

MSRB Meeting 04-19-07

Comments Received and Actions Taken Re: Proposed Rules for Amendments to General Parameters

01-18-07 Draft	Comment	Actions Taken
	Require prior notification for any diagnostics.	<i>No action; this would create an unnecessary burden</i>
	Add rules for MRI scans of other body parts like the ones for low back pain	<i>No action at this time; MSRB will consider this issue in the future.</i>
	Add medical imaging rules for lower extremity injuries	<i>No action at this time; MSRB will consider this issue in the future.</i>
	Allow insurer to divert patients to lower cost providers of radiology services so long as they provide a comparable service.	<i>No action at this time; MSRB will consider this issue in the future.</i>
	Allow the insurer to substitute a therapeutically equivalent implanted spinal cord stimulator.	<i>No action at this time – DLI is currently doing a full scale review of spinal cord stimulators</i>
p. 4, l. 45 & p. 6, l. 12	Is it possible to do a second FCE if the patient's condition has deteriorated, changed after surgery, or the job duties change?	<i>No action; departures are already available in the rules. This has not been an issue in regard to low back pain cases.</i>
p. 8, l. 9	Change title from RSD to CRPS	<i>Add CRPS to the title.</i>
p. 8, l. 16	Use the IASP definitions for CRPS	<i>Add the IASP definition as a third category in subpart 1A.</i>
p. 8, l. 31	Disagree with using injections, PT should be tried first	<i>No action; the rule does not prohibit the use of physical therapy as a first line of treatment.</i>

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Comments Received and Actions Taken Re: Proposed Rules for Nonsteroidal Anti-Inflammatories

12/7/06 Draft	Comment	Actions Taken
	Use of chemical names instead of trade names is confusing to everyone but a health care provider	<i>No action; the chemical name is more inclusive</i>
	These rules eliminate any provider discretion and will cause providers to refuse wc patients	<i>No action; there is no evidence that other treatment parameters have had this effect</i>
	Who decides what is the "lowest clinically effective dose"	<i>Clarify that this decision is made by the treating physician</i>
1. 3	Add that preference should be given to etodolac, ibuprofen, nabumetone, and naproxen	<i>No action; preference is being given to the least expensive medications; these are second line drugs</i>
1. 4	The duration of therapy and GI side-effects should preclude the listing of ketorolac	<i>No action; there is insufficient evidence to support this recommendation</i>
1. 6	Change "are another class" to "are a subclass"	<i>No action; the change has no effect on the substance of the rule</i>
1. 7	Change "but not to exceed" to "and not to exceed"	<i>No action; the change has no effect on the substance of the rule</i>
1. 12	The requirement to use generics makes no sense except to lower costs	<i>No action; generics are already required by other state laws</i>
1. 13	Delete generic diclofenac because of reports of increased cardiovascular toxicity	<i>Add a clarification - "unless there is a medical contraindication documented by the prescribing physician"</i>
1. 14	One week trials are too short	<i>No action; this was recommended by the MSRB</i>
1. 14	Who decides that the pain has been reduced by > 50%	<i>Clarify that this decision is made by the treating physician</i>
1. 19	Who decides what is the shortest duration needed?	<i>Clarify that this decision is made by the treating physician</i>
1. 27-29	The FDA maintains a warning against using COX-2 inhibitors in patients with aspirin allergy	<i>Conform to FDA</i>
1. 27	Add "non-acetylated salicylates"	<i>Moot if rules conform to FDA</i>
1.31	COX-2 inhibitors are very effective treatment; restricting their use in this way does not make sense	<i>No action; the review of the evidence shows that they are no more effective than other NSAIDs</i>

