

Workers' Compensation Seminar

Sept 27, 2013

Alan Colledge, PT MD

<http://www.laborcommission.utah.gov>

Outline of Presentation

- ▶
- ▶ Why Workers' Compensation
- ▶ Causation
- ▶ Where are we going?
 - ▶ Medical Panels
 - ▶ Medical fee Rule
 - ▶ Pain
 - ▶ Injury-Illness
 - ▶ Apportionment
 - ▶ Treatment Guidelines
 - ▶ Impairment Guides



Handouts-Reference Material

- ▶ Medical Standards
- ▶ Utah Pain Guidelines
- ▶ RSA
- ▶ Utilization Review
- ▶ Patient Handouts
 - ▶ Employee WC Handout
 - ▶ Pain
 - ▶ Pain-Herniated
 - ▶ Disc-Degenerative Disc
- ▶ Slides on Labor Commission Website



We Have To Determine

- ▶ How to allocate resources.
- ▶ How to help the system avoid financial collapse.
- ▶ Which behaviors and coping styles to reward.
- ▶ How to identify patients who are likely to succeed.
 - Obama Care



How are we to decide...

- ▶ Who gets what care **FIRST**.
- ▶ Who gets what care **SECOND**.
- ▶ Who gets what care **NEVER**.
- ▶ Who gets what care **ENDLESSLY**.



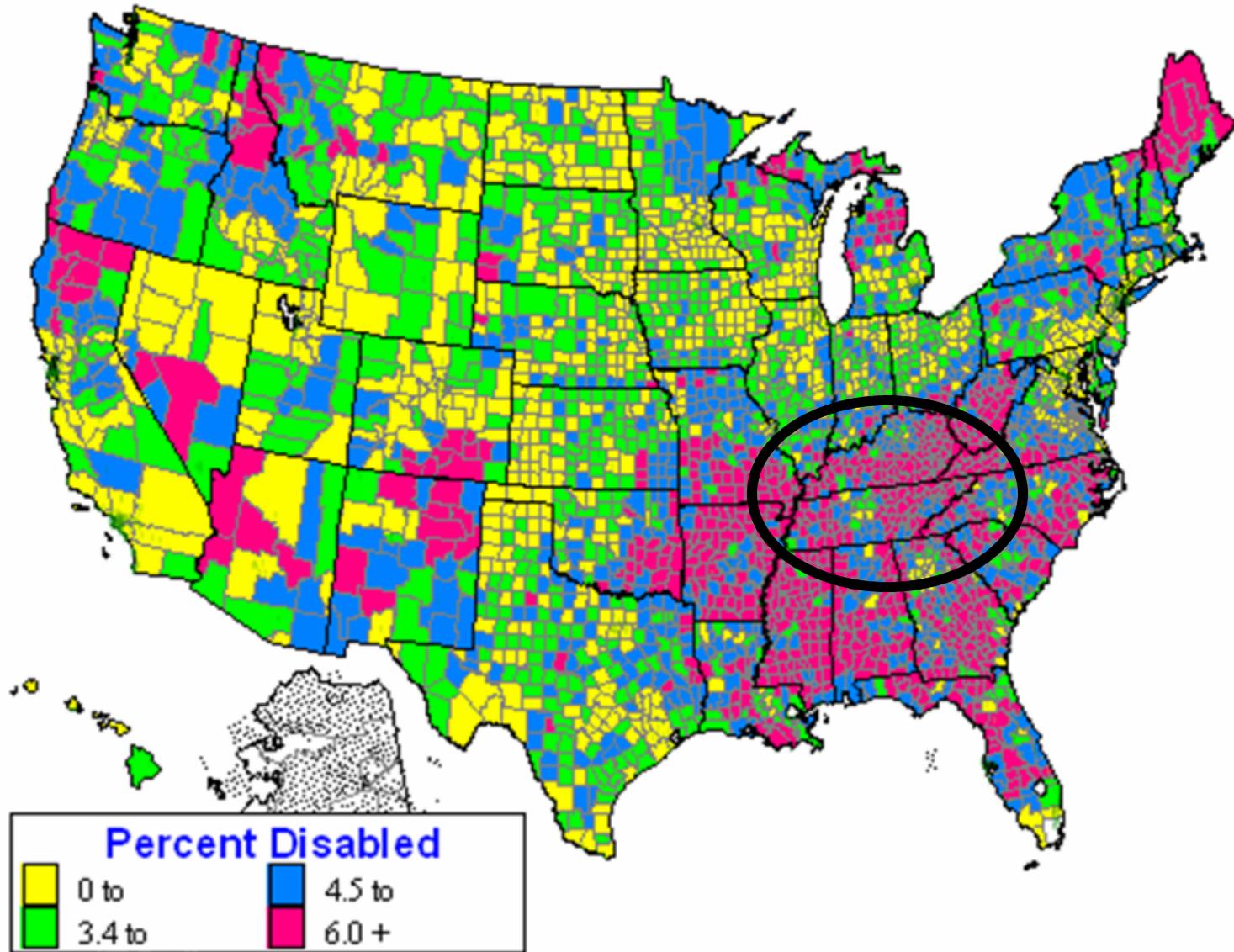
Disability in US Counties, 1999

04/04/01

University of Virginia

Southeastern Rural Mental Health

Source: Social Security Administration and Bureau











\$200 Billion Dollars/Year

▶ **\$13,182 / Claim**

▶ **\$24,000 / Lost-time**





Geneva Steel Plant



United States Steel Corporation
Geneva Works

Rolling Mills Division
70-RM-10

REPORT OF SERIOUS INJURY

NAME AND NUMBER OF INJURED EMPLOYEE: L. D. Colledge, #38576

OCCUPATION OF EMPLOYEE: Spell Foreman - Maintenance

DATE AND TIME OF INJURY: April 13, 1970 - 9:50 a.m.

LENGTH OF TIME ON OCCUPATION: February 19, 1949 - 21 Years 1 Month

TOTAL PLANT SERVICE: 23 Years 3 Months

DIVISION INVOLVED: Rolling Mills

IMMEDIATE SUPERVISOR: M. Laird

DIVISION SUPERINTENDENT: L. E. Ringger

CAUSE CLASSIFICATION: Unsafe Condition

NATURE AND EXTENT OF INJURY: Extensive second and some third degree burns to back, upper shoulders and both upper arms.

DESCRIPTION OF INCIDENT:

Injured was following a conduit to determine possible damage to conduit and wiring which furnishes the 440 volt power supply to the man cooling fans in the slab scarfing area. Injured stepped upon a column base pedestal to observe for any obvious damage to the conduit. As he stepped from the pedestal base to ground level

Aron Ralston said the process took about an hour. "I felt pain and I coped with it," "I moved on."



Medical Benefits

~~PS2~~ ADERT

Employer must pay for worker's weight loss surgery

Citation: *PS2, LLC v. Childers*, 910 N.E.2d 809 (Ind. Ct. App. 2009)

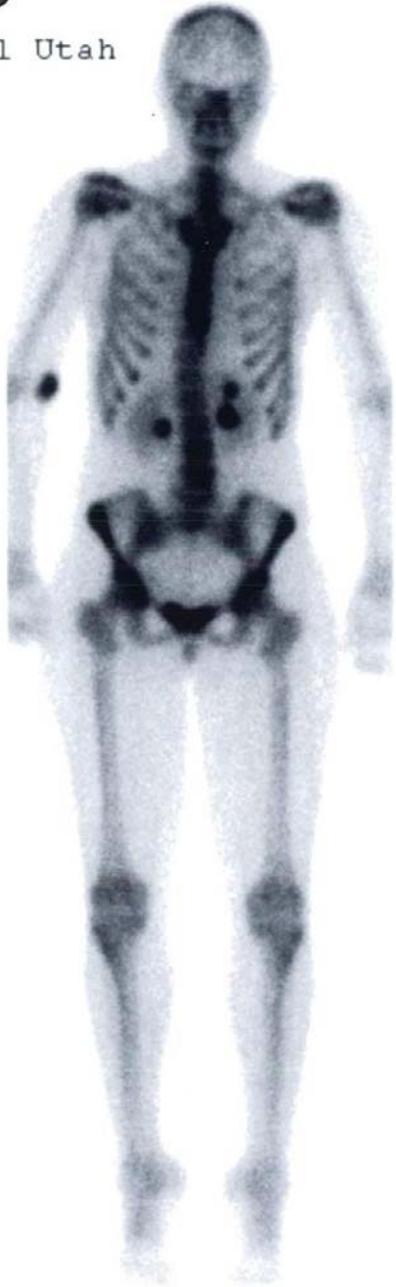
A pizza parlor must pay for weight-loss surgery for a cook, who needed the operation before undergoing surgery to correct a work-related back injury, according to the Indiana Appeals Court.

The cook, Childers, was a 25-year-old man who weighed about 340 pounds and smoked about 30 cigarettes a day when he was hurt at work in March 2007. The accident occurred when he was hit in the back by a freezer door, resulting in an injury to his lower back.

By this time, Childers' weight had "ballooned to 380 pounds," according to the treating physician, who counseled that treatment of his back problem was "doomed to fail" unless Childers lost some weight. He said that because of Childers' weight, spinal fusion surgery presented a "high risk for nonunion and failure." The treating physician noted that Childers had been unable to lose weight on his own and recommended that Childers consult a doctor about lap band or gastric bypass surgery to "get his weight down to a more reasonable level."

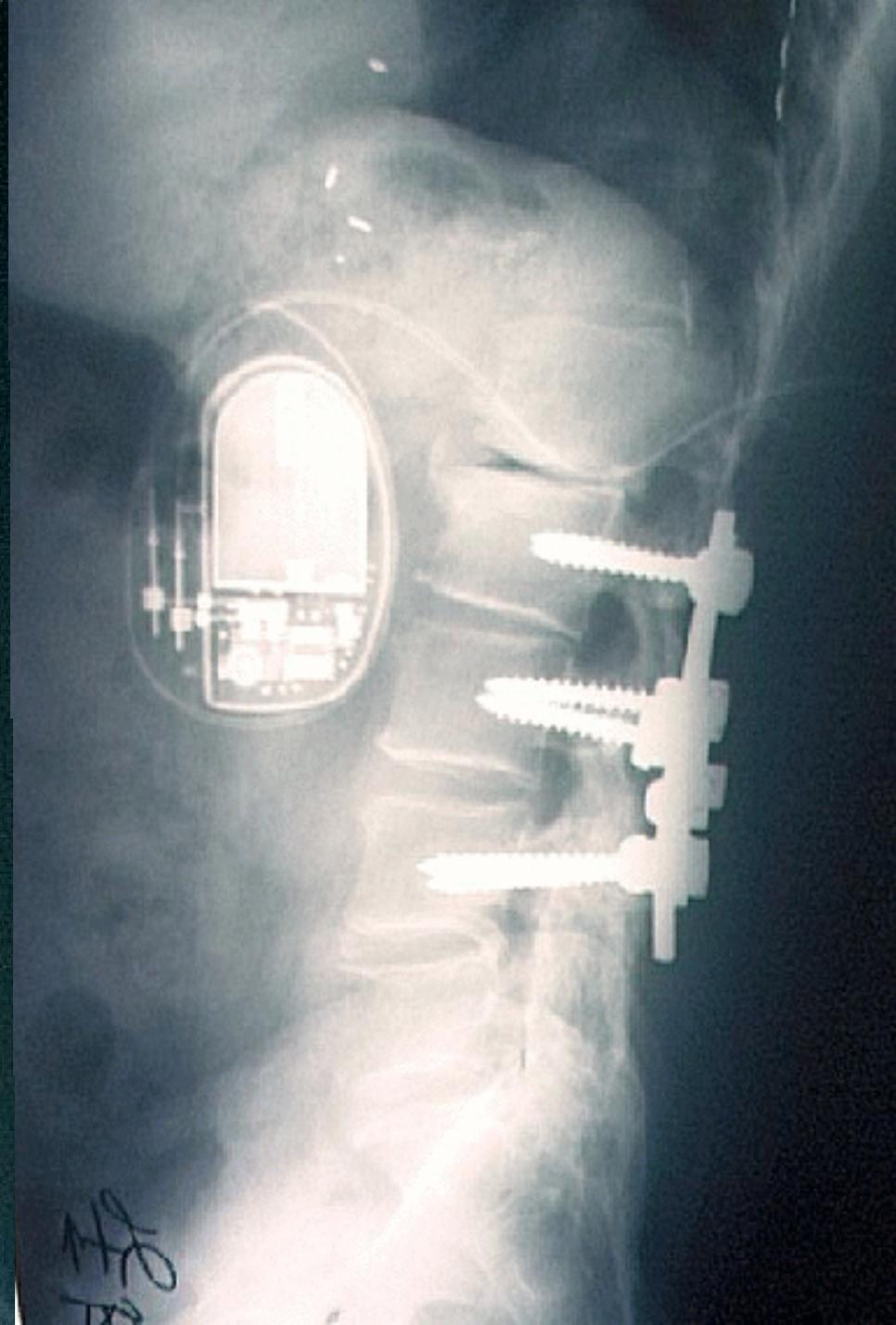
Central Utah

R



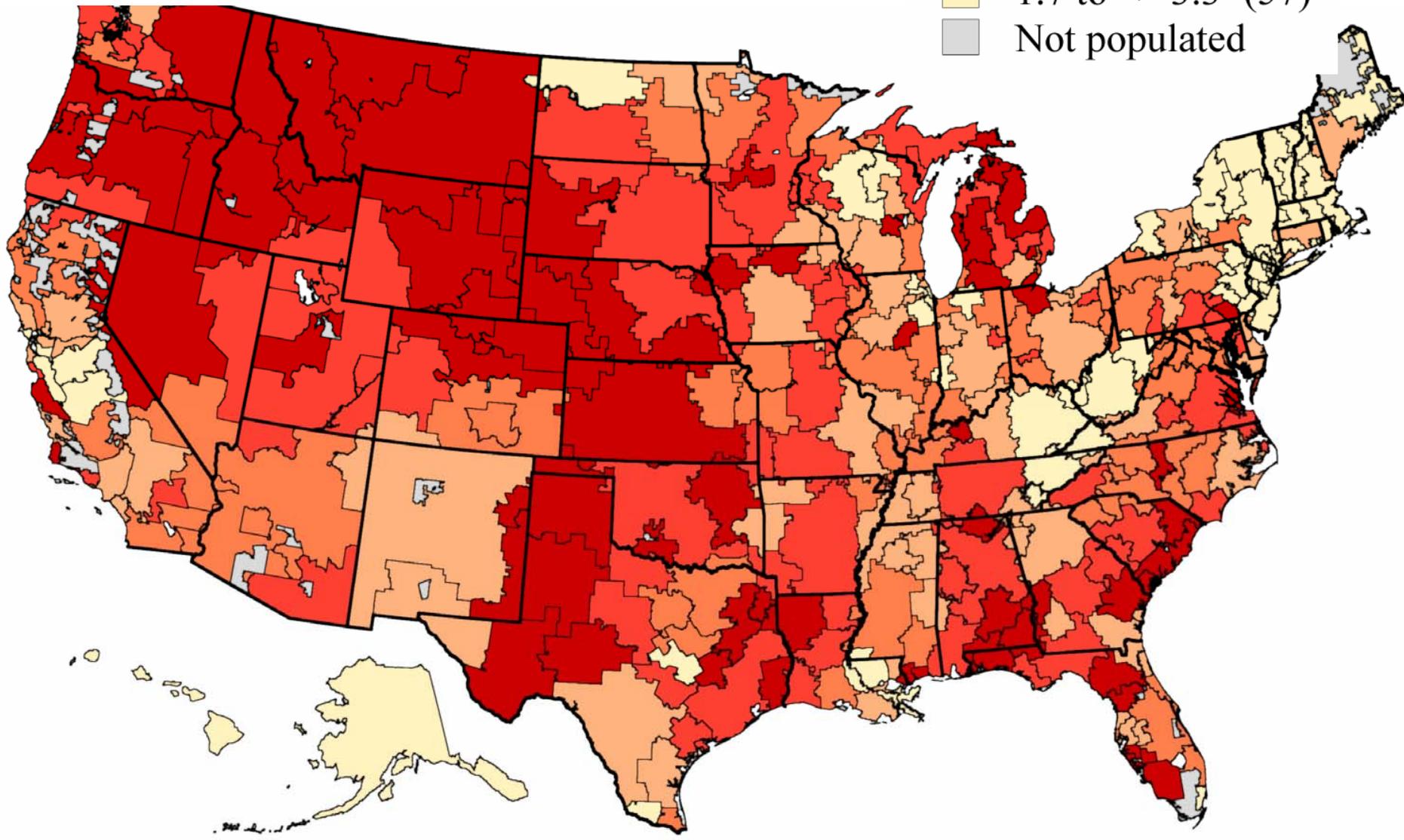
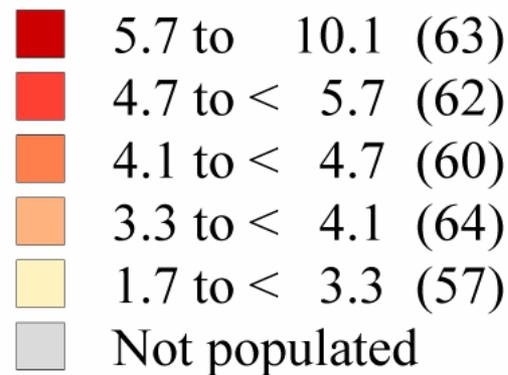
L





