

# Providing Optimal Treatment through the use of EBM/MTUS

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## What is Evidence-Based Medicine

“...the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

...means integrating individual clinical expertise with the best available external clinical evidence from systematic research.”

Sackett DL, et al. *BMJ*. 1996;312:71-80.

## What is Evidence-Based Medicine

“A set of principles and methods intended to ensure that to the greatest extent possible, medical decisions, guidelines, and other types of policies are based on and consistent with good evidence of effectiveness and benefit.”

Eddy DM. *Health Affairs*. 2005;24(1):9-17.

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## How Many Contemporary Medical Practices Are Worse Than Doing Nothing or Doing Less?

- Almost half of the established medical practices that are tested are found to be no better than a less expensive, simpler, or easier therapy or approach

Prasad V, Vandross A, Toomey C, et al. A decade of reversal: an analysis of 146 contradicted medical practices. *Mayo Clin Proc*. 2013;88(8):790-798.

## The Downside of EBM

- What about the doctor's clinical judgment?
- What about new or experimental procedures?
- In many areas of medicine, there are no treatment guidelines; and where there are, they are often unreliable, conflicting and incomplete
- Even where there are well established guidelines, they are written for the average patient - What if you are not average?
- Often written by people who are not disinterested
- Misused and misinterpreted by UR companies paid by payers

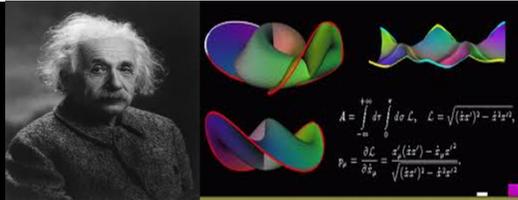
## MEEAC

- § 9792.26. The MTUS regulations created a Medical Evidence Evaluation Advisory Committee (MEEAC), which reviews the latest medical evidence and advises the division about incorporating new evidence-based guidelines into its MTUS
- MEEAC's recommendations are advisory in nature and do not constitute scientifically based evidence

## MTUS = AUTHORIZATION for TREATMENT AND/OR TESTING

- All treatment in California must be consistent with the MTUS (LC §5307.27) which is presumptively correct as a matter of law (LC §4604.5 (a))

THE MTUS IS THE  
UNIFYING THEORY OF  
RELATIVITY IN THE NEW  
SYSTEM BUT YOU MUST  
KNOW CLEARLY HOW IT IS  
APPLIED



## Medical Treatment Utilization Schedule

- Doctors in California's workers' compensation system are required to provide evidence-based medical treatment
- That means they must choose treatments scientifically proven to cure or relieve work-related injuries and illnesses
- Text of Regulation and MTUS

[http://www.dir.ca.gov/dwc/DWCPPropRegs/MTUS\\_Regulations/MTUS\\_Regulations.htm](http://www.dir.ca.gov/dwc/DWCPPropRegs/MTUS_Regulations/MTUS_Regulations.htm)

## Labor Code Section 4610.5(c)(2)

- (2) "Medically necessary" and "medical necessity" mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition:
  - (A) The guidelines [i.e., the **MTUS**] adopted by the administrative director pursuant to Section 5307.27.
  - (B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
  - (C) Nationally recognized professional standards.
  - (D) Expert opinion.
  - (E) Generally accepted standards of medical practice.
  - (F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

## Report Writing

- Physician needs to provide a clear, legible and concise history and physical examination followed by diagnoses and then recommendations for EBM medical care
- Problems:
  - Boilerplate report especially with electronic medical record (EMR)
  - No EBM statement to support request
  - Flood of overlapping treatment requests
  - No documentation to support past efficacy for request

## Medical Reporting

- The medical reporting should contain documentation that the injured worker
  - Is educated about and understands the diagnoses and that
  - The goals of treatment are:
    - Less discomfort
    - Improved ADL function
    - Staying at or returning to work
  - Goals will/have been met to justify prescribed treatment
- Request for treatment support by MTUS / EBM

## Getting to YES

- A “bullet-proof” report would be one that clearly shows how the injured worker is appropriate for treatment that meets MTUS/EBM Guidelines and, when possible, clearly indicates the negative ramifications of not receiving the recommended treatment

## Documentation

- History, physical findings, tests and imaging studies support diagnosis and treatment request
- Report should list red flags that demand treatment
- Report should document functional improvement

## Documentation

- Report should document progression of treatment
  - Simple/conservative to complex/invasive
  - Document timeline (how many weeks have passed?)
- Report should note failure of lower level of treatment to date
  - Should distinguish 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> 4<sup>th</sup> line treatment options

## Documentation is #1

- It doesn't really matter where the prescription is in the process – UR, IMR, or expedited hearing – ***every treatment request must be properly documented, fully substantiating the need for the treatment***
- Treatment request absent adequate documentation = Denial
- Getting it right in the first place is the only viable strategy
  - Requesting physician
  - UR needs to get it right

## IMR Decisions\*

- **Denial** if too early, simple diagnosis (sprain, etc.) no conservative treatment, no red flags, negative physical exam, test will not alter treatment course
  - No EBM support for request in report
- **Approval** if delayed recovery, neurological deficit, chronic condition, conservative treatment didn't help, + physical findings
  - Good EBM support for request in report

\*Opinion based on my review of IMR decisions

## Functional Restoration Medically Necessary

- A functional restoration approach is medically necessary and has not yet been provided to cure or relieve the effects of the industrial injury
  - Surgery, PT, acupuncture, chiropractic, injections, medications, have been ineffective
  - Medications despite escalation have not proven effective and are in fact disabling
  - There is a documented sleep disturbance and sexual dysfunction
  - Weight gain is noted with an increased BMI
  - There is evidence of reversible deconditioning
  - There is evidence of psychological consequences with anger, fear of reinjury, maladaptive coping, mood disturbance, depression, irritability, emotional distress and somatic preoccupation

## IW Meets FR Criteria and is Onboard

- IW is not a candidate for surgery or other invasive interventions; or wishes to avoid additional options of surgery due to fear of complications or further delays in recovery
- There is documented loss of functional ability with medically reasonable potential for improved performance and functional capacity
- IW has reasonable expectations and is committed to full participation to meet the goals of increased function, medication reduction/optimization, self-sufficiency, and return to life activities including work, MMI status and case resolution

# Getting to YES with UR & IMR

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This document is meant to help physicians and others better serve injured workers through understanding how to provide requests for treatment that meets evidence-based medicine guidelines leading to authorization for medical care. While not foolproof, if physicians follow the directions below they can avoid most authorization denials through UR and IMR. This does involve a little extra work at the front end, but it saves having to deal with and respond to denials of care which only clog up the physician's office and take up time while leaving the injured worker patient without needed medical care.

## The Rules

- Doctors in California's workers' compensation system are required to provide evidence-based medical treatment.
- All treatment in California must be consistent with the MTUS (LC §5307.27) which is presumptively correct as a matter of law (LC §4604.5 (a)).
  - Requests that are inconsistent with the MTUS = Denial / Non-Certified.
- The physician can go down the right hierarchy when the MTUS does not address the treatment request, does not adequately consider unique treatment requests, or where there is stronger and more up-to-date scientific evidence to support the request.
- Text of Medical Treatment Utilization Schedule Regulations (MTUS):  
[http://www.dir.ca.gov/dwc/DWCPPropRegs/MTUS\\_Regulations/RegulationsFinalClean.pdf](http://www.dir.ca.gov/dwc/DWCPPropRegs/MTUS_Regulations/RegulationsFinalClean.pdf)
- The physician must choose treatments scientifically proven to cure or relieve work-related injuries and illnesses.
- §9792.25. Presumption of Correctness, Burden of Proof and Strength of Evidence  
[https://www.dir.ca.gov/t8/9792\\_25.html](https://www.dir.ca.gov/t8/9792_25.html)
  - (a) The MTUS is presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addressed in the MTUS for the duration of the medical condition.
  - The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury.
  - (b) For all conditions or injuries not addressed by the MTUS, authorized treatment and diagnostic services shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community.
  - (c)(1) For conditions or injuries not addressed or at variance by either subdivisions (a) or (b) above or where a recommended medical treatment or diagnostic service covered under subdivision (b) is at variance with another treatment guideline also covered under subdivision (b), ACOEM's strength of evidence rating methodology is used.
    - Evidence-base: Insufficient – Limited – Moderate - Strong

- Labor Code Section 4610.5(c)(2) as revised by SB863:
  - (2) "Medically necessary" and "medical necessity" mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition:
  - (A) The guidelines adopted by the administrative director pursuant to Section 5307.27.
  - (B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
    - (<http://www.ncbi.nlm.nih.gov/pubmed/>)
  - (C) Nationally recognized professional standards.
    - ACOEM, ODG, Others (see <http://www.guideline.gov/>)
  - (D) Expert opinion.
  - (E) Generally accepted standards of medical practice.
  - (F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

### Overview of MTUS:

For many body parts (see below), the MTUS uses the ACOEM 2004 2<sup>nd</sup> Edition although all Chapters have been updated. If the 2004 Chapter does not provide the most accurate and up to date scientific evidence based medicine supported request for treatment, consider #2 - #7 hierarchy above.

- ❖ The updated ACOEM Chapters can be purchased at <https://webportal.acoem.org/Purchase/CatalogSearchResults.aspx?Option=2&Topic=15> for \$5.95 a Chapter. They can also be found at <http://www.guideline.gov/search/search.aspx?term=acoem>.
- ❖ You can purchase use of the Official Disability Guidelines (ODG) at <http://odg-disability.com/orderform.htm> for \$350/year. The 2011 version can also found at <http://www.guideline.gov/search/search.aspx?term=work+loss+data>.
- ❖ Many Guidelines including ACOEM and prior ODG versions can be obtained free at <http://www.guideline.gov/>

### CA DWC Medical Treatment Utilization Schedule (MTUS)

[https://www.dir.ca.gov/dwc/MTUS/MTUS\\_RegulationsGuidelines.html](https://www.dir.ca.gov/dwc/MTUS/MTUS_RegulationsGuidelines.html)

- **Neck and Upper Back Complaints**
  - ACOEM 8 (2004, 2<sup>nd</sup> Edition)
  - Acupuncture Medical Treatment Guidelines
  - Postsurgical treatment Guidelines
- **Shoulder Complaints**
  - ACOEM 9 (2004, 2<sup>nd</sup> Edition)
  - Chronic Pain Medical Treatment Guidelines
  - Postsurgical treatment Guidelines
- **Elbow Disorders**
  - ACOEM 10 (Revised 2007)
  - Acupuncture Medical Treatment Guidelines
  - Chronic Pain Medical Treatment Guidelines
  - Postsurgical treatment Guidelines

- **Forearm, Wrist & Hand Complaints**
  - ACOEM 11 (2004, 2<sup>nd</sup> Edition)
  - Acupuncture Medical Treatment Guidelines
  - Chronic Pain Medical Treatment Guidelines
  - Postsurgical treatment Guidelines
- **Low Back Complaints**
  - ACOEM 12 (2004, 2<sup>nd</sup> Edition)
  - Chronic Pain Medical Treatment Guidelines
  - Postsurgical treatment Guidelines
- **Knee Complaints**
  - ACOEM 13 (2004, 2<sup>nd</sup> Edition)
  - Acupuncture Medical Treatment Guidelines
  - Chronic Pain Medical Treatment Guidelines
  - Postsurgical treatment Guidelines
- **Ankle and Foot Complaints**
  - ACOEM 14 (2004, 2<sup>nd</sup> Edition)
  - Acupuncture Medical Treatment Guidelines
  - Chronic Pain Medical Treatment Guidelines Postsurgical treatment Guidelines
- **Stress Related Conditions**
  - ACOEM Chapter 15 (2004, 2<sup>nd</sup> Edition)
- **Eye Conditions**
  - ACOEM Chapter 16 (2004, 2<sup>nd</sup> Edition)
- **Chronic Pain Complaints**
  - Chronic Pain Medical Treatment Guidelines  
([https://www.dir.ca.gov/dwc/MTUS/MTUS\\_RegulationsGuidelines.html#14](https://www.dir.ca.gov/dwc/MTUS/MTUS_RegulationsGuidelines.html#14))
- **Acupuncture**
  - Acupuncture Medical Treatment Guidelines  
([https://www.dir.ca.gov/dwc/MTUS/MTUS\\_RegulationsGuidelines.html#13](https://www.dir.ca.gov/dwc/MTUS/MTUS_RegulationsGuidelines.html#13))
- **Postsurgical Therapy / Treatment**
  - **Postsurgical Treatment Guidelines**  
([https://www.dir.ca.gov/dwc/MTUS/MTUS\\_RegulationsGuidelines.html#15](https://www.dir.ca.gov/dwc/MTUS/MTUS_RegulationsGuidelines.html#15))

## Report Writing

- Physician needs to provide a clear, legible and concise history and physical examination followed by diagnoses and then recommendations for evidence-based medicine (EBM) medical care.
- Timely submitted reports will help expedite proposed treatment and avoid unnecessary delays unrelated to the UR process.
- Avoid boilerplate paragraphs especially with an electronic medical record (EMR).
- State how the medical treatment is supported by the MTUS or how your request is supported by another medical standard and why every standard ranked higher in the hierarchy (see hierarchy above) is inapplicable to the injured worker's medical condition.
- Walk the UR or IMR Reviewer through the treatment course and documented how the treatment request meets the MTUS or EBM standards.
- The medical reporting must contain documentation that the injured worker is educated about and understands the diagnoses and additionally should note specific goals to be achieved and documented with treatment which include:

- Less discomfort
- Improved activities of daily living function
  - Improved sleep
  - Increased ADLs such as cleaning the house, mowing the lawn, etc.
- Staying or returning to work

### **Post-UR & IMR Denial**

- If there has already been a UR denial, discuss how the Utilization Reviewer erred in the analysis.
- What documentation or evidence or report did the Utilization Reviewer miss or not consider.
- Learn from your UR mistakes - If the UR physician has pointed out legitimate errors in your reporting, correct the deficiency prior to IMR.

### **Explanation of the Request for Initial Authorization**

- The report should contain an explanation that the request/prescription for treatment is to achieve and will result in a positive outcome (and therefore be efficacious) by way of less pain and improved activities of daily living - ADLs (including SAW/RTW) which are measured and documented at the next visit.
- The report should clearly state that the prescription/request is supported by MTUS or whatever scientific article or guidelines you are using and is supported by evidence-based medicine or is otherwise justified.
- A “bullet-proof” report would be one that clearly shows how the injured worker is appropriate for treatment and, when possible, clearly indicates the negative ramifications of not receiving the recommended treatment
- Even if the prescription/recommendation doesn’t quite fit the guidelines; make sure further details are provided with regards to your request. For example: While the patient has attempted PT in the past without lasting benefit and the prescription is in excess of what guidelines recommend for this diagnosis, previous PT notes show care consisted primarily of passive modalities. Current PT will consist of (list active therapies) that should have a much greater chance of creating functional gains and thus should be considered for this specific patient. The more patient specific the treatment plan can be, the easier the argument can become to move outside of guidelines which are often based on averages.

### **Explanation of the Request for Additional/Continued Treatment Authorization**

- To justify additional or continued treatment you will have to clearly document how the initial similar treatment resulted in a positive outcome (less pain, increased ADLs, etc.) and why additional similar care will further result in a further benefit.

### **Documentation is #1**

- It doesn’t really matter where you are in the process – UR, IMR, or expedited hearing – every treatment request must be properly documented, fully substantiating the need for the treatment. A treatment request absent adequate documentation = UR or IMR Denial. Getting it right in the first place is the only viable strategy.

### **Documentation Specifics**

- Note progression of treatment: Simple/conservative to complex/invasive.

- Document timeline (how many weeks have passed?).
- Note failure/lack of improvement with lower level of treatment to date.
- Distinguish 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup>, line treatment options.
- Document history, physical findings, tests and imaging studies support diagnosis and treatment request.
- List red flags that demand treatment and risks associated with denial of care.
- Document functional improvement.
- Use the MTUS / ODG / ACOEM Guideline as a Checklist: If the prescription/requested is supported in the guideline, describe how the injured worker meets the requirements for that treatment.

### **IMR Denials and Approvals**

- Denial if too early in treatment course for the specific request without documentation in support of variance from the guidelines, simple diagnosis (sprain, etc.) does not warrant treatment request, no conservative treatment, no red flags, negative physical exam, test will not alter treatment course.
- Approval if delayed recovery, neurological deficit, chronic condition, conservative treatment didn't help, positive physical findings.

### **IMR Denial: Remains in effect for 12 months unless:**

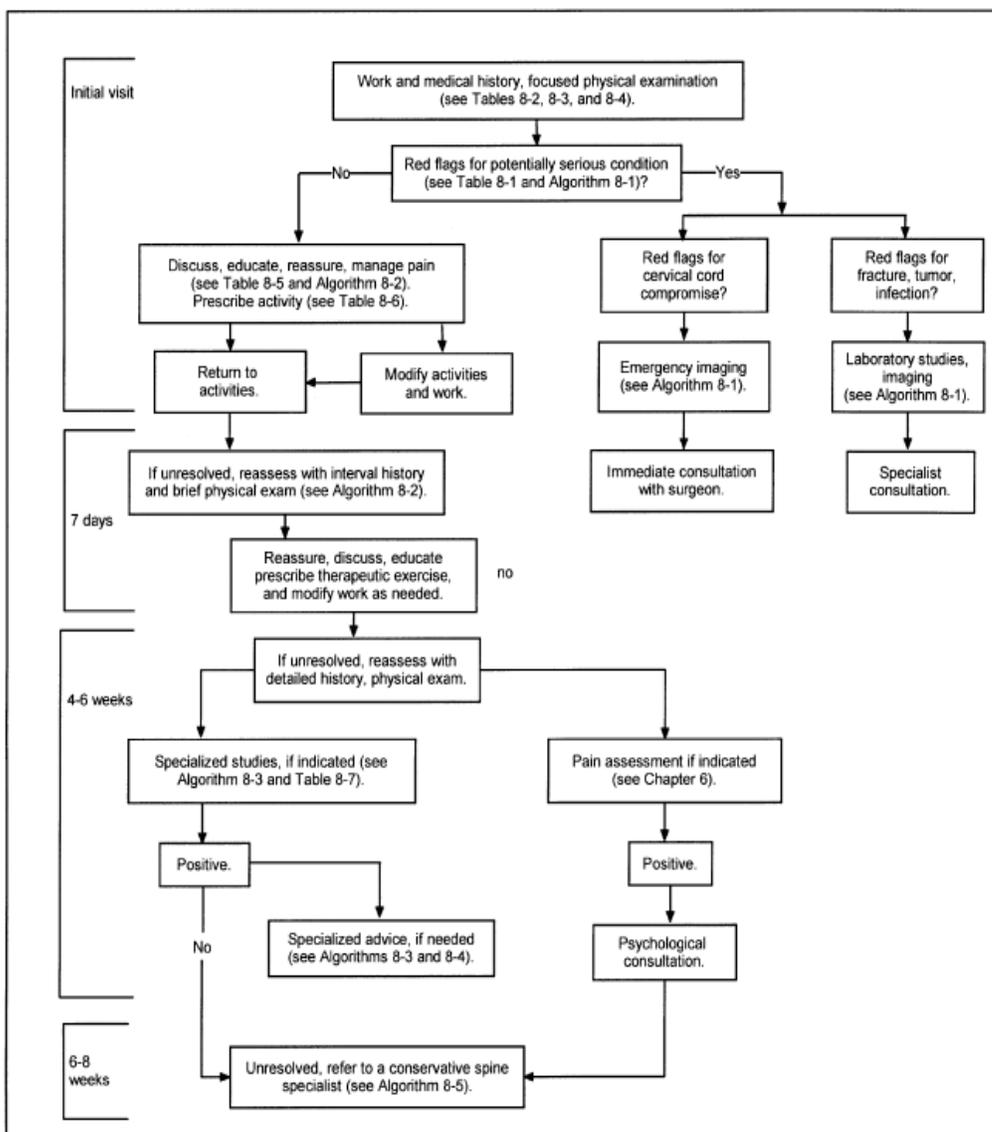
- Has there been a substantial change in the patient's condition - a change in the facts and/or clinical status?
- Was the IMR determination the result of a plainly erroneous expressed or implied finding of fact?
- If an IMR denial is in place, or other alternative treatment options?

## **Neck and Upper Back Complaints - ACOEM 8 (2004 2<sup>nd</sup> Edition)**

The “secret” to avoiding UR & IMR denials is to follow the ACOEM 2004 Guidelines and if they are not adequate or up to date, to use other guidelines per the DWC MTUS hierarchy or to provide clearer justification otherwise for the request /prescription. See ACOEM 2004, Chapter 8, for full details. Pertinent summaries and algorithms from the ACOEM, 2004 2<sup>nd</sup> Edition are listed below.

# Summaries and Algorithms from the ACOEM, 2004 2<sup>nd</sup> Edition

**Master Algorithm.** ACOEM Guidelines for Care of Acute and Subacute Occupational Neck and Upper Back Complaints



## Summary of Recommendations and Evidence

See Table 8-8.

*Table 8-8. Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints*

<b>Clinical Measure</b>	<b>Recommended</b>	<b>Optional</b>	<b>Not Recommended</b>
History and physical exam	Basic history and exam (C) History of cancer infection (B) History of significant trauma (D) Neurologic exam (C)		
Medication (See Chapter 3)	Acetaminophen (C) NSAIDs (B)	Muscle relaxants (C) Opioids, short course (C)	Use of opioids for more than 2 weeks (C)
Physical treatment methods		Physical manipulation for neck pain early in care only (B) At-home applications of heat or cold (D) Radio-frequency neurotomy (C)	Traction (B) TENS (C) Other modalities (D)
Injections		Epidural injection of corticosteroids to avoid surgery (D) Botulinum toxin (dystonia only) (B)	Facet injection of corticosteroids (D) Diagnostic blocks (D)
Rest and immobilization		1 or 2 days' partial bed rest for severe pain (D)	Bed rest longer than 1 or 2 days (B) Cervical collar more than 1 or 2 days

Table 8-8. (continued)

Clinical Measure	Recommended	Optional	Not Recommended
Activity and exercise	Maintenance of activity levels while recovering (B) Office instruction on exercises after initial pain decreases (D) Low-stress conditioning and aerobic exercises to avoid debilitation (D)		
Detection of neurologic abnormalities	EMG to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural injection (D)	SEPs if spinal stenosis or myelopathy suspected (D)	EMG for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent (D)
Radiography	Initial studies when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present (D)		Routine use in first 4 to 6 weeks if red flags are absent (D)
Other imaging procedures	MRI or CT to evaluate red-flag diagnoses as above (D)		Imaging before 4 to 6 weeks in absence of red flags (C, D)
	MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure (D). If no improvement after 1 month, bone scan if tumor or infection possible (D)		Preoperative diskography (D)

Table 8-8. (continued)

Clinical Measure	Recommended	Optional	Not Recommended
Surgical considerations	<p>Careful preoperative education of the patient regarding expectations, complications, and short- and long-term sequelae of surgery (D)</p> <p>Indications clear for failed conservative treatment and history, exam, and imaging consistent for specific lesion (D)</p>		<p>Discectomy or fusion without conservative treatment 4 to 6 weeks minimum (D)</p> <p>Discectomy or fusion for nonradiating pain or in absence of evidence of nerve root compromise (D)</p>

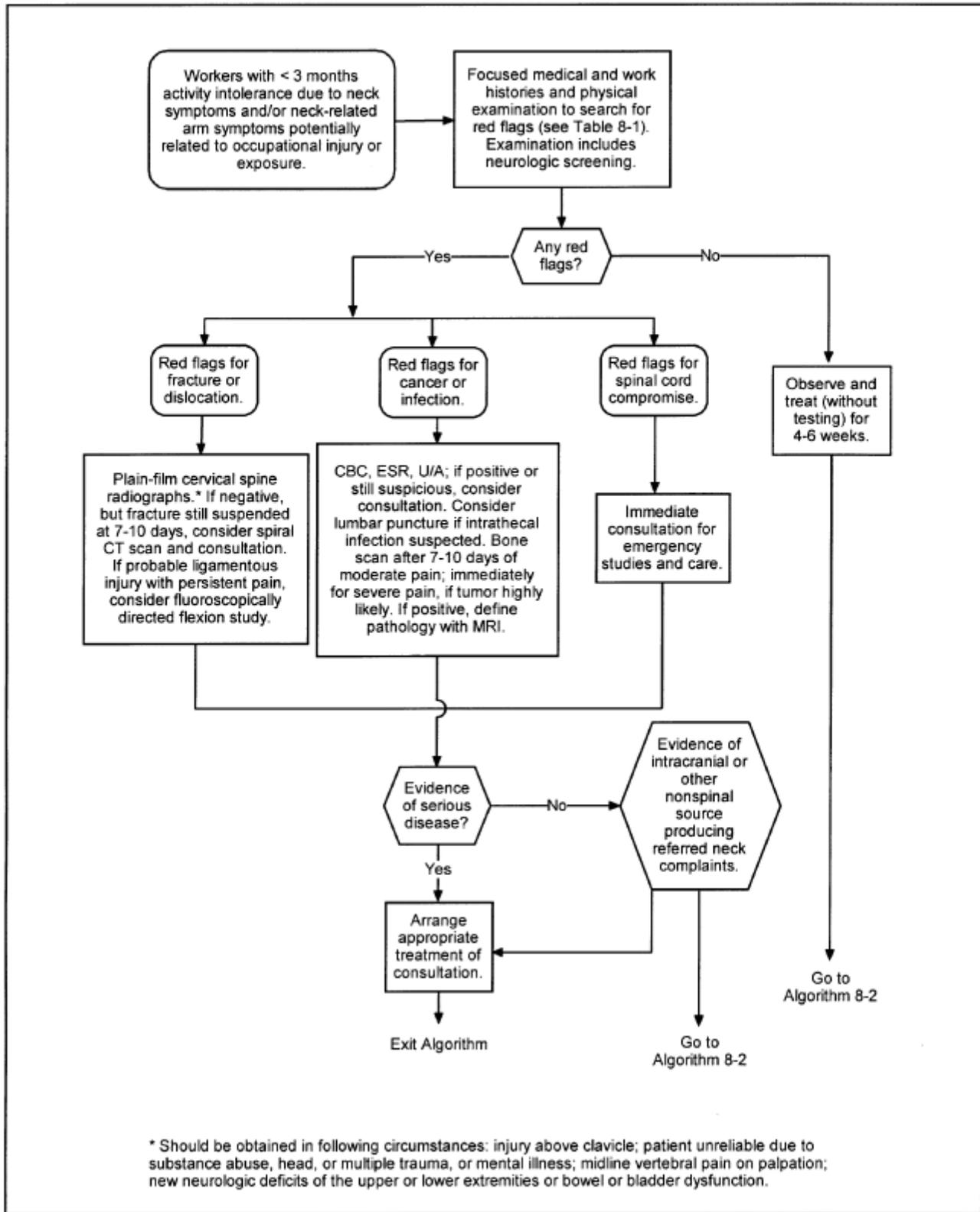
A = Strong research-based evidence (multiple relevant, high-quality scientific studies).

