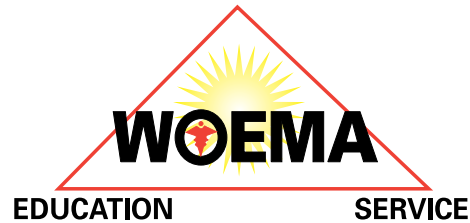


LEADERSHIP



QUARTERLY NEWSLETTER • SUMMER 2009

President's Message

**There are opportunities.
Be alert. Seek the prospects.**



Steve Schumann, MD

How does the medical marketplace for the Occupational Medicine physician look to you? From my perspective, there are significant challenges but also some great opportunities.

No question the national incidence of injury continues to decline, and in many states payment for services has not kept up with financial indices. We are burdened by bill review, utilization review and network discounts. Nevertheless, for the nimble and efficient OEM practice, there are excellent prospects.

Here's what I see from the clinic level where I spend most of my day — primarily patient care but also planning and administration.

- 1. Preventive Medicine:** President Obama's health initiative will include a plan for health and wellness. WOEMA is working with members of Congress through ACOEM, as well as independently, in an effort to direct funds to Occupational Medicine programs that work with employers to foster employee health and productivity.
- 2. Employer Relations:** Employers are more concerned than ever about minimizing injury and illness, in both the work place and elsewhere. Employers pay the bills for health care by paying premiums for medical insurance. Occupational medicine is one of the few specialties with daily direct access to employers. Enhance your relationships and assure continuing business.
- 3. Electronic Health Records:** President Obama's health plan also intends to provide incentives for physicians who use EHRs. If you don't already have an EHR System,



The WOEMA Board of Directors meeting in San Francisco in January included many new and outstanding members, enthusiastic and committed to success for our organization.

consider investing in one.

There is additional good news: WOEMA is as dynamic and vibrant as at any time in the past. Our recent January 24 Board of Directors meeting in San Francisco included many new and outstanding members, enthusiastic and committed to success for our organization in 2009. Your physician leaders come from many provider organizations and include a broad array of talent and experience. We have new leadership in the web site, legislation, education, and other areas, while retaining excellent talent from prior years.

While we planned for 2009, we committed to seeking to deliver "Value to Members" as we implement all activities. It's not lost on your Board that WOEMA/ACOEM membership retention occurs only when members experience real value and we are committed to delivering. Educational resources through the web site will expand this year, as will other content on the web site. WOEMA will remain active in the legislative and regulatory arenas in all five-member states as we work to represent member interests.

Our signature event, WOHC 2009 will be presented in Scottsdale, AZ this year. We have selected a terrific venue at the FireSky Resort & Spa and the Planning Committee has been hard at work planning our best event ever. You should not miss this excellent conference September 10-12.

So, there are opportunities. Be alert. Seek the prospects. In addition, most importantly, stay tuned to WOEMA. ♦

Medical Guidelines for the Lead-Exposed Worker

Occupational Lead Exposure — Time for a Stronger Standard

BY JAMES P. SEWARD, MD, MPP, FACOEM, MEDICAL DIRECTOR, HEALTH SERVICES DEPARTMENT
LAWRENCE LIVERMORE NATIONAL LABORATORY



James P. Seward, MD

The current OSHA lead standard is outdated. Based on research over 30 years old, the OSHA lead standard does not reflect new findings that indicate a likelihood of health effects at blood lead levels far lower than permissible by regulation. Studies have shown reproductive and developmental effects that may begin at blood lead levels as low as 5-10 mcg/dL. Effects on hypertension and renal function have also been demonstrated at levels below the worker lead removal protection limits.

Over the past year, a panel of WOEMA member physicians has been working with the California Department of Public Health's Occupational Lead Prevention Program to advise on a new set of management guidelines for physicians to use in caring for workers with lead exposure. These guidelines have now been released by CDPH. This is a step in the right direction, but the real fix would be a revision of the OSHA and the Cal-OSHA Lead Standards.

The Occupational Health Branch, California Department of Public Health recently thanked WOEMA for the role of its scientific advisory panel in writing the Medical Guidelines for the Lead-Exposed Worker. They produced a document that will be of practical value to the health care

provider caring for lead-exposed workers.

WOEMA Lead Advisory Panel members included myself as the Panel Chair and the following members:

Leslie Israel, DO, MPH

Associate Clinical Professor
University of California, Irvine

Robert C. Blink, MD, MPH

Medical Director
Work Care, Inc.

Hong Zhang, MD, MPH, MS

Medical Director
Sutter Employee Health

Paul J. Papanek, Jr., MD, MPH

Chief, Occupational Health Services
Metro Los Angeles Kaiser On-the-Job

T. Warner Hudson, MD, FACOEM

Life Connections Health Center
ACOEM Vice President

Medical Guidelines for the Lead-Exposed Worker is available for download at <http://ww2.cdph.ca.gov/programs/olppp/Documents/medgdln.pdf>.