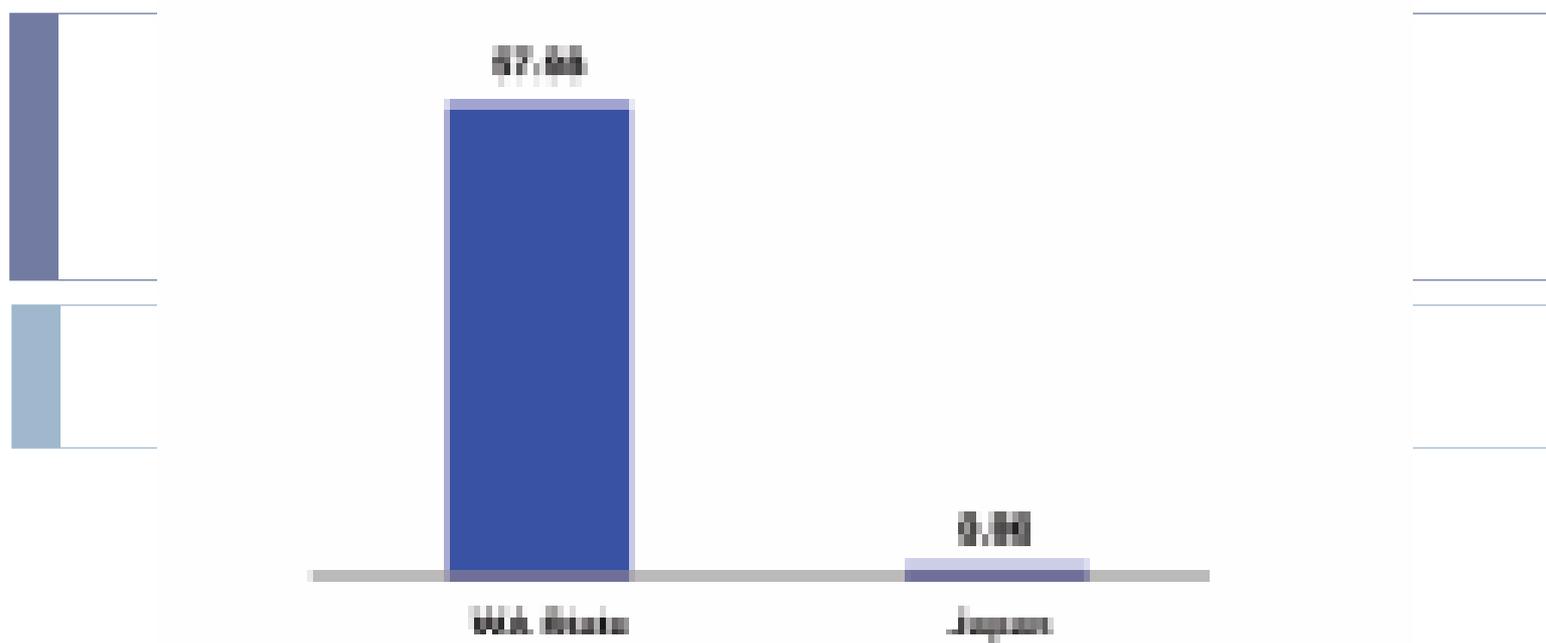
Back Surgery Rates per 1,000 Medicare Beneficiaries

By Hospital Referral Region, 2003-2007



Back pain claim rate in 1999 was 60 times higher in Washington State than in Japan.

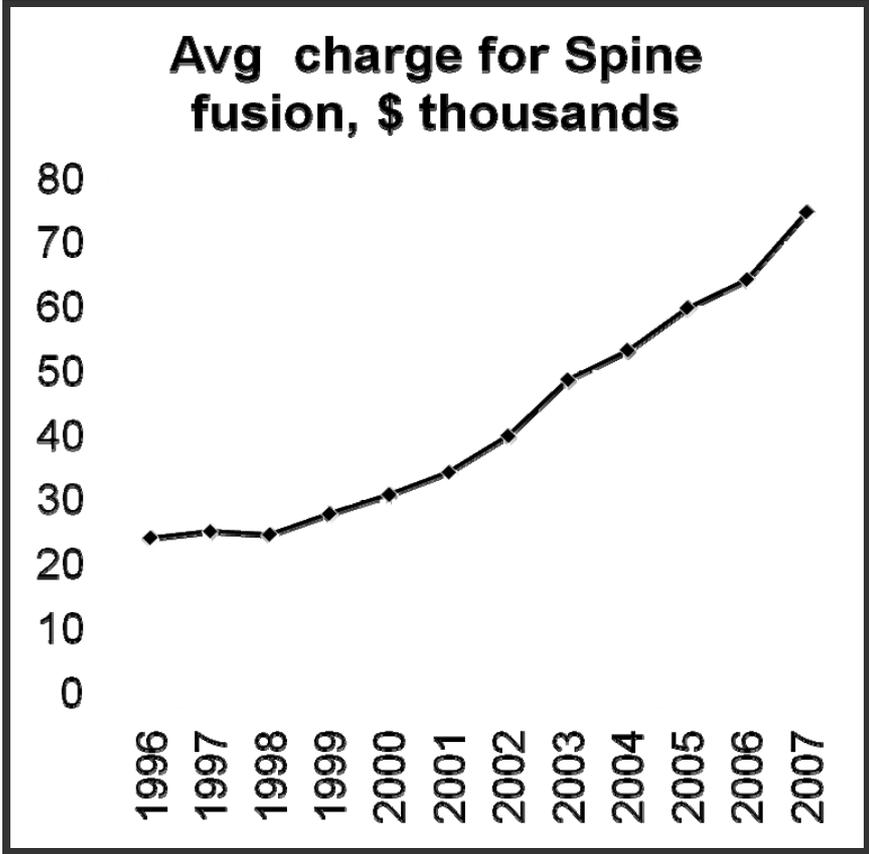
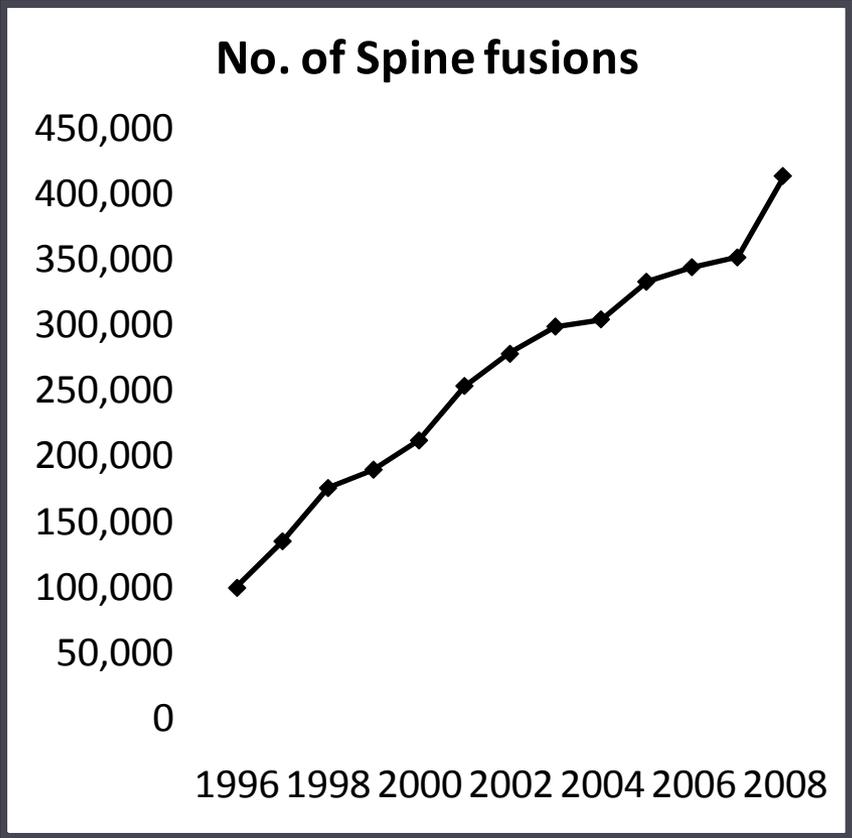
Figure 1: Rate/1,000 Workers, W/O Back Pain Claims
(=3 Days Time Loss)



Financial Interests in Spine Instrumentation

- ▶ Manufacturers acknowledge “giving surgeons millions of dollars in consulting fees, royalty payments, research grants”
- Pedicle screws: add ~\$13,000 per operation; \$4 billion/yr
- ▶ Gov’t investigating charges of illegal kickbacks; Medtronic has paid \$40 million settlement
- ▶ Ongoing investigations of companies and surgeons: surgeons forming their own companies

Nationwide spine fusion numbers & charges (source: HCUPnet, AHRQ)

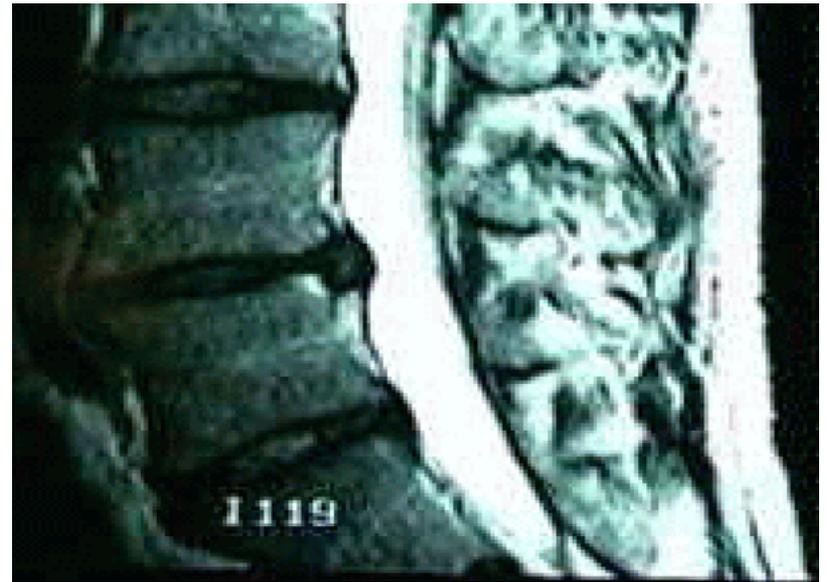
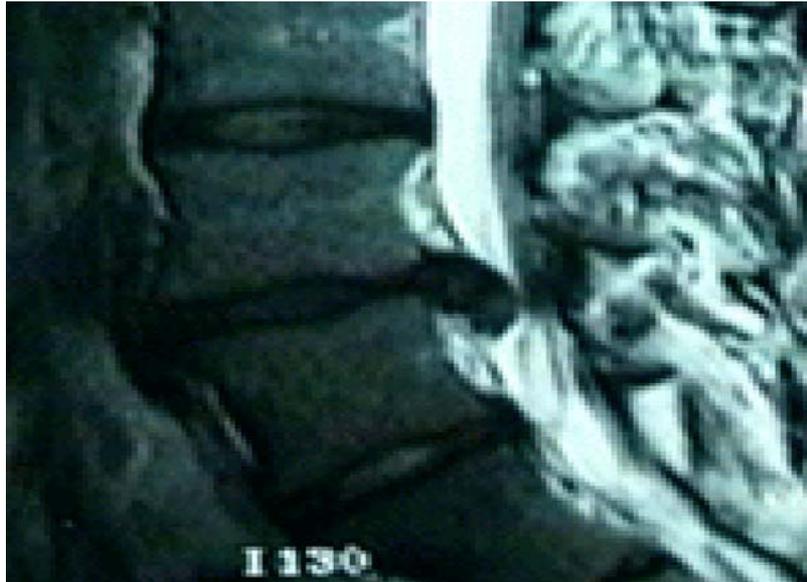


(All spinal levels, all indications, all techniques)

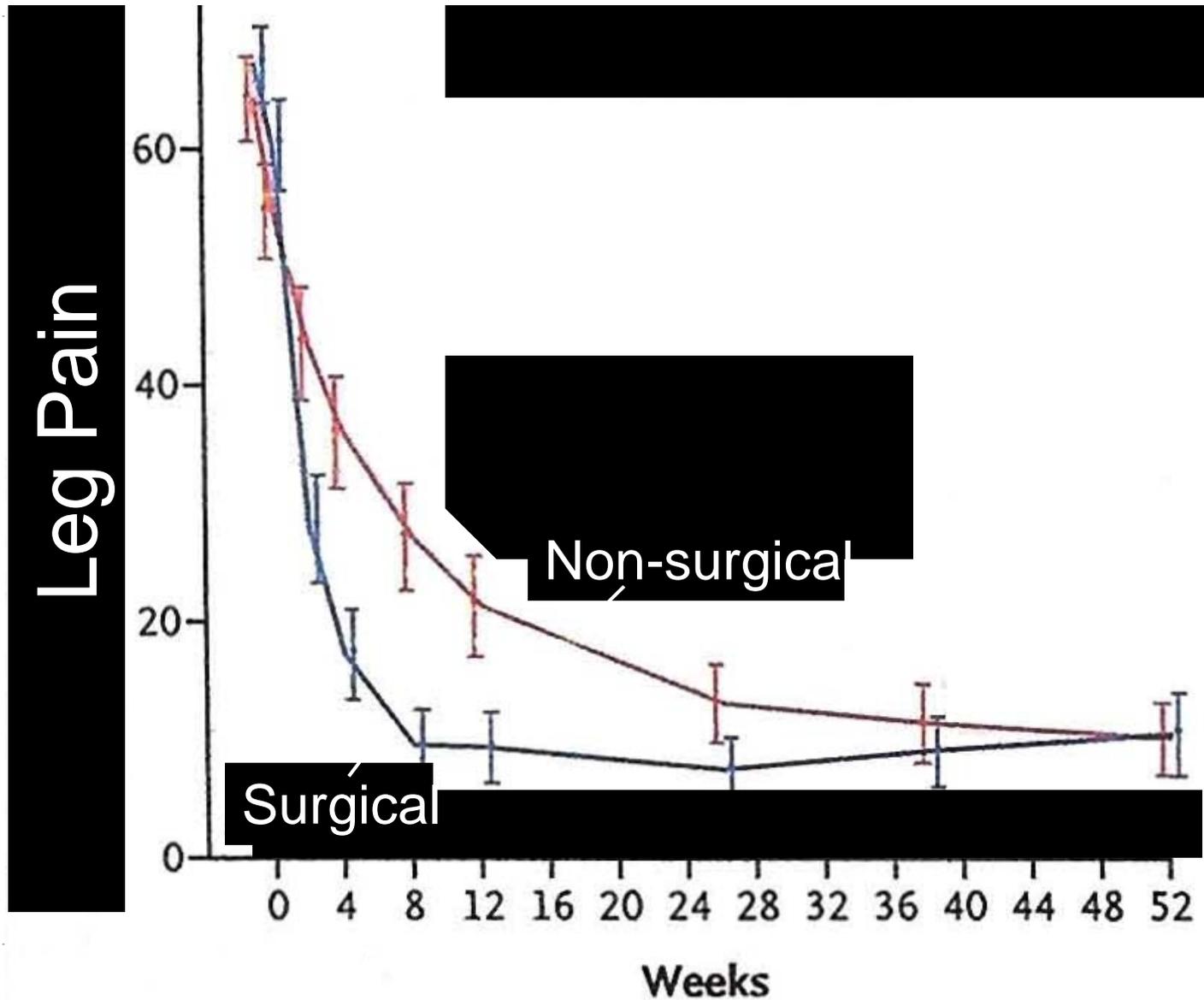
AHRQ Literature Synthesis: Fusion for LBP & Degenerative Discs alone 2006: Draft

- ▶ Fusion for axial back pain: 4 RCT's fail to show clinically meaningful advantage of surgery over rehab (>15 points on Oswestry)
- ▶ Instrumentation augments fusion rate, but higher complications, and no advantage in symptoms demonstrated
- ▶ Conclusion: fusion for degen. disc disease has no conclusive advantage over nonsurgical Rx, short-term or long-term





Can Patients with a Herniated Disc get better without surgery?



