MINUTES

KENTUCKY WORKERS' COMPENSATION
REGULATORY ADVISORY COMMITTEE

MEETING
JULY 30, 2018

A meeting of the Regulatory Advisory Committee (RAC) was held on July 30, 2018, beginning at 1:00 p.m., in the Oscar Morgan Conference Room at the Department of Workers' Claims, 657 Chamberlin Avenue, Frankfort, Kentucky.

Chief Administrative Law Judge Douglas W. Gott called the meeting to order. Roll call was taken with the following members present: Douglas W. Gott, John B. Coleman, Chris Davis, Dale Hamblin, Peter Naake, Kenneth J. Dietz, and Scott M. Miller. Also in attendance was Commissioner Robert Swisher. Judge Gott noted that the meeting is held in accordance with KRS 61.823(4)(a), the Open Meetings statute, and that notice of the meeting was published as required. Minutes of the July 9, 2018 meeting were reviewed. Judge Davis moved approval of the minutes, seconded by Judge Coleman. The minutes were approved with no changes.

Judge Gott presented committee members with a handout of a draft of regulations for the continuation of medical benefits prepared by Commissioner Swisher. He asked for input, first from committee members, and indicated that discuss from participants in the audience would follow. Judge Coleman reported that his subgroup met regarding the development of regulations for extension of benefits beyond the statutory 780 weeks, and a concern regarding the process by which claimants would be notified had arisen. Mr. Miller felt that claimants should receive notice via certified mail. A discussion followed regarding methods by which claimants can be notified, including the currently accepted practice of sending a letter through regular mail to claimants notifying them of the cessation of temporary total disability benefits. Judge Coleman noted that approximately 5% of claimants are still receiving medical treatment 15 years following an injury. Commissioner Swisher indicated that he was not inclined to adopt a regulation requiring notification by certified mail since the cessation of medical benefits after 780 weeks is a statutory determination. Claimants will have been notified at the time of an opinion or settlement agreement that medical benefits are to remain in effect for 780 weeks unless a claimant files an application for a continuation.

Mr. Naake noted that the statute requires that the Commissioner notify a claimant at 754 weeks that medical benefits will cease. He felt this statutory requirement was different from the current regulations, and that a plaintiff could potentially argue that he or she had not been given adequate notice that medical benefits were ending. He noted that the risk is to the insurer who may retain liability if proper notice is not made. Judge Davis indicated that a determination needs to be made as to where the Department will draw the line that the Commissioner has made sufficient effort to notify a claimant. Judge Gott also added that electronic addresses are becoming more and more in use, and that the forms presently used by the Department will mostly likely be

modified to include email addresses. Commissioner Swisher also indicated that the committee had previously discussed adding language to opinions and settlement agreements setting out the new statutes and informing a claimant of the requirements that must be met in order to apply for an extension beyond 780 weeks. Discussion followed that insurance carriers were also going to be asked to keep the Department aware of changes in a claimant's address whenever possible. The goal is to have all parties involved aware that addresses need to be kept up to date in order to be able to contact a claimant at the appropriate time prior to the cessation date of medical benefits.

Judge Coleman indicated that a medical provider would be required to complete a form or submit a report regarding the continued need for medical benefits. He suggested also giving medical providers access to set minimum and maximum costs for completion of disability forms.

Judge Davis indicated that his subgroup held some of the same concerns regarding notification of claimants as required by the statute on cessation of medical benefits. Mr. Hamblin asked the question what happens should a claimant not be notified. A short discussion followed resulting in a consensus that in such a case, a plaintiff would be able to seek treatment and a carrier would have the ability to challenge any treatment sought. Mr. Hamblin asked the question if it was necessary to prove that a plaintiff had been notified, such as is done with certified mail. Mr. Dietz noted that notice is different than service. Judge Coleman stated that receipt of an unsigned certified mail card would not stop a proceeding from moving forward. Mr. Miller stated that while it may not be required by due process that a claimant be served via certified mail, it does give an extra layer of assurance that a claimant has been notified. Mr. Naake felt that the finality of a claim would be more difficult without proof of service that notice has been given to a claimant, and once a plaintiff's claim becomes final, the liability of a carrier is released. Judge Gott requested that with the recommendations presented to the Commissioner, he consider them and report back to the committee at the next meeting his feelings on the subject of notice to a claimant at 754 weeks that medical benefits will soon cease.

Mr. Hamblin referred to the proposed regulations at B(1)(c) requiring a description of medical treatment sought. Commissioner Swisher indicated that it cannot always be done with certainty and can be fairly general. It may be that a claimant simply needs to have access to additional medical treatment when needed in the future without a request for a specific procedure. The regulation should leave the door open to any treatment, and a defendant/carrier is always able to file a medical dispute should it wish to challenge treatment.

