November 30, 2017

Jacqueline Kurth, Medical Resource Office Manager
Industrial Commission of Arizona
800 W. Washington
Phoenix, AZ 85007

RE: Expanding Applicability of the Official Disability Guidelines

Dear Ms. Kurth:

Until an employee injury occurs, our primary goal is to reduce the likelihood of injury and the severity of those injuries that do occur. Once an injury has occurred, our primary goal is to return the employee, as far as possible and as quickly as possible, to his or her preinjury condition. Secondary goals include a workers' compensation system that is predictable, timely, and cost effective.

A general tenet is that we take employees the way we find them, including their frailties and comorbidities. Employees may not recover as quickly and fully as they should and workers' compensation systems tend to become complex and introduce frictional costs. Uncertainty results in unnecessary delays. We all recognize that the system cannot be relegated to checklists, schedules, and formulas. We need a system where treatment that is generally accepted as effective can be as automatic as practicable but where flexibility allows us to address the needs of individuals and to develop newer, innovative, and more effective treatment.

Unfortunately, some physicians have misappropriated the term "evidence based medicine" to mean that if they can't see evidence of an injury on a diagnostic image that there was never an injury. Evidence based medicine relies upon a body of work that has documented effective treatment strategies for a study group of individuals for known conditions. It also provides information on treatment regimens that have proven to not be effective, or as effective, for those study groups. The work is not exhaustive and not all studies carry the same level of credibility. Treatment guidelines, such as the ODG and ADOEM, simply point to what has been documented as being effective or ineffective in the past.

I like to use Education as a corollary. Schools use curriculum and teaching methods that have proven effective for a substantial portion of the student population. However, not all students learn this way, and if we don't recognize differences and use alternative strategies that are effective for each individual we will allow them to languish, fall behind, and miss their potential, and we ultimately fail in our educational mission and objectives. Treatment guidelines are no different. They tend to work well for the majority of the injured workforce when the diagnosis is correct, comorbidities are identified, and the injured worker is compliant. They will not prove effective for everyone but they should help ensure injured workers don't languish.

Because treatment guidelines have proven effective for the majority, specific authorization for recommended treatment should be the exception, not the rule. While not necessarily presumptive in nature, authorization should be as streamlined and as close to automatic as practicable. The converse is

also true. While denials may be almost automatic when treatment that is not recommended in the ODG is prescribed without supporting documentation, there needs to be process for good faith consideration of alternate, individual treatment methodologies.

In its most simple form, one of three things is happening when an employee's progress languishes: (1) a misdiagnosis or failure to recognize comorbidities, (2) a non-compliant employee, or (3) this treatment just isn't effective for this employee. No matter the root cause, application of the ODG to those conditions it addresses should help us identify ineffective treatment more quickly.

Medical practitioners should be able to recommend alternative treatment and describe why the treatment is appropriate, how its effectiveness will be measured, and how it will be beneficial for all parties. The recommendation may be due to ineffectiveness of prior treatment consistent with treatment guidelines. It may be due to the inherent lag in publication of scientific studies and their inclusion in ODG. (Several comments of chapter reviewers identified some of these shortcomings.) Development of new, effective, and innovative treatment, by definition, requires that we have a means to authorize something other than past practice, where appropriate.

We can learn from the experience of other states. We started slowly, limiting application to chronic pain management, to give us an opportunity to ensure the system was effective, supportive, responsive, and avoided unnecessary frictional costs. We recognized and directly addressed the opioid crisis and its impact before the rest of the Arizona community. General application of treatment guidelines can have a similar impact, although it may take longer to document and demonstrate.

While general application of treatment guidelines will make a difference for all claims, it will have the greatest impact upon the most difficult cases. Looking at national statistics for claims that ultimately reach the excess layer above self-insurers can provide perspective.

Only 10% of the claims that will ultimately be filed with excess insurers were catastrophic in nature. The remaining 90% of employees got progressively worse over time and the impact of these injuries will last a lifetime. Think of the impact upon the injured worker and his or her family, and the employer and insurer. As implementation of treatment guidelines identifies ineffective treatment and lack of progress earlier in an employee's care, it is these employees who will benefit most greatly.

I've spoken with commissioners from many states and have heard an almost universal response. Use of treatment guidelines has made a positive impact on improving care, leading to superior outcomes and resulting in reduced cost. It has reduced conflict in the system, streamlined processes, and provided for more timely care. As such, I can only recommend that remaining chapters of the ODG be adopted in Arizona. Rather than adopting separate treatment guidelines, the areas where the ODG's currency is lagging could be addressed in an ICA adopted (Arizona) supplement.

Sincerely,

David M. Parker, ARM-P