NOTES FROM A SEMINAR:
NORTHEASTERN REHABILITATION ASSOCIATES
ANNUAL SEMINAR 2018

Wilkes-Barre, PA
October 16, 2018

Northeastern Rehabilitation Associates convened its annual occupational medicine seminar on October 16, 2018. The venue, like the last few years, was the Mohegan Sun at Wilkes-Barre, PA. This seminar is a can't-miss if one is interested in immersion in the critical medical and medico-legal topics of our field. Added features: the conference is well-organized and the speakers are uniformly well-prepared and remarkable in their ability to communicate often complex knowledge to a non-physician audience. On the topic of the audience – my attentive colleagues seemed to be largely nurse case managers and adjusters, though a number of lawyers and judges were also present. It seemed, in any event, that the physician presenters addressed many of the topics with the audience of their fellow medical professionals in mind.

For example, the initial presentation, "Evaluation and Management of Hip Pain," by Dr. Sherly Oleski, concentrated exclusively on the anatomy and dysfunction of the hip joint, and how pathologies surrounding the same are diagnosed and treated. (She illustrated her presentation with the image, reproduced above, of the starting line of Scranton's Steamtown Marathon, 2018. It is true indeed that one cannot have hip dysfunction and hope to endure the 26.2!) Dr. Kelly Williams, meanwhile, an expert on and enthusiast in using ultrasound in surgical procedures, explained in detail how an ultrasound-guided carpal tunnel release operation is now available.

Dr. Scott Naftulin described a new minimally invasive operation for stenosis. It goes by the term "MILD" (minimally invasive lumbar decompression). This technology, he noted, has actually been around for some time, but because at first Medicare would not pay for the same, few doctors were using it. CMS now allows MILD in certain cases and a number of physicians, including Dr. Naftulin, are administering the treatment.

Dr. Christopher Connor endorsed, in general, the use of spinal cord stimulators in cases of failed back syndrome. He also reviewed the "Budapest Criteria," utilized by some physicians in diagnosing CRPS. Notably, in diagnosing the condition, the import of *bone scan* results has lessened. A negative bone scan, Dr. Connor stated, currently is thought *not necessarily* to mean that there is no RSD.

The seminar power-point slides were provided on a thumb-drive. I have set forth here select items which I discerned, from my notes, as highpoints for the lawyer and judge.

1. ***The opioid overuse/abuse crisis.*** Several presentations were not on anatomy, diagnosis, and treatment but, instead, implicated the social and psychosocial issues that are often current in our field. Dr. Lucian Bednarz was a critical lecturer in this regard, speaking, as he has in the past, on opioid use in the chronic pain context and the overuse/abuse crisis that has unfolded in recent decades. The doctor noted at the outset the phenomenon of the "pendulum swinging" regarding the prescription of opioids. For many years – in those decades when opioids were recommended for chronic pain – "prescribing to tolerance" was the rule. That approach is now conceived as the *old model* – the new model is *de facto* limits on prescriptions by, if nothing else, what workers' compensation insurance and other carriers will pay. And, of course, guidelines from the federal and state governments now exist that establish ceilings on prescriptions.

Dr. Bednarz seemed sympathetic to governmental and other advocacies against widespread opioid prescription for chronic pain. Of course, in general, physicians must be careful in their prescriptions of opioids given their oath, "first, do no harm" (*primum non nocere*). We now know that overuse of opioids can be dangerous and even fatal. He quipped, "drug lords in the modern day are not from third world countries, but are graduates from American medical schools."

The doctor also reviewed our state's Prescription Drug Monitoring Program (PDMP). With regard to that program, see https://www.health.pa.gov/topics/programs/PDMP/Pages/PDMP.aspx (state agency posting noting that "[a]s of June 11, 2018, the Pennsylvania Prescription Drug Monitoring Program is sharing data with 17 other states and D.C. Interstate sharing of data helps prescribers and pharmacists get a more complete picture of their patients' controlled substance prescription histories, regardless of which state they filled their prescription in."). He remarked that such databases can be valuable, observing that benzodiazepines* (*i.e.*, Xanax, Valium, Ativan, and Klonopin) and opioids are especially risky when used in combination. *See also* https://americanaddictioncenters.org/prescription-drugs/dangers-of-mixing. On the subject of overdoses, particularly fatal ones, the doctor observed that many involve multiple drug combinations.

