WORKERS' COMPENSATION
MEDICAL ADVISORY COMMITTEE
August 4, 2017
9 a.m. – 11:30 a.m.

MAC Committee Members Present: Ronald Bowman, MD; Gary Rischitelli, MD, Brad Lorber, MD; Timothy Craven MD (MCO Representative); Julio Ordonez, MD; Tom Williams, PT, Ryan Weeks (Employer Representative), Constantine Gean, MD (Insurer Representative) *{via teleconference}*, Susan Strom, DC, Lon Holston (Worker Representative)

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

MAC Committee Members Absent: Jon Soffer, ANP DNP

Agenda Item	Discussion
Welcome, Introductions (0:00:00)*	Dr. Bowman called the meeting to order at 9:02 a.m.
Administrative discussion (0:00:05)*	**Review and approve minutes for June 6, 2017 MAC Meeting** Dr. Lorber moved to approve the minutes. The June 6, 2017 minutes were approved as drafted.
Administrative discussion (0:00:30)*	For 2018, meeting dates were shifted to the third Friday of the month. The dates will be sent out to MAC members and posted online.
Technology Review: Spinal Cord Stimulator subcommittee recommendation (0:01:53)*	*The following is a summary of the discussion; please refer to audio recording for details.* <u>*Subcommittee work*</u> ▪ Dr. Craven, Dr. Strom, Dr. Ordonez, and Dr. Braddock (Majoris) reviewed literature on spinal cord stimulators (SCS), along with other documents provided by stakeholders. ▪ The subcommittee agrees that SCS is not experimental, outmoded, or non scientific. Dr. Craven thinks it comes down to effectiveness. The subcommittee had some disagreements about when SCS should be used. For injured workers, the two primary uses for SCS are for failed back syndrome and chronic regional pain syndrome (CRPS).The subcommittee is not proposing a blanket statement about not using SCS. ▪ According to Dr. Braddock, MHN Caremark doesn't approve SCS and generally doesn't think they are worthwhile. Providence MCO approves SCS with guidelines. Dr. Braddock noted that Majoris does review some cases, but doesn't approve SCS for failed back syndrome. ▪ SCS has been used a long time, so it is not a new technology. The question is when it would be helpful to use, and how much help SCS is. ▪ The subcommittee didn't look at costs. ▪ There are side effects and problems with SCS, however, that's due to device issues. Those kinds of problems can occur with any type of device. ▪ The subcommittee thinks that SCS is probably relevant for CRPS and phantom limb pain.

Dr. Craven's commentary

- Dr. Craven made a list of the studies he considers level one and two, which is primarily what he based his opinion on.
- Dr. Craven has found that SCS is good for neuropathic pain (like CRPS), but he doesn't think it is proven for back pain without neuropathic symptoms. Dr. Craven thinks that if it is primarily axial pain, SCS is not very effective. SCS has been reportedly used for post amputation pain, but Dr. Craven hasn't seen studies on it.

Dr. Strom's commentary

- SCS has evolved over time. There are more types and approaches, and there seem to be more effective therapies (like the high frequency therapy).
- A sticking point is whether workers' compensation patients are benefitting to the same degree as non workers' compensation patients. Dr. Strom thinks it would be unfair to deprive workers' compensation patients a therapy that is still evolving and having better success rates.
- Workers' compensation patients are a very difficult group to set aside. Sometimes it takes a long time for a workers' compensation patient to get a surgery approved. By the time it is approved, most workers probably aren't going to be returning to work. In that case, the question is whether SCS is still an effective way to get off opioids and have a better quality of life (rather than returning to work).
- MAC possibly needs to build in some sort of psychological evaluation where there are measures for determining if a workers' compensation patient with failed back syndrome will respond more favorably. Dr. Strom doesn't think the data shows that no one responds favorably, but many do not. It may have to do with some psychological or psychosocial issues that develop around loss of work and loss of capacity.
- If we jump on a new technology too quickly, we're anticipating success at outset. Sometimes the new technology may fail to have good outcomes. In this case, SCS has been around about 20 years. SCS is not going to go away, it is just going to keep improving. Dr. Strom thinks we need to keep it an option open to injured workers, but create some conditions around who it will be allowed for. Dr. Strom doesn't want to just deny SCS overall, and would support creating exclusion and inclusion criteria. Dr. Strom noted that MCOs can create their own requirements regarding SCS.
- Some of the research said that there was trend towards more a favorable response for failed back syndrome when using newer technology.
- Very few studies look only at injured workers, or they aren't separated out from the rest of the study group. Sometimes it hard to tell what the true outcome would be for injured workers.

Dr. Braddock's commentary

- SCS technology is evolving and there are several forms of SCS that are not proven to be effective. Majoris tries to continually go back and look at their data and has looked at various sources of data (including the Washington state data, and MHN Caremark's data). The studies on SCS are limited for the workers' compensation population though.
- Dr. Braddock believes that in the general population, SCS probably has some benefit for failed back syndrome. However, he thinks there are incentives in the general population that aren't necessarily present in the workers' compensation

population, and that's why the general population is more successful. If you look only at workers, Dr. Braddock thinks SCS is not very successful. It creates false hope for injured workers and sets them up for failure. There is data to show that (e.g., SAIF data, Majoris data).