Neurological Recovery in RCT for Herniated Disc (N=64 w/Paresis)

	<u>Non-Surgery</u>	<u>Surgical</u>
4 yr: Total recovery dorsiflexion	44%	43%
Total recovery plantar flexion	56%	75%
10 yr: Recovery all weakness	84%	84%

True “Need” for Spine Surgery

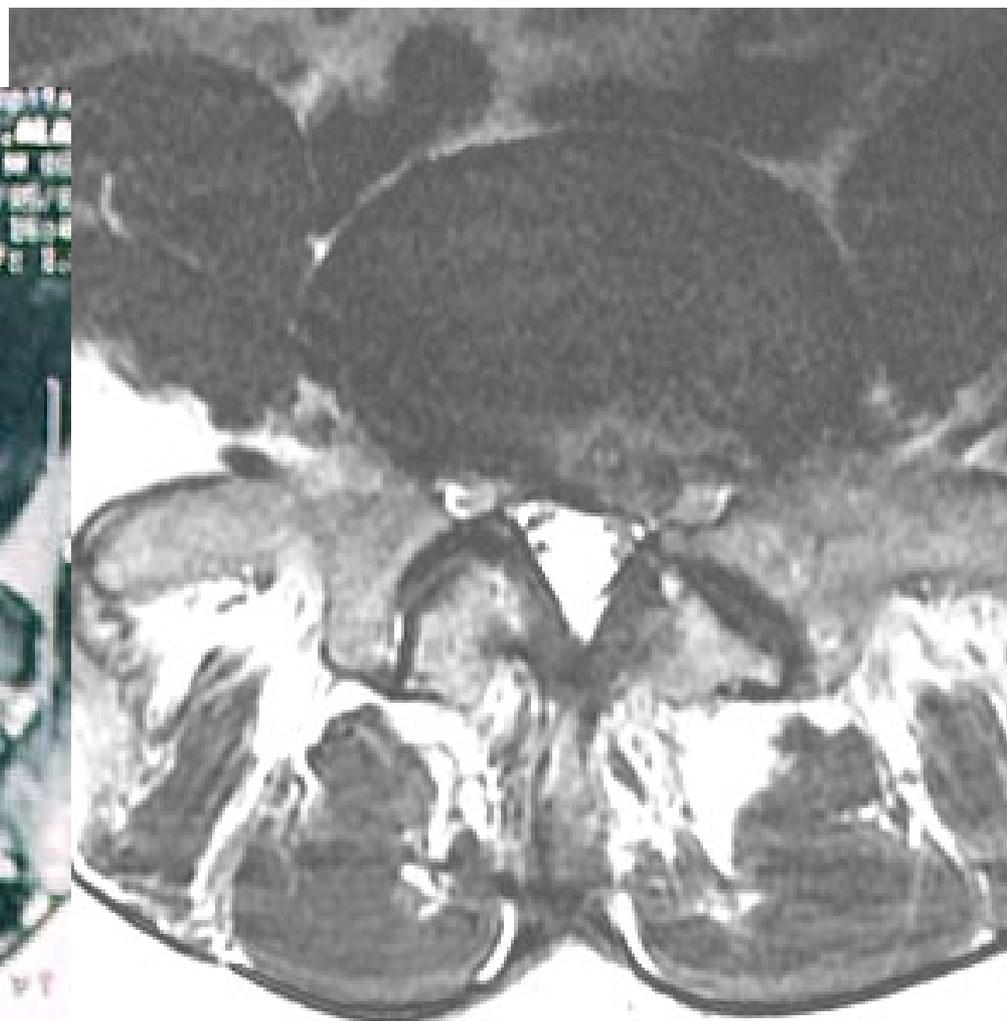
- ▶ Cauda Equina syndrome: bilateral leg weakness, difficulty walking, bowel or bladder dysfunction (usually urinary retention)
- ▶ Progressive neurologic deficit
- ▶ Certain cases of fracture, tumor, infection





F









5



6

[R]

[L]





A]

[F]

[F]

C109
W1007



Medical Panels



Consistency

- ▶ Medical panels set precedent of what medical procedures and treatments are acceptable within the medical community for injured workers.
- ▶ Complaints from both claimant and defense bar:
 - ▶ Guaranteed the same worker seeing two different medical panels would have opposite findings and conclusions.
 - ▶ Continue to have inconsistent findings and reports.
 - ▶ label obscure or highly unlikely diagnosis.
 - ▶ recommendations for tests or procedures that lack validity;
 - ▶ Probability of future problems or needs are far reaching;
- ▶ Too much involvement in pain issues.
- ▶ Not enough experience with panel members as to

▶ **Recommendations:**

- ▶ Appoint an experienced panel member to be panel medical supervisor.
- ▶ Would be paid by commission for supervisory work.
 - ▶ Responsible for quality medical panel members and reports.
 - ▶ Review reports before submission.
 - ▶ Instruct panel members on how to write reports
 - ▶ Recruit experienced panel members
 - ▶ Expect evidence base medicine in reports – Daubert decisions
- ▶ ▶ Education members as to bio psycho social

Medical Fee Advisory Committee

- ▶ Administrative:
 - ▶ Ron Dressler
 - ▶ Alan Colledge, PT, MD
- ▶ Providers:
 - ▶ Orthopedic Surgeon Dean Walker, MD
 - ▶ Primary Occupational Physician Phil Jiricko, MD
 - ▶ Occupational Physician: Ed Holmes
 - ▶ Physical Therapists: Dell Felix PT
 - ▶ Chiropractor: James D. Knight DC
 - ▶ Nurse Practitioner: Deborah M. Judd, MSN, FNP-C



Medical Advisory Committee

- ▶ Injured Worker Legal Representative
 - ▶ Dawn Atkin
 - ▶ Employer Legal Representative
 - ▶ Dori K. Petersen
 - ▶ Payers: WCF-Roger Stuart, MD
 - ▶ Other Carriers Representative
 - ▶ Truman Child CEO
 - ▶ Self Insured
 - ▶ M. Jeff Rowley
 - ▶ Coding Specialists
 - ▶ WCFU: Peg Howarth
 - ▶ Mari Ann Randall, INGENIX
 - ▶ Melessa Fannesbeck, INGENIX
-
- ▶▶ Karine McOmie



Medical Fee Standards 2013



Effective Dec 2013-Nov 2014

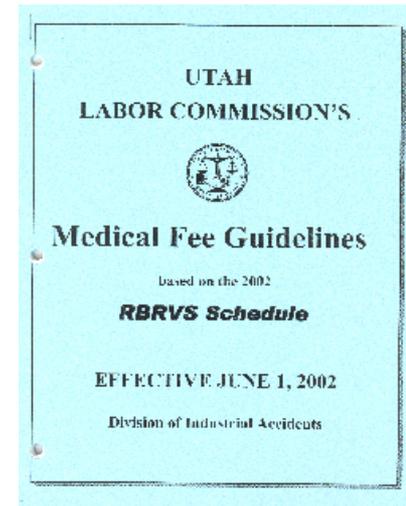
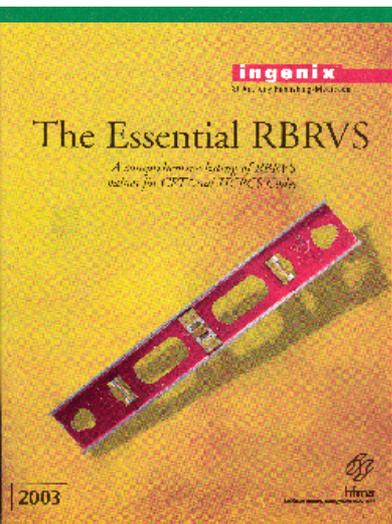
Distribution of Medical Payments in Utah

Percent of Workers Compensation Medical Payments, Average, 1996–2002

Hospital Services	40.8
Complex Surgery and Anesthesia	10.3
Physical Therapy	8.4
Office Visits	7.8
Drugs and Supplies	7.0
Surgical Treatments	4.4
Diagnostic Radiology	2.8
Complex Diagnostic Testing	2.3
Emergency Services	1.9
Pathology	0.2
All Other	14.0

Source: NCCI





CPT Number	RBRVS	X	Utah Conversion Factor	
99203	2.56	X	\$46	= \$117.76



2012 Medical Schedule

- ▶ **First Quarter 2013**
- ▶ **2013 American Medical Association (AMA)
Current Procedural Terminology(CPT**



Annual Update-Dec each year

- ▶ Compare with Other Payers in the State
 - ▶ MEDICARE
 - ▶ BX-BS
 - ▶ IHC Care
 - ▶ DMBA
 - ▶ PEHP
 - ▶ CIGNA
 - ▶ ALTIUS



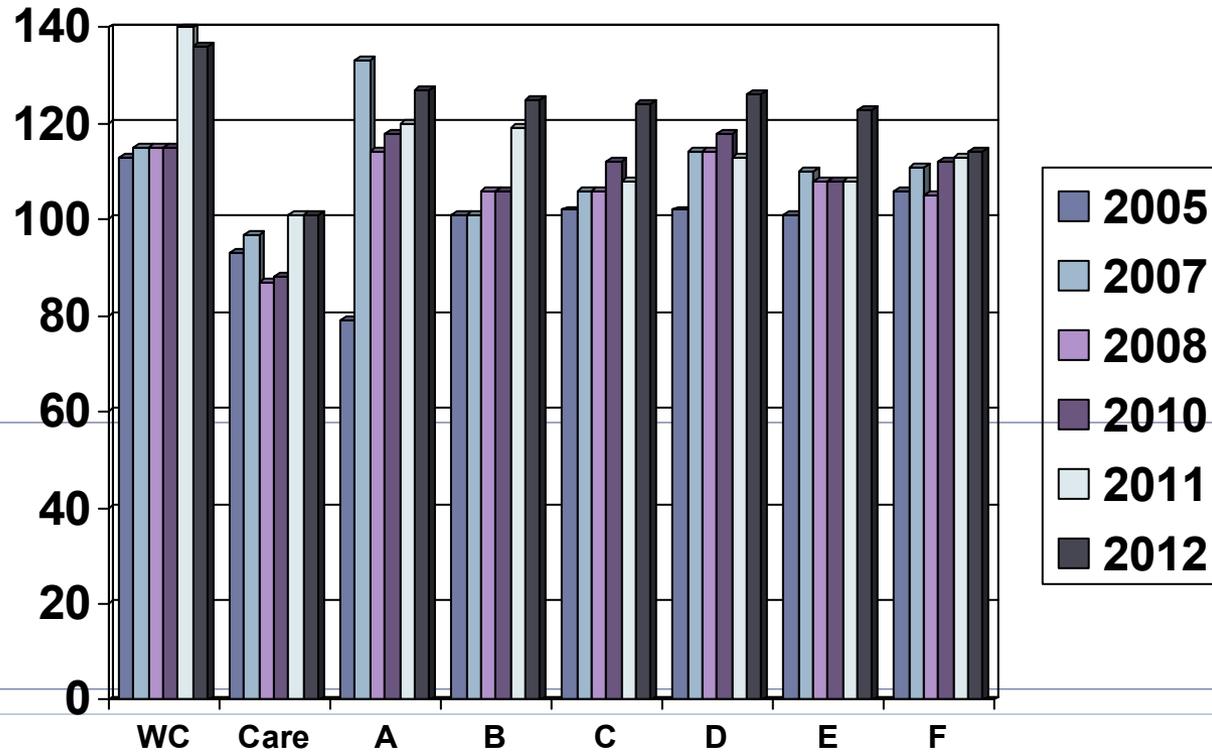
Must maintain Access for Injured
Workers to Quality Medical
Providers

Need to remain Competitive with
other Payors

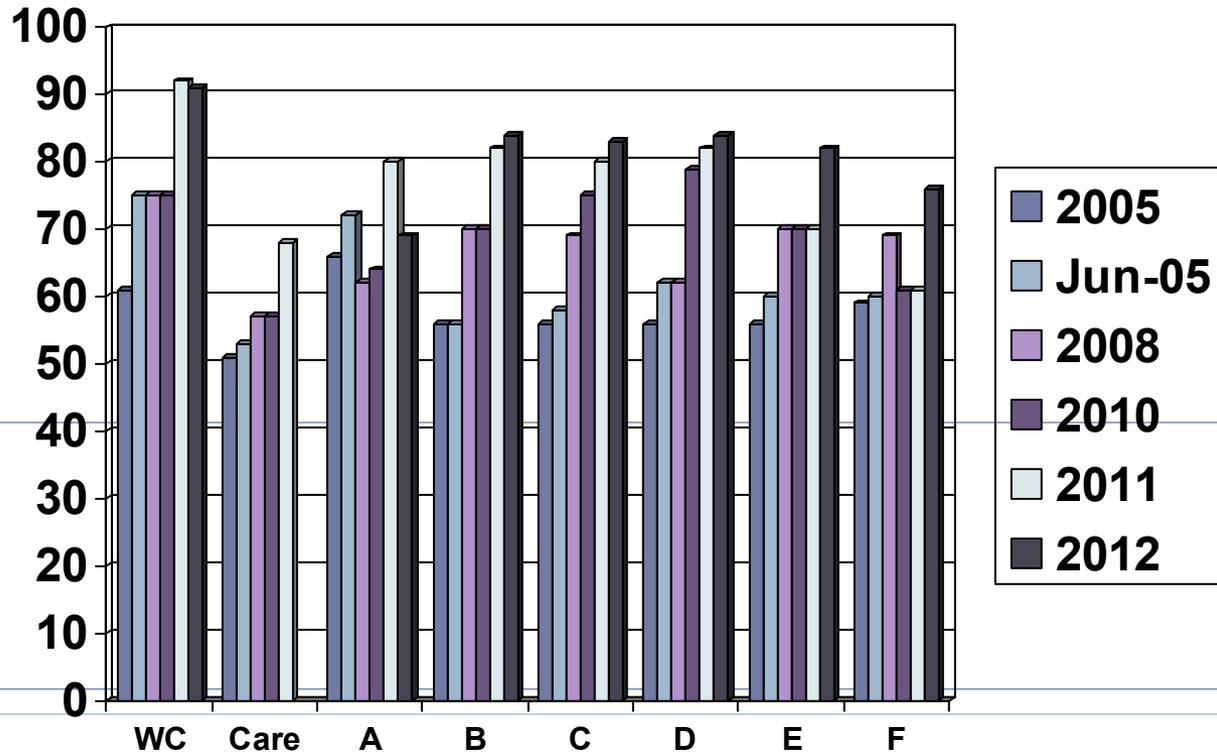
- ▶ How we compare over the years to other payers



