Health Care Provider Advisory Committee
Meeting Minutes
Aurora Medical Center in Summit
May 5, 2017

Members Present: Mary Jo Capodice, DO (via telephone); BJ Dernbach (chair); Amanda Gilliland; Ted Gertel, MD; Richard Goldberg, MD; Barb Janusiak, RN; Michael M. McNett, MD; James O'Malley (acting chair); Jim Nelson; Jennifer Seidl, PT; Peter Schubbe, DC; and Ron Stark, MD.

Excused: Scott Hardin, MD; Maja Jurisic, MD; Stephen Klos, MD; and Jeff Lyne, DC.

Staff Present: Kelly McCormick and Frank Salvi, MD.

Observers: None

1. **Call to Order/ Introductions:** Mr. O'Malley convened the Health Care Provider Advisory Committee (HCPAC) meeting at approximately 10:05 a.m., in accordance with Wisconsin's open meetings law. HCPAC members and Worker's Compensation Division (WCD) staff introduced themselves.

2. **Acceptance of the January 20, 2017 meeting minutes:** Dr. Schubbe moved to approve the minutes of the January 20, 2017 meeting. Dr. McNett seconded the motion. The minutes were unanimously approved without correction.

3. **Future meeting dates:** The HCPAC members agreed they will meet on August 11 and October 13, 2017. A tentative meeting date of January 19, 2018, was set with an alternate snow date of January 26, 2018.

4. **Survey of practitioners to update minimum ratings in ch. DWD 80 of the Wisconsin Administrative Code:** Several HCPAC members requested that a link to the survey be resent; it was decided to resend the e-mail request with the survey link to the entire HCPAC. Dr. Capodice indicated that many occupational medicine doctors do not assign permanent partial disability (PPD) ratings and their patients usually return to baseline. Dr. Schubbe advised that chiropractors very rarely give PPD ratings. A brief discussion took place about other challenges that may be limiting survey participation.

5. **State of Wisconsin Open Records Video:** Mr. Dernbach introduced a video created by the Department of Administration related to Wisconsin Public Records Law. Each agency is required to ensure all employees and members of all boards, councils, and commissions attached to the agency complete public records training on an annual basis. The five public record responsibilities of all employees are: 1. Recognize when you have a public record, 2. Understand what is not a public record, 3. Understand how to properly maintain public records, 4. Recognize a public records request and handle that request

appropriately, and 5. Know where to go for help. Questions or issues that may arise in the future by HCPAC members regarding records should be brought to Mr. Dernbach. Resources are also available on the Department of Justice's website.

6. **Cooperation guidelines for attorneys and physicians:** A publication prepared by the State of Connecticut Workers' Compensation Commission designed to promote cooperation between attorneys, physicians and other health care practitioners was distributed. Dr. Stark stated the section regarding subpoenas and reasonable fees was helpful. He suggested it would be helpful to distribute the document or something similar to worker's compensation attorneys so that expectations are clear. Dr. Capodice indicated that information was still being gathered for training modules and also indicated there is a joint workgroup with the Wisconsin State Bar Association and the Wisconsin Medical Society. Dr. Gertel suggested that the WCD moderate a workgroup to avoid having the information skewed by one side or the other.

7. **Review of ch. DWD 81 of the Wisconsin Administrative Code:** The HCPAC continued its review of the worker's compensation treatment guidelines in ch. DWD 81 of the Wisconsin Administrative Code. The following changes were proposed:

   a. Section 81.07 (1) (b) 1. Amend the paragraph and remove references to ICD-9 codes as follows:
   1. Regional neck pain includes referred pain to the shoulder and upper back. Regional neck pain includes the diagnoses of cervical strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, joints, nerves, or other soft tissues of the cervical spine and that affects the cervical region, with or without referral to the upper back or shoulder~~, including ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3, 925, and 926.1 to 926.12~~.

   b. Section 81.07 (1) (b) 2. Remove references to ICD-9 codes:
   2. Radicular pain, with or without regional neck pain, with no or static neurologic deficit includes the diagnoses of brachialgia, cervical radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and other diagnoses for pain in the arm distal to the shoulder believed to originate with irritation of a nerve root in the cervical spine~~, including ICD-9-CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, and 724 to 724.00~~. In these cases, neurologic findings on history and examination are either absent or do not show progressive deterioration.

