WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #5

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OFFICE OF WEST VIRGINIA SECRETARY OF STATE

NOTICE OF AGENCY ADOPTION OF A PROCEDURAL OR INTERPRETIVE RULE OR A LEGISLATIVE RULE EXEMPT FROM LEGISLATIVE REVIEW

AGENCY: Workers' Compensation Division Bureau of Employment Programs TITLE NUMBER: 85

CITE AUTHORITY: 21A-2-6(1),-6(2),-6(14);21A-2-19;21A-3-7(b),-7(c);23-1-1

RULE TYPE: PROCEDURAL ____ INTERPRETIVE ____

EXEMPT LEGISLATIVE RULE X
CITE STATUTE(s) GRANTING EXEMPTION FROM LEGISLATIVE REVIEW

21A-2-6(1),-6(2),-6(14);21A-2-19;21A-3-7(b),-7(c);23-1-1

AMENDMENT TO AN EXISTING RULE: YES ____, NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: ____

TITLE OF RULE BEING AMENDED: ____

IF NO, SERIES NUMBER OF NEW RULE BEING ADOPTED: Series 20

TITLE OF RULE BEING ADOPTED: Guidelines for the Treatment of Workers' Compensation Injuries

THE ABOVE RULE IS HEREBY ADOPTED AND FILED WITH THE SECRETARY OF STATE. THE EFFECTIVE DATE OF THIS RULE IS October 1, 1995

Andrew N. Richardson

Authorized Signature

Andrew N. Richardson

Bureau of Employment Programs
Legal Services Division
Post Office Box 3922
Charleston, West Virginia 25339-3922

Gaston Caperton
Governor

Andrew N. Richardson
Commissioner

August 23, 1995

The Honorable Ken Hechler
Secretary of State
State Capitol Building
Charleston, WV 25305

Re: Filing of Proposed
Legislative Rule,
Title 85, Series 20;
"Guidelines for the Treatment
of Workers' Compensation Injuries"

Dear Secretary Hechler:

Please consider this letter to be my written approval of the above noted proposed rule.

Pursuant to Enrolled Committee Substitute for House Bill 4030, Regular Session, 1994, the department of Commerce, Labor and Environmental Resources was abolished. Pursuant to that same bill and to Executive Order No. 5-94 of the Governor, the commissioner of the Bureau of Employment Program is empowered to promulgate rules without the consent or approval of a department secretary.

Thank you very much for your assistance in this matter.

Very truly yours,

Andrew N. Richardson
Commissioner

TITLE 85
EXEMPT LEGISLATIVE RULES
BUREAU OF EMPLOYMENT PROGRAMS
WORKERS' COMPENSATION DIVISION

SERIES 20
Protocols and Guidelines for the Treatment of Workers' Compensation Injuries

§85-20-1. General.

1.1. Scope. -- This rule implements the provisions of West Virginia Code, §23-4-3, §23-4-3a, §23-4-3b, §23-4-3c and 23-4-8 regarding the protocols and guidelines required for the medical, surgical, dental and hospital treatment of claimants for injuries sustained in the course of and resulting from work.

1.2. Authority. -- West Virginia Code, §21A-2-6(1), -6(2) & -6(14); §21A-2-19; §21A-3-7(b) & -7(c); and §23-1-1. Pursuant to West Virginia Code, §21A-3-7(c), rules adopted by the compensation programs performance council and the commissioner are not subject to legislative approval as would otherwise be required under West Virginia Code, §29A-3-1 et seq. Public notice requirements of that chapter and article, however, must be followed. Pursuant to Enrolled Committee Substitute for House Bill 4030, Regular Session, 1994, the Department of Commerce, Labor and Environmental Resources was abolished. Pursuant to that same bill and to Executive Order No. 5-94 by the Governor, the Commissioner of the Bureau of Employment Programs is empowered to promulgate rules and regulations without the consent or approval of a departmental secretary.

1.3. Filing Date. -- August 23, 1995

1.4. Effective Date. -- October 1, 1995

§85-20-2. Purpose of these rules.

The purpose of this rules is to implement the provisions of West Virginia Code, §23-4-3, §23-4-7a(a), -7a(b) and -7a(h) and §23-4-8 which relate to the development of protocols and guidelines for the treatment of claimants for injuries sustained in the course of and resulting from work. Payment for other periods including mechanical appliances and devices pursuant to W. Va. Code §23-4-3(a)(1) is to be made when such services or mechanical devices are reasonably required. The protocols and guidelines adopted by this rule have been approved by the health care advisory panel and recommended to the compensation programs performance council for its adoption. The rule is applicable to evidence submitted by any party to a claim and to evidence gathered by the division.

§85-19-3. Definitions.

guidelines adopted by this rule have been approved by the health care advisory panel and recommended to the compensation programs performance council for its adoption. The rule is applicable to evidence submitted by any party to a claim and to evidence gathered by the division.

§85-20-3. Definitions.

As used in these rules, the following terms have the stated meanings unless the context of a specific use clearly indicates another meaning is intended.

3.1. "Commissioner" means the Commissioner of the Bureau of Employment Programs pursuant to West Virginia Code, §21A-2-1, and West Virginia Code, §23-1-1, and any deputies designated pursuant to West Virginia Code, §21A-2-12 & -13.

3.2. "Division" means the Workers' Compensation Division within the Bureau of Employment Programs as provided for by West Virginia Code, §21A-1-4, and West Virginia Code, §23-1-1 et seq.

3.3. The following will be referred to throughout the rule by the abbreviation indicated.

3.3.1. Magnetic resonance imaging - MRI

3.3.2. Encephalogram - EEG

3.3.3. Cat Scan - CT scan

3.3.4. Electromyogram - EMG

§85-20-4. Adoption of Standards.

4.1. The treatment provided for the injuries listed in this section are designed to assist health care providers in the evaluation and treatment of claimants. As the guides are not intended to dictate results and it is recognized that individual cases may differ, deviation from the guides is anticipated as necessary in some cases. The treaters/examiners report must thoroughly document and explain the action taken and the basis for the deviation from the guide.

§85-20-5. Treatment guidelines: post concussion syndrome.

5.1. Post concussion syndrome is a clinical syndrome characterized by a variety of vague symptoms including a

headache, dizziness, memory dysfunction and depression, following head trauma. There is little relationship between the serious nature of the trauma and the severity and duration of the symptoms.

5.2. The diagnostic criteria consists of a persistent dysfunctional state following head trauma without clinical or laboratory sign of serious intracranial or cervical spine disorder.

5.3. The appropriate diagnostic tests and evaluations are as follows:

5.3.1. Neurological examination;

5.3.2. MRI;

5.3.3. EEG;

5.3.4. Electronystagmyogram; and

5.3.5. Neuropsychological testing if no improvement after four weeks.

5.4. Symptomatic therapy for post concussion syndrome includes:

5.4.1. Analgesia;

5.4.2. Medication for labyrinthine dysfunction;

5.4.3. The use of narcotic medications is not indicated; and

5.4.4. Severe dizziness or mental/emotional problems may require hospitalization for acute care rehabilitation.

5.5. While the estimated duration of care is variable, a return to work is anticipated in four weeks or less.

5.6. The anticipated outcome is full recovery. In some cases there may be residual symptomatology such as dizziness or mental/emotional changes. These conditions may be disabling and may be permanent.

§85-20-6. Treatment guidelines: corneal abrasion.

6.1. Corneal abrasion is usually caused by a foreign body

striking the eye resulting in a disruption of the corneal epithelium. The foreign body does not remain in the eye.

6.2. The diagnostic criteria consists of complaints of pain and blurred vision. Photophobia may or may not be present.

6.3. Appropriate diagnostic tests and evaluations include a determiniation of visual acuity, a slit lamp examination and, when indicated, a dilated fundus examination.

6.4. Treatment is administered on an outpatient basis and consists of topical antibiotics, cycloplegics, and a pressure patch. For severe pain analgesics may be indicated.

6.5. The duration of care consists of daily visits up to 72 hours with a return to work within two days unless there are complications.

6.6. The anticipated outcome is full recovery.

§85-20-7 Treatment guidelines: corneal foreign body.

7.1. Corneal foreign body generally occurs when striking stone; hot metal may perforate the cornea and enter the eye. Contaminated foreign bodies pose a risk for corneal ulcers or systemic toxicologic effect.

7.2. The diagnostic criteria consists of pain which occurs either immediately after the injury or within the first twenty-four hours, accompanied by a sensation of something in the eye, and photophobia. The pain is aggravated by blinking or moving the eye. Vision may be affected if the foreign body is in the visual axis.

7.3. The appropriate diagnostic tests and examinations consist of a comprehensive examination, including determination of visual acuity, a slit lamp examination and dilated fundus examination when indicated to rule out intraocular foreign bodies. An orbital x-ray or CT scan may be indicated if there is a suspicion of ocular or orbital penetration.

7.4. Treatment is administered on an outpatient basis and consists of the following:

7.4.1. Removal of embedded foreign body;

7.4.2. Topical antibiotics, cycloplegics, and pressure patch;

7.4.3. Analgesics for the first several days;

7.4.4. Daily visits until the cornea is healed; and

7.4.5. If a scar remains in the visual axis, corrective lenses or surgery may be required to attain optimal vision.

7.5. In uncomplicated cases the claimant is expected to return to full work within one to two days.

7.6. Full recovery is expected unless the foreign body leaves a significant scar in the visual axis, in which case decreased visual acuity may be permanent.

§85-20-8 Treatment guidelines: hyphema.

8.1. Hyphema is bleeding within the anterior chamber of the eye, typically caused by a severe blunt trauma to the eye rupturing intraocular blood vessels. Hyphema may be associated with disruptions of the trabecular meshwork and lead to angle recession glaucoma. Early complications include elevated intraocular pressure causing blood staining of the cornea, vision loss, and most significantly, rebleeding which will occur in up to 30% of the cases within the third to fifth day. Rebleeding may cause marked elevation of intraocular pressure, corneal blood staining and visual loss. Late complications may include angle - recession glaucoma and cataract. Claimants at considerable risk for complications include those with sickle cell or other coagulopathy.

8.2. Diagnostic criteria consists of a history of a blunt trauma to the eyes. The physical findings may include red blood cells visible within the anterior chamber, a layered clot filling the entire anterior chamber and/or intraocular pressure elevation.

8.3. The appropriate diagnostic tests and examinations are as follows:

8.3.1. Immediate referral to an opthalmologist as this is an ocular emergency;

8.3.2. A comprehensive examination by an ophthalmologist including a slit lamp exam, determination of the intraocular pressure, and a dilated fundus examination if possible;

8.3.3. Orbital x-rays may be indicated to rule out other orbital injuries; and

8.3.4. A platelet count and coagulation study as indicated as well as a sickle prep, and hemoglobin electrophoresis as indicated.

8.4. Appropriate treatment is as follows:

8.4.1. Outpatient treatment is indicated if the hyphema is not severe, there are no complications present and the claimant is reliable. Treatment consists of the following:

a. Strict bed rest for five days;

b. Daily eye examination;

c. Medication which may include the following: topical cycloplegics, steroids, ocular hypotensive and oral prednisone and/or aminocaproic acid;

d. Hard shield to be worn day and night; and

e. A gonioscopy after 2-3 weeks.

8.4.2. Inpatient treatment is indicated for significant hyphema, marked intraocular pressure elevation, complication or unreliable care and consists of the following:

a. Medication as noted for outpatient care;

b. Hospitalization with strict bed rest for five days; and

c. Surgical evacuation of the clot.

8.5. Return to full work is anticipated in three weeks for uncomplicated cases. Evidence of disruption of intraocular structures dictates lifetime monitoring for glaucoma and cataracts.

8.6. The anticipated outcome is resolution of the hyphema with return of visual acuity.

§85-20-9 Treatment guidelines: eyelid laceration.

9.1. Eyelid lacerations may occur from blunt injuries or from laceration by a sharp object. They may involve only skin,

eyelid muscles, eyelid margin, the lacrimal drainage system and may be associated with an orbital foreign body.

9.2. The diagnostic criteria consists of laceration and bleeding, which may be profuse.

9.3. The appropriate diagnostic tests and examinations consist of a comprehensive examination including a visual acuity and a slit lamp examination to rule out an additional injury. A dilated fundus examination may be conducted when indicated.

9.4. Appropriate treatment is as follows:

9.4.1. Outpatient treatment is appropriate for uncomplicated lacerations. Sutures are generally removed in one to two weeks and medication may include antibiotics and analgesics.

9.4.2. Inpatient treatment is appropriate for injuries involving the lacrimal drainage system or those penetrating the orbit. The surgical repair may or may not require general anesthesia. Intravenous antibiotics are often indicated. Depending on the severity of the injury and overall condition of the claimant, a one to two day hospital stay may be required. Medications may include topical, oral or parenteral antiobiotics and analgesics.

9.5. In uncomplicated cases the claimant is expected to return to full work within two weeks with medical follow-up in four weeks. Damage to the eyelid muscles resulting in traumatic ptosis may require six to twelve months to resolve, or may ultimately require surgical repair.

9.6. The anticipated outcome is full recovery.

§85-20-10. Treatment guidelines: canalicular laceration.

10.1. Laceration in the medial eyelid may injure the upper or lower canaliculus or lacrimal sac, resulting in constant tearing or abscess in the lacrimal sac (dacryocystitis). The presence of an infection within the lacrimal system usually requires surgical repair.

10.2. The appropriate diagnostic criteria consists of a laceration in the medial eyelid. Any laceration to the punctum may include canalicular laceration. Tearing or bloody tears and laterally displaced punctum may be present.

10.3. The appropriate diagnostic tests and examinations consist of a comprehensive examination, including visual acuity, slit lamp, examination, dilated fundus examination and probing of the canaliculus. Orbital x-rays or CT scan is appropriate if a fracture or foreign body is suspected.

10.4. Appropriate treatment is as follows:

10.4.1. Outpatient treatment is appropriate for simple lacerations and repair. Treatment consists of surgical repair including stent placement and topical drops and oral antibiotics as indicated.

10.4.2. Inpatient treatment is appropriate for contaminated or complicated wounds. Treatment consists of the following:

a. Surgical repairing; may include complex reconstruction;

b. Antibiotics and topical medications as indicated; and

c. Lacrimal bypass surgery if repair is unsuccessful.

10.5. The estimated duration of care in uncomplicated cases is two weeks with follow-up in 3 - 6 months.

§85-20-11 Treatment guidelines: orbital contusion.

11.1 An orbital contusion is usually a result of blunt trauma causing swelling and ecchymosis of the orbit not associated with any fractures or significant lacerations.

11.2 The diagnostic criteria consists of a history of a blunt trauma to the ocular area, with progressive swelling of the lids, ptosis, proptosis of the eye and diplopia .

11.3. The appropriate diagnostic tests and examinations consist of:

11.3.1. Comprehensive examination, including an assessment of visual acuity, slit lamp examination, and a dilated fundus examination;

11.3.2. Orbital x-rays; and

11.3.3. CT scan may be indicated.

11.4. The appropriate treatment is as follows:

11.4.1. Outpatient treatment is appropriate in injuries without complications. Treatment includes analgesics, ice packs and systemic antibiotics as indicated.

11.4.2. Diminished visual acuity or severe pain may indicate a more extensive injury and may warrant inpatient treatment for further evaluation and treatment.

11.5. In uncomplicated cases the estimated return to work is one to two days. Disability may be longer if diplopia or ptosis persist.

11.6. The anticipated outcome is resolution of the swelling and diplopia with return of normal ocular motility.

§85-20-12 Treatment guidelines: orbital fracture.

12.1. Fractures of the orbit may be indirect, resulting in a "blowout" of the orbital floor or medial wall, or direct involving fractures of the orbital rims.

12.2. The appropriate diagnostic criteria consists of a history of blunt trauma to the eye, usually by an object larger then the bony orbital opening. The eye may appear proptosis or enophthalmic. Ocular motility is usually diminished. There is usually numbness over the cheek due to injury to the infraorbital nerve. There may be a palpable fracture of the orbital rim. There may also be a fracture of the zygomatic arch.

12.3. The appropriate diagnostic tests and examinations are as follows:

12.3.1. A comprehensive examination by an ophthalmologist is necessary, including a visual acuity, slit lamp examination and dilated fundus examination;

12.3.2. X-ray of the orbits; and

12.3.3. Coronal CT scan.

12.4. Appropriate treatment is as follows:

12.4.1. In uncomplicated cases outpatient treatment is appropriate and consists of the following:

12.4.1.a. Outpatient follow-up for 1 - 2 weeks;

12.4.1.b. Oral antibiotics; and

12.4.1.c. Analgesics may be required.

12.4.2. Inpatient treatment is appropriate for severe fractures or other complicated injuries. Treatment consists of the following:

a. Surgical repair;

b. Medications include antibiotics and analgesics; and

c. Hospitalization from 1 - 3 days.

12.5. The estimated duration of care is as follows:

Diplopia may resolve spontaneously within one to two weeks with small fractures not requiring repair. Double vision generally resolves within two to three weeks after surgical repair unless there is intrinsic damage to the extraocular muscles.

Modified work may be required with diplopia resolved. Heavy work can generally be resumed three weeks after injury if surgery is not required, or three weeks after surgical repair.

12.6. The anticipated outcome is resolution of diplopia and normal functioning of the eye. Numbness over the cheek may persist for one year or longer and is not affected by surgical repair.

§85-20-13 Treatment guidelines: corneoscleral lacerations.

13.1. Corneoscleral lacerations are potentially severe injuries resulting from sharp objects making forceful contact with the globe.

13.2. The appropriate diagnostic criteria consists of:

13.2.1. A detailed examination by an ophthalmologist including visual acuity, slit lamp exam, intraocular pressure and dilated fundus exam.

13.2.2. CT scan of orbits may be required.

13.3. Appropriate treatment is as follows:

13.3.1. Small partial thickness lacerations:

13.3.1.a. Follow-up and/or patching; and

13.3.1.b. Bandage contact lens application and follow-up.

13.3.2. Full thickness corneal lacerations:

a. Bandage lens application;

b. Cyanoacrylate tissue adhesive and protective shield;

c. Surgical repair under general anesthesia and hospitalization;

d. Cycloplegic, steroid and antibiotic drops; and

e. Hospitalization: 0 - 7 days.

13.4. The estimated duration of care and anticipated outcome:

13.4.1. Partial thickness laceration:

The claimant should wear a protective shield for three to six weeks. Modified work may be done after several days. Normal visual function after six weeks.

13.4.2. Full thickness simple corneal lacerations:
Treatment lasts from two to four months. Protective shield should be worn for six weeks. Return to full work after suture removal in three to four months if vision is adequate for fusion.

13.4.3. Lacerations involving lens, uveal tissue and retina:

Six months to achieve stability after which contact lens correction of the aphakic condition may allow good visual recovery.

§85-20-14. Treatment guidelines: chemical ocular injuries.

14.1. Chemical injuries may result from an almost infinite variety of agents contacting the ocular surface, with the extent of the injury largely a function of the nature of the substance involved, how much ocular surface is involved, and duration of exposure.

14.2. The appropriate diagnostic criteria is as follows:

A detailed examination is performed after copious irrigation (see treatment). It is vitally important to know the chemical causing the injury, its concentration and amount of exposure.

In alkali burns, the Hughes classification (grading or corneal haziness and loss of blood vessels at limbus) is helpful in assessing long term prognosis.

14.3. The appropriate treatment is as follows:

14.3.1. Acute phase (0 to 7 days).

a. Immediate copious irrigation using any nontoxic irrigating solution;

b. Detailed ophthalmologic exam, including pH level of eye secretions;

c. Topical steroids, antibiotic drops, topical ascorbate and cycloplegic agents;

d. Follow-up outpatient for 3 weeks;

e. Immediate referral to ophthalmologist for alkaline burns; and

f. Monitoring for systemic effect of toxin.

14.3.2. Severe chemical injuries should be hospitalized for treatment for several days.

14.4. The estimated duration of care depends on the extent of the initial injury. Milder injuries may permit return to work after several days. Moderate chemical injuries (if bilateral) may need several weeks to recover. Severe burns (if bilateral) may be blinding. In many cases corneal transplants may be able to restore vision.

§85-20-15. Treatment guidelines: cervical musculoligamentous injury (sprain/strain).

15.1. Symptoms are believed to be related to a partial stretching or tearing of the soft tissues (muscles, fascia, ligaments, facet joint capsule, etc.). Neck pain may be accompanied by vague upper extremity complaints. The recovery period is of variable duration, but generally is less than three

or four weeks.

15.2. The appropriate diagnostic criteria consists of the following:

15.2.1. Pertinent historical and physical findings documenting the mechanism and degree of force and the time sequence before the onset of symptoms is important. The onset of neck pain and paraspinal muscle spasm begins either suddenly after the injury occurs or develops gradually over the next 24 hours. This pain is usually aggravated by motion of the neck and frequently is relieved by rest. It can be accompanied by paresthesia or a sense of weakness in the upper extremities related to the muscle spasm in the neck. Physical findings include tenderness to palpation, spasm of the paravertebral muscles and aggravation of the pain with motion.

15.3. The appropriate diagnostic tests and examinations are as follows:

15.3.1. If indicated by examination, anteroposterior, lateral, lateral flexion and extension x-rays of the spine and open mouth view to visualize the odontoid process are appropriate. Other x-rays may be added to the roentgenographic series as indicated. Straightening of the cervical spine is frequently observed on the lateral x-ray.

15.3.2. Further imaging may be indicated depending upon clinical course.

15.4. The appropriate treatment is as follows:

15.4.1. Outpatient treatment:

a. Nonoperative treatment:

A. Indications: Almost all claimants with cervical musculoligamentous (sprain/strain) can be treated conservatively. However, disruption of intervertebral ligaments with subluxation is an indication for surgery.

B. Treatment options:

(a) Analgesics;

(b) Muscle relaxants;

(c) Anti-inflammatory drugs, non-steroidal;

(d) Physical modalities and/or rehabilitative procedures may be helpful;

(e) Occasional trigger point injections may be helpful; and

(f) Manual manipulation and mobilization.

15.4.2. Inappropriate treatment:

a. Operative treatment is inappropriate for cervical strain;

b. Narcotic medication for prolonged period of time; and

c. Inpatient treatment.

15.5. The estimated duration of care is 1 to 4 weeks; not to exceed 8 weeks.

15.6. The anticipated outcome:

15.6.1. Resumption of normal activity without residual symptoms in most cases.

15.7. Modifiers (age, and co-morbidity).

15.7.1. If the claimant has not responded to the above-outlined treatments within four weeks, the claimant must be referred to an appropriate specialist.

§85-20-16. Treatment guidelines: acute herniated cervical disc.

16.1. A cervical disc syndrome is a condition in which there is a bulging or rupture of the intervertebral disc. This may be lateral, compressing a root and causing a radiculopathy, or midline, compressing the spinal cord and causing a myelopathy. This most often occurs at the C4-5, C5-6 and the C6-7 disc levels.

When the C4-5 disc ruptures there is pressure on the C5 root. This may cause pain over the top of the shoulder in the "epaulet" distribution. Tingling is not common. There may be weakness of the deltoid muscle. Occasionally the biceps reflex is diminished. When the C5-6 disc ruptures there is pressure on the C6 root with pain as well as tingling and decreased sensation over the thumb and index finger, weakness of elbow flexion, and

diminution of the biceps and brachial radialis reflexes. When the C6-7 disc ruptures there is pressure on the C7 root with pain and tingling in the index and middle fingers, weakness of elbow extension, and diminution of the triceps reflex. There can be more extensive weakness than noted above, although the description is that of the classic syndrome. There may be changes in other reflexes, and the sensory abnormalities may be somewhat variable. Pain, sensory changes or weakness may predominate because of ill-defined differences in sensibility of the different components of the nerve. Over time the pain may resolve due to permanent damage to pain fibers, leaving the claimant with motor and sensory dysfunction which still may merit decompression.

Myelopathic symptoms may occur due to central disc protrusion and cause sensory (particularly posterior column) and motor dysfunction in the arms and legs, and bladder and bowel symptoms.

16.2. The appropriate diagnostic criteria is as follows: The onset may be sudden or insidious. Neck pain is common, especially at night and with the neck in extension. Neck motions are frequently limited and cause an exacerbation of pain. The hallmark is arm pain and/or paresthesia. The pain is often described as a sharp, shooting pain that radiates from proximal to distal along the anatomic course of the nerve.

The Spurling test (neck extension and tilting the head toward the painful arm followed by axial compression of the cervical spine) is often positive. The neurological exam may be normal if compression is not too severe or there may be weakness, sensory impairment and/or altered reflexes.

16.3. Appropriate diagnostic tests and treatments are as follows:

16.3.1. In the face of a typical history and physical examination, plain spine x-rays are indicated since treatment may be altered if there are associated problems such as ostephytes.

16.3.2. Non-operative treatment:

a. Cervical traction;

b. Cervical collar may be used; not to exceed one week;

c. Use of analgesics, mild relaxants, and non-steroidal anti-inflammatory drugs; and

d. Appropriate physical medicine referral to include

physical agents; exercise, and manipulation/mobilization.

e. Indications for inpatient admission:

A. Inability to control pain; and

B. Progressive neurological deficit.

16.3.3. Claimants with significant neurologic deficit, uncontrollable pain, or who fail to improve after two to four weeks should be referred for consultation to a surgeon who does cervical operations.

16.3.4. Neuro-Imaging examinations:

a. Myelography followed by CT scan with contrast medium in place. Myelography with CT scan is the established test for evaluating the presence of nerve root compression. To warrant treatment, abnormalities must relate to the clinical problems of the claimant. There is no reason to admit a claimant to a hospital overnight for a myelogram. Persistent post-myelogram syndrome should be treated by hydration, caffeine, and/or blood patch as an outpatient procedure;

b. MRI, although occasionally it may not provide complete information about root compression or bony anatomy; and therefore,

c. EMG and nerve conduction velocity studies may be required to determine exact level of compression and rule out peripheral nerve compression, but should be delayed 21 days from onset of symptoms.

16.3.5. Inappropriate diagnostic tests and examinations:

a. Computed tomography without myelographic dye, although this may be helpful for other conditions such as infection or tumor;

b. Myeloscopy;

c. Dermatomal somatosensory evoked potentials;

d. Thermography; and

e. Spinoscopy.

16.3.6. Operative treatment:

a. Failure of non-operative treatment to relieve

symptoms;

b. Quality of claimant's life significantly impaired; or

c. Presence of significant or progressive neurologic deficit, either radiculopathy or myelopathy diagnosis confirmed by myelogram with CT scan, or by MRI

16.3.7. Procedure options:

a. Laminectomy with excision of disc or arthritic spur or foraminotomy. Fusion is not indicated for a simple disc. Discharge 2 - 4 days post op. Posterior fusion is not indicated unless approved.

b. Anterior cervical diskectomy, especially in cases where there is medial compression. Discharge 1-3 days post op.

c. Complicated - after wound infection, thrombophlebitis, spinal fluid leak, or other significant complication has been controlled; and

d. Rehabilitation may be required.

16.4. The estimated duration of care is as follows:

16.4.1. Non-operative treatment - if still symptomatic by six weeks, must be referred for surgical consultation; and

16.4.2. Operative treatment - depending on degree of neurological impairment and persistent pain. If pain persists over three months after surgery, the claimant should be referred for comprehensive pain management. If a disabling neurological deficit persists more than three months, vocational guidance should be considered. If a fusion has been done, the claimant may require short and/or long term modified work.

§85-20-17 Treatment guidelines: low back musculoligamentous injury (sprain/strain).

17.1. Strains and sprains are a common cause of acute low back pain encountered in the general population. These injuries often are the result of the mechanical stresses and functional demands placed on the low back area by everyday activities. Symptoms are believed to be related to a partial stretching or tearing of the soft tissues (muscles, fascia, ligaments, facet joint capsule, etc.) The conditions, for the vast majority of claimants, are of short duration and complete recovery is the general rule. Most claimants with a musculoligamentous injury to the low back recover rapidly, with 50% to 60% of claimants

recovering within one week.

17.2. The appropriate diagnostic criteria consist of:

Onset of low back pain and paraspinal muscle spasm begins either suddenly after the injury occurs or develops gradually over the next 24 hours. The pain is usually relieved by rest and aggravated by motion of the back. The pain usually does not radiate below the knee, and the strain is not accompanied by paresthesias or muscle weakness in the legs. Physical findings include low back tenderness to palpation, loss of normal lumbar lordosis, and spasm of the paravertebral muscles. Straight leg raising and other tests that cause spinal motion may increase low back pain. The claimant may stand with a list to the side or in a flexed position. The neurological examination and nerve root stretch tests usually are negative.

17.3. Appropriate and inappropriate diagnostic tests and examinations are as follows:

17.3.1. Although the diagnosis of a musculoligamentous injury is not based on radiographic criteria, plain x-rays may be indicated based on mechanism of injury (actual trauma, hyperextension, compression), a high index of clinical signs of pathology, or treatment plan for manipulative therapy. Pain which persists (no improvement) longer than 2-4 weeks or worsens may also be criteria for x-rays.

17.3.2. Inappropriate diagnostic tests and examinations during the acute phase of the first four weeks:

a. CT scan;

b. MRI;

c. Bone scan;

d. Myelography;

e. EMG;

f. *Thermogram;

g. *Evoked Potentials;

h. *Myeloscopy; and

i. *Spinoscopy;

*Never appropriate

17.3.3. Failure to improve in four weeks warrants an appropriate second opinion be obtained.

17.4. Treatment considerations are as follows:

17.4.1. Nonoperative treatment:

a. Indications: Almost all claimants with low back musculoligamentous (sprain/strain) can be treated satisfactorily. No indications exist for the use of surgery in the treatment of low back musculoligamentous injuries.

b. Treatment options:

A. Short-term bed rest for approximately 2 days with appropriate positioning;

B. Analgesics;

C. Muscle relaxants as needed;

D. Anti-inflammatory nonsteroidal medication;

E. Referral for physical medicine (PT, OT, DC, DO, and physiatrist);

F. Physical modalities in conjunction with proper body mechanics and flexibility, endurance, and strength reactivation exercises;

G. Manipulation of spine;

H. Occasional trigger point injections; and

I. Lumbosacral corset or brace.

17.4.2. Inappropriate treatment:

a. Operative treatment is inappropriate for low back strain;

b. Prolonged bed rest beyond two days;

c. Narcotic medication for prolonged period;

d. Home traction; and

e. Inpatient treatment.

17.5. The estimated duration of care: 0 to 4 weeks; not to exceed 8 weeks.

17.6. The anticipated outcome is resumption of normal activity without residual symptoms in most cases. Transitional activities may be required.

17.7. Modifiers (age, and co-morbidity).

Co-mobidity (e.g., degenerative disc disease, spondylolisthesis, segmental instability, osteoporosis, spine deformity) may be associated with a higher incidence of persistent symptoms.

§85-20-18. Treatment guidelines: herniated lumber disc.

18.1. Claimants under treatment by their own physician who fail to improve after two to four weeks - refer to an orthopedic surgeon or neurosurgeon for consultation and/or treatment.

Herniations occur most commonly through a posterolateral defect, but midline herniations may occur. Resulting compression of the spinal nerve root causes inflammation and pain, usually along the anatomic course of the nerve. In the lumbar spine, this most often occurs at the L4 and L5 disc levels, causing pressure on the corresponding L5 and S1 nerve roots. As a result of both mechanical and biochemical changes around the nerve root, the claimant will experience pain, paresthesia, and possibly weakness in the leg or legs usually below the knee. The rare herniations at the L1, L2 and L3 levels are usually associated with pain, paresthesia, and weakness above the knee. Back pain may or may not be a presenting complaint with any herniated lumbar disc.