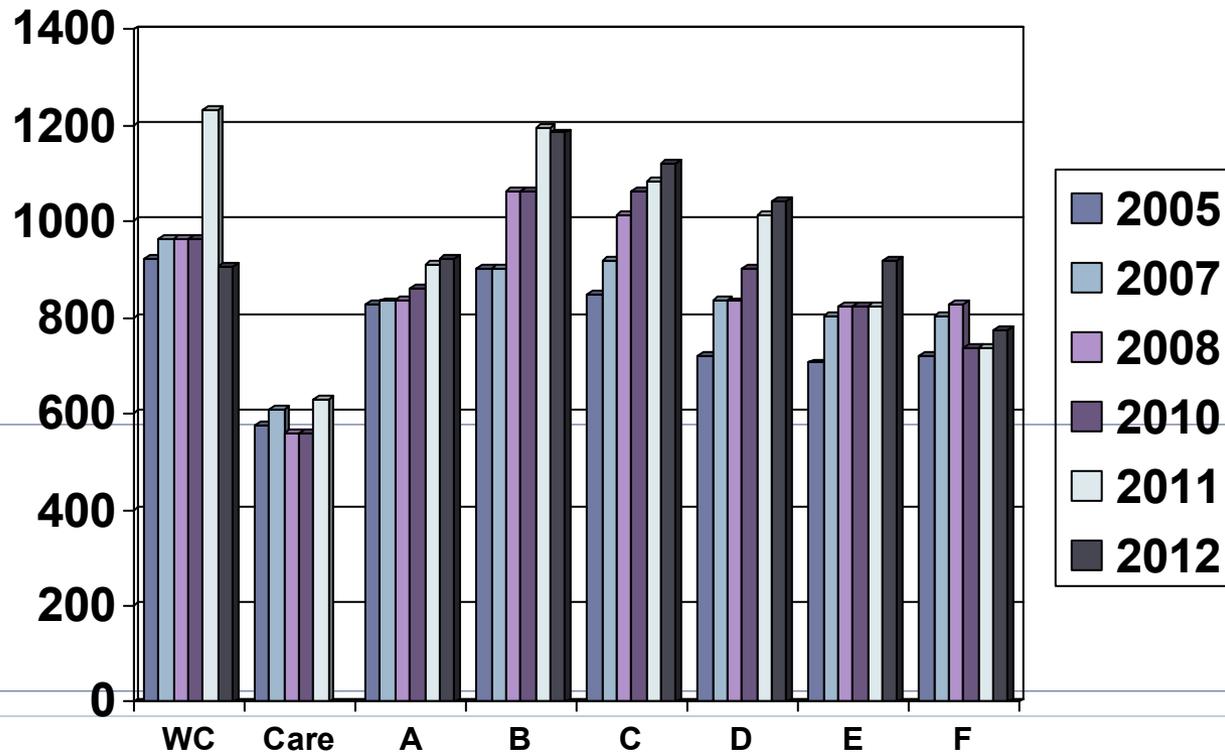
99203 30 min new patient



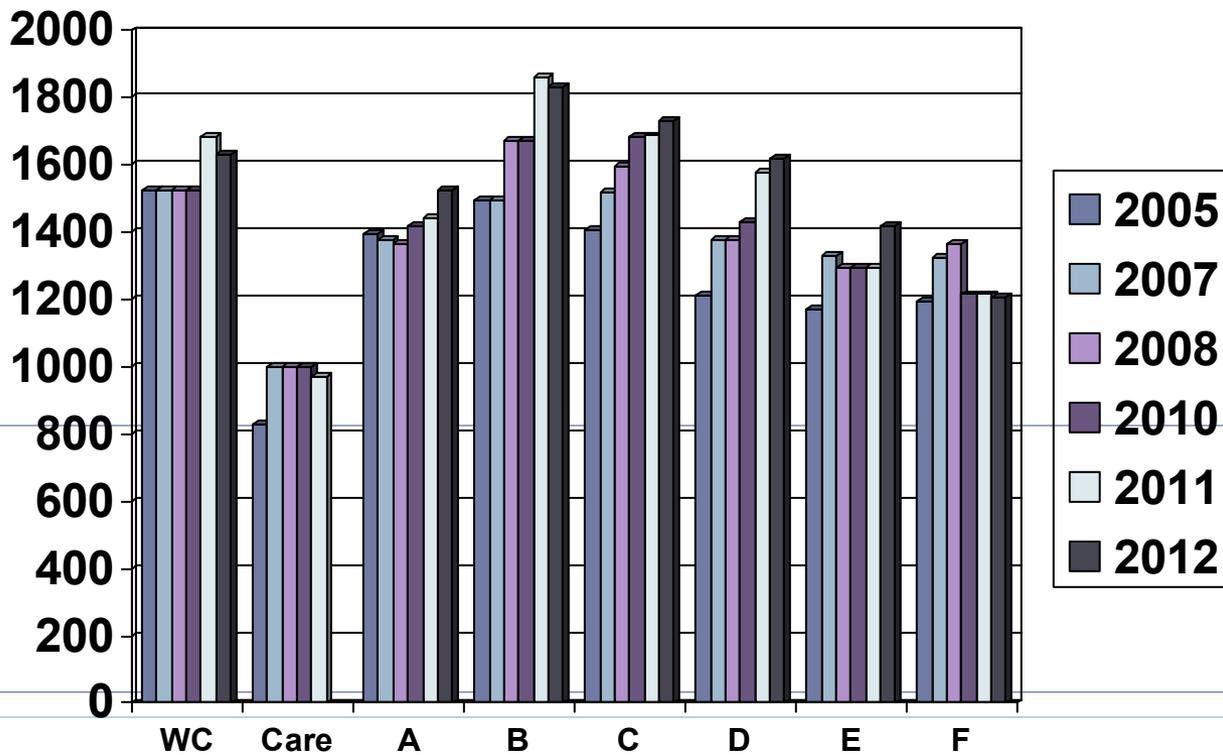
99213 15 min Follow Up Increase from \$45



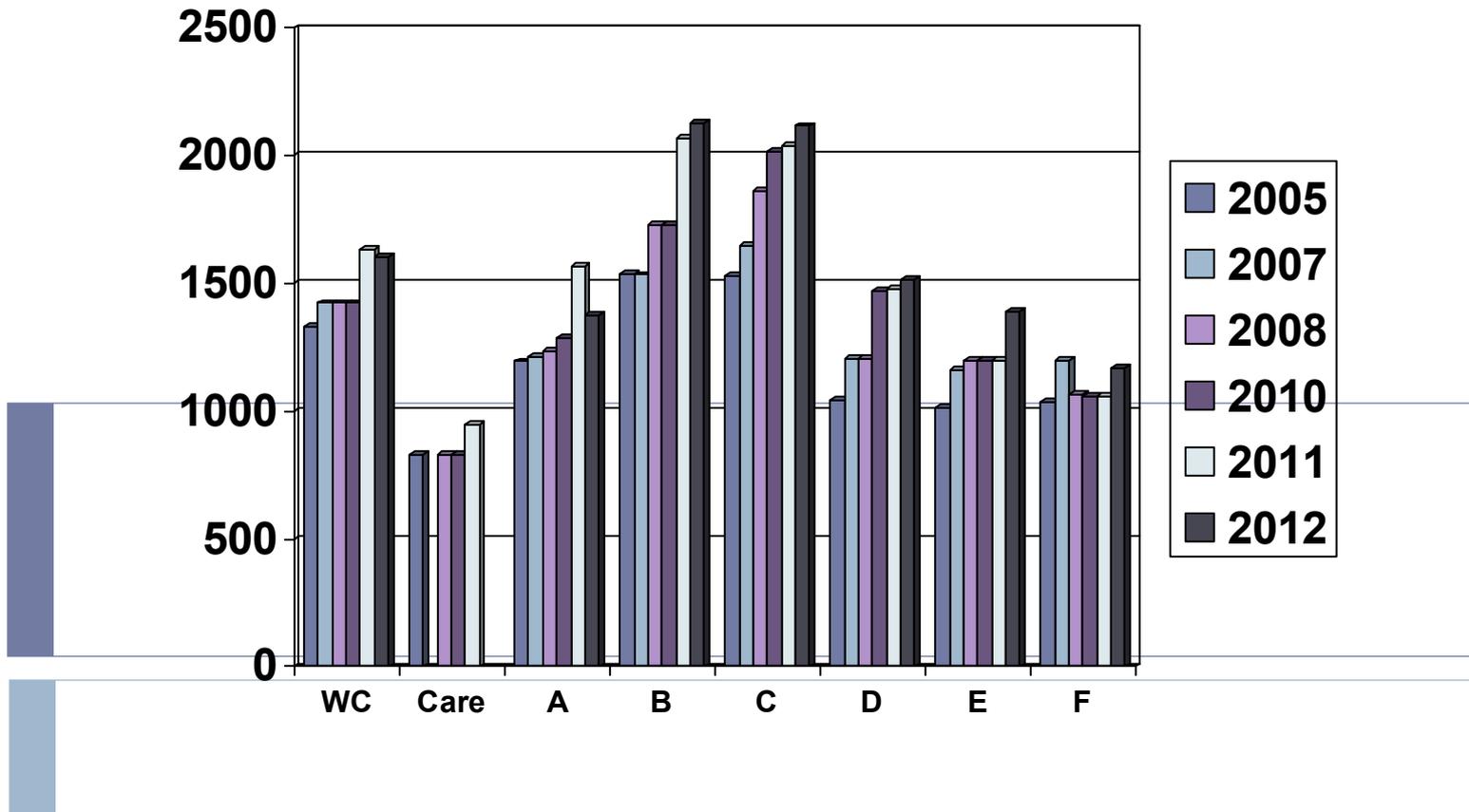
29881 Knee Arthroscopy Surgery Meniscectomy including shaving



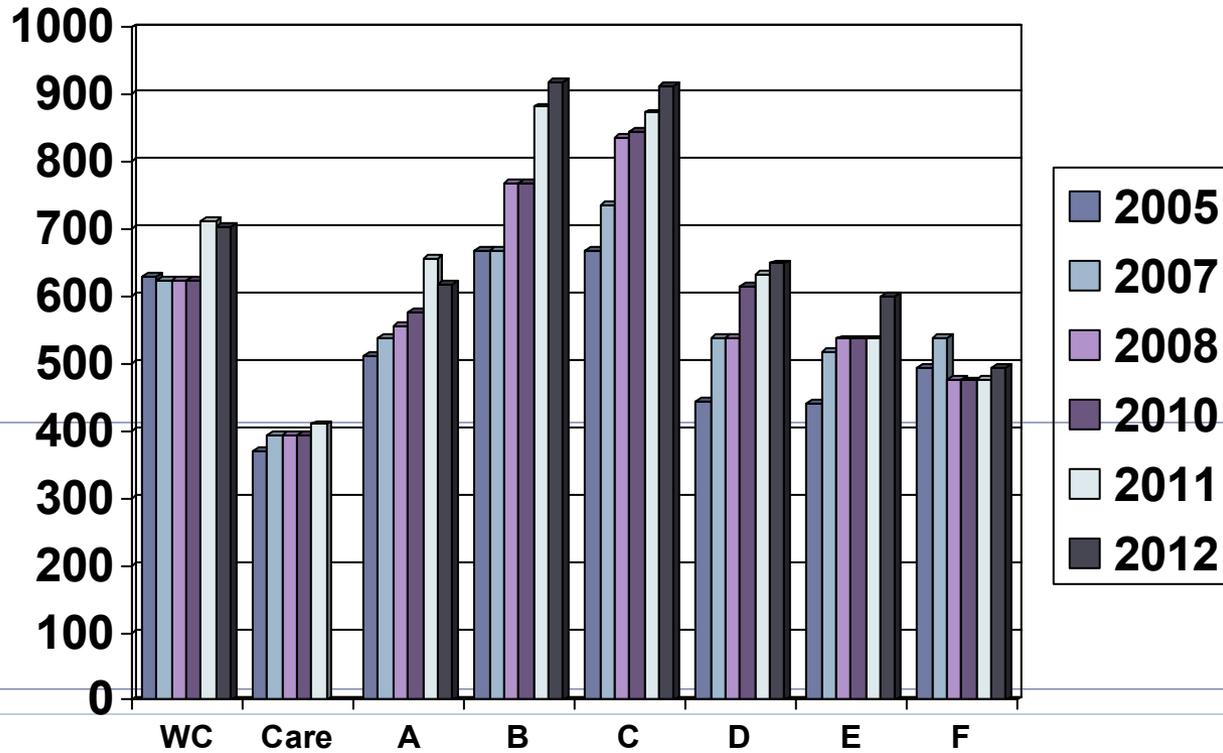
29888 Knee Arthroscopy Surgery Aided anterior cruciate repair



