Official Disability Guidelines (ODG) Treatment in Workers’ Comp

Another important tool from the CSIMS Utilization Review Toolbox - Offered at a discount to CSIMS members

CSIMS Member Dinner
April 2007
Background on WLDI

- Independent Database Development Company Focused on Workplace Health & Productivity
- Founded in 1995
- Offices in Texas and California
- “The only way to achieve real and lasting cost-savings in workers’ comp is through the delivery of quality and timely care”
  - Charles W. Kennedy, MD, Senior Medical Editor, Official Disability Guidelines – Treatment in Workers’ Comp
- This is best achieved by using evidence based guidelines.
- Mission: To create, maintain and market information databases to implement standards for managing workforce health and productivity based on strict principles of evidence-based methodology, with ongoing focus on healthcare cost containment
Major Advantages of ODG

1. Evidence-Based (ODG even includes links to abstracts of the supporting evidence)
2. Integrated Treatment and Duration Guidelines
3. Accepted by AHRQ for NGC
4. Ongoing Updates, Annual Editions
5. Independent, Multidisciplinary
6. Comprehensive
7. Designed for UR & Clinical Practice
8. Proven Results
Evidence-Based

- Comprehensive, ongoing literature review with alphanumeric evidence ranking system
- Aggregate of over 10 million lost time cases, with duration guidelines integrated with treatment recommendations
- “Most direct form of evidence that can be offered in court” under Federal Rules of Evidence
- Recommendations linked to abstracts of evidence, so that it can be consulted and quoted directly
- Founding member of the Evidence-Analysis Committee for American Academy of Orthopaedic Surgeons
Accepted in NGC by AHRQ

- Agency for Healthcare Research and Quality’s (AHRQ) National Guideline Clearinghouse (NGC) at www.guidelines.gov
- Based on a systematic literature search and review of existing scientific evidence published in peer-reviewed journals
- In English and developed, reviewed, or revised within the last five years
- One of the few accepted workers’ comp guidelines
Ongoing Updates, New Editions Annually

- Update process in continuous operation
- Scientific medical literature review (new studies evaluated and posted continuously)
- Survey data analysis (OSHA, CDC, Claims)
- Expert panel validation (80-Member Advisory Board, annual peer-review)
- ODG is the clear leader (competition typically updates every 3-5 yrs)
Independent, Multidisciplinary

- WLDI is independent of any single provider group or medical specialty
- Not just occupational doctors, orthopedic surgeons, or physical therapists, etc.
- Bridges the interest of all specialties based on best available medical evidence
- Considerable provider acceptance
Independent, Multidisciplinary (cont’d)

- WLDI is in the guideline business, focused on researching and publishing evidence based medical guidelines.
  - WLDI does not rely solely on volunteer contributors, as do many medical specialty guidelines.
  - In addition to an extensive internal editorial staff, WLDI retains doctors who are leaders in their fields to act as chapter leads on a compensated basis.
  - Unlike volunteers who may have other priorities, these WLDI editors are incentivized to focus their efforts on one objective: creating the highest quality guideline.
Comprehensive

- ODG covers acute and chronic conditions and procedures that represent 99% of workers’ comp costs
- Example: Procedure Summary for the Low Back chapter has over 175 unique entries
- Medical specialty guidelines, on the other hand, are very limited in scope
- ODG includes extensive pharmaceutical guidelines
Designed for UR & Clinical Practice

- Clear and unambiguous ("Recommended" or "Not Recommended", with links to evidence)
- Number and frequency of visits identified
- Patient selection criteria, where appropriate
- Codes for Auto-Approval applies CPT codes to ICD9 codes, for decisions to approve/pay for procedures (will facilitate “auto-payment” of charges)
- Treatment Planning for ideal cases (practice)
ODG is not “cookbook” medicine

Procedure Summary typically lists over 100 therapies for each chapter

Many are supported by the evidence, while many are not supported by the evidence

The objective is to clearly separate the two, and provide links to the evidence
Provider Guideline Issues: “Cook Book” Medicine?

