WORKERS' COMPENSATION
MEDICAL ADVISORY COMMITTEE
December 1, 2017
9 a.m. – 11:30 a.m.

MAC Committee Members Present: Ronald Bowman, MD; Brad Lorber, MD; Timothy Craven MD (MCO Representative); Julio Ordonez, MD; Tom Williams, PT; Ryan Weeks (Employer Representative), Susan Strom, DC

DCBS Staff Present: Cara Filsinger, Juerg Kunz, Kim Ritts, Lou Savage

MAC Committee Members Absent: Jon Soffer, ANP DNP; Gary Rischitelli, MD; Constantine Gean, MD (Insurer Representative); Lon Holston (Worker Representative)

Agenda Item	Discussion
Welcome, Introductions (0:00:00)*	Dr. Bowman called the meeting to order at 9:05 a.m.
Administrative discussion (0:00:12)*	**Review and approve minutes for June 6, 2017 MAC Meeting** Dr. Bowman moved to approve the minutes. The August 4, 2017 minutes were approved as drafted.
Administrative discussion (0:01:49)*	Juerg discussed an advisory committee meeting for medical fee and payment rules, and medical services rules. On January 1, 2018 there will be a temporary fee schedule where new codes are adopted that were published by CMS and AMA so that providers can use those new codes in Workers' Compensation. April 1, 2018 is when the temporary fee schedule will be replaced with a new permanent fee schedule.
Technology Review: Spinal Cord Stimulator subcommittee recommendation (0:04:46)*	*The following is a summary of the discussion; please refer to audio recording for details.* <u>*Subcommittee work on SCS*</u> ▪ The subcommittee, consisting of Dr. Craven, Dr. Strom, Dr. Ordonez, and Dr. Braddock, really hasn't met. Amongst the subcommittee members, there is a difference in opinion on how SCS should be used. ▪ Dr. Craven has created a spreadsheet from level 1 and 2 studies, totaling 16 studies. ▪ Since the last meeting, SAIF has sent updated SCS data. Dr. Craven had questions about their data and conclusions, but hasn't gotten a response from SAIF. The return to work data was low, i.e., only eight percent had an improvement, but there was a reduction of opioid use. The average time from date of injury to SCS implantation is about 13 years. The study showed a significant opioid use reduction at about 2-3 years out. The data did not include diagnoses. ▪ Dr. Craven found that in one study, 45% of patients had failed back syndrome, 55% had other diagnoses. In summary, the studies for SCS show that it's effective, at least the published studies show that it has helped patients' pain which was the main parameter. In the studies, they also talked about complications from SCS. Generally, it was favorable that it was effective. Literature show that SCS is effective for failed back, CRPS, and didn't see much information for phantom limb pain. Some of the studies said they didn't exclude

injured workers, but didn't give percentage of how many were injured workers.

- Dr. Craven talked about a study by University of Washington in 2010 that was only injured workers. There were 159 injured workers and the conclusion was there was no evidence for greater effectiveness for SCS compared to pain clinic treatment or usual care after 6 months. There were 159 injured workers in the study, but in the SCS group there were 52. Of the 52, only 25 got permanent SCS. They compared the SCS group to the pain clinic group as well as the usual care group. Based on the study, the State of Washington does not cover SCS for injured workers.
- Dr. Craven thought is was a good idea to look at the four MCO's and what their policies were. Providence and Kaiser's guidelines are very similar, Majoris and MHN have their own. MHN has a few cases of SCS and will consider SCS to treat chronic neuropathic pain associated with spinal cord injury and phantom limb pain.
- Dr. Braddock wanted to clarify that the current status for SCS is that it is compensable, but it is up to the MCO to make the decision. Dr. Craven confirmed that is correct. The MCO can deny the SCS but the injured worker can appeal the denial to the state. If the injured worker is not under an MCO, the insurer can approve or disapprove and bring an appropriate dispute to WCD.
- Dr. Braddock asked if things could just be left the way they are. If things are working, just leave it alone or add guidelines if necessary.
- Dr. Craven doesn't feel that it should be non-compensable, which would essentially be like Washington.
- Dr. Craven asked if we do a final recommendation. Dr. Bowman clarified that someone will make a motion to keep the current status of SCS, or non-compensable, or compensable under certain conditions.
- Dr. Ordonez asked if the present guideline included failed back syndrome. Dr. Bowman stated it is up to the MCO to decide. Dr. Craven stated that with Providence, when a request is received for SCS for failed back syndrome, even though failed back syndrome is covered, he will still review it and make sure the request is appropriate. That is why the MCOs have criteria.
- Dr. Bowman doesn't believe there is evidence that SCS should be non-compensable.
- Dr. Bowman requested proposing a motion. Dr. Craven would like to wait until everyone has had an opportunity to review the draft. Dr. Bowman is in favor of making a decision and moving on because next meeting there may not be a quorum. Juerg stated that if there was a vote today, a position will be drafted and that's what will be voted on. Juerg recommends waiting until a recommendation is drafted. Dr. Craven questioned why the current draft wouldn't be used. Cara clarified that the current draft has conditions listed, and it sounds like everyone wants a less specific recommendation. Juerg will write the draft.
- Dr. Lorber moves to keep SCS compensable as currently defined. Tom Williams seconded.
- Cara and Juerg will create draft and it will be a revision of the current draft. It will be sent to all members so they have time to review it before the February meeting.