Judge Coleman noted that proposed regulation B(7) states the claimant shall have the burden of proof. He questioned the need for this statement. Mr. Dietz indicated that a claimant has the burden to show that treatment is necessary and must file a medical report when making application for extension of benefits that will convince an administrative law judge sufficiently enough to grant the requested continuation. If a claimant does not meet the burden of establishing the necessity to hear the application,

then the defendant/carrier would not be required to file anything in defense of the application for extension of medical benefits.

Judge Gott asked for comments from the audience. Melissa Stevens of AIG Insurance expressed concerns regarding the timeline for a carrier to respond to a request noting that the 45 days set out in the proposed regulations is not sufficient for a carrier to obtain medical records, utilization review or an independent medical evaluation in some cases. Judge Gott stated that most medical disputes are currently resolved within the first 30 days. Ms. Stevens noted that most medical disputes are filed by the carriers and utilization review or an independent medical evaluation has already been performed prior to the filing of the dispute. She also noted that if a plaintiff is not actively treating at the time the application is made, it can be difficult for the carrier to respond without having sufficient time to obtain medical records and reviews. Judge Davis indicated that a carrier may always have the opportunity to request additional time but the committee did not want to set the initial response time out too far into the future resulting in all application for extension of benefits claims to be drawn out longer than necessary. Mr. Hamblin noted that there is a difference between a claimant requesting a specific treatment or simply continued coverage for the right to obtain treatment when needed. The goal is for the carriers to be able to "take claims off the books", but not to get rid of claimants that will require future treatment. A claimant's medical provider should have an expectation of future medical needs. Certainly claims without current information will be the most problematic for the carrier, but the claimant will be required to obtain a medical report stating any future treatment needs. Judge Davis stated that ALJs will recognize a carrier's need for additional time in certain instances. Mr. Dietz indicated that a defendant may still contest any treatment, and a general request for additional treatment does not exclude a carrier from contesting any treatment in the future.

Ms. Stevens asked how carriers would be given notice of a claimant's request for continuation of medical benefits. She noted there are TPAs that may handle a claim but that TPA may not be the claim holder at the end of the 780 weeks. Commissioner Swisher reported that the LMS electronic filing system currently captures and tracks all of the parties involved in a claim, including the parent insurance companies. He would take another look at what LMS stores insofar as listing parent insurance companies and report back to the committee at the next meeting.

Judge Gott turned the focus of the meeting to the issues of developing regulations for implementation of a drug formulary and treatment guidelines. This committee, along with the Medical Advisory Committee, are working together to meet the deadlines set out by the Legislature. He asked for comments from the committee subgroups regarding the First Fill issue and the Legacy Claims issue. Judge Coleman reported that his subgroup had reviewed the regulations being developed by the state of Montana. He felt they contained good guidance regarding obtaining expedited decisions when a medical provider prescribes a medication that is not approved on the drug formulary list. While Montana has a medical director, the same steps could be determined through utilization review in Kentucky. A medical provider would be able to look at the formulary posted to the Department's website, and if he was unable to prescribe a "Y" drug for the patient, he would have to give a reason for the need of a

drug not initially approved. The insurance carrier would then send the request to utilization review and, if denied, the claim would then move to a medical dispute. With a Legacy Claim, a medical provider would need to meet the time limit established by the regulations, and if the provider was unable to do that, an explanation as to why would be required. Again, the request would go to utilization review to be either accepted or denied by the carrier. Judge Coleman felt it would be an easy transition if the drug formulary is published on the website for the medical provider to access. Mr. Miller would like to keep the process close to what is currently in place stating that educating the medical providers will make it easier. He also suggested that costs be published on the website.

Judge Davis stated that his subgroup had more questions than answers regarding implementation of a drug formulary and treatment guidelines. Judge Gott noted that Kentucky does not have the amount of resources other states do. Mr. Naake felt that the regulations should address who is responsible for sending notice to which parties. He gave an example that should a plaintiff be prescribed an "N" drug, who will be told that it is an "N" drug and who will tell the medical provider. He also felt that incorporating utilization review into the regulations was necessary when a prescribed medication is denied. There should be a form for the medical provider to explain why the "N" drug is being prescribed over a "Y" drug. Then the insurance carrier can make the decision to accept the liability or try to get the medical provider to change the medication to a preferred drug.

Commissioner Swisher noted that Kentucky currently does not require mandatory prior authorization before medical treatment is provided. The process needs to be streamlined in order to allow a carrier to make a decision and notify the medical provider who can then request reconsideration of a denial. He reported that the Medical Advisory Committee has expressed concerns about the delay in obtaining peer-to-peer contact and suggested that the two parties set specific times when they will be available for consultation. Prior authorization can be blended into the utilization review process with the utilization process amended to make it work better. Because of the limited time and resources, Kentucky will most likely adopt either ODG or ACOEM. This will make the updating process more efficient as well.