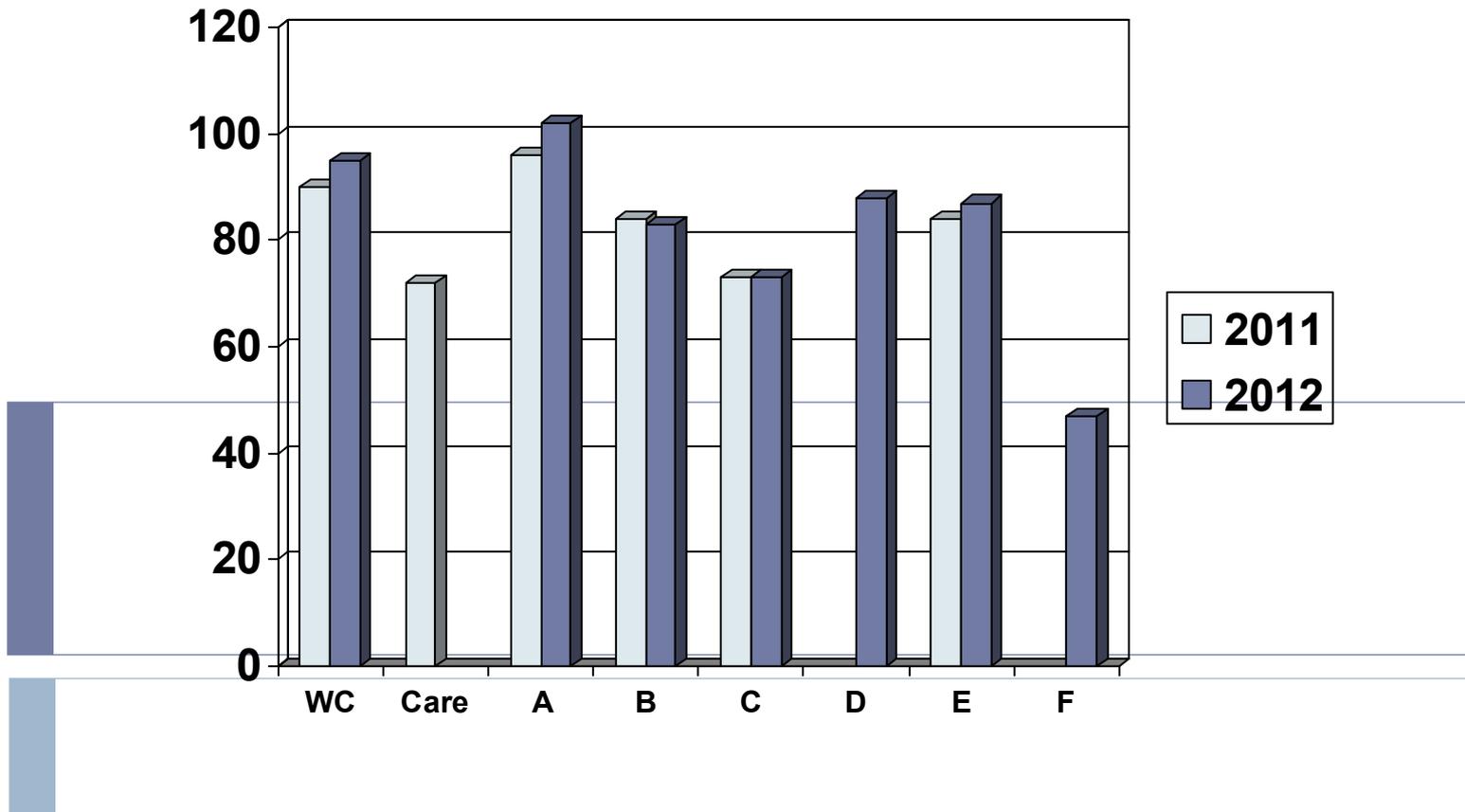
63030 Low Back Disc Surgery



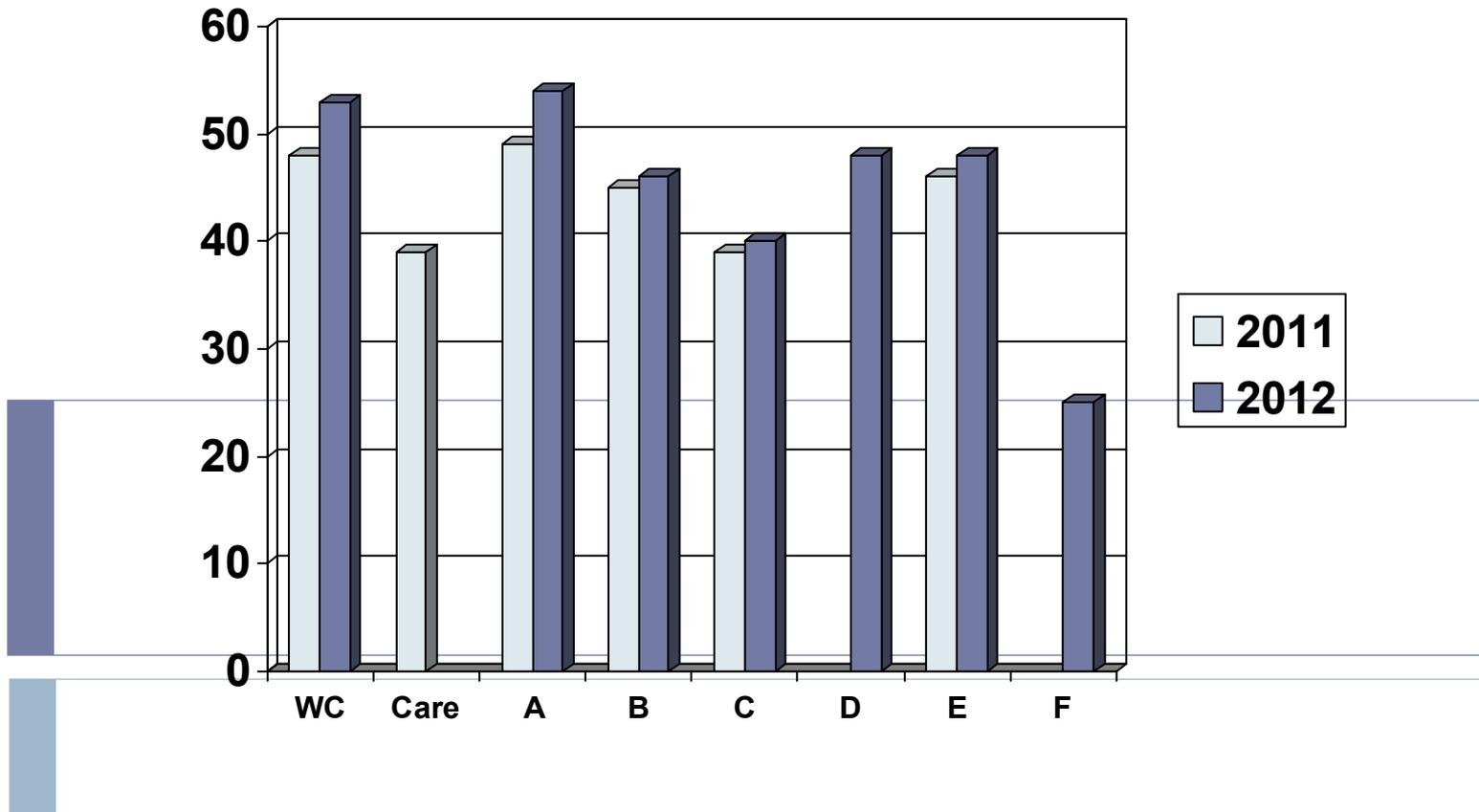
64721 Carpal Tunnel Surgery



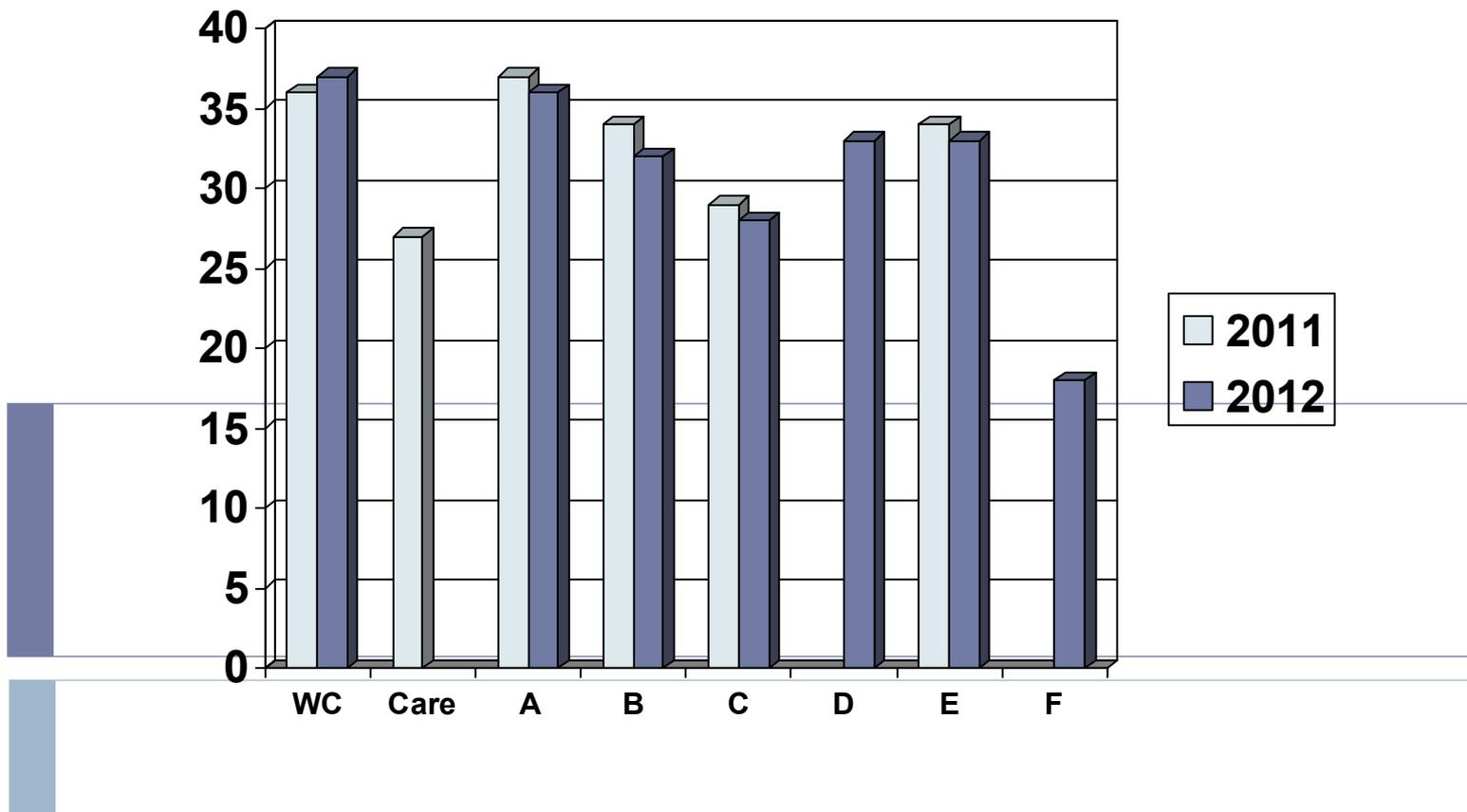
97001 Physical Therapy, new patient



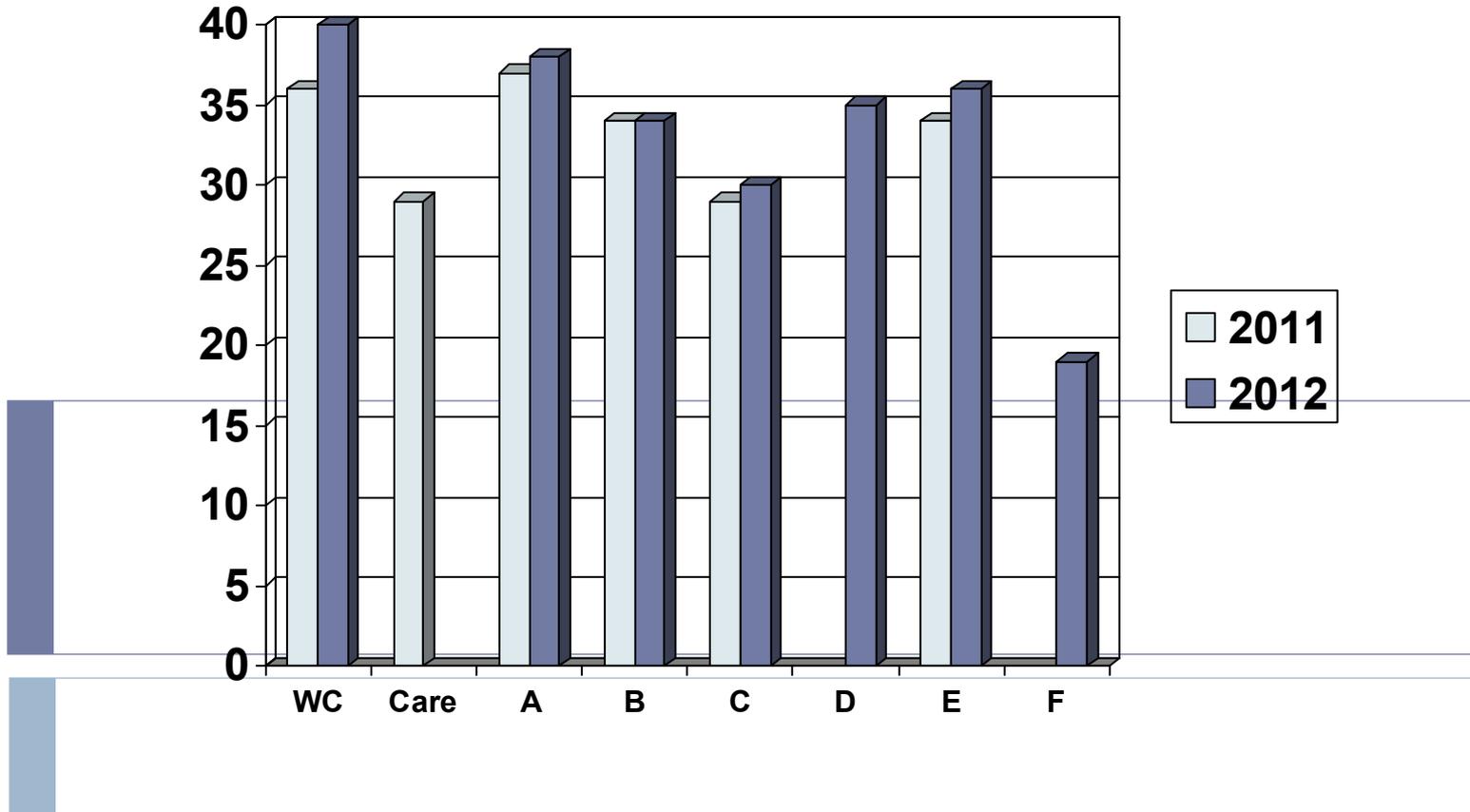
97002 Physical Therapy, re eval patient



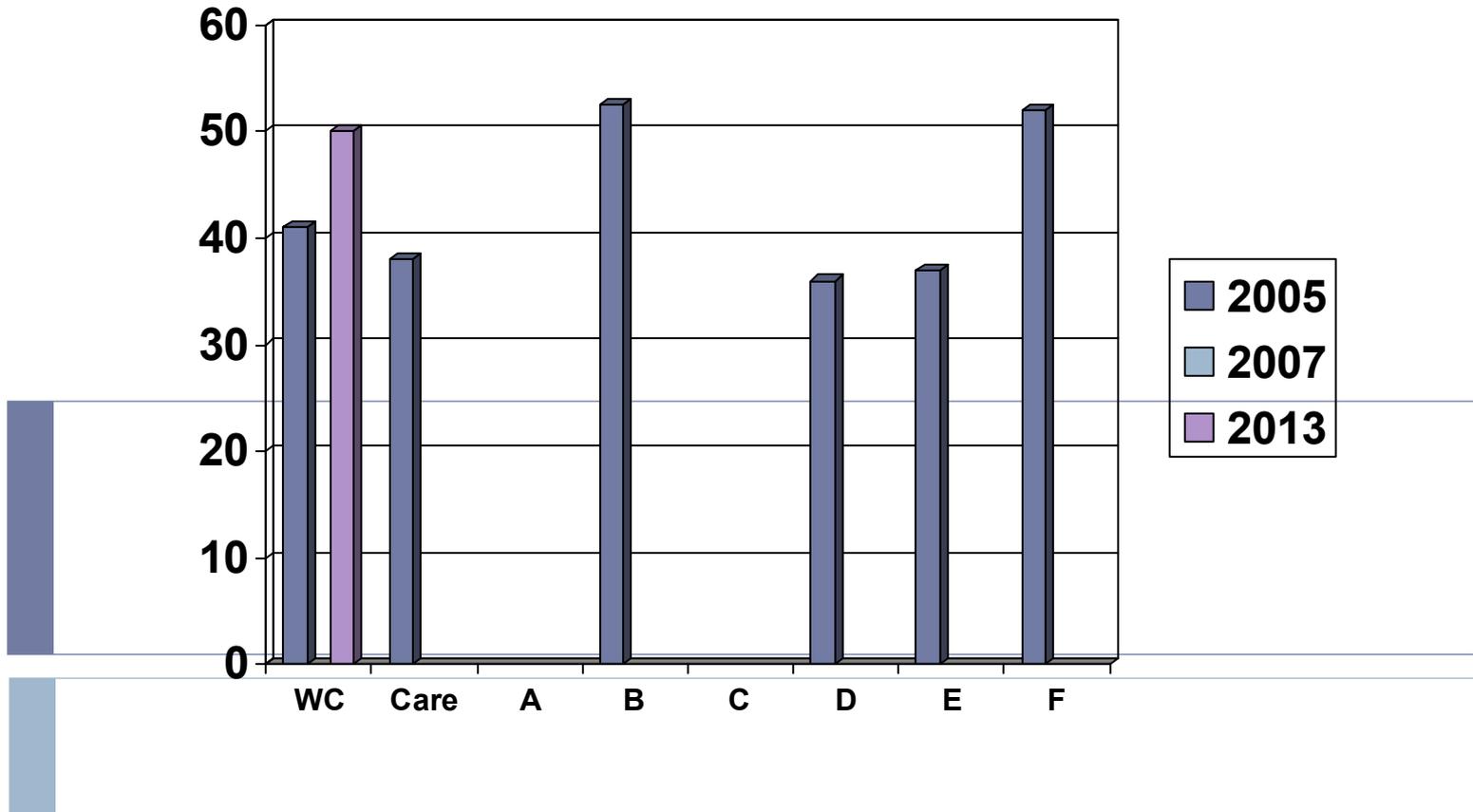
97140 Physical Therapy, manual therapy



97110 Physical Therapy Therapeutic Ex



Anesthesia at 15 min units



Re establishing the prior conversion factors (2011)