18.2. The appropriate diagnostic criteria consist of:

Back pain is usually the first symptom and may or may not abate as the pain and paresthesias begin to radiate down the leg. The leg pain is often described as a sharp, shooting pain that radiates along the anatomic course of the nerve from proximal to distal. The onset may be sudden or insidious. The claimant often has difficulty getting up from sitting or supine positions and commonly leans or lists to one side or the other. Motion of the spine is limited due to pain and muscle spasm. The neurological examination may be normal if the compressed nerve is still functional, or it may yield objective evidence of impaired nerve function (e.g. atrophy, weakness, sensory alteration or diminished reflex) depending upon the nerve root affected. Signs of nerve root tension (e.g. positive straight leg raising) may also be present.

When the L4 disc herniates, it usually causes pressure on the L5 nerve root resulting in weakness of the great toe extensor

or other dorsiflexor muscles of the foot and sensory loss along the medial aspect of the foot to the great toe, but it is usually not associated with reflex abnormality. When the L5 disc herniates, it usually causes pressure on the S1 nerve root, resulting in a sensory deficit in the posterior calf area and lateral aspect of the foot in addition to a diminished Achilles' reflex and occasional weakness of the plantar flexors of the foot.

18.3. Diagnostic test and examination considerations are as follows:

18.3.1. Clinical diagnosis is supported by these studies:

a. Plain spine radiographs (and on rare occasions bone scans) to rule out other conditions such as tumor, infection, fracture and congenital anomalies, if not previously done;

b. MRI; and

c. Myelography with CT scan.

18.3.2. Inappropriate diagnostic tests and examinations:

a. Myeloscopy;

b. Dermatomal somatosensory evoked potentials;

c. Thermography; and

d. Spinoscopy.

18.3.3. Supporting evidence.

EMG may be helpful in rare cases. Discography can occasionally be helpful. Selective lumbar nerve block may be helpful for diagnosis.

18.4. The appropriate treatment is as follows:

18.4.1. Outpatient treatment:

a. Nonoperative treatment:

A. Short period of bed rest, up to 10 days with analgesics, mild relaxants, and nonsteroidal anti-inflammatory drugs;

B. Physical medicine and/or rehabilitation; and

C. Orthotics.

The value of periods of bed rest has not been demonstrated. Complete bed rest for prolonged periods may be deleterious to the body and should be closely monitored. A significant number of claimants will respond to a nonoperative treatment program for herniated lumbar disc. The physician should be aware that those claimants who have marked, early limitation of straight leg raising and those claimants who have symptoms or physical findings suggestive of cauda equina syndrome may need early surgery. Close monitoring is indicated in those settings.

18.4.2. Inpatient treatment.

a. Nonpoperative treatment.

A. Indications for admission.

(a) Inability to control pain; and

(b) Severe or progressive neurologic deficit.

B. Treatment options.

(a) Monitored bedrest with parenteral medications.

C. Indications for discharge.

(a) Uncomplicated - relief or improvement of leg and/or back pain.

(b) Exceptions:

(A) No response to nonoperative treatment options requiring consideration of surgical intervention; and

(B) Spinal headache after myelogram requiring IV fluids or blood patch.

b. Operative treatment:

A. Indications: diagnosis confirmed by myelography with CT scan, or MRI, plus one of the following three.

(a) Failure of nonoperative treatment to relieve symptoms;

(b) Quality of claimant's life significantly impaired;

and

(c) Presence of significant or progressive neurologic deficit.

B. Procedure options:

(a) Open removal; and

(b) Percutaneous diskectomy by special approval.

C. Indications for discharge:

(a) Uncomplicated - One to three days after diskectomy.

(b) Complicated - after wound infection, thrombophlebitis, spinal fluid leak, or other significant complication has been controlled.

D. Home health care may be required for a short period.

E. Physical modalities and/or rehabilitative procedures.

(a) Some monitoring of the claimant's activities may be necessary;

(b) General fitness, flexibility, and simple spinal muscle strengthening are all important;

(c) Claimant should be instructed in walking program with a gradual increase in physical activities; and

(d) Strengthening exercises or work simulation activities may be indicated for some claimants.

F. Supporting evidence.

Diskectomy has been proven to be a safe and effective procedure in some claimants with herniated disc. Such surgical intervention remains elective (in the absence of a severe neurologic deficit) and the decision is based on the surgeon's clinical judgement and the claimant's personal assessment of the extent to which quality of life has been impaired.

18.5. The estimated duration of care is as follows:

18.5.1. Nonoperative treatment - maximum medical improvement 0 - 12 weeks.

18.5.2. Operative treatment - 0 - 12 weeks.

18.6. Modifiers (age, and co-morbidity).

Claimants with symptoms suggestive of cauda equina syndrome will require a different approach to treatment. Cauda equina syndrome is a surgical emergency. Symptoms include low back pain and paralysis with loss of bladder and bowel control. Once this diagnosis is suspected, the claimant should undergo prompt referral and neurodiagnostic evaluation.

§85-20-19 Treatment guidelines: lumbar fusion.

19.1. Indications of lumbar fusion:

19.1.1. Injuries to bone or soft tissue that cause instability;

19.1.2. Cancer;

19.1.3. Symptomatic spondylolisthesis; and

19.1.4. Documented instability for other cause.

a. For first surgery only, degenerative disc disease with pre-operative documentation of instability.

b. Pseudoarthrosis.

c. For second or third time disc surgery, must have second, medical opinion and prior approval.

19.2. Contraindications for lumbar fusion.

19.2.1. Primary surgery for a new, acute disc herniation with unilateral radiation leg pain.

19.3. Surgical procedures.

19.3.1. Bony fusion with or without instrumentation.

§85-20-20 Treatment guidelines: shoulder injury guidelines.

20.1. The term "shoulder complex" refers to the humerus, clavicle, scapula and their surrounding supporting connective tissue and emphasizes their interdependent relationship. Articulations of the "shoulder complex" are the sternoclavicular, acromioclavicular, scapulothoracic, glenohumeral, and subacromial arch.

Fractures, separations, or subluxations/dislocations of components within the "shoulder complex" result from trauma to the shoulder girdle or upper extremity. Soft tissue strains or sprains may result from either trauma or longstanding accumulative microtrauma. The rotator cuff is particularly vulnerable to overuse pathology.

Treatment of "shoulder complex" injuries is directed to restoring balanced motion in the entire complex. Because of the importance of the soft tissues, physical therapy is very important and can be lengthy. On the other hand, because the shoulder complex is so adaptable, most individuals can find alternative patterns of function in their work, home, or recreational needs while they are undergoing physical rehabilitation.

20.2. The appropriate diagnostic criteria are as follows:

20.2.1. History and physical.

a. Mechanism of injury - single episode or repetitive microtrauma.

b. Pain pattern - pain at rest, pain related to work, activities of daily living, or recreational activities, night pain; painful arc of motion; position of comfort; relative position of the pain; relative position of the neck; referred pattern (pain below the elbow suggests a radicular component).

c. Range-of-motion - active glenohumeral and scapulothoracic balance; passive forward flexion, external rotation, internal rotation, and abduction compared to the opposite side.

d. Palpation - point or zone of maximum tenderness.

e. Neurological - motor, sensory, muscle stretch reflexes for C5, C6, C7, C8 and T1 roots.

f. Special tests - apprehension; drop arm; impingement; Yergason; posterior apprehension; sulcus sign; clunk; AC spring; Adson; "winged" scapular; lateral scapular slide.

20.3. The appropriate diagnostic tests are as follows:

20.3.1. Routine imaging:

a. Shoulder series - internal, external, and transaxillary or transcapular lateral (a transthoracic lateral is of no benefit except in humeral shaft fractures, posterior

dislocations of the shoulder may be missed).

b. Special imaging - requires pre-authorization and specialty referral.

A. CT scan;

B. MRI;

C. Arthrogram; and

D. EMG/NCV.

20.4. The guidelines for appropriate specialty referral are as follows:

20.4.1. Failure of improvement or resolution of symptoms with conservative treatment in four weeks;

20.4.2. Radiographic evidence of fracture, subluxation, or dislocation;

20.4.3. Initial presentation of hemarthrosis;

20.4.4. Significant lack of motion compared to opposite side; and

20.4.5. Suspected neurologic injury.

20.5. Appropriate treatment is as follows:

20.5.1. Fracture - subluxation/dislocation (requires specialty referral).

a. Nonoperative or operative:

A. One to four weeks of immobilization; and

B. Physical therapy beginning in one to four weeks and continuing up to six months.

20.5.2. Sternoclavicular or acromioclavicular strain or grade 1 (nondisplaced sprain).

a. Nonoperative:

A. One to seven days of immobilization;

B. Physical therapy, modalities and range-of-motion, one to six weeks;

C. Duration of care - one to six weeks;

D. Anticipated results - resolution of symptoms and resumption of normal activities. May develop degenerative arthritis at a later date.

b. Operative (specialty referral) - no indication except evidence of degenerative changes after prolonged conservative management.

20.5.3. Rotator cuff tendinitis/bursitis.

a. Nonoperative.

A. Local steroid injections at three to six week intervals (not to exceed three);

B. Physical therapy - up to three months at decreasing intervals;

C. Job activity modification if indicated; and

D. NSAIDs.

b. Operative (specialty referral).

A. Indications.

(a). Failure of improvement after three to six months of conservative care;

(b). Positive impingement sign; and

(c). Arthrogram or MRI to determine integrity of rotator cuff.

B. Physical therapy following surgery, three to six months at decreasing intervals.

20.5.4. Rotator cuff tear.

a. History - sudden onset of pain and inability to initiate active abduction; passive abduction relatively normal; plain x-rays revealed not acute bony changes.

b. Nonoperative.

A. Physical therapy one to three weeks;

B. Specialty referral if no improvement.

c. Operative (specialty referral).

A. Arthrogram or MRI confirms tear; and

B. Physical therapy following surgery, three to six months at decreasing intervals.

20.5.5. Adhesive capsulitis (frozen shoulder).

a. History -- insidious pain and loss of motion in the glenohumeral joint.

b. Nonoperative.

A. Physical therapy tried one to six weeks;

B. Glenohumeral joint injection with saline distention using short acting steroids plus Xylocaine - limit two at three week intervals; and

C. Specialty referral if no improvement after six to eight weeks.

c. Operative (specialty referral).

A. Manipulation if no improvement after three months.

d. Other conditions which (require specialty referral).

A. Thoracic outlet syndrome;

B. Brachial plexus injuries; and

C. Ruptured biceps tendon, proximally or distally.

§85-20-21 Treatment guidelines: carpal tunnel syndrome.

21.1. Median nerve compression at the wrist, commonly called carpal tunnel syndrome, is characterized by paresthesia in the thumb and radial digits and wrist pain which may radiate proximally. It is often bilateral. The causative factor is felt to be compression of the median nerve in the carpal tunnel, either directly from the transverse carpal ligament or from crowding by other structures within the carpal tunnel. Predisposing factors include (1) overuse or repetitive motion of the hand and/or wrist; highly repetitive wrist movements, awkward wrist positions, vibratory tools, significant grip forces, (2) systemic conditions such as diabetes mellitus, pregnancy, arthritis, thyroid dysfunction or other metabolic conditions, (3)

space-occupying altering conditions within the carpal tunnel such as fracture, tenosynovitis, tumor or aberrant muscles; (4) external compression from constrictive bandages or jewelry etc; (5) peripheral neuropathy; or (6) idiopathic.

21.2. The appropriate diagnostic criteria consist of:

Claimants usually complain of painful, burning paresthesia or numbness involving the thumb, index finger, long finger and occasionally the radial aspect of the ring finger or the entire hand. These symptoms are usually worse while lying down or sitting quietly. Activities such as driving, holding a telephone, or fixing one's hair often precipitate the paresthesia. The most common complaints usually include nocturnal paresthesia, clumsiness with loss of fine dexterity, and dropping things. The claimant often feels as if there is a loss of circulation. The paresthesia are often relieved by actively working the fingers, shaking the hand, or holding it in a dependent position. Pain is usually present over the palmar wrist area and may radiate proximally as far as the shoulder or neck.

Findings are consistent with those of a nerve irritation. Tinel's test may be positive over the median nerve in the proximal palm, or wrist. Numbness in the fingers may be elicited with the wrist in extreme extension or flexion (Phalen's test). There may be decreased sensation distal to the wrist particularly over the thumb, index, and long fingers, inability to flex or oppose the thumb or abduct it in its own plan; and thenar muscle atrophy. There can be significant variations in location of pain and sensory changes. The examiner also needs to evaluate additional or alternate sites of compression which can produce similar symptoms.

21.3. Appropriate diagnostic tests and examinations are as follows:

21.3.1. Radiographs of hand and wrist if indicated by history and exam;

21.3.2. EMG and NCS;

21.3.3. Response to rest, splinting of wrist, and carpal tunnel steroid injection;

21.3.4. Laboratory studies if symptoms suggest an underlying disease such as diabetes mellitus or thyroid dysfunction; and

21.3.5. Radiograph of cervical spine upper extremity and/or chest if symptoms suggest a more proximal disease process.

21.4. Evolving diagnostic tests and examinations:

21.4.1. CT scan and MRI; only if indicated by previous plain films and history of space occupying deformity or mass;

21.4.2. Wrist arthrogram; if findings suggestive of carpal instability; and

21.4.3. Carpal canal pressure measurements and vibratory measurements are not indicated for clinical management.

21.5. Supporting evidence.

Since double crush syndromes (entrapment of a nerve at more than one level) and systemic diseases causing carpal tunnel syndrome are not unusual, a thorough evaluation is essential. Steriod injections are usually not curative, but an improvement following injection is normally a good predictor of improvement following surgical release. Nerve conduction studies have approximately a 95 percent accuracy rate. However, it must be understood that there is variability in skill of test and diagnostic reference criteria do vary. This should be carefully monitored by the referring physician and by a question and answer mechanism.

21.6. The appropriate treatment consists of the following:

21.6.1. Nonoperative treatment.

a. Indications:

A. Symptoms mild;

B. Recent onset of symptoms;

C. Pregnancy; other systemic problems which may be treated medically;

D. Onset of symptoms associated with work or non-work exposure plausibly associated with subjective and/or objective findings; and

E. Associated with other surgical conditions i.e. cervical radiculopathy.

b. Treatment options.

A. Splint wrist in neutral;

B. Nonsteroidal anti-inflammatory drugs;

C. Steroid injections;

D. Eliminate or modify aggravating activities;

E. Treatment of systemic disease;

F. Manipulation by a DC or DO no longer than 8 weeks; and

G. Self care - ice, elevation, range of motion, stretching, postural correction, etc.

c. Rehabilitation.

A. Modification of activities, postural and upper extremity position(s) and tools; and

B. Gradual progression of strengthening and endurance activity and exercises once symptoms have decreased or subsided.

21.6.2. Ambulatory surgery.

a. Indications:

A. Unresponsive to, or progression of symptoms and objective findings despite, nonoperative treatment;

B. Thenar atrophy or objective impairment of sensibility (widened two-point discrimination or diminished light touch);

C. Intolerable numbness and pain; and

D. Mass or deformity in carpal tunnel.

b. Treatment option.

A. Surgical intervention as indicated by presentation and intraoperative findings.

b. Home health care: When self-care is compromised during the early post-op period, homemaker services may be required in some instances. Examples: amputation or limiting injury of the opposite hand.

d. Rehabilitation.

A. Brief post-operative splinting;

B. Finger and wrist range of motion;

C. Scar massage after sutures removed;

D. Grip and pinch strengthening;

E. Range of motion exercises of affected extremity; and

F. Progressive activity reintroduction.

e. Supporting evidence: Carpal tunnel release relieved pain and paresthesia in up to 90% of claimants with correct diagnosis. Significant pre-operative median nerve involvement, concurrent medical conditions and/or inability to modify aggravating exposures may affect post-operative functional recovery.

21.6.3. Inpatient treatment.

a. Nonoperative: rare, only if associated with other trauma or condition, i.e. crush injury, burn, etc.

b. Operative treatment.

A. Indications for admission:

(a). Compartment syndrome of forearm;

(b). Other serious medical condition which increases surgical or anesthetic risk; and

(c). Complication at time of out-patient procedure.

B. Treatment options: same as for ambulatory claimant.

C. Indications for discharge: medical condition stabilized.

D. Home health care: same as for ambulatory claimant.

E. Rehabilitation: same as for ambulatory claimant.

21.7. The estimated duration of care is as follows:

21.7.1. Nonoperative treatment: zero to three months - permanent activity modification may be indicated depending on objective findings and past duration of symptoms.

21.7.2. Operative treatment: Usually only several days unless there is profound weakness or sensory loss.

21.8. The anticipated outcomes are as follows:

21.8.1. Improved sensation and/or motor function and/or autonomic dysfunction;

21.8.2. Elimination of paresthesia; and

21.8.3. Improvement in pain.

21.9. Modifiers (age, sex, and co-morbidity): Pregnant and nursing women usually have decreased or resolved symptoms shortly after delivery or cessation of lactation, but persistent symptoms may require surgical release. Age and gender do not matter. A coexistent neurological or systemic disorder, i.e. diabetes, thyroid dysfunction, amyloidosis etc., may make symptoms more severe and less likely to fully resolve following treatment.

§85-20-22. Treatment guidelines: injuries to the knee.

22.1. The vast majority of knee injuries result from direct trauma to the joint or are caused by torsional or angulatory forces. These injuries vary in severity from simple ligamentous strains to complex injuries involving ligamentous disruption with meniscal damage and associated fracture.

This guideline is designed to guide the practitioner in the appropriate management of these injuries and to establish a logical sequence for the diagnostic evaluation and treatment of the more complex injuries.

In general, knee injuries should be referred for orthopedic consultation and/or treatment under the following circumstances:

22.1.1. Failure of a presumed knee sprain to show progressive resolution and respond to appropriate conservative treatment in a period of three (3) weeks;

22.1.2. Radiographic evidence of an associated fracture;

22.1.3. The initial presence of a tense hemarthrosis or the development of a recurrent hemarthrosis;

22.1.4. An acutely locked or an acutely dislocated knee;

22.1.5. Clinical evidence of gross ligamentous instability; and

22.1.6. A presumed diagnosis of a meniscal injury.

§85-20-23. Treatment guidelines: knee sprains.

23.1. These are common injuries resulting from the application of a torsional or angulatory force to the knee and are characterized by pain, mild swelling, localized tenderness, increased discomfort or weight bearing, negative x-rays, and no clinical evidence of instability.

23.1.1. The appropriate diagnostic tests.

a. Plain x-rays.

23.2. The appropriate and inappropriate treatment is as follows:

23.2.1. Nonoperative treatment.

a. Medications to include nonnarcotic analgesics and nonsteroidal anti-inflammatory drugs;

b. Application of ice, compression dressings, and temporary partial restriction of weight bearing;

c. Physical modalities and/or rehabilitative procedures;

d. Duration of care - estimated duration of care is three weeks, not to exceed six weeks; and

e. Anticipated result - resolution of symptoms and resumption of normal activities.

23.3.2. Inappropriate treatment:

a. Surgery;

b. Inpatient; and

c. Greater than three weeks without consultation.

§85-20-24. Treatment guidelines: meniscal injuries.

24.1. The mechanism of injury is similar to that for knee sprains but symptoms of pain and swelling fail to resolve in the anticipated period of time and the symptoms frequently include a sensation of "catching or giving away" of the joint and a history of locking of the joint may be elicited.

Clinical findings may include joint space tenderness, a mild

effusion and restricted range-of-motion and positive McMurray's sign.

24.2. The appropriate diagnostic tests are as follows:

24.2.1. Plain x-rays;

24.2.2. Arthrocentesis;

24.2.3. MRI;

24.2.4. Arthrogram; and

24.2.5. Diagnostic arthroscopy.

24.3. The appropriate treatment is as follows:

24.3.1. Outpatient/nonoperative treatment.

a. Short-term use of nonsteroidal anti-inflammatory drugs in conjunction with an arthrocentesis and short-term immobilization with a period of limited weight bearing;

b. Physical modalities and/or rehabilitative procedures.

24.3.2. Outpatient/operative treatment.

a. Options include arthroscopic meniscectomy and/or arthroscopic meniscal repair; and

b. Physical therapy/rehabilitation.

24.3.3. Inpatient/nonoperative treatment not indicated.

24.3.4. Inpatient operative treatment - The reasons for admission for surgical treatment may include the presence of associated medical conditions, a concomitant knee injury such as a fracture of the tibial plateau or a major ligamentous disruption, or the presence of other injuries which require inpatient treatment.

24.5. The duration of treatment may vary up to three (3) months. The claimant's age and pre-existence of arthritic changes within the joint will influence the duration of treatment.

24.6. The anticipated outcome is as follows:

24.6.1. Improved knee function with minimal residual

symptoms; and

24.6.2. Possible predisposition to the development of traumatic arthrosis of the knee.

§85-20-25. Treatment guidelines: foot and ankle injuries.

25.1. Injuries to the foot and ankle usually relate to a specific traumatic event and have a predictable clinical course depending on the severity index of the initial injury. For simplicity, injuries will be discussed relative to the anatomic region of the foot and ankle (ankle, hindfoot, midfoot, forefoot or phalanges).

25.2. The appropriate diagnostic criteria is as follows:

25.2.1. Pertinent historical and physical findings:

a. Onset of pain and/or swelling is related to a single event, either a twisting injury, fall or direct blunt trauma. The degree of the injury can be judged quickly by determining which one can bear weight and the degree of initial swelling. The more severe injuries will have greater swelling, inability to bear weight, and may have obvious deformity.

25.3. Diagnostic test and examination considerations are as follows:

25.3.1. If differentiation between a soft tissue ligamentous injury and a fracture is required, x-rays in several planes are appropriate in all cases;

25.3.2. CT scans may be indicated in hind foot injuries to define subtle fractures, tarsal coalitions or the degree of displacement in three planes in acute injuries;

25.3.3. Bone scans are occasionally indicated in long standing pain problems to rule out stress fracture or inflammatory causes of foot pain (after four weeks of pain with normal X-rays).

25.3.4. MRI rarely indicated - should require specialty consultation; and

25.3.5. EMG and vascular studies (non-invasive arterial perfusion or arteriography at the request of the specialist.

25.3.6. Inappropriate diagnostic tests:

a. Thermogram.

25.3.7. Indications for specialty referral:

a. Displaced fractures;

b. Neurovascular compromise; and

c. Pain and swelling greater than three weeks.

25.4. The appropriate treatment is as follows:

25.4.1. Non-operative.

a. Sprains (No fracture seen on x-ray)

A Rest, ice compression and elevation(RICE);

B. Crutches and splinting (one through three days);

C. Early mobilization as pain allows. This may involve active supervised physical therapy;

D. Usual course - several days to three weeks; and

E. Referral to specialist required if no improvement by three weeks.

b. Fractures.

A. Simple non-displaced:

(a). Ankle - Specialty referral -Will require special splinting or casting for three to six weeks and may require an additional two to four weeks of physical therapy rehabilitation.

(b). Hind foot - Same as ankle.

(c). Midfoot - Same as ankle but course is usually two to four weeks shorter.

(d). Forefoot - Specialty referral not required special shoe or cast may be necessary. Usually resolved in three to six weeks.

(e). Phalanges - Same as forefoot, simple taping and/or modified shoe usually all that are necessary.

c. Displaced fractures.

Specialty referral is mandatory. Non-operative treatment

requires casting for three to six weeks followed by up to four weeks of rehabilitation.

25.4.2. Operative.

All operative decisions require specialty referral.

a. Sprains.

Indicated when there is a complete dislocation/ subluxation without a fracture anywhere in the ankle, hindfoot, or midfoot. May be indicated in the forefoot.

b. Fractures.

A. Simple - may be indicated in ankle.

B. Displaced - Usually indicated in ankle, hindfoot, midfoot, and forefoot. Displaced phalange fractures can sometimes be treated non-operatively.

§85-20-26. Appropriate intervention and time frame.

26.1. Therapy may be initiated as early as the day of injury; indications for the focus of (early) intervention include:

26.1.1. Acute management of pain/spasms;

26.1.2. Instruction in range of motion and stretching exercises;

26.1.3. Use of passive modalities;

26.1.4. Assessment of return to work readiness and identifying necessary work modifications; and

26.1.5. Claimant education in healing process and body mechanics.

Time Frame: May range from one visit only to 1 to 2 hours per day.

26.2. Expansion of therapy programs is indicated when claimants do not return to work at their former level. Exercise programs are progressively increased to include strengthening and conditioning exercises. Work simulation activities (also gradually increased) focus on essential work tasks needed, such as pushing, pulling, lifting, etc.

Time Frame: 1 to 4 hours per day, 3 to 5 days per week.

26.3. Progress reports to physician and employer should identify continuing complaints, progress made, further rehabilitation needs, and level of return to work readiness. A claimant may continue in therapy, if indicated, after return to work.

26.4. Therapy evaluations must be provided by a professional licensed to perform such activities.

26.5. Initiation of therapy intervention may not be indicated when:

26.5.1. Few objectively measured deficits are found on evaluations;

26.5.2. Subjective cause of pain is only finding;

26.5.3. Pain behaviors are interfering with return to work process;

26.5.4. Claimant is not compliant with treatment pain; and

26.5.5. Inappropriate treatment is exclusive use of passive modalities.

§85-20-27. Physical medicine.

27.1. Claimants with complicating factors which have prevented a return to work by the 60th day require case management, with independent medical evaluator guidance, for determination of appropriate care.

27.1.1. Recommendations for use of physical medicine:

a. Physical medicine should be initiated as early as the day of injury; indications for and focus of (early) intervention include:

A. Acute management of pain and spasms;

B. Use of passive modalities as adjunct to active treatment;

C. Manual therapy for restoring joint function;

D. Instruction in range of motion and stretching

exercises;

E. Assessment of return to work readiness and identifying necessary work modifications;

F. Claimant education in healing process, body mechanics, proper resting positions, and home treatment program; and

G. Time frames may range from one visit to daily visits in accordance with above treatment guidelines.

b. Evaluations must be provided by professionals licensed to perform such activities.

c. Initiation of treatment may not be indicated when:

A. Few objectively measured deficits are found on evaluations;

B. Subjective complaints of pain are the only finding;

C. Pain behaviors are interfering with the return to work process; and

D. Claimant is not compliant with the treatment plan.

d. Inappropriate treatment is the exclusive use of passive modalities throughout the course of treatment.

e. Exercise programs are progressively increased to include strengthening and conditioning exercises. Any work simulation activities (also gradually increased) should focus on essential work tasks (pushing, pulling, lifting, etc.). Time frames may range form 1 to 4 hours per day, 3 to 5 days per week in accordance with above treatment guidelines.

f. Progress reports to the referring physician, workers' compensation, and the employer should identify continuing complaints, progress made, further rehabilitation needs, and level of return to work readiness. A claimant may continue in therapy, if indicated, after return to work in accordance with above treatment guidelines.

§85-20-28. Severability

28.1. If any provision of these rules or the application thereof to any entity or circumstance shall be held invalid, such invalidity shall not effect the provisions or the applications of these rules which can be given affect without the invalid

provisions or application and to this end the provisions of these rules are declared to be severable.

Response to Comments

In response to comments received regarding Series 20 the following changes were made.

a. The word protocol was removed from the rule.

b. An old and new version of the physical medicine guideline portion had erroneously been merged. The old version was deleted.

c. The nonoperative cervical treatment guidelines were brought into line with the nonoperative lumbar treatment guidelines.

No changes were made to Series 21 and 22.

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Telephone: (304) 485-9124
Fax: (304) 485-9127

Bureau of Employment Programs
Legal Services Division
c/o Lisa Kern
P.O. Box 3922
Charleston, West Virginia 25339

April 27, 1995

RE: Title 85, Series 20

Dear Lisa Kern:

I am writing you with regards to recommendations for the evaluation and treatment protocal for injuries which directly affect the spine. At present there exists enough scientific information to substantiate conservative treatment measures for herniations which affect the cervical as well as, the lumbar spine. On the other hand, there exists little supportive evidence based on scientific studies to make initial recommendations for surgical intervention of the spine at any level.

If a patient presents with only a sensory deficiet such as a paresthesia to the lower or upper extremity, this patient should not even be considered for a surgical consultation. As an example, with the proper history and evaluation, this patient should be ruled out for a number of neurological indications such as polyneuropathy, cauda equina syndrome and a host of other problems.

Should this patient present with a motor weakness and the history is based on an acute injury not historically related to some paraoxysmal progression, the patient should be allowed initial conservative treatment. Here lies the recommendations put forth by the AHCPR guidelines which states that a patient should be allowed treatment for a brief period (usually 4 weeks) before any special testing is ordered.

Should the history or clinical presentation dictate otherwise and the patient fail to demonstrate improvements with their treatment choice, special imaging studies or perhaps EMG should be made available (pending the suspected diagnosis). If this study indicates a disc herniation in the absence of any other contributing factors, the doctor should advise appropriate chiropractic intervention.

Based on the evidence available, chiropractic intervention has a greater success rate at treating various spinal conditions including those related to a disc herniation. Surgical intervention for the lumbar spine should be considered an extreme last option and only then when the patient is allowed to modify their work activities. As is demonstrated in the literature, surgical intervention immediately sets the environment for instability. By further returning this employee to the same physically demanding job, increased risks for reinjury is most likely.
Use of various modalities including distraction/flexion has a very good track record of improving patients conditions in returning them to pre-injury states. A program of properly applied cervical traction coupled with a program of home rehabilitation focusing towards strengthening the supporting structures has resulted in very good results for cervical disc injuries.

I might further recommend use of various enzymes and herbs which enhance cellular healing at this level. Use of the enzyme bromelian acts as mother natures antiinflammatory and butcher's broom acts to strengthen the venious return further providing a way for the inflammatory reaction to be reduced. Use of these supplements can provide an additional angle of healing for the chiropractic physician capable of implementing such a treatment rational.

Let me end by further explaining that many of these ligamentous injuries would be prevented if a state wide program was implemented to evaluate workers who are subjected to greater physical demands. The scientific literature is substantiating everyday that injuries appear to occur to a joint when loss of proper mobility, such as fixation is present.

Injury is implicated to a higher degree to a person who has lost mobility in the joint. This is measured through imaging studies which reveal degenerative changes to that area i.e., bone spurring, degeneration, etc. Chiropractic principles directly place an importance on restoring normal joint movements to these areas through properly applied treatment. If a worker lacks proper joint mobility, the chance for injury is very high. By implementing a "true" program of back injury prevention, you must include a well designed chiropractic orientated approach.

This truly provides a prevention program which could be orchestrated between employers and the workers' compensation system. By assessing and providing workers access to preventative measures such as this, the state and its industry base could potentially decrease costs associated with disability and lost work time at the same time potentially increasing productivity.

What I have written about in this letter is valid, scientific and field tested. If you or the panel would like to discuss any of this further I would love to discuss it with you. I look forward to assisting the state in these matters.

Sincerely,

Byron R. Folwell, D.C.
Doctor of Chiropractic

Notice of Public Comment

The Workers' Compensation Division has filed for public comment a proposal for three legislative rules. They are:

1. **Protocols & guidelines for the treatment of different types of injuries most commonly experienced by workers' compensation claimants (Title 85, Series 20).**
2. **Guidelines for controlled substances (Title 85, Series 21).**
3. **Guidelines for psychiatric impairment ratings, evaluations and evidence (Title 85, Series 22).**

These rules were recommended by the Health Care Advisory Panel. A brief description of these rules is located on the reverse side of this notice. If you would like a complete copy of these rules, you may contact the Secretary of State's office. Comments from any concerned party are requested.