Evidence based guidelines are not “cook book” medicine
- Guidelines identify many different approaches to therapy, noting which ones work and which do not
- There is no single approach that is right for every patient
- Providers should make patient care decisions using own judgment enhanced by access to the latest scientific studies
- Treatment guidelines can minimize uncertainty
- Providers who follow guidelines can be assured they will get paid, and minimize “managed care” headaches and paperwork
- Providers will have more time to focus on patient care
- Results in faster treatment, avoiding delayed recovery, litigation, etc.
Labor Guideline Issues: *Denial of Care?*

- The primary beneficiaries of evidence-based guidelines are patients
  - The scientific studies are focused on **one outcome**: what is most successful in getting the patient better
  - Many therapies are proven to be harmful to patients, and guidelines can minimize these
  - Prolonged unnecessary treatment in and of itself, along with delayed return to activity, has also been proven to be harmful
  - Injured workers should get **faster** care
Using ODG Treatment in CA

- Although California has officially adopted the ACOEM Guidelines, ODG Treatment can be used to supplement where necessary.
- ODG Treatment has been adopted in 16 states and provinces, including the most recent adoption by the State of Texas.
Welcome to www.odgtreatment.com

Integrated with Treatment Guidelines (ODG Treatment in Workers' Comp, 5th edition)
(Click on picture of books below to enter site)
CONTENTS

Section A (Treatment Guidelines)

I. ODG Treatment Index

Section B (Return-to-Work Guidelines, including links to the Treatment Guidelines)

II. ICD-9 Index

II. Keyword Index

III. CPT® Index

Section C (Impairment Guidelines)

I. IAIABC Contents

Section D (Front matter)

I. Preface
847.2 Lumbar sprains and strains

Return-To-Work Summary Guidelines

<table>
<thead>
<tr>
<th>Dataset</th>
<th>Midrange</th>
<th>At-Risk</th>
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<tbody>
<tr>
<td>Claims data</td>
<td>17 days</td>
<td>69 days</td>
</tr>
<tr>
<td>All absences</td>
<td>10 days</td>
<td>41 days</td>
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</table>

Return-To-Work "Best Practice" Guidelines

Mild (grade I), clerical/modified work: 0 days
Mild, manual/heavy manual work: 7-10 days
Severe (grade II-III), clerical/modified work: 0-3 days
Severe, manual work: 14-17 days
Severe, heavy manual work: 35 days
With radicular signs, see 722.1 (disc disorders)
Obesity comorbidity (BMI >= 30), multiply by: 1.31

Capabilities & Activity Modifications for Restricted Work:

Clerical/modified work: Lifting with knees (with a straight back, no stooping) not more than 5 lbs up to 3 times/hr; squatting up to 4 times/hr; standing or walking with a 5-minute break at least every 20 minutes; sitting with a 5-minute break every 30 minutes; no extremes of extension or flexion; no extremes of twisting; no climbing ladders; driving car only up to 2 hrs/day.

Manual work: Lifting with knees (with a straight back) not more than 25 lbs up to 15 times/hr; squatting up to 16 times/hr; standing or walking with a 10-minute break at least every 1-2 hours; sitting with a 10-minute break every 1-2 hours; extremes of flexion or extension allowed up to 12 times/hr; extremes of twisting allowed up to 16 times/hr; climbing ladders allowed up to 25 rungs 6 times/hr; driving car or light truck up to a full work day; driving heavy truck up to 4 hrs/day.

Description: Injury to the ligament (sprain) or to the muscle (strain) of the lower back. Sprains and strains are usually accompanied by a tearing of the tissue as well as symptoms of pain, limited motion, swelling, bruising, and/or a change in sensation.

