

Medical Treatment Guidelines in Washington Workers' Compensation June 2010

The Medical Treatment Guidelines (also called Medical Practice Guidelines or Review Criteria) are developed by the Washington State Department of Labor and Industries' Office of the Medical Director (OMD) in collaboration with practicing physicians and medical advisors. These guidelines are used for physician education, in the utilization review program and in the claim management process. These guidelines are based on the best available scientific literature and outcome data, if available, for Washington's injured workers. For the most current list of Medical Treatment Guidelines, go to: <https://lni.wa.gov/patient-care/treating-patients/treatment-guidelines-and-resources/>

GUIDELINE PROCESS

BACKGROUND

The need for L&I to establish treatment guidelines was recognized in 1988 when the inpatient utilization review (UR) program was established. It was then that L&I published its first guideline to establish admission criteria for the inpatient non-surgical treatment of back pain. Within one year, these admissions fell by 60 percent. L&I then requested help from the Washington State Medical Association (WSMA) Industrial Insurance Advisory Committee to draft more guidelines and criteria. The first guideline established by this partnership was in 1989 for lumbar fusions with input being provided by several prominent spine surgeons from the Seattle area. Between 1989 and 2004, 18 more guidelines were established in this manner.

As the inpatient UR program grew, so did the need for more guidelines and criteria. L&I originally contracted with a vendor who used nationally recognized proprietary surgical criteria to establish medical necessity. However, in many cases they lacked sufficient detail and specificity for OMD's goal of assuring quality care for injured and ill workers. Today, the UR program provides medical necessity reviews for inpatient admissions, selected outpatient surgeries, and other services using OMD's treatment guidelines, and where there are none, national criteria are used.

NEW PROCESS BEGINS

New legislation was passed in 2007 authorizing OMD to form a new panel of advisers. After nominations were received, 14 physicians from statewide clinical groups, specialties, and associations were appointed to serve on the Washington State Industrial Insurance Medical Advisory Committee (IIMAC). Under authority of RCW 51.36 the committee:

“...shall advise the department on matters related to the provision of safe, effective, and cost-effective treatments for injured workers, including but not limited to the development of practice guidelines and

coverage criteria, review of coverage decisions and technology assessments, review of medical programs, and review of rules pertaining to health care issues.”

This collaboration between state government and community based clinical experts enables a robust discussion and analysis of scientific research and cost, utilization, and outcome data on a broad array of topics related to the quality of medical care received by injured workers. It provides a method of developing evidence based guidelines where many perspectives are considered.

The IIMAC meets with L&I’s medical director and staff at least quarterly to address medical practice issues in the workers’ compensation system. These meetings are subject to the Open Public Meetings Act (RCW 42.30). Subcommittees with additional specialty trained physicians may also meet on selected topics requiring their expertise. The process for developing each guideline usually employs the following steps:

Prioritization of guidelines according to agreed upon criteria
Guideline development through best available evidence and expert consensus
Implementation through communication, education, and application
Evaluation to see if it achieved the desired outcome and to insure it’s still current

The goals are a) to distinguish between clear-cut indications for procedures and those that are questionable and b) to implement evidence based treatment guidelines that will be implemented in a fair manner. Well designed guidelines will increase the proportion of surgical requests authorized for workers who truly require surgery, and will decrease the proportion of such authorizations among workers who do not fall within the guideline.

PRIORITIZATION OF GUIDELINES

Prioritization depends on several criteria including:

1. Cause for concern
 - a. Patient safety – is there a risk to the patient?
 - b. Efficacy – what does the outcome data look like?
 - c. Utilization – what is the prevalence and cost?
 - d. Practice variation – if there is wide variation from best practice, why?
 - e. Rapidly emerging or diffusing technology – what are the implications?
2. Business needs
 - a. Business partner needs e.g. IIMAC members or clinical specialists
 - b. Needs of the Utilization Review program
 - c. Controversy regarding procedure, drug, or device
 - d. Legal requirements (e.g. Health Technology Assessment Clinical Committee decisions, FDA rulings, Board of Industrial Insurance Appeal decisions, etc.)
3. Economies of scale
 - a. Medical services or procedures are related (e.g. same specialty area) so it makes sense to develop both guidelines together

- b. Other agencies and payers (e.g. the Agency Medical Directors' Group) are working on an issue/guideline so it makes sense for us to work it.
4. Age of guideline (for revisions)
- a. Review of current guideline indicates need to revise it.
 - b. National Guidelines Clearinghouse requires review & update every 5 years.