These are exempt legislative rules which means they do not require the approval of the Legislature before they become effective. Following the comment period, the Compensation Programs Performance Council will review the comments, adopt such changes as they may find appropriate, and then vote to either accept or reject each proposed rule. If accepted, the rule will become effective 30 days after final filing with the Secretary of State.

The Division will hold two public hearings on the rules:

Date:	April 10, 1995	**Date:**	April 13, 1995
Time:	10:00 a.m.	**Time:**	10:00 a.m.
Location:	Jerry West Lounge, WVU Coliseum, Morgantown	**Location:**	Room 202, Charleston Civic Center, Charleston

It is suggested you file written comments along with any oral comments you may make at the hearing. If you cannot attend a hearing, you have until May 1, 1995 to mail written comments to the following address:

Bureau of Employment Programs
Legal Services Division
c/o Lisa Kern
P.O. Box 3922
Charleston, WV 25339

(over)

West Virginia
Workers' Compensation Division
601 Morris Street
Charleston, WV 25301

MAR. 09 1995

BYRON R FOLWELL DC
3211 EMERSON AVENUE
PARKERSBURG WV 26104

Synopsis of Three Legislative Rules

1. **Protocols and Guidelines for the Treatment of Workers' Compensation Injuries (Title 85, Series 20).**

This rule provides protocols and guidelines for the treatment of eleven different types of injuries as well as guidelines for therapy and physical medicine. The injuries addressed are post concussion syndrome, injuries to the eye, cervical musculoligamentous injury, herniated cervical disk, low back musculoligamentous injury, herniated lumbar disk, lumbar fusion, shoulder injuries, carpal tunnel syndrome, knee and foot injuries and ankle injuries. This list will be updated periodically as additional treatment guidelines are developed by the Health Care Advisory Panel.

2. **Guidelines for Controlled Substances (Title 85, Series 21).**

This rule provides guidelines for the prescription of schedule II-IV Controlled Substances. It provides recommendations for the documentation of controlled substances prescribed within the guidelines. The rule contains a list of contraindications for the use of controlled substances. It also lists the additional documentation required for authorization for medications beyond the guidelines. Included, too, are the DEA Schedules for Controlled Substances. The guidelines are for use by the physician in the management of chronic nonmalignant pain.

3. **Guidelines for Psychiatric Permanent Impairment, Evaluations, Evidence and Ratings of Psychiatric Impairment Due to Workers' Compensation Injuries (Title 85, Series 22).**

This rule provides guidelines for psychiatric impairment ratings, evaluations and evidence. It requires an evaluator conduct a thorough examination of the claimant including a psychological examination. The rule requires that all bold face points in the guideline (Appendix A) be addressed by the evaluator. The evidentiary weight given to reports will be influenced by how well it demonstrates that the evaluation and examination that it memorializes were conducted in accordance with the rule.

Webster Hall
4415 Fifth Avenue
Pittsburgh, PA 15213
Telephone (412) 681-3100

Commonwealth of Pennsylvania Approved
Peer Review Organization

Robert M. Yanchus, M.D.
Medical Director

Pittsburgh
Medical
Assessment
Center

April 28, 1995

Lisa M. Kern, Counsel
Legal Services Division
Post Office Box 3922
Charleston, West Virginia 25339-39222

Dear Ms. Kern:

In reviewing protocols and guidelines for the treatment of different injuries most commonly experienced by workers' comp claimants (Title 85, Series 20), I have the following suggestions:

Page 16, the preferred diagnostic study, in my opinion, would be MRI over myelography/CT scan. It is not only noninvasive but, in my opinion, is superior.

It is also my opinion that both MRIs and myelograms/CTs are ordered too frequently and too prematurely for treatment of a benign condition, such as a cervical or lumbar disc. They should not be ordered until there has been a failure of conservative treatment and surgery is being considered.

On page 23, reference is made to discectomies, classifying them as open and percutaneous--the latter, by special approval. I would like to submit the recommendation that a procedure known as chemonucleolysis be added to the armamentarium of treating disc injuries. Two reprints are enclosed defining the benefits of this procedure. Both Vert Mooney, M.D., professor of orthopedics at the University of California, and Mark D. Brown, professor and chairman of the Department of Orthopaedics, University of Miami School of Medicine, are well respected individuals and have come to the conclusion that this is an excellent way of treating herniated discs which do not have a free fragment.

Sincerely,

Robert M. Yanchus, M.D.

RMY/mds
Enclosures (2)

March 1994

UNIVERSITY OF Miami
SCHOOL OF MEDICINE

Mark D. Brown, M.D., Ph.D.
Professor and Chairman
Department of Orthopaedics and Rehabilitation
University of Miami School of Medicine

Dear Colleague:

I have been treating patients with herniated lumbar discs by chymopapain injection since 1973, and in 1983 published a book on the subject entitled "Intradiscal Therapy". The FDA approved this technique in 1982, and the procedure was widely performed for several years. On a national level there were reports of some severe complications from chymopapain, and as a consequence adverse publicity concerning the procedure. Therefore, the technique became unpopular in this country. I continued to use chymopapain in appropriately selected patients with excellent clinical results and high patient satisfaction. Over the past ten years there have been a number of developments and refinements of the technique which I thought I should bring to your attention.

A screening method to determine patients who would develop allergic reactions to chymopapain is now available, and with its use, the incidence of severe systemic allergic reactions has been almost non-existent. We have a much better understanding of the natural history of disc herniation and can better select patients. Also, with the use of MRI we can select with accuracy those patients who will respond to the technique. The incidence of complications in over 200,000 patients compared to a comparable series of patients undergoing surgical disc excision, have shown that chymopapain injection is three to five times safer than surgery. Using a smaller dose of chymopapain without compromising the efficacy has resulted in a lower occurrence of post-injection back pain and muscle spasm.

I now perform the procedure in ambulatory surgery and my patients usually return to work within one week. My current success rate with this treatment exceeds 80%, with no indication of long term recurrence of symptoms. Chymopapain injection is more cost effective than all other invasive treatment techniques for herniated lumbar discs.

If you have a patient who in your opinion would benefit from a safe, cost effective alternative treatment for symptomatic lumbar disc displacement, I would be happy to accept the referral and to discuss the patient with you.

Sincerely,

Mark D. Brown, M.D., Ph.D.
Professor and Chairman

To arrange a consultation with me, please contact:
Janet Tompkins, RN, MS
Phone (305) 547-6725
Fax (305) 547-5669

Department of Orthopaedics and Rehabilitation (R-2)
P.O. Box 016960
Miami, Florida 33101

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UCSD MEDICAL CENTER
225 DICKINSON STREET, 8894
SAN DIEGO, CALIFORNIA 92103-8894

December 1993

Dear Clinician:

This is to announce that I have returned to the use of chymopapain for the treatment of herniated lumbar discs. Please let me identify the various reasons for this decision.

I have always been pleased with the clinical results available from chymopapain and indeed started using it as it became available to various research clinicians in the early 1970's. Due to a few spectacular allergic reactions, and some negative bias in the scientific community, it was withdrawn from the market in the United States in 1977. It reappeared with a new formulation in the mid-1980's and persists today available to appropriately trained physicians in the form of Chymodiactin. It has been used throughout the world other than the United States since the 1970's for an increasing number of patients. I personally stopped advocating its use to my patients when percutaneous discectomies became available. The chief reason was my unwillingness to take on an additional medical-legal burden which I thought was associated with chymopapain use.

Important facts have since emerged from the continued world-wide experience and continued use in several centers in the United States. Appropriate pre-operative testing and improved product formulation now make it nearly risk free from allergic reaction. A recent study from England of a thousand patients had no allergic reactions.

Recognition that lower dosages than earlier used are just as effective has reduced the incidence of post-injection back pain. Thus treatment morbidity is now comparable to other percutaneous procedures.

With increased needs for cost reduction, chymopapain injection emerges as the least expensive of all invasive methods to treat the lumbar herniated disc. As an outpatient surgery procedure with no specialized equipment necessary, cost to the payment source is the least of all systems.

(OVER)

With improved imaging techniques, and better understanding of the pathophysiology of disc herniation, better patient selection is now available. Many series worldwide now have over 80 percent success rate for a procedure that has no post-surgical morbidity. Long-term results (over ten years post injection) show no deterioration in efficacy or increased incidence of nerve root irritation.

Litigation related to chymopapain injection is no longer a problem. It is now well documented that the complication rate is far less than with open surgery. Thus I believe it is now time to return to this procedure. I believe it is safe and effective, and it offers minimal opportunity for post-treatment deterioration.

I will appreciate the opportunity to evaluate your patients who have an interest in the least expensive and the least invasive method of surgical care for herniated lumbar discs.

Respectfully,

Vert Mooney

Vert Mooney, M.D.
Professor of Orthopaedics

VM/tcpm623J.VM

D: 12-01-93
R: 12-02-93
T: 12-04-93

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1710 Harper Road
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Bureau of Employment Programs
Legal Services Division
c/o Lisa M. Kern
Counsel
P.O. Box 3922
Charleston, WV. 25339.

Dear Ms. Kern,

Please find enclosed a copy of the West Virginia Chapter of the American Physical Therapy Association Position Statement on the Workers' Compensation Division's Protocols & Guidelines for the Treatment of Workers' Compensation Injuries, Title 85: Series 20. Also included, is supporting documents relating to the oral comments made by myself on behalf of my professional colleagues at the public hearing on April 10, 1995 in Charleston.

My colleagues and I commend the efforts of the Health Care Advisory Panel to establishing guidelines to assist clinicians in providing appropriate and timely treatment to workers' compensation claimants with commonly experienced injuries.

As I stated on April 10, a principle concerns of West Virginia Chapter of the American Physical Therapy Association pertains to:

* The interchangeable usage of the terms guidelines and protocol in the proposed legislative rules.

* The potential for the inappropriate use of this document, by departments within the Workers' Compensation Division and the Bureau of Employment Programs, to restrict claimants access to and and withhold payment from providers for appropriate and medically necessary care that falls within the norms of clinical practice but outside the guidelines established by this document.

4/27/95 MB. RPT.

I would also again like to make comment on the difficulty that I, and a number of my fellow physical therapists, had in obtaining a copy of the Health Care Advisory Panel recommendations to the Compensation Programs Performance Panel.

I trust that the information I have provided will be found to be of assistance in drafting the legislative rules. I look forward to receiving a revised copy of the final proposed legislative rules which includes the provisions included in the West Virginia Chapter of the American Physical Therapy Association Position Statement.

I invite members of the Health Care Advisory Panel and Compensation Programs Performance to contact me with any questions they have.

Thank you for your attention to and assistance in this matter.

Sincerely,

Mick Bates, P.T.

4/27/95 MB. RPT.

WEST VIRGINIA CHAPTER OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION STATEMENT ON THE WORKERS' COMPENSATION DIVISION'S PROTOCOLS & GUIDELINES FOR THE TREATMENT OF WORKERS' COMPENSATION INJURIES

The American Physical Therapy Association is a national association representing more than 60,000 physical therapists, physical therapist assistants, and students of physical therapy. The West Virginia Chapter of the Association represents the more than 200 members of the association active in providing health care to the citizens of West Virginia. The members of the APTA are eager to continue working to make the West Virginia Workers' Compensation system one that provides Workers' Compensation claimants with access to high-quality health care that our society can afford.

APTA recommendations focus on provision of comprehensive high-quality care, documented cost savings, and appropriate utilization of physical therapy services. As rehabilitation care coordinators for patient with function impairments, physical therapists can and should play a major role in achieving the clinical effectiveness and cost efficiencies that are so critical. In this regard, recognition of their role in primary care, especially in the area of musculoskelatal disorders, must be afforded. The members of the APTA believe that in order to proved claimants with the care they deserve, the protocol and guidelines for the treatment of workers compensation injuries must include a number of critical provisions, some of which are highlighted below.

QUALITY OF CARE

Every claimant has the right to receive high-quality health care services, and any legislative rule should both guarantee this right and acknowledge the need for professional expertise and specialty care. The American Physical Therapy Association supports the following provisions to ensure high-quality care.

* Any development of practice parameters and guidelines should ensure the participation of professional practitioners in this effort.

* Practice parameters and guidelines must be clearly identified as guidelines and not enforced as a method of cost containment, nor restrict claimants access to care determined clinically necessary by the licensed professional providing that care.

* Measures of outcome must truly assess the effects of change.

* Appropriate ratios of physical therapy providers to claimants should exist in all environments where care in provided.

* APTA supports efforts to promote the timely and coordinated treatment and the thorough rehabilitation of workers Compensation injuries through provision of case management services

PREVENTION

The concept of injury prevention must be broadened. Both a healthy work force and significant cost savings will result. An estimated 40 million Americans live with some form of disability, and the total costs for their care is estimated at 6.5% of GDP. West Virginia has one of the highest Permanent Total Disability award rates for Workers' Compensation injuries in the nation. Physical therapy services have been demonstrated to be a cost effective in a variety of health care settings; a limited course of physical has been shown to shorten hospital stays, prevent future injury, and improve health outcomes.

COST CONTAINMENT

As health care providers, physical therapists witness firsthand the impact of spiraling cost of health care. We are in a position to recognize ways in which health care costs can be lowered, but the current system precludes such input from professional providers. As a result, we recognize the need for efforts to contain costs and allocate resources effectively, and the APTA supports such efforts. It is crucial, however, that any process for allocating health care resources includes input from the broad spectrum of health care providers who are authorized by state law to provide health services. The following area comments on specific cost containment options:

Physician Self-Referral

* The APTA strongly supports a ban on physician self-referral to physical therapy services. The excess costs to the health care system associated with physicians permitted to own, and self-refer patients to, such services as laboratory, radiology, pharmacy, and physical therapy have been well documented. The State of Florida, for example, found an increase in visits per patient of some 39% to 45% in joint-venture facilities compared to non-joint-venture facilities, with gross revenue and net revenue per patient 30% to 40% higher. This adds unnecessarily to the costs of health care. The Florida study

also found that licensed physical therapists and physical therapist assistants employed in non-joint-venture facilities spent approximately 60% more time per visit treating patients than did licensed physical therapists and physical therapist assistants working in joint-venture facilities.

Payment Rates

* APTA supports payment schedules that are appropriate to he service provided. We support the development of payment rates that take into consideration the professional expertise and technology required for the provision of high quality services based on community standards. APTA supports a system in which payment is equitable and in which the development of provider fee systems, capitation systems, and case payments is established through adequate provider involvement and review of utilization.

*APTA supports the development of payment rates, whether they are based on reasonable costs per service or reasonable costs per visit. Provisions should be made for stop-loss contingencies and payer risk-sharing methodologies.

* APTA supports restriction of the use of billing codes to those professionals who are licensed to perform the services covered by such codes.

* APTA supports administrative simplification in provider record keeping and communication with the Workers' Compensation Division. Providers must be freed of paperwork and permitted to spend their time treating claimants and practicing their profession. Areas that need simplification include eligibility determinations, coverage determinations, service authorization, billing enquiries, and payment remittances. Record keeping, documentation requirements and billing procedures must be standardized as well.

* APTA opposes the use of global budgets, expenditure targets, and CPT code caps as a means of containing costs. Such arbitrary approaches have an adverse effect on the availability of care and the quality of care provided.

WHO ARE PHYSICAL THERAPISTS?

Physical therapists are key members of the health care team and an integral part of the health care delivery system. The education and clinical experience of physical therapists uniquely prepares them to coordinate care related to functional improvement and functional disability. Physical therapists help 900,000 individuals daily to restore health, alleviate pain and to prevent the onset of disease. The benefits of rehabilitation and physical therapy services are well documented and services are covered in nearly all federal, state and private insurance plans. Today's physical therapy profession serves a dynamic comprehensive health care role in improving and maintaining quality of life for millions of Americans and thousands of West Virginians.

Physical therapists provide care at the acute, rehabilitative, and preventative stages, and strive to achieve increased functional independence and decreased function impairment. Though timely and appropriate intervention, the physical therapist frequently reduces the need for costlier forms of care as surgery and shortens the length of institutional stays. Physical therapists provide preventative care that forestalls or prevents the development of functional deterioration and the need for more intensive care through hospitalization.

Physical therapists are health care professionals who are:

*Graduates of professional programs of physical therapy accredited by the American Physical Therapy Associations Commission on Accreditation in Physical Therapy Education, which is recognized by the council on Post-Secondary Accreditation and the United States Department of Education,

* Professionally educated at the university level, and

* Licensed by all states and territories of the United States

##########

ARTICLE 20, CHAPTER 30 OF THE CODE OF WEST VIRGINIA

30 - 20 - 1. Legislative findings and declaration of public policy.

The legislature of the state of West Virginia hereby determines and finds that in the public interest persons should not be engaged in the practice of physical therapy or act as physical therapy assistants without the requisite experience and training and without adequate regulation and control; and that it is necessary to protect the citizens of this state from the unauthorized, unqualified and unregulated practice of physical therapy. It is therefore declared to be the public policy of this state that the practice of physical therapy affects the general welfare and public interest of the state and its citizens; that persons without the necessary qualifications, training and education and persons not of good character should not engage in the practice of physical therapy or act as physical therapy assistance; and that the evil of such unauthorized and unqualified practice may be best prevented and the interests of the public best served by regulating and controlling such practice as provided in this article.

30 - 20 - 2. Definitions

(f) "Physical therapy" means the therapeutic treatment of any person by the use of massage, mechanical stimulation, heat, cold, light, air, water, electricity, sound and exercise, including mobilization of the joints and training in functional activities for the purpose of correcting or alleviating any physical or mental condition or preventing the development of any physical or mental disability, and the performance of neuro-muscular-skeletal tests and measurements as an aid in the diagnosis, evaluation or determination of the existence and the extent of body malfunction.

##########

DIPLOMATE OF
THE AMERICAN BOARD OF
PHYSICAL MEDICINE
AND REHABILITATION

FELLOW OF
THE AMERICAN ACADEMY OF
DISABILITY EVALUATING
PHYSICIANS

PRASADARAO B. MUKKAMALA, M.D.

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DIPLOMATE OF
THE AMERICAN BOARD OF
ELECTRODIAGNOSTIC
MEDICINE

DIPLOMATE OF
THE AMERICAN
ACADEMY OF
PAIN MANAGEMENT

April 26, 1995

Lisa Kern, Counsel
Legal Services Division
P.O. Box 3922
Charleston, West Virginia 25339-3922

RE: Protocols and Guidelines for the Treatment of Workers' Compensation Injuries

Dear Ms. Kern:

I reviewed the Protocols and Guidelines for the Treatment of Workers' Compensation Injuries and in general I concur with the guidelines. However, I do have some concerns and comments as follows:

1). In my experience, the chronic pain management programs have not been effective. In theory, the chronic pain management programs are very appealing, but in practice they have not been effective. I strongly encourage the Compensation Fund to stay away from the chronic pain management programs to the degree possible.

2). Similarly, work hardening programs have not proven to be effective. I have noticed over the years that work hardening programs have been overused or I should even say abused. That type of abuse leads to waste of limited and useful resources and I would caution the Workers' Compensation Fund to be extremely selective in approving work hardening programs.

With those two exceptions, I concur with the Protocols and Guidelines for the Treatment of Workers' Compensation Injuries.

Yours sincerely,

Prasada Rao B. Mukkamala

PRASADARAO B. MUKKAMALA, M.D.

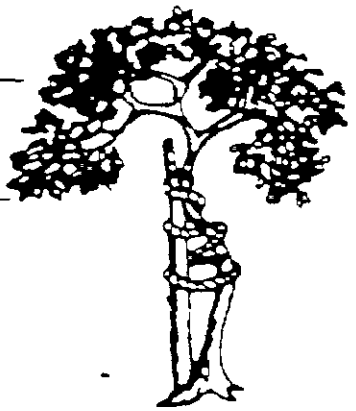
Lisa Kern
April 26, 1995

PBM/ks

cc: Sarah Smith
Bowles, Rice, McDavid, Graff & Love
P.O. Box 1386
Charleston, West Virginia 25325-1386

Carl F. Renaghan, M. D., Inc.

Independent Orthopaedic Examinations, Consultations & Reports



March 23, 1995

Sarah E. Smith, Esq.
Bowles, Rice, McDavid, Graff & Love
P. O. Box 1386
Charleston, West Virginia 25325-1386

Re: Workers' Compensation Regulations

Dear Ms. Smith:

In reply to your March 17, 1995 communication in which you enclosed a copy of the "Summary of Proposed Exempt Legislative Rule Protocols and Guidelines for the Treatment of Workers' Compensation Injuries, Title 85, Series 20", as recommended by the Health Care Advisory Panel, one must congratulate that panel on a thorough but concise presentation of the diagnostic and therapeutic aspects of the various work-related injuries described therein.

I am in strong agreement with that section of the protocols which relate to musculoskeletal problems. I have only a few comments:

On page 12 regarding "cervical musculoligamentous injury (sprain/strain)", and on page 17 regarding "low back musculoligamentous injury (sprain/strain)", in each of these cases, the simple complaint of "neck pain" or of "low back pain" should not be translated to imply that there has been "a partial stretching or tearing of the soft tissues (muscles, fascia, ligaments, facets, joint capsule, etc.)", merely on the basis of a subjective complaint. If such an interpretation is to be assigned (that there may have been partial stretching and/or tearing of various soft tissues), then there should be documentation of a sufficient and appropriate trauma by all individual observers. Otherwise the diagnostic impression of "neck pain and/or low back pain" of "undetermined origin", should be the appropriate label.

Second, on page 14, "occasional trigger point injections may be helpful", I believe is not in keeping with the current scientific view of the socalled pathology of trigger points. (Please see enclosed "Back Letter", Vol 8, No. 3, 1993, pages 1 & 2, wherein the pathology of trigger points and/or tender points, do not meet scientific muster.) I believe that socalled trigger point injections should not be included as a helpful option in the treatment of neck pain or low back pain. Occasional trigger point injections are also listed on page 19 as a treatment option for low back pain.

4620½ MacCorkle Avenue, S.W., South Charleston, WV 25309
Mailing Address: P. O. Box 8827, South Charleston, WV 25303-0827
Telephone: (304) 768-0630

Lastly, page 19 lists "muscle relaxants as needed". Probably muscle relaxants should not be viewed as being an appropriate prescription for treatment of complaints of nonspecific neck pain and/or nonspecific low back pain. The Agency for Health Care Policy and Research, released on December 8, 1994 statements in which they said "muscle relaxants were found to be no more effective than NSAIDS and without added effect when combined with NSAIDS for relieving a low back patient's discomfort. "The efficacy of muscle relaxants, in combination with their side effects reported as common in 30% of patients (drowsiness, potential for dependency) place them only in the option category for treatment symptoms. This finding was reported by AHCPR in part II of their Low Back Pain Guidelines and was reported on page 2 and page 4 of the Spine Letter, Vol. 2, No. 3, March 1995.

Thank you for sending the material and I hope you will transmit this information appropriately.

Sincerely yours,

Carl J. Roncaglione, M.D.

CJR/mlt

Encl.

THE BACK LETTER

A digest of current information and literature

Vol. 8, No. 3

INSIDE: Special Section on Mobility Assessment

Trigger Points Fail Scientific Scrutiny

Two recent studies question the usefulness of so-called trigger points in the evaluation and treatment of back pain. The studies also raise doubts about the diagnosis known as myofascial pain syndrome, which is often defined by the presence of trigger points.

Trigger point examination is a widely used but controversial type of assessment. Some researchers believe that myofascial trigger points are a major cause of back pain and other pain syndromes. According to trigger point experts Janet G. Travell, MD, and David G. Simons, MD, "Active myofascial trigger points are largely responsible for that scourge of mankind, musculoskeletal pain." (See *Myofascial Pain and Dysfunction: The Trigger Point Manual*, Williams & Wilkins, Baltimore, 1983.)

Yet a recent scientific analysis of the physical examination of the back doesn't mention trigger points. (See the *Journal of the American Medical Association*, 12 Aug. 1992.) The study was authored by Richard A. Deyo, MD, of the University of Washington in Seattle, and associates.

"We couldn't find any scientific evidence to validate trigger-point examination," explains co-author James Rainville, MD, of New England Back Care Center.

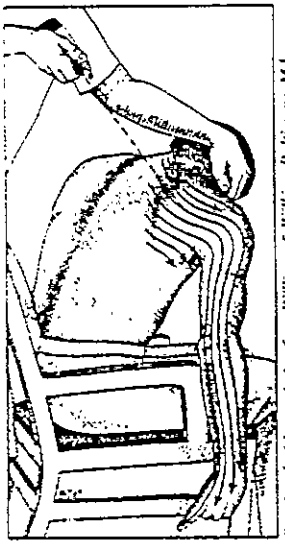
One of the most important pieces of evidence for or against any medical examination procedure is intertester reliability. This is the degree to which independent examiners applying the same test agree on the exam findings. Tests that aren't reliable don't yield consistently useful information.

At the time of the study, Deyo et al. found no evidence on the reliability of trigger-point examinations. Pathological studies surveyed by the research team also failed to provide compelling evidence of differences between trigger points and normal tissue.

Trigger points can be defined as areas in muscle and other soft tissue that produce focal tenderness as well as distinctive patterns of referred pain when palpated. They are thought to be critical in defining myofascial pain syndrome—which, according to Travell and Simons, means "pain and/or autonomic phenomena referred from active myofascial trigger points with associated dysfunction."

The diagnosis of an active trigger point, according to Travell and Simons, involves four criteria: focal tenderness, tenderness occurring in a palpable taut band of muscle fibers, local twitch response, and reproduction of the pain pattern on mechanical stimulation.

In addition to active trigger points, Travell and Simons postulate the existence of "latent" trigger points—which are painful only when palpated, according to these researchers. Latent trigger points may have all of the characteristics of active trigger points when palpated, but aren't the primary cause of a patient's pain.



Reprinted with permission from Williams & Wilkins, Baltimore, Md.

Trigger points, used to define myofascial pain syndrome, must be differentiated from tender points, which are used to help define fibromyalgia syndrome. Tender points are specific areas over muscle, bone, tendon, and fat that are painful when palpated, but are generally not associated with particular patterns of pain referral.

Dolores A. Nice, PT, and colleagues from Virginia Commonwealth University used the trigger-point criteria of Travell and Simons to examine 50 patients who were referred to a physical therapy clinic for back pain. (See the *Archives of Physical Medicine and Rehabilitation*, October 1992.) The study focused on the presence or absence of three different trigger points in the back: a trigger point in the area of the iliocostalis lumborum muscle, and two trigger points in the area of the longissimus thoracis muscle.

The testers were 12 fulltime physical therapists who routinely treat patients with

Continued on page 2

Back Patients: A Depressed Lot

Back specialists may need to become more adept at identifying mental disorders in their patients. According to two recent studies, clinicians see these disorders all the time, whether they recognize them or not.

A new study of patients admitted to the Productive Rehabilitation Institute of Dallas for Ergonomics (PRIDE) finds that nearly 60% have symptoms of at least one major psychiatric disorder.

"Clinicians should be aware of potentially high rates of emotional distress syndromes in chronic low-back pain and enlist mental health professionals to help maximize treatment outcomes," write the authors, Peter B. Polatin, MD, et al. in *Spine* (January 1992).

Even among patients with acute back pain, the rate of mental disorders is probably high. A major new study finds that 52 million adults in the United States—28.1% of the

Continued on page 6

IN THIS ISSUE

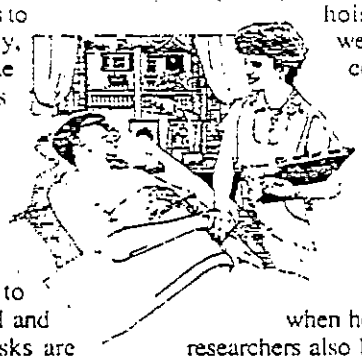
How to Prevent Injuries In Nurses

Simple ergonomic interventions can have a powerful impact on work-related back injuries, even in professions that are notoriously hard on the back. According to a new study from Wisconsin, the number of back injuries at two nursing homes dropped by almost 50% simply by altering patient-handling techniques. (See *Ergonomics*, Vol. 35, No. 11, 1992.)

Back injuries are a major occupational hazard in nursing professions, and both injury rates and disability rates appear to be rising. "The low-back pain experienced by nursing personnel is greater than the published statistics indicate," assert A. Garg and B. Owen of the University of Wisconsin at Milwaukee. "Nurses perceive back pain as an inevitable part of the nursing practice."

Garg and Owen point out that the back-injury problem in nursing homes appears to be even more severe than in hospitals.

Attempts to lower the injury rates in hospitals and nursing homes have produced indifferent results. Most rely on education: instruction on lifting techniques, body mechanics, and back care. However, this type of approach has had little apparent impact. Other interventions, which have been focused on improving the physical fitness and strength of nurses, seem to have helped motivate some nurses to show up at the gym regularly, but have had little effect on the less physically ambitious rank-and-file.



In a trial program, Garg and Owen decided to take an ergonomic approach. "Instead of focusing on the behavior of people, [the] ergonomics approach seeks to design work so the physical and mental demands of the tasks are within the capabilities of the workers," the researchers explain.

Garg and Owen analyzed the job tasks and spinal stresses of nurses in two nursing homes in Wisconsin. They focused on patient-handling tasks associated with the greatest stress on the back, and then selected equipment to ease those stresses.

The first goal was to reduce the number of times that infirm patients had to be physically lifted and transferred by nursing personnel over the course of the work day. A mechanical hoist and sling was installed to help lift patients who couldn't walk. The hoist was equipped with a weighing device, so patients could be weighed without having to be transferred to a scale. Patients who were more ambulatory were fitted with a "walking belt"—a corset equipped with canvas handles on the sides that nursing-home personnel could clutch when helping patients move. The researchers also brought in a shower chair which could be used for all toileting and bathing.

Before the intervention, toileting and bathing required six patient transfers: bed to wheelchair, wheelchair to toilet, toilet to wheelchair, wheelchair to chairlift or bathtub, bathtub or chairlift to wheelchair, and wheelchair to bed. After the program was instituted, it involved only two transfers: shifting the patient to the shower chair using the hoist or

Continued on page 5

Trigger Points Fail Scrutiny

Continued from page 1

back pain. Three of the therapists had specialized training in trigger-point examination, and all of the therapists were given a written description of Travell's and Simons's examination method. The therapists were randomly paired and examined a total of 197 trigger points among the 50 patients.

Overall, the reliability was "consistently poor," write the study authors. A statistical analysis suggests that "different therapists are unable to reliably determine when a trigger point is present in a patient with low back pain."

The researchers conclude that the usefulness of trigger point examination in low-back pain patients "should be questioned."

Two factors could possibly have influenced the study results. First, in only half of the examinations was the trigger-point examination performed exactly according to the Travell and Simons method. And second, nine of the 12 therapists were inexperienced in trigger-point examination. (Trigger-point examination, according to some proponents, is heavily dependent on the skill and experience of the examiner.)

But these reservations don't apply to a second study by Frederick Wolfe, MD, et al. involving pioneer trigger-point examiner David Simons, MD. (See the *Journal of Rheumatology*, Vol. 19, No. 6, 1992.)

In this study, four experts on myofascial pain syndrome and four experts on fibromyalgia examined three groups of patients: seven patients with fibromyalgia, eight with myofascial pain syndrome, and eight healthy persons. The experts looked for the presence of trigger points in the upper body and back.

