

OFFICIAL DISABILITY GUIDELINES VS. CURRENT ORTHOPAEDIC LITERATURE

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The views presented here are
mine.

Not necessarily those of the Illinois
State Medical Society

UTILIZATION REVIEW UNDER 2011 LAW

‘When a payment for medical services has been denied
...pursuant to UR, **the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standards of care used by the person or entity performing the UR...is reasonably required to cure or relieve the effects of his or her injury.**’

THE ROLE OF GUIDELINES

- “The evaluation must be accomplished by means of a system that identifies the utilization of health care services based on a standard of care nationally recognized peer review guidelines as well as nationally recognized treatment guidelines and evidence-based medicine based upon standards as provided in this act.”

EFFECT ON PRACTICE

- THE LEGISLATION HAS SUBSTITUTED THE CONCEPT THAT THE UR IS CORRECT FOR THE ASSUMPTION THAT THE TREATER HAS THE BEST KNOWLEDGE ON HOW TO TREAT THE PATIENT.
- THE LEGISLATION HAS RESULTED IN AN EXPLOSION OF 'PEER REVIEW' WHETHER JUSTIFIED OR NOT. PHYSICIANS ARE INUNDATED.
- MORE AND MORE PHYSICIANS HAVE JUST GIVEN UP TRYING TO RESPOND TO UR

OFFICIAL DISABILITY GUIDELINES

- COMPILED BY WORK LOSS DATA INSTITUTE
- 'EVIDENCE BASED'
- REVISED EVERY YEAR
- THE MOST COMMON SOURCE FOR UTILIZATION REVIEWERS

Work Loss Data Institute

An Independent Group
That compiles the ODG

Editorial Advisory Board

- Multiple members including a number of insurance company executives
- Multiple specialists including some with University ties
- A large number of physicians in Occupational Health
- Not a single orthopaedic 'thought leader' that I recognized

- This edition of *ODG Treatment* **incorporates the latest findings from Work Loss Data Institute's rigorous, comprehensive and ongoing systematic literature search and review of existing scientific evidence published in peer-reviewed journals.** Together with the annual release of *Official Disability Guidelines*, and *ODG Top 200 Conditions*, the *ODG* product line has emerged as the industry leader in disability duration and medical treatment guidelines for workers' compensation and non-occupational disability cases.
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- Designed for use by providers, employers, insurance claims professionals, and state workers' comp authorities, *ODG Treatment* is the only reference to unite evidence-based protocols for medical treatment with normative expectations for disability duration for every illness and injury, organized by ICD9 diagnosis.

Response to my letter of concern to the AAOS about Guidelens

- Preston, this has been a long hard issue for AAOS. The history I am afraid will find you disappointed. AAOS & ACOEM agreed some years ago to approach work compensation guidelines in an EBM fashion. After some great effort, the demonstration was abandoned due to the reluctance of ACOEM to use a more rigorous process than consensus. .. AAOS has recently reviewed our participation and frankly we are as frustrated as you by the current "consensus" guidelines.
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William O. Shaffer, MD
Medical Director
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

- *Evaluating the Body of Evidence:* While ODG has a 30-step alphanumeric rating system for each individual referenced study, **ODG describes and summarizes the entire body of medical evidence** within the Procedure Summary topic, as support for the overall ODG recommendation on a topic

EVIDENCE BASED MEDICINE



EVIDENCE BASED MEDICINE

- VERY POPULAR CONCEPT
- RELEVANT IN RESEARCH
- SOUNDS LIKE A REALLY GOOD IDEA
- PROBLEM AT PRESENT ORTHOPAEDIC LITERATURE DOES NOT CONTAIN MANY LEVEL 1 ARTICLES
- DOES THAT MEAN THAT THE LEVEL 2-4 ARTICLES ARE NOT RELEVANT?
- EXAMPLE: TORN ROTATOR CUFF

LEVEL 1 STUDY FOR ROTATOR CUFF TEARS

- RANDOMIZE LARGE NUMBER OF PATIENTS BETWEEN REPAIR AND NONREPAIR GROUPS
- PROBLEM: WHAT PATIENT WOULD WANT TO JOIN SUCH A STUDY?
- GIVEN WHAT WE KNOW ABOUT THE EFFECT OF DELAYING CUFF REPAIR, WHAT SUCH A STUDY EVEN BE ETHICAL

AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

- PUBLISHED AAOS CLINICAL PRACTICE GUIDELINES
- [Achilles Tendon Rupture](#)
- [Anterior Cruciate Ligament Injuries](#)
- [Carpal Tunnel Syndrome: Diagnosis](#)
- [Carpal Tunnel Syndrome: Treatment](#)
- [Distal Radius Fractures](#)
- [Glenohumeral Joint Arthritis](#)
- [Hip Fractures in the Elderly](#)
- [Orthopaedic Implant Infection in Patients Undergoing Dental Procedures: Prevention](#)
- [Osteoarthritis of the Knee \(Non-arthroplasty\)](#)
- [Osteoarthritis of the Knee \(Arthroplasty/Surgical Management\)](#)
- [Osteochondritis Dissecans](#)
- [Pediatric Developmental Dysplasia of the Hip in Infants up to Six Months of Age: Detection and Management](#)

- [Pediatric Diaphyseal Femur Fractures](#)
- [Pediatric Supracondylar Humerus Fractures](#)
- [Periprosthetic Joint Infections](#)
- [Rotator Cuff Problems](#)
- [Symptomatic Osteoporotic Spinal Compression Fractures](#)
- [Venous Thromboembolic Disease: Prevention](#)

VOLUME OF ORTHOPAEDIC LITERATURE

- EXPLODING
- FOR 4 LEVEL 1 AND 2 STUDIES ON ARTICULAR CARTILAGE IN THIS MONTHS AMERICAN JOURNAL OF SPORTS MEDICINE ALONE
- THE ODG SYSTEM DOES NOT ALLOW EVALUATION OF UP TO DATE LITERATURE (OR DOES IT IGNORE IT?)
- CANNOT HAVE GUIDELINES WITHOUT EXPERTS TO EVALUATE MOST RECENT LITERATURE

ODG GUIDELINES IN CLINICAL PRACTICE

- PT
- INJECTION
- ROTATOR CUFF TEAR
- MRI VS MRA
- ARTHROSCOPY FOR CHONDRAL LESIONS
- ARTICULAR CARTILAGE RESURFACING

ODG Guidelines and PT/Word Conditioning

- There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted.

PT/WORK CONDITIONING

- PROBLEM: THESE GUIDELINES ARE AT BEST GUESSES ABOUT THE DURATION OF PT
- ORTHOPAEDIC LITERATURE DOES NOT CONTAIN ANY INFORMATION ABOUT DURATION OF PT
- MULTIPLE PROTOCOLS ARE AVAILABLE THAT ENVISION REHAB OVER 6-9 MOS OR MORE BECAUSE ALL THE PROTOCOLS CONTAIN CERTAIN PHASES AND GOALS

EXAMPLES OF PHASED APPROACH TO PT FOLLOWING ACL RECONSTRUCTION

- PHASE 1: CONTROL SWELLING AND DECREASE PAIN
- PHASE 2: REGAIN FULL RANGE OF MOTION
- PHASE 3: REGAIN FULL STRENGTH
- PHASE 4: ADVANCE TO BALANCE, COORDINATION NEEDED FOR HIGHER LEVEL ACTIVITY
- PHASE 5: COMPLETION OF HIGH PERFORMANCE TASKS

ODG GUIDELINES FOR PT AFTER ACL RECONSTRUCTION

- **Sprains and strains of knee and leg; Cruciate ligament of knee (ACL tear) (ICD9 844; 844.2):**
- Medical treatment: 12 visits over 8 weeks
- Post-surgical (ACL repair): 24 visits over 16 weeks

COST SAVING ACL REHAB PROTOCOL

- • 2-10 weeks post-op—3 times per week
- • 10-12 weeks post-op—2 times per week
- • 12+ weeks post-op—1 time per week or as needed for 4-6 wks
- 40
- Does not include high level advanced activity such as uneven ground, working on beams, etc

