



MEETING MINUTES
March 6, 2009

Members Present: Ronald Bowman, M.D., Chair; Franklin Wong, M.D.; Gary Rischitelli, M.D.; John Braddock, M.D.; Frank Prideaux, D.C.; Timothy Keenen, M.D., Vice-Chair; Hans Carlson, M.D.; Tom Williams, P.T.; Joey Blubaugh; and Maria Carraher, Injured Worker Representative

Members Absent: Brad Lorber, M.D.

WCD Staff Present: Jacqueline Sewart, Juerg Kunz, and Denise Hunt

Approval of Prior Meeting Notes:

The committee members reviewed the minutes dated November 14, 2008. A motion was made by Dr. Wong and seconded by Dr. Rischitelli to approve the minutes as written.

Committee Member Replacement: *Dr. Bowman and Jacqueline Sewart*

With the resignation of Pam DeVisser, FNP, which terminated her seat on the committee, discussion focused on possible replacement options. Pam's term was due to expire in December 2008; however she resigned just prior to that on November 13, 2008. Statutorily we are supposed to have no more than eight providers on the committee. At this point in time we have seven providers which means we do not have to fill the vacancy right away. There was a suggestion to appoint a family practitioner to the committee who is well experienced in workers' compensation. Discussion on the topic found that there may be difficulty in finding someone from primary care due to the heavy patient care population that most of these providers have and out of that population, only a small percentage are being treated for work injuries. Another difficulty is many of those primary care providers are not familiar with the whole workers' compensation process, and these providers may find it hard to take time out of their busy practice to attend meetings. Other suggestions include:

- Contacting the Oregon Academy of Family Practitioners and ask them if they have someone in their organization that has a particular interest in workers' compensation and have them nominate someone
- To obtain a representative, ideally, someone out of the Willamette Valley area in family practice that is interested in workers' compensation
- Contacting the OMA Section Chair of Family Practice to see if there is an interest

Since there is time to find a replacement member, it was decided to look around to see what options are available to the committee. In referring to the statute, it says "the maximum number of medical providers shall be eight and the medical providers shall constitute a majority of members at all time". The committee currently has seven providers which constitutes a majority. Further discussion will resume on this issue when all the options have been reviewed and brought back at a future meeting for further discussion.

Mailing of Committee Packets: *Dr. Bowman*

Dr. Bowman stated he was asked to bring up the question to the division if the committee could get their packets containing informational material sent to them sooner? In regards to the informational material for this meeting, instead of mailing out individual packets, a group e-mail was sent to the committee members on 2-25-09 with a statement that read "If you prefer not to receive this information via email, please let Jacqueline Sewart know". Out of the nine members, we had two requests for hard copies that were placed in the U.S. mail. The division's goal is to have the informational packets e-mailed no later than a week prior to the meeting, and will make every effort to get the information out sooner.

Department of Consumer & Business Services Staff Changes: *Jacqueline Sewart*

The committee was informed that the department as a whole is going through significant budget issues that resulted in staffing changes. Approximately 83 positions within DCBS have been eliminated. The Workers' Compensation Division took the hardest hit of any division in the department. The reason being is that other divisions have other types of funding available to them. The Medical Section lost two positions and one individual was bumped due to seniority bumping rights. Denise Hunt, the Medical Section's Administrative Assistant, was bumped from her position. She will be relocated to another division within DCBS and today will be her last Medical Advisory Committee meeting. Additional questions and responses on how these new department changes affect work load and stakeholders were discussed.

Drug Utilization: *Juerg Kunz and Sata Hackenbruck*

The committee reviewed a previously mailed out memorandum addressing the Medical Advisory Committee's follow-up questions and requests for additional data from a prior meeting. One of the follow-up questions asked pertained to the prescribing habits of various provider specialties. However, the division only captures provider types such as MD, DO, etc., but not specialties, such as orthopedic surgeon, family practitioner, etc. The committee then went into a discussion period reviewing the responses to the following follow-up questions:

- 1) Number of claims using one or more opioids: Total dispenses and payments for claims with one type of opioid (by generic name), two kinds of opioids, and three or more opioids
- 2) Top 10 diagnoses for opioid use by dispenses: Disabling claims, non-disabling claims, and combined
- 3) Distribution of opioid dispenses before and after claim closure
- 4) Time lag from 1st doctor visit to 1st fill opioid
- 5) Time lag from injury date to 1st fill opioid
- 6) Correlation between length of the claim (lag from injury date to the latest closure date) and how soon opioid is dispensed
- 7) Number of morphine (pain) pumps and spinal cord stimulators per service year
- 8) Number of opioid dispenses per claim in one year period prior to pump or stimulator implantation and in one year period after
- 9) Percentage of claims with lumbar fusion that have opioid dispenses