Dr. Bednarz, fielding a nurse's question, on how physicians discern drug-taking behavior, responded that part of the dynamic is "gestalt," but he also noted other factors – like the patient naming the precise drug that he or she wants, even referring to it by its nickname. These types of behaviors, he posited, certainly constitute red flags. (This writer knew only the term "benny"; an impressive list, in any event, can be found at https://lastingrecovery.com/know-drugs-street-names-benzodiazepines/.)

Dr. Connors, who later also spoke on chronic pain, remarked miscellaneously that the opioid drug Opana is now off of the market. He noted that that when treating chronic pain patients and trying to get them off such drugs, it is preferred that the drug is slowly reduced. He used the term "titrating down." For a briefing on titration in general, see https://www.verywellmind.com/what-does-titration-of-medication-mean-20899. As for Opana

* A class of sedative medications usually prescribed for insomnia, anxiety, seizures, and other conditions.

having been taken off the market, see the IWP post, "Voluntary Removal of Opioid Opana ER from the Market," http://info.iwpharmacy.com/voluntary-removal-of-opioid-opana-er-from-the-market.

2. ***Medical Marijuana: Storm & Stress.*** Dr. Michael Wolk, as he did at the Labor & Industry Conference in Hershey, June 2018, spoke on the issue of medical marijuana, with a focus on "what we have learned." The doctor's 49 updated slides are detailed – a must for one's review – and feature a bibliography at the conclusion.

As in Hershey, the doctor talked about medical marijuana as an alternative to opioids. The doctor had at least some sympathy with the proposition, noting that, objectively, medical marijuana seems less hazardous than do opioids; after all, the incidence of marijuana-induced fatalities (through overdoses), is essentially zero. In this regard, the amount of marijuana one would have to ingest to result in *death* is extremely high.

Dr. Wolk undertook a segue from the subject of the Dr. Bednarz presentation – the now-discredited recommendation of using opioids for chronic pain. Dr. Wolk, in this regard, noted that this movement was heralded by a medical interest group advocacy that pain should be the "fifth vital sign." Ironically, some now *denounce* the idea that pain should be such a vital sign. It is notable, in this regard, that pain is not objective, as are the other vital signs. "Pain," the criticism goes, "is a symptom, not a vital sign …." In contrast, "blood pressure, heart rate, respiratory rate, and temperature can be measured objectively." *See*, *e.g.*, https://www.medpagetoday.com/publichealthpolicy/publichealth/57336 (detailing the debate).

The liberal use of opioids was most memorably taken to an extreme by chronic pain patients walking around sucking the "Actiq" lollipop, a product initially intended for those dying of cancer. The doctor wondered out loud whether "we are making the same mistake with medical marijuana that we did with opioids." In other words, is society embracing the use of medical marijuana without being educated as to its potentially dysfunctional and long-term effects?

Dr. Wolk, while not rejecting the efficacy of medical marijuana in some cases, was firm in his belief that the liberalization of medical marijuana law in substantial contributing aspect is reflected by states wanting *tax revenues*. He is convinced of this because (for at least one reason), the *medical community* did not push for such liberalization. The doctor, with his slides, graphically displayed the specifics – showing that states which have legalized marijuana are achieving extraordinary tax revenues. The doctor was critical of this phenomenon and opined that tax revenue, as a basis for legitimizing medical marijuana, was reflective (my term) of a perverse incentive. Certainly this is so "when we do not have all the research on the many possible risks" of medical marijuana.

Other potential legal and societal problems exist as well. Among these are inconsistencies with the status of legality among the states, and the confusion caused when individuals are using both medical and recreational marijuana as well. And, of course, a

seemingly insurmountable tension exists surrounding (1) legalized state medical marijuana; and (2) criminalized federal drug possession laws. This tension, for now, is a mighty one for players in the workers' compensation community.

