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YOUR GUIDE TO GUIDELINES

TAKING OUR PULSE

In the clinical practice of medicine, as well as in the medical management tools we apply to facilitate high-quality care and timely return-to-work (RTW), guidelines play an important role. This issue of the Medigram is dedicated to discussing various types of guidelines: how they are developed and applied, and the impact they may (or may not) have in the delivery of medical services.

The objectives of guidelines can be summarized as follows:

1. Achieve better and more predictable results for the majority of patients
2. Establish a standard of care with projected disability durations
3. Define necessity and appropriateness of medical treatments
4. Provide expectations for recovery, cost, and risks for complications

JUST WHAT THE DOCTOR ORDERED

Evidence-based medicine is “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research.” (Sackett D, 1996)

So, the process begins with sound, rigorous, and reproducible research, which is then translated into treatment guidelines (also known as best practices) based on expert physician consensus. Guidelines are produced by all sorts of organizations that are stakeholders in medical care.

There is a useful government resource that serves as a repository for every published medical guideline and it can be sorted by the producing entity, and the topic/specialty. Check it out.

<http://www.guideline.gov/index.aspx>

In our industry, there are two particularly useful guideline sources that are often used, and in some cases are state-mandated. They are the ODG (Official Disability Guidelines, produced by the Work Loss

Data Institute); and the MDG/ACOEM (Medical Disability Guidelines, American College of Occupational and Environmental Medicine).

Broadspire's preferred resource is the ODG, which was described as follows in a recent article:

“The most widely adopted guideline in workers compensation is the Official Disability Guidelines (ODGs) maintained by the Work Loss Data Institute. These guidelines are based on a comprehensive analysis of the medical literature with preference given to high-quality, systematic reviews, meta-analyses, and clinical trials. The guidelines are available in digital form for use with medical bill and utilization review systems. These treatment guidelines were designed to ensure injured workers receive appropriate medical care, while limiting ineffective and unproven medical interventions in workers’ compensation. They are based on a combination of evidence-based analysis and workers’ compensation claims analytics, representing over three million claims and \$20 billion dollars of incurred costs.”¹

However, a handful of states have mandatory requirements to use some components of MDG/ACOEM, and these are utilized accordingly.

When we speak of guidelines in the workers compensation and disability/absence arenas, it is helpful to divide them into three categories:

A. RTW (duration) guidelines

Duration guidelines provide users with estimates of diagnosis-based recovery and return-to-work timeframes. This can guide the medical management process, and when shared with physicians and patients they can create reasonable expectations about anticipated RTW after injury or illness. Durations which seem to be excessive, or are heading in that direction, can trigger intensified clinical review and early intervention.

There are actually two sets of durations listed for every diagnosis.

1. Best practice durations

These represent physician-generated estimates of how long physical recovery (healing) and RTW should take based on a purely "scientific" perspective. For example, a lumbar disc displacement (ICD code 722.1) per ODG should optimally resolve in 42 days. This duration is adjusted up or down based on the type of work the claimant performs, as well as whether surgery has taken place.

2. Actual durations

For this same condition, ODG tells us that the average actual RTW duration derived from its large claim database, is 99 days. So while in the ideal world, the claimant ought to be back at work in 42 days, (and this should be the goal of physicians and case managers), in the real world, given psychosocial factors, legal maneuvers, and numerous other complicating issues, the duration is likely to be longer, averaging 99 days.

In the last few years, predictive models have been created that permit one to build a more customized statistical picture of actual RTW duration.

For example, the ODG predictive duration calculator allows one to enter these claimant-specific characteristics: our claimant with disc displacement is 55 years old, resides in Illinois, and performs heavy work (per the DOL job classification). He has diabetes, is obese, and has been started on opioids within the last 15 days. The calculator yields a predicted duration of 198 days, considerably higher than the mean across all claims of 99 days. Knowing this, the adjuster is alerted to engage all appropriate resources in order to optimally manage the claim to its most favorable possible outcome.

B. Treatment guidelines

There are also two flavors of treatment guidelines.

1. The first type helps to determine whether a particular test/procedure is medically necessary and appropriate for a particular condition. Our unfortunate gentleman with the disc displacement has seen a physician and is being considered for a minimally-invasive micro-discectomy on an outpatient basis. ODG tells us that this can be "recommended" assuming that certain explicit criteria are met. On the other hand, had he been seen by a different physician, and advised to undergo IDET (intradiscal electrothermal annuloplasty) this would have been a "not recommended" service. IDET was frequently used some years ago until compelling research documented its ineffectiveness, and it has now fallen entirely out of favor.

Obviously this type of guideline is extensively used in our utilization review process, and all potential non-certifications are reviewed by one of our physician reviewers.

2. The second type of treatment guideline is also known as a treatment plan or algorithm. Rather than looking at one specific procedure in isolation (as above), it provides a step-wise, chronological sequence for evidence-based clinical management of a particular condition. The ODG treatment planning section details the timing of physician visits for our claimant's back problem; the examination and testing protocols staged by date; and advice and therapy appropriate at each visit, covering the entire episode of care from initial complaint through to conservative resolution or definitive interventional procedures, if required. For our claimant with back pain, the plan identifies exactly when to initiate physical therapy, what medications to prescribe, when to consider an MRI or a trial of epidural steroid injections.

Treatment planning guidelines are especially useful for nurse case managers as they follow the course of a claim and determine whether the treatment plan appears effective and reasonable. This can guide discussions with the treating physician, or stimulate a peer review with a peer-to-peer teleconference for that purpose.

C. Disability criteria

Disability criteria help to establish whether an illness is sufficiently intense to prevent a claimant from working at their own occupation, and can identify an alternative physical demand level that may be more appropriate for that severity of illness. There are no commercially available guidelines of this type, so Broadspire has uniquely developed them internally, supplementing research evidence with the expertise of our peer review panel covering 34 different specialties. We have developed criteria for 38 of the most common medical conditions.

