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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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1 PUBLIC HEARING

2 Oakland, California

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

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5 MS. OVERPECK: Okay. Good morning everyone. It is  
6 10:00. So I am going to begin the public hearing. My name is  
7 Destie Overpeck, and thank you all for coming.

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

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

21 We do not have court reporters today. We are  
22 using tape recording to record what you say, so please be  
23 really careful about clearly stating your name, who you  
24 represent, and speaking slowly so that when we do transcribe  
25 it we'll get your testimony accurately.



1 comments this morning on behalf of my colleague, William  
2 Fehrenbach, Medtronic Neuromodulation State Government Affairs  
3 Director, who unfortunately could not fly in today to testify.

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

10 Ms. Nevans and Dr. Searcy have had an open-door policy whenever  
11 we or any of the implanting physicians with whom we work had  
12 questions or wanted to provide information.

13 While our state government affairs staff has strong  
14 relationships and works closely with workers' compensation  
15 officials throughout the country on a regular basis, we  
16 regularly cite California DWC as truly remarkable both in their  
17 knowledge base and open-door policy. We California citizens  
18 are very lucky to have such a strong leadership and staff at  
19 DWC.

20 Second, we'd like to thank the members of the Medical  
21 Evidence Evaluation and Advisory Committee for their strong  
22 work over the past one-and-a-half years on the development of  
23 this chronic pain chapter. Their dedication and knowledge  
24 combined with DWC staff and leadership expertise has resulted  
25 directionally in a very strong, fair, and balanced approach,

1 both overall as well as for this chronic pain chapter. We have  
2 analyzed it regarding therapies in which we are involved and  
3 have also spoken extensively with interventional pain  
4 physicians with whom we work, and all that have reviewed the  
5 proposal generally believe that, while not perfect, it is  
6 directionally strong. We have identified a few areas that  
7 could use additional clarification and others that we suggest  
8 be changed. But again, overall, we believe directionally this  
9 is a strong, balanced product and are appreciative of the work  
10 of staff and the MEEAC committee.

11 Third, it deserves note that this strong, balanced  
12 work and the balanced MEEAC committee involves work,  
13 participation, and input from all relevant types of medical  
14 specialties who are representing various specialty societies.  
15 The active inclusion of various medical professionals and  
16 societies no doubt has been key to helping to ensure that end  
17 product is balanced. This balanced process and product stands  
18 in stark contrast to the recently updated ACOEM low back and  
19 draft chronic pain chapters and related ACOEM processes which  
20 neither included formal representation of any of the national  
21 medical societies known for being involved in many of the  
22 interventions being reviewed, nor do they reflect any relevant,  
23 substantive, evidence-based and expert-medical-consensus-based  
24 comments or conclusions which have subsequently been made by  
25 these various relevant expert societies to ACOEM. This

1 contrast is remarkable, and not surprisingly the products vary  
2 dramatically. Again, kudos to DWC for opting a much stronger  
3 process and resulting in a far superior product than updated  
4 ACOEM allows.

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

13 Thank you for your time and again for your fairness,  
14 open-door policy, and balanced work product. We Californians  
15 are very lucky indeed.

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

17 **STEPHEN CATOLLICA**

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

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

1 are four items that I'd like to highlight.

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

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

19           With respect to the strength of evidence rating  
20 methodology, we are going to remind the Division that back in  
21 2006, December of 2006, we cautioned against adoption of that  
22 rating scale, and in our written comments we reiterate our  
23 comments from that -- from that month. But I'll read just one  
24 paragraph from it:

25                           "We want to alert the Division that

1                   this apparent solution simply trades  
2                   one conflict for another and will perhaps  
3                   exacerbate debates and delays over requested  
4                   treatment."

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

20                  We believe that the Division must provide guidance in  
21                  this critical area, avert unwarranted conflicts, and streamline  
22                  numerous interactions. What interactions? Well, the first  
23                  would be the most obvious between the adjuster, the UR vendor,  
24                  and the treating physician. But there is another one that we  
25                  believe is of equal and maybe even greater importance. And

1 that is between the judge, the applicant, and perhaps the  
2 defense when a question becomes -- a question of UR approval  
3 comes before them. Judges don't have formal training. They  
4 need guidance in how to compare what the QME might say in that  
5 situation. We believe that the Division needs to provide that  
6 guidance within the regulation.

