DEPARTMENT OF LABOR AND INDUSTRY

Meeting minutes: MSRB PTSD Workgroup

Date: Sept. 13, 2018
Minutes prepared by: Anita Hess
Location: DLI Minnesota Room

Attendance

Workgroup members	Interested parties
Beth Baker	Kim Olson – MSRB RN alternate, Corvel
Elisha Harris (phone)	
Dan Wolfe	**Guests**
	Deb Anger – LMCIT
DLI staff members	Rob Boe – LMCIT
Ernest Lampe	Rob Prall – LMCIT
Chris Leifeld	Mimi Lynn – MCIT
Ethan Landy	Karen Ebert – MCIT
Laura Zajac	Patty Prentice – LMCIT
Anita Hess	Brian Gould (phone) – psychiatrist, Courage Kenny
Pam Carlson	Tiffany Grzybowski (phone) – HealthEast

Alexis Russell	

Call to order

Chairwoman Dr. Beth Baker welcomed everyone to the third PTSD Workgroup meeting. Introductions were made around the room. Baker stated the workgroup will meet again Sept. 26 from noon to 1 p.m. and will hear from Veterans Affairs (VA).

Overview of PTSD data

a) Deb Anger and Patty Prentice, League of Minnesota Cities Insurance Trust

Deb Anger, League of Minnesota Cities Insurance Trust (LMCIT), explained she submitted information about LMCIT post-traumatic stress disorder (PTSD) claims data to the workgroup ahead of the meeting. She and her colleagues are here today to answer questions about those comments. They provided scenarios about some successful return-to-work situations and some not so successful.

Baker noted one of the LMCIT suggestions was to begin a diagnosis as soon as possible. Anger explained that under the statute, they need to pay or deny a claim within 14 calendar days of the first day of lost time from work. If a diagnosis is not made until 30 days, it forces them to deny a claim for the injured worker. Ernest Lampe noted the diagnostic criteria require the symptoms to last for 30 days. In many cases, symptoms resolve spontaneously during that time. Baker stated the legislation requires diagnosis by a psychiatrist or a psychologist and it's difficult to see a psychiatrist or psychologist within 14 days. Lampe said the claim would initially be acute stress disorder and then could change to PTSD. Acute stress disorder is not included in the statutory definition.

Lampe noted LMCIT recommended flexibility in the parameters and asked Anger what treatments they had in mind. Anger said they do not have any treatments in mind, but would like the parameters to be a living document that can be updated and re-evaluated. Lampe indicated a risk of rules is that they are too rigid, as opposed to the more flexible "guidelines." Anger stated the goal is to get people well and the concern is if a treatment isn't working, there be another treatment available in the rules.

Dan Wolfe asked if he was correct that if the guidelines change, the rules have to be reviewed. Lampe confirmed this was the case. Baker expressed concern that the American Psychological Association (APA) guidelines may not change for many years, even as new data is available.

Baker said subpart 6 of the draft rule states only one therapy modality should be used at a time. She did not see this in the APA guideline and would rather therapists have the flexibility to use the modalities they think are appropriate. Laura Zajac said the Department of Labor and

Industry (DLI) would followup on this issue. Lampe noted research studies are usually structured so that only one modality is given at a time.

b) Karen Ebert, Minnesota Counties Intergovernmental Trust

Karen Ebert, attorney, Minnesota Counties Intergovernmental Trust (MCIT), presented to the workgroup regarding their PTSD claims experience. She said MCIT allows members to jointly self-insure for workers' compensation. MCIT covers 80 counties for a total of 27,000 employees. It does not cover the large metropolitan counties.

Ebert explained that since the statute was amended in 2013, MCIT has received 40 claims for PTSD-only, of which 23 were denied. Most of the denials were due to lack of a required psychological or psychiatric diagnosis of PTSD. MCIT is seeing that usually patients use an employee assistance program (EAP) and are seen by a licensed clinical social worker. They may get a diagnosis by a family practice doctor, but not by a psychiatrist or psychologist. As the LMCIT mentioned, MCIT only has 14 days to accept or deny the claim. Eventually, the employees may get the proper diagnosis.

