

QUARTERLY NEWSLETTER • SUMMER 2008

## WOEMA Readies for Fee Schedule Debate

BY WOEMA LOBBYIST, DON SCHINSKE



**C**alifornia's Division of Workers' Compensation has released its update from the Lewin Group that reports on changes in

reimbursement expected from a switch from the Official Medical Fee Schedule (OMFS) to an RBRVS-based payment system. Under the Lewin Group modeling, the adoption of a single-modifier, RBRVS-based schedule with no new dollars added to the system would boost payments for Evaluation & Management (E & M) codes by 20 percent.

Payments for the surgical codes, on the other hand, would drop 25.9%. This dynamic sets the stage for debate among the physician specialties in the coming months. WOEMA and its primary care allies will fight for the long-overdue increase in E & M payments while other specialties will aim to protect existing reimbursement levels.

Those tensions surfaced May 19 and 20, at two informational hearings on the Lewin update in Los Angeles and Oakland. The authors noted that their work, so far, has been based on a dollar-neutral assumption, and that more modeling will be forthcoming based on various levels of expanded overall expenditures. The question of new dollars is important: the easiest

path politically for WOEMA and its allies is one in which E & M reimbursement can be raised with little or no effect on surgical payments. DWC Medical Director Dr. Anne Searcy explained that the Division has made no decision yet about expanding the pool of available dollars. She noted that DWC is already starting to informally calculate some possible increases, and that the Lewin Group will now crunch out several alternatives.

At the May 20 hearing in Oakland, as WOEMA advocate, I pressed DWC and the Lewin authors on two points:

- That all additional modeling done by The Lewin Group incorporate the 28 percent increase in physician work and practice costs associated with the practice of occupational medicine relative to the similar code payments in Medicare. This disparity was noted in the original 2002 Lewin Group report on the fee schedule, but was not incorporated in the update. WOEMA noted that this component of the RBRVS payment calculation has likely increased under the system reforms of 2004, and continues to rise owing to such regulatory changes as the newly proposed PR-2 form, which requires additional reporting and assembly time.
- That the discussions on RBRVS conversion include information from other states about any changes in utilization,

patient satisfaction, and return-to-work measures that occurred after their own switch to an RBRVS system. That is, are there other things besides making physician pay more equitable to recommend the RBRVS switch?

For their part, representatives from the surgical specialties argued that the fee schedule should not reduce payment for the procedural codes to the point where patient access to care is affected. The Lewin authors – Al Dobson and Pete Welch, chiefly – noted that the use of multiple conversion factors is frequently used to “soften” the blow of an RBRVS conversion. However, WOEMA and its allies will continue to argue that the use of multiple conversions would serve only to lock in the existing disparities.

And so the debate, as the process begins in earnest over the next couple of months, will focus on several factors in the fee schedule:

- Whether the new schedule will come with new dollars overall, or will simply reallocate the current reimbursement pie
- The number of conversion factors
- The so-called “ground rules,” meaning the specific payment rules for particular codes (i.e., the cascading downward of payments for multiple similar procedures).

*Continued on page 10*

# WOEMA Utilization Review Guide: Instructive Cases

BY PETER SWANN, MD, NEWSLETTER EDITOR

**W**hat follows are three hypothetical variations of the same case, meant to illustrate the real world of utilization review; 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's UR commentary is given.

## VARIATION 1:

### Treating Physician Request: Consultation with a hand specialist

#### Clinical history:

Physician notes from 01/27/08, 02/05/08, 02/20/08, 04/10/08 and 05/02/08 were received and reviewed. The patient has had wrist pain from a ganglion cyst since 01/26/08. It was treated conservatively with Motrin®, intermittent wrist support, activity modifications and three PT visits with transient improvement only. He saw a hand specialist on 03/02/08 who recommended continued non-surgical care with surgery reserved for lack of



improvement with conservative treatment. Now, two months later, wrist pain and ganglion continue. There was no mention in the information received of whether the patient underwent aspiration of the ganglion, with/without steroids, and, if so, what the result was or what the rationale was for further consultation.

I called Dr. Jones on 05/10/08; he was unavailable so I left a message for him to call me to discuss the request. I called again on 05/11/08 and left another message. No call-back had been received as of the time of this report.

#### Reviewer Recommendation:

Non-certification of this request is recommended.

#### Rationale:

The physician notes are not clear on whether the patient has failed conservative care; there is no mention of aspiration or injection. Further, there is no rationale given for the consultation, or description of questions to be answered or what is to be gained by consultation. Given the lack of such information in the notes supplied, and my inability to discuss these questions with the requesting physician despite two attempts, it is not possible to certify this request as consistent with the ACOEM Guidelines noted below.

