443 Lafayette Road N.
St. Paul, Minnesota 55155
www.dli.mn.gov

MINNESOTA DEPARTMENT OF LABOR & INDUSTRY

(651) 284-5005
1-800-DIAL-DLI
TTY: (651) 297-4198

Special Meeting of the
Medical Services Review Board
February 12, 2009
Minutes

Members Present:

Beth Baker, M.D.
Barbara Baum, MS PT
Jeffrey Bonsell, D.C.
Glenda Cartney
Michael Goertz, M.D.
Charles Hipp, M.D.
Gregory Hynan, D.C.
Reed Pollack
Elizabeth Shogren, R.N.

Members Excused:

Philip Bachman, M.D.
Barbara Gibson, M.D.
Rose Hatmaker
Kathi Hendrickson, R.N.
Robin Peterson, PT
Andrew Schmidt, M.D.
Jon Talsness, M.D.
Andrea Trimble Hart

Staff:

Kate Berger
Julie Klejewski
William Lohman, M.D.
Patricia Todd
Lisa Wichterman
Jana Williams

Visitors:

Lisa Eckroth, Purdue

The meeting was called to order by Chairperson Beth Baker at 5:05 p.m. A quorum was present. Members and staff introduced themselves. Glenda Cartney was introduced as a new member and will serve as the labor alternate.

A special meeting of the MSRB was called to review comments and recommendations on the proposed rules for amendments to the Treatment Parameters. The Board unanimously agreed to vote either yes or no on each comment on the grid without going through motion or second.

Approval of the October 23, 2008, Minutes

Barbara Baum made a motion to approve the October 23, 2008, minutes as presented. Charles Hipp seconded the motion. All voted in favor of the motion.

Proposed Rules for Amendments to Treatment Parameters

Discussion on the status of treatment parameter rules at the revisor. Some of the new rules for the treatment parameters have been sent to the revisor. The rules discussed at this meeting have not been sent yet as the MSRB needed to vote on these particular rules. The Sonar is in the process of being drafted. The comments received and actions taken are listed in the table below.

MSRB Meeting 02-12-09
Comments Received and Recommendations and Actions Taken Re: Proposed Rules for Amendments to Treatment Parameters

11-18-08 Draft	Comment	Recommendations and Actions Taken
p. 6 (B1, B2)	Remove diclofenac and replace with etodolac and nabumetone. Diclofenac has a higher incidence of cardiovascular toxicity relative to other nonselective NSAIDs.[1]	*Remove diclofenac as an initial option. Two high quality studies are offered with the comment. The first, a systematic review (BMJ), shows that ibuprofen and diclofenac have equivalent CV risk among all patients. The second, a national registry study with > 58,000 patients (Circulation), shows that diclofenac has an approximately 50% higher CV risk in post-MI patients. Given the prevalence of cardiovascular disease in Minnesota and the fact that two inexpensive and widely available options would remain, diclofenac should be relegated to a second line agent. There is no evidence that etodolac and nabumetone have a lower CV risk than naproxen or ibuprofen warranting their inclusion as a first line agent. Moreover, they are much more expensive that ibuprofen and naproxen. They would be available under B(1) for patients with contraindications to ibuprofen and naproxen and B(2) for patients who failed ibuprofen and naproxen .* **Board vote:** All in favor of recommendation

[1] Kearney PM, Baigent C, Godwin J, Halls H, Emberson JR, Patrono C "Do selective cyclo-oxygenase-2 inhibitors and traditional non-steroidal anti-inflammatory drugs increase the risk of atherothrombosis? Meta-analysis of randomised trials" *BMJ* 2006; 332: 1302-1308
Gislason GH, Jacobsen S, Rasmussen JN, Rasmussen S, Buch P, Friberg J, Schramm TK, Abildstrom SZ, Køber L, Madsen M, Torp-Pedersen C "Risk of Death or Reinfarction Associated With the Use of Selective Cyclooxygenase-2 Inhibitors and Nonselective Nonsteroidal Antiinflammatory Drugs After Acute Myocardial Infarction" *Circulation* 2006; 113: 2906-2913

