Senate Counsel & Research

G-17 STATE CAPITOL
75 CONSTITUTION AVENUE
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX (651) 296-7747

JO ANNE ZOFF SELLNER
DIRECTOR

Senate
State of Minnesota

S.F. No. 795 - Coverage for Interpreter Services

Author: Senator Linda Higgins

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: February 21, 2005

S.F. No. 795 requires a health plan to cover language interpreter services provided to non-English-speaking enrollees. These services may be provided in person or by telephone. A health plan company may provide these services directly or may require the provider or health care facility to provide or arrange interpreter services. In either case, the person providing the interpreter service must bill the health plan company and not the provider. Providers or health care facilities that employ or contract with interpreters shall be reimbursed directly by the health plan company. A health plan company, upon request, must provide to enrollees the policies and procedures for addressing the needs of non-English-speaking enrollees.

KC:vs

Senators Higgins, Kleis, Senjem and Johnson, D.E. introduced--
S.F. No. 795: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; requiring coverage for or provision of language interpreter services for enrollees; proposing coding for new law in Minnesota Statutes, chapter 62Q.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [62Q.40] [LANGUAGE INTERPRETER SERVICES.]

A health plan must cover language interpreter services provided to a non-English-speaking enrollee in order to facilitate the provision of health care services by a provider or health care facility. For purposes of this section, "provider" has the same meaning as provided under section 62J.03, subdivision 8; and "health plan" includes coverages excluded under section 62A.011, subdivision 3, clauses (7), (9), and (10). Language interpreter services may be provided in person or by telephone. A health plan may provide language interpreter services directly to a non-English-speaking enrollee. Where a provider or health care facility is required to provide or arrange for language interpreter services for an enrollee, a health plan shall reimburse the party providing interpretive services directly for the costs of language interpreter services provided to the enrollee. Persons providing language interpreter services that are reimbursed by a health plan must bill the health plan for such services and may not bill the provider or health care facility providing or

arranging for such services. Providers and health care facilities that employ or contract with language interpreters may bill and shall be reimbursed directly by health plan companies for such services. A health plan company shall provide to enrollees, upon request, the policies and procedures for addressing the needs of non-English-speaking enrollees.

Sec. 2. [EFFECTIVE DATE.]

Section 1 is effective the day following final enactment and applies to plans issued or renewed to provide coverage to Minnesota residents on or after that date.

Senator ..... moves to amend S.F. No. 795 as follows:

Page 1, line 9, after "enrollee" insert "or an enrollee who is deaf or deafblind"

Page 1, line 16, before the period, insert "or other accessible technology" and after "plan" insert "company"

Page 1, lines 20 and 24, after "plan" insert "company"

Page 2, line 6, before the period, insert "and enrollees who are deaf or deafblind"

Adopted on Feb. 22, 2005

Senator Higgins moves to amend S.F. No. 795 as follows:

Page 1, line 16, after "plan" insert "company"

Page 1, line 20, after "plan" insert "company may require that interpreter services for its enrollees be provided by interpreters who are approved or provided by contract or otherwise by the health plan company. Where a health plan company does not have approved interpreters or does not directly provide interpreter services for its enrollees, the health plan company"

Page 1, line 24, after "plan" insert "company" in both places

Passed

Senator Berglin moves to amend S.F. No. 795 as follows:

Page 1, line 8, before "A" insert "(a)"

Page 2, after line 6, insert:

"(b) A health plan company shall not increase premium rates to cover the cost of providing or associated with providing language interpreter services required under paragraph (a)."

Failed

Senator Kiscaden moves to amend S.F. No. 795 as follows:

Delete everything after the enacting clause and insert:

"Section 1. [LANGUAGE INTERPRETER SERVICES STUDY.]

The commissioner of commerce, in consultation with the commissioners of health, human services, and emloyee relations, and representatives of health plan companies, health care providers, and non-English-speaking communities, shall study and make recommendations on providing language interpreter services to non-English-speaking patients in order to facilitate the provision of health care services by health care providers and health care facilities. The recommendations shall include:

(1) a regulatory system for language interpreters, which includes appropriate standards for education, training, and credentialing to ensure the availability of professional interpreter services when needed; and

(2) criteria for determining financial responsibility for providing interpreter services to enrollees of health plans, including the responsible party for arranging interpreter services and for reimbursement for these services.

The commissioner of commerce shall submit these recommendations to the legislature by January 15, 2006."

Amend the title accordingly

Passed

February 22, 2003

Senator Linda Higgins, Dist. 58
328 State Capitol
St. Paul, MN 55155

Dear Senator Higgins,

Thank you for introducing S.F. 795 requiring health plans to cover payments for language interpreter services. This is a real problem for our member practices across the state, especially where we have high populations of workers that speak a language other than English.

S.F. 795 places the responsibility for payment of interpreters where it should be, at the plan level. Chiropractic services are often times billed at the $35 to $85 range depending on the service being provided. The interpretive service we are billed currently is in the range of $150 - $200. You can see we cannot even cover the costs of the interpreter. Something must be done to correct this problem or providers will no longer be able to accept these patients.

The Minnesota Chiropractic Association has joined with the Minnesota Provider Coalition to lobby in support of S.F. 795. Please let us know how we can support your efforts to resolve this problem.

Sincerely,

Dr. Matt Caron
President

12445 River Ridge Blvd., Ste 100
Burnsville, MN 55337
952 882-9411 • FAX 952 882-9397

MINNESOTA
PODIATRIC
MEDICAL
ASSOCIATION

LEGAL COUNSEL-LEGISLATIVE LOBBYIST
MICHELLE M. BARRETTE
BARRISTER BUILDING
1465 ARCADE STREET
ST. PAUL, MN 55106
(651) 778-0575
FAX (651) 778-1149

February 22, 2005

Chairwoman Becky Lourey
Health and Family Security Committee
G-24 State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155-1606

Re: Senate File 795 - Language Interpreter Services

Dear Senator Lourey and Committee Members:

The Minnesota Podiatric Association (MPMA) consisting of 130 Podiatric Physicians and Surgeons supports Senate File 795 which requires payers, including health plans, to reimburse for language interpreter services.

Podiatric Physicians and Surgeons provide quality and cost effective foot care services to patients who are non-English speaking but there is a need for reimbursement costs for language interpreter services. Currently the Podiatric Physician and Surgeon must pay out of their pocket for the full costs of the interpreter services. Placing the obligation to pay for these services on all health care payers is the fairest way for Podiatrists to comply with federal law and to insure consistent quality services for non-English speakers who require foot care.

Please vote yes for this bill which will assure that language barriers will not impede important communication between the patient and the Podiatrist.

Very truly yours,

Michael Joyce (mmb)

Michael Joyce, D.P.M.
MPMA Board Member

☑ VOTE YES!

HF 757 (Abeler)/SF 795 (Higgins)
Language Interpreter Services

- Health care evaluation and treatment requires clear communication between the patient and doctor, nurse or therapist to be effective.

- Language barriers impede this essential communication and may even result in an inaccurate diagnosis or poor patient compliance with treatment recommendations.

- Minnesota has been the destination for immigrants seeking new opportunities throughout its history. Recent waves of immigration largely from Somalia, Laos, Vietnam and numerous Spanish-speaking countries is enriching our communities in may ways, but also impacting how we provide services. Because many immigrants speak little or no English, it is essential that qualified interpreters be available when non-English speakers require health care services.

- Federal law, the Civil Rights Act of 1964 Title VII, requires health care providers to arrange for interpreter services, yet provides no payment mechanism.

- Minnesota law currently requires many payers to either provide translators or reimburse clinics and hospitals for these important services.

  - PMAP requires participating health plans to provide language interpreters and they all comply by keeping a roster of trained interpreters who are available on request.

  - Workers' Compensation insurance carriers are required to pay for language interpreter services.

  - No-Fault Auto insurance carriers are required to pay for language interpreter services for the benefit of persons injured in auto accidents.

  - Medical Assistance pays a small fee ($25/hour) for language interpreter services for eligible individuals.

- The balance of payers, including health plans such as Medica, Blue Cross and Blue Shield, and HealthPartners, are currently not required to reimburse for language interpreter services. They should be required to cover interpreters.

- Unreimbursed costs for language interpreter services falls disproportionately on clinics and hospitals located in communities with substantial numbers of recent immigrants.

- Placing the obligation to pay for translator services on all health care payers is the most appropriate way to comply with federal law and insure consistent services for non-English speakers who require access to our health care system.

Please join these organizations
in supporting the

Language Interpreter Services Bill
SF 795 (Higgins)/HF 757 (Abeler)

Minnesota Medical Group Management Association

Minnesota Medical Association

Minnesota Academy of Ophthalmology

Hennepin Medical Society

Ramsey Medical Society

Minnesota Provider Coalition

Minnesota Society of Anesthesiologists

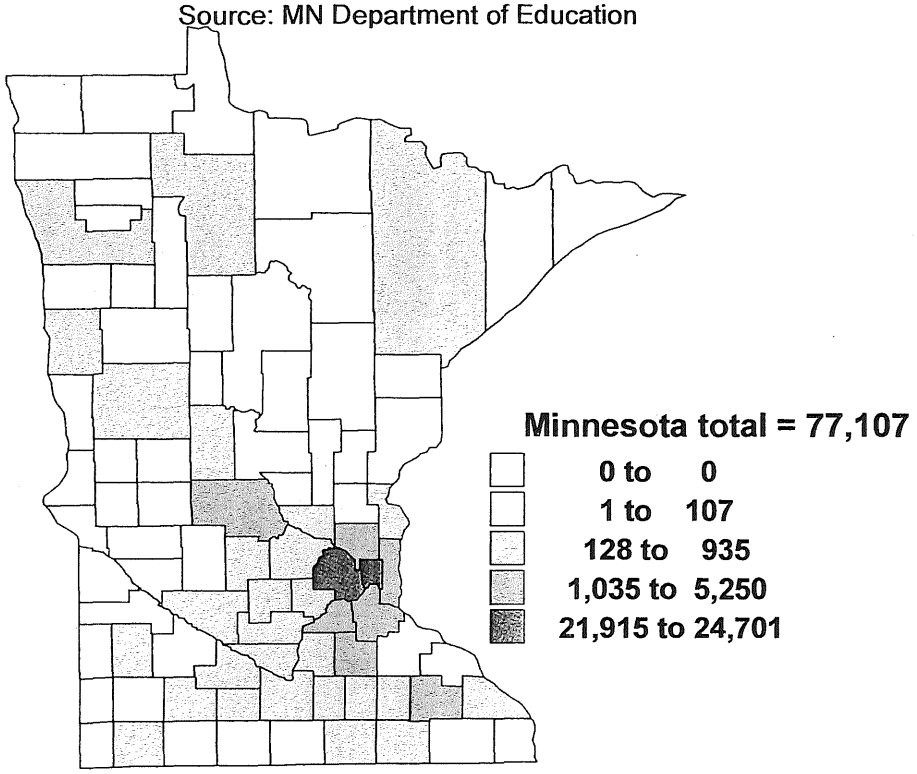
Hennepin Faculty Associates

Hennepin County Medical Center

Students Who Do Not Speak English at Home

2003-2004 School Year

Source: MN Department of Education



Hennepin County Medical Center

HCMC Level I Trauma Center

CARING FOR MINNESOTA

Interpreter Services at Hennepin County's Medical Center

Hennepin County's Medical Center (HCMC) began employing interpreters in 1978. In 2004 HCMC required a staff of 60 full-time equivalent interpreters and support staff to meet the rising demand. HCMC provided this service to 25,800 unique individuals who registered for medical care 83,200 times and required over 100,000 interpreter interactions or encounters. While Spanish is the language that dominates this service (70% of interpreter-dependant registrations in 2004), HCMC provides interpretation in 49 languages. Specialty language clinics, e.g., Spanish, Russian, Somali and others have been established at HCMC to provide a clinical environment that is not only language specific but more culturally sensitive and patient friendly. In 2004, the top six languages [by number of *registrations*] were:

Spanish - 58,624	Somali - 11,521	Hmong - 1,452	Russian - 1,389
Vietnamese -1,041	Laotian - 955	Others 8,217	

In 2004 HCMC provided medical services to 25,828 unique interpreter-dependant patients averaging 3.22 registrations-per-person or, a total of 83,199 registrations for medical care – a 4,000 visit increase over 2003.

- Accurate communication between healthcare professionals and patients reduces medical errors, increases patients comfort level and ensures more precision in diagnostics.

- Cost for HCMC's Interpreter Service averages $3.19M per year (2002-2004).

- Average revenue/reimbursement to HCMC for interpreter services (2002-2004) was approximately 18 percent of departmental costs.

Senate File #795 and its companion H.F. 757, if passed, would ensure that the costs for medical interpreter services incurred by healthcare providers be shared more equitably with Minnesota's health plans and insurers. We encourage your support for this legislation.

Testimony- SF 795
Interpreter Services Bill
March 1, 2005
Capitol Room 15

Judy Hawley, PT, Executive Director
MN Chapter American Physical Therapy Association (MN APTA)

Madam Chair and Members of the Committee:

My name is Judy Hawley, and I am here to urge you to support of SF 795 regarding interpreter services. I am representing the physical therapy profession in MN. We have over 1,500 members in MN APTA.

It is important that our non-English-speaking patients and clients have the interpreter services they need. The patient deserves to have the best care possible, and that can only be done when there is clear and effective communication. That is not the issue.

What is at issue is the payment for these interpreter services. Right now, the provider bears the cost for interpreter services. There are a few different scenarios for how providers and clinics are charged. We are either billed by the minute, and we get billed a fee if the patient cancels close to their appointment time, or doesn't come in for their appointment and we don't cancel the interpreter appointment at least 2 hours in advance. The other scenario is that we get billed for a minimum of 2 hours of service, no matter how much time the patient is in our clinic, and again, we also pay for these services if the patient cancels their treatment. Our average visit time per patient is 30-60 minutes.

Some of the health plans-- PMAP, WC, no-fault auto and MA-- reimburse for translator services. On the other hand, the major insurers in MN-- Medica, BCBSMN, and Health Partners-- are not required to reimburse for interpreter services.

We literally lose money almost every time we see a patient that requires an interpreter. The amount we are charged by the interpreter service is, almost always, higher than the reimbursement we receive for the services we provide on that same date of service. We don't even break even, we lose money. It is not fair for providers to be expected to lose money each time we see a non-English-speaking person.

I want to share with you some cost data for a two physical therapy private practices, to give you an idea of the kinds of non-reimbursed costs they incur in order to provide interpreter services. One suburban physical therapy private practice with multiple sites incurred over $30,000 in interpreter expenses in 2004. Another physical therapy clinic paid over $13,000 during 2004 for interpreter services at just one of their urban clinics.

We believe the provider and the health plan must work together on this issue. As providers, we are committed to making sure we communicate effectively with our non-English-speaking patients. We believe it is only right that the health plan pay for the interpreter services for these patients, and include these costs in the calculation of their premiums.

Thank you for the opportunity to testify. I am happy to try to answer any questions you might have.