#### Guidelines Utilized:

ACOEM Guidelines, Chapter 11: Table 11-7, Pg 273 "...ganglion, or trigger finger: referral to surgeon only after patient education and conservative treatment, ...have failed (C, D) ACOEM Guidelines, Chapter 7, page 127, note "the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification."

#### WOEMA Newsletter Editor's UR Commentary:

UR physicians cannot read our minds. The physician notes hinted at a possible failure of conservative care to date, but there were unanswered questions in the mind of the UR physician concerning prior treatment received and its success or failure, and the rationale for the requested consultation was not clear. Despite two attempts, the UR physician was unable to discuss the details with the requesting physician. 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

*Continued on page 5*

# Fair Reimbursement for Cognitive Services: Gains Made, Work To Do

BY PETER SWANN, MD, NEWSLETTER EDITOR



**T**he California Department of Workers' Compensation (DWC) is once again discussing a long-awaited revision to the Workers'

Compensation California Official Medical Fee Schedule (OMFS). With that in mind, it is helpful to review where we are, how we got there and plan for the future, with respect to physician payment in California.

Physician payment can be broadly divided into two categories; reimbursement for cognitive services (CPT codes 99201-99205 for initial visits and 99211-99215 for follow-up visits – collectively called Evaluation & Management codes or E & M codes) and reimbursement for procedural services (many other CPT codes). When a patient sees her physician in the office and discusses the risks and benefits of one treatment approach over the other, the physician is reimbursed based on the E & M code submitted for that visit. If the patient decides to proceed with a procedure-based treatment, the physician performs the procedure and then is reimbursed based on the fee associated with the procedural CPT code. Procedures are performed in the office, outpatient surgical centers and in the hospital, depending on the complexity of the patient's medical care and the procedure itself.

The California OMFS uses relative values that were developed by the California Medical Association in 1956. These relative values were developed

based on the "usual and customary fees" charged at the time. They were adopted by the DWC in 1965 and revised in 1974. By 2002, California workers' compensation reimbursement for E & M-based cognitive office services averaged about 70% of the Medicare fees for the same codes. Procedural codes, by contrast, were mostly higher than Medicare fees for the same codes — sometimes several hundred percent higher.

In 2003, at the request of the DWC, The Lewin Group studied the California "Practice Expenses Associated with the Provision of Evaluation and Management Services" in the workers compensation system. Their report noted that practice expenses associated with E & M services in the California workers compensation system are 29% higher than for the same services for Medicare patients. In short, this study showed that, despite OMFS reimbursement of E & M codes averaging 70% of Medicare rates, it cost physicians 29% more to provide those services (e.g., more paperwork, phone calls, equipment, staff, etc.) than if they had seen Medicare patients for the same visits.

On 01/01/2004, many provisions of SB228 took effect, one of which was a renewed mandate for the Administrative Director of the DWC to revise the OMFS and provide for ongoing updates. Later that year, however, SB899 was passed. One of its many provisions was a continuation of the then current OMFS until 2006, with a 5% reduction in reimbursement

for CPT codes that were reimbursed at above Medicare rates. It was in this atmosphere, and with the information noted above, that in the spring of 2004, WOEMA engaged the services of Advocacy and Management Group (AMG) to help in the legislative and advocacy arenas. Needless to say, among many reasons for this decision was the wish by WOEMA leadership to achieve fair reimbursement for occupational medicine services within the workers compensation system.

Over the next several years, WOEMA leadership and AMG worked tirelessly to represent WOEMA members with legislators, the Governor, the DWC, the California Medical Association, specialty groups and other medical groups on many legislative and administrative issues including fair reimbursement for occupational medicine. On 02/15/2007, the work toward fair reimbursement saw its first success when the DWC raised the fees for E & M codes to equal Medicare fees for the same codes (an average increase of almost 30%). ♦

## 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](http://www.woema.org) and provide us with your name and email address.

## Western Occupational & Environmental Medical Association Annual Election of Officers & Directors

In accordance with the WOEMA bylaws, the Nominating Committee chaired by Craig Conlon, MD, has submitted a proposed slate for the Board of Directors and Officers to be presented to the WOEMA members at the **Annual Business Meeting on Friday, September 19, 2008, 12:30 p.m. at the Napa Valley Marriott in Napa, CA** during the 2008 Western Occupational Health Conference.