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I. 31	This item should note that if a patient is already taking aspirin then there is no advantage in using a COX-2 inhibitor	<i>No action this is already part of the rule at l. 35-38</i>
L.33	Change to "documented history"	<i>No action; this is already required in the rule</i>
L. 33	Change "gastrointestinal disease" to "gastrointestinal bleed or peptic ulcer disease"	<i>Change to "gastrointestinal bleed or gastrointestinal disease"</i>
I. 34	Eliminate g.i. side-effects from non-selective NSAIDs as an indication for COX-2 inhibitors	<i>No action; evidence shows that this is a legitimate indication for COX2 inhibitors</i>
I. 37-38	Would the gastroprotective agent be covered by WC	<i>No action; this is an issue that needs to be decided on a case-by-case basis</i>
	Changes Recommended by the Department	
	Frame the proposed rule as a subpart of a new treatment parameter with an introductory paragraph: "Subparts --- to --- of this rule do not require a physician to prescribe any class of drugs in the treatment of any patient, but apply only when the physician has elected to prescribe from one of the specified classes of drugs for the symptomatic relief of musculoskeletal pain."	<i>Approved</i>
	Delete MR 5221.6200 subpart 10, 5221.6205 subpart 10, 5221.6210 subpart 10, 5221.6300 subpart 10: "Scheduled and nonscheduled medications"	<i>Approved</i>

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Comments Received and Actions Taken Re: Proposed Rules for Nonsteroidal Anti-Inflammatories

1. 1	<p>Add a definition:</p> <p>“Non-steroidal anti-inflammatory drugs are drugs with analgesic, antipyretic and anti-inflammatory effects. The term "non-steroidal" is used to distinguish these drugs from steroids. NSAIDs act as inhibitors of the enzyme cyclooxygenase. For the purposes of this rule NSAIDs includes arylalkanoic acids, 2-arylpropionic acids (profens), n-arylanthranilic acids (fenamic acids), pyrazolidine derivatives, oxicams, coxibs, sulphonanilides, and diflunisal but not other salicylates or acetaminophen.”</p>	<i>Approved</i>
1. 1	Change “relief” to “symptomatic relief”	<i>Approved</i>
Additional Actions Originating from Member Concerns Expressed at the Time of the Meeting		
	Physicians are not the only health care providers that can prescribe medications	<i>Change “physician” to “health care provider”</i>
1. 13	What constitutes a “medical contraindication”	<i>Develop a definition for consideration by the Board</i>
	Chiropractors may recommend OTC medications though they cannot prescribe; what are the implications for this proposed rule?	<i>The Department is directed to investigate the issue and report back to the Board.</i>

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Comments Received and Actions Taken Re: Proposed Rules for Muscle Relaxants