c. Section 81.07 (1) (b) 3. Amend the subdivision to read:
3. Radicular pain, with or without regional neck pain, with progressive neurologic deficit, includes the same diagnoses as subd. 2., except in these cases there is a history of progressive deterioration in the neurologic symptoms and physical findings, including worsening sensory loss, increasing muscle weakness, loss of muscle control, and progressive reflex changes.

d. Section 81.07 (1) (b) 4. Amend the subdivision to read:
4. Cervical compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated or pathologic reflexes, ~~an extensor plantar response,~~ bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes.

e. Section 81.07 (1) (h) Replace entire paragraph as follows:
(h) During the period of initial nonsurgical management, computerized range of motion or strength testing may be performed but shall be done in conjunction with an office visit with a health care provider's evaluation or treatment, or physical or occupational therapy evaluation or treatment. A health care provider may order computerized range of motion or strength measuring test during a period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. ~~A health care provider may not order computerized range of motion or strength measuring tests during the period of initial nonsurgical management, but may order these tests during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing may be performed but shall be done in conjunction with an office visit with a health care provider's evaluation or treatment, or physical or occupational therapy evaluation or treatment.~~(*Note: This is the same language as in s. 81.06.)*

f. Section 81.07 (1) (i) 6. Change to read:
6. Does the patient have a ~~chronic pain syndrome or psychogenic~~ pain disorder with related psychological factors? (*Note: This is the same language as in 81.06.)*

g. Section 81.07 (1) (i) 7. Change to read:
7. In cases in which surgery is an appropriate~~possible~~ treatment, are psychological factors likely to interfere with the potential benefit of the surgery? (*Note: This is the same language as in s. 81.06.)*

h. Section 81.07 (1) (j) Delete the word "differential":

(j) All of the following are guidelines for diagnostic analgesic blocks or injection studies and include facet joint injection, facet nerve block, epidural ~~differential~~ spinal block, nerve block, and nerve root block.

i. Section 81.07 (1) (k) Replace entire paragraph as follows:
(k) Functional capacity evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity evaluation include neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task, or work activity.

1. A functional capacity evaluation is not typically necessary during the period of initial management.

2. A functional capacity evaluation may be appropriate in any of the following circumstances:

a. To delineate the patient's physical capabilities.

b. To provide information about the patient's ability to do a specific job.

3. A functional capacity evaluation is not the appropriate tool to establish baseline performance before treatment.

4. A health care provider may direct only one completed functional capacity evaluation per injury unless one or more of the following exceptions exist at which time another functional capacity evaluation may be appropriate:

a. An exacerbation of the injury occurs.

b. A major change in the patient's health status occurs.

c. The patient undergoes surgery that significantly changes the patient's physical status.

d. If the initial functional capacity evaluation was for a particular job and there is a change in the job to which the patient is returning.

e. Final determination of PPD is necessary.~~Functional capacity assessment or evaluation is a comprehensive and objective assessment of patient's ability to perform work tasks. The components of a functional capacity assessment~~

~~or evaluation include neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine a patient's physical capacities in general or to determine and report work tolerance for a specific job, task, or work activity.~~

~~1. Functional capacity assessment or evaluation is not necessary during the period of initial nonoperative care.~~

~~2. Functional capacity assessment or evaluation is necessary in any of the following circumstances:~~

~~a. To identify the patient's permanent activity restrictions and capabilities.~~

~~b. To assess the patient's ability to do a specific job.~~ (*Note: This is the same language as in s. 81.06.)*

j. Section 81.07 (2) (a) 2. Add language as follows:
2. Subsection (12) governs radicular pain with no neurologic deficits or static neurologic deficits.

k. Section 81.07 (2)(c) Change as follows:
(c) In general, a course of treatment is divided into the following ~~3~~4 phases:
1. First, all patients with neck problems, except patients with radicular pain with progressive neurological deficit or myelopathy under sub. (1) (b) 3. and 4., shall be given initial nonsurgical care that may include both active and passive treatment modalities, injections, durable medical equipment, and medications. These modalities and guidelines are described in subs. (3), (4), (5), (8), and (10). The period of initial nonsurgical management begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment shall result in progressive improvement as specified in sub. (9).