**Chairman of the Board**  
**Roman Kownacki, MD, MPH**  
Kaiser Richmond Medical Center  
*Richmond, CA*



**President**  
**Steven Schumann, MD**  
Doctors on Duty/Salinas Urgent Care  
*Salinas, CA*



**President-Elect**  
**Paul Papanek, Jr., MD, MPH**  
Kaiser Permanente  
*Los Angeles, CA*



**First Vice President**  
**Roger Belcourt, MD, MPH, FACOEM**  
Concentra  
*Reno, NV*



**Second Vice President**  
**Walter Newman, Jr., MD**  
Newman Medical Group  
*San Jose, CA*



**Secretary/Newsletter Editor**  
**Peter Swann, MD, FAAFP (2009)**  
Concentra  
*Walnut Creek, CA*



**Treasurer**  
**Dinesh Govindarao, MD, MPH, FACOEM (2010)**  
Concentra  
*Oakland, CA*



**Board of Directors:**  
**Leslie Israel, DO, MPH**  
UC Irvine, *CA (2009)*



**Sarah Jewell, MD**  
UCSF, *San Francisco (2009)*



**Paula Lenny, MD, MPH**  
Kaiser Permanente  
*Paia, HI (2010)*



**Contested Election #1 —  
for a 3-year term on the Board:**  
**Taha Ahmad, MD, MPH**  
Kaiser Permanente  
*Lancaster, CA*



**Ramon Terrazas, MD, MPH**  
San Francisco Fire Department  
*San Francisco, CA*

**Contested Election #2 —  
for a 3-year term on the Board:**  
**Patrick Luedtke, MD, MPH**  
Utah Department of Health  
*Sandy City, UT*

**Peter Vasquez, MD**  
MBI Industrial Medicine  
*Phoenix, AZ*



WOEMA thanks the following Board Members who are completing their service on the WOEMA Board:

James Seward, MD, MPP, FACOEM, *Chair of the Board*

Alan Randle, MD, FACOEM, *Treasurer* & Elyn McIntosh, MD, MPH, FACOEM, *Director*

## Utilization Review Guide

*Continued from page 2*



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 all that is needed is clarification of some details, as was the situation in this case.

### VARIATION 2:

#### Treating Physician Request:

#### Consultation with a hand specialist

##### Clinical History:

Physician notes from 01/27/08, 02/05/08, 02/20/08, 04/10/08 and 05/02/08 were received and reviewed. The patient has had wrist pain from a ganglion cyst since 01/26/08. It was treated conservatively with Motrin®, intermittent wrist support, activity modifications and three PT visits with transient improvement only. He saw a hand specialist on 03/02/08 who recommended continued non-surgical care with surgery reserved for lack of improvement with conservative treatment. Now, two months later, wrist pain and ganglion continue. There was no mention in the information received of whether the patient underwent aspiration of the ganglion, with/without steroids, and, if so, what the result was or what the rationale was for further consultation.

I called Dr. Jones on 05/10/08; he was unavailable so I left a message for him to call me to discuss the request. I called again on 05/11/08 and spoke with Dr. Jones. He explained that consultation was again sought for a new opinion about the need for aspiration with/without steroids vs. surgical excision, given the lack of efficacy of conservative care to date. (Dr. Jones has

no experience in ganglion aspiration/injection and does not perform this himself.)

##### Reviewer Recommendation:

Certification of this request is recommended.

##### Rationale:

The physician notes, and the conversation with the requesting physician, together document a failure of conservative care to date, with consultative questions needing answers that include possible surgical intervention. This is consistent with ACOEM Guidelines, as noted below.

##### Guidelines Utilized:

ACOEM Guidelines, Chapter 11: Table 11-7, Pg 273 "...ganglion, or trigger finger: referral to surgeon only after patient education and conservative treatment, ...have failed (C, D) ACOEM Guidelines, Chapter 7, page 127, note "the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification."

##### WOEMA Newsletter Editor's

##### UR Commentary:

This request was approved because the requesting physician came to the phone when the UR physician called. The physician notes hinted at a failure of conservative care to date but there were unanswered questions in the mind of the UR physician concerning prior

treatment received and the rationale for the requested consultation. These questions were answered when the details were discussed, physician to physician. 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 01/27/08, 02/05/08, 02/20/08, 04/10/08 and 05/02/08 were received and reviewed. The patient has had wrist pain from a ganglion cyst since 01/26/08. It was treated conservatively with Motrin®, intermittent wrist support, activity modifications and three PT visits with transient improvement only. He saw a hand specialist on 03/02/08 who recommended continued non-surgical care with surgery reserved for lack of improvement with conservative treatment. Now, two months later, wrist pain and ganglion continue. Consultation again sought for new opinion about the need for aspiration with/without steroids vs surgical excision, given the lack of efficacy of conservative care to date.

##### Reviewer Recommendation:

Certification of this request is recommended.

