Health Care Provider Advisory Committee
Meeting Minutes
Webex Conference Meeting
August 6, 2021

Members Present: John Bartell, RN; Mary Jo Capodice, DO; Andrew Floren, MD; Barb Janusiak, RN; David Kuester, MD; Jennifer Seidl, PT; Kelly Von-Schilling Worth, DC; Timothy Wakefield, DC; and Nicole Zavala.

Excused: David Bryce, MD; Theodore Gertel, MD; and Richard Goldberg, MD; and Steven Peters (Chair).

Staff Present: Joe Brockman, John Dipko, Kelly McCormick, Jim O'Malley (Acting Chair), Laura Przybylo, Frank Salvi, MD, and Lynn Weinberger.

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, and called the roll. A quorum was present.

2. **Acceptance of the January 22, 2021 meeting minutes:** Dr. Floren made a motion, seconded by Dr. Capodice, to accept the minutes of the January 22, 2021 meeting. The minutes were unanimously approved without correction.

   Mr. O'Malley explained the circumstances for cancellation of the meeting scheduled on May 7, 2021. The Statements of Scope authorizing the Department to engage in rule making for s. DWD 80.32, (minimum permanent partial disability ratings), ch. DWD 81 (WC treatment guidelines), and some amendments to ch. DWD 80 primarily related to self-insurance expired. In the past Statements of Scope remained in effect indefinitely. Due to a recent law change Statements of Scope have a two and one-half (2 ½) year time limit. The Statements of Scope for our administrative rules were renewed and the Department is once again authorized to go forward with amending the minimum permanent partial disability ratings and worker's compensation treatment guidelines.

3. **Future meeting dates:** The HCPAC members agreed to schedule the next meeting on October 1, 2021. Tentative dates were also selected for future meetings on January 21, 2022 (virtual meeting), and May 6, 2022 (in-person meeting).The possibility of meeting more frequently if the meetings are held virtually was also discussed.

4. **Review of survey of practitioners to update minimum PPD ratings in s. DWD 80.32 of the Wisconsin Administrative Code:** The HCPAC members resumed review of the recommended changes to s. DWD 80.32.

   a. The HCPAC members discussed and approved the content and format for the tables of disability related to nerve injuries contained in Tables 80.32-1 through 80.32-4.

Table 80.32—1

Complete Loss of Function of Referenced Nerves

Digital sensory loss for hand	
Any digit complete	55% at joint proximal to level of involvement
Any digit palmar surface	40% at joint proximal to level of involvement
Any digit dorsal surface	15% at joint proximal to level of involvement
Digital nerve	20% at joint proximal to level of involvement
Ulnar nerve complete loss	
Motor and sensory involvement above mid forearm	50% at elbow
Motor involvement only above mid forearm	45% at elbow
Sensory involvement only above mid forearm	15% at elbow
Motor and sensory involvement below mid forearm	40% at wrist
Motor involvement only below mid forearm	35% at wrist
Sensory involvement only below mid forearm	15% at wrist
Median nerve complete loss	
Motor and sensory involvement above mid forearm	65% at elbow
Motor involvement only above mid forearm	45% at elbow
Sensory involvement only above mid forearm	45% at elbow
Motor and sensory involvement below mid forearm	50% at wrist
Motor involvement only below mid forearm	15% at wrist
Sensory involvement only below mid forearm	45% at wrist
Radial nerve complete loss	
Motor and sensory involvement including triceps	45% at shoulder
Motor involvement only including triceps	40% at shoulder
Sensory involvement only including upper arm	5% at shoulder
Motor and sensory involvement below elbow	40% at elbow
Motor involvement only below elbow	35% at elbow
Sensory involvement only below elbow	5% at elbow
Axillary nerve complete loss	
Motor and sensory involvement	35% at shoulder
Motor involvement only	30% at shoulder
Sensory involvement only	5% at shoulder
Musculocutaneous nerve complete loss	
Motor and sensory involvement	30% at shoulder
Motor involvement only	25% at shoulder
Sensory involvement only	5% at shoulder
Peroneal nerve complete loss	
Motor and sensory involvement causing foot drop	40% at ankle
Motor involvement only causing foot drop	35% at ankle
Sensory involvement only (dorsal foot)	10% at ankle
Plantar nerve complete loss	
Sensory involvement (plantar foot)	15% at ankle