Dr. Wolk suggested that, were he a utilization review peer, he would likely opine that medical marijuana is not reasonable and necessary treatment, as insufficient research exists to support efficacious use. The doctor did seem sympathetic to the proposition that medical marijuana should only be found reasonable and necessary if opioid use is in fact reduced. The doctor did admit to a bias against medical marijuana, though he certainly made his case for why that bias exists. He found, in any event, the use of medical marijuana in children especially troublesome. The doctor remarked that he realized that some insurers will perhaps find medical marijuana attractive, as it is much less expensive than costly opioids.

Commenting on problems with medical marijuana use and its interface with employment law, the doctor stated that medical marijuana agents stay in the user's system for 30 days. One cannot tell, upon testing, whether an individual has been using medical marijuana or, on the other hand, recreational marijuana.

It is notable that it is the dispensary personnel (as opposed to physicians) who interface with the patient and then choose and sell the precise type of marijuana product. This fact is a major irony of the medical marijuana legalization phenomenon. Still, the *container*, at least in Pennsylvania, will list the particular ingredients. This will key the sophisticated physician with regard to whether the desired compounds are or are not in the medical marijuana.

The doctor identified the medical marijuana and Americans with Disabilities Act concerns. In this regard, one can imagine a scenario where an injured worker can return to work and undertake his labor, using medical marijuana; but then is fired under an employer zero-tolerance program for testing positive for medical marijuana. The doctor raised the issue as to whether such employer discipline would constitute a violation of the Americans with Disabilities Act. The doctor ably recognized the leading Colorado case in this largely unexplored area, which case held that firing was legitimate. *See Coats v. Dish Network*, 350 P.3d 859 (Colorado 2015) (state supreme court holding that model employee, a quadriplegic who used medical marijuana for spastic disorder, was not wrongfully terminated as a result of his medical marijuana use). *See* https://www.cannalawblog.com/coats-v-dish-network-and-firing-employees-for-cannabis/.

3. ***Chronic Traumatic Encephalopathy***. Dr. Paul Horchos spoke on Chronic Traumatic Encephalopathy (CTE). The doctor noted that while CTE has been much in the news, with the attention given to football players of all ages, in fact the ailment itself was identified in medical literature in the 1920's. The problem has been identified in boxers, and of course the term "punch drunk" has long been used to describe veterans of the sport. Even in the 1920's, this was cleverly denominated as "dementia pugilistica."

An intriguing phenomenon of CTE is that some individuals develop the situation after significant head trauma, whereas others do not. He drew a dichotomy between "wooden-headed" players versus those with glass jaws.

Dr. Horchos remarked that some research has suggested that ALS, or Lou Gehrig's Disease, is in fact connected to the same type of head trauma that gives rise to CTE. In this regard, football players and military combat veterans have a higher incidence of ALS than the general public. According to seemingly dependable Internet post, "CTE is known to cause a wide-range of symptoms. The most well-known are memory problems, difficulty controlling emotions or anger issues, and severe depression. However, some people with CTE also develop symptoms similar to a variant of ALS that causes cognitive impairment…. According to [the] lead author [of a new study] …these overlapping symptoms may be caused by the same build up, or aggregates, of tau proteins."). *See* https://traumaticbraininjury.net/2018/01/16/study-finds-link-between-cte-and-lou-gehrigs-disease/.

On the related issue of traumatic brain injury (TBI), Dr. Horchos emphasized that the symptoms of the same *do not* get worse over time. Thus, when the patient who has TBI, or is believed to have TBI, complains of worsening symptoms, the physician faces a challenge.

NURSE CASE MANAGER ROLE AND ETHICS DISCUSSED AT NORTHEASTERN REHABILITATION ASSOCIATES SEMINAR

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The role and ethics of nurse case managers was addressed at several of the seminars I attended this year. For example, at ABA workers' Compensation-Nashville, during a panel discussion about the opioid abuse crisis, a defense attorney strongly recommended to carrier representatives the use of nurse case managers in suspected overuse or abuse situations. Meanwhile, at the Texas Bar Association annual workers' compensation CLE, in-house counsel for a large non-subscriber indicated that, in its voluntary plan, the company had its own employee nurse case managers, and she conceived of a nurse serving in such capacity as "just one employee helping another …."