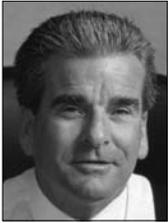
##### Rationale:

The physician notes clearly document

*Continued on page 6*

# WOEMA Advocates for Occupational Medicine

BY STEVE SCHUMANN, MD, LEGISLATIVE AFFAIRS COMMITTEE CHAIR



**W**OEMA serves as the eyes, ears and voice of occupational and environmental medical policy of the capitols of its

five Western States – Utah, California, Hawaii, Arizona, and Nevada. We advocate on frontline issues for our members and their patients, and keep them informed of legislative and regulatory policymaking that affects:

- **The practice of occupational health**
- **Public and environmental health**
- **Physician scope of practice issues**
- **Physician pay and the medical marketplace**

Our activities are keyed to meet the needs and interests of MDs, DOs and public health professionals.

WOEMA is working to improve reimbursement in Workers Compensation programs. We are helping to lead a coalition of provider groups that is seeking greater payment for cognitive services as part of a full overhaul of

the Official Medical Fee Schedule in California. The Division of Workers Compensation is expected to start developing a new Fee Schedule later this year. When it does, WOEMA will be there, insisting on fairer reimbursement for our members.

We work with fellow provider organizations to promote sound policy changes based on the best available science. WOEMA representatives serve on California Medical Association's Workers Compensation Technical Advisory Committee and its Council on Legislation, and consult with the medical associations in other WOEMA states.

WOEMA supports ACOEM in its efforts to promote the Practice Guidelines. We have advocated for the use of the guidelines as the Workers' Compensation treatment standard in California as well as in other states.

A WOEMA poll last year queried our members about the importance of the organization's efforts to monitor and report on legislative and regulatory issues. An overwhelming majority responded with support.

A significant portion of our annual budget underwrites this effort. In order to remain active, we must have member financial support as well. We ask you to respond by making a contribution, which can be mailed to the WOEMA office at 575 Market Street, Suite 2125, San Francisco, CA 94105. ♦

**Thanks to the following WOEMA members who have already contributed to the Legislative Fund in 2008:**

D. Winston Cheshire, MD  
 Craig F. Conlon, MD, PhD  
 Andrew D. Horpeniuk, MD, MPH  
 Corky J. Hull, MD, MPH  
 Roman P. Kownacki, MD, MPH  
 Paula Lenny, MD, MPH  
 Scott C. Levy, MD, MPH  
 Walter S. Newman, Jr., MD  
 Paul J. Papanek, Jr., MD, MPH  
 Dennis E. Pocekay, MD, MPH  
 Steven C. Schumann, MD  
 James P. Seward, MD, MPP, FACOEM  
 Peter D. Swann, MD, FAAFP

## Utilization Review Guide

*Continued from page 5*



a failure of conservative care to date, with consultative questions needing answers that include possible surgical intervention. This is consistent with ACOEM Guidelines, as noted below.

### **Guidelines Utilized:**

ACOEM Guidelines, Chapter 11: Table 11-7, Pg 273 "...ganglion, or trigger finger: referral to surgeon only after patient education and conservative treatment, ...have failed (C, D) ACOEM Guidelines, Chapter 7, page

127, note "the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment,

or work capacity requires clarification."

### **WOEMA Newsletter Editor's UR Commentary:**

This is the gold standard. The physician notes supplied with the UR process document the consultation requested and clearly spell out the rationale for it. No phone calls are needed. No messages...no voicemail...no voicemail "tag"...no frustration... JUST A SUCCESSFUL APPROVAL! ♦

# News You Can Use from the Literature

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



**A**dherence to a Mediterranean diet is associated with a reduced risk of diabetes (incidence rate ratios = 0.41 and .17 for moderate and

high adherence, respectively, vs. low adherence) per a prospective cohort study of 13,380 university graduates without DM followed for a median of 4.4 years. A 136 item food frequency questionnaire assessed dietary habits. *BMJ*. 2008 May 29. [Epub ahead of print]

■ **Low Vitamin D is associated with significant back pain in older women (OR=1.96) but not men**, per a study of 958 persons (ave age= 75.1, women; 73.9, men) based on pain scores and with Vitamin D (25(OH)) below 25 nmol/L defined as deficiency. *J Am Geriatr Soc*. 2008 May;56(5):785-91. Epub 2008 Mar 5

■ **QuantiFERON (QFT) indicates latent TB infection (LTBI) more accurately than the TB skin test (TST) and provides a sensitive way to detect progress to active TB** per a study of 601 close MTB-case contacts given TST and QFT testing and subsequently observed for 103 weeks. 40.4% (243/601) of contacts were TST positive at a 5-mm cutoff, whereas only 66 (11%) were QFT positive. Also, 14.6% of QFT positive progressed to active TB vs. 2.3% of TST positive). *Am J Respir Crit Care Med*. 2008 May 15;177(10):1164-70.

