STATE OF CALIFORNIA

Department of Industrial Relations

Division of Workers' Compensation

PUBLIC HEARING

Monday, August 11, 2008
Ronald Reagan State Office Building
300 South Spring Street
Los Angeles, California

P A N E L

Carrie Nevans
Division of Workers' Compensation
   Administrative Director

Dr. Anne Searcy
Division of Workers' Compensation Medical Unit
   Medical Director

Destie Overpeck
Division of Workers' Compensation
   Chief Counsel

Reported by:  Sonia E. Garcia
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PUBLIC HEARING

LOS ANGELES, CALIFORNIA

MONDAY, AUGUST 11, 2008, 10:03 A.M.

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MS. OVERPECK: Good morning, everyone. My name is Destie Overpeck. Is this on? Do you all hear me?

UNIDENTIFIED VOICE: Yes.

MS. OVERPECK: Okay. We are here today for a hearing on the Division of Workers' Compensation's Proposed Regulations for the Medical Treatment Utilization Schedule. They are at Title 8, California Code of Regulations, Sections 9792.20 through 9792.26.

The proposed regulations would update the elbow disorders chapter by adopting the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines of their elbow chapter. The regulations would also add two new sections to the MTUS chronic pain guidelines and postsurgical treatment guidelines.

The regulations also are going to restructure the MTUS into a clinical topics format, which will allow easier updates in the future.

Today we have on the panel Carrie Nevans, our administrative director; Anne Searcy, directly next to me, our medical director; we have the court reporters who will be taking down everything that we say; and our regulation
coordinator Maureen Gray.

When you come up to speak, please give your business card, or if you don't have one, something written down with your name and of the entity that you are speaking on behalf of and give it to Maureen. If you have any written comments, please also give those to Maureen Gray and then come to the podium. We will call you based on the sign-in sheet that we have. If you haven't signed in and wish to speak, please go to the back of the room and sign in so that we don't miss anyone, but we'll also call at the end if anybody else would like to have any comments.

The hearing will go on as long as everyone is here and has something to say, although I don't anticipate that it's going to go on beyond lunchtime.

If you have any written comments that you do not have with you today, you can e-mail them to our office, you can fax them, but you need to have them in by 5:00 p.m. today.

All the --

(Sotto voce comment by panel member.)

MS. OVERPECK: Oh. 5:00 p.m. tomorrow. Thank you.

All the comments that are given to us, either orally or written, will be reviewed. They have equal weight and we will use them in considering whether to make any changes to the proposed regulations.

All right. So I am going to call the first person
that we have listed here who is Francis Riegler.

DR. RIEGLER: Someone want to take this piece of paper
with my name on it?

MS. OVERPECK: Right behind you.

If I can just remind you, when you start speaking, say
your name and who you represent.

FRANCIS RIEGLER, M.D.

DR. RIEGLER: Yes. Thank you.

Can everyone hear me? Okay.

Good morning. I'm Dr. Francis Riegler. I'm an
interventional pain physician based in Palmdale, California,
and I'm here testifying on behalf of myself, my practice and
patients, as well as in my role as the current president of the
California Society of Interventional Pain Physicians. Thank
you.

First and foremost, on behalf of CSIPP and myself, I'd
like to commend the entire Division, and specifically Dr. Anne
Searcy for her outstanding leadership in implementing the 2000
reform laws, and in the development of the Medical Treatment
Utilization Schedule, and specifically the recent -- recently
proposed chronic pain chapter.

I've watched from afar and I've also heard from CSIPP
immediate past president Dr. Stan Helm, who I'm sure most of
you know, as well as from Dr. Joshua Prager, who both have been
involved with DWC discussions in these past few years. They've
been telling me that Dr. Searcy has been outstanding and she continues to -- to be so in her duties.

I'm also hearing that, while she has a strong knowledge base, she continues to be more than open to new information and others' expert opinions, both traits that make her outstanding in her job. And I'd just like to add that I observed some of this directly myself at the California Society of Industrial Medicine and Surgery meeting.

