Health Care Provider Advisory Committee
Meeting Minutes
Aurora Medical Center in Summit
January 19, 2018

Members Present: Amanda Gilliland, RN; Richard Goldberg, MD; Barb Janusiak, RN; Maja Jurisic, MD; Frank Lasee, Chair; Michael M. McNett, MD; James O'Malley (Acting Chair); Jim Nelson (via telephone); and Jennifer Seidl, PT.

Excused: Mary Jo Capodice, DO; Ted Gertel, MD; Scott Hardin, MD; Stephen Klos, MD; Jeff Lyne, DC; and Peter Schubbe, DC.

Staff Present: Kelly McCormick and Frank Salvi.

Observers: None

1. **Call to Order/ Introductions:** Mr. O'Malley convened the Health Care Provider Advisory Committee (HCPAC) meeting at approximately 10:15 a.m., in accordance with Wisconsin's open meetings law. Mr. Frank Lasee introduced himself as the new Administrator of the Worker's Compensation Division (WCD). The members of the HCPAC and WCD staff introduced themselves.

2. **Acceptance of the August 11, 2017 and October 13, 2017 meeting minutes:** Ms. Seidl made a motion to approve the minutes of the August 11, 2017 and October 13, 2017 meetings. The motion was seconded by Dr. McNett. The minutes were unanimously approved without correction.

3. **Future meeting dates:** The HCPAC members agreed to schedule the next meeting on May 4, 2018. A meeting date of August 3, 2018 and a tentative meeting date of October 12, 2018 were also scheduled.

4. **Correspondence:** Mr. O'Malley reviewed the correspondence received since the last meeting. A letter dated October 12, 2017 was received from Mr. John Murray, Executive Director of the Wisconsin Chiropractic Association. In his letter, Mr. Murray raised the same concerns as Dr. Kelly Worth previously raised about denials by insurance carriers based on the inappropriate use of the Treatment Guidelines in ch. DWD 81 of the Wisconsin Administrative Code. Former WCD Administrator BJ Dernbach responded by letter to Mr. Murray on October 23, 2017 stating the Treatment Guidelines are factors to be used only by expert reviewers in rendering opinions to resolve necessity of treatment disputes between providers and insurance carriers filed with the WCD. Mr. Dernbach's letter also stated that no statutory authority exists to allow the use of the Treatment Guidelines for utilization of treatment reviews to deny treatment. In his letter, Mr. Dernbach informed Mr. Murray that the WCD website was updated to reflect this information. Hard copies of Mr. Murray's letter and the WCD response were distributed.

5. **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. *Update s. 81.08 (13) (a) 2. as follows*:

2. The only surgical procedures necessary for patients with myelopathy are decompression, microdiscectomy, and arthrodesis. For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be ~~necessary~~ considered consistent with sub. (6) (d).

The change to s. 81.08 (13) (a) 2. resulted in the following updates to ss. 81.06 (11) (b) 6., 81.07 (11) (b) 6., 81.07 (12) (b), 81.07 (13) (a) 2., 81.07 (14) (a) 2., 81.08 (11) (b) 6., and 81.08 (12) (b):

Section 81.06 (11) (b) 6.:

6. The only surgical procedures necessary for patients with regional low back pain are decompression of a lumbar nerve root, microdiscectomy, or lumbar arthrodesis, with or without instrumentation, which shall meet the guidelines of sub. (6) and s. DWD 81.12 (1). For patients with failed back surgery, spinal cord stimulators or intrathecal drug delivery systems may be ~~necessary~~ considered ~~and~~ consistent with sub. (6) (d).

Section 81.07 (11) (b) 6.:

6. The only surgical procedures necessary for patients with regional neck pain only ~~is~~ are decompression, microdiscectomy, or cervical arthrodesis, with or without instrumentation, which shall meet the guidelines in sub. (6). For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be ~~necessary~~ considered consistent with the guidelines of sub. (6) (d).

Section 81.07 (12) (b):

(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. It shall be provided within the guidelines of sub. (11) (b), with the following modifications: The only surgical procedures necessary for patients with radicular pain are decompression of a cervical nerve root which shall meet the guidelines of sub. (6) and s. DWD 81.12 (1) (c), microdiscectomy, and cervical arthrodesis, with or without instrumentation. For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be ~~necessary~~ considered consistent with sub. (6) (d).