B = Moderate research-based evidence (one relevant, high-quality scientific study or multiple adequate scientific studies).

C = Limited research-based evidence (at least one adequate scientific study of patients with neck and upper back disorders).

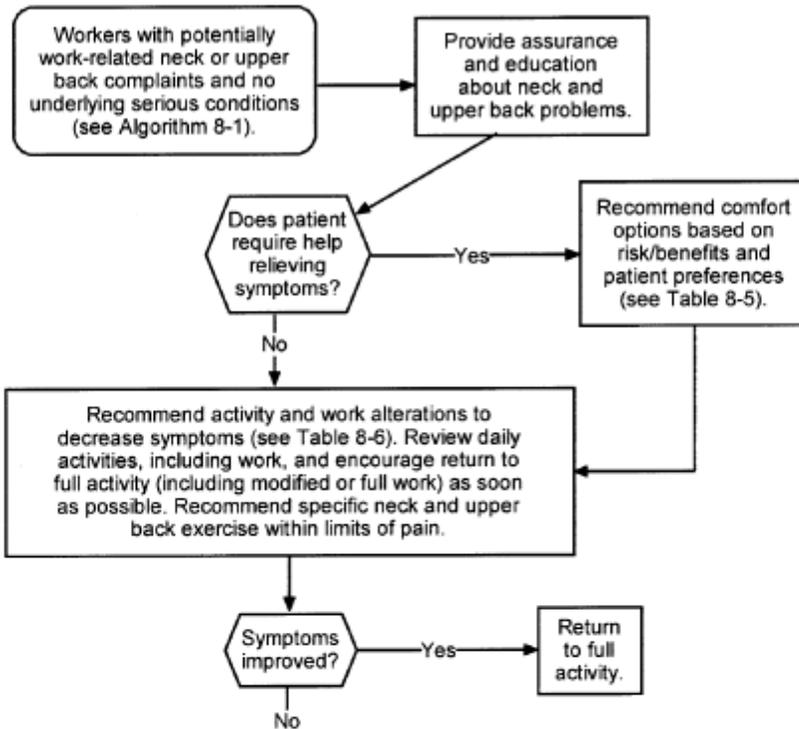
D = Panel interpretation of information not meeting inclusion criteria for research-based evidence.

**Algorithm 8-1. Initial Evaluation of Occupational Neck and Upper Back Complaints**

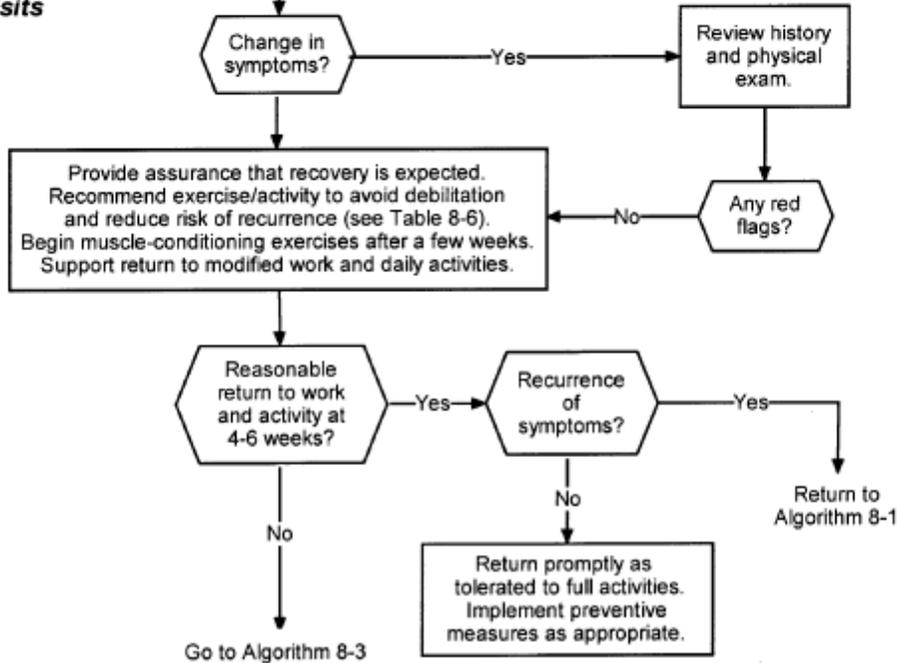


**Algorithm 8-2. Initial and Follow-up Management of Occupational Neck and Upper Back Complaints**

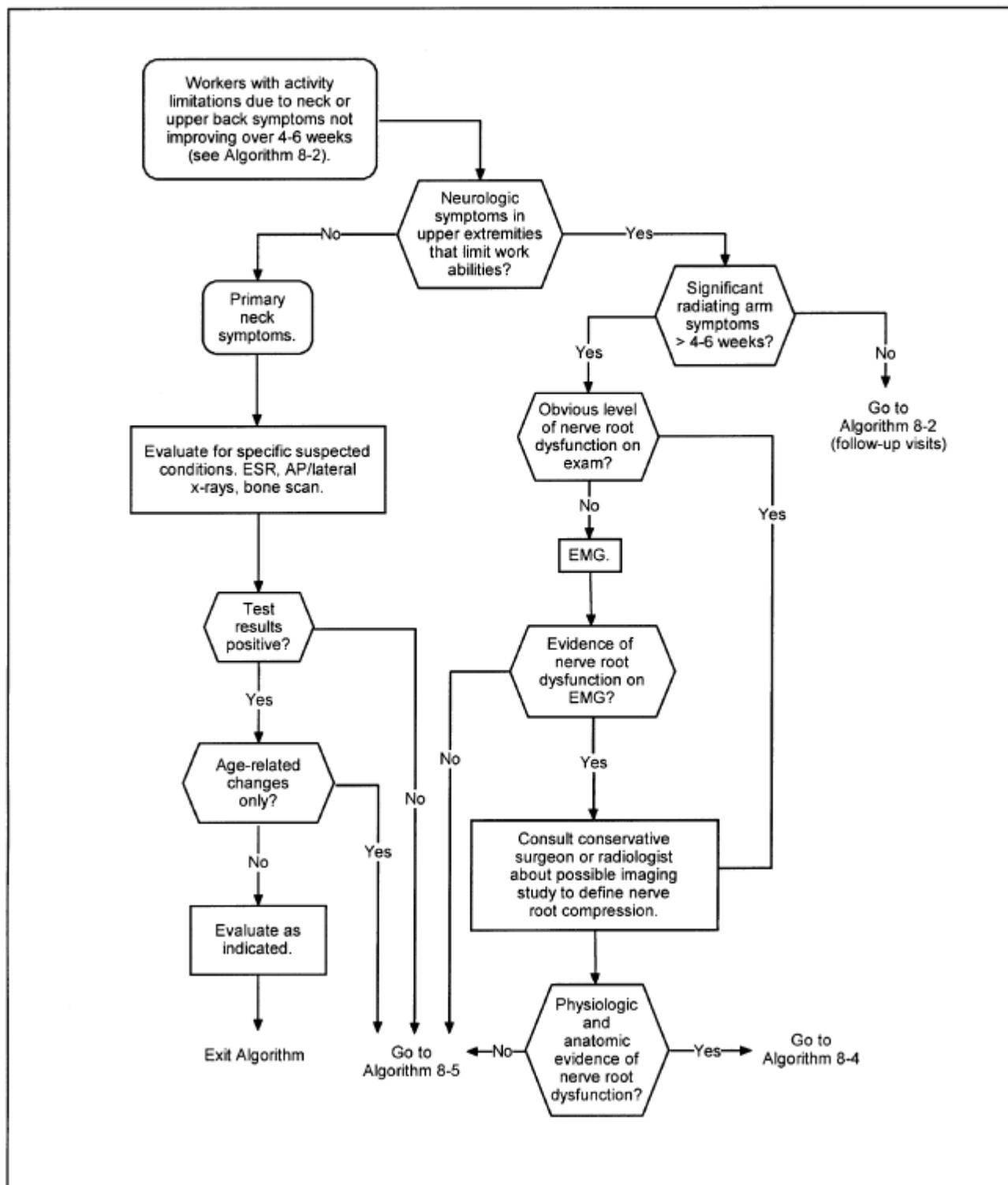
**Initial Visit**



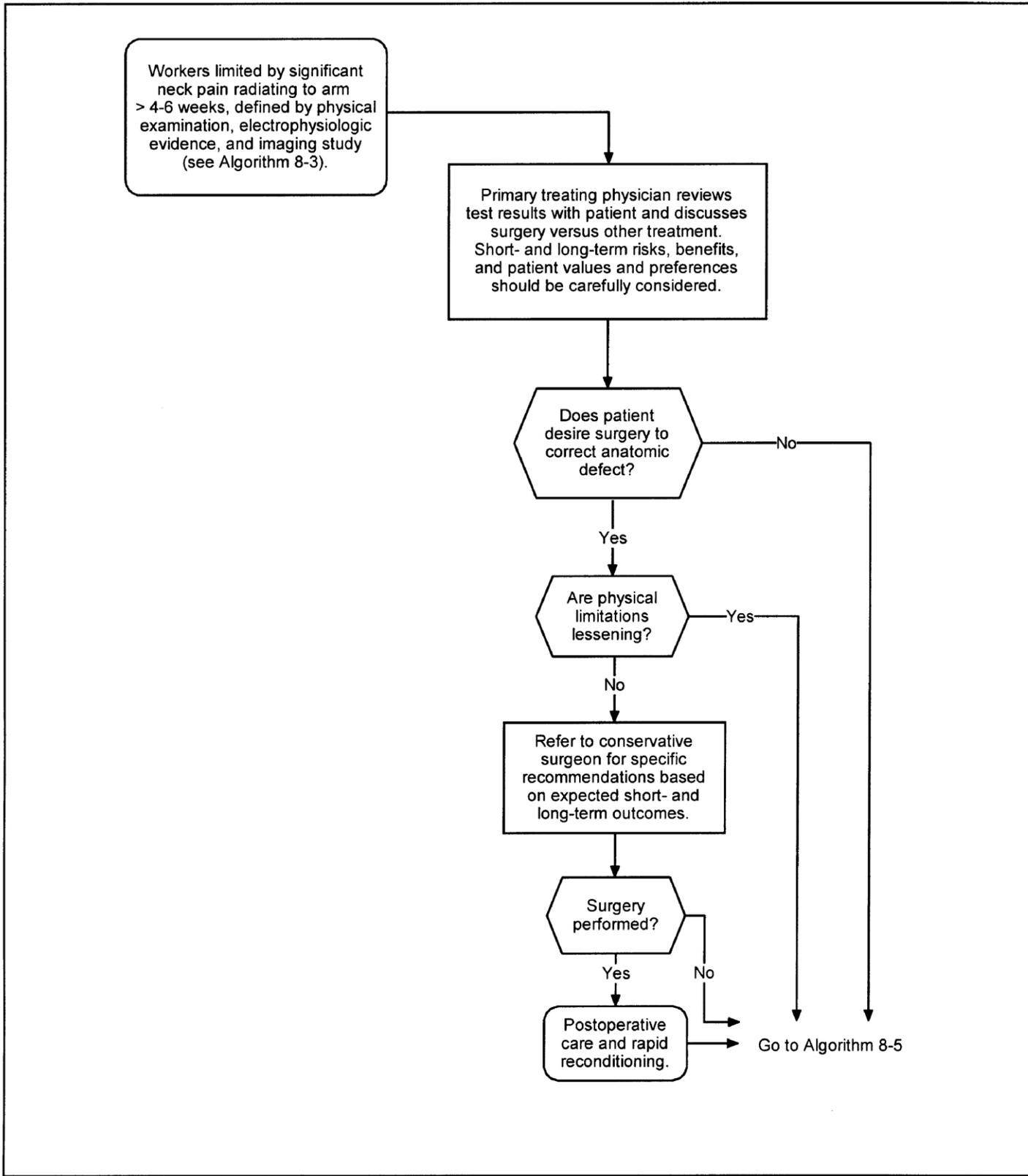
**Follow-up Visits**



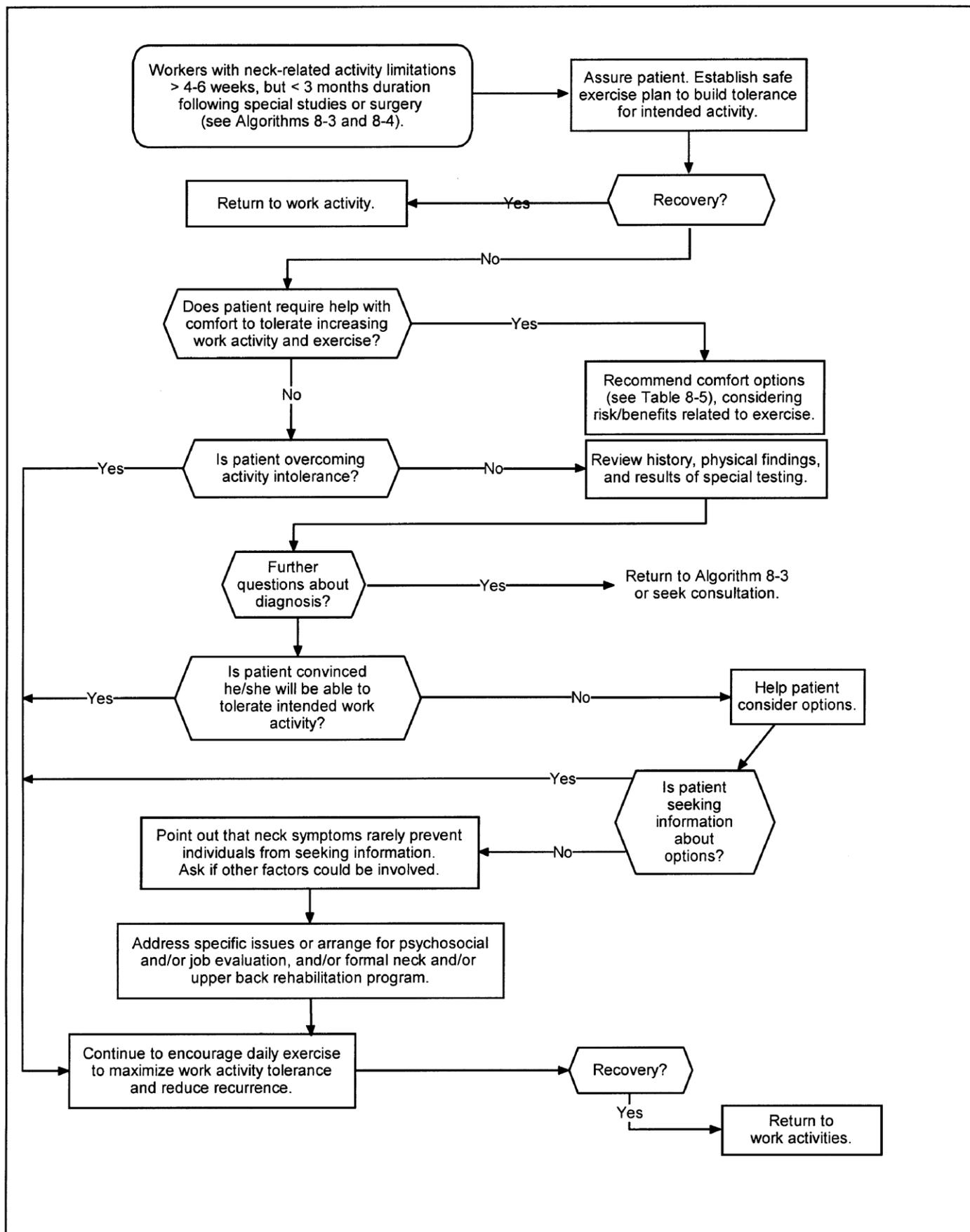
**Algorithm 8-3. Evaluation of Slow-to-recover Patients with Occupational Neck or Upper Back Complaints (Symptoms > 4 Weeks)**



**Algorithm 8-4. Surgical Considerations for Patients with Persistent Radiating Arm Pain**

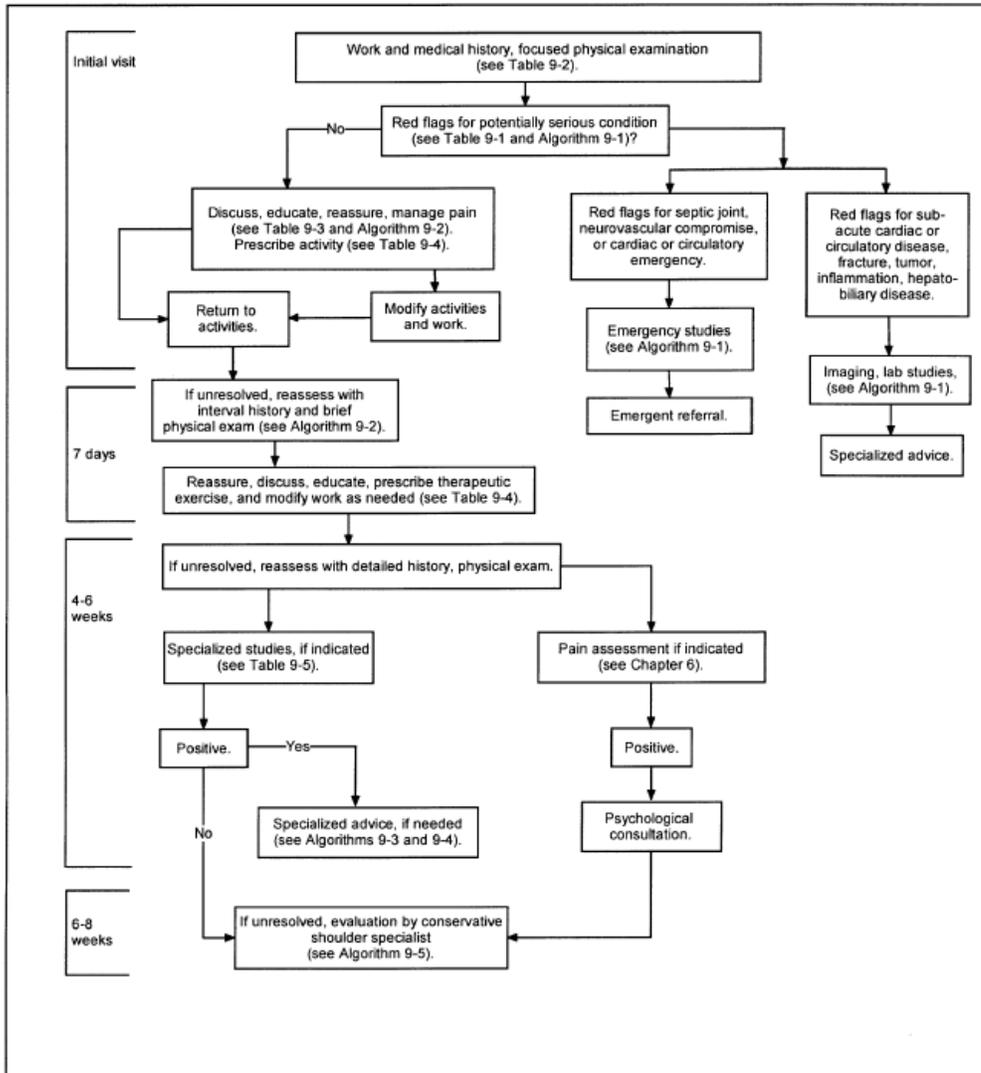


**Algorithm 8-5. Further Management of Occupational Neck and Upper Back Complaints**



# Shoulder Complaints ACOEM Chapter 9 (2004)

**Master Algorithm.** ACOEM Guidelines for Care of Acute and Subacute Occupational Shoulder Complaints



## Summary of Recommendations and Evidence

See Table 9-6.

Table 9-6. Summary of Recommendations for Evaluating and Managing Shoulder Complaints

Clinical Measure	Recommended	Optional	Not Recommended
History and physical exam	Focused history and exam Search for red flags (e.g., for tumor, infection, angina) (C)		
Patient education	Patient education regarding condition or disorder, expectations of treatment, side effects, etc. (D)		
Medication (See Chapter 3)	Acetaminophen (C) NSAIDs (B)	Opioids, short course (C)	Use of opioids for more than 2 weeks (C) Muscle relaxants (D)
Physical treatment methods, activities and exercise	Maintain activities of other parts of body while recovering (D) Maintain passive range of motion of the shoulder with pendulum exercises and wall crawl (D) Treat initially with strengthening or stabilization exercises for impingement syndrome, rotator cuff tear, instability, and recurrent dislocation (C, D)	At-home applications of heat or cold packs to aid exercises (D) Short course of supervised exercise instruction by a therapist (D)	Passive modalities by a therapist (unless accompanied by teaching the patient exercises to be carried out at home) (D)

Table 9-6. (continued)

Clinical Measure	Recommended	Optional	Not Recommended
Injections	<p>Two or three sub-acromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears (C, D)</p> <p>Diagnostic lidocaine injections to distinguish pain sources in the shoulder area (e.g., impingement) (D)</p>		Prolonged or frequent use of cortisone injections into the sub-acromial space or the shoulder joint (D)
Rest and immobilization	<p>Brief use of a sling for severe shoulder pain (1 to 2 days), with pendulum exercises to prevent stiffness in cases of rotator cuff conditions (D)</p> <p>Three weeks use, or less, of a sling after an initial shoulder dislocation and reduction (C)</p> <p>Same for AC separations or severe sprains (D)</p>		Prolonged use of a sling only for symptom control (D)
Detection of physiologic abnormalities	<p>Rarely, nerve conduction time of the suprascapular nerve for cases of severe cuff weakness unaccompanied by signs of a rotator cuff tear (D)</p>		EMG or NCV studies as part of a shoulder evaluation for usual diagnoses (D)

Table 9-6. (continued)

Clinical Measure	Recommended	Optional	Not Recommended
Radiography		For acute AC joint separations, stress films (views of both shoulders, with and without patient holding 15-lb weights) (D)	Routine radiographs for shoulder complaints before 4 to 6 weeks of conservative treatment (D) Stress films for instability (D)
Other imaging procedures	MRI for preoperative evaluation of partial-thickness or large full-thickness rotator cuff tears (C, D)	Arthrography for preoperative evaluation of small full-thickness tears (C) Bone scan for detection of AC joint arthritis (D)	Routine MRI or arthrography for evaluation without surgical indications (D) Ultrasonography for evaluation of rotator cuff (C)
Surgical considerations	Anterior repair for recurrent dislocation after 2 to 3 dislocations (D) Resection of outer clavicle for chronic disabling AC joint pain after conservative care of acute separation (C) Rotator cuff repair after firm diagnosis is made and rehabilitation efforts have failed (D) Capsular shift surgery for disabling instability (D) Subacromial decompression after failure of non-operative care (C)		Anterior repair for initial shoulder dislocation (C) Acute repair of AC separation (C) Acute repair of rotator cuff tears, except for massive acute tears (C) Surgery for recurrent dislocation of instability before rehabilitation efforts (C)

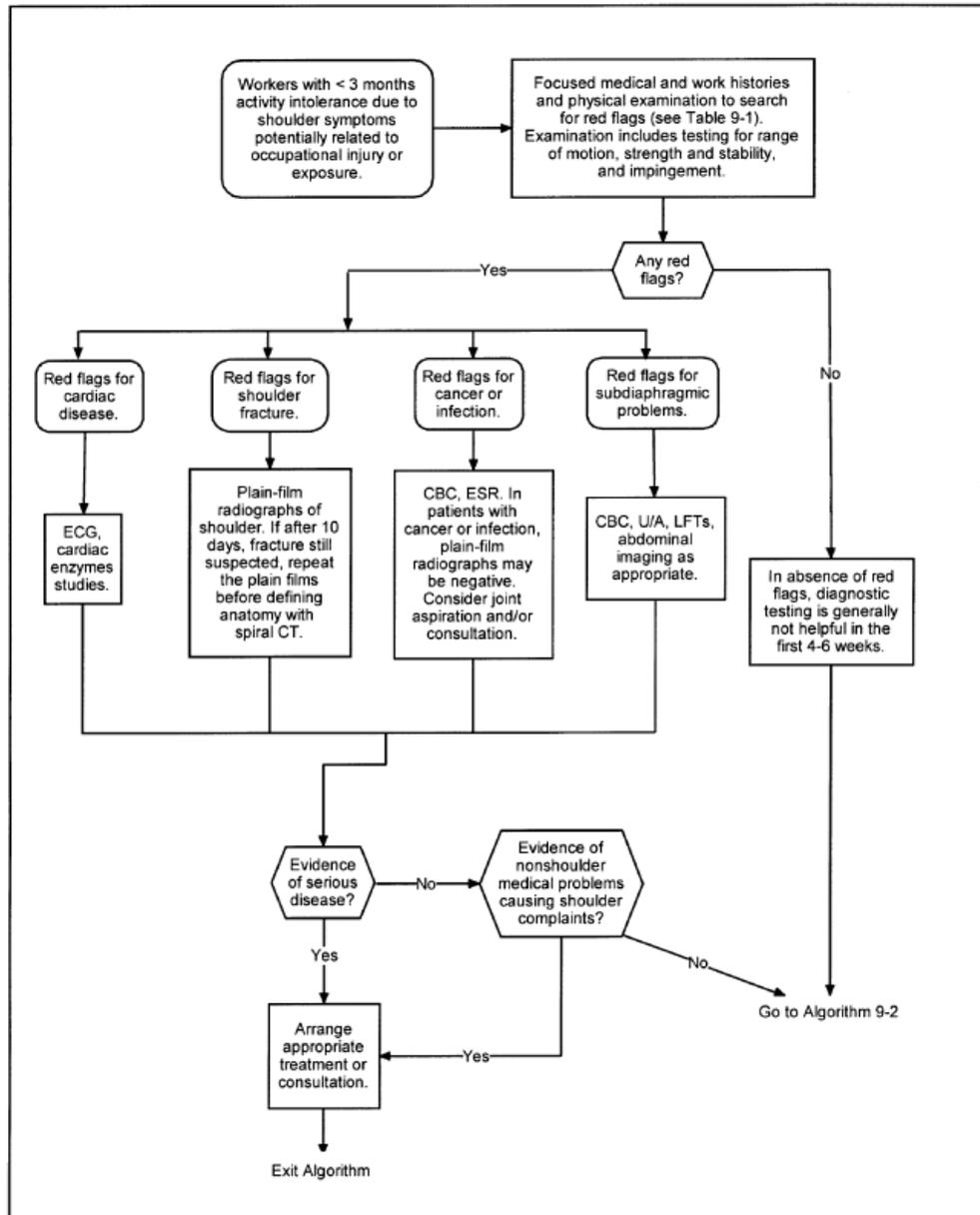
A = Strong research-based evidence (multiple relevant, high-quality scientific studies).