Judge Coleman stated that he likes the Montana regulations for First Fill and Legacy Claims. Commissioner Swisher stated that the treatment guidelines are not meant to be more than a list of the best practice procedures, and they must allow for clinical judgment and variances in treating each patient. Giving this assurance will more likely get medical providers to comply with the regulations. Judge Gott felt that the drug formulary must be consistent with adopted treatment guidelines noting that it would be very difficult for a medical provider to make a case for prescribing an "N" drug working outside of treatment guidelines. Commissioner Swisher agreed stating that the drug formulary and treatment guidelines will be consistent.

Mr. Naake asked if First Fill regulations would always pertain to an emergency situation. Commissioner Swisher indicated that procedural processes will need to be developed for any issues falling outside of the treatment guidelines. Judge Davis noted that medications prescribed in a First Fill situation should be for no more than seven

days, and that the carrier would be responsible for the cost of First Fill. Some medications are limited to three days, so a seven day limit would catch most everything. While there is always a possibility for a fraudulent claim, Mr. Brian Allen noted that there are ways to screen them out. There are certain classes of medications that are not related to injuries and would never be approved for First Fill. The treatment guidelines can exclude some medications from the First Fill list, and a pharmacy will have access to which drugs are accepted and which are not. He stated that in his experience with other states, the insurance carrier and medical providers are able to work it out and that initial fill process works very well.

Ken Eichler from ODG encouraged the committee to make the process easy for medical providers when asking for peer-to-peer contact, and one way to do that is to allow for a mid-level practitioner, such as a P.A., to perform the peer-to-peer interview in place of the primary medical provider. He noted that the state of Montana has two part-time medical directors but it is still a slow process compared to other states. "N" drugs must be turned around within 72 hours by obtaining utilization review or discussion between the carrier and provider. He stated that the process needs to be easy enough to deter a patient from simply going to the emergency room for treatment. Rosalie Faris stated that medical providers are used to obtaining prior authorizations, as this is required in other practice areas, not just in workers' compensation cases. She stated that utilization review generally is turned around within 48 hours but an appeal time can take as many as 10 days. The appeal time could be shortened for drugs by allowing for expedited appeals which can generally be obtained within 24 hours, before a patient is released from a hospital. She noted that most of the "Y" drugs do not address extent and duration, only necessity, and the regulations should not be written so tightly that "Y" drugs cannot be challenged. Even preferred drugs must be prescribed appropriately for the right condition.

Following a short break, the committee reconvened. Judge Gott told the committee and attendees that copies of the regulations from Montana, Tennessee, Texas and New York were available to anyone who wanted them as well letters submitted from IWP and Mitchell.

Mr. Eichler stated that the drug formulary is a list of drugs, assigned as preferred or non-preferred. This makes it easier for medical providers when prescribing for their patients. He also offered access to a flow chart of steps required when a patient is given a prescription through the point of that medication being filled by a pharmacist. The formulary, however, does not solve the problem of First Fill, and is used after the urgency has passed. Ms. Stevens stated that carriers do not want to pay for medications before a claim has been determined to be compensable. Commissioner Swisher stated that First Fill is the exception to that. Mr. Dietz stated that he would like to see a mechanism developed to verify that a workers' compensation claim has been filed. Commissioner Swisher felt that the risk to the employer is outweighed by the benefit to the injured worker. The purpose is to give the injured worker the benefit of the doubt. Developing the process for First Fill will involve determining how far the regulations will go in granting payments.

Tamara Todd Cotton stated she has faced many problems in delays obtaining treatment for clients with carriers stating that the investigation is ongoing. A discussion followed regarding obligations for First Fill without obtaining pre-authorization, as it is independent and separate from the drug formulary. Some medications will need to be carved out of the First Fill list such as compound creams which will always require pre-authorization.

Commissioner Swisher reported that Dr. Snyder from Tennessee will attend a meeting on August 30, and he asked that this committee combine its meeting with the Medical Advisory Committee to hear his presentation. Judge Gott asked that the Regulatory Committee meet at 11:00 a.m. on August 30, and then meet jointly with the Medical Advisory Committee at 2:00 p.m.

Ed O'Daniel asked if the two overlapping projects before the Department, those being the development of the treatment guidelines and the drug formulary, would include pain management and opioids. He also asked if the Commissioner controlled the effective date of implementation of either. Commissioner Swisher stated that it is his hope that the project yields both although implementation dates may be different. It is his intention to have both done before the end of 2018, but is not sure that that is going to be possible. He agreed that the drug formulary and treatment guidelines go hand-in-hand, and these committees will work aggressively to get these done. Mr. Eichler noted that the formulary is evidence-based and not cost-driven, and that the evidence must come from the guidelines.

Commissioner Swisher reported that on Tuesday, July 31, the Department will hold two separate sessions for stakeholders to discuss amending the pharmacy fee schedule. These meeting are open to the public and anyone interest is welcome to attend.

Upon motion by Judge Coleman, seconded by Judge Davis, the meeting was adjourned at 3:20 p.m.