Guidelines

- Juerg noted that the main task is to make a recommendation to the Administrator on whether the SCS should be compensable or whether it should be excluded. If the recommendation is to be excluded and we adopt that in the rules, that would

mean that no patients with a workers' compensation claim will get a SCS. With the artificial disc, MAC put parameters around compensability, which was a new thing. Are we getting into treatment guidelines and parameters, and is this something that should stay with the MCOs?

- Dr. Bowman raised the point that if it was decided that guidelines would be appropriate, it could potentially need to go through legislative changes. Juerg clarified that with the artificial disc, it happened that way, but it's not very clear.
- With the artificial disc replacement, surgeons were requesting artificial disc surgeries and they were trying to be conservative because it was new technology so it was a special situation. But with SCS, the technology has been around for a long time, so would suggest not getting into treatment guidelines for a number of reasons.

Platelet Rich Plasma

- Dr. Lorber stated that he, Dr. Bowman, and Dr. Strom are on the subcommittee. The studies that Dr. Lorber has been looking at haven't changed his opinion on platelet rich plasma. There are a lot of articles and he hasn't finished looking through them yet. It's tough to make a conclusion based on the information. There is no set material for how platelet rich plasma is done.
- Dr. Bowman has found studies with good science and good randomization, but they don't define what the PRP is. He doesn't feel like they will have something comparing apples to apples to make a good conclusion.
- Dr. Craven asked if general health insurance covers PRP, Dr. Strom confirmed that they do not. Dr. Lorber responded that it is all cash pay.
- Dr. Lorber found that insurers were wanting to cover PRP for lateral epicondylitis and nothing else.
- Dr. Craven asked how long PRP has been non-compensable. Dr. Lorber responded that procedures are always compensable until the committee deems them non-compensable, and at least meeting it was stated that it was still experimental.
- Juerg said that many years ago, the MAC committee basically told WCD that PRP should be considered a form of prolotherapy. About 3 years ago the committee revised that and said that it should not be considered prolotherapy but it should still be excluded and that's when it appeared in the rules.
- Dr. Bowman thinks what they're dealing with now is, is it unproven or not? It's not really experimental, it's been around for awhile, we just don't know the results.
- Dr. Craven talked about getting requests for Providence MCO and he did his own research. He didn't approve them because of guidelines and being non-compensable, but he wondered if they would be helpful in some cases. For instance, chronic lateral epicondylitis. But if he feels it's reasonable, then he would approve it. But since it's not on the compensable list, he can't approve it. Dr. Bowman thinks that can be overridden, especially when next step is surgery anyway. Juerg clarified that an insurer may choose to pay for something that they don't have to pay for. Since it's non-compensable, if it came to WCD as a dispute, WCD could never force an insurer to pay for it. Ultimately it's up to the insurer. Dr. Bowman brought up that if it were compensable, insurers would have to pay for it whether it was appropriate or not. Juerg clarified that an insurer would only have to pay if it was appropriate. That is one of the tasks of MCOs, they determine appropriate treatment for the injured worker. If the injured worker is not in an MCO, it would come to the division and WCD would make the decision.

Dr. Bowman asked what kind of credentials the people reviewing these cases have, are there physicians? Juerg stated that when there are treatment disputes the Medical Resolution Team may send the injured worker to an independent physician.

- Tom Williams asked about the cost of PRP. Dr. Strom responded that treatment is $5,000. Tom Williams said that it is similar to 10 physical therapy appointments, articles that he's read have stated that long term, it shows no difference to physical therapy. He's seen a few people who have had the PRP treatment and physical therapy. Are we adding to the cost for no difference in what alternative treatment would be? Dr. Lorber said that the cost varies depending on who is doing the procedure. He has seen prices vary from $200-$2,000.
- Dr. Craven asked if the injection is only once. Dr. Lorber stated that it could be a couple of times. Dr. Craven said that he is getting a lot of Sports Medicine physicians who are using PRP and wonders if it is popular in athletes. Dr. Bowman says that's where it originated. Dr. Lorber stated that a lot of athletes actually retire shortly after receiving the injection.
- Dr. Craven says that in the future when he receives requests for PRP, he'll begin reviewing them and decide based on merit for a patient. Dr. Lorber added that it is a safe procedure. Dr. Bowman stated that is uses the patient's own blood. With lateral epicondylitis there's a good medical analysis done about a year ago and they showed that of all the treatments, nothing was superior, including surgery.

The meeting adjourned at 9:51 a.m.

The next MAC meeting will be held on February 16, 2018.

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*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