B = Moderate research-based evidence (one relevant, high-quality scientific study or multiple adequate scientific studies).

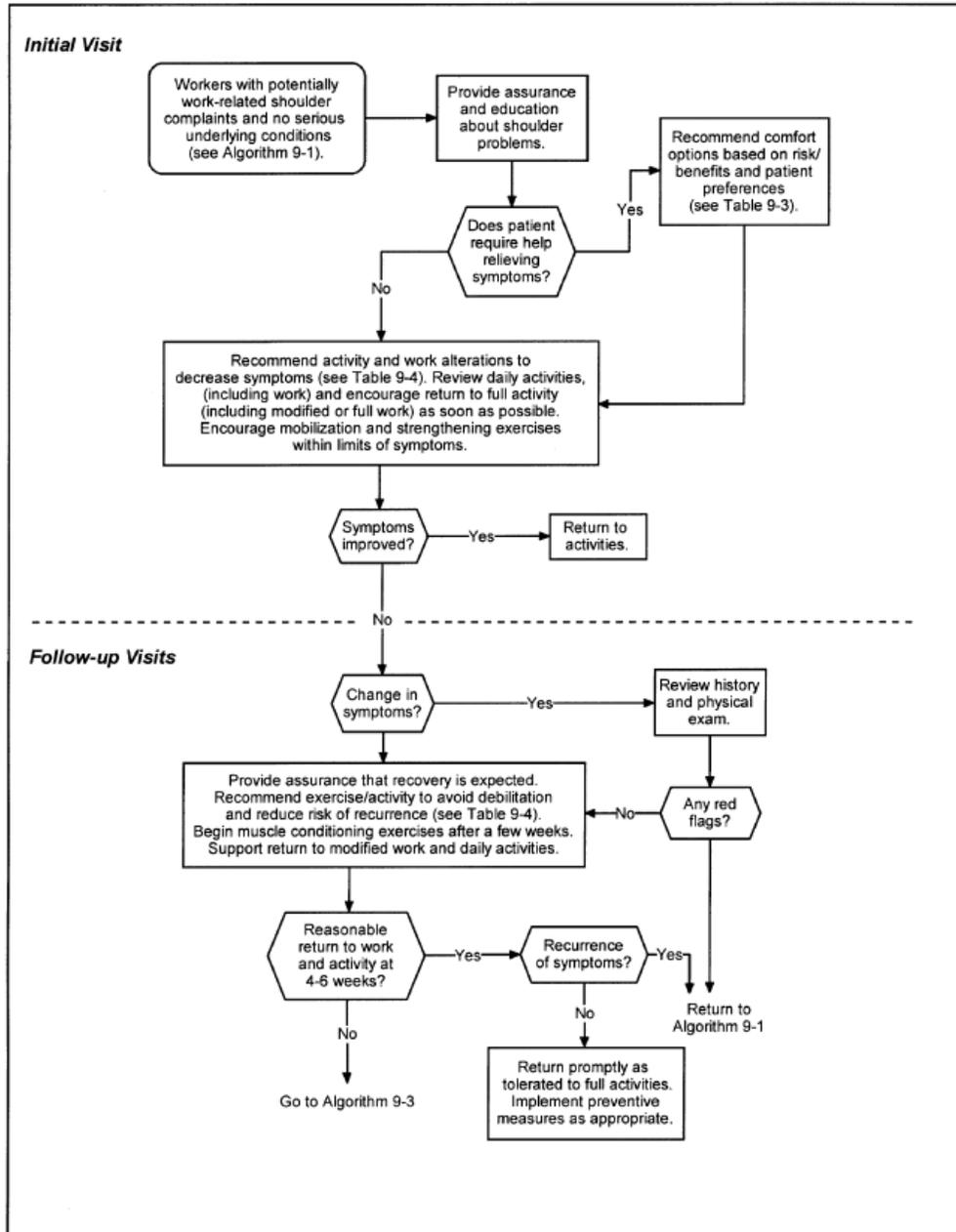
C = Limited research-based evidence (at least one adequate scientific study of patients with shoulder disorders).

D = Panel interpretation of information not meeting inclusion criteria for research-based evidence.

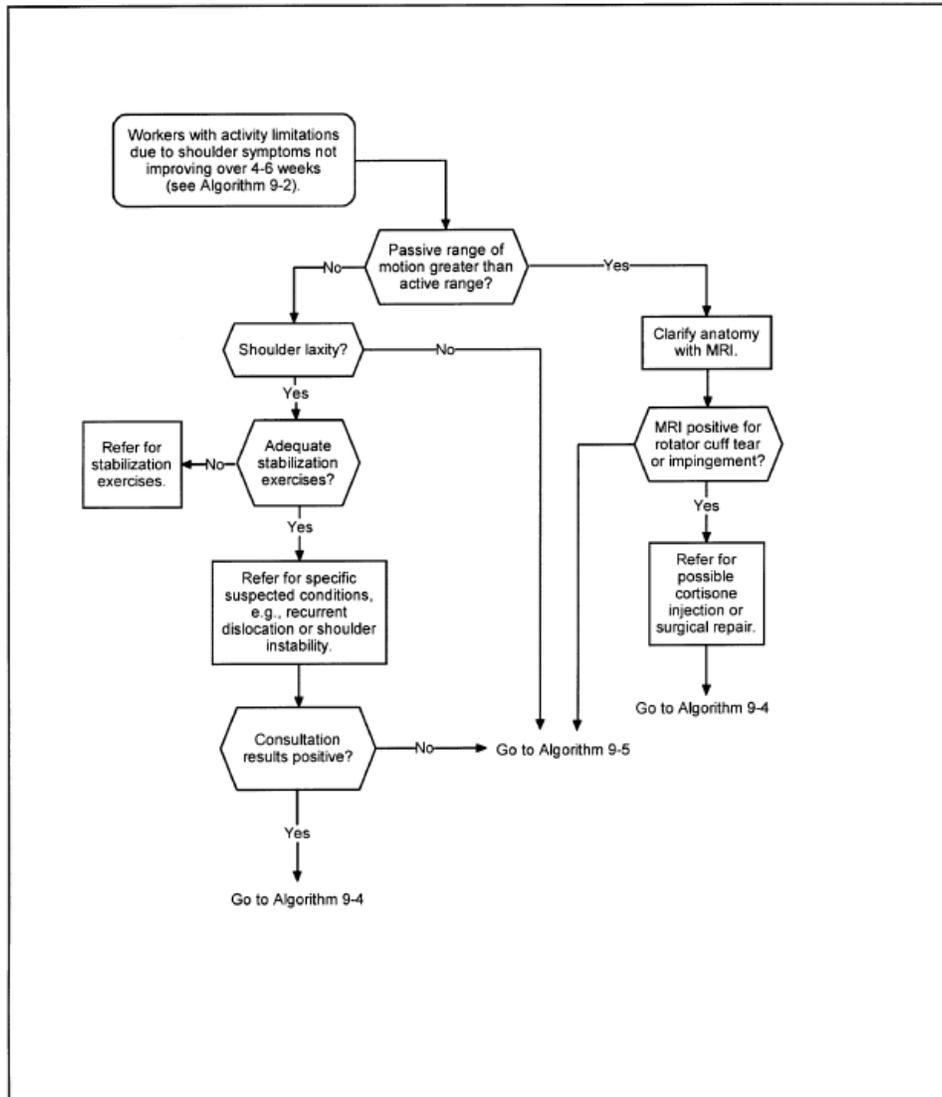
**Algorithm 9-1. Initial Evaluation of Occupational Shoulder Complaints**



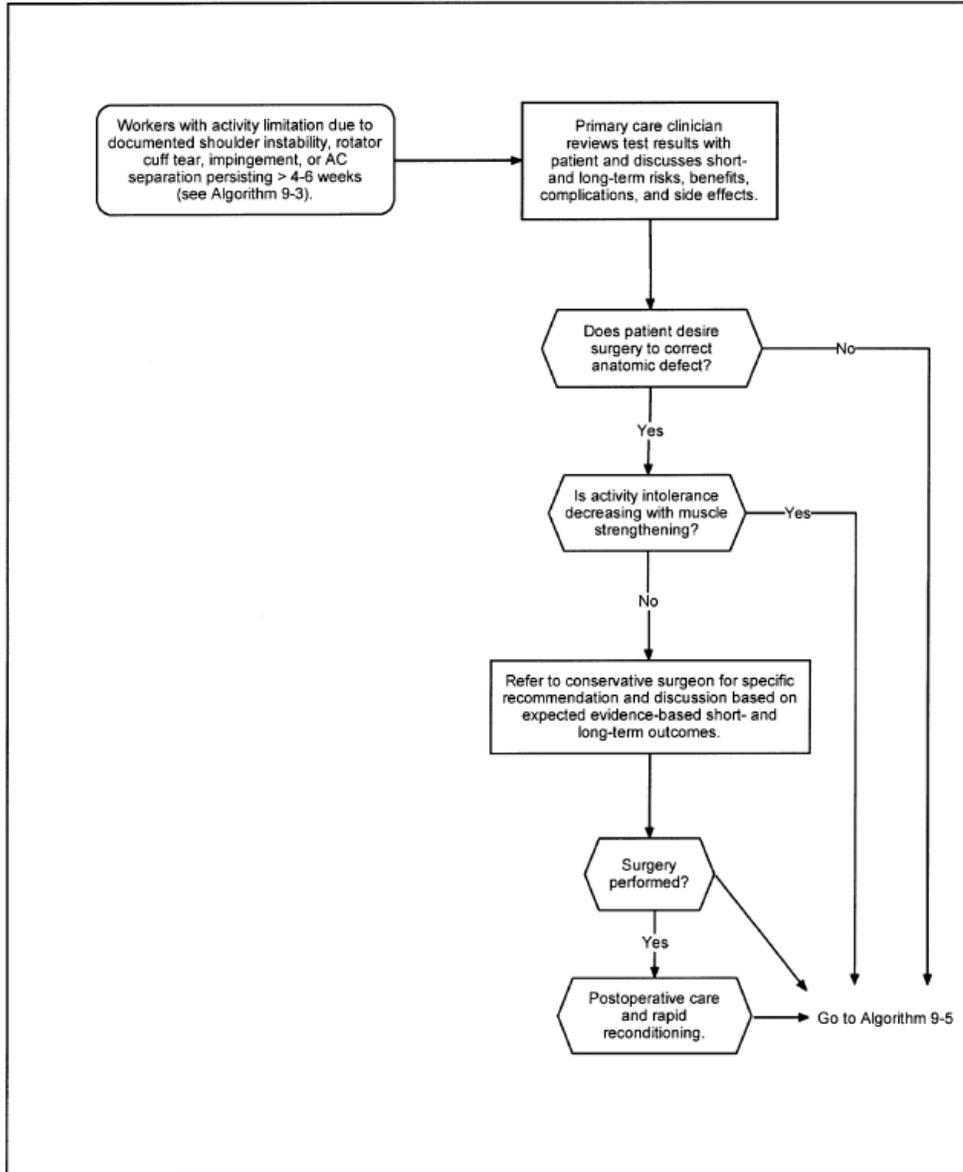
**Algorithm 9-2. Initial and Follow-up Management of Occupational Shoulder Complaints**



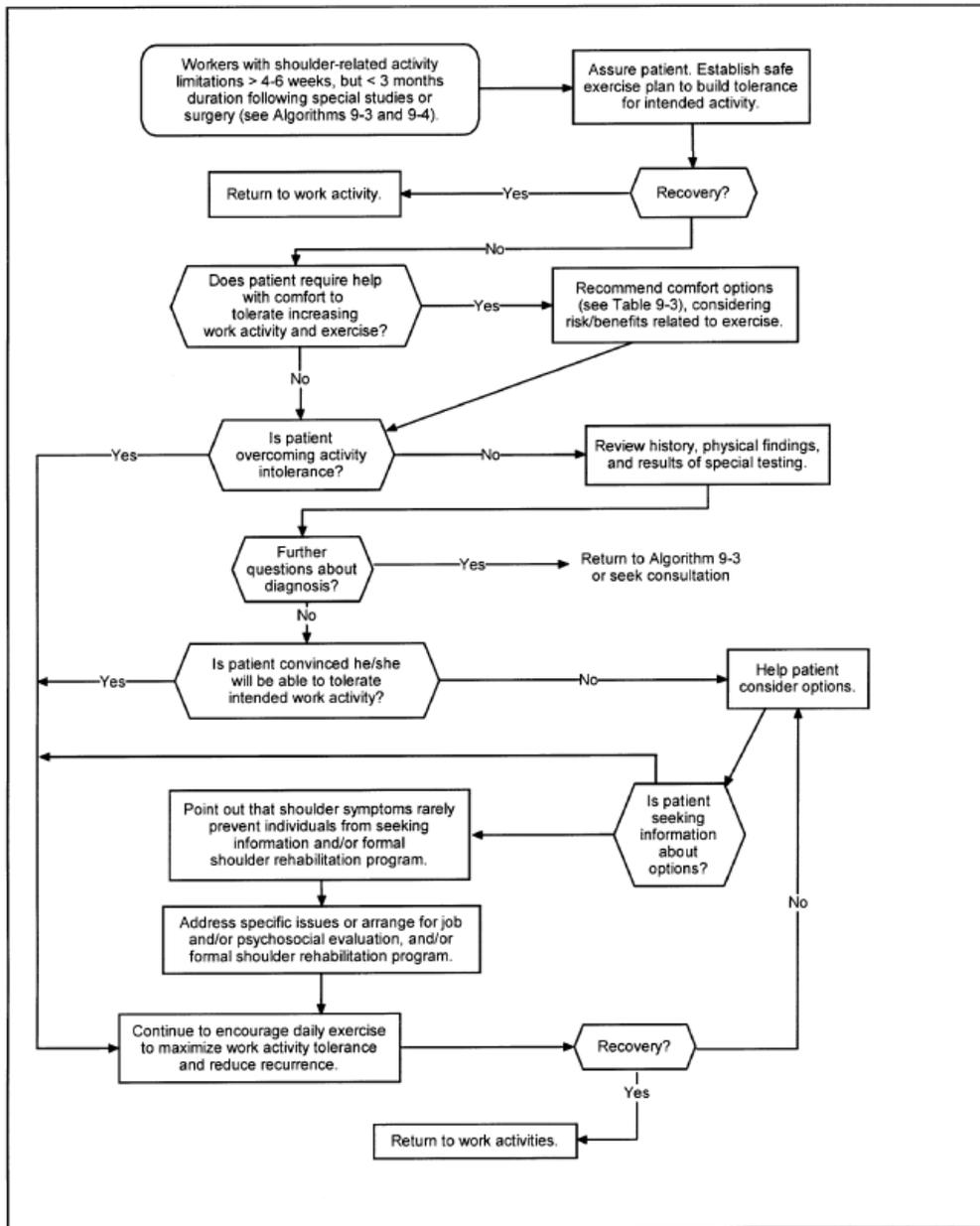
**Algorithm 9-3.** Evaluation of Slow-to-recover Patients with Occupational Shoulder Complaints (Symptoms > 4 Weeks)



**Algorithm 9-4.** Surgical Considerations for Patients with Anatomic and Physiologic Evidence of Shoulder Instability, Complete Rotator Cuff Tear, or Impingement Syndrome Coupled with Persistent Complaints



**Algorithm 9-5. Further Management of Occupational Shoulder Complaints**



## Elbow Disorders - ACOEM Chapter 10 (Revised 2007)

Accesses 9/29/13 <http://www.guideline.gov/content.aspx?id=38447>

### Summary Tables: Recommendations and Evidence

Table 1 summarizes the recommendations from the Evidence-based Practice Elbow Panel for diagnostic testing for elbow disorders. Table 2 is a summary of recommendations for managing these disorders. Table 3 summarizes the recommendations for using ergonomic interventions and return-to-work programs. The recommendations are based on critically appraised higher quality research evidence and on expert consensus observing First Principles when higher quality evidence was unavailable or inconsistent. The reader is cautioned to utilize the more detailed indications, specific appropriate diagnoses, temporal sequencing, prior testing or treatment, and contraindications that are elaborated in more detail for each test or treatment in the body of this Guideline in using these recommendations in clinical practice or medical management. These recommendations are not simple "yes/no" criteria, and the evidence supporting them is in nearly all circumstances developed from typical patients, not unusual situations or exceptions.

Recommendations are made under the following categories:

- Strongly Recommended, "A" Level
- Moderately Recommended, "B" Level
- Recommended, "C" Level
- Insufficient-Recommended (Consensus-based), "I" Level
- Insufficient-No Recommendation (Consensus-based), "I" Level
- Insufficient-Not Recommended (Consensus-based), "I" Level
- Not Recommended, "C" Level
- Moderately Not Recommended, "B" Level
- Strongly Not Recommended, "A" Level

**Table 1. Summary of Recommendations for Diagnostic and Other Testing for Elbow Disorders**

Test	Recommendation(s)
<p><b>Antibodies</b></p>	<p>Antibody levels to evaluate and diagnose patients with elbow pain that have reasonable suspicion of rheumatological disorder – <b>Recommended, Insufficient Evidence (I)</b>.</p> <p>Antibody levels as a screen to confirm specific disorders (e.g., rheumatoid arthritis) – <b>Strongly Recommended, Evidence (A)</b></p>
<p><b>Elbow Arthroscopy</b></p>	<p>Arthroscopy to evaluate and diagnose patients with elbow pain that have suspicion of intraarticular body, and other subacute or chronic mechanical symptoms – <b>Recommended, Insufficient Evidence (I)</b></p> <p>Arthroscopy for diagnosing acute elbow pain – <b>Not Recommended, Insufficient Evidence (I)</b></p> <p>Arthroscopy for diagnosis or treatment in acute, subacute, or chronic patients with osteoarthritis in the absence of a remediable mechanical defect such as symptomatic loose body – <b>Not Recommended, Insufficient Evidence (I)</b></p> <p>Arthroscopy with chondroplasty for treatment of osteoarthritis – <b>Not Recommended, Insufficient Evidence (I)</b></p>
<p><b>Bone Scans</b></p>	<p>Bone scanning for select use in acute, subacute or chronic elbow pain to assist in the diagnosis of osteonecrosis, neoplasms and other conditions with increased polyostotic bone metabolism, particularly where there is more than one joint to be evaluated – <b>Recommended, Insufficient Evidence (I)</b></p> <p>Bone scanning for routine use in elbow joint evaluations – <b>Not Recommended, Insufficient Evidence (I)</b></p>
<p><b>Computerized Tomography (CT)</b></p>	<p>Routine CT for evaluation of acute, subacute, or chronic elbow pain – <b>Not Recommended, Insufficient Evidence (I)</b></p> <p>CT for evaluating patients with osteonecrosis or following traumatic dislocations or arthroplasty-associated recurrent dislocations – <b>Recommended, Insufficient Evidence (I)</b></p> <p>CT for those with need for advanced imaging but have contraindications for MRI – <b>Recommended, Insufficient Evidence (I)</b></p> <p>Helical CT for select patients with acute, subacute or chronic elbow pain in whom advanced imaging of bony structures is thought to be potentially helpful – <b>Recommended, Insufficient Evidence (I)</b></p>
<p><b>C-Reactive Protein, Erythrocyte Sedimentation Rate, and Other Non-Specific Inflammatory Markers</b></p>	<p>Erythrocyte sedimentation rate and other inflammatory markers for screening for inflammatory disorders or prosthetic sepsis with reasonable suspicion of inflammatory disorder in patients with subacute or chronic elbow pain – <b>Recommended, Insufficient Evidence (I)</b>. Ordering of a large, diverse array of anti-inflammatory markers without targeting a few specific disorders diagnostically is not recommended.</p>
<p><b>Electromyography and Nerve Conduction Studies (Electrodiagnostic Studies [EDS])</b></p>	<p>EDS to assist in the diagnosis of subacute or chronic peripheral nerve entrapments, including ulnar neuropathies, radial neuropathies and median neuropathies – <b>Recommended, Insufficient Evidence (I)</b></p> <p>Quality EDS to assist in securing a firm diagnosis for those patients without a clear diagnosis – <b>Recommended, Insufficient Evidence (I)</b></p> <p>EDS as one of two methods to attempt to objectively secure a diagnosis prior to surgical release – <b>Recommended, Insufficient Evidence (I)</b></p> <p>EDS for initial evaluation of most patients as it does not change the management of the condition – <b>Not Recommended, Insufficient Evidence (I)</b></p>

<b>Magnetic Resonance Imaging (MRI)</b>	<p>MRI for diagnosing osteonecrosis – <b>Recommended, Insufficient Evidence (I)</b></p> <p>MRI for routine evaluation of acute, subacute, or chronic elbow joint pathology, including degenerative joint disease – <b>Not Recommended, Insufficient Evidence (I)</b></p> <p>MRI for evaluation of biceps tendinosis or ruptures – <b>Recommended, Insufficient Evidence (I)</b></p>
<b>X-rays</b>	<p>X-rays for evaluation of acute, subacute or chronic elbow pain – <b>Recommended, Insufficient Evidence (I)</b></p> <p>X-rays to rule out osteomyelitis or joint effusion in cases of significant septic olecranon bursitis – <b>Recommended, Insufficient Evidence (I)</b></p> <p>X-rays that include at least 2-3 views to diagnose elbow fractures – <b>Recommended, Insufficient Evidence (I)</b></p> <p>X-rays that include at least 2-3 views for elbow dislocation to rule-out fractures – <b>Recommended, Insufficient Evidence (I)</b>. Repeat x-rays after reduction are also recommended.</p> <p>For elbow sprains, x-rays that include at least 2-3 views to rule-out fractures – <b>Recommended, Insufficient Evidence (I)</b>. Repeat x-rays are also recommended if there is failure to improve as clinically expected over approximately a week.</p> <p>X-rays for biceps tendinosis or ruptures – <b>Recommended, Insufficient Evidence (I)</b></p>
<b>Single Proton Emission Computed Tomography (SPECT) and Positron Emission Tomography (PET)</b>	<p>SPECT and PET for diagnosing acute, subacute or chronic elbow pain – <b>Not Recommended, Insufficient Evidence (I)</b></p>
<b>Ultrasound</b>	<p>Diagnostic ultrasound for the evaluation and diagnosis of biceps tendinosis or ruptures – <b>Recommended, Insufficient Evidence (I)</b></p> <p>Diagnostic ultrasound for the evaluation and diagnosis of other elbow disorders, including osteonecrosis, osteoarthritis, dysplasia, and fractures – <b>No Recommendation, Insufficient Evidence (I)</b></p> <p>Diagnostic ultrasound for the evaluation and diagnosis of ulnar neuropathies at the elbow – <b>No Recommendation, Insufficient Evidence (I)</b></p>
<b>Gram Stain and Culture and Sensitivity</b>	<p>Aspiration of the fluid and analyses including Gram stain and culture and sensitivity to determine infection for olecranon bursitis – <b>Recommended, Insufficient Evidence (I)</b></p>