For more information on the health effects of lead, see "Indecent Exposure: Lead Puts Workers and Families at Risk." (<http://healthresearchforaction.org/perspectives/occupational-lead-exposure.pdf>) Co-authors include WOHC 2008 speaker **Michael Kosnett, MD**. HRA starts with research findings and then translates

those findings into innovative policies. The article discusses research conducted since OSHA established its lead standards showing that lead causes significant health problems in adults at lower levels than the standards allow. Cumulative exposure to low to moderate levels of lead has been associated with hypertension, decreased kidney function, decreased brain function, and reproductive problems, among others. The article also discusses needed revisions in OSHA's lead standards, as well as promising solutions for avoiding lead exposure. HRA hosted a Policy Briefing in Sacramento on March 19, 2009 to discuss the issues raised. Additional stakeholder meetings are being planned for northern and southern California. Contact Ray Meister, MD, MPH, raymond.meister@cdph.ca.gov with any questions. ♦

WOEMA Newsletter Available On-Line

Current and past issues of the WOEMA newsletter can be found on the WOEMA website. If you would prefer to receive this newsletter electronically, visit www.woema.org and provide us with your name and email address.

WOEMA Utilization Review Guide: Instructive Cases

BY PETER SWANN, MD, NEWSLETTER EDITOR



Peter Swann, MD

What follows are three hypothetical variations of the same case, meant to illustrate the real world of utilization review and the application of evidence-based medicine. They will hopefully guide you toward better use of medical techniques and technologies while pointing out office procedures that are critical if your requests are to be approved in a utilization review environment.

The cases that follow use the following format:

1. Request from the physician is stated.
2. Clinical history that is pertinent to the request, as obtained from the submitted records, is summarized.
3. Recommendation of the reviewer.
4. Rationale of the reviewer is given.
5. Guidelines used by the reviewer in reaching a decision are given.
6. WOEMA Newsletter Editor UR Commentary is given.

Variation #1

Treating Physician Request:

Continuation of physical therapy for low back 3 times per week x 2 weeks

Clinical history:

Physician notes from 12/20/2008, 01/20/2009, 02/16/2009, 03/19/2009 were received and reviewed. The patient apparently has low back pain related to work dating to 12/16/2008. He has been treated conservatively with Naprosyn, Tylenol, Vicodin, and Soma and has received six physical therapy visits to date. The latest progress note received, dated 03/19/2009, reports "the patient continues to complain of low back pain." No other subjective symptoms are noted. Physical exam on

that date notes "the back shows tenderness of the lumbar paraspinals, lumbar range of motion is reduced." No other physical exam findings are reported. Diagnosis given is lumbar strain. Plan as of that date is "continue medications and physical therapy 3 times per week x 2 weeks." It is not mentioned what medications the patient is currently taking nor whether it is felt that the patient is improving or has failed conservative treatment to date. No rationale is given for why it is felt further physical therapy will be more successful than passed physical therapy or, indeed, whether it is felt the patient has improved with physical therapy previously received.

I called Dr. Smith on 04/01/2009; he was unavailable so I left a message for him to call me to discuss the request. I called again on 04/02/2009 and left another message. No call-back had been received as of the time of this report.

Reviewer Recommendation:

Non-certification of this request for physical therapy for the low back 3 times per week x 2 weeks is recommended.

Rationale:

Given the information supplied, or lack thereof, especially the lack of information concerning the patient's progress with previously received physical therapy, and my inability to discuss these questions with the requesting physician despite two attempts, this request can not be considered consistent with the guidelines noted below.

Guidelines Utilized:

ACOEM Guidelines, Chapter 12: Low Back Complaints, page 300

"Physical modalities such as mas-

sage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies, but they may have some value in the short term if used in conjunction with a program of functional restoration. Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At home local applications of heat or cold are as effective as those performed by therapists."

Work Loss Data Institute, Official Disability Guidelines, 9th Ed., 2004, Electronic Version - low back chapter: Physical therapy (PT) - Recommended as an option. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. See also Exercise. Direction from physical and occupational therapists can play a role in this, with the evidence supporting active therapy and not extensive use of passive modalities. The most effective strategy may be delivering individually designed exercise programs in a supervised format (for example, home exercises with regular therapist follow-up), encouraging adherence to achieve high dosage, and stretching and muscle-strengthening exercises seem to be the most effective types



Continued on page 4

Utilization Review Guide

Continued from page 3



of exercises for treating chronic low back pain. (Hayden, 2005) Studies also suggest benefit from early use of aggressive physical therapy (“sports medicine model”), training in exercises for home use, and a functional restoration program, including intensive physical training, occupational therapy, and psychological support. (Zigenfus, 2000) (Linz, 2002) (Cherkin-NEJM, 1998) (Rainville, 2002) Successful outcomes depend on a functional restoration program, including intensive physical training, versus extensive use of passive modalities. (Mannion, 2001) (Jousset, 2004) (Rainville, 2004) One clinical trial found both effective, but chiropractic was slightly more favorable for acute back pain and physical therapy for chronic cases. (Skargren, 1998) See also specific physical therapy modalities, as well as Exercise and Work conditioning. [Physical therapy is the treatment of a disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, activities of daily living and alleviating pain. (BlueCross BlueShield, 2005)]