2. Second, for patients with symptoms persisting beyond six weeks who are not progressing towards functional restoration, a reassessment should be performed looking for barriers to recovery. This may include but is not limited to reconsidering the diagnosis and/or evaluating psychosocial issues or motivational factors. The treatment plan should then be modified accordingly.

~~2~~3. ~~Second~~Third, after consideration of sub. 2, ~~for~~ patients with persistent symptoms~~,~~ may be considered for ~~initial nonoperative care is followed by a period of~~ surgical evaluation. This evaluation shall be completed in a timely manner. Surgery, if necessary, shall be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11) to (14), and s. DWD 81.12 (1). A treating health care provider may do the evaluation or may refer the patient to another health care provider.

a. Patients with radicular pain with progressive neurological deficit or myelopathy may require immediate surgical therapy.

b. Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical management.

c. Surgery shall follow the guidelines in subs. (6), (11) to (14), and s. DWD 81.12 (1).

d. A decision against surgery at any particular time does not preclude a decision for surgery made at a later date.

~~3~~4. ~~Third~~Fourth, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be necessary. Chronic management modalities are described in s. DWD 81.13 and may include durable medical equipment as described in sub. (8). (*Note: This is the same language as in s. 81.06.)*

l. Section 81.07 (3) (a) change to:
(a) *General.* Except as set forth in par. (b) or s. DWD 81.04 (5), a health care provider may not direct the use of passive treatment modalities in a clinical setting as set forth in pars. (c) to (i) beyond a total of 12 ~~calendar~~ weeks of continuous or interrupted treatment after any of the passive modalities in pars. (c) to (i) are initiated. There are no limitations on the use of passive treatment modalities by the patient at home. (*Note: This is the same language as in s. 81.06.)*

m. Section 81.07 (3) (b) 2. Add the following language:
2. The treatment is not given on a regularly scheduled basis, but only after a documented assessment of response to treatment and ongoing or persistent need.

n. Section 81.07 (3) (b) 5. Delete language as follows:

5. The additional 12 visits for passive treatment does not delay ~~the required~~ surgical or chronic pain evaluation required by this chapter.

o. Section 81.07 (3) (b) 6. Change as follows:
6. Passive care is not ~~necessary while~~recommended for ~~the~~ patient<u>s</u> ~~has~~ <u>with</u> chronic pain syndrome.

p. Add Section 81.07 (3) (b) 7. as follows:
<u>7. An aggravation or exacerbation of the initial injury that limits a patient's function may warrant additional episodes of passive treatment in conjunction with active treatment.</u>

q. Section 81.07 (3) (c) Add language as follows:
(c) Adjustment or manipulation of joints. For purposes of this paragraph "adjustment or manipulation of joints" includes chiropractic and osteopathic adjustments or manipulations <u>and physical therapy manipulations</u>. All of the following guidelines apply to adjustment or manipulation of joints:

r. Section 81.07 (3) (d) 2. Modify as follows:
2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, ~~hydrocollators,~~ heating pads, ice packs, ~~and~~ cold soaks<u>, and other durable medical equipment</u> that can be applied by the patient without health care provider assistance. Home use of thermal modalities may not require any special training or monitoring, other than that usually provided by a health care provider during an office visit. (*Note: This is the same language as in s. 81.06.)*

s. Section 81.07 (3) (e) Delete language as follows:
(e) Electrical ~~muscle~~ stimulation. For purposes of this paragraph, "electrical ~~muscle~~ stimulation" includes galvanic stimulation, transcutaneous electrical nerve stimulation, interferential, and microcurrent techniques. All of the following guidelines apply to electrical ~~muscle~~ stimulation:

1. Electrical ~~muscle~~ stimulation given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

2. Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device shall be in a supervised setting in order to ensure proper electrode placement and patient education. All of the following guidelines apply to home use of an electronic ~~muscle~~ stimulation device:

a. Time for patient education and training is one to 3 sessions.

b. Patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment shall be reevaluated by a health care provider before continuing home use of the device.