**Table 2. Summary of Recommendations for Managing Elbow Disorders**

Elbow Disorder	Treatment with Evidence Rating/Recommendation Level		
	Recommended	No Recommendation	Not Recommended
<b>Contusion</b>	<p>Education (I)</p> <p>NSAIDs (I)</p> <p>Acetaminophen (I)</p> <p>Ice (I)</p> <p>Compression (I)</p> <p>Range-of-motion exercises (I)</p> <p>Avoidance of immobilization (I)</p>		
<b>Lateral Epicondylalgia (Lateral Epicondylitis)</b>	<p>Restrict patient work to tasks that do not involve high-force, stereotypical hand gripping or pinching or use of high-amplitude vibrating hand-held tools (I)</p> <p>Education (I)</p> <p>NSAIDs for acute, subacute, or chronic lateral epicondylalgia (B)</p> <p>NSAIDs for post-operative lateral epicondylalgia (I)</p> <p>Proton pump inhibitors for patients at substantially increased risk for gastrointestinal (GI) bleeding (A)</p> <p>Misoprostol for patients at substantially increased risk for GI bleeding (A)</p> <p>Sucralfate for patients at substantially increased risk for GI bleeding (B)</p> <p>H2 blockers for patients at substantially increased risk for GI bleeding (C)</p> <p>Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed (I)</p> <p>Acetaminophen or aspirin as first-line therapy for patients with cardiovascular disease risk factors (A)</p> <p>Acetaminophen for elbow pain, particularly for patients with contraindications for NSAIDs (I)</p> <p>Topical NSAIDs for acute, subacute, or chronic lateral epicondylalgia (B)</p> <p>Topical NSAIDs for post-operative lateral epicondylalgia (I)</p> <p>Opioids for select treatment of patients with post-operative lateral epicondylalgia (I)</p> <p>Tennis elbow bands, straps, and braces for acute, subacute, or chronic lateral epicondylalgia (I)</p> <p>Cock-up wrist braces for acute, subacute, or chronic lateral epicondylalgia (I)</p>	<p>Manipulation or mobilization for acute, subacute, or chronic lateral epicondylalgia (I)</p> <p>Massage, including friction massage, for acute, subacute, or chronic lateral epicondylalgia (I)</p> <p>Magnets and pulsed electromagnetic field for acute, subacute, or chronic lateral epicondylalgia (I)</p> <p>Acupuncture for acute, subacute, or post-operative lateral epicondylalgia (I)</p> <p>Biofeedback for acute, subacute, or chronic lateral epicondylalgia (I)</p> <p>Transcutaneous electrical nerve stimulation for acute, subacute, or chronic lateral epicondylalgia (I)</p> <p>Electrical nerve stimulation for acute, subacute, or chronic lateral epicondylalgia (I)</p> <p>Diathermy for acute, subacute, or chronic lateral epicondylalgia (I)</p> <p>Glucocorticosteroid</p>	<p>Opioids for acute, subacute, or chronic lateral epicondylalgia (I)</p> <p>Soft tissue mobilization for acute, subacute, or chronic lateral epicondylalgia (C)</p> <p>Extracorporeal shockwave therapy for acute, subacute, or chronic lateral epicondylalgia (A)</p> <p>Phonophoresis for acute, subacute, or chronic lateral epicondylalgia (C)</p> <p>Low-level laser therapy for acute, subacute, or chronic lateral epicondylalgia (B)</p> <p>Botulinum injections for acute, subacute, or chronic lateral epicondylalgia (I)</p> <p>Polidocanol injections for acute, subacute, or chronic lateral epicondylalgia (C)</p>

	<p>Home exercises for acute, subacute, chronic, or post-operative lateral epicondylalgia (I)</p> <p>Physical or occupational therapy for acute, subacute, chronic, or post-operative lateral epicondylalgia (C)</p> <p>Self-application of heat or cold for acute, subacute, chronic, or post-operative lateral epicondylalgia (I)</p> <p>Iontophoresis with administration of either glucocorticosteroids or NSAIDs for acute, subacute, or chronic lateral epicondylalgia (B)</p> <p>Ultrasound for acute, subacute, or chronic lateral epicondylalgia (C)</p> <p>Acupuncture for select patients with chronic lateral epicondylalgia (I)</p> <p>Glucocorticosteroid injections for subacute or chronic lateral epicondylalgia (B)</p> <p>Glucocorticosteroid injections using bupivacaine as an adjunct for subacute or chronic lateral epicondylalgia (C)</p> <p>Platelet-rich plasma injections for chronic lateral epicondylalgia (C)</p> <p>Autologous blood injections for chronic lateral epicondylalgia (C)</p> <p>Surgical lateral epicondylar release for chronic lateral epicondylalgia (I)</p> <p>Radiofrequency microtenotomy for chronic lateral epicondylalgia (C)</p>	<p>injections for acute lateral epicondylalgia (I)</p> <p>Platelet-rich plasma injections for acute or subacute lateral epicondylalgia (I)</p> <p>Autologous blood injections for acute or subacute lateral epicondylalgia (I)</p> <p>Periarticular sodium hyaluronate and glycosaminoglycan injections for chronic lateral epicondylalgia (I)</p> <p>Prolotherapy injections for acute, subacute, or chronic lateral epicondylalgia (I)</p> <p>Sonographically guided percutaneous tenotomy for acute, subacute, or chronic lateral epicondylalgia (I)</p>	
<b>Medial Epicondylalgia (Medial Epicondylitis)</b>	As there is almost no quality literature on medial epicondylalgia, treatment of this condition is by analogy to lateral epicondylalgia (see above) and should be considered "Insufficient Evidence" recommendations.		
<b>Olecranon Bursitis</b>	<p>Education (I)</p> <p>Soft padding of the elbow, soft elbow supports, and ace wraps (I)</p> <p>Modifying activities to avoid direct pressure over the olecranon and allowing time to reabsorb the fluid (I)</p> <p>Aspiration of a clinically infected or questionably infected bursa (I)</p> <p>Surgical drainage (I)</p> <p>Surgical resection of the bursa for chronic bursitis with recurrent drainage (I)</p>	<p>NSAIDs (I)</p> <p>Glucocorticosteroid injections (I)</p>	
<b>Elbow Fractures, Including Non-displaced Radial Head Fractures</b>	<p>NSAIDs and acetaminophen to control pain (I)</p> <p>Elbow slings for non-displaced and occult radial head fractures (I)</p> <p>Casts for non-displaced and occult radial head fractures (I)</p> <p>Opioids for select patients with pain (I)</p> <p>Surgical fixation for displaced elbow fractures (I)</p> <p>Education, usually by physical or occupational therapists, for select patients needing education after cast removal (I)</p> <p>Physical or occupational therapy for select patients with functional debilities, or those unable to return to work after cast removal (I)</p>		<p>Routine referral for physical or occupational therapy after cast removal for otherwise healthy patients who are able to return to work (I)</p>

<b>Elbow Dislocations</b>	<p>Education (I)</p> <p>NSAIDs and acetaminophen (I)</p> <p>Opioids for select patients with pain (I)</p> <p>Posterior elbow splint and slings (I)</p> <p>Anesthetic, with or without opioid, intraarticular injection(s) either pre-reduction or post-reduction for pain management (I)</p> <p>General anesthesia to facilitate reduction in select patients (I)</p> <p>Surgery to repair elbow joints that either recurrently dislocate or are otherwise unstable after dislocation(s) (I)</p>		
<b>Elbow Sprains</b>	<p>Education (I)</p> <p>NSAIDs and acetaminophen (I)</p> <p>Opioids for select patients with pain from severe elbow sprains (I)</p> <p>Slings (I)</p>		
<b>Biceps Tendinosis (or Tendinitis) and Tears/Ruptures</b>	<p>Education (I)</p> <p>NSAIDs and acetaminophen (I)</p> <p>Opioids for select patients with pain from moderately severe to severe biceps tendinosis, particularly with nocturnal sleep disruption. Post-operative patients are also candidates. (I)</p> <p>Slings and splints for biceps tendinosis, ruptures, and post-operative patients (I)</p> <p>Range-of-motion transitioning to strengthening exercises for biceps tendinosis, ruptures, and post-operative patients (I)</p> <p>Surgical repair of distal biceps rupture (I)</p>		
<b>Triceps Tendinosis (or Tendinitis) and Tears/Ruptures</b>	<p>There are no quality studies for this disorder, thus treatment by analogy to biceps tendinosis and tears/ruptures is recommended (see above).</p>		
<b>Ulnar Neuropathies at the Elbow (including Condylar Groove-Associated Ulnar Neuropathy and Cubital Tunnel Syndrome)</b>	<p>Removal from job tasks with repeated or sustained elbow hyperflexion (I)</p> <p>Education (I)</p> <p>Patients should be taught to sleep with elbows extended rather than flexed (I)</p> <p>Patients should avoid hyperflexed (&gt; 90°) elbow postures at work or during avocational activities (I)</p> <p>Exercise for rehabilitation of patients with post-operative ulnar neuropathy at the elbow with significant deficits (I)</p> <p>NSAIDs and acetaminophen for postoperative pain management of ulnar neuropathy-related pain (I)</p> <p>Limited use of opioids for a few days to a couple weeks for select patients who have undergone recent ulnar neuropathy surgery, particularly if complications have occurred (I)</p> <p>Nocturnal elbow splinting or bracing for acute, subacute, or chronic ulnar neuropathies at the elbow (I)</p> <p>Ultrasound for acute, subacute, or chronic ulnar neuropathies (I)</p>	<p>Exercises for acute, subacute, or chronic ulnar neuropathy at the elbow (I)</p> <p>Oral or injections (condylar groove or cubital tunnel) of glucocorticosteroids for acute, subacute, or chronic ulnar neuropathies at the elbow (I)</p> <p>Other vitamins for acute, subacute, or chronic ulnar neuropathies (I)</p> <p>Lidocaine patches for acute, subacute, or chronic ulnar neuropathies with pain (I)</p> <p>Topically administered ketamine for acute,</p>	<p>NSAIDs and acetaminophen as a primary treatment for acute, subacute, or chronic ulnar neuropathies at the elbow (I)</p> <p>Routine use of opioids for acute, subacute, or chronic ulnar neuropathies at the elbow (I)</p> <p>Pyridoxine for routine treatment of acute, subacute, or chronic ulnar neuropathies in patients without vitamin deficiencies (I)</p> <p>Magnets for management of pain for acute, subacute, or chronic ulnar neuropathies (I)</p> <p>Low-level laser therapy</p>

	<p>Simple decompression for patients who fail non-operative treatment for subacute or chronic ulnar neuropathies or patients who have emergent or urgent indications (e.g., acute compression due to fracture, arthritides or compartment syndrome with unrelenting symptoms of nerve impairment). (C)</p> <p>Anterior subcutaneous transposition for patients who fail non-operative treatment for subacute or chronic ulnar neuropathies or patients who have emergent or urgent indications (e.g., acute compression due to fracture, arthritides or compartment syndrome with unrelenting symptoms of nerve impairment). (I)</p> <p>Medial epicondylectomy for patients who fail non-operative treatment for subacute or chronic ulnar neuropathies or patients who have emergent or urgent indications (e.g., acute compression due to fracture, arthritides or compartment syndrome with unrelenting symptoms of nerve impairment). (I)</p>	<p>subacute, or chronic ulnar neuropathies with pain (I)</p> <p>Acupuncture for acute, subacute, or chronic ulnar neuropathies at the elbow (I)</p> <p>Biofeedback for acute, subacute, or chronic ulnar neuropathies at the elbow (I)</p> <p>Manipulation and mobilization for acute, subacute, or chronic ulnar neuropathies at the elbow (I)</p> <p>Massage for acute, subacute, or chronic ulnar neuropathies at the elbow (I)</p> <p>Soft tissue massage for acute, subacute, or chronic ulnar neuropathies at the elbow (I)</p> <p>Iontophoresis for acute, subacute, or chronic ulnar neuropathies at the elbow (I)</p> <p>Phonophoresis for acute, subacute, or chronic ulnar neuropathies at the elbow (I)</p>	<p>for acute, subacute, or chronic ulnar neuropathies (I)</p> <p>Anterior submuscular transposition for subacute or chronic ulnar neuropathies (I)</p>
<p><b>Radial Nerve Entrapment (including Radial Tunnel Syndrome)</b></p>	<p>In the absence of quality evidence for treatment of these radiculopathies, it is recommended that the treatments for ulnar neuropathy at the elbow (see above) be used to infer treatment for radial neuropathies.</p>		
<p><b>Pronator Syndrome (Median Neuropathies in the Forearm)</b></p>	<p>In the absence of quality evidence for treatment of these radiculopathies, it is recommended that the treatments for ulnar neuropathy at the elbow (see above) be used to infer treatment for median neuropathies.</p>		

## Forearm, Wrist & Hand Complaints - ACOEM Chapter 11 (2004)

*Table 11-4. Methods of Symptom Control for Forearm, Wrist, and Hand Complaints*

<b>RECOMMENDED</b>		
<b>Nonprescription Medications</b>		
Acetaminophen (safest)		
NSAIDs (aspirin, ibuprofen) (secondary choice)		
<b>Physical Modalities</b>		
Adjust or modify workstation, job tasks, or work hours and methods		
Stretching		
Specific hand and wrist exercises for range of motion and strengthening		
At-home local applications of cold packs first few days of acute complaints; thereafter, applications of heat packs		
Aerobic exercise to maintain general conditioning		
Initial and follow-up visits for education, counseling, and evaluating home exercise		
<b>Prescribed Pharmaceutical Methods</b>		
Other NSAIDs		
<b>OPTIONS</b>		
<b>Ligament/Tendon Strain</b>	<b>Tendinitis/Tenosynovitis</b>	<b>DeQuervain's Syndrome</b>
Limit motion that causes pain	Limit motion of inflamed structures Injections of lidocaine and corticosteroids	Limit motion of inflamed structures with wrist and thumb splint
<b>Trigger Finger</b>	<b>Carpal Tunnel Syndrome</b>	<b>Ganglion</b>
Injection of lidocaine and corticosteroids	Splinting of wrist in neutral position at night & day Injections of lidocaine and corticosteroids	Corticosteroid injection Aspiration
<b>Nonspecific Hand or Wrist Pain</b>		
None		

## Summary of Recommendations and Evidence

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See Table 11-7.

Table 11-7. Summary of Recommendations for Evaluating and Managing Forearm, Wrist, and Hand Complaints

Clinical Measure	Recommended	Optional	Not Recommended
History and physical exam	Basic history, focused exam, and search for red flags (C)		
Patient education	Patient education regarding prevention, diagnosis, prognosis, and expectations of medical treatment (D)		
Medication (See Chapter 3)	Acetaminophen (C) NSAIDs (B)	Opioids, short course (C) Rarely, corticosteroids (C)	Use of opioids for more than 2 weeks (C)
Physical treatment methods	Instructions for home exercises	At-home applications of heat or cold packs (D)	Passive modalities TENS units (C) Biofeedback (D)

Table 11-7. (continued)

Clinical Measure	Recommended	Optional	Not Recommended
Injections	Injection of corticosteroids into carpal tunnel in mild or moderate cases of CTS after trial of splinting and medication (C) Initial injection into tendon sheath for clearly diagnosed cases of DeQuervain's syndrome, tenosynovitis, or trigger finger (D)	Initial injection of corticosteroids in moderate cases of tendinitis (D)	Repeated or frequent injection of corticosteroids into carpal tunnel, tendon sheaths, ganglia, etc. (D)
Rest and immobilization	Splinting as first-line conservative treatment for CTS, DeQuervain's, strains, etc. (C)	Prolonged splinting (leads to weakness and stiffness) (D) Prolonged post-operative splinting (C)	
Activity and exercise	Stretching Aerobic exercise Maintaining strength and mobility of all remaining body parts while recovering from wrist problems (C)		Reduced general activities while recovering (D)
Detection of neurologic abnormalities	NCV for median (B) or ulnar (C) impingement at the wrist after failure of conservative treatment		Routine use of NCV or EMG in diagnostic evaluation of nerve entrapment or screening in patients w/o symptoms (D) Use of vibrometry for screening (C)
Radiography	Plain films for suspected scaphoid fractures, repeat films in 7-10 days (D)	Limited bone scan to detect fractures if clinical suspicion exists (C)	Routine use for evaluation of forearm, wrist, and hand (D)
Other imaging procedures		Use of arthrography, MRI, or CT scans prior to history and physical examination by a qualified specialist (D)	

Table 11-7. (continued)

Clinical Measure	Recommended	Optional	Not Recommended
Surgical considerations	<p>Early surgical intervention for severe CTS confirmed by NCV may be indicated (B)</p> <p>Tendinitis (DeQuervain's), ganglion, or trigger finger: referral to surgeon only after patient education and conservative treatment, including splinting and injection, have failed (C, D)</p>		
Psychosocial factors	<p>Consider counseling for severe hand injuries (D)</p> <p>Awareness by treating practitioner of interplay between physical, economic, and psychological factors in patients with MSDs (C, D)</p>		

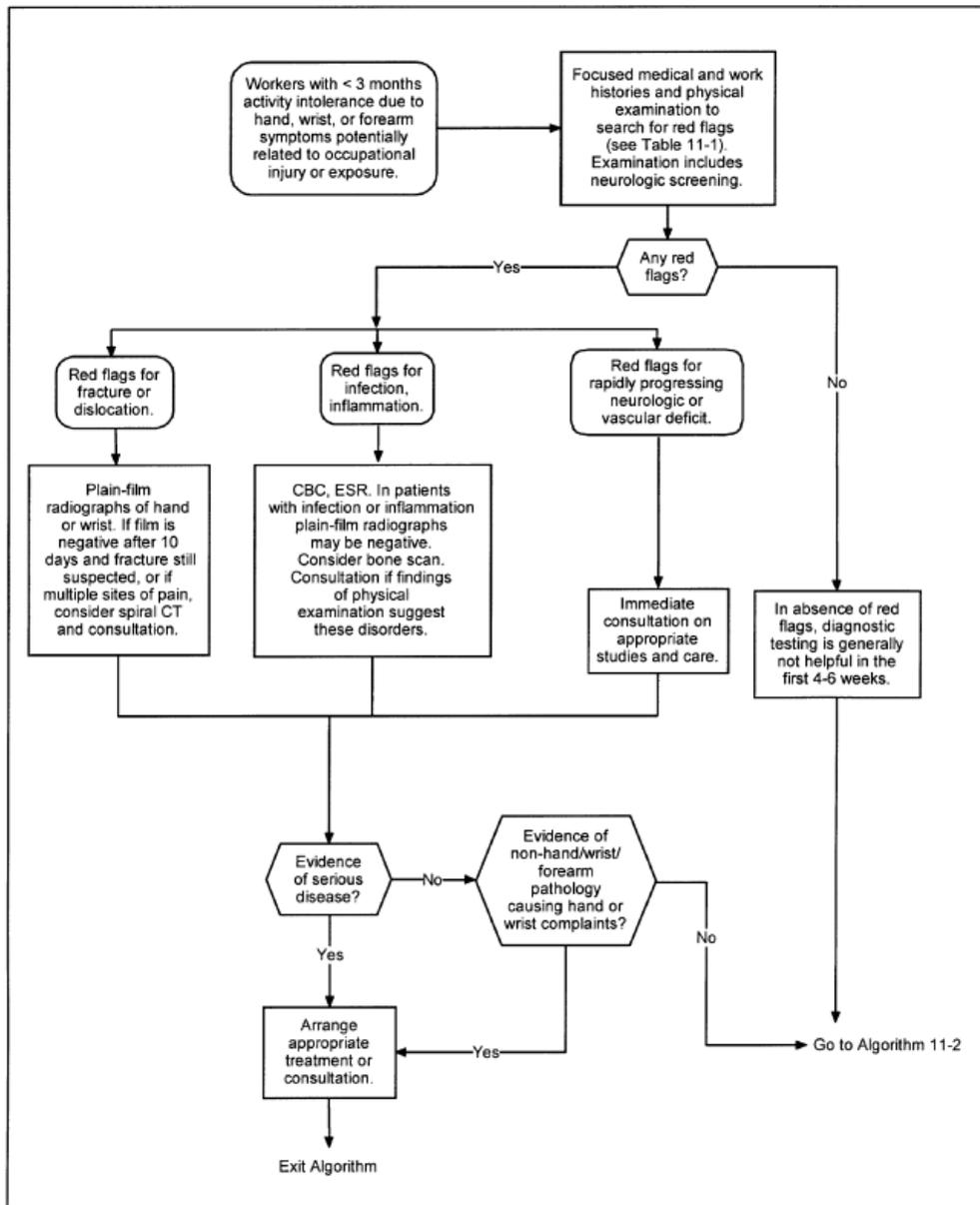
A= Strong research-based evidence (multiple relevant, high-quality scientific studies).

B= Moderate research-based evidence (one relevant, high-quality scientific study or multiple adequate scientific studies).

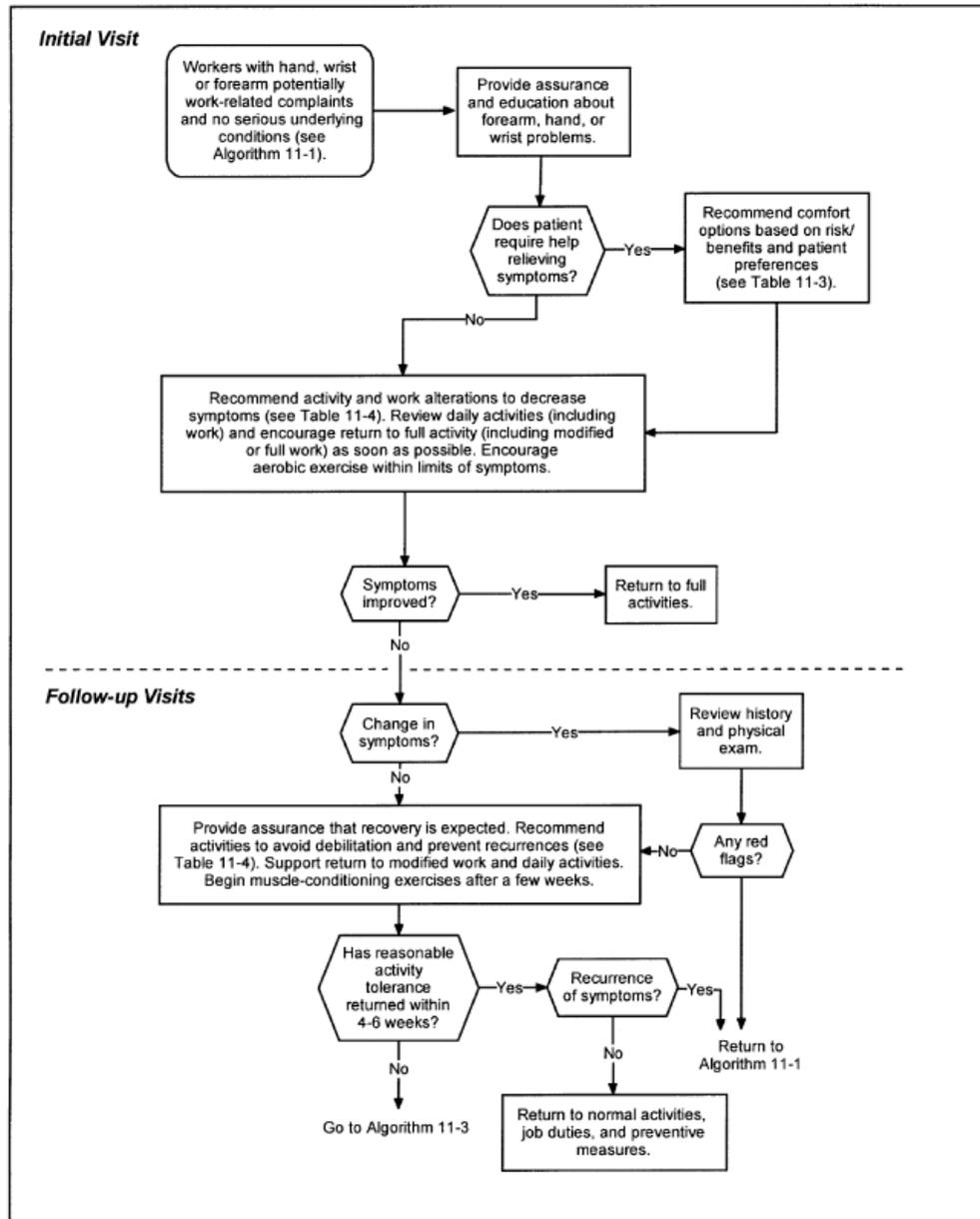
C= Limited research-based evidence (at least one adequate scientific study of patients with forearm, wrist, or hand disorders).

D= Reviewer or consensus interpretation of evidence not meeting inclusion criteria for research-based evidence.