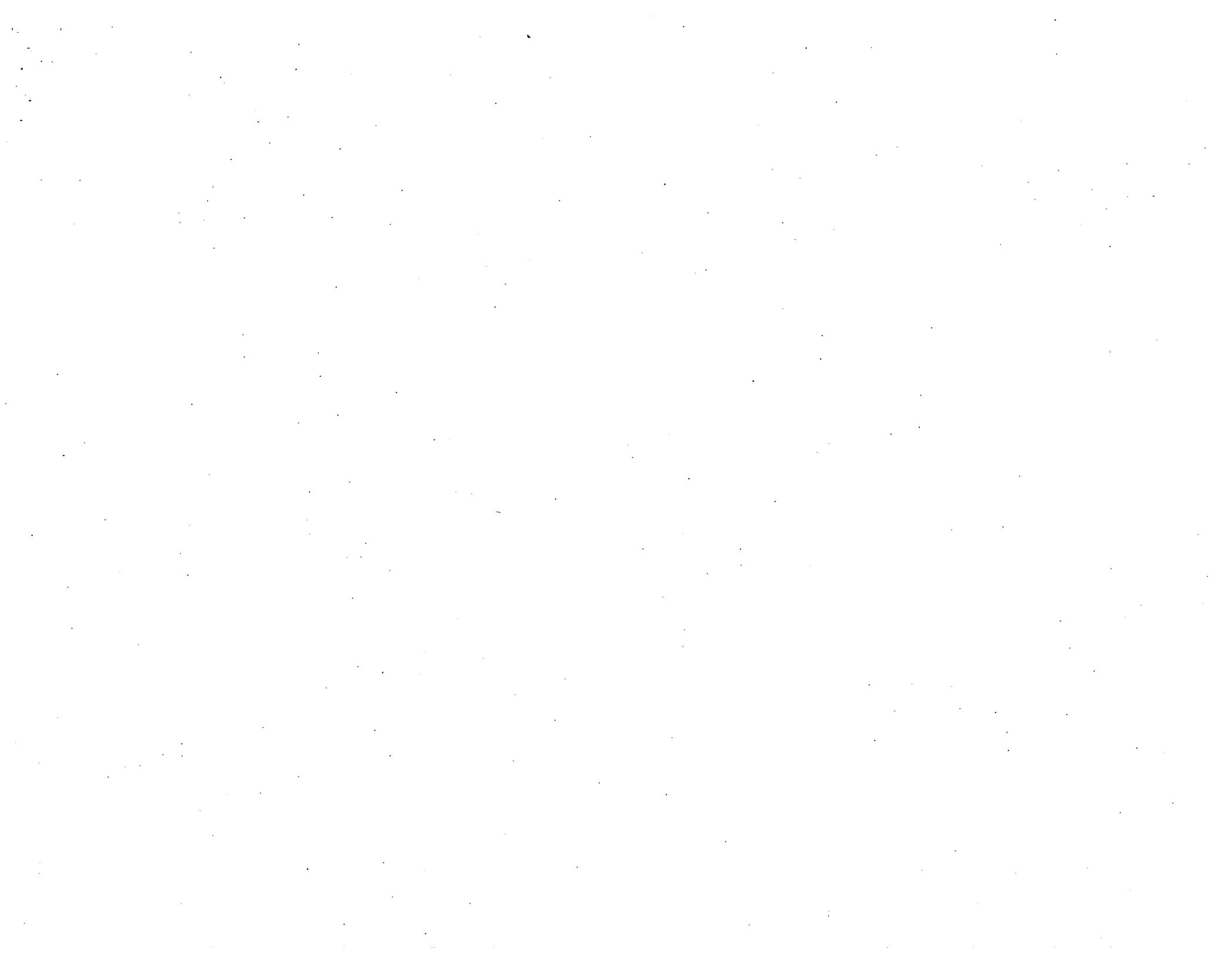
12/5/06 Draft	Comment	Actions Taken
	Use of chemical names instead of trade names is confusing to everyone but a health care provider	<i>No action; the chemical name is more inclusive</i>
	These rules eliminate any provider discretion and will cause providers to refuse wc patients	<i>No action; there is no evidence that other treatment parameters have had this effect</i>
1. 3	The exclusion of baclofen is short-sighted; it is very effective in patients with spinal cord trauma	<i>Clarify that this rule only applies to the symptomatic relief of musculoskeletal pain</i>
1. 5	Who decides what is the "lowest clinically effective dose"?	<i>Clarify that this decision is made by the treating physician</i>
1. 8	Since a doctor can "defeat" the requirement for a generic by writing "Brand is Medically Necessary," require the patient to pay the difference.	<i>No action; there is no authority to do this by rule</i>
1. 8	The requirement to use generics makes no sense except to lower costs	<i>No action; generics are already required by other state laws</i>
1. 9	Eliminate carisoprodol because it is metabolized to meprobamate and is subject to abuse	<i>Add a clarification - "unless there is a medical contraindication documented by the prescribing physician"</i>
1. 11	One week trials are too short	<i>No action; this was recommended by the MSRB</i>
1. 13	Replace "pain" with "incidents of spasm"	<i>No action; this rule addresses the treatment of musculoskeletal pain</i>
1. 13	Who decides that the pain has been reduced by >50%?	<i>Clarify that this decision is made by the treating physician</i>
1. 14	Require combinations when available	<i>No action; the treating physician should determine whether both drugs in a combination are needed</i>
1. 17, 27 & 29	Replace "indicated" to "authorized"	<i>No action; authorization is a payment concept; these rules address appropriate treatment</i>
1. 19	Consider breaking down the use into acute and chronic indications	<i>No action; item B does differentiate by duration of condition</i>
1. 22	Two week prescriptions are more expensive than one month prescriptions; allow one month prescriptions and	<i>No action; this is not medically appropriate</i>