The topic was front and center at the annual Northeastern Rehabilitation Associates seminar, convened at the Wilkes-Barre Mohegan Sun. The session, specifically, addressed the role and ethics of nurse case and other disability managers in the workers' compensation process. The nurse case manager Regina Stanton and Attorney Christopher Pavuk (Chartwell Law Offices, Scranton) presented the discussion.

1. ***Goals of disability management.*** The speakers introduced the issue by discussing the goals of disability management. Those goals are to help facilitate treatment in pursuit of maximum medical improvement and, also, assist in the worker's return to gainful employment. Attorney Pavuk, for his part, generally conceived of nurse case managers as having two roles. These are, first, the facilitation of treatment; and, second, the investigative role.

2. ***Types of disability management.*** At least three types of case management exist. The first is the most simple: coaching over the telephone. The second is field management, which is the most familiar to the practicing attorney. The final, meanwhile, is "single task" efforts when a nurse case manager is – often at the last moment – dispatched to undertake, *ad hoc,* facilitation of treatment or some other task.

3. ***Need for and Issues Surrounding Communication***. Ms. Stanton stressed that, if at all possible, the nurse case manager should contact the worker before appearing at an appointment. Sometimes, however, that is not possible. For example, if the nurse is dispatched to the emergency room by the insurance company client, obviously no preparation for the meeting is possible. For best results, she attempts, in her work, to build rapport with the worker and his or her attorney. As to the visit itself, Ms. Stanton always inquires of the worker, "may I go in the exam room with you?"

Ms. Stanton and Attorney Pavuk stressed that the nurse case manager's report is "not confidential to you" or the client. Thus, statements reflecting bias must be avoided. The nurse case manager's report can be subject to discovery and/or subpoena.

4. ***Communication by Nurse Case Manager with Treating Physician***. The perennial issue arose: Can the nurse case manager communicate with the physician? The panelists, for guidance, here identified two CFR-based HIPAA Regulations, 45 C.F.R. § 160.103 (definitions) and 164.512(l). These federal regulations indicate that the privacies individuals enjoy under HIPAA do not apply in the workers' compensation context. The latter regulation provides, "Standard: Disclosures for workers' compensation. A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault." The definition of "covered entity," meanwhile, includes a "health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter."

Despite this inapplicability, it is still true that what health care providers can reveal to employers and their agents is information *relative to the work injury*. Indeed, if a worker tries to tell Ms. Stanton too much, she will admonish, "don't tell me any confidential information…." She will advise the patient that such collateral information may be conveyed to the employer. Ms. Stanton fully recognized the tension that exists in this regard. That is, the nurse case manager is employed by and reporting to the insurance company, but is an advocate for the patient. She summarized, "We advocate for the client [the injured worker], but our customer is the workers' compensation insurer – so, there must be balance."

Of course, on occasion, a worker and/or his lawyer may say: "No, the nurse case manager is not permitted to talk to the physician." Under her practice, she still may do so, if the physician in question indicates that such interface is still acceptable. Ms. Stanton ventured, "more and more physicians welcome us. [The nurse case manager] is now accepted … and even expected." Still, she seems to approach the issue on a case-by-case basis. If the doctor will still talk to her, she will, despite the lawyer's prohibition, do so.

Yet, critically, she will first consult the adjuster. If the adjuster does not want the nurse case manager to push the envelope on this point, she will not do so. One need not be an advocate on this issue to infer from this remark that the nurse case manager is operating as an agent of the carrier.

Attorney Pavuk, for his part (perhaps departing from Ms. Stanton's view), opined that it was a "best practice" at the point of objection by claimant's counsel, for the nurse case manager to back off. At least one reason, Mr. Pavuk ventured, is that the whole relationship is not supposed to be adversarial.

Mr. Pavuk identified a Wilkes-Barre WCOA office ruling on a penalty petition involving this issue. A nurse case manager had talked to a physician after counsel's disallowance. Counsel then filed a penalty petition alleging a violation of HIPAA. The penalty petition was denied. In that case, Judge Snyder recounted the dispute at length, noted the seriousness of the dispute, but ultimately ruled that counsel had not identified any provision of the *Workers' Compensation Act* that had been violated after the nurse case manager continued, over her objection, to interface with the treating physician. *See Claim of W.T.* (circulated 9.11.2015, Snyder, WCJ).

