STATE OF CALIFORNIA

Department of Industrial Relations

Division of Workers' Compensation

PUBLIC HEARING

Tuesday, August 12, 2008
Elihu Harris State Office Building
1515 Clay Street
Oakland, California

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PUBLIC HEARING

Oakland, California

Tuesday, August 12, 2008, 10:00 a.m.

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MS. OVERPECK: Okay. Good morning everyone. It is 10:00. So I am going to begin the public hearing. My name is Destie Overpeck, and thank you all for coming.

This is the hearing for the Division of Workers' Compensation's Medical Treatment Utilization Schedule and its Proposed Regulations, Section 9792.20 through 9792.26. These regulations would update the Elbow Disorders Chapter by adopting ACOEM Elbow Chapter. They would also propose -- or add two new sections to Chronic Pain Guidelines and Postsurgical Treatment Guidelines. Also, the regulations would restructure our current Medical Treatment Utilization Schedule into a clinical topics format which will allow for easier updates.

With me here today is our Medical Director, Dr. Anne Searcy, and Minerva Krohn, who has been drafting the regulations.

We do not have court reporters today. We are using tape recording to record what you say, so please be really careful about clearly stating your name, who you represent, and speaking slowly so that when we do transcribe it we'll get your testimony accurately.
When you come up to speak, please give Maureen Gray, our Regulations Coordinator, either your business card or a piece of paper with your name and the entity for whom you're speaking. If you have any written comments, please also leave them with Maureen.

The public comments close today at 5:00 p.m. So you can e-mail in written comments before the end of the day, you may fax them to us, you can bring them up to us on the 18th floor. But be sure you get them in by the end of today if you have anything additionally you want to add.

Everything that you say, whether it's orally or in writing, we will review and we will consider before sending out another 15-day revision. There is -- equal weight applies. So if you do have things in writing, you don't actually have to restate them all. We don't enter into any discussion. We are here to hear your comments.

And so let's begin, and what I'm going to do is go through the sign-in sheet and go through the names. If you didn't sign up at the end and you do want to give a comment, I will call if anybody else has anything else to say.

So the first speaker is Sunny Sutton.

**SUNNY SUTTON**

MS. SUTTON: Good morning. My name is Sunny Sutton and I'm the Therapy Access Senior Regional Manager for Medtronic Neuromodulation. I am pleased to present brief
comments this morning on behalf of my colleague, William Fehrenbach, 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 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 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. We 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 over the past one-and-a-half years on the development of this chronic pain chapter. Their dedication and knowledge combined with DWC staff and leadership expertise has resulted directionally in a very strong, 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 have 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 end product is balanced. This balanced 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 these various relevant expert societies to ACOEM. This
contrast is remarkable, and not surprisingly the products vary dramatically. Again, kudos to DWC for opting a much stronger process and resulting in a far superior product than updated ACOEM allows.

Fourth, as mentioned above, we have additional comments to make, but in deference to time today we will be submitting those in writing by today'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 again for your fairness, open-door policy, and balanced work product. We Californians are very lucky indeed.

MS. OVERPECK: Thank you, Ms. Sutton. Steve Catollica?

STEPHEN CATOLLICA

MR. CATOLLICA: Good morning, my name is Steve Catollica. I represent the California Society of Industrial Medicine and Surgery, California Society of Physical Medicine and Rehab, and VQ Ortho Care today.

We submitted previous comments July 25th with respect to the adoption of the pain chapter and its content, and I won't go through that today. But in today's written comments, which were transmitted to you late yesterday afternoon, there
are four items that I'd like to highlight.

The first is 9792.23, clinical topics, and I'll explain a little bit about that in a moment. Second, as you heard the previous speaker, use of the ACOEM strength of evidence met a rating methodology as found in 9792.25(c), paragraphs (A) and (B). Third, language found within the chronic pain guidelines, chronic pain programs, page 24. And fourth, the requirement to demonstrate functional improvement as found throughout the proposal's language.

First, 9792.23, clinical topics. Without going into extreme detail right at this point, umm, letter B, number -- uhh, paragraphs -- sub-paragraphs one and two, we believe are not necessary, and we explain in our written comments why that -- we believe that's so. But just very quickly, we believe that each begins with a conditional phrase, an assumption that renders the remainder of the sentence confusing and misleading. We -- we'll recommend that they be stricken, or changed significantly, and we provide that new language.

With respect to the strength of evidence rating methodology, we are going to remind the Division that back in 2006, December of 2006, we cautioned against adoption of that rating scale, and in our written comments we reiterate our comments from that -- from that month. But I'll read just one paragraph from it:

"We want to alert the Division that
this apparent solution simply trades
one conflict for another and will perhaps
exacerbate debates and delays over requested
treatment."

So just as we stated 18 months ago, we believe it's
inappropriate as a matter of public policy to adopt proprietary
strength-of-evidence scale that's not widely distributed. Now
in our previous comments we also said they were unpublished
because they were at the time, but they are now. Suffice to
say that they're not widely distributed. They are not widely
used by other entities, and it creates confusion. For example,
ODG's explanation of medical literature ratings bears little
resemblance to the ACOEM strength-of-evidence scale and
methodology. So is one to infer therefore that the method used
by ODG to evaluate evidence and any resulting recommendation
is inferior or simply stated in different terms? How does
one compare the descriptions of the relative strength of
evidence as presented by ODG with ACOEM scale which would be
part of the regulation, or is.

We believe that the Division must provide guidance in
this critical area, avert unwarranted conflicts, and streamline
numerous interactions. What interactions? Well, the first
would be the most obvious between the adjuster, the UR vendor,
and the treating physician. But there is another one that we
believe is of equal and maybe even greater importance. And
that is between the judge, the applicant, and perhaps the
defense when a question becomes -- a question of UR approval
comes before them. Judges don't have formal training. They
need guidance in how to compare what the QME might say in that
situation. We believe that the Division needs to provide that
guidance within the regulation.

The third section. In the document of the -- part of
the rulemaking file titled chronic pain guidelines, chronic
pain programs on page 24 of that document, there are a number
of descriptive terms used for the general use of
multi-disciplinary pain management programs. And it's --
specifically, on page 24, subparagraph 1, the second paragraph,
essentially goes through what summary reports are necessary and
then makes this statement:

"Treatment is not suggested for longer
than two weeks without evidence of
demonstrated efficacy as documented by
subjective and objective gains."

Now, while we would not disagree with that statement,
we believe that in practice that's going to manifest itself in
no more than two weeks of authorization at a time. And you can
see, that if that becomes the case, that the cessation of
treatment, authorization of treatment, the need for a report,
and the accompanying request for further treatment, will cause
a delay in what might be a 12- to 14-week chronic pain program.
So the stop/start cycle that this administrative statement makes, or could cause, we believe needs to be addressed, and we describe how that might be done in our written comments.

