

**ODG**  
***Official Disability Guidelines 2004, Ninth Edition and Treatment in Workers' Comp***

A Critical Analysis prepared by:

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The current trend in the healthcare field is development of “best practices, evidence-based” guidelines. In general, guidelines serve as background information to assist the physician in deciding the proper course of care based on the best available evidence. Guidelines are not cookbooks or prescriptions for care, and using them out of context is to use them inappropriately. The style of the Official Disability Guidelines (ODG) is particularly problematic and a source of potential misuse and abuse. The medical necessity of care is found in the patient’s file, not in a guideline document that references specific numbers of treatments and duration. The purpose of this paper is to identify areas of potential problems in the ODG as they relate to Chiropractic case management. The authors of this paper would suggest the use of best practices guidelines developed by The Council on Chiropractic Guidelines and Practice Parameters, due for release in early 2005. The ODG is not accurate or useful in relation to Chiropractic care.

Points of Interest:

- The editorial advisory board of the ODG is comprised of 78 people, including 62 doctors of medicine, 2 doctors of Osteopathy, and 2 doctors of Chiropractic.
- The DCs on the panel included; Dr. Preston B. Fitzgerald representing the National Board of Forensic Chiropractors, and Dr. Dennis DiGiorgi representing American Board of Quality Assurance and Utilization Review Physicians.
- The American Chiropractic Association, representing the largest number of doctors of Chiropractic in the world, was not represented.
- The ODG Treatment Workers’ Comp has been divided into three sections:
  - Treatment Protocols: Provides a step-by-step approach to scientifically proven diagnostic and clinical treatment plans for work-related injuries. **Comment: “Scientifically proven” is ill defined. In our opinion the reference to specific numbers of treatment cannot be supported by the various articles referenced in ODG. Specific numbers (CPT codes) no doubt will become the greatest area of misuse and abuse of ODG. If history repeats itself, the ODG could be, and likely will be, used as an easy way to avoid the much more laborious work involved in a legitimate file review to determine medical necessity.**
  - Procedure Summaries: Provides a concise synopsis of the effectiveness of each procedure, linked to the supporting medical evidence in abstract form, which has

been ranked, highlighted and indexed. This section exemplifies the intent behind the movement to evidence-based medicine.

- Codes for Automated Approval: Assigns procedure codes (CPT) to diagnosis (ICD9) codes with a field for “maximum occurrences”, based on the **ideal protocol** [emphasis added], for use in decisions to approve treatment.
- The term “Best Practice” describes the use of these pathways to manage disability. [page 16] These guidelines focus on return-to-work, and are not as detailed as clinical best practice guidelines, but they do include the various paths of treatment suggested by clinical best practice guidelines. [page 16]
- **IMPORTANT**: “These guidelines are meant to be used to identify cases that are out of the norm, where questions may be asked, such as what makes them different. Especially where there is a great variation in severity, for example, for some cancers, additional information may be requested and the additional time out of work may be justified. If the patient has co-morbidities that are not specifically identified in the guidelines, application of the guidelines is more difficult. **The final opinion regarding any medical condition and the ability of a patient to return to work should rest with the physician treating the patient.** [emphasis added] Where the “Best Practice” disability duration guidelines indicate “by report”, variances in the data made it impossible to select a benchmark number of days, and the report by the evaluating physician should guide the amount of time off work.” [page 17]
- **IMPORTANT**: “Some physicians consider the return-to-work dates in the “Best Practice” guidelines to be aggressive, and there may be some cases that do not meet these guidelines. This may result in disagreement between case managers and physicians. **The best practices take into account the best circumstances.** [emphasis added] Some patients can return to work earlier than the best practices suggest, and others later than suggested. Such variables as age, co-morbid conditions, severity, job type and other items can impact disability duration and **must always be taken into account.** When patients fall outside these values, most notably if the projected disability duration exceeds “Best Practice” estimates, the case manager should consult the treating physician as to why the case might not fit the “Best Practice” guidelines. [page 17-18]
- The Return to Work Summary Guidelines show **estimated** [emphasis added] days out of work (based on national norms)...[page 18]

- **Chiropractic Guidelines:** “These guidelines provide accepted optimal benchmarks for the number of visits with a chiropractor and the period of time during which these visits take place. Support for the chiropractic guidelines is relevant medical literature, combined with consensus review by experts. A major source was the “Mercy Guidelines”, the consensus document created by the American Chiropractic Association in conjunction with the Congress of State Chiropractic Associations, entitled *Guidelines for Chiropractic Quality Assurance and Practice Parameters, Proceedings of the Mercy Center Consensus Conference*. Many of the philosophies described above under “Physical Therapy Guidelines” should also apply to the chiropractic guidelines. More specifically, in addition to a “six-visit clinical trial”, every six visits thereafter the treating chiropractor should validate improvement in function as it relates to the patient’s essential job functions, hours working, or a standard pain scale in order for treatment to continue.” [page 20]

**Comments:** The Mercy guidelines were developed nearly 15 years ago. While the document contained the most current scientific data available at the time, a great deal of new literature has been produced since Mercy. Therefore reliance (“a major source”) on Mercy is inherently inaccurate compared to contemporary literature.

