ODG, ACOEM, and Other Guidelines

Laurence A. Miller, M.D.
NASSCO (General Dynamics),
AIG
10/3/12
Caveats

• Editorial Advisory Board in the past of the Medical Disability Advisor
• Editorial Advisory Board of ODG
• Minor Input to the First ACOEM Guideline
• Use certain State Guidelines: CO, MA, MS, NY, CA-MTUS, not familiar with all Guidelines
• Most Familiar with the Guidelines I employ the most frequently-**ODG**, ACOEM
• I Have Preferences!
Intent of Discussion

• Know the Guidelines: ODG, ACOEM & Others
• Understand what they are NOT
• Understand how they are used:
  – Provider
  – UR
• Know the expected results
• Understand the challenges
Guidelines in WC

• When did GL begin to be utilized:
  – Advisory: 1980s
  – UR: 2000
• Guidelines have become more focused and specific.

• What are the most important: Past-ACOEM, ODG, PR
• What are now the most important: ODG, ACOEM, State
• The term “Evidence Based”
• Consensus
• State Mandated Guidelines
Why UR

• Studies across the world, in various medical practice environments show:
  – Practice variation is remarkable
  – Practice dependant upon training
  – Practice dependant upon peer pressure
  – Practice is dependant upon the economic environment
  – Practice is dependant upon controls, including UR!!!
Treatment Varies State by State

Ratio of Total Rates of Spine Surgery to the U.S. Average by Hospital Referral Region (2002-03)

Reviews

• Normally two or more levels
  – Screening
  – 1\textsuperscript{st} Level
  – 2\textsuperscript{nd} Level (Physician)
• Need ease of use at all levels.
• Preferably automated (at lower levels to minimize friction and expedite treatment)
• Require a decent UR IT System (\textbf{the greatest failing of most programs}).
• Clearly understood by all parties in the process: Easier if Mandated.
Content of Guidelines

- Broad Coverage of Procedures, etc.
- Focused for an individual procedure
- Understandable: Language must be simple and concise
- “Yes”, or “no”. Not can be, maybe, etc.
- Indicate in specific language why or why not in no uncertain terms, with references
- Make sure reviews are not full of extraneous and diverting, non-substantive “chatter”.
What is a good review using Guidelines?

• Short and to the point.
• NOT a recap of the case-expensive and non-productive
• Addresses the issue in question, and then gives a clear answer.
• Clearly states either “Yes” or “No”, or an appropriately negotiated number.
Guidelines

- ODG
- ACOEM: Three Editions plus revised Chapters, new Chapter on Drugs (2013)
- Medical Disability Advisor: Presley Reed
- IHQ, McKesson (not available)
- State Guidelines: CO, NY, MA, MS, etc.
- Specialty Guidelines: ASIPPP
- National Guideline Clearing House
- Others: Medicare, The “Blues”, Aetna
Two Types of Guidelines

- Evidence Based: Utilizing medical studies to indicate the best outcomes that can be achieved. (“What works, what does not”, and under what circumstances.) Rated as to quality of the Study used for the recommendation.
  - ACOEM, ODG, some specialty guidelines.
- Consensus Guidelines: A group recommends treatment options.
  - Most specialty societies
  - Many (if not all) State Guidelines
    - CO, NY, MS (injection), MA
ODG -TWC

ODG Treatment
Integrated Treatment/Disability Duration Guidelines

Explanation of Medical Literature Ratings
(Ratings “1a” through “11c” noted under summary of each study)

Back to ODG - TWC Index

(updated 03/09/11)

**Individual Study Ratings** (medical treatment studies)

Ranking by Type of Evidence (treatment procedures):

STUDIES

1. Systematic Review/Meta-Analysis
2. Controlled Trial – Randomized (RCT) or Controlled
3. Cohort Study - Prospective or Retrospective
4. Case Series
5. Unstructured Review

OTHER:

6. Nationally Recognized Treatment Guideline (from guidelines.gov)
7. State Treatment Guideline
8. Other Treatment Guideline
9. Textbook
10. Conference Proceedings/Presentation Slides
11. Case Reports and Descriptions

