WORKERS' COMPENSATION
MEDICAL ADVISORY COMMITTEE
April 7, 2017
9 a.m. – 11:30 a.m.

MAC Committee Members Present: Ronald Bowman, MD; Jon Soffer, ANP DNP, Brad Lorber, MD; Lon Holston (Worker Representative), Timothy Craven MD (MCO Representative); Julio Ordonez, MD; Gary Rischitelli, MD; Constantine Gean, MD (Insurer Representative); Susan Strom, DC; Tom Williams, PT

DCBS Staff Present: Sally Coen, Cara Filsinger, Juerg Kunz

Agenda Item	Discussion
Welcome, Introductions (0:00:00)*	Dr. Bowman called the meeting to order at about 9:00 a.m.
Administrative discussion (0:00:32)*	**Review and approve minutes for Friday, November 4, 2016 MAC Meeting** Dr. Lorber moved to approve the minutes, Lon Holston seconded. All members present approved the November 4, 2016 meeting minutes as drafted.
Administrative discussion (0:01:20)*	**Staff Updates** Sally Coen (Workers' Compensation Division) provided an update on the recent *Brown v. SAIF* decision. ▪ The Oregon Supreme Court issued its decision on March 30 and unanimously reversed the Court of Appeals decision issued in 2014. The Court of Appeals had ruled for purposes of combined condition claims, terms used in statute (work injury and compensable injury) were not the same as the accepted condition. Prior to that time, in the workers' compensation industry, those terms were used interchangeably. WCD issued administrative rules in 2015 to distinguish between the work injury, compensable injury, and accepted condition. The primary impact of these changes was on the reconsideration processes and reconsideration of claim closure. This included medical arbiter exams, determining the extent of the permanent disability, and determining when the worker is medically stationary. ▪ The Oregon Supreme Court took a broader view of statutory language and recognized the statute has inconsistencies. The Supreme Court concluded that for purposes of a combined condition claim, a compensable injury is not the work accident, but the accepted condition that results from the work accident. The decision is not final yet and does not become effective until the appellate judgment is issued, which be at least 21 days after the date of the decision. ▪ On April 3, WCD issued an industry notice informing insurers, self-insured employers, service companies, and the industry how WCD is handling the effects of this decision in handling requests for reconsideration on claim

closures. For requests for reconsideration that are currently pending, WCD will review those decisions keeping the Supreme Court decision in mind. WCD does not plan to abate any orders on reconsideration that are final. Orders that are not final may be appealed to the Hearings Division.

- WCD has identified some narrow changes to be made through temporary rules, which memorialize the Supreme Court's decision. The phrase "directly resulting from the work injury" will be removed. The temporary rules will be adopted next week. Although the Supreme Court decision is not final, WCD is moving forward to avoid unnecessary confusion.
- WCD is implementing an expedited permanent rulemaking process. There will be stakeholder advisory committee meeting on April 20 to discuss the temporary rules and any other changes that may need to be made. The rule making process will be limited to only changes necessitated by the *Brown* decision.
- WCD has bulletins and forms that need to change. WCD is also issuing a letter to medical arbiters to provide guidance. When scheduling the exams and sending questions to arbiters, WCD will provide direction at that time as well.

Discussion

- Dr. Bowman noted that he's done some arbiter exams in the past and that questions regarding repetitive use have gotten longer which gets confusing. Sally responded that the Appellate Review Unit has been looking at those specific questions and creating a standardized list.

- Dr. Craven asked if the focus will be on accepted conditions (versus compensable conditions that are not accepted yet). Sally said that was correct, the focus will shift back to what the insurer has accepted, as opposed to everything that may have resulted from the work injury.

- Dr. Craven asked if insurers could choose to not cover treatment because the condition isn't accepted. Sally responded that could possibly happen. The worker has the right to make a claim for additional conditions after the initial acceptance. Dr. Craven asked if the insurer treats a condition throughout the claim but it hasn't been accepted, does the treatment indicate acceptance of condition? Juerg responded that statute allows insurers to pay for things (even if not accepted), but it doesn't mean they accept the condition. Dr. Gean commented that this limits conditions that evolve over time and the number of conditions covered. If a condition is not covered initially, it will be harder to say that it should be covered later.

- Sally noted that *Brown v. SAIF* was directed at combined conditions as well. Dr. Gean noted that repetitive motion conditions tend to expand, and the Brown decision will limit that.