GUIDELINE DEVELOPMENT

Guideline development uses the best available scientific evidence and expert consensus. The process can be described in the following steps:

1. Once a guideline or group of guidelines is selected, a subcommittee is formed with selected IIMAC members, practicing physician specialists, and contracted utilization review physicians. Other clinical specialists may be invited to give presentations to help inform the subcommittee.
2. A systematic review and summary of the relevant peer reviewed medical literature is done and is presented to the subcommittee for their review. Claim and billing data from Labor & Industries may also be reviewed.
3. The findings from the literature review are categorized and adapted into the first draft following these general areas (this will vary slightly for each guideline):
 - I. Introduction
 - II. Establishing Work-Relatedness
 - III. Making the Diagnosis
 - A. Case Definition (symptoms and signs)
 - B. Relevant diagnostic tests (e.g. imaging, electro-diagnostic, lab etc.)
 - IV. Treatment
 - A. Conservative Treatment
 - B. Surgical Treatment
 - V. Return to Work (RTW)
 - A. Early Assessment, including occupational health quality indicators
 - B. Returning to Work following Surgery
 - VI. Worksheets, Tools, Forms
 - VII. Guideline Summary or Algorithm for professional nurse reviewers
4. Subcommittee members critique and revise the guideline based on what is most useful for the clinician in diagnosing and treating the condition in question. Additional expertise, consultation, and literature searches may also be added. The result is a second draft guideline that is then shared with the full advisory committee to obtain their input.
5. After the full advisory committee has given their input and any recommended changes are made, this third draft guideline is posted on the web and distributed via a provider listserv for public review and comment.
6. Once all public comments are received and reviewed, responses are provided by the subcommittee. Both comments and responses are posted on the web.
7. The subcommittee may make further revisions to the draft guideline based on public input and any other information they have received. This then results in a fourth draft.
8. The fourth draft is presented to the full advisory committee in an open public meeting. Oral comments are invited from the public, and the full committee may recommend further changes, potentially creating a fifth and final draft.

9. Once the full committee makes the advisory recommendation to adopt the guideline, it becomes final and is again posted on the web and distributed via the provider listserv.
10. L&I then posts on the web a Provider Bulletin announcing the new or revised guideline and distributes it via the provider listserv.

IMPLEMENTATION

Most guidelines are implemented within the utilization review (UR) program. L&I guidelines have priority over other proprietary guidelines and criteria that may exist. Where L&I guidelines are not available, proprietary ones may be used. Reviewers apply each guideline as a standard for the majority of requests in the Washington workers' compensation program. For the minority of workers who appear to fall outside of the guideline and whose complexity of clinical findings exceeds the specificity of the guideline, further review by a physician is conducted.

When a surgical procedure is requested for a patient who meets the guideline criteria, the reviewer will recommend approval to the claim manager. If the criteria are not met, the request will be referred to a physician consultant who will review the patient's file, offer to discuss the case with the requesting physician, and make a recommendation to the claim manager. The flexibility built into this decision making process is important in two ways. First, it enables the IIMAC to develop surgical indications fairly quickly. Second, it plays a major role in legitimizing the work of the subcommittee in the eyes of practicing physicians in Washington.

Completed guidelines are communicated to practicing physicians via L&I's website and through its provider listserv (to join, go to: <https://public.govdelivery.com/accounts/WADLI/subscriber/new>). Education and training will be provided to reviewers and staff to ensure their proper application within the UR program. Where possible, continuing medical education (CME) credits may be offered.

EVALUATION

The department makes an effort to evaluate the medical treatment guidelines and criteria at least every three years to ensure they are current and effective. The evaluation may be based on several factors, some of which include:

- Whether there is new scientific literature indicating an update is necessary
- Reviews and discussions with the department's advisory committees
- Cost and utilization data
- Worker-based health outcomes
- Reports from our utilization review vendor
- Claim reviews
- Issues raised by providers, injured workers, or employers