Section 81.07 (13) (a) 2.:

2. The only surgical procedures necessary for patients with radicular pain are decompression of a cervical nerve root that shall meet the guidelines of sub. (6) and s. DWD 81.12 (1) (c), microdiscectomy, or cervical arthrodesis, with or without instrumentation. For patients with failed back surgery, spinal cord stimulators or intrathecal drug delivery systems may be ~~necessary~~ considered consistent with the guidelines of sub. (6) (d)

Section 81.07 (14) (a) 2.:

2. The only surgical procedures necessary for patients with myelopathy are anterior or posterior decompression of the spinal cord, microdiscectomy, or cervical arthrodesis with or without instrumentation. For patients with failed back surgery, spinal cord stimulators or intrathecal drug delivery systems may be ~~necessary~~ considered consistent with the guidelines of sub. (6) (d).

Section 81.08 (11) (b) 6.:
6. The only surgical procedures necessary for patients with regional thoracic back pain only ~~is~~ are decompression, microdiscectomy, or thoracic arthrodesis with or without instrumentation, which shall meet the guidelines of sub. (6) and s. DWD 81.12 (1) (d). For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be ~~necessary~~ considered consistent with sub. (6) (d).

Section 81.08 (12) (b):
(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. It shall be provided within the guidelines of sub. (11) (b), with the following modifications: The only surgical procedures necessary for patients with radicular pain are decompression, microdiscectomy, or arthrodesis. For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be ~~necessary~~ considered consistent with sub. (6) (d).

b. *Update s. 81.09 (2) (a) as follows:*
(a) All medical care for upper extremity disorders, appropriately assigned to a category of sub. (1) (b) 1. to ~~6~~5., is determined by the diagnosis and clinical category that the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11) to (16) as follows:

~~1. Subsection (11) governs epicondylitis.~~

~~2~~1. Subsections (11) and (12) govern~~s~~ epicondylitis, tendinopathy, and tendonitis of the elbow, forearm, wrist, and hand.

~~3~~2. Subsection (13) governs upper extremity nerve ~~entrapment~~ syndromes.

~~4~~3. Subsection (14) governs upper extremity muscle pain syndromes.

~~5~~4. Subsection (15) governs shoulder impingement syndromes.

~~6~~5. Subsection (16) governs traumatic sprains and strains of the upper extremity.

c. *Add language to s. 81.09 (2) (b):*
(b) A health care provider shall at each visit reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information if the new clinical information is causally related to the initial mechanism of injury. Bases for changing the clinical category include~~ing~~ symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed, the treatment plan shall be appropriately modified to reflect the new clinical category. The health care provider shall record any clinical category and treatment plan changes in the medical record. A change of clinical category may not in itself allow a health care provider to continue a therapy or treatment modality past the maximum duration specified in subs. (3) to (10) or to repeat a therapy or treatment previously provided for the same injury, unless the treatment or therapy is subsequently delivered to a different part of the body.

This change also updates ss. 81.06 (2) (b), 81.07 (2) (b), and 81.08 (2) (b):

Section 81.06 (2) (b):
(b) A health care provider shall~~,~~ at each visit~~,~~ reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information if the new clinical information is causally related to the initial mechanism of injury. Bases for changing the clinical category include~~ing~~ symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. ~~If~~ When the clinical category is changed, the treatment plan shall be appropriately modified to reflect the new clinical category. The health care provider shall record any clinical category and treatment plan changes in the medical record. A change of clinical category may not in itself allow a health care provider to continue a therapy or treatment modality past the maximum duration specified in subs. (3) to (10) or to repeat a therapy or treatment previously provided for the same injury, unless the treatment or therapy is subsequently delivered to a different part of the body.

Section 81.07 (2) (b):
(b) A health care provider shall at each visit reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information if the new clinical information is causally related to the initial mechanism of injury. Bases for changing the clinical category include~~ing~~ symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed, the treatment plan shall be appropriately modified to reflect the new clinical category. The health care provider shall record any clinical category and treatment plan changes in the medical record. A change of clinical category ~~shall~~ may not in itself allow a health care provider to continue a therapy or treatment modality past the maximum duration specified in subs. (3) to (10) or to repeat a therapy or treatment previously provided for the same injury, unless the treatment or therapy is subsequently delivered to a different part of the body.