Fourth point is functional improvement. We're concerned that the Division's overlooked a critical aspect of successful medical recovery in its use of functional improvement, and it's defined in 9792.20. Functional improvement's used repeatedly throughout the MTUS as the sole or threshold criteria for continuing medical treatment. While no one would argue the functional improvement could be a fundamental measure of the efficacy of the treatment, we suggest that the Division has inadvertently omitted the fact that therapies of many types and under many chronic circumstances are extremely successful. Vital, in fact, if they maintain function. In other words, when therapy is diminished or withdrawn, the result is instability, deterioration and less functionality. Examples include kidney dialysis, stretching exercises, strengthening and cardiovascular exercises. We go on to explain what we're talking about and give some examples from 9792.24(c) where, in fact, the language of the guideline points out where functional -- maintaining function is just as important as documenting functional improvement as it's defined. But I will go to 4(B) for the ones that I would cite. And it reads this way:

"In cases where no functional improvement
is demonstrated, postsurgical treatment
shall be discontinued at any time during
the postsurgical physical medicine period."

The situation described is exactly what we're speaking about. Therapy can bring a patient to an improved but maintenance level. Yet the guideline completely ignores the possibility of deterioration if therapy is diminished or discontinued, as that paragraph suggests. Maintenance of a level of function might be considered part of the definition of MMI, Maximum Medical Improvement. If so, following this functional improvement mandate, while in the midst of trying to settle that claim, could cause deterioration and loss of function at its most critical junction.

So we again believe that the Division must expand the possible postsurgical therapies to include those that maintain function as individual situations dictate.

Thank you.

MS. OVERPECK: Thank you.

Denise Nieber-Montoya?

MS. NIEBER-MONTOYA: That's okay. (Unintelligible comment.)

MS. OVERPECK: Marilyn Hoffmeister?

MS. HOFFMEISTER: I'm not speaking.

MS. OVERPECK: Sorry, you did say that.

Sue Borg.
MS. BORG: I can only see the tops of your heads, but that will do.

My name is Sue Borg, and I'm the President of the California Applicants' Attorneys Association, and we offer the following comments this morning. Our more detailed written response to these proposed regulations have been submitted electronically yesterday.

Our biggest concern about these guidelines is that they be viewed as recommended guidelines and not as a rigid formula for treatment that applies to every injured worker. Although "evidenced and scientifically based", these guidelines cannot and do not apply to each and every patient, nor do they invalidate the experience and knowledge and clinical judgment of the physician.

The guidelines should be a tool to be used by the physician to help identify the most effective treatment for the injured worker. In practice, however, these guidelines are too often used as a club by the insurance adjuster to deny treatment. This not only harms injured workers who can be permanently impacted by improper delays in treatment, but also causes unnecessary complications for your Division in the form of additional and unnecessary expedited hearings, for example, which in turn adds unnecessary costs to employers.

We believe that the language used to define the
adopted treatment guidelines must recognize the difference between how they are read by physicians as opposed to how they are applied by claims adjusters. Specifically, we question how claims adjusters will interpret the proposed definition of the term "functional improvement" in Section 9792.20. As amended, functional improvement now means a quantifiable improvement in activities of daily living. How will this be interpreted? How are daily living activities quantified? We believe this change will cause unnecessary problems as claims adjusters struggle to figure out how to quantify the improvement in ADLs and deny requested treatment in the meantime. We urge that the change to this section be deleted and that the current language which requires a clinically significant improvement be retained.

We also repeat our comments from the initial adoption of these guidelines regarding the general requirement that functional improvement must be shown in order to authorize continued treatment. As noted by Mr. Catollica and as noted in the statutory mandate of Labor Code Section 4600, the provision of treatment that is required is reasonably required to cure or relieve the injured worker. Unfortunately, for some injured workers, functional improvement may not be possible, but continued treatment may prevent a deterioration of their physical condition. Functional improvement should be a goal in most cases, but in some cases merely maintaining the current level of functional capacity requires continuing treatment.
We recognize that proposed Section 9792.24.3(c)(4)(A) allows additional treatment where the worker sustains an exacerbation. However, to require that the worker actually experience this exacerbation before authorizing added treatment, when clinical evidence indicates that discontinuation of the treatment will lead to deterioration of the worker's condition, is both harmful to the worker and wasteful to the system.

We repeat our recommendation that the definition of functional improvement be amended to provide that it also encompasses those situations where continued treatment is necessary to maintain the worker's current functional capacity and/or to prevent deterioration of the worker's condition.

Another language problem that we believe will cause problems is the provision in the Chronic Pain Medical Treatment Guidelines, section two on chronic pain programs. That language states the treatment is not suggested for longer than two weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. Although we understand this sentence from a medical point of view, in reality it will simply cause delays and interruption of treatment in virtually every case. In practice, the way this will work is that claims adjusters will authorize only the initial two weeks of treatment. And it is a simple fact that if a physician requests an extension of treatment near the end
of the initial two-week period, which is likely, given the need
to demonstrate the efficacy of the treatment, it is a certainty
that the authorization will not be communicated in time to
prevent an interruption in the treatment. Given that any
interruption in treatment can be devastating to workers
experiencing chronic pain problems, we suggest that this
section be amended to provide the authorization, umm, be
provided for the recommended course of treatment, but that
bi-weekly the physician shall provide evidence to the claims
adjuster of demonstrated efficacy as documented by subjective
and objective gains. At the very least, we recommend that an
initial authorization of two weeks of treatment should include
an automatic extension of two added weeks where the physician
provides evidence to the claims adjuster prior to the
expiration of the initial two-week period of demonstrated
efficacy.

Finally, we note in the notice of hearing that the
Division used October 31st, 2007 version of ODG, Chronic Pain
Guidelines, and it is our understanding that these guidelines
are updated from time to time, and that there are some
revisions that have been adopted since the version used for
these proposed regulations. Inasmuch as the process for
rebutting the adopted MTUS is unnecessarily complicated and
burdensome, we believe it is imperative that the adopted
guidelines be based on the most current medical evidence.
We therefore request that the Division review the updates to the Chronic Pain Guidelines issued by the Work Loss Data Institute since October 31st, 2007, and incorporate these changes into the Chronic Pain Medical Treatment Guidelines.

Thank you.

MS. OVERPECK: Thank you, Ms. Borg.

James Kyle?

