WSIA Liaison Meeting Agenda

DATE:	**September 11, 2017**	**LOCATION:**	**TC304A&B**
TIME:	**9:00am-12:00pm**	**FACILITATOR:**	**Jim Nylander**

Attendees: ☐ Kris Tefft, ☐ Lisa Vivian, ☐Patrick Reiman, ☐ Glenn Hansen, ☐ Jim Nylander, ☐ Brian Schmidlkofer, ☐LaNae Lien, ☐ Gina Mayo, ☐ Mike Ratko, ☐ Simone Javaher

Time	Subject	Discussion Leader
9:00-9:05	**Safety Tip** – Handout	Jim
9:05-10:30	**WSIA Topics** • Medical EDI Status – any issues, how L&I to use date (Patrick) • L&I Metrics (Patrick) • Wage Matrix – where is it on L&I site? (Patrick) • ER Counsel CAC access (Patrick) • Response times from the Claims section (Kris) • Adjudicators following the RCW's and WAC's (Kris) • Time Frames (Kris) • Interlocutory process and how it should be handled (Kris)	Jim/LaNae/Brian
10:30-11:30	**SI Updates** • OMD Policy Updates • Tier 2 and Tier 3 Updates • Rules Review Workgroup Update • Claims Performance Measures • New Certs • New Hires	Simone Brian Mike/Jim LaNae Brian LaNae/Brian
11:30-12:00	**Round Table**	All

NOTE:

WSIA Liaison Committee Report

Glenn Hansen, WC Manager, Multicare Health System
Patrick Reiman, Director Claims, Sedgwick
Sept. 11, 2017

The Liaison Committee met with representatives from the Department of Labor & Industries on Sept. 11, 2017. Present for the meeting in whole or part of meeting from the Department were Jim Nylander, LaNae Lien, Mike Ratko, Gina Mayo and Simone Javaher. Present from WSIA were Kris Tefft, Lisa Vivian (by phone), Glenn Hansen (by phone) and Patrick Reiman.

As your representatives for the WSIA Liaison Committee we can provide assistance in resolving claim management issues, policy or procedure concerns or specific individual claim related issues through our bi-monthly meetings with the L&I representatives.

Please contact S-I Employer Representative Glenn Hansen, Self-Insured Employer Representative 253-459-6803 or email at glenn.hansen@multicare.org or TPA Representative Pat Reiman at 206-214-2813 or email at patrick.reiman@sedgwickcms.com with any issues you would like discussed during our next scheduled meeting in November.

GENERAL

Handout on school zones and kids-see attached.

WSIA ITEMS

Medical EDI

Approximately 9 SIE yet to register, approximately 25% reporting and balance in some phase of testing. Daniel Brittan (sic) will be moving to new position/department. DOI has been removed as an error field. Pat inquired about one combined medical EDI and SIEDRS report. Feedback was two different systems and commonality of data limited to DOI, Claim No. and Account Number. Ginny Klapstein has good knowledge of both SIEDRS and Medical EDI. Discussion around use of data and will be utilized to stimulate investigation if risk threshold categories yellow or red. Reports will be on CAC eventually for SIE to view. We asked L&I to republish risk categories. Also as goes to data warehouse now should have all WA data not just State Fund for cross comparison / benchmarking with other states. An overview of medical EDI will be provided in the Nov. colloquium. Glenn inquired on if potential use for provider education on improper billing such as bundle/unbundled issues. Karen Jost to work with providers, but if billing error shouldn't be passed into medical EDI until proper billing received from provider.

Wage Matrix

Wage matrix developed during Tier 1 of audit Is not published on L&I site. Looking to incorporate into claim adjudication guide. Claims team also needs brought into loop on matrix discussed items on wage calculation.

ER Attorney CAC access

Project has passed security group. Now in programming estimate phase and should have update by next meeting. CAC programming usually quicker to change than some other areas of programming.

