**Health Care Provider Advisory Committee**
**Meeting Minutes**
**Webex Conference Meeting**
**January 20, 2023**
**DRAFT**

Members Present: Andrew Floren, MD; Theodore Gertel, MD; Richard Goldberg, MD; Barbara Janusiak, RN; David Kuester, MD; Steven Peters (Chair); Kelly Von-Schilling Worth, DC; Timothy Wakefield, DC; and Nicole Zavala.

Excused: John Bartell, RN; David Bryce, MD; and Jennifer Seidl, PT.

Staff Present: Mark Kunkel, Jim O'Malley, Kelly McCormick, Laura Przybylo, and Frank Salvi, MD.

1. **Call to Order/Introductions:** Mr. O'Malley, acting chair, convened the Health Care Provider Advisory Committee (HCPAC) meeting at approximately 10:10 a.m., in accordance with Wisconsin's open meetings law, and called the roll.

2. **Acceptance of the October 7, 2022 meeting minutes:** Dr. Floren made a motion, seconded by Ms. Janusiak, to accept the minutes of the October 7, 2022 meeting. The minutes were unanimously approved without correction.

3. **Future meeting dates:** The HCPAC members agreed to schedule the next meeting on May 5, 2023 as a virtual meeting. Tentative meeting dates of August 4, 2023 and October 6, 2023 were also selected. The members discussed virtual, in-person, and hybrid meeting options.

4. **Review of survey of practitioners to update minimum PPD ratings in s. DWD 80.32 of the Wisconsin Administrative Code:** Mr. O'Malley indicated that the Worker's Compensation Advisory Council (WCAC) will hold its first meeting of the biennium in February. The WCAC will likely schedule a meeting in March when the HCPAC could present recommendations regarding the minimum PPD ratings. The Department will advise the HCPAC members of the date and time of the meeting once it is set and encourage the members to be present to answer questions the members of the WCAC may have about proposed changes to the minimum PPD ratings.

   The Department reviewed the analysis that included the rationale for the proposed changes to minimum PPD ratings in s. DWD 80.32 recommended by the HCPAC. During the discussion the following recommended changes to the analysis were made:

   a. In the current rule there no minimum disability rating for sensory involvement only to the radial nerve including the upper arm. The recommendation is to establish a minimum rating of 5% at the shoulder. The rationale for establishing this minimum rating is that the radial nerve is an important component of function for those working with their hands (sensation over the posterior arm and forearm and dorsal surface of the hand), though it is of lesser importance compared to median and ulnar nerve sensation.

b. **Note regarding Tables 80.32—1 through 80.32—4**

The current rule does not include minimum ratings for sensory deficit or pain and motor deficit due to specific upper or lower extremity peripheral nerve injuries. The recommendation is to establish minimum ratings for sensory deficits based on altered sensation and pain, and minimum ratings for motor deficits based on decreased strength and limitations on range of motion. ~~The rational for this recommendation is to establish ratings consistent with current medical consensus used for determining disability ratings.~~

~~The recommended chart for the above-referenced nerve injuries as well as two additional charts to assist practitioners in rating nerve injuries are reflected on pages 20 and 21.~~

Table 80.32-1 provides a reference for complete motor or sensory deficits.

Incomplete sensory deficits, pain and weakness are of major importance to extremity function. While s. 80.32 of the Wis. Admin. Code states that findings of weakness, decreased endurance, decreased sensation, heat or cold intolerance, pain, or other functional deficits shall result in an estimate higher than the minimum, variation in the rating of disability associated with these factors is quite high. Tables 80.32—2 and 80.32—3 are designed to provide guidance when rating these elements of disability. Common Nerve-Related Surgical Procedures (See Table 80.32—4 on Page 21)

c. The current rule does not include a minimum disability rating for carpal tunnel release. The recommendation is to establish a minimum rating of 2% at the level of the wrist for a carpal tunnel release. The rationale for this minimum rating is that carpal tunnel release involves a demonstratable anatomic change to the wrist by cutting the carpal ligament. ~~Following the procedure people frequently experience scarring, sensory deficits, and motor deficits.~~

There is no minimum rating for cubital tunnel release in the current rule. The recommendation is to establish a minimum rating of 2% at the level of the elbow. The rationale for this minimum rating is that cubital tunnel release involves a demonstratable anatomic change by releasing the cubital tunnel. ~~Following the procedure people frequently experience scarring, sensory deficits, and motor deficits.~~

For ulnar nerve transposition there is no minimum rating in the current rule. The recommendation is to establish a minimum rating of 5% at the elbow. The rationale for establishing this minimum rating is that an ulnar nerve transposition involves a demonstratable anatomic change by moving the nerve. ~~Following the procedure people frequently experience scarring, sensory deficits, and motor deficits.~~

d. With the current rule there is a minimum permanent disability rating of 75% for ankylosis of a finger at the middle joint at mid-position. The recommendation is to decrease the minimum rating to 70%. The rationale for decreasing this minimum rating is to more accurately reflect the relative contribution of this ankylosed joint to finger function.

**5. Discuss treatment guidelines for COVID-19:** The WCD provided claim status information for COVID-19 claims reported to the WCD as of January 12, 2023. The total reported claims involving COVID-19 was 7,099 of which 4,343 were denied. The majority of the remaining

claims had been accepted or were no lost time while a very small number were under investigation or litigated. WCD did not have any information as to whether any of these claims involved long COVID. The Department of Heath Services (DHS) is working on a paper entitled "Long COVID Surveillance using Workers Compensation Claims – Wisconsin, March 1, 2020-July 31, 2022." Although it has not yet been published DHS provided a summary/abstract of the paper indicating that:

- The authors defined a long COVID case as any claimant whose claim period was at least four weeks and an acute COVID case as any claimant whose claim period was less than four weeks.

- Approximately 1 in 8 COVID claims from March 1, 2020 to July 31, 2022 could be categorized as Long COVID cases

- The majority of those Long COVID cases had a claim period less than 60 days; a few cases had a claim period greater than 180 days, with a sizable minority between 60-179 days

- None of the claims were for permanent disability, likely because it has not yet been medically defined

- Claimants who had been hospitalized for COVID were more likely to have Long COVID than those who had not been hospitalized

- Vaccination was associated with reduced likelihood of Long COVID claims

- Most Long COVID claims were in healthcare.

Dr. Wakefield asked if any claims involving adverse reactions from the COVID-19 vaccine had been reported. Such a claim would potentially be work related if the employer required the vaccine as a condition of employment but the WCD was unable to determine if any claims had been submitted.

6. **Review of ch. DWD 81 of the Wisconsin Administrative Code:** Deferred.

7. **New Business:** None.

8. **Adjournment:** A motion to adjourn was made by Dr. Floren and seconded by Dr. Von-Schilling Worth. The meeting was adjourned at approximately 11:45 a.m. The next meeting is scheduled for May 5, 2023.