Concerns regarding SF 795: Requiring Health Plans to reimburse providers for interpreter services

Increased Health Care Costs

- Currently **interpreter services are considered part of the cost of doing business as a provider.** If clinic staffs are to be considered a medical expense, **this will represent an increased financial shift onto the health plans and, ultimately, those who purchase health care coverage.**

- Health plans would be responsible for reimbursing any interpreter agency that provided services to its members. **This would be problematic when it comes to controlling quality, costs, and abuse.**

- **Existing health plan contracts with providers would have to be expanded** to cover the commercial populations, since they currently do not. Amendments to the contracts would need to be made.

Broad Scope

- **This new requirement would apply not only to health insurance but also to categories of insurance normally excluded from mandates, including Medicare supplement policies.** This would also mandate benefits for a Medicare supplement policy at 100 percent coverage (not the typical 80/20), resulting in a significant premium increase to seniors.

- The **definition of "provider" includes any person or entity whose services would be reimbursed under the Medical Assistance program.** This means that a health plan would have to pay for interpreter services for commercial fully insured members even when the service involved is not covered in the fully-insured benefit set (e.g., non-skilled home care, special transportation, pharmacy dispensing).

- **The inclusion of long-term care insurance in the bill's applicability seems to conflict with the exclusion of Skilled Nursing Facilities from the definition of "provider"** in 62J.03 Subd 8.

Quality Issues

- **There is no licensure or recognized certification for foreign language interpreters in Minnesota.** There are no uniform minimum standards or requirements in order to become an interpreter. Health plans have developed their own processes for verifying the quality standards of the agencies with which they contract. **In signing agreements, providers accept responsibility for the quality of services furnished to our members.**

- **Under this bill, health plans would have to reimburse not only contracted providers, where members have this quality assurance, but for non-participating providers where the same level of quality is not assured.**

- **There have been cases of fraud,** including family members "interpreting" for each other and billing providers or health plans. There has been at least one lawsuit against a provider by a patient claiming poor quality interpretation. **This bill would exacerbate these problems and expose health plans to an uncontrollable and unfair level of liability.**

Mandates and Applicability

- **Providers must already furnish interpretation for patients under federal LEP (Limited English Proficiency) regulations.** Creating state legislation to shift financial responsibility for federal mandates sets a bad precedent.

- **Federal LEP regulations include limits on the services required** ("reasonability" standard). This bill places no such limits.

- **State mandates such as this push more employers either to become self-insured in order to avoid the mandates, or to stop offering health insurance altogether because of unsustainable costs. This bill is more likely than most to worsen this situation because of its broad applicability and potentially high cost for fully insured groups.**

- **Since any eventual mandate would not apply when the patient is an ERISA plan member, providers would still be obligated to provide interpretation for ERISA members, as they do now, under federal mandates for LEP (Limited English Proficiency.) This split will create even more confusion that we have already on these services.**

Senate Counsel & Research

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX (651) 296-7747

JO ANNE ZOFF SELLNER
DIRECTOR

Senate
State of Minnesota

S.F. No. 973 - Medication Therapy Management Services

Author: Senator Becky Lourey

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: February 14, 2005

S.F. No. 973, paragraph (a), provides medical assistance coverage for medication therapy management services. Medication therapy management is the following pharmaceutical care services provided by a licensed pharmacist:

(1) performing or obtaining assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) selecting, initiating, modifying or administering medication therapy;

(4) monitoring and evaluating a patient's response to therapy;

(5) performing a comprehensive medication review;

(6) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(7) providing verbal education and training in the understanding and use of the patient's medication;

(8) providing information, support services, and resources designed to enhance patient adherence with the therapeutic regimens; and

(9) coordinating and integrating medication therapy management services within the broader services being provided to the patient.

Paragraph (b) states that nothing in the section shall be construed to expand or modify the scope of practice of the licensed pharmacist.

Paragraph (c) requires the commissioner of human services to convene a medication therapy management advisory committee to advise the commissioner on the implementation and administration of the medication therapy management services.

Paragraph (d) requires the commissioner to evaluate the effect of medication therapy management on quality of care, patient outcomes, and program costs and to report to the legislature by December 15, 2007.

KC:dv

Senators Lourey; Kelley; Johnson, D.E.; Kiscaden and Berglin introduced--
S.F. No. 973: Referred to the Committee on Health and Family Security.

A bill for an act

relating to medical assistance; requiring medical assistance to cover medication therapy management services; amending Minnesota Statutes 2004, section 256B.0625, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13h. [MEDICATION THERAPY MANAGEMENT CARE.] (a) Medical assistance covers medication therapy management services. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) selecting, initiating, modifying, or administering medication therapy;

(4) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(5) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(6) documenting the care delivered and communicating

essential information to the patient's other primary care providers;

(7) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(8) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(9) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) For the purposes of reimbursement for medication therapy management, the commissioner may enroll individual pharmacists as medical assistance providers and shall seek to ensure that participating pharmacists represent all geographic regions of the state.

(c) The commissioner, after receiving recommendations from professional medical associations, professional pharmacy associations, and consumer groups shall establish a nine-member Medication Therapy Management Advisory Committee, to advise the commissioner on the implementation and administration of medication therapy management services and the development of eligibility criteria for enrollees and providers. The committee shall be comprised of: two licensed physicians; two licensed pharmacists; two consumer representatives; and three members with expertise in the area of medication therapy management, who may be licensed physicians or licensed pharmacists. The committee is governed by section 15.059, except that committee members do not receive compensation or reimbursement for expenses.

(d) The commissioner shall evaluate the effect of medication therapy management on quality of care, patient outcomes, and program costs and shall report to the legislature

by December 15, 2007. The commissioner may contract with a vendor or an academic institution that has expertise in evaluating health care outcomes for the purpose of completing the evaluation.

Senator ..... moves to amend S.F. No. 973 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13h. [MEDICATION THERAPY MANAGEMENT CARE.] (a) Medical assistance covers medication therapy management services for a recipient taking four or more prescriptions to treat or prevent two or more chronic medical conditions, or a recipient with a drug therapy problem that is identified or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) selecting, initiating, modifying, or administering medication therapy under the terms of collaborative practice agreements;

(4) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(5) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(6) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(7) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(8) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(9) coordinating and integrating medication therapy

management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued under chapter 151;

(2) have graduated from an accredited college of pharmacy on or after May of 1996; or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting; and

(4) make use of an electronic patient record system that meets state standards.

(c) For the purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) The commissioner, after receiving recommendations from professional medical associations, professional pharmacy associations, and consumer groups shall convene a nine-member Medication Therapy Management Advisory Committee, to advise the commissioner on the implementation and administration of medication therapy management services. The committee shall be comprised of: two licensed physicians; two licensed

pharmacists; two consumer representatives; and three members with expertise in the area of medication therapy management, who may be licensed physicians or licensed pharmacists. The committee is governed by section 15.059, except that committee members do not receive compensation or reimbursement for expenses. The advisory committee shall expire on June 30, 2007.

(e) The commissioner shall evaluate the effect of medication therapy management on quality of care, patient outcomes, and program costs, and shall include a description of any savings generated in the medical assistance program that can be attributable to this coverage. The evaluation shall be submitted to the legislature by December 15, 2007. The commissioner may contract with a vendor or an academic institution that has expertise in evaluating health care outcomes for the purpose of completing the evaluation.

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Delete everything after the enacting clause and insert:

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(2) have graduated from an accredited college of pharmacy on or after May of 1996; or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting; and

(4) make use of an electronic patient record system that meets state standards.

(c) For the purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) The commissioner, after receiving recommendations from professional medical associations, professional pharmacy associations, and consumer groups shall convene a nine-member Medication Therapy Management Advisory Committee, to advise the commissioner on the implementation and administration of medication therapy management services. The committee shall be comprised of: two licensed physicians; two licensed

pharmacists; two consumer representatives; and three members with expertise in the area of medication therapy management, who may be licensed physicians or licensed pharmacists. The committee is governed by section 15.059, except that committee members do not receive compensation or reimbursement for expenses. The advisory committee shall expire on June 30, 2007.

(e) The commissioner shall evaluate the effect of medication therapy management on quality of care, patient outcomes, and program costs, and shall include a description of any savings generated in the medical assistance program that can be attributable to this coverage. The evaluation shall be submitted to the legislature by December 15, 2007. The commissioner may contract with a vendor or an academic institution that has expertise in evaluating health care outcomes for the purpose of completing the evaluation.

Leech Lake Band Of Ojibwe
Twin Cities Office

Medicine Project
1305 E. 24th Street
Minneapolis, MN 55404

More Information (612) 722-4924
Fax (612) 729-6035

Appointments
(612) 721-0207

Native American Community Clinic

Native American Community Clinic

Indian Health Board
Of Minneapolis, Inc.

Peters Institute Of
Pharmaceutical Care,
College of Pharmacy,
University of Minnesota

FAIRVIEW

Fairview Pharmacy Services

Medicine Project
1305 E. 24th Street
Minneapolis, MN 55404

Medicine Project
Pharmaceutical Care

In collaboration with:
Native American Community Clinic
Indian Health Board Of Minneapolis, Inc.
Fairview Pharmacy Services
Peters Institute Of Pharmaceutical Care,
College of Pharmacy, University of Minnesota

The **Leech Lake Twin Cities Office** in collaboration with the **Native American Community Clinic, Indian Health Board of Minneapolis, Fairview Pharmacy Services** and the **Peters Institute of Pharmaceutical Care, College of Pharmacy, University of Minnesota** to develop the **Medicine Project for Pharmaceutical Care**.

The Medicine Project provides a new service to address the medication-related needs for tribal community members. The Medicine Project is a collaborative practice with a clinical pharmacist working together with physicians at the Native American Community Clinic (NACC) and the Indian Health Board (IHB). Transportation is available, co-pays will be covered by the program (depending on eligibility).

What is the Medicine Project?

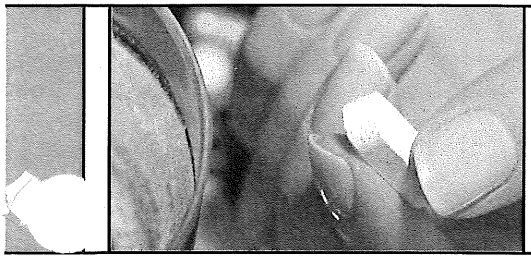
A clinical pharmacist provides a face-to-face (in person) consultation with you about your medications, multivitamins or any other over-the counter medicines. If the pharmacist identifies any drug therapy problems, he will make recommendations to you and your doctor. The clinical pharmacist is responsible for all of your medication therapy needs and is held accountable for that commitment. This means that the pharmacist will work with you and your doctor to **ensure that**:

1) Your medications are working and safe.
2) You are on the correct medication.
3) You have access to getting your medications.
4) You understand the purpose of your medications.

- If you need transportation, let staff know when scheduling appointment.
- Bring your MA insurance card, (medical assistance), medications and vitamins with you to the appointment.

Call (612) 721-0207 to schedule an appointment:

LEECH LAKE BAND OF OJIBWE



MEDICATION THERAPY MANAGEMENT SERVICES THROUGH MEDICAID

THE VALUE OF PHARMACISTS SERVICES AND MTMS

- Iowa, Wisconsin, Washington, Missouri, Mississippi, and Florida have implemented MTMS programs in Medicaid prescription and medical expenditures and have reported improved patient health outcomes and health care expenditure savings. The Missouri Medicaid program has showed decreased ER visits and hospitalizations for patients receiving MTMS compared to a control group not receiving MTMS and that there is an absolute savings of $10,000 per patient per year in those patients receiving MTMS. These services have proven to improve outcomes and save money in the health care system.

THE PROBLEM OF MEDICATION MISUSE AND PATIENT CARE

- The use of medications and the number of medications available to patients have greatly increased and will continue to increase. These medications are a great advancement in the care of patients; however, if not used properly the medications may not be effective and could be unsafe for patients. Physicians, nurse practitioners, and physician assistants can benefit from the drug therapy knowledge of pharmacists. Pharmacists can partner with patients and providers through MTMS to make sure that the medications are utilized correctly, ensure patient compliance and proper dosage, increase generic substitutions, and prevent drug-drug interactions. According to the Institute of Medicine, more than $176 billion is wasted each year on the improper and unsafe use of medications.

PHARMACISTS TRAINING

- For more than 15 years, Minnesota pharmacists graduating from the University of Minnesota College of Pharmacy have been educated with an increased focus on drug therapy knowledge and patient care expertise. Many pharmacists in practice have also received continued education to enhance better care for patients through medication therapy management services. Pharmacists are educated in the various aspects of disease states including; pathophysiology, diagnosis, monitoring and treatment. Pharmacists also know exactly how medications work and are absorbed by the body. Pharmacists are the only health professional whose educational focus is on medication use to this extent. Encompassing all this knowledge, pharmacists are unique members of the healthcare team who can help patients and fellow providers make the best use of medications with MTMS.

MINNESOTA PHARMACISTS ASSOCIATION • 1935 West County Road B-2, Suite 450 • Roseville, MN 55113

651-697-1771 Metro • 800-451-8349 MN • Fax: 651-697-1776 • Liz@mpha.org • Abbie@mpha.org

Your pharmacist...

Serves you and your community every day through...

- Expert care and counseling for better medication use
- Health promotion and disease prevention services and education
- Assuring the integrity of the medication supply
- Active participation in emergency preparedness programs

Whether it's a simple question about your medicines or a major health policy question on medications and their proper use...

your pharmacist is your best resource.

HOW CAN YOU expand the role of pharmacists to IMPROVE HEALTH CARE in your state?

You can ensure the pharmacy profession is a vital player in improving patient care and decreasing health care costs by:

- Incorporating pharmacists in your emergency preparedness plan.
- Enabling pharmacists to provide immunizations, such as flu shots, to high-risk patients and also provide other vaccines to the general public in response to an emergency/disaster.
- Promoting and supporting legislation and regulations to expand collaborative practice arrangements between pharmacists and physicians.
- Supporting pharmacy school expansions and pharmacy student scholarships.
- Enabling pharmacists to utilize new technologies such as central fill operations, automated dispensing equipment, and electronic prescription transmission.
- Developing pharmacist-based disease state management programs for Medicare and Medicaid beneficiaries that will reduce total health care costs and utilization.
- Ensuring that pharmacists receive fair and adequate compensation for their services.

Pharmacists improve health care...

Pharmacists improve patient care and control health care costs.

Pharmacists improved the health of diabetes and sthma patients[1].