JAMES KYLE

MR. KYLE: Good morning. My name is James Kyle, K-y-l-e. I'm here as an injured worker, that I'd like to -- bear with me -- address the guidelines and the process that I have personally gone through from this workers' comp. I am a multiple injured worker, and I can understand the -- changing the rules and the process to try to make things simplified, but what it has done, it has really created an adversity that ultimate -- that has caused delays in seeking treatment by going through the -- using the peer review and taking the work away from the claims adjusters as it used to be.

Let me go back a few years before this law went into effect in 2001. Before, I had a good working relationship with my claims adjuster wherein that I was able to make calls to have treatment expedited by giving factual information to the claims adjuster, which in turn received documentation within a 24- to 36-hour period as to not cause delays, wherein that I was off work anywhere from four to seven months to return 100
percent in full because there was no delays. There was no other entities involved to contradict physician's statements, contradict MRI reports, films of x-rays, CAT scans, of that nature. And ultimately, I was back 100 percent.

Since this has started, with this revamping of the rules and so forth, it has -- my doctor has authorized me to have post-operative therapy, and you have this mandatory X-number amount of visits per operation, the information is sent to the workers' comp carrier. The claims adjuster who used to just look it over and, for the most part, authorize it, now they are told, or have been told, as far as I'm concerned, to send everything down to a review, wherein other physicians, who look over supposedly the medical information that is submitted by the physician along with the films and so forth, but their decisions are based upon what is written in a guideline. Their final decision either to deny or go ahead and to approve, that is always made up, the decision, based upon a guideline.

I have had extended, unnecessary delays because of that because, number one, when claims adjusters are asked to send down written documentation for review, they have not, in my case, sent down all the pertinent, necessary information for the panel to review. There have been reports, that I feel was purposefully deleted, that has not given the panel enough information to make a valid determination to either approve or
deny. Then when again information is submitted and the panel reviews, it is not based upon other physicians' documentation, is not based upon the film that has been submitted, it is not even based upon the age of the injured worker, it is not even based other medical problems that the injured worker has. It is based upon just a simple guideline that does not reflect and is not even put in writing to deny or approve, which again has caused a lot of problems on my part.

I have made this known to my attorney, and I'm here today as an injured worker to say that when I was given 12 visits, per se, after I had my last operation, after I reached a certain plateau of the treatment -- and I am very proactive in my own affairs. I don't like to sit idly by. You know, I'm -- I want to have control of my life, you know. That after I reach a certain plateau, go back for a doctor visit, the doctor insists that I need further therapy, he writes out a prescription. Well okay, now here is where the delay comes in. Instead of the claims adjuster recognizing the previous report, and knowing that certain operations are required anywhere from maybe 12 to 18 months and some operations do, especially if there are multiple injuries and multiple operations, I have to stop. I have to wait. Two weeks go by. The information is sent back to deny based upon the guideline. So now we have to go to court. That is another two months' delay just to get on the calendar. Then you're talking about another 30-day delay
before -- or more, before a decision is rendered. All the while I am sitting idly by and I am not getting any kind of treatment. So my condition regresses, and in some cases it has deteriorated wherein that I had to have either another operation, or if the judge approves continuous therapy and I start back to therapy anywhere from three to four, five, six months later, and in one instance it was over a year, it did not do any good because it is like starting all over again, you know.

I don't know -- the way this is set up is not practical, and it's really -- you depend on qualified operating physicians who actually treat the injured worker, but you have people miles away who make decisions that are in a lot of cases not even in that field or have not -- or not expertise in performing certain types of operations, and you rely on that versus the qualified physician who actually knows the patient and has a history and has medical documentations and pictures to support that.

The other thing that causes delays, that has caused delays with me, is when you have the attorney sometimes that interfere wherein in one case I was scheduled for an operation and was stopped the day before because the attorney wanted to talk -- he had talked to another physician and they said, well, we need some more information after this approval was done. So what it did, it deteriorated my condition again. Ultimately, I
had the operation, but there was a four-, five-week delay in that.

I had a operation that was a two-part operation that was actually approved by the workers' comp carrier. I had the first part -- they knew it was a two-part operation. I had the first part of the operation, and when I was scheduled to have the second part, they rescinded the authorization a month before I was scheduled to have surgery. That caused a six-and-a-half-month delay when, had I had the operation, I would not had to have another subsequent operation a year-and-a-half later because my condition deteriorated. Then it did not really take 100-percent effect like it should have been had I not been delayed. I don't want to go off into detail as to the kind of operation it was, but it was -- trust me, it was a two-part operation.

And I want to emphasize that these guidelines can hold true for some things, but from a realistic scale -- you have a young man that played college football. A few years ago, tore up his knee. Youngster. He had multiple -- he had double-digit operations. He had months, years, of therapy. But they were on time. But his ultimate goal was to have control of his life and get back on his feet to play football. Now, he lost his leg. But that youngster went to San Jose State. If you saw on TV, that he got the -- he reached his dream to come out with a artificial leg on the last play to
play football. But the point I am making is that had there not been any delays in his recovering process -- not to say he wouldn't have lost his leg, but if there had been delays, I don't think that he would have been able to come up, to perform, put on a uniform and make that last play for San Jose State.

So it's a fact, and I'm living proof, that -- I have been going through this for four years. I should have been back to work at least 18 to two years ago. But because of these interference and these panels of people down there making decisions based upon a guideline -- I'm not in -- my name is not in there. Age is not considered. Multiple injuries are not considered. You know, and like I said, it's -- it's -- to me, it's a slap in the face for these physicians that have been in business for 20, 30, 40 years, and they are the best -- they are the best at what they do and substantiate everything in writing.

I wish that you would know to just look at this and do something about it, because I am not the only one. It has caused a lot of adversities in my personal life as well. Financially. To sit back and can't get paid is -- well, I'm not harping on the money. But had there not been delays, I wouldn't be in that kind of position like others, wherein they have lost their families, lost their home, lost their job, or even lost their own life.
Behind what you're trying to do, the intent, I take it is good. But the actuality and the way it's handled, the application of it and process of it, is not. It really is not. And I want to thank you for giving me this time.

MS. OVERPECK: Thank you for your comments.

Diane Przepiorski?

DIANE PRZEPIORSKI

MS. PRZEPIORSKI: Good morning. I'm Diane Przepiorski with the California Orthopedic Association, and I appreciate the time before the Division today to comment on your regs.

As you know, COA was the sponsor of a AB1073, and we very much appreciate the Division moving forward with the development of the postsurgical guidelines, treatment guidelines. And also, we'd like to compliment the Division on the way you went about developing the guidelines, and that is not necessarily just relying on published guidelines but going out to the community as well, seeking input and trying to take the best of all worlds to develop the best guidelines that you can come up with. I think that ultimately over time as the MEEAC continues to refine guidelines, they will become models for other states to look at. So I think the way you went about at least the postsurgical guidelines, we very much appreciated it. Our members appreciated being able to provide input.