- Dr. Braddock thinks SCS is scientific for CRPS and phantom limb pain and others, but unproven for failed back syndrome. Dr. Braddock thinks that MAC should take an unproven stance for failed back syndrome until MAC gets more data (especially for newer SCS technology). Dr. Braddock suggested looking at MCO data.

Dr. Ordonez's commentary

- Dr. Ordonez agrees with everything said about the indications. The American Association of Neurological Surgeons (AANS) has a list of criteria online, which includes pain not associated with malignancy and poor response to conservative treatment for a minimum of 6 months. This is important, because in the literature there are a number of patients who got SCS soon after surgery and that is not indicated. The criteria also states that there must be a low chance of success for revision surgery; the patient is no longer going to benefit from any additional surgery.
- Other criteria are that the patient shouldn't have a pacemaker, and that the patient shouldn't have any major psychiatric disorder. The psychiatric criteria are difficult to evaluate, but Dr. Ordonez thinks patients should be seen by a psychologist before insertion of a SCS.
- The patient should also be willing to get off pain medication as soon as possible after implanting the SCS. There should also no active litigation during that period. Dr. Ordonez didn't see any discrimination against failed back syndrome in the AANS criteria.
- Aetna has a more complete list about the indications and contraindications.
- SCS guidelines are something that should probably be revised every year.

Litigation and guidelines

- Dr. Bowman commented that ongoing litigation on a case seems to be a straightforward exclusion.
- Juerg noted that it is the workers' right to appeal an MCO decision or insurer disapproval. Juerg thinks we need to differentiate between a claim in litigation versus a specific treatment. Juerg suspects that with SCS, claim litigation is over by that time. Most of the time, he thinks SCS is being discussed years after the injury, when litigation may not be as prevalent.
- Jaye Fraser, SAIF Corporation, commented that sometimes there could be litigation on a combined condition where SCS is involved. There's never a hard and fast rule in workers' compensation, but Jaye thinks that parameters could be created.
- Dr. Craven noted he wouldn't recommend putting mention of litigation in the guidelines.

Psychological considerations

- Dr. Braddock noted that interviews with patients indicate high expectations that the pain will go away completely. When you look at the SAIF data of workers' compensation patients, none are off opioids. They may decrease their use, but aren't entirely off.
- Dr. Bowman thinks a psychological evaluation sounds like a good idea. Dr. Gean

noted in his experience, it is not very common that psychological issues are an exclusion.

- Lon Holston commented that a worker who has been in pain would likely be willing to meet requirements (like a psychological evaluation) to get SCS.

Guidelines

- Juerg noted that as a regulatory agency, WCD does not go into the details of MCO guidelines. MCOs have the latitude to decide on the details of their guidelines.
- Dr. Rischitelli pointed out that nationally, there are two major commercial treatment guidelines, Official Disability Guidelines (ODG) and MDGuidelines by the American College of Occupational and Environmental Medicine (ACOEM). ODG has been adopted by about 24 states, while the MDGuidelines has been adopted or referenced by about 12 states. Put together, that makes up more than two-thirds of the workers' compensation systems in the United States.
- Dr. Rischitelli noted that California is a bellwether state for managing workers' compensation medical care. California's guidelines indicate specific conditions for SCS: failed back syndrome, CRPS, post amputation or phantom limb pain, post herpetic neuralgia, spinal cord injury dysesthesia (specifically pain in lower extremities associated with a spinal cord injury), pain associated with multiple sclerosis, and peripheral vascular disease.
- Dr. Rischitelli described California's definition of failed back syndrome (for the initial request to perform a SCS trial). California's definition states "Persistent pain in patients who have undergone at least one previous back operation and are not candidates for repeat surgery." They also require the following prerequisites (all of which must be present):
    - Symptoms are primarily lower extremity radicular pain
    - Limited response to non interventional care
    - Psychological clearance indicates both realistic expectations and clearance for the procedure
    - No current evidence of substance abuse issues
    - No other contraindications to the trial
    - Permanent placement requires evidence of 50% pain relief and medication reduction, or functional improvement after the temporary trial.
- Dr. Craven noted that Providence MCO has its own guidelines that he uses primarily for SCS, but he looks at ODG a lot. ODG recommends SCS only in selected patients in cases where less invasive procedures have failed or are contraindicated.
- Dr. Strom pointed out that if we exclude SCS for failed back syndrome, how will MAC gather data on the effectiveness of newer technology?
- Dr. Rischitelli pointed out that the concept of failed back syndrome is problematic. According to the definition he read, it is a patient who still has pain five years after surgery, and they aren't a candidate for another surgery. It doesn't say anything about why or where that pain is coming from. SCS is essentially neuromodulation where you're trying to stop pain transmission, so you know it is neurogenic pain, and that it isn't very effective for nociceptiove pain. Why did that even get entrenched in the literature? Dr. Rischitelli thinks that MAC should say that it is a modality of treatment for intractable radiculopathic, regardless of where the pain came from. What we want to make sure is that people aren't putting SCS in people who have mechanical back pain, where SCS won't help. Maybe that will help side step the failed back syndrome issue.
- Tom Williams noted that in his experience, the people who have the most success

