The California Commission on Health and Safety and Workers' Compensation

Updated and Revised CHSWC Recommendations to DWC on Workers' Compensation Medical Treatment Guidelines

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Background

Labor Code Section 77.5, enacted in 2003 by Senate Bill (SB) 228:

- Requires the Commission on Health and Safety and Workers' Compensation (CHSWC) to conduct a survey and evaluation of evidence-based, peer-reviewed, nationally recognized standards of care, including existing medical treatment utilization standards, and including independent medical review, as used in other states, at the national level and in other medical benefit systems.
- Requires CHSWC to issue a report of its findings and recommendations to the Administrative Director (AD) for purposes of adopting a medical treatment utilization schedule. The report shall be updated periodically.

Labor Code Section 5307.27, enacted in 2003 by SB 228, requires the AD of the Division of Workers' Compensation (DWC), in consultation with CHSWC, to adopt a medical treatment utilization schedule by December 1, 2004, based on CHSWC study recommendations pursuant to Section 77.5.

CHSWC presented the RAND report to the AD November 14, 2004 together with the CHSWC recommendations. The recommendations included the American Academy of Orthopedic Surgery (AAOS) guidelines for low back care. Since that time the AAOS guidelines have been withdrawn, therefore this recommendation has been revised.

1. Present CHSWC/RAND Report to AD

   The Commission on Health and Safety and Workers' Compensation submits the CHSWC study by RAND report on medical treatment guidelines for the AD's consideration.

2. Recommend Consideration of RAND Findings in the Adoption of Medical Treatment Utilization Schedule

   - CHSWC recommends that the AD consider adopting a utilization schedule based on ACOEM guidelines.
   - CHSWC recommends that the AD consider adopting interim guidelines for specified therapies, including chiropractic, physical therapy, occupational therapy, acupuncture, and biofeedback, consisting of a prior authorization process in which the indications for treatment and the expected progress shall be documented, and documentation of actual functional progress shall be required at specified intervals as a condition of continued authorization for the specified modalities.
   - CHSWC recommends that the AD consider incorporating into the utilization schedule a process to be followed in determining appropriate treatment for conditions that are not addressed by the foregoing components of the schedule, so that at least minimum decision-making criteria will be applicable even to conditions that are not subject to any other components of the schedule.

- CHSWC recommends that, after the adoption of interim guidelines as described above, the AD consider adopting additional guidelines to supplement ACOEM guidelines on an ongoing basis as studies and evaluations of those additional guidelines are completed.

3. Recommend Establishing Ad Hoc Advisory Group

   CHSWC recommends that the DWC and CHSWC jointly establish an ad hoc advisory group to receive expert advice and stakeholder input on the many questions that must be addressed in assembling a comprehensive set of guidelines.

4. Recommend Further Studies to be Conducted Jointly by DWC and CHSWC

   - Evaluate additional guidelines for inclusion as supplements to the ACOEM guidelines.
   - Assess the potential for developing a comprehensive set of guidelines or review criteria to identify overuse and under use.
   - Monitor and evaluate the performance of the medical treatment utilization schedule as valid and comprehensive clinical practice guidelines that address the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases.
   - Monitor the effect of the statutory caps on chiropractic, physical therapy, and occupational therapy visits and compare these caps to scientifically based, nationally recognized, peer-reviewed guidelines.
   - Monitor and evaluate the implementation of the medical treatment utilization schedule in utilization review (UR) processes and practices, including denials of authorization, grants of deviations from the schedule, grants of exceptions to the caps on chiropractic, physical therapy, and occupational therapy visits, and effects upon case outcomes.
   - Evaluate the validity and appropriateness of disability management guidelines addressing disability durations and return to work.

Discussion of Recommendations for Adoption of Guidelines

CHSWC recommends the ACOEM guidelines as the primary basis for the medical treatment utilization schedule because their flexibility allows medical decisions to take into consideration the full range of valid considerations and thus to provide optimal care for individual patients. The effectiveness of care to mitigate disability should prevail over administrative efficiency of the UR tool, although efficiency of administration is an undeniable asset to effectiveness of care. It is contemplated that the ACOEM criteria may be translated into a step-by-step automated process. Once that is done, it will ameliorate the drawbacks of the ACOEM guidelines.

Numerous gaps and weaknesses in the ACOEM or any other existing set of guidelines will have to be filled by reliance on other guidelines. Guidelines for Specific Therapies

The comprehensive guideline sets evaluated by RAND are generally weak regarding physical modalities such as chiropractic and physical therapy. In addition, stakeholder input indicates ACOEM is weak for occupational therapy, acupuncture and biofeedback. Anecdotal reports of widespread denials of these forms of treatment indicate a need to address these forms of treatment in the medical treatment utilization schedule. Recognizing that general guidelines are subject to abuse by both excessive treatment and unwarranted denials, CHSWC recommends that specific guidelines be established for these therapies. The quality of the guidelines developed by specialty organizations in these fields has not been independently evaluated, so CHSWC cannot recommend those specialty guidelines. Instead, CHSWC recommends using National Institutes of Health consensus statements and other states' established guidelines, such as Colorado, to compose guidelines containing:

- A list of conditions for which each modality may be appropriate,
- A documentation process to justify the initiation of a treatment plan,
- A documentation process to justify continuation of a treatment plan by demonstrating functional improvement at specified intervals, and
- A maximum number of visits and duration of course of treatment.