Patient Selection Criteria: Multiple studies have shown that patients with a high level of fear-avoidance do much better in a supervised physical therapy exercise program, and patients with low fear-avoidance do better following a self-directed exercise program. When using the Fear-Avoidance Beliefs Questionnaire (FABQ), scores greater than 34 predicted success with PT supervised care. (Fritz, 2001) (Fritz, 2002) (George, 2003) (Klaber, 2004) (Hicks, 2005) Without proper patient

selection, routine physical therapy may be no more effective than one session of assessment and advice from a physical therapist. (Frost, 2004)

ODG Physical Therapy Guidelines – Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT.

Sprains and strains of back: 10 visits over 5 weeks.

WOEMA Newsletter Editor UR Commentary:

UR physicians cannot read our minds. The information received from the treating physician failed to describe whether the patient was improving with physical therapy and/or whether another rationale existed that explained why further PT was needed. Furthermore, the UR physician was unable to get answers to those questions despite two calls to the treating physician's office. Without complete information, the UR physician had no choice but to recommend non-certification of the request.

TAKE HOME MESSAGE:

1. Make sure the notes clearly explain what is requested, why it is requested, and, when possible, why the request is consistent with ACOEM Guidelines (or other evidence based medical guidelines when ACOEM Guidelines do not speak to a request).
2. WHENEVER POSSIBLE, TALK TO YOUR UR COLLEAGUES WHEN THEY CALL. It will decrease staff time and frustration and minimize unnecessary denials. Often times all that is needed is clarification of some details, as was the situation in this case.

Variation #2:

Treating Physician Request:

Continuation of physical therapy for low back 3 times per week x 2 weeks

Clinical history:

Physician notes from 12/20/2008, 01/20/2009, 02/16/2009, 03/19/2009 were received and reviewed. The patient apparently has low back pain related to work dating to 12/16/2008. He has been treated conservatively with Naprosyn, Tylenol, Vicodin, and Soma and has received 6 physical therapy visits to date. The latest progress note received, dated 03/19/2009, reports “the patient continues to complain of low back pain.” No other subjective symptoms are noted. Physical exam on that date notes “the back shows tenderness of the lumbar paraspinals, lumbar range of motion is reduced.” No other physical exam findings are reported. Diagnosis given is lumbar strain. Plan as of that date is “continue medications and physical therapy 3 times per week x 2 weeks.” It is not mentioned what medications the patient is currently taking nor whether it is felt that the patient has failed conservative treatment to date. No rationale is given for why it is felt further physical therapy will be more successful than passed physical therapy or, indeed, whether it is felt the patient has improved with physical therapy previously received.

I spoke with Dr. Smith on 04/01/2009 and we discussed the case in detail. Although it is not apparent from the chart note, the patient has made significant progress with conservative treatment to date. Dr. Smith estimated that after 6 physical therapy visits the patient had experienced a 50% improvement in pain and a 60%

Continued on page 11



Test Your OCC-Q Quiz

COMPILED BY PAULA LENNY, MD, MPH

Welcome to a new feature of the WOEMA Newsletter designed to help you test your knowledge of relevant occupational and environmental topics. See if you can accurately answer the following questions. The answers appear on the bottom of page 10.



Paula Lenny, MD, MPH

TOPIC:

Organophosphate Pesticide Poisoning

1. What statement(s) is true regarding "aging" of the AChE- OP complex?
 - a. It is yet another consequence of growing old
 - b. The enzyme-phosphoryl bond is strengthened by loss of one alkyl group
 - c. Atropine is no longer effective in dephosphorylating the AChE-OP complex
 - d. Aging occurs over 12-24 hours
 - e. All of the above

2. Loss of AChE function causes:
 - a. Muscarinic (parasympathetic) effects
 - b. Nicotinic (sympathetic, parasympathetic or somatic muscle) effects
 - c. CNS effects
 - d. a and c only
 - e. a, b and c

3. What is the usual cause of death from acute organophosphate poisoning?
 - a. Cardiac arrest
 - b. CNS depression
 - c. Respiratory failure
 - d. Vascular collapse
 - e. None of the above

4. Organophosphate-Induced Delayed Neuropathy (OPIDN) is related to phosphorylation and inhibition of AChE.
True or False?

True or False?

5. In the absence of exposure, low levels of RBC cholinesterase are seen in which of the following:
 - a. Leukemia and multiple myeloma
 - b. Hereditary spherocytosis and polycythemia
 - c. Newborns
 - d. Liver disease
 - e. a and c

Welcome New Members!