- Patients reported higher quality of life and significant improvement in asthma control.
- Changes based on their recommendations reduced hospital visits, urgent care visits, emergency room visits, and length of stay.
- Pharmacist-recommended drug therapy saved employers over $1900 per year per individual. **These cost savings were a result of fewer physician visits and shorter hospital stays.**

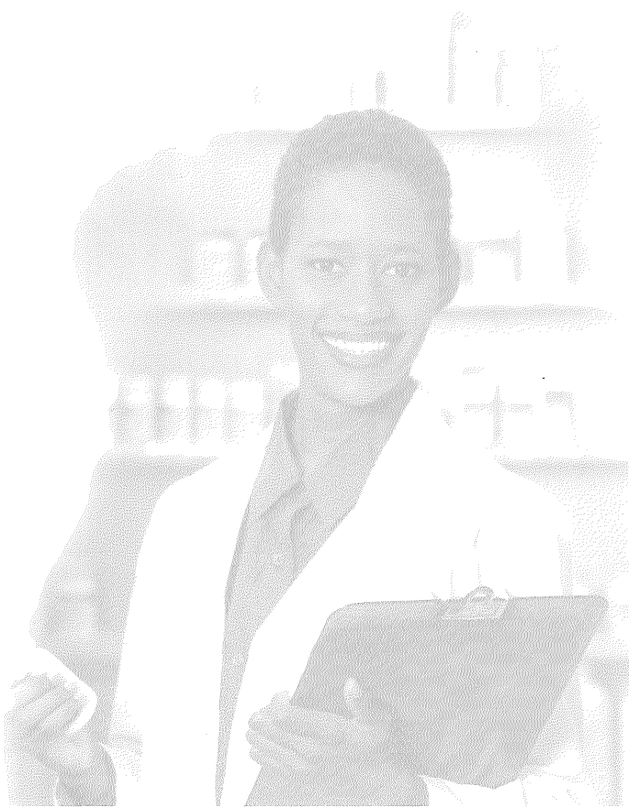
An employer with 500 patients enrolled in this program could save over $958,000/year.

...and control health care costs

Over and over, studies show that day-to-day interaction with pharmacists can improve health and save money. Paying pharmacists for providing pharmaceutical care services to patients can greatly improve care, yet decrease total health care costs.

In 2000, adverse drug reactions and treatment failures in the U.S. cost $121.5 billion in hospital admissions, $13.8 million in physician office visits, and over 200,000 deaths[2].

With their special skills and knowledge, pharmacists practicing pharmaceutical care can decrease these unnecessary expenses.



Promoting Cost-Effective Health Care

Pharmacists routinely strive to improve care and promote the use of cost-effective drugs and devices to both prescribers and their patients.

Pharmacists managing patients' medications for high cholesterol were able to help patients achieve a 90% compliance rate with their medication compared to the national average rate of 40%[4].

In another example, thousands of pharmacies in the state of Michigan have signed up to promote generic drug use in a pilot program being conducted by Blue Cross Blue Shield.

Collaborative Drug Therapy Management allows pharmacists and physicians to work together to improve patient care.

Collaborative Drug Therapy Management (CDTM) is a coordinated approach to patient care.

CDTM enables pharmacists and physicians to voluntarily enter into agreements to jointly manage a patient's drug therapy. Thirty years of research has shown that pharmacist interventions improve outcomes.

Forty states currently have specific laws that allow CDTM... others are developing or reviewing proposed legislation or regulations that would enable pharmacists to participate in CDTM.

Pharmacists: Important members of the health care team

Advantages of Collaborative Drug Therapy Management

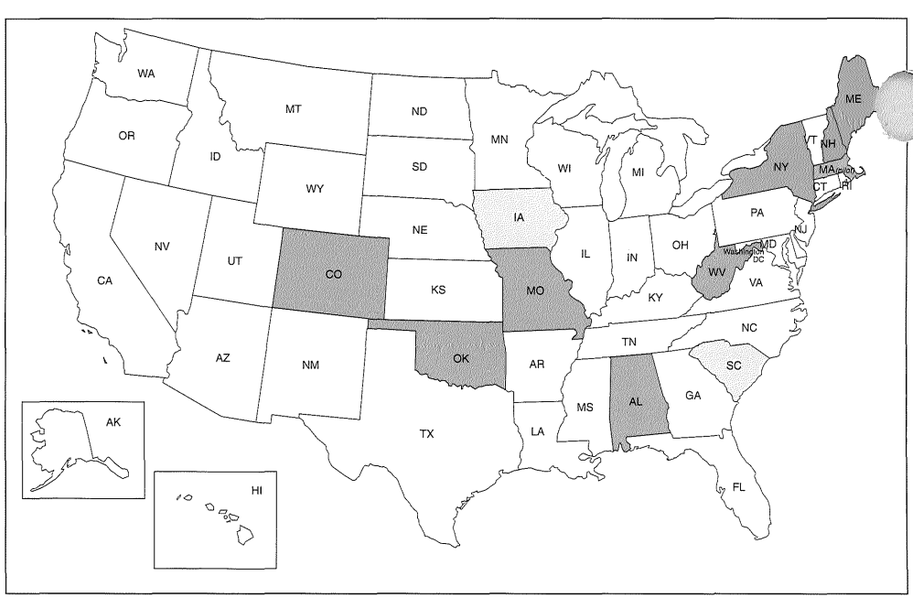
- Improves drug therapy results;
- Reduces delays in modifying drug regimens;
- Increases patient adherence to their drug therapy plan;
- Reduces adverse drug reactions through early detection; and
- Saves money by reducing emergency room and office visits.

Pharmacy activities in Collaborative Drug Therapy Management can include:

- Assisting physicians to improve medication management and continuity of care;
- Initiating, modifying, continuing, discontinuing, and monitoring a patient's drug therapy;
- Ordering, performing, and interpreting medication-related laboratory tests;
- Assessing patient response to therapy;
- Counseling and educating a patient on medications; and
- Administering certain medications such as vaccines.

Collaborative Drug Therapy Management

- No (10)
- Subject to interpretation (2)
- Yes (38)



With an existing infrastructure of hospital, community and other specialty pharmacies, as well multiple wholesaler distribution networks, pharmacy is uniquely positioned to provide necessary pharmaceutical access, distribution, and patient education services in response to a public health emergency or crisis.

Pharmacies and pharmacists are critical to your emergency response plan.

Two important reasons that every state and local emergency prepardness plan should include pharmacies...

1. **In a major public health crisis, pharmacists are able to immediately collaborate with physicians and other prescribers in managing the drug therapy of individual victims.... even before packages from the National Pharmaceutical Stockpile can be ordered or delivered.**

2. **Hundreds of pharmacists in 40 states are currently providing, or have been trained to provide flu and other immunizations... and could be utilized to conduct emergency vaccinations.**

Pharmacies and pharmacists play critical roles in emergencies

There is a pharmacy within five miles of virtually every household in America... all state emergency plans should include the valuable skills of pharmacists and their convenient locations.

Pharmacists have the specialized education, training, experience and legal responsibility to provide the following services in an emergency event:

- Selecting pharmaceuticals and related supplies for national or regional stockpiles and local emergency inventories
- Planning deployment of supplies
- Developing treatment guidelines
- Ensuring proper packaging, handling, labeling and dispensing of emergency supplies of pharmaceuticals
- Ensuring proper control of pharmaceuticals
- Educating patients who receive medications
- Providing drug therapy management to patients
- Advising public health officials on appropriate messages for the public on the use of pharmaceuticals after terrorist incidents

The anthrax mailings of October 2001 taught us a valuable lesson - medications cannot be dispensed and administered in a "vacuum."

Patients should have their medication profile screened for dangerous drug interactions before being given any new medication by a pharmacist.

Pharmacist intervention could have prevented a great deal of inappropriate use of Cipro - by teaching patients how to use it properly, or by identifying patients who would best be treated with other effective antibiotics.

In 40 states, pharmacists are authorized to administer vaccines, but in the interest of emergency preparedness, all states should be encouraged to allow pharmacists to provide this important service.

Are pharmacists part of your emergency plans?

Ensure fair and adequate Medicaid reimbursement for pharmacist services.

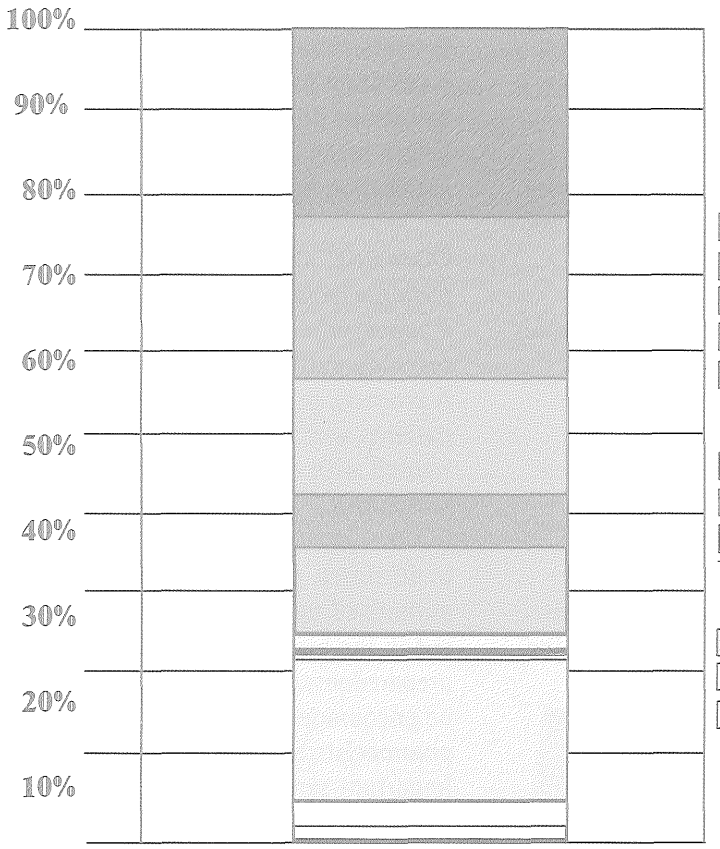
Medicaid reimbursement: ensuring fair and adequate compensation

The average net pharmacy margin on a prescription is less than 2%[26]. Saving a few dollars on each prescription may sound good, but if removing the pharmacist's services results in a $600 emergency room visit - the savings disappear.

Access to drugs and pharmacist services is important to ensure Medicaid recipients receive the drugs needed to keep them out of hospitals and emergency rooms. But, no pharmacy or pharmacist-run clinic can operate at a loss.

Pharmacies and clinics have fixed costs associated with safely delivering medications to patients, such as the drug acquisition cost, labor and inventory costs. These fixed costs cannot be reduced when payments are cut... except by reducing services, decreasing hours, and closing pharmacies. Payment must keep pace with escalating fixed costs.

For example, it costs retail pharmacies between $6.43 and $10.87 to fill a prescription[25], not including the cost of the drug. Too often, payers view a prescription medication as a commodity without taking into consideration the valuable services a pharmacist provides to ensure safe and effective drug therapy.



Profit Margins and Cost Components of Retail Prescriptions

Pharmaceutical Manufacturers

- Cost of materials - $11.04 (22%)
- SG&A - $11.54 (23%)
- R& D - $7.02 (14%)
- Taxes - $2.51 (5%)
- Net Profit - $6.02 (12%)

Drug Wholesalers

- Cost of Ops - $1.00 (2%)
- Taxes - $0 (<1%)
- Net Profit - $0.50 (1%)

Retail Pharmacies

- Cost of Ops - $9.03 (18%)
- Taxes - $0.82 (1%)
- Net Profit - $1.01 (2%)

Source: NDC Health, Hoover's Company Information, PhRMA, Retail Census, U.S. Bureau of the Census; average prescription price in 2002 was $53.10.

Numerous studies show that quality pharmacy services and increased interaction between patients and their pharmacists reduce total health care costs. (see "Evidence" document in folder pocket)

Medication does not work alone. Pharmacists working closely with seniors and helping them manage their medications will decrease medication use problems.

With the passage of a new outpatient drug benefit for the Medicare program in late 2003, the nation's seniors will have improved access to medications and the medication therapy management services of pharmacists. Beginning in 2006, medication therapy management services are a required component of any outpatient drug benefit offered to Medicare beneficiaries. Is your state pharmaceutical assistance program working with pharmacists to improve medication use for all seniors in your state? Pharmacists are ready to work with you to make it happen.

Including pharmacists' services in a senior drug benefit plan will improve care and save money.

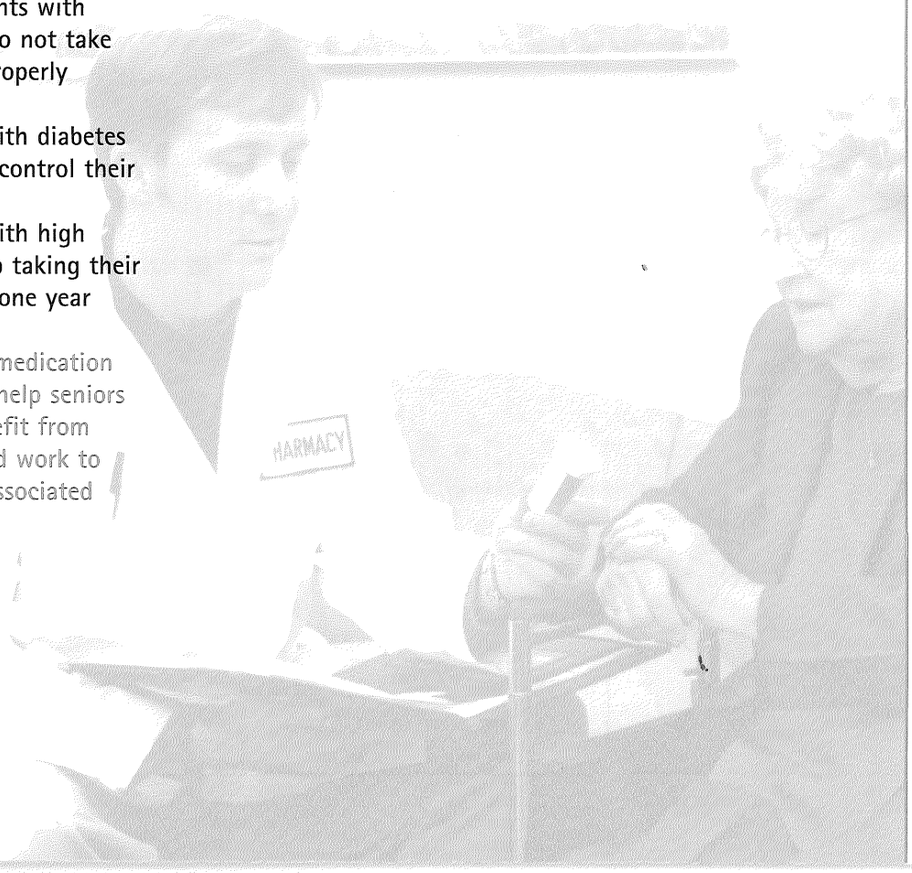
Pharmacists' services are critical to a successful senior drug benefit program

Senior citizens use more prescription and nonprescription drugs than any other age group[25] ... Consequently, this group experiences a proportionally higher number of problems with their medication use, such as debilitating side effects, accidental overdosage or underdosage, and drug interactions with nonprescription, herbal, and nutritional supplements. **Frequent advice, counseling, and educational programs by pharmacists can prevent, or decrease the severity of, the problems seniors often experience with their medications.**

Here's why you need pharmacists in your senior drug benefit program:

- **Over 50% of patients with chronic disorders do not take their medication properly (non-compliance)**
- **40% of patients with diabetes do not adequately control their blood sugar**
- **40% of patients with high blood pressure stop taking their medication within one year**

Pharmacists are the medication use experts and can help seniors obtain the most benefit from their medications and work to minimize problems associated with medication use.