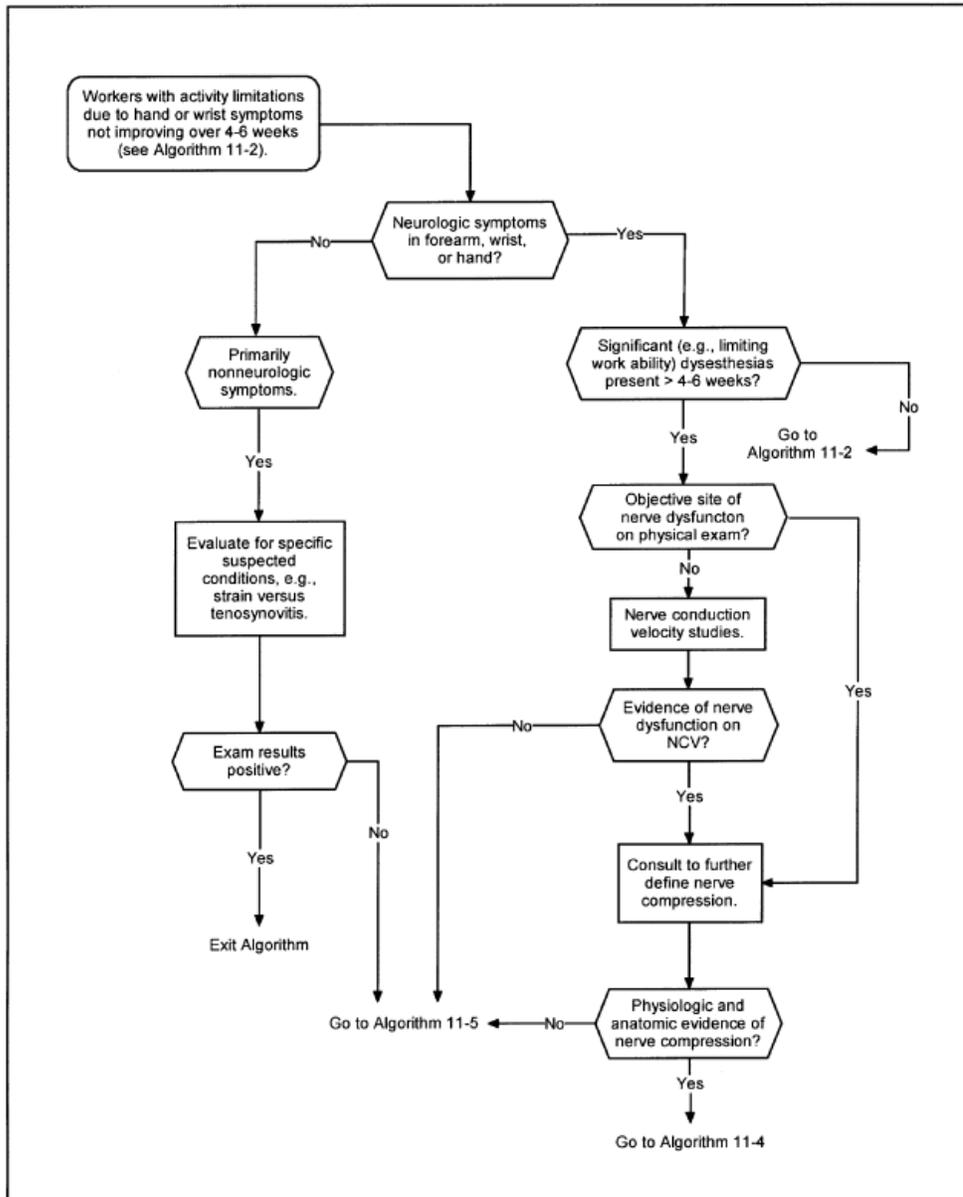
**Algorithm 11-1.** Initial Evaluation of Occupational Forearm, Wrist, and Hand Complaints



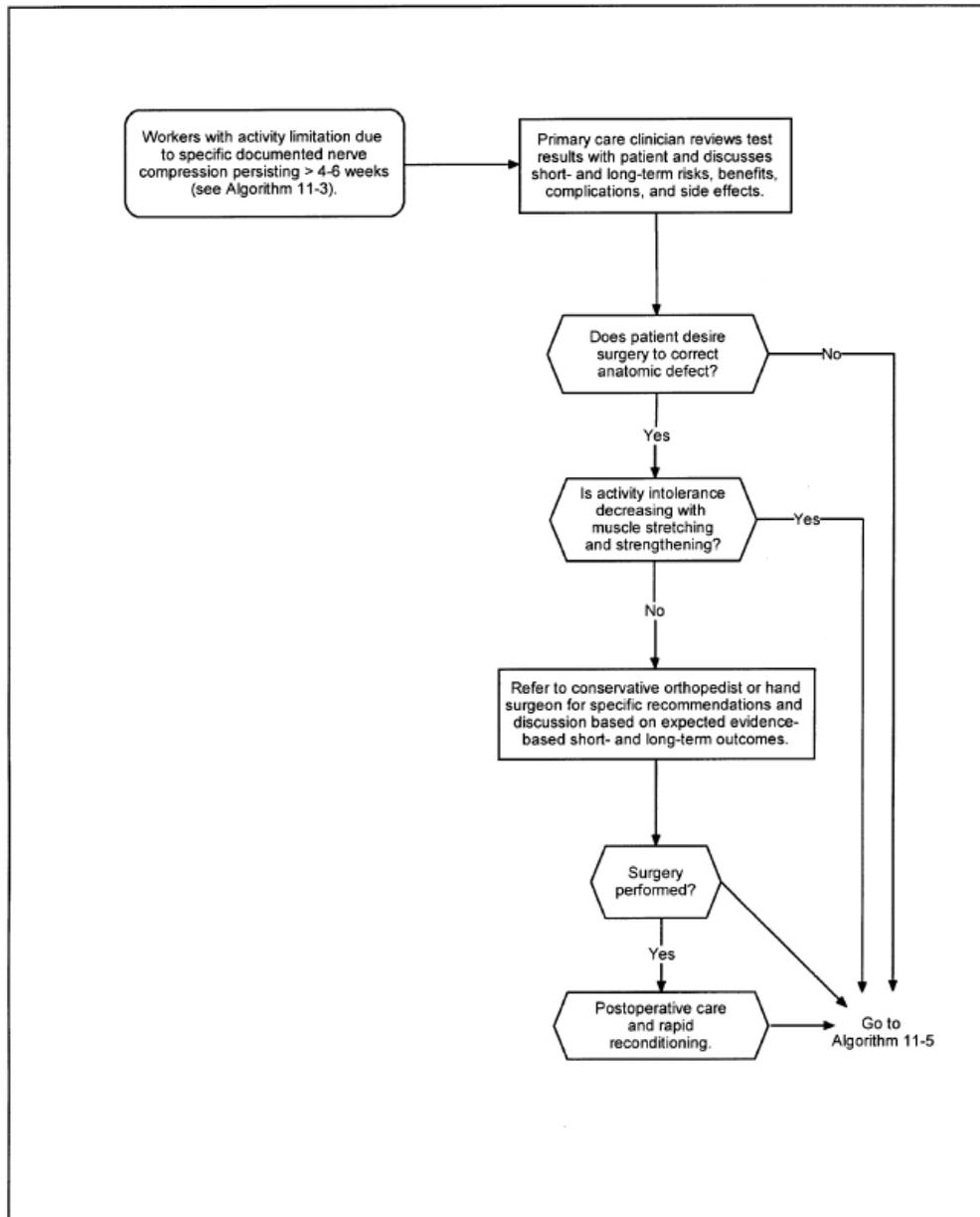
**Algorithm 11-2. Initial and Follow-up Management of Occupational Forearm, Wrist, and Hand Complaints**



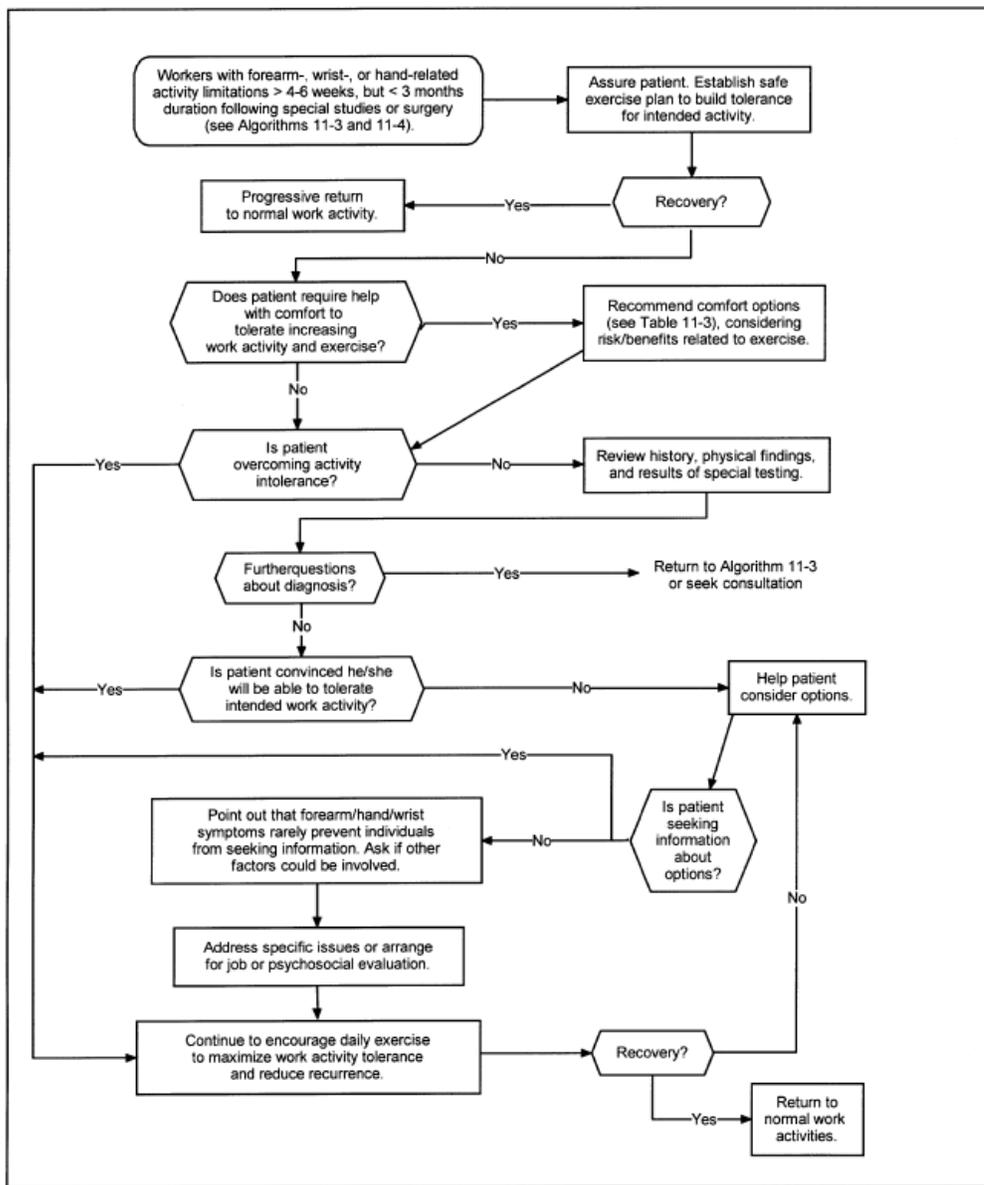
**Algorithm 11-3.** Evaluation of Slow-to-recover Patients with Occupational Forearm, Wrist, and Hand Complaints (Symptoms > 4 Weeks)



**Algorithm 11-4.** Surgical Considerations for Patients with Anatomic and Physiologic Evidence of Nerve Root Compression and Persistent Forearm, Wrist, and Hand Symptoms

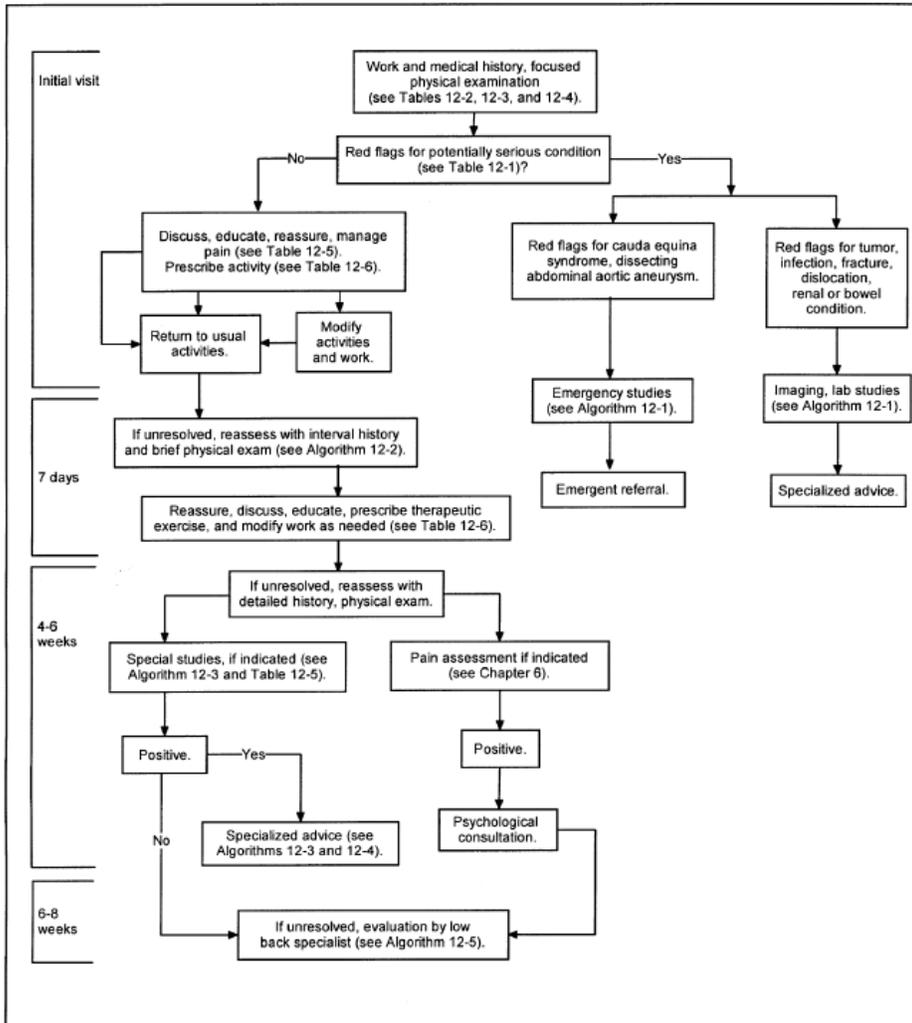


**Algorithm 11-5. Further Management of Occupational Forearm, Wrist, and Hand Complaints**



# Low Back Complaints - ACOEM Chapter 12 (2004)

**Master Algorithm.** ACOEM Guidelines for Care of Acute and Subacute Occupational Low Back Complaints



## Summary of Evidence and Recommendations

See Table 12-8.

Table 12-8. Summary of Recommendations for Evaluating and Managing Low Back Complaints

Clinical Measure	Recommended	Optional	Not Recommended
History and physical exam	Basic history (B) History of cancer or infection (B) Signs or symptoms of cauda equina syndrome (C) History of significant trauma (C) Psychosocial history (C) Straight- and crossed-leg raising tests (B) Focused neurologic exam (B)	Pain drawing and visual analog scale (D)	
Patient education	Patient education about low back symptoms (B) Back school in occupational settings (C)	Back school in nonoccupational settings (C)	
Medication (See Chapter 3)	Acetaminophen (C) NSAIDs (B)	Opioids, short course (C) Muscle relaxants (C) Phenylbutazone (C)	Using opioids for more than 2 weeks (C) Oral corticosteroids (C) Colchicine (B) Antidepressants (C)
Physical treatment methods	Manipulation of low back during first month of symptoms without radiculopathy (C)	Manipulation for patients with radiculopathy (C) Relaxation techniques (D) At-home applications of local heat or cold to low back (D) Shoe insoles (C) In occupational setting, corset for prevention (C)	Manipulation for patients with undiagnosed neurologic deficits (D) Prolonged course of manipulation (longer than 4 weeks) (D) Traction (B) TENS (C) Biofeedback (C) Shoe lifts (D) Corset for treatment (D)

Table 12-8. (continued)

<i>Clinical Measure</i>	<i>Recommended</i>	<i>Optional</i>	<i>Not Recommended</i>
Injections		Epidural corticosteroid injections for radicular pain, to avoid surgery (C) Needle acupuncture (D)	Epidural injections for back pain without radiculopathy (D) Trigger-point injections (C) Ligamentous injections (C) Facet-joint injections (C)
Bed rest		Bed rest for 2 days for severe radiculopathy (D)	Bed rest for more than 2 days (B)
Activities and exercise	Temporary avoidance of activities that increase mechanical stress on spine (D) Gradual return to normal activities (B) Low-stress aerobic exercise (C) Conditioning exercises for trunk muscles after 2 weeks (C)		Back-specific exercise machines (D) Therapeutic stretching of back muscles (D)
Detection of physiologic abnormalities	If no improvement after 1 month, consider: Bone scan (C) Needle EMG and H-reflex tests to clarify nerve root dysfunction (C) SEPs to assess spinal stenosis (C)		EMG for clinically obvious radiculopathy (D) Surface EMG and F-wave tests (C) Thermography (C)
Radiographs of lumbosacral spine	When red flags for fracture are present (C) When red flags for cancer or infection are present (C)		Routine use during first month of symptoms in absence of red flags (B) Routine oblique views (B)
Imaging	CT or MRI when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative (C) MRI test of choice for patients with prior back surgery (D) Assure quality criteria for imaging tests (B)	Myelography or CT myelography for preoperative planning if MRI is unavailable (D) MR neurography (D)	Using imaging test before 1 month in absence of red flags (B) Diskography or CT diskography (C)

Table 12-8. (continued)

Clinical Measure	Recommended	Optional	Not Recommended
Surgical considerations	Discuss surgical options with patients with persistent and severe sciatica and clinical evidence of nerve root compromise if symptoms persist after 4-6 weeks of conservative therapy (B) Standard diskectomy or microdiskectomy for herniated disk (procedures have similar efficacy) (B)	Chymopapain, used after ruling out allergic sensitivity, acceptable but less efficacious than diskectomy to treat herniated disk (C)	Disk surgery in patients with back pain alone, no red flags, and no nerve root compression (D) Surgery for spinal stenosis within the first 3 months of symptoms (D) Surgery for spinal stenosis when justified by imaging test rather than patient's functional status (D) Spinal fusion in the absence of fracture, dislocation, complications of tumor, or infection (C)
Psychosocial factors	Social, economic, and psychological factors can alter patient's response to symptoms and treatment (B)	Referral for evaluation prior to surgical intervention (C)	Referral for extensive evaluation and treatment prior to exploring patient expectations or psychosocial factors (D)

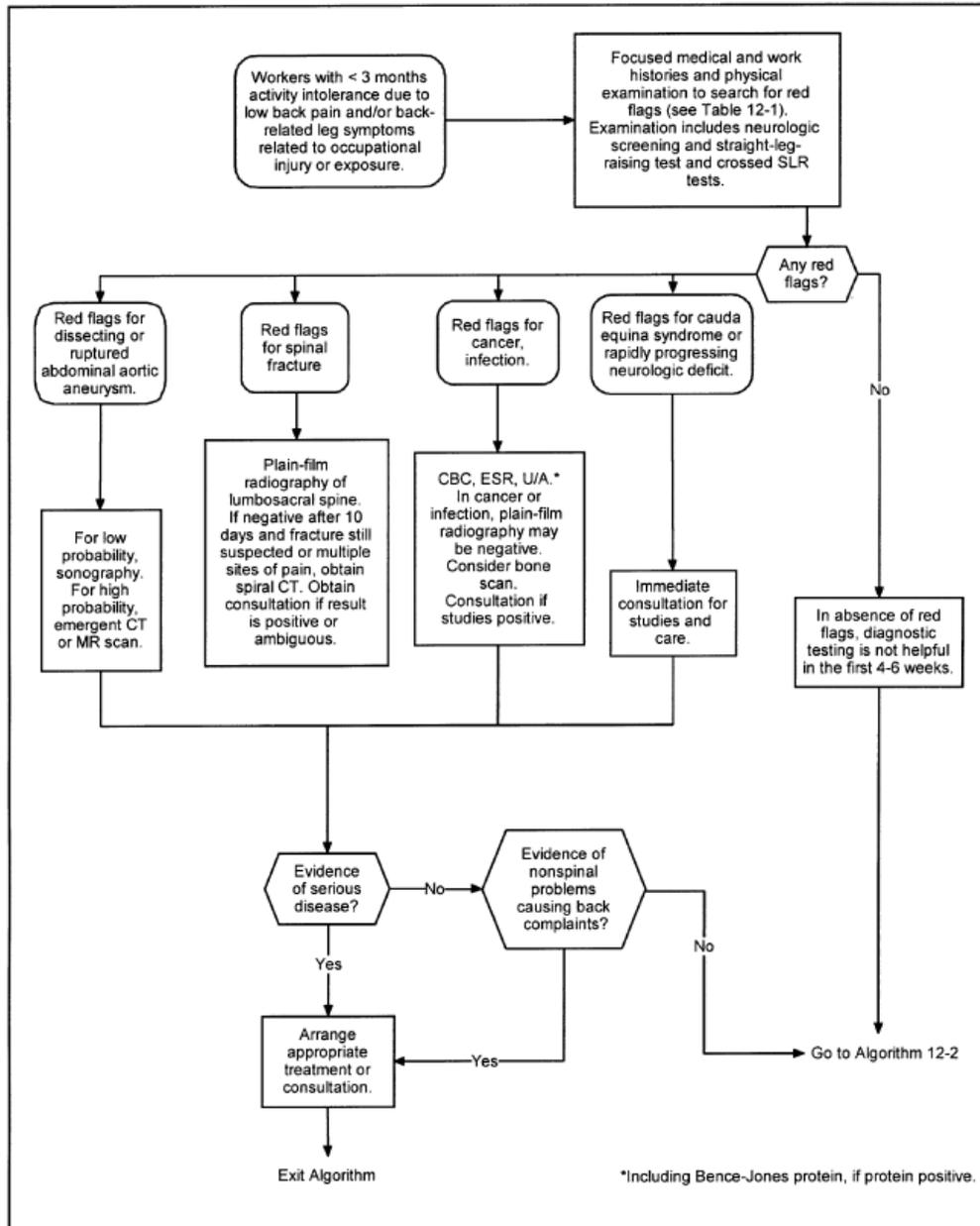
A = Strong research-based evidence (multiple relevant, high-quality scientific studies).

B = Moderate research-based evidence (one relevant, high-quality scientific study or multiple adequate scientific studies).

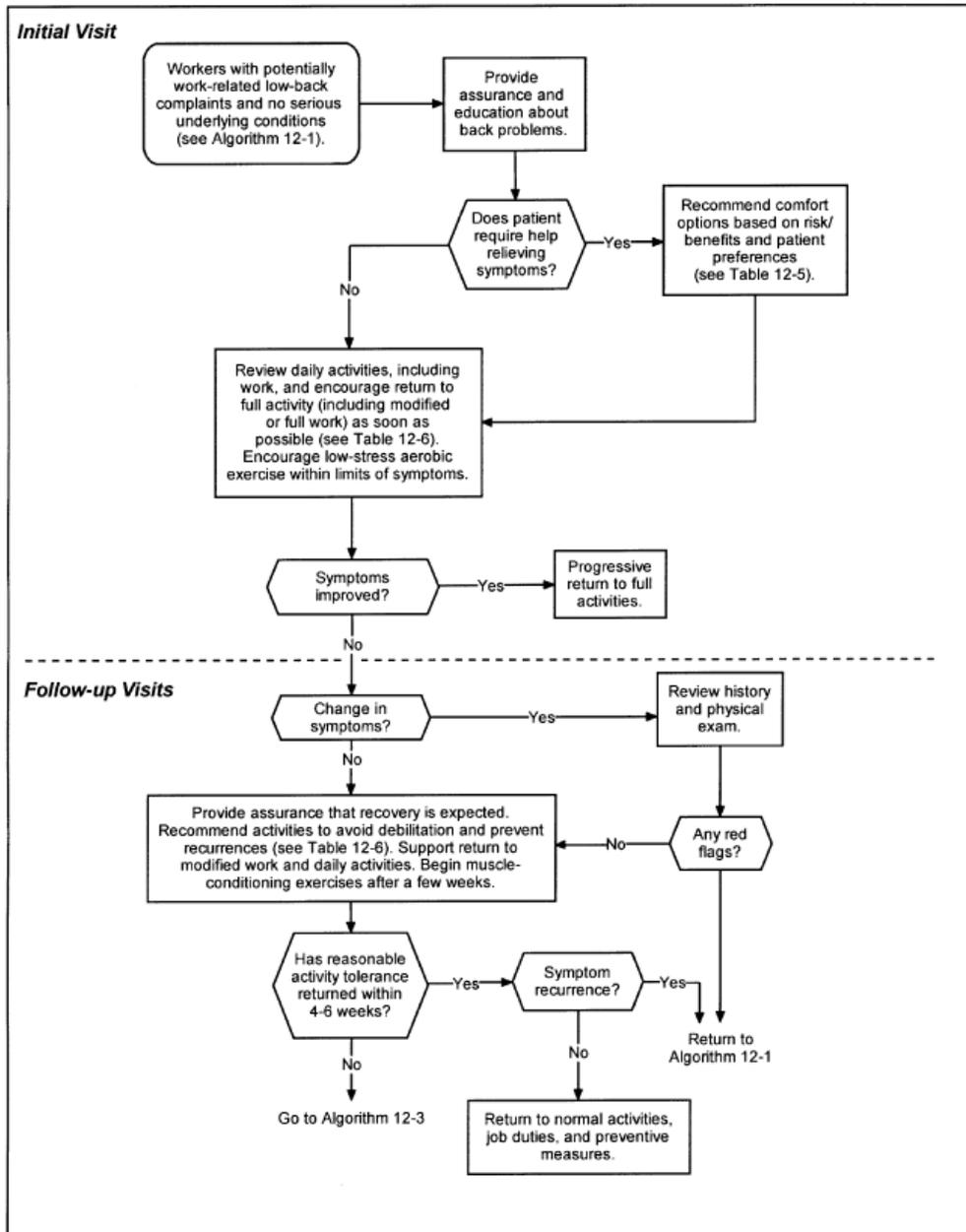
C = Limited research-based evidence (at least one adequate scientific study of patients with low back complaints).