■ **Oral prednisolone is as safe and effective as naproxen for acute gout attacks**, per a randomized, double-blind trial of 120 patients (89% men; mean

age, 57), compared with treatment either oral naproxen (500 mg twice daily) or oral prednisolone (35 mg QD) for 5 days in with microscopically confirmed monoarticular gout. In both groups, reductions in pain (VAS) and disability at 90 hours were similar; and both showed full resolution at 3 weeks. *Lancet* 2008 May 31; 371:1854

■ **Use of multiple biomarkers improved the prediction of death from cardiovascular causes (CVD) by 17%** (C statistic = 0.766 with vs. 0.664 without) in those without prior CVD, per a study over 10 years of 1135 men (ave base age =71) of whom 315 died; 136 due to CVD. These markers reflect heart cell damage, LV dysfunction, renal failure, and inflammation (troponin I, N-terminal pro-brain natriuretic peptide, cystatin C, and C-reactive protein, respectively). *NEJM* 2008 May 15;358(20):2107-16.

■ **FDA expanded indications for bisphosphonate** (Reclast, Zolmeta zoledronic acid) to now include use as fracture prevention after the occurrence of a hip fracture. [www.FDA.gov](http://www.FDA.gov)

■ **A BMI of 18.5-<25, vs. >=35 had a 45% greater pancreatic cancer risk** with significant associations among (1) nonsmokers (HR = 1.70) but not recent smokers and (2) waist circumference (fourth vs. first quartile HR = 2.53) in women but not men. The authors observed no association with physical activity. NIH-AARP Study (ages 50-71 yr.) where a subcohort (302,060 of 495,035 ) were surveyed (654 pancreatic cancer cases ID'd) with a self-administered baseline questionnaire. *Am J*

*Epidemiol*. 2008 Mar 1;167(5):586-97. Epub 2008 Feb

■ **A high serum level of trans-monounsaturated fatty acids, presumably reflecting a high intake of industrially processed foods, is probably one factor contributing to increased risk of invasive breast cancer in women** concluded a 7-yr follow up study, with 363 cases of incident invasive breast cancer were documented among 19,934 women who, completed a diet history questionnaire and provided serum samples. An increased risk of breast cancer was associated with increasing levels of the trans-monounsaturated fatty acids palmitoleic acid and elaidic acid (highest quintile vs. lowest: OR = 1.75). *Am J Epidemiol*. 2008 Apr 4 [Epub ahead of print]

■ **Weight loss counseling occurred at only 52% of the visits (and counseling for weight loss, exercise and diet combined was provided to no more than 25% of patients)**, despite the observation that obesity-related comorbidities were treated more aggressively, per an analysis of 55,858 adult physician office visits sampled in the 1995-1996 National Ambulatory Medical Care Surveys. Specific interventions to address obesity are infrequent in visits to US physicians. *Arch Fam Med*. 2000;9:631-638

■ **Overall, Americans spent 54.9% of their monitored time, or 7.7 hours/day, in sedentary behaviors**, particularly older adolescents and adults aged >=60 years, who spent about 60% of their waking time in

*Continued on page 8*

## News You Can Use

Continued from page 7

sedentary pursuits. Based on 6,329 participants with at least one 10-hour day of monitor wear. Females were more sedentary than males before age 30 years, but this pattern was reversed after age 60 years. Mexican-American adults were significantly less sedentary than other US adults, and White and Black females were similarly sedentary after age 12 years. *Am J Epidemiol.* 2008 Apr 1;167(7):875-81. Epub 2008 Feb

■ **A randomized trial documented regression of carotid atherosclerosis and left ventricular mass with aggressive risk factor reduction in type 2 diabetes**, per a 3-year randomized trial to included 499 American Indian patients with type 2 diabetes and no history of cardiovascular events with one group with an LDL target of  $\leq 70$  mg/dL and SBP  $\leq 115$  mm Hg vs controls (control targets = 100 mg/dL and 130 mm Hg respectively). Outcomes were adverse events, intimal medial thickness (IMT) of the common carotid artery and cardiac ultrasound measures. Compared to baseline, IMT decreased by 0.012 mm (vs. 0.038 mm control); LV mass decreased by 2.4 g/m<sup>2.7</sup> (vs. 1.2 g/m<sup>2.7</sup> control) in the standard treatment group. However, antihypertensive therapy had 38.5% vs. 26.7% (standard treatment) adverse events. *JAMA.* 2008;299:1678-1689