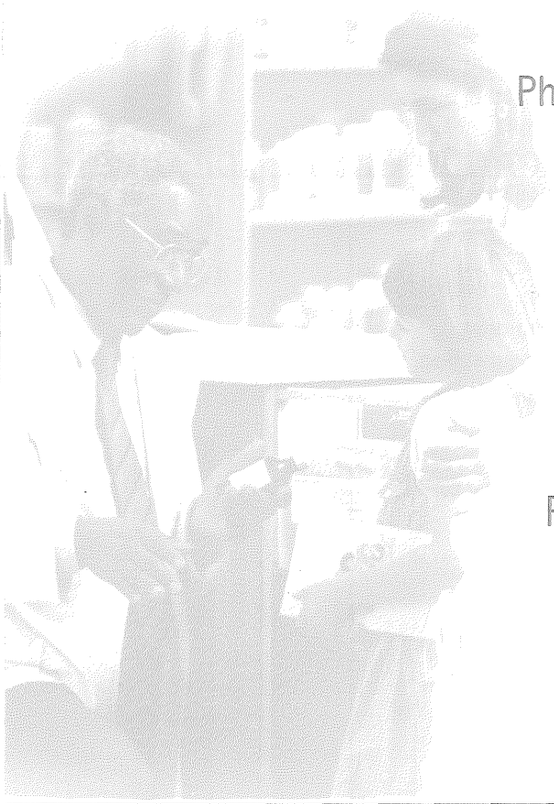


PHARMACISTS
enhance patient safety

Pharmacists prevent costly adverse effects and medication errors.

"Because of the immense variety and complexity of medications now available, it is impossible for nurses or doctors to keep up with all of the information required for safe medication use. The pharmacist has become an essential resource... and thus access to his or her expertise must be possible at all times."

Institute of Medicine, *To Err Is Human, 1999*



Pharmacists prevent medication errors

A recent study published in February 2002 showed that as the number of pharmacists involved with patient care rose in U.S. hospitals, the medication error rates dropped from an average of 700 per hospital per year to 245 per hospital per year... a 65% decrease[12].

While medication errors can occur anywhere during the care of a patient, the simple truth is that medication errors are preventable events. Pharmacists are medication use experts, and their increased involvement in patient care dramatically reduces adverse drug reactions and medication errors.

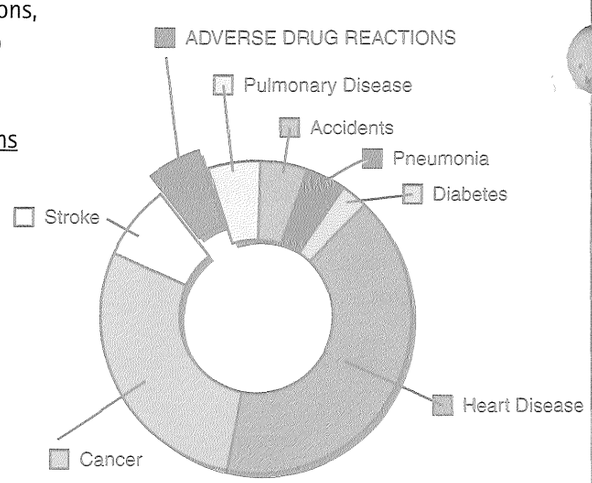
Pharmacists prevent adverse drug effects...
the 4th leading cause of death in the U.S.

Pharmaceutical care services are invaluable in today's health care arena. An explosive growth of available medications has led to a rapid expansion of drug-related problems.

EXAMPLES OF PROBLEMS THAT PHARMACISTS SOLVE EVERY DAY INCLUDE:

- Improper medication selection
- Too little or too much of a medication
- Failing to take a prescribed medication
- Adverse drug reactions or effects
- Medication use with no indication
- Untreated medical problems

By informing patients and prescribers of potential adverse effects or drug interactions, pharmacists help patients avoid complications or hospitalizations that add unnecessary costs to your states' health care budget.



Causes of death in the U.S.

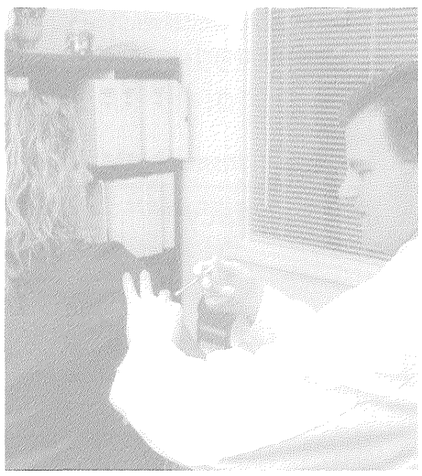
PHARMACISTS deliver immunizations

Pharmacist-provided immunizations and health screenings save lives and money.

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM), one of the largest and most prestigious medical societies, recognizes that pharmacist involvement in drug therapy results in improved safety, better patient outcomes, and lower medical costs.

"[ACP-ASIM] supports the use of the pharmacist as an immunization information source, host of immunization sites, and immunizer, as appropriate and allowed by state law."

ACP-ASIM position paper released January 2002 in the *Annals of Internal Medicine.*



Improves access... especially for high-risk patients like the elderly

Many states could save hundreds of thousands of dollars by increasing their flu and pneumonia immunization rates[21]. Pharmacists can help. Each year, thousands of patients are hospitalized due to influenza or complications arising from influenza infection. Thousands die... from an illness that is largely preventable.

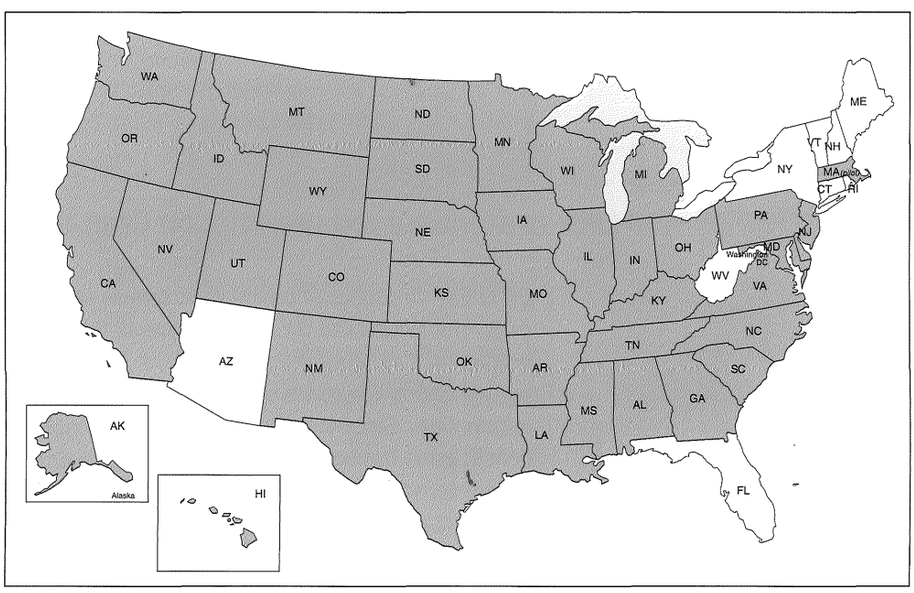
The number of states that allow pharmacists to administer immunizations has increased to 37. Pharmacies not only provide convenient access to immunizations, but also can easily identify high-risk patients that would most benefit from receiving specific vaccines and immunize them onsite.

Also... when pharmacists are legally allowed to provide immunizations, they become another valuable public health resource if emergency vaccinations are required after a bioterrism event or other public health crisis.

Pharmacist-Delivered Immunizations

States where phamacists can immunize

As of April 2004



Barriers to utilizing pharmacies and pharmacists... ...and what you can do to help remove them.

Providing more pharmacist services to Medicaid patients will save millions of dollars.

The increased demand for pharmacist services

Demand for pharmacists remains high. Community pharmacies, hospitals, and managed care organizations are currently challenged to maintain hours of operation and continue important patient care services.

Help minimize the effects of this increase in demand by:

- Supporting expansions of existing Schools and Colleges of Pharmacy.
- Providing additional scholarships and student loans for pharmacy students.

Restrictive regulations on pharmacy automation and technology

The annual number of prescriptions dispensed in the U.S. is projected to grow from three billion in 2001 to **four billion** in 2005[27], a **33%** increase, in part due to the increasing use of medications by "baby boomers" and expanded longevity of the American population.

Unfortunately, the number of pharmacists is only expected to grow **3.9%** by 2005[27]. Enabling pharmacists to use the most modern technologies such as dispensing machines, central fill operations, and electronic prescription transmission will allow the pharmacists to use more of their time working with patients to improve therapy and reduce costs.

Ensure that pharmacies can utilize new technologies that improve pharmacy efficiency, patient safety and patient care.

Role of support staff in pharmacy operations

Well-trained technicians assist pharmacists in many activities allowing pharmacists to spend more time helping patients use their medication. States that allow for various ways to train and utilize technicians will help decrease the workload on pharmacists and enable them to provide better patient care.

Ensure pharmacies are able to safely utilize well-trained technicians... which will decrease the effect of the yearly increase prescription volume on workload.

Lack of standardized prescription drug benefit cards

Every day thousands of pharmacists cannot efficiently fill prescriptions because they do not have all the information needed on a patient's drug benefit card. Thousands of hours are wasted calling employers or insurance companies to obtain the information. Since 1996, a standard for prescription drug benefit cards has been available, but unfortunately, many employers and third party payers have refused to voluntarily use the standard.

Require the use of standardized drug benefit cards so that pharmacies can operate more efficiently and provide better care.

EVIDENCE OF THE VALUE of the Pharmacist

This document summarizes key studies that demonstrate the broad range of pharmacist-provided patient care services that have resulted in:

- Improved Disease & Drug Therapy Management
- Greater Patient Satisfaction
- Improved Quality of Life
- Significant Cost Containment and Savings

In a study evaluating the effect of pharmacists providing pharmaceutical care services on the economic outcomes of patient care, an average benefit of $16.70 of value to the health care system was realized for each $1 invested in clinical pharmacy services.

This benefit was observed in a variety of health care settings (community, government, and university hospitals; clinic settings) and included drug dosing and drug therapy management services provided by pharmacists.

Over 20 studies and demonstration projects confirm that pharmacists add value to the health care system by improving care and decreasing cost.

Pharmacists Impact on Health Care Cost and Quality	Study Citation
Pharmacists providing asthma management services and pharmaceutical care to two employers decreased cost, **improved care,** and improved work absence rates.	[1]The Asheville Project. *Pharmacy Times.* Romaine Pierson Publishers, Inc. Westbury:NY. October 1998. Bunting B. (excerpt) Asheville Project Continues to Produce Positive Results. *America's Pharmacist.* May 2000:43-44
This study shows that costs associated with drug-related problems in the US **exceeds $177 billion** - more than the cost of the drugs themselves.	[2]Ernst FR, Grizzle, AJ. Drug-Related Morbidity and Mortality: Updating the Cost-of-Illness Model. *Journal of the American Pharmaceutical Association.* 2001: Mar-Apr; 41(2):192-199
Pharmacists providing services for an HMO to patients in their community **saved** an average of $20 per prescription.	[3]Knapp KK, Katzman H, Hambright JS et al. Community pharmacist interventions in a capitated pharmacy benefit contract. *American Journal of Health-System Pharmacy.* 1998; 55(11):1141-5
Pharmacists providing pharmaceutical care to patients with high cholesterol in their community improved patient compliance with medication from a national average of 40% to 90%.	[4]Bluml BM, McKenney JM, Cziraky MJ. Pharmaceutical care services and results in Project ImPACT: Hyperlipidemia. *Journal of the American Pharmaceutical Association* 2000;40(2):157-165
Pharmacists providing pharmaceutical care services to patients in long-term care facilities **increased the number of patients receiving optimal care** by 45% - resulting in an estimated $3.7 billion in cost avoidance.	[5]The Fleetwood Project, American Society of Consultant Pharmacists

EVIDENCE OF THE VALUE of the Pharmacist

Pharmacists Impact on Health Care Cost and Quality	Study Citation
Pharmacists providing pharmaceutical care to patients in an ambulatory care clinic saved nearly $250,000 in one month.	[6]Hatoum HT, Witte KW, Hutchinson RA. Patient care contributions of clinical pharmacists in four ambulatory care clinics. *Hospital Pharmacy.* 1992; 27(3): 203-6, 208-9
Pharmacist services provided in community pharmacies **saved** approximately $3.47 per prescription.	[7]Dobie RL, Rascati KL. Documenting the value of pharmacist interventions. *American Pharmacy.* 1994; May; NS34(5):50-4
Pharmacists working with patients with high blood pressure in an HMO family practice saved $20.61/patient in drug costs and **decreased the number of drugs prescribed.**	[8]Forstrom MJ, Ried LD, Stergachis AS et al. Effect of a clinical pharmacist program on the cost of hypertension treatment in an HMO family practice clinic. *Annals of Pharmacotherapy.* 1990; 24(3):304-9
Pharmacists collaborating with physicians to care for high-risk patients reduced the number of prescriptions per patient and **saved nearly $600 per year per patient in drug costs.**	[9]Jameson J, VanNoord G, Vanderwoud K. The impact of the pharmacotherapy consultation on the cost and outcome of medical therapy. *Journal of Family Practice.* 1995; Nov.; 41(5):469-72
Pharmacists providing disease management services in their community saved an average of $2700 per year per patient in total medical costs.	[10]Munroe WP, Kunz K, Dalmady-Israel C et al. Economic evaluation of pharmacist involvement in disease management in a community pharmacy setting. *Clinical Therapeutics.* 1997; 19(1):113-23
Pharmacists providing pharmaceutical care services generate a return-on-investment (ROI) of $17.00 per patient for every dollar invested.	[11]Schumock, GT, Butter M.G. et al. Evidence of the economic benefit of clinical pharmacy service – 1996-2000. *Pharmacotherapy.* 2003; 23: 113-125
As hospitals **increased the number of pharmacists** providing pharmaceutical care, **medication errors have decreased** by over 65%.	[12]Bond C., Raehl C. Clinical Pharmacy Services, Hospital Pharmacy Staffing, and Medication Errors in the United States Hospitals. *Pharmacotherapy.* 2002: 22(2):134-47

During a 6-month period, pharmacists joined doctors, residents, and other members of the patient care team on patient rounds in the intensive care unit at a large, urban teaching hospital.

Results showed:

- **Preventable adverse drug events decreased by 66%.**
- A projected $270,000, related to adverse drug events, could be saved annually.
- 366 of the 400 pharmacist interventions were related to medication errors.
- Pharmacist interventions helped prevent incomplete orders, incorrect dosages and frequency, less-than-optimal drug choices, and duplicate prescriptions.

Pharmacists working in their communities produced a 74% **increase in vaccination rates** by advising high-risk patients of infection risk and describing where to go to be vaccinated.

Patient acceptance was excellent, with pharmacists administering 1060 doses of influenza vaccinations and 198 pneumococcal vaccinations to 1067 patients.

EVIDENCE OF THE VALUE of the Pharmacist

Pharmacists reviewed drug therapy and found ways to improve medication use in nearly 65% of all patients.

- Drug therapy changes based on the pharmacists recommendations reduced unscheduled hospital visits, urgent care visits, emergency room visits, and hospital days.
- Pharmacist recommended drug therapy changes saved over $640 per year in health costs per individual ($280,000/year per pharmacist).