t. Section 81.07 (3) (f) 1. b. Modify as follows:
b. Maximum treatment frequency is up to ~~3~~5 times per week for the first one to 3 weeks and decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

u. Section 81.07 (3) (h) Change as follows:
(h) *Manual therapy*. For purposes of this paragraph, manual therapy techniques consist of, but are not limited to connective tissue massage, joint mobilization and manipulation, manual traction, passive range of motion, soft tissue mobilization and manipulation, dry needling techniques and therapeutic massage. Manual therapy techniques may be applied to one or more regions. All of the following guidelines apply to manual therapy:~~Manual therapy. For purposes of this paragraph, "manual therapy" includes soft tissue and joint mobilization, therapeutic massage, and manual traction. All of the following guidelines apply to manual therapy:~~ (*Note: This is the same language as in s. 81.06.)*

v. Section 81.07 (3) (j) Modify as follows:
(j) Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest shall not be prescribed for more than ~~7~~2 days. (*Note: This is the same language as in s. 81.06.)*

w. Section 81.07 (3) (k) 4. Change as follows:
4. Maximum continuous duration is up to 3 weeks unless patient is status post~~fusion~~ cervical spine surgery.

x. Create Section 81.07 (3) (L) as follows:
(L) *Laser or light therapy.* Non-thermal light therapy uses light with specific characteristics, primarily wavelength, power, and delivery mode to provide photons of light to cellular tissue to treat specific medical conditions. The main responses to non-thermal light therapy are pain reduction, inflammation reduction, and accelerated tissue healing. (*Note: This is the same language as in s. 81.06.)*

y. Update Section 81.07 (4) as follows:
(4) ACTIVE TREATMENT MODALITIES.

(a) Active treatment modalities shall be used as set forth in pars. (b) to (f). A health care provider's use of active treatment modalities may extend past the 12-week limitation ~~on~~as with passive treatment modalities, as long as acceptable reasons, as set forth in s. 81.04(5) are documented~~so long as the maximum durations for the active treatment modalities are not exceeded~~.

(b) Education shall teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. ~~The maximum number of treatments is 3 visits, which include an initial education and training session and 2 follow-up visits.~~Education is provided continuously and reflected through active treatment modalities.

(c) Posture and work method training shall instruct the patient in the proper performance of job activities based on essential job duties as reported by the employer. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. ~~The maximum number of treatments is 3 visits.~~This is an ongoing part of treatment and is reflected through active treatment modalities.

(d) Worksite analysis and modification shall examine the patient's work station, tools, and job duties. A health care provider may make recommendations for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of ~~treatments is 3~~ visits is 3 per individual injury.

(e) Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, shall include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise shall, at least in part, be specifically aimed at the musculature that impacts function of the cervical spine. Aerobic exercise and extremity strengthening may be performed as adjunctive treatment, but may not be the primary focus of the exercise program.

(f) Exercises shall be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance shall be objectively measured. A health care provider may objectively measure the treatment response as often as necessary for optimal care after the initial evaluation. Subds. 1. and 2. govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by s. DWD 81.13.

1. 'Guidelines for supervised exercise.' One goal of an exercise program shall be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition shall be promoted. All of the following guidelines apply to supervised exercise:

a. Maximum treatment frequency is ~~3~~5 times per week for the first week, 3 times per week for the next ~~3~~2 weeks, and decreasing in frequency after the third week until the end of the maximum treatment duration period in subd. 1. b.

b. Maximum duration is 12 weeks.

2. 'Guidelines for unsupervised exercise.' Unsupervised exercise shall be provided in the least intensive setting appropriate to the goals of the exercise program and may supplement or follow the period of supervised exercise. All of the following guidelines apply to unsupervised exercise:

a. Maximum treatment frequency is up to 3 visits for instruction and monitoring.

b. There is no limit on the duration or frequency of exercise at home.

8. **New Business:** The members representing Labor and Management on the Worker's Compensation Advisory Council (WCAC) will exchange proposals for inclusion in the Agreed Upon Bill at the next WCAC meeting on May 9, 2017. These proposals as well as proposals from the Worker's Compensation Division (WCD) and the public will be posted on the DWD website.

9. **Adjournment:** There was a motion to adjourn by Ms. Seidl, seconded by Dr. Goldberg. The motion passed unanimously. The meeting was adjourned at approximately 12:35 p.m.