Diane N. Ballerino-Regan, MD, BS, MS

San Diego, CA

Amber L. Brothers, BSN, MSN

Santa Monica, CA

Eve D. Currie, FNP

Fallbrook, CA

Greg Hirokawa, PhD

Delano, CA

Haitham Juma, MD

San Diego, CA

Stephen Kumar, MD, MPH

Irvine, CA

Martha A. La Marre, PA-C

Phoenix, AZ

Clara Nguyen, MD

Alhambra, CA

Patrick D. O'Callahan, MD, FAAFP

Stanford, CA

JoAntonette Roa, RN, BSN, MSN

San Fernando, CA

Michael D. Roberson, PT, MBA

Phoenix, AZ

Maria G. Robles, PA-C

Tucson, AZ

Erika L. Schwilk, MD

San Francisco, CA

Christopher M. Tang, MD

Los Angeles, CA

Vance K. Vanier, MD, MBA

Foster City, CA

William Wang, DO

San Gabriel, CA

Joy M. White, MD

Residency Program Profile

The Loma Linda University Occupational Medicine Division

BY KAOCHOY SAECHAO, MD MPH, STAFF PHYSICIAN - KAISER PERMANENTE SOUTH BAY OCCUPATIONAL HEALTH SERVICE
AND WAYNE S. DYSINGER, MD, MPH, CHAIR, DEPARTMENT OF PREVENTIVE MEDICINE, DIRECTOR,
FAMILY AND PREVENTIVE MED RESIDENCY, LOMA LINDA UNIVERSITY

The current president of Loma Linda University (LLU) is Richard H. Hart, MD, DrPH, a board-certified Preventive Medicine physician who has advocated for public health, service and global outreach throughout his career, and completed several medical missions in Tanzania, Africa. It is this spirit, steeped in national and international disease prevention, that trickles down to the institution of 55 academic programs and over 4,000 students nestled among the San Bernardino mountains.

Loma Linda University was established in 1905, with the School of Medicine soon following in 1909. The formal General Preventive Medicine (GPM) residency was started in 1979, and the Occupational & Environmental Medicine component (OEM) commenced in 2000. The current 30 residents in the GPM, OEM, and combined Family and Preventive Medicine Residency make Loma Linda's Graduate Medical Education in this area one of the largest in the country.

One unique aspect of the LLU medical school is a core Preventive Medicine class that threads throughout all four years of the medical school curriculum. This dovetails nicely with the Preventive Medicine residency program, where 4th year medical students can match straight into a Preventive Medicine residency.

The Occupational & Environmental Medicine residency program at LLU is a clinically-oriented program with significant global opportunities. The main clinical rotations include: the LLU Occupational Medicine Medical Center, Veterans Affairs Occupational

Medicine and specialty clinics, San Bernardino County Employee Wellness Clinic, and the Patton State Hospital, where epidemiology projects such as TB screening are conducted. Under the leadership of Dr. Wayne Dysinger, the OEM division has ongoing international connectivity, with programs including:

- Faculty and staff exchanges occur frequently between Sir Run Run Shaw Hospital in Hangzhou, China.
- A United States Agency for International Development (USAID) grant to help develop a teaching hospital in Kabul, Afghanistan.
- Numerous other medical mission opportunities available in Africa, Latin America and elsewhere.

All OEM residents are required to complete a senior research project



LOMA LINDA UNIVERSITY

prior to graduation. The three current residents have diverse research projects. One resident is working on clarifying occupational medicine resources in Latin American countries. Another is working with Stater Brothers Grocery Stores to evaluate disability management issues and the possibility of having on-site physical therapy. And the final resident is interested in an international health project as well.

The Occupational & Environmental Medicine division at Loma Linda University has a young but well-established program rooted in a tradition of service, prevention and international health. These overarching goals of the division parallel that of the institution and its leader, both of which have a rich history of disease prevention. ♦

New UCSF OEM Clinic Facility

UCSF has opened a new clinical facility that houses the new combined Occupational and Environmental Medicine Clinic at UCSF/Mt. Zion. This clinic provides diagnostic consultations for complex clinical problems in occupational or environmental health. The clinic specializes in toxicology, occupational or environmental respiratory disease, occupational neurology, reproductive toxicology, ergonomic and musculoskeletal issues.

Among the specialty services available are respirator fit testing and medico-legal reports by qualified medical evaluators. The clinic is staffed by board certified occupational and environmental medicine specialists, medical toxicologists, a pediatrician, and an industrial hygienist. We provide training for fellows, residents, industrial hygiene and occupational health nursing students. **Contact: UCSF Occupational and Environmental Medicine Clinic, 2330 Post Street, Suite 460, San Francisco, CA 94115, Appointments: 415-885-7580, Fax: 415-771-4472, OEMclinic@ucsf.edu.**



WOEMA Legislative and Regulatory Update

BY DON SCHINSKE, WOEMA LOBBYIST



Don Schinske

In a year of national healthcare reform, WOEMA successfully persuaded the ACOEM House of Delegates in April to adopt a resolution endorsing the following policies:

- Universal health coverage for America's workers
- A Mechanism for Reimbursing Physicians for Workplace Preventive Services
- A Mechanism for Financial Support of Occupational Medicine Residency Programs
- Predictable and Fair Fee Schedules for Occupational Medicine Services, including medical services under Workers' Compensation
- Financial Incentives to Physicians for Use of an Electronic Health Record
- Use of Evidence-Based Guidelines for Occupational Medicine Practice
- Incentives to patients and other value-based health care benefits for healthy behaviors or lifestyle changes

WOEMA's goal this spring has been to develop a set of policy planks that will guide our future legislative activity and responses, and which we also aim to inject into the national reform debates.

