WORKERS' COMPENSATION
MEDICAL ADVISORY COMMITTEE
July 19th, 2024
1pm – 2:30pm

MAC Committee Members Present: Ronald Bowman, MD; Brad Lorber, MD; Lon Holston (Worker Representative); Constantine Gean, MD (Insurer Representative); Jennifer Lawlor, MD; Eric C. Hubbs, DC; Raymond Brumbaugh, MD (MCO Representative):

DCBS Staff Present: Sara Kessler, Juerg Kunz, Angela (Angie) Blake, Baaba Ampah

MAC Committee Members Absent: Ryan Weeks (Employer Representative); Tom Williams, PT

Agenda Item	**Discussion**
Welcome, Introductions	Dr. Bowman calls the meeting to order at **1:00 p.m.**
Administrative discussion	**Review and approve minutes for October 20, 2023, MAC Meeting**
(00:00:00)	Dr. Bowman presented the meeting minutes from the October 23, 2023, meeting. Dr. Lorber moved to approve the minutes and Dr. Gean seconded the motion. The motion passed.
(00:00:23)	Sara Kessel informed the group that Dr. Brumbaugh is the newest MCO representative. Dr. Bowman added that Dr. Brumbaugh is a medical director and a physiatrist who has had decades of experience with workers' compensation issues.
Platelet Rich Plasma (00:01:06)	The conversation shifted to Platelet Rich Plasma (PRP) injections. Dr. Bowman mentioned Juerg Kunz did an exhaustive literature search on PRP injections. He continued up to this point, Platelet Rich Plasma has not been compensable, and results from the literature search will be discussed.
(00:02:03)	Dr. Gean stated that Juerg put together an incredible spreadsheet using all the research articles he found on Platelet Rich Plasma. Dr. Gean explained the basic concept of PRP injections. The PRP subcommittee reviewed the literature and selected those that were thought to be the most representative of good science. There was strong evidence showing a reduction of pain in the knee, epicondylitis, and/or shoulder conditions. In respects to function, such as range of motion, there were mixed results. Dr. Lorber added that PRP is not inferior to steroid, and studies show that PRP is safer to use than a steroid. The subcommittee recommends 3 months as the earliest use of PRP after unsuccessful conservative treatment. Dr. Bowman explained the studies used were Meta-analysis, which is when a subject is investigated, and the investigators collect the data form the numerous different studies.

(00.07:21)	Dr. Lorber explained that the subcommittee does not recommend PRP injections with any surgical interventions. He continued that the subcommittee recommended to review the subject again in 3 years, since research is currently very modest.
(00:08:35)	Dr. Gean added that the whole area of biologic treatments is exploding due to many different kind of biologic treatments. This is the reason the committee recommended a 3 year reevaluation. Dr. Bowman noted that one of the on-going problems is that PRP's process is proprietary, and the industry does not share how they to have a leg up on their competition.
(00:10:14)	Juerg explained that currently, the rule states PRP is an excluded treatment and is not compensable. Based on the recommendation by MAC, they could propose to change the rule to make it compensable, specifically for the knee, epicondylitis and the shoulder. He continued that by rule, there could be a requirement of a minimum amount of conservative treatment be provided, and only after failure of those treatments, PRP injections would become compensable. He noted that because it is in the rule, he would propose to specify the length of conservative treatment to a specific amount time, rather than a range of, e.g., three to six months, before PRP injections become compensable.
(00:11:55)	Juerg asked the committee to vote on the subcommittee's recommendation. He went on to say that he will put together a document with MAC's recommendation based on the subcommittee's recommendation, as was done with the Artificial Disc, and circulate the document to be approved by committee at the next meeting. He will also put together specific proposed rule language that would become effective on April 1st 2025.
(00:13:02)	Dr. Lawlor made a motion to support the subcommittee recommendations, and Dr. Hubbs seconded the motion. There was no opposition amongst the group. The motion passed. Juerg Kunz thanked the subcommittee for all their hard work that they have done on this topic. Dr. Brumbaugh asked if PRP is approved by an MCO prior to the rule being adopted, is it okay to do so outside of normal guideline. Juerg answered that PRP is not compensable under the rule, which means the insurer won't have to pay for it, even if the MCO approves it. However, the injurer may agree to pay for PRP.
(00:15:18)	Brandon Smith asked if the PRP sub-committee information will be available for public view. Juerg answered that he will post MAC's recommendation after it is finalized.