ODG AND INJECTIONS

53 YO ASSEMBLER

- LATERAL EPICONDYLITIS FOR 3 MOS.
- DOMINANT ARM
- UNABLE TO WORK
- GAVE STEROID INJECTION (ENDORSED BY ODG)
- FU CALL FROM RETROSPECTIVE PEER REVIEWER WHO STATED THAT THE INJECTION WOULD NOT BE APPROVED BY ODG GUIDELINES IF WORK STATUS OF OFF WORK WAS NOT CHANGED TO RETURN TO RESTRICTED WORK
- PROBLEM: SHE HAD ALREADY BEEN PLACED AT RESTRICTED WORK BY THE PREVIOUS PHYSICIAN BUT CONTINUED TO HAVE PAIN

ODG AND ROTATOR CUFF TEARS

55 YO IRONWORKER ACUTE TEAR



ASSUMING YOU ARE THIS PATIENT

- HOW MANY OF YOU WOULD WANT YOUR ROTATOR CUFF FIXED?
- HOW MANY WOULDN'T?

WHAT DO ODG GUIDELINES SAY?

- NO SURGERY
- SURGERY IS OK

ODG GUIDELINES 2014

- **Indications for surgery—Rotator cuff repair:**

Conservative care: Recommended 3-6 months...Treatment must be directed toward gaining full ROM...PLUS

Subjective Clinical Findings: Pain with active arc of motion 90-130 degrees. AND Pain at night

- Objective Clinical Findings: Weak or absent abduction ...AND Tenderness over rotator cuff...AND Positive impingement sign and temporary relief of pain after injection
- Imaging studies: Conventional imaging studies and Gadolinium MRI or ultrasound

AAOS 2013

- APPROPRIATE USE CRITERIA FOR OPTIMIZING THE MANAGEMENT OF FULL-THICKNESS ROTATOR CUFF TEARS
- Patient Scenarios 434
- R = Rarely Appropriate, M = May Be Appropriate, A = Appropriate
- Under this scenario repair of this acute traumatic care is appropriate

SO

- UR physician can employ the guidelines to state that repair is not indicated
- Surgery is not performed
- The ironworker sits at home collecting TTD for 3-6 months
- The insurers pays for physical therapy
- The odds are that he needs the surgery, but
- Because the surgery has been delayed the result may very well not be as good as if he had it immediately

ODG ON MRI VS MRI ARTHROGRAM

51 YO ELECTRICIAN DECORATED WAR VETERAN

- 3 MOS SP TRACTION INJURY TO SHOULDER
- FAILED NONOP RX INCLUDING 6 WKS OF PT
- PRESENTED TO ME WITH PAIN AND FINDINGS CONSISTENT WITH LABRAL/BICEPS TEAR (POSITIVE OBRIEN SIGN)
- PRIOR PLAIN, POOR MRI READ AS SHOWING 'SMALL PARTIAL THICKNESS CUFF TEAR'
- ANTICIPATING UR ISSUES IN THE FUTURE, I GIVE A CORTISONE SHOT WHICH DOES NOT HELP
- I REQUEST MRI ARTHROGRAM

MRI VS MRI ARTHROGRAM

- SUMMARY OF CURRENT LITERATURE
- MRI IS GOOD FOR DIAGNOSING FULL THICKNESS ROTATOR CUFF TEAR
- MRA IS BETTER FOR TEARS OF THE GLENOID LABRUM, BICEPS OR PARTIAL THICKNESS ROTATOR CUFF TEARS

