

WORKERS' COMPENSATION
MEDICAL ADVISORY COMMITTEE

July 8, 2016
9 a.m. – 11:30 a.m.

MAC Committee Members Present: Ronald Bowman, MD; Franklin Wong, MD (MCO Representative); Constantine Gean, MD (Insurer Representative); Gary Rischitelli, MD; Tom Williams, PT; Susan Strom, DC; Lon Holston (Worker Representative)

DCBS Staff Present: Lou Savage, Cara Filsinger, Juerg Kunz, Summer Tucker

MAC Committee Members Absent: Timothy Keenan, MD (Vice-Chair); Jon Soffer, RN,NP; Brad Lorber, MD

Agenda Item	Discussion
Welcome, Introductions (0:00:00)*	Dr. Bowman called the meeting to order at 9:06 a.m.
Administrative discussion (00:00:38)*	Committee Updates Dr. Bowman went over some recent changes in the committee and the division. <ul style="list-style-type: none">○ Lou Savage is now the permanent administrator of the Workers' Compensation Division (WCD). Lou has worked in consumer and business issues in non profit, private, and public sectors before getting involved with the Workers' Compensation Division. Lou was a senior policy advisor and legislative director for ten years. Lou has also served as the administrator of the Management-Labor Advisory Committee and Insurance Commissioner from 2011-2013.○ Dr. Wong is retiring from MAC. Dr. Wong joined MAC in May 2000 as the MCO representative, and he has been consistently active in participating in committee discussion. Dr. Wong spearheaded the opioid epidemic discussion before it was widely discussed, and he has also been involved in discussions on marijuana and spinal cord stimulators. He has been a consistent and excellent contributor to MAC discussions.○ Dr. Timothy Craven will be filling Dr. Wong's position as the MCO Representative. He is the medical director of Providence MCO. Dr. Craven has years of experience leading the MCO but also has decades of experiences as an occupational medicine physician.○ Joey Blubaugh has resigned from the committee due to medical reasons. MAC is looking for a replacement to fill the employer representative position. Please send any suggestions to Cara or Juerg.
Administrative discussion (00:05:51)*	Review and approve minutes for Friday, March 11 2016 MAC Meeting The committee approved the March 11, 2016 meeting minutes as drafted.
Administrative discussion (00:06:03)*	Staff Updates <ul style="list-style-type: none">▪ The Oregon Health Authority has formed a taskforce focused on developing guidelines for prescribing opioids. Juerg has joined the taskforce as a representative for WCD.<ul style="list-style-type: none">○ The taskforce has adopted the Centers for Disease Control and Prevention (CDC) guidelines for opioids as the foundation for prescribing opioids in Oregon. The taskforce has also formed workgroups to make the guidelines more Oregon specific.○ Right now, the CDC guidelines are lacking in any reference to marijuana use. Marijuana is legal in Oregon, but on a federal level, marijuana is an illegal substance. Hopefully, the workgroup will come up with some guidelines for marijuana use.○ It can be difficult for physicians to know what guidelines to use. Hopefully, the taskforce will get broad acceptance of these guidelines in Oregon, so physicians could