LNI Service

Examples from community shared. On file copy request from L&I feel may be isolated incident or timing issue with other things happening on particular request, but L&I will document in writing specific process and time frames for their support staff as not in place per LaNae's follow up. Also discussed should a cover sheet be developed for these.

On interlocutory process this group had previously worked out timeframes in 2015 so as to be consistent within SI L&I team-see attached. Admitted on occasion exceptions take place. The document/policy will be updated and considered to incorporate in adjudication guidelines. Chemical claims present their own unique challenges in this area. L&I has looked at variances to established process.

On customer service issues reminder to escalate to supervisor and/or team lead then LaNae or Brian. L&I looking at upgrades to phone system to track call timeliness. SI section on study did have high positive result on calls being answered on central number, question becomes transferred or direct number calls.

Adjudicator error in reply on period of time for physician to reply to concurrence vs. WAC acknowledged.

Discussed review of claims performance measures and new goals / stretch goals as possibility with WSIA / SI section.

SFT File Material to LNI

LaNae shared message to go to community once confirms all working well with new pilot on large SIE and open up on first come/first serve basis. Anticipate couple weeks.

Surety Improvement Project

Modeling being done.

Second Injury Fund Assessments

Rates not available yet. Discount rate being lowered by 1/10%. Challenge is unable to borrow from other funds for this and close to zero balance 3Q2016 so would need emergency assessment which trying to avoid and bring more stable rates to the assessment.

SELF-INSURANCE UPDATE

OMD Policy Updates

See handout from Simone on Occupational Health Best Practices which was developed for updates to the community and discussion held. Also Simone provided payment policy on acupuncture pilot which SIE may participate in, but are not required to do so (see handout). Pat asked as look at SIMP could data tell us if less use of SIMP due to opioid tightening. New attending physician handbook will have links to resources and a

general question area if feel clarity needed or not covered area in handbook. Glenn inquired on migraines and pension cases/post pension treatment-see attachment.

Audit

Formal report/update to be provided when Brian returns. Tier 2 completed on approximately 120 SIE. Determined 80% as pass/fail threshold. If 70-80% then move to performance improvement plan with standardized document to be provided by L&I. If minimal files subject to review may be voluntary improvement plan requested. 6 SIE to Tier 3 which will look at all benefits delivered. Unsure when letters will go out to Tier 3 or those whom need performance improvement plan. Hope to have Tier 3 done by year end.

Penalty issues in abeyance as didn't allow SIE response input prior to issuance like normal penalty. Misstep in understanding by penalty team and thought review limited to just findings of timeliness without consideration as to why may have not been timely i.e. SIE response to penalty.

Rules Review Committee

Claim allowance and closure authority seem to be sticking point. Mike R. still optimistic progress will be made. Jim N. talked about focus on items between allowance and closure and L&I being involved only if dispute resolution. All agree hard to modernize within existing RCW/WAC but trying to lay groundwork for changes. Move to communication vs. legal order system. 9/29 is next meeting.

SI-CAMS

Pleased metrics didn't fall during summer months. See hand out. SI-CAMS has helped with consistency on timeliness at SI Adjudicator desk level.

Staffing

Lost Nate from Unit I. Will provide updated contact list. Melissa Dier moving to operations from training and Melinda Bonson may be returning to training. Interviewing for Mgmt Analysis to replace Daniel Brittan

Certifications/Surrenders

Hobby Lobby and Tractor Supply 4/1, none 7/1, General Dynamics 10/1.

PROCEDURE 4.01

SELF-INSURANCE

Section: Claims **Effective: 7/16/15**
Title: Interlocutory Request
Created: 7/6/15 **Updated:**
Reference: WAC 296-15-420 (2) How must a self-insurer request an interlocutory order?

This procedure applies when an employer requests an extension for additional time to investigate the validity of a claim. The interlocutory period will follow the 60 calendar days the self-insured employer is given after the notice of claim (generally SIF-2 or PIR) to allow, deny, or request and interlocutory order.