D = Panel interpretation of information not meeting inclusion criteria for research-based evidence.

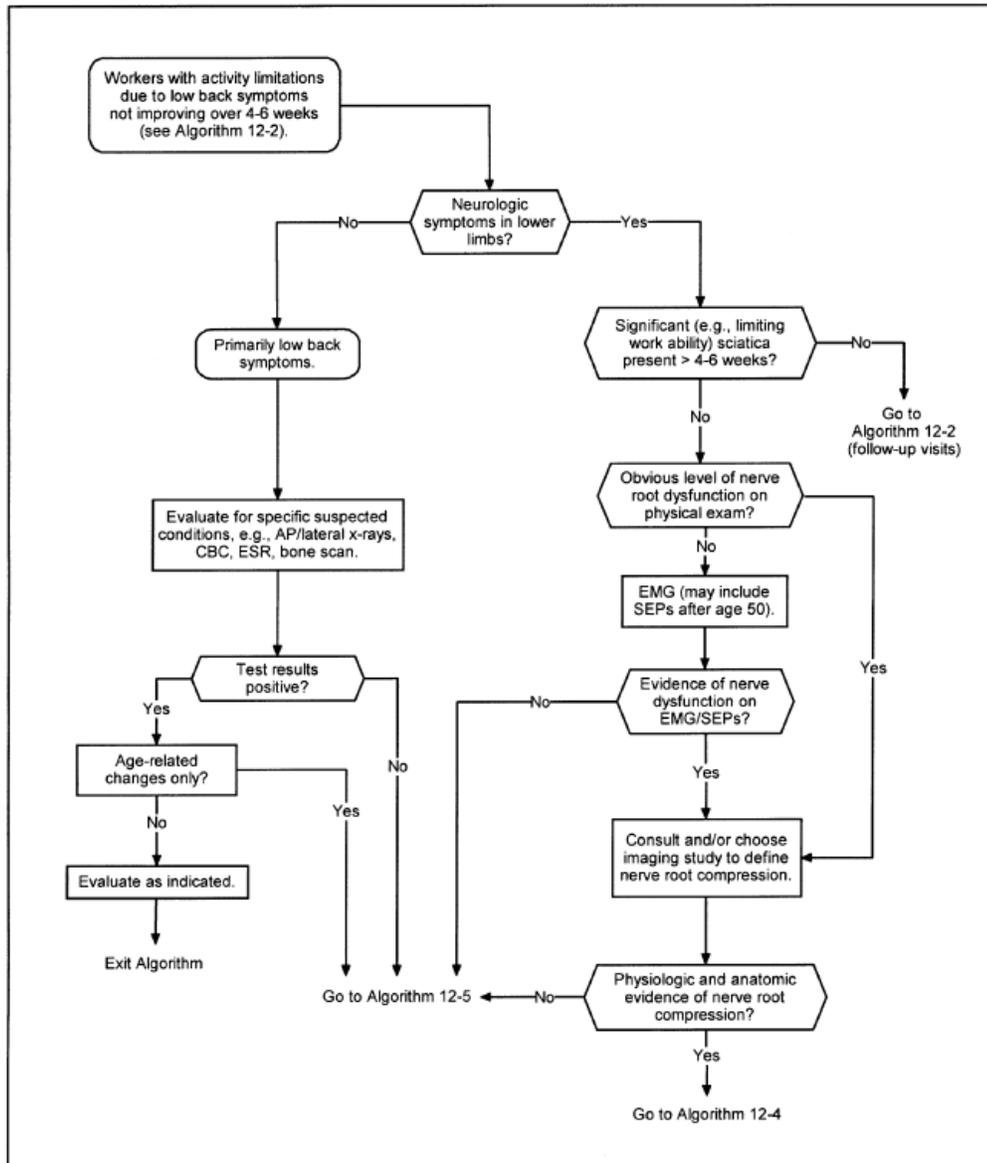
**Algorithm 12-1. Initial Evaluation of Occupational Low Back Complaints**



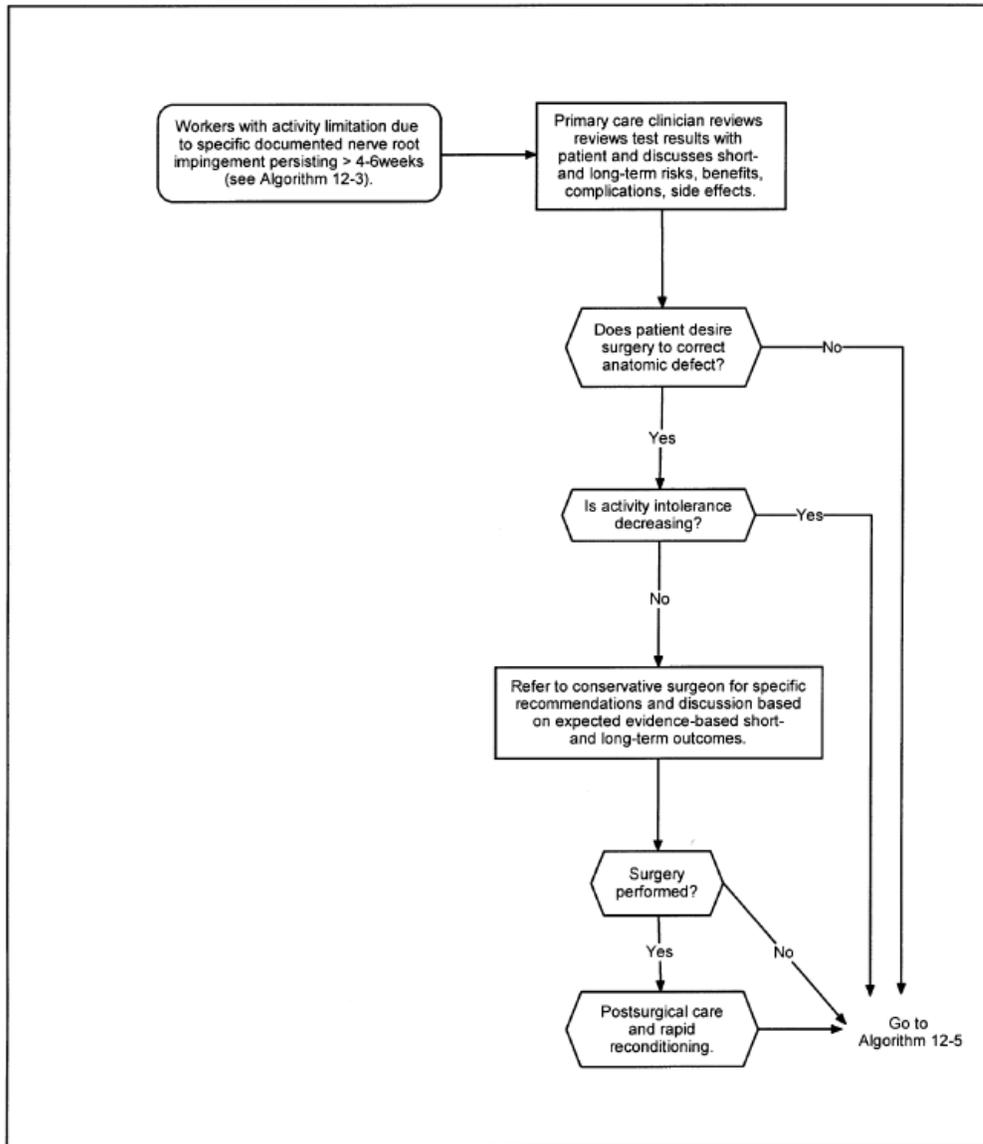
**Algorithm 12-2. Initial and Follow-up Management of Occupational Low Back Complaints**



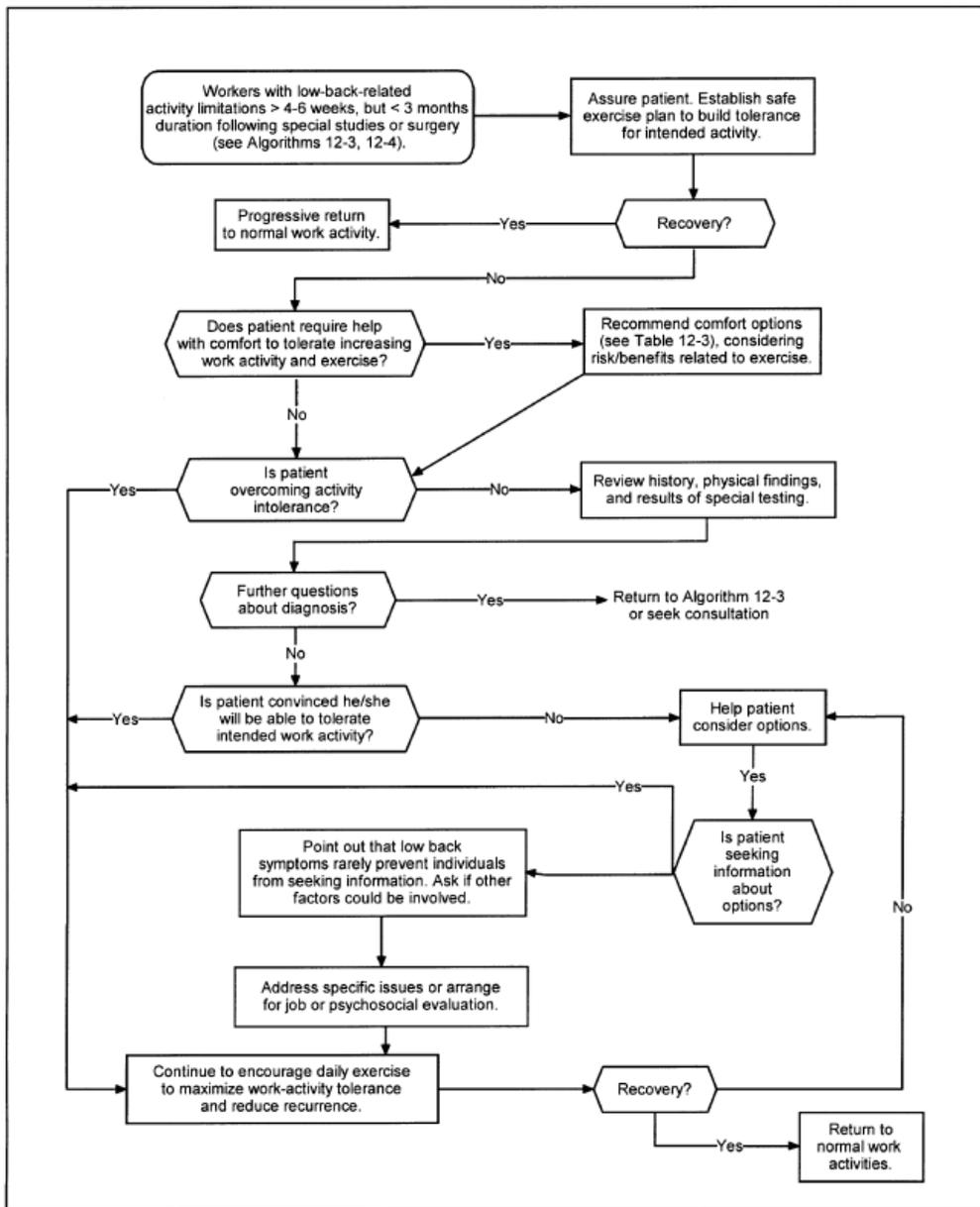
**Algorithm 12-3. Evaluation of Slow-to-recover Patients with Occupational Low Back Complaints (Symptoms > 4 Weeks)**



**Algorithm 12-4. Surgical Considerations for Patients with Anatomic and Physiologic Evidence of Nerve Root Compression and Persistent Low Back Symptoms**

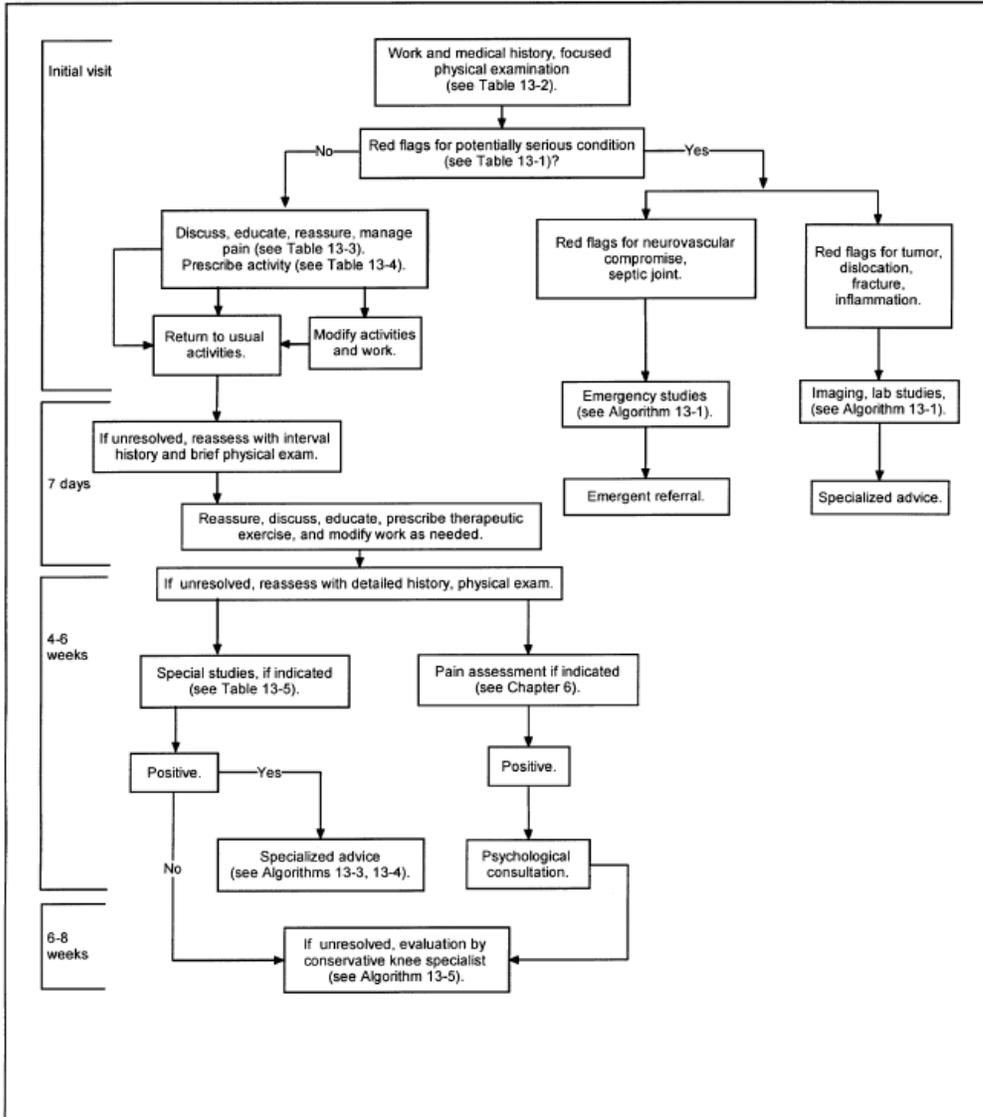


**Algorithm 12-5. Further Management of Occupational Low Back Complaints**



# Knee Complaints - ACOEM Chapter 13 (2004)

**Master Algorithm.** ACOEM Guidelines for Care of Acute and Subacute Occupational Knee Complaints



## Summary of Recommendations and Evidence

See Table 13-6.

Table 13-6. Summary of Recommendations for Evaluating and Managing Knee Complaints

Clinical Measure	Recommended	Optional	Not Recommended
History	Basic history, with careful search for mechanism of injury (C, D)		
Physical exam	Focused physical exam, including ligament testing and careful search for any swelling (C, D)		
Patient education	Patient education Full disclosure of diagnostic accuracy, prognosis, and expectations of treatment (D)		
Medication (See Chapter 3)	Acetaminophen Aspirin (C, D)	Opioids for severe pain NSAIDs (C, D)	Use of opioids for more than 2 weeks (C, D)
Physical treatment methods	Nonoperative rehabilitation for medial collateral ligament injuries (C, D) Short postoperative rehabilitation for ACL repair prior to home exercise program (D) Conservative treatment for selected ruptures of the ACL (D) Exercises for cases of anterior knee pain or ligament strain (D)		Passive modalities without exercise program (D) Manipulation (D)
Aspirations and injections	Aspiration of tense acute effusions (D) Aspiration of tense prepatellar bursa (D)	Repeated aspirations or corticosteroid injections (D)	Aspiration through infected area (D)
Rest and immobilization	Short period of immobilization after an acute injury to relieve symptoms (C)	Functional bracing as part of a rehabilitation program (D)	Prophylactic braces (D) Prolonged bracing for ACL deficient knee (D)

Table 13-6. (continued)

Clinical Measure	Recommended	Optional	Not Recommended
Activity and exercise	Stretching Aerobic exercise Maximal activity of other body parts while recovering from knee injury (D)		Excessive rest (may lead to generalized debilitation) (D)
Detection of neurologic abnormalities			Electrical studies (contraindicated for nearly all knee injury diagnoses) (D)
Radiography	Plain-film radiographs for suspected red flags (C)	Plain-film radiographs for tense hemarthroses (C)	Routine radiographic film for most knee complaints or injuries (C)
Imaging	MRI study to determine extent of ACL tear preoperatively (C)		MRI for ligament collateral tears (C)
Surgical considerations	Arthroscopic meniscectomy or repair for severe mechanical symptoms and signs or serious activity limitations if MRI findings are consistent for meniscal tear (C, D) ACL repair for symptomatic instability (i.e., serious activity limitation) if results of Lachman and pivot-shift tests and MRI are positive (C, D)	ACL reconstruction before rehabilitation has been attempted (C, D)	Surgical repair of isolated MCL ruptures (D) Immediate surgical reconstruction of all ACL tears on basis of MRI findings without physical findings confirming diagnosis or worker life demands requiring high knee performance (D)

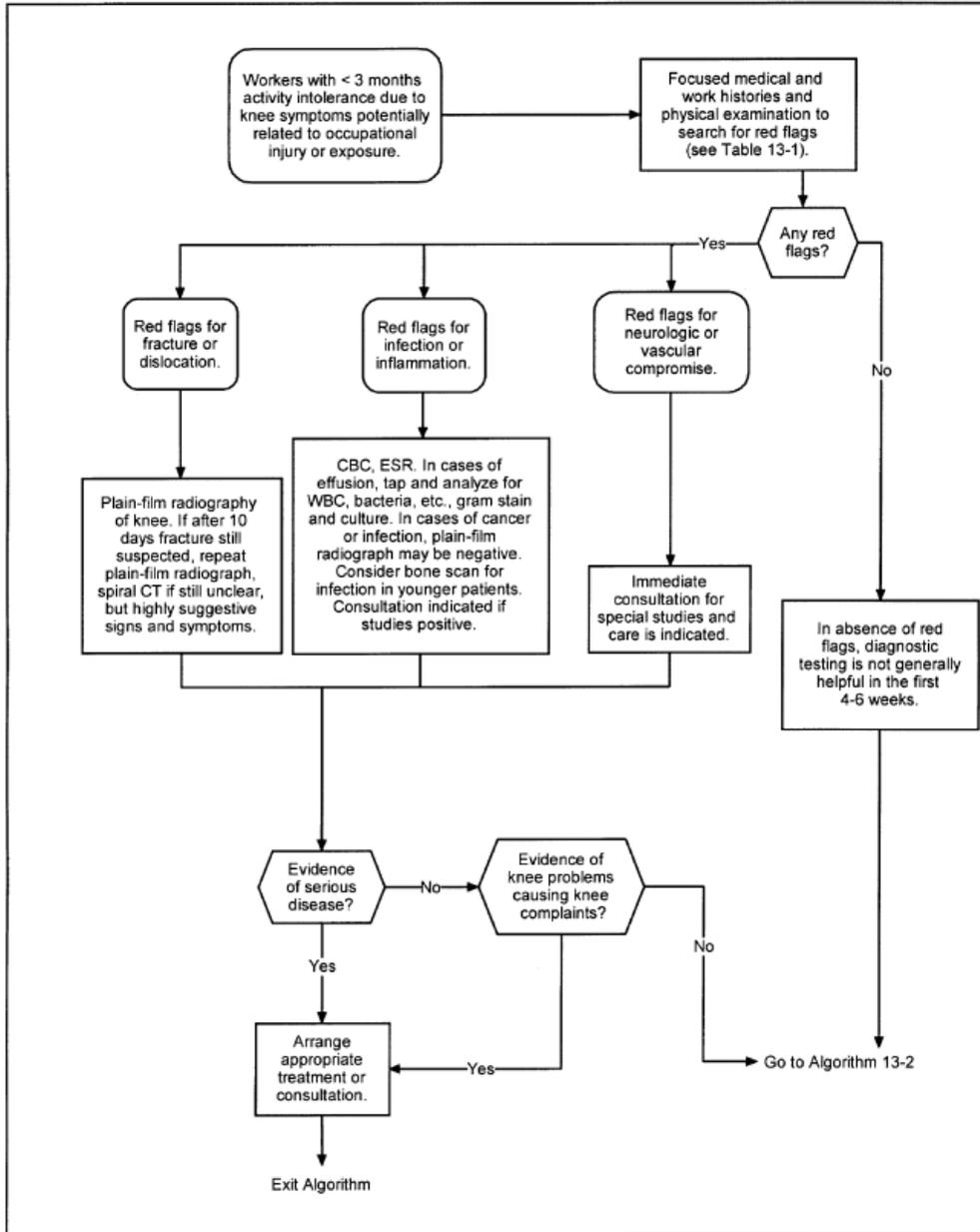
A=Strong research-based evidence (multiple relevant, high-quality scientific studies).

B=Moderate research-based evidence (one relevant, high-quality scientific study or multiple adequate scientific studies).

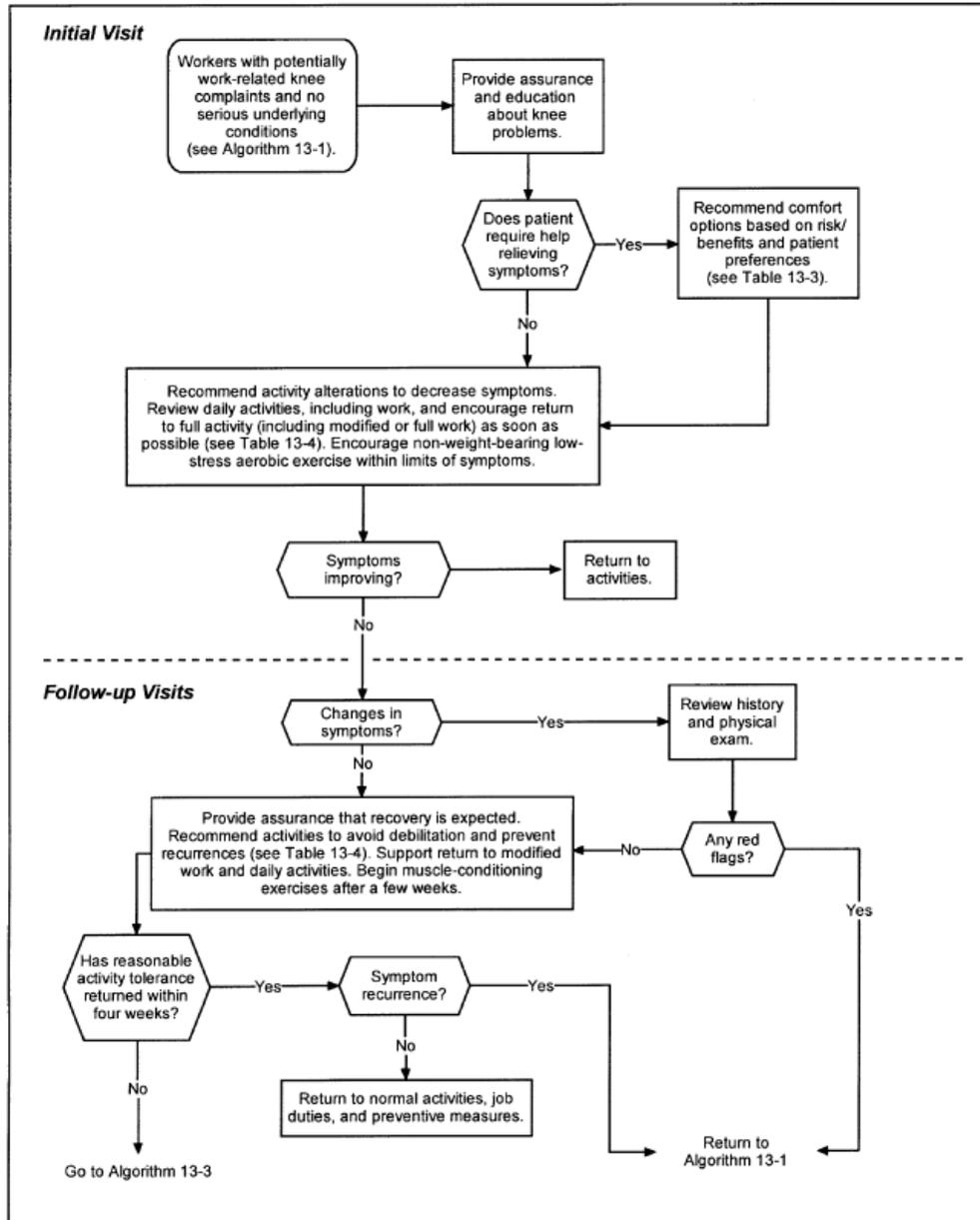
C=Limited research-based evidence (at least one adequate scientific study of patients with knee complaints).