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

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

19           Now, while we would not disagree with that statement,  
20 we believe that in practice that's going to manifest itself in  
21 no more than two weeks of authorization at a time. And you can  
22 see, that if that becomes the case, that the cessation of  
23 treatment, authorization of treatment, the need for a report,  
24 and the accompanying request for further treatment, will cause  
25 a delay in what might be a 12- to 14-week chronic pain program.

1 So the stop/start cycle that this administrative statement  
2 makes, or could cause, we believe needs to be addressed, and we  
3 describe how that might be done in our written comments.

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

25 "In cases where no functional improvement

1 is demonstrated, postsurgical treatment  
2 shall be discontinued at any time during  
3 the postsurgical physical medicine period."

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

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

17 Thank you.

18 MS. OVERPECK: Thank you.

19 Denise Nieber-Montoya?

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

22 MS. OVERPECK: Marilyn Hoffmeister?

23 MS. HOFFMEISTER: I'm not speaking.

24 MS. OVERPECK: Sorry, you did say that.

25 Sue Borg.

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

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

14           We also repeat our comments from the initial adoption  
15 of these guidelines regarding the general requirement that  
16 functional improvement must be shown in order to authorize  
17 continued treatment. As noted by Mr. Catollica and as noted in  
18 the statutory mandate of Labor Code Section 4600, the provision  
19 of treatment that is required is reasonably required to cure or  
20 relieve the injured worker. Unfortunately, for some injured  
21 workers, functional improvement may not be possible, but  
22 continued treatment may prevent a deterioration of their  
23 physical condition. Functional improvement should be a goal in  
24 most cases, but in some cases merely maintaining the current  
25 level of functional capacity requires continuing treatment.

1           We recognize that proposed Section 9792.24.3(c)(4)(A)  
2 allows additional treatment where the worker sustains an  
3 exacerbation. However, to require that the worker actually  
4 experience this exacerbation before authorizing added  
5 treatment, when clinical evidence indicates that  
6 discontinuation of the treatment will lead to deterioration of  
7 the worker's condition, is both harmful to the worker and  
8 wasteful to the system.

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

14           Another language problem that we believe will cause  
15 problems is the provision in the Chronic Pain Medical Treatment  
16 Guidelines, section two on chronic pain programs. That  
17 language states the treatment is not suggested for longer than  
18 two weeks without evidence of demonstrated efficacy as  
19 documented by subjective and objective gains. Although we  
20 understand this sentence from a medical point of view, in  
21 reality it will simply cause delays and interruption of  
22 treatment in virtually every case. In practice, the way this  
23 will work is that claims adjusters will authorize only the  
24 initial two weeks of treatment. And it is a simple fact that  
25 if a physician requests an extension of treatment near the end

1 of the initial two-week period, which is likely, given the need  
2 to demonstrate the efficacy of the treatment, it is a certainty  
3 that the authorization will not be communicated in time to  
4 prevent an interruption in the treatment. Given that any  
5 interruption in treatment can be devastating to workers  
6 experiencing chronic pain problems, we suggest that this  
7 section be amended to provide the authorization, umm, be  
8 provided for the recommended course of treatment, but that  
9 bi-weekly the physician shall provide evidence to the claims  
10 adjuster of demonstrated efficacy as documented by subjective  
11 and objective gains. At the very least, we recommend that an  
12 initial authorization of two weeks of treatment should include  
13 an automatic extension of two added weeks where the physician  
14 provides evidence to the claims adjuster prior to the  
15 expiration of the initial two-week period of demonstrated  
16 efficacy.

17           Finally, we note in the notice of hearing that the  
18 Division used October 31st, 2007 version of ODG, Chronic Pain  
19 Guidelines, and it is our understanding that these guidelines  
20 are updated from time to time, and that there are some  
21 revisions that have been adopted since the version used for  
22 these proposed regulations. Inasmuch as the process for  
23 rebutting the adopted MTUS is unnecessarily complicated and  
24 burdensome, we believe it is imperative that the adopted  
25 guidelines be based on the most current medical evidence.