THE REPORTER: I'm sorry, can you slow down.

MS. OVERPECK: Try to slow down, please.

DR. RIEGLER: I'm sorry.

Would you like me to start from -- from now?

THE REPORTER: Yes, please.

DR. RIEGLER: Okay.

Well, in any case, I observed Dr. Searcy at the California Society of Industrial Medicine and Surgery meeting in Berkley, California, and -- and clearly, this talent is coming through in conjunction with that of other DWC leadership, including that from Carrie Nevans, the administrative director, in the development of the Medical Evidence Evaluation Advisory Committee, also known as MEEAC, as well as the development of the entire schedule.

Further, the structure and functioning and balance of the MEEAC committee and its work has been remarkable. A special thank you to all of the physicians who took time from
their clinical schedules to participate in this important work. The dedication, participation, and input from all relevant types of medical specialties who are representing various specialty societies in a fair and balanced manner has been truly amazing. Again, only this type of fair and balanced process could yield a directionally fair approach and proposal.

As my national society, the American Society of Interventional Pain Physicians, has informed me, this MEEAC process and the MTUS product stands in stark contrast to the recently updated ACOEM low back and draft chronic pain chapters and related ACOEM processes which neither included formal representation of any of the national medical societies known for being involved in many of the interventions being reviewed, nor do they reflect any relevant substantive evidence-based and expert medical consensus-based comments and conclusions which have subsequently been made by these various relevant expert societies to ACOEM.

Upon request, I can have my national society chapter share with you the latest volley of evidence-based comment letters back and forth between national expert societies and ACOEM, all with the upshot that ACOEM has refused to change any of their recommendations. The contrast at DWC and MEEAC in process and subsequent products is really dramatic.

Again, thank you for steering clear of these unbalanced, overly conservative, updated ACOEM guidelines.
Given my relatively new role as president of the California Society of Interventional Pain Physicians, while I have reviewed the proposal, I have not fully had time to digest and analyze all of the nuances which are involved.

I have, however, had several discussions with colleagues, and while we again support DWC directionally in this approach, a few areas that could use additional clarification and others that we will suggest be changed. And in conjunction with various other societies, we will be submitting these in writing by Tuesday's deadline. The comments relate primarily to concern regarding inclusion by DWC of ACOEM's evidenced ranking scale and the need for further clarification regarding how functional improvement goals fit within statutory guarantees of pain treatment that simply relieves symptoms.

Thank you for your time and again for your fair process, open-door policy, and balanced work product. CSIPP stands ready to assist DWC and the MEEAC committee as we move forward and sort through the various comments that will be raised in order to further improve an already strong product.

And I'm sorry, I just kind of talk fast naturally.

MS. OVERPECK: Thank you, Dr. Riegler.

Jessica Holmes.

JESSICA L. HOLMES

MS. HOLMES: Good morning. Can everyone hear me? Okay.
My name is Jessica Holmes, and I'm a regional manager in the Health, Economics and Reimbursement Department of Boston Scientific's Neuromodulation Division.

Boston Scientific is a worldwide developer and manufacturer of medical devices and has advanced the practice of less invasive medicine across a wide range of medical specialties. The Neuromodulation Division of Boston Scientific is dedicated to the treatment of patients suffering from chronic intractable pain through spinal cord stimulation and established minimally invasive treatment covered by virtually all government and commercial health plans and most workers' compensation programs throughout the United States.

On behalf of Boston Scientific, I appreciate the opportunity to comment at these hearings on the recently published California Division of Workers' Compensation proposed regulations to update the Medical Treatment Utilization Schedule.

We applaud Ms. Nevans, Dr. Searcy, the DWC staff and the physician advisory board in the action taken in proposing new chronic pain guidelines based largely on the work law state institute's Official Disability Guidelines. We understand that current California DWC guidelines rely primarily on the American College of Occupational Environmental Medicine Practice Guidelines 2nd Edition 2004, and we have substantial concerns with the recent updates to the low back chapter and
draft chronic pain chapter. Of particular concern are updated
ACOEM recommendations against coverage of more than 50 percent
of tests, treatments and therapies considered standard practice
in the medical community, including spinal cord stimulation.