Ebert said that in most of the PTSD claims she reviewed there is anxiety and depression. In terms of treatment, she said it is important to have something to measure. They have limited resources in the smaller counties. The claims MCIT accepted were made by deputies, correctional officers and 911 dispatchers.

The PTSD patients Ebert sees receive more than one modality at a time; for example, EMDR and CBT. Almost all of the patients receive anti-depressants and anti-anxiety medications.

Wolfe asked if any of the accepted claims were receiving only one psychotherapy treatment modality. Ebert replied no. Baker added that is what she has seen as well, although sometimes the treatment notes are not clear what modality the therapist is using. Ebert said she has not seen EMDR as a stand-alone treatment.

c) Kim Olson, Corvel Corporation

Kim Olson, Corvel Corporation, gave a PowerPoint presentation about PTSD treatment data related to 2017 and 2018 dates of service. Olson reviewed the bills Corvel received with a PTSD diagnosis according to the ICD-10 codes. She started with 99 claims, but 66 of the claims had dates of injury before 2017. Olson looked at the 33 claims with dates of injury from 2017 to 2018. Five claims were in the new presumption rule because they were brought by corrections and police officers. All but one of the 33 claims had a physical injury as well. Olson reviewed the specific details of these claims, including the treatment, if available.

Olson is often seeing that patients are not getting proper treatment for PTSD because they are not being seen as frequently as they should. She was surprised the claims were almost evenly split between male and female, with slightly more female than male. Olson reviewed the different types of providers who diagnosed the patients with PTSD.

In all 33 claims, only 14 of the claims would have met the PTSD criteria within the first 30 days after the traumatic event. However, this would not be an official diagnosis because symptoms have to last for 30 days. In the 31- to 90-day range, Olson found 10 claims; in the greater than 90-day range, there were nine claims.

Olson did not think the treatment was aggressive enough. Another problem was instances where PTSD was listed as an ICD-10 code (diagnosis) on the bill, but not in the provider's notes. Also, patients do not always follow through with counseling recommendations. Olson saw that EMDR was being done in a pain clinic and, often, in the context of a head injury or concussion.

Olson noted two success stories where the patients' PTSD resolved through 14 to 24 psychotherapy sessions.

Workgroup discussion and review of draft rule language

Zajac, DLI attorney, reviewed the draft PTSD treatment parameter rule language dated Sept. 7, 2018, which was sent to the workgroup before the meeting.

Baker suggested on page two, subpart 3, the language "history of mental health treatment" be changed to "history of mental health conditions" to allow for situations where there was a prior diagnosis of a mental health condition but no treatment. She also recommended examples of the assessment tools be added and an assessment tool be required for diagnosis.

There was discussion about who should perform the initial evaluation — the diagnosing provider, the therapy provider or both providers.

Baker noted the VA refers to trauma-based treatment modalities and wondered if that term should be added to subpart 5, because all of the modalities listed are trauma-based.

Wolfe asked whether the patient is limited to one change in therapist within the first 60 days. Zajac will follow up on this by reviewing current law governing a change in primary health care providers.

Baker asked whether the rules should state specifically that a patient should only have additional therapy past 16 weeks if they continue to meet the DSM-V diagnostic criteria for PTSD and have significant subjective complaints and functional impairment. Also, the patient's diagnosis of PTSD should be re-validated before additional treatment. Baker thought the therapist could do this re-diagnosis. Lampe noted there is a complete psychological assessment required for patients who are not responsive to therapy or drop out. Baker explained some patients drop out of therapy because they are better and would not need a psychological assessment. She suggested the language be changed to allow for this.

Baker recommended examples of medications be included. She asked Dr. Brian Gould if the propranolol is helpful, because it is not mentioned in the VA and APA documents. Gould said propranolol is used in clinical practice, even though it isn't mentioned in the algorithms. However, he didn't think it would be a big loss to drop propranolol from the draft language.

Adjournment

Baker said discussion of the draft rules will be continued at the next meeting and asked that comments be sent to Alexis Russell in the meantime. Baker thanked everyone.