKINGTON:

Okay.

JUDGE LARAMORE:

Okay. So we're not going to agree. There's a disagreement between our doctor, our GP and your chiro or two GPs, two doc in the boxes, okay, intern or whatever that he needs this specialty care. The claimant, the patient can file a 1008 with our office and file a motion asking for the judge to look at the issue of Choice of Physician in that specialty. And you can get on the docket for a hearing within about two weeks.

MS. TARKINGTON:

So the patient can do that?

JUDGE LARAMORE:

Yes.

MS. TARKINGTON:

Okay. Where -- and this might be a stupid question, but where is the patient supposed to know that? From where? Or who? Because I can guarantee you, my patients don't know that.

JUDGE LARAMORE:

You know, your ignorance of the law is no excuse. You ever heard of that? Okay.

MS. TARKINGTON:

Right.

JUDGE LARAMORE:

You know, you can't -- you know, that's just the way it is. Now, I would suggest that if you've got patients that don't understand it, that they open the phone book and call and make an appointment and see -- there's lawyers all out here. They'll throw you cards like crazy, you know, so that they can file that motion.

MS. TARKINGTON:

Okay.

JUDGE LARAMORE:

And they could call our office. We have an ombudsman in our office, a DRS who will talk to unrepresented claimants for people who just call with questions, look, I'm having trouble. And they'll tell them, come down here and pick up this form and we'll make sure that you get the form filled out and we'll get you in front of the judge. But you're always at a disadvantage if you're an unrepresented claimant. They should all have representation.

MS. TARKINGTON:

Right. I totally agree. And patient care should come first no matter what. That's how I believe it should be.

JUDGE LUNDEEN:

And so just that you know in the future, if you have a pen, or you can contact our office. But you can find this actual statute, which is very, very self-explanatory in Title 23, which is the Workers' Compensation Act, Section 1121.B1. And it specifically states that the employee shall have the right to select one treating physician in any field or

specialty. Employee shall have the right to an expedited summary proceeding pursuant to Revised Statute 23, Section 1201.1.K8 when denied his right to an original physician of choice.

A Workers' Compensation judge shall set the hearing for the matter within three days of receiving the employee's motion for the expedited hearing. The hearing shall be held not less than ten nor more than 30 days after the employee or his attorney files the motion for an expedited hearing.

Then, it goes on to talk about how the judge provides it. Now in case you don't remember all of that or couldn't write that quickly, you can go on to Laworks.net and you can find it there. Or you can go onto the Louisiana Legislature's website and you can pull it up under the Title, which is 23 and then the actual statute number, which Subsection 1121. And you can find many things there.

And since you are -- I assume you're working in the medical field? Are you a medical provider?

MS. TARKINGTON:

Yes, ma'am.

JUDGE LUNDEEN:

All right. Well, you're also one more line of advocacy for that patient. So although your patient may not be a lawyer, now you know what to tell them.

MS. TARKINGTON:

Right. Exactly. We don't do -- we've never really done Workman's Comp, so I have two cases with attorneys now. And that's why I don't know a lot. I'm -- and that's what I came here for is to learn and make sure that my patients get the best care first and foremost before anything. And that's when the pharmacies were talking and Dr. Zimmerman and these attorneys, and I agree that patient care should come first. It's all the other stuff that we have to go through, and I think that needs to change as well and do a smooth transition and make sure our patient gets better faster.

JUDGE KELLAR:

If you go to Laworks.net, under Workers' Compensation, you can find a list of all of

the district courts and the ombudsman in each one of those offices called a Dispute Resolution Specialist or DRS. You can call them and they can help your claimant navigate the system. They're not going to give them legal advice, but they'll tell them what forms they need to file in order to get the relief that they're seeking.

MS. TARKINGTON:

Thank you.

MR. GREEN:

There's also some well-written bulletins on the website.

JUDGE KELLAR:

Can't hear you. Who are you?

MR. GREEN:

There's also some --

JUDGE KELLAR:

Who are you, Will Green?

MR. GREEN:

There's also some extremely well-written bulletins on the website.

JUDGE KELLAR:

Who are you, Will Green?

MR. GREEN:

My name is Will Green. And I was just going to say, I appreciate y'all doing this. I think, you know, the reality is, there's a lot questions, but there's a lot of good answers to the questions. And, you know, we -- one of the -- what I -- when I worked at the Workforce Commission, one of the best parts of my job was getting to go out and actually sitting in the physicians' offices and, you know, there was a lot of issues.

But the reality is that it was just that they knew the questions, they just didn't know how to get the answers. And there is a lot of good answers and there is a lot of solutions to your problems out there that are already in the law.

