

Medical Services Review Board

Jan. 16, 2014 minutes

Members present

Jeffrey Bonsell, D.C., chairman
Beth Baker, M.D.
Russell Gelfman, M.D.
Ernest Lampe, M.D.
Brennan McAlpin
Matthew Monsein, M.D.
Michael Goertz, M.D.
Reed Pollack
Kathi Henrickson, R.N. (by phone)
Gregory J. Hynan, D.C.

Member alternates present

Kimberly Olson, R.N.
Natalie Haefner
Margaret Spartz, M.D.
Robin Peterson (by phone)
Cally Theisen, M.D.
Aysel Atli, M.D.

Visitors present

Robert Leeman, Health Partners
Eric Huppert, Allina Health

Ceil Jung, SFM
Susan Giguere, MAPS
Anna Thompson, Medtronic
Tara Mulloy, HP
David C. Wulff, MNAJ
Buzz Cummins, SISF

Members absent

Andrew Schmidt, M.D.
Brian Konowalchuk, M.D.
Dan Wolfe, P.T., G.D.M.T.
Jody Ruppert, OTR/L
James Samuelson

Staff members present

Kris Eiden
Sandra Barnes
Kate Berger
Lisa Wichterman
Chris Leifeld

Call to order and introductions

The meeting of the Medical Services Review Board (MSRB) was called to order at 4 p.m. by Chairman Dr. Jeffrey Bonsell. A quorum was met.

Approval of the minutes

The minutes the Oct. 10, 2013, meeting were presented for approval. Margaret Spartz moved to approve them. Kimberly Olson seconded the motion. The board voted unanimously to approve the minutes. We need to have a roll call vote because we have members on the phone; we have that passed.

Meeting agenda

There were no additions to the agenda. Reed Pollack moved to approve the agenda; Dr. Beth Baker seconded the motion. We need to have a roll call vote because there are members on the phone. The board unanimously approved.

Announcements and update

Deputy Commissioner Kris Eiden

- Introduced Natalie Haefner, a new member of the MSRB.
- Introduced Anita Hess, who will be providing support.
- The *Medical Cost Reimbursement Study* was distributed. Members should contact Kris with any feedback.

Business

Rulemaking Update: Dr. Bill Lohman

- Regarding IDDS and spinal cord stimulators, they are in the process of completing the SONAR.

Draft rules for chronic pain management, dated Dec. 5, 2013: Dr. Bill Lohman

- Additions and changes to the rule from the most recent board meeting are in red. The board reviewed the public comments and the recommendations.

Agreed to suspend the rules and consider each proposed change as a motion made and seconded.

Motion by Dr. Michael Goertz; Baker seconded the motion. (See table below for the comments reviewed and the decisions made by the board.)

Comment	Board decision
Add a requirement that the patient complete a "multidimensional validated opioid risk assessment tool" to "determine ... appropriateness of long-term opioid management"	<i>No further action needed</i>
Add a requirement that patients at high risk have more frequent and stringent monitoring	<i>No further action needed</i>
Add a requirement that for patients at high risk, co-management with addiction specialist be considered	<i>No further action needed</i>
Add a requirement for thorough history and physical at initiation and at regular intervals	<i>No action</i>
Add a requirement that the patient's family be involved in an on-going educational process regarding long-term opioid use and alternative or adjunctive non-opioid therapy options, which includes both verbal discussions with the prescribing health care provider and written education material	<i>No action</i>
Doses of opioids in excess of 120 mg morphine equivalent should be considered a general limit, require close monitoring and documentation of clinically meaningful improvement (or sustained improvement) in pain and function	<i>No further action needed</i>
Doses of opioids in excess of 200 mg morphine equivalent a day should be avoided	<i>No action</i>
Due to addiction potential, withdrawal symptoms and sedating side effects, benzodiazepines and other similar drugs found in this class are not generally recommended	<i>No action</i>
Add a requirement that the patient refrain from drinking alcohol	<i>No action</i>
Require random urine drug-testing once a year for low-risk patients, twice a year for moderate-risk patients, and three to four times a year for high-risk patients and patients receiving more than 120 MEQ a day	<i>Patients taking > 120 MEQ should have drug testing at the same frequency as high-risk patients (twice a year)</i>