The process provides for a standard 30 day extension confirmed by a department interlocutory order starting from the 60 calendar day notice of claim arrival regardless when the request was made. An additional extension of 30 calendar days may be given with good cause. The maxium review period is 120 calendar days from the notice of the claim.

For occupational disease the self-insured employer is provided the standard 30 calendar days starting from the 60 calendar day notice of claim arrival and an additional 30 calendar day extension with good cause. Plus, a further 30 calendar day extension with good cause for a total of 150 calendar days from the notice of claim.

If no request for allowance or denial is made by the self-insured employer, then the department may make a decision based on the information in the claim, or may determine if more information is still needed, and if so, may intervene to adjudicate the claim and obtain necessary information.

ACTION BY	**ACTION**
Claims Initiation Staff	Receives interlocutory request from TPA or SIE via SIF5. • Initiates claim. • Creates interlocutory work item and forwards to WCA 1.
WCA 1	Review interlocutory work item for timeliness. • If not timely, review to determine if medical supports allowance. o If medical supports, issue allowance order. ▪ Send letter with explanation for allowance to SIE/TPA. o If medical does not support, issue IE letter and assign a 10 business day deadline. Set SICAM work item review date to 3-4 business days after deadline. Forward SICAM work item to WCA 3. • If timely, review for reasonable explanation. o If reasonable explanation provided, issue interlocutory order and send AH letter to TPA or SIE with deadline of 60 calendar days after the notice of claim (generally SIF-2 or PIR). Set SICAM work item review date to 3-4 business days after deadline. Forward SICAM work item to WCA 3. o If no reasonable explanation provided, review for medical support. ▪ If medical supports claim allowance, issue allowance order. Send letter with explanation for allowance to SIE/TPA. ▪ If medical does not support claim allowance and notice of claim is within 60 calendar days, send IN letter with request for the specific information needed. Set SICAM work item

	review date for 2-3 business days after department receipt deadline. • If more than 60 calendar days have passed since receipt of notice, send IE letter to TPA and request a response within 10 business days. Set SICAM work item review date for 2-3 business days after department receipt deadline. Forward SICAM work item to WCA 3.
WCA 3	Receives and review interlocutory work item from WCA 1. Adheres to deadlines established by procedure. • At date of review, if no response has been received from SIE/TPA, issues IE letter. o If no response to IE letter, allow claim. • If SIE/TPA responds with supporting information, allow claim. • If SIE/TPA requests an extension, grant or deny based on good cause. Extensions are an additional 30 calendar days following the 60 calendar days initially allowed from notice of claim. Send AJ letter to SIE/TPA. Resets SICAM work item review for 2-3 business days after department receipt deadline. • If injury claim, SIE/TPA is eligible for one additional 30 calendar day extension (maximum interlocutory period of 120 calendar days). If occupational disease claim, SIE/TPA is eligible for two additional 30 calendar day extensions (maximum interlocutory period of 150 calendar days). • Upon review of last extension, adjudicates claim based on medical provided.

Advisors: Gabe Baez, Melinda Bonson, Neal Boyer, Tina Delatorre, LaTrisha Gallegos, Christina Gonzalez, Trisha Green, Julie Hill-Craig, Corinna Triance
Manager: LaNae Lien
Author: Bill Bailey

Program Manager: Jim Nylander
SharePoint Administrator: Bill Bailey

Washington State Health Care Authority

Health Technology Clinical Committee
Findings and Decision

Topic: Treatment of chronic migraine and chronic tension-type headache
Meeting date: May 19, 2017
Final adoption: July 14, 2017

Meeting materials and transcript are available on the HTA website:
www.hca.wa.gov/about-hca/health-technology-assessment/meetings-and-materials

Number and coverage topic:

20170519B - Treatment of chronic migraine and chronic tension-type headache

HTCC coverage determination:

Treatment of chronic migraine with OnabotulinumtoxinA is a **covered benefit with conditions**.