A question was asked by the committee if they could take a look at the drug formulary? It was stated that if you (the division) want to control costs, that would be the first place to look. In response to that, the division first

Drug Utilization Continued: *Juerg Kunz and Sata Hackenbruck*

needs to look into whether we have any authority pertaining to drug formularies. After that we can do research on different formularies that are available and bring them back to the committee for review. Discussion on “cost saving” prescribing habits followed. It was stated that the reality is the division is not going to change the prescribing habits of providers unless they inform providers on what drugs will or will not be paid for. Juerg will research these questions and will get back to the committee with his findings.

Lumbar Fusion: *Juerg Kunz*

The committee reviewed and discussed the handout on Lumbar Fusion Surgeries 2000-2006 that contained the following data: Count of lumbar fusion surgeries and median time from injury to surgery per calendar year; count of lumbar fusion surgeries by diagnosis/calendar year; median time between surgery and claim closure; and return to work status at claim closure.

The committee initially found the average number of lumbar fusion surgeries done annually (153) lower than expected. After some discussion committee members determined that this figure was a reasonable number and very close to being accurate. The big issue surrounding lumbar fusion is not necessarily the number of fusions; but the concern regarding the high costs, both for medical care and for disability. Thus, even though the number of surgeries seems low, it does not mean that the issue is not important.

Secondly, a comment was made on the numbers comparing lumbar strain and herniated disc surgeries and the diagnosis of “lumbago” came into question because of its unusual association with having surgery. Sata from the Information Management Division (IMD) explained that the ICD-9 code listed is the one with the most payments for that claim. At the first treatment the initial diagnosis (ICD9 code) gets assigned which may be lumbago. The initial code may never get changed; if it does, it usually gets changed right before surgery. This would explain why lumbar fusions are performed on patients for such diagnoses as lumbar strain or lumbago.

The division was asked this question: Pertaining to your dispute resolution section of the Workers’ Compensation Division what lands on their desks regarding lumbar fusions that is unclear and is in need of an answer? And secondly, how could the committee put together some kind of information to help in that decision making process? After further discussion, the committee made a suggestion on what direction they should go next on this; that is to do what the committee did with cervical and lumbar artificial disc replacement (ADR) with fusion: The committee wants to see if they can agree on indications for surgery as a guide for dispute resolutions. Similar to ADR, the committee wants to look at outcome studies and literature based on the validity criteria. It was shared that some studies are clearer than others, but it is going to be “muddier” than the artificial disc literature.

A motion was made by Dr. Keenen and seconded by Dr. Braddock to begin a process to look at lumbar fusions in a similar fashion to how we looked at lumbar artificial disc and cervical artificial disc replacements. Juerg will start the process by gathering literature on lumbar fusion.

009 / 010 Rules: *Juerg Kunz & Jacqueline Sewart*

A few changes were proposed to the 009 & 010 rules. Currently, these are still draft proposals and the division hopes to have the proposed rules ready in about 1½ weeks. Juerg informed the committee on which rules had proposed changes made to them.

009 / 010 Rules Continued: *Juerg Kunz & Jacqueline Sewart*

The following is a list of proposed changes to the 009 rules:

- As every year, adopt the most current versions of the RBRVS, The Physicians' Current Procedural Terminology, etc. OAR 436-009-0004
- The division does not anticipate any changes to conversation factors
- Clarify the late billing issue 436-009-0010(5) - still require medical providers to submit bills within 60 days of the date of service. The insurer has to pay the bill in full as long as the bill is submitted within 12 months (1 year). With few exceptions, if the bill is submitted later than a year after the date of service, the bill does not have to be paid
- Exclude cervical artificial disc replacement with certain devices from compensability. OAR 436-009-0015(6)
- Hospital charges (housekeeping) – procedural codes must be included if a procedure was actually done
- Ambulatory Surgical Centers (ASC) – The division proposes to continue to use the Medicare groups 1-9 and manually list certain CPT[®] codes without a ceiling in selected groups
- Clarified how Nurse Practitioners/Physician Assistants should get paid particularly involving surgical codes – they get paid 15% if they assist a surgeon. When the nurse practitioner or physician assistant is the primary provider then they get paid at 85%