Other names: Lower back sprain, Lower back strain

ICD-10 Code: S33.50
Elective care -- As needed

<table>
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<th>Workers' Comp Costs per Claim (based on 95,654 claims)</th>
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<tr>
<td>Quartile</td>
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<tr>
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<tr>
<td>Medical</td>
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<td>Total</td>
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Disability Duration Adjustment Factors by Age

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RTW Claims Data (Calendar-days away from work by decile)

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<th>30%</th>
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RTW Post Surgery (Calendar-days away from work by decile)

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<td>365</td>
<td>365</td>
</tr>
</tbody>
</table>

Low back disk surgery (CPT 63030)

| 41  | 51  | 58  | 92  | 142 | 205 | 321 | 365 | 365 | 365  | 182.98 |
Official Disability Guidelines

ODG Treatment

CONTENTS

Background & Description

Explanation of Medical Literature Ratings

Ankle & Foot (updated 04/03/07)

Burns (updated 10/27/06)

Carpal Tunnel Syndrome (updated 03/06/07)

Elbow (updated 02/23/07)

Eye (updated 12/3/06)

Fitness for Duty (updated 12/3/06)

Forearm, Wrist, & Hand (updated 12/27/06)
ODG Integrated Treatment/Disability Duration Guidelines

Low Back Problems

Note: The Treatment Planning sections outline the most common pathways to recovery, but there is no single approach that is right for every patient and these protocols do not mention every treatment that may be recommended. See the Procedure Summaries for complete lists of the various options that may be available, along with links to the medical evidence.

Identify Radicular Signs

- First visit may be with Primary Care Physician MD/DO (50%), Orthopedist (33%), or Chiropractor (17%)
- Determine presence or absence of radiculopathy:
  - Medical history
  - Sensation: Feeling pain radiating below the knee (calf or lower), not just referred pain (pain radiating to buttocks or thighs), & dermatological sensory loss
  - Straight leg raising test (sitting & supine), productive of leg pain
  - Motor strength and deep tendon reflexes
  - Document flexibility/ROM (fingertip test), muscle atrophy (calf measurement), local areas of tenderness, visual pain analog, sensation alternation
- Rule out “red flag” diagnoses, including diagnostic studies, for specialist referral:
  - Cauda Equina Syndrome [ICD9 344.6] (Schedule emergency procedure)
  - Fracture, Compression fracture, Dislocation, Wound [ICD9 733.13, 805.4, 805.5, 806.4, 806.5, 839.2, 838.3, 876, 911, 922.3, 926.11, 942, 952.2]
  - Cancer, Infection [ICD9 171.7, 195.8, 215.7]
  - Dissecting/Ruptured Aortic Aneurysm [ICD9 441.0]
  - Others (prostate problems, endometriosis/gynecological disorders, urinary tract infections, & renal pathology)
  - Note: This guideline should not be used to suggest appropriate procedures for other conditions or comorbidities. When the treating doctor suspects any other diagnosis, they may decide what necessary testing should be performed, which may include laboratory tests such as erythrocyte sedimentation rate (ESR), complete blood count (CBC), and urinalysis (UA) to screen for nonspecific medical diseases (especially infection and tumor) of the low back.

Without Radiculopathy (90% of cases)
### Procedure Summary – Low Back

<table>
<thead>
<tr>
<th>Procedure/topic</th>
<th>Summary of medical evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Click to jump ahead: A B C D E F G H I J K L M N O P Q R S T U V W X Y</td>
<td>See Work</td>
</tr>
</tbody>
</table>

#### Activity restrictions

**Acupuncture**

- Not recommended for acute low back pain. (Tulder-Cochrane, 2000) (Furlan-Cochrane, 2005)
- Recommended for chronic low back pain using a short course of treatment. (See the Pain Chapter.)
- Acupuncture has been found to be more effective than no treatment for short-term pain relief in chronic low back pain, but the evidence for acute back pain does not support its use. (Furlan-Cochrane, 2005) (Manheimer, 2005) (van Tulder, 2005)
- These authors have reported that acupuncture provides a greater effect than sham treatment, while others have reported non-significant differences between the two modalities (Brinkhaus, 2006). In this latter case, both modalities were shown to be more effective than no treatment. Acupuncture has not been found to be better than other treatment (either conventional or alternative) in terms of pain or function. Acupuncture has been shown to add to the treatment effect of conventional therapy (improving pain and function) when compared to conventional therapy alone. (van Tulder, 2005) (Manheimer, 2005) (Furlan-Cochrane, 2005)
- Overall outcomes from trials have been mixed, with some lower-quality trials producing positive results, but trials with higher validity scores tending to be negative or inconclusive. There is a tendency for patient expectations to influence the outcome independently of the treatment itself. (Tulder-Cochrane, 2000) (Cherkin, 2001) (van Tulder-Spines, 1999) (Smith, 2000) (Cherkin-Anzais, 2003) (Giles-Spines, 2003) (Muller, 2005) (Airaksinen, 2006)
- A recent RCT comparing usual care to acupuncture plus usual care found that at 24 months the acupuncture/usual care subjects were significantly more likely to report 12 months pain free and less likely to report they required use of medication for pain (after only 10 treatments that were performed at the beginning of the protocol). (Thomas, 2005)
- Note: This recent Thomas study prompted the UK Health Tech Assessment to recommend acupuncture for chronic LBP. For an overview of acupuncture and other conditions in which this modality is recommended see the Pain Chapter.