Treatment of chronic tension-type headache with OnabotulinumtoxinA is **not a covered benefit**.

Treatment of chronic migraine or chronic tension-type headache with acupuncture, massage, trigger point injections, transcranial magnetic stimulation, or manipulation/manual therapy is **not a covered benefit.**

HTCC reimbursement determination:

Limitations of coverage:

For treatment of chronic migraine (as defined by the International Headache Society), OnabotulinumtoxinA is covered when the following criteria are met:

1) Has not responded to at least three prior pharmacological prophylaxis therapies from two different classes of drugs AND
2) Condition is appropriately managed for medication overuse

OnabotulinumtoxinA injections **must be discontinued** when the condition:

1) Has shown inadequate response to treatment (defined as <50% reduction in headache days per month after two treatment cycles) OR
2) Has changed to episodic migraine (defined as <15 headache days per month) for three consecutive months.

Maximum of five treatment cycles. Additional treatment cycles may be considered at agency discretion.

Non-covered indicators:

NA

Agency contact information:

Agency	Phone Number
Labor and Industries	1-800-547-8367
Public Employees Health Plan	1-800-200-1004
Washington State Medicaid	1-800-562-3022

HTCC coverage vote and formal action:

Committee decision

Based on the deliberations of key health outcomes the committee decided that it had the most complete information: a comprehensive and current evidence report, public comments, and state agency utilization information. The committee also determined that current evidence is sufficient to make a determination on this topic.

The committee concluded that the current evidence on treatment of chronic migraine and chronic tension headaches should be considered and voted on separately. The committee discussed and voted separately on the evidence for use of OnabotulinumtoxinA injections; massage, trigger point injections, manipulation, and transcranial magnetic stimulation; and acupuncture treatment for chronic migraine and chronic tension headaches. The committee considered the evidence and gave greatest weight to the evidence it determined, based on objective factors, to be the most valid and reliable.

Based on these findings, the committee voted to cover with conditions OnabotulinumtoxinA injections for chronic migraine.

Separately, the committee voted to not cover:

- OnabotulinumtoxinA injections for chronic tension headaches;
- Massage, trigger point injections, manipulation, and transcranial magnetic stimulation for chronic migraines and chronic tension headaches; and
- Acupuncture for chronic migraine and for chronic tension headaches.

	Not covered	Covered under certain conditions	Covered unconditionally
OnabotulinumtoxinA injections for chronic migraine	1	8	0
OnabotulinumtoxinA injections for chronic tension headaches	9	0	0
Massage, trigger point injections, manipulation, and transcranial magnetic stimulation for chronic migraine	9	0	0
Massage, trigger point injections, manipulation, and transcranial magnetic stimulation for chronic tension headaches	9	0	0
Acupuncture for chronic migraine and chronic tension headache	7	2	0

Discussion

The committee reviewed and discussed the available studies of treatment of chronic migraines. Details of study design, inclusion criteria and other factors affecting study quality were examined. A majority of committee members found the evidence sufficient to determine that select treatment for chronic migraine were equivalent for safety and equivalent for effectiveness compared to alternatives for some conditions, and more in some cases for cost-effectiveness. Based on the information reviewed and considered the committee identified conditions for coverage. A majority of the committee voted to cover OnabotulinumtoxinA injections for chronic migraine with conditions.

Limitations

OnabotulinumtoxinA injections are a covered benefit with conditions in adults with chronic migraine (defined as headaches on ≥15 days per month of which ≥8 days are with migraine) if:

1) They have not responded to at least three prior pharmacological prophylaxis therapies from two different classes of drugs AND
2) Their condition is appropriately managed for medication overuse

OnabotulinumtoxinA injections must be discontinued in people whose condition:

1) Has shown inadequate response to treatment (defined as <50% reduction in headache days per month after two treatment cycles) OR
2) Has changed to episodic migraine (defined as <15 headache days per month) for three consecutive months.