I really just have a couple of comments this morning.

It seems like what we don't want to do in these
regulations is just exchange a problem that we had with legislated, 24-visit postsurgical guidelines or physical therapy treatments, to problems with guidelines. And when we were working on the legislation, we realized that not even judges had the discretion -- or it is at least a gray area that judges had discretion to authorize additional rehab visits if they felt that it was necessary. We really feel strongly that the guidelines need to contain some sort of a statement that says just because the procedure is not listed on your list of procedures that could potentially need rehabilitative surgeries, that it doesn't mean that never would a patient that had a particular surgery would need some postsurgical rehabilitation following the surgery. And we also think as part of that is -- realization is that not all patients are going to fit into, you know, X-number of visits for a rotator cuff repair. I think we realized that when we were gathering information for the Division, that even with good surgeons, their practice patterns are very different, and we want to make sure that we have optimal outcome. So patients with co-morbidities, multiple injuries, there is going to be exceptions to these rules. And we feel strongly that in this particular set of guidelines, even though it's inherent in all guidelines that they're just guidelines, that there be a clear statement that Division did not intend that there not be any postsurgical rehabilitation, of procedures that aren't listed,
or you couldn't go beyond what is recommended by ODG or MEEAC for certain situations.

And I think -- and then my second comment really kind of responds to what we have been hearing here this morning. Continuity of care, I think, is critical in the rehab. If -- you know, it's bad enough when we have to wait several weeks before we can start rehab. But then in the course of the rehabilitative service, you don't want to stop and start. So it seems to me that's missing in all of this. I mean, we have -- pain management is not a new phenomenon in workers' comp. But it seems what's missing is the involvement of the claims administrators. It seems like if they would take more active management of the patient and not just rely on, 'Are we going to send this request to utilization review?' I'm not here to say that UR is a bad thing, but they're certainly further removed from the case. They don't have -- often have access to all of the medical records. And if the the claims administrator had -- took a more active role in approving cases where they feel that additional rehab could be necessary, it might eliminate some of the stopping and starting that we're fearing might happen through the UR process.

So those are our comments. Overall, we're supportive of the Division moving forward with the postsurgical treatment guidelines, and we just don't want to go back to a situation where we had problems with the legislation and then we're just
shifting now to problems with the guidelines. So I think you have an opportunity to make the Division's intent clear here, and we have some language that we would suggest that you could add to the regulations.

Thank you.

MS. OVERPECK: Thank you.

TIM MADDEN

MR. MADDEN: Good morning. Tim Madden, representing the California -- California Occupational Medicine Physicians. We are an association of 30 clinics here in California treating injured workers. We're the primary treating physicians in the workers' compensation system.

We'd like to echo a number of the comments and commend the Division for the work that's been done on these proposed regulations. We believe these are a strong improvement over the current guidelines, and for our members it provides them more flexibility to treat injured workers, to treat them quickly, timely, effectively, and return them to work when they're able, but provides some flexibility to our -- our members.

We also are strongly encouraged with the activity of the MEEAC and the model that's been pursued in California. We think it brings more of a hands-on approach to developing these guidelines, and it's reflected in this, and so we are anxious to see it implemented and also to see fuller chapters addressed
down the road.

We did have one specific comment to mention as it relates to the language in Section 9792.24.3(c)(1). The language reads:

"Only the surgeon who performed the operation,"

Comma,

"a nurse practitioner,"

Comma,

"or a physician assistant working with the surgeon or a physician designated by a surgeon can make a determination of medical necessity."

It appears that the comma after "nurse practitioner" was inadvertently included.

In the following page, in 9792.24.35(a), it picks up the language without the comma. So the potential here is when you include the comma, it would say that a nurse practitioner could make a determination of medical necessity, which we believe that is not their intention. If it is your intention, we would have a strong opposition to that language. We just wanted to point that out. We will be submitting written comments this afternoon, and thank you again.

MS. OVERPECK: Thank you.

Dr. Laurence Badgley.
DR. LAURENCE BADGLEY

DR. BADGLEY: Laurence Badgley. I'm from Eureka, California, and I've been in the practice of medicine, continuous practice of medicine, for 40 years. I have my medical office in Eureka where I care for hundreds of injured workers, and amongst these, a group with the most prevalent diagnosis would be those with chronic low back pain.

I'm directing my comments to Section 9792.23.5, low back complaints.

The current ACOEM guidelines misrepresent contemporary medical scientific literature of low back pain secondary to mechanical injury. Authoritative peer-reviewed medical literature establishes that between 16 and 30 percent of chronic low back pain resulting from injury is due to sacroiliac joint biomechanical dysfunction. The ACOEM guidelines are absent algorithms for diagnosis of this type of work injury. As a result of this oversight, the following three circumstances have occurred within the workers' compensation medical system in California:

Number One. Tens of thousands of injured workers are misdiagnosed annually and never receive therapy specific to their injury. These errors occur despite the requirements that work injuries be specifically diagnosed.

Number Two. Primary treating physicians and qualified medical examiners have little incentive to become knowledgeable
about chronic low back pain due to sacroiliac joint dysfunction and to incorporate this knowledge into their evaluations.

Number Three. Many injured workers who have nonsurgical chronic low back pain exit their workers' compensation evaluations, ratings, and settlements with incorrect diagnoses, ongoing suffering, and physical inability to ever re-enter the workplace.

These circumstances, were they to occur in the private medical arena, would be called medical malpractice.

These circumstances, as extrapolated from my own examinations of hundreds of injured workers, each year costs the California workers' compensation medical system hundreds of millions of dollars that could have otherwise been saved and/or more appropriately expended.

The development of guidelines and algorithms for diagnosing work-related sacroiliac joint injury is not problematic. In early 2007, the ODG guidelines set forth a set of criteria for diagnosing this specific work injury. I have used the ODG criteria to encourage utilization reviewers to authorize care for tens of injured workers who would have otherwise been relegated within the ACOEM guidelines to a status of disabled and permanent and stationairy, and all based upon incorrect diagnoses.

I'm willing to advise others about these matters and thereby help to improve the rehabilitation of thousands
of injured workers who currently suffer total disability and ongoing neglect within the current system of workers' compensation medical care.

Thank you.

MS. OVERPECK: Thank you.

Dr. Steven Schumann.

DR. STEVEN SCHUMANN

DR. SCHUMANN: Good morning. Thank you for your time.

My name is Steven Schumann. I'm a practicing physician in occupational medicine; and I represent ACOEM, the American College of Occupational and Environmental Medicine; as well asWOEMA, ACOEM's western regional counterpart component, Western Occupational and Environmental Medical Association, as president-elect.