- use the guidelines for all patients.
- Dr. Bowman noted that he thinks there would be 3 groups of pain: acute, perioperative, and chronic, which are all a little different.
 - The CDC guidelines currently focus on chronic opioid prescriptions. This is concerning to Juerg from the workers' compensation perspective since workers' compensation frequently deals with acute patients. Often, opioid use continues from the acute into the chronic phase. Currently, there is very little in the CDC guidelines about acute pain or the transition to chronic opioid use. One of the workgroups will look specifically into that topic and hopefully develop some more guidelines. Juerg is not sure that the workgroup will look at post operation use of opioids.
- Dr. Bowman asked if the taskforce has a pain physician. Juerg said that he could email a list of the physicians on the panel along with the CDC guidelines.
- Dr. Bowman asked if the guidelines could be used by indemnity insurance companies. Juerg said this is the hope.
- WCD has its own guidelines regarding opioids, but they are limited. There's a possibility that WCD may switch over to the guidelines developed by the task force. At this point, there is no rule requirement that physicians must use WCD's guidelines. A question to address in the future is whether the guidelines should be mandatory.
- Dr. Gean mentioned that the Washington guidelines have been adopted by Kaiser Permanente in Northern California. They made it a standard of care, so if a Kaiser physician was not following the guidelines, their supervisor would have the physician refer patients to a higher level of evaluation. The guidelines were not enforced as rules, but put in a context where physicians were expected to pay attention to them.
- Juerg noted that even if WCD were to make opioid guidelines more mandatory by rule, there would still need to be exceptions.
- Dr. Bowman noted that some patients think that they still need to be on opioids 2-3 months after their surgery. Dr. Bowman has noticed that the publicity regarding the opioid use has been helpful in his practice when he responds to patients who still want to use opioids.
- Dr. Bowman mentioned that if the task force needs any advice about perioperative narcotics, he is happy to help.
- Cara gave the committee an overview of an issue that the Counseling Services for Injured Workers subcommittee of the Management-Labor Advisory Committee is currently addressing. In particular, they are looking into the concept of providing counseling for injured workers. At this point in time, it is unclear what services are available in the marketplace. Based on some parameters that the subcommittee has agreed on, they will put out a request for information to obtain more information on what's available, costs, and what services are provided.
- Cara will be picking dates for the 2017 committee meetings. She will be sending the dates out through email soon.

**Myofascial Pain
Presentation**
(00:15:46)*

- Dr. Gean and Dr. Craig Morris gave a presentation on myofascial pain syndromes and what Liberty Mutual is doing regarding myofascial pain. Dr. Craig is the medical director of F.I.R.S.T Health in Torrance, California. He is a former professor of chiropractic at Cleveland Chiropractic College in Los Angeles, and the author of the textbook "Low Back Syndromes: Integrated Clinical Management." He recently became licensed in Oregon and is board certified in chiropractic rehabilitation. Currently, he is helping Liberty Mutual develop protocols for myofascial pain syndrome.
 - Dr. Gean noted that they are becoming aware of a lot of potential (or what appear to be) progressive neuropathies that are actually myofascial pain. Myofascial pain can be addressed by myofascial release techniques, trigger point injections, and other strategies.
 - Dr. Gean and Dr. Steve Levitt found that they had a number of cases that were not improving. Dr. Levitt knew from clinical practice that myofascial pain seemed to be a part of this issue. Dr. Gean started to wonder what to do with these cases. Together, Dr. Gean and Dr. Levitt
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came to the conclusion that there is more to be learned about myofascial pain. Dr. Gean and Dr. Levitt started talking to Dr. Morris and Dr. Jules Steimnitz about what to do for myofascial pain.