Legislative Co-Chair Paul Papanek, MD, has been discussing with ACOEM how to best coordinate our advocacy on these issues, as ACOEM pursues its own similar principles with the Congressional authors of healthcare reform legislation. The immediate goal is to promote a single, coherent set of

messages from occupational medicine. Once the details are worked out, WOEMA members will be asked to directly assist in Congressional lobbying efforts.

Those wishing to see the full text of WOEMA's Policy Planks or of ACOEM's Health Reform Action Plan for Prevention can visit www.woema.org.

Meanwhile, Legislative Co-Chair Steve Schumann, MD, a member of the California Medical Association's Workers' Compensation Technical Advisory Committee, introduced a WOEMA proposal to that group that we pursue an interim boost in reimbursement to 125-percent of Medicare for the 10 main visit codes, 99201-99205 and 99211-99215. For a copy of the proposal, please contact Dr. Schumann at scs211@earthlink.net, or Don at dschinske@calcapitol.com.

Previously, WOEMA had been advocating for a full overhaul of the Official Medical Fee Schedule (OMFS), a position we still support. However, the more limited goal seems more appropriate given the poor economy, the dire state budget, and a major increase in Work Comp medical costs (which likely owes more to rising costs for utilization review and medical-legal rather than clinical services).

The CMA Work Comp TAC, which includes physicians from many specialties, expressed support for the proposal including the addition of two consultation codes. Hopefully, with support from CMA and other allies, we can press for the interim increase until a full overhaul can be pursued.

One challenge, for the time being, is lack of clear direction at the Division of Workers' Compensation. OMFS issues, the ongoing work on the Medical Treatment Utilization Schedule, and

proposed regulations to change the PR-2 reporting form, all seem suspended while top posts at DWC seem in flux. No replacement has been named yet for Executive Medical Director Anne Searcy, MD, who left in December. This was followed by the departure of Acting Administrative Director Carrie Nevans in March, for health reasons.

Legislative and budget problems have kept most policy proposals fairly modest. In California, which is chronically at the brink of insolvency, a new double-digit budget shortfall is destined to swamp all but a few bills. Current proposals that WOEMA is lobbying in the Capitol include:

SB 145 (DeSaulnier) – WOEMA opposes this bill. Would provide that "Race, religious creed, color, national origin, age, gender, marital status, sex, sexual orientation, or genetic predisposition" cannot be a factor in apportionment or determination of disability. Carried by the chair of the Senate Labor and Industrial Relations Committee, the bill pits the sponsoring applicant attorneys against employer groups. Proponents argue that the mere existence of risk factors should not figure into causation.

SB 186 (DeSaulnier) repeals the sunset date for allowing workers to predesignate a personal physician. WOEMA supports this bill, which has already moved through the Senate.

AB 664 (Skinner) would extend the presumption to all hospital employees for neck or back impairment, blood-borne infectious disease, or MRSA. WOEMA opposes. Bill is in Assembly Appropriations.

AB 933 (Fong) – This WOEMA-supported bill would require all

Continued on page 10

News You Can Use from the Literature

COMPILED BY CONSTANTINE J. GEAN, MD, MS, MBA, FACOEM
REGIONAL MEDICAL DIRECTOR, LIBERTY MUTUAL



In apparently healthy individuals with normal LDL but with high high-sensitivity C-reactive protein (hsCRP), a 44%

reduction in the overall incidence of major cardiovascular events was seen in subjects given rosuvastatin (Crestor), for a median follow-up time of 1.9 years, according to a prospective, randomized, placebo-controlled study of 15,548 initially healthy men and women participating in the JUPITER trial. 'Events' included arterial revascularization, hospitalization for unstable angina, MI, stroke, or CV death. Subjects with ≤ 130 mg/dL LDL cholesterol and ≥ 2.0 mg/L hsCRP were randomized to receive 20mg rosuvastatin/day, or placebo and were followed for 1.9 yrs (median; max = 5 yrs; NOTE: the JUPITER trial was stopped early based on large observed reduction in CVS morbidity and mortality in treated patients). Compared with placebo, participants allocated to rosuvastatin who achieved LDL cholesterol less than 1.8 mmol/L had a 55% reduction in vascular events (hazard ratio [HR] = 0.45), and those achieving hsCRP less than 2 mg/L had a 62% reduction (HR = 0.38). A 65% reduction in vascular events was seen in patients with rosuvastatin who achieved both LDL cholesterol less than 1.8 mmol/L and hsCRP less than 2 mg/L (HR = 0.35) vs. a 33% reduction in those who achieved one or neither target (HR = 0.67). Neither myopathy or cancer rate was significantly enhanced in the rosuvastatin group; however, there was an increased

incidence of physician-reported diabetes. Achieved hsCRP concentrations were predictive of event rates irrespective of the lipid endpoint used. *Online The Lancet*: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)60447-5/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60447-5/fulltext).