On behalf of ACOEM, I'd like to thank you for the opportunity to comment today on DWC's proposed rule to amend the Medical Treatment Utilization Schedule. Another colleague representing ACOEM, Dr. Kurt Hegmann, is here today, and he will offer more detailed comments on specific portions of the proposed rule.

Before I begin my testimony, I think it's worth taking a moment to respond to some inaccuracies from yesterday's hearings in southern California.

An online newsletter covering workers' comp issues attributed comments to several of those who testified
yesterday, which are flatly wrong and need to be corrected for
the record. I won't spend a lot of time on this, but because
the speakers misrepresented ACOEM's guidelines yesterday, I
think it's very important that you have the facts.

First, comments suggesting ACOEM's guidelines don't
reflect evidence-based studies are simply wrong. If anything,
ACOEM's guidelines more -- include more evidence from
randomized clinical trials than other guidelines being
currently used.

And to suggest that our evidence is weaker, as one
speaker put it, really bends reality. Our rating system, which
DWC adopted a year ago, demands the highest standards of
evidence possible in the process of making recommendations.

I also want to assure that ACOEM has been very fair
and accommodating to several of the organizations that
testified yesterday in accepting their input for our
guidelines. We actually postponed our publishing process in
order to give them additional time to comment last fall on
our chronic pain guidelines. We would be happy to share
information about our peer-review process, which is transparent
and very inclusive.

Now let me turn to our comments regarding the proposed
rules.

Let me begin by saying that we appreciate the State of
California's leadership in implementing evidence-based medical
treatment guidelines to ensure that injured workers receive quality medical care in a timely and appropriate manner. ACOEM has worked closely with California in the past, and we look forward to an ongoing relationship dedicated to providing the best care possible for injured workers and the best guidelines for physicians.

ACOEM supports the proposed reorganization of the MTUS to make it more user friendly and to allow the DWC to adopt and/or update portions of the MTUS through formal rulemaking without affecting other parts of the MTUS.

As you go forward with your efforts to improve the MTUS and care for injured workers, we urge you to consider several principles that we consider essential.

First, is that any guidelines adopted should be truly evidence-based. Practice guidelines are only as good as the methods used to develop them, and ACOEM is very proud of the extensive effort we have made over the last several years to build what is arguably the finest infrastructure in existence for the development of occupational medicine guidelines. Our new and improved methodology involves literally thousands of hours of effort by a large development team that includes more than 50 physicians, as well as a full-time administrative staff. At the heart of their work is the creation of a completely transparent, state-of-the-art methodology that adheres to all of the recognized standards for evidence-based
medicine, including those developed by AMA and AGREE.

In evaluating the soundness of methodology, we hope that you will put a premium, and we know you do, as we do, on two fundamentals: Evidence must be subjected to a clearly articulated, consistent, valid and reliable grading system; and in order to be valid, that system must evaluate, grade and critique the entire body of high and moderate quality literature on a topic. Of all the evidence, quality randomized clinical styles -- trials and crossover trials should be standard as we strive as far as offering the best basis for decision-making on what treatment -- treatments are effective for the care of injured workers. Finally, and again in the best long-term interest of the State of California, we urge you to place a premium going forward on guidelines that offer original evaluations of quality studies of injured workers as the cornerstones of the methodology. Guidelines based on original evaluation of evidence, rather than secondary evaluations contained in review articles, are inherently more valid and reliable and will ensure the quality outcomes the state hopes to achieve.

Now, some comments about the chronic pain guidelines.

The Division is to be commended for its decision to expand MTUS to include a more detailed approach to chronic pain. Chronic pain in today's workplace represents a challenge to physicians caring for injured workers, but it should be
noted that reaching agreement on an evidence-based guideline for treatment of chronic pain is an exceedingly complex, difficult, and often controversial effort.

While we all applaud -- while we applaud all you have done recently to build a strong guideline-based medical review system, and specifically for expanding the discussion of chronic pain, we do have some concerns about the details of the proposed changes to MTUS. I will make some very general observations; and my colleague, Kurt Hegmann, will offer a much closer look at the issues at hand.

ACOEM has just completed the chronic pain update to its comprehensive practice guidelines. As we have all -- as we have completed all research, evidence evaluation, synthesis and peer review of the ACOEM chronic pain update, we are in a unique position to assess DWC's proposed treatment guideline. After thorough review, we believe that the Division's proposal would benefit from inclusion of added content on this update. Our chronic pain panel members, trained in our evidence-based methodology, found some shortcomings in the proposed treatment guideline that we would like to share with the DWC in order to make the most informed decisions going forward. Of particular note is what we believe to be a lack of specificity in treatment options and the potential for confusion among providers and payers that could result from combining treatment recommendations authored by the Division and adapted from ODG.
Combining recommendations in this way utilizes two completely different article-grading methods and methods to develop guidance while presenting recommendations on two different formats in a given topic. We believe it's worth taking a second look at this part of the proposed proposal to ensure no inconsistency is introduced to the overall system.

In addition, the proposed chronic pain treatment guideline appears to be quite limited, potentially restricting services to injured workers. Dr. Hegmann will discuss this in more detail, but let me summarize by saying that we believe treatment options must include as much specificity as the evidence allows in order for guidelines to achieve their full potential in reducing harmful variations in care and reducing cost.

As a remedy, we encourage the Division to use portions of the ACOEM chronic pain update to supplement or modify the proposed rule if necessary.

Let me conclude by reiterating that, beyond these specific issues, ACOEM is an enthusiastic supporter of California's efforts to shape an effective guideline system, and would be pleased to offer any additional analysis, review or recommendations to improve the current proposal. We are delighted that the Division proposes to adopt updated guidelines for elbow disorders developed by ACOEM, and we look forward to our continued collaboration with the Division.
and the State of California to ensure that injured workers receive quality medical care.

Thank you for the opportunity to speak.

MS. OVERPECK: Thank you for your comments.

Dr. Matthew Hughes.

DR. HUGHES: I'd like to withdraw.

MS. OVERPECK: Sure.

Frank Navarro.

FRANK NAVARRO

MR. NAVARRO: Good morning, my name is Frank Navarro. I am with the California Medical Association.

It's good to be here to share CMA's comments. I won't go into every detail of those comments, but I would like to express California Medical Association's support of what the MEAC or MEEAC has recommended.

One thing that we would ask I think that is very important has to do with the hierarchy of evidence tables. And we would like the Division to reopen that and consider the importance of consensus-based opinions. There is a paucity of recommendations -- excuse me -- evidence-based -- excuse me. I am so sorry. Evidence-based medicine or studies. And we believe that the way the regulations are written, it would ignore a physician's acumen.