The myofascial-pain experts agreed on several aspects of the examination but not on the presence of active trigger points. Identification of trigger points varied almost fivefold among the examiners. The examiners also showed significant disagreement over the presence of taut bands and muscle twitch.

Wolfe et al. believe that the definition of a trigger point may need to be revised, and that any definition must be backed by data on reliability and validity.

"The issue of the definition of a trigger point is crucial," Wolfe et al. point out. "Diagnosis and differential diagnosis [of myofascial pain syndromes] depends on trigger points, as does treatment, including drug therapy for those without trigger points and interventions like muscle injections or spray-and-stretch for those with trigger points."

Rainville, a physiatrist who is director of rehabilitation at New England Back Care Center in Boston, says he has experimented with trigger-point examination in his own practice, but has since abandoned this form of assessment because he felt it involved attaching pathological labels to tissue where there was little objective evidence of abnormality. Rainville believes that applying treatments on the basis of such questionable findings could promote dependency among patients, who become accustomed to treatment.

There is also some concern about possible overutilization of trigger-point examination and treatment.

"Trigger point examinations are easy to do, and no one can stand over your shoulder and refute your findings," Rainville remarks. Without some gauge of usefulness, examination and treatment of dubious value could continue *ad infinitum*, in the absence of any objective evidence of pathology.

For more information, contact: Dolores A. Nice, Virginia Spine Therapy, 700 West Grace St., Suite 304, Richmond, Va. 23220.

Post Marked 5/1

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May 1, 1995

95 MAY -2 PM 12:18
BEP-LEGAL DIVISION

Lisa M. Kern, Esquire
Legal Services Division
Post Office Box 3922
Charleston, West Virginia 25339-3922

Re: Proposed Protocols and Guidelines for the Treatment of Workers' Compensation Injuries

Dear Ms. Kern:

On behalf of our employer clients, we appreciate this opportunity to comment on the Protocols and Guidelines for the Treatment of Workers' Compensation Injuries recommended by the Health Care Advisory Panel.

In general, we believe the Protocols and Guidelines should help curb the economic drain on the workers' compensation system which results from inappropriate or unnecessarily prolonged treatment, both by savings in direct medical care expenses and by facilitating early return of claimants to active employment. We applaud the Division's and the Panel's efforts to comprehensively address treatment issues, and to provide parameters for both treating physicians and Division personnel in managing the health care needs of workers' compensation claimants.

Although we are in essential agreement with the Protocols and Guidelines as proposed, we offer the following general comments:

1. If these Protocols and Guidelines are to be successful, it is imperative that Division personnel receive adequate training, as proposed, and that the Medical Support Groups include trained health care providers at least in a consulting capacity. In addition to training on treatment issues, personnel should also receive training in objectivity to minimize unconscious overidentification with the claimants with whom they are personally dealing on a sometimes frequent basis.

2. Without effective monitoring, these Protocols and Guidelines will be meaningless. In order for monitoring to be effective, not only must Division personnel be adequately trained, but they must have well-designed technological support. In that regard, it is also important that computer entry personnel receive adequate training to ensure that the information necessary to effectively monitor is properly entered and coded.

3. It is important to monitor and enforce the clear intent of the Protocols and Guidelines that before treatment goes beyond the parameters set forth, the claimant and his or her treating physician must have the concurrence of another health care provider with greater or additional expertise than the treating physician. Clearly, the second opinion must be well-documented and not allowed to become pro forma.

4. We are pleased that the use of physical therapy at earlier stages in the recovery process is being encouraged. It is important, however, that the Division monitor physical therapy to ensure that it is being administered by appropriately trained health care providers and that the use of passive, as opposed to active, physical therapy is not abused.

5. Although we recognize the need for consideration of modifiers in assessing type, extent and duration of treatment, if these Protocols and Guidelines are to have their anticipated impact, it is essential that modifiers not be used as a license to extend treatment but as exceptions which require documentation and justification with specific objective findings. Exceptions must not become the rule.

6. There are references throughout the Protocols and Guidelines to "appropriate specialists." Although we recognize the need in the context of these rules to use that generic term, it is essential that Division personnel be trained to recognize appropriate specialists on a case by case basis, in order to avoid "doctor shopping" and minimize "cronyism."

7. Chronic pain management programs and work hardening programs can be effective in limited claims, but are ripe for abuse and can result in a major economic drain on the workers' compensation system with little or no corresponding benefit. We urge the Division to carefully monitor the use of such programs and to require objective proof of results before treatment continues.

8. Underlying these Protocols and Guidelines should be the basic public policy, recognized as a part of workers' compensation law, that claimants who are non-compliant with appropriate treatment, including physical medicine, should not be rewarded for that non-compliance. Claimants should be encouraged to cooperate with treatment to the fullest extent in order to minimize economic loss not only to themselves personally but also tc the Division and to both self-insured employers and employers who subscribers. Failure to comply, which causes unnecessarily prolonged treatment and delays in return to work, should result in the suspension of benefits.

9. These Protocols and Guidelines would be strengthened by including a discussion of the need to allocate between work-related and not work-related impairment, and by providing guidelines for such allocation, similar to those set forth in the Proposed Guidelines for Psychiatric Permanent Impairment Evaluations, Evidence and Ratings of Psychiatric Impairment Due to Workers' Compensation Injuries. Although such allocation is frequently difficult, if the workers' compensation system is to serve its intended purpose of compensating for and treating only work-related injuries, it is imperative that treating physicians and evaluators alike be required to distinguish work-related from nonwork-related impairment.

In addition to the above more general comments, we offer the following with respect to specific sections of the Proposed Protocols and Guidelines:

1. With reference to §15.1, relating to cervical musculoligamentous injury, and §17.1, relating to low back musculoligamentous injury, it is important that objective complaints of "neck pain" or "low back pain" not be considered conclusive evidence of soft tissue injury, but rather that other findings consistent with that diagnosis be present.

2. The effectiveness of "trigger point injections", authorized as a treatment in §§15.4.1 and 17.4.1, is the subject of considerable debate. Generally, trigger point injections are recognized as effective, if at all, only at the acute stage. Routine or prolonged use should be eliminated unless the effectiveness of the treatment is documented by objective findings of improvement by appropriate specialists.

3. The elimination of overnight hospital admissions for a myelogram, in §16.3.4, is applauded as an appropriate cost-saving measure.

4. With reference to §§16, 17 and 18, relating to herniated discs, we appreciate the effort to control the use of certain diagnostic tests by generally requiring conservative treatment for a period of two to four weeks before more extensive, and expensive, testing is ordered. However, there are instances where the claimant clearly has the clinical signs of an operative lesion at the time of his first examination. In those cases, once confirmed by an appropriate specialist, authorization to proceed with diagnostic testing at an earlier stage should be forthcoming so that proper treatment is received and unnecessary delay in the recovery process is not experienced.

5. We believe that the detail with which §21, relating to carpal tunnel syndrome, is drafted may be unnecessary and a cause for confusion when reviewed by both treating physicians and evaluators. We are also concerned that the section fails to adequately differentiate between work-related and nonwork-related conditions. In particular, we recommend that this section be amended to provide for a higher scrutiny before carpal tunnel syndrome is determined to be work-related when the claimant also evidences an underlying condition, such as diabetes, thyroid dysfunction or pregnancy, well-recognized as independent contributors to the development of that syndrome.

For your reference and information, we are also enclosing correspondence we received from Dr. Carl J. Roncaglione and Dr. Prasadarao B. Mukkamala related to these Protocols and Guidelines, and commend their comments to you.

Again, we appreciate the efforts of the Division and the Health Care Advisory Panel in drafting these Protocols and Guidelines. We hope our constructive comments are carefully considered and that our recommendations are adopted.

Very truly yours,

BOWLES RICE MCDAVID GRAFF & LOVE

Phyllis M. Potterfield

PP/bmk
Enclosures

337094

May 1, 1995

BEP-LEGAL DIVISION
95 APR 31 PM 2:32

John Kozak
Director of Legal Services
Workers' Compensation Division
4700 MacCorkle Avenue, S.E.
Charleston, WV 25304

Dear John,

I have been asked to write on behalf of both the HCAP physical medicine sub-panel and the administrative issues sub-panel to ask that specific corrections be made in the physical medicine guidelines chapter of the "Protocols and Guidelines for the Treatment of Workers' Compensation Injuries."

The two sub-panels, while meeting in joint session, recently noticed that some of the original language in the physical medicine guidelines chapter had been altered between the time it was approved by the full HCAP and the time it was presented to the Performance Council. We ask that the proposed "Protocols and Guidelines for the Treatment of Workers' Compensation Injuries" be altered as follows:

27.1 Physical medicine guidelines were developed to avoid monitoring of 100% of claims where physical medicine is provided. ~~However, these guidelines do not supercede the previous/diagnostic-related treatment guidelines.~~

27.2 Case management will begin at any point lack of progress is identified. ~~In some instances this may be before sixty days post injury. If physical medicine treatment exceeds 60 days post-injury, case management is a necessity.~~ but particularly at thirty days and at sixty days after treatment has begun.

27.3 ~~If there is a question about the frequency and duration of physical medicine treatments, refer to the appropriate diagnostic related treatment guidelines.~~

The sub-panel would also like to point out that the entire section numbered 26.1 through 26.5.5 should be deleted since it is repeated via 27.10.1. This section is an ancient version of

what eventually was produced by the physical medicine sub-panel and approved by HCAP. Please note that for a completely accurate listing of the proper text for all of this, see the attached document entitled Physical Medicine.

Please note that numbering will have to be reworked due to the need to delete 26.1 through 26.5.5.

If I can assist in clarifying any of these desired changes, please call me at 304-345-1466.

Sincerely,

William P. McDonald, DC

cc: Pat Posey
Kendall Wilson
Bill Sale
Ralph Smith
Jack Brautigam

PHYSICAL MEDICINE

Physical Medicine guidelines were developed to avoid monitoring of 100% of claims where physical medicine is provided.

Case management will begin at any point lack of progress is identified, but particularly at thirty days and at sixty days after treatment has begun.

All treatment is expected to be terminated when the worker reaches maximum medical improvement. Workers who continue to report pain and dysfunction, while showing no significant measurable or objective signs of improvement, have reached maximum medical improvement and must be discharged or referred to an appropriate specialty.

If care continues to the 30th day and the worker has not returned to work, the treating physician may arrange a consultation for a second opinion; care cannot continue past the 45th day unless the consulting doctor recommends further care.

If care continues to the 30th day and the worker is back to work, shows significant documented functional and clinical signs of improvement, and has not reached maximum medical improvement, continued care is appropriate. Such treatment should not exceed the 60th day. Workers with complicating factors which have prevented a return to work by the 60th day require case management, with IME guidance, for determination of appropriate care.

Treatment is not to exceed 10 visits in the initial 14 days and must decrease in frequency after that. In no case should the treatment exceed 16 visits in the initial 30 days or 12 in the second 30 days.

Active case management by the Division is required for any care beyond 60 days. It is incumbent upon the provider to monitor the worker's progress and to notify the case manager in a timely manner to ensure continuity of care.

Care beyond the 60th day is limited to workers who 1) display a significant complicating factor, 2) are back to work or enrolled in a work conditioning\hardening program, and 3) have significant documented functional and clinical signs of improvement. Such workers are to be treated on an as needed basis only, with treatment not to exceed two visits per week.

Workers who have returned to work and experience flare-ups of their injuries due to job related activities, may be treated a maximum of 12 times over the 14 months following an injury. Such treatment may not be regularly scheduled and must not delay a surgical or chronic pain evaluation.

RECOMMENDATIONS FOR USE OF PHYSICAL MEDICINE:

1. Physical medicine should be initiated as early as the day of injury; indications for and focus on (early) interventions include:
   * acute management of pain and spasms.
   * use of passive modalities as adjunct to active treatment.
   * manual therapy for restoring joint function.
   * instruction in range of motion and stretching exercises.
   * assessment of return to work readiness and identifying necessary work modifications.
   * worker education in healing process, body mechanics, proper resting positions, and home treatment program.
   * time frame may range from one visit to daily visits according to above treatment guidelines.
2. Evaluations must be provided by professionals licensed to perform such activities.

3. Initiation of treatment may not be indicated when:
   * few objectively measured deficits are found on evaluations.
   * subjective complaints of pain are the only findings.
   * pain behaviors are interfering with the return to work process.
   * worker is not compliant with treatment plan.

4. Inappropriate treatment is exclusive use of passive modalities throughout the course of treatment.

5. Exercise programs are increasing progressively. These programs include strengthening and conditioning exercises. Any work simulation activities (also gradually increased) should focus on essential work tasks (pushing, pulling, lifting, etc.). Time frame any range form 1 to 4 hours per day, 3 to 5 days per week in accordance with above treatment guidelines.

6. Progress reports to the referring physician, workers'compensation, and the employer should identify continuing complaints, progress made, further rehabilitation needs, and level of return to work readiness. A worker may continue in therapy, if indicated, after return to work according to above treatment guidelines.

COLUMBIA/HCA A New Commitment To Healthcare...Together
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BEP-LEGAL DIVISION
95 APR 31 PM 2:28

Bureau of Employment Programs
Legal Services Division
c/o Lisa M. Kern
Counsel
P.O. Box 3922
Charleston, WV. 25339.

Dear Ms. Kern,

Please find enclosed a copy of the West Virginia Chapter of the American Physical Therapy Association Position Statement on the Workers' Compensation Division's Protocols & Guidelines for the Treatment of Workers' Compensation Injuries, Title 85: Series 20. Also included, is supporting documents relating to the oral comments made by myself on behalf of my professional colleagues at the public hearing on April 10, 1995 in Charleston.

My colleagues and I commend the efforts of the Health Care Advisory Panel to establishing guidelines to assist clinicians in providing appropriate and timely treatment to workers' compensation claimants with commonly experienced injuries.

As I stated on April 10, a principle concerns of West Virginia Chapter of the American Physical Therapy Association pertains to:

* The interchangeable usage of the terms guidelines and protocol in the proposed legislative rules.

* The potential for the inappropriate use of this document, by departments within the Workers' Compensation Division and the Bureau of Employment Programs, to restrict claimants access to and and withhold payment from providers for appropriate and medically necessary care that falls within the norms of clinical practice but outside the guidelines established by this document.

4/27/95 MB. RPT.

I would also again like to make comment on the difficulty that I, and a number of my fellow physical therapists, had in obtaining a copy of the Health Care Advisory Panel recommendations to the Compensation Programs Performance Panel.

I trust that the information I have provided will be found to be of assistance in drafting the legislative rules. I look forward to receiving a revised copy of the final proposed legislative rules which includes the provisions included in the West Virginia Chapter of the American Physical Therapy Association Position Statement.

I invite members of the Health Care Advisory Panel and Compensation Programs Performance to contact me with any questions they have.

Thank you for your attention to and assistance in this matter.

Sincerely,

Mick Bates, P.T.

4/27/95 MB.RPT.

WEST VIRGINIA CHAPTER OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION STATEMENT ON THE WORKERS' COMPENSATION DIVISION'S PROTOCOLS & GUIDELINES FOR THE TREATMENT OF WORKERS' COMPENSATION INJURIES

The American Physical Therapy Association is a national association representing more than 60,000 physical therapists, physical therapist assistants, and students of physical therapy. The West Virginia Chapter of the Association represents the more than 200 members of the association active in providing health care to the citizens of West Virginia. The members of the APTA are eager to continue working to make the West Virginia Workers' Compensation system one that provides Workers' Compensation claimants with access to high-quality health care that our society can afford.

APTA recommendations focus on provision of comprehensive high-quality care, documented cost savings, and appropriate utilization of physical therapy services. As rehabilitation care coordinators for patient with function impairments, physical therapists can and should play a major role in achieving the clinical effectiveness and cost efficiencies that are so critical. In this regard, recognition of their role in primary care, especially in the area of musculoskelatal disorders, must be afforded. The members of the APTA believe that in order to proved claimants with the care they deserve, the protocol and guidelines for the treatment of workers compensation injuries must include a number of critical provisions, some of which are highlighted below.

QUALITY OF CARE

Every claimant has the right to receive high-quality health care services, and any legislative rule should both guarantee this right and acknowledge the need for professional expertise and specialty care. The American Physical Therapy Association supports the following provisions to ensure high-quality care.

* Any development of practice parameters and guidelines should ensure the participation of professional practitioners in this effort.

* Practice parameters and guidelines must be clearly identified as guidelines and not enforced as a method of cost containment, nor restrict claimants access to care determined clinically necessary by the licensed professional providing that care.

* Measures of outcome must truly assess the effects of change.

* Appropriate ratios of physical therapy providers to claimants should exist in all environments where care in provided.

* APTA supports efforts to promote the timely and coordinated treatment and the thorough rehabilitation of workers Compensation injuries through provision of case management services

PREVENTION

The concept of injury prevention must be broadened. Both a healthy work force and significant cost savings will result. An estimated 40 million Americans live with some form of disability, and the total costs for their care is estimated at 6.5% of GDP. West Virginia has one of the highest Permanent Total Disability award rates for Workers' Compensation injuries in the nation. Physical therapy services have been demonstrated to be a cost effective in a variety of health care settings; a limited course of physical has been shown to shorten hospital stays, prevent future injury, and improve health outcomes.

COST CONTAINMENT

As health care providers, physical therapists witness firsthand the impact of spiraling cost of health care. We are in a position to recognize ways in which health care costs can be lowered, but the current system precludes such input from professional providers. As a result, we recognize the need for efforts to contain costs and allocate resources effectively, and the APTA supports such efforts. It is crucial, however, that any process for allocating health care resources includes input from the broad spectrum of health care providers who are authorized by state law to provide health services. The following area comments on specific cost containment options:

Physician Self-Referral

* The APTA strongly supports a ban on physician self-referral to physical therapy services. The excess costs to the health care system associated with physicians permitted to own, and self-refer patients to, such services as laboratory, radiology, pharmacy, and physical therapy have been well documented. The State of Florida, for example, found an increase in visits per patient of some 39% to 45% in joint-venture facilities compared to non-joint-venture facilities, with gross revenue and net revenue per patient 30% to 40% higher. This adds unnecessarily to the costs of health care. The Florida study

also found that licensed physical therapists and physical therapist assistants employed in non-joint-venture facilities spent approximately 60% more time per visit treating patients than did licensed physical therapists and physical therapist assistants working in joint-venture facilities.

Payment Rates

* APTA supports payment schedules that are appropriate to he service provided. We support the development of payment rates that take into consideration the professional expertise and technology required for the provision of high quality services based on community standards. APTA supports a system in which payment is equitable and in which the development of provider fee systems, capitation systems, and case payments is established through adequate provider involvement and review of utilization.

*APTA supports the development of payment rates, whether they are based on reasonable costs per service or reasonable costs per visit. Provisions should be made for stop-loss contingencies and payer risk-sharing methodologies.

* APTA supports restriction of the use of billing codes to those professionals who are licensed to perform the services covered by such codes.

* APTA supports administrative simplification in provider record keeping and communication with the Workers' Compensation Division. Providers must be freed of paperwork and permitted to spend their time treating claimants and practicing their profession. Areas that need simplification include eligibility determinations, coverage determinations, service authorization, billing enquiries, and payment remittances. Record keeping, documentation requirements and billing procedures must be standardized as well.

* APTA opposes the use of global budgets, expenditure targets, and CPT code caps as a means of containing costs. Such arbitrary approaches have an adverse effect on the availability of care and the quality of care provided.

WHO ARE PHYSICAL THERAPISTS?

Physical therapists are key members of the health care team and an integral part of the health care delivery system. The education and clinical experience of physical therapists uniquely prepares them to coordinate care related to functional improvement and functional disability. Physical therapists help 900,000 individuals daily to restore health, alleviate pain and to prevent the onset of disease. The benefits of rehabilitation and physical therapy services are well documented and services are covered in nearly all federal, state and private insurance plans. Today's physical therapy profession serves a dynamic comprehensive health care role in improving and maintaining quality of life for millions of Americans and thousands of West Virginians.

Physical therapists provide care at the acute, rehabilitative, and preventative stages, and strive to achieve increased functional independence and decreased function impairment. Though timely and appropriate intervention, the physical therapist frequently reduces the need for costlier forms of care as surgery and shortens the length of institutional stays. Physical therapists provide preventative care that forestalls or prevents the development of functional deterioration and the need for more intensive care through hospitalization.

Physical therapists are health care professionals who are:

*Graduates of professional programs of physical therapy accredited by the American Physical Therapy Associations Commission on Accreditation in Physical Therapy Education, which is recognized by the council on Post-Secondary Accreditation and the United States Department of Education,

* Professionally educated at the university level, and

* Licensed by all states and territories of the United States

############

ARTICLE 20, CHAPTER 30 OF THE CODE OF WEST VIRGINIA

30 - 20 - 1. Legislative findings and declaration of public policy.

The legislature of the state of West Virginia hereby determines and finds that in the public interest persons should not be engaged in the practice of physical therapy or act as physical therapy assistants without the requisite experience and training and without adequate regulation and control; and that it is necessary to protect the citizens of this state from the unauthorized, unqualified and unregulated practice of physical therapy. It is therefore declared to be the public policy of this state that the practice of physical therapy affects the general welfare and public interest of the state and its citizens; that persons without the necessary qualifications, training and education and persons not of good character should not engage in the practice of physical therapy or act as physical therapy assistance; and that the evil of such unauthorized and unqualified practice may be best prevented and the interests of the public best served by regulating and controlling such practice as provided in this article.

30 - 20 - 2. Definitions

(f) "Physical therapy" means the therapeutic treatment of any person by the use of massage, mechanical stimulation, heat, cold, light, air, water, electricity, sound and exercise, including mobilization of the joints and training in functional activities for the purpose of correcting or alleviating any physical or mental condition or preventing the development of any physical or mental disability, and the performance of neuro-muscular-skeletal tests and measurements as an aid in the diagnosis, evaluation or determination of the existence and the extent of body malfunction.

##############

DIPLOMATE OF
THE AMERICAN BOARD OF
PHYSICAL MEDICINE
AND REHABILITATION

FELLOW OF
THE AMERICAN ACADEMY OF
DISABILITY EVALUATING
PHYSICIANS

PRASADARAO B. MUKKAMALA, M.D.

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CHARLESTON, WV 25302

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DIPLOMATE OF
THE AMERICAN BOARD OF
ELECTRODIAGNOSTIC
MEDICINE

DIPLOMATE OF
THE AMERICAN
ACADEMY OF
PAIN MANAGEMENT

April 26, 1995

Lisa Kern, Counsel
Legal Services Division
P.O. Box 3922
Charleston, West Virginia 25339-3922

RE: Protocols and Guidelines for the Treatment of Workers' Compensation Injuries

Dear Ms. Kern:

I reviewed the Protocols and Guidelines for the Treatment of Workers' Compensation Injuries and in general I concur with the guidelines. However, I do have some concerns and comments as follows:

1). In my experience, the chronic pain management programs have not been effective. In theory, the chronic pain management programs are very appealing, but in practice they have not been effective. I strongly encourage the Compensation Fund to stay away from the chronic pain management programs to the degree possible.

2). Similarly, work hardening programs have not proven to be effective. I have noticed over the years that work hardening programs have been overused or I should even say abused. That type of abuse leads to waste of limited and useful resources and I would caution the Workers' Compensation Fund to be extremely selective in approving work hardening programs.

With those two exceptions, I concur with the Protocols and Guidelines for the Treatment of Workers' Compensation Injuries.

Yours sincerely,

Prasada Rao B Mukkamala

PRASADARAO B. MUKKAMALA, M.D.

Lisa Kern
April 26, 1995

PBM/ks

cc: Sarah Smith
Bowles, Rice, McDavid, Graff & Love
P.O. Box 1386
Charleston, West Virginia 25325-1386

HUNTINGTON PHYSICAL
THERAPY SERVICES, INC.
P. O. Box 8141
Huntington, WV 25705-8141

April 11, 1995

Lisa M. Kern, Counsel
Legal Services Division
P. O. Box 3922
Charleston, WV 25339-3922

Dear Ms. Kern,

I am writing regarding your request for written comments for "Series 20 Protocols and Guidelines for the Treatment of Workers' Compensation Injuries".

This is a great deal of work and I would like to commend the Health Care Advisory Panel on the work involved and the results of this endeavor.

I would like to request consideration for several changes and addendum's regarding the evaluation and treatment of musculo-skeletal injuries. My suggestions are as follows:

85-20-16 Treatment guidelines: acute herniated cervical disc.
16.3.2 Non-Operative treatment:
Only home cervical traction is recommended under these guidelines.

I am requesting physical therapy and/or rehabilitation should be recommended as it is recommended for treatment for Herniated Lumbar Disc. [Please turn to the guidelines 18.4. B. (page 21)]

Physical Medicine procedures are crucial to treatment. The cervical spine is another section of the spine. The anatomy, physiology, and bio-mechanics are different but not to such an extent that physical therapy should not be used as an inexpensive treatment prior to consideration of operative intervention. Some treatment procedures are posture correction, cervical traction (greater weight than 7 lbs. monitored by a licensed physical therapist), active exercise, and passive exercise. The work by Hickey and Hukins, Nachemson, Adams and Hutton, McKenzie, Onel, Krag, and others exhibits the disc material moves according to the external stresses placed on it. These external stresses are how the disc herniates posterior and posterior lateral in the first place, producing the symptoms that cause the client to seek health care. These stresses must be

removed or altered in such a fashion to reduce/correct the disc herniation. This is possible through education and the above listed treatment procedures.

85-20-26.1. I would like to reinforce the concept of early intervention. Early intervention will reduce scar tissue formation, pain, fear and enhance the concept of return to work. It may allow job modification for an alternative duty at the work site without lost time.

I am concerned about rushing people through physical medicine. Once these individuals have completed physical medicine at an accelerated pace, then what happens? We must have in place programs of work conditioning, work hardening, vocational education, and possibly sheltered workshops for individuals with musculo-skeletal problems.

We must also bring the employers on board for this concept. The employer must understand that they are also part of the problem. Alternate work duties by the employer should allow these injured workers to return to work the day of the injury. When injured workers can return to work at less than 100% of their physical capacity their will be less need for work hardening, vocational education, and long term disability payments. All research has shown the earlier an individual can be returned to the job site the complicating factors of back pain are reduced. These factors being family problems, alcoholism, psychological problems, total life awards, etc. (Please see the attached "Calculating the Value of Provider Intervention)

This document, "Series 20 Protocols and Guidelines for the Treatment of Workers' Compensation Injuries", must be reassessed on an annual or semi annual basis. Comparing this treatment protocol and the time frames to what is actually happening in the clinic will provide a much more accurate tool. This tool can then be used more effectively to curtail the outliers and deficiencies in physical medicine.

Allowing this document to be dynamic and not static will make it much more useful and credible. In the long term usage there will be less frustration and more adherence by providers and reviewers.

Thank you for the opportunity to present these concerns to you and the Performance Council. If I or any other members of the WV Chapter of the American Physical Therapy Association can be of additional assistance, please contact me.

Sincerely;

Hugh C. Murray, PT

HUNTINGTON PHYSICAL
THERAPY SERVICES, INC.
P. O. Box 8141
Huntington, WV 25705-8141

April 11, 1995

Lisa M. Kern, Counsel
Legal Services Division
P. O. Box 3922
Charleston, WV 25339-3922

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Thank you for the opportunity to present these concerns to you and the Performance Council. If I or any other members of the WV Chapter of the American Physical Therapy Association can be of additional assistance, please contact me.

Sincerely;

Hugh C. Murray, PT

CALCULATING THE VALUE OF PROVIDER INTERVENTION

To calculate the value of working with an occupational health provider to prevent and manage work-related injuries, certain assumptions may be made. The following formula is based on date from the National Safety Council and other sources:

Injury rate: 8.1 work-related injuries per 100 employees across all industries. (1992 data)

Lost work time: 46% of reported injuries result in lost work time; the average number of low work days per lost time case is 18.2.

Wage replacement: Average of $150 per day per injured worker.

Workers' comp: Average of $1,700 in workers' compensation costs per employee.

Premium: 70% of workers' compensation premium is variable cost that is usually experience-rated.

For example, Acme Co. has 300 employees and an average injury incidence e rate:

- 300 employees x 8.1 injuries per 100 employees = 24 injuries per year.
- 46% x 24 injuries result in lost work time = 11 lost work time injuries per year.
- 18.2 lost work days x 11 lost work time injuries = 200 lost work days per year.

If Acme Co. works with an occupational health program and reduces the number of injuries and lost work days by 10%:

- 90% of 24.3 injuries = 21.6 injuries
- Total lost work time for 21.6 injuries (21.6 x 45% x 16.38 lost work days per injury) = 162 lost work days per year
- 200 lost work days - 162 lost work days = 38 fewer lost work days per year
- Wage replacement cost savings: $150 x 38 saved lost work days = $5,700
- Workers' comp premium savings: Acme Co. pays $510,000 ($1,700 x 300 employees) per year; $357,000 (70% of $510,000) is variable experience-rated. Acme Co. saves $67,830 ($357,000 x 38/200) in the experience-rated variable expense side of Workers' Compensation premiums.

Thus, a modest 10% reduction in both the number of injuries and lost work days saves Acme Co. approximately $73,530, not including retraining, production disruption, potential litigation and other expenses.

{PARTNERS, Volume 1 Number 3, 1993
Published quarterly by the National Association
of Occupational Health Professionals

TEAYS PHYSICAL THERAPY CENTER, INC.

Sports · Industrial · Orthopedic Rehabilitation

Cindy W. Skiles, P.T.
Angie T. Lambert, P.T.
Pam D. Mitchell, P.T.

April 7, 1995

Lisa A. Kern, Counsel
Legal Services Division
P. O. Box 3922
Charleston, WV 25339-3922

Comments Regarding Protocols and Guidelines For The Treatment of Workers' Compensation Injures / Title Number 85.

Dear Ms. Kern:

I am making a written comment regarding Treatment Guideline 85-20-16 for Acute Herniated Cervical Disc. Over the past 10 years treating cervical disc problems, I have found that appropriate therapeutic exercise, postural education, and close follow-up progression of a treatment plan is extremely effective in many cervical disc problems. Under Section 16.3.2 Non-Operative Treatment, there are no indications of physical rehabilitation under the direction of a licensed physical therapist. It is recommended that home cervical traction in bed be 7 lbs. This is very light traction, and this should, as well, be monitored and progressed by a knowledgeable physical therapist so that symptoms are decreased as soon as possible. It is also my experience that a hard cervical collar often times promotes a forward head position, thereby leading to increased cervical disc protrusion. I agree with Section 16.3.3, that patients who are having significant neurological deficit, or uncontrollable pain, and fail to improve after 2 - 4 weeks should be referred for a surgical consultation.

It is interesting to note that under Section 85/20/18, Treatment Guidelines for Herniated Lumbar Disc, under the direction of a physical therapist, rehabilitation is one of the recommended non-operative treatments. Cervical and lumbar disc problems, from a physical therapy treatment approach, can be treated similarly and the treatment outcomes can be very effective for both spinal areas.

In summary, I would like to see physical therapy rehabilitation included in the Non-Operative portion of Cervical Disc Dysfunctions, so that residual problems can be resolved quickly, and the claimant may return to work and continue with activities of daily living as soon as possible.

Sincerely,

Cindy Skiles

CWS/jsm

Cindy W. Skiles, P.T.

Suite 204 · Seville Center
1401 Hospital Drive · Hurricane, WV 25526 · (304) 757-7293

ROBINSON & RICE, L.C.