1 We therefore request that the Division review the updates to  
2 the Chronic Pain Guidelines issued by the Work Loss Data  
3 Institute since October 31st, 2007, and incorporate these  
4 changes into the Chronic Pain Medical Treatment Guidelines.

5 Thank you.

6 MS. OVERPECK: Thank you, Ms. Borg.

7 James Kyle?

8 **JAMES KYLE**

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

19 Let me go back a few years before this law went into  
20 effect in 2001. Before, I had a good working relationship with  
21 my claims adjuster wherein that I was able to make calls to  
22 have treatment expedited by giving factual information to the  
23 claims adjuster, which in turn received documentation within a  
24 24- to 36-hour period as to not cause delays, wherein that I  
25 was off work anywhere from four to seven months to return 100

1 percent in full because there was no delays. There was no  
2 other entities involved to contradict physician's statements,  
3 contradict MRI reports, films of x-rays, CAT scans, of that  
4 nature. And ultimately, I was back 100 percent.

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

19           I have had extended, unnecessary delays because of  
20 that because, number one, when claims adjusters are asked to  
21 send down written documentation for review, they have not, in  
22 my case, sent down all the pertinent, necessary information  
23 for the panel to review. There have been reports, that I feel  
24 was purposefully deleted, that has not given the panel enough  
25 information to make a valid determination to either approve or

1 deny. Then when again information is submitted and the panel  
2 reviews, it is not based upon other physicians' documentation,  
3 is not based upon the film that has been submitted, it is not  
4 even based upon the age of the injured worker, it is not even  
5 based other medical problems that the injured worker has. It  
6 is based upon just a simple guideline that does not reflect and  
7 is not even put in writing to deny or approve, which again has  
8 caused a lot of problems on my part.

9 I have made this known to my attorney, and I'm here  
10 today as an injured worker to say that when I was given 12  
11 visits, per se, after I had my last operation, after I reached  
12 a certain plateau of the treatment -- and I am very proactive  
13 in my own affairs. I don't like to sit idly by. You know, I'm  
14 -- I want to have control of my life, you know. That after I  
15 reach a certain plateau, go back for a doctor visit, the doctor  
16 insists that I need further therapy, he writes out a  
17 prescription. Well okay, now here is where the delay comes in.  
18 Instead of the claims adjuster recognizing the previous report,  
19 and knowing that certain operations are required anywhere from  
20 maybe 12 to 18 months and some operations do, especially if  
21 there are multiple injuries and multiple operations, I have to  
22 stop. I have to wait. Two weeks go by. The information is  
23 sent back to deny based upon the guideline. So now we have to  
24 go to court. That is another two months' delay just to get on  
25 the calendar. Then you're talking about another 30-day delay

1 before -- or more, before a decision is rendered. All the  
2 while I am sitting idly by and I am not getting any kind of  
3 treatment. So my condition regresses, and in some cases it has  
4 deteriorated wherein that I had to have either another  
5 operation, or if the judge approves continuous therapy and I  
6 start back to therapy anywhere from three to four, five, six  
7 months later, and in one instance it was over a year, it did  
8 not do any good because it is like starting all over again, you  
9 know.

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

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

1 had the operation, but there was a four-, five-week delay in  
2 that.

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

16 And I want to emphasize that these guidelines can hold  
17 true for some things, but from a realistic scale -- you have a  
18 young man that played college football. A few years ago, tore  
19 up his knee. Youngster. He had multiple -- he had  
20 double-digit operations. He had months, years, of therapy.  
21 But they were on time. But his ultimate goal was to have  
22 control of his life and get back on his feet to play football.  
23 Now, he lost his leg. But that youngster went to San Jose  
24 State. If you saw on TV, that he got the -- he reached his  
25 dream to come out with a artificial leg on the last play to

1 play football. But the point I am making is that had there not  
2 been any delays in his recovering process -- not to say he  
3 wouldn't have lost his leg, but if there had a been delays