One more statement has to do with the ODG. CMA TAC technical -- excuse me -- Workers' Compensation Technical
Advisory Committee has looked at ODG and ACOEM, and we lean
towards ODG, particularly on these -- this set of proposed
regs. One thing that we would ask -- and we don't want to
delay these anymore. We really want these regs out there. But
since there is a revision to the ODG chronic pain guidelines,
what we would ask for you to consider would be integrating the
proposed language from the MEEAC, M-E-E-A-C -- I should call it
"MEEAC", I guess -- incorporating those recommendations and
looking at ODG and incorporating the rest of the
recommendations that are in there. So we don't want to confuse
it, but we want -- what we want is the reference to the studies
that ODG refers to in this most recent update.

In speaking with ODG or -- excuse me -- with the
publisher of ODG guidelines, they are more than happy to
provide you with that analysis, and I can arrange for that to
happen.

And I think that's the end of my comments.

Thank you so much. You guys have done a great job. I
would like to commend Carrie Nevans. I wish she was here
today. I look forward to her being confirmed for this position
that she has done such a great job in so far. There has been a
remarkable change in the Division. It is far more
collaborative than it's ever been. I personally believe that
when I walk away from a meeting that -- and Dr. Searcy, Destie,
you have really listened to what CMA is talking about. And I
want to thank you and close with that.

If you have any questions of me, I'd be happy to answer.

MS. OVERPECK: No. Thank you, though.

MR. NAVARRO: Okay.

MS. OVERPECK: Tom Waldorf.

**TOM WALDORF**

MR. WALDORF: My name is Tom Waldorf. I'm representing work comp providers in California.

I wanted to specifically bring up from our providers the issue of the topical analgesic creams that were not recommended in the ACOEM guidelines, and basically read a letter from one of our providers. And then we also have one of our compounded pharmacists that we work with that wanted to make some recommendations. I will read from his letter and receive comments from that:

"To Whom It May Concern, please consider this my formal professional objection to the DWC's proposal to effectively abolish the use of compounded topical medications. As a full-time PM&R physician, the majority of my practice consists of the management of both acute and chronic work-related injuries. I have innumerable examples of cases in my practice in which the use of compounded
medication, those not available via the
commercial pharmacies, resulted in
symptomatic and functional improvement for
injured workers.

"The use of topical treatments, although
well established in compounded form for soft
tissue injuries, is rather novel in the world
of evidence-based medicine as it relates to
the commercial pharmaceutical industry, the
evidence of the commercial products approved
by the FDA for topical management of pain
conditions. That said, we are limited as
practitioners to only a couple of active
ingredients, doses and delivery vehicles.
The use of compounded medications has allowed
us as the providers to expand the concept of
topical treatment for pain to include more
conditions and a much larger patient base.
As an example, the Flector patch has recently
been approved for acute short pain due to minor
sprain/strains. With the active ingredient,
non-steroidal diclofenac, the Flector patch is
sometimes not tolerated by patients because
it is not strong enough. It has a delivery
method (patch) that is irritating to the patient,
or the patch does not adhere properly. The use of a topical indocin, another non-steroidal, which is not available commercially, allows me to hand pick the dose, change dose intervals, and provide the patient with a different delivery method, a cream base.

"Another example is a Lidoderm patch, FDA approved for the use of certain nerve conditions. Again, this is available only in a five percent and a single-delivery method. I will not be able to treat my pain -- my burn patient who has such severe pain in his feet that he cannot wear socks or shoes, much less the patches. He is only able to continue gainful employment with the use of compounded ten percent lidocaine cream applied twice daily under his socks and steel shoes.

"It is clear by the proposal that the medical literature supporting compounding is being ignored. Double-blinded control clinical trials are expensive. Pharmaceutical companies will not pay for further studies since they cannot patent compounds and receive any financial gain. How ironic is it that opioids are fully endorsed and prescribed in sometimes escalating doses despite
the lack of well-designed controlled trials supporting functional improvement, yet side effects, dependency, hormonal balance and addiction are known complications and encountered on a daily basis. I have yet to encounter such issues with topical compounded medication."

Thank you.

DR. SEARCY: Could you just mention the name of the doctor who wrote that?

MR. WALDORF: Yes. That is Dr. Jeffrey Scott, board certified physical medicine doc in Modesto.

MS. OVERPECK: Robert Seik.

ROBERT SEIK

MR. SEIK: Hello. My name is Robert Seik. I am a pharmacist. I am the compounded pharmacist that Tom referred to. And I am here just to make a couple of remarks, you know, having a short amount of time to review some of the comments that were made in the recent ACOEM guidelines and the denial to actually recommend some of the compounded creams based on what is evidence-based medicine. And I am bringing these comments from two perspectives where I've spent, you know, my career bifurcated in two different places. And for ten years I worked in the pharmaceutical industry actually managing clinical trials, writing documentation for new drug applications that have actually been submitted to the FDA. And I do note that
there is great deal of importance to evidence-based medicine, and what constitutes that evidence, you know, is clear to me that it is very important. However, what I notice from the guidelines and the references that were used to the application of transdermal or topically applied compounded creams or variations of different ingredients that can be utilized, is that there is quite a bit of information that I felt was left out, in other words, referenced in that material. So rather than read to you my nicely assembled 12-page document which you can do in your free time -- I jest -- there are 35 references that I have given you that talk about, you know, very specifically the application of these products and the clinical utility that they give the practitioner.

The other part of my career has been actually, you know, becoming a compounding pharmacist, leaving the drug industry and actually pursuing, you know, my own business. So I am here representing, you know, the fact that I do provide that type of services to doctors that want access to these products. And there is -- although there is a great deal of evidence-based medicine that I submit exists in 35 references that I have given, a lot of the importance of clinical trials and I think how different ranking systems may or may not affect people with various disease types such as chronic pain based are on these large randomized placebo controlled trials. It may not always be financially feasible for companies to engage
in these because there is a great deal of issue with regard to
the patentability of products and the actual mechanics involved
for small companies, like compounding pharmacies that provide
these things, that do not have the ability to submit these for
such, you know, large randomized clinical controlled trials,
but does not, you know, take away from the clinical utility of
that practitioner, like Dr. Jeffrey Scott and many other
practitioners that my company works with and my colleagues in
compounding pharmacy that -- that are accredited and certified
by independent organizations and sometimes by the state. The
guidelines in which we function to provide high quality product
for utilization, their patients allows us to take a look at
what may not be, you know, very large randomized clinically
controlled trials which, statistically speaking, we --
remember, these are trials that are designed to detect small
differences between a placebo and an active drug or, God
forbid, if pharmaceutical companies go head to head to look at
-- at one therapeutic application, one drug, and compare it
against another, you need large numbers of patients to detect
small differences in order to gain FDA approval. And even with
FDA approval we are not always assured of the drug's safety,
and I can list on one hand at least a handful of withdrawals
including Vioxx, most recently from the market, drugs that are
made through what is a very rigorous and grotesquely expensive
process to get medications approved, unfortunately for many of
the large drug companies, only to have them later on withdrawn because of toxicities that may not have been identifiable or easily identifiable in, you know, still what are relatively large clinical trial populations in the studies that were submitted for approval of the drug. And that being said, even with the drug approved and the lack of toxicity being identified, you know, follow on trials as we've seen recently in the press for stories on Vitorin with absolutely no effect, you know, for some of the major applications and cardiovascular disease as well.

