President’s Message

WOEMA has started out the year with new energy. At the January board retreat the committee chairs planned key initiatives that will further increase our effectiveness on behalf of the membership. There are truly some exciting things coming down the pike, and here are some highlights.

This year’s Western Occupational Health Conference is shaping up to be an awesome event. Ellyn McIntosh, MD has been chairing the effort, and the planning committee has organized an absolutely first-rate meeting with some stellar extra-curricular events. The list of speakers is an all-star cast, including NIOSH Director John Howard, MD. Recognizing the important role that occupational medicine physicians play in emergency planning and response, we are offering a post-conference one-day certification in Basic Disaster Life Support. I encourage all of you to hold October 4-7 for this WOHC in San Diego.

Kudos go to our Legislative Committee, its chairperson Steve Schumann, MD and our lobbyist Don Schinske for their excellent work last year. WOEMA had a voice in the successful efforts to increase the new California workers’ compensation fee schedule (OMFS) change is, at least in part, due to the hard work of many within WOEMA. The end result is an increase in office-based E&M codes ranging from 17% to almost 36% with an average increase of about 26%! The new fees, compared with some of the old fees, are shown below:

<table>
<thead>
<tr>
<th>OMFS Section</th>
<th>Procedure Code</th>
<th>New Fee</th>
<th>Old Fee</th>
<th>%Change</th>
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<tbody>
<tr>
<td>E&amp;M</td>
<td>99201</td>
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<td></td>
<td></td>
</tr>
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<td>99202</td>
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<tr>
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<tr>
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<tr>
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<td>72.25</td>
<td>24.0%</td>
</tr>
<tr>
<td>E&amp;M</td>
<td>99215</td>
<td>129.41</td>
<td>110.55</td>
<td>17.1%</td>
</tr>
</tbody>
</table>

Welcome New Members!

Venkataramana Adapa, MD, MPH  Mark Greenspan, MD
Patrick Bradley, PhD  Gary L. Heastan, PA-C, BS
Liza M. Del Muro, ANP  Shahzad Jahromi, MD, MD
Mirasol R. Fajardo, NP, ANP  David M. Salter, MD, MRO
Monica A. Garcia, FNP  Vernon J. Williams, MD
President’s Message

Continued from page 1

the reimbursement rates for physicians under the California Official Medical Fee Schedule (see box on page 1). WOEMA has Legislative Committee representatives in all of our member states and will continue its efforts to monitor and influence legislation this year. Our Education Committee has renewed vigor under the leadership of Leslie Israel, DO of UC Irvine and will explore expanded CME opportunities, including the possibility for WOEMA to offer online CME. Dennis Pocekay, MD has taken over the Membership Committee and will work with ACOEM on a new membership drive. The Young Physicians and Residency Scholarship Committees have been merged under the guidance of Bob Pandya, MD and Taha Ahmad, MD with a new focus on expanding WOEMA relationships with the Occupational Medicine Residency Programs and engaging recent graduates in WOEMA.

These efforts and our ongoing work on many other fronts are great opportunities for you to participate. One of the most rewarding aspects of WOEMA membership has always been the opportunity to work with colleagues to do creative things. I urge you to contact one of the committee chairs (see list on page 5) and get involved.

Western Occupational Health Conference

October 4-7, 2007
Loews Coronado Bay Resort, San Diego, CA

Conference Highlights:

- The Future of Occupational Medicine, Robert McLellan, MD, MPH
- New Issues & Developments on the NIOSH Research Agenda, John Howard, MD
- Latest on the ACOEM Guidelines Update, Kurt Hegmann, MD, MPH
- Sleep Apnea and Commercial Drivers Update, Natalie Hartenbaum, MD
- The New Asbestos: Food Flavorings – Diacetyl, Kathleen Kreis, MD
- The Reproductively Destructive Workplace, Fred Fung, MD
- Basic Disaster & Life Support (BDLS) Training & Certification
- Naval Vessel Hospital Ship Tour • Power Orthopedics: The Spine plus much more.....