D=Panel interpretation of information not meeting inclusion criteria for research-based evidence.

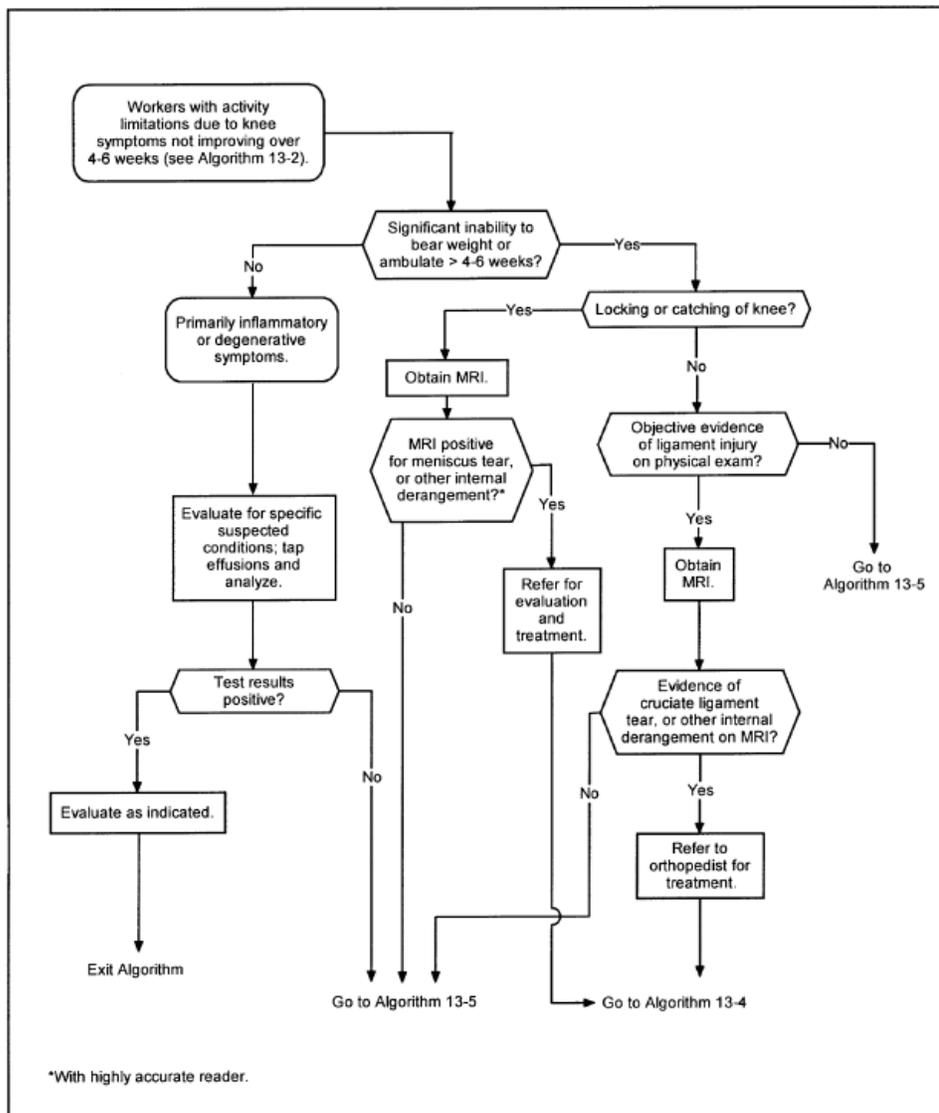
**Algorithm 13-1. Initial Evaluation of Occupational Knee Complaints**



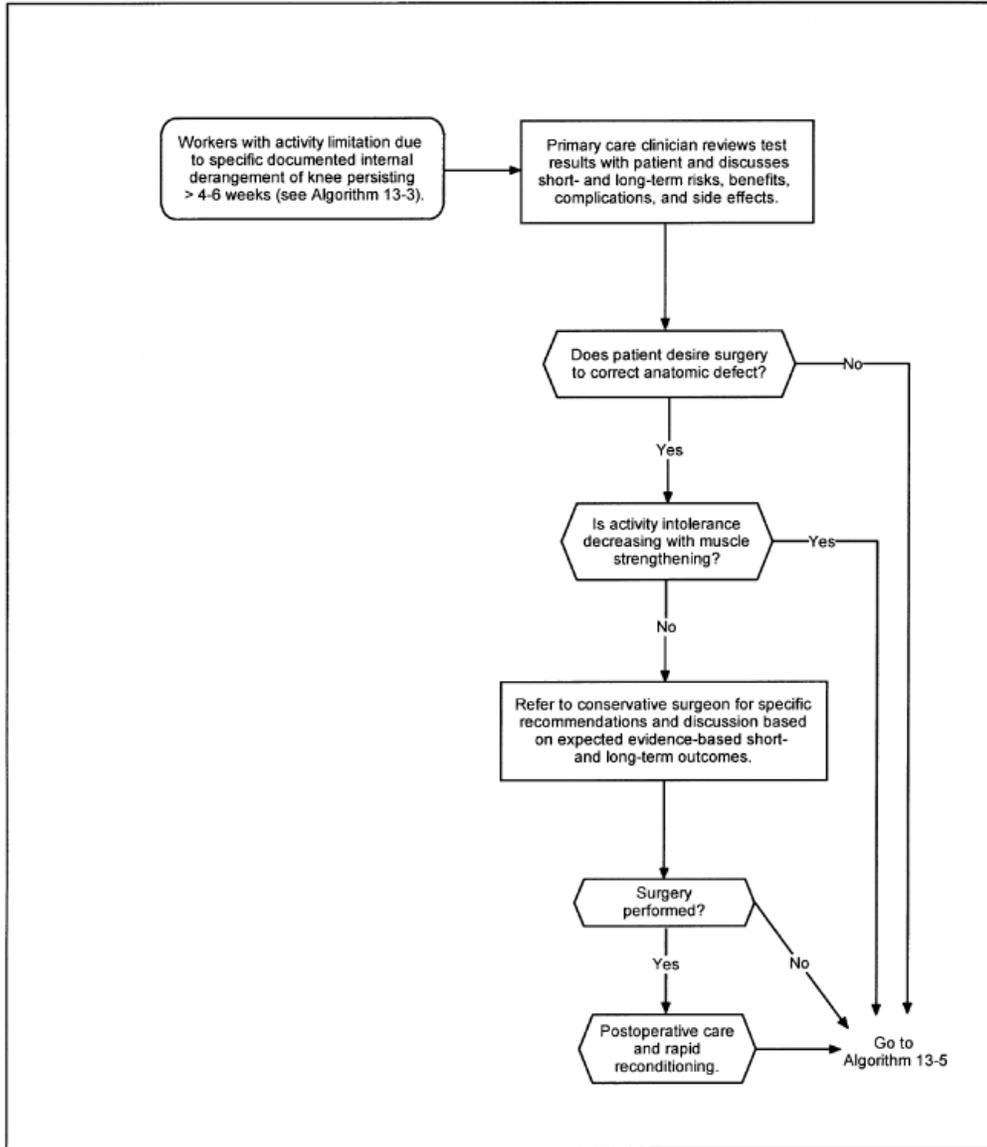
**Algorithm 13-2. Initial and Follow-up Management of Occupational Knee Complaints**



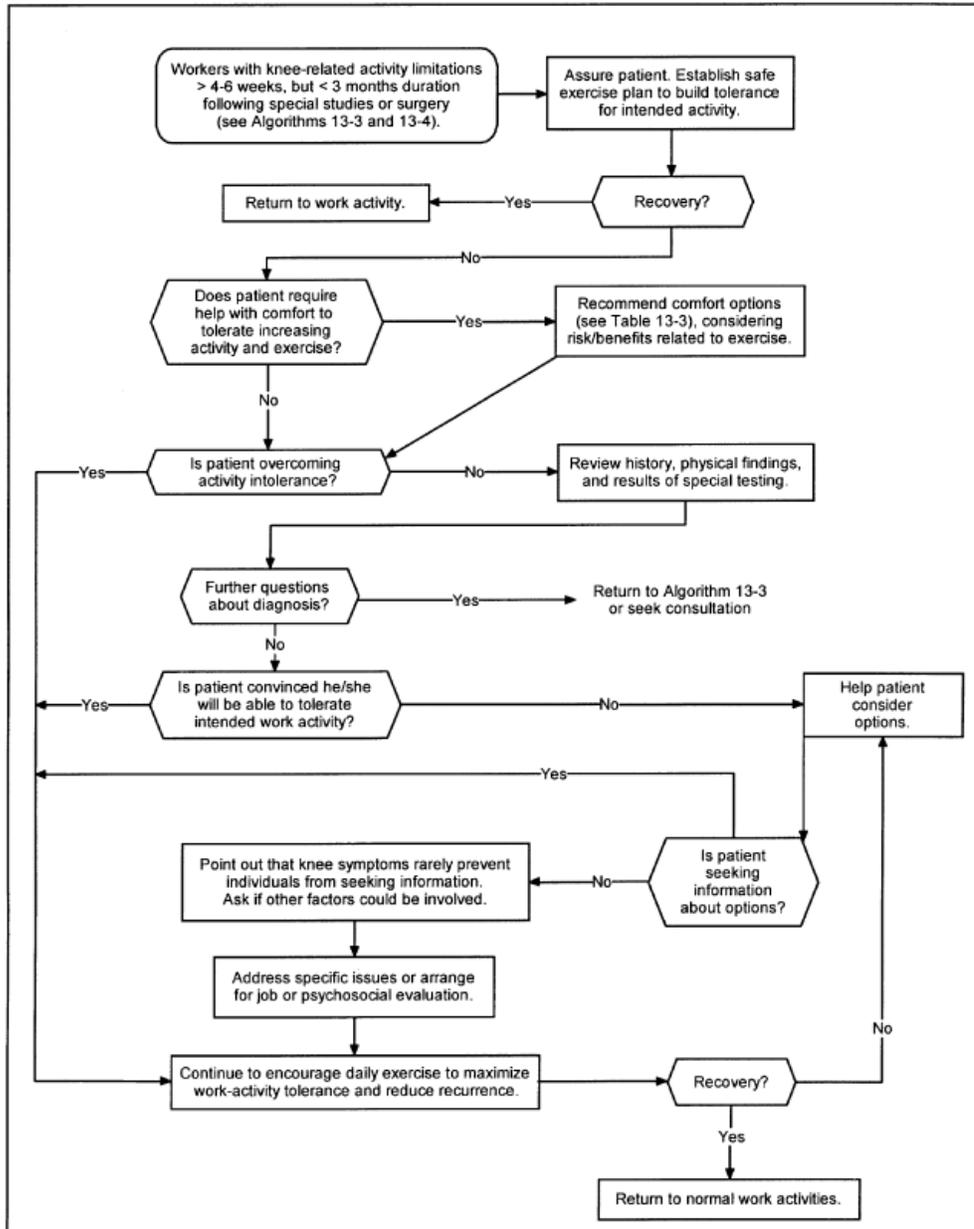
**Algorithm 13-3.** Evaluation of Slow-to-recover Patients with Occupational Knee Complaints (Symptoms > 4 Weeks)



**Algorithm 13-4. Surgical Considerations for Patients with Anatomic Evidence of Torn Meniscus or Ligament and Persistent Knee Symptoms**

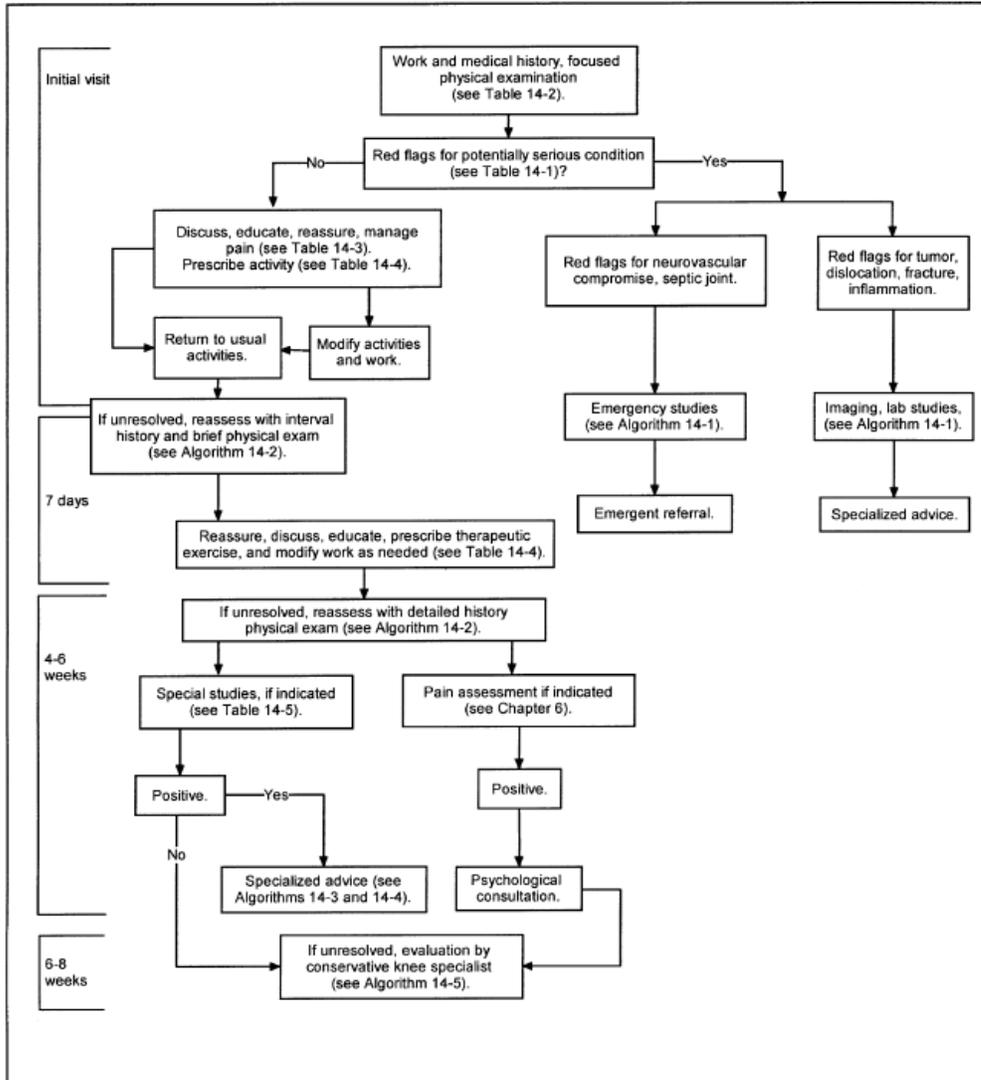


**Algorithm 13-5. Further Management of Occupational Knee Complaints**



# Ankle and Foot Complaints - ACOEM Chapter 14 (2004)

**Master Algorithm.** ACOEM Guidelines for Care of Acute and Subacute Occupational Ankle and Foot Complaints



## Summary of Recommendations and Evidence

See Table 14-6.

Table 14-6. Summary of Recommendations for Evaluating and Managing Ankle and Foot Complaints

Clinical Measure	Recommended	Optional	Not Recommended
History and physical exam	Basic history and physical exam, including evaluation of ability to bear weight, tenderness, and ligament stability (C)		
Patient education	Patient education regarding diagnosis, prognosis, and expectations of treatment (D)		
Medication (See Chapter 3)	Acetaminophen (C) NSAIDs (B)	Opioids, short course (C) NSAID creams (D)	Use of opioids for more than 2 weeks (C)
Injections	For patients with point tenderness in the area of a heel spur, plantar fasciitis, or Morton's neuroma, local injection of lidocaine and cortisone solution (D)		Repeated or frequent injections (D)
Physical treatment methods	For acute injuries, at-home ice applications, range-of-motion and strengthening exercises, as taught by primary provider (D)	Pneumatic or pulse devices to reduce swelling (C) ESWT for plantar fasciitis (C) Coupled electrical stimulation or impulse compression for fracture (C)	Passive physical therapy modalities, except as initial aid prior to home exercises (D) Laser treatment (B)
Rest and immobilization (e.g., braces, supports)	For acute injuries, immobilization and weight bearing as tolerated; taping or bracing later to avoid exacerbation or for prevention (C) For acute swelling, rest and elevation (D) For appropriate diagnoses, rigid orthotics, metatarsal bars, heel donut, toe separator (C)	Tension night splints for plantar fasciitis (B)	Prolonged supports or bracing without exercise (due to risk of debilitation) (D)

Table 14-6. (continued)

Clinical Measure	Recommended	Optional	Not Recommended
Activity and exercise	Stretching Aerobic exercise Maintenance of general activity to avoid debilitation (C) Early mobilization of patients with ankle sprain (C)		Full activity in presence of swelling and other signs of acute trauma (D)
Detection of physiologic abnormalities			Electrical studies for routine foot and ankle problems without clinical evidence of tarsal tunnel syndrome or other entrapment neuropathies (D)
Radiography	Plain-film radiographs only for patients with acute ankle injuries who have signs identified in Ottawa Criteria ankle rules (B) Further evaluation if radiographic films show ankle effusion > 13 mm anteriorly (C)		Routine plain-film radiographs for ankle injuries (B) Routine radiographic films for soft tissue diagnoses (D)
Surgical considerations	Bunionectomy if conservative treatment fails and radiographs are positive for > 14-degree intermetatarsal angle (D) Excision of neuroma if conservative treatment (injections, toe separator) fails (D) Reconstruction of lateral ankle ligament for symptomatic patients with ankle laxity demonstrated on physical exam and positive stress films (C)		Diagnostic arthroscopy of ankle if diagnosis obtainable by other non-invasive method (D) Arthroscopy of ankle for synovial impingement before conservative care, including injections, is tried (D)

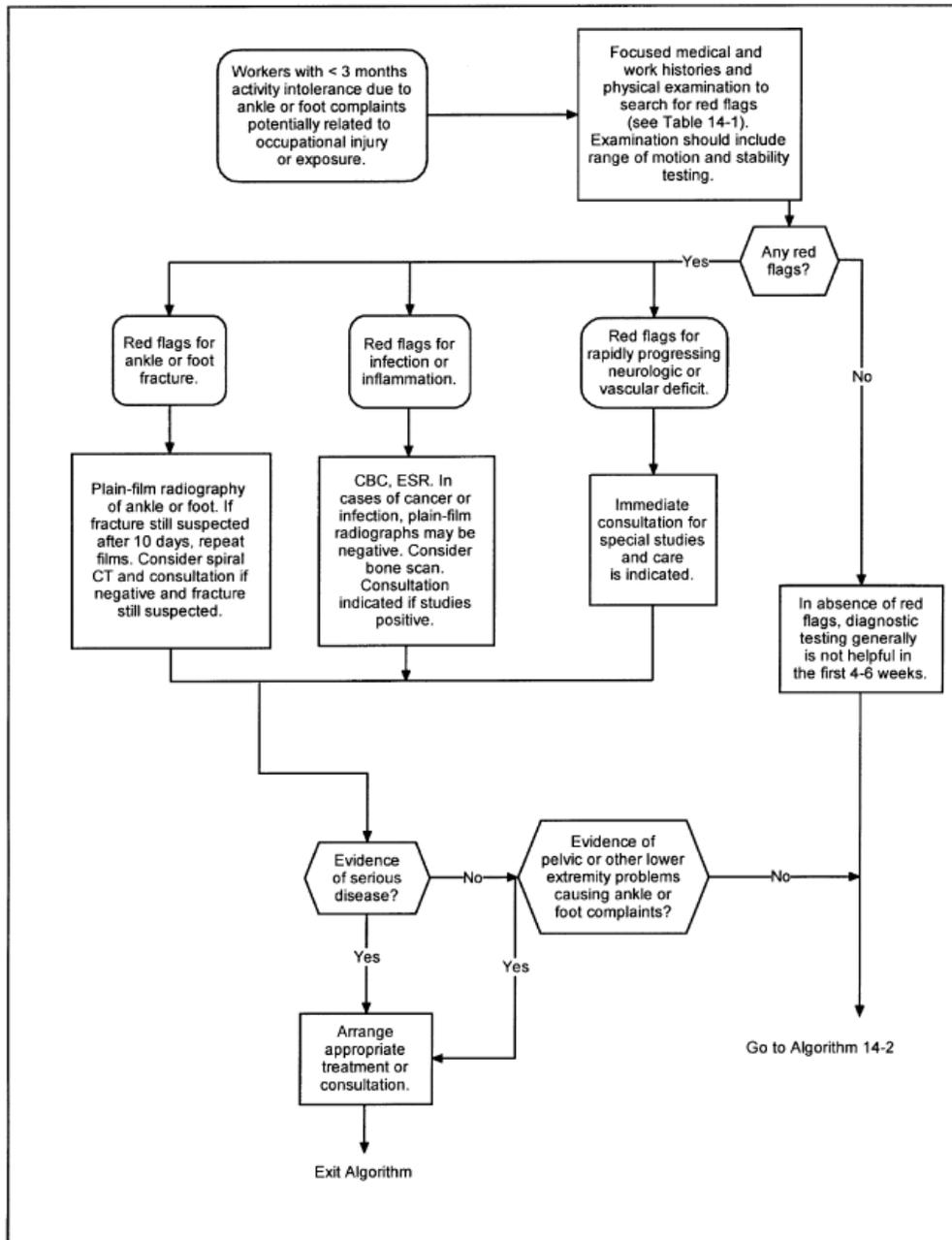
A= Strong research-based evidence (multiple relevant, high-quality scientific studies).

B =Moderate research-based evidence (one relevant, high-quality scientific study or multiple adequate scientific studies).

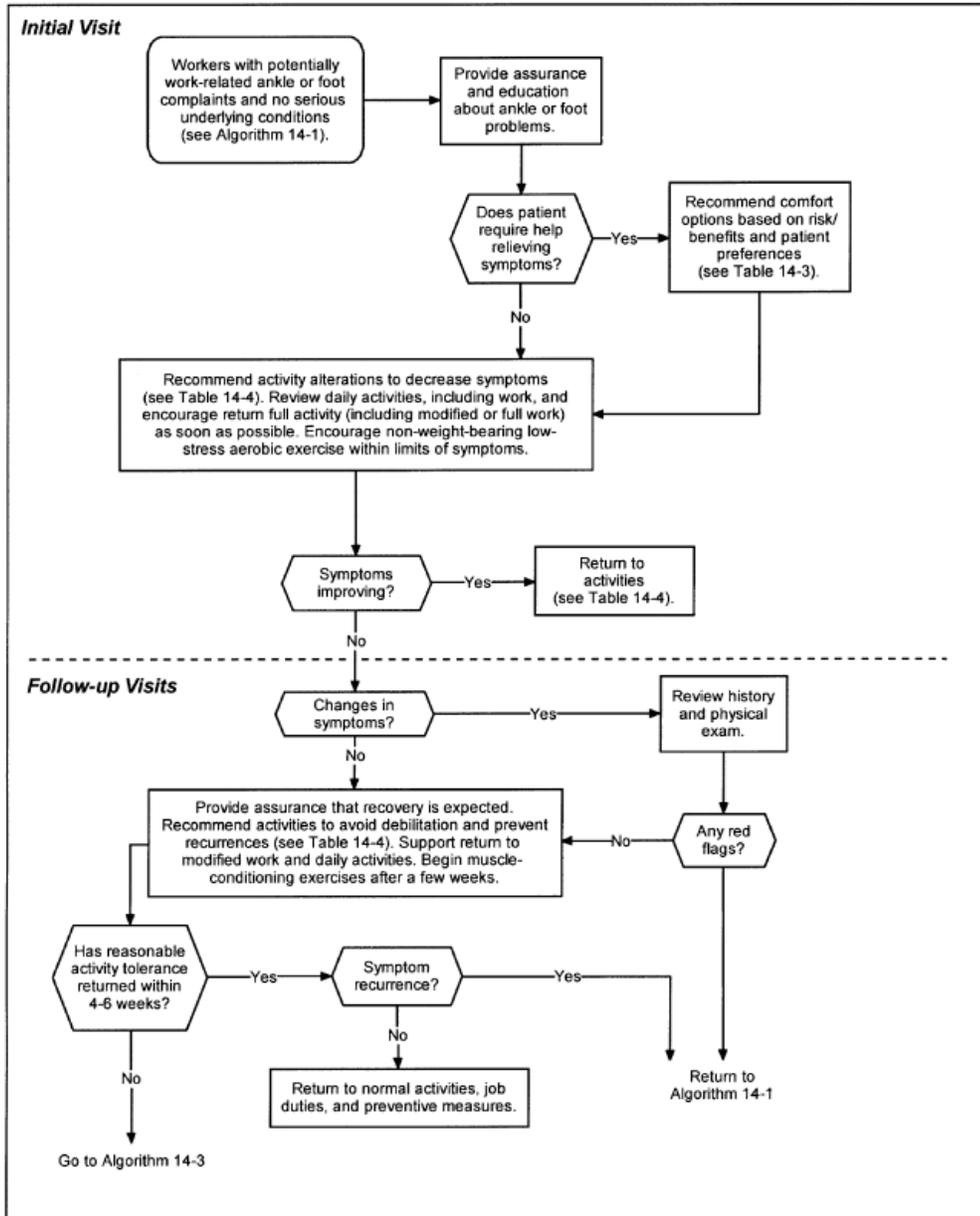
C=Limited research-based evidence (at least one adequate scientific study of patients with foot or ankle complaints).

