

Evidence Based Medicine....

What you need to know about ACOEM, ODG, Etc.

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Goals of Discussion



1. Disclosure
2. What is Evidence Based Medicine (EBM) and the application to WC?
3. EBM Guidelines Used in Workers' Comp
 - Treatment Guidelines
 - Return-to-Work Guidelines
4. What are the Most Common Guidelines
 - Proprietary
 - National Guideline Clearinghouse
 - State Adoptions of Guidelines
5. How can it be used?
6. What is the effect of EBM (% Savings)?

Disclosure



- *Editorial Advisory Board for Official Disability Guidelines (11th ed. 2006) & ODG Treatment in Workers' Comp (4th ed. 2006), etc.*
- *Advisory Board for the Medical Disability Advisor, Earlier Edition, (Reed Group)*
- *Worked on First Edition of ACOEM Guidelines (Presently in Second Edition, 2004)*
- *Creation of Guidelines..some presently owned by Kckesson. (Patterns of Treatment).*
- *Some slides courtesy WLDI.. not indicative of a bias or endorsement of ODG Guidelines.*
- **NO FINANCIAL INTEREST IN ANY GUIDELINE!**

A “Sea Change”



- OLD VIEW OF MEDICAL TREATMENT REVIEW....based upon...
 - Opinion (But whose?)
 - Experience (Biased)
 - Supposition (I Believe...)
 - What was “taught” (When, where, by whom?)
 - “Because I care” (We all do!)
 - “No alternatives” (Not a good idea if morbidity and mortality are involved, or if interruption to return to work and function.)
 - “Why not?” (What are the risks)
 - Community Standards (Biased by Geography)
 - Specialty Society Recommendations (Self-Interest)



*"Give it to me straight, Doc.
How long do I have to ignore your advice?"*

But.....The Proposed Treatment....



- Is it effective? (New studies with greater “sensitivity and specificity”)
- Do patients get better, without significant complications or great risk? (Larger studies)
- Are they more likely to be better than worse?
- Is it cost, time, & risk effective?
- Do people go back to work and normal ADLs?
- What about bad “outcomes”, death, physical damage, etc.?
- Are there “other” motivations for the treatment?

Evidence Based Healthcare: Part of the Solution



According to the Centre for Evidence-Based Medicine,
"Evidence-based medicine is the conscientious, explicit
and judicious use of current best evidence in making
decisions about the care of individual patients."

- Based upon Pathology (the “denominator”)
- It is “Science”
- It is “Logical”
- Focuses on Outcome vs. Risk (Cost a separate issue)
- Based upon:
 - Studies
 - Rated as to Quality of the Studies and Utility
 - Quantitative!!!!!!!!!!!!

Where is it used?



- Group Health Care...The standard!
 - Blue Cross, Blue Shield, Kaiser, etc.
- Workers' Compensation (increasingly mandated, including states)
- Other areas....General Liability
- Increasingly noted on “information sites” on the internet.
- Present in Patient Communication Materials!!!!

Guidelines in Work Comp



Three kinds of guidelines:

- 1) **Medical treatment guidelines..**
(*ODG Treatment Guidelines, ACOEM Practice Guidelines (Second Edition), State Guidelines (CO, WA, MA, etc.), Medical Disability Advisor, Specialty Guidelines*)
- 2) **Return-to-work guidelines**
(*ODG, Milliman USA, Medical Disability Advisor*)
- 3) **Impairment guidelines**
(*AMA Guides, etc.*)

Evidence Based Medicine



- **The Treatment Guidelines:**
 - *Official Disability Guidelines* (ODG), Work Loss Data Institute
 - ACOEM-Occupational Medical Practice Guidelines, Second Edition: American College of Occupational and Environmental Medicine
 - *Medical Disability Advisor*, The Reed Group
 - *InterQual*: Owned by McKesson
 - State Specific Guidelines
 - CT, MA, WA, CO, etc. Some good, some poor, others not relevant or effective.
 - Some have Disability Durations (ODG, MEDICAL DISABILITY ADVISOR)
 - Some are Computer Based and Can be Automated: InterQual and ODG
- ALL are **COST EFFECTIVE** (\$100 to \$300 per user).
- Available in paper (book) format, online, or through interactive software (InterQual, ODG)