The DWC's decision to update the proposed MTUS based
on ODG versus ACOEM guidelines is a positive development for
chronic pain patients and providers. Additionally, we strongly
believe that the newly proposed MTUS will provide greater
clarity than existing ACOEM guidelines in establishing
appropriate treatment modalities for patients suffering from
work-related injury or illness.

Thank you for your consideration of these comments and
for your work on behalf of workers' compensation patients and
providers in the state of California.

MS. OVERPECK: Thank you, Ms. Holmes.

Richard Katz.

RICHARD S. KATZ

MR. KATZ: Good morning. My name is Richard Katz. I'm
the finance officer for the California Physical Therapy
Association.

We provided comments previously in their written
format, so this is just a highlight of a couple questions we
have.

Specifically, under item 9792.24.3(b)(1) --

You got all that?
this section states that the following postsurgical physical medicine period as defined in Section 9792.24.3(a)(3) that treatment reverts back to the applicable 24-visit limit. If the 24-visit limit has been removed statutorily for -- for postsurgical patients, how can one revert back to the treatment limit that never applied to that injury?

Also, if there is a limit after the 6-month postsurgical physical medicine period, does that mean that the injured worker isn't entitled to an additional 24 visits beyond what they already received?

Section 9792.24.3(c)(5)(A) on page 13 uses the words "should" and "allows." Does the DWC consider the use of this word prescriptive or suggestive? They use the word "should" multiple times throughout the proposed language.

I also want to thank you for your time that you put -- the effort you put into this process and appreciate the belated comment.

MS. OVERPECK: Thank you, Mr. Katz.

Next, I have Mark Telles.

MARK A. TELLES

MR. TELLES: Good morning. My name is Mark Telles, and I'm a therapy access senior manager for Medtronic Neuromodulation.

I work and live in southern California, and I'm
pleased to present brief comments this morning on behalf of my colleague William Farenblack, Medtronic Neuromodulation State Government Affairs Director who, unfortunately, could not fly in today to testify.

First and foremost, Medtronic wants to thank the entire Division, and specifically Carrie Nevans and Dr. Anne Searcy, for their outstanding leadership during the past few years as DWC stought (phonetic) -- sought to strike a fair and balanced approach to the Medical Treatment Utilization Schedule in general and specifically, most recently, on the chronic pain chapter.

Ms. Nevans and Dr. Searcy have had an open-door policy whenever we, or any of the implanting physicians with whom we work, had questions or wanted to provide information. While our state government affairs staff has had strong relationships and works closely with workers' compensation officials throughout the country on a regular basis, we regularly cite California DWC as truly remarkable, both in their knowledge base and open-door policy. California citizens are very lucky to have such a strong leadership and staff at DWC.

Second, we'd like to thank the members of the Medical Evidence Evaluation and Advisory Committee for their strong work for the past 1.5 years on the development of this chronic pain chapter. Their dedication and knowledge, combined with the DWC staff, and their leadership expertise, has resulted in
directionally -- has resulted directionally in a very strong
and fair and balanced approach both overall as well as for this
chronic pain chapter.

We have analyzed it regarding therapies in which we
are involved and have also spoken extensively with
interventional pain physicians with whom we work. And all that
had reviewed the proposal, generally believe that, while not
perfect, it is directionally strong. We have identified a few
areas that could use additional clarification and others that
we suggest be changed. But, again, overall we believe
directionally this is a strong, balanced product and are
appreciative of the work of staff and the MEEAC committee.

Third, it deserves note that this strong, balanced
work and the balanced MEEAC committee involves work,
participation, and input from all relevant types of medical
specialties who are representing various specialty societies.
The active inclusion of various medical professionals and
societies no doubt has been key to helping to ensure that the
end product is balanced. This balance process and product
stands in stark contrast to the recently updated ACOEM low back
and draft chronic pain chapters and related ACOEM processes,
which neither included formal representation of any of the
national medical societies known for being involved in many of
the interventions being reviewed, nor do they reflect any
relevant, substantive, evidence-based and expert medical
consensus-based comments or conclusions which have subsequently
been made by the various relevant expert societies to ACOEM.
The contrast is remarkable and, not surprisingly, the products
vary dramatically.