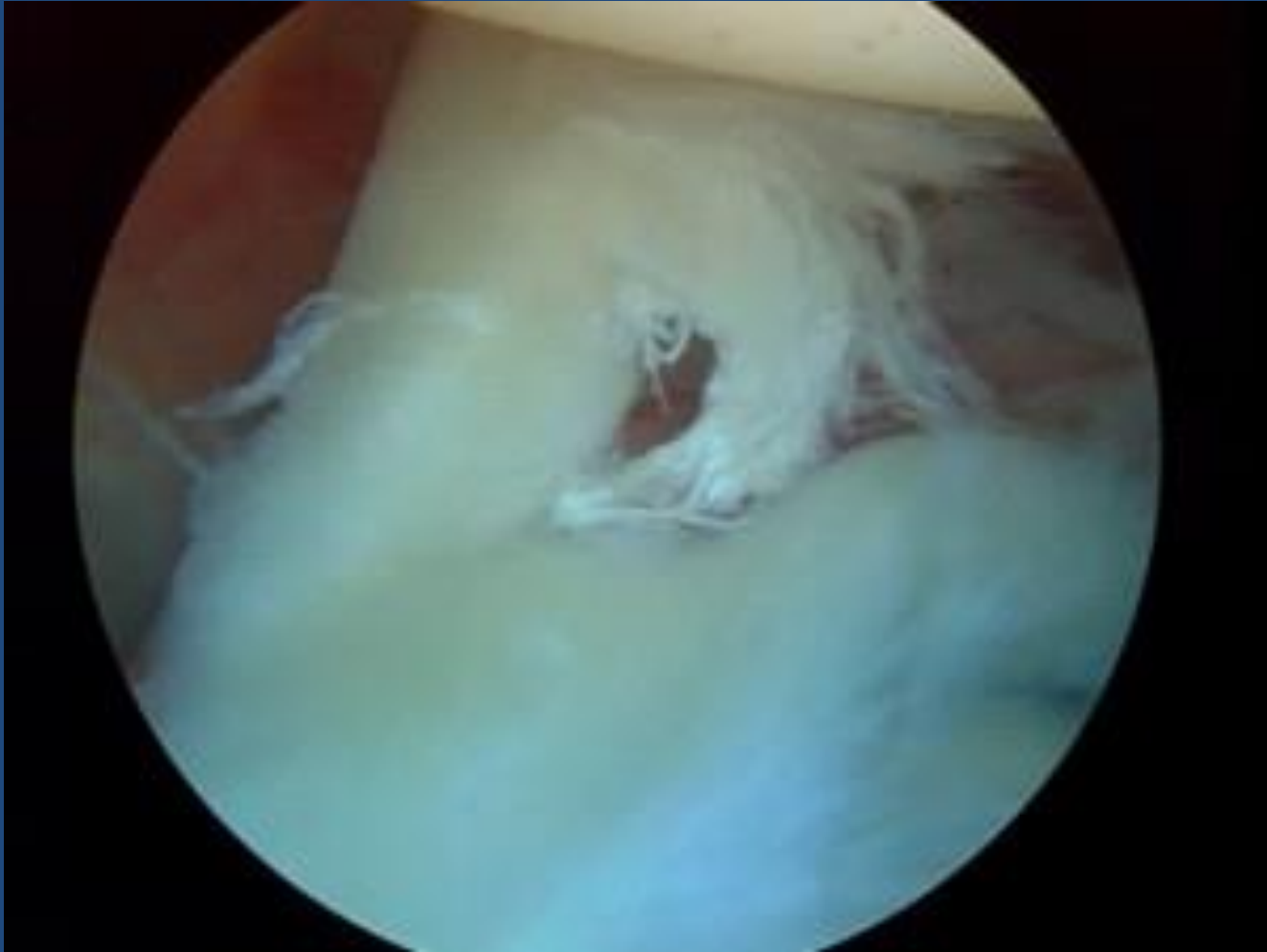
ODG GUIDELINES CITED BY REVIEWER

- ’
- ODG: ‘Non-contrast MRI is sufficient for rotator cuff tears, and contrast enhancement is recommended for SLAP tears.’
- DENIAL FOR MRI ARTHROGRAM: ‘There is no documentation that there is a labral tear in this case and therefore the request is denied.’

REST OF THE STORY

- MRA IS REFUSED BY INSURANCE COMPANY
- IME IS FINALLY OBTAINED FROM A WELL RESPECTED SURGEON
- SURGERY IS PERFORMED 3 MONTHS LATER

TORN GLENOID LABRUM AND BICEPS



- The pathology found at surgery would have been easily diagnosed by mri arthrogram and was not seen on plain mri. This could have been expected. The denial by the carrier of the request for mri arthrogram led to prolonged pain and disability for this pt.

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- # SIGNED BY Preston M Wolin, MD,
M.D. (PMW) 03/16/2016 11:41AM

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ODG AND CHONDRAL INJURIES

41 yo policeman

- 6 mos history of pain and locking after an injury
- Failed nonoperative treatment
- MRI read as 'degenerative changes in articular cartilage'. In actuality damage can be either acute or chronic.
- I document that the changes are not 'degenerative' but traumatic and go along with his mechanism of injury, symptoms and physical findings.