About San Diego

San Diego is California’s second largest city where blue skies keep watch on 70 miles of beaches and a gentle Mediterranean climate begs for a day of everything and nothing. Bordered by Mexico, the Pacific Ocean, the Anza-Borrego Desert and the Laguna Mountains, San Diego county’s 4,200 square miles offer immense options for business and pleasure. And with the Mexican city of Tijuana just minutes from downtown, San Diego is an international experience with all the comforts of a city leading the nation in biomedical, high-tech and telecommunication industries.
On behalf of the WOEMA Board of Directors and Conference Planning Committee, we invite you to join us on Coronado Island in San Diego, California this October 4-7, 2007 for The Western Occupational Health Conference.

Our conference theme: “Work Healthy. Live Well.” represents our collective goal of ensuring a healthy, productive workforce for our patients. It also represents a personal goal we have for ourselves as physicians. To that end, we gather this October to gain the latest insights into vaccines, updates on guidelines (ACOEM, NFPA), rehabilitation, treating back and neck injuries, pain management, toxicology, and much more. In addition, our opening keynote speaker, Dr. John Howard, Director of the National Institute for Occupational Safety and Health (NIOSH) promises to bring us the most up-to-date information from Washington that has implications for how we practice medicine.

There will be a lot to talk about with the ACOEM Guidelines update coming out this year…and this is your chance to meet with your occupational medicine colleagues to share practices, experiences, and challenges.

And if you are looking for a diversion from the day-to-day doldrums, WOHC has plenty to offer to spice things up! We’ve even started our course earlier in the morning and ended earlier in the afternoon to allow for more fun in the San Diego sun.

A trip to SeaWorld with VIP reserved show seating and a private (behind the scenes) tour is on the schedule for your family and friends to enjoy while you are busy in the seminars on Friday. On Friday evening, you and your guest will be whisked away to a twilight San Diego Zoo Safari Tour and Dinner. On Saturday evening, you’ll be part of a mini-regatta as you embark on a Sunset Sail on San Diego Harbor. Jump on one of more than 20 sailboats stocked with gourmet food and wine for you and your 6-8 sailing mates to enjoy.

WOHC ‘07 will provide new friendships, and you will find our Conference, “Work Healthy. Live Well.” of great value to you and your patients.

I look forward to greeting you personally in San Diego!

Ellyn McIntosh, MD, MPH, FACOEM, Conference Chair, WOHC ‘07

Medicine and Occupational Health – Global
ExxonMobil Corporation
The ACOEM Practice Guidelines: Who Are They For?

The ACOEM Practice Guidelines (2nd edition) certainly made an impact. It has been adopted by states, carriers, and provider networks across the country. The management and revision of the Guidelines has become a major commitment of the College. However, members of ACOEM are entitled to ask:

“Why are we involved in this effort and what benefit do we get out of it?”

The answer is: A lot of benefit, often in ways that are not obvious. The Guidelines was developed primarily for health care providers. Specifically, the goals are “to improve the efficiency with which the diagnostic process is conducted, the specificity of each diagnostic test performed, and the effectiveness of each treatment in relieving symptoms and achieving cure.” The Guidelines provides a solid foundation in clinical practice for better clinical outcomes, less disability, and better lives for injured workers.

However, the Guidelines has been adopted in California and are increasingly used for utilization review by insurance professionals, attorneys, workers’ compensation managers, and payers. That is good for practitioners who practice evidence-based medicine. Having a consistent set of guidelines gets everyone on the same page. It means fewer claims rejected and better outcomes overall. It also means having legal and procedural grounds on which to insist that alternative treatment be considered for patients who have special problems, because that, too, is an integral part of the Guidelines.

Good occupational physicians already practice evidence-based medicine, with or without the support of the Guidelines. For these conscientious practitioners, little changes when the Guidelines is adopted by their state or network. The Guidelines also clarify how occupational health care differs, when it does, from conventional medical management of non-occupational injuries and illness.

Occupational medicine assumes good medical practice, based on evidence of effectiveness and safety, but has to take into account the objectives of occupational health care – early and safe return to work and, if that is not possible, appropriate assignment of responsibility and prevention of disability. Our field is founded on certain specific principles that sometimes need to be spelled out so we don’t forget them – prevention, thorough documentation, integrated treatment modalities, work-relatedness, disability prevention and management, and functional assessment. These principles recur in everything we do, whether it is management of an initial injury or an independent medical evaluation. They are the value that we add.