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606-329-8014

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CHAPMANVILLE, WV 25508
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S. Charleston Office
411½ D STREET, SUITE 8
S. CHARLESTON, WV 25303
304-746-0650

Williamson Office
3RD AVENUE & LOGAN STREET
WILLIAMSON, WV 25561
304-235-7206

April 10, 1995

Lisa M. Kern, Esquire
Legal Service Division
Post Office Box 3922
Charleston, WV 25339-3922

Re: Comments to Protocals and Guidelines for the Treatment of Workers' Compensation Injuries

Dear Ms. Kern:

Perhaps the most frustrating aspects of my job in representing workers injured before the Fund is the everchanging protocals governing treatment. As these treatment guidelines have evolved, so too has the resolve of many physicians to avoid the bureaucratic nightmare of treating compensation claimants.

The proposed "Protocals and Guidelines for the Treatment of Workers' Compensation Injuries" will only strengthen the resolve of physicians to opt out of providing treatment to injured workers. In this regard, the enclosed letter by Dr. John O. Mullen of the Scott Orthopedic Center is instructive on the negative impact of the proposed treatment guidelines. Of particular importance is Dr. Mullen's comment that the proposed guidelines will create a "micro-managed system with no doctors to take care of these patients." Scott Orthopedic Center, which has the only orthopedic surgeon staff in Huntington (with the exception of Dr. Valentine) is no longer accepting workers' compensation claimants.

I wholeheartedly agree with the comments made by Dr. Mullen. Moreover, I can state from personal experience that it has been increasingly more difficult for my clients to obtain treatment following a workers' compensation injury because fewer and fewer physicians choose to navigate through the Fund's maze of chaotic, rigid and oftentimes inconsistent treatment policies. It is the rigidity of the proposed guidelines which upsets

physicians the most, as they are more or less handcuffed in the treatment setting. This straight jacket approach can only expose these physicians to liability, and more importantly, could open a door of liability straight to the Fund.

Sincerely,

Timothy P. Rosinsky

Timothy P. Rosinsky
Attorney at Law

TPR/jad

Enclosure

cc: John O. Mullen, M.D.

COLLEGE OF LAW
WEST VIRGINIA UNIVERSITY

May 1, 1995

John H. Kozak
Director, Legal Services Division
Bureau of Employment Programs
P.O. Box 3922
Charleston, WV 25339-3922

Re: Comments on Proposed Rules: Series 20, 21, 22

Dear Mr. Kozak:

I am submitting these comments with regard to the above proposed rules to you and the Performance Council.

First: I assume that these proposed rules have been sent to the appropriate groups and individuals within the medical community -- and not only to the usual list of people who provide comments on rules. For example, Series 20, dealing with ophthalmic conditions should be reviewed by ophthalmologists, or musculoskeletal injury treatment should be reviewed by orthopedists and physiatrists who are not on the HCAP, including those who are members of the faculty at the state's medical schools; similarly, Series 21 must be reviewed by those in the medical community, including physiatrists, who manage chronic pain and Series 22 needs to be reviewed by psychiatrists and psychologists. Without the benefit of comments from these experts, the Performance Council cannot judge the appropriateness of these recommendations. If this has not been done, I strongly urge you and the Performance Council to delay implementation until comments can be solicited from these experts. The Health Care Advisory Panel does not, and can not, represent fully the medical views of the experts in the State of West Virginia. I believe that it is essential that the medical community have some consensus regarding medical recommendations for treatment if these treatment protocols are going to be successful as a guide for improving treatment of occupationally injured workers -- and not just as a mechanism for cost containment for the Workers' Compensation Division. This is particularly important because an increasing number of physicians are expressing reluctance to accept workers' compensation claimants as patients,

because of the slow payment and intervention into medical practice by the Workers' Compensation Division. Notably, this is in sharp contrast to the current success of the Public Employees Insurance Agency health program, which (despite aggressive claims management) has achieved a fairly high level of acceptance in the provider community.[1] Inappropriate adoption of standards such as these will merely drive more providers, including many highly qualified providers, away from the population; you have an obligation to ensure that this population of work-injured people is served, and served well, by the health care provider community in West Virginia.

In part, I make this suggestion because I -- and many others who frequently comment on rules -- am not a physician. I would not presume to dispute the treatment guidelines themselves, ***to the extent they simply represent recommendations for the appropriate medical treatment for medical conditions***, since I clearly lack medical expertise.

Second: There is at least one element in these rules which appears to go beyond the issue of appropriate treatment: I am very concerned about the return to work/duration of symptoms/duration of treatment guidance which can be found in various places throughout Series 20 (see, *for example*, §§ 85-20-5.5, -6.5, -7.5, -8.5; §85-20-15.1; §85-20-15.5; §85-20-17.5 and so on) as well as in Series 22 (§85-22-5 "Norms of recovery"). My concern relates to at least three issues:

> First, the guidance in these rules does not in any way recognize the different types of work and the different levels of work disability -- not medical impairment -- which relate to the nature of work, not the nature of injury. To set a single return to work goal for each injury, without any regard to the nature of work which an individual performs, is, in many cases, inappropriate. Although this may work for certain kinds of small and specific injuries, including some eye injuries, it is not these injuries which have resulted in long periods of ttd in the past. When this same approach is used for musculoskeletal injuries, then the rule suggests that mine workers and office workers will be treated alike. For example, although noting that recovery may be of variable duration, the rule states that symptoms related to sprains and strains "generally is less than three or four weeks." See §85-20-15.1. The rule further says that treatment of strains and sprains is "not to exceed 8 weeks." See §85-20-15.5, §85-20-17.5. This creates a presumption that further treatment will not be paid for (at least without a fight) and that all workers will recuperate -- and therefore return to

---

[1] I serve as a public member of the five member Finance Board which governs the PEIA program. In that capacity, I have had the opportunity to review the financial and operating plans of that agency and to talk extensively to health care providers regarding their problems with PEIA and other state programs, including workers' compensation.

work -- in this period. Given the wide variation in the nature of these sprain/strain injuries as well as the differing demands of claimants' jobs, this provision allows for inadequate individual evaluation.

Second, the recommendation fails to take into account the highly individualized nature of recovery from injuries. In particular, the blanket assumption that recovery from psychiatric conditions "usually leads to maximum degree of recovery in 6 months" (see §85-22-5) is highly problematic. Was medical literature introduced to support this contention -- or is it simply an attempt to set administrative cost-saving guidelines? If the latter, the workers' compensation law, which requires the payment of temporary total disability until there is medical evidence that the individual has reached maximum degree of improvement or can return to work, makes this provision legally questionable.

Third, and related to these two other concerns: are these guidelines intended for use only by physicians -- or will they be used to cut off eligibility for temporary total disability benefits before an individual can return to work or to force return to work prematurely? It would be highly inappropriate to terminate ttd benefits for individuals based upon these population guidelines which fail to take into account either an individual's own healing or the work which that individual generally performs. Language should be added to both Series 20 and 22 which clearly states that, in making determinations regarding both medical and ttd indemnity benefits, the individual's specific situation will at all times be fully considered.

Third: Series 22's approach to bias (§85-22-5.2) is troubling. In particular, it would seem that a treating physician is in fact the very best physician to evaluate a claimant's condition. In fact, a variety of other disability programs give additional weight to any report filed by an applicant's treating physician, on the theory that this physician is most likely to be very familiar with the individual's condition. I found it remarkable and highly objectionable that this section says "(c). Mixing of roles - both treating and evaluating the claimant" constitutes evidence of pro-plaintiff evaluation bias. This subsection (c) should be deleted from this rule.

Fourth: To the extent that these protocols will act as guidance for medical treatment and both contain costs and improve treatment, they are clearly a good idea. To the extent, however, that they are merely used to deny additional, alternative, medically appropriate treatment or are used to force premature return to work, then they are simply another mechanism for the Workers' Compensation Division to externalize costs inappropriately to others, including health care providers and claimants. Language should be added to both Series 20 and 22 which indicates that these rules

constitute guidance and that, when supported by appropriate documentation, the Division ***shall*** consider such evidence and make determinations on a case-by-case basis, with full regard to the importance of assisting the claimant in achieving a maximum degree of medical improvement.

Sincerely,

Emily A. Spieler
Professor of Law

ATTENDANCE SHEET

MORGANTOWN, APRIL 10, 1995

NAME	REPRESENTING	ADDRESS
William Walter	WVUH P.T.	376 Patteson Dr. Morgantown WV 26505
Louise Hawkinberry	Employers Service Corp	PO Box 3389 Charleston WV 25333
Tom Mancini	legal Services WC	
JOHN KOZAK	BEP	CHAS.
Vicki Lee	WVUH PT	376 PATTESON DR.
Sue Holvey	WCD	Glenville, WV
+ Tim Dewie	SHENANDOAH Valley PT.	MARTINSBURG
Jerri Downey	Shenandoah valley PT	martinsburg
Karen Orr	Shan K. Wang, M.D. Orthopedic	1346 Locust FAIRMONT, WV
Dave Laurie	LOCAL 1058	MORGANTOWN
Thomas Wooten	UMWA Local 1058	Reedsville.
+ RICK VAGLIENTI M.D	No. WV. PAIN MGMT CTR	MGTN
THOMAS W TURPIN.	President L.U. 1058.	morgantown WV
JOSEPH LAWSON	L.U. 1058	" "
+ MIKE MARTIN	AFFILIATED PT SCRV	112 Hill St Bridgeport

ATTENDANCE SHEET

MORGANTOWN, APRIL 10, 1995

NAME	REPRESENTING	ADDRESS
JACK BRALITIGAM	MPTA	1000 J.D. ANDERSON DR. MGTN
Debbie K Boyles	MGH	1200 JD Anderson Dr MGT
Betty Bailey	MGH	MGTN. WV
Paula Mullenax	"	"
Amy Welch-Ramsey	MtView	1160 VanVoorhis Rd.
Linda Lupa	MtView	" "
Eric Keefer	"	" "
Debbie McSorley	HeathSouth	2380 McCurley Rd. Morgantown PA
Roger Hammack	"	"

ATTENDANCE SHEET

CHARLESTON -- APRIL 13, 1995

NAME	REPRESENTING	DO YOU WISH TO SPEAK?
Lora Mancuso	WC Legal Division	No
Diana McCoy	McCoy & Assoc.	No
Sarah W. Coyne	Mid-Ohio Valley Health Dept.	No.
Virginia Cash	" " " "	No
Roberta Templeton	River Cities Anesthesia	No
Teresa Jones	" " "	No
Mindy Christian PTA	Putnam General Hosp	no
(2) Karol Salazar P.T.	Putnam Gen. Hosp	~~No~~ Yes
Babette Robinson	Academia of WV	~~No~~
Tracy McClure	"	NO
Nellie Cooke	"	NO
Kathy Fink	"	NO
Paul Bailey	"	NO
Judy Kirk	"	NO
Anna Lynn	"	NO

(1) Mick Bates - 1. West Virginia Physical Therapy Association. Yes.

2. Concord Academic Center Physical Therapy.

ATTENDANCE SHEET

CHARLESTON -- APRIL 13, 1995

NAME	REPRESENTING	DO YOU WISH TO SPEAK?
Gina Mazzei	Bowles Rice, et. al	NO
Lynn C. Papadakis	" " " "	No
Lisa Edwards	Hyth Podiatry Assoc	No
Paula Zwick-Perdue	Eye Consultants of Huntington	No.
Joan Tokarz	ESC	NO
Kay Moorman Cates	ESC	NO
Pam FARRIS	ESC	NO
Pauline Hanson	ACT	Yes No
Ed PANCAKE	Thos. P. MAHONEY, LC	NO
Angie T Lambert PT	Teays Physical Therapy Cte	No.

ATTENDANCE SHEET

CHARLESTON -- APRIL 13, 1995

NAME	REPRESENTING	DO YOU WISH TO SPEAK?
Sandra Gill	Midi Home Care	No
[signature]	Chapman & Black Law Firm	
Pauline Hanson	ACT Foundation	~~Yes~~ No
Gary Tillis	Act Foundation	NC
(3) Scott Lloyd	UMWA District 6	~~Maybe~~ YES

SCOTT ORTHOPEDIC CENTER

Incorporated

Orthopedic Surgery & Rehabilitation

FRANCIS E. SCOTT, M.D. (1929-1974) • THOMAS F. SCOTT, M.D. • COLIN M. CRAYTHORNE, M.D. • ROBERT W. LOWE, M.D. • JOHN O. MULLEN, M.D.
EARL J. BOSTER, M.D. • KYLE R. HEGG, M.D. • JACK R. STEEL, M.D. • STEVEN A. LOVEJOY, M.D. • LUIS E. BOLANO, M.D. • JOHN M. IAQUINTO, M.D.

March 26, 1995

James Robinson
Attorney At Law
Robinson & Rice, L.C.
P.O. Box 407
Huntington, WV 25708

Dear Mr. Robinson:

I have a copy of the note you sent to Dr. Craythorne who sent me a copy, regarding the synopsis of the rules and regulations that are going to be applied for Compensation, and I assume these are protocols to be followed by a gatekeeper family physician for referral for specialty care.

This has got to be a plaintiff lawyer's dream come true!

First of all, the flaws in the Workmen's Compensation system really have nothing to do with the medical management of these patients. Medical management in West Virginia is no different than in of the other 49 states. Secondly, in just skimming over these, I find the so called mid foot sprain, which is supposed to be a minor problem is, in my experience, a significant long term problem. That is the most blatant thing I see. Also, I can just see a family doctor sitting on some poor guy with a herniated disc, paralysis, and a foot drop, etc. waiting out the three months required, and watching his bladder go out, then watching the plaintiff's attorney come and tear him apart, and also sue the State for setting up such stupid rules.

In complicated problems, I have no objection to protocol management. However, one cannot micro-manage this problem. I think if you saddle a family practitioner with regulations, it is going to end up with poor management. I remember in the Vietnam War, the Army still was required to go out and take all shrapnel out of head injuries, and fortunately in the Navy we

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were not required to do that, and indeed the Army casualties had about a third again as many deaths from head injury as did the Navy, primarily because they had to dig around in brain tissue to bring out some hardware that did not need to be taken out, or it was at a very high risk of killing the patient in getting it out.

I have a deeply based hesitancy about administrative micro-management, and the resultant quality of care. I don't think this is going to save any money; I think it is going to in fact delay appropriate treatment on a lot of these things, and the delay of treatment in and of itself increases the disability. The so called "three month rule" which if the patient is off work for more than three months, has a much higher likelihood of not returning to work than a patient who is off less than three months.

I don't have a great stake in this personally, because I don't see Compensation cases any more unless it is on an absolute emergency basis, and I think that probably several orthopedic surgeons in this State will be joining me once they read about this, so you will have a micro-managed system with no doctors to take care of these patients.

You might pass on to these people who are passing all these rules, that they are listening to people who are quoting numbers from large metropolitan areas, etc. The State as a whole is under-served in almost all specialties. In my own specialty, orthopedic surgery, the problem is not finding patients, its closing the door at the end of the day. I think you will find that family practitioners have the same problem, internists have the same problems, and neurosurgeons have the same problem. If the Compensation Commission wishes to set up micro management of these Compensation patients, they may find they are not only micro managed, they are taking care of the patients themselves.

Sincerely,

John O. Mullen, M.D.

JOM/mas

May 1, 1995

John Kozak, Esquire
Executive Secretary
Workers' Compensation Division
Bureau of Employment Programs
601 Morris Street
Charleston, West Virginia 25301

RE: *Comments to Title 85, Series 20, 21 and 22*

West Virginia

Self-Insurers

Association

P.O. Box 1573

Charleston

West Virginia

25326

Dear Mr. Kozak:

Please find enclosed the West Virginia Self-Insurers Association's comments to the proposed rules to Title 85, Series 20 - *Protocols and Guidelines for the Treatment of Workers' Compensation injuries*; Title 85, Series 21 - *Guidelines for Controlled Substances*; and Title 85, Series 22 - *Guidelines for Psychiatric Permanent Impairment, Evaluations, Evidence and Ratings of Psychiatric Impairment Due to Workers' Compensation Injuries.*

Sincerely,

Henry C. Bowen

Henry C. Bowen
Executive Secretary

enc.
cc: WVSIA Board of Managers
HCB/blf

WEST VIRGINIA SELF INSURERS ASSOCIATION
COMMENTS TO
TITLE 85 SERIES 20

PROTOCOLS AND GUIDELINES FOR THE TREATMENT OF WORKERS' COMPENSATION INJURIES

§ 85-20-2 -- Purpose of these Rules

The purpose of these Rules is explained in this section, as well as in the introduction, as intended to establish parameters for the treatment of claimants' work-related injuries sustained in Workers' Compensation claims. However, the guidelines for each particular type of medical condition do not adequately require that the appropriate treatment be related to a compensable injury. Rather, the protocols refer to appropriate treatment for the condition in general. For example, sub-section 17, which relates to the treatment for low back strains, begins by stating that strains and sprains are a common cause of acute low back pain encountered in the general population, and sub-section 21, which relates to carpal tunnel syndrome, provides that the disease can be caused by external factors such as diabetes, pregnancy, a tumor or tight jewelry. These regulations should provide that treatment recommended or requested be reasonably related to a compensable injury, rather than the particular condition without regard to etiology.

§ 85-20-15.4.B(a-c) -- Cervical Injury

These sections provide that analgesics, muscle relaxants, and anti-inflammatory drugs are appropriate treatment options for cervical strain/sprains. The Association does not disagree that such medication may be appropriate. The Association urges caution with regard to narcotic medication. The Association is aware that subsection 15.4.2.b provides that narcotic medication

for a prolonged period of time is improper. However, such a recommendation is too vague. Too frequently do members of the Association have employees who receive excess narcotic medication. Such medication in excess violates the purpose of this proposed rule, which is to facilitate the injured employee's return to employment, yet the treating physician who prescribes such medication often continues to certify its reasonableness. The Association urges that this rule specify the amount of time an injured employee may receive narcotic medication, or at least incorporate by reference the proposed *Guidelines for Controlled Substances*, and provide that any additional such medication be authorized only upon a detailed discussion by the doctor as to why it is necessary.

§ 85-20-15.4.B(f)

It is recommended in this sub-section that manual manipulation and mobilization is an appropriate form of treatment for a cervical strain/sprain. The Association does not believe that such treatment, *per se*, is medically unreasonable. However, it is not uncommon for such treatment to reach unreasonable proportions. The Association recommends that chiropractic treatment that includes manual manipulation and mobilization should be limited in a reasonable manner by these regulations. Specifically, the number of visits per month, and duration should be limited. The Association recommends that unless the case is exceptional, chiropractic treatment that includes manual manipulation and mobilization should not exceed one visit every two weeks for a period no longer than six months. Chiropractic manual manipulation and mobilization beyond this level should be recommended by a physician other than the injured claimant's treating chiropractor.

§ 85-20-17.3.3 -- **Back Injury**

The Association agrees that with regard to employees who suffer low back sprain\strains who do not recover within one week, as described in subsection 17.1, and in fact do not improve within four weeks, require that a second opinion be obtained. The Association recommends that unless some evidence suggests that the alleged injury is beyond a sprain\strain, continued temporary total disability should not be certified or acknowledged by the Workers' Compensation Division, until a second opinion provided by a qualified physician supports such a determination.

§ 85-20-17.4.1.b.B-D

These sections provide that analgesics, muscle relaxants, and anti-inflammatory drugs are appropriate treatment options for low back strain/sprains. The Association does not disagree that such medication may be appropriate, but urges caution with regard to narcotic medication. The Association is aware that subsection 17.4.2.c provides that narcotic medication for a prolonged period of time is improper. However, such a recommendation is too vague. Too frequently do members of the Association have employees who receive narcotic medication in excess. The Association urges that this rule specify the amount of time an injured employee may receive narcotic medication, and that any additional such medication be authorized only upon a detailed discussion by the doctor as to why it is necessary.

§ 85-20-17.4.1.b.E,G

It is recommended that manual manipulation and mobilization is an appropriate form of treatment for a low back strain/sprain. The Association does not believe that such treatment,

per se, is medically unreasonable. However, it is not uncommon for such treatment to reach unreasonable proportions. The Association recommends that chiropractic treatment that includes manual manipulation and mobilization should be limited in a reasonable manner by these regulations. Specifically, the number of visits per month, and duration should be limited. The Association recommends that unless the case is exceptional, chiropractic treatment that includes manual manipulation and mobilization should not exceed one visit every two weeks for a period no longer than six months. Chiropractic manual manipulation and mobilization beyond this level should be recommended by a physician other than the injured claimant's treating chiropractor.

§ 85-20-18.4.a.A-C

The Association agrees that an excessive period of inactivity can inhibit the recovery process. The Association recommends, therefore, that if a period of inactivity of no more than two weeks does not improve the claimant's condition, then corrective treatment should be immediately pursued, which may include aggressive physical therapy or physical rehabilitation. The Association recommends that the Workers' Compensation Division should not tolerate an injured employee's desire or treating physician's unsupported recommendation that inactivity without further rehabilitative treatment is necessary. The Association would recommend that if the injured employee or treating physician makes such a recommendation, then a second opinion is warranted.

§ 85-21.7.1.D

This subsection provides that non-operative treatment for carpal tunnel syndrome may be extended from 0 - 3 months depending on findings and symptoms; the Association suggests

that the rules require the treating physician to certify the claimant able to return to employment, with or without restrictions, within that period of time; if temporary total disability is extended, then the treating physician should provide a detailed explanation as to why.

§ 85-20-26

The Association agrees that therapy programs are an appropriate method to help return injured employees to work; however, if extensive therapy is necessary, the Association would request that detailed therapy plan be drafted setting forth the extent of the program, as well anticipated results. The Association believes that progress reports to the physician and employer should be mandatory.

WEST VIRGINIA SELF INSURERS ASSOCIATION
COMMENTS TO
TITLE 85 SERIES 21

Guidelines for Controlled Substances

§ 85-21-1. General.

1.1. Scope . -- These rules implement the provisions of West Virginia Code, §23-4-3(a)(1) & -3(a)(2).

1.2. Authority. -- West Virginia Code, § 21A-2-6(1), -6(2) & -6(14); § 21A-2-19; § 21A-3-7(b) & -7(c); and § 23-1-1; and § 23-4-3(a)(1) & -3(a)(2) § 23-4-3(a)(3). Pursuant to West Virginia Code, § 21A-3-7(c), rules adopted by the compensation programs performance council and the commissioner are not subject to legislative approval as would otherwise be required under West Virginia Code, § 29A-3-1 et seq. Public notice requirements of that chapter and article, however, must be followed. Pursuant to Enrolled Committee Substitute for House Bill 4030, Regular Session, 1994, the Department of Commerce, Labor and Environmental Resources was abolished. Pursuant to that same bill and to Executive Order No. 5-94 by the Governor, the Commissioner of the Bureau of Employment Programs is empowered to promulgate rules and regulations without the consent or approval of a departmental secretary.

1.3. Filing Date. --

1.4. Effective Date. --

§ 85-21-2. Purpose of these rules.

The purpose of these rules is to implement the provisions of West Virginia Code, § 23-4-3(a)(1) & -3(a)(2) and § 23-4-3(a)(3) and with regard to providing guidelines to physicians for

the use of controlled substances. These rules are also to be utilized by workers' compensation in its capacity as monitor of claims.

§ 85-21-3. Definitions.

As used in these rules, the following terms have the stated meanings unless the context of a specific use clearly indicates another meaning is intended.

3.1. "Commissioner" means the Commissioner of the Bureau of Employment Programs pursuant to West Virginia Code, § 21A-2-1, and West Virginia Code, § 23-1-1, and any deputies designated pursuant to West Virginia Code, § 21A-2-12 & -13.

3.2. "Division" means the Workers' Compensation Division within the Bureau of Employment Programs as provided for by West Virginia Code, § 21A-1-4, and West Virginia Code, § 23-1-1 et seq.

§ 85-21-4.

4.1. The guidelines are for use by the physicians in the management of chronic nonmalignant pain. Chronic nonmalignant paid in defined as pain persisting beyond the expected normal healing time for an injury, for which traditional medical approaches have been unsuccessful.

4.1.1. The guidelines cannot apply uniformly to every claimant. The guidelines cannot be the sole determining basis for identifying claimants at risk for a drug use problem. Mere application of the guidelines cannot substitute for a thorough assessment of the claimant or medical chart by qualified health care professionals. Workers' Compensation claimants that are presently receiving medication treatment beyond the guidelines must be addressed on a case-by-case basis.

Comment: The West Virginia Self-Insurers Association ("WVSIA") suggests that this rule require the preparation of a treatment plan for each claimant who is presently receiving treatment beyond the guidelines. In addition, the WVSIA suggests that the rule require a physician who intends to continue to prescribe medication beyond the guidelines to obtain authorization from the workers' compensation division.

4.2. Guidelines for the prescription for controlled substances schedules II - IV (refer to table § 85-21-A for controlled substances schedule).

4.2.1. Schedule II drugs should be prescribed on an outpatient basis for no longer than two weeks after initial injury or following a subsequent operative procedure.

4.2.2. Schedule III drugs should be prescribed on an outpatient basis for no longer than six weeks after initial injury or following a subsequent operative basis.

4.2.3. Schedule IV opioid drugs should be prescribed on an outpatient basis for no longer than six weeks after initial injury or following a subsequent operative basis.

4.2.4. Schedule IV sedative and anxiolytic drugs should be prescribed on an outpatient basis for no longer than six months after initial injury or following a subsequent operative procedure.

4.2.5. To prescribe medications beyond the above guidelines, authorization must be obtained from the workers' compensation division. Authorization requests must include documentation as described in Sections 4.3. and 4.5. It is recommended that providers utilize less potent medications when continued use is indicated. See Section 4.6.

4.3. Documentation recommendations for controlled substances prescribed within the guidelines.

4.3.1. A thorough medical history, physical examination, diagnosis and treatment plan should be documented, with particular attention focused on determining the cause(s) of the claimant's pain, sleeplessness or anxiety.

4.3.2. The treatment plan should include the following information:

a. A list of all current medications (with doses), including medications prescribed by other physicians (whenever possible);

b. Therapies and procedures other than medications to manage/relieve pain;

c. Consultations with health care professionals;

d. Further planned diagnostic evaluation; and

e. Follow-up plan to assess progress.

Comment: The WVSIA recommends that the treatment plan also include the duration of all of the medication currently being consumed by the claimant and an estimated duration of medications to be prescribed.

4.3.3. The above standards for documentation are being recommended for inclusion in the provider's records. These records should be submitted to the Workers' Compensation Division.

4.4. Relative contraindications for the use of controlled substances.

4.4.1. History of alcohol or other substance abuse or dependence;

4.4.2. History of chronic, high dose benzodiazepine use or prolonged opioid use;

4.4.3. History of "doctor-shopping" (seeking care for multiple physicians or history of frequent change of physicians);

4.4.4. Active alcohol or other substance abuse or dependence; and

4.4.5. Off work for more than six (6) months.

4.4.6. When special circumstances warrant the use of these drugs in the types of claimants noted above, it should be justified in the medical record, and the risks and benefits must be weighed.

Comment: The WVSIA suggests that controlled substances not be prescribed to claimants with active alcohol or substance dependence. In addition, the WVSIA suggests that the "special circumstances" that warrant the prescription of controlled substances where the prescription is contraindicated be defined.

4.5. Additional documentation required for authorization for treatment beyond the guidelines.

4.5.1. Documentation should include:

a. Description of reported pain, insomnia, or anxiety relief from each medication;

b. Justification of the continued use of controlled substances beyond the guidelines;

c. Documentation of attempts at weaning and/or tapering dosage;

d. If weaning attempts have failed (include history of contraindications); and

e. Alternative treatments under consideration.

4.5.2. Informed consent should be obtained from the claimant and include the risks and benefits of prescribed medications. The explanation should be documented, along with expected outcomes, duration of treatment, and prescribing limitations.

4.5.3. The treatment plan should be revised as new information develops which alters the plan.

4.5.4. When the provider requests authorization for surgical procedures that are likely to require medication use beyond the guidelines, please address the need for extended use in the initial authorization request so that the authorization will be reviewed prior to surgery.

4.6. Proper use of controlled substances.

4.6.1. Pain medication (opioids):

a. Adequate doses of medication in appropriate strength and frequency to control acute pain;

b. Fixed dosage schedules rather than PRN will enhance compliance and minimize the risk of addiction; and

c. Progressive use of less potent medication, tapering of doses and diminishing frequency of dosing should be used to wean the claimant off of narcotics.

4.6.2. Sedatives and anxiolytic medication;

a. The use of sedative and anxiolytic medications for six weeks or less can be effective. Benzodiazepines are preferred;

b. Use beyond several weeks should trigger exploration of depression and consultation with a mental health professional; and

c. Use for anxiety should not be continued beyond three months. Tapering is usually required.

Comment: The WVSIA suggests that the term, "mental health professional" be replaced by the term, "licensed psychiatrist." Mental health professionals, other than licensed psychiatrists, are neither authorized nor qualified to prescribe medication.

§ 85-21-5. Severability.

5.1. If any provision of these rules or the application thereof to any entity or circumstances shall be held invalid, such invalidity shall not effect the provisions or the applications of these rules which can be given affect without the invalid provisions or application and to this end the provisions of these rules are declared to be severable.

Table § 85-21-A

a. The Controlled Substance Act of 1970 regulates the manufacturing, distribution and dispensing of drugs that have abuse potential. The Drug Enforcement Administration (DEA) within the US Department of Justice is the chief federal agency responsible for enforcement.

A. DEA Schedules: Drugs under jurisdiction of the Controlled Substances Act are divided into five schedules based on their potential for abuse and physical and psychological dependence. All controlled substances listed in Drug Facts and Comparisons are identified by schedule as follows:

Schedule I (C-I)	High abuse potential and no accepted medical use (e.g., heroin, marijuana, LSD).
Schedule II (C-II)	High abuse potential with severe dependence liability (e.g., narcotics, amphetamines, dronabinol, some barbiturates).
Schedule III (C-III)	Less abuse potential than schedule II drugs and moderate dependence liability (e.g., nonbarbiturate sedatives, nonamphetamine stimulants, limited amounts of certain narcotics).

Schedule IV (C-IV)	Less abuse potential than schedule III drugs and limited dependence liability (e.g., some sedatives, antianxiety agents, non-narcotic analgesics).
Schedule V (C-V)	Limited abuse potential. Primarily small amounts of narcotics (codeine) used as antitussives or antidiarrheals. Under federal law, limited quantities of certain c-v drugs may be purchased without a prescription directly from a pharmacist if allowed under specific state statutes. The purchaser must be at least 18 years of age and must furnish suitable identification. All such transaction must be recorded by the dispensing pharmacist.

WEST VIRGINIA SELF INSURERS ASSOCIATION
COMMENTS TO
TITLE 85 SERIES 22

GUIDELINES FOR PSYCHIATRIC PERMANENT IMPAIRMENT, EVALUATIONS, EVIDENCE AND RATINGS OF PSYCHIATRIC IMPAIRMENT DUE TO WORKERS' COMPENSATION INJURIES

§ 85-22-1 -- General

1.1 For the sake of consistency, reference should be made to protocols and guidelines required for "the psychiatric and psychological evaluation and examination" of claimants. As drafted, the scope of the rule addresses "psychiatric evaluation and psychological examination." It would be more consistent to use the term psychiatric and psychological throughout the rule, as opposed to using one or the other.

§ 85-22-3 -- Definitions

3.5 The definition of "aggravation" should be the result of an act, action, or circumstance "that intensifies or makes worse a psychiatric or psychological condition; an unfavorable progression of claimant's psychiatric or psychological condition." The rule as drafted refers to the worsening of a medical condition. Because this rule addresses psychiatric and psychological impairment, then the appropriate term would be the claimant's psychiatric or psychological condition. This would also be consistent with § 3.4, defining "causation," which also refers to psychiatric condition.