The bulk of the savings were not related to drug costs, rather they were associated with fewer unscheduled physician visits and fewer hospital days.

The ASCP Fleetwood Project is a three-phase initiative to demonstrate the impact of consultant pharmacist services on patient outcomes and health care costs.

The first phase of this project was pharmacoeconomic analysis of the cost of medication-related problems in U.S. nursing facilities and the impact of consultant pharmacist services on those costs. The study found that :

- Consultant pharmacist-conducted drug regimen review increases the number of patients who experience optimal therapeutic outcomes by 43% and **saves as much at $3.6 billion** annually in costs associated with medication-related problems.

Pharmacists Impact on Health Care Cost and Quality	Study Citation
Pharmacists providing pharmaceutical care to patients in a managed care organization **saved $640 per patient per year.**	[13]Borgsdorf LR, Miano JS, Knapp KK. Pharmacist-managed medication review in a managed care system. *American Journal of Hospital Pharmacy* 1994; Mar 15; 51(6):772-7
Pharmacist services saved over $75,000 in 3 months time and **prevented additional medical problems from occurring** by identifying prescribing errors.	[14]Rupp MT. Value of community pharmacists' interventions to correct prescribing errors. *Annals of Pharmacotherapy.* 1992 December; 26(12):1580-4
Pharmacist services **saved** over $32 per prescription.	[15]Fincham J, Gottlob A. The Kansas report. *America's Pharmacist.* 1997 May; 119(5): 30-3
Pharmacists providing pharmaceutical care services to diabetic patients in their community **saved $219,000 per year.**	[16]Fincham JE, Lofhom PW. Saving money and lives. Pharmacist care for diabetes patients. *America's Pharmacist.* 1998 March; 120(3): 49-52
Pharmacists providing pharmaceutical care services in a general medicine clinic saved nearly $4 per prescription and **decreased the number of prescriptions** per patient.	[17]Britton ML, Lurvey PL. Impact of medication profile review on prescribing in a general medicine clinic. *American Journal of Hospital Pharmacy.* 1991 February; 48(2):265-70
Pharmacists providing pharmaceutical care in 1000 hospitals **saved nearly 400 lives and $5.1 billion** in health care costs.	[18]Bond CA, Raehl CL, Pitterle ME, Franke T. Health care professional staffing, hospital characteristics, and hospital mortality rates. *Pharmacotherapy* 1999;19(2):130-8. Bond CA, Raehl CL, Franke T. Clinical pharmacy services, pharmacy staffing, and the total cost of care in U.S. hospitals. *Pharmacotherapy* 2000 June; 20(6):609-21
Pharmacists providing pharmaceutical care services in an intensive care unit **decreased adverse events by 66% and saved $270,000** by avoiding adverse events.	[19]Leape LL, Cullen DJ, Dempsey Clapp M, et al. Pharmacist participation on physician rounds and adverse drug events in the intensive care unit. *JAMA (Journal of the American Medical Association)* 1999 Jul 21; 282(3):267-70

EVIDENCE OF THE VALUE of the Pharmacist

Pharmacists working with patients in their community provided targeted patient education, systematic patient monitoring, patient feedback and behavior modification. The economic impact of these interventions was evaluated.

The study found that improved patient adherence to their medication regimens resulted in increased drug costs, but an overall reduction in medical costs.

- The average cost for asthma patients was higher in the intervention group, suggesting improved adherence to treatment.
- **Savings** for total monthly medical costs ranged from $143.96 to $293.39 per patient per month.

Today's health care funding challenges will require payers to utilize the most cost effective care without compromising quality.

America's pharmacists contain health care costs while improving quality... a rare combination in today's environment.

Pharmacists Impact on Health Care Cost and Quality	Study Citation
Pharmacists providing pharmaceutical care in a VA outpatient clinic reduced the number of medications taken by patients by an average of 2.4 prescriptions.	[20]Galt KA. Cost avoidance, acceptance, and outcomes associated with a pharmacotherapy consult clinic in a Veterans Affairs medical center. *Pharmacotherapy* 1998 Sept-Oct;18(5):1103-11
Pharmacists providing flu and pneumonia immunizations increased vaccination rates in high risk patients by 74%; saving thousands of dollars in health care costs associated with complications resulting from influenza infection.	[21]Grabenstein JD, et al. Community pharmacists as immunization advocates: a pharmacoepidemiologic experiment. *International Journal of Pharmacy Practice* 1993;2:5-10. Fox AT, Tjhio DA, Teeters JH. Implementation of a pharmacy based immunization program within a health care system. *Pharmacotherapy* 2000;20:365;abstract 159. Grabenstein JD, et al. Community pharmacists as immunization advocates: cost-effectiveness of a cue to influenza vaccination. *Medical Care* 1992;30:503-13
Community pharmacists providing pharmaceutical care to asthma patients in an HMO decreased hospitalizations by 77% and decreased emergency room visits by 78%.	[22]Rupp MT, McCallian DJ, Sheth KK. Developing and marketing a community pharmacy-based asthma management program. *Journal of the American Pharmaceutical Association;* 1997 Nov-Dec; 37(6):694-9
In one month, six pharmacists providing pharmaceutical care decreased the drug costs from a cohort of patients by 41%.	[23]McMullin, T., Hennenfent J., etal. A prospective, randomized trial to assess the cost impact of pharmacist-initiated interventions. *Archives of Internal Medicine.* 1999 Oct 25; 159(19):2306-9
This study shows that costs associated with drug-related problems exceeds $77 billion annually. These costs could be cut by more than 50% if pharmaceutical care was provided to all patients.	[24]Bootman JL Johnson JA. Drug-related morbidity and mortality. A cost-of-illness model. *Archives of Internal Medicine.* 1995 Oct 9; 155(18):1949-56
Patients treated with blood thinners in a pharmacist-managed anticoagulation clinic had fewer emergency room visits, fewer hospitalizations, and showed a total cost savings of $1,621 per patient.	Chiquette E, Amato MG, Bussey HI. Comparison of an anticoagulation clinic with usual medical care. Anticoagulation control, patient outcomes, and health care costs. *Archives of Internal Medicine* 1998;158:1641-7

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[25]Chain Industry Profile, 2002

[26]Hoover's Company Information, May 12, 2003, www.hoovers.com

[27]NACDS Economics Department

[28]Attitudes and Beliefs About the Use of Over-the-Counter Medicines: A Dose of Reality. Harris Interactive, Inc. 2002

[29]Eisenburg, D. To The Rescue. *Time Magazine.* 2001; April 23

PHARMACISTS' SERVICES
can save state Medicaid dollars

Billions of dollars can be saved by utilizing pharmaceutical care

Here's one example of how pharmaceutical care works:

In a study comparing patients starting on blood thinners treated with usual medical care to those treated in a pharmacist-managed anticoagulation (blood thinner) clinic, it was found that patients treated in the pharmacist-managed clinic had:

- Fewer emergency room visits (from 22% to 6%)
- Fewer hospitalizations (from 19% to 5%)
- Fewer bleeding episodes (from 35% to 8.1%)
- Fewer blood clot complications (from 11.8% to 3.3%)

Total cost savings: $1,621 per patient... or $1,621,000 per thousand patients.

More pharmaceutical care savings

Pharmacists working in community pharmacies, managed care, long-term care, home care, and other areas save nearly $17 in health care cost for every dollar invested in pharmacy services[11] ... in other words:

Providing pharmaceutical care to patients at a cost of $500,000 would yield over $8,500,000 in cost savings.

Imagine how much more could be done to care for patients if an extra $8.5 million were available.

State	2002 Drug Payments	Estimated Cost of Rx Drug-Related Illness and Death	Estimated Net Savings from Pharmaceutical Care Services
Alabama	$478,039,508	$233,663,700	$138,328,910
Alaska	---	---	---
Arizona	---	---	---
Arkansas	$286,666,058	$186,986,494	$110,696,005
California	$3,648,195,035	$1,931,403,138	$1,143,390,657
Colorado	$196,128,613	$36,519,613	$21,619,611
Connecticut	$363,675,493	$82,463,487	$48,818,3
Delaware	$95,071,847	$31,323,894	$18,543,745
District of Columbia	$47,754,463	$55,535,427	$32,876,973
Florida	$1,748,930,895	$463,770,462	$274,552,113
Georgia	$860,752,056	$480,622,630	$284,528,597
Hawaii	$90,206,216	$41,984,587	$24,854,875
Idaho	$79,831,962	$29,701,769	$17,583,447
Illinois	$1,308,779,763	$397,239,516	$235,165,793
Indiana	$648,255,298	$176,579,455	$104,535,037
Iowa	$290,670,341	$53,735,150	$ 31,811,209
Kansas	$195,964,974	$43,794,421	$25,926,297
Kentucky	$673,213,513	$69,640,146	$100,426,966
Louisiana	$715,254,094	$290,385,624	$171,908,290
Maine	$250,071,092	$65,915,130	$39,021,757
Maryland	$318,529,614	$154,810,912	$91,648,060
Massachusetts	$949,890,388	$303,799,737	$179,849,444
Michigan	$712,113,875	$334,430,108	$197,982,624

PHARMACISTS' SERVICES
can save state Medicaid dollars

Again, billions of dollars in health care costs would be saved by paying pharmacists to provide pharmaceutical care and disease state management.

These programs improve care and control costs by:

- Improving medication use and patient compliance to therapy
- Detecting and avoiding drug-drug interactions and allergic reactions
- Suggesting lower-cost drug therapy alternatives
- Suggesting that a drug be discontinued

State	2002 Drug Payments	Estimated Cost of Rx Drug-Related Illness and Death	Estimated Net Savings from Pharmaceutical Care Services
Minnesota	$322,670,381	$132,007,604	$78,148,501
Mississippi	$517,059,587	$344,014,888	$203,656,814
Missouri	$835,996,596	$332,622,425	$196,912,475
Montana	$78,370,828	$12,359,582	$7,316,873
Nebraska	$197,802,584	$58,937,268	$34,890,862
Nevada	$92,904,637	$20,738,081	$12,276,944
New Hampshire	$102,090,937	$13,067,839	$7,736,161
New Jersey	$668,452,082	$152,477,298	$90,266,561
New Mexico	$83,772,944	$136,660,258	$80,902,873
New York	$3,482,567,496	$1,033,322,297	$611,726,799
North Carolina	$1,122,737,042	$247,313,730	$146,409,728
North Dakota	$53,046,799	$8,284,242	$4,904,271
Ohio	$1,380,579,809	$447,192,429	$264,737,918
Oklahoma	$273,058,170	$129,714,223	$76,790,820
Oregon	$277,727,878	$99,529,891	$58,921,696
Pennsylvania	$707,197,468	$335,711,710	$198,741,332
Rhode Island	$127,361,626	$55,679,225	$32,962,101
South Carolina	$497,839,780	$265,254,270	$157,030,528
South Dakota	---	$24,503,607	$14,506,135
Tennessee	$972,650,782	$693,667,665	$410,651,258
Texas	$1,623,768,624	$440,013,145	$260,487,782
Utah	$135,484,313	$19,014,796	$11,256,759
Vermont	$34,615,259	$53,955,668	$31,941,755
Virginia	$460,320,679	$66,391,733	$39,303,906
Washington	$529,858,278	$256,094,602	$151,608,004
West Virginia	$290,278,394	$89,227,584	$52,822,730
Wisconsin	$342,705,494	$144,827,070	$85,737,625
Wyoming	$37,874,963	$9,995,994	$5,917,628
Total	$29,206,788,528	$1,186,884,523	$ 6,622,635,634

Medicaid State Drug Utilization Data, Centers for Medicare and Medicaid Services, http://cms.hhs.gov/medicaid/drugs/drug5.asp. Drug-related morbidity and mortality in ambulatory patients in the U.S. have been estimated to cost $177 billion annually, or approximately $215 per physician visit ($225.04 in 2002 dollars) (J Am Pharm Assoc 2001; 41:192-199).

Based on the number of outpatient physician visits, the direct cost for drug-related morbidity and mortality in ambulatory Medicaid beneficiaries is estimated for each state. Provision of comprehensive pharmacy services, as described in the accompanying materials, could reduce the total U.S. cost of drug-related morbidity and mortality in ambulatory patients by $45.6 billion annually, or approximately $68 per physician visit (Am J Health Syst Pharm 1997; 54:554-8). Based on the number of outpatient physician visits, the direct cost savings are estimated for each state.

The Alliance for Pharmaceutical Care is a consortium of ten national organizations working together to educate the public, policy makers, and other key decision makers about the important role that pharmacists play in the ever-evolving health care system.

Alliance for Pharmaceutical Care

The American Association of Colleges of Pharmacy provides leadership in advancing and enhancing the quality of pharmacy education at all levels. AACP is a national organization whose mission is to serve its member colleges and schools and their respective faculties:

- by acting as their advocate at the national level;
- by providing forums for interaction and exchange of information among its members;
- by recognizing outstanding performance among its member educators, and;
- by assisting member colleges and schools in meeting their mission of educating and training pharmacists and pharmaceutical scientists.

Contact: Will Lang
1426 Prince Street • Alexandria, VA 22314-2841
Phone: (703) 739-2330
wlang@aacp.org
www.aacp.org

The American College of Clinical Pharmacy (ACCP) is a professional and scientific society that provides leadership, education, advocacy, and resources enabling clinical pharmacists to achieve excellence in practice and research. ACCP's membership is composed of practitioners, scientists, educators, administrators, students, residents, fellows, and others committed to excellence in clinical pharmacy and patient pharmacotherapy.

Contact: Ed Webb
1101 Pennsylvania Ave., NW, Suite 600 • Washington, DC 20004-2514
Phone: (202) 756-2227
ewebb@accp.com
www.accp.com

The Academy of Managed Care Pharmacy (AMCP) is a professional association of pharmacists and associates who serve patients and the public through the promotion of wellness and rational drug therapy by the application of managed care principles. The mission of AMCP is to serve as an organization through which the membership pursues its common goals; to provide leadership and support for its members; to represent its members before private and public agencies and health care professional organizations; and to advance pharmacy practice in managed health care systems. The Academy now has more than 4,800 members nationally who provide comprehensive coverage and services to the more than 200 million Americans served by managed care.

Contact: Ann Curry
100 North Pitt Street, Suite 400 • Alexandria, VA 22314
Phone: (703) 683-8416
acurry@amcp.org
www.amcp.org

The American Pharmacists Association (APhA) is the first established and largest professional association of pharmacists in the United States. APhA's 53,000 members include practicing pharmacists, pharmaceutical scientists, pharmacy students, pharmacy technicians, and others interested in advancing the profession. The Association is a leader in providing professional information and education for pharmacists and an advocate for improved health through the provision of comprehensive pharmaceutical care.

Contact: Mitch Rothholz
2215 Constitution Avenue, NW • Washington, DC 20037-2985
Phone: (202) 429-7549
mrothholz@aphanet.org
www.aphanet.org

The American Society of Consultant Pharmacists (ASCP) is the national professional association representing over 7,000 pharmacists who provide medication distribution and consultant services to manage and improve drug therapy outcomes of individuals residing in long-term care environments. ASCP members are America's Senior Care Pharmacists, serving the full spectrum of long-term care settings, including nursing homes, subacute care and assisted living facilities, psychiatric hospitals, facilities for the mentally retarded, correctional institutions, hospice, and home care.