Of course, many practitioners do not follow the principles of good occupational medicine. They may tend to favor procedures over conservative treatment when the latter is equally effective and safer. They may prefer their own approaches to treatment. They may be a little out of date. They may simply not like what they consider being told how to practice medicine. In such cases, the practitioner has a bigger problem than the ACOEM Practice Guidelines.

The Guidelines does put pressure on such practitioners. The guidelines place a burden of evidence on the practitioner to justify why a procedure that may be less effective, more costly, less safe, or unproven should be used, or why a given test or diagnostic procedure that may be less efficient, more costly, less safe, or less reliable should be used in diagnosis. They force the practitioner to document why a departure from a practice guideline is indicated in a particular case, which in turn protects the practitioner in the event of future liability.

Physicians may not be used to such scrutiny but the demands for accountability are not going to go away. This is the future of medicine. And it is far better to judge occupational health-care by guidelines designed for the occupational context than to wait for other guidelines to be imposed that do not reflect our reality and that of our patients.

It is to the strong advantage of occupational physicians that the Guidelines reflect the best evidence available and are appropriate for the care of injured workers. The Guidelines is a response to much bigger changes that have to do with rising expectations for quality of care: increased expectations for good outcomes, medical safety, stopping over-utilization, curbing unproductive and even harmful procedures, trimming costs, and spurring advances in medicine based on the best available evidence. The Guidelines establishes best practices based on what is known to work and conform to what conscientious occupational physicians are already doing.

One reason that workers’ compensation divisions, carriers, and networks...
WOEMA 2007 Board of Directors & Officers

2007 WOEMA Officers, Directors and Committee Chairs after their board retreat at UC Berkeley in January 2007.

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Sarah A. Jewell, MD
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Ellyn G. McIntosh, MD
Walter S. Newman, Jr., MD

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News You Can Use from the Literature

Compiled by Constantine J. Gean, MD, MS, MBA, FACOEM
Vice President and Chief Medical Officer, Unum Provident

There was a nearly 8-fold variation in regional rates of lumbar discectomy and laminectomy and a nearly a 20-fold range in rates of lumbar fusion among Medicare enrollees between 2002 and 2003. Also, there has been a marked increase in rates of fusion. Lumbar fusion spending increased more than 500% ($75 to $482 million). In 1992, lumbar fusion represented 14% of total spending for back surgery; by 2003, it was 47% of spending. This is per a repeated cross-sectional analysis using Dartmouth Atlas Project national Medicare data for fee-for-service Medicare beneficiaries over age 65 in 306 US Hospital Referral Regions. Spine, 2006 Nov 1;31(23):2707-14.

The CDC released new guidance on state and community planning strategies for decision-makers, and individuals, to consider; these vary based on the severity of an influenza pandemic. The CDC outlines “non-pharmaceutical interventions” to reduce contact between people as much as possible during the 8-to-10-week long waves of illness. Specific tactics may include: (1) asking ill persons to remain at home or not go to work until they are no longer contagious (7 to 10 days) and to take antiviral medication if available and effective, (2) asking household members of ill persons to stay at home for 7 days, (3) dismissing students from schools and closing child care programs for up to three months, (4) recommending social distancing of adults in the community and at work, which may include closing large public gatherings (e.g., banning concerts and sporting events), changing workplace environments and shifting work schedules. http://www.pandemicflu.gov.

Antioxidant supplements significantly increased mortality (RR=1.05) with beta carotene (RR=1.07), vitamin A (RR=1.16), and vitamin E (RR=1.04), singly or combined, significantly increasing mortality in 47 low-bias trials with 180,938 participants, (after exclusion of selenium trials). However, when all low- and high-bias risk trials of antioxidant supplements were pooled together there was no significant effect on mortality (RR, 1.02). Vitamin C and selenium had no significant effect on mortality. This was per a literature review of 68 randomized trials with 232,606 participants (385 publications) in randomized trials published by October 2005. JAMA 2007 Feb 28;297(8):842-57.