3.10 The definition of "temporary total disability, psychiatric" is totally off the statutory mark. Pursuant to W.Va. Code § 23-4-1f, in order for mental impairment to be compensable, it must be accompanied by a physical injury. As drafted, the definition of

psychiatric temporary total disability would allow a claimant to be considered disabled if his or her psychiatric condition "in and of itself" rendered him or her unable to function in the work setting. The definition should delete the "in and of itself" clause and instead read as follows:

> "A psychiatric condition that, in combination with a physical condition, makes the claimant unable to function in the work setting."

As proposed, this definition violates the Workers' Compensation Act.

§ 85-22-5 -- Psychiatric Evaluation and Impairment Guidelines

5.2 This section presents a laundry list of "pro-plaintiff" and "pro-defense" evaluation "biases." These so-called biases appear to be based on apparent prejudices in and of themselves, and for the most part, may apply to any evaluator, regardless of whether the evaluation is being performed for the claimant or the employer.

Also, pursuant to § 5.2c, the guidelines for payment of temporary total disability benefits for psychiatric claims should reflect more accurately the provisions of W. Va. Code § 23-4-1f, which, as stated above, provides that in order for mental impairment to be compensable, it must be accompanied by a physical injury. This provision, as written, allows for too much speculation beyond the scope of that which is permitted by statute.

5.6 The claimant's "personal history," as a guideline, is perhaps more important in a psychiatric evaluation than any other type of evaluation. Accordingly, this section should be expanded to include the requirement of more details concerning the claimant's life, background, and family history, medical or otherwise.

5.16.1 This provision should remove reference to the West Virginia Division of Workers' Compensation, as it may be the case that the examination was performed and the report prepared for the claimant or employer.

§ 85-22-6 – Psychological Examination Guidelines

6.2 This provision, concerning guidelines for psychological examination, is unclear at the very least, and inconsistent with the entire rule at most. Specifically, it sets forth "guidelines for psychologists to use when performing psychological evaluations for the Division of Workers' Compensation." (emphasis supplied) If this statement is designed to limit use of these guidelines to those evaluations performed at the request of the Division, then this is inconsistent with the purpose as set forth in § 85-22-2, which provides:

> "This rule is applicable to evidence submitted by any party to a claim and to evidence gathered by the division."

However, if it is not intended to be limited to Division evaluators, then this provision should be reworded to provide that the guidelines are for use when performing psychological evaluations for workers' compensation purposes.

General Provisions

The Rules should contain a provision authorizing a Division decision maker to exclude from consideration any report submitted by a party which does not adhere to the guidelines set forth by the Rule.

Also, the severability provision is labelled § 85-22-7. In reality, it should be "§ 85-22-8."

Appendix B -- Conditions Likely and Unlikely to be Related to Trauma or Work

This appendix is not necessary because the only mental impairment that would be compensable would be that which is accompanied by physical injury. Accordingly, if the medical impairment is related to a trauma or work-induced injury, to a reasonable degree of certainty, then such impairment would indeed be compensable. On the other hand, the claimant's mental impairment is not related to a work-related physical injury, then it is not compensable. Many of the disorders set forth in the list in Appendix B may be the result of a physical injury which is work-related or non-work-related. Consequently, it is not necessary to make such broad generalizations about these disorders, per se.

Appendix C -- Psychiatric Evaluations and Reports

The levels of impairment appear to be arbitrary and broad in their percentage range, thus allowing for less predictability and stability in analyzing a Workers' Compensation claim where psychiatric impairment is alleged to exist.

Appendix D -- Psychiatric Impairment Probability

Like Appendix B, this appendix is unnecessary in that it is the hope of all that a psychiatric evaluation would be performed by a professional who is trained in the field of psychiatry. Accordingly, it is unlikely that such a professional would need to rely on a list containing fundamental probability of psychiatric impairment.

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(Plus all the volunteer help we can get)

STATE OF WEST VIRGINIA
SECRETARY OF STATE

Building 1, Suite 157-K
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Charleston, WV 25305-0770

TO: John Kozak

AGENCY: Worker's Compensation

FROM: JUDY COOPER, DIRECTOR, ADMINISTRATIVE LAW DIVISION

DATE: November 9, 1995

THE ATTACHED RULE FILED BY YOUR AGENCY HAS BEEN ENTERED INTO OUR COMPUTER SYSTEM. PLEASE REVIEW, PROOF AND RETURN IT WITH ANY CORRECTIONS. IF THERE ARE NO CORRECTIONS, PLEASE SIGN THIS MEMO AND RETURN IT TO THIS OFFICE. YOU WILL BE SENT A FINAL VERSION OF THE RULE FOR YOUR RECORDS.

PLEASE RETURN EITHER THE CORRECTED RULE OR THIS FORM WITHIN TEN (10) WORKING DAYS OF THE DATE YOU RECEIVED THIS REQUEST. CALL IF YOU HAVE ANY QUESTIONS.

SERIES: 20 TITLE: 85 Worker's Compensation

* THE ATTACHED RULE HAS BEEN REVIEWED AND IS CORRECT.

SIGNED: _____

TITLE OF PERSON SIGNING: _____

DATE: _____

****

* THE ATTACHED RULE HAS BEEN REVIEWED AND NEEDS CORRECTING. THE CORRECTIONS HAVE BEEN MARKED.

SIGNED: _____

TITLE OF PERSON SIGNING: Director, Legal Services Division

DATE: 11/21/95

NOTE: IF YOU ARE NOT THE PERSON WHO HANDLES THIS RULE, PLEASE FORWARD TO THE CORRECT PERSON.

BEFORE THE WORKERS' COMPENSATION PERFORMANCE COUNCIL

IN RE: PUBLIC HEARING ON THE PROPOSED GUIDELINES SERIES 21, 22 AND 23

TRANSCRIPT OF PROCEEDING had at the public hearing in the above-referenced matter, held on Thursday, April 13, 1995, at 10:00 a.m. in Room 202, Charleston Civic Center, Charleston, West Virginia, pursuant to notice.

ANGELA A. ROBINSON, Subcontractor

REBECCA L. BAKER
Certified Court Reporter
2300 Shadyside Road #5
St. Albans, West Virginia 25177
(304) 727-2965

APPEARANCES FOR THE WORKERS' COMPENSATION PERFORMANCE COUNCIL

MR. PAUL THOMPSON

MR. FRED TUCKER

MR. THOMAS ROTENBERRY

MR. ANDY RICHARDSON

MR. EVERETT SULLIVAN

MR. THAD EPPS

MR. JOHN KOZAK

* * * * * * * * * * *

I N D E X

April 13, 1995.

MR. RICHARDSON: This is the Charleston public hearing regarding three sets of regulations being proposed by the West Virginia Workers' Compensation Division. Those sets of regulations are as follows: They are Title 85, Series 20, regarding protocols and guidelines for the treatment of selective workers' compensation injuries. Title 85, Series 21, regarding guidelines for controlled substances. And Title 85, Series 22, regarding guidelines for psychiatric permanent impairment evaluations, evidence and ratings of psychiatric impairment due to workers' compensation injuries.

If those are subject matters that you are interested in, you are in the right place. If they are not, you may want to check the schedule board out in the hall.

My name is Andy Richardson, Commissioner of Employment Programs and Chairman of the Compensation Programs Performance Council. Several members of the performance council have joined us this morning to participate in hearing your comments. If I could start

at the far left of the table, I would like each performance council member to introduce themselves and to say anything that they would like to say in introductory remarks.

MR. THOMPSON: I'm Paul Thompson just waiting to hear your comments.

MR. TUCKER: My name is Fred Tucker.

MR. ROTENBERRY: Tom Rotenberry.

MR. EPPS: Thad Epps.

MR. SULLIVAN: I'm Everett Sullivan and I'm glad to see all of you here this morning.

MR. RICHARDSON: We have other members of the performance council that are not here and were not able to join us today including Dick Humphreys from Morgantown, David Harris and Dan Shruman.

We also have some staff from the Workers' Compensation and the Bureau of Employment programs present. What I would like is for those staff members to stand and introduce themselves. One is already standing and I'll start with him.

MR. KOZAK: John Kozak. I'm the director of Legal Services for the Bureau.

MS. KERN: I'm Lisa Kern and I'm counsel with the Legal Services Division.

MR. MANCINO: Tom Mancino. I'm a paralegal with Legal Services.

MS. GREENWOOD: Judy Greenwood, director of research and information in liaison to the health care-- status support to the health care advisory panel.

MR. RICHARDSON: The regulations that are under consideration came before the compensation program's performance council in the form of recommendations from Health Care Advisory Panel. The Health Care Advisory Panel was established under 1990 amendments to the law and is charged with advising the division and the commissioner with regard to the development of different guidelines and methods of rating and issues of that nature.

We have two of the panel members present today and I would like them to introduce themselves at this time.

MS. POSEY: I'm Pat Posey. I'm a registered nurse and a professional counselor and work in terms of

issues related to manage care, issues related to rehabilitation.

DR. TULLY: I'm Dr. C. Carl Tully. I'm an M.D. I was a professor of family practice and I was a family practice physician.

MR. RICHARDSON: With that we'll move forward into the hearing. And I only have one person that says; I have two that say maybe on the sign-up sheet in their interest in speaking. I am going to defer the maybe until after the yes. And I can't read the writing of the yes. I think it's --

MR. BATES: Bates.

MR. RICHARDSON: I would recommend that in the future we include on the sign-up sheet, write legibly.

MS. HANSON: Would you put yes on there for Pauline Hanson. I did not put yes.

MR. RICHARDSON: And our next speaker will be Pauline Hanson.

MR. BATES: Good morning and first of all I would like to thank you for the opportunity to address some of these issues that have been raised for

discussion this morning. My name is Nick Bates. I'm a physical therapist working in Beckley, West Virginia. I'm here today representing myself and my professional colleagues, Columbia Heights Raleigh General Physical Therapy in Beckley as well as the West Virginia chapter of physical therapy association.

I will attempt to keep my comments brief. I would like to start with a few general things first of all and then move on to some quick comments about specific items in the guidelines that I've had the opportunity to look at.

Before the first of May, myself and colleagues from the chapter will be submitting a written physician's paper for your perusal. We haven't had the opportunity to put that together as yet. You will have that in time to reflect on that before making final decisions.

I would like to start by commending the Health Care Advisory Panel for their efforts to establish some guidelines that deal with the significant variations in the methods of care and also some of the inappropriate use that we've seen of the use of passive modalities by

unlicensed and unqualified providers.

Overall the document is to be commended. I mean, it's content, there are elements of it that are stronger than others. One item that concerns myself and my colleagues is the use of the word protocol and guideline interchangeably. In establishing guidelines I think that the Health Care Advisory Panel has done the community of health care providers dealing with these sorts of cases and the system a great service. In establishing protocols, it is the concern of myself and people that I work with that these could lead to the arbitrary setting of caps or limitations on physical procedures and rehabilitation. That issue is important.

A number of third-party payers at the moment are attempting to do this and it does not exist at the moment any firm evidence suggesting that such restrictions lead to the overall improvements in the standard of care limited to those people and that we're attempting to serve or any economic savings for the paying groups.

I have additional concern and is something

that has come to my attention the last 48 hours from the Workers' Compensation Division, also HCX which would seem to go contrary to the Health Care Advisory Panel's efforts to promote early and aggressive rehabilitation in returning these individuals to work. And this involves the pre-certification of all physical meds and procedures -- all rehabilitation procedures -- following our initial evaluation. I was advised of this yesterday and I know that very few people at the moment are aware of that.

A final general concern here would be that these guidelines, which could have been fairly wide reaching ramifications for a number of people within the state within the health care community and also for workers have not been from my point of view distributed widely. And a note is given to groups, concerned individuals and a difficulty in obtaining a copy of those guidelines has been fairly extensive and has lead me to not be ready to prepare a written position today. I will have that later on this month. I obtained my copy of the guidelines from a colleague in Martinsburg, who had contacted legal services on a

number of occasions in an attempt to obtain a copy of the documentation. He received one copy and then we was forced to photocopy the documents and distribute them immediately to our physical therapists earlier this month.

Having worked with the workers' compensation system for over 12 months, my facility for over three years, we received no notification of these revised guidelines and without his efforts, I would not have been aware of these going into place.

If I can go specifically to some of the sections of the document, Section 85-20-15.

MR. RICHARDSON: Which one?

MR. TUCKER: Which one, sir?

MR. BATES: 85-20-15. Section 15, 17.1, Page 14. In that section there of the guidelines as I'll refer to them, states that the claimants will respond to above treatments. Within four weeks the claimant must be referred to an appropriate specialists. Concern there in terms of the definition of what an appropriate specialist would be. If we turn to 20-16, 3.2, Section A under un-operative treatment.

Home cervical traction, e.g. bed of seven pounds, two hours, four times a day for seven to 10 days.

MR. TUCKER: Which page?

MR. BATES: Page 15. I'm sorry. This is difficult for me to follow as well. Concern there is with regard to the need to place specific perimeters as to the degree, length and limit on that particular procedure.

MR. TUCKER: I'm sorry. What did you say your concern with that was?

MR. BATES: In stating in bed, seven pounds, two hours, four days a week -- four hours a day for seven to ten days. That being a guideline or protocol isn't based upon any specific study or --

MR. TUCKER: Is it your concern how they derived at seven pounds, two hours, four times a day for seven to 10. Is that what your concern is, sir?

MR. BATES: Yes.

MR. TUCKER: How they derived --

MR. BATES: How they derived at that and if in arriving at that, that places unlisted restriction on the clinical decisions of those who are in a

position to make those decisions to how much, how long, how frequently, how infrequently that particular treatment option may or may not be indicated.

MR. RICHARDSON: So, your concern is just flat out whether there ought to be a guideline?

MR. BATES: A guideline is fine but whether or not this represents an attempt to place some sort of --

MS. POSEY: It does not. It's e.g., for example, and therefore does not mean that that's a protocol. They're guidelines in the regard that home traction is an appropriate non-operative activity and for example they gave a prescription that someone had come up as a -- probably a neurosurgeon gave that but that's an example as opposed to a specific protocol. E.g., means for example.

MR. SULLIVAN: We were explained that these were just guidelines.

MR. BATES: Well, in the initial introductions on the first page, a synopsis of issues, these rules provide protocols and guidelines for the treatment of injuries.

MS. POSEY: I think it's appropriate to raise the issue of what me mean by definition of protocol and that's certainly something that Health Care Advisory Panel can consider with input from professionals who raise a legitimate concern about that.

I know that the controlled substances are certainly protocols. Well, they're not even protocols because you can alter the recommendation by giving reasons why you want to depart from the guides. So, it may be that protocols are not -- unless we specifically define what we mean by protocol, maybe that's a term we want to reconsider.

MR. BATES: A number of the issues that I will continue to raise -- and I don't wish to go down this line by line -- but if these are to be treated as protocols then I feel obliged to get into it line by line. Instead of used as guidelines and examples, suggestions e.g., then that's not necessary. And as I said, the overall contents of the document is excellent. There are some sections that are better than others and from my perspective --

MS. POSEY: Would you agree -- Carl has worked with us on these and I think -- would you agree with me that protocol does not mean a prescribed way that you have to do but what we're suggesting that these are guidelines and if a practitioner wants to provider wants to deviate from the guides, they need to give some reason why they're straying some distance from what we recommended. But as far as this is cast in stone, this is the only way you can do it, that was not the intent of the Health Care Advisory Panel.

MR. BATES: I'm sure that that is not the intent of the panel themselves being providers who deal with these situations. But as we've seen in a number of other sittings when you start out with guidelines and what you end up with is restrictive practices limits, caps.

MS. POSEY: No. That was not the intent.

MR. TUCKER: Mr. Chairman, I would like to have a point of inquiry myself. How are these individuals who are going to be living under these proposed rules that you've adopted going to approach the type of situation that this gentleman is raising?

Is each practitioner going to have inquire of HCAP or someone in the division's office to get an interpretation before they can treat anybody after they make their evaluation on that?

MR. RICHARDSON: What's contemplated is that these will be published.

MR. TUCKER: I understand that.

MR. RICHARDSON: And circulated to practitioners in the workers' compensation medicine area.

MR. TUCKER: That's not my question. If they're adopted as proposed, I'm sure that they will be distributed to the practitioners who deal with these three -- 20, 21, 22. My question is: If a practitioner is out into the private sector trying to treat people based upon these guidelines and they're particular treatment that they want -- that they feel is necessary for a person that's coming to them for treatment, does not necessarily fall within the verbiage of the proposed rules, are they going to have deal with the division or someone in the division or someone in HCAP before they can proceed with their

treatment? I think that's a viable question that needs to be answered. What I'm hearing is people that's on the HCAP saying that wasn't the intent but still the language says, you, know certain things that these --

MR. RICHARDSON: I think in the regulations, Fred, you have two different things. You've got what are considered to be best practices by the Health Care Panel and encouragement to follow that type of practice. In addition to that, you have rules. And an example would be on the drugs. The drug regulation, Series 21, that's essentially a rule. And it's a rule that says that there have got to be exceptional circumstances to go beyond that rule and it's because we've had an inordinate number of individuals in the past that would be get onto a pain pill or some other type of drug and end up with a substance abuse problem as a result of that problem.

In addition to that, the example that Mr. Bates gave a few minutes ago under Section 15.7.1, the example there would be that, you know, if a physical therapist, if a chiropractor or other handle the care of an individual with these particular problems for a

certain period of time and there was not improvement demonstrated, then there would be a requirement that that person then be referred to an orthopedic surgeon, neurosurgeon, person of that nature.

Mr. Bates raised a legitimate question regarding the terminology here of an appropriate specialist and that's the kind of input we need on these regulations. I didn't here him questioning the issue of at some juncture referring a person on to a person of greater specialty.

MR. BATES: No.

MR. RICHARDSON: It's an issue of defining precisely what kind of specialty that would be. So,, you know, is that a guideline or just a -- is that a rule or just sort of a best practice. Well, I would say that's probably kind of a rule, isn't it? If you take care of someone for a while and they're not showing improvement and you can't quantify that improvement then a few people in the practice of physical medicine would dispute that someone else probably needs to take a look at that person.

MR. ROTENBERRY: That doesn't mean he wasn't

appropriate.

MR. RICHARDSON: Well, the appropriateness is -- what they're talking about is a specialty. And, you know, basically this particular section -- and maybe I shouldn't look on that as an example -- but this particular section is oriented toward physical therapist or a chiropractic surgeon or an osteopath who does manipulations or I suppose even a family practitioner for that matter who might do manipulations. And at some juncture -- what the rule recognizes is that at some juncture that individual should be referred to a person with greater specialty to deal with the particular physical problems that that person --

MS. POSEY: If I may clarify that a little bit because a lot of people with sprain/strains get seen in an emergency room and referred to surgical specialists who have already decided within the first two to four weeks that this individual is not a surgical candidate then they would refer to the appropriate specialist, i.e., a physical medicine specialist. So, it can both ways. It's not just

physical medicine. It's whomever is treating this individual, if they've shown no improvement within 30 days, if not a documented measurable improvement, someone else from some other specialty needs to look at that individual. And, so, it can be either a neurosurgeon who has seen this individual and it's not a surgical case or it might be a physical medicine specialist whose doing something and the person is not improving. So, it can go either way.

MR. THOMPSON: Who will make the referral.

MS. POSEY: That's the beauty of your case management approach in workers' comp. The provider is not given this stuff to do in a vacuum, you're not given these and said follow them and we're not going to give you any assistance. The claims managers who manage the cases will be in contact with those providers and asking questions and finding out how the person is progressing. They'll also be talking to the injured worker who may say, I don't feel I'm improving and the physical specialist says or whatever specialist is seeing them says, "Well, we think there's an improvement," when there's some obvious disagreement

about whether improvement is there or not, then maybe a case manager needs to be face to face with the worker and the provider to find out what is going on.

So, there will be a great deal of guidance provided from workers' comp or from whomever is managing the case to assist on how to move forward with returning that injured worker to work.

DR. TULLY: May I say something about the rules? These rules were formulated by using rules and regulations from other states, like Rhode Island, Michigan, New York, California, whatever. We took the best that we could find and these are rules that are more or less suggestions and not set in stone but if in this case with the person with the cervical traction, if you're going to do this for 50 days, we think that's a variation. If you're going to use 30 pounds, we think that may be a variation. So, these are rules that we're suggesting that be used that are formulated by experts that we sort of tapped their brains and used some of our own.

MR. BATES: I do not doubt the intention nor the best effort of the Health Care Advisory Panel.

Again, I'll say, overall this is an excellent document. It's a step in the right direction. These guidelines we use more frequently many, many people would benefit. But my concern is when guidelines become protocols. On Page 39, Section 85-27.1, physical medicine guidelines were developed to avoid monitoring of 100 percent of claims where physical medicine is provided. However, these guidelines do not supersede the previous diagnostic related treatment guidelines.

These diagnostic treatment guidelines -- those guidelines I have never seen. I have been unable to obtain. These diagnostic related treatment guidelines represent a cap or a time limit or a dollar amount limit on services.

MS. POSEY: By the way, this got into the rule before we actually changed the wording and we have a written recommendation that that be changed and I can read to you what the change is if you would like to hear it.

MR. BATES: Thank you.

MS. POSEY: Physical medicine guidelines

were developed to avoid monitoring of 100 percent of claims where physical medicine is provided. Case management will begin at any point lack of progress is identified but particularly at 30 days and at 60 days after treatment has begun.

And that we propose should change that particular sentence. However, these guidelines do not supersede. We picked that up after it got into the rule and we're aware -- we think that needs to be changed.

MR. BATES: Are there other sections or--

MS. POSEY: I'm not prepared to say. That's the only one I know of at the moment.

MS. GREENWOOD: That's the only one that slipped, that there was a glitch between the guidelines that were published and the final guidelines recognized and approved by the Health Care Advisory Panel. This particular section was the only few lines of several sentences that got caught in a time warp. You're welcome to continue.

MR. BATES: That is a little bit of concern. The revised documents is not the document that we have reviewed but I can understand --

MS. POSEY: Well, we got a look at the rule and recognized that this was not the intent. So, we too agree and we understand. That's why the public hearing is here because we said, "Can we correct it?" And they said, "No. You'll have the opportunity at the public comment."

MS. GREENWOOD: There was about a week, half a week even of time there that the Performance Council met and the Health Care Advisory Panel and there was this one slippage.

MS. POSEY: We hope that's all.

MS. GREENWOOD: That is the only one. I'm confident that's the only slip between the cup and the lip.

MR. BATES: That particular issue regarding protocols and guidelines, we leave that for now with the understanding -- it is my understanding that some form of definition -- it's suggested that some form of definition needs to applied there. Is that correct or have I misunderstood our discussions regarding what is a protocol, what is a guideline?

MS. POSEY: Protocols are stiffer. What do

you think, John, does he need to address everyone of these in light of if the protocol is the assigned term then he needs to make comment about each thing that he thinks is not appropriate as protocol?

MR. RICHARDSON: He can do that now or in writing later if he'd like to do that. One of the things that occurs to me in listening to all this, I think that the revision coming out of this process is that we probably need to identify specifically which items a protocol, which is a guideline and put that into the definition.

MS. POSEY: You were talk being 27.1.2 on Page 39.

MR. BATES: I need to go back from there. A number of my comments here again pertain to that issue regarding protocols versus guideline. So, I will attempt to just quickly run through them and pick out anything that deals with other than that concern. You got lucky, I jumped all the way to the end. Section 27.10.

MR. RICHARDSON: Page?

MR. BATES: The last page, 40. Second to

last page, Page 40. In Section 26 it appears that these are the same thing.

MS. POSEY: Say again.

MR. BATES: These appear to say the same thing in the copy that I have.

MS. POSEY: Cite the numbers again.

MR. BATES: 27.10.

MS. POSEY: 27.10.

MR. BATES: 27.10-1A, 26.11. I hope I've given you the right referencing.

MS. POSEY: Now, remember one has to do with the ankle and the other has to do just with physical medicine.

MS. GREENWOOD: No. No. Appropriate intervention time-frame is 26.1.

MS. POSEY: Yeah, but it has to do with the foot and ankle.

MS. GREENWOOD: No.

MS. POSEY: It does, too. Look at the very top.

MR. RICHARDSON: Well, we will look at that. You're welcome to -- we're not putting you on

any kind of time limit.

MR. BATES: I hope to be all but finished. Again, my concern in not going through this stuff line by line is that if there are revisions made, I would like to see the revised documents before I am --

MR. TUCKER: You would like to see the revised copy, is that what you're saying, sir?

MR. BATES: Yes. Before I provide the written comments or before I become subject to these guidelines.

MR. RICHARDSON: Do you know Jack Brye? He's a physical therapy in Morgantown.

MR. BATES: No, sir, not personally.

MR. RICHARDSON: Jack is a member of the Health Care Advisory Panel and has worked, I believe, closely with other physical therapists on this. If you'll see me after the meeting, I'll give you his telephone number and you may want to contact him to discuss the background on the development of this and in addition to him we have Dr. John Deboyce from Wheeling. Do you know John?

MR. BATES: No. I've only been in this area

about 12 months.

MR. RICHARDSON: We appreciate your thoughts and comments. They are exactly why we do public hearings of this nature and the comment period is actually open until, I believe, the beginning of June, the end of May. What is the deadline?

MR. TUCKER: May 1.

MR. RICHARDSON: We've got another series out that are open until June 1. So, we look forward to your comments and I believe that you have the address where to write on any of the comments that you have on the issues. Any further questions for Mr. Bates?

MR. TUCKER: I have a couple I want to ask. Sir, you -- and if I make misstate, I'm just trying to ascertain what your comments were. One of your difficulties was using the word protocols and guidelines in describing the rules. Also, did I detect that in your statement that if these protocols or rules were adopted, you had a fear they would set a limit or cap on rehabilitation?

MR. BATES: Yes. I think the intention of the Health Care Advisory Committee was to promote

rehabilitation in returning workers to the work force as quickly as we can. Sometimes when that's attempted to be done, in doing so, you produce guidelines or suggested methods of treatment then they're latched onto by the financial arm of workers' compensation board or the division and then those suggested guidelines become caps or limits.

MR. TUCKER: So, your concern is -- if I make a false statement just feel free to correct me -- but what I ascertain what your statement was that the new rules, protocols or whatever you want to call them, as they are now that as you know them now, if they were used you would have concern that they would limit or set a cap on rehabilitation and that the standard of care would be affected.

MR. BATES: Yes. The decision making process would be taken out of the hands of those people who are able to make those decisions.

MR. TUCKER: So, your concern is that the proper to make the decision would be eliminated; is that correct?

MR. BATES: Yes. That the guidelines would

not take into account the significant variation in the clinical picture that does exist. Our best practice situations arise where that's not the case. And as we've seen it before, an attempt to do the right thing has resulted in restrictions to the service.

MR. TUCKER: And the cure becomes more of a cause than the cure; is that what you're saying?

MR. BATES: Exactly.

MR. TUCKER: And one final question. Did I understand you to say that you felt they were not aggressive enough on returning people back to the workplace?

MR. BATES: No.

MR. TUCKER: Did I misunderstand that?

MR. BATES: Yeah. Probably my accent.

MR. TUCKER: If they understand me, they can understand you. As a point of information also, you said you were not, as far as you're not on the mailing list, I guess, for --

MR. BATES: No.

MR. BATES: I think we need to try to address that somehow. I think you need to see one of

the people from legal staff and get your name on that list and I would advise anybody here, also, that's interested in doing that, do that. They are very good about -- if they know who to send them to, people are interested, they have no problem with sending those. But in all fairness, they don't really know who those are unless -- if you have a concern and your in it, I would suggest you get with one of those folks. Any other proposed rules and regulations that you might want to have comment or input, we may have to address that some way with you. I don't think there's a problem with that. I appreciate your comments and thank you for coming today, sir.

MR. RICHARDSON: There is absolutely no effort -- I mean, these are out for public comment, they're published and the state register sent out to various groups of interests and, you know, I regret that you felt you had a hard time getting a copy of those regulations but it's certainly nothing conscious. And if you would like copies of those regulations, simply give us your name address and we'll be sure these are forwarded to you each time they're

promulgated.

MR. KOZAK: I would just like the record to note that we sent out 15,000 copies of summary to everybody who's on the billing system within the computer and anybody who bills us in their own name or under a name got one of those copies.

MR. RICHARDSON: Summary that's on the top --

MR. KOZAK: In a different form.

MR. BATES: My problem was not in obtaining the summary.

MS. GREENWOOD: Lisa, was not a notice sent out advising everyone that they could obtain copies from the Secretary of State office?

MS. KERN: Correct.

MR. BATES: My difficulty wasn't really -- it was with obtaining the document itself.

MS. GREENWOOD: The notice, I think, read that the document was obtainable from the Secretary of State's office.

MR. THOMPSON: I guess the question would be, are you on record? Do you bill us?

MR. BATES: Yes. Frequently.

MR. RICHARDSON: Then you got some -- thank you. So, the next speaker will be Pauline Hanson. Pauline?

MS. HANSON: Are there certain issues that can be discussed today, Mr. Richardson?

MR. RICHARDSON: This is a public hearing regarding Series 20, proposed regulations for the protocols and guidelines for the treatment of selective workers' compensation injuries. Series 21, regarding guidelines for controlled substances. And Series 22, regarding guidelines for psychiatric permanent impairment evaluations, evidence and ratings of psychiatric impairment due to workers' compensation injuries.

MS. HANSON: Well then maybe I'm not going to be able to speak because my questions were like on collections. So, maybe I'm not going to be allowed to speak if it doesn't pertain to this.

MR. KOZAK: What you may want to do is hold that until after this public hearing is over.

MR. RICHARDSON: Let us complete our public

hearing and we would certainly welcome comments or thoughts from anyone at the close of the public hearing on anything generally. But we need to stick to the subject during the public hearing period of our subject.

MR. THOMPSON: Andy, I would like to hear another example on that 16-3.2A. It was given from the other end of the table there, I think.

MR. RICHARDSON: Before we do that, if it's okay, and Pat if you'll hold that thought, let me ask if any of the -- there were a couple of folks listed as maybe and I would like to give them an opportunity if that would be okay, Paul.

MR. THOMPSON: Yes, sir.

MR. RICHARDSON: To offer their comments and then we can hear from Pat and or Dr. Tully regarding any of the actual recommendations of the Health Care Panel. After that we can adjourn the public hearing and get off the dime on the transcription process and hear any other comments.

The yes -- that's all we have that have expressed yes. I have Carol Salazar, physical therapist

from Putnam County. Would you like to speak?

MS. SALAZAR: Yes, please.

MR. RICHARDSON: Please come forward.

MS. SALAZAR: I'm Carol Salazar. I'm the director of rehab services at Putnam General Hospital. I've done a variety of physical therapy from home care to rehab to nursing home and now acute care. So, I think I have a little bit of experience when dealing with several types of injuries.

I just wanted to reiterate my mixed point about obtaining this document. It was really a very difficult thing to obtain. Thankfully a colleague in Martinsburg was able to obtain it and he copied and distributed it to us at our last meeting. I'm the co-membership chair for the state and I would be more than happy to supply anyone with a list of physical therapist for the entire state. This document came as a huge surprise to all of us who are in all aspects of care for the entire state. So, notices may have gone out but either the administrators are hogging them or we're not getting them. My CEO had no idea that this document existed, neither did my CFO.