Section 81.08 (2) (b):
(b) A health care provider shall~~,~~ at each visit~~,~~ reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information if the new clinical information is causally related to the initial mechanism of injury. Bases for changing the clinical category include~~ing~~ symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed, the treatment plan shall be appropriately modified to reflect the new clinical category. The health care provider shall record any clinical category and treatment plan changes in the medical record. A change of clinical category may not in itself allow a health care provider to continue a therapy or treatment modality past the maximum duration specified in ~~this section~~ subs. (3) to (10) or to repeat a therapy or treatment previously provided for the same injury, unless the treatment or therapy is subsequently delivered to a different part of the body.

d. Change s. 81.09 (2) (c) to read:
(c) When treating more than one clinical category or body part for which the same treatment modality is appropriate, then the treatment modality shall be applied ~~simultaneously~~ at the same visit, if possible, to all necessary areas.

e. Change s. 81.09 (2) (d) 1. to read:
1. First, all patients with an upper extremity disorder shall be given initial nonsurgical management, unless otherwise specified. Initial nonsurgical management may

include any combination of the passive, active, injection, durable medical equipment, and medication treatment modalities listed in subs. (3), (4), (5), (8), and (10), appropriate to the clinical category. The period of initial nonsurgical treatment begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. To continue ~~I~~initial nonsurgical treatment, it shall result in progressive improvement as specified in sub. (9).

f. Create a new s.81.09(2)(d)2. and renumber through 4. as follows:

2. Second, for patients with symptoms persisting beyond six weeks who are not progressing towards functional restoration, a reassessment shall 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 as specified in sub. (1)(i). The treatment plan shall then be modified accordingly.

~~2~~3. ~~Second, for~~Third, after consideration of sub. 2, patients with persistent symptoms~~,~~ may be considered for ~~initial nonsurgical management 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 (16), and s. DWD 81.12 (2). A treating health care provider may do the evaluation or may refer the patient to another health care provider.

a. 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.

b. Surgery shall follow the guidelines in subs. (6), (11) to (16), and s. DWD 81.12 (2).

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

~~Third~~4. Fourth, for those patients who are not candidates for surgery or refuse surgery, or who do not have ~~complete~~ adequate recovery of function ~~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).

g. Change s. 81.09 (3) (a) to the following:

(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.

h. Update s. 81.09 (3) (b) to the following:

(b) *Additional passive treatment modalities.* A health care provider may direct an additional 12 visits for the use of passive treatment modalities over an additional 12 months if all of the following apply:

1. ~~The patient is released to work or is permanently totally disabled and t~~The additional passive treatment may result in progressive improvement in, or

maintenance of, functional status achieved during the initial 12 weeks of passive care.

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.

3. A health care provider documents in the medical record a plan to encourage ~~the patient's independence~~ self-efficacy and decreased reliance on health care providers.

4. Management of the patient's condition includes active treatment modalities during this period.

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

6. Passive care is not ~~necessary while the~~ recommended for patients ~~has~~ with chronic pain syndrome.

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.

Sections 81.06 (3) (b), 81.07 (3) (b), and 81.08 (3) (b) should also be updated as above with one change:
1. ~~The patient is released to work or is permanently totally disabled and t~~The additional passive treatment ~~shall~~ may result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care.

i. Add the following phrase to s. 81.09 (3) (c):
(c) *Adjustment or manipulation of joints.* For purposes of this paragraph, "adjustment or manipulation of joints" includes chiropractic and osteopathic adjustments or manipulations and physical therapy manipulations. All of the following guidelines apply to adjustment or manipulation of joints:

j. Update s. 81.09 (3) (d) 2. to read:
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, and other durable medical equipment 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.

k. Update s. 81.09 (3)(e) 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. ~~Treatment~~ Electrical stimulation given in a clinical setting:

a. Time for treatment response is ~~2~~3 to ~~4~~5 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 ~~muscle~~ 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 electrical stimulation device:

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

b. Patient may use the electrical stimulation device unsupervised 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.

l. Update ss. 81.06 (3) (g), 81.07 (3) (g), 81.08 (3) (g), 81.09 (3) (f) and 81.10 (2) (g) with the following deletion:

Acupuncture treatments. For purposes of this paragraph, "acupuncture treatments" include ~~endorphin-mediated analgesic therapy that includes~~ classic acupuncture and acupressure. All of the following guidelines apply to acupuncture treatments:

m. Correct spelling of "phonophoresis" in s. 81.09 (3) (g):