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Comments Received and Actions Taken Re: Proposed Rules for Muscle Relaxants

	refills, and let the patient throw away what isn't needed.	
1. 24	Muscle relaxants should not be used for more than 4-6 weeks post injury	<i>No action; there is insufficient evidence to support this recommendation</i>
1. 25	One month's worth of a muscle relaxant is inappropriate	<i>No action; there is insufficient evidence to support this recommendation</i>
1. 26	Muscle relaxants should only be used as needed in chronic conditions	<i>No action; proposed rules would allow "as needed use" but would prohibit prolonged use (more than 3 months)</i>
1. 26	This contradicts the evidence that long-term muscle relaxant treatment is effective	<i>No action; there is insufficient evidence to support this recommendation</i>
1. 29	The exclusion of benzodiazepines is short-sighted; they are very effective in patients with spinal cord trauma	<i>Clarify that this rule only applies to the symptomatic relief of musculoskeletal pain</i>
1. 29	The PDR says that benzodiazepines are effective muscle relaxants	<i>No action; evidence review shows that the benefits are outweighed by the side-effects</i>
Changes Recommended by the Department		
	Frame the proposed rule as a subpart of a new treatment parameter with an introductory paragraph: "Subparts --- to --- of this rule do not require a physician to prescribe any class of drugs in the treatment of any patient, but apply only when the physician has elected to prescribe from one of the specified classes of drugs for the symptomatic relief of musculoskeletal pain."	<i>Approved</i>
	Delete MR 5221.6200 subpart 10, 5221.6205 subpart 10, 5221.6210 subpart 10, 5221.6300 subpart 10: "Scheduled and nonscheduled medications"	<i>Approved</i>
1. 1	Add a definition: "A muscle relaxant is a drug which decreases the tone of a muscle. For the purposes of this rule muscle relaxants include carisoprodol, chlorzoxazone, cyclobenzaprine,	<i>Approved</i>

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 Comments Received and Actions Taken Re: Proposed Rules for Muscle Relaxants

	metaxalone, methocarbamol, orphenadrine, and tizanide but not other medications that may be used to treat spasticity.”	
I. 4	Change “treatment” to “symptomatic relief”	<i>Approved</i>
Additional Actions Originating from Member Concerns Expressed at the Time of the Meet		
	Physicians are not the only health care providers that can prescribe medications	<i>Change “physician” to “health care provider”</i>
I. 9	What constitutes a “medical contraindication”	<i>Develop a definition for consideration by the Board</i>



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Comments Received and Actions Taken Re: Proposed Rules for Narcotic Analgesics

12/5/06 Draft	Comment	Actions Taken
	Use of chemical names instead of trade names is confusing to everyone but a health care provider	<i>No action; the chemical name is more inclusive</i>
	These rules eliminate any provider discretion and will cause providers to refuse wc patients	<i>No action; there is no evidence that other treatment parameters have had this effect</i>
	Rules do not reflect current thinking about treatment of pain.	<i>Clarify that these are rules for choice of narcotic whenever they are used and for prescribing for the acute use; add language to coordinate with rules for long-term use of opiates.</i>
	Quantity limitations may lead to more frequent office visits	<i>No action; if so, those visits may be indicated for appropriate care</i>
	Allow use of strong narcotic for severe pain	<i>No action; proposed rules do not prohibit use of strong narcotic for severe pain.</i>
	Rules should take into account genetic characteristics of the patient in regard to the conversion of codeine to morphine or hydrocodone to hydromorphone	<i>No action; proposed rules do not prohibit the treating physician from making these kinds of determinations.</i>
1. 2	Remove levorphanol: more potent than morphine with longer half-life with euphoria as known side-effect	<i>Add a clarification - "unless there is a medical contraindication documented by the prescribing physician"</i>
1. (2) & 10	Add hydromorphone	<i>Accept; it was inadvertently left out of the list.</i>
1. 4	Break down into acute and chronic indications	<i>Clarify that these are rules for choice of narcotic whenever they are used and for prescribing for the acute use; add language to coordinate with rules for long-term use of opiates.</i>
1. 6	Who decides what is the "lowest clinically effective dose"	<i>Clarify that this decision is made by the treating physician</i>
1. 8	The requirement to use generics makes no sense except to lower costs	<i>No action; generics are already required by other state laws</i>
1. 11	One week trials are too short	<i>No action; this was recommended by the MSRB</i>