The benefits of fish intake exceed the potential risks. For women of childbearing age, benefits of modest fish intake, excepting a few selected species, also outweigh risks. Per a study of articles through April 2006 on MEDLINE, governmental reports, and meta-analyses, and evaluation of (1) intake of fish or fish oil on cardiovascular risk, early neurodevelopment, cardiovascular and neurologic outcomes in adults, and health risks of dioxins and PCB’s in fish (note: article ranks species by contaminant level). The study showed that modest consumption of fish (e.g., 1-2 servings/wk), esp. if higher in the n-3 fatty acids eicosapentaenoic acid (EPA) and docosahexanoic acid (DHA), reduces coronary death risk by 36% and total mortality by 17% (250 mg/d of EPA and DHA appears sufficient for primary prevention). Individuals with > or =5 servings/wk should limit intake of species highest in mercury levels. Women of childbearing age and nursing mothers should consume 2 seafood servings/wk, limiting intake of selected species. JAMA 2006 Oct 18;296(15):1885-99.

A 50% lower risk of colorectal cancer was associated with a serum 25(OH)D level >/=33 ng/mL, compared to <12 ng/mL suggesting daily intake of 1000-2000 IU/day of vitamin D(3) could reduce the incidence of colorectal with minimal risk. Five studies of serum 25(OH)D were combined and the pooled results were divided into quintiles with median 25(OH)D values of 6, 16, 22, 27, and 37 ng/mL. The pooled odds ratio for the highest quintile versus the lowest was 0.49 for colorectal cancer. Am J Prev Med 2007 Mar;32(3):210-6 [Editor’s note: RDA, adult = 400IU].

400 mg of celecoxib once daily significantly reduced the occurrence of colorectal adenomas within three years after polypectomy. Follow up colonoscopies at year 1 of subjects (who had had adenomas removed before enrollment) with 557 placebo group and 840 celecoxib group subjects revealed that 264 and 270, respectively, were found to have at least one adenoma at year 1, at year 3, or both. The Continued on page 9
Happenings on the Legislative Front

WOEMA Physician named to CA Treatment Guidelines Advisory Committee

WOEMA’s Bernyce Peplowski, DO, has been named to the Division of Workers’ Compensation’s new medical evidence evaluation advisory committee. Dr. Peplowski, the medical director at Zenith Insurance, will represent occupational and environmental medicine on the committee alongside representatives from 15 provider specialties. The group will evaluate evidence and make recommendations to DWC on updating or revising the guidelines for allowable treatment within the Workers’ Compensation system.

DWC Medical Director Anne Searcy, MD explained that the group’s first task will be to review ACOEM’s new chapter on elbow treatment. The group’s first quarterly meeting is scheduled for March 19. Members serve two-year terms.

CA Access Study Released

DWC has also released its much awaited report on access to care in the system following implementation of the 2003 and 2004 reforms: www.dir.ca.gov/dwc/AccessMedTreatmentReport2006/AccessToMedicalTreatmentInCAWC2006.html

The study, conducted by the UCLA Center for Health Policy Research (CHPR), found that workers in the main are satisfied (78%) with the care they receive under the new system, and that most (83%) reported having access to quality care. The report did note poorer health outcomes and satisfaction among certain groups, including ethnic/racial minorities and patients whose injuries require 10 or more visits.

Providers themselves tended to overestimate the access problem for patients, although the study found no great exodus by providers from the system. Most, however, expressed dissatisfaction with the fee schedule, particularly if paid a high discount from OMFS. The report notes that physicians billing under the Evaluation and Management codes receive on average 13% below the Medicare fee schedule.

“Therefore,” the researchers conclude, “increases in the fee schedule, at least for some services, or limits on the discounts insurers can pay below the fee schedule, may be warranted to ensure board provider participation in the WC system.”

CA Governor/Legislators Propose 24/7 Care

WOEMA will track a number of proposals introduced in California in 2007. In the next couple of weeks, WOEMA representatives will be meeting with Governor Schwarzenegger’s Administration staff to discuss the governor’s proposal to pilot a 24/7 care program, which would combine group health and Workers’ Comp coverage for members of CalPERS, the state’s massive public employee pension system.