(g) *Phoresis.* For purposes of this paragraph, "phoresis" includes phonoph~~e~~oresis and iontophoresis. All of the following guidelines apply to phoresis:

n. Update s. 81.09 (3) (h) as follows:

(h) *Manual therapy.* For purposes of this paragraph, ~~"~~manual therapy~~"~~ ~~includes~~ techniques consist of, but are not limited to connective tissue massage, joint mobilization and manipulation, manual traction, passive range of motion, soft tissue ~~and joint~~ mobilization and manipulation, dry needling techniques and therapeutic massage~~, and manual traction~~. Manual therapy techniques may be applied to one or more regions. All of the following guidelines apply to manual therapy:

o. Update s. 81.09 (3) (i) as follows:

(i) Splints, braces, and other movement-restricting appliances. Bracing required for longer than 2 weeks shall be accompanied by active motion exercises to avoid stiffness of the uninvolved tissues and prolonged disability. Maximum continuous duration is 8 weeks, with the exception of mallet finger, which is 12 weeks. Prophylactic use is allowed indefinitely. ~~All of the following guidelines apply to splints, braces, and other movement-restricting appliances:~~

~~1. Time for treatment response is 10 days.~~

~~2. Maximum treatment frequency is limited to intermittent use during times of increased physical stress or prophylactic use at work.~~

~~3. Maximum continuous duration is 8 weeks. Prophylactic use is allowed indefinitely.~~

p. Create s. 81.09 (3) (k) as follows:

(k) *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.

q. *Update s. 81.09 (4) (a) to read*:
(a) A health care provider shall use active treatment modalities 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 treatment for the active treatment modality is not exceeded~~.

r. Update s. 81.09 (4) (b) to read:
(b) Education shall include teaching the patient about pertinent anatomy and physiology as it relates to upper extremity function for the purpose of injury prevention. Patient e~~E~~ducation includes training on posture, biomechanics, and relaxation. Patient education shall be ongoing and reflected through active treatment modalities. ~~The maximum number of treatments is 3 visits which include an initial education and training session, and 2 follow-up visits.~~

This change also requires updates to 81.06 (4) (b), 81.07 (4) (b), and 81.08 (4) (b) as follows:
(b) Education shall include teaching the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Patient ~~E~~education includes training on posture, biomechanics, and relaxation. Patient education shall be ongoing and reflected through active treatment modalities. ~~The maximum number or treatments is 3 visits, which include an initial education and training session and 2 follow up visits.~~

s. *Update s. 81.09 (4) (c) to read*:
(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. This is an ongoing part of treatment and is reflected through active treatment modalities.~~The maximum number of treatments is 3 visits.~~

t. Update s. 81.09 (4) (d) to read:
(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.

u. Update s. 81.09 (4) (e) as follows:
(e) Exercise, which is important to the success of a 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 upper extremity. While aerobic exercise may be performed as adjunctive treatment, this shall not be the primary focus of the exercise program.

v. *Update s. 81.09 (4) (f) 1. a. to read:*
a. Maximum treatment frequency is ~~up to 3~~ 5 times per week for the first week, 3 times per week for the next 2 weeks, and decreasing in frequency after the third week ~~3 weeks and shall decrease with time~~ until the end of the maximum treatment duration period in subd. 1. b.

w. *Create ss. 81.06 (5) (b) 1. d., 81.07 (5) (b) 1. d., 81.08 (5) (b) 1. d. and 81.09 (5) (b) 4. as follows:*
Health care providers shall educate, instruct, and actively encourage patients to utilize myofascial self-care techniques in conjunction with trigger point injections.

x. *Update and renumber s. 81.09 (5) (d) to read:*
(d) All of the following guidelines apply to injections for median nerve entrapment at the carpal tunnel:

1. Ideally the treatment is administered within the first 6 to 8 weeks.

~~1~~2. Time for treatment response is within one week.

~~2~~3. Maximum treatment frequency may permit repeat injection in one month if there is a positive response to the first injection. Only 3 injections to different sites per patient visit.

~~3~~4. Maximum treatment is 2 injections to any one site over the course of treatment.

6. New Business: None.

7. Adjournment: Dr. McNett made a motion to adjourn, which was seconded by Dr. Jurisic. The motion passed unanimously. The meeting was adjourned at approximately 12:25 p.m. The next meeting is scheduled for May 4, 2018.