D= Panel interpretation of evidence not meeting inclusion criteria for research-based evidence.

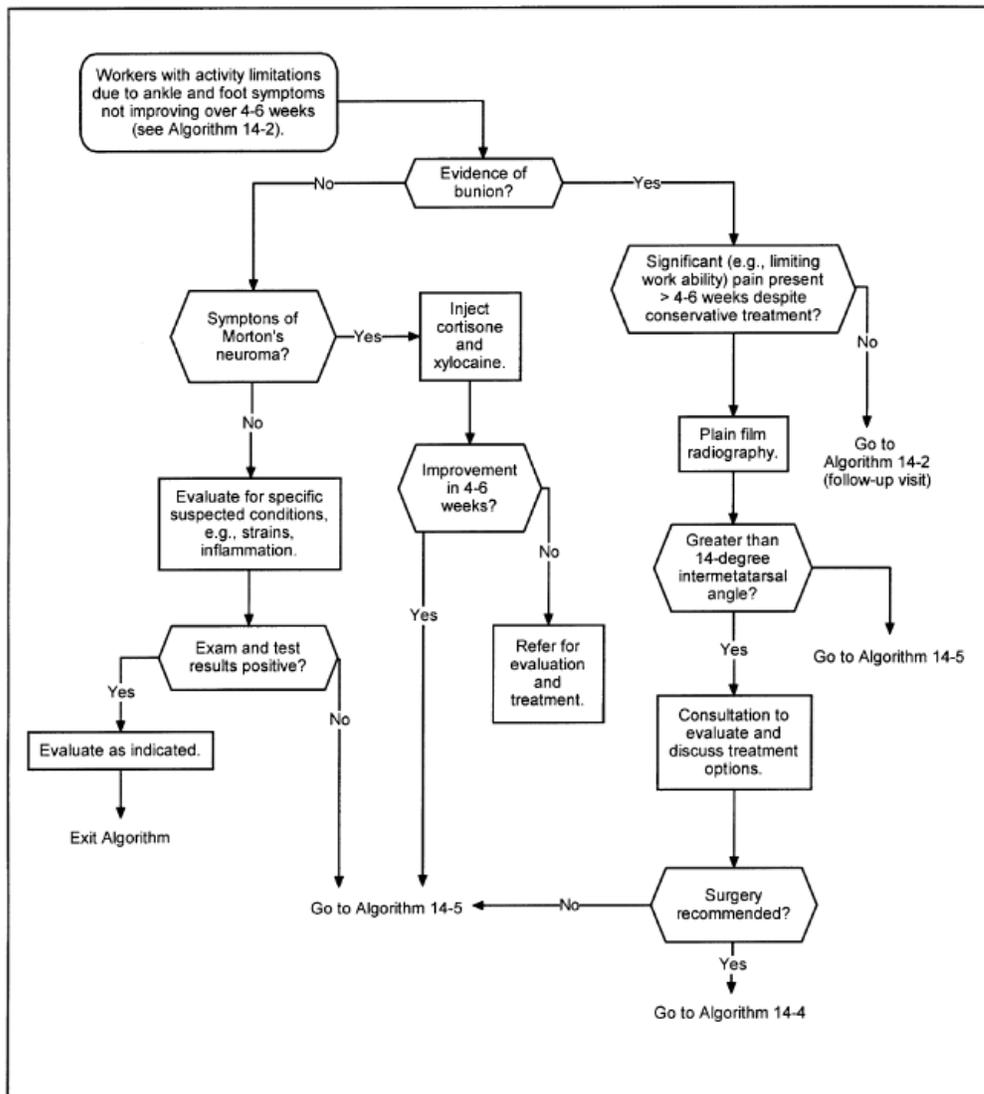
**Algorithm 14-1. Initial Evaluation of Occupational Ankle and Foot Complaints**



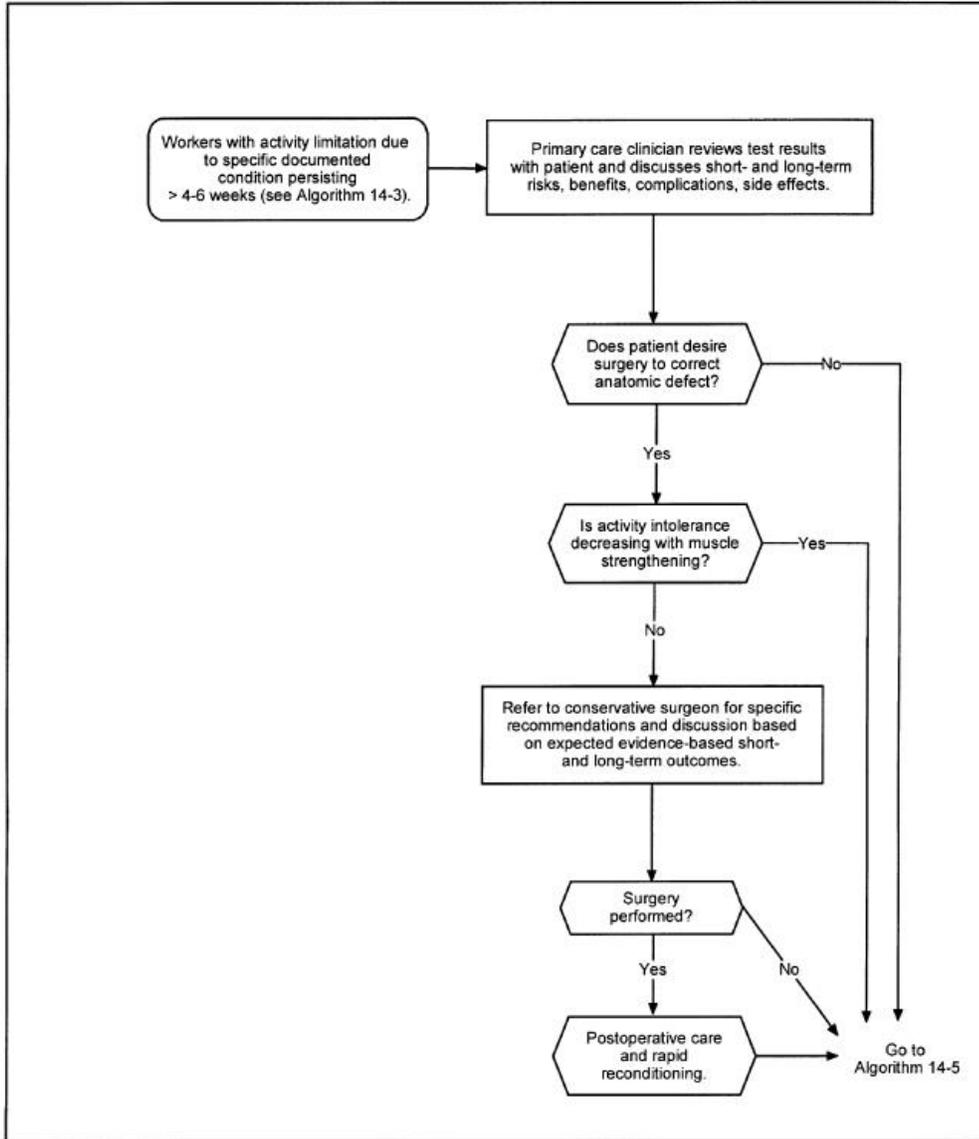
**Algorithm 14-2. Initial and Follow-up Management of Occupational Ankle and Foot Complaints**



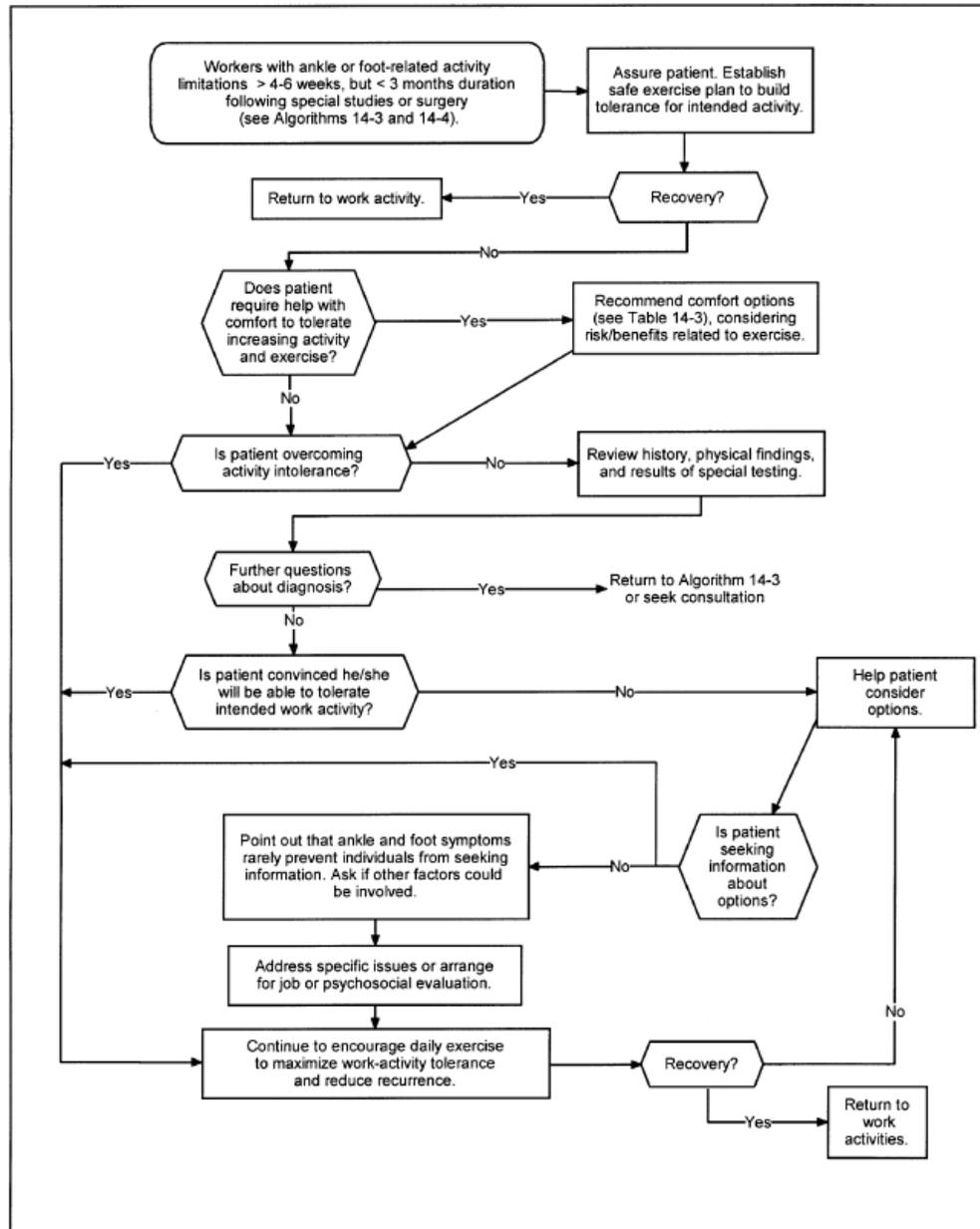
**Algorithm 14-3. Evaluation of Slow-to-recover Patients with Occupational Ankle and Foot Complaints (Symptoms > 4 Weeks)**



**Algorithm 14-4.** Surgical Considerations for Patients with Anatomic and Physiologic Evidence of Bunion, or Morton's Neuroma, and Persistent Symptoms



**Algorithm 14-5. Further Management of Occupational Ankle and Foot Complaints**



## **Chronic Pain Complaints – MTUS Chronic Pain Medical Treatment Guidelines**

Text of Medical Treatment Utilization Schedule (MTUS) can be found at the following Internet Link:

[http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS\\_Regulations/RegulationsFinalClean.pdf](http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS_Regulations/RegulationsFinalClean.pdf)

## **Acupuncture – MTUS Acupuncture Medical Treatment Guidelines**

The MTUS §9792.24.1. Acupuncture Medical Treatment Guidelines can be found at the following Internet

Link: [http://www.dir.ca.gov/t8/9792\\_24\\_1.html](http://www.dir.ca.gov/t8/9792_24_1.html)

## **Post-Surgical MTUS Treatment Guides**

The MTUS §9792.24.3. Postsurgical Treatment Guidelines can be found at the following Internet Link:

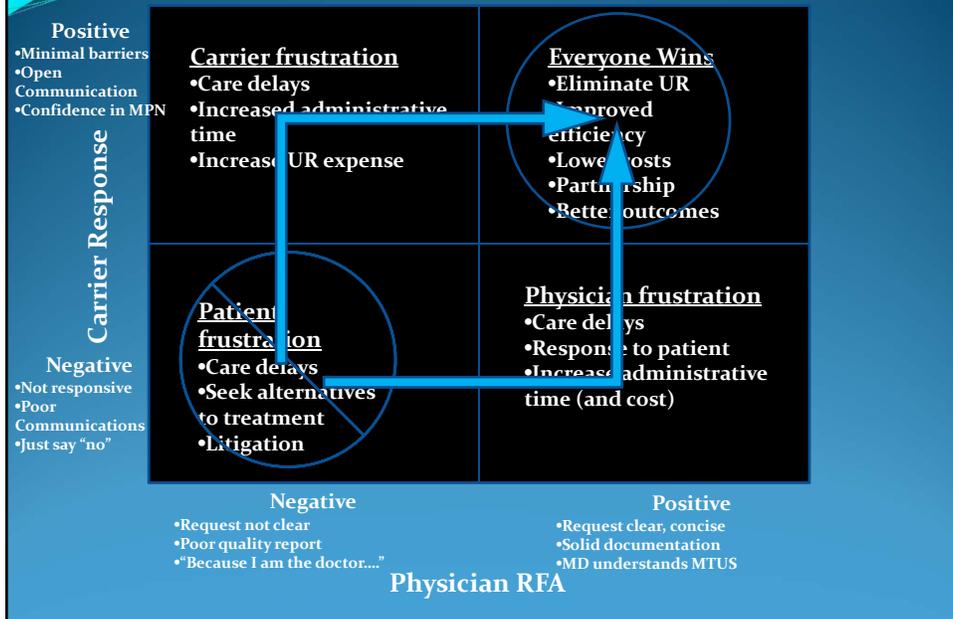
[http://www.dir.ca.gov/t8/9792\\_24\\_3.html](http://www.dir.ca.gov/t8/9792_24_3.html)

# DWC 21<sup>st</sup> Annual Educational Conference

## Providing Optimal Medical Care: Perspectives on UR

Roman Kownacki, MD, MPH  
 Medical Director, Occupational Health  
 Kaiser Permanente Northern California  
 E-mail: [Roman.Kownacki@kp.org](mailto:Roman.Kownacki@kp.org)

### The Dynamics of Treatment Requests



## Medical Requests for Authorization

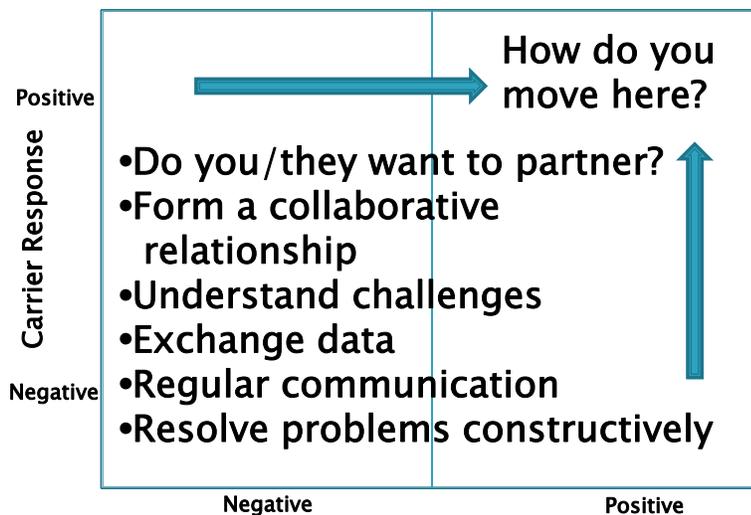
- Treatment Philosophy – EBM
  - Training in WC including MTUS
  - Feedback
  - Review documentation of denied requests
  - Make it easy to approve by using the language of MTUS/Guidelines
  - Demonstrate performance
- How do you move?

Negative

Positive

Physician RFA

## Creation of a Partnership





# State Fund Utilization Review Program

Dr. Dinesh Govindarao  
Chief Medical Officer

January 15, 2014

State Compensation Insurance Fund

## Topics

- State Fund UR Program
- Request for Authorization (RFA)
- How to Submit an RFA
- Returned RFA
- Tips For Submitting RFA

State Compensation Insurance Fund

## State Fund UR Program

- 1996 – Established a Medical Quality Assurance Program
- 2004 – Implemented the SCIF Utilization Review Program in compliance with regulatory requirements
  - 1<sup>st</sup> level review – Claims Pre-authorization based on Treatment Guidelines (EBM)
  - 2<sup>nd</sup> level review - State Fund contracted with physicians to perform utilization review
- In 2012, State Fund contracted with UROs to perform 2<sup>nd</sup> level utilization review

State Compensation Insurance Fund

## Request for Authorization (RFA)

- Request for Authorization – Written request for a specific course of proposed medical treatment CCR 9792.6.1 (t)
  - DWC Form RFA
  - Completed and signed by the physician
  - Supported by medical report indicating MTUS or other evidence-based guidelines

State Compensation Insurance Fund

# How to Submit an RFA ?

- Complete the DWC Form RFA
- Attach medical report substantiating the need for the requested treatment
- Fax to State Fund Regional Office
- Information available at the State Fund Web site:
  - "I am a Medical Provider" section
  - Request for Authorization section

[www.statefundca.com/provider/TreatmentAuthorization.asp](http://www.statefundca.com/provider/TreatmentAuthorization.asp)

State Compensation Insurance Fund

## statefundca.com

The screenshot shows the homepage of the State Compensation Insurance Fund website. At the top, there is a navigation bar with links for EMPLOYERS, BROKERS, MEDICAL PROVIDERS, EMPLOYEES, and STATE AGENCIES. Below this is a banner for the 100th Anniversary of the State Fund. The main content area features a large image of two people with the text "We protect the people who make California work". Below this image is a purple box titled "I'M A MEDICAL PROVIDER" which contains several links: "Treating Physician's Guide", "State Fund Medical Provider Network", "State Fund MPN General Provisions and Criteria FAQs", "Request for Authorization" (highlighted with a red arrow), "Submitting Medical Bills Electronically", and "Family & Health Services". To the right of the main content area, there are several service links: "REQUEST A QUOTE", "RENEW YOUR POLICY", "MAKE A PAYMENT / REPORT PAYROLL", "FILE A CLAIM", and "FIND A DOCTOR". A "Customer Support" section is also visible at the top right.

State Compensation Insurance Fund

# Returned RFA

- From a non-provider
- Blank form
- No or incomplete medical report

State Compensation Insurance Fund

# Incorrectly Submitted RFA

SCEF REC 04/11/2013 PRSCAN 22 04/11/2013 09:41 AM 037647 4 6  
§ 9785.5, Request for Authorization

State of California  
Division of Workers' Compensation  
Request for Authorization for Medical Treatment (DWC Form RFA)

To accompany the Doctor's First Report of Occupational Injury or Illness, Form DLOR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or narrative report substantiating the requested treatment.

Check box if the patient faces an imminent and serious threat to his or her health.  
 Check box if request is written confirmation of a prior oral request.

<b>Patient Information</b>	<b>Provider Information</b>
Patient Name: See attached	Provider Name: See attached
Date of Birth: See attached	Practice Name: See attached
Date of Injury: See attached	Address: See attached
Employer: See attached	City, State, Zip Code: See attached
Claim Number: See attached	Telephone Number: See attached
	Fax Number: See attached
	Provider Specialty: See attached
	Provider State License Number: See attached
	National Provider ID Number: See attached

**Claims Administrator Information**

Claims Administrator: See attached  
Adjuster Name (if known): See attached  
Address: See attached  
City, State, Zip: See attached  
Telephone Number: See attached  
Fax Number: See attached

Requested Treatment: (See Instructions for guidance; attach additional pages if more space is required.)  
Other: State the requested treatment in the below space or indicate the specific page number(s) of the accompanying medical report on which the requested treatment can be found. Include supporting evidence as necessary. More than one treatment request may be included.

Diagnosis:	See attached
ICD Codes:	See attached
Procedure Requested:	See attached
CPT/HCPCS Codes:	See attached
Other Information:	See attached
(Frequency, Duration, Quantity, Facility, etc.)	See attached

Date of Request: 3/20/13  
Provider Signature: [Redacted]

**Claim Administrator Response Approving Treatment:**  
You may use this form for approving a treatment request. A request for additional information, or a decision to modify, delay, or deny a request for authorization cannot be made using this form. Please review all limitations and requirements set forth in California Labor Code section 4710 and California Code of Regulations, title 8, sections 9792.9 and 9792.9.1.

**A decision on the requested medical treatment must be made within 72 working days from receipt of this request for authorization, or 14 calendar days, whichever is shorter, except for authorization requests to transfer a decision. For an extended review, one month in a case of impairment or serious health threat, the maximum is 72 hours. Authorizations may not be renewed, and a request for continuation without documentation reflecting an attempt to obtain the necessary information, cannot be made.**

The requested treatment(s) is approved  
 The request has been previously denied by utilization review

Date request for authorization received: \_\_\_\_\_  
Date of response to request: \_\_\_\_\_  
Claims Administrator/Authorized Agent Signature: \_\_\_\_\_  
Adjuster/Authorized Agent Name (print): \_\_\_\_\_

DWC Form RFA (Version 12/2012)

State Compensation Insurance Fund

# Tips For Submitting RFA

- Submit DWC Form RFA with all information
- Specify the recommended treatment
- Cite MTUS or other appropriate medical guidelines
- Attach medical report
- **Fax** (not mail) to State Fund Office
- Calling the adjuster/reviewer back

# Correctly Submitted RFA

Apr. 16, 2013, 9:48AM [Redacted] No. 5264 P. 1

State of California  
 Division of Workers' Compensation  
 Request for Authorization for Medical Treatment (DWC Form RFA)

To accompany the Doctor's First Report of Occupational Injury or Illness, Form DLOR 001, a Treating Physician's Progress Report, DWC Form P20-6, or narrative report substantiating the requested treatment.

Check box if you prefer cover on treatment and return threat to job or her health.  
 Check box if request is written confirmation of a prior oral request.

**Patient Information**  
 Patient Name: [Redacted]  
 Date of Birth: [Redacted]  
 Date of Injury: 10/1/12  
 Employee: [Redacted]  
 Claim Number: [Redacted]

**Provider Information**  
 Provider Name: [Redacted]  
 Practice Name: [Redacted]  
 Address: [Redacted]  
 City, State, Zip Code: [Redacted]  
 Telephone: [Redacted]  
 Fax Number: [Redacted]  
 Provider Specialty: [Redacted]  
 Provider State License Number: [Redacted]  
 National Provider ID Number: [Redacted]

**Claim Administrator Information**  
 Adjuster Name: [Redacted]  
 City, State, Zip: [Redacted]  
 Telephone Number: [Redacted]  
 Fax Number: [Redacted]

Requested Treatment: (See Instructions for patients attach additional pages if more space is required.)  
 Minor use the requested treatment in the below space or indicate the specific page number(s) of the substantiating medical report on which the requested treatment can be found. Include supporting evidence or necessary. Minor Use use requested request may be included.

Diagnosis: Right Knee Internal Derangement  
 Procedure Requested: Rt Knee Total Arthroscopy and debridement  
 CPT/PCS Code: 26082, 26087  
 Other Information: FACILITY: Clovis Community Hospital  
 (Frequency, Duration, Quantity, Modality, etc.)

Date of Request: 4/16/13  
 Provider Signature: [Redacted]

**Claim Administrator/Response Approving Treatment:**  
 You may void this form by approving a written request. A request for additional information, or a decision to modify, delay, or deny a request for authorization cannot be made using this form. Please review all instructions and requirements set forth in California Labor Code sections 4610 and California Code of Regulations, title 8, sections 99933 and 99934.

A decision of the patient's selected treatment must be made within 90 calendar days from receipt of this request for authorization. If a patient selects a request for authorization, the patient may request a decision. For an extended period on the date of the patient's selected treatment, the patient may request a decision. For an extended period on the date of the patient's selected treatment, the patient may request a decision.

The requested treatment(s) is approved  
 The request has been previously denied by limitation review

Date request for authorization received: [Redacted]  
 Date of response to request: [Redacted]  
 Claim Administrator/Authorized Agent Signature: [Redacted]  
 Adjuster/Authorized Agent Name (print): [Redacted]

DWC Form RFA (Valid 1/1/2012)

# Collaboration

Physicians

Employers

Injured Employee

Claims  
Administrators



**All stakeholders important to  
provide timely, appropriate &  
quality medical treatment**