Ranking by Quality within Type of Evidence:

a. High Quality
b. Medium Quality
c. Low Quality

**Evaluating the Body of Evidence** (and prognostic/diagnostic/economic studies)
<table>
<thead>
<tr>
<th>Recommendation Level</th>
<th>Level Evid.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Recommended (2+ Hi-quality)</td>
<td>“A” Level Evid.</td>
</tr>
<tr>
<td>Moderately Recommended (1 Hi, Mult. Mod)</td>
<td>“B” Level Evid.</td>
</tr>
<tr>
<td>Recommended (1+Mod. quality)</td>
<td>“C” Level Evid.</td>
</tr>
<tr>
<td>Insufficient Quality Evidence Recommended</td>
<td>“I” Level Evid.</td>
</tr>
<tr>
<td>Insufficient Quality Evidence No Recommendation</td>
<td>“I” Level Evid.</td>
</tr>
<tr>
<td>Insufficient Quality Evidence Not Recommended</td>
<td>“I” Level Evid.</td>
</tr>
<tr>
<td>Not Recommended</td>
<td>“C” Level Evid.</td>
</tr>
<tr>
<td>Moderately Not Recommended</td>
<td>“B” Level Evid.</td>
</tr>
<tr>
<td>Strongly Not Recommended</td>
<td>“A” Level Evid.</td>
</tr>
</tbody>
</table>
Results of ACOEM 3rd Systematic Reviews: Quality of Clinical Decisions Based Upon Quality Evidence
Rand: Evaluating Treatment Guides for California

- 72 guidelines narrowed using screening criteria: (1) Evidence-based, (2) peer-reviewed, (3) nationally recognized, (4) address common therapies, (5) updated every three years, (6) multidisciplinary

- ODG & ACOEM finalists, Colorado fails criteria

AGREE Technical Quality Scores-
1. McKesson*
2. ODG
3. ACOEM
4. Intracorp
5. AAOS

*Discontinued
• AHTA searched and reviewed guidelines worldwide, narrow to 27 using AGREE Instrument
  – Threshold of 80% in Rigor Scores to identify higher quality
  – Used ADAPTE Collaboration protocol, “consistency between recommendations and underlying evidence”

• Colorado Guides determined to be "Purely Consensus Guidelines" (pg 87) and disqualified

• ODG rated #2 worldwide after Canadian Diagnostic Imaging Guideline (Bussieres ‘08), which “covers only on a narrow area of diagnostic imaging”, ACOEM close behind.
ODG: From the WLDI

• Independent Database Development Company
  – Started in 1995, with offices in Texas and California
• Best known for ODG product line, in 17th edition for return-to-work and 10th edition for treatment
• “Most widely used WC guideline in California & the world
  – Used by most TPA’s and work comp carriers
  – Used by treating doctors
  – Adopted by many States
ACOEM Practice Guidelines

APG1 – First Edition 1997
APG2 – Second Edition, online version 2004
UMK – Expanded online version 2006
ACOEM-3rd Edition 2010
I-pad application 2011
Ongoing updates (Elbow, LB, Neck) 2012
New Chaps: Respiratory, Opioids, SDM 2013

Widely used by employers, insurers, and mandated in some states

CA, NV and NY (Low Back Disorders)
Guideline Examples: State

• MS-”There is no recognized “series of epidural injections..a trial of ESIs is permitted ..if there is appropriate documentation of a recognized indication”.

• MA-Two Guidelines, Nos. 23 and 27..in contradiction. Which to use, when, how, no one knows.
• Radiculopathy must be documented with objective findings consistent with imaging or electrodiagnostic studies and not responsive to conservative treatment.

• Only 2 levels.

• Repeat requires pain relief of 50%+ for 6-8 wks, with documentation of improved function, decreased medications, etc.
• An epidural glucocorticosteroid injection is recommended as an option for treatment of acute or subacute radicular pain syndromes. Its purpose is to provide a few weeks of partial pain relief while awaiting spontaneous improvement. An epidural steroid injection may cause short-term improvement which may assist in successfully accruing sufficient time to ascertain if conservative care will succeed. An “option” means there should be no requirement that a patient receive and fail treatment with epidural glucocorticosteroids, especially repeated injections, prior to discectomy. One only.
ODG and ACOEM: Link to Evidence

• ODG
  – Direct Hyperlink
  – Easy to use with provider calls. A quick “click” if using the online version.
  – Reference appears in “Cut and Paste” after each item.

• ACOEM
  – Indirect: But, well rated as to quality.
  – Somewhat cumbersome if on the phone with a doctor.
  – Good research.
Updates

- **ODG**
  - Updated regularly, stated to be monthly, but each “Chapter” appears to undergo a review every 2-4 months with additions and elaboration.
  - New Research appears regularly.
  - New Treatments, or problematic issues are frequently inserted to expand coverage.