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 Comments Received and Actions Taken Re: Proposed Rules for Narcotic Analgesics

1. 13	Who decides that the pain has been reduced by >50%?	<i>Clarify that this decision is made by the treating physician</i>
1. 11-13	Eliminate “one-week” and “in reducing the patient’s pain by at least 50%”	<i>No action; a 50% reduction is the consensus standard used in the medical literature to assess analgesic efficacy</i>
1. 18 & 30	Change “indicated” to “authorized”	<i>No action; authorization is a payment concept; these rules address appropriate treatment</i>
1. 24	Two week prescriptions are more expensive than one month prescriptions; allow one month prescriptions and refills, and let the patient throw away what isn’t needed.	<i>No action; this is not medically appropriate</i>
1. 24 & 26	Delete “worth”	<i>Accept</i>
1. 27	Limiting narcotics to 3 consecutive months seems to go against accepted medical practice	<i>No action; the rule does not limit narcotics to 3 consecutive months; it merely references another set of rules that deal with that situation.</i>
1. 29	The PDR says that meperidine is an effective analgesic.	<i>No action; evidence review shows that the benefits are outweighed by the side-effects</i>
1. 32-33	Delete item D; transcutaneous administration is very effective at minimizing side-effects and providing a stable blood level.	<i>No action; there is no evidence that these delivery systems are more effective or safer than oral dosing in patients with normal gastrointestinal absorption</i>
1. 32-33	The treating physician should be able to use patches if they are considered more effective.	<i>No action; there is no evidence that these delivery systems are more effective or safer than oral dosing in patients with normal gastrointestinal absorption</i>
	Add a new part addressing trans-mucosal drugs such as Actiq and Fentora: they have no indications in treating workers’ compensation patients	<i>Add a new item restricting the use of oral transmucosal or buccal preparations to the treatment of breakthrough pain in patients with a documented disorder that prevents the use swallowed medication.</i>

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 Comments Received and Actions Taken Re: Proposed Rules for Narcotic Analgesics

Changes Recommended by the Department	
<p>Frame the proposed rule as a subpart of a new treatment parameter with an introductory paragraph:</p> <p>“Subparts --- to --- of this rule do not require a physician to prescribe any class of drugs in the treatment of any patient, but apply only when the physician has elected to prescribe from one of the specified classes of drugs for the symptomatic relief of musculoskeletal pain.”</p>	<i>Approved</i>
<p>Delete MR 5221.6200 subpart 10, 5221.6205 subpart 10, 5221.6210 subpart 10, 5221.6300 subpart 10: “Scheduled and nonscheduled medications”</p>	<i>Approved</i>
<p>1. 1 Add a definition:</p> <p>“An opioid is any agent that binds to opioid receptors. There are three broad classes of opioids: opium alkaloids, such as morphine and codeine; semi-synthetic opioids such as heroin and oxycodone; and fully synthetic opioids such as pethidine and methadone.”</p>	<i>Approved</i>
<p>1. 4 Change “treatment” to “symptomatic relief”</p>	<i>Approved</i>
Additional Actions Originating from Member Concerns Expressed at the Time of the Meet	
<p>Physicians are not the only health care providers that can prescribe medications</p>	<i>Change “physician” to “health care provider”</i>
<p>What constitutes a “medical contraindication”</p>	<i>Develop a definition for consideration by the Board</i>