Opioid Guidelines (0:11:41)*

The following is a summary of discussion; please refer to audio recording for details

Background

Juerg provided background on the statewide discussion on opioid guidelines.

- In 2016, the Oregon Health Authority established an opioid taskforce which decided to use Centers for Disease Control and Prevention (CDC) opioid guidelines as the foundation for prescribing opioids in Oregon and developed a brief addendum to address Oregon-specific concerns. The task force published the guidelines called *Oregon Opioid Prescribing Guidelines: Recommendations for the Safe Use of Opioid Medications* in late 2016. In January 2017, the Oregon Medical Board (OMB) endorsed the guidelines. There is pending legislation that requires the OMB, the Board of Dentistry, and the Oregon State Board of Nursing to notify providers that they license off those guidelines. These CDC based opioid guidelines are possibly becoming more of a standard for Oregon.

- One common complaint is that workers' compensation is different than everything else. This is potentially an opportunity for workers' compensation to adopt guidelines being used in general health.

- The CDC guidelines are specifically for chronic opioid use, and have only a few points about short term (or acute) usage. Workers' compensation often sees acute opioid use more than in general health. Oftentimes, an acute condition that requires opioid use leads to chronic use. It is a possibility to keep the short term WCD guidelines and replace the long term guidelines with the CDC guidelines.

Questions for MAC

- Should workers' compensation encourage use of or officially endorse the CDC based guidelines, or continue with the WCD guidelines?
- If the guidelines are incorporated, how strongly should WCD enforce the use of them?

Differences between guidelines

Jon Soffer and Dr. Lorber highlighted some of the differences.

- The statewide guidelines provide a dosage guideline, but the WCD ones don't. Otherwise, they are very similar.
- The WCD guidelines are easier to read, and nice for educational purposes. In contrast, some states have very long guidelines.

Use of opioids

Jon Soffer asked if there is any utilization review process for non MCO patients, and if there is any cutoff.

- Juerg responded that WCD doesn't do utilization review, but suspects insurers keep an eye on that.

- Dr. Gean noted that Liberty tracks morphine equivalent dose (MED) on cases. Not all primary care physicians do a great job when prescribing opioids. When usage is excessive, there is nurse or physician review. Beyond a certain MED, there are letters and calls to doctors.
- Jon Soffer and Dr. Lorber noted that they haven't been contacted regarding opioids. Dr. Lorber mentioned that he's never heard from insurers about opioids for non MCO patients. He gets more contacts from Blue Cross than insurers.
- Dr. Craven noted that Providence often gets contacted by the insurer, due to the cost or because they know the community standard.
- Jon Soffer commented that Pacific Source (a non workers' compensation insurer) won't pay for MED in excess of 90 milligrams per day. It becomes a prior authorization medicine even if the medicine isn't expensive. Dr. Lorber noted that Medicare monitors the number of tablets instead of MED.
- Dr. Ordonez thinks that if there is an outlier in opioid usage, we may need to ask the doctor to clarify the departure from the guidelines. Opioids should be monitored before seeing if the doctor is consistently overprescribing, but not for a sporadic case that may be an outlier.
- Jon Soffer noted that MCO enrolled patients often have many more restrictions, particularly for chronic opioid prescribing. If patients don't comply with the rules, their medicine won't be paid for. Dr. Lorber commented that those rules are standard of care (e.g., drug screens, PDMP queries). A lot of doctors don't follow that standard of care (although more are now).

<u>Endorsement discussion</u>

- Dr. Lorber recommended endorsing the CDC guidelines for consistency, but not require them.
    - If the provider doesn't follow the guidelines, it is already noted in the guidelines that they should be documenting why.
    - The CDC guidelines are targeted at primary care providers, not at specialists. Dr. Lorber thinks that they should be directed at specialists.
    - The WCD guidelines are easier to read, and it would be easier to keep as food for thought. Additionally, you can't get to long term usage without an acute phase, so it reminds doctors to refrain from prescribing opioids unnecessarily.
- Dr. Craven commented that MAC should endorse the CDC guidelines since it is a state guideline and been endorsed by the state licensing board. Dr. Craven opposes having too many guidelines because it can be hard for the providers. However, guidelines are helpful during the utilization review process. Additionally, sometimes providers don't know about the guidelines and need education.
- Jon Soffer recommended adopting the state standard.
- Dr. Rischitelli asked if MAC should keep the acute guidelines. Dr. Lorber recommended keeping for educational purposes.