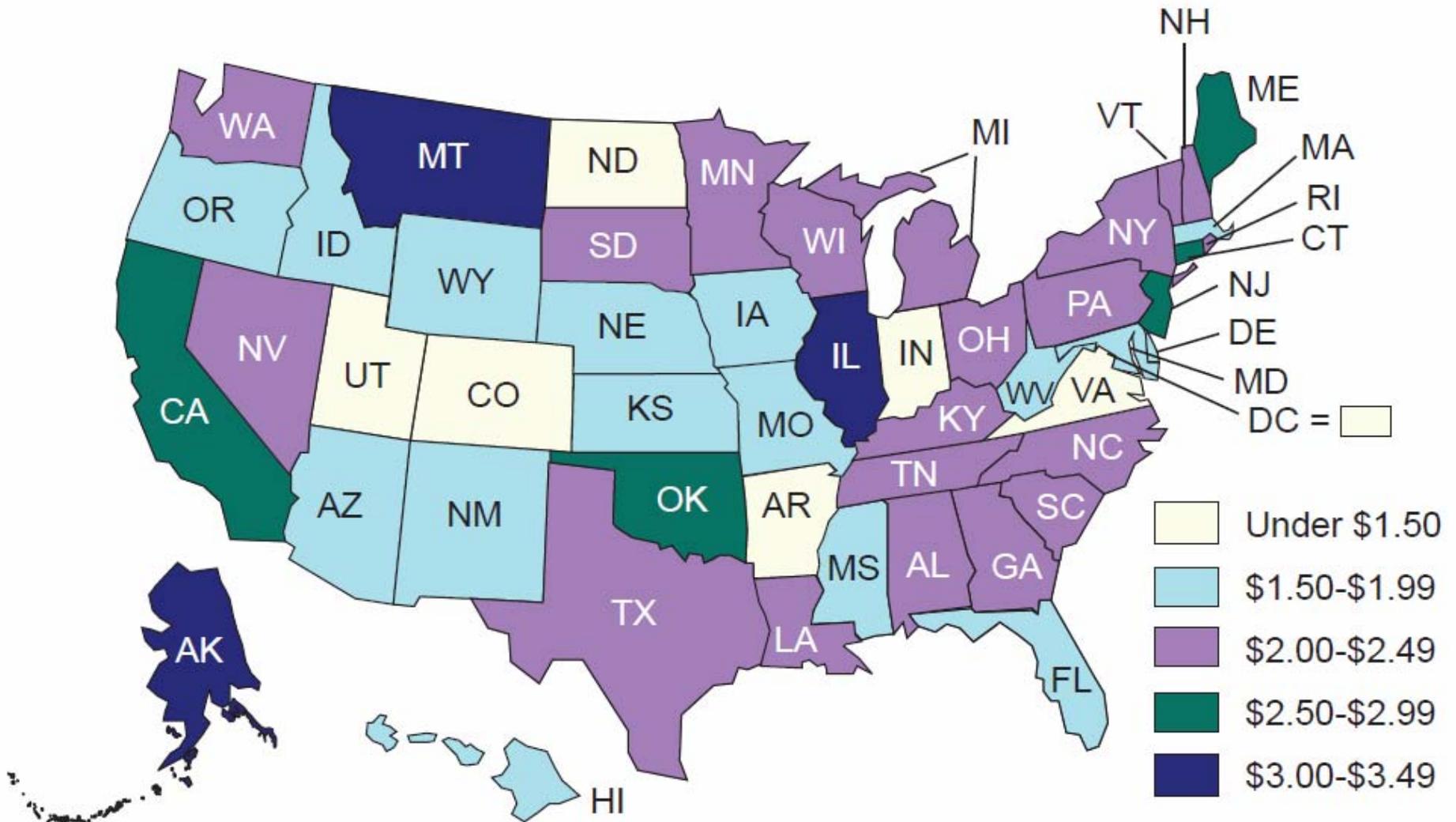
A projected increase of 0.7%

Voted 9/10 for this

Medicine	\$46	
E and M	\$46	
Restorative Services	\$46	
Anesthesiology*	\$50	
Pathology and Laboratory **	\$52	
Radiology	\$53	
Surgery	\$37	
Surgery in all 20000 codes, codes 49505-49525, and all 60000 codes		\$58



Figure 1. 2010 Workers' compensation premium index rates



HOSPITAL / AMBULATORY SURGICAL CENTERS

- ▶ The Labor Commission does not have a Hospital or Ambulatory Surgical Center fee schedule.
- ▶ **Obama care**



PHARMACY SCHEDULE

- ▶ The Labor Commission does not have a pharmacy fee schedule.



Managed Care

Preferred provider programs

- ▶ Section 34A-2-111 of the Utah Workers' Compensation Act allows self insured employers and insurance carriers to develop “preferred provider programs” to provide medical care for injured workers.



Medical Fee Schedule

Provides Basic Reimbursement

- ▶ Contract:
- ▶ Special preauthorization
- ▶ Providers may present to the Medical Committee



Disputes for billing

- ▶ The Division of Industrial Accidents can review the dispute pursuant to the Medical Fee Guidelines and the RBRVS,
- ▶ Division of Adjudication can be requested to make a formal determination.



Impairment Ratings billings

▶ **BULLETIN - 1 - 2013**

▶ To: Medical Care Providers

▶ Workers' Compensation Insurance

▶ Date: June 24, 2013

▶ Re: Billing Items

▶ There have been several issues related to billing that have come to the attention of the Division of Industrial Accidents. Please note the following items and contact the Division with any questions.

▶ **Medical Payment Review:** Pursuant to R612-300-25 providers have 1 year to submit a bill for services rendered. Payors shall review the bill and compensate the provider the appropriate fee within 45 days of billing. If there is a dispute over the amount paid, the provider can request the payor to re-evaluate the fee(s). The request for re-evaluation shall be in writing, shall describe the areas of disagreement, include supporting documentation, and be submitted within 1 year of the original payment. Within 30 days of the receipt of the request, the payor shall either pay the additional fee or respond with a written explanation of the basis for its denial. If the provider continues to disagree, the matter can be submitted to the Labor Commission for review and adjudication of the dispute.

Contacts

- ▶ ESIS Contact person
- ▶ Martha.arciniega@esis.com
- ▶ 503-598-1492

- ▶ Sedgwick-Dean Sarty
- ▶ 614-376-5591

- ▶ Traveler's Contact Person:
- ▶ Connie Booth traveler 720 963 7182
- ▶ cbooth@travelers.com



NON-PHYSICIAN SERVICES

-
- ▶ The defined as medical providers may provide services only under the direction of, or by the prescription of, a licensed physician or nurse practitioner:
 - ▶ physician's assistants
 - ▶ registered physical therapists
 - ▶ registered occupational therapists
 - ▶ registered nurses
 - ▶ licensed practical nurses
 - ▶ licensed psychologists
 - ▶ speech pathologists
 - ▶ Audiologists
-
- ▶

Paramedical Personnel Reimbursement

- ▶ Physician Assistants 75%
- ▶ Nurse Practitioners 75%
- ▶ Medical Social Workers 75%
- ▶ Nurse Anesthetists 75%
- ▶ Physical Therapy Assistants 75%



ASSIGNED A “O” RVU VALUE

- ▶ Artificial discs
- ▶ Percutaneous diskectomy
- ▶ endoscopic diskectomy
- ▶ IDEPT
- ▶ Platelet rich plasma injections
- ▶ thermo rhizotomies
- ▶ heat or chemical treatments for discs are still considered investigational.
- ▶ VAX D or other unique mechanical vertebral traction



ASSIGNED A “O” RVU VALUE

- ▶ Massage therapy
- ▶ Athletic Training Evaluation
- ▶ Acupuncture
- ▶ Diathermy
- ▶ Infrared Therapy
- ▶ Ultraviolet Therapy
- ▶ Cold Laser Therapy



Professional Self Treatment

- ▶ Any professional that treats themselves and then bills insurance for that treatment would be practicing unprofessional conduct and should be reported to the Utah Division of Occupational and Professional Licensing.



Guidelines Application

▶ Treatment

- ▶ Evidence based
- ▶ Updated bi annual
- ▶ Peer reviewed
- ▶ affordable

▶ Utilization review

- ▶ 2 level

▶ RSA

- ▶ Restorative services
-

PATIENT	Last Name First Middle		Home Address, City, State, Zip			
	Social Security Number		Date of Birth		Date of Injury	
	Age	Height	Weight	Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes	Pack per Day for _____ Year	
				Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes	Drinks per Week _____	
Employer's Name Floor #			Street Address, City, State, Zip			
Physician			Street Address, City, State, Zip			
Adjuster			Phone #		Fax #	
Provider Name/Specialty			Street Address, City, State, Zip			
Tax ID#			Primary Diagnosis (ICD-9 Code)			
Phone 1		Fax 1		Secondary Diagnosis (ICD-9 Code)		
Referring Physician			Current Medications			
Precondition/Post-Health Conditions That Could Impact Recovery						
Findings Initial Visit			Initial Treatment Plan, Description and/or CPT Codes			
Usual Restrictions _____ NONE General Pains, Finest _____ NONE Range of Motion Loss _____ NONE Resting Pain _____ MODERATE Weight Walking _____ SEVERE X-ray Findings _____ Soft Tissue Injury _____ Other Symptoms _____						
Patient's General Function/Ability: 1=Low 10=High/Normal			# Phys Visit /WK	C12	C13	C14
Hours per Day the Patient is Currently Working			# Phys Visit			
Patient's Current Job Functions/Responsibility Per Shift: B=Base C=Casual D=Emergency E=Continuous			Patient's Capabilities Phys Visit	Authorized Request 1 - 34-5912	Authorized Request 60 - 20 Visits	Authorized Request 2148 Visits
BEM: Body Pain _____ Motion _____ Freq _____ Recycled _____ Motion _____ Freq _____						
Walking Time _____ Hrs _____ Freq _____						
Grip _____ LBS _____ FREQ _____						
Lifting Capacity Max Lbs _____ Freq _____ Floor Work Max Lbs _____ Freq _____ Walk Staircase Max Lbs _____ Freq _____ Climb Stair Max Lbs _____ Freq _____ Carry Max Lbs _____ Freq _____			Max. Lbs _____	Max. Lbs _____	Max. Lbs _____	Max. Lbs _____
Repeat Movements _____ Hrs _____ Freq _____						
Stitch _____ Hrs _____ Freq _____						
Stitching at Over Time _____ Hrs _____ Freq _____						
Workload Exceeded by Medical Conditions/Probs						
Anticipated date of "Flow Status Recovery"						
Number of visits Allowed / Hours Scheduled			C	C	C	C
# Requested Visits			S	S	S	S
Signatures/Date Submitted						
# Visits to be visited, Pending, Denied # Times to be approved, less than requested, from medical opinion.			S	S	S	S
Signatures/Date Resubmitted						

Utilization Review-223

Form 223 Authorization Request for Medical Procedures / Carrier Response

PLEASE PRINT OR TYPE

P A T I E N T	Last Name First Middle			Street Address, City, State, Zip	
	Social Security Number		Date of Birth	Phone Number	Date of Injury
	Employer's Name		Street Address, City, State, Zip		Phone Number
C A R R I E R	Name			Street Address, City, State, Zip	
	Adjustor			Phone Number	Fax Number
P R O V I D E R	PROVIDER'S INITIAL REQUEST (Level One)				
	Provider's name			Street Address, City, State, Zip	
	Degree and Specialty			Phone Number	Fax Number
	Diagnosis			Best Time to Contact Provider (Business Days)	
	Date of Verbal Transmission	Requested Procedure(s) Supportive Documentation Attached if Needed			
C A R R I E R	CARRIER'S RESPONSE (Level One)				
	Date of Verbal Transmission	Responsible Person	Acceptance Signature	Denial Signature(Attach Criteria Utilized)	
P R O V I D E R	PROVIDER'S REQUEST FOR CARRIER'S PHYSICIAN REVIEW (Level Two)				
	Date of Verbal Transmission	OPTIONAL - Explanation and/or Additional Information			
C A R R I E R	CARRIER'S PHYSICIAN'S RESPONSE (Level Two)				
	Date of Verbal Transmission	Name of Responsible Physician	Acceptance Signature	Denial Signature(Attach Criteria Utilized) If denied, a copy of this form must be faxed to the Labor Commission	
P A T I E N T	PATIENT'S ACKNOWLEDGMENT OF RESPONSIBILITY IF PROCEDURE IS DENIED BY CARRIER				
	I agree that I may become liable for the cost of the medical procedure if it is ultimately determined to not be compensable				
P A T I E N T	Date	Patient's Signature			

Notice to Claimant: If you are in disagreement with the carrier and cannot resolve your differences by talking with the carrier and/or your treating physician, you should then call the Labor Commission, Division of Industrial Accidents for further instructions. 801-530-6800.