The following is a list of proposed changes to the 010 rules:

- The division proposes to adopt relative & absolute contraindications for the cervical artificial disc replacement as recommended by the Medical Advisory Committee on November 14, 2008
- MCO enrollment letter – the insurers would have the ability to provide the worker a web address with available attending physicians instead of a written list of APs with the enrollment notice. Workers that do not have access to the internet can have a list mailed to them; they have 7 days to make this request. In those cases where the worker requests a written list of available attending physicians, the enrollment notice is not complete until the insurer sends the requested list

AMA 6th Edition: *Jacqueline Sewart*

The committee reviewed a handout on the medical perspective on adoption of AMA Guides 6th Edition charter statement developed by the division. MLAC has requested that the MAC look at this statement. The Workers Compensation Division is currently using methods out of the 3rd Edition AMA Guide which was revised in 1990. External stakeholders went to MLAC and requested that they look at the 6th Edition. MLAC in turn requested that MAC, as the medical provider community, determine if the 6th Edition is an evolution in medical knowledge and worth our time, costs, and effort to switch to the 6th Edition? The charter statement includes key objectives MLAC would like addressed which are:

- Does the 6th Edition represent an evolution in medical knowledge?
- Would the 6th Edition result in improved validity, clarity, and inter-rater or consistency?
- Currently, ratings of impairment are calculated by insurers, based on medical findings and measurements. What role would the physicians and insurers need to change with the adoption of the 6th Edition?
- Could attending physicians readily interpret and apply the 6th Edition? If not, what would enable them to do so?
- Who could rate impairment using the 6th Edition?

AMA 6th Edition Continued: *Jacqueline Sewart*

- Would Oregon's "major contributing cause" law be a deterrent to adoption?
- Could a comparison rating using current calculation versus the 6th Edition be undertaken? (The department would prefer to do an extensive study to identify the effects of the system and we would like to compare the current ratings versus the methodology they are using out of the 3rd versus the 6th? And would we be able to do that with what is in the patient's file? If not, what would we need?)
- From a medical perspective, what questions would need to be addressed by policy-makers prior to adopting the 6th Edition?
- Are there other roles, requirements, processes or issues that Oregon's policy-makers need to understand?
- Overall, what would be the advantages and drawbacks of adopting the 6th Edition?

Discussion on this topic revealed that there may be 10 to 20 states currently using the 6th Edition Guide. Dr. Keenen directed two questions to Dr. Rischitelli. The first one was: Do you know of a resource where we can get some kind of ideas of how the 6th Edition compares to the previous editions? The second question asked was: Major contributing cause in Oregon, how is that different from other states and does this conflict with it? Dr. Rischitelli stated that his initial impression is it shouldn't really matter. I'm not sure that it is relevant. Because of the issue at claim closure of rating impairment, I am not sure the 6th Edition really changed much in terms of the major contributing cause standard. Those rules are set; all we are doing is changing the grids. Where the 6th Edition is different is this, it is an improvement in that it has moved away from the mechanical application of range of motion to a more functional evaluation. This is a tremendous step forward. The 6th Edition requires a lot more, e.g. there is a questionnaire for a lot of the conditions that is like MSF36 (the quick dash). It gives you narrow categories of impairment based on diagnoses. Then you move from this default coupled with percentage points based on the response to the functional assessment, clinical studies, and one other (unnamed) modifier. There are also some difficulties because you cannot do a retrospective review of records because those questionnaires and other things that are essential to grade in the 6th Edition are not currently being used.

Dr. Rischitelli suggested that the most accurate way of doing a study is to begin with a small pilot study of physicians. There are advantages of the 6th Edition. The risk of inconsistency goes down, because the range of discretions shrinks. At this point in time, more information on this topic is needed. The committee asked the department if they could provide them with some cliff notes.

Tasks:

- Juerg will research the committee's drug formulary questions and respond back to them with his findings
- Juerg will review research articles and collect exclusion criteria for lumbar fusion, similar to what he did for lumbar and cervical artificial disc replacement.
- Division to send committee members cliff notes pertaining to the AMA Guides 6th Edition

Tabled Items:

- Registry for Cervical Disc & Lumbar Disc
- Botox

Adjournment:

Meeting began at 9:00 a.m. and adjourned at approximately 11:40 a.m.

Next Meeting:

- May 15, 2009 9:00 a.m. - 11:30 a.m. Clackamas Community College Training Center, Wilsonville

Recorder: Denise Hunt