- Juerg noted that if MAC adopts the guidelines, the insurers may interpret them as being enforceable. The OMB only endorsed the guidelines. Dr. Craven noted that MAC endorsed the WCD guidelines.

Dr. Craven made a motion to endorse the Oregon guidelines. Dr. Gean seconded. All members present voted aye.

Technology review: subcommittee on lumbar and cervical artificial disc
(0:30:25)*

The following is a summary of discussion; please refer to audio recording for details

Background

Juerg provided background on the subcommittee.

- MAC has previously recommended that the lumbar and cervical artificial disc should be compensable only on a very limited basis, and developed treating guidelines in form of relative and absolute contraindications. However, a question came up regarding long term outcomes of the artificial discs. At that time, there were only two year studies available, so MAC wanted to revisit this once there were some longer term studies. The longer term studies still look favorable for what MAC adopted, but there has not been an official report from the subcommittee.

Subcommittee conclusions

- Dr. Lorber and Dr. Keenan last met over a year ago, and at that time they concluded that there was no need to change the recommendations. The long term FDA studies still weren't complete at the time. The subcommittee has done additional research and concluded that the rule wouldn't change since there was no data warranting a change.

Discussion

- Dr. Craven noticed that MAC has special rules for artificial discs; but there are other prosthetics surgeries that don't require special approval. Dr. Bowman responded that MAC's job is to determine what is compensable, and one of the criteria is whether the procedure is proven. MAC looked at early studies to see what was reasonably proven and determined that one disc level was shown to be effective but it wasn't reasonable to apply to multiple levels.
    - Dr. Rischitelli noted that for other types of prosthetic joints (e.g., knee replacement) the alternative is a fusion, which has a tremendous disability associated with it. Artificial discs were a new alternative to lumbar fusion, with the expectation that by preserving motion, there would be less disability. However, there was very little evidence to prove that.
    - Dr. Craven noted that it became an administrative rule and that he was surprised by that. Dr. Bowman said that is what it evolved into.
    - Juerg pointed out that ORS 656.245 (3) provides the authority that based on MAC advice, WCD can exclude procedures from being compensable (if it is unproven, unscientific, experimental, or

outmoded).

- Dr. Bowman commented that the focus now isn't on new technology, but the results. Adjustments will be warranted if long term outcomes show changes in artificial disc effectiveness compared to fusions. MAC tries to review studies focused on workers' compensation patients, but it is difficult to get statistically significant studies.

- Dr. Gean noted that the FDA may have approved a two level disc replacement for a particular manufacturer. Dr. Bowman commented that his understanding is that FDA approval means it is not injurious, but that doesn't necessarily mean it is effective.

- Dr. Ordonez said that he doesn't do disc surgery, but he has done follow up. Dr. Ordonez thinks that complications are not as high as they used to be. It seems like artificial disc works for preserving motion about two years or so, and the initial results are as good as a fusion. The current criteria are reasonable.

Recommendation

- Juerg asked for an official recommendation from MAC. He noted if the rules stay the same, MAC needs to decide whether the topic should be revisited at a set time. Dr. Lorber suggested holding off on a recommendation until the final FDA study is published.
- Cara and Juerg will find out if the FDA has published anything and provide an update at the next MAC meeting. If needed, MAC will establish a subcommittee or make an official recommendation for future review.

Technology Review: Spinal Cord Stimulator
(0:46:58)*

The following is a summary of discussion; please refer to audio recording for details

Subcommittee summary and comments

Dr. Craven

- The FDA approved the first SCS in 1989 and they are usually last resort treatment for pain control. In workers' compensation, they have been requested primarily for failed back surgery syndrome and chronic regional pain syndrome.
- Dr. Craven believes SCS is effective in selected patients and should be compensable. These are difficult patients that are very impacted by chronic pain, and are likely not working. Dr. Craven thinks for these patients, it would be unreasonable to say that the goal is getting them back to work, because he doesn't think the SCS will get them back to work.
- The studies the subcommittee looked at were primarily focused on pain control. Studies have shown SCS does provide relief, but not complete relief. There are problems with complications (usually not severe), such as infection or the leads not working properly.
- SCS is commonly used in the community and covered with other insurers

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in the private market. The state of Washington is an exception; they don't cover SCS for workers' compensation. They did a study which was not supportive of using SCS in the injured worker population.
- Dr. Craven thought that the subcommittee needed a pain specialist or someone with more experience with SCS. Dr. Craven doesn't see many requests for them.
- Dr. Craven suggested reviewing all the MCO guidelines for SCS.