The documentation process should assure that a physician is accountable for a prolonged course of physical modalities without discouraging brief trials of inexpensive therapies in cases where those therapies have arguable merit. The primary criteria for authorizing and continuing such therapies should be the restoration of the injured employee's level of function and, where feasible, an early and sustained return to work. Until these guidelines are developed, CHSWC recommends that the AD adopt interim guidelines that establish a prior authorization process that requires documentation of functional improvement to justify the initiation and continuation of a treatment plan.

Gaps Must be Addressed with Medical Judgment on an Individual Basis

Even when supplemented by additional guidelines as described above, ACOEM guidelines will still leave gaps. Since ACOEM guidelines became the legislated standard for UR on January 1, 2004, there have been frequent reports of UR decisions to withhold authorization for treatment solely because the treatment was not covered by ACOEM guidelines.[1] If true, these reports demonstrate that the fallback language of Section 4604.5[2] is insufficient to fill the gaps that are inherent in any set of guidelines. It is therefore recommended that the medical treatment utilization schedule require that a competent medical professional exercise expert judgment in determining whether

[1] . There is ambiguity between "not recommended" meaning the absence of a recommendation and "not recommended" meaning a negative recommendation. To avoid the ambiguity of "not recommended," this discussion uses "not covered" to mean the absence of a recommendation. Reports of UR denials suggest that some UR systems are construing "not covered" as equivalent to a negative recommendation, without further medical- review of the appropriateness of treatment.

[2] Labor Code Section 4604.5(e) provides: "For all injuries not covered by the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines or official utilization schedule after adoption pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines generally recognized by the national medical community and that are scientifically based."

treatment not covered by ACOEM guideline is medically appropriate, and that other guidelines relied upon by the treating physician or known to the medical professional should be considered in making that determination. The treatment prescribed by the utilization schedule in these cases could be determined in accordance with a general definition of appropriate medical treatment, interpreted in a particular case by a licensed physician and surgeon, consideration being given to the best available scientific evidence in a hierarchy ranging from evidence-based medicine guidelines accepted by the National Guidelines Clearinghouse, down to the personal opinion of one physician (not based on higher-quality evidence) at a minimum.

Inclusion of these decision-making procedures within the utilization schedule will mean that decisions made according to these procedures will enjoy the presumption of correctness, while decisions that do not follow these procedures will be inconsistent with the medical treatment utilization schedule.

Summary of Recommended Medical Treatment Utilization Schedule

CHSWC recommends that the AD adopt the ACOEM guidelines as the medical treatment utilization schedule that will be statutorily presumed to be correct. Accordingly, where the applicable guideline contains a recommendation either for or against a particular treatment purportedly applicable to the injured employee's condition, that recommendation shall be presumed correct. (A "recommendation" may be explicit or implicit. Examples of implicit recommendations include the implied recommendation to conduct an examination by virtue of the fact that further recommendations depend on the examination findings.)

CHSWC recommends that the AD establish interim guidelines for specified therapies that will require the prescribing physician to establish meaningful measures of objective improvement in a patient's level of function. The guideline should permit the continuation of those modalities beyond a brief trial period, and up to a specified limit, if the patient's level of function meets objective progress criteria.

CHWC recommends that the AD specify that where the applicable guidelines do not contain a recommendation either for or against a particular treatment purportedly applicable to the injured employee's condition, the correct treatment shall be determined by a physician according to the general definition of appropriate treatment in light of the best available scientific evidence.

The effect of the recommended structure of the guidelines in UR should be to encourage efficient processing of requests for authorization. Routine treatment should be summarily authorized by frontline claims administrators more complex questions should be submitted to reviewers, allowing reviewers to reject treatments that are inconsistent with a clear guideline and putting the burden on the treating physician to document and justify deviations from the guideline. Where there is no applicable recommendation within the guidelines, however, the absence of a recommendation should not be construed as a negative recommendation. Instead, the absence of a recommendation should be construed as an invitation to call upon other evidence both to support the physician's request for authorization and to justify any UR decision to delay, modify, or deny that authorization. Under this plan, where high-quality evidence is not available, the expertise of the treating physician carries some weight, and if uncontradicted, it prevails.