So the existence of literature is one thing. The existence of the clinical significance is another, and, you know, I encourage the panel to take a look at the antithesis of that and evaluate on the practitioner's bases and hear the words of those who, through use some of the products that my company would provide and get their feedback from the patients that have been benefited from them and look at the value of, you know, single patient clinical trials which have been done. And some of these references do include that, and there is a large body of literature that supports that, because when -- when you have a disease or a condition that is relatively stable, and you can detect an enormous difference in the functionality or the perceived pain for the patient in this sense that we're talking about, then the randomized placebo controlled trial may mislead -- what you want to consider, may
not necessarily dictate what is ultimately, umm, you know, the
list of products or the armamentarium that the practitioner has
access to.

So I'll close my remarks with that, and I'll submit
this document for your review which includes many, many
references.

DR. SEARCY: Thank you.

MR. SEIK: Thank you.

MS. OVERPECK: Gerald Rogan, M.D.

GERALD ROGAN, M.D.

DR. ROGAN: Good morning. My name is Dr. Jerry Rogan,
Gerald Rogan. I'm a representative today of the
Musculoskeletal Clinical Research Associates, LLC, that provide
consultative services to the orthopedic device industry for --
in hope to get coverage of various devices manufactured by
their clients when there is sufficient evidence to warrant
coverage.

So I recognize today that you are -- I was a
practicing family doctor in Walnut Creek for 18 years and an
emergency room doctor before that. And -- but lately I have
been working as a consultant to the health care industry.

My conflict of interest is that I am paid an hourly
fee and have no vested interest in the outcome financially, one
way or the other.

I recognize that in the future you are going to be
working on some surgical options, and the reason I chose to
make a remark today is only because the surgical option as
mentioned under Section 9792.23.5(d), namely that there is no
surgical option, so the question is when is the surgical option
appropriate is something that I know you'll be considering in
the future. And so I wanted to speak to that just for a
moment, and just in basic general terms because there is
nothing specific to talk about today.

But MCRA and myself, we support the use of
evidence-based guidelines, and I'm very pleased to hear that
that's your focus as well. And we would like to work with the
Department of Industrial Relations in the guideline development
that is going forward about the surgical treatment of chronic
low back pain thought to be due to degenerative disk disease.
We would like to work with you to see if you would agree that
there is enough scientific evidence available to allow for
multiple surgical options for the treatment of degenerative
disk disease in the lumbar spine, one of which could include
the use of artificial disks.

So that's our emphasis going forward, that we would
like to see some review of the evidence that we would bring
forward to you to show that an artificial disk treatment for
certain selected patients who would otherwise get surgery,
who would otherwise get fusion surgery, may be an appropriate
alternative to fusion.
And there are -- so that's the -- that's the basis. And I think it would be more relevant to go into the specifics at a later time when there is a surgical policy. So that is all I have to say unless you have any questions.

Thank you.

MS. OVERPECK: Thank you.

Kurt Hegmann.

KURT HEGMANN

DR. HEGMANN: Good morning. My name is Kurt Hegmann, and I represent ACOEM, the American College of Occupational and Environmental Medicine. I also practice occupational medicine including caring for injured workers, including workers with chronic pain, including also directing one of the nation's 17 education research centers in occupational health and safety. You have two of those centers here in California.

I serve as the editor-in-chief of ACOEM's Occupational Medicine Practice Guidelines.

As Dr. Schumann noted, I'll focus today on specific elements to have suggestions to improve the DWC proposal. ACOEM believes that it should ideally be strengthened in order to provide the highest quality medical care for injured workers and optimal usability for health care professionals.

Our written comments will address the Division's proposed adoption of ACOEM's guidelines for elbow disorders.

I'd like to spend the rest of my time today addressing
issues we identified in the Division's proposed chronic pain guidelines.

As Dr. Schumann just mentioned, earlier this year we finished our update for chronic pain. I am in the process of completing this very detailed work. We conducted what may well be the most extensive review of chronic pain studies and literature attempted to date.

The ACOEM update was a culmination of thousands of hours of evidence review, of grading of articles, critiquing of articles, literature review and ultimately a robust debate by a multi-disciplinary panel of experts with representation from a cross section of specialties to cover the diverse needs of injured workers with chronic pain from primary care, where most of them are seen, through tertiary care.

In comparing the proposal with findings of our recent review, we do think that there are some issues, including a few recommendations that may help. Before I discuss specifics, let me make some general observations.

First, we believe that although mistreating or undertreating pain is a significant concern, another concern needs to be risk for patients and physicians from overtreatment by physicians of the patients with chronic pain, especially if they have potential for adverse effects. Even non-invasive treatments can result in irreparable harm to the patient's socio-economic status, home life, personal relationships, and
quality of life.

Evidence is gathering that the use of active treatment modalities including exercise, education and activity modifications should be emphasized over passive treatments such as medication, injections or physical modalities, as they produce better clinical outcomes for patients and workers with chronic pain.

As noted earlier, we are also concerned with potential confusion for providers and payers introduced by a combination of treatment recommendations authored by the Division and adapted from ODG. Use of these two different methods provides for substantial confusion to the reader. Areas of confusion may include difficulties with understanding the evidence, inability to objectively test the recommendations for reproducibility, and impairment of the ability to develop or subsequently revise guidance.

The Division should be lauded for its use of one of these methods which appears to follow specific methodology, resulting in more clear testable and reproducible development of evidence. The other is unclear and appears generally untestable.

As a general observation, the proposed rule appears to be limited and lacks specificity in expressing recommendations. We have some concern about the potential for restriction on access of care by injured workers. For example, in our update
we have 221 recommendations we have come up with, which is more
than there are in the proposed rule.

In order to help, ACOEM has given permission to the
Division to use portions of its chronic pain update to help
address some of these areas to supplement where it may be
beneficial to do so.