So, on that note. Anyway what I would like to -- one point I wanted to bring up was the point that Nick made was the difference between protocol and guidelines. And I understand that some of the more specific things to do with pharmacological agents and things need protocols but it seems as though it's subjective.

How do I know when I call workers' compensation that that case worker understands the difference between a protocol and a guideline? How do I know that they're capable of making an objective decision based on -- well, we understand it says seven pounds for seven days but this is just a guideline? How do I know the next time I call that person won't say, "Well, according to these rules it says you're supposed to do this."

So, I'm concerned with the subjectivity of some of these guidelines and I want to make sure that all of your staff understands that they're guidelines versus protocols and that kind of thing. The intent may be as a guideline, but I'm not so sure it will trickle all the way down to the people I work with every day.

So, that's a concern.

Unlike Nick, I am going to go line by line but I hope that I won't be too boring. If we look at Page 14-D at the top, this is dealing with -- basically my point for this is this happens to deal with cervical muscular ligamentous injury. My concerns of the whole document is in some instances they make specifics to physical therapy, occupational therapy, etcetera, referral. But in other instances the guidelines state physical modalities and/or rehabilitative procedures may be helpful.

In some offices, chiropractor's offices, physician's offices now, there are secretaries and non-trained people doing rehabilitative procedures and billing for those things. If this was in a physical therapy office, it would be done my a trained professional.

So, I'm concerned with two things. One, who is doing the modalities? Are they trained? Is there a license number attached to who is performing that procedure? And also does this mean it is a physical medicine referral or is just that someone has an

ultrasound machine in their office and their giving ultrasound treatment.

Further on in the document, there are specific instances where it says physical medicine referral but it's not consistent throughout the document. So, I'm concerned about that.

The other concern I have is, in several of these different injuries it talks about waiting four weeks, waiting 30 days, before an appropriate specialist is consulted. What happens when that worker comes in the emergency room with a neck injury and they're given medication according to the guidelines and they go home and sit for 30 days? There is no reference here that they should be referred to someone and should be looked after for 30 days. Is the caseworker going to call them on the 31st day and say,"Are you better? What have you done for 30 days?" Or should there be something indicated in here that a referral to someone needs to be made.

You know an ankle sprain can be healed in a week if the appropriate person is brought. And, so, if you've called in the right personnel, you've gotten

that patient back to work in a week. Whereas if you didn't, they're home 30 days on workers' comp's tab. So, early referral is real important.

And I don't know if that should be a guideline from the start. I'm not sure it needs to be a surgical specialist and I'm trying to educate my ER doctors that just because someone comes in with an ankle sprain doesn't mean they need an orthopedic surgical consult. Sometimes if they just refer them to PT right from the ER, they're set. You know, I can a apply the vice principle and they're back to work within a week. So, it just depends. But I think you need to consider that. There seems to be a lag time between injury and when you look at that patient again.

Again on Page 15, the gentleman that had a question about cervical traction he's left and I was hoping I could help him with this. I'm glad again that this is just for example. But again, in this instance there's no referral here to physical therapy. Where are they going to get their home traction unit? Are they going to go down to the local pharmacy and get a traction unit to take home? Who is going to instruct

them?

MR. RICHARDSON: Ms. Salazar, he'll be right back.

MS. SALAZAR: We can go back to that. We have a lot of DME people who some are more ethical than others. We may have a run on home cervical traction units and you'll see the price go from $20 to $200 if this becomes a guideline. Home cervical traction isn't always indicated and if you look at physical therapy studies, a lot of -- this does specifically say bed but a lot of over-the-door traction is not effective, especially at seven pounds. So, I'm concern about the specifics of that and also who is giving away this equipment. I don't necessarily want to become a DME vendor but by all means, I would much rather I instruct my patients in home traction than a high school student who happens to work at the local pharmacy.

Now, referring to Page 19. This is a low back musculoligamentous injury sprain/strain under Section 17.4.2, inappropriate treatment, home traction. I might have to go to jail but I give several of my people who have ligamentous injuries traction. I think

this is something that is too specific and home traction may not be indicated but certainly --

MS. POSEY: For low back strain you do that?

MS. SALAZAR: For low back strain, absolutely.

DR. TULLY: Well, the neurosurgeons and the orthopedists tell us that it's ineffective.

MS. SALAZAR: Well, I can tell you that I can pull records of many, many people who come to me with low back strain who may not have palpable paravertebral spasm but definitely have interspinous spasm than none of my modalities can reach and the only way I can get to that spasm is to give them static traction. And they're like new human beings when you get them off the table. Home traction for that injury may not be indicated. That's very expensive. Home traction used for the lumbar spine if you get a good traction unit, you're looking at 400 or $500.

MS. POSEY: And for strain/sprain I think that's inappropriate. I don't think that's an issue.

MS. SALAZAR: It may take one visit to my office and one session of pelvic traction to get enough

of a stretch to make it worthwhile and that certainly isn't --

MS. POSEY: If you will notice 17.4.1F would cover your traction and I think they were correct that home traction is inappropriate, period. So, I don't that really should be an issue.

MS. SALAZAR: If we look at Page 22 at the top of the page, the inpatient treatment of disc. There's is no indication there -- there isn't any inpatient treatment for physical medicine. So, I'm just concerned with this, if someone is admitted with low back, will they meet the criteria for admission? Does that mean I can't get an inpatient referral or I won't meet the criteria if I get one? I have also treated several people who were admitted for one or two days because of intractable back pain who get treated by me with ice and modalities and exercise and go home feeling much better. So, we're not listed on there and I'm concerned about that.

Again, on Page 23 when you're looking at complicated after wound infection. And D and E, physical modalities and/or rehabilitative procedures.

Is that by referral or is that someone in the hospital or in the office doing that treatment? I think that needs to be specified.

Page 24 for lumbar fusion. It talks about the indications for lumbar fusion but it does not indicate anywhere in here that physical medicine is necessary. And again with someone who has had back surgery, physical medicine is definitely necessary to get them moving again and functioning.

On Page 26 at the very top of the page it talks about -- I'm sorry skip that. One thing Nick brought up that I would like to also talk about is the appropriate -- actually it's on Page 26, 20.4, the guidelines for appropriate specialty referral are as follow. One thing I'm concerned with is that -- one thing that frustrates me is I have some very complacent physicians who my patients go see once a month and they say, "Keep going to PT. Keep going to PT." And I keep saying, "PT is not helping." Is there someplace in this document where I can refer? Why can't I call workers' comp and say, "My patient is not getting better. He's been six months, once a month to this

physician who prescribes PT and medicines. Something else needs to be done."

It seems like my patients say you're the only one who will listen to me but I have no credibility when it comes to workers' compensation. You're not alone. I can decide what I want to do with my patient and prescribe his treatment for his back pain but I can't call you and say, "Boy, you're really wasting your money at a hundred bucks a visit to this doctor. I think you ought to try something else."

I think there needs to be more two-way communication. I'm there seeing my patient three to five days a week. I know what's going on with my patient. I'm not saying they're all bad physicians but there certainly are some that are not listening. And I would like to be able to pick up the phone and say, "Okay, caseworker we need to do something about this."

We do that all the time in our hospitals. We're working with medicare guidelines. I can go to my physicians and say, "This isn't working. Can I try something else?" I think we need that kind of communication with the workers' comp system. You know,

I'm not alone. I know many other PT's who are just frustrated by the whole process.

MR. EPPS: I don't mean to interrupt your testimony but I guess my question -- I think you just answered what I was going to ask. In your relationship with the patient and the physician, what's different between workers' compensation and patients that you serve that aren't being funded by workers' comp? What's the difference?

MS. SALAZAR: There isn't much difference except that --

MR. EPPS: You spoke about the relationship between you and the physician and the inability maybe, I mean, the idea that the doctors says keep doing PT. My question is: How is that different with workers' comp as opposed to your treating of a patient that isn't covered by workers' comp that's covered by something else?

MS. SALAZAR: I think some of the difference is, for example Aetna. I'm on the phone almost everyday with Aetna. Aetna will only allow me to treat, for example, maybe for four sessions before we

have to talk again. And I think this idea of case management is a very good idea as long as it's consistent. With Aetna they will tell me, "It doesn't sound like they're getting better." Or I can call Aetna and say, "They're getting better. You only gave me four, give me two more and I know I can get them cured." So, I think there's that communication, which we've never had.

So, if your idea is to implement case management and that kind of thing, I think that will help that. But it seems like if I don't have MD or DO after my name a lot of my credibility is shot because I'm only the PT who said something. Whereas I may be the only one involved in the patient's care who has given them a thorough exam. So, that's my point.

Page 26. Now, we're talking about shoulder complex, the failure of improvement or resolution of symptoms with conservative treatment for four weeks. Again, there hasn't been a PT referral. What does that mean? Does someone strain their shoulder and go home for four weeks? What's conservative? If someone has a simple shoulder strain and they come into therapy, they

may be back to work in a week.

So, again, I'm concerned about that four weeks. That's a long time. Some conservative treatments are heat and rest and that may be fine but four weeks is an awful long time for a simple musculoskeletal strain.

Non-operative fracture subluxation on same page 20.5.1. Physical therapy beginning on four weeks and continuing up to six months. That perimeter is kind of limiting but it should be okay.

My other problem was on Page 28. Adhesive capsulitis 20.5.5. Physical therapy tried one to six weeks. With someone with a pure adhesive capsulitis, six weeks may not be enough time and I'm concerned that that limitation. Again, you know, we may be able to call and say we're almost better but I'm concerned with that time limit.

For rotator cuff tear back on Page 27, 20.5.4 physical therapy following surgery -- excuse me that's B -- physical therapy following surgery three to six months at decreasing intervals. Right now the standard protocol for my orthopedic surgeons is absolutely no

active movement for our rotator cuff repairs for six to eight weeks, completely only passive motion to 90 degrees only in flexion. So, I'm very concerned about that limitation. It may be three months before my patients can actively scratch their head for the first time. The docs are really limiting their rehab because of their surgical procedures and so having that kind of time-frame may be very limiting on returning the patient to work.

Page 29, 21.3.3, carpal tunnel. Response to rest, splinting of wrist, steroid injection. Again there's no reference made here to any physical medicine referral. Who is giving the splints? Who is instructing on rest and application of splints? Page 30 in regards to carpal tunnel again, 21.6. The appropriate treatment consists of the following -- non-operative there is no indication for a physical medicine referral in that section at all either.

Page 31, surgical intervention -- excuse me, down at the bottom of the page, letter A. Surgical intervention is indicated by presentation and intraoperative findings. And then you have B, home

health care rehabilitation. I think that the committee is limiting themselves with home health care rehabilitation for a carpal tunnel or any kind of surgery for that does not necessarily need to be done at home.

MS. POSEY: I can tell you how this came about. The example is, you have a person who has carpal tunnel and has surgery and they have an arm missing and therefore could not give themselves self care. Therefore, someone might need home health care in the sense of homemaker duties and so on. It has nothing to do specifically with treatment. It's an example of when there's a compromise of activities of daily living due to some problem with the unaffected limb.

MS. SALAZAR: Okay. When you go down that list it talks about rehabilitations and then you have another series of A to E. If that's the concern and you want to refer someone ti home health, I think you need to indicate that there will be a rehab referral. I wouldn't want a home health aid going into the home and performing these series of interventions on someone

who was just recently postoperative for carpal tunnel. So, it does say rehabilitation but again it doesn't say by whom.

On Page 34, non-operative treatment again of the knee. It does not in 23.2.1, letter C, physical modalities and/or rehabilitative procedures again do not specifically indicate whether that's a physical medicine referral or who is giving that care.

Page 35, outpatient non-operative treatment, 24.3.1. Again physical modalities and or rehabilitative procedures, there is no indication as to who is delivering the service.

I think that is all.

MR. RICHARDSON: Ms. Salazar, you would do us a great service if your comments would also be prepared in writing --

MS. SALAZAR: Okay.

MR. RICHARDSON: -- and submitted according to the advertisements in the regulations. Are there questions?

MR. EPPS: I have a comment. I commend you for being very thorough in going through this.

MS. SALAZAR: Thank you. Sir, is there anything I can help you with the cervical traction question?

MR. THOMPSON: No. I just wanted to hear another example. It was listed under 16.3.2.

MR. RICHARDSON: Don't lose that thought, Paul. Well, thank you very, very much for your comments. Thank both of you for taking the time to come today to make these comments. The only other maybe that I have listed is here is Scott Lloyd.

MR. LLOYD: I would like to say something very quickly. My name is Scott Lloyd. I'm an attorney for the United Mine Workers, District 6. I handle all of the workers' compensation cases for union members in the northern panhandle of West Virginia who are dues paying miners in that union. Presently we have about 1,200 files, 400 of which are actively in litigation at the Office of Judges, more are mute, just in the preliminary stage.

Obviously my opinion is going to be a little bit claimant skewed and I want to point out one thing that some of things I'm going to say. My position with

the United Mine Workers is a salaried position. I receive the same amount of money regardless of how many cases I have. So, what I'm about to say is not indicated based on my fear of not getting a certain amount of recovery from a case or something along those lines. A lot of things I'm concerned about, our district doesn't even take fees on, such as temporary total disability awards.

Now, most of my -- I'm going to state these as concerns. They're really questions because I don't know how this is really going to work in implementation yet. And I'm all for -- like everyone else has said here -- I'm all for some sort of changes to help these people get quick treatment and back to work as quick as possible. The biggest problem I've seen in the years that I've been doing this is the inability to get treatment, appropriate quick treatment, which causes lengthy periods of disability, which makes rehabilitation -- and I think that any of the physical therapists would agree that when they get to them very late, there's not as much that they can do for them at that point in time.

But basically let me just -- I'm not going to go line by line. I made a few notes of a few areas and a few phrases that caused me concerns. In the rules on the treatment for the certain kinds of injuries, there are a lot of statements such at the end of the proposed treatment that the claimant should be fully recovered or have no limitations after this type of treatment.

Now, I don't know what exactly that means. I'm concerned of a crossover as to how that will be used in a sense of will -- if the treating physician sees these phrases, is he going to be afraid or somewhat hesitant to continue sending 219's down and recommending treatment if his client is not better because he wants to make sure he gets paid? Where I'm from, we're having a hard enough time keeping doctors on -- treating our people, especially psychiatrists -- I'll get to that in a minute.

It's hard enough to get these people seen and the biggest concern I spend -- I spend half my time with doctor's offices trying to help them get paid and they don't want to see clients that they think they're not going to get paid on. And I'm concerned that when

they see a guy who should be fully recovered within four weeks and they don't think he is, what are they going do? Are they going to return him to work against their better judgment or are they going to back off? What are they going to do? That's my concern.

I don't know how it's going to work in practice. I don't know if there will be any crossover between them and your agencies. Second, what if, let's say for some reason a claim is closed on a temporary total disability basis for one of these types of injuries that says he should be fully recovered within four and let's say it's closed because adequate information was not provided. If you file a reopening application from this physician, are we going get answers back that treatment modalities have been expended and the anticipated period of disability has expired, therefore, you should not be on anymore temporary total disability benefits.

I'm concerned about that because I think everyone, I mean, we have so many back injuries in the coal mine and everyone is different. Some go back in two weeks. Some of these guys are 55 years old and

have been bending for 25 years in the coal mine. Their back was already -- it's had so much degenerative disc disease or what have you in there before they had this injury, it's a lot different for them than it would be for a 22 year old who lifted something and had a minor injury and bounces right back and he's back at work. And plus, is he returning to a coal mine or is he returning to an office? That's a big difference and I am speaking solely for the coal miners. That's why I'm down here and that's our biggest concern.

Moving to the psychiatric guidelines. I realize that that is, even as a claimant's attorney, you know, I'm not -- I didn't just fall off the turnip truck. I read some of those reports; they bother me. I mean, I'm not going to sit here and tell you that -- I won't lie to you and say that I haven't tried to use them as a claimant's attorney but they do bother me. You know, I have to; it's my job. But there are some concerns there but my biggest concern -- I'm going to be honest -- my biggest concern is the type of report you're asking from these doctors -- we have a very hard time getting psychiatrist in the northern panhandle to

even see people that we think legitimately need psychiatric help. And I'm afraid that when they read -- when they read the type of report that you're requesting from them, they're going to feel that that is too much for what they get paid or don't get paid or whatever and they're not going to do it properly. That puts our claimants in a disadvantage.

I kind of noticed a conflicting -- and this is where I'm going to try to kind of point out a couple of lines here just once. On the definition section of the psychiatric guides when it talks about temporary total disability. It does give a definition for temporary total disability under the psychiatric guide, inability to return to your job essentially. Then when it goes to Page 6, C at the top it basically says -- and I'm paraphrasing -- but you can't temporary total disability on a psychiatric unless you're hospitalized, if you read that. That's the way I read it. Maybe I'm misinterpreting it but it seems to me that those two are kind of conflicting.

If you're going to define temporary total disability and the definitions, then a psychiatrist

ought to be able to put a person off of work for something other than a manic episode requiring hospitalization or, you know, something along those lines or extreme depression. Because I know our doctors, the doctors that I've dealt with find a lot of times that, you know, they don't want to put them in hospitals but they need to be treated and they need to go through a plan and work often times is part of the problem for them. You know, especially in the coal mines when you're working mandatory overtime, swing shifts, nighttime, daytime, all the time, sometimes it doesn't benefit them to be back to work and I'm just concerned. I may be reading more into it than what it says but they appear to be a little bit conflicting, if you just read them on the surface.

The other thing that bothered me and I'll give another section here, 85-22-5, 5.2, deals with the independent evaluator.

MR. RICHARDSON: Where is that?

MR. LLOYD: 85-22-5, 5.2. I didn't write the page number. I'm sorry about that.

MS. GREENWOOD: Page 3.

MR. RICHARDSON: Go ahead.

MR. LLOYD: Talking about an independent evaluator and I've assuming -- I don't know whether that means his treating psychiatrist or does that mean for disability purposes and if it means only for disability purposed, I'm confused by -- let's say you have a standard claimant now that's off six months with a herniated disc and he may never go back to the work he was doing before and he's pretty depressed about it and his MD says I think you should see a psychiatrist for a little bit. He goes over and he sees one. This doctor now under the rules now can get up to 10 visits without prior authorization. So, he starts treating him on those 10 visits but after the third he has to provide a report and then he'll be referred out to a --

MR. EPPS: Commissioner or psychiatrist?

MR. LLOYD: Eventually that commissioner or psychiatrist is going to give either a maximum improvement disability rating, what have you. From reading that, it sounds like that his treating psychiatrist would be given very little credence in any opinions he may have towards his level of disability

because he is -- the way that's written -- he is biased or because he treats this man primarily, he's not an independent evaluator. That concerns me, because like I said, it's hard enough to get these people in to see anyone let alone when it comes to the disability portion of a litigation or whatever, if that person is going to be -- these guidelines, protocols, whatever are going to be used in determining the weight or credibility of evidence because he happens to be a treating psychiatrist. That's going to hurt a lot of our people as far as maximizing their recovery on a claim and that's what they want to do.

MR. RICHARDSON: I can't find what you're referring to. Are you referring to the objective evaluator?

MR. LLOYD: Just a moment.

MS. GREENWOOD: Bottom of Page 3.

MR. TUCKER: The examiner should not be a treating physician or vice versa. Is that your concern, sir?

MR. LLOYD: Yeah. The psychiatric examiner should be an objective evaluator who has no conflict of

interest and no prejudgment regarding the claimant's condition or the presence or absence of impairment. Bias in an examiner is an inherent risk performing these examinations and self-scrutiny. And then it -- let's see -- there is a tendency to identify with the referring sources. I don't know what that means.

MR. RICHARDSON: Let me see if I can clarify this. I didn't write this. This was prepared again through the Health Care Advisory Panel and in fact a subgroup of psychiatrists. But what they are saying is that a psychiatric evaluation should be conducted by an objective evaluator and then it goes on to spell out in Sub-A those type of things that might be characterized as pro-plaintiff evaluation bias. And in Sub-B, those characteristics that might be pro-defense evaluations. And, you know, I'm not sure I really understand --

MR. LLOYD: What I'm saying is, I'm not grasping by this statement in here -- I'm not grasping by this statement in here, I'm not grasping, you know, certainly there is going to be no affect on a psychiatrist being able to treat an individual. What happens when he gets his disability evaluation by one

of your physicians, one of the commissioner's examining physicians and that doctor says, "Well, he's got dysthymia It's directly related to this injury or post-dramatic stress and he's got a 20 percent permanent partial disability from this. We think he's maximally improved. He's not going to get any better. He's going to require treatment on and off for many years."

My client wants to litigate that. Based on this, I'm concerned about an overlap of evidentiary weight or credibility if the only guy he can use is his treating psychiatrist. He can't afford to go to another independent evaluator. He can't afford two or three like the employer can. He can't do that. So, he's got one and that's his treating psychiatrist. And I'm concerned about the way some of these things-- I guess it goes back to my original point, I'm not sure how these are going to work when their actually implemented. And I'm concerned about a little bit of crossover between the medical portion of your office filtering into the litigation portion of either the Office of Judges or initial decisions by your office

because of these guidelines.

MR. RICHARDSON: So, your concern is that these types of objectivity issues would chill the consideration of the treating physician's opinion on the extent of the psychiatric impairment?

MR. LLOYD: Either they would be afraid to render it or it would -- the fact of rendering it, my fear is, would make no difference anyway because of the way these guidelines are written, much more credence would be given to the one-time evaluator.

MR. RICHARDSON: I understand.

MR. LLOYD: And I don't feel that -- with a psychiatric condition it's a little bit different when you're saying, "The guy has herniated disc L-4, L-5." You plug that into --

MR. RICHARDSON: I understand now what you're saying. And I think it's a point that needs to be addressed by the panel and given consideration.

MS. GREENWOOD: I may shed a little light from several years ago, three, four maybe when the psychiatric sub-panel was meeting. The concern here and this thing strings on if you notice 5.2 for, you

know, two full pages plus a little bit, was to spell out that the focus was really on the examiner and not the interchange between the treating and the examiner.

MR. LLOYD: Uh-huh.

MS. GREENWOOD: But to spell out, put out front potential examiner by biases as spelled out here, pro-plaintiff, pro-defense which biases are there and to display those in this document. There was no thinking at the time of diminishing the treating.

MR. LLOYD: I understand but in reality the only true independent doctor who fits into this category is yours.

MR. RICHARDSON: But the reality is, Scott, that our -- the people that do independent examinations for the division also have plaintiff oriented practices and defense oriented practices. And consequently when they conduct an independent evaluation, we want them to be cognizance of the potential for a pro-claimant oriented bias or a pro-defense oriented bias. I think that was the goal there. How many psychiatrist are there in West Virginia?

MR. LLOYD: I mean, I'm going into Ohio now

for psychiatrists.

MR. RICHARDSON: When you look at the pool of psychiatrists that you draw from, it is a sufficiently small enough pool that the independent examination process -- there's not a pool of psychiatrists over there and all they do are independent exams. In fact, most of them, in all candor, on any given situation may have conducted evaluations relative to an individual with a plaintiff or claimant oriented perspective, as well as a defense oriented.

MR. LLOYD: I don't want to belabor the point but that was a concern. The other thing and this just may be my own -- I didn't quite grasp. I think it's in the same section somewhere where it talks about claimants' doctors' reports, I believe, and it essentially says don't use big words. I mean, that's essentially what it says. And I'm wondering, whose benefit is that for. I mean, psychiatrists, I can't even talk to them half the time because that's all they do use. I mean, I have to go -- whether it be yours or the employer's or mine. You know, when you're talking

about manic depressive episodes and -- whose benefit are they talking about? Don't use big words. I mean, my question is, why don't use big words? Their profession uses big words.

MS. POSEY: I think you're talking about use of conclusive terms and statements based on the unclear named tests that place controversially or nonspecific categorical terms. See, they're using big words --

MR. LLOYD: This is the one I'm talking about, use of numerous medical eponyms and jargon that are not explained in the text of the report and are not obvious to the reader.

MR. RICHARDSON: Where are you?

MR. LLOYD: The same section she was quoting from but a little further down. Page 4, H. I mean, it's a minor point. It's just my question, what is the that? I mean, if the guy is going to use a medical definition, does he then have to go back and explain what posttraumatic stress syndrome is to someone. I mean, that's what it sounds like to me. And I don't know whose benefit that's for.

MS. GREENWOOD: This was a whole exercise

section of the psychiatric sub-panel trying to work as a panel and reconcile their inner-differences. None of it is really--

MR. LLOYD: The last thing -- I'm going to get out of here -- but the last thing I wanted to say, again, I started by saying that I'm all for and my clients are all for and my client, The United Mine Workers, is all for aggressive treatment, aggressive therapy, quick therapy, quick return to work. I'm not going -- I'm not here to just keep them off -- I don't get paid to keep them off.

The question that I'm concerned about is -- and I'll give you an example -- when you have a lot of hands in the fire, so to speak, a lot of people telling what's appropriate, what's not appropriate in these guidelines. In our typical case, we've got someone from employer service, we have, you know, a physical therapy place, we have the doctor, we have the, you know, the commissioner, maybe the treatment team now, all these people. And then you have a claimant.

An example of a gentleman who had a foot crush injury, was off on total temporary total disability,

was doing everything, had no lawyer for quite a long period of time, almost the first he was off, doing everything that was requested of him -- no disrespect to the physical therapists here, I don't mean to do that all -- and they tried him on aggressive physical therapy. That was the goal with employer services. Get him in there; get him back to work. Get him on the treadmill. Put his work boot on. Get him going. He kept telling everybody, "I'm hurting. I can't do this. There's something wrong with my foot. There is something wrong with my foot."

This goes on and on for almost a year until he finally gets to another specialist after he got a lawyer -- I'm not saying that had anything to do with that, maybe he would have got there anyway -- but the gentleman has problems now that may never be fixed. And going towards disability and the funds financial situation, had he got to the right people first off, he may not have near the degree of permanent impairment that he's going to end up with because of the long period of time and the leaning towards just physical therapy. Hurry up. Get back to work. Don't send him

to any of these other doctors.

And I like I said, I'm all for that as long as people -- and I think the physical therapists said that, too -- most of them if things aren't getting better would like to have the authority and I would like them to be able to say, get him to another doctor. Get him out of here. We're not helping him. And I think that would be very beneficial to my people because in every profession from lawyers to doctors, yeah, there's a group of people that aren't up to snuff. Everybody knows that. There's is nothing we can do about that.

But on the whole I would like people like her to have that authority to be able to do something like that or call somebody and say, "We're not helping," before this gets any worse. If it's something like RSD that has a window of treatment, you know, let's get him out of there and get him to a specialist. And as long as these in practice work that way, and some of the concerns are addressed, then I think it would be a good thing. But I'm just afraid of some of those items. That's it.

MR. RICHARDSON: Questions for Mr. Lloyd? Scott, thank you very much. Your comments are well thought out and would you please again prepare your written comments for consideration.

MR. LLOYD: Sure.

MR. TUCKER: Commissioner, I got a question. Maybe somebody could enlighten me, maybe somebody from HCAP or Dr. Tully. Why do we get into putting in on Page 4, 5 and 6 about--

MR. RICHARDSON: Where are you? On the psychiatric?

MR. TUCKER: Why do we get into putting in A, pro-claimant evaluation biases and B, pro-defense evaluation biases. Why do we get into that in putting those into a rule or a guideline? Why do we do that?

MS. POSEY: I think Judy had already answered that Fred.

MR. TUCKER: Maybe I missed it.

MS. POSEY: Yeah, I think. She said when the sub-panel worked on this material, they were aware among themselves as people who did exams for employers or employees that there were certain things that might

crop up in a report that didn't have a place there as an objective report. So, they wanted to be specific about what people should be aware of, show them up as nonobjective.

MR. TUCKER: But to me what you're doing is putting something in there that muddies the water, causes more litigation, you know, causes more confusion. Now, in all due respect to the psychiatric panel that entered this in, you know, this is the problem that I've experienced in psychiatric treatment of claimants is the fact that we get into all this B.S. and stuff, you know, put it in here to start with. You know to me and all due respect to the HCAP panel, you're creating problems.

MS. GREENWOOD: But the physicians who work on this from both sides that had -- that knew their own predispositions and those of their co-colleagues on the panel, all of them wanted to spell out, to put it on the table to make it clear what they should be looking for in reading reports. There was no disagreement between the psychiatrist that may do a few more claimant than the defense evaluations. We can take

this back to the psychiatric sub-panel and have them review it, given the comments.

I'm just giving you the history of what they were resolving within their own sub-panel and a amongst themselves.

MR. TUCKER: I would like to clarify -- maybe for ignorance -- why we needed it to start with. I'm a layman.

MS. GREENWOOD: I was just giving you the history, we can take it back to the sub-panel and have them reevaluate the placement of that particular part of the rule.

MR. RICHARDSON: Other questions or comments by the panel members? Now, Mr. Thompson you had a question on the physical --

MR. THOMPSON: I forgot what it was now.

MR. RICHARDSON: I think that if I recall correctly it was on Page 15 of the Series 20 proposal regarding protocols and guidelines for the treatment of selective workers' compensation injuries. It had home cervical traction and then a such as or e.g. in bed, seven pounds, two hours, four times a day, for seven to

ten days. You had asked Ms. Posey if she could possibly give other examples of that.

MS. POSEY: Well, I think a physical therapist would be in a better position to say what another example would be but maybe in bed with five pounds for one hour, three times a day for four days or something. Would that be -- it would be that kind of thing.

MR. BATES: I would be very happy to provide those professional services to the gentleman on the end of the table.

MS. SALAZAR: I don't think you need for example.

MR. RICHARDSON: We understand that, but he did ask for another example.

MR. BATES: There's a huge variation in the amount of force, length of time, in which something would be applied depending on the particular sort of problem with the spine or supporting structures that you were trying to treat. Anything more than about 25 might give you some concerns. Anything less than or around about five or seven, you're not going to be

doing too much at all. That's very broad, very general.

MS. POSEY: I think what the panel wanted to avoid was the idea that you send somebody home with a traction apparatus and said, do traction. They wanted a prescription by a rehab professional, physical therapist, to say what should be done.

MR. RICHARDSON: And maybe the right way to deal with that is to say in the rule that that prescription or the treatment must be articulated or something.

MS. GREENWOOD: There should be a prescription, make a generic statement rather.

MR. RICHARDSON: Mr. Thompson, did that respond to your question?

MR. THOMPSON: Yes.

MR. RICHARDSON: Other panel members, any questions, comments? After having heard comments from -- does anyone who expressed on the sign-in sheet that they did not wish to speak, has anyone reconsidered and now decided they would like to speak?

Well, then I want to thank everyone in attendance for taking the time to be here today.

Personally, I think that the insights will be useful in the further refinement of the proposals from the Health Care Advisory Panel. Again, comment period remains until --

MR. KOZAK: May 1st.

MR. RICHARDSON: Comments are to be sent to --

MR. KOZAK: Attention: Lisa Kern, Post Office Box 3922, Charleston, 25339.

MR. RICHARDSON: And with that, I declare the meeting adjourned.

(Whereupon, the hearing was concluded)

REPORTER'S CERTIFICATE

STATE OF WEST VIRGINIA,

COUNTY OF KANAWHA, to-wit:

I, Angela A. Robinson, Court Reporter and Subcontractor for Rebecca L. Baker, Official Reporter do hereby certify that the foregoing is, to the best of my skill and ability, a true and accurate transcript of all the proceedings as set forth in the caption hereof.