Table 80.32—2

Characterization of Sensory Deficit or Pain Due to Specific Upper or Lower Extremity Peripheral Nerve Injury*	% of Total Loss
Normal sensation and no pain	0%
Altered (decreased) sensation +/- minimal pain forgotten during activity - Diminished light touch	1-25%
Altered (decreased) sensation +/- mild pain that interferes with some activity - Diminished light touch, 2-Point discrimination	26-60%
Altered (decreased) sensation +/- moderate pain that prevents many activities - Diminished protective sensation (pain, temperature or pressure can cause damage before being perceived)	61-80%
Absent superficial sensation +/- abnormal sensation or severe pain that prevents most activity - Absent protective sensation	81-99%
Absence of all sensation or severe pain that prevents all activity	100%

*For combined sensory and motor deficits (See Table 80.32-3), average the percentages rated for each component alone then multiply that percentage by the value for the specified nerve.

Table 80.32—3

Characterization of Motor Deficit Due to Specific Upper or Lower Extremity Peripheral Nerve Injury*	% of Total Loss
Full strength (5/5) and full active range of motion for muscles innervated by specified nerve - No activity limitations	0%
Mildly decreased strength against resistance (5- or 4+/5), but full active range of motion - Mildly diminished endurance or ability to perform activities	1-25%
Moderately decreased strength against resistance (4 or 4-/5), but full active range of motion - Moderately diminished endurance and ability to perform activities	26-60%
Decreased strength (3/5) full active range of motion against gravity, but not against resistance - Substantial activity deficits	61-80%
Decreased strength (2/5) full active range of motion with gravity eliminated - Inability to perform most activities for muscles innervated by specified nerve	81-95%
Severely decreased strength (1/5) slight contractility but no range even with gravity eliminated - No functional movement of muscles innervated by specified nerve	96-99%
Absent strength (0/5) no contractility - No movement of muscles innervated by specified nerve	100%

*For combined sensory (See Table 80.32-2) and motor deficits, average the percentages rated for each component alone then multiply that percentage by the value for the specified nerve.

Table 80.32—4

Common Nerve-Related Surgical Procedures	Minimum Disability
Carpal Tunnel Release	2% at wrist
Cubital Tunnel Release	2% at elbow
Ulnar Nerve Transposition	5% at elbow

b. Dr. Kuester sought clarification regarding terminology for ratings based on loss of motion at the knee. The HCPAC recommend removing the "Remaining range" language for the knee as it had done in other sections. The HCPAC recommended updating ratings at the knee for motion loss as follows:

Loss of flexion (normal flexion 135°)	
Severe limitation 90° loss	25%
Moderate limitation 45° loss	10%
Mild limitation 30 ° loss	5%
Loss of extension (normal extension 0°)	
Severe limitation 30° loss	30%
Moderate limitation 20° loss	15%
Mild limitation 10° loss	5%

c. The appropriate minimum rating for implantation of an artificial spinal disc was discussed. The current minimum rating for implantation of an artificial spinal disc is 7½% per level. Following a review of the results of the survey of practitioners, the HCPAC recommended increasing the rating to 10% per level as this was the average survey response rating for implantation of an artificial spinal disc.

d. Ratings for spinal decompression of 5% per level and spinal fusion procedures of 7% per level were discussed. It was the consensus of the HCPAC that ratings should not vary for procedures performed at different levels of the spine.

e. It was recommended to remove the language regarding "cervical fusion" and change the title for s. DWD 80.32 (11) from "Back" to "Spine".

f. The disability rating for the implantation of spinal cord stimulators in s. DWD 80.32 (11) was discussed. It was the consensus of the HCPAC that the rule specify the implantation of the spinal cord stimulator must be permanent for the minimum rating to apply.

g. The HCPAC discussed examples for disability ratings at the end of s. DWD 80.32. The group encouraged use of examples demonstrating calculation of disability for multiple spinal procedures. Language clarifying that the ratings apply to procedures for the same date of injury was also added.