Contact: Joe Hill
1321 Duke Street • Alexandria, VA 22314-3563
Phone: (703) 739-1300 x141
jhill@ascp.com
www.ascp.com

ASHP is the 30,000-member national professional association that represents pharmacists who practice in hospitals, health maintenance organizations, ambulatory care clinics, long-term care facilities, home care, and other components of health care systems. ASHP, which has a long history of medication error prevention efforts, believes that the mission of pharmacists is to help people make the best use of medicines. Assisting pharmacists in fulfilling this mission is ASHP's primary objective. The Society has extensive publishing and educational programs designed to help members improve their professional practice, and it is the national accrediting organization for pharmacy residency and pharmacy technician training programs. For more information, visit ASHP's Web site, www.ashp.org or www.safemedication.com.

Contact: Maria Spencer
7272 Wisconsin Avenue • Bethesda, MD 20814
Phone: (301) 657-3000
mspencer@ashp.org
www.ashp.org

The Healthcare Distribution Management Association (HDMA) is the national trade association that represents pharmaceutical and related health care product distributors throughout the Americas. It is a leader in stimulating innovations that enhance the distributors' role in health care distribution and the services they provide to their customers.

Contact: Dan Bellingham
1821 Michael Faraday Drive, Suite 400 • Reston, VA 20190
Phone: (703) 787-0000
dbellingham@hdmanet.org

Founded in 1933 and based in Alexandria, Virginia, the **National Association of Chain Drug Stores (NACDS)** membership consists of more than 210 retail chain community pharmacy companies. Collectively, chain community pharmacy comprises the largest component of pharmacy practice with over 100,000 pharmacists. The chain community pharmacy industry is comprised of more than 20,000 traditional chain drug stores, 8,800 supermarket pharmacies and nearly 6,300mass merchant pharmacies. The NACDS membership base operates more than 34,000 retail community pharmacies with annual sales totaling over $500 billion, including $180 billion in sales for prescription drugs and $68 billion for over-the-counter (OTC) medications and health and beauty aids. Chain operated community retail pharmacies fill over 60% of more than 3 billion prescriptions dispensed annually in the United States. Additionally, NACDS membership includes nearly 1,034 suppliers of goods and services to chain community pharmacies. NACDS international membership has grown to include 108 members from 33 foreign countries. For more information about NACDS visit www.nacds.org.

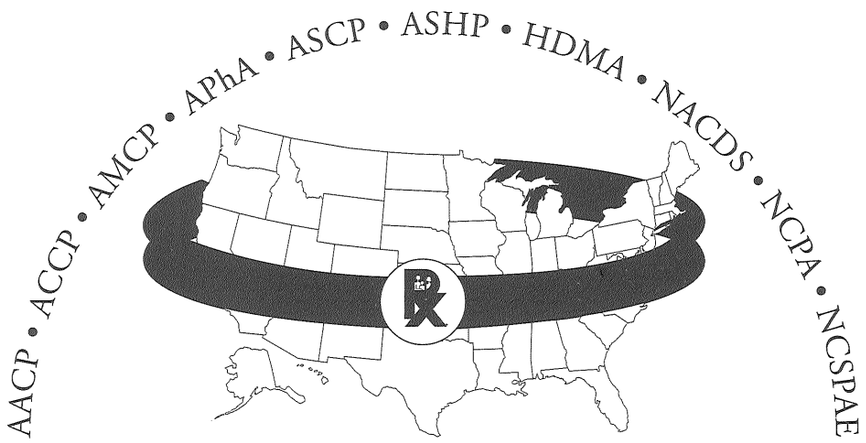
Contact: Cathy Polley
413 North Lee Street • Alexandria, VA 22313-1480
Phone: (703) 549-3001 x239
cpolley@nacds.org
www.nacds.org

The National Community Pharmacists Association (NCPA) represents the nation's community pharmacists, including the owners of nearly 24,000 pharmacies. The nation's independent pharmacies, independent pharmacy franchises, and independent chains represent a $67 billion marketplace, dispensing nearly half of the nation's three billion retail prescription medicines.

Contact: Regenia Benjamin
205 Daingerfield Road • Alexandria, VA 22314-2885
Phone: (703) 683-8200
regenia.benjamin@ncpanet.org
www.ncpanet.org

The National Council of State Pharmacy Association Executives (NCSPAE) provides education programs for the exchange and dissemination of information, ideas, experience, and opinions and to provide a forum for discussion and study in the interest of improved state association administration and management. Other purposes include fostering the highest possible professional standards for state pharmacy association executives, promote the development of efficient methods, procedures and techniques for managing affairs of the state associations and to advance professional standards associated with pharmacy practice.

Contact: Rebecca P. Snead
5501 Patterson Avenue, Suite 200 • Richmond, VA 23226
Phone: (800) 527-8742
becky@vapharmacy.org



Alliance for Pharmaceutical Care

Pharmacists for Quality Patient Care

Every day, pharmacists:

- Improve care;
- Control cost;
- Ensure safe medication use; and
- Protect patient confidentiality and privacy.

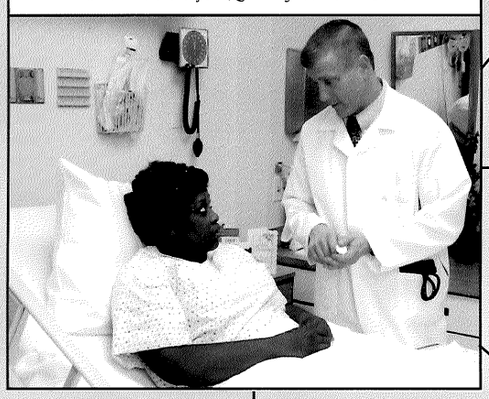
Pharmacists do this by:

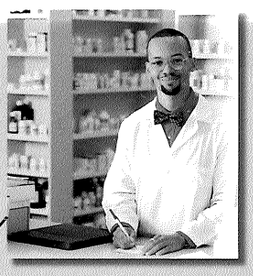
Checking for important drug interactions, especially when the prescriptions are from more than one prescriber.

Pharmacists see thousands of patients who have prescriptions that may interact with a prescription or nonprescription medication prescribed by a different physician.

AACP • ACCP • AMCP • APhA • ASCP • ASHP • HDMA • NACDS • NCPA • NCSPAE

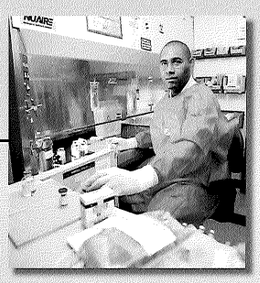
Alliance for Pharmaceutical Care
Pharmacists for Quality Patient Care





Answering thousands of questions each day from patients about potential side effects; and foods, drinks, or activities that should be avoided while on a medication.

Patients depend on pharmacists to provide information on how to ensure they get the most benefit from their drug therapy.



Providing information and advice on nonprescription drugs and self-care.

Did you know that only 34% of consumers know the active ingredient in their brand of pain reliever and only 11% of consumers understand that liquid pain relievers formulated for infants are usually more concentrated than formulations for older children[28]?

Checking the written prescription order for complete and accurate information.

Studies estimate that 150 million phone calls are made each year regarding prescriptions that require clarifications to be made with the prescriber before the medication can be dispensed[29].

Ensuring that policies and procedures designed to protect patient privacy and confidentiality are followed at all times.

Guided by a professional Code of Ethics, pharmacists view and transmit sensitive patient health information in a confidential and secure manner every day.

PHARMACISTS FOR QUALITY PATIENT CARE

Senate Counsel & Research

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX (651) 296-7747

JO ANNE ZOFF SELLNER
DIRECTOR

Senate
State of Minnesota

S.F. No. 564 - Adverse Medical Examinations

Author: Senator John Marty

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801)

Date: February 18, 2005

S.F. No. 564 places limits on adverse medical examinations.

Section 1 (65B.56) states that the obligation to submit to an adverse medical examination when claiming auto insurance benefits only applies to requests from an obligor that has paid in a timely manner all medical bills relating to the injury in question that the obligor is responsible for. This section also limits the number of adverse examinations for auto insurance claims and workers' compensation claims a physician can perform to 24 in any calendar year. The physician may conduct a chart or other paper review but benefits or claims cannot be denied based on such an examination. Testimony or other evidence from a physician who has physically examined the person may be considered as a basis for denying a claim or benefit.

Section 2 (176.136) changes independent examination to adverse examination.

Sections 3 and 4(176.155) make the same changes as described in **section 1** for workers' compensation claims.

KC:ph

Senators Marty, Higgins, Lourey and Anderson introduced--

S.F. No. 564: Referred to the Committee on Health and Family Security.

A bill for an act

relating to integrity and fairness in medical examinations; regulating certain medical examinations; amending Minnesota Statutes 2004, sections 65B.56, subdivision 1; 176.136, subdivision 1c; 176.155, subdivision 1, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 65B.56, subdivision 1, is amended to read:

Subdivision 1. [ADVERSE MEDICAL EXAMINATIONS; INTEGRITY; AND DISCOVERY OF CONDITION OF CLAIMANT.] Any person with respect to whose injury benefits are claimed under a plan of reparation security shall, upon request of the reparation obligor from whom recovery is sought, submit to ~~a physical~~ an adverse medical examination by a physician or physicians selected by the obligor as may reasonably be required. The obligation to submit to an examination applies only to requests from a reparation obligor that has timely paid all medical bills for which it is responsible related to the injury for which the examination is sought.

The costs of any examinations requested by the obligor shall be borne entirely by the requesting obligor. Such examinations shall be conducted within the city, town, or statutory city of residence of the injured person. If there is no qualified physician to conduct the examination within the city, town, or statutory city of residence of the injured

person, then such examination shall be conducted at another place of the closest proximity to the injured person's residence. Obligors are authorized to include reasonable provisions in policies for mental and physical examination of those injured persons.

If requested by the person examined, a party causing an examination to be made shall deliver to the examinee a copy of every written report concerning the examination rendered by an examining physician to that person, at least one of which reports must set out in detail the findings and conclusions of such examining physician.

An injured person shall also do all things reasonably necessary to enable the obligor to obtain medical reports and other needed information to assist in determining the nature and extent of the injured person's injuries and loss, and the medical treatment received. If the claimant refuses to cooperate in responding to requests for examination and information as authorized by this section, evidence of such noncooperation shall be admissible in any suit or arbitration filed for damages for such personal injuries or for the benefits provided by sections 65B.41 to 65B.71.

A physician may not perform more than a total of 24 adverse examinations under this subdivision and section 176.155, subdivision 1, in any calendar year whether done for one or more reparation obligors or employers.

A physician may perform a chart or other paper review, but benefits or claims may not be denied on evidence based on such an examination. Testimony or other evidence by a physician on behalf of the reparation obligor concerning the medical condition of the injured person may be considered as a basis for denying a claim or benefit if the physician has physically examined the person.

The provisions of this section apply before and after the commencement of suit.

Sec. 2. Minnesota Statutes 2004, section 176.136, subdivision 1c, is amended to read:

Subd. 1c. [CHARGES FOR ~~INDEPENDENT~~ ADVERSE MEDICAL EXAMINATIONS.] The commissioner shall adopt rules that reasonably limit amounts which may be charged for, or in connection with, ~~independent or~~ adverse medical examinations requested by any party, including the amount that may be charged for depositions, witness fees, or other expenses. No party may pay fees above the amount in the schedule.

Sec. 3. Minnesota Statutes 2004, section 176.155, subdivision 1, is amended to read:

Subdivision 1. [EMPLOYER'S PHYSICIAN.] The injured employee must submit to an adverse examination by the employer's physician, if requested by the employer, and at reasonable times thereafter upon the employer's request. The obligation to submit to an examination applies only to requests from an employer that has timely paid all claims for medical benefits related to the injury for which it is responsible. The adverse examination must be scheduled at a location within 150 miles of the employee's residence unless the employer can show cause to the department to order an examination at a location further from the employee's residence. The employee is entitled upon request to have a personal physician present at any such examination. Each party shall defray the cost of that party's physician. Any report or written statement made by the employer's physician as a result of an examination of the employee, regardless of whether the examination preceded the injury or was made subsequent to the injury, shall be made available, upon request and without charge, to the injured employee or representative of the employee. The employer shall pay reasonable travel expenses incurred by the employee in attending the examination including mileage, parking, and, if necessary, lodging and meals. The employer shall also pay the employee for any lost wages resulting from attendance at the examination. A self-insured employer or insurer who is served with a claim petition pursuant to section 176.271, subdivision 1, or 176.291, shall schedule any necessary examinations of the employee, if an examination by the employer's physician or

health care provider is necessary to evaluate benefits claimed. The examination shall be completed and the report of the examination shall be served on the employee and filed with the commissioner within 120 days of service of the claim petition.

No evidence relating to the examination or report shall be received or considered by the commissioner, a compensation judge, or the court of appeals in determining any issues unless the report has been served and filed as required by this section, unless a written extension has been granted by the commissioner or compensation judge. The commissioner or a compensation judge shall extend the time for completing the adverse examination and filing the report upon good cause shown. The extension must not be for the purpose of delay and the insurer must make a good faith effort to comply with this subdivision. Good cause shall include but is not limited to:

(1) that the extension is necessary because of the limited number of physicians or health care providers available with expertise in the particular injury or disease, or that the extension is necessary due to the complexity of the medical issues, or

(2) that the extension is necessary to gather additional information which was not included on the petition as required by section 176.291.

Sec. 4. Minnesota Statutes 2004, section 176.155, is amended by adding a subdivision to read:

Subd. 1a. [RESTRICTIONS ON ADVERSE EXAMINATIONS.] A physician may not perform more than a total of 24 adverse examinations under subdivision 1 or section 65B.56, subdivision 1, in any calendar year whether done for one or more employers or reparation obligors.

A physician may perform a chart or other paper review but benefits or claims may not be denied on evidence based on such an examination. Testimony or other evidence by a physician on behalf of the employer concerning the medical condition of the injured person may be considered as a basis for denying a claim or benefit if the physician has physically examined the person.

ANDREW J. MORRISON
KENT CHARPENTIER*
GARY M. HAGSTROM+
BARBARA G. LAWTON
BRIAN P. THOMPSON

SARAH D. SQUILLACE - LAW CLERK
DEANNE BAHTI - LAW CLERK
KIM OSTHOFF - PARALEGAL

LAURENCE F. KOLL - OF COUNSEL

KOLL MORRISON CHARPENTIER & HAGSTROM

ATTORNEYS AT LAW

WEST-1430 FIRST NATIONAL BANK BUILDING
332 MINNESOTA STREET
ST. PAUL, MINNESOTA 55101
FAX 651 • 223-5362
E-MAIL: lawfirm@KMCHlaw.com

TELEPHONE 651 • 291-9155

MEMORANDUM

TO: Health & Family Security Committee Members

FROM: Andrew J. Morrison

DATE: March 1, 2005

RE: Senate File 564 (House File 1261) - Independent Medical Examinations

Senator Marty has introduced Senate File 564, which would limit the number of independent medical evaluations performed by a physician to a maximum of twenty-four in a calendar year. This legislative proposal affects Minn. Stat. § 65B.56 (no-fault) and Minn. Stat §§ 176.136 and 176.155 (workers' compensation).