Comments Received and Actions Taken Re: Proposed Rules for Long-term Use of Opioids

12/7/06 Draft	Comment	Actions taken
	These rules will cause providers to refuse wc patients	<i>No action; there is no evidence that other treatment parameters have had this effect</i>
	These rules assume that most injured workers abuse narcotics and their doctors are co-conspirators.	<i>No action; the rules do not make this assumption but rather reflect current medical standards for the use of long-term narcotics</i>
	These rules cannot be handled by pharmacy adjudication software.	<i>No action; these are not rules intended to be implemented through on-line adjudication of prescriptions.</i>
p. 1, l. 5	Defining long-term use on the basis of the physician's intention is vague; how is this identified?	<i>Clarify that this is documented by the treating physician in the medical record.</i>
p. 1, l. 8	Defining long-term as more than 3 months seems too short a time to justify these draconian rules	<i>Tabled for further discussion</i>
p. 1, l. 21	Requiring the patient to meet all of these criteria will allow the insurer to delay or deny treatment.	<i>Clarify that this is determined by the treating physician and the decision documented in the medical record</i>
p. 1, l. 23	Who decides this?	<i>Clarify that this is determined by the treating physician and the decision documented in the medical record</i>
p. 1, l. 25	Most injured workers are depressed; does this mean that everyone has to have a psychiatric evaluation?	<i>Clarify that this is determined by the treating physician and the decision documented in the medical record</i>
p. 1, l. 26	Who decides which specialist the patient sees?	<i>Clarify that this is determined by the treating physician and the decision documented in the medical record</i>
p. 1, l. 27	Require that the "physician specializing in chronic pain medicine" be Board-certified in pain management.	<i>No action; this could unnecessarily restrict access.</i>
p. 1, l. 29	Will the patient have to get testimonials from every physician they have ever seen to prove this? This would be a gross invasion of privacy.	<i>Clarify that this is determined by the treating physician and the decision documented in the medical record</i>
p. 1, l. 31	How is this determined?	<i>Clarify that this is determined by the treating physician and the decision documented in the medical record</i>
p. 1, l. 31	Delete; this is not a contraindication.	<i>Clarify this by adding a definition of abuse.</i>

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Comments Received and Actions Taken Re: Proposed Rules for Long-term Use of Opioids

p.1, l. 37 - 45	Delete; none of these are contraindications to treatment.	<i>No action– these are only POTENTIAL problems that should be considered by the treating physician prior to starting long-term opioid treatment</i>
p. 1, l. 39	This would eliminate all women between the ages of 18-55.	<i>No action recommended – this is only POTENTIAL problems that should be considered by the treating physician prior to starting long-term opioid treatment</i>
p. 1, l. 46	Does this require the treating physician to do lengthy evaluations and reports?	<i>Clarify that this is determined by the treating physician and the decision documented in the medical record</i>
p. 2, l. 1	This eliminates the treating physician’s discretion and places the decision in the hands of a consultant with less knowledge of the patient.	<i>No action recommended; it is standard medical practice to solicit a consultant’s opinion regarding care in complicated cases.</i>
p. 2, l. 13-45	This is an unreasonable burden.	<i>Tabled for further discussion</i>
p. 2, l. 20	Limiting prescriptions to 7 days is more costly than 30 day prescriptions.	<i>No action; rules do not limit the prescriptions to 7 days but to multiples of 7 days.</i>
p. 2, l. 22	This restricts the patient to a “Hobson’s” choice.	<i>Clarify that this is not meant to restrict the patient’s access to other modalities of treatment that are otherwise allowed</i>
p. 2, l. 27	This unnecessarily restricts the physician’s discretion and will lead to more ER visits	<i>No action; the physician has complete discretion in developing a plan to handle these situations</i>
p.2, l. 34	This will require documentation and if it is missing the insurer will deny treatment	<i>No action; the rule only requires that the physician documents that the discussion took place; this is similar to current procedures used in documenting consent to treatment.</i>
p.2, l. 39	Require the proxy designation in writing	<i>Clarify where the name of the proxy will be documented.</i>
p. 2, l 41-2	Allow an alternative pharmacy in emergencies if approved by the treating physician or proxy	<i>Accept; some departure is needed to address unusual circumstances</i>