Maximum of five treatment cycles.

Action

The committee checked for availability of a Medicare national coverage decision (NCD). Medicare does not have a NCD for treatment of migraines and chronic tension headaches.

The committee discussed clinical guidelines identified for chronic migraine and chronic tension headaches treatment from the following organizations:

- Diagnosis and management of headaches in young people and adult; National Institute for Health and Care Excellence (NICE) 2012.
- Botulinum toxin type A for the prevention of headaches in adults with chronic migraine; National Institute for Health and Care Excellence (NICE) 2012.
- Practice guideline update summary: botulinum neurotoxin for the treatment of blepharospasm, cervical dystonia, adult spasticity, and headache; American Academy of Neurosurgeons (AAN) 2016.
- Guideline for Primary Care Management of Headache in Adults; Towards Optimized Practice (TOP) 2016.

The committee's determinations are consistent with these guidelines.

The committee chair directed HTA staff to prepare a findings and decision document on selected treatment of varicose veins for public comment; followed by consideration for final approval at the next public meeting.

Health Technology Clinical Committee Authority:

Washington State's legislature believes it is important to use a science-based, clinician-centered approach for difficult and important health care benefit decisions. Pursuant to chapter 70.14 RCW, the legislature has directed the Washington State Health Care Authority (HCA), through its Health Technology Assessment (HTA) program, to engage in an evaluation process that gathers and assesses the quality of the latest medical evidence using a scientific research company and that takes public input at all stages.

Pursuant to RCW 70.14.110 a Health Technology Clinical Committee (HTCC), composed of eleven independent health care professionals, reviews all the information and renders a decision at an open public meeting. The Washington State HTCC determines how selected health technologies are covered by several state agencies (RCW 70.14.080-140). These technologies may include medical or surgical devices and procedures, medical equipment, and diagnostic tests. HTCC bases its decisions on evidence of the technology's safety, efficacy, and cost effectiveness. Participating state agencies are required to comply with the decisions of the HTCC. HTCC decisions may be re-reviewed at the determination of the HCA Administrator.

Payment for Acupuncture Services During the Pilot

Definitions

CPT® and HCPCS code modifiers and Local Codes mentioned:
–25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.
1582M Needle acupuncture; must include 30 minutes of direct patient care, may include electroacupuncture, all visit costs including needles are bundled. Billable only once per day with a maximum of 10 visits per claim regardless of provider.

Prior Authorization

Acupuncture does not require prior authorization.
The following requirements must be met:

- Documentation of the referral from the attending provider must appear in the claim file, *and*
- The treatment provided must be for low back pain and related to an accepted condition, *and*
- The claim must be allowed and open.

Who may perform acupuncture services to qualify for payment

Providers who perform acupuncture within their scope of practice must have an approved L&I provider number specifically for acupuncture.
Providers must agree to the terms of the pilot via the acupuncture supplemental application and be accepted into the pilot by L&I and comply with the terms of the pilot.

Services that can be billed

L&I allows for billing of acupuncture and electroacupuncture during this pilot. No other modalities are authorized. All types of acupuncture are billed under billing code **1582M**.
The maximum fee for **1582M** is **$107.78**.

Requirements for billing

Providers must maintain documentation in each workers' medical records and chart notes must be submitted with each bill to document the treatment. See Medical Aid Rules and Fee Schedule (MARFS) Chapter 2: Information for All Providers for documentation requirements.
If billing for Evaluation and management (E/M) visits a narrative report must be submitted per the description and level of the visit as described in Current Procedural Terminology (CPT).
Modifier -25 must be appended to an E/M code when reported with another procedure on the same date of service.
The E/M visit and procedure must be documented separately.
To be paid, **modifier -25** must be reported in the following circumstances:

- Same patient, same day encounter, and
- Same or separate visit, and
- Same provider, and
- Patient condition required a significant separately identifiable E/M service above and beyond the usual pre and post care related to the procedure or service.