Again, kudos to DWC for opting for a much stronger
process and resulting in a far superior product than updated
ACOEM guidelines.

Fourth, as mentioned above, we have additional
comments to make, but in deference to time today, we'll be
submitting those in writing by Tuesday's deadline. The
comments relate to concern regarding inclusion by DWC of
ACOEM's evidence ranking scale, the need for further
clarification regarding how functional improvement goals fit
within statutory and constitutional guarantees of pain
treatment that simply relieves symptoms.

Thank you for your time, and Californians are very
lucky indeed.

MS. OVERPECK: Thank you for your comments.

Laura Stewart.

LAURA LAN STEWART

MS. STEWART: Good morning. My name is Laura Stewart.
I'm a occupational therapist. I'm here to represent
Occupational Therapy Association of California and myself, and
my patients, and 10,000 practicing occupational therapists.
Okay.
Thank you for developing those guidelines. We just have two comments.

Under the postsurgical treatment guidelines, specifically carpal tunnel syndrome, ulnar nerve entrapment, head injury, hip, pelvis, thigh, and knee, we'd like the language to be changed from "physical therapy" to "physical medicine" because occupational therapists play a very important role in rehab those patients and, therefore, I think we should be included in the guidelines. Okay?

Second thing is the -- under the chronic pain medical treatment, same thing, we'd like to -- since occupational therapy is a vital part of the team, we like to see the language to change from "physical therapy" to "occupation and physical therapy." Okay?

Thank you very much for your time and that's it.

Okay. Thank you.

MS. OVERPECK: Thank you.

George Balfour.

GEORGE W. BALFOUR, M.D.

DR. BALFOUR: Good morning. I'm George Balfour. I'm a practicing hand surgeon here in the Van Nuys community. I'm also president of the California Society Industrial Medicine and Surgery, and I'm also representing the board of the California Orthopaedic Association.

You have received the letter from the California
Orthopaedic Association stating that that organization is basically in support of the postoperative treatment guides as written; however, we have some concerns. One concern is, we are worried about the language such that they not -- that the interpretation not be that these are caps but guidelines for the utilization of various diagnoses. We are concerned that consideration be made for co-morbidities such as diabetes or age which might require greater utilization. We would encourage the language such that the tendency of the utilization review physicians not be the selection of a lowest available guide which goes on but rather demonstrates the greatest needs of the patient.

Personally, I have noticed that, in review of the -- Amendments C and E, that, basically, the level of evidence noted was at Level 1, a low level of evidence. And I would suggest that there should be an ongoing effort of the Division to continue research efforts in the true needs for specific diagnoses.

There is a host of data available among the practitioners of California, which I'm sure we would make available to the Division, that demonstrate what the true needs in any given specific diagnosis is. Just for an example, in tennis elbow, the guide mentions six visits, and it's my clinical impression that many of those patients take -- have greater needs. It be a -- I'm sure it is possible, using some
of the survey methods presently available on -- on the web to research that data less -- inexpensively, and I would encourage the Division to do so.

Thank you very much.

MS. OVERPECK: Thank you.

Now I don't have the most recent few people who walked in sign-in, but if you would like to speak, could you please just walk up to the podium and state your name.

All right. It looks like -- oh, here comes someone.

ROBERT R. THAUER

MR. THAUER: Morning. I represent a nonprofit industry group called the Alliance of Physical Therapy, Rehabilitation & Medical Technology.

MS. OVERPECK: Could you state your name?

MR. THAUER: The members and endorsing organizations of this alliance are primarily manufacturers and providers of physical therapy devices, home medical equipment, and orthotics.

We have also submitted written comments but would like to take a few moments and comment on the proposed changes to the Medical Treatment Utilization Schedule.