FULL THICKNESS LOSS ARTICULAR CARTILAGE



PEER REVIEWER

- Cites ODG Guidelines in denial of care
- States that the Guidelines do not approve the use of arthroscopy in 'degenerative arthritis'
- I write an appeal letter

- I am requesting a formal appeal for the denial decision on this individual for the following reasons. First, I attempted to contact the review physician but was unable to do so within the time demand given because of the fact that I was in the operating room. Second, it is not clear what the specialty of the review physician is. Third, the denial is based on knee arthroscopy not being recommended for "osteoarthritis". This is apparently based on an MRI reading referring to 'degenerative changes'. The reviewing physician should have known that whether the loss of articular cartilage is traumatic or atraumatic, the MRI appearance is the same. A radiologist cannot know what the cause is. The patient had a specific trauma. This patient does not have osteoarthritis. He has a chondral injury of his femoral condyle. He has mechanical symptoms of locking and catching. He has point tenderness on physical examination. He has failed non-operative treatment. He is disabled from police work. There are no other treatment options. I specifically request that the appeal be obtained from an orthopaedic surgeon with sports medicine specialty certification.

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4 wks later

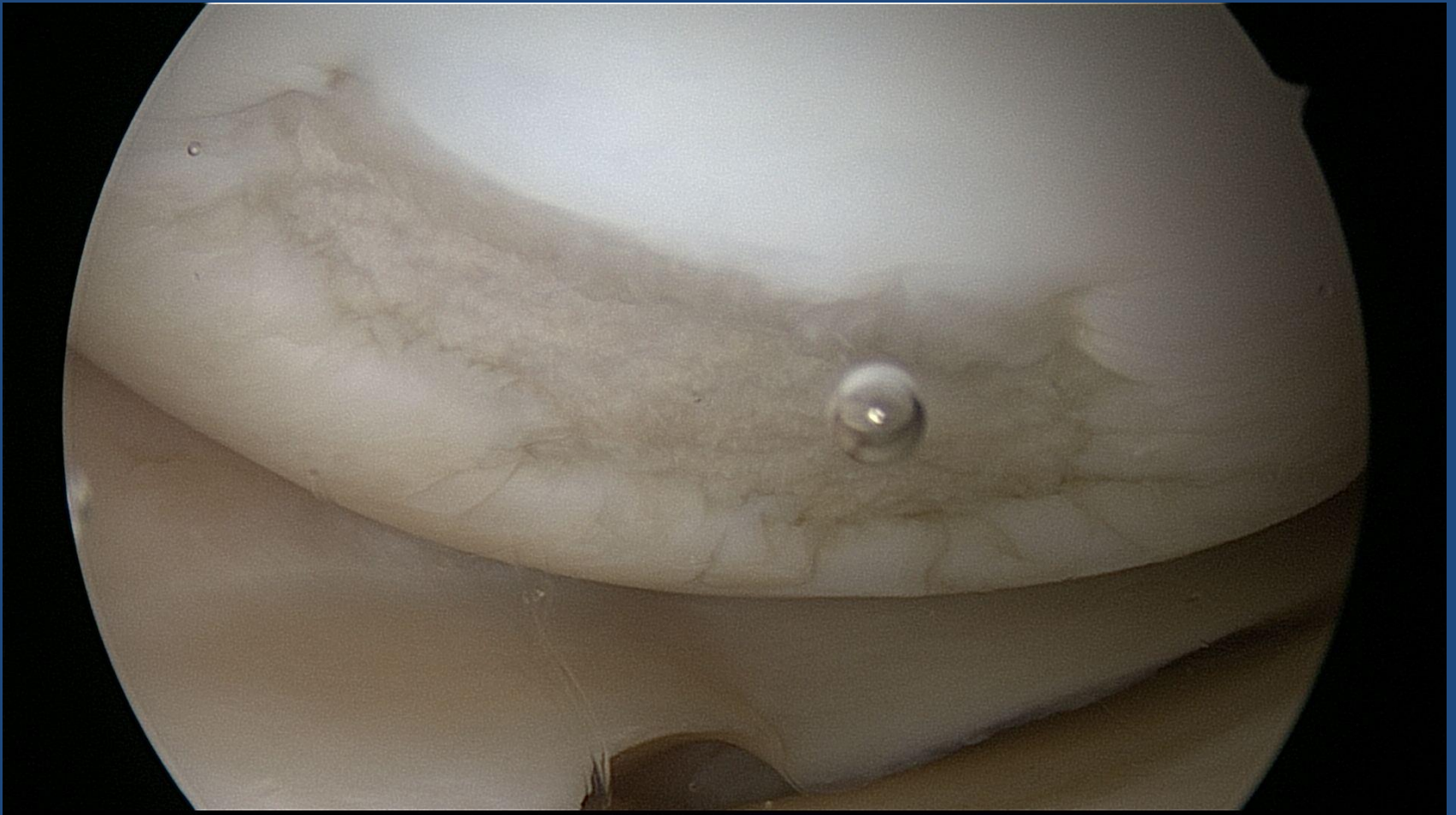
- An appeal reviewer contacts me
- States he has approved surgery
- He says that there never should have been a denial in the first place.