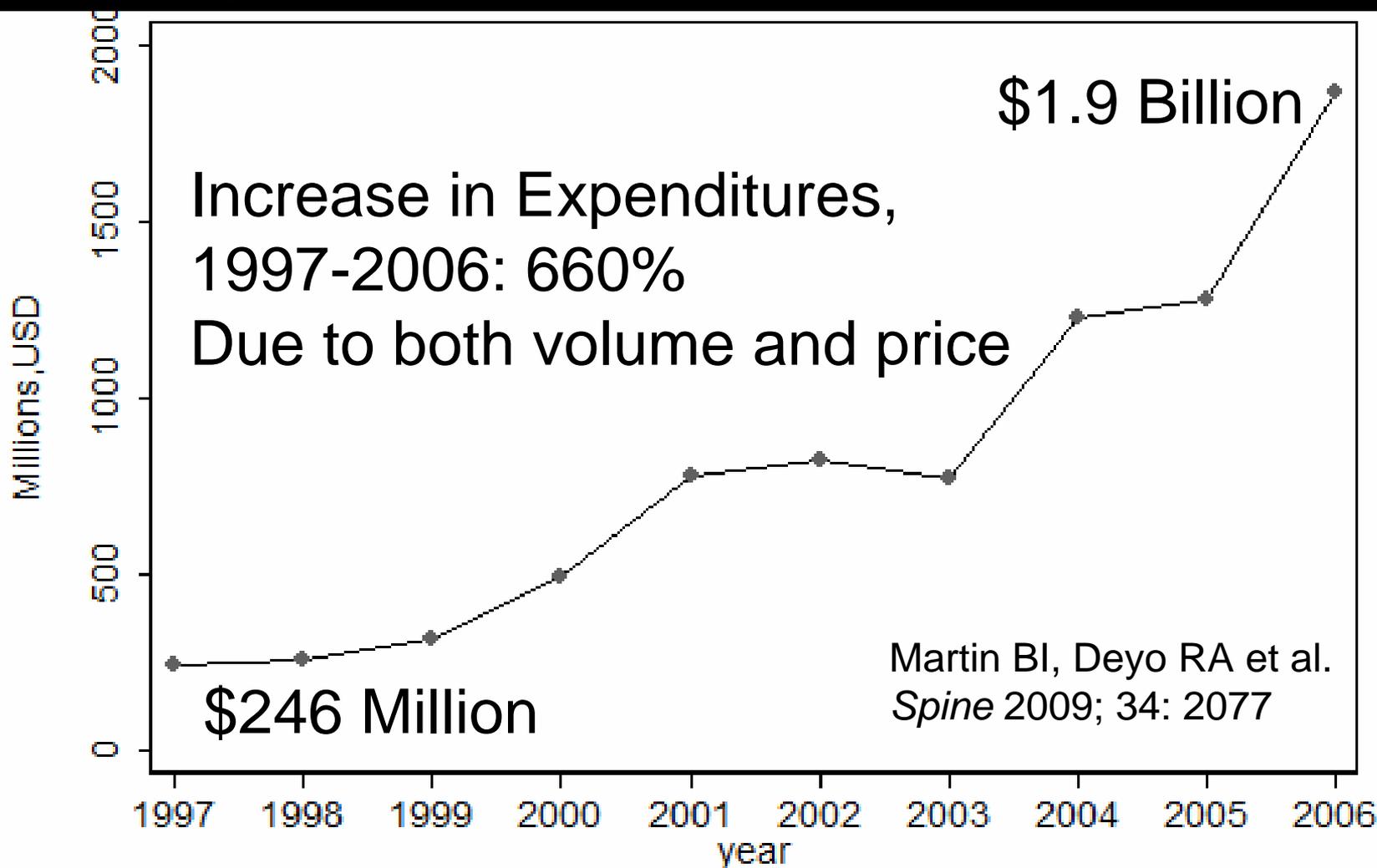


Official Form 223 Revised 2/09
 State of Utah • Labor Commission • Division of Industrial Accidents
 160 East 300 South • P.O. Box 146610 • Salt Lake City, UT 84114-6610 • Telephone: (801) 530-6800
 Fax: (801) 530-6804 • Toll Free: (800) 530-5090 • www.laborcommission.utah.gov

Narcotics-Pain

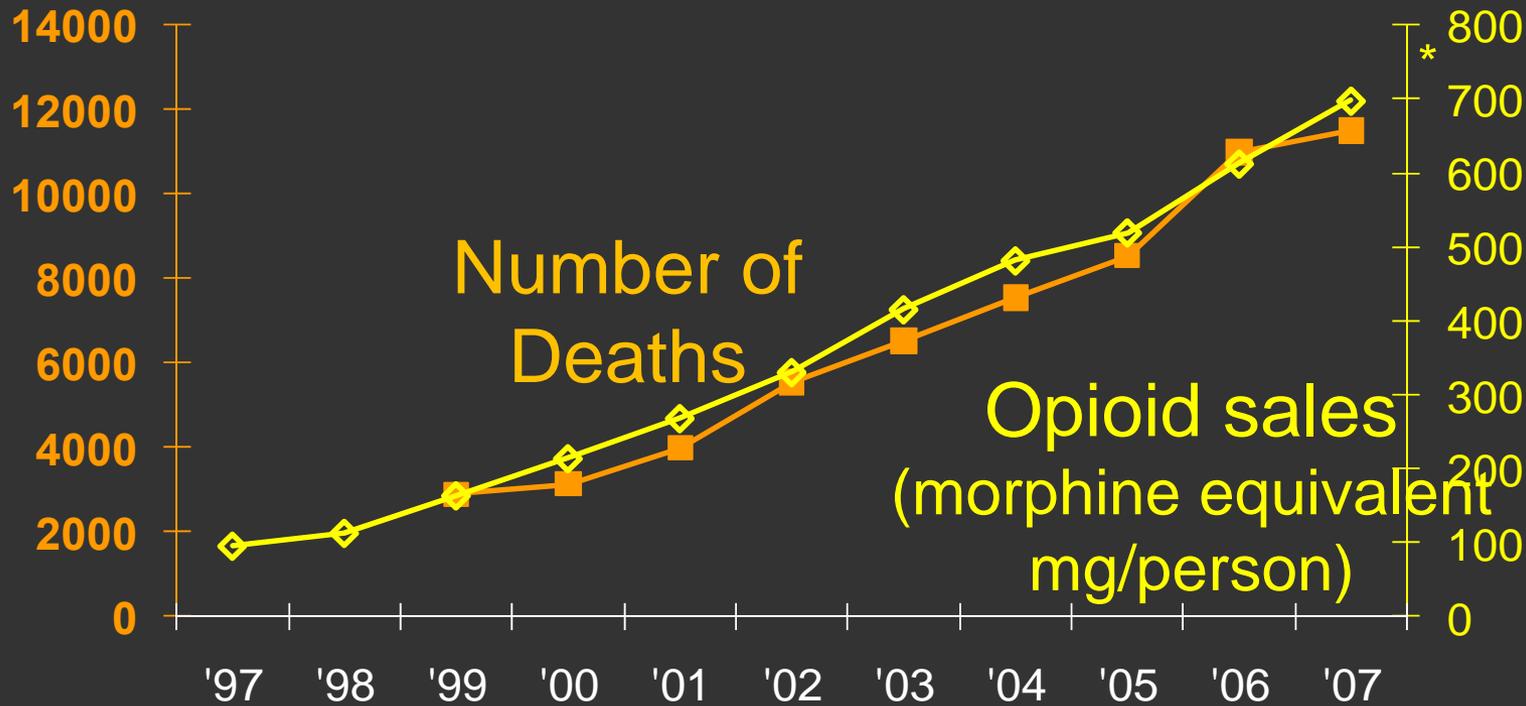


Estimated Opioid Expenditures, Adults With Spine Problems: 1997-2006, MEPS



expenditures for all years converted to 2006 equivalents using consumer price index medical component

Unintentional overdose deaths involving opioid analgesics vs. per capita sales



Source: Nat. Vital Statistics System, multiple cause of death dataset, and DEA ARCOS

* 2007 opioid sales figure is preliminary. Slide from Len Paulozzi

Case Report: Gen. David Fridovich

- ▶ 2006: 54 y.o. General doing leg presses at Marine gym in Hawaii, after visit to Iraq. Felt a twinge.
- ▶ Continued weight training, handball, racquetball several days, then awoke barestand; pain radiating from low back down left leg
- ▶ ER: X-ray: “shattered bones”, “pinched nerves”. Motrin, morphine initially, then Roxicet & OxyContin
- ▶ “If drugs for pain relief, more drugs = more relief”
- ▶ Reported “fogginess”, anxiety, depression: decreased dose, but continued Roxicet & Oxycontin. Became “isolated, combative”



Gen. David Fridovich, (continued)

- ▶ 2008 –Spine fusion; increased dose of opioids postoperatively
- ▶ Few weeks later, told he had a long-standing opioid dependency.
- ▶ Underwent 4-week detox program, begun on Buprenorphine
- ▶ Named deputy commander of special forces in May, 2010
- ▶ Detox cleared his head, eased temperament, brightened outlook on life. “I should probably take an ad out... apologizing for everything I’ve said or done, because I’m a different person”



Some Key Features of the case

- ▶ Tough guy; not a whiner, not homeless, not a drug abuser, not lazy
 - ▶ Opioids started early; necessary?
 - ▶ Hard to stop
 - ▶ Continued even after surgery
 - ▶ Change in mood (?)
 - ▶ Felt better when finally tapered (off?)
-



Efficacy? Systematic Reviews on Opioids for Chronic LBP (RCTs)

- ▶ Poor quality studies; none >16 weeks
- ▶ Non-significant reduction in pain compared to non-opioids or placebo
- ▶ Diagnosed substance use disorder:
 - current- up to 24%
 - lifetime- up to 54%
- ▶ Cochrane: benefit for chronic LBP questionable

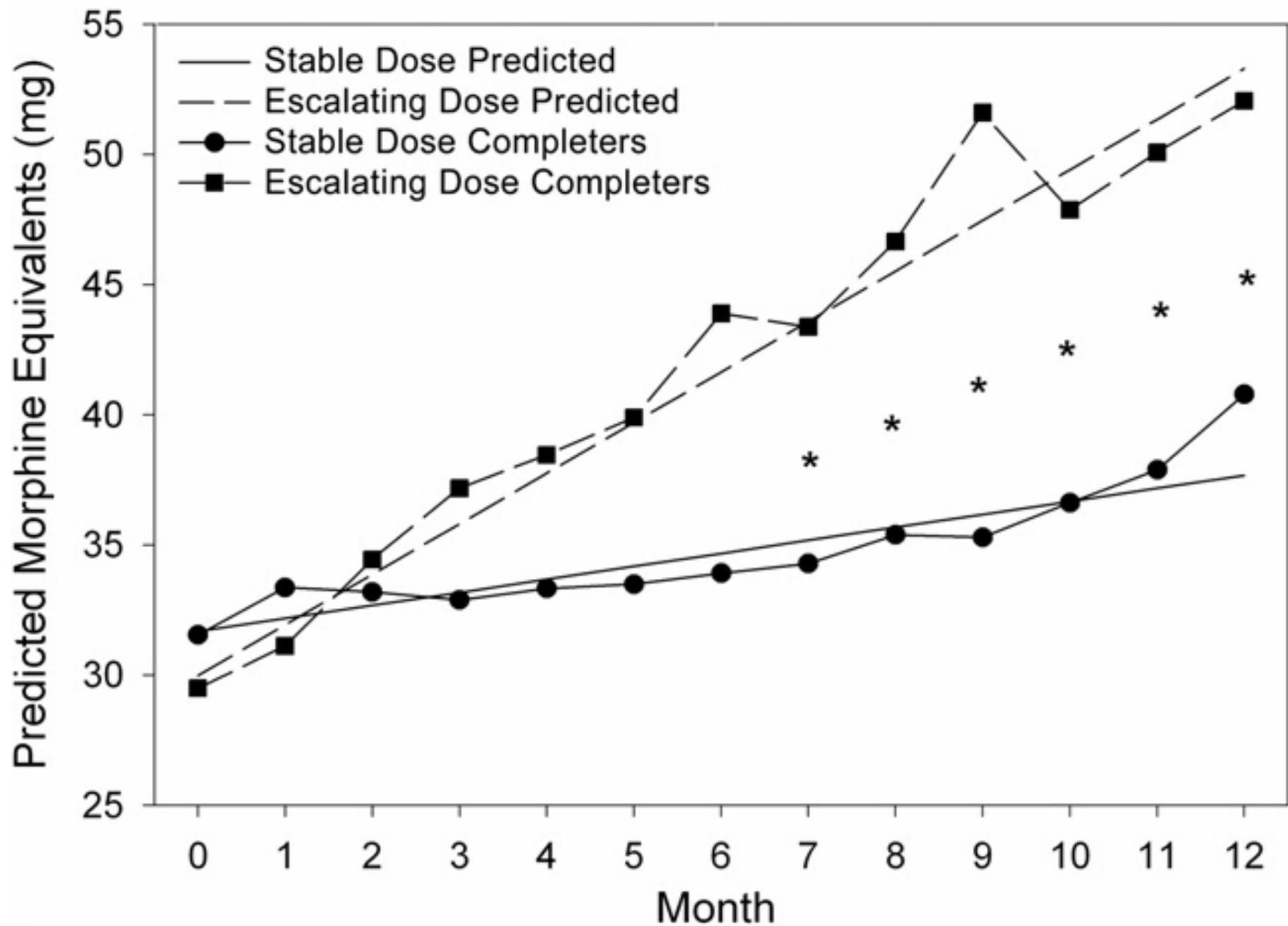
Martell BA et al. *Ann Intern Med* 2007; 146: 116-127

Deshpande A et al. *Cochrane Database Syst Rev* 2007; 18: CD004959

A Randomized Trial of 2 Prescription Strategies for Opioid

- ▶ 135 patients referred to a specialty pain clinic at a Veterans Affairs Hospital for 12 months
- ▶ Even in carefully selected patients there is a significant risk of problematic opioid misuse.
- ▶ Although in general there were no statistically significant differences in the primary outcomes between groups.





Other Concerns about Long-term Opioid Use

- ▶ Decreased drive, libido, erectile dysfunction due to hypogonadism
- ▶ Osteoporosis, fractures; 2x risk over 50 mg/day (over age 60)
- ▶ Hyperalgesia: may paradoxically make pain worse. Neuroplastic changes in brain & spinal cord

Ballantyne JC, Mao J. *N Engl J Med* 2003; 349: 1943-53

Saunders KW...Von Korff. *J Gen Int Med* 2010; 25: 310-15.

Fishbain DA, et al. *Pain Med* 2009; 10: 829-39

Role of drug industry?

- ▶ 1996 Joint APS/AAPM statement: \$500K contributed by Purdue Pharma; headed by Dr. David Haddox, later hired by Purdue
- ▶ “Who taught us to do all this? In large part, it has been the drug companies that have for years picked the message and the messengers while sponsoring much of the postgraduate education and all major pain meetings.”



Retreat from liberal opioid prescribing

- ▶ “I have come to question whether the long-term [opioid] treatment of nonmalignant pain is causing more harm than good...Suddenly, I find myself to be a believer who has lost his faith”

-Mitch Katz, SF (now LA) Dir. Of Public Health

- ▶ “We are providing a treatment that for many patients is not improving their pain but is compromising their lives and futures”

-Jane Ballantyne, Anesthesiologist, pain specialist,
now at U. of Washington



Role of Marketing in increases?

OxyContin and Actiq Marketing Practices

- ▶ Company falsely marketed Oxycontin as safer, less addictive than competitors
- ▶ 2007: company and 3 executives plead guilty felony, agree to \$634 million fines; probation
- ▶ 2008: Cephalon settles for off-label marketing several drugs, including Actiq: settled federal criminal and civil charges for \$425 million



Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain

Utah Department of Health
2009



Predicting Opioid Misuse by Chronic Pain Patients A Systematic Review and Literature Synthesis

- ▶ 6 published articles addressing clinician-based predictors of substance misuse
- ▶ 9 published studies evaluating the predictive ability of clinical interviews and self-report measures
- ▶ Conclusion: Review of the published studies reveals that no one procedure or set of predictor variables is sufficient to identify CPP at-risk for opioid misuse or abuse.