with SCS were not expecting to go back to work. A failed SCS might be one where someone that was expecting to go back to work, but did not end up going back to work. MAC could treat SCS like a salvage procedure to reduce pain and improve function, but without the expectation that they will go back to work. If we ignore return to work, it might change how we do exclusion criteria. If we're trying to promote the best possible outcome, we could make some exclusions to ensure better outcomes.

- Ryan Weeks noted that the employers are thinking about the financial aspect of getting an employee back to work. If the worker is not returning to work, we're all paying for it anyways (this is more of the wellness side). It is our responsibility to take care of people.
- There are a variety of SCS technologies. There is traditional low frequency SCS, high frequency SCS, burst frequency, and a dorsal root ganglion SCS. Dr. Craven believes that once a patient is eligible for SCS, it is micromanaging the case to determine what type they use. In his point of view, if they are a candidate for SCS, they should speak with a specialist about which type to try. He wouldn't recommend looking into different types as a committee.
- Dr. Lorber noted that the type of SCS affects whether MAC says SCS is proven or unproven.

SCS and opioids

- Lon Holston described how opioid usage can cause problems for a worker. Lon thinks that MAC needs to be proactive in the pain arena. SCS is not going to be successful 100 percent of the time, but if MAC can help get an injured worker off opioids, that is what we are here for.
- Dr. Ordonez noted that from a doctor's standpoint, if they're at the end of the road, they have to come up with some kind of solution (like SCS). Otherwise, you have a patient with recurring pain who is requesting narcotics. It is very difficult to see someone in pain and unable to help.
- Dr. Craven noted that doctors are moving away from high dose opioids. As a result, SCS is one of the alternatives doctors may be looking at more for patients on high doses of opioids. Dr. Lorber commented with the current climate regarding opioids, there will probably more information from studies coming out about getting people off them.

Miscellaneous SCS information

- Dr. Braddock noted that patients have to go through a psychological evaluation before getting a stimulator.
- Dr. Braddock pointed out that SAIF's data on failure is consistent with other literature.
- Dr. Craven noted that SAIF's data shows no significant change in return to work, but some reduction in opioids.
- Dr. Craven noted that at the last meeting, there was a comment that most studies exclude workers' compensation patients. He looked at the 18 level one or two studies and only found one that excluded workers' compensation patients. The rest didn't state workers' compensation as an exclusion nor how many cases were workers' compensation patients.
- In the last two years, WCD's Medical Resolution Team (MRT) received 14 disputes involving SCS. Three were approved, two were disapproved, five were dismissed (that could be that the worker withdrew the request, or the attending physician no longer supports it), one was stipulated out (the parties agreed on

	something), and three are currently before MRT for review. Juerg does not know how many are enrolled in MCOs. *Next steps* ▪ MAC currently does not take a position on compensability of SCS. At this point, SCS is compensable. MAC's task to make a statement based on the available science. ▪ If MAC says SCS is unproven, SCS would become non compensable and there would be no way around it. Alternatively, MAC could say SCS is not appropriate unless it is used for certain conditions, which would be more like a guideline. MAC currently does this with artificial discs. ▪ If a worker is enrolled in an MCO, they are subject to MCO guidelines. The state is not prohibited from creating guidelines, but MCOs are intended to manage care. ▪ Dr. Strom suggested brainstorming some conditions and bringing them to the next meeting. ▪ Dr. Craven will provide a spreadsheet for the full committee that summarizes the level one and two studies the subcommittee has found and reviewed. He'll focus on failed back syndrome, since that's the one that is controversial. ▪ Cara confirmed with Dr. Bowman that MAC agrees that some conditions do appear to be proven for SCS. Dr. Bowman responded that those conditions are CRPS, phantom limb pain, and spinal cord dysesthesia.
Technology review: Study classification discussion (1:29:00)*	▪ MAC needs to establish what level one and two evidence means. It would be helpful to have a reference for determining whether a study is level one or two. ▪ Juerg provided a variety of options, including the North American Spine Society's definition of levels of evidence. ▪ MAC could ask outside parties who submit evidence to identify level one and two evidence. ▪ MAC will do a trial using the North American Spine Society's definition. Dr. Craven will apply it to the SCS studies he is compiling. The plasma rich platelet subcommittee will also utilize it.
	The meeting adjourned at 10:40 a.m. The next MAC meeting will be held on December 1, 2017.

*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