■ **Women who experience 2 or 3 GI symptoms had adjusted odds ratios of 3.3, 3.0 and 2.8, respectively, for "often" having back pain** per a cross-sectional analysis of survey data of 38,050 women from 3 age cohorts. Possible factors cited were visceroso-

matic convergence, altered pain perception, increased spinal loading when straining and reduced abdominal muscle support of the abdominal contents and spine. *Clin J Pain - 01-MAR-2008; 24(3): 199-203*

■ **Potential for missed work may explain parents' request for antibiotics for child's acute otitis media** per a sensitivity analysis using quality-adjusted life-days (QALDs) and assessing the parent's value of the benefit of avoiding resistance to antibiotics vs. the cost of lost work. Parents would have to have a 0.77 QALDs to hit the break-even point with dollar cost of missed days of work for parents having the greatest influence. This is a potential barrier to implementing the 2004 American Academy of Pediatrics acute otitis media guidelines. *Pediatrics.* 2008;121:669-673

■ **Mild traumatic brain injury (TBI) occurring among soldiers deployed in Iraq is strongly associated with PTSD and physical health problems 3 to 4 months after the soldiers return home** per a survey of 2,525 U.S. Army soldiers 3 to 4 months after their return from 1 year deployment to Iraq. Of those with loss of consciousness (LOC), 43.9% met criteria for PTSD (vs. 27.3% of those reporting only altered mental status). Soldiers with mild TBI, primarily those who had LOC, were significantly more likely to report poor general health, missed workdays, medical visits, and a high number of somatic and postconcussive symptoms than were soldiers with other injuries. *NEJM, Volume 357 (5):2016-2027, 1/31/08*

■ **Six month follow-up is as effective as 3 month follow-up for people with hypertension** per an RCT study of 609 controlled essential hypertensives on at least one antihypertensive drug, 30-74 y/o, randomised to 3 or 6 mo. follow-up for 3 years (Mean = 33.6 mo). At 36 months, mean blood pressure, patient satisfaction and adherence to treatment was equivalent between treatment groups. *BMJ* 2004; 328: 204-206

Continued on page 10



**Lifestyle.**  
It's about moving in the right circles.

**Concentra**, the nation's largest provider of Occupational Medicine, is succeeding in all the right places. We are an \$800 million company with more than 300 medical centers. If you are looking for a career that also respects your personal time, you've got to start moving in the right circles. Concentra.

The following opportunities are available.

**STAFF PHYSICIANS – Las Vegas, NV**  
Day and night shifts, full-time salaried positions + benefits + bonus.

Las Vegas is the nation's fastest-growing metro area, with exceptional job growth, a warm climate and unparalleled resort and entertainment choices. Residents pay no personal income tax, meaning that Nevadans keep more of the money they earn. It's no wonder that Outlook recently named Las Vegas as one of the top five cities in the country to live!

**MEDICAL DIRECTOR – Denver, CO**  
Daytime hours – Monday-Friday 8am-5pm.

Board certification in occupational medicine or primary care specialty is required.

The "Mile High City" at the foot of the majestic Rocky Mountains is large and modern, with symphony and opera, a wealth of year-round recreation, and superb sightseeing in Red Rocks Park, City Park, Washington Park, Confluence Park, Cherry Creek State Park, and more.

For information on these and many other opportunities across the country, please visit [www.concentra.com](http://www.concentra.com) and click on careers. You may also send CV to [Carole\\_Fleming@concentra.com](mailto:Carole_Fleming@concentra.com).

We are a diverse team dedicated to making healthcare accessible and affordable. EOE

Results  
Powered By  
**Concentra.**

# Western Occupational Health Conference

## September 18 - 20, 2008

NAPA VALLEY MARRIOTT, NAPA, CA

WOEMA is pleased to invite you to join us in the Napa Valley this September for WOHC 2008. The theme, **Making It Work: Tools for Success in Occupational Medicine**, guides the framework for this year's conference. Our goal is to provide you with continuing education and tools to help you achieve successful outcomes with your patients, employer, and clients.

CME: QUALIFIES FOR UP TO 22 HOURS OF CATEGORY 1 CREDIT FOR PHYSICIANS



### CONFERENCE HIGHLIGHTS:

Keynote address by California Lt. Governor John Garamendi

ACOEM Guidelines: An Evidence-Based Approach to Chronic Pain – *Kurt Hegmann, MD, MPH*

The Latest Research on Upper Extremity Disorders – *David Rempel, MD, MPH*

Does Minor Trauma Cause Serious Low Back Pain Illness? – *Eugene Carragee, MD*

Current Issues in Commercial Driver Medical Examinations – *Natalie P. Hartenbaum, MD, MPH*

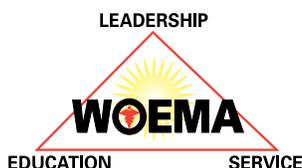
Impact of Chemical Exposure in the Workplace & Environment

Narcotics and Drug Abuse

Power Ortho: The Upper Extremity, plus much more...