I may now turn to a few specific issues.

We spoke of the draft document. Seems a bit unclear.

There are some recommendations that come up that do not seem to
be particularly relevant directly to chronic pain. For
example, acute pain is mentioned, and postmastectomy patients
are mentioned. Although chronic pain is now almost universally
accepted as a biopsychosocial condition, there is little
guidance to help the provider as far as how to adapt and
implement that.

The lack of treatment algorithms is also an area for
potential improvement. Algorithms provide further guidance
about the sequence of treatment, and some providers very much
like those algorithms, although admittedly some do not.

Nevertheless, for those who like them, they do help to provide
a quick, accurate guidance for busy clinicians.

Work-hardening or work-conditioning programs are not
mentioned, and yet we believe that they are beneficial and
they are established and often accredited.

In addition to these general issues, there are a
few specific issues that may be also of assistance. The section on medication contains the following, that there are few studies of the use of medications in the subacute or chronic pain periods. We have identified over 50 such studies, however, and that may be of assistance. The document appears to endorse the use of a specific widely used class of anti-depressants for treatment of chronic pain which is a selective serotonin reuptake inhibitors or SSRIs. There is evidence that these medications are effective for treatment of the non-occupational condition, fibromyalgia. However, all the other studies on typical occupational injuries such as spine pain and those sorts of things going back 15 years document that they are ineffective compared with placebo for treatment of these typical occupational conditions, and yet the proposal appears to endorse these medications.

Complex regional pain syndrome is an infrequent but very painful and costly disorder. The current document does little to help guide clinicians towards the treatments that evidence shows are more effective. As two examples, for example, dysphosphonates appear to have the largest magnitude reductions in pain ratings. The text also states that studies on calcitonin have "mixed results", yet our careful review of the evidence indicates that the two higher quality studies both had positive beneficial results. It was only the single lower quality study which was negative which suggests that these are
in fact efficacious interventions.

Arthritis is addressed in a fairly limited manner. There are over a hundred quality studies on dozens of treatments that appear to have been overlooked and thus aren't addressed. It is recommended that the diagnosis be deferred for comprehensive review.

Quality evidence also documents that adding corticosteroids to trigger point injections produces no added benefits while simultaneously potential -- exposing patients to an unnecessary adverse effect.

In summary, please let me reiterate that ACOEM fully supports the Division's attempt to create high quality standards for the treatment of injured workers with chronic pain. By addressing these issues we believe your effort will be significantly enhanced. We look forward to assisting you and improving the care of injured workers in the state of California.

Thank you.

MS. OVERPECK: Thank you.

Nancy Chance.

MS. CHANCE: Good morning. My name is Nancy Chance.

I don't represent any group. I'm here on behalf of my husband, Richard Chance, who is a live, breathing person, who is trapped in the workers' compensation system. I'm here to
tell you our story. I'm here to tell you about utilization review and how it doesn't work, and I don't have any other forum. I went to my legislators; they suggested I come here. I wrote a letter and testified last time, and I got a response, so I just want to tell you a little bit about our -- our situation and tell you what we've been through since December 11th of 2006.

My husband was hit by a speeding motorcycle. He suffered an open-book pelvic fracture, a fracture to his femur, a fracture to his fibula and his tibia. He suffered traumatic brain injury and spent 29 days in Stanford, in ICU. He was then transferred back to Sacramento, where we are from, and spent another two weeks at Mercy Rehabilitation Hospital.

From day one, I've had trouble getting anybody to respond. It said right in his discharge papers that he needed to see a neurologist. Well, we had to get an authorization, and it had to go to medical -- it had to go to utilization review, but it was in the discharge papers. Why would that have to happen? It took four months for him to see a neurologist.

In June of '07, he was diagnosed with non-communicating hydrocephalus because of the head trauma that he suffered. He needed a VP shunt put in; that happened in May of 2008.

There are people, real, live people, that are part of
the system. And I appreciate that you're looking at guidelines
and all those kinds of things, but my husband's not an elbow,
and he's not a shoulder, and he's not a back; he's a whole
person. And our whole life has been turned upside down, and --
and I think that you're talking about these guidelines and
utilization review and authorizations, somebody needs to
remember us.

You know, Richard worked 33 years. He's contributed
to society. I had a -- I had an uninsured motorist policy that
I can't get my hands on because now workers' comp is going to
get that, even though we were hit by an uninsured motorist with
no driver's license. You know, we -- if he was hit walking
across the street, I could have taken care of myself because my
healthcare, my good healthcare that we both had, would have
taken care of him, and I wouldn't have had to wait and wait and
wait for everything he needs.

He currently stills sleeps in a hospital bed in our
downstairs bedroom. I haven't slept in the same bed with my
husband in 20 months.

So when you're considering guidelines, when you're
considering the things that you're doing, please remember him
and the many, many, many people like him, because the other
part I want you to remember is Richard has me. I don't take
"no" for an answer. Every time they said "no" to me, I fought
back.
I happen to know of people who have the same exact injuries that have permanent brain damage because they didn't have somebody that fought back when they were told "no," when they were denied; and they were. Denial, denial, fight back, denial. It's ridiculous. It really is.

And I'm not -- I know it's not your fault, but somebody has to hear me, so that's why I'm here. I'm not a doctor. I'm not an anybody except this man's wife, and he's really important to me.

Thank you.

MS. OVERPECK: Thank you.

I don't have any additional names in front of me. Is there anyone else here today who wanted to provide comments?

**KRISTINE SHULTZ**

MS. SHULTZ: Kristine Shultz, representing the California Chiropractic Association. Thank you so much for the opportunity to testify today.

Our organization shares the concerns of some of the other provider groups about there needs to be some language in there, we believe, to be clearer. The patients with contra-indications, patients with special circumstances, may need more care than the number of visits that are prescribed under the guidelines.

We also are concerned that -- about the DWC adopting an older version of the ODG guidelines. There have been some
changes to ODG in the spring, and that they're significant. We believe that if for some reason, for legal reasons, you can't adopt the most current version, at the very least, if you're doing another 15-day revision, to adopt this spring -- that spring version rather than the October.

There's also one instance where the guidelines called for exercise after surgery when it may not be appropriate for every patient. I'll submit written comments by the close of business with those specifics and the specific suggested language.

Thank you very much.

MS. OVERPECK: Thank you.

Are there any additional individuals who would like to make a comment at this time?

(No response.)

MS. OVERPECK: All right. Hearing nothing, we will close our public hearing. And don't forget, if you do have any written comments, please submit them to us before 5:00 o'clock today.

Thank you all for participating.

(The public hearing was then adjourned.)

---oOo---