WOEMA’s Legislative Committee, co-chaired by Steven Schumann, MD and Peter Swann, MD, will meet in early April to discuss possible positions on a number of bills including:

AB 644 (Dymally), which would require that UR discussions between a reviewer and provider be “directed toward an evaluation of the medical treatment requested by the physician treating the injured worker, and not to an examination of the specialty of the physician requesting the treatment.” http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_0601-0650/ab_644_bill_20070221_introduced.html

AB 1073 (Nava) provides that UR be done only by California-licensed physicians, and removes the 24-visit limit on physical therapy and chiropractic treatment. http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_1051-1100/ab_1073_bill_20070223_introduced.html

SB 352 (Padilla) would exempt public safety officers from the cap on

Continued on page 8
also of interest are companion bills AB 550 (Ma)/ SB 723 (Yee), which would allow the State Compensation Insurance Fund to operate in the group health market.

In addition, there are multiple bills this year addressing various environmental health concerns, including AB 294 - Manganese pollution, AB 513 - Prohibition on PBDEs, AB 833 – Creation of California Toxic Release Inventory Program, and SB 973 – State tracking of the sale and manufacture of “chemicals of concern.”

Also new is AB 1605 (Lieber), which would create a deputy level position of State Public Health Nurse to serve in the new Dept. of Public Health.

Arizona Treatment Guidelines Bill
Meanwhile the Arizona Legislature will be considering a bill requiring the Industrial Commission to adopt evidence-based treatment guidelines for its Workers’ Compensation system by 2009. The draft language of the bill provides that until that time, the ACOEM Practice Guidelines will stand as presumptively correct.

The bill also provides for creating of a Workers Compensation Evidence Based Medicine Advisory Committee similar to new body in California, which would advise the commission on adoption of a permanent set of guidelines, assess quality of evidence, and make recommendations for modifications. The Arizona Medical Association to provide input on the bill’s language.

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Basic Disaster Life Support
Training & Certification
Sunday, October 7, 2007 • 8:00 am – 4:00 pm
Loews Coronado Bay Resort, San Diego, CA

A disaster can strike at any time. Earthquakes, mudslides, wildfires, floods, explosions and terrorist attacks are not isolated events. As a physician, nurse, or paramedic, are you prepared to help? Have you received systematic training in disaster recognition and response, or the incident command system? Basic Disaster Life Support (BDLS) is a standardized, systemic training for clinicians that was developed in part and will be taught by the Medical College of Georgia, Center of Operational Medicine. Don’t miss this opportunity to get the training now. Preparedness is key to your success.

For registration and more information call, 415.927.5736

Utah Liability Law Signed
The State of Utah has enacted legislation immunizing physicians from malpractice claims when providing care following natural disasters, pandemic events, or acts of bioterrorism. Governor Huntsman signed the S.B. 153 on March 6.

Meanwhile, the Utah Labor Commission is also considering standards for its adoption of medical treatment guidelines in its Workers’ Comp system. H.B. 150, passed in 2006, required the state to establish “a reasonable health care treatment protocol program” that includes “implementation of medical treatment and quality care guidelines that are…scientifically based [and] peer reviewed.” Draft language for those standards also provides that the guidelines be updated at least every two years, easily accessible, and “reasonably priced.” Parties with guidelines they want considered for adoption would submit them to the Labor Commission for review.

Hawaii Boosts Work Comp Payments
Hawaii’s Dept. of Labor and Industrial relations adjusted payments for more than 1,200 of codes, out of concern that reimbursement was too low to keep providers in the system. By statute, fees are based on 110 of Medicare, although a review of the codes should wide disparities. Evaluation and Management codes were raised an average of 20.7 percent, compared to a 4.2% increase for the Medicine codes, 29.3% for the surgical codes, and 6.6% for other services.

The Hawaii Legislature this spring is again considering a Workers’ Comp reform package. As currently written, SB 1060 would incorporate three separate sets of treatments guidelines as the treatment standard, including the first seven chapters of the ACOEM Practice Guidelines. WOEMA has requested that SB 1060, which is now in a joint House/Senate conference committee, include just the ACOEM guidelines to ensure that injured workers receive care based on the highest-level scientific evidence.
cumulative rate of adenomas detected through year 3 was 33.6 percent in the celecoxib group and 49.3 percent in the placebo group (RR= 0.64). Authors note that over expression of COX-2 has been associated with colorectal adenomatous polyps and cancer. *N Engl J Med.* 2006 Aug 31;355(9):885-95

- **Folic acid supplementation** slowed the decline in hearing of the speech frequencies associated with aging, per a double-blind, randomized, placebo-controlled trial conducted from September 2000 to December 2004 with 728 older men and women given placebo or oral folic acid 800 mcg/day for 3 years. 3-year change in hearing thresholds [both ears low and high frequencies] was followed and after 3 years, thresholds of the low frequencies increased by 1.0 dB in the folic acid group and by 1.7 dB in the placebo group Folic acid did not affect the decline in hearing high frequencies. *Ann Intern Med.* 2007 Jan 2;146(1):I20.

- **Active migraine with aura** was associated with increased risk of major CVD, myocardial infarction, ischemic stroke, and death due to ischemic CVD Major CVD (1st ischemic stroke, nonfatal MI) were assessed in this prospective cohort study of 27,840 US women 45 years or older in the Women’s Health Study, free of CVD and angina at study entry (1992-1995). At baseline, 5,125 (18.4%) reported any hx. of migraine (5,610 with prior year migraine, of whom, 1,434 (39.7%) had aura sx). During a mean of 10 years of follow-up, 580 major CVD events occurred. Compared with women with no migraine history, women who reported active migraine with aura had hazard ratios of 2.15 for major CVD, 1.91 for ischemic stroke, 2.08 for MI, 1.74 and 1.71 for angina, and 2.33 or ischemic CVD death. *JAMA* 2006 Jul 19;296(3):283-91.

- **Total expenditures for acute and chronic respiratory conditions** were $88 to $103 lower per immunized Medicare beneficiary than for non-immunized, per a survey samples of 175,000 beneficiaries between 1999 and 2003 (response rate = 64% to 71%, depending on year). Savings were assessed using inpatient, outpatient, and professional services expenditures for immunized vs. non-immunized between 1999 and 2003. *Am J Prev Med* 2007 Feb;32(2):107-15.

- **Fibromyalgia symptoms** were significantly improved in an acupuncture group (vs. controls) as measured by Fibromyalgia Impact Questionnaire, given immediately, at 1 month and at 7 months after treatment. Largest differences in scores were seen at 1 month (42.2 vs 34.8 in the control and acupuncture groups, respectively). This a prospective, partially blinded, controlled, RCT of 25 patients receiving true acupuncture compared with a 25 controls with simulated acupuncture. Fatigue and anxiety were the most significantly improved symptoms during the follow-up period. *Mayo Clin Proc* 2006 Jun;81(6):749-57.

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**USE THE NEW**

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WOEMA offers a new way to find jobs. Members can post resumes and browse resumes on-line. Employers and recruiters can also advertise job opportunities. Find out about this new service by visiting www.woema.org and clicking on “Job Bank”.

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**News You Can Use**

*Continued from page 6*

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- Providing automated computer-tailored feedback in an Internet weight loss program was as effective as human e-mail counseling at 3 months, per a study of 192 adults (49.2 +/- 9.8 years), with BMI = 32.7 +/- 3.5, were randomized to 1 of 3 Internet treatment groups: No counseling, computer-automated feedback, or human e-mail counseling. At 3 months, completers in both the computer-automated feedback (weight change = -5.3 +/- 4.2 kg) and human e-mail counseling (-6.1 +/- 3.9 kg) groups had significantly greater weight losses than the no counseling group (-2.8 +/- 3.5 kg) and these groups did not differ from each other. At 6 months, weight losses were significantly greater in the human e-mail counseling group (-7.3 +/- 6.2 kg) than in the computer-automated feedback (-4.9 +/- 5.9 kg) or no counseling (-2.6 +/- 5.7 kg) groups. *Arch Intern Med.* 2006 Aug 14-28;166(15):1620-5.