■ **Estimated radiation dose associated with cardiac CT angiography (CCTA) corresponds to 12 mSv, which equals the dose of 600 chest x-rays or 1.2 x the dose from an abdominal CT study** per a cross-sectional, multicenter, observational study of estimated radiation dose in 1965 patients undergoing CCTA between February and December 2007. *JAMA*. 2009 Feb 4;301(5):500-7.

■ **Compared with drinking lukewarm or warm tea, esophageal squamous cell carcinoma was associated with drinking hot tea (odds ratio = 2.07) or very hot tea (OR = 8.16)** per a case control study (300 cases, 571 matched controls). Also associated with a significantly increased risk (compared with drinking tea ≥ 4 minutes after being poured) was drinking tea 2-3 minutes after pouring (OR=2.49) or less than two minutes after pouring (OR = 5.41). *BMJ* 2009;338:b929 – 3/26/09.

■ **Percent of cases with early opioid prescribing for acute LBP varied significantly by state and ranged from 5.7% (MA) to 52.9% (SC),** per a study of cases from workers' compensation (WC) claims filed between 1/1/02 and 12/31/03 for states with ≥ 40 cases of acute, work-related, low back pain. Of 8,262 claimants, 21.3%

received at least one early opioid prescription (≥ 1 prescription within 1st 15 days). Three factors explained 79% of the between-state variation: state household income inequality, no. of physicians per capita, and WC cost containment effort score. *Am. J. Ind. Med.* 2009; 52:162-71.

■ **30% of museum employees studied were sensitized to at least one fungal allergen.** A total of 103 employees of the Polish National Museum were assessed using a questionnaire, skin prick tests and workplace Mycological analysis. Logistic regression indicated duration of occupational exposure > 5 years, family history of atopy, presence of a cat at home, sinusitis, allergic rhinitis and a history of frequent respiratory infections were risk factors for the development of sensitization to fungi in this working group. *Occup Med (Lond)*. 2009 Mar 26.

■ **Only 1.5% of U.S. hospitals have a comprehensive electronic-records system (i.e., present in all clinical units), and an additional 7.6% have a basic system (i.e., present in at least one clinical unit).** Computerized provider-order entry medication systems were in only 17% of hospitals. Larger urban hospitals and teaching hospitals were more likely to have electronic-records systems. *N Engl J Med*. 2009 Mar 25. [Epub – in print 4/16/09].

■ **There was an observed 43% reduction in the risk of venous thromboembolism (VTE) among those treated with statin therapy during a median follow-up of 1.9 years in**

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News You Can Use



Continued from page 8

a study of 17,802 apparently healthy men and women in the JUPITER trial with both low-density lipoprotein (LDL) cholesterol levels of > 130 mg/dl (3.4 mmol per liter) and high-sensitivity C-reactive protein levels of ≥ 2.0 mg/L. The rates of VTE were 0.18 and 0.32 event per 100 person-years of follow-up in the rosuvastatin and placebo groups, respectively (HR = 0.57); rates for unprovoked VTE (i.e., no known malignant condition, trauma, hospitalization, or surgery) were 0.10 and 0.17 (HR = 0.61) and for provoked VTE (i.e., with cancer or during or shortly after trauma, hospitalization, or surgery) HR = 0.52. The rosuvastatin treatment effect was similar to and independent of the previously reported reduction in cardiovascular events.

Online NEJM: <http://content.nejm.org/cgi/content/full/NEJMoa0900>.

■ **Individuals in blue-collar occupations were approximately 50% more likely to be classified as insufficiently active** and this occupational variability in leisure-time physical activity was not explained by hours worked, per a secondary analysis of cross-sectional data from the 1995 Australian Health Survey, assessing those 18-64 years ($n = 24,454$). Hours worked was categorized into 8 levels (1-14 h to more than 50 h/wk). Activity sufficient for health, was expenditure of 800 METS-min/week). *Prev Med.* 2000 Dec;31(6):673-81.

■ **Reduced-calorie diets result in clinically meaningful weight loss regardless of which macronutrients they emphasize per a study of 811** overweight adults assigned randomly to one of four diets each diet had different

targeted percentages of energy derived from fat, protein, and carbohydrates. Among the 80% of participants who completed the trial, the average weight loss was 4 kg; 14 to 15% of the participants had a reduction of at least 10% of their initial body weight. *N Engl J Med.* 2009 Feb 26;360(9):859-73.