Napa Valley offers interesting educational site tours and the perfect location for exciting social events including dinner and wine tasting at the fabulous Markham Vineyards Winery.

The conference headquarters hotel is the Napa Valley Marriott Hotel & Spa. For reservations call 800-228-9290. Be sure to identify yourself with "WOHC" in order to receive the reduced group room rate of \$245.



JOINTLY SPONSORED BY:

Western Occupational & Environmental Medical Association (WOEMA)

American College of Occupational & Environmental Medicine (ACOEM)

## Fee Schedule Debate

*Continued from page 1*

- Effects of the changes on patient access (i.e., potential decline in participation by surgeons, versus the potential increase in participation by psychologists and psychiatrists).

Dr. Searcy did make one point clear at the meeting: DWC has no plans to adopt the Medicare modifier for the schedule, both because the Medicare modifier does not translate well to occupational health, and because of political vicissitudes of Medicare funding.

The Medical Director did urge stakeholders to submit comments on the Lewin Report, suggestions for additional modeling, their own office data, and other comments to herself and Administrative Director Carrie Nevans.

At the hearing WOEMA spoke directly with representatives from

the other specialties, offering to work together toward a common recommendation. Such discussions will occur as well within the CMA's Workers Compensation Technical Advisory Committee, where WOEMA Legislative Chair Steve Schumann, MD, holds a seat.

Also on the regulatory front, WOEMA issued an alert to members urging them to contact DWC and oppose the Division's proposed changes to the PR-2 form. The new form includes a "discussion" section in which the provider must explain why the particular treatment was ordered, as well as a requirement that all prior treatment orders for that injury be attached. WOEMA has no issue with the intent of the change – which is to ensure a sound basis for treatment – but is opposed to the extra work required absent any adjustment in the fee schedule. Indeed, the basic problem with the pro-

posed change, as well as the adoption of the restrictive pharmacy fee schedule last year, is that even rational fixes to the current system are unduly burdensome unless payment for the basic Work Comp visit codes gets fixed.

Pending changes in the draft regulations by the Division, WOEMA will oppose their adoption through the formal hearing process.

On the Legislative front, WOEMA this month issued a letter to Hawaii Governor Linda Lingle, urging her to sign HB 2929. The bill provides that employers and employees agree upon an independent medical examiner, which is a switch from current arrangement of employer choice. WOEMA expects to continue to provide input to the Hawaii lawmakers in their longstanding, often contentious efforts, to reform one of the more expensive workers' comp programs. ♦

## News You Can Use

*Continued from page 8*

=33.6 mo). At 36 months, mean blood pressure, patient satisfaction and adherence to treatment was equivalent between treatment groups. *BMJ 2004; 328: 204–206*

■ **Viewing a stressful soccer match more than doubles the risk of an acute cardiovascular event.** 4,279 cardiovascular events were assessed in the greater Munich area with events during the World Cup (6/9/06 to 7/9/06) assessed by ER physicians compared those events during the control periods in '06, '05 and '03. On days of matches involving the German team, the incidence of cardiac emergencies was 2.66 times that during the control period; for men, the incidence was 3.26 times that during the control period and for women,

1.82 times. Authors indicate preventive measures are urgently needed. *NEJM Volume 358(5):475-483; January 31, 2008*

■ **A high dietary folate intake may reduce the risk of cerebral infarction** per analysis of 26,556 male Finnish smokers, aged 50-69 years, enrolled in the Alpha-Tocopherol, Beta-Carotene Cancer Prevention Study with mean follow-up of 13.6 years. The multivariate relative risk of cerebral infarction was 0.80 for men in the highest versus lowest quintile of folate intake. Vitamin B(6), vitamin B(12), and methionine intakes were not significantly associated with any subtype of stroke. *Am J Epidemiol. 2008 Feb 12 [Epub ahead of print]*

■ **Patients taking Chantix may experience impairment of the ability to drive or operate heavy machinery** and should tell their health care provider about any history of psychiatric illness prior to starting, per a 2/1/08 FDA Public Health Advisory on the prescription medication used to help patients stop smoking. Agency was evaluating postmarketing adverse event reports on Chantix related to changes in behavior, agitation, depressed mood, suicidal ideation, and actual suicidal behavior — it appears increasingly likely that there may be an association between Chantix and serious neuropsychiatric symptoms. <http://www.fda.gov/cder/drug/infopage/varenicline/default.htm> ♦