- The Mayo Clinic recognizes myofascial pain mainly due to trigger points, which cause pain in unrelated parts of the body. A lot of pain that is myofascial trigger points will show up referred in the wrist, epicondyles, and the upper arm. Many surgical decisions are made before that is fully evaluated.
 - 3 important points on myofascial pain:
 - Myofascial pain is extremely common, appearing in 50% of people.
 - Myofascial pain is often mistaken for compressive neuropathies.
 - Non surgical approaches to myofascial pain do exist and can relieve symptoms enough to eliminate the need for surgery. These approaches should be considered before resorting to surgery.
 - “Myofascial Pain and Dysfunction – The Trigger Point Manual” (Janet Travell and David Simons) is landmark work on myofascial pain.
 - There are many misconceptions about myofascial pain. Myofascial pain:
 - Is not fibromyalgia.
 - Is not a disease, it is a symptom.
 - Treatment is multi disciplinary.
 - A trigger point is a local area of spasm and intense pain within a muscle. Electromyographic evidence, tomography, and many other approaches show that trigger points exist. Trigger points are a part of a symptom complex.
 - Referred pain is a significant problem. The theory is that due to afferent convergence, pain signals get summarized by the brain. This can then confuse the brain about the actual source of pain.
 - In “Myofascial Pain and Dysfunction – The Trigger Point Manual”, Dr. Travell and Dr. Simons mapped typical referral points for each muscle. Referral points can be both local and distant.
 - One of the statements in Dr. Morris’s and Dr. Schneider’s textbook is that they feel that there is always a myofascial component. However, it doesn’t mean necessarily mean that the myofascial pain must be addressed in every case.
 - Indicators of trigger points:
 - Sensitivity to cold breezes (Patients that always need a jacket, or when cold, their symptoms flare up). Symptoms tend to be worse when waking up in the morning due to hours of immobility and stiffness.
 - Symptom resolution with application of heat.
 - Non dermatomal dysesthesia
 - Symptoms improve after the patient “warms up.”
 - Symptoms provoked by inactivity or physical overload.
 - Dr. Bowman asked if myofascial pain is a component or related to Complex Regional Pain Syndrome (CRPS) or Reflex Sympathetic Dystrophy Syndrome (RSD). Dr. Morris responded that there is a central overlap. Myofascial pain is both mechanical and neurological, while CRPS and RDS are neurological conditions. However, CRPS/RDS and myofascial pain have distant approaches and need to be addressed differently. Dr. Gean noted that myofascial pain doesn’t generally fit the criteria for CRPS.
 - Dr. Morris noted that using maps to demonstrate the source of the patient’s issues can help relax a patient. For Dr. Morris, the most important thing in his practice is patient education. Manual techniques and other things are supportive of Dr. Morris’s efforts to help patients regain confidence and overcome fear of certain activities and behaviors. A big part of treatment is education on learning how to manage and take control of the pain.
 - Dr. Gean noted that there are three things that Liberty Mutual is focusing on:
 - Upper extremity pain generally associated with repetitive stress injuries.
 - Cervical pain with trapezius and scapular involvement, and referred pain.
 - Pseudo radiculopathy
 - Dr. Gean noted that when things aren’t making sense, the concept they are trying to
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communicate to physicians is that it is ok to refer out to see if there is a myofascial component.

- Dr. Gean summarized Liberty Mutual's approaches for myofascial pain.
 - Education
 - If a doctor suspects that myofascial pain may be an issue, trying myofascial therapy for 6-12 sessions (regular physical therapy will tend to cause myofascial pain to flare up).
 - Using biofeedback to address perpetuating factors.
 - Using the Peter Edgelow program (a gentle approach to stretching).
 - Trigger point injections (these can be either long acting or short acting). Generally, Liberty Mutual authorizes up to 5 injections. If there is enough improvement, the injections are better than surgery.
 - Dr. Bowman asked a question about lateral epicondylitis. He's had some patients where it is not in the epicondyle but instead in the muscle belly distal to the epicondyle. Dr. Bowman asked if that is a myofascial syndrome, whether there would be findings in an MRI, and how treatment would be different from standard treatment for lateral epicondylitis. Dr. Gean responded that a diagnosis would be needed. Dr. Morris said that after a diagnosis, he would use manual techniques and home exercises. Dr. Gean also suggested referral to a Physical Medicine and Rehabilitation (PMNR) to see if trigger point injections are appropriate. Trigger point injections can be diagnostic as well as therapeutic.
 - Liberty Mutual is trying to improve awareness to increase referrals to PMNRs to see whether the problem is myofascial pain.
 - Tom Williams asked if Dr. Morris uses Graston techniques or Astym in treatment. Dr. Morris said yes, Graston techniques can be involved. It helps to have a team put together for treatment to deal with different aspects of the problem (for instance, lateral epicondylitis that influences trigger points).
 - Dr. Morris mentioned how in his own experience, myofascial pain was an indication of a dental problem. Dr. Morris noted that the muscles and nervous system mirror each other, so if there's an irritation, sometimes the muscles may be first thing to tell you that there is a problem.
 - Lon Holston asked Dr. Morris if he has seen patients who have long term pain and a phantom psychosis (resulting from a revolving door of diagnosis and treatment). Dr. Morris responded that patients can become more on edge, and as a result, their limbic system activates and tends to cause trigger points to come up. Patients can get stressed and feel like they are losing control. For patients with chronic cases, they need to calm down and know that there are means for them to regain control. The best approach is to controlling chronic pain syndrome is to focus on things other than pain, fear, and confusion.
 - Dr. Rischitelli asked whether acupuncture is a viable treatment. Dr. Morris responded that acupuncture has worked.
 - Dr. Gean noted that sometimes just disrupting the trigger point seems to be effective. Many people use steroids. However, if you're doing repeated trigger points, you can get a myopathy and pils.
 - If you hear your patient say anything on the following list, these may be indications of myofascial pain.
 - "Physical therapy made me worse"
 - "The surgery never made me better"
 - "The epidural steroids didn't help the back"
 - "When I'm stressed out, my pain is getting worse"
 - "My surgeon says I have electronegative carpal tunnel syndrome"
 - "I got this knot in my muscle"
 - Dr. Gean advised thinking about myofascial pain and non surgical approaches before going to surgery.
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**Roundtable with
Lou Savage
(00:47:31)***