If the opinion of the treating physician is not backed by citations to scientific evidence, it may be outweighed by the opinion of a UR physician based on his or her expertise plus references to controlling principles of medicine. Where higher-quality evidence is available, the highest-quality evidence that is applicable to an individual case should determine the treatment. In any event, the exercise of a physician's expertise would be required, not just an automatic rejection of any treatment that is "not in ACOEM."

The effect of the recommended structure of the guidelines in medical provider network (MPN) quality-of-care issues should be to encourage treatment according to prevailing best practices where the case is not covered by ACOEM. Since an independent medical review (IMR) doctor's opinion would be adopted by the AD as the decisive interpretation of the treatment schedule, the MPN will need to give adequate care even in the "not covered" cases if the MPN is going to retain control.

Discussion of Recommendations for Further Study

- Evaluate additional guidelines for inclusion as supplements to ACOEM guidelines.

  To cover important topics that are not adequately addressed by ACOEM guidelines, additional guidelines will be needed. The first step is to identify the most significant gaps in the guidelines that are adopted and to evaluate existing guidelines that could be adopted to fill those gaps.

- Assess the potential for developing a comprehensive set of guidelines or review criteria.

  Some of the RAND clinical panelists felt that California could do a lot better if we started from scratch. This may or may not be feasible. A preliminary assessment could be undertaken to evaluate the cost and feasibility of starting from scratch, compared to adding supplements or modifying the ACOEM.

- Monitor and evaluate the performance of the medical treatment utilization schedule as valid and comprehensive clinical practice guidelines.

  The RAND study evaluated comprehensiveness and validity across certain broad topics. Once a utilization schedule is adopted, additional gaps will probably be recognized and scientific errors will be recognized. Maintaining an adequate set of guidelines will require systematic monitoring for these shortcomings so that additional or alternative guidelines can be adopted for specific topics.

- Monitor the effect of the statutory caps on chiropractic, physical therapy, and occupational therapy visits and compare these caps to scientifically based, nationally recognized, peer-reviewed guidelines.

  The 24-visit caps on these therapies in Labor Code Section 4604.5(d) were the result of a political process but not necessarily consistent with evidence-based, scientifically valid, nationally recognized, peer-reviewed standards. For example, it has been suggested that the 24-visit cap on physical therapy is excessive for

most cases but inadequate for cases in which physical therapy was properly used in an effort to treat conservatively and then more physical therapy was required following surgery. Further data is needed to assess the effect of these caps and to support future considerations for adjusting these caps or for removing arbitrary caps in favor of evidence based guidelines.

- Monitor and evaluate the implementation of the medical treatment utilization schedule in UR processes and practices, including denials of authorization, grants of deviations from the schedule, and grants of exceptions to the caps on chiropractic, physical therapy, and occupational therapy visits, and evaluate the effects of these processes and practices upon case outcomes.

  CHSWC has received a variety of complaints about the implementation of ACOEM guidelines in UR: UR reviewers are denying necessary care where ACOEM guidelines do not apply; UR reviewers are misusing ACOEM guidelines to deny care even where it does apply; UR reviewers are denying care without a physician's review as required by the Labor Code; treating physicians do not know how to substantiate a request for authorization; and ACOEM guidelines are too limited and the UR reviewers do not allow for cases that are not addressed by the ACOEM guidelines.

  It would appear from anecdotal reports that the guidelines are not being applied in UR as intended by the Legislature. The Legislature provided that the guidelines could be rebutted to justify a variance in individual cases[3] and that no treatment should be denied by the UR process except by a physician.[4] It is contemplated that treatment in compliance with the guidelines should be promptly approved by a lower- level reviewer, and variances should be approved when appropriate on a case-by-case basis. Only the questionable treatment requests need to go to a physician reviewer, and then the physician reviewer should exercise professional judgment in determining what treatment is medically necessary for the patient. The implementation of UR should be monitored to determine if the industry is carrying out the intent of the Legislature.

  Although the situation appears to be improving it would still appear from anecdotal reports that the guidelines are sometimes applied inflexibly, resulting in denials of treatments that are safe and inexpensive but of disputed efficacy. Proponents of certain treatments contend that their treatments would reduce disability and overall case costs. Study of UR performance could reveal whether flexibility in approving such treatments might produce shorter disability durations and overall cost savings, despite the fact that the treatments are not required by the guidelines.

  Study of UR performance could develop a profile of best practices for UR that achieve maximum economy not solely through denial of unnecessary treatment but also considering overall costs including the duration and extent of disability.

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[3] Labor Code Section 4604.5(a) provides, in part, "The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury."

[4] Labor Code Section 4610(e) provides, "No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve."

- Evaluate the validity and appropriateness of disability management guidelines addressing disability durations and return to work.

  Disability management is a neglected component of medical case management. Some guidelines for disability durations have been published, but there is no consensus as to their validity. These could be evaluated to determine their validity and applicability to assist employees in returning to work.