- Fibromyalgia symptoms were significantly improved in an acupuncture group (vs. controls) as measured by Fibromyalgia Impact Questionnaire, given immediately, at 1 month and at 7 months after treatment. Largest differences in scores were seen at 1 month (42.2 vs 34.8 in the control and acupuncture groups, respectively). This a prospective, partially blinded, controlled, RCT of 25 patients receiving true acupuncture compared with a 25 controls with simulated acupuncture. Fatigue and anxiety were the most significantly improved symptoms during the follow-up period. *Mayo Clin Proc* 2006 Jun;81(6):749-57.
ACOEM Practice Guidelines

Continued from page 3

adopt the Guidelines is to reduce costs. This is a perfectly valid reason if the cost-savings come from discouraging ineffective or unnecessary care rather than denying care that is needed. However, cost savings are consistent with better management overall.

Let us take a look at one example of the implications of the Guidelines. More than 80% of patients with lumbosacral nerve root irritation due, presumably, to herniated discs, recover without surgery. Here is a representative case drawn from a workers’ compensation claim:

A 48-year-old woman experiences the sudden onset of low back pain after picking up a box. She describes the pain as mild and she had a similar incident 6 months before. No further documentation of past medical history is available. On physical examination, she has slight tenderness of the paravertebral muscles around the lumbar spine and discomfort with right lateral and forward bending. Straight leg raising is normal. A lumbar X-ray was performed and findings were reported as “negative wet reading.” She was treated with naprosyn, Soma, alternating cold and hot packs, given a lumbar support, and referred to physical therapy, for two weeks of therapy three times per week. She was given range of motion studies. She was placed on modified duty. An appointment to return to clinic was made for several weeks later.

Now, leaving aside for the moment whether the patient needs this regimen, let us examine what it costs as a baseline, for later comparison (HCFA 1500 schedule).

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203 Medications</td>
<td>$130.00</td>
</tr>
<tr>
<td>Physical therapy for education, not treatment</td>
<td>$400.00</td>
</tr>
<tr>
<td>Total</td>
<td>$570.00</td>
</tr>
</tbody>
</table>

What is wrong with this picture? (It may be easier to ask what is right.)

First, the ACOEM Practice Guidelines specify an appropriate history. The purpose is to identify those “red flag” conditions that, although rare, indicate serious pathology requiring physician attention and caution: pathological fracture, metastatic disease, infection, spinal stenosis, etc. Lumbar spine X-rays have no place in the management of acute low back pain unless there a history of trauma or “red flags” for spinal pathology, which are rare. Given the radiation dose to bone marrow and the pelvis, this imaging modality carries an avoidable risk, which may be low for any one individual patient but is significant when hundreds of patients are irradiated unnecessarily every year. Imaging studies are often (perhaps usually) misleading in back pain because radiographically visible lesions are very frequent in people without pain and frequently antedate the onset of pain in acute low back pain cases, and so “false positives” are common. Lumbar supports have never been shown to be effective in preventing low back pain, although many employers use them. Six sessions of physical therapy should not be necessary. Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, TENS, PENS, and biofeedback have no proven efficacy in acute low back pain. Dependence on such aggressive treatment also means that when the injured worker has another episode of low back pain, this unnecessarily intensive medical management will be repeated.

Nonprescription medications are recommended for low back pain, with acetaminophen being safest. (The management plan got this right: Short-term muscle relaxants may be useful for acute muscle spasm. Short-term opiates are rarely needed and then only for less than two weeks.) Specific low back exercises for range of motion, strengthening, and stretching may be useful, as are relaxation and aerobic exercise. One or two visits for education, counseling, and evaluation are all that should be required.

Now let us look at the cost when the treatment plan follows the Guidelines:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203 Medications</td>
<td>$130.00</td>
</tr>
<tr>
<td>Physical therapy for education, not treatment</td>
<td>$40.00</td>
</tr>
<tr>
<td>Total</td>
<td>$1635.00</td>
</tr>
</tbody>
</table>

The evidence-based care results in the same or better outcome, probably more rapid return to work, lower public health risk, and only a third of the cost. Another benefit is that it is so simple that the next time the patient has a twinge of back pain, she will probably be able to manage it herself. Good care is care that has been shown to work, not expensive care.

The “business of medicine” should align with the mission, values, ethics, and science of medicine. Following the Guidelines is one way, perhaps the best, to ensure this and to demonstrate it to the world.

Do you have a comment about the ACOEM Guidelines? Send it as a “Letter to the Editor” c/o WOEMA, 575 Market Street, Suite 2125, San Francisco, CA 94105 or e-mail to: woema@hp-assoc.com. We will publish letters to the editor in the next issue.

NOTE: The 2007 Western Occupational Health Conference being held October 4-7 in San Diego will include a plenary session on the ACOEM Guidelines presented by Kurt Hegmann, MD.


Have you ever had the sneaking suspicion that natural products and supplements had somehow moved to firmer ground than you thought possible? Maybe you heard Chasteberry for PMS stimulates mu and kappa receptors but you can’t quite recollect what these receptors are supposed to receive? Or your patient refers to Black Cohosh and you’re thinking: “Poultice, rock group or incantation?” Well, when it comes to evidence-based medicine in this arena, there is a “new marshal in town”. Easy to access credible information is now found at Medline Plus which has added a wonderful new reference under the “Drugs and Supplements” tab — this area now has easy to read, weight-of-evidence-based monographs on herbs and dietary supplements (from the company Natural Standard). These detailed documents give a “Level of Evidence Grade” to each of the (typically multiple) health claims for a given supplement and these assessments all have references. [Grades are: A: Strong scientific evidence for this use; B: Good scientific evidence; C: Unclear evidence; D: Fair evidence against; F: Strong evidence against; and Inadequate information]. The monographs also include sections on: Background, Synonyms, Dosing, Safety, Interactions and Methodology. Many popular herbal supplements are included. The Medline Plus monographs will suffice for most medical users, however if you are really into this area, the NIH’s Office of Dietary Supplements (“ODS”) has A LOT of information on dietary supplements and vitamins and the ODS acts as a single source for many of these on-line resources such as: NIH Databases and Research Resources (including IBIDS and ingredient databases), USDA Databases (including Food Composition databases), Government reports on RDA’s and DRI’s, and highly-researched Vitamin and Mineral Supplement Fact Sheets (e.g., “Infection, acute exercise, pregnancy and lactation, and states such as physical trauma increase chromium losses and can lead to deficiency.”) These latter fact sheets give the nitty-gritty facts on what’s actually known and what is merely speculation.

Do yourself and your patients a favor and check them out — you won’t be disappointed.

**Interesting and Useful Web Sites**

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

**Western Occupational Health Conference**

**SPECIAL EVENTS ON FRIDAY OCTOBER 5, 2007**

9:00 am – 2:00 pm
Private Tour of Sea World: SPECIAL SPOUSE/GUEST EVENT
Your family and guests will enjoy a once in a lifetime experience at this world famous adventure park – home of Shamu. This fun-filled day includes transportation to and from SeaWorld including a private behind the scenes tour, and VIP reserved seats to two shows.

4:30 pm - 10:00 pm
San Diego Zoo-Fest & Dinner
Join us for our first ever “WOHC Zoo-Fest” the signature event for WOHC 2007. No trip to San Diego is complete without a visit to the world famous Zoo. Our evening begins with a private twilight guided tour of the San Diego Zoo. Enjoy a gourmet dinner amidst the animals, wine, and live musical entertainment with a Caribbean Steel Drum Band. This evening promises to be a Rrrrroaring good time!

(This event is sponsored by Sanofi-Aventis)
Support Our Residency Programs

WOEMA Seeks Member Assistance for Industry Rotations

WOEMA is teaming up with Occupational Medicine Residency Programs in an effort to provide support and encourage careers in the field of Occupational Medicine. If you are interested in offering your industry site for a rotation or walk-through, please contact the residency director in your area:

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