- **ACOEM**
  - Every 3-6 years
  - Updates are now by “Chapters”
  - Seems to be a change in attitude toward the intent of the Guidelines over time.
  - Initially general, then specific, then more general.
Specialty Orientation

• ODG
  – Multispecialty
  – Multi-payer
    • WC
    • Other types of payers
  – Focuses on the treatment, not the provider type.
  – Independent Guideline Publisher

• ACOEM
  – Focused on Occ. Med. Providers
  – Publisher is a Specialty Society—though without some of the burdens of other (more particular) specialties.
  – Has a more Acute Care in Occ. Med. Focus......
Intent of the Guidelines

• ODG
  – Maximize Guideline Success….If you can’t use the Guideline..it has no value
  – Improve Quality of Care and Control Costs.
  – Integrates Care and Disability as they are a continuum.

• ACOEM
  – Improve Quality of Care, reduce variation
  – Costs seem secondary-though are not ignored.
  – Care is the focus, disability control “expected” to follow good care.
Ease of Use

- ODG
  - Multiple Formats
    - Print
    - On-line
- RTW and Treatment Integrated
- UR Codes
- Claims Integration
- Easy to Navigate

- ACOEM
  - Print
  - On-line
- Treatment only
- Complex to Navigate
- Navigation is improving
Effect

- ACOEM and ODG in CA
  - 60-70% Decrease in Medical Costs
  - Other States: 60%+ saving...

- ODG
  - 50-70%

- State Guidelines
  - Costs go UP!!
    - Oklahoma
    - NY

- Specialty Guidelines: No evidence of any positive effect
Official Disability Guidelines

ODG: Good to Go! (link to complimentary online self training tool)

ODG Treatment

Background & Description

Explanation of Medical Literature Ratings (updated 08/09/11)

Ankle & Foot (updated 08/15/12)

Burns (updated 08/14/12)

Carpal Tunnel Syndrome (updated 08/14/12)

Diabetes (updated 08/14/12)

Elbow (updated 08/15/12)

Eye (updated 04/26/12)

Fitness for Duty (updated 03/22/12)
Hospitalization

Not recommended for low back pain in the absence of major trauma (i.e., acute spinal fracture, spinal cord injury, or nerve root injury), acute or progressive neurologic deficit, or the patient’s inability to manage basic ADLs at home and alternative placement in a Skilled Nursing Facility is not available or appropriate. These recommendations are based on medical practice and are consistent with other evidence-based guidelines.

Criteria for Hospital Admissions:

I. Acute Major Back Trauma is Suspected: Back injury occurred within the past 7 days; & Major trauma was sustained (e.g., fall from a height or back crushed by heavy object); & Examining physician documents or suspects acute spinal fracture, spinal cord injury, or nerve root injury. Hospital Admission Criteria: May be individualized.

II. Acute Major Back Trauma Not Suspected: Patient Has Neurologic Findings Suspected to be Acute or Progressive: No history of recent major injury, & Patient complains of symptoms suggesting acute or progressive neurologic deficit [typically these include: (1) progressive weakness or numbness in one leg (and occasionally both legs), or (2) loss of control of bowel or bladder function, or (3) progressive numbness in the perineal region], & The examining physician indicates that the patient has (or probably has) an acute or progressive neurologic deficit. Hospital Admission Criteria: If a patient has a new or progressive neurologic deficit, he/she may be hospitalized in order to facilitate surgical decision-making, to provide close observation of further progression, or to help the patient compensate for neurological deficits (e.g., to determine whether the patient needs to learn intermittent catheterization). If a patient does NOT have a new or progressive neurologic deficit, the only valid reason for hospitalization is that he/she cannot manage basic ADLs at home. Duration of hospitalization should be brief. The great majority of these patients who are admitted to a hospital can be discharged in 1 to 3 days (if spine surgery is not performed). Prolonged bed rest usually does more harm than good in a patient with low back pain. Admission for the purpose of bed rest is not acceptable.

III. Acute Major Back Trauma Not Suspected: Patient Has Back Pain without Evidence of Acute or Progressive Neurologic Findings: No history of recent major trauma; & Patient complains of back pain with or without symptoms in the legs (occasionally patients will complain mainly of symptoms in the legs but the evaluating physician concludes that symptoms are not caused by lumbar radiculopathy) & No evidence of acute or progressive neurologic deficit. Hospital Admission Criteria: The primary valid reason for hospitalizing these patients is that they cannot manage basic ADLs at home. Example, the patient lives alone and is unable to get to the bathroom. If a patient is admitted through the emergency department, the decision to admit should be made with the concurrence of the attending physician, unless the attending physician cannot be reached. Duration of hospitalization should be brief. The great majority of these patients who are admitted to a hospital can be discharged in less than 24 hours. Admission for the purpose of bed rest or traction alone is not acceptable. The need for parenteral narcotics is a valid admission criteria. A patient should not be admitted to a hospital that does not have the capacity to assess ADLs, develop a treatment plan, and provide physical therapy within the first 24 hours. For hospital LOS after admission criteria are met, see Hospital length of stay (LOS).