**ODG Acupuncture Guidelines:**

- Initial trial of 3-4 visits over 2 weeks
- With evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy.)

#### Adhesiolysis

- See Adhesiolysis, percutaneous & Adhesiolysis, spinal endoscopic.

Institute for Research in Extramural Medicine, Vrije Universiteit, van der Boechorststraat 7, Amsterdam, Netherlands, 1081 BT. mw.van_tulder.emgo@med.vu.nl.

BACKGROUND: Although low back pain is usually a self-limiting and benign disease that tends to improve spontaneously over time, a large variety of therapeutic interventions are available for the treatment of low back pain. OBJECTIVES: The objective of this review was to assess the effects of acupuncture for the treatment of non-specific low back pain. SEARCH STRATEGY: We searched the Cochrane Complementary Medicine Field trials register, the Cochrane Controlled Trials Register (1997, issue 1), Medline (1966 - 1996), Embase (1988 - 1996), Science Citation Index and reference lists of articles. SELECTION CRITERIA: Randomised trials of all types of acupuncture treatment that involves needling for subjects with non-specific low back pain. DATA COLLECTION AND ANALYSIS: Two reviewers blinded with respect to authors, institution and journal independently assessed trial quality and extracted data. MAIN RESULTS: Eleven trials were included. The methodological quality was low. Only two trials were of high quality. Three trials compared acupuncture to no treatment, which were of low methodological quality and provide conflicting evidence. There was moderate evidence from two trials that acupuncture is not more effective than trigger point injection or transcutaneous electrical nerve stimulation (TENS). There was limited evidence from eight trials that acupuncture is not more effective than placebo or sham acupuncture for the treatment of chronic low back pain. REVIEWER'S CONCLUSIONS: The evidence summarised in this systematic review does not indicate that acupuncture is effective for the treatment of back pain.

Publication Types: Review PMID: 10796434

Rating: Ib, Meta Analysis
Explanation of Medical Literature Ratings
(Ratings “1a” through “11c” noted under summary of each study)

Ranking by Type of Evidence:
(click on links to go to explanation)

STUDIES
1. Systematic Review/Meta-Analysis
2. Controlled Trial – Randomized (RCT) or Controlled
3. Cohort Study - Prospective or Retrospective
4. Case Series
5. Unstructured Review

OTHER:
6. Nationally Recognized Treatment Guideline (from guidelines.gov)
7. State Treatment Guideline
8. Other Treatment Guideline
9. Textbook
10. Conference Proceedings/Presentation Slides
11. Case Reports and Descriptions

Ranking by Quality within Type of Evidence:
(click on links to go to explanation)

a. High Quality
b. Medium Quality
c. Low Quality

Ranking by Type of Evidence

1. Systematic Review/Meta-Analysis

Systematic Reviews: Written by reviewers who use explicit and rigorous methods to identify, critically appraise, and synthesize relevant studies from the published medical research. They use the process of systematically locating, appraising, and synthesizing evidence from...
CSIMS members receive 30% discount

CSIMS has partnered with WLDI to extend a 30% discount to CSIMS members.

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CSIMS Member Price: $227.50/user/year (regularly $325)

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ODG Trial Access
Open Until May 1st

Access will be open until May 1, 2007.
Go to:
www.odgtreatment.com

Username: csims (lowercase)
Passcode: 0501 (numeric)

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www.worklossdata.com