- Lou Savage is now the permanent administrator of the Workers' Compensation Division.
- Lou thinks it is important to hear from MAC about big picture issues that WCD ought to look at in order to get ahead of some issues that may come up in the future. Lou asked the committee if there are any issues that could impact the medical side of the workers' compensation system that WCD should look into.
- Dr. Gean commented on:
 - Microprocessor control devices (e.g., exoskeletons and bionic limbs) are of interest to Liberty Mutual. Liberty Mutual is getting requests for the exoskeleton called "Rewalk", which is an upright wheel chair that could be used by patients who have control of their arms. However, there are still patients who will not be able to use the exoskeleton. These are expensive devices and require additional personal assistance.
 - Setting standards for functional recovery programs. These programs are expensive (\$40,000-\$60,000), multidisciplinary, and require a lot of resources. Traditional multidisciplinary teams are focused on chronic pain management for long term patients. Some patients are now requesting these services very early (9 months – 1 ½ years).
 - Dr. Wong noted that he doesn't have a sense that this phenomenon has arrived in Oregon yet. Dr. Wong has observed that some of the good programs are gone now due to lack of funding. Dr. Wong could see pseudo programs potentially opening up.
- Dr. Wong has noticed issues where a worker will have chronic, complex pain, multiple IMEs and consultations, and everyone agrees that the worker is medically stationary. Then at the closing exam, the attending physician will not agree that the worker is medically stationary. A notice of closure cannot be issued unless the attending physician agrees that the worker is medically stationary. Dr. Wong has noticed that there is no recourse for the worker when the attending physician doesn't agree, and the worker is left waiting for the claim to close.
 - Dr. Wong has also noticed that medical arbiters are asked about permanent impairment, but not if the worker is medically stationary.
- Tom Williams noted he would be curious to see a cost comparison of opioids and physical therapy.
- Lon Holston suggested looking into follow up activities that could assist workers that have issues with opioid usage. Lon noted that if a worker is cut off from pain medication when they go to work, they may try to seek out medication on their own to maintain an addiction. Lon thinks that a check in or evaluation before the worker goes back to work may be helpful.
- Dr. Bowman
 - Hassle factor and access to care is still an issue, particularly in rural areas. In rural areas, there are a limited number of physicians, and they don't want to deal with the paperwork for workers' compensation. An injured worker may have to go a couple hundred miles for care.
 - Lou asked if access to care has improved. Dr. Bowman responded that it comes and goes. A family doctor in a rural area may experience political issues with families because they are treating both ways, i.e. the workers' compensation patient as well as that patient's family
 - Biologics (e.g. platelet rich plasma injections) are being used in sports medicine.
 - Dr. Bowman would like the division to continue to consult the committee on compensability guidelines as they have done in the past.

**Technology
Review:
Subcommittee on
lumbar and
cervical artificial
disc
(01:04:46)***

Dr. Keenan and Dr. Lorber were both absent, so this topic is on hold until the next meeting.