Hospital length of stay (LOS)

Recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. For prospective management of cases, median is a better choice that mean (or average) because it represents the mid-point, at which half of the cases are less, and half are more. For retrospective benchmarking of a series of cases, mean may be a better choice because of the effect of outliers on the average length of stay. Length of stay is the number of nights the patient remained in the hospital for that stay, and a patient admitted and discharged on the same day would have a length of stay of zero. The total number of days is typically measured in multiples of a 24-hour day that a patient occupies a hospital bed, so a 23-hour admission would have a length of stay of zero. (HCUP, 2011)

ODC hospital length of stay (LOS) guidelines:

- **Discectomy (ICD 80.51 - Excision of intervertebral disc)**
  - Actual data - median 1 day; mean 2.1 days (± 0.0); discharges 109,057; charges (mean) $26,219
  - Best practice target (no complications) - 1 day

- **Laminectomy (ICD 02.09 - Laminectomy: laminotomy for decompression of spinal nerve root)**
  - Actual data - median 2 days; mean 3.5 days (± 0.1); discharges 106,600; charges (mean) $24,978
  - Best practice target (no complications) - 1 day

- **Lumbar Fusion, posterior (ICD 81.08 - Lumbar and lumbosacral fusion, posterior technique)**
  - Actual data - median 3 days; mean 3.9 days (± 0.1); discharges 161,761; charges (mean) $66,900
  - Best practice target (no complications) - 3 days

- **Lumbar Fusion, anterior (ICD 81.06 - Lumbar and lumbosacral fusion, anterior technique)**
  - Actual data - median 3 days; mean 4.2 days (± 0.2); discharges 33,521; charges (mean) $110,156
  - Best practice target (no complications) - 3 days

- **Lumbar Fusion, lateral (ICD 81.07 - Lumbar fusion, lateral transverse process technique)**
  - Actual data - median 3 days; mean 3.8 days (± 0.2); discharges 15,125; charges (mean) $89,088
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ODC hospital length of stay (LOS) guidelines:

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Median LOS</th>
<th>Mean LOS</th>
<th>Charges Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discectomy (lcc 80.51 - Excision of intervertebral disc)</td>
<td>1 day</td>
<td>2.1 days</td>
<td>$26,219</td>
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<td>3.8 days</td>
<td>$89,088</td>
</tr>
</tbody>
</table>

http://www.odg-twc.com/odgtwc/low_back.htm#hospitalization
**Example of ODG Guideline**

### Procedure Summary – Low Back

<table>
<thead>
<tr>
<th>Procedure/topic</th>
<th>Summary of medical evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Not recommended due to the lack of sufficient literature evidence (1 Chinese study). There are promising initial results. Acupuncture, the use of fingers rather than needles (as in acupuncture) to press on various points in the body, conferred an 81% reduction in significant disability compared with physical therapy in this RCT conducted in Korea. Cheung, 2008). However, because the study was conducted in a country where acupuncture is widely accepted, the results may be hard to replicate in the U.S. Some have suggested self-applied acupuncture can be used by patients on their own as part of home physical therapy.</td>
</tr>
</tbody>
</table>

### Activity restrictions

- See N/A

### ODG Acupuncture Guidelines:

- Initial trial of 3-4 visits over 3 weeks
- With evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy)

- Adjuvant medication to improve outcomes

- Adhesionosis

- Adhesionosis, parametric

- Adhesionosis, parametric & Adhesions, spinal endoscopy

- Adhesions, spinal endoscopy

- Adhesions, spinal endoscopy
**Official Disability Guidelines**

*ODG: Good to Go!* (link to complimentary online self training tool)

### ODG Workers Compensation Drug Formulary

**NDC Code (National Drug Code) Inquiry**

**NDC Code:** 00002-0435

<table>
<thead>
<tr>
<th>NDC Number</th>
<th>00002-0435</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>Generic Class</td>
<td>Fluoxetine</td>
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<tr>
<td>Brand Name</td>
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<tr>
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<tr>
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<td>Sarafem Capsules</td>
</tr>
<tr>
<td>Status</td>
<td>Y</td>
</tr>
</tbody>
</table>

Click [here](#) for Explanation of Rows.
State Adoption: Future

• ODG
  – 23 States
  – Partial Use in CA
  – Challenges ongoing in some states to state guidelines

• ACOEM
  – One State+