Dr. Strom
- Dr. Strom noted that it seems that there is more information about advanced forms of neurostimulation (e.g., high frequency or bursts), and she is not sure if those were being actively studied before. The literature reviews are not for or against the burst form yet because there is not enough long term evidence to support or oppose. Some of the literature the subcommittee read on high frequency stimulation found there was no difference from sham treatment.
- Dr. Strom thinks that MAC needs to focus on how useful SCS is the long term for injured workers. Dr. Strom also noticed one study compared implants to external forms and found that there was no improvement over the external. There are more complications and risks involved with surgery.
- Dr. Strom doesn't think SCS should be covered under workers' compensation. There isn't anything that shows more injured workers are returning to work or using less opioids.

Dr. John Braddock
- Dr. Braddock noted that many of the articles the subcommittee examined were sponsored studies. There were very few that Dr. Braddock thought were on point on how SCS really affects the patient.
- Last year, Washington State looked at the effectiveness of SCS in the workers ' compensation system for the third time and concluded in the short term there may be some benefit, but at the one year mark SCS is no longer effective. There is no difference in success rates or improvement in the patient's lifestyle at the one year mark. That corresponds with Majoris' study of 14 patients, which found at one year the worker had either not returned to the same job or was doing lower levels of work, opioid levels hadn't changed much, and pain scales did not change much.
- Dr. Braddock feels strongly that in the workers' compensation population, SCS is not beneficial in the long term. There is tremendous cost associated with them, and 20% fail within a year. Majoris' position is that if SCS is used should be used in very specific circumstances (e.g., CRPS, phantom limb pain).

<u>Discussion</u>
Using SCS
- Dr. Ordonez commented that the intensity on external SCS has to be turned up very high to reach the spinal cord and can result in symptoms like

paresthesia, muscle contractions, and spasms. The dorsal column stimulator is more appropriate, and effective. Dr. Ordonez thinks it is one of the treatments that should be available for injured workers. SCS is adopted in most hospitals and insurance companies.

- Dr. Braddock thinks that patients are looking for life long relief, not six months of limited pain for high cost and complications.
- Dr. Rischitelli pointed out the placebo effect may impact SCS.
- Dr. Bowman asked if SCS is typically a last resort. Dr. Braddock responded yes, and that there are a lot of criteria to meet (e.g., failed back syndrome, conservative therapy, not being a surgical candidate, psychological evaluation, physical examination). Patients have to go through a trial, and if that is successful, then they can get SCS. It involves extensive effort to get SCS, and if it doesn't help, why do them?
- Dr. Lorber noted that it was mentioned that SCS is meant for end of stage treatment, but in reality, that's not the case. He has seen acute use of SCS.

Effectiveness

- Dr. Bowman asked about what MAC would consider ideally effective when looking at implanted SCS. If it cuts off at one year, Dr. Bowman doesn't think MAC can say that is effective.
- Dr. Craven noted that not all effectiveness stops at one year; however it is a grey area. SCS is reversible though, while other options (like lumbar fusion or surgery) are not. Dr. Craven also noted that the longest study he saw was 2 years.
- Dr. Braddock noted that Washington studied patients for longer than one year. At one year, there was no significant improvement, and that didn't change further down the road. Theoretically, it is procedure that provides benefit for six months. Dr. Braddock thinks that to some extent, SCS are experimental. SCS may be beneficial, but the ones available don't seem that effective.
- Dr. Gean said that Liberty's standard for SCS is sustained quantitative functional improvement, decreased drugs, liberalization of work restriction or return to work. Dr. Gean noted that from the insurer point of view, SCS seem to work in the first six to twelve months, but don't work in the long term. However, SCS is a significant commitment for the patient. Dr. Gean pointed out that that Dr. Strom made a good point; as time goes on, technology comes and goes.
- Dr. Gean asked Dr. Lorber about the SCS effectiveness for musco-skeletal and failed back versus CRPS. It seems that CRPS tends to benefit more than failed back. Dr. Lorber responded that he has a patient with CRPS that it works on very well on.
- Dr. Craven noted that in literature he reviewed CRPS works better than failed back. Additionally, from what he can tell, SCS seems more likely to help patients with neuropathic pain.