Companies that arrange and schedule independent medical evaluations and some of the doctors who perform them have the following concerns about the implications of this bill:

1. Due process requires that plaintiffs and defendants alike be permitted to present the evidence they feel is necessary to advance and support their respective positions.

   Under the current judicial system, a plaintiff or defendant may obtain medical opinions from a physician of their choosing and present the physician's opinions to the trier of fact. Both parties have the right to choose an expert that they trust and respect to review the evidence and render an opinion to the trier of fact. This choice is fundamental to a fair adjudicative process.

   The proposed bill would act to limit a litigant's ability to obtain expert testimony from a physician of its choice if that physician already conducted twenty-four independent medical examinations during the calendar year. This restriction unfairly penalizes a litigant by limiting its choice of medical experts simply because the desired expert previously rendered medical opinions in matters having no connection to or bearing on the plaintiff's injury and claims.

Limiting a litigant's choice of medical experts allows medical providers to treat (or over treat) patients and may result in unnecessarily increased medical costs while restricting a judicial system that is currently working for the best interest of all parties. This bill would provide an unfair advantage to medical providers who provide excessive treatment to the detriment of litigants and policyholders.

2. The trier of fact should continue to consider the relevance and weight of independent medical examinations, not the legislature.

Under the current judicial system, both the plaintiff and defendant are permitted to present the evidence that they feel is necessary to prove or defend their case to a trier of fact, be it an arbitrator, judge, administrator law judge, or jury. It is the trier of fact that weighs the evidence and ultimately renders a decision. Regardless of the outcome, both parties are currently permitted to present their evidence and be heard in court.

The current judicial systems also provides adequate remedies to a party who feels that a medical expert's report is unsupported by the evidence, biased, or otherwise incredible. Both the plaintiff and defendant are permitted to object to the evidence and proffer evidence to support the assertion that the opinions of the medical expert do not have evidentiary value. The trier of fact determines, based on all of the evidence, whether or not the medical opinions are inadequate or biased and gives the opinions the appropriate weight. The trier of fact is in the best position to determine the amount of evidentiary value to give to a particular medical opinion. The proposed bill would operate to exclude relevant medical evidence without regard to its evidentiary value.

Prior attempts have been made to limit the information that could be disclosed to an independent medical evaluator in order to restrict the right of parties to obtain an independent medical examination. We support the principle that independent medical evaluators should be able to review all medical information that he or she deems relevant to the decision making process. The independent medical evaluator's opinions will continue to be reviewed and weighed by the trier of fact.

3. Independent medical examinations help contain medical treatment and costs within the no-fault and workers' compensation systems.

Outliers in the no-fault and workers' compensation systems, such as plaintiffs who exaggerate their disability or medical providers who provide treatments beyond community standards, should not be permitted to unnecessarily drive up medical costs. The current judicial system provides a system of checks and balances by ensuring that a defendant can obtain an independent medical examination. The independent medical evaluator can review treatment and complaints of pain and disability to determine whether or not local medical standards have been exceeded in a particular case. Restricting the independent medical evaluation process would destroy this system of checks and balances and allow the outliers to overcharge the system. This would result in increased costs for all policyholders.

4. Limiting the number of independent medical examinations a medical physician can perform during a calendar year unjustly restricts a defendant's ability to obtain medical testimony from well-qualified medical physicians.

The no-fault statute requires that an independent medical evaluation be conducted in the "city or town of statutory residence of the injured person: or at "another place of the closest proximity to injured person's residence." The workers' compensation statute requires that independent medical evaluations be conducted "within 150 miles of the employee's residence unless the employer can show cause to the department to order an examination at a location further from the employee's residence." The unintended but practical effect of these statutory requirements is to limit a defendant's choice of medical experts. The proposed bill would unfairly place further restrictions upon a defendant's right to choose a medical expert.

Companies that arrange and schedule independent medical examinations have difficulty finding well-qualified physicians who will perform independent evaluations. These companies also have difficulty obtaining blocks of time from practicing physicians who are willing to travel and conduct independent medical evaluations. Frequently physicians will not travel unless they are guaranteed a minimal number of evaluations to compensate them for their time away from their active practice. Other physicians include independent medical evaluation exams as a small part of practice, perhaps one or two a week, and are unwilling to travel. Unlike plaintiffs who are permitted to see the doctor of their choice and whose doctors are not restricted to testify at a predetermined number of trials, defendants have only a limited number of doctors from whom they select to complete an independent medical examination.

Limiting a medical expert to conducting no more than twenty-four evaluations during a calendar year is arbitrary, would further restrict a defendant's right to select the independent medical evaluator of its choice, and provide medical providers who over treat plaintiffs with an unjust and unnecessary advantage before the trier of fact.

Based upon the above concerns, we respectfully request that you and the entire legislature oppose Senate File 564 and any future proposed legislation that purports to restrict defendants' access to the medical expert of their choosing and takes away the trier of facts role of weighing and evaluating all relevant medical evidence.

AJM/hmh

March 1, 2005

Madam Chair – Members of the Committee, my name is Rick Reidt. Thank you for the opportunity to provide information concerning Senators Marty, Higgins, Lourey and Anderson's bill regarding "fairness and integrity" in no-fault automobile insurance and workers compensation independent medical examinations.

As a brief background, I have provided chiropractic treatment in private practice in the State of Minnesota for the last 18 years. In addition, I have been registered with the Minnesota Board of Chiropractic Examiners to provide Independent Examinations since August 22, 1997.

I am often called on as a chiropractic expert to perform independent evaluations. It has been my observation that the current system works well. Under the current system, a plaintiff or defendant may obtain a physician of their choosing and present the physician's opinions to the court. Both parties have the right to choose an expert that they trust and respect to review the evidence and render an opinion. This choice is fundamental to a fair legal process.

Due process requires that plaintiffs and defendants be permitted to present the evidence they feel is necessary to support their respective positions. The proposed bill would limit a defendant's ability to obtain expert testimony from a physician of their choice if that physician has already conducted 24 independent evaluations during that calendar year. This restriction unfairly penalizes a defendant by limiting its choice of a medical expert simply because that expert had rendered other medical opinions in matters that have no connection to or bearing on the plaintiff's injury and claims.

Concerning the examination process, it has been my experience that the independent examination that I perform and the history that I obtain from the examinee is as comprehensive and often more comprehensive than the examination conducted by the examinee's treating provider. In addition, I provide a comprehensive review of the available medical records which, in most cases, is not provided by the treating provider.

You may wonder why a practicing chiropractor or physician would chose to perform an independent examination.

perform Independent Examinations for several reasons:

1. I find the processes both professionally challenging and interesting. It allows me to utilize my clinical experience to provide a fair, independent opinion based on all of the available facts.

2. It allows me to participate in the policing of my profession.

3. I often find that the recommendations I make are in the best interest of the examinee as they result in a more appropriate, effective treatment course that can decreases the patient's pain and suffering.

In my view, this bill would be the equivalent of limiting an attorney to accept no more than 24 cases per year or limiting a chiropractor or physician to evaluate and treat no more than 24 no-fault or workers compensation cases per year. This bill would unfairly restrict medical experts from providing more than 24 opinions per year to a requesting party.

I encourage you to **please vote against SF 564.** The current system works very well and is in the best interest of all parties.

Respectfully Submitted,

Rick Reidt, DC

SPEECH PRESENTATION NOTES

February 22, 2005

Bruce Mack, M.D.

I would like to talk to you about what a doctor does in office. As patients, you probably see the visit as potentially intimidating and you may be worried about what you will be told.

As a doctor, I see people with symptoms of pain, numbness, perhaps imbalance or dizziness. Often the source of their symptoms is benign. It could reflect a pinched nerve at the wrist (carpal tunnel syndrome), a mild imbalance from inner ear dysfunction, a migraine headache, or may simply be a pain or sensation whose source cannot be identified but still not an omen of something bad to come.

I find that my office role is often advisory. I listen to the symptoms, make some inquiries, do an examination, and frequently tell the person that the symptoms are okay to have. For instance, the tingling in the little finger may be just from leaning on the elbow; the pain in the neck going to the shoulder may be a mild consequence of a pinched nerve; a very bad headache can still reflect only migraine rather than a tumor or an aneurysm. Although I sometimes order a diagnostic test, more commonly I order nothing, explaining to the patient why I am satisfied with the history and examination and trying to explain how I have reached my conclusion. People often just want to know that the symptom they are having is okay to have. If the process is painful, they want to know what their treatment alternatives are.

I realize that many symptoms are transient, so sometimes I just ask the person to call me back in a month to let me know how he or she is doing. I encourage them to call earlier if there is a change that is worrisome to them. I explain that we may pursue the symptom if it becomes more intrusive or is accompanied by other problems but that I do not expect this to happen. There are some processes including recurrent headaches or seizures for which I will have the patient begin medication. Often the medication is elective, something the person can take if he or she feels the symptoms are intrusive, but I explain that treatment is optional. Most symptoms are self-limited and not indicative of a serious medical problem. Most symptoms resolve themselves and do not require physical or pharmacologic treatment.

In my role as a doctor, I realize that I have the privilege of being considered fair and knowledgeable by the patient. This is an assumption that the patient makes without even knowing me, and very different from what a salesperson or a promoter of a service might expect. It is a privilege and one that must be honored by honesty and frankness on my part. The person with the tingling in the hand may be worried about multiple sclerosis. If I explain my reason for thinking this is a nerve pinched at the wrist, the person leaves content and appreciative of the explanation. If I am sloppy or lazy, I can easily convince the patient to have an MRI of the brain and of the spinal cord as well as electrodiagnostic studies of the nerve. These are often unnecessary, as they do not contribute to understanding or to treatment. Sometimes they are necessary, and I try to use them appropriately and discreetly.

When I perform IMEs, I am looking at the caregivers' performance with the same scrutiny with which I expect someone could review my own practice. I understand that people are in pain after accidents, but I also understand that with time the pain will lessen and probably cease. Traditional medicine, physical therapy, and chiropractic treatment rarely promote healing. The body does that. The care providers are sources of information and may promote physical or pharmacological means by which the patient can achieve comfort during the healing process. It is the duty of the care provider to realize that most healing is spontaneous and that reiterated treatment offered for months at a time is creating dependency without actually promoting or accelerating the healing process.

I feel that patient care should be discreet and pertinent. If my patient is not improving from a course of treatment, I either change the treatment or confess that I am unable to provide the relief that he or she is seeking. It would be inappropriate for me to say, "Take this medication, although it is not helping you," and also, "Come back frequently so I can re-prescribe it." In my performance of independent medical examinations, I bring seriousness and a sense of responsibility as well as 30 years of clinical experience. I always spend sufficient time with the person I examine to allow a complete discussion of the person's post-accident symptoms and that person's response to the treatment that has been offered. I examine the person carefully as I would my own patient, and I review the often-voluminous records to try to understand how the symptoms are related to the accident and whether the treatment has been effective. I sometimes find that the treatment has been ineffective but excessively ineffective as it is promoted again and again, despite lack of relief. I find that many imaging studies are ordered, yet few alter the course of treatment. It is rare to find that an MRI of the spine is followed by a treatment alteration or a surgical procedure that relieves the patient's symptoms.

First and foremost, I am a clinician, not an advocate of insurance company interests. It pleases me to determine that the claimant's symptoms are valid and are supported by records and examination findings. The skills that enable me to diagnose and treat dysfunction are also usefully applied in cases where is no dysfunction but only disproportionate claims of such and excessive treatment of nonorganic symptoms. Most people fall in the middle of these extremes: people who have been hurt and are getting better. It behooves the care providers to foster independence rather than an endless cycle of treatment and referrals with benefit only to the care providers. It is my feeling that a legislative limitation of the number of examinations I can perform per year will not help the valid claimants but only foster a misuse of time and resources as money and services are directed at symptoms which cannot be validated and symptoms which never cease. I speak only for myself, but I try to have the ethics and performance standards that I would expect from my legislators, my insurance agent, or my car dealer. We are all craftsmen and should be vigilant and pleased when the craft is practiced well.

Thank you.

BJM/ar: D: 02/22/05 T: 02/22/05

Mark Larkins, M.D.
Southdale Office Centre
6800 France Avenue South, Suite #00
Edina, Minnesota 55435
Phone: 952-925-5882
Fax: 952-925-9861

July 20, 2004

Mr. Steven L. Viltoft
LaBore, Giuliani, Cosgriff & Viltoft, Ltd.
P.O. Box 70
Hopkins, MN 55343-0070

RE: [redacted]
Your File Number: [redacted]
Date of Injury: February 1, 2002
Reference Number: [redacted]

Dear Mr. Viltoft:

At your request, I performed an Independent Medical Evaluation of [redacted] on July 20, 2004. This took place in Edina, Minnesota.

Ms. [redacted] understands that a patient/physician relationship does not exist as a result of today's evaluation. She was also informed that an interview and physical examination will take place and that records will be reviewed in order to formulate an independent medical report for the requesting party.

HISTORY: Ms. [redacted] is a [redacted]-year-old right-handed white female. In 2002, she was rear-ended while traveling on 35W. She is amnestic to the event. Apparently, her vehicle was pushed under a truck. She was subsequently taken to Abbott Northwestern Hospital, where she was evaluated. Initially, she had neck pain, left hand numbness, and a knee injury secondary to the steering column. She was given a neck brace. On Monday, she was seen at the Bloomington Lake Clinic. She also underwent physical therapy for four to five months with no relief. She was evaluated by Dr. Southern, who suggested a possible fusion. By her report, she has never had discography.

She also saw Bryan Lynn, M.D., who ordered x-rays and an MRI. An EMG has not been done. She mainly has upper cervical spine and left arm discomfort, as well as elbow discomfort. She also complains that her left first three digits tingle. She also indicates that she loses her balance and falls.

Ms. [redacted] currently takes Neurontin 100 mg three times a day, Vicodin five times a day, and Vioxx.

MEDICAL RECORD REVIEW: The available medical records were reviewed.

Records from Bloomington Lake Clinic were reviewed. These include records that date back to 1991 and are basically primary care issues from her primary care physicians. There are a number of medical issues. Ms. [redacted] had a number of what appeared to be syncopal episodes of an unknown origin in December 2002.

There is a report dated February 2, 2002 relative to a February 1, 2002 motor vehicle accident. Apparently, Ms. [redacted] was the restrained driver who was stopped at 35W and Crosstown at 1:00 p.m. when her vehicle was rear-ended by a car that was traveling approximately 50 miles an hour. Her vehicle was subsequently pushed into a truck that was in front of her vehicle. Apparently her vehicle actually went underneath the truck. Her airbag did not deploy subsequent to the accident. She was transported to the Emergency Room at Abbott Northwestern Hospital, where x-rays were done. She was there until 6:00 or 7:00 p.m. that night. She was given Naprosyn and lorazepam. She awakened with numbness in her hands with a sensation of swelling, problems taking a deep breath, and pain with mastication. She was felt to have neck and bilateral shoulder and chest muscular and ligamentous pains secondary to the motor vehicle accident.

By her report, Ms. [redacted] indicated that she would have liked to try to get by on muscle relaxants alone, but she was given Vicodin as well.

Ms. [redacted] was rechecked on February 8, 2002. She had persistent central chest pain, which made it uncomfortable for her to breathe. It was felt that she had sternum, rib, and connective tissue strain secondary to the motor vehicle accident. She was given a chest wrap with Ace wrap.

On February 5, 2002 Ms. [redacted] complained of tingling in both of her hands, generalized paresthesias, and trouble doing things like taking lids off of jars. She also had some difficulty with lateral rotation of her neck. Despite all of this, she felt that she was slightly improved.
Ms. [redacted] was rechecked again on February 19, 2002. She was given amitriptyline by Dr. Boardman. She was gradually improving.

Another syncopal episode occurred on February 14, 2002 in physical therapy. In a note dated February 21, 2002, there is indication that she apparently fell in physical therapy several days prior.

In another followup visit on February 15, 2002, Ms. [redacted] returned for a recheck on persistent occipital, trapezial, posterior cervical, and shoulder pain. She had slowed down with her physical therapy and had complaints of shortness of breath when lying flat during therapy sessions. She had difficulty sleeping at night. She did not feel that Naprosyn was providing much relief nor did the hydrocodone. She was given samples of Vioxx.

There is another visit dated March 12, 2002. Ms. [redacted] requested forms for economic assistance.

There is another followup on April 2, 2002, and it was felt that Ms. [redacted] had sustained a whiplash injury.

There is another followup dated March 7, 2002. She continued to have episodes of shortness of breath and persistent neck, shoulder, and chest pain. She again followed up on April 2, 2002, when there was another syncopal episode. There is another followup visit on April 9, 2002.

Ms. [redacted] again followed up on January 27, 2003. She was now following with Dr. Southern from Orthopedic Surgery. She was scheduled for surgery in the near future, namely a C4-5, C5-6, and C6-7 discectomy.

On the followup visit of May 12, 2004, she had a significant loss of range of motion of the neck. Grips simply were weaker on the left hand than on the right. "She has numbness and pain in an unusual distribution, kind of a glove distribution of the hand, but her reflexes seem to be intact." According to these notes, she was seeking a third opinion regarding the disc operation at the Mayo Clinic.

Notes from the Hennepin County Medical Center were reviewed. There is a cervical spine MRI, which was done on February 1, 2002, which shows degenerative disc disease at C4-5, C5-6, and C6-7. The AP and lateral views of the cervical spine done on January 1, 2002, again show degenerative disc disease. Cervical MRI done on July 7, 2003 shows multiple level disc disease, with no changes when compared with the previous MRI scan.

A lumbar MRI done on November 7, 2002 shows a mild disc protrusion at L5-S1 and a fair amount of left lateral disc protrusion at L4-5.

The Minneapolis Clinic of Neurology notes were reviewed as well. The initial note from Dr. Hubbard dated March 19, 2002 was reviewed. At that time, Ms. [redacted] was evaluated for persistent headaches, neck pain and back pain, as well as upper extremity numbness. "I suspect that her problems are predominantly myofascial in origin." She was recommended to pursue with myofascial trigger point injections.

Records from Orthopedic Surgeons dated March 25, 2003 indicated that Ms. [redacted] was waiting for Dr. Southern to return. There was a followup visit from Steven Moen, M.D.

There are notes relative to an August 29, 2002 followup visit with Dr. Southern, with the aim of doing a discography at C4 through T1. It was felt that Ms. [redacted] had significant cord compression at C4-5 and C5-6, and he recommended a limited fusion at C4-5 and C5-6 with cord decompression followed then by a fusion with allografts restoring the loss of height and maximizing the lordosis of the segments treated.

In Dr. Southern's initial narrative report dated September 27, 2002, he noted that there were degenerative changes at C4-5, C5-6 and C6-7. It was his opinion that a high-speed motor vehicle accident would be sufficient to initiate a chronic and long-lasting pain syndrome by aggravating the underlying asymptomatic degenerative disc disease present prior to the accident. At that point, he recommended prolonged conservative care.

Another follow-up visit from September 22, 2003 at the Institute for Low Back Pain and Neck Care was reviewed. The particular fusion at C4-5, C5-6 and C6-7, as well as its impact on her neck pain and headache issues were discussed.

Ms. [redacted] was seen by Dr. Bryan Lynn, M.D on July 14, 2003. He recommended bilateral C4-5, C5-6, and C6-7 facet injections.

The lumbar spine MRI from November 7, 2002 was reviewed.

PHYSICAL EXAMINATION: Ms. [redacted] is a very pleasant although uncomfortable, middle-aged white female. She has tenderness to palpation of her spine. She has limited range of cervical motion of about 50%. She has a nonanatomic motor exam with some deficits in her left arm. Otherwise, she approximates normal motor function with supraspinatus and infraspinatus, deltoids, biceps, triceps, brachioradialis, wrist flexion, extension, pronation, supination, and hand intrinsics. Reflexes are 1 to 2+. No muscle atrophy is noted. She has a negative Tinel's sign and Phalen's test. Toes are downgoing. She has normal lower extremity reflexes. She has a negative Hoffman's and Trömner's test. No occipital trigger points are noted. She has normal scalp sensation.

DISCUSSION/CONCLUSIONS: The following opinions are provided within a reasonable degree of medical certainty, based on my interview and examination of Ms. [redacted], as well as the records reviewed and my experience as a board certified neurosurgeon.

1. It is my opinion that Ms. [redacted] diagnosis is myofascial neck and left arm pain, as well as C4-5, C5-6, and C6-7 degenerative disc disease.

2. As noted above, Ms. [redacted] has myofascial neck and left arm pain of unknown etiology. The etiology of her degenerative disc disease is normal wear and tear and the aging process.

3. It is my opinion that Ms. [redacted] did not sustain a permanent injury as a result of the February 1, 2002 accident.

4. Relative to the accident at issue, it is my opinion that Ms. [redacted] is capable of returning to pre-loss activity levels, including occupational duties. However, as a result of her myofascial pain and degenerative disc disease she may self-restrict herself.

5. It is my opinion that Ms. [redacted] prognosis with respect to the accident at issue is excellent; however due to her continued myofascial complaints, her prognosis is guarded.

If you have any further questions, please contact me through the office listed above.

Sincerely,

Mark Larkins, M.D.
Neurosurgery

ML/aes

date of service: 7-20-04
dictation received: 7-20-04, 8-02-04
transcribed: 7-20-04, 8-02-04

Dear Senator Marty:

I am a doctor practicing in Minnesota. Recently an acquaintance alerted me to the Minnesota Senate's website, specifically the section regarding S.F. No. 564. After reading this revised legislation, I felt the need to write to you regarding my thoughts on this bill.

I have practiced in Minnesota for many years. Approximately 10 or 15 years of my practice has involved, to a large extent, working with plaintiffs who have been injured in motor vehicle accidents, or have suffered other injuries, sometimes resulting in disability. As I have worked with these patients, I have testified in court and depositions (for the plaintiff and the defense) regarding workers compensation, auto insurance, and disability claims. I have worked closely with approximately 50 plaintiff attorneys regarding these cases.

In addition, I have performed numerous "paper reviews," in which I have reviewed patients' medical records. As a result of these reviews, I have written many reports for insurance companies, commenting on the impact of physical injuries on individuals who make claims for insurance benefits.

In addition, I have approximately 10 years of experience working very closely with auto, workers compensation, and disability insurance companies, and in this capacity have worked almost exclusively with the defense. When I examine patients in my own practice to assess for the consequences of injuries, I write independent medical examination reports that are typically delivered through IME companies to insurers. In brief, I have an intimate knowledge of both plaintiff/claimant and defense perspectives in this field.

Throughout my years of practice, I have grown more concerned about the actions of some companies that perform independent medical examinations. Unfortunately, some of these entities are prone to hire doctors, to whom they refer large volumes of business, who routinely say that there is either little or nothing wrong with claimants.

Alternatively, these doctors often attribute injuries to causes for which the insurance company is not required to cover. This latter problem is very common in auto insurance matters, where I see problems with doctor objectivity that are, *by far, worse than in any other area of insurance.* Here, doctors routinely attribute injuries suffered in car accidents to largely unrelated minor injuries or illnesses that pre-existed or post-dated the motor vehicle accidents in question.

One of my colleagues at a major hospital in Minneapolis who has seen a large volume of patients over many years. Many of these patients have been severely injured, according to numerous treating doctors, such as myself. However, I have never read even one of his reports that is in reasonable agreement with the overall opinions of the claimants' treating doctors. He consistently and selectively omits and distorts important information, leading the reader to erroneous conclusions. This type of practice is not limited to my colleague.

I have also worked with numerous companies that have performed independent medical examinations. While some of these companies have been above reproach, there are

others that are little more than criminal organizations. For example, I have consistently heard that they routinely edit doctor's reports without doctor's knowledge. These companies seem to select only the most conservative doctors. In my personal experience, I have found that after I indicated that claimants' injuries have caused claimants significant problems, these companies immediately end their referrals to me.

This same impression of bias holds true for some companies that perform independent file reviews of claimant injuries. Let me say first of all very clearly, I think that there is a legitimate role for file reviews, in which doctors review claimants medical records and give the insurance companies recommendations about such things as treatment, diagnosis, and disability. However, these file reviews are also sometimes abused. I have seen some insurance companies request these reviews, instead of more expensive but thorough independent medical examinations, which would often be more appropriate and fair to claimants.

Let me comment on a couple of other issues that pertain to this bill. In my experience, companies that perform independent medical examinations usually have relatively little oversight over the quality of the reports generated by their doctors. They tend to do all types of examinations, for example orthopedics, neurology, psychiatry, etc. In a hospital setting, where I am comfortable working, there are departments with department chairs who oversee these diverse professionals. For example, there is a head of the heart transplant program, of neurology, obstetrics, and so forth. This oversight helps ensure that doctors practicing in diverse specialties consistently treat their patients appropriately. This same degree of oversight, at least as far as I have seen, does not exist in virtually all companies that perform independent medical examinations. I strongly believe that IME companies should be required to offer much closer professional oversight over the quality aspects of the reports. Perhaps this would require all physicians who specialize in the particular area examined to oversee all reports of that type.

I believe that limiting the number of independent medical examinations that doctors can perform each year is, overall, a good idea. While certainly not a perfect solution, I believe that this would eliminate some of the problems caused by the worst IME doctors who see hundreds of examinees each year. I believe that this limitation should be reasonable, and permit doctors who perform IMEs to perform a reasonable number of examinations so they can develop and maintain their forensic skills. However, again, the worst problems usually result from doctors who perform extraordinarily high numbers of these examinations each year, and who generate biased reports that are overlooked by IME companies.

I am sending this letter to you, Senator Marty, anonymously. If my identity were revealed, I believe it would have severe consequences for my independent practice.

Good luck with your efforts.

SCHWEBEL GOETZ & SIEBEN

ATTORNEYS AT LAW

A Professional Association

February 14, 2005

Michael A. Bryant, Esq.
Bradshaw & Bryant Law Offices
1505 Division Street
Waite Park, MN 56387

RE: Mahtaub Eagen

Dear Mike:

I am enclosing for your review a copy of the hearing transcript from my no-fault arbitration. I apologize for taking so long to get to you but for some reason even though I told the court reporter I wanted a copy, they didn't print it up until I made a second request.

I think the most helpful testimony in this deposition appears on pages 78 and 79. Basically, Ms. Day agrees that they result in 100% denial and then she changes it to 90%. Either way, I find it outrageous that there would be a 90% denial rate. You and I both know that the denial rate is really 100%. In my career I have yet to see one adverse exam that did not result in a denial of benefits.

Please feel free to forward this on to whomever you think needs it to be helpful to our cause.

Sincerely,

Richard L. Tousignant
Direct Dial Number: (612) 344-0455
rtousignant@schwebel.com

RLT/cc
Enclosure

5120 IDS Center, 80 South Eighth Street, Minneapolis, Minnesota 55402-2246
Minneapolis: 612-377-7777 St.Paul: 651-777-7777
Toll Free: 800-752-4265 Fax: 612-335-6811
www.schwebel.com

that's the only dispute we have here today. And my question for you is are you agreeing with that or are you finding something else that I'm not seeing here?

A I thought it should be looked into.

Q Well, yeah. And I understand that that's your job. The question is for today is there anything I'm not hearing that's different than what we've heard so far that you have some evidence of?

A No.

Q Okay. And you're not claiming she's a liar or she's dishonest or fraudulent here?

A No.

Q Okay. That's what I was getting to. Now, you're the one that selected Dr. Carlson to examine Ms. [redacted]?

A Yes.

Q And you've used him in the past, correct?

A No.

Q You've never use Dr. Carlson?

A No.

Q Has your company ever used Dr. Carlson?

A I have no idea because we are individuals.

Q He's on your approved list though, isn't he?

A We don't have an approved list for doctors because we go through different providers.
Q Well -- okay. Tell us which provider you went through for Dr. Carlson.
A I believe it was Premier.
Q And that's on your approved list?
A Right.
Q You have to go through a certain list of companies and those are the only ones that you can use for these adverse exams?
A No. I use one or two companies. Another adjuster may use another company.
Q Okay. But anyway, you've become familiar with the company and you hire their doctors. That's your standard, isn't it?
A Yes.
Q Okay. I'm curious about that because you reviewed the medical records before you asked Dr. Carlson to examine Ms. [redacted], didn't you?
A Yes.
Q You were familiar with the file?
A Yes.
Q You picked an orthopedic surgeon. Was there anything in the medical records indicating the need for surgery or any broken bones from this

car accident?

A No. I picked him because he would be an expert in the field of referring for physical therapy and treatment.

Q A neurologist would not?

A I normally don't go and use neurologists on a soft tissue injury with no objective findings.

Q How much did you pay Dr. Carlson for his examination and report?

A I don't remember.

Q If I told you it was $1800, would that sound right?

A Whatever. If it's in here and it's 1800, that's probably what I paid.

Q Would you agree that when you do these adverse examinations or I'll call them IMEs, if you like, with regard to soft tissue chiropractic and physical therapy care, they result in a denial of benefits 100 percent of the time?

A No.

Q You have some reports that don't deny benefits? I'm talking about a denial.

A Not in this file.

Q I'm talking about overall in your work for EMC when you hire these doctors, it is a true

statement that there is a denial of benefits in soft tissue cases 100 percent of the time? And let me explain what I mean by that. The doctor may say I don't want her to go to the chiropractor anymore. Now she goes to physical therapy or she needs no further care or it's from a different injury or anything else. That does happen a hundred percent of the time, doesn't it?

A Yeah. Well, 90 percent.

Q All right. In my career I've never seen one. That's why I'm asking. I've seen over 15,000 and I'm still waiting for number one and I'm sure it's coming some day. Now, Dr. Carlson, the doctor you hired, recommended future care, correct?

A He recommended one visit in a home exercise program.

Q And that's what she was getting from this physical therapy place. She was getting information on how to exercise and how to take care of herself, correct? That was part --

A Well --

Q You heard her testify that was part of what she said she gets there?