5. ***Should the process be regulated?*** In response to this writer's inquiry, Ms. Stanton would find valuable a regulation or Bureau policy statement to guide the rights and responsibilities of nurse case managers.

It is notable that several states do indeed regulate the process. *See* Justin D. Beck, *Nursing the Wound: The Law and Ethics of Disability Management in Workers' Compensation*, PBA WC Law Section Newsletter, Vol. VII, No. 133 (PBA 2018), www.davetorrey.info.

APPENDIX

The Department of Health & Human Services website posting on the applicability of HIPAA to state workers' compensation programs.

Disclosures for Workers' Compensation Purposes

[A commentary on 45 C.F.R. § 164.512(l)]

Background

The HIPAA Privacy Rule does not apply to entities that are either workers' compensation insurers, workers' compensation administrative agencies, or employers, except to the extent they may otherwise be covered entities. However, these entities need access to the health information of individuals who are injured on the job or who have a work-related illness to process or adjudicate claims, or to coordinate care under workers' compensation systems. Generally, this health information is obtained from health care providers who treat these individuals and who may be covered by the Privacy Rule. The Privacy Rule recognizes the legitimate need of insurers and other entities involved in the workers' compensation systems to have access to individuals' health information as authorized by State or other law. Due to the significant variability among

such laws, the Privacy Rule permits disclosures of health information for workers' compensation purposes in a number of different ways.

How the Rule Works

Disclosures Without Individual Authorization. The Privacy Rule permits covered entities to disclose protected health information to workers' compensation insurers, State administrators, employers, and other persons or entities involved in workers' compensation systems, without the individual's authorization:

• As authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness without regard to fault. This includes programs established by the Black Lung Benefits Act, the Federal Employees' Compensation Act, the Longshore and Harbor Workers' Compensation Act, and the Energy Employees' Occupational Illness Compensation Program Act. See 45 CFR 164.512(l).

• To the extent the disclosure is required by State or other law. The disclosure must comply with and be limited to what the law requires. See 45 CFR 164.512(a).

• For purposes of obtaining payment for any health care provided to the injured or ill worker. See 45 CFR 164.502(a)(1)(ii) and the definition of "payment" at 45 CFR 164.501.

Disclosures With Individual Authorization. In addition, covered entities may disclose protected health information to workers' compensation insurers and others involved in workers' compensation systems where the individual has provided his or her authorization for the release of the information to the entity. The authorization must contain the elements and otherwise meet the requirements specified at 45 CFR 164.508.

Minimum Necessary. Covered entities are required reasonably to limit the amount of protected health information disclosed under 45 CFR 164.512(l) to the minimum necessary to accomplish the workers' compensation purpose. Under this requirement, protected health information may be shared for such purposes to the full extent authorized by State or other law. In addition, covered entities are required reasonably to limit the amount of protected health information disclosed for payment purposes to the minimum necessary.

Covered entities are permitted to disclose the amount and types of protected health information that are necessary to obtain payment for health care provided to an injured or ill worker. Where a covered entity routinely makes disclosures for workers' compensation purposes under 45 CFR 164.512(l) or for payment purposes, the covered entity may develop standard protocols as part of its minimum necessary policies and procedures that address the type and amount of protected health information to be disclosed for such purposes.

Where protected health information is requested by a State workers' compensation or other public official, covered entities are permitted to reasonably rely on the official's representations that the information requested is the minimum necessary for the intended

purpose. See 45 CFR 164.514(d)(3)(iii)(A). Covered entities are not required to make a minimum necessary determination when disclosing protected health information as required by State or other law, or pursuant to the individual's authorization. See 45 CFR 164.502(b). The Department will actively monitor the effects of the Privacy Rule, and in particular, the minimum necessary standard, on the workers' compensation systems and consider proposing modifications, where appropriate, to ensure that the Rule does not have any unintended negative effects that disturb these systems.