■ **Ginkgo biloba had no effect on the rate of progression to dementia or AD in participants with mild cognitive impairment (MCI)** at 120 mg bid per a randomized, double-blind, placebo-controlled clinical trial between 2000 and 2008 with a median follow-up of 6.1 years of 3,069 volunteers aged ≥ 75 years with normal cognition ($n = 2587$) or MCI ($n = 482$) at study entry and assessed every six months for dementia. Overall dementia rate was 3.3 vs. 2.9 per 100 person-years in G. biloba vs placebo groups respectively and was not a significant difference.

JAMA. 2008 Nov 19; 300(19):2253-62.

■ **In 2007, almost 4 out of 10 adults had used Complementary and Alternative Medicine (CAM) therapy in the prior 12 months**, per the NHIS, a continuing, nationwide in-person survey of approximately 40,000 civilian households, (~100,000 persons). Most commonly used therapies were nonvitamin, nonmineral, natural products (17.7%) and deep breathing exercises (12.7%). Between 2002 and 2007 increased use was seen among adults for acupuncture, deep breathing exercises, massage therapy, meditation, naturopathy, and yoga. CAM use for head or chest colds showed a marked decrease from 2002 to 2007 (9.5% to 2.0%). <http://nccam.nih.gov/news/cam->

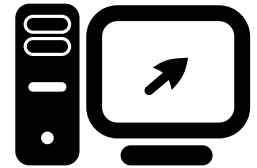
stats/2007/index.htm.

■ **Lumbar belt wearing improved significantly the functional status, the pain level, and the pharmacologic consumption in 197 subacute low back pain (LBP)** patients randomly assigned to lumbar belt use or no lumbar belt use over 0 and 90 days. Comparing the lumbar belt group vs. the control group between days 0 and 90 after first report of LBP, EIFEL functional scores were 7.6 vs. 6.1, VAS pain score reductions were 41.5 vs. 32.0 and cessation of medicine consumption at day 90 was 60.8% vs. 40%. *SPINE* 2009 Feb 1;34(3):215-20.

■ **The U.S. FDA warned 9 companies to stop manufacturing 14 unapproved narcotic drugs marketed in several dosage forms widely used to treat pain.** Those companies receiving warning letters are Boehringer IR; Cody Labs; Glenmark; Lannett; Lehigh Valley Tech; Mallinckrodt; Physicians Total; Roxane Labs; and Xanodyne. This action does not include oxycodone capsules. <http://www.fda.gov/bbs/topics/NEWS/2009/NEW01983.html>.

■ **CMS proposes no Medicare coverage for virtual colonoscopy** (aka CT colonography) is the conclusion of a proposed decision memorandum issued on February 11 by the Centers for Medicare and Medicaid Services (CMS) which indicated said the "evidence is inadequate to conclude that CT colonography is an appropriate colorectal cancer screening test" to be covered for Medicare beneficiaries. <http://www.cancer.gov/ncicancerbulletin/022409/page8>. ♦

Interesting and Useful Web Sites



CONTRIBUTED BY CONSTANTINE J. GEAN, MD, MS, MBA, FACOEM
REGIONAL MEDICAL DIRECTOR, LIBERTY MUTUAL

Travel Medicine:

Up-to-date and as it breaks (www.promedmail.org)

Off to Erdu but want to check which way the medical winds blow prior to departure? No local contacts in Zhejiang to call? Well, the world wide web offers a great solution and you don't have to be an expert in Wu dialects to participate.

The ProMED-mail site is great. This is a moderated e-mail system and global electronic reporting system for outbreaks of emerging infectious diseases and toxins. ProMED-mail has operated as an official program of the International Society for Infectious Diseases, and is dedicated to rapid global dissemination of information on outbreaks of infectious diseases and acute exposures to toxins that affect human health, including those in animals and in plants grown for food or animal feed. ProMED-mail is open to all sources and a team of expert human, plant, and animal disease moderators screen, review, and investigate reports before posting to

the network, which reaches over 40,000 subscribers in at least 185 countries. (ProMED-mail is also available in Portuguese, ProMED-PORT, and in Spanish, ProMED-ESP)

The operation has a similar feel to an open blog but with the significant advantage of moderator quality screening prior to posts. Maps of outbreaks, recalls/alerts, calendar of international events related to travel medicine and a nifty search function for archived postings are features of this great site. It looks to be quite helpful for late-breaking news to supplement the standard CDC (www.cdc.gov/travel/) immunization information and U.S. State Department travel warnings (<http://travel.state.gov/>) sites.

Frax Tool

(<http://www.shef.ac.uk/FRAX/tool.jsp?locationValue=9>)

Answer the age-old question, "What the Frax?" with the WHO fracture prediction tool ('Frax'®). Developed from a study of population-based cohorts from Europe, No. America, Asia and Australia, this site gives the 10-year probability of future fracture based on 12 risk factors including femoral neck bone mineral density (BMD). The tool is specific for 12 different countries and 4 different racial types. ♦

WOEMA Legislative and Regulatory Update

Continued from page 7

UR physicians to be licensed in-state. Bill has cleared the Assembly Insurance Committee.