Risk Assessments

	Low Risk	Moderate Risk	High Risk
History of Substance	None	Tobacco only	Alcohol Drugs
Psychometrics			
Brief Pain Inventory Form			
Current Opioid Misuse Measurement COMM			
Sf 12			
Screeener & Opioid Asses for Pain SOAPP-R			
Sheehan Disability Scale			
Opiod Risk Tool			
Addiction Behaviors Check List			
Intuition			



Recommended Followup Dispositions

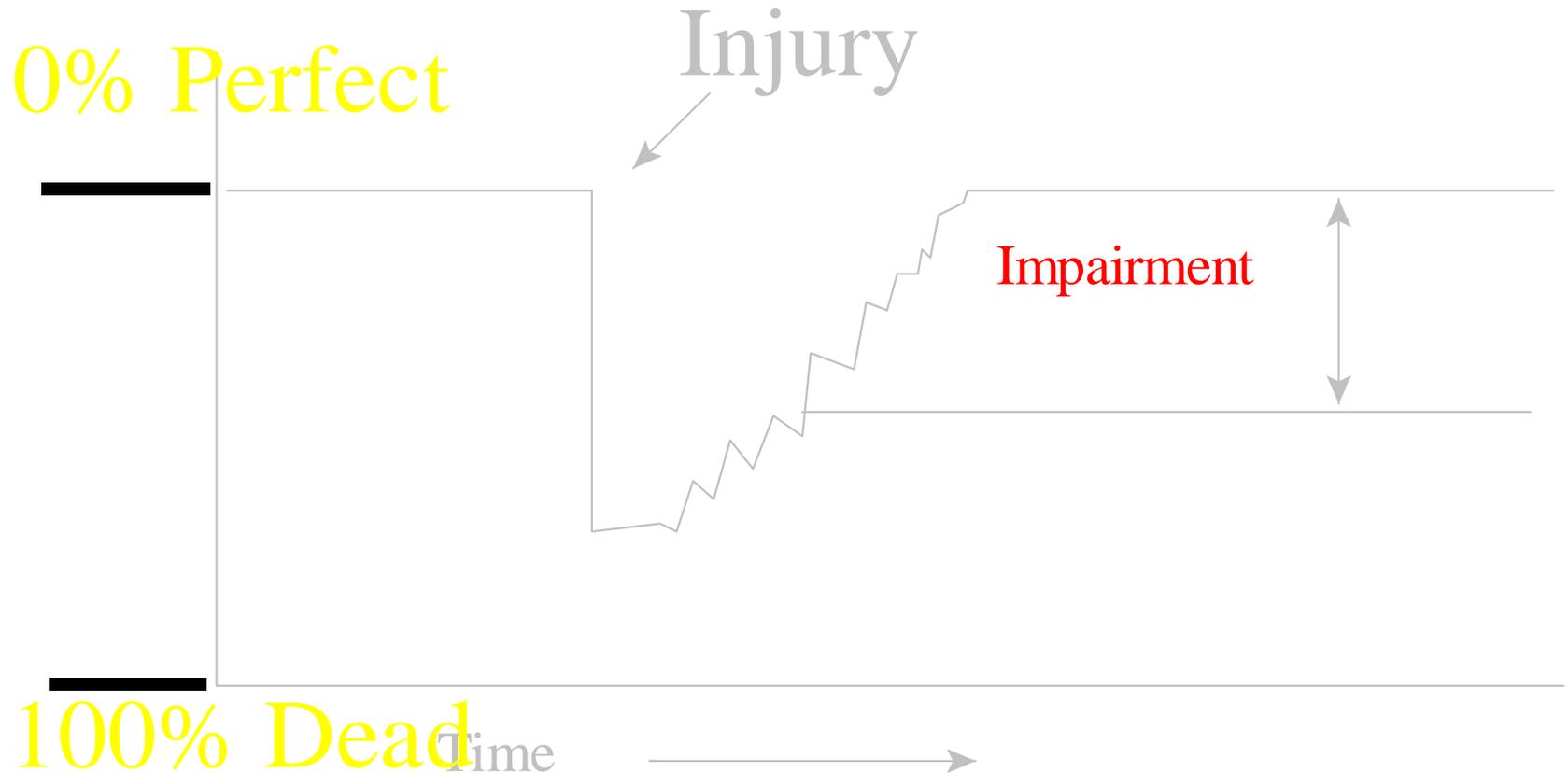
	Low Risk	Moderate Risk	High Risk
Risk Disclaimer Handout-Patient-Family	+	+	+
Treatment Agreement	+	Enforced	Strongly Enforced
Followup Visits-Writing	Monthly at first Then Every 3 Months	Every 2 weeks then taper	More Frequent-adjust as necessary Possible Weekly
DOPL	1 x yr.	2 x yr.	Frequently
Office Documentation	Functional		
Family member consultation	As needed	+ -	+
Pill Count	no	+ -	Every visit
Urine Drug Screen	Initial	Random	Regular Screening Plus random
Comorbidities		Anxiety-Depression-Sleep disorders	Anxiety-Depression-Sleep disorders
Rapid onset Narcotics	-	+ -	-
Restrictions	+ -	+ -	
Consults	-	+ -	Addiction Consults
Refills	Q 3month	1-3 months	1week – 1 month

State Education

- ▶ Jan 2014
- ▶ 4 hours mandatory Education
- ▶ Dopl updated



Recovery Graph, Impairment



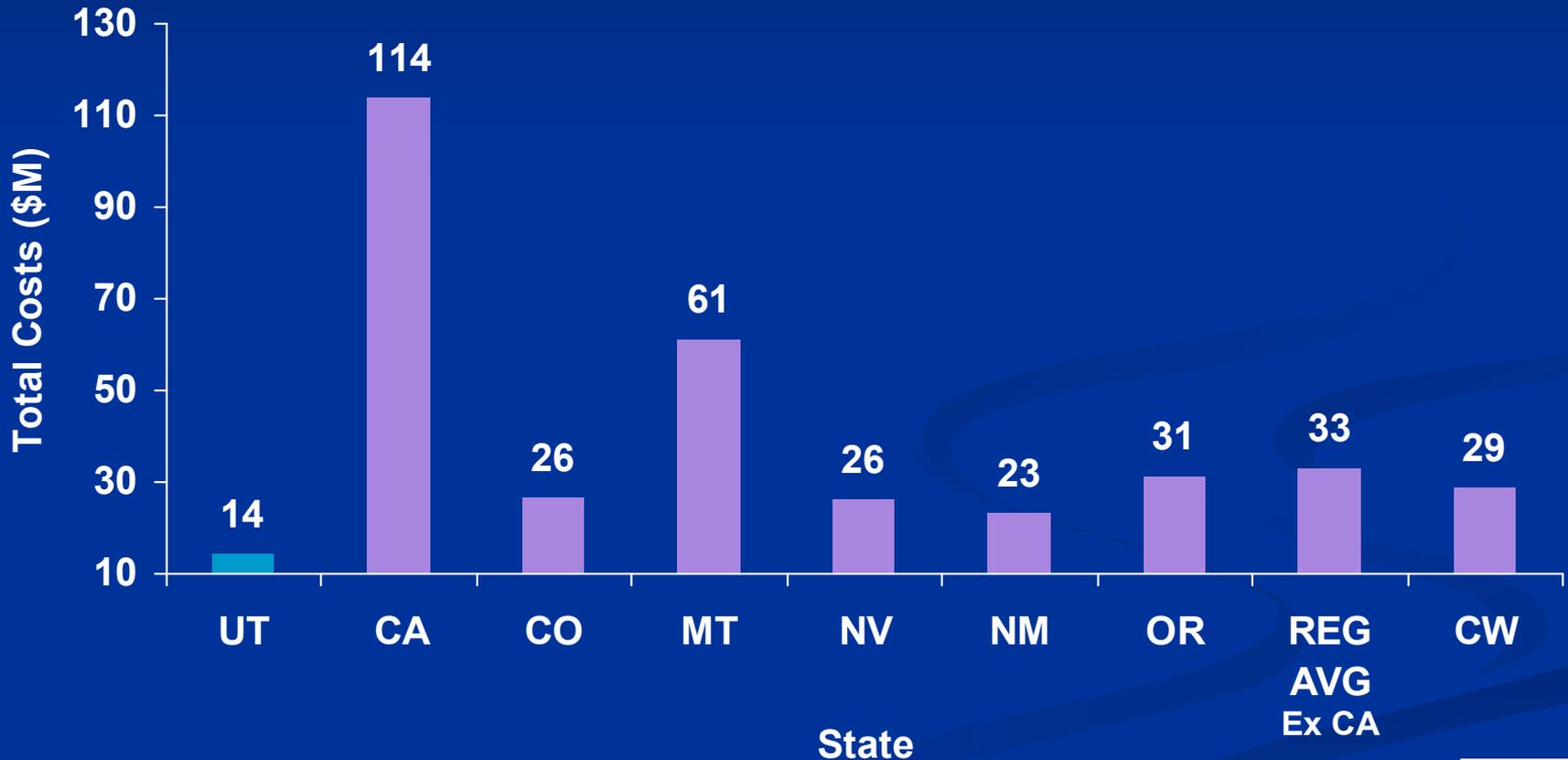
MAY 1, 2006

- ▶ **Overview**
- ▶ **Rules**
- ▶ **Apportionment**
- ▶ **Reporting**
- ▶ **Billing**
- ▶ **Spinal**
- ▶ **TMJ**
- ▶ **Cumulative Trauma**
- ▶ **Neuropathy**
- ▶ **Dental**



Utah's Permanent Partial Impairment Average Total Costs 2002

Impairment Costs per 100,000 Workers



Based on NCCI's WCSP data.
Based on policies expiring in 2002.



Impairment Ratings

- ▶ Greater equity across injured workers.
- ▶ Speedier payments to injured workers
- ▶ Resolution of injured workers' frustrations, which allows workers to move on with their lives.
- ▶ Fewer disputes and litigation
- ▶ Lower jurisdiction administrative costs.
- ▶ Comparable statistics
- ▶ Development of an international impairment standard for jurisdictions to consider.



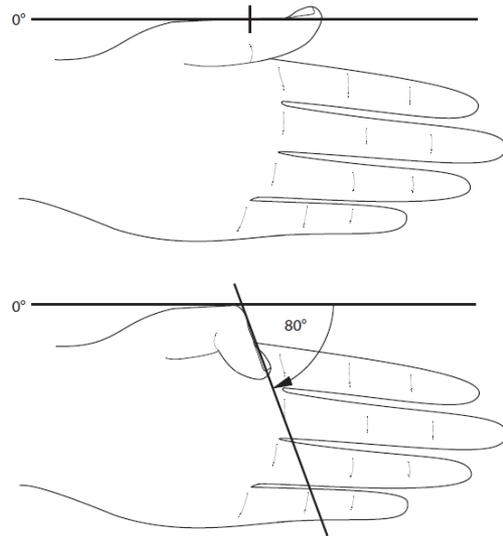
Overview for Physicians

- ▶ **Importance of Medical Objectivity in the Calculation of Utah Impairment Ratings**
- ▶ **General Guidance for Utah Physician/Raters**
- ▶ **Reporting of Impairment Ratings**
- ▶ **Confidentiality of Information**
- ▶ **Methodology for Calculating the Impairment Ratings:**
 - ▶ **Diagnosis**
 - ▶ **Causation**
 - ▶ **Stability**
 - ▶ **Calculation of Impairment**
 - ▶ **Apportionment**
 - ▶ **Capabilities Assessment work restrictions as relates to essential job functions or generaic us depart of labor**
 - ▶ **Future Medical Treatment**

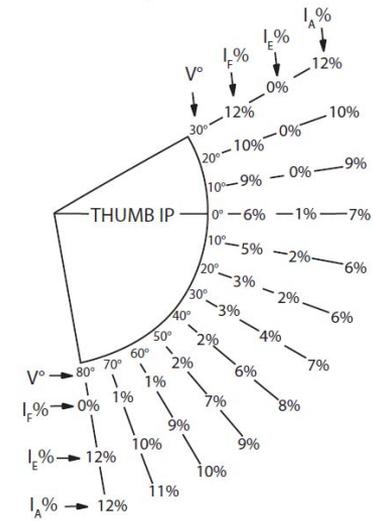


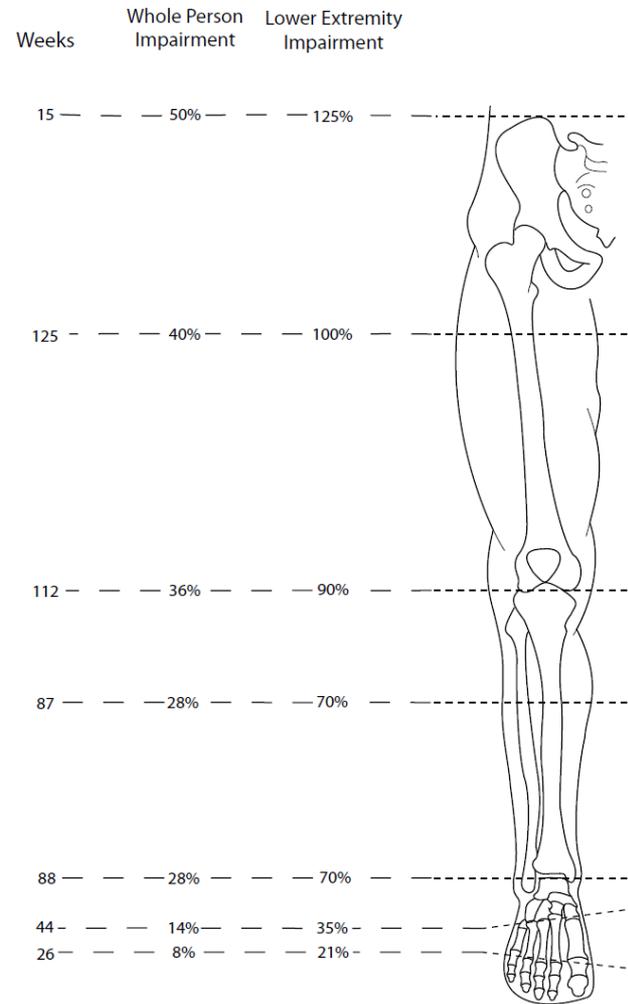
FAD

Hand: ROM-Thumb IP



- $I_A\%$ = percent impairment due to ankylosis
- $I_E\%$ = percent impairment due to loss of extension
- $I_F\%$ = percent impairment due to loss of flexion
- V° = measured angles of motion





Individual Nerve Loss of the Upper Extremity

Complete Loss of Unilateral Peripheral Nerves Maximum Upper Extremity Impairment Signs or symptoms of organic disease or injury are present, and there is anatomic loss or alteration:			
Nerve	Sensory Deficit / Pain %	Motor Deficit %	Combined Motor-Sensory Deficits %
Pectoralis	0%-UE	4%-UE	4%-UE
Spinal accessory	0%-UE	10%-UE	10%-UE
Axillary	5%-UE	38%-UE	41%-UE
Medial antebrachial cutaneous	4%-UE	0%-UE	4%-UE
Medial brachial cutaneous	4%-UE	0%-UE	4%-UE
Suprascapular	5%-UE	15%-UE	19%-UE
Subscapular nerves	0%-UE	6%-UE	6%-UE
Long thoracic	0%-UE	16%-UE	16%-UE
Thoracodorsal	0%-UE	8%-UE	8%-UE
Dorsal scapular	0%-UE	4%-UE	4%-UE
Radial (entire)	4%-UE	40%-UE	42%-UE
Sparing of triceps	4%-UE	36%-UE	39%-UE
Sparing of triceps and wrist extensors	4%-UE	32%-UE	35%-UE
Musculocutaneous	4%-UE	26%-UE	29%-UE
Median (entire) Involves FPL, FDP, FDS, PQ and intrinsics of the hand	38%-UE	34%-UE	58%-UE

Chapter 18: Mental and Behavioral Conditions

- ▶ **Category 1-Objective/Measurable Brain Dysfunction**
- ▶ **Category 2 - Mental Stress Claims**



Chapter 18: Mental and Behavioral Conditions

- ▶ **Category 2 - Mental Stress Claims**
- ▶ ***Physical-Mental Claims***
 - ▶ ***significant*** physical injury such as a spinal cord injury, extremity amputation or severe disfigurement and then develops a significant adjustment disorder or secondary depression.



Chapter 18: Mental and Behavioral Conditions

- ▶ ***Mental-Physical Claims***
 - ▶ This situation can occur when a person is exposed to an *extraordinarily* stressful mental situation on the job and incurs a physical disorder directly as a result of that on-the-job stressful exposure. [\[81\]](#)



Chapter 18: Mental and Behavioral Conditions

Mental - Mental Claims

- ▶ **Examples of a mental stress-mental case disorder would be when an employee witnesses a robbery at work where a coworker is shot and suffers substantial Post traumatic stress disorder (PTSD).**
- ▶ **Another example would be when a worker has been physically raped at work resulting in substantial PTSD.**



Thank You

- ▶ Willing to assist?
- ▶ Drcolledge.com