And just to see the light bulb go off in some offices was pretty amazing and they'd say, oh, my gosh, I didn't know those answers were there. And I think one of the things that the office did was, to me, incredible was contracting with a guidelines provider. And every physician in here, every medical provider, I think, still has access to that medical guidelines software where you can

literally go in there, put an ICD or a code in and it will just spit out for you exactly what documentation you need to get to hear.

So when there's tools like that, but it's just, I think, getting -- you know, getting the answers in place. And Madam Director, you know, you've talked about a lot of these things. So I think the ball is already rolling on where you don't have answers to the questions, they are common questions, and so you have put some solutions in place.

But, you know, there's a process there. And so I guess in furtherance of that, will there be an opportunity for the issues, the questions that maybe we don't have an answer for and maybe are a gray area, will those be vetted through the Advisory Council and discussed or can you comment on that for me, please?

JUDGE KELLAR:

We actually have a 2715 Committee. The rules which help us to navigate medical treatment guidelines are in litigation at the 19th Judicial District Court. And so what we would like to do is to offer a compromise to

the plaintiffs by way of modifying these rules before we have to actually go back to a trial on the merits. So we have a Committee, it's 2715, for that purpose.

But, you know, I think everybody in that room just about is an attorney or some stakeholder. But we realized -- I realized that we haven't heard from you. You are the guys who actually use 2715.

And although we sit in our Ivory Tower and we can, you know, rein down some rules for you to work, we didn't hear from you. And I'm glad that I have taken this opportunity to hear from the guys who actually work with 2715 around the state because you have been very insightful in the sense that I've heard a lot of things that I never imagined were difficulties.

So while the 2715 team will be trying to make modifications to a rule, we will have the benefit of the transcripts of all of the Town Hall Meetings that we've had throughout the state to refer to. And we will be making modifications based upon the comments that you've given us, the suggestions that you've

given us.

And then once we've done that, we will take what we believe was sufficient modifications to the Workers' Comp Advisory Council and probably give them copies of the transcript as well so they'll know what your comments were, and then submit what we think is a fix to the plaintiffs and hopefully resolve the issues. That's what I intend to do.

MR. GREEN:

Thank you.

JUDGE KELLAR:

Yes, sir?

MR. BLACKWOOD:

Can you tell us who is on your 2715 Committee and how it was derived; like, who appointed the people to it?

UNKNOWN:

It's a secret.

JUDGE KELLAR:

No, it is not a secret. We have Meredith Trahant, Attorney General in our office who has been working closely with the litigation since it began; Chuck Davoli, who is on the

Advisory Council; Michael Morris is on the Advisory Council; and Will Green; myself. Am I missing someone?

MR. GREEN:

Greg Hubachek.

JUDGE KELLAR:

Greg Hubachek, who was on the Advisory Council. He was not reappointed this year. But these people were chosen because they're either intimately familiar with the litigation like Meredith or they helped to write the original 2715 Rules. So we're hoping they'll be instrumental in revising it and myself, of course. The Director -- the Executive Director of the agency, Ava Deja and the Deputy Director of the agency, Kathy Wells, have both sat in on some of the those 2715 meetings.

DR. ZIMMERMAN:

Why aren't there any medical providers on that committee?

JUDGE KELLAR:

Excuse me?

DR. ZIMMERMAN:

Why aren't there any medical providers on

that committee?

JUDGE KELLAR:

Well, we only have one Medical Director that we listen to in terms of the 1009 process.

DR. ZIMMERMAN:

But you've reached out to the community for input beyond your agency.

JUDGE KELLAR:

Yes, we have. And what Dr. Picard generally does is advise us on the medical treatment guidelines themselves, the four that are currently part of the guidelines, the technical, medical stuff. The 2715 is more the process by which we implement the medical treatment guidelines. Does that --

DR. ZIMMERMAN:

And the life blood of the providers who use them.

JUDGE KELLAR:

I understand. Thank you.

Is there anything further?

Dr. Picard, at this time, would you like to tell us some of the things that we look for when you are reviewing the 1009s?

DR. PICARD:

Yes. So this is repetitive for some of the people that I see that have been in some of the other meetings. But with the 1009, it's a disputed claim where you have an insurance company on one side of that claim and a provider or patient representative on the other side.

The procedure or therapy or whatever it happens to be that's been requested on behalf of the injured worker that has been denied by the insurance company that have made the decision on whether that denial is going to stand, because the procedure does not meet the medical treatment guidelines or that it's going to be reversed, and I'm going to approve it, because I think it does meet the medical treatment guidelines. From the insurance company's standpoint, one of the big problems we see is with tacit denials.

Because what happens in that instance is I don't have anything from the insurance company to explain why they denied the procedure. So my decision is based completely upon the provider's documentation as to

whether or not that meets the medical treatment guidelines. More often, that's going to result in an approval. Of course, I still look at it to be sure it does meet the guidelines.