In addition, WOEMA's Legislative Committee reviewed several pieces of Workers Compensation reform legislation and approved supporting one of them (SB 62/HB1288), which would require that independent medical review be conducted by a physician consented to by both employer and employee. ♦



Dr. Constantine Gean received the ACOEM President's Award from Dr. Robert Orford for his outstanding work advancing ACOEM through active involvement. The award was presented at the ACOEM President's Reception during the American Occupational Health Conference in San Diego on April 25. In accepting the award Dr. Gean said: "Working with ACOEM and WOEMA, I now see that occupational medicine is growing into its own special genius. Our unique perspective will make us lead players in the new 'symphony' being written right now by the legislature and by the broader house of medicine."



Test Your OCC-Q Quiz Answers

1. b 2. a, b, and c 3. c 4. False 5. a and c

Utilization Review Guide

Continued from page 4



improvement in lumbosacral range of motion. He further stated that with 6 additional PT visits he expected the patient to achieve his preinjury status and if that occurred in less than 6 PT visits, PT would be discontinued at that time.

Reviewer Recommendation:

Certification of this request is recommended.

Rationale:

The physician notes, combined with the conversation with the requesting physician, document improvement of the patient's medical condition with current physical therapy. Further, although he has not yet reached maximum medical improvement, the plan is to discontinue PT if that occurs in less than the requested 6 visits. The request for physical therapy is therefore consistent with the medical guidelines noted below.

Guidelines Utilized:

ACOEM Guidelines, Chapter 12: Low Back Complaints, page 300
"Physical modalities such as massage, diathermy (as noted above under Variation #1)

Work Loss Data Institute, Official Disability Guidelines, 9th Ed., 2004, Electronic Version - low back chapter: Physical therapy (PT) - Recommended as an option. There is strong evidence (as noted above under Variation #1)

WOEMA Newsletter Editor UR Commentary:

This request was approved because the requesting physician came to the phone when the UR physician called. The physician notes lacked the detail needed for request approval. The details concerning patient improvement with

physical therapy were subsequently supplied when the two physicians spoke by phone. Taking the call facilitated an appropriate request certification and avoided the frustration of messages, voicemail, voicemail 'tag' etc.

TAKE HOME MESSAGE: WHENEVER POSSIBLE, TALK TO YOUR UR COLLEAGUES WHEN THEY CALL. It will decrease staff time and frustration and minimize unnecessary denials.

Variation #3

Treating Physician Request:

Consultation with a hand specialist

Clinical history:

Physician notes from 12/20/2008, 01/20/2009, 02/16/2009, 03/19/2009 were received and reviewed. The patient apparently has low back pain related to work dating to 12/16/2008. He has been treated conservatively with Naprosyn, Tylenol, Vicodin, and Soma and has received 6 physical therapy visits to date. The latest progress note received, dated 03/19/2009, reports "the patient continues to complain of low back pain. Though the pain continues, it is 50% better after his initial 6 PT visits. PT also reports he is able to move much better and is doing more at work and at home." Physical exam on that date notes "the back shows tenderness of the lumbar paraspinals, lumbar range of motion is now 60 % of normal (compared with 20% of normal pretreatment). Gait and DTRs are normal." Diagnosis given is lumbar strain. Plan as of that date is "continue medications and physical therapy 3 times per week x 2 weeks. Will see PT in 1 week and if less than 6 PT visits are needed, PT will be discontinued at

that time."

Reviewer Recommendation:

Certification of this request is recommended.

Rationale:

The physician notes document improvement of the patient's medical condition with current physical therapy. Further, although he has not yet reached maximum medical improvement, the plan is to discontinue PT if that occurs in less than the requested 6 visits. The request for physical therapy is therefore consistent with the medical guidelines noted below.

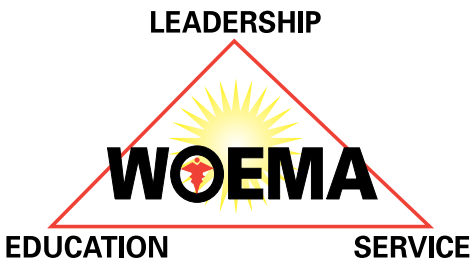
Guidelines Utilized:

ACOEM Guidelines, Chapter 12: Low Back Complaints, page 300 "Physical modalities such as massage, diathermy" (as noted above under Variation #1)

Work Loss Data Institute, Official Disability Guidelines, 9th Ed., 2004, Electronic Version - low back chapter: Physical therapy (PT) - Recommended as an option. There is strong evidence (as noted above under Variation #1)

WOEMA Newsletter Editor UR Commentary:

This is the gold standard. The physician notes supplied with the UR process document patient improvement with prior PT and clearly spell out the rationale for it, while spelling out the process for its early discontinuation if clinically appropriate. No phone calls are needed. No messages...no voicemail...no voicemail "tag"...no frustration...JUST A SUCCESSFUL APPROVAL! ♦



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