Disability criteria are widely applied in the STD/LTD/absence management arena, and may also be very helpful in evaluating the impact of comorbid conditions related to occupational claims. Our long-suffering disc-degenerated diabetic claimant may be incapacitated from his heavy-level job if his retinopathy deteriorates to 20/80 or worse (without an ability to accommodate), or a localized neuropathy emerges which compromises his work duties, or his blood sugars are poorly controlled.

CIRCULATING IN THE PRESS

Does following guidelines make a difference to outcomes in workers compensation?

Yes. A recent landmark study demonstrates significant improvements in medical costs and claim duration in those physicians who are more compliant with ODG treatment guidelines in comparison to their less compliant peers.

“When all levels of medical complexity are considered, those claims in the low compliance group had a 13.2% increase in claim duration and a 37.9% increase in medical incurred when compared with claims in the high compliance group.

As the medical complexity of the claim increases, so does the difference in duration and medical spend between the low and high compliance groups. In the top 10% of claims for medical complexity, the difference in duration of the claim and medical spend between the low and high compliance groups is 18% and 38%, respectively.

Across all levels of medical complexity, the mean number of appropriate procedures for the high compliance and low compliance groups was similar. When we evaluated the mean number of inappropriate procedures, we found a striking difference between the low and high compliance groups. The study demonstrated an increase in the number of inappropriate procedures performed per claim in the low compliance group across all medical complexities. This finding suggests that the primary driver of increasing duration and medical spend in the low compliance group (or the bottom 50% of the population) is the addition of inappropriate care to the injured worker.”¹

Is there a need for more consistency in medical decision making?

“The problem is that physicians don’t know what they’re doing. That is how David Eddy, MD, PHD, a healthcare economist and senior advisor for health policy and management for Kaiser Permanente, put the problem in a Business Week cover story about how much of healthcare delivery is not based on science. Plenty of proof backs up Eddy’s glib-sounding remark.

The plain fact is that many clinical decisions made by physicians appear to be arbitrary, uncertain and variable. Reams of research point to the same finding: physicians looking at the same thing will disagree with each other, or even with themselves, from 10 percent to 50 percent of the time during virtually every aspect of the medical-care process – from taking a medical history to doing a physical examination, reading a laboratory test, performing a pathological diagnosis and recommending a treatment. Physician judgment is highly variable.

Give surgeons a written description of a surgical problem, and half of the group will recommend surgery, while the other half will not. Survey them again two years later and as many as 40% of the same surgeons will disagree with their previous opinions and change their recommendations. Research studies back up all of these findings, according to Eddy.”²

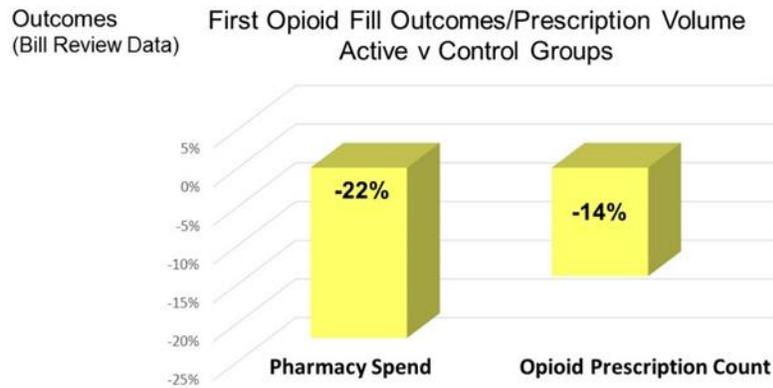
How can we improve physician adherence to guidelines?

- “1. *Pay the right amount for quality and activities that support adherence and coordinate Pay for Performance programs across payers.* Our survey data show that significant increases in Pay for Performance incentives may accelerate the adoption of guidelines. Demonstration programs are needed to determine the right level of payment incentives and as more payers implement such programs, the standardization and coordination of such programs will be critical to their success.
2. *Invest in and encourage IT innovations that advance clinical decision support.* To support guideline adoption, IT systems need to provide useful data to the physician at the point of care; feedback loops so physicians can measure their practice patterns against other colleagues; interoperability between inpatient and outpatient facilities and among physicians to exercise autonomy and clinical judgment and respond to patient preferences.
3. *Encourage innovation in guideline development and use.* To improve physician “buy-in” to guidelines, physicians need to be engaged in the guideline development and review process. In addition, because guidelines become obsolete so quickly, it is important to speed the process of guideline development so that the dissemination and use of guidelines keeps pace with medical advances. Finally, guidelines need to be actionable, brief and written in “plain English.”
4. *Train physicians on guideline usage.* The expert panel and literature suggest that training of medical students, residents and practicing physicians may be necessary to re-orient practice toward guidelines.
5. *Enable and promote comparative data sharing among physicians.* To change physician culture, beliefs and habits, data collection and data sharing are essential. While there is much debate about the value of public reporting of physician quality measures and outcomes, expert panelists and key informants agree that transparency *within* physician practices – that is, allowing a physician to compare data on his/her own practice to that of his/her peers – is extremely effective in fostering adherence to guidelines.”³

Has Broadspire educated physicians on guidelines? Was it successful?

Yes and yes. Evaluating the first opioid fill component of our comprehensive pain program, we performed a randomized controlled study to see whether sending a complete set of pain management

guidelines to physicians who had just started a claimant on opioids was effective. As presented at the recent RIMS conference, we found that there were significant reductions in opioid prescriptions, cost and dosages in the group that received educational information, compared to the control group that did not.



REFERENCES:

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