Form 3245- Return to Work Status	Dr. Bowman mentioned that the topic was brought up recently. It is a modification of the current Return to Work form in an attempt to streamline the process. He asked if the Return to Work form was legally required for Oregon Workers' Compensation on patients. Juerg answered that the Return to Work
(00:21:27	Form is not legally required as doctors can use own form, However, if the insurer insists on a specific form then they must use Form 3245.
(00:23:46)	Dr. Bowman expressed that the return-to-work form is a form of communication that is difficult to get right.
(00:24:13)	Dr. Lorber said that the issue with the 3245 Form is the nonsensical things such as crouch, crawl, balance and how many times a day, which makes no sense. He continued that the form will not be perfect, however, he likes some of the ideas Majoris came up with. Dr. Bowman asked if there are similar forms from other states. He continued that it is important to get the worker back to the work environment
(00:26:43)	Dr. Gean mentioned that the state of Washington Workers' Compensation has an activity form. He will send the form for distribution. Dr. Gean continued that it is a marvel of conciseness, and yet it has the detail needed. The doctors making a prescription of what the patient can do, focusing on function. He expressed that the 3245- Return to Work Status is too detailed and it should be explained to physicians to only fill out relevant information.
(00:27:23)	Dr. Gean shared that based on his experience, employers and insurers feel as if it is a lot of work and it causes delays. Lon Holston mentioned that an alternative is a worker not having any work at all. Dr. Gean added that it is better for a worker to come back to work even at a light capacity.
(00:29:14)	Sara Kessler will send Washinton's Return to Work form to members. She also brought up SAIF's input regarding potential changes to the organization of the work status section on the 3245- Return to Work form. Dr. Lorber stated that the regular or modified work section was a minimal feature compared to the form. Doctors can understand the form as it is, but it may be beneficial to improve the form overall.
(00:31:45)	Juerg Kunz will do research on different forms form other states and share them with the committee.
(00:34:22)	Dr. Bowman added that the intent of changing the form is to make it increasingly intuitive for managing workers' compensation patients for physicians. This topic will be addressed at the next meeting.

Insurance Authorization Update: (00:37:57)	Dr Bowman asked if Majoris had input to give on insurance authorizations, specifically physical therapy (PT). A Majoris representative (observer at meeting) mentioned that during the last meeting, there were questions about workflow, dates, and why PT needed to be approved ahead of time. She explained that Majoris is focused on giving workers appropriate medical care for their injury and medical necessity, while insurers are focusing on compensability. Majoris' goal is ensuring that requests match the prescription, if progress is being made, and if the treatment is worth it. She mentioned that Majoris gives a 5-day grace period to PT requests. This is to work with different clinics' set up and how the process works to continue to care of the injured worker. Some clinics may continue to treat while others may not request a new authorization until they have completed care, which can cause a gap in care. Some clinics will continue to provide treatment while waiting for authorization, while others will not continue treatment until they receive authorization.
(00:42:28)	Dr. Bowman states in a medical office, as a business principle, providing care without a medical authorization may not be the best practice. It can work if there is an already an established relationship, but it may not always work out. Dr. Bowman then asked why authorizations are in 30-day intervals and if it is a statute. Majoris representative answered that it is not a statute but a set standard that physical therapy clinics have where their expectation is that an evaluation is done every 4 weeks. Juerg added that the administrative rule from the Physical Therapy Board requires every 4 weeks or every month.
(00:44:12)	Lon Holston asks if there is a mechanism for preauthorization for Majoris that the physician sends notice. The Majoris representative mentioned that the first 12 visits within 30 days following surgery do not require recertification. In Majoris' case by approving surgery, you are then approving some physical therapy right after.
(00.45:22)	Dr. Lorber expresses that part of the problem is that at times the MCO will approve it, but the insurer will not approve it. When it gets denied, the patients may get charged with the bill.
(00:46:33)	Dr. Gean asks how common is it that PT is needed, but it is delayed and how many complaints and what percentage of cases have delays? Dr. Bowman mentions that about 10% or less of patients he has treated have had delays in their physical therapy.
(00:48:53)	Dr. Bowman expresses his curiosity about why authorization is every month, when for example, it is known that a patient might need physical therapy for about 5 months. Majoris' representative answers that sometimes treatment stalls and they want to make sure the worker is making progress. Communication can be a problem with surgeons. Also, physical therapist will see patient several times post-op and use up the allotted treatments within in a month, which when it is authorized to be used within five or six months. Which is excessive care for the worker.
(00:50:38)	Dr. Gean asks if there is a way to study how common it is, and how should we measure. Dr. Bowman mentioned that it is common and retroactive authorization

	is not good for everyone. It is not a good business practice for therapist to continue therapy without authorization.
(00:54:15)	Dr. Bowman notes that going forward, it will be helpful to track specifics if something comes up and then look at it. Juerg mentioned that Tom Williams was going collect some data from big and small PT clinics. Sara will follow up to see if he was able collect anything. Dr Lawlor reiterated what should be standard for requesting PT and authorization: Identifying what the problem is and where the problem is. It is an area of opportunity to see where the glitches are, what are the variables slowing it down. Dr. Lawlor suggests starting with MCOs as they track the information routinely already and then somehow drilling down that information with the insurers directly would be the next step.
(00:56:03	Dr. Lawlor mentions that one potential role or goal for the group should be determining what the timeframe for requesting authorization for physical therapy is.
(00:58:08)	Dr. Bowman proposes that for injured workers that need surgery that requires authorization, he would request both physical therapy and surgery all at once.
(00:58:28)	Dr. Lawlor suggests to think the different aspects like if it should be a longer window, or should it be total number of visits and says it should be one of the big questions to ask MCOs or insurers. It is to determine if there is a problem, what and where is problem to avoid big delays to seeking medical assistance. Dr. Gean talks about California having a time limit of 5-10 days and if not objected during that time it becomes authorized.
(01:08:28)	Dr. Bowman adjourned the meeting at **2:12 p.m.** The next MAC Meeting is scheduled for October 18, 2024.

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