Require urine drug-testing whenever patient exhibits aberrant behavior	<i>No further action needed</i>
Unacceptable results from urine drug-screening may include: 1) negative for opioids prescribed; 2) positive for amphetamine or methamphetamine; 3) positive for cocaine or metabolites; 4) positive for drugs not prescribed; 5) positive for alcohol; or 6) positive for illegal substances	<i>No further action needed</i>
The prescribing physician must document in the medical record, plans for addressing non-adherent behaviors	<i>No further action needed</i>
In cases of incipient or actual dependency, the prescribing physician shall refer the employee for an appropriate evaluation and treatment of the dependency per 5221.6050, subp 4	<i>No further action needed</i>
Require at least semi-annual follow-up	<i>Patients taking > 120 MEQ should have follow-up at the same frequency as high-risk patients (at least quarterly)</i>
At each follow-up, require assessment of pain control and improvement in physical, emotional and/or social functioning	<i>No further action needed</i>
Require evaluation function using objective documentation, such as physical therapy progress notes, employment records, exercise diaries, family reports, clinician observations, or validated instruments or rating scales, every six months after the patient is on stable opioid dosing	<i>No further action needed</i>
Require documentation of daily dosage of all controlled substances prescribed	<i>Require office notes identify the drug prescribed, the dose, the dosing schedule and the number of pills dispensed</i>
Add: "Weaning or discontinuance of opioids is recommended when it is found they are not contributing significantly to improving pain control or functionality"	<i>No further action needed</i>
Change to require review of the Minnesota Prescription Monitoring Program whenever urine drug-testing is done	<i>Require review of patients taking > 120 MEQ at the same frequency as high-risk patients (at every follow-up visit)</i>
Require follow-up at least semi-annually; many other jurisdictions require semi-annual follow-up; annual follow-up contradicts 5221.6105 subp. 3C(3)	<i>Tabled (issues already discussed and decided)</i>
Require urine drug-testing at least annually	<i>Tabled (issues already discussed and decided)</i>
Should these rules apply to patients already on long-term opiates when they are adopted?	<i>Require patients already on long-term opiate treatment meet the following requirements within three months of the effective date of these rules: maintenance of pain relief and function; monitoring of treatment; treatment agreement; and specialist referral for patients taking > 120 MEQ</i>
Require an objective test to determine if there is any psychiatric disorder prior to treatment	<i>No action</i>

Change "health care provider" to "licensed physician"	<i>No action</i>
Require that patients have been seen by both a pain medicine specialist and by a specialist in the area, system or organ of the body identified by the source of the pain prior to starting treatment	<i>No action</i>
Limit judicial discretion	<i>Tabled (rules cannot limit judicial discretion)</i>
Require the provider to document "an appropriate history and physical"	<i>Tabled (issues already discussed and decided)</i>
Require the provider to document a "discussion of risks, benefits, informed consent, rules for safe use"	<i>No action</i>
Add a definition of "safety sensitive"	<i>Delete requirement for referral of patients in safety-sensitive jobs</i>
Define "safety sensitive" as "a position subject to drug and alcohol testing because the nature of the employee's duties and responsibilities indicate there is a potential that impaired performance due to drugs or alcohol or both could result in injury or death to the employee or others"	<i>Delete requirement for referral of patients in safety-sensitive jobs</i>
Require that urine drug-testing be random	<i>Tabled (issues already discussed and decided)</i>
Specify the goals of treatment incorporate improvement in pain and function	<i>No action</i>
Specify the 120 MEQ threshold applies to adult patients	<i>No action</i>

Adjournment

Dr. Matthew Monsein moved to adjourn the meeting. Goertz seconded the motion. The meeting was adjourned.

Next meeting: April 17, 2014