# Interesting and Useful Web Sites

CONTRIBUTED BY CONSTANTINE J. GEAN, MD, MS, MBA, FACOEM



## The Site Deserves a Gold Medal! (<http://www.medal.org>)

With respect to algorithms, this site is medically equivalent to the city of gold. The Medical Algorithms Project informally known as “MedAl” (<http://www.medal.org>) has 11,000+ medical algorithms developed over 15 years and is entirely self-funded. It is a collaboration of prominent physicians (Institute for Algorithmic Medicine) who have collected from the peer-reviewed biomedical literature reliable equations. They have placed information for each algorithm in a remarkably cogent standardized format - with clear, concise, referenced and easily searchable algorithms from ALL areas of medicine. After a free and fast registration, on the start-up page there is a single search line where you put in a term (or multiple terms) such as “bronchitis”. With one click you are taken to a list of referenced algorithms (in my example, the ‘CDC Criteria for Bronchitis, Tracheobronchitis, [etc.] came up as #4 [of 32] and I clicked on it to see a practical and clinically useful 1-page algorithm for bronchi-

tis (an Excel diagnosis questionnaire with algorithm score was attached as well). Equally useful is a “Contents by Specialty” button that lists algorithms by a chosen specialty with each specialty divided into practical subgroups which organize the algorithms. I found ‘Migraines’ and ‘Peripheral nerve Injury/Entrapment’ sub-sections in the ‘Neurology’ section and ‘Low Back Pain and lumbar Spine Surgery’ sub-group in the ‘Musculoskeletal’ Section. Two other sections, ‘Rheumatology’ and ‘Occupational Medicine Disability’ had numerous useful algorithms [with the latter including some AMA Guide rating algorithms — made simple!]. It is difficult to believe so many algorithms could be made so simple and accessible. This site has to be seen to be believed. Try it out! (Site contributed by Dr. Stephen Levit.)

## Epocrates On-Line (<https://online.epocrates.com/public/portkey/>)

The PDR is heavy and can give you a TFCC tear if you aren’t careful (and the print size seems to shrink with each

passing year!). Well, these problems are now solved with the well known Epocrates, famous for Palm Pilot downloads and minuscule pocket drug compendiums, (<http://www.epocrates.com>), which is now on-line for free. Doses, pill sizes and pictures, cautions, drug monograph, etc. are all easily accessed and constantly updated. In essence, it is the concise information you need and free to boot. Hard to beat.

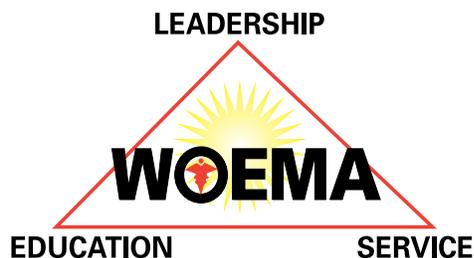
## E-BizMBA (<http://www.ebizmba.com/articles/health>)

Lists the 20 most popular health websites. Updated each month by a combination of inbound Links, Google Page Rank, Alexa Rank, and U.S. traffic data (these are listed by site). Find out what your patients are looking at and beat them to the punch! Quite interesting. ♦

## Welcome New Members!

John W. Alchemy, MD, *Santa Rosa, CA*  
Sandeep Guntur, MD, *Foster City, CA*  
Thieuha T. Hoang, MD, *Irvine, CA*  
William J. Hopper, MD, MBA, CPE, *Alameda, CA*  
Amy J. Khan, MD, MPH, *Reno, NV*  
Bock J. Kim, DDS, *Bell Gardens, CA*  
Nita Kohli, MD, MPH, BSEE, BA, FPO, AP

Randall H. Leefeldt, MD, *Woodland, CA*  
Mohammad A. Mahmud, MD, PhD, *Corona, CA*  
Daniel W. Rhodes, MD, *Coronado, CA*  
Walter N. Simmons, MD, *Phoenix, AZ*  
Dennis Stephens, MD, *San Ramon, CA*  
Melinda F. Vertin, ANP, OHNP, COHN-S, MSN, *San Jose, CA*



RETURN SERVICE REQUESTED

FIRST-CLASS MAIL  
US POSTAGE  
**PAID**  
San Francisco, CA  
Permit No. 11751

Western Occupational and Environmental Medical Association

575 Market Street, Suite 2125 • San Francisco, CA • 94105

SUMMER 2008

# Mark Your Calendar!

## Western Occupational Health Conference

### September 18 – 20, 2008

NAPA VALLEY MARRIOTT, NAPA, CA

*See page 9 for more details...*