Angela A. Robinson

ANGELA A. ROBINSON, Court Reporter
Subcontractor for Rebecca L. Baker,
Official Reporter

BEFORE THE WORKERS' COMPENSATION PERFORMANCE COUNCIL

IN RE: PUBLIC HEARING ON THE PROPOSED GUIDELINES, SERIES 21, 22 AND 23

TRANSCRIPT OF PROCEEDING had at the public hearing in the above-referenced matter, held on Monday, April 10, 1995, at 10:00 a.m. in the Jerry West Lounge, West Virginia University, Morgantown, West Virginia, pursuant to notice.

ANGELA A. ROBINSON, Subcontractor

REBECCA L. BAKER
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REPORTER'S CERTIFICATE

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I, Angela A. Robinson, Court Reporter and Subcontractor for Rebecca L. Baker, Official Reporter do hereby certify that the foregoing is, to the best of my skill and ability, a true and accurate transcript of all the proceedings as set forth in the caption hereof.

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ANGELA A. ROBINSON, Court Reporter
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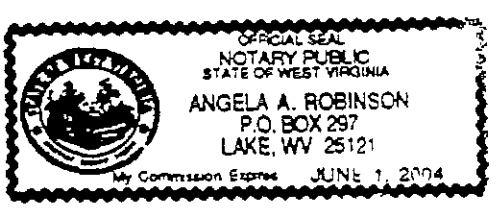

April 10, 1995.

MR. TUCKER: My name is Fred Tucker. We have some other members of the Performance Council with us that I'll introduce. I convey to you the apologies of the commissioner who had to attend a interim committee meeting in the state legislature on workers' comp. He sends his apologies. He will try to make the meeting in Charleston.

We have another meeting on these same proposed guidelines in Charleston, West Virginia, I think, this Thursday. But I would like to welcome everyone here. If you do want to speak we'll -- make sure you signed the roster. We'll just go down in the order you signed the roster. The information that I have, today we're here for the purpose of having a public hearing for comment on Series 20, 21 and 22.

Series 20 is the protocols and guidelines for the treatments of workers' compensation injuries under Series 20. Series 21 is guidelines for controlled

substances. And Series 22, psychiatric permanent impairment evaluations, evidence and ratings of psychiatric impairment due to workers' compensation injuries.

What we would like to do is if you are going to speak, if you want to address all three -- we've got some more people coming so we'll wait just a moment.

Once again I would like to welcome everyone here. The purpose of today's meeting is a public hearing for comments, written or verbal on Series 20, 21, and 22 of the proposed guidelines and treatment and protocol for workers' compensation under three entitlements. That's the treatment of workers' compensation injuries under 20, controlled substance under 21 and psychiatric permanent impairment evaluations and ratings and psychiatric impairment due to workers' compensation injuries. Those are the three.

We will be very informal today. As I said prior to some of you folks just coming in, Commission Richardson couldn't be with us today due to a

commitment. He had an interim committee meeting with the state legislature on workers' comp in Charleston. He sends his apologies. I would like to introduce you to the rest of the members of the performance council. To my right Mr. David Harris, Richard Humphreys, Thomas Rotenberry, my name is Fred Tucker and this is Mr. Everett Sullivan and this is our court reporter, Angela Robinson.

John, could I have the other list of those folks over there, please? Now, I will go down the list -- whoever wants to be first, it doesn't make any difference to me. Who wants to start the thing off? I've got a list the way you signed it, I can call your name if you want to speak you can feel free to do so or we could just start with the front row and come forward. It doesn't make any difference to me, whichever way you want to do it. Do you want to go off the list of how you signed in? Would that be fair?

William Walter?

MR. WALTER: No.

MR. TUCKER: Louise Hockenberry?

MS. HOCKENBERRY: Just observing.

MR. TUCKER: Tom Mansion?

MR. MANSION: No. Just observing.

MR. TUCKER: Vicky Legg?

MS. LEGG: I'm just here observing.

MR. TUCKER: Sue Hobney?

MS. HOBNEY: (Indicates no.)

MR. TUCKER: Tim Divine? Will you speak Mr. Divine?

MR. DIVINE: Yeah.

MR. TUCKER: Sit right up here. However you want to do it, just so this lady here -- make sure she gets your name. I would like also anyone that wants to speak, later on if you would, if you could as a privilege for us to reduce it to writing and send it to the members of the council, we'd appreciate it. Go ahead, sir.

MR. DIVINE: I don't know how you want to go about discussing the document. There's several

questions pertinent to the document that I have about the committees, about other things like that. If it's specific comments to the document you'd like right now, maybe at the end the others, it doesn't matter. Whatever order you would like to take them.

MR. TUCKER: Sir, like I said, we have three series that we're here to have a combined public hearing on. I guess whatever one of the three that you want to start with. If you just want to address one or all three, feel free to do so. And as far as questions, we have Mr. John Kozak, the general counsel with us. He may be able to help us in that endeavor but we'll try to answer any questions you have and maybe the council may not know because we have just, you know, received these things ourself and the purpose of it is to try to get you folks input. So, you go right ahead, sir.

MR. DIVINE: I guess the first question is, this is the performance council, right? So, you are the individuals who will be making the determinations

on any changes of this document.

MR. TUCKER: Yes, sir.

MR. DIVINE: And we don't have before us the people from HCAP, right?

MR. TUCKER: No, sir. I don't think there's anybody here -- yes, there is.

MR. DIVINE: One thing that I would request is maybe among the other documents that would be made available to the public would be the complete list of those individuals that participated in HCAP and their backgrounds and possibly how they were chosen or selected. We're from the Eastern Panhandle and I know that there are members of the Eastern Panhandle on the HCAP committee, no physicians or care people.

MR. KOZAK: I can address part of that. How they were chosen, the 1990 legislation created the health care panel and it just said that there had to be at least a minimum of five members to be appointed at the will and pleasure of the commissioner. And what he basically did is he tried to take a representative of

each of the specialty groups, subspecialty groups that dealt with workers' compensation claimant, particularly the folks that could come to meetings. They meet at least once a month in Charleston and a number of subgroups meet as subcommittees.

Normally what they'll do is, let's say we have an orthopedic problem, Bill Sayle, who's the orthopedist on the panel itself has a group of folks from around the state that he then corresponds with about whatever the issue is and then he reports back to the panel on behalf of that group. But I can get you a list of names. I have them with me as a matter of fact.

MR. DIVINE: That would be great. Another one of the things that seem to be missing from the document and I don't know if this is something that can be included or maybe sent out later at a different time but an annotated bibliography list of where the protocols and guidelines came from.

In other words, what is the scientific basis

behind the document. It looks like a lot of care and preparation has gone into the creation of the document but to be sure that this less or more than just a number of people's opinions. It would interesting to see the scientific data and then the bibliographies related to the conclusions. I had a question too I guess about and specifically the area that I'm most interested in as a physical therapist representing private practice is with the physical rehabilitation documents and that would be the one I would specifically be referring to.

And the question that I have is, I did see throughout the document that there is an indication particularly at the end that case management will be done anytime any of the perimeters have been exceeded in terms of the norms of care that the document discusses. My question is: Is this going to be peer-viewed? Is this going to be done entirely within the workmen's compensation fund or is HCX going to be the reviewer of this? I have some understanding from

HCX that they will be the reviewers, that this is part one -- the document passing is part one.

Part two, HCX will then put on, for example, a physical therapy peer review. Individuals around the state have already been talked to about being the peer reviewers. And then that goes back to on the economic page. It says, "Divisional experience and one-time training policy yearly, expenses thereafter for medical professionals to assist the division." Does that mean a contract with HCX?

I think everybody's anticipation was that compensation would be more a peer reviewed or with an agency or a state rather than outside the state. The other thing that I had a question about was what happens to these individuals at the conclusion when they've gone through the system, they've had their brief rehabilitative care? Do they automatically then go into vocational rehab? It seems to be one of the parts of our system that's excessively burdened with the return to work issue. There's just some typos in

the document but I don't know if those are so much important because I'm sure there will be an editor reading through that.

When they indicate physical therapy or physical rehabilitation or rehabilitation or outpatient treatment, who specifically is indicated by that? Is that by the State Practice Acts? Who can render that care is the question I would have. And specifically, I think and particularly going back to the annotated bibliographies that I spoke of, there's a particular protocol for all cervical patients where they receive home traction, 7 pounds, 2 hours, 4 times a day for 7 to 10 days in the initial protocol. I kind of have a question about that in terms of the scientific validity. And presently the workers' compensation fund does not frequently reimburse for home cervical traction. So, that would have to be a change in workers' compensation that they will now do that.

MR. BRAUTIGAM: Tim, I might just add right there that these weren't written as a protocol to be

followed. I think it was acceptable care and the thing is, everything even if it's written with regards to -- my name is Jack Brautigam and I'm from Morgantown Physical Therapy and I sit as an alternate or co-alternate member on the Health Care Advisory Panel. A number of different specialties including neurosurgery, orthopedics physiatry, psychiatry, family practice --

MR. DIVINE: Nursing, pharmacy --

MR. BRAUTIGAM: Nursing, pharmacy, workers' compensation sat down and developed these things. So, some of these things even when they apply to what you might think is a physical therapy related issue are suggestions of other disciplines and again they're not -- they're guidelines and they're not specific treatment protocols. I think that's the biggest thing to remember. Not everything is a protocol and if you're reading it like that then --

MR. DIVINE: It doesn't make a lot of sense.

MR. BRAUTIGAM: Right. Well, it doesn't make a lot of sense and plus it's not appropriate. That's not for everyone one. Basically, as I recall, that was probably a neurosurgical recommendation right there that some neurosurgeons like to take some of their patients and place them on home traction as a trial. And, again, whether that as a physical therapist that would be my treatment protocol or my treatment plan, which it probably would not be, it still is an acceptable plan to some of the other professionals on the panel.

MR. DIVINE: The question is how restrictive the document will be. I mean, as a source -- as a guideline it seems a fairly acceptable document but in talking to HCX, my understanding from the person I spoke with, that the document will become a restrictive document. That it will be something that will be held to.

In other words, even with the offering of physical rehab measures it very definitely spells out

when they're appropriate, when they're not appropriate and how long they're appropriate and what frequency they're appropriate. To me that's a fairly restrictive guideline. If we're willing to take these as a suggestion then I kind of wonder the importance of having such a document.

MS. HOBNEY: Could I say something there? Let me address that. I'm Sue Hobney. I'm a nurse with workers' comp that is now doing case management. I'm the only one they have right now, in the plans there are more. To address your question earlier about case management, the plan is for it to be in-house. That's what we're doing right now. Right now I work with Team 2, which a Marion/Monongalia County. HCX is not involved in any way. The claims' managers monitor them and they are in fact at this present already using the guidelines. And how it's being stressed is every case is different; we know that and these are only guidelines. And kind of how the process is evolving now is we meet once a week and that's myself with the

team and I'm now -- last week just started meeting with the Martinsburg Team, also. They're fairly new.

MR. DIVINE: Who is that? We have several rehab nurses that tried to get in touch --

MS. HOBNEY: With the claims team in Charleston that's going to be handling all the cases in the Panhandle area. So, I meet with them in Charleston. I have a list of their complete names but they're just the claims' members. What we do at this point is when they have someone that seems to be deviating significantly from the guidelines, they bring it to the meeting. We address it. If I feel like, as a nurse, I'm really not sure, you know, what is going on here. Why then, I also meet once a week with the medical support group which is subcommittee from HCAP that's made up of the orthopedic surgeon, the chiropractic doctor, the osteopath, Jack, a rehab specialist, a nurse and myself and a psychiatrist also. And there is to be a neurosurgeon on it, he just hasn't been able to attend. I make a copy of the

complete case, take it to them, they review it, and make their recommendations. What I tell health care providers is they also in turn have that same option. If a claims' manager would tell you, you know, you've exceeded the guidelines. I don't feel that more physical therapy is indicated. Then you can request that case management intervention be addressed and then it will be taken to the medical support group, which is physicians basically with myself and a vocational specialist and Jack as physical therapist.

So, it's very multi-disciplinary discipline. And it's addressed in that manner. But they are being used right now and they're simply being used in that manner as guidelines and as of right now, that's how we plan to continue to use them, not as protocol that it has to be stuck by. But in order for the system to work consistently, there had to be specific guidelines that were available to the health care providers because I think that's one problem that the health care providers always had previously with utilization review

when done by an outside company is that they were not given the information. They weren't made privy to these guidelines that they're supposedly following. And I think that's what workers' comp is trying to do, actually make it much better for the providers by making the information available to them that they're trying to follow and then that way everyone can work together a little bit better. But case management will be provided in-house is the plan at this time.

MR. DIVINE: Well, that may be the plan but I have some confusion then because I spoke with HCX before I came up here. We found this out through a physician that when a workmen's compensation claimant comes to our office after the first visit we have to fill out an HCX form, submit it to HCX. It is then reviewed. At that point we will be given the green light to treat or not to treat for a limited number of treatments. HCX has already contacted peer reviewers within the state. They're no longer doing utilization review which was in the past.

In the past, as a physical therapist, they were interested in my opinion about the claimant's progress. They would talk only to the physician and to the claimant. My question to HCX was: Why are you interested in talking to us now? And it's not because they are no longer doing utilization review but they actually have added a physical therapy department our specific case. I know one of the peer reviewers in the state now. He's been contacted to go to Charleston for a training period. I asked why we had not been formally notified in any kind of document. They said that they were not going to formally notify but that it was going to go out, "Word of mouth." And they are waiting upon the passage of this guideline. That's part one. Part two is, HCX will be doing physical medicine review.

MS. HOBNEY: Now, what you have to understand is the transition period. The claims' team for the Martinsburg area has only been up since, what, the first of February and they're not handling that

many cases as of yet. They're not handling every new case that comes in.

So, workers' comp cases are now being handled two different ways. What they call current state, which is any claims that were already opened prior to the claims' team in that area becoming active are being handled by HCX. HCX is intervening there. Any future state claims, which is how they're referred to, which are claims that are being handled by the new claims' teams, with the claims' management system that workers' comp is implementing. HCX at this time is not involved in any way. They don't do any authorization. They're not involved in absolutely any way at this time. So, it's very confusing to you as a provider because we're still -- while we're in transition we just have to handle them two different ways. Because as the claims' team is new and coming on board, why, they just can't handle every claim in that area. And it's confusing to you, I know, but once it's all evolved then it will be much easier.

MR. DIVINE: So, the information I received was incorrect and the form that they FAXed me to fill out with every new presentation of a claimant was wrong. I should not send that to them.

MS. HOBNEY: Well, it depends on whether that claim is being handled by a claims' manager or if it's being handled by HCX. Now, one way you can find that out is, just ask the claimant. If the claimant has a claims' manager, they will know. They may only be able to tell you their first name but at some place they will have their name and telephone number written down.

Also, and I don't know how your business is run but on the compensability letter, rather than being signed by the commissioner, if they have a claims' manager that compensability letter is signed by the actual claims' manager with her direct phone number and address. That's another way you can tell.

A little problem with that is though a lot of the larger facilities that letter actually goes to a

business office that's someplace else rather than directly to the office. But the claimant will know if they have a claims' manager because these claims' managers contact them immediately when they receive the 1, 2, 3 form. They also contact the employer and the physician immediately and they have contact, you know, fairly frequent contact with the claimant just to check and see how they're doing and so on and so forth. So, the claimants are familiar if they have a claims' manager.

MR. DIVINE: I'm never seen that document but is there a number that we can have that we can call and we can identify that directly rather than relying upon the claimant? Is there a number in Charleston or your number?

MS. HOBNEY: I can get that number for you because what you would need is the team leader for the team in your area and I'll have to get that number for you.

MR. DIVINE: And then they can tell us right

away whether HCX will be reviewing or -- you know, the difficulty is --

MS. HOBNEY: It is confusing but it's transition and any transition, you know, tends to be a little bit confusing. Workers' comp department has made -- just tried their very hardest to make it the least confusing as they can but the change is so dramatic going to the claims' management system and, you know, the feedback they've gotten so far, the areas where it's very active is just excellent. The employers, the physicians, the claimants, everyone is much happier with it but it's transition and it is going to be confusing at times.

MR. DIVINE: The case management idea is the most ideal of situations and that's probably our greatest concern is that we may or may not move fully to case management within the state rather than going to an outside firm such as an HCX which has been picked up and dropped by many states, including New York, as a non-cost-effective manner in which to deal with

claims.

I would like to know and if we could possibly get some kind of a guide as to the time frame that this hopefully will transpire and take place in. There is some confusion and I think maybe HCX needs to be contacted because they're giving out giving contrary information to that which you just gave me. So, that's a concern. The guidelines themselves are nicely generated. There's a lot of nice information if they're used as a guideline, I think that's an appropriate usage of them but if they become a restrictive guideline, I think there's a problem with that. I'll go ahead and let somebody else have the podium and maybe another couple of questions will come up. But that's my big concern. I'd like to see a better passage of information.

MR. TUCKER: We'll see to it, Mr. Divine, that your questions are answered. The panel may not be able -- but the information that you need, we'll see to it that you get that from the division.

John, what is the comment period for this? Do you know? We need to get that information. Like I said, we would like to have your written comment and I would like to make sure that you get the information that you need, sir.

MR. DIVINE: Particularly since this goes into effect without legislative action.

MR. KOZAK: The comment period ends at 5:00 on May 1st.

MR. DIVINE: And 30 days thereafter -- after the panel has reviewed it, it becomes law?

MR. TUCKER: Right. Like I said, if you don't get your information you need, you know, see to it that, you know, that the council -- before we take any action we will try to have all your questions answered, sir, to the best that we can. Okay? We appreciate your comments. Sir, I have one question. Do you have any idea how many of these particular situations are being handled by case management, what percentage right now?

MS. HOBNEY: I just happen to I have the March 7th claims' status report that I can give you. I don't have the April one yet. When I was in Charleston last week the computers were all down because of the move and everything. That's the March that gives the claims' status report of the seven teams that are up and actually last Thursday they graduated two more teams, teams eight and nine graduated and they have now started.

MR. SULLIVAN: Are they the ones, Sue, over in Martinsburg?

MS. HOBNEY: No. That's teams six and seven. They graduated I believe it was February. Team six is the Martinsburg, Eastern Panhandle. Team seven is the Wheeling, Northern Panhandle.

MR. TUCKER: But that is the -- what we're operating under right now is that protocol right now -- the team management concept?

MS. HOBNEY: Right. The claims' management concept. On team two and I want to say the first five

teams but I know the first four teams are now handling 100 percent of all new cases in their area and in fact are going back and taking over old cases or picking them up. But they are handling 100 percent of the claims.

MR. TUCKER: That's the new cases?

MS. HOBNEY: Right.

MR. SULLIVAN: Do you have a percentage of all claims that are being handled by the case management teams?

MS. HOBNEY: It's on here someplace but I'm trying to find where it was.

MR. TUCKER: Any of the panel have anything they want to ask that speaker? At this time I would like to introduce a late arrival. Mr. Paul Thompson is also a member of the council.

Janet Downey?

MS. DOWNEY: No.

MR. TUCKER: Karen Ash?

MS. ASH: No.

MR. TUCKER: David?

DAVID: No.

MR. TUCKER: Tom?

TOM: (Indicates no.)

MR. TUCKER: Dr. Vaglienti?

DR. VAGLIENTI: I just have a couple of specific comments. First, I would like to request that a copy of Title 85, Series 21 be sent to me so I can review it in detail to 99 J.D. Anderson Drive, Suite 4, Morgantown, West Virginia. Then a few specific comments with respect to protocols and guidelines for treatment under cervical disc herniation and lumbar disc herniation. Epidural steroid injections were not present and should be and are clearly cost-effective and scientifically proven to shorten return to work time and need to be included if not. My partners and I who treat chronic pain patients and some acute workers' comp injuries have had concern that physicians who specifically treat chronic pain were not part of the health care advisory panel.

We have made attempts through Jack Brautigam and through our local senators to see that one of us could possibly play an alternate role because we feel it's important and you gentlemen certainly know it's important because if you look at your numbers, a very few percentage of injured workers will come to need chronic pain management, however, they will consume the lion's share of available moneys out there, which may then rob money needed to treat those acutely injured workers who have a better chance of returning to work. So, we feel very strongly that this is an important omission which should be corrected if at all possible.

Secondly, with respect to the guidelines for controlled substances, I would say that in light of the fact that there is an absence on the advisory panel of chronic pain management physicians that this particular guideline be rethought and that in this day and age the use of chronic narcotics for chronic nonmalignant pain does not carry the stigma that it did at one time and is in fact very effective in a limited number of

patients. I would strenuously reject a rule which had a list of contraindications for the use of controlled substances specifically without any input. In dealing with chronic narcotic use on a regular basis and in only having the synopsis of the guideline to go by, I could really think of no contraindication to the use of controlled substances. Certainly no hard contraindications, perhaps a relative contraindication or two but nothing specific that would limit me from giving a person a pain pill if he needed it -- he or she needed it.

And in addition to that, I would like for you-all to know that through Senators Oliverio and Mansion, we will be attempting to introduce some legislation next year that makes it easier for practitioners to treat chronic pain of malignant and nonmalignant origin because we want to dispel a lot of the bad rumors and bad stories that are out there about the use of narcotics. Many people are very functional on small doses of oral narcotic and, in fact, some

could even return to work if it were not specifically disallowed by their employer or low doses of pain pills and this is done now throughout the world.

I'll take any questions if there are any, if not, I appreciate the opportunity to speak.

MR. HARRIS: Do we have a copy of Series 21 here?

MR. KOZAK: I brought a limited number with me and they're all gone.

MR. TUCKER: I can give him mine. You can have mine at the end of meeting. Do you have to leave?

DR. VAGLIENTI: No. I'm going to stay for a little while longer.

MR. TUCKER: I would be glad to let you have mine.

DR. VAGLIENTI: I'd like specifically to say that we're working closely with Sue and her teams to in-service and educate them about the use of chronic pain treatment facilities and their regiments and

really would like to be involved when that comes up. I know that Dr. Cochran, who is a physiatrist, has been working on some guidelines which we initially reject on their face -- that they're now how pain management is practiced in 1995 and we would appreciate the opportunity for input. Thank you, again.

MR. TUCKER: John, what did you say the comment period was?

MR. SULLIVAN: May 1st.

MR. KOZAK: 5:00.

MR. TUCKER: We welcome written comments too, doctor, if you so desire, sir.

MS. HOBNEY: And I might here go ahead and answer your question. I finally found it on here. As of the first of March -- so this number has already increased now that we're in the first of April -- as in the first of March, 20 to 25 percent of all currently opened total temporary disability claims were being managed by claims' teams. So, it's progressing along really well. So, that's increased by now even.

MR. TUCKER: Anybody else have any questions? If not, Tom, do you have anything you want to say?

TOM: No.

MR. TUCKER: Joe?

JOE: No.

MR. TUCKER: Mike Martin?

MR. MARTIN: I had one thing I really needed to clarify. The institution of case management that will be primarily for a number of treatments and it won't be so much for -- to make sure that -- what I'm trying to get at is the guidelines won't limit our ability to perform certain types of procedures or treatments.

MS. HOBNEY: The guidelines are simply that; they're guidelines. You have to understand and maybe that's what I think a lot of the providers don't understand completely, the whole transition process that's going on in the workers' comp department right now. They are switching to the claims' management

process, the employees that were down there are now being trained. They had originally contracted with an outside company to do the training, they're now doing the training in-house. And the claims' managers are civil servants that have worked for workers' comp previously.

So, they come from all different types of backgrounds. Some of them have more medical than others and so on and so forth. But in order to provide consistent treatment, they needed guidelines to go by and they are simply that, guidelines. And in the way it is supposed to work, there would never be a decision made but what you would be consulted. And I think, Mike, you've spoke with me and you've already spoke with many claims' managers that are there anytime there's a problem.

If you think maybe we should try this or maybe we should try that, they're open for your comments. But the guidelines are made available so that everybody is kind of aware of what's expected and it's to get

away from these -- so that where they just go on and on forever, the claimant is not showing any improvement yet the same treatment keeps being rendered for months and months and months and we have nothing to go by. An by the guidelines then we can they have something to go by to at least question, this is not proceeding as a normal low back injury would and they know at what point to start really questioning a little bit more, at what point to refer it for case management, which at this time, you know, would be myself, which would be a nurse. And I might add that, you know, with the case management we make the home visits to the claimants, make visits with the physicians, at least talk to all those that are involved and do the case management. But it's simply guidelines so that care can be more consistent and there's something to go by.

MR. MARTIN: My concern is that if an attending physician makes a certain diagnosis and there is a certain number of treatments that are supposed to go with that diagnosis, then our hands will be tied to

deviate from that but that's not going to be the case.

MS. HOBNEY: I mean, every case is going to be different. This person is going to have other contributing factors. Now, that's what needs to be made known and that's where a little bit of the responsibility is going to fall back on to the physician and the care providers to provide this information to the claims' managers. You know, number of six on the 219 says, "Has anything happened to cause a delay in this recovery?"

Well, on the previous 219 the doctor was expecting a return to work date of 2-15. The new one comes in and says, "No. He won't be able to return to work until 5-15." So, he's delaying recovery period by three months, yet, in block number six where it says, "Did anything happen to delay recover?" He marks "no." So, I think it's going -- a little bit of the responsibility at this point if you're not following the guidelines -- if it's treatment is falling outside the guidelines then, yes, the care providers are going

to be a little bit more responsible to provide information to the division as to why this person is falling outside the guidelines. That does not mean you're going to be cut off.

If it's legitimate, you know -- the whole goal is recovery for these people. We by no means want to just say, "Okay. If your diagnosis is this, you're going to get this and that's all you're going to get." That's not what we want at all.

MR. MARTIN: Thank you.

MR. TUCKER: Does anybody else have any questions? Jack Brautigam?

MR. BRAUTIGAM: I just one specific thing on the 85.20, on the treatment guidelines with regards to acute herniated cervical disc under 16-3.2 nonoperative treatment that this section be consistent with the herniated lumbar disc and stating appropriate referral for physical medicine which would include P.T., O.T., D.C., D.O., M.D. referral under the herniated cervical disc guidelines. And this is just a general comment

that I hope that these would be structured and I'm not sure in the review process if there's a designated time for the review of the treatment guidelines with regards to their ethicacy and also for their revision so that they can remain.

Right now there have been somewhat of what -- I think as they were made as guidelines and they were made to be dynamic document and I would hope that there would be something that could be placed in there to insure that they remain current and a dynamic working document.

MR. TUCKER: Let me see if I follow you, Jack. What you're saying is that you would like to see the rules contain language that would keep them current with any changes in the --

MR. BRAUTIGAM: Right. So that current revisions can be made and they can remain dynamic. If we find errors as we're working through it that they can be revised. Thank you.

MR. TUCKER: Thank you. Anybody else have

any questions? Betty Bailey?

MS. BAILEY: No comment. Just observing.

MR. TUCKER: Paula Mullinex?

MS. MULLINEX: (Indicates no.)

MR. TUCKER: Amy Welch?

MS. WELCH: No comment.

MR. TUCKER: Linda.

LINDA: Nothing. Just observing.

MR. TUCKER: Eric Kessler?

MR. KESSLER: No comment.

MR. TUCKER: And Debbie Malloy?

MS. MALLOY: (Indicate no.)

MR. TUCKER: Roger Hamrick?

MR. HAMRICK: No.

MR. TUCKER: Does anybody else have any comments? Yes, sir.

MR. DIVINE: Two more questions. One had to do with Item No. 16.3.3, which reads, "Claimants with significant neurological deficit, uncontrollable pain, or who fail to improve after two to four weeks should

be referred for consultation to a surgeon who does cervical operations." In an area, even as well served as the Eastern Panhandle, might tell you that there are few physicians currently orthopedic or neurosurgeons who will see spinal compensation patients and I might also tell you that if a cervical patient after four weeks is not responsive to care must therefore be sent to a specialist who does spinal surgery. They're going to have to come to Morgantown or Charleston or they're going to have to go out of state for services.

So, there might be consideration about changing that to possibly an orthopedic or a neurosurgeon or someone who takes care of spinal patients who may or may not do spinal surgery but typically manages spinal patients. That may be more efficient and at some point in the future if the patient is not responsive then the referral to a spinal surgeon. The other question that I identified that came up was -- and this was another conversation with HCX again -- to make things as efficient as they can

particularly for the case management team and currently we correspond to you-all by telephone calls or by our daily progress notes. And as in the past, we've tried to give you the information most pertinent to your evaluation of the patient and for example the green form, the IME form which the physicians use to evaluate back patients was literally not available to my physicians for usage.

MS. HOBNEY: It is available and in fact that is on the medical support group it's one of the things that we had recommended because we have a lot of trouble. Neurosurgeons, time wise, don't have time for that. And there is a number that you can call at workers' comp to get forms. Just call and request these fact forms and they're available to you and we're more than happy for the physical therapist to fill them out.

MR. DIVINE: For any allied health person. But in the past -- if I'm not correct, you can correct me. But in the past they were not available to

non-physicians. We had called the department or the division and had been told if we're not a physician we could not have them. I did obtain them from the state senator.

MS. HOBNEY: I've been there since January and they've been available since then. Prior to that, I don't. You may very well be correct. But I have been there since January and they have been available since then. The problem might have come because of just right under the bottom it says, "To be completed by the physician." And, Jack, you can correct me if I'm wrong but that's how-- originally they were developed for the attending physician.

MR. BRAUTIGAM: So, I think somebody gave you misinformation because I've been using them for two years.

MR. DIVINE: I think that happens to frequently. Every time we call, we get a different answer.

MS. HOBNEY: And in those instances, that's

where the claims' management is going to be great. Because then you're going to have somebody you can call and say -- and what I was alluding to was because this does say "To be completed by the physician." The department where the forms are generated from may have felt that they were only to be supplied to physicians and that was not correct.

MR. DIVINE: My point with that being it would be nice if maybe as a injunctive document HCAP could then come up with some functional recording of pertinent information that case management may need. At present it must be awfully hectic every time you receive an initial evaluation or update or progress note from various clinics and practices, there's probably information that's missing that would be helpful when you're evaluating that claimant's need or information that's really not demonstrative of any objective findings and I think as the document like the guidelines are taken, there also should be some documents indicating what perimeters need to be

routinely recorded so that as assessment can be made on an official basis. When I spoke to HCX they said they have absolutely no preference to functional outcomes, none of the scales or models is that they are currently using. Those documents exist and maybe someone could find it but that might be real worthwhile venture is to come up with pertinent information which can be added to in them.

MR. TUCKER: Anyone else? Any questions or comments? I would reiterate one more time that May 1st is the end of the comment period. If anyone wants to have written comment, you can obtain the address from Mr. Kozak and send them to his attention. He'll see to it that the council gets them and then the council will react to those and take into consideration -- also we will once again, Mr. Divine, we'll see that you do get the questions answered that you need, if not, you let us know. Anyone else? John, you have anything you want to say?

MR. KOZAK: If anybody does want to mail me

anything, it's Post Office Box 3922, Charleston, 25339. My last name is K-O-Z-A-K.

MR. TUCKER: Does any member of the council have anything they would like to say at this time?

MR. HARRIS: I would like to thank each and everyone of you for coming out especially you-all who made public comments. We certainly will take those into consideration in our deliberations of these matters.

MR. TUCKER: Anybody else? If not I declare the meeting closed and I appreciate everybody coming. Have a good trip home.

(Whereupon, the hearing was concluded)

APPEARANCES FOR THE WORKERS' COMPENSATION PERFORMANCE COUNCIL

MR. PAUL THOMPSON

MR. RICHARD HUMPHREYS

MR. THOMAS ROTENBERRY

MR. FRED TUCKER

MR. EVERETT SULLIVAN

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