But without having the other side, without having the insurance company's reasoning or showing some cause for their denial, then that's going to be a problem for the insurance company, because most of those are going to be approved.

The other thing that I do need to see from the insurance company when I do get a denial letter that documents why they deny a procedure is the information in that letter has to be correct. So often times, the insurance company might suggest that a patient does not have radiculopathy, for example, when the provider does clearly state that they do. So if that information is incorrect, I'm going to side with the provider, assuming everything is documented and meets the guidelines from the patient's representative standpoint.

From the provider standpoint, and that's the other side of the 1009 dispute, their

claim has been denied and they want relief, which is why they're requesting us to take a look at it. Basically, what I just need to see is good documentation to show why the procedure or therapy or whatever they're requesting meets the guidelines. As long as those guidelines criteria are documented, then that procedure is going to be approved.

If I deny a procedure, you can be assured it's because it doesn't meet the guidelines. And there are specific guidelines that apply for a particular procedure, certain surgical procedures, injections and so forth, certain things have to be documented to say that procedure meets the guidelines and it should be approved. As long as that documentation is there, then we can approve and override the insurance company's denial.

In that case or in the case that I'm going to say the insurance company was right, which is less than a third of the time, based on the numbers we've looked at, it's going to be clearly stated in the denial letter that comes from our office what was missing and why that procedure does not meet the guidelines.

So if therapy wasn't done or some other criteria that hasn't been documented, that provider or patient representative has the option to go back and do that therapy or document what wasn't there and file another 1010 and possibly get that procedure approved.

Yeah, the other thing is we -- I'm sorry.

JUDGE KELLAR:

Go ahead.

DR. PICARD:

There is some other things to add is we do need adequate documentation. Sometimes we get very little documentation to go by. You can't just request a procedure and send me a brief note saying, you know, I want this procedure. There has to be adequate documentation that therapy was done and other things that are required as per the guidelines.

Any specific questions regarding guidelines of a dispute problem that anybody would like to add?

DR. ZIMMERMAN:

I was told by the Assistant Attorney General Green in the past that the 1010

process is governed by a different standard than the 1009 process. Is that accurate?

I was told that the 1010 process is governed by medical necessity; whereas, the 1009 process is governed by guidelines. Is that -- am I understanding that correctly?

JUDGE KELLAR:

Why don't we let Will Green clarify that for us?

MR. GREEN:

Can you repeat the question? You know, Dr. Zimmerman, we talked a lot and as you've done today, yet separate conversations. And I enjoyed every one of them. I learned some and I think, hopefully, you did about the internal process. And I think it's helped me in my new role working for a self-insured fund.

But, boy, I don't -- the only thing, again, I don't serve in that capacity and I definitely don't give legal advice. And, hopefully, I didn't back then. But the 1009 process from the 1008 is, you know, there's a preponderance of evidence standard on variances and things like that. And then, there's a -- for the -- to overturn the

Medical Director at the 1008 level, maybe that's what I was referring to.

And I'll get -- since I don't serve in that capacity, I don't necessarily feel comfortable, but there is definitely different standards depending on if it's a 1009 to a 1008 or a variance or not covered versus something in the guidelines. And I know there's different aspects to that, but I don't remember anything about the 1010 and 1009.

JUDGE LUNDEEN:

May I?

JUDGE KELLAR:

Sure.

JUDGE LUNDEEN:

The medical treatment guidelines, and I'll let the doctor address this in variances because they're slightly different. But the guidelines are the guidelines. They tell you what you have to produce in order to meet the guideline and to get the treatment approved. That's the standard. When you come out of the guideline process, when you are appealing the 1009 to the court by filing a 1008 form.

So you're not filing a lawsuit saying you

don't like what the Medical Director said, the burden is clear and convincing that the Medical Director got it wrong and didn't follow the guidelines. So that's the only legal difference.

But the medical treatment guidelines don't have different guidelines as written. They are what they say they are. You have to meet certain requirements in order to get your medical care approved. And I'll let the doctor address the requirements for variances. They are different, but they are very specific.

DR. ZIMMERMAN:

Before we get to that, is there a stip for when carriers deny based on criteria other than the guidelines?

JUDGE LUNDEEN:

No. That's one of the issues that we're looking at is putting more teeth into this. Certainly, you have the right to come to our courts and we will determine whether or not the carriers have done something in conformity with -- or, actually, we don't look at that. What we look at is what the Medical Director

did. That's what we're bound by. That's what the legislature told us were our rules in determining whether or not we can overturn the Medical Director's findings.

DR. ZIMMERMAN:

Give you a concrete example, Sedgewick hires a --

JUDGE LUNDEEN:

And let me give you -- let me interrupt you for a moment. We asked you to speak in terms of hypothets. We ask you not to address pending cases directly.