ODG AND CARTILAGE TRANSPLANT

23 yo trapeze artist

- Injured when he fell
- Pain and locking for 6 mos
- I recommend an arthroscopy

Large full thickness chondral defect



The lesion is a large one

- Literature shows that the best treatment for this condition is a cartilage transplant
- Autologous chondrocyte implantation
- What does ODG say?

ODG 2014

- **ODG Indications for SurgeryTM -- Autologous chondrocyte implantation (ACI):**
- **Criteria** for autologous chondrocyte implantation (ACI):
- **1. Conservative Care:** Failure of conservative therapy (minimum of 2 months of physical therapy). PLUS
- **2. Subjective Clinical Findings:** Injured worker (IW) is capable and willing to follow the rehabilitation protocol and post-operative weight bearing restrictions. AND Presence of disabling pain and/or knee locking. PLUS
- **3. Objective Clinical Findings:** Failure of established surgical interventions (i.e., microfraction, drilling, abrasion) (diagnostic arthroscopy, lavage, or debridement is not considered adequate to meet this criterion) AND Focal articular cartilage defect

MICROFRACTURE



MICROFRACTURE

- CHEAPER THAN CARTILAGE TRANSPLANT
- BUT THIS LESION IS TOO BIG FOR EVEN THE BIGGEST ENTHUSIASTS
- MOST IMPORTANTLY THE CARTILAGE THAT IS FORMED IS SCAR TISSUE AND NOT NORMAL CARTILAGE

PROBLEM WITH ODG

- THERE ARE AT LEAST 2 ARTICLES IN THE PEER REVIEWED LITERATURE THAT SHOW THAT MICROFRACTURE BEFORE ACI PRODUCES A WORSE RESULT
- Minas et al. 2009 and Pestka et al 2012 AJSM
- OVERALL CURRENT LITERATURE SHOWS RESTORATIVE OR REGENERATIVE TREATMENT IS BETTER THAN MICROFRACTURE
- QUESTION: IS ODG ESSENTIALLY ADVOCATING A PROCEDURE THAT COULD MAKE A GOOD RESULT LESS LIKELY?
- WHERE WAS THE 'RIGOROUS PROCESS OF REVIEWING LITERATURE' WHEN THIS GUIDELINE WAS WRITTEN

TAKE HOME POINTS

- ODG GUIDELINES ARE THE ONES BEING USED FOR UR IN WORKERS COMPENSATION CASES
- THE METHODOLOGY IS QUESTIONABLE
- THE GUIDELINES ARE OFTEN AT ODDS WITH CURRENT ORTHOPAEDIC LITERATURE
- SHOULD THEY BE USED TO DICTATE THE STANDARD OF CARE FOR INJURED WORKERS?

PROPOSALS

- DO NOT ASSUME THAT ODG IS THE STANDARD OF CARE
- IN CASES OF DISPUTE REGARDING UR THE PEER PHYSICIAN SHOULD HAVE THE SAME TRAINING AS THE TREATER—BOARD CERTIFIED WITH SPECIAL CERTIFICATION IN SPORTS MEDICINE
- CONSIDER CURRENT LITERATURE TO BE AT LEAST IF NOT MORE IMPORTANT AS ODG
- FIND A PHYSICIAN THAT IS WILLING TO RESPOND TO DENIALS