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Comments Received and Actions Taken Re: Proposed Rules for Long-term Use of Opioids

p. 2, l. 44	This will require lengthy and burdensome documentation thus increasing costs.	<i>No action; the rule only requires that the physician documents that issue was considered; physicians treating workers' compensation patients are already required to write work restrictions.</i>
p. 2, l. 47	The written agreement must allow the physician to depart from the agreement whenever there are exigent circumstances	<i>No action; the treating physician and patient can enter into a new agreement if the condition changes.</i>
p. 2, l. 47	Item D should include random drug testing.	<i>No action; this is not part of the current medical standards for the use of long-term narcotics</i>
P. 3, l.4	Require that the written agreement be given to the dispensing pharmacy.	<i>No action; this would create an unnecessary burden on pharmacists</i>
p. 3, l. 16	This is completely unreasonable and assumes that an injured worker is lying.	<i>No action; the rules do not make this assumption but rather reflect current medical standards for the use of long-term narcotics</i>
p. 3, l. 18	This is completely unreasonable and assumes that an injured worker is lying.	<i>No action; the rules do not make this assumption but rather reflect current medical standards for the use of long-term narcotics</i>
p. 3, l. 24-29	This suggests that the provider wouldn't do this anyway and since it is vaguely written it will give the insurer reasons to deny treatment.	<i>Remove language that might be considered vague- "actively monitor treatment" and "to be vigilant for signs of addiction" – these requirements are spelled out elsewhere</i>
p. 3, l. 26	Add "or distribution to others"	<i>No action; physicians already have obligations in this regard</i>
p. 3, l. 27-29	What if the provider terminates treatment and the patient goes and gets narcotics from someone else, does the insurer have to pay?	<i>No action– This is a liability issue and outside of the authority of the TxParam.</i>
p. 3, l. 27-29	What if the provider terminates treatment and the patient has become dependent on the narcotics and medically-monitored withdrawal is necessary, does the insurer have to pay?	<i>No action– This is a liability issue and outside of the authority of the TxParam.</i>

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Comments Received and Actions Taken Re: Proposed Rules for Long-term Use of Opioids

p. 3, l. 32 -	Item E should include a requirement to report suspected diversion to the appropriate state agency.	<i>No action; a provider's obligations in this circumstance are governed by the licensing boards.</i>
p. 3, l. 37	Make follow-up monthly during the first year and no less than quarterly thereafter.	<i>No action; this would create an unnecessary burden</i>
p. 4, l. 7	Change to "Board-Certified Pain Medicine Specialist"	<i>No action; this could unnecessarily restrict access.</i>
	Add a new section specifying what happens to a provider who violates these rules	<i>No action; rules already exist for provider discipline.</i>
	Specify what an insurer can do if the rules are not followed	<i>No action; the insurer has the same options as they do for any other dispute about treatment</i>
	Add a section that forbids the use of trans-mucosal drugs	<i>No action; defer this to the rules regarding choice of opiate medications.</i>
	Changes Recommended by the Department:	
p. 1, l. 16	Change "oral narcotic medications and to transdermal narcotic" to "oral., oral transmucosal, buccal and transcutaneous narcotic medications"	<i>Approved</i>
p. 1, l. 18	Add language clarifying that the choice of narcotic medication used is governed by the rules on narcotic analgesics	<i>Approved</i>
p. 3, l. 28	Change "at any time" to "if"	<i>Approved</i>
p. 3	Add language to allow a new agreement, superseding any previous agreement, whenever it is deemed medically necessary by the treating provider.	<i>Approved</i>