Examples:

Patient A	Surgery #1	Laminectomy	5% PTD
	Surgery #2	Fusion	increases to 12% PTD
Patient B	Surgery #1	Laminectomy & Fusion	12% PTD
	Surgery #2	Re−fusion	increases to 19% PTD
	Surgery #3	Laminectomy at New Level	increases to 24% PTD
	Surgery #4	Fusion at Level of Surgery #3	increases to 31% PTD
	Surgery #5	Re−fusion at Level of Surgery #4	increases to 38% PTD

These examples apply to procedures attributed to the original date of injury.

5. **Review of ch. DWD 81 of the Wisconsin Administrative Code.** The HCPAC resumed review of ch. DWD 81 beginning with s. DWD 81.13.

   a. Ms. Seidl proposed several changes to s. DWD 80.13 recommended by the Wisconsin Physical Therapy Association (WPTA) that were adopted by the HCPAC.

      1. Add additional sentence to s. DWD 81.13 (2) (a) as follows:
      (a) *Home-based exercise programs.* Home-based exercise programs consist of aerobic conditioning, stretching, and flexibility exercises, and strengthening exercises done by the patient on a regular basis at home without the need for supervision or attendance by a health care provider. Maximum effectiveness may require the use of certain durable medical equipment that may be prescribed within any applicable treatment guidelines in ss. DWD 81.06 to 81.10. The patient shall be provided 1 to 3 visits for home exercise, with periodic reassessments for ongoing progression and maintenance, not to exceed 6 visits annually.

      2. Update s. DWD 81.13 (2) (d) as follows:
      1. 'Indications.' The patient is ~~disabled from~~ unable to perform usual work and requires reconditioning for specific job tasks or activities and the reconditioning cannot be done on the job. A health care provider shall document the reasons why work hardening cannot be accomplished through a structured return to work program. Work conditioning is necessary when only physical and functional needs are identified. Work hardening is necessary when, in addition to physical and functional needs, behavioral, and vocational needs are also identified that are not otherwise being addressed.

      2. 'Guidelines.' The program shall have specific goals stated in terms of work activities.~~, for example "able to type for 30 minutes."~~ There shall be an individualized program of activities and the activities shall be chosen to simulate required work activities or to enable the patient to participate in simulated work activities. There shall be a specific timetable of progression in those activities, designed so that the goals may be achieved in the prescribed time. There shall be a set frequency and hours of attendance and the program shall maintain adequate documentation of attendance. There shall be a set duration of attendance. Activity restrictions shall be identified at completion of the program.

   b. Dr. Von-Schillingworth presented a draft for a proposed new section in ch. DWD 81 that includes treatment guidelines for injuries to the lower extremities similar to the guidelines for upper extremities contained in s. DWD 81.09. The HCPAC discussed whether treatment guidelines should be adopted for injuries to the lower extremity injuries. Mr. O'Malley stated treatment guidelines for lower extremity injuries were not originally included in ch. DWD 81 because they were not included in the Minnesota Worker's Compensation Treatment Parameters after which Wisconsin's guidelines were modeled. Mr. O'Malley will request staff to conduct a research project about the total number of injuries to the upper extremities compared to the lower extremities for the last few years and present this data at the next meet.

c. The HCPAC decided to defer discussion about Chronic Regional Pain Syndrome (CRPS) in s. DWD 81.10 and chronic pain management programs in s. DWD 81.13(2)(e) until some of the members more familiar with this area are present. Additional discussion about treatment related to opioid addiction and updating language from "chemical dependency" to "substance use disorders" is also needed.

6. **Adjournment:** Ms. Seidl made a motion to adjourn, which was seconded by Dr. Capodice. The motion passed unanimously. The meeting was adjourned at approximately 12:20 p.m. The next meeting is scheduled for October 1, 2021.

[MINUTES HCPAC MEETING 8.6.21]