Please note the “six-visits clinical trial” should not be confused or interpreted as an arbitrary limit. This guideline, similar to past guidelines, only suggests that if no improvement is noted, ongoing treatment should be reconsidered. In our opinion, six visits or two weeks is a benchmark that should be respected by every treating physician or therapist. For example, every patient managed medically or by a physical therapist should be considered for spinal manipulation (if indicated) if medical management and/or PT failed to demonstrate improvement, and visa versus. The literature clearly suggests that doctors of Chiropractic provide 94% of all spinal manipulation therapy (SMT) in this country. The literature also suggests the use of physicians specifically and adequately trained in the art of spinal manipulation. Chiropractic physicians possess by far more training in SMT than any other type of physician or therapist.

Please also note that a standard pain scale is adequate to document or monitor the need for ongoing treatment. It would be improper for case managers, consultants, nurse reviewers, etc. to impose personal arbitrary requirements such as outcome assessment tools (OATS). While certainly useful, OATS are not currently the industry standard or the holy grail of documentation.

- **Medical costs:** The costs only cover cases that were hospitalized.

## Condition Specific Issues

### General Issues and Comments:

- **Risk of Stroke References:** Throughout the guidelines there exists a very inappropriate reference to “risk of stroke” in every section pertaining to Chiropractic management/treatment to the neck. While the risk of stroke is important for each physician to consider, and Chiropractic physicians are well trained in the indications and contraindications of spinal manipulation, the ODG inappropriately highlights the risk associated with spinal manipulation and makes no mention of the dangers of various medical treatments that pose a much higher risk. For example, current literature suggests that spinal manipulation is safer than non-steroidal anti-inflammatory medication (NSAIDs) by a factor of several hundred times. 16,500 patients per year die in this country due to use of NSAIDs. Another 20,000 deaths per year are attributable to Tylenol, yet the ODG is silent on those issues. Current literature suggests that no valid tests exist to adequately and reliably screen a person for risk of stroke, and that the real risk is as rare as 1 in 2-5.85 million adjustments, or 1 in 8 million office visits. Factually, spinal manipulation is one of the safest treatments that exist for neck pain/conditions and should be encouraged rather than subtly discouraged.
- **Specific treatment and duration numbers:** The greatest weakness of the ODG guideline pertains to this issue. Often no attempt is made to differentiate between mild, moderate, and severe conditions; therefore any reference to specific numbers of treatments over specific periods of time is inherently inaccurate compared to the actual facts of each unique case. Our past experience with claims managers, consultants, and nurse reviewers merits serious caution since the ODG guidelines will likely be used inappropriately by replacing the need to understand the uniqueness of each patient, relying instead on hard and fast numbers provided by ODG as an easy reference.
- **Lack of scientific validation to support ODG recommendations:** While the ODG Treatment in Workers’ Comp 2004 cites numerous studies to support the recommendations; the process is truly reliant on a medically dominated committee’s interpretation of the data. We have no confidence that a committee comprised of 62 MDs and various other experts from the health services sector, and only 2 DCs who do not represent the majority of practicing Chiropractors, can without bias produce a credible recommendation for Chiropractic care. There are no papers that can be cited that consistently supports the use of such rigid numbers/recommendations.

Examples:

722.0 Displacement of cervical intervertebral disc without myelopathy.

ODG suggests 10 visits over 8 weeks. [page 901]

722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy.

ODG suggests 18 visits over 6-8 weeks, avoid Chronicity and gradually fade the patient into active self-directed care. [page 902]

722.8 Postlaminectomy syndrome.

ODG suggests 14-16 visits over 12 weeks.

723.1 Cervicalgia

ODG suggests 9 visits over 8 weeks.

723.4 Brachia neuritis or radiculitis NOS

ODG suggests trial of 6 visits, and then presumably 18 visits over 6-8 weeks.

It remains unclear whether the initial 6 visits are included in the 18, or in addition to the 18, allowing a total of 24 visits. Additionally, we are not certain of the intent of the statement..."Patient selection based on previous chiropractic success—". This statement is repeated numerous times throughout the document.

