

## July 24, 2014 Industrial Insurance Medical Advisory Committee Meeting

### Minutes for Meeting

Topic	Discussion & Outcome(s)
	<p><b>Members present:</b> Drs. Bishop, Carter, Chamblin, Friedman, Gutke, Harmon, Howe, Lang, Nilson, Tauben, Thielke, Waring  <b>Members absent:</b> Drs. Seaman and Zoltani  <b>L&amp;I staff present:</b> Gary Franklin, Lee Glass, Leah Hole-Marshall, Teresa Cooper, , Ian Zhao, Joanne McDaniel, Hal Stockbridge, Jami Lifka, Diane Reus, Vicki Kennedy, Steve Reinmuth, Nicholas Reul, Simone Javaher, Jo Waldschmidt,  <b>Public:</b> Regine Neiders, Grace Wu, Lauren Campbell, Luke Carson</p> <p>No one joined by phone.</p>
Welcome and minutes approved	The minutes from the April 24, 2014 meeting were read and unanimously approved.
Update on Advisory Committee on Healthcare Innovation and Evaluation (ACHIEV)	<p>Dianna Chamblin presented the highlights of the ACHIEV meeting which took place right before the IIMAC.</p> <p>Enrollment in the medical provider network has surpassed 20,000. The network impacts costs by removing low-quality providers, whose claims costs tend to be higher. An update was given on the surgical best practices pilot. Gary Franklin updated the committee on the risk of harm work; identifying providers who show a pattern of low quality care or harm to patients. The group is particularly looking at deaths from opioid prescribing, and repeated spinal surgeries. Other topics were the expansion of COHE's, criteria for top tier COHE providers, and activity coaching. The activity coaching pilot at L&amp;I is called PGAP. The program is expanding. At least one IIMAC member has had a good experience with the program helping a worker become more motivated and self-directing in getting back to work.</p>
Attending Provider Handbook and communication with providers	Hal Stockbridge reviewed the discussion the IIMAC had at their last meeting to come up with ideas to better communicate with providers. He talked about a new listserv and members gave their thoughts on receiving messages—for example, once a month at the same time would be good, and a subject line that makes it clear that it is important medical information. Members suggested that the agency might be more directive in its efforts to get providers to familiarize themselves with guidelines and take advantage of the free CME credits; for example, reminding providers that they must follow the guidelines.
Central Desktop review	Teresa reviewed the use of the Central Desktop work-sharing platform, and demonstrated an instructional video draft that would be customized for IIMAC and AMDG members. Members would be interested in the finished video, but still have reservations about using the system. They don't know when to check the site. Teresa offered to activate the system of notifying members when something is added to the site, and we will try that for now.
Psych care project	<p>Jami Lifka presented the results of her research on collaborative behavioral health care service models. She presented the basics of the models used in WA Medicaid and Group Health, and outlined the possible next steps.</p> <p>Stephen Thielke reviewed the DSM 5 project and told the committee about the rule changes that would need to happen to take into account the new edition. He showed the potential language for the rules which would be affected: in PTSD, assessment of functioning, and advising providers on which edition of the DSM to use. There was some discussion about the use of the WHODAS functional assessment tool: it is long and seems more time-consuming to doctors compared to tools they have been using, such as the Oswestry or Roland-Morris. Gary Franklin suggested that for short-term</p>



	<p>mental health care or assessment, a brief tool is fine, but if psych care is prolonged, use of the WHODAS should probably be encouraged. IIMAC members also discussed their experiences with and questions about somatic symptoms and how to diagnose and treat them.</p>
Facet neurotomy guideline changes	<p>L&amp;I presented the changes to the facet neurotomy guideline made necessary by the recent HTCC statewide decision on facet neurotomy.</p> <p>Medial branch blocks are the only injections that can be used as diagnostic tools before a facet neurotomy. This decision effectively rules out the use of facet blocks in all cases. L&amp;I will also have to make this change to the spinal injection coverage decision.</p> <p>IIMAC members do not completely agree with the facet neurotomy decision made by HTCC. They asked if a disclaimer could be considered, such as “This aspect of the guideline does not reflect the opinion of the IIMAC”. Will consider, but probably unnecessary, since neither the facet neurotomy nor spinal injections decisions are actually IIMAC guidelines.</p>
Proximal median nerve entrapment—5-year guideline update	<p>After hearing the research review, the IIMAC agreed by consensus that there is not sufficient evidence compelling enough to make any changes to the substance of the guideline.</p>
Cervical subcommittee update	<p>Summary of the progress on the cervical conditions guideline so far. Highlights were: defining selective nerve root blocks and the volume of anesthetic that should be given (0.5 cc), a new device for two-level cervical artificial disc replacement has been approved, hybrid surgeries and pseudarthrosis are special topics being examined. Much discussion on payment for cervical surgeries: there is much variability, and IIMAC wonders if payments could be bundled in such a way as to de-incentivize a more expensive surgery when a less expensive one would have the same result. OMD management will look into this. We need to allow 2 hours to discuss the cervical guideline at the next meeting, with public comment.</p>
Smoking cessation products and payment	<p>Continuing discussion of when to recommend, mandate, or pay for smoking cessation. Comments:</p> <ul style="list-style-type: none"><li>-How would smoking cessation requirement (4 or more weeks before surgery) fit or conflict with the requirements of the ortho/neuro project, where surgery has to be done within 2 weeks of being approved.</li><li>-Chantix can cause vasoconstriction. Implications for after surgery? Chantix also may increase the risk of suicide in some people.</li><li>-Mandating that patients stop smoking is very problematic.</li><li>-Surgeons agree that patients need to cease smoking; they need back up and help from other entities.</li><li>-Leah—perhaps we could have a general supportive payment policy, then have specifics in guideline.</li><li>-Gary—there is a strong correlation between nicotine use and opioid use.</li><li>-Gary—could we include in Qualis checklist for surgeries, “have you addressed smoking?”</li><li>-Urine cotinine tests are needed to verify smoking cessation.</li><li>-L&amp;I should support cessation and track outcomes, but not make it an absolute requirement.</li></ul>
Other	<p>Dr. Lang mentioned that he has been seeing patients who are injured from “physical force training” being done by agencies such as DOC and DNR for employees. This will be referred to the SHARP program at L&amp;I, Dr. Franklin to follow up.</p>