State Adoptions of Workers' Comp Guidelines



- Many States have written their own guideline (AR, **CO**, CT, MA, MN, RI, **WA**)
- Problems exist w/State Guidelines
 - Not necessarily evidence-based
 - Tend to be more political
 - **Colorado/Washington/ MA** may be exceptions
- Some dropping own guideline, adopting national guideline (CA, FL, OH, TX)
- Laws/rules adopting UR guidelines under consideration in many states

National Guideline Clearinghouse (NGC)



- The NGC, created by AHRQ (Agency for Healthcare Research & Quality), in partnership with AMA and AAHP
- <http://www.guidelines.gov>
- May 1, 2006 access to 1,903 guidelines from 238 different organizations
- Some are focused on workers' comp (can browse by organization on site)

Treatment Guidelines Use



- It is the new “Language” with physicians.
- Utilization review/management
- Clinical practice..sets a standard, reduces variability
- Not “cookbook medicine” (may cite many therapies to choose from in EBM)
- Allows for the application of science, not opinion or hearsay
- EBM makes this non-adversarial, and ultimately, defensible



FRENETIC WANDERINGS WWW.SWENSONFUNNIES.COM

WOULD YOU PRIESTS GET OUT OF THE WAY! WHAT THIS GIRL NEEDS IS A CHIROPRACTOR!



ONE OF THE DELETED SCENES PUT BACK IN THE NEWLY RESTORED RELEASE OF THE EXORCIST.

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Official Disability Guidelines

Common Cost Containment Strategies In Workers' Compensation
(Click on State/Province Name for Treatment Guidelines)

Jurisdiction	Treatment Guidelines	Limited Provider Choice	Limited Provider Change	Medical Fee Schedule	Hospital Payment Regulation	Mandated Managed Care ²	Mandated Utilization Review
Alabama	none	X	X	X	X		
Alaska <i>(withdrawn)*</i>	Considering per SB130 (2005)		3	X	X		
Alberta	Own (15)						
Arizona	none	X ⁴					
Arkansas	Own (1)	X	X	X	X		X
British Columbia	ODG						
California <i>(withdrawn)*</i>	ACOEM	X ⁴			X		
Colorado	Own (10) + ODG (state fund)	X	X	X	X	X	X
Connecticut	Own (4) + ODG (state fund)	X	3	X			
Delaware	none						
Florida <i>(withdrawn)*</i>	AHRQ (ODG + others)	X	X	X	X		X

Let's Try a Question...

ACOEM: Acupuncture.. Foot



What does ACOEM state.....

- ACOEM, 2nd Ed., Chap. 14, p. 371, states “invasive techniques (e.g., needle acupuncture.....) ... have no proven value”
- Would we make exceptions... always “Yes”
 - Chronic Pain, Asian Background, etc.
- Limits number...HOW?
- If no clear positive objective response.....No more therapy.

Another...ACOEM & "TENS"



- TENS UNIT-Low Back

ACOEM, 2nd Ed., Chapt. 12, page 300, bullet #3, states that transcutaneous electrical neurostimulation (etc.)...have no proven efficacy”.

ACOEM: Back Surgery



- ACOEM, 2nd Ed., Chapt. 12, pp. 305-307 would recommend surgery only with failure of conservative treatment and objective documentation of pathology that can be addressed by surgery.
- Multiple other comments about specific surgery...including discectomy, IDET, Spinal Stenosis, and Fusion (“No good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem”).

ODG-Lets take a look..



- Organized differently.
- Less Verbal
- More focused
- More documentation for the comment..directly footnoted.
- NOT Better...Just Different!
- Hardcopy, Online, Parts are Automated.

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[Search](#) [Contents](#) [Keyword Index](#) [ICD-9 Index](#) [Contact Us](#) [Help](#)

Official Disability Guidelines

CONTENTS

Section A (Treatment Guidelines)

I. [ODG Treatment Index](#)

Section B (Disability Duration Guidelines, including links to the Treatment Guidelines)