**Technology
Review: Spinal
Cord Stimulator
(01:05:08)***

- Majoris and SAIF provided data on patients who have gotten the spinal cord stimulator (SCS).
 - The Majoris data is 11 cases where they tracked the patient from before they got the SCS to the present.
 - SAIF provided data on opioid use and work status for workers who got a spinal cord stimulator. According to SAIF's data, the SCS had no effect on work status. Patients using opioids decreased to 61% a year after surgery (from 80%). However, the patients who continued to use opioids after surgery used opioids at the same level (despite having the SCS).
 - Dr. Bowman asked if the numbers provided had statistical power.
 - Dr. Braddock noted that the Majoris numbers are not very strong.
 - Juerg pointed out that one thing the committee may need to look into is whether there should be only one category for SCS. There might be different outcomes for high frequency SCS, so the committee may have to separate high and low frequency SCS.
 - Dr. Gean commented that a 20% reduction in use of opioids is good, but there is an issue of cost to the system.
 - Cara clarified that SAIF's data is only for SAIF, not system wide.
 - The committee is reviewing the literature on SCS later this year to see whether SCS is effective.
 - Juerg noted that WCD (due to several reasons), was not able to produce usable data on opioid use and SCS.
 - Dr. Craven commented that even if the data is limited, it still may be worth writing an article and publishing it.
 - Dr. Braddock mentioned that there are some extensive studies from Washington on SCS. Those studies show that SCS is not very helpful.
 - Mary Ryan (with Medtronic Spinal Cord Stimulation) noted that there is not a lot of data on the workers' compensation population. Mary made some additional observations and comments about SCS, listed below.
 - Mary pointed out that SCS is end of the line treatment for patients. All other options must be exhausted before a patient is eligible for SCS. According to the SAIF data, patients on average got the SCS about 12 years after the date of injury. Mary would ask whether return to work is a metric for this population. Mary has read that generally if a worker has been off work for 6 months, they aren't going back to work.
 - Mary thinks that opioid reduction is an extremely important metric for people with chronic pain. Mary noted two factors that may affect the correlation between SCS and keeping a patient on opioids. First, opioid use is a physician decision, and physicians may need better education on opioid reduction. Mary thinks that better education would be very helpful. Second, Medtronic has found that injured workers who get SCS are severely injured patients. They are difficult patients who have exhausted all other remedies. Mary thinks that any data on workers' compensation patients is useful, but she would like to put that data in context.
 - SCS is designed to address only certain types of pain. Patients may have other types of pain that make opioid use necessary.
 - Mary would be happy to work with the committee. She could have one Medtronic's practicing physicians in Oregon come in and talk about the SCS.
 - Medtronic wants to have good patient outcomes with SCS.
 - Mary could supply information on randomized control trials of high frequency SCS.
 - Dr. Rischitelli noted that there are tremendously dichotomous outcomes from SCS. 80% of patients have no reduction in use of opioids, 20% have a strict reduction. What is the difference between the two populations? Dr. Rischitelli suggested conducting a factor analysis to figure out why it was successful for 20% of patients, which could lead to better patient selection.
 - Dr. Wong asked if SAIF could add another year or two to their opioid use data. In the Turner studies, the workers who had improvement had it in the first 6 months. By one year, it had
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reduced. In two years, the SCS didn't seem to have made much of a difference. Dr. Wong would be interested to see (for the 20% not using opioids anymore) whether they stayed off opioids or if they were back on opioids 2 years later.

- Jaye Fraser said that SAIF can do that.
 - Dr. Bowman noted that the committee would solicit public testimony (after review of literature on SCS). Cara will be working with Juerg to determine the timing on public testimony.
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The meeting adjourned at 10:24 AM.

The next MAC meeting will be held on September 9, 2016.

*The audio files for the meeting minutes and public testimony (both written and audio) can be found here:
<http://wcd.oregon.gov/medical/mac/Pages/mac-meetings.aspx>