724.2 Lumbago

ODG suggests: Mild: 6 visits in 2 weeks  
Severe: Trial of 6 visits over 2 weeks.  
Severe: with evidence of objective functional improvement, a total of 18 visits (12 additional) over 6-8 weeks. **Elective care: as needed.**

724.3 Sciatica

ODG suggests: Trial of 6 visits over 2 weeks.  
With improvement, total up to 18 visits, (12 additional) over 6-8 weeks.

846 Sprains and strains of the sacroiliac region [page 1136]

**ODG suggests: PT only. No mention is made of Chiropractic in the introductory section...the most common injury in the work place!**

846.0 Lumbosacral

ODG suggests: No mention made of Chiropractic treatment.

847 Sprains and strains of other and unspecified parts of the back.

ODG suggests: Mild 6 visits over 2 weeks.  
Severe: Trial of 6 visits over 2 weeks.  
Severe: With evidence of improvement, up to 18 visits over 6-8 weeks. Elective care—as needed.

847.0 Neck sprain/strain

ODG suggests: Mild (grade 1): up to 7-10 visits over 2-3 weeks.  
Moderate (grade II): Trial of 7-10 visits over 2-3 weeks.  
Moderate (grade II): With evidence of improvement,  
Total up to 20 visits over 6-8 weeks.  
Severe (grade III and auto trauma): trial of 15-20 visits over 4-6 weeks.  
Severe (grade III and auto trauma): with evidence of objective functional improvement, total of up to 50 visits over 6 months, avoid Chronicity.

847.2 Lumbar sprain and strains.

ODG suggests: Mild up to 6 visits over 2 weeks.  
Severe: Trial of 6 visits over 2 weeks.  
Severe: with improvement, total of up to 18 visits over 6-8 weeks. Elective care: as needed.

We challenge the ODG to produce a credible reference suggesting that 10 visits for a cervical disc versus 18 for a lumbar disc, or 14-16 visits for a post-surgical patient, is anything but a wild guess. In our opinion, these numbers are overly restrictive and will lead to unnecessary surgical intervention in a significant number of cases.

**IMPORTANT:** Secondly, while the Chiropractic profession certainly encourages the shift towards active patient directed care, the ODG could easily be misinterpreted (as Mercy was in the past) to suggest that no Chiropractic care is

appropriate after 18 visits. Clearly this document includes no such limit to Chiropractic involvement for chronic pain sufferers.

Best practice guidelines should be a source of information to provide the physicians with choices based on the best available medical evidence. Treatment guidelines based on rigid numbers and case averages is a concept already outdated and laden with potential conflict between physicians and case managers.

- **Restriction of scope of practice:** The Chiropractic community is justifiably concerned over the potential to restrict treatment to only limited spinal conditions. For example, the ODG provides no mention of Chiropractic management and or/manipulative treatment for extremities, seemingly limiting Chiropractic to only the spine, unless we restrict treatment to typical physical therapy procedures. An entire body of literature pertaining to the beneficial effects of joint mobility and deleterious effects of joint tightness seem to have been omitted from ODG that would have supported extremity manipulation.

## **ODG Treatment in Workers' Comp**

We are particular concerned over the confusion created by differing treatment recommendations between the Disability Guideline (DG) and the Treatment Guideline (TG). The DG suggests 18 visits over 6-8 weeks for a typical non-radicular lumbar sprain/strain. The TG seems to suggest "End manual therapy at 4 weeks" after what appears to be just 3 visits. [page 415 TG] The example provided in the very beginning of the TG is that of a typical computer screen presumably available to a case manager, that indicates the treatment protocols for low back pain, includes only 3 visits over a 4 week period, ending manual therapy at 4 weeks.

More troublesome is the fact that the section under "radiculopathy" completely omits Chiropractic management and the various conservative spinal manipulative techniques, that are supported by both the literature and decades of clinical experience. Furthermore, the ODG Treatment guidelines actually support the use of epidural steroid injections (ESI) on the second visit, despite the contemporary literature criticizing the use and effectiveness of ESI.

Lastly, the ODG actually recommends a referral for both high cost diagnostic tests and referral to an orthopedic surgeon without even the benefit of a trial period of Chiropractic care.

The BWC system in Ohio has experienced a dramatic increase in both drug expenditures, and hospital based costs and PT since the inception of HPP in 1997. If these guidelines are adopted as written, the system will likely experience an even

greater shift in drug, hospital, and surgical costs for the most prevalent injuries suffered by injured workers, by forcing injured workers into unproven, dangerous, and high cost medical management.