DR. ZIMMERMAN:

I'm not speaking of pending cases directly.

JUDGE KELLAR:

Not even specific cases.

DR. ZIMMERMAN:

I'm -- I'm not speaking --

JUDGE KELLAR:

This is a hypothet; right?

DR. ZIMMERMAN:

This is hypothetically in the future, an individual carrier who might or might not be called Sedgewick, and hires an individual UR

reviewer who might or might not be called Saeed Hayek, who uses a criteria of, has the patient returned to work or not. That is his only criteria as to whether or not he will approve care. He does that consistently. And it's his only criteria on every case.

I would love to be able to say that he should not be able to review for that carrier before the 1010 process, but I can't. And I'd love to be able to have the Committee allow him to be excluded when he refuses to follow the guidelines.

JUDGE LUNDEEN:

So we are -- Judge Laramore is going to answer. Let me -- may I finish first?

JUDGE LARAMORE:

Yes.

JUDGE LUNDEEN:

The likelihood is that if the medical treatment guidelines have been met when you file your 1009, you're going to get that medical care regardless of what this particular examiner says.

DR. ZIMMERMAN:

Thirty days later.

JUDGE LUNDEEN:

The second part is that your recourse right now may not be under the medical treatment guidelines, but a complaint might be more appropriate to the Department of Insurance. Or if we can help to educate a carrier about the guidelines, if you want to contact us, so that we can provide education to people who are working with this within the system, we are happy to do so.

And I'll turn it over to Judge Laramore.

DR. ZIMMERMAN:

Who would I contact? The director?

JUDGE LARAMORE:

No.

DR. ZIMMERMAN:

No? Okay.

JUDGE LARAMORE:

The insurance company and the employer get the right to choose whoever they wish to examine the patient periodically or to do their UR or they can call on a genie. We don't care. The employee, the claimant gets the right to treat with whomever they wish. You or somebody else can -- the insurance

carrier may not like who he wants to treat. It does not matter.

If they're using a UR person that you don't like and you say it's going to be the same thing every time, well, then it just is. And you can treat it like a tacit denial and shove it right on up the ladder to Dr. Picard here and show that you've done the right thing that you need to do. We don't want to get into a situation where anybody's controlling each side's right to the choice of physician of their choice. That is not even a slippery slope. That's a freaking cliff, okay. And we don't want to go there.

JUDGE KELLAR:

Listen --

DR. ZIMMERMAN:

What --

JUDGE KELLAR:

Dr. Zimmerman?

DR. ZIMMERMAN:

-- about --

JUDGE KELLAR:

Listen.

DR. ZIMMERMAN:

I --

JUDGE KELLAR:

Listen. And I think I already said that there's a lot of gamesmanship in the system. I don't know who this individual is and I don't know if he's playing games or whatever. But I do believe that if there is somewhere in the system where an individual company or individual is deliberately denying procedures that are in the medical treatment guidelines and you can show that it's a deliberate misrepresentation, then I think there needs to be some teeth in the guidelines. Because if it's clearly in there, then the injured worker is clearly entitled to it.

But we don't have anything in the rules at the moment which says that if it's clearly in there and he's clearly entitled to it and the adjustor or payor or UR denies it, that they should be assessed a penalty and attorney fee. So I think that in some cases in the medical treatment guidelines, we need some stips. And they are not in there.

So I hear you. And we are addressing those kinds of issues.

DR. ZIMMERMAN:

Okay.

JUDGE KELLAR:

Thank you so much.

Anyone else?

Okay. Thank you guys so much for coming this afternoon and telling us the challenges and rewards of the medical treatment guidelines. We've heard you. I've been all around the state. This is the seventh and final Town Hall Meeting. We are going to consider your comments and try to incorporate some of them into revisions of the rule.

And, Dr. Zimmerman, we are going to consider a provider on that panel to redo the rules. And, hopefully, these have been beneficial to the extent that we are able to make modifications that are going to make the medical treatment guidelines more user-friendly for you.

If you did not make a comment or ask a question or suggestion that you wanted to, we are still available to you. You can find each of us on -- except Dr. Picard. Nobody can talk to him. You can find all of us on the

website Laworks.net under Workers' Compensation. I'm Sheral Kellar, Judge Lundeen, Judge Laramore, Denise Lee, Mediator, Ms. Freda Chaucer in the Medical Services Section. Thank you.

(WHEREUPON, THE MEETING ADJOURNED.)

REPORTER'S CERTIFICATE

I, KELLY S. PERRIN, a Certified Court Reporter, Certificate #23035, in good standing with the State of Louisiana, as the officer before whom this meeting was taken, do hereby certify that the foregoing 124 pages;

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