MS. OVERPECK: Can I interrupt you for just a second.

MR. THAUER: Sure.

MS. OVERPECK: Could you state your name, please?

MR. THAUER: Robert Thauer.
MS. OVERPECK: Thank you.

MR. THAUER: Our organization joins with many others from the California workers' compensation medical community in support of the adoption of the official disability guidelines from Work Loss Data Institute as presumptively correct for the treatment of chronic pain conditions and its addition to the Medical Treatment Utilization Schedule.

The DWC has proposed adoption of the October 2007 version of the ODG chronic pain chapter.

We support using the most current version of ODG as it has been updated in a number of areas since the October 2007 version and will be nearly a year old when this rule-making process is finalized.

Understanding that there will be a need for the Medical Evidence Evaluation Advisory Committee -- I wish I could pronounce the acronym -- to quickly review the changes and that the proposed regulations may need some changes, we still believe that the executive medical director, Dr. Searcy, and her advisory committee could conduct this review expeditiously. Any revisions to proposed regulations should only require another 15-day comment period, and that 15-day period may well be necessary for other changes that may be proposed from public comments.

Optimally, the Division could quickly review any changes and keep the rule-making timetable consistent with your
original goal to finalize these changes.

We would also encourage that a system be put in place so that, as the underlying guidelines that have been adopted are updated, that the State of California can periodically update their guidelines so that everybody is using the most current guideline, whether it be the State, the provider, or utilization review.

In addition to our request to adopt the current ODG guidelines, our membership has commented on one section of the electrotherapy draft guidelines. We all know the physicians are looking for effective, non-pharmacologic, non-invasive options to treat the complex subject of pain management. Electrical stimulation is one of several viable options that a physician may find to be an appropriate treatment for pain. This is a well-accepted clinical treatment modality for pain.

With the legislative mandate limiting physical therapy visits, the chronic pain patient often doesn't have access to clinical physical therapy, therefore, we would like to propose that accommodations be made in the -- in one section of the draft guidelines where a particular modality ICS, interferential current stimulation, has a limitation by ODG not necessarily by the State, but the State is adopting this language. And in this section, it says that this modality is possibly appropriate for the following conditions if it has documented and proven to be effected -- effective as applied by
a licensed physical therapist. Pain is ineffectively controlled due to diminished effectiveness of medications or pain is ineffectively controlled with medications due to side effects or history of substance abuse or significant pain from postoperative or acute conditions, limits the ability to perform exercise programs or physical therapy treatment, or the pain is unresponsive to conservative measures, for example, repositioning, heat, ice, et cetera.

The guidelines suggest that this electrotherapy modality could be beneficial, could reduce pain, could help reduce medication complications, and promote exercise and improve function.

Unfortunately, the guideline assumes that the patient can be treated or is being treated regularly in a physical therapy clinic or that the physician may not be the appropriate treatee or decision-maker. We ask the Division to change the language of this sentence to read "possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or by a licensed physical therapist." The physician is ultimately responsible for the treatment. He determines the use and efficacy of modalities. The physician should have the option to utilize this modality without the current restriction.

In conclusion, we support -- we applaud, actually, the Division's efforts to review and update the Medical Treatment
Utilization Schedule. We encourage you to adopt the most current version of ODG, and we request that you address the clarification and change that I just detailed.

Thank you very much.

MS. OVERPECK: Thank you, Mr. Thauer.

Is there anybody else in the audience who would like to make an oral comment? In that case, we will conclude our public hearing today.

I'd like to remind you that you have until tomorrow at 5:00 o'clock to submit any written comments to the Division of Workers' Compensation.

Thank you for your attendance and your input today.

And the hearing is now closed.

(Whereupon, the hearing was concluded at 10:30 a.m.)

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CERTIFICATION

I hereby certify that the foregoing is a full, true and correct transcript of the proceedings taken by me in shorthand on the date and in the matter described on the first page hereof.

__________________________
Sonia E. Garcia
Official Reporter
Workers' Compensation Appeals Board

Date: [date]