Issues with studies

- Small numbers can be an issue with studies on SCS. Additionally, finding

studies specific to workers' compensation can be difficult.

- Dr. Bowman noted that in past testimony, the statistics weren't good, but there was positive anecdotal evidence. MAC's job is determine whether it effective or not on a regular basis.
- Bias is something to keep in mind when reviewing literature on SCS. Dr. Lorber received an article from an insurer where almost all of the authors were sponsored by the company behind the SCS being studied. However, Dr. Craven noted a lot of the SCS articles are sponsored, so if excluded, there wouldn't be much literature to look at. He did find a sponsored article that came out negative.
- There was a suggestion from Claudia (from Dr. Ordonez's office) that younger patients might show more improvement from SCS. Claudia also asked if it would be easier to narrow down to specific age ranges. Dr. Craven and Dr. Braddock didn't see data to support that. Dr. Braddock noted that the studies weren't age specific, while Dr. Craven commented that he didn't necessarily find any differences by age range. Dr. Rischitelli pointed out that the numbers are small, and stratifying by age would make the numbers so small that they won't be helpful.

SCS and workers' compensation

- Dr. Craven was troubled at the idea of having criteria for injured workers that mean SCS isn't covered in workers' compensation because study results for workers' compensation aren't good.
- Dr. Gean commented that there is a presumption that general public and injured workers have the same physiology and dynamics. However, once extraneous factors of workers' compensation (litigation, psychosocial issues, workplace dynamics) are added, there are some differences. There is a body of literature about those impacts on workers' compensation cases. Dr. Gean thinks there is not enough data to say that just because the injury was work related, the treatment won't work. The data is very suggestive, but he feels there isn't enough to start making conclusions like that.
- Dr. Rischitelli noted that Washington State has staff members who are experts in evidence based medicine review. The fact that they have that resource makes it worthwhile to consider their guidelines beyond opinion. Dr. Craven noted Hayes, Inc. (an organization that does evidence based medical review), reviewed literature and said that SCS is effective. Additionally, Official Disability Guidelines (ODG) indicate that SCS is not experimental, and recommended it for selected cases.
- Dr. Rischitelli noted that in Washington, SCS is not covered for other groups beyond workers' compensation, including state employees, Medicaid, and corrections.

<u>Public comment</u>

Mary Ryan (Medtronic Spinal Cord Stimulation) provided some comments on SCS. Mary requested that MAC take comments on SCS at the next meeting or allow industry respond to comments made today.

- Mary noted that articles pulled for the literature review are the most recent

but not necessarily the highest quality. She noted that if industry sponsored research wasn't published, there wouldn't be any publishable literature.
- Mary thinks MAC needs to look at the quality of the research conducted in order to determine whether it should be considered.
- Mary noted that the Washington State study doesn't cover SCS for workers' compensation, state employees, Medicaid, or corrections. However, for most other payers in the country or most workers' compensation divisions, SCS is widely covered and has had a Medicare national coverage determination for over 20 years. She disagrees that SCS is a largely experimental therapy; it has a wide body of evidence behind it.

Next steps

- Juerg proposed inviting public comments on SCS at the next MAC meeting before making a recommendation. Dr. Bowman suggested that MAC should encourage submission of evidence based testimony since that's what MAC will base a decision on. Dr. Bowman noted he's looking for objective, randomized, placebo, or controlled studies. Dr. Bowman thinks that anecdotal information won't be helpful. Dr. Gean had similarly suggested that people providing public testimony need to cite peer reviewed literature.
- Dr. Richitelli expressed concern that if people are selected to provide testimony, there may be individuals who will provide biased testimony in favor of SCS. He wants to make sure that all viewpoints are represented, and that there is a fair assessment of the literature.
- Juerg will circulate provisional criteria for testimony and submit to the MAC members. Once finished, that information will be posted to the public as soon as possible. If there are specific providers that should be notified, let Cara or Juerg know. MAC members can invite people to provide testimony, and participants can submit comments in written format or testify in person

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The meeting adjourned at about 10:40 a.m.

The next MAC meeting will be held on June 2, 2017.

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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