I. [ICD-9 Index](#)

II. [Keyword Index](#)

III. [CPT® Index](#)

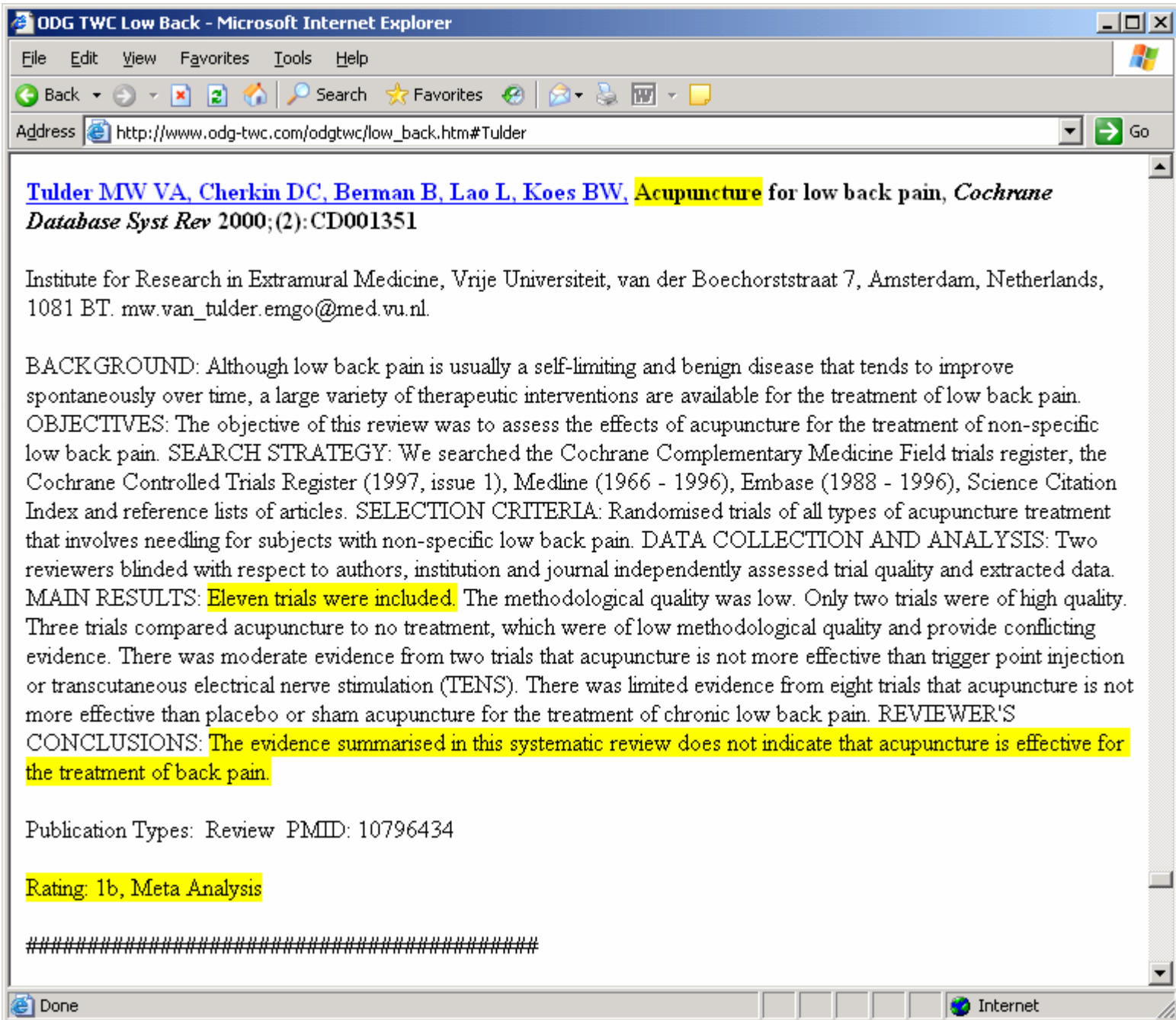
Section C (Impairment Guidelines)

I. [IAIABC Contents](#)

Section D (Front matter)

Applet fphover started

Internet



Tulder MW VA, Cherkin DC, Berman B, Lao L, Koes BW, Acupuncture for low back pain, Cochrane Database Syst Rev 2000;(2):CD001351

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: 1b, Meta Analysis

#####

ODG TWC Low Back - Microsoft Internet Explorer

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Address http://www.odg-twc.com/odgtwc/low_back.htm#ODGIndicationsforSurgeryDiscectomy Go

ODG Indications for Surgery™ -- Discectomy/laminectomy:

I. Symptoms/Findings (confirm presence of radiculopathy), requiring ONE of the following:

- A. L3 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps weakness
 - 3. Unilateral hip/thigh/knee pain
- B. L4 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
 - 3. Unilateral hip/thigh/knee/medial pain
- C. L5 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
 - 2. Mild-to-moderate foot/toe/dorsiflexor weakness
 - 3. Unilateral hip/lateral thigh/knee pain
- D. S1 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
 - 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
 - 3. Unilateral buttock/posterior thigh/calf pain

II. Imaging Studies, requiring ONE of the following:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

- 1. MR imaging
- 2. CT scanning
- 3. Myelography
- 4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

- A. Activity modification (\geq 2 months)
- B. Drug therapy, requiring at least ONE of the following:
 - 1. NSAID drug therapy
 - 2. Other analgesic therapy
 - 4. Muscle relaxants
 - 5. Epidural Steroid Injection (ESI)
- C. Support provider referral, requiring at least ONE of the following:
 - 1. Manual therapy (massage therapist or chiropractor)

Internet

How is EBM used?



- Language and Specificity of Diagnosis:
 - Example: Lumbago vs. Facet Related Pain
- Discussion:
 - Example: Back Fusion, with Radiculopathy, does not treat radicular pain.
- Compromise:
 - Example: Guidelines recommend 2 PT visits, 3 approved
- Focus on Treatment That Works.



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“It’s a new procedure. We can surgically implant tiny detour signs so food won’t go to your thighs.”

Use Continued.



- Problem Areas:
 - New Technology, Rare Procedures, Complex Diagnoses, Multiple Diagnoses, Issues not dealt with by a specific guideline. (Go to www.scholar.google.com and look for a study with controls)
- How: UR/Claims, Provider, & Patient Expectations
- The Effect....
 - CA..reduces costs by (??) in two years

Example – CA Experience



- Projection:
 - “UC Berkeley Study projects impact of ACOEM Guidelines in California to be a 36.7% savings or \$3.1 billion” (Neuhauser, 2003)
- Actual (*effect of multiple reforms*):
 - “California Workers' Comp Insurance Rating Bureau recommends another 5% rate drop, bringing the cumulative reduction in rates to 41.7% since 2003” (WCIRB 07/22/05)
- Latest information (9/1/06)
 - Cumulative rate decline of almost 60%!

Return-to-Work Guidelines



- Expected time away from work
- Prospective CM; modified duty
- Retrospective benchmarking
- May trigger actions
- Reduce delayed recovery
- Facilitate communication among all parties (on the “same page”)

847 Sprains and strains of other and unspecified parts of back - Microsoft Internet Explorer

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847.2 Lumbar sprains and strains

Dataset	Midrange	At-Risk
Claims data	18 days	71 days
All absences	9 days	47 days

Return-To-Work "Best Practice" Guidelines

Mild, clerical/modified work: 0 days
Mild, manual work: 10 days
Severe, 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 \geq 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;

Done Internet

EBM Addresses “Problem Points” For Medical Intervention



- How does this relate to WC.... and YOU?
 - “Variable of Time”-Set Triggers for When Claim is Reviewed. (All claims over 2 wks with TD, PT beyond 6 visits)
 - Variable of Body Part-Location has an effect on Claim. (All backs, any bilateral CTS)
 - Diagnoses-Look at all claims with a Specific Diagnosis. (Spine with Radiculopathy, TOS, etc.)
 - Treatment-Look at all Claims with a Certain Treatment Request. (PENS, Thermography, IDET, etc.)
 - Defines the Effective Physician: Look at all claims with a Specific Specialty Involved.
 - Network: Create a Network that follows EBC (New Study in the JOEM-Louisiana.

One Thing Becomes Another!



Conclusions



- Becomes the Standard for **Everyone** in the System.
- We apply evidence-based guidelines to improve outcomes in workers' comp
 - Reduce excessive/unnecessary utilization of medical services
 - Reduces Morbidity
 - Reduces Costs
- Easier for workers to get needed care
- States can reduce administrative “friction” by being clear to providers about what treatments will get paid for, allowing them to focus on care

Conclusions (continued)



- Communication improved among all parties with shared expectations on time away from work and appropriate care
- Focuses on restoration of function capacity (not “chasing the pain”)
- Quickly identify effectiveness of any procedure (Saves time)
- Automate payment for appropriate treatment

Questions:

