EVIDENCE-BASED UPDATES TO THE MEDICAL TREATMENT SCHECULE (MTUS)	RULEMAKING COMMENTS 30 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
General Comment	Commenter supports the proposed updates the MTUS, ensuring that treatment for injured workers remains governed by evidence-based guidelines that are the most currently available from ACOEM. Commenter especially appreciates the adoption of a Workplace Mental Health Disorders section, starting with the adoption of ACOEM's Post Traumatic Stress Disorder and Acute Stress Disorders Guideline.	Denise Niber, Claims and Medical Director California Workers' Compensation Institute (CWCI) Written Comment February 15, 2019	Agree.	None.
9792.23.8 Posttraumatic Stress Disorder and Acute Stress Disorder Guideline (ACOEM December 18, 2018)	Commenter offers the following observations and proposed changes to the Summery of Recommendations: 1. Eye Movement Desensitization and Reprocessing (EMDR) is an accepted form of treatment and, in fact, high effective in certain selected patients who are less psychotherapy oriented or who respond more to physiological treatment. The Eye Training Method to desensitize hyper-alertness is used by the CIA and FBI on traumatized members. I feel that it should be considered a Moderately Recommended,	Dominick Addario, MD, Health Sciences Clinical Professor, Voluntary – UCSD Department of Psychiatry, Qualified Medical Evaluator for the State of California Comments directed to Michael Rott, Esq, submitted by Diane Worley, CAAA Written Comment February 12, 2019	Disagree: ACOEM conducted a comprehensive literature search related to Eye Movement Desensitization and Reprocessing (EMDR) treatment. 20 articles were considered for inclusion, 11 randomized trials and 2 systematic reviews that met ACOEM's inclusion criteria. There are a few moderate quality studies for EMDR, but the highest quality study, also the only sham-controlled trial, found a lack of efficacy regarding the eye-movement component. Thus, there are no trials able to document	None.

EVIDENCE-BASED UPDATES TO THE MEDICAL TREATMENT SCHECULE (MTUS)	RULEMAKING COMMENTS 30 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Evidenced-based treatment.		efficacy of the eye-movement component.	
	2. Group Therapy is widely used by the VA in treatment of returning veterans who have experienced an exposure to horrific carnage and death experiences. The experience of sharing with comrades the nature of the injury and how it has affected one is often very positive and remedial. Group therapy, therefore, should also be included in the Recommended category.		Disagree: A "No recommendation, insufficient evidence" is the conclusion for Group Therapy. Again, ACOEM conducted a comprehensive literature search related to Group Therapy. Group therapy has low adverse effects, is moderate cost depending upon treatment duration, and has conflicting evidence of efficacy.	None.
	3. In regard to medications, specifically, antidepressant medications, although more of the significant research has involved sertraline and paroxetine, one cannot exclude the whole array of similar agents in the Selective Serotonin Reuptake Inhibitors (SSRI) such at escitalopram and citalopram, as each patient differs in regard to neurophysiological brain		Disagree: Escitalopram and Citalopram are recommended for the treatment of patients with PTSD. Although the literature for both Escitalopram and Citalopram are not as conclusive as the other SSRI's listed, neither one of these medications are being excluded from the whole array of similar agents under SSRI. In addition, treatment recommendations for SSRI's	None.

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	receptor response. Limiting medications to one or two of the antidepressants would not be appropriate. In regard to use of antipsychotics, patients with severe PTSD who develop paranoid or highly intrusive thinking and severe major depressive symptoms benefit from the full array of antipsychotic medications. Excluding one form the other would not be appropriate. A particular agent finding itself in the recommended category is only because more research has been done with that agent than others in the same family or class of drugs that can be equally effective. Various conditions such as hypertension, depression, and anxiety can be chronic, long-term conditions. Utilization Review decisions that allow for one month of treatment are ludicrous and oftentimes life-threatening to patients. Can you imagine providing one month of treatment for		are NOT limited to a one-month approval. Finally, issues raised by commenter regarding the Utilization Review process goes beyond the scope of this rulemaking. Generally, as long as the clinical documentation is consistent with the recommendations found in the MTUS – ACOEM guidelines Utilization Review or Independent Medical Review approvals should not be an issue.	

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	someone with labile hypertension who is at risk for a stroke? The same is true for depression that requires long-term treatment. One-month approvals are totally inconsistent with the medical literature and has no scientific basis.			
General Comment	Commenter opines that over the last ten years, in regard to the recommendations for treatment that there has been a deterioration of services and viable treatment options to assist injured workers. Commenter states that there has been mismanagement and abuse of the Utilization Review Process and that a high number of patients going through the process have had their proposed treatment plans denied by doctors who have never examined the patient, who are not experienced or specialists in their field and are not licensed to practice medicine in California. Commenter opines that the Utilization process needs to be improved and that it is physically and mentally impossible for the designated California physician medical reviewer,	Dominick Addario, MD, Health Sciences Clinical Professor, Voluntary – UCSD Department of Psychiatry, Qualified Medical Evaluator for the State of California Comments directed to Michael Rott, Esq, submitted by Diane Worley, CAAA Written Comment February 12, 2019	Disagree: Comments regarding the Utilization Review Process goes beyond the scope of this rulemaking.	None.

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	to whom the out of state physicians report, to review these cases for accuracy and quality.			
9792.23.7 Ankle and Foot Disorders Guideline (ACOEM July 16, 2018)	Commenter requests that the Division consider the following common evidence-based, peer-reviewed, treatment procedures and modalities commonly performed by licensed acupuncturists as a treatment option for California injured workers: a. Acupuncture As A Therapeutic Treatment For Plantar Fasciitis: https://www.evidencebasedacupuncture.org/present-research/acupuncture-plantar-fasciitis/ b. Acupuncture Plantar Fasciitis Relief confirmed: https://www.healthcmi.com/Acupuncture-Continuing-Education-News/1806-acupuncture-plantar-fasciitis-relief-confirmed c. Acupuncture Promotes Ankle Injury Recovery: https://www.healthcmi.com/Acupuncture-Continuing-Education-News/1920-acupuncture-promotes-ankle-injury-recovery d. Acupuncture and Arthrolysis Ankle Discovery	Tiffany Tuftee, President RA Adock, Executive Director California State Oriental Medical Association (CSOMA) February 14, 2019 Written Comment	Disagree: As far as studies/articles listed as "a. through d." it is not clear if ACOEM reviewed the studies cited by commenter but she is encouraged to submit these studies to ACOEM through the following web address: https://acoem.formstack.com/forms/stakeholderpatientinput ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same processes (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACOEM guidelines.	None.

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	https://www.healthcmi.com/Acupuncture-Continuing-Education-News/1788-acupuncture-and-arthrolysis-ankle-discovery e. Study Shows Tai Chi and Physical Therapy Were Equally Helpful For Knee Osteoarthritis. https://nccih.nih.gov/research/results/spotlight/tai-chi-knee-osteoarthritis_2016 f. Moxibustion Treatment for Knee Osteoarthritis: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0101973		Disagree: As far as studies/articles listed as "e. and f." they go beyond the scope of this rulemaking because they relate to conditions or injuries that are addressed in the Knee Disorders Guideline which is not part of this rulemaking. In either case, commenter is free to submit these studies pursuant to the instructions provided in the previous response.	None.
9792.23.1 Cervical and Thoracic Spine Disorders Guideline (ACOEM October 17, 2018)	Commenter requests that the Division consider the following common evidence-based, peer-reviewed, treatment procedures and modalities commonly performed by licensed acupuncturists as a treatment option for California injured workers: a. Acupuncture: An Overview of Scientific Evidence: https://www.evidencebasedacupuncture.org/present-research/acupuncture-scientific-evidence/	Tiffany Tuftee, President RA Adock, Executive Director California State Oriental Medical Association (CSOMA) February 14, 2019 Written Comment	Disagree: As far as study/article listed as "a." it is not clear if ACOEM reviewed the studies cited by commenter but she is encouraged to submit these studies to ACOEM through the following web address: https://acoem.formstack.com/forms/stakeholderpatientinput ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts	None.

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	b. Meta-analysis: acupuncture for low back pain https://www.ncbi.nlm.nih.gov/pubmed/15838072		submissions of evidence from any source. All literature is reviewed following the same processes (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACOEM guidelines. Disagree: As far as the study/article listed as "b." it goes beyond the scope of this rulemaking because it relates to conditions or injuries that are addressed in the Low Back Disorders Guideline which is not part of this rulemaking. In either case, commenter is free to submit this study pursuant to the instructions provided in the previous response.	None.
9792.23.7 Elbow Disorders Guideline (ACOEM August 23, 2018)	Commenter requests that the Division consider the following common evidence-based, peer-reviewed, treatment procedures and modalities commonly performed by licensed acupuncturists as a treatment option	Tiffany Tuftee, President RA Adock, Executive Director California State	Disagree: As far as this referenced study/article it is not clear if ACOEM reviewed the studies cited by commenter but she is encouraged to submit these studies to	None.

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	for California injured workers: **Acupuncture and moxibustion for lateral elbow pain: a systematic review of randomized controlled trials.** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4012509/?fbclid=IwAR3tqlv-4qKlMycmutNSqeUvjZPA**VuKPBFtRgxLynP7atitsrLMD7v2Kgc8**	Oriental Medical Association (CSOMA) February 14, 2019 Written Comment	ACOEM through the following web address: https://acoem.formstack.com/forms/stakeholderpatientinput ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same processes (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACOEM guidelines.	
9792.23.8 Workplace Mental Health: Posttraumatic Stress Disorder and Acute Stress Disorder Guideline	Commenter requests that the Division consider the following common evidence-based, peer-reviewed, treatment procedures and modalities commonly performed by licensed acupuncturists as a treatment option for California injured workers:	Tiffany Tuftee, President RA Adock, Executive Director California State Oriental Medical Association	Disagree: As far as studies/articles listed as "a. through d." it is not clear if ACOEM reviewed the studies cited by commenter but she is encouraged to submit these studies to ACOEM through the following web address:	None.

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(ACOEM December 18, 2018)	a. Acupuncture's Role in Solving the Opioid Addiction: https://www.sciencedirect.com/science/article/abs/pii/S2095496417603789 **b. Efficacies of Acupuncture and Anxiety:** https://www.evidencebasedacupuncture.org/present-research/acupuncture-anxiety/ c. Tai Chi and Qigong for the treatment and prevention of mental disorders https://www.sciencedirect.com/sdfe/pdf/download/eid/1-s2.0-S0193953X13000129/first-page-pdf d. Randomized trial of acupuncture to lower blood pressure https://www.ncbi.nlm.nih.gov/pubmed/17548730	(CSOMA) February 14, 2019 Written Comment	https://acoem.formstack.com/forms/stakeholderpatientinput ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same processes (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACOEM guidelines.	
9792.23.1 Cervical and Thoracic Spine Disorders Guideline (ACOEM October 17, 2018)	Commenter commends ACOEM on their extensive work on this guideline and agrees with many of the conclusions in the updated guideline. However, he opines that there are conclusions that were drawn on other topics that are not supported by careful evaluation of the literature.	Timothy Maus, MD President Spine Intervention Society February 11, 2019 Written Comment	Agree.	None.

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	After review of the revised guideline, commenter makes the following observations and recommends access to treatment that the guide does not recommend for specific patients: **Evidence does suggest that cervical epidural steroid injections are effective for many patients with cervical radicular pain, providing short-term relief with demonstrated surgery-sparing effects.**		Disagree: Commenter suggests there is "evidence" suggesting that cervical epidural steroid are effective. However, ACOEM has comprehensively evaluated the medical literature and concluded that "There are *no quality trials* [emphasis added] comparing systemic steroids (oral, or intravenous or intramuscular) to placebo for treatment of cervical radiculopathy.	None.
	Commenter notes that the panel has recommended the use of oral steroids for acute cervical radicular pain. The panel has referenced the literature on lumbar radicular pain and concluded that the use of oral steroids is supported by this literature. However, the two studies that were referenced show clinically insignificant improvement in function without improvement in pain [1]and clinically		Disagree: Commenter incorrectly describes the conclusions of the first study referenced as [1] by stating it shows "insignificant improvement in function" when in fact, ACOEM's conclusion was it "…resulted in modestly improved function…" Commenter also incorrectly describes the	None.

[1] Goldberg H, Firtch W, Tyburski M, Pressman A, Ackerson L, Hamilton L, et al. Oral steroids for acute radiculopathy due to a herniated lumbar disk: a randomized

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	insignificant improvement in pain without improvement in function for less than three days (from IV steroids) [2]		conclusions of the second study referenced as [2] below by stating it shows "clinically insignificant improvement in pain" when in fact, ACOEMS's conclusion was it, "provides a small and transient improvement in sciatic leg pain…"	
	A systematic review and meta-analysis concluded that there is no benefit of systemic steroids over placebo, and there are more side effects when they are used [3]Epidural steroid injections, however, were not recommended for acute, subacute, or chronic cervical radicular pain due to insufficient evidence. The SIS Standards Division reviewed the published literature on cervical transforaminal epidural steroid		Disagree: Here is a summary of ACOEM's rationale to the question posed by commenter. ACOEM concludes that there are no quality trials comparing systemic steroids (oral or intravenous or intramuscular) to placebo for treatment of cervical radiculopathy. By analogy to lumbar radiculopathy; however, it is expected there is limited	None.

clinical trial. JAMA. 2015;313(19):1915-23.

[2] Finckh A, Zufferey P, Schurch MA, Balague F, Waldburger M, So AK. Short-term efficacy of intravenous pulse glucocorticoids in acute discogenic sciatica. A randomized controlled trial. Spine (Phila Pa 1976). 2006;31(4):377-81.

[3] Roncoroni C, Baillet A, Durand M, Gaudin P, Juvin R. Efficacy and tolerance of systemic steroids in sciatica: a systematic review and meta-analysis. Rheumatology (Oxford, England). 2011;50(9):1603-11

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	injections for the treatment of cervical radicular pain and concluded that approximately 50% of patients experience at least 50% relief of pain or at least four weeks and that there may be surgery-sparing effects [4]While the evidence in support of cervical epidural steroid injections is not robust, and in fact, was graded as very low quality in the SIS review [4] the evidence *against* the use of systemic steroids is strong [3]. Commenter finds it perplexing why the conclusion of this panel was to recommend for the use of oral steroids, yet against the use of cervical epidural steroid injections.		ability of oral steroids to briefly improve cervical radiculopathy. Thus, by inference from lumbar radiculopathy, oral steroids are recommended for limited use in the treatment of radiculopathy patients who have inadequate pain management with NSAIDs and who decline epidural injection. The SIS Standards Division review do not appear to be a trial incorporated by ACOEM. Stakeholder input is welcomed by ACOEM and can be submitted through this web site: https://acoem.formstack.com/forms/stakeholderpatientinput	
	Cervical medial branch RF neurotomy is an effective treatment for patients with chronic axial neck pain who experience significant relief from dual medial branch		Disagree: Radiofrequency (RF) neurotomy involves the use of a radiofrequency electrode to create a heat lesion to destroy the nerve supplying	None.

[4] Engel A, King W, MacVicar J. The effectiveness and risks of fluoroscopically guided cervical transforaminal injections of steroids: a systematic review with comprehensive analysis of the published data. Pain Med. 2014;15(3):386-402.

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	blocks. **TON RF neurotomy is a very effective treatment for appropriately selected patients with cervicogenic headache**. Commenter is concerned over the lack of a recommendation (for or against) regarding percutaneous radiofrequency neurotomy (RF) for the treatment of chronic cervical/thoracic pain confirmed by diagnostic medial branch blocks. On page 304 of the guidelines, the document states that, "Radiofrequency lesioning is invasive, has adverse effects, and is costly. There is evidence of a lack of efficacy for treatment of lumbar pain, thus there is an unreconciled dispute in the literature (ineffective in the lumbar spine, but perhaps some efficacy in the cervical spine)." Commenter strongly disagrees with this interpretation of the literature. The literature regarding RF neurotomy in the lumbar spine has demonstrated lack of benefit from the procedure when the procedure is		the facet joint and some surrounding muscle. Because results can be permanent, there should be good evidence of long-term benefit prior to recommending this procedure. Commenter is correct that ACOEM concludes "No Recommendation, Insufficient Evidence." The trials behind the rationale had potential fatal flaws or bias or suggests a lack of efficacy. Accordingly ACOEM's "No Recommendation, Insufficient Evidence" recommendation is the proper interpretation of the evidence, given the lack of quality trials and the permanency of the destruction of the nerve supplying the facet joint. Disagree: Commenter appears to miss this line in ACOEM's guideline, "This is not recommended as a first or second line procedure and is recommended only in the setting of participation in an	None.

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	performed on inappropriately selected patients using improper technique.[5] [6] [7] However, when dual diagnostic medial branch blocks are used to select patients, and when the procedure is performed in accordance with the technical standards recommended by the Spine Intervention Society, the procedure is effective both in the lumbar spine [8] [9] and the cervical spine[10]. In fact, no other procedure has approached the		active rehabilitation program in a patient who is motivated in increase his/her daily functioning." (Last sentence page 304). With regards to the technical standards recommended by SIS it does not appear to be a trial incorporated by ACOEM. Stakeholder input is welcomed by ACOEM and can be submitted through this web	

[5] Juch JS, Maas ET, Ostelo RG, et al. Effect of radiofrequency denervation on pain intensity among patients with chronic low back pain: The mint randomized clinical trials. JAMA. 2017;318(1):68-81.
[6] Leclaire R, Fortin L, Lambert R, Bergeron YM, Rossignol M. Radiofrequency facet joint denervation in the treatment of low back pain: a placebo-controlled clinical trial to assess efficacy. Spine. 2001;26(13):1411-6; discussion 7.
[7] van Wijk RM, Geurts JW, Wynne HJ, Hammink E, Buskens E, Lousberg R, et al. Radiofrequency Denervation of Lumbar Facet Joints in the Treatment of Chronic Low Back Pain: A Randomized, Double-Blind, Sham Lesion-Controlled Trial. The Clinical Journal of Pain. 2005;21(4):335-44.
[8] Dreyfuss P, Halbrook B, Pauza K, Joshi A, McLarty J, Bogduk N. Efficacy and validity of radiofrequency neurotomy for chronic lumbar zygapophysial joint pain. Spine (Phila Pa 1976). 2000;25(10):1270-7.
[9] MacVicar J, Borowczyk JM, MacVicar AM, Loughnan BM, Bogduk N. Lumbar medial branch radiofrequency neurotomy in New Zealand. Pain Med. 2013;14(5):639-45.
[10] MacVicar J, Borowczyk JM, MacVicar AM, Loughnan BM, Bogduk N. Cervical medial branch radiofrequency neurotomy in New Zealand. Pain Med. 2012;13(5):647-54.

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	same level of success – elimination of pain, complete restoration of activities, no need for additional health care, and return to work – that has been demonstrated by RF neurotomy. Commenter is also concerned about the recommendation against percutaneous radiofrequency neurotomy for the treatment of cervicogenic headache. The studies referenced to support this decision contain major flaws. One cited study reported minimal benefit of RF neurotomy in 12 patients diagnosed by clinical evaluation[11]. SIS agrees that patients should not be selected for RF neurotomy based on clinical evaluation alone. Lack of demonstrated benefit from a study that selects its patients in this manner does not add meaningful information to the literature. Dual diagnostic blocks are required to establish an accurate diagnosis of facet joint pain. In fact,		site: https://acoem.formstack.com/forms/stakeholderpatientinput Disagree: The studies cited by commenter referenced as [11] and [12] below are two of several studies cited by ACOEM to point out potential flaws or bias or lack of efficacy concerning RF neurotomy treatments to support ACOEM's neutral or negative recommendations. Therefore, we disagree with commenter's statement that the "studies therefore add nothing to the literature about the effectiveness of RF neurotomy. As pointed out above, commenter appears to miss this line in ACOEM's guideline, "This is not	None.

[11] Stovner LJ, Kolstad F, Helde G. Radiofrequency denervation of facet joints C2-C6 in cervicogenic headache: a randomized, double-blind, sham-controlled study. Cephalalgia. 2004;24(10):821-30

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	the authors of this study concluded that, "a consistent and marked (close to 100%) effect of facet joint blockade should probably be among the inclusion criteria" [11] The second study that was used to support the decision to recommend against percutaneous RF neurotomy for cervicogenic headache also selected patients based on clinical features[12]. Additionally, this study used small (22 gauge) needles, inadequate lesion temperature (60-67oC) for an unspecified amount of time, and only treated the C3-4 through C5-6 facet joints (thereby missing the most commonly involved facet joint in cervicogenic headache – the C2-3 facet joint). The above-referenced studies therefore add nothing to the literature about the effectiveness of RF neurotomy for cervicogenic headache in properly selected patients, and should not be used to determine policy.		recommended as a first or second line procedure and is recommended only in the setting of participation in an active rehabilitation program in a patient who is motivated in increase his/her daily functioning." (Last sentence page 304)	

[12] Haspeslagh SR, Van Suijelkom HA, Lame IE, Kessels A, Van Kleef M, Weber WE. Randomised controlled trial of cervical radiofrequency lesions as a treatment for cervicogenic headache. [ISRCTN07444684]. BMC Anesthesiology. 2006;6(1).

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	Specifically, he wishes to highlight strong evidence in support of third occipital nerve (C2-3) RF neurotomy. For patients with suspected pain arising from the C2-3 zygapophysial joint, who have achieved greater than 80% relief of index pain with dual diagnostic blocks using appropriate techniques, third occipital nerve RF neurotomy is a proven, effective procedure. In patients with chronic neck pain, the representative prevalence of cervical zygapophysial joint pain is in the order of 60% in patients. [13] [14] [15] [16] [17]This makes it the single most common basis for chronic neck pain, and the only condition that can be		Disagree: Of the six trials cited by commenter below, the only study cited by ACOEM is [14] referenced below. Interestingly, ACOEM states "The initial study for the cervical spine (1187) suggesting efficacy was small-sized, is now more than 20 years old, has not been reproduced in a quality study, which is concerning." The remaining studies cited by commenter below [13] [15] [16] [17] and [18] are not cited by ACOEM. Stakeholder input is welcomed by ACOEM and can be submitted through this web site:	None.

[13] Barnsley L, Lord SM, Wallis BJ, Bogduk N. The prevalence of chronic cervical zygapophysial joint pain after whiplash. Spine 1995; 20:20-26.
[14] Lord S, Barnsley L, Wallis BJ, Bogduk N. Chronic cervical zygapophysial joint pain after whiplash: a placebo-controlled prevalence study. Spine 1996; 21:1737-1745.
[15] Manchikanti L, Singh V, Rivera J, Pampati V. Prevalence of cervical facet joint pain in chronic neck pain. Pain Physician 2002; 5:243-249.
[16] Yin W, Bogduk N. The nature of neck pain in a private pain clinic in the United States. Pain Med 2008; 9:196-203.
[17] Cooper G, Bailey B, Bogduk N. Cervical zygapophysial joint pain maps. Pain Medicine 2007; 8:344-353.

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	diagnosed using validated diagnostic tests. No other causes of neck pain have diagnostic tests that have been validated, and there has been no other cause in which the prevalence has been determined. In patients with positive responses to controlled, medial branch blocks, the segments most commonly positive are C2-3 and C5-6 followed by C6-7.[17] In 1994, a substantive study using controlled diagnostic blocks of the third occipital nerve, which is the innervation to the C2-3 zygapophysial joint[18], reported their yield in patients with headache after whiplash[19]. It reported a prevalence of 54% of headache stemming from the C2-3 zygapophysial joint. **It should be apparent that the C2-3 zygapophysial joint is a substantial pain generator not only in those**		https://acoem.formstack.com/forms/stakeholderpatientinput However, it is unlikely that ACOEM missed the studies cited by commenter because Barnsley, Manchikanti, and Bogduk are named authors in numerous trials cited by ACOEM in this guideline. However, the specific studies cited by commenter were not used. ACOEM's methodology in drafting their guidelines requires the use of the highest medical evidentiary support. The methodology used by ACOEM to ensure that their guideline recommendations are made with the highest medical evidentiary support is transparent to the public since 1997. Their methodology has been regularly updated since then, and has always been	

[18] Bogduk N. The clinical anatomy of the cervical dorsal rami. Spine 1982; 7:319-330.
[19] Lord S, Barnsley L, Wallis B, Bogduk N. Third occipital nerve headache: a prevalence study. J Neurol Neurosurg Psychiatry 1994; 57:1187-1190.

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	with neck pain but in those with cervicogenic headache as well[20]. If non-invasive conservative care fails to provide adequate pain relief for those with pain originating from this articulation, then C2-3 zygapophysial joint denervation via third occipital nerve thermal RF neurotomy should remain a viable option for this substantial subset of patients rather than relegating these patients to continued suffering or reliance on analgesics. There has been a seminal RCT on cervical medial branch neurotomy that demonstrates that the positive outcome of the procedure is clearly not due to placebo effects[21].This study did not access the C2-3 level due to documented technical limitations of RF neurotomy of this level (at the time of the study) attributable to anatomic		transparent and available to the public and can be found here: https://journals.lww.com/joem/FullText/2017/09000/Methodology_for_ACOEM_s_Occupational_Medicine.12.aspx Disagree: ACOEM has reviewed the trial cited by commenter as [21] below. ACOEM states, "The initial study for the cervical spine (1187) suggesting efficacy was small-sized, is now more than 20 years old, has not been reproduced in a quality study,	None.

[20] Dwyer A, Aprill C, Bogduk N. Cervical zygapophyseal joint pain patterns. I: A study in normal volunteers. Spine 1990;15:453-7.

[21] Lord SM, Barnsley L, Wallis B, McDonald GM, Bogduk N. Percutaneous radio-frequency neurotomy for chronic cervical zygapophyseal joint pain. N Eng J Med 1996;335:1721-1726.

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	variation of its nerve supply (third occipital nerve)[22]. More recently, following the Lord RCT, the technical limitations of the RF technique have been addressed, which compensates for the unique anatomy of the third occipital nerve[23]. Prospective observational evidence outside of RCTs can demonstrate the effectiveness of a procedure. In fact, when the outcomes of well-performed prospective trials demonstrate dramatic and sustainable results that are reproducible across studies, one could argue that the need to demonstrate that the effects of the procedure are not due to placebo effects alone are seriously minimized. This is more so the case when the procedure itself is in the same region of the spine for essentially the same anatomical condition (zygapophysial joint pain) and when the index		which is concerning." Disagree: Commenter cites [23, 24 and 25] all of these trials are prospective observational studies, not randomized controlled trials (RCTs). As previously mentioned, ACOEM's methodology in drafting their guidelines requires the use of the highest medical evidentiary support which means that their recommendations are supported by high quality RCTs. Prospective and retrospective cohort studies are searched if there are no RCTs or systematic reviews identified. The RF neurotomy recommendations in ACOEM's guidelines are supported by RCTs. Although the methodology scores in	None.

[22] Lord SM, Barnsley L, Bogduk N. Percutaneous radiofrequency neurotomy in the treatment of cervical zygapophyseal joint pain: a caution. Neurosurgery 1995;36:732-739.

[23] Govind J, King W, Bailey B, Bogduk N. Radiofrequency neurotomy for the treatment of third occipital headache. J Neurol Neurosurg Psychiat 2003; 74:88-93.

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	procedure has already been shown to be effective in an RCT, for which the results cannot be attributed to a placebo effect[21]. This is indeed the case for C2-3 zygapophysial joint denervation, as compared to other cervical zygapophysial joints[23]. Since the third occipital nerve RF technique has been appropriately modified following the seminal Lord RCT, three studies evaluating the effectiveness of third occipital nerve neurotomy have been published. [23] [24][25] In a prospective trial, Govind specifically investigated the efficacy of radiofrequency neurotomy of the third occipital nerve for the treatment of headache via a modified technique[23]. Modifications to the technique used included: using a large gauge electrode; holding the electrode firmly in place throughout the period of coagulation; and placing consecutive, parallel lesions no further		some of these RCTs were good, all of the RCTs used to support ACOEM's recommendations had potential flaws or biases or showed a lack of efficacy. Accordingly ACOEM's "No Recommendation, Insufficient Evidence" recommendation is the proper interpretation of the evidence, given the lack of quality trials and the permanency of the destruction of the nerve supplying the facet joint. Finally, as already pointed out above, commenter appears to miss this line in ACOEM's guideline, "This is not recommended as a first or second line procedure and is recommended only in the setting of participation in an active rehabilitation program in a patient who is motivated in increase his/her daily	

[24] Barnsley L. Percutaneous radiofrequency neurotomy for chronic neck pain: outcomes in a series of consecutive patients. Pain Medicine 2005; 6:282-286.
[25] MacVicar J, Borowczyk JM, MacVicar AM, Loughnan B, Bogduk N. Cervical medial branch neurotomy in New Zealand. Pain Medicine 2012;13:647-654.

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	than one electrode-width apart. As a result of these modifications, previous results of third occipital neurotomy were reversed. Instead of four out of 10 patients obtaining relief[22], 86% of 49 patients obtained complete relief of pain. At the time of publication, the median duration of relief was 297 days, with eight patients experiencing ongoing, complete relief. Of the 14 patients who underwent repeat neurotomy when their pain recurred, 12 (86%) regained complete relief. In regards to the safety profile of third occipital nerve neurotomy, it should also be noted that there were no major complications, and side effects (dysesthesia, ataxia, local itchiness) were self-limited and resolved within 7-10 days, apart from one patient having a side effect for 4 weeks. Another study was undertaken to explicitly test if the outcomes reported in the controlled trial could be replicated in conventional practice; it showed that they were[24]. Of 35 patients treated, 21 (60%) obtained complete relief of pain for at least 12		functioning." (Last sentence page 304) Disagree: See above response.	None.

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	weeks in the first instance and for a median duration of 44 weeks. In this study, treatment was provided at the C2-3 level in 50% of the patients. In the third study, two clinicians evaluated their outcomes after being trained in proven technically effective lesioning techniques[25]. The outcomes of all their consecutive patients over five years in their respective practices were audited. Treatment was provided at all levels from C2-3 to C6-7, and C2-3 was the most common level treated. The criteria for a successful outcome were complete relief of pain for at least six months, accompanied by restoration of activities of daily living, return to work (if applicable), and no further need for any other health care for their index pain. In the two practices, 74% and 61% of patients achieved a successful outcome. Relief lasted a median duration of 17–20 months from the first radiofrequency neurotomy, and 15 months after repeat treatments. Allowing for repeat treatment, patients maintained relief for a median duration of 20-26 months, with some		Disagree: See above response.	None.

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	60% still having relief at final follow-up. These studies clearly demonstrate that 60-86% of patients with C2-3 facet pain can be effectively rendered pain free for a duration of relief from 10-17 months. No other nonsurgical treatment in the cervical spine can rival this degree and duration of relief. There are minimal to no high-quality rigorous trials of non-invasive conservative care (*i.e.* physical therapy, chiropractic, medications) for sub-occipital neck pain or cervicogenic headache, to aid in drawing comparisons to third occipital nerve neurotomy regarding efficacy or cost-effectiveness. When considering potential surgical treatments, cervical fusion is the only valid consideration. However, fusion is rarely indicated; primarily when there is C2-3 segmental instability or spondylolisthesis. Even in properly selected patients, surgery of the upper cervical spine has a relatively high morbidity and mortality, and surgery may be contraindicated in some patients. Preservation of access to a		Disagree: See above response.	None.

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	proven, effective treatment is particularly critical when there are few valid, proven, and equally safe alternative options. An RCT establishing that the results of third occipital nerve RF neurotomy are not due to placebo effects as an absolute condition of coverage is not necessary in light of the magnitude of effects for this intervention when appropriately performed on the correct patients [262728], but one important consideration has been often overlooked. It would be impossible to perform a true blinded RCT on C2-3 facet RF. Patients who receive an effective third occipital nerve neurotomy develop time-limited neuropathic symptoms followed by cutaneous numbness in the distribution of the nerve. The active		Agree in part; Disagree in part: Agree that it's not necessary to have an RCT establishing that the results of third occipital nerve RF neurotomy are not due to placebo effects as an absolute condition. Disagree: Commenter implies that the evidentiary standard needed to support a recommendation is impossible to meet. We disagree with commenter's implied standard. Again, ACOEM recommendations are supported by high quality evidence. RCTs support	None.

[26] Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. BMJ 1996;312,71–72.
[27] Concato J, Shah N, Horwitz RI. Randomized, controlled trials, observational studies, and the hierarchy of research designs. NEJM 2000;342:1887–1892.
[28] Anglemyer A, Horvath HT, Bero L. Healthcare outcomes assessed with observational study designs compared with those assessed in randomized trials. Cochrane Database Syst Rev. 2014 Apr 29;4:MR000034.

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	arm would clearly be aware of such symptoms and know they received the treatment and those that receive the sham would not have such symptoms. Additionally, those that receive diagnostic third occipital nerve blocks also develop temporary numbness in the same distribution and learn that such is associated with an active block and this would be an expectation following a technically well performed active C2-3 facet neurotomy. It is our recommendation, consistent with local coverage determinations proposed by the Multisociety Pain Workgroup and adopted by several Medicare Contractors, that for patients with suspected pain arising from the C2-3 zygapophysial joint, who have achieved greater than 80% relief of index pain with dual diagnostic blocks using previously described techniques, third occipital nerve RF neurotomy should be a covered procedure.		ACOEM's recommendations. There are numerous RCTs addressing RF neurotomy and ACOEM has even categorized some of those RCT's as "moderate-quality" sham controlled trials with good methodology scores. However, all of the RCTs used to support ACOEM's recommendations had potential flaws or biases or showed a lack of efficacy. Accordingly ACOEM's "No Recommendation, Insufficient Evidence" recommendation is the proper interpretation of the evidence, given the lack of quality trials and the permanency of the destruction of the nerve supplying the facet joint. Finally, as already pointed out above, commenter appears to miss this line in ACOEM's guideline, "This is not recommended as a first or second line procedure and is recommended only in the setting of participation in an active rehabilitation program in a patient who is motivated	