p. 6 (C3)	As written, the statement is broadly worded enough to allow virtually any manner of dyspepsia to justify use of Celebrex. Patients not falling into categories one or two should undergo a documented "step-therapy" (specifically, to include requiring use of a gastroprotective agent with a non-selective NSAID) before use of Celebrex is approved.	*No action. Nothing prevents a treating physician from adopting the step approach recommended in the comment. However, a step approach may not always be appropriate: one agent (COX-2 inhibitor) may be preferable to two agents (non-selective NSAID plus gastroprotective agent) in situations where compliance with treatment may be an issue.* **Board vote:** All in favor of recommendation
p. 7 (D3)	This disallows use of a mail-order system for the first year after injury. We recommend changing the stipulation to "more than six (6) months after the date-of-injury (DOI)."	*No action. The need for NSAID medication may not be stable in the first year of treatment. Since generic NSAIDS are relatively inexpensive, the additional savings from mail order systems are probably slight in those cases in which NSAIDs are used continuously in months 6 through 12.* **Board vote:** All in favor of recommendation
p. 8 (B2)	We recommend removing the requirement to complete a 1-week trial with codeine before use of more potent, generic opioids.	*Remove codeine from subitem 2. The equianalgesic dose of codeine comparable to the usual doses of the other opioids listed is quite high and it would be inappropriate to require a trial of codeine when hydrocodone, oxycodone and morphine has failed.* **Board vote:** All in favor of recommendation
p. 8 (D)	Also ban the use of propoxyphene. Propoxyphene is associated with more addiction and renal toxicity than other opioids in the elderly.	*No action. While the concern for elderly patients is significant, the elderly make up a small proportion of patients in the wc system. Banning this agent in all wc patients is not justified. In any case, propoxyphene is not one of the agents that can be initially chosen in B(1) and only if the other options failed could propoxyphene be prescribed. This is unlikely given the relative potencies.* **Board vote:** All in favor of recommendation

P. 8 (E)	Do not restrict the use of transcutaneous opioids. In chronic conditions, it [transcutaneous preparation] is useful to ensure a baseline control of pain. Such use enhances patient compliance. Patients who wait until they are experiencing pain to use an opioid analgesic frequently use more opioid milligrams than those who maintain a baseline of control and respond appropriately with breakthrough management. Further, anything done to encourage the use of oral agents (e.g., Oxycontin) which are more easily abused should be discouraged.	*No action. Patients on properly developed oral dosing regimens do not have to "wait for pain to develop" to take their medications. Conversely, even patients on transdermal preparations will have breakthrough pain requiring oral medication. Since oral dosing can provide equivalent pain relief at lower cost, transdermal preparation should be reserved for those patients who have a disorder that prevents adequate oral dosing.* **Board vote:** All in favor of recommendation
p. 9 (F)	Do not allow any use of transmucosal or buccal preparations.	*No action. It is possible that these medications will be needed on a rare basis for patients with noncancer pain who cannot swallow medication or reliably retain swallowed medication. The rules must accommodate rare circumstances and identify when they occur.* **Board vote:** All in favor of recommendation
p. 9 (Subp 4)	Remove carisoprodol and include baclofen. Carisoprodol has higher abuse potential, relative to other muscle relaxants. Baclofen (oral and intrathecal) is the mainstay of treatment for patients who experience spasticity due to such conditions as multiple sclerosis or spinal cord injury.	*No action. The abuse potential of carisoprodol is well known and the time limits on the use of muscle relaxants in C minimize the risk. Subpart 4 explicitly excludes anti-spasmodics, such as baclofen, from these rules. These rules would not limit a treating physician's use of baclofen in lieu of a muscle relaxant. Rules for anti-spasmodics could be developed using the MSRB's evidence-based approach in a round of recommendations at a later date.* **Board vote:** All in favor of recommendation
Changes Recommended by the Department:		
p. 5 (Subp 1)	Limit these rules to the outpatient use of these medications.	*The rules were developed in the context of the outpatient prescription of NSAIDs, opioids, and muscle relaxants. Application of these rules could lead to inappropriate limitations on treatment in an inpatient setting.* **Board vote:** All in favor of recommendation

p. 10 (C2)	Change "one week's worth" to 'one month's worth"	*This corrects a transcription error.* **Board vote:** All in favor of recommendation

New Business

There was positive discussion on telephonic meeting appearance with web access. Both MSRB members and the audience could appear telephonically and view the meeting documents on the web. One board member would be required to physically attend the meeting.

Meeting Conclusion

Members discussed what work they want to prioritize in the next year.

Motion to adjourn by Charles Hipp and seconded by Reed Pollack. All voted in favor. Meeting adjourned at 6:28 p.m.

Respectfully submitted,

Lisa Wichterman

Lisa Wichterman