Scheduling back-to-back appointments doesn't meet the criteria for using **modifier -25**.
See MARFS Chapter 10: Evaluation and Management (E/M) Services for more information about billing E/M codes including documentation guidelines.

Payment limits

A treatment visit within this pilot is billed under code **1582M**. This visit must include needle acupuncture. Billing for **1582M** is limited to a total of 10 visits per claim regardless of which provider has billed. **1582M** is only payable once per day.

CPT codes **97810, 97811, 97813,** and **97814** are not payable.

An E/M visit must be documented in the narrative of the office visit and is paid based upon the requirements described in the CPT.

Work Item	Target	September	October	November	December	January	February	March	April	May	June	July	August
Allowance													
In (Newly Received)		171	164	68	143	#REF!	531	829	706	736	743	574	729
Out (Completed During Month)		563	704	500	987	#REF!	972	1190	708	770	748	642	755
Completed within 30 days		106	268	68	122	#REF!	804	1160	692	762	731	633	747
Issued within 30 days percentage	98%	19%	38%	14%	12%	#REF!	83%	97%	98%	99%	98%	98%	99%
Average days to complete		45	42	60	57	#REF!	22	9	7	6	5	6	7
Pending		245	27	97	302	#REF!	183	70	25	28	20	20	85
Denial													
In (Newly Received)		373	381	374	366	#REF!	427	552	416	396	420	291	421
Out (Completed During Month)		364	575	407	353	#REF!	480	567	401	426	413	320	443
Completed within 30 days		334	479	389	340	#REF!	473	555	397	418	402	311	435
Issued within 30 days percentage	98%	92%	83%	96%	96%	#REF!	99%	98%	99%	98%	97%	97%	98%
Average days to complete		13	17	10	10	#REF!	8	8	6	7	7	7	6
Pending		182	61	50	99	#REF!	78	73	63	34	65	50	65
Closure PPD													
In (Newly Received)		194	185	191	196	#REF!	230	272	215	215	263	222	195
Out (Completed During Month)		285	221	219	219	#REF!	238	323	256	245	212	278	253
Completed within 60 days		253	187	198	200	#REF!	227	291	240	235	195	260	233
Issued within 60 days percentage	90%	89%	85%	90%	91%	#REF!	95%	90%	94%	96%	92%	94%	92%
Average days to complete		30	29	27	26	#REF!	22	25	22	20	22	20	22
Pending		132	128	132	149	#REF!	199	146	128	142	193	152	121
Closure TC/NC													
In (Newly Received)		435	443	471	458	#REF!	602	650	561	645	680	484	493
Out (Completed During Month)		596	629	618	587	#REF!	618	868	729	628	703	639	629
Completed within 60 days		486	508	545	487	#REF!	512	721	646	549	602	570	570
Issued within 60 days percentage	90%	82%	81%	88%	83%	#REF!	83%	83%	89%	87%	86%	90%	91%
Average days to complete		41	43	37	40	#REF!	34	34	30	30	33	30	29
Pending		565	521	612	752	#REF!	763	600	539	641	642	492	398
Protest													
In (Newly Received)		303	308	311	261	#REF!	279	360	271	339	256	232	356
Out (Completed During Month)		371	315	302	335	#REF!	314	353	316	327	361	327	415
Completed within 90 days		331	277	251	294	#REF!	270	309	285	287	324	273	342
Issued within 90 days percentage	90%	89%	88%	83%	88%	#REF!	86%	87%	90%	88%	90%	83%	82%

Average days to complete		51	48	49	50	#REF!	52	50	49	45	48	55	50
Pending		461	493	509	491	#REF!	435	464	448	504	444	428	433
Wage														
In (Newly Received)		627	648	681	598	#REF!	683	936	909	974	829	689	866
Out (Completed During Month)		791	826	679	814	#REF!	1007	1154	1130	868	896	775	896
Completed within 60 days		675	624	414	526	#REF!	850	1065	1021	807	835	718	828
Issued within 60 days percentage	70%	85%	76%	61%	65%	#REF!	84%	92%	90%	93%	93%	92%	92%
Average days to complete		38	43	50	50	#REF!	34	26	24	20	22	24	23
Pending		790	816	1095	1259	#REF!	767	672	464	607	569	476	439

OCCUPATIONAL HEALTH **BEST PRACTICES**

Working together to keep people working

Health Policy News for Self-Insured Employers
September, 2017

Completed Work

Be sure to check out the web page, ProviderNews.Lni.wa.gov for postings about new health care policies and guidelines. The latest ones are:

Ankle and Foot Surgical Guideline

This brand new guideline was approved at the July 27th meeting of the Industrial Insurance Medical Advisory Committee (IIMAC) and becomes effective on October 1, 2017. This guideline increases the number of ankle and foot surgeries that will require utilization review prior to any authorization.

Negative Pressure Wound Therapy (NPWT)

This new HTCC-based coverage decision becomes effective October 1, 2017. The decision permits the use of a negative pressure wound system after a complete wound therapy program was tried but was unsuccessful in healing the wound. There are some contraindications based on FDA safety warnings and when used, certain criteria must be met to continue use.

Sacral Nerve Stimulation for Treatment of Fecal Incontinence

This new coverage decision became effective September 1, 2017. This was not an HTCC decision. It is covered only for treatment of a neurological condition or abnormality of sphincter anatomy where the impairment resulted from the workplace injury or disease. It requires prior authorization.

Work that is Underway

Acupuncture

We have now enrolled 215 Acupuncture providers in the pilot. The first stage of pilot rule making (filing the CR-101 form) occurred on September 5th. SIEs are not required to allow acupuncture treatment. More information can be found at www.lni.wa.gov/acupuncturepilot.

SIMP Review and Study

A few IIMAC members met with L&I staff in August to discuss multidisciplinary pain programs and how they can best be integrated with a continuum of collaborative pain management strategies. This project requires framing of key questions and scope definition before we involve other

advisors and SIMP providers. Since this is also being coordinated with the larger Healthy Worker 2020 strategy, a lot of coordination is required. The next meeting will occur the end of September.

Non-surgical Use of Peri-neural Blocks

We will soon be examining the use of peri-neural blocks for use in non-perioperative settings. While this is a standard practice for anesthesia, we have received inquiries about peri-neural injections for non-perioperative pain management. Literature is being reviewed now.

Neurogenic Thoracic Outlet Syndrome Guideline

No further update at this time.

Superior Capsular Reconstruction of the Shoulder with Allograft

We are reviewing this procedure for effectiveness and medical necessity. It was not reviewed in 2013 when the shoulder surgery guideline was developed. If we develop surgical criteria for allowance, and if the IIMAC votes to approve it, we will add it to the shoulder guideline.

New Attending Provider Resource Center Coming Soon

After years of relying on paper copies of the Attending Doctors' Handbook, it is now being converted to an online resource. Web programming is occurring during September and we hope for an effective date of October 1, 2017. Making this once formidable resource a web based resource will allow us to keep it current and add, delete, or change content as needed. Hence, it will be a dynamic resource designed to adjust to provider education needs and changes in administrative processes, treatment guidelines, or policies etc.

Health Technology Decisions from the WA Health Technology Clinical Committee

Treatment of chronic migraine and chronic tension-type headache

While the HTCC already made their final decision in July to cover OnabotulinumA toxin for treatment of chronic migraine, it is taking some time to implement the coverage decision. Rules and claim instructions are being examined so they will be in alignment with the decision. We also have to address ways to confirm that such headaches are related to the accepted condition(s) on the claim. A final coverage decision is expected by the end of October.

Varicose veins

This HTCC decision was also finalized in July, but further research and review is required to determine when it can be considered work related.