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			in increase his/her daily functioning." (Last sentence page 304)	
	In summary, commenter requests that the Division work in collaboration with the Spine Intervention Society to eliminate inappropriate utilization of these treatments while preserving access in appropriately selected patients.		Agree in part; Disagree in part: Agree that the DWC will consider all comments and listen to input provided by SIS as we draft our regulations. Disagree: The MTUS Treatment Guidelines are standards of care that are incorporated by reference into the MTUS regulations. MTUS treatment recommendations may be rebutted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably necessary (see Labor Code section 4604.5). Therefore, SIS should provide stakeholder input to ACOEM if they believe ACOEM's recommendations are inaccurate. Stakeholder input is welcomed by ACOEM and can be submitted through this web site:	None.

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			https://acoem.formstack.com/forms/stakeholderpatientinput	
Free Access to MTUS Guidelines	Commenter wants to thank the Division for working with the Reed Group to make the MTUS Guidelines available to medical providers on a complimentary basis.	Diane Przepiorski Executive Director California Orthopaedic Association (COA) February 15, 2019 Oral Comment	Agree.	None.
Review, Development and Update of Future MTUS Guidelines	Commenter recommends that the Division encourage the Reed Group to give reviewing organizations more time than 30 days to review proposed updates and changes. Additionally, commenter recommends that Reed Group give reviewing organization advance notice before submitting guidelines for review.	Diane Przepiorski Executive Director California Orthopaedic Association (COA) February 15, 2019 Oral Comment	Agree: The DWC has relayed this comment to ACOEM and its publisher ReedGroup. However, the DWC has no influence with ACOEM's guideline development methodology which has been in place since 1997 and is internally updated by their Guideline Methodology Committee.	None. No "action" with regards to the proposed regulations but the DWC has relayed this comment to ACOEM and its publisher ReedGroup as suggested.
Review, Development and Update of Future MTUS Guidelines	Commenter would like to reiterate and emphasize Ms. Przepiorski's comment that the Reed Group should understand that their expert reviewers for proposed and/or updated guidelines need more than 30 days to review their proposed draft.	Steve Cattolica Principal SC Advocates February 15, 2019 Oral Comment	Agree: The DWC has relayed this comment to ACOEM and its publisher ReedGroup. However, the DWC has no influence with ACOEM's guideline development methodology which has been	None. No "action" with regards to the proposed regulations but the DWC has relayed this comment to ACOEM and its publisher ReedGroup

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	Commenter states that this is not enough time to look through thousands of pages and provide evidence-based alternatives to substantiate treatment modalities when the reviewer recommends a revision. He opines that this constitutes more than a full time job for 30days and is an unreasonably short amount of time to do a thorough job reviewing the material.		in place since 1997 and is internally updated by their Guideline Methodology Committee.	as suggested.
9792.23.8(a) Workplace Mental Health	Commenter recommends that the Division retain the last sentence stricken from this subsection pertaining to chronic pain which states: "If the injured worker's psychological condition, treatment, or evaluation is unrelated to chronic pain, then medical care and evaluation shall be in accordance with other medical treatment guidelines or peer reviewed studies found by applying the Medical Evidence Search Sequence set forth in section 9792.21.1" Additionally, commenter recommends that the Division substitute the word "chronic pain" for the disorder	Steve Cattolica Principal SC Advocates February 15, 2019 Oral Comment	Disagree: The Workplace Mental Health guidelines is a series of guidelines, beginning with the guideline Posttraumatic Stress Disorder and Acute Stress Disorder Guideline, which will be replacing the ACOEM Stress Related Conditions guideline deleted from the MTUS on December 1, 2017. As a placeholder regulation until ACOEM's publication of the Workplace Mental Health guidelines, section 9792.23.8 instructed the public to use the Chronic Pain Guideline for psychological conditions, treatment, or evaluation related	None.

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	specified, specifically covered in this section, and then go on to reiterate the importance of the evidence, medical evidence search sequence as the alternative. Commenter opines that to for too long mental health diagnoses were relegated to the pain guidelines which is not always appropriate and to strike this sentence from the subsection would be an error.		to chronic pain or, in the alternative, to apply the Medical Evidence Search Sequence set forth in section 9792.21.1 to find treatment recommendations for psychological conditions, treatments, or evaluations unrelated to chronic pain. The language commenter wishes to retain in section 9792.23.8(a) was merely a placeholder regulation and will now be deleted as unnecessary. The Medical Evidence Search Sequence in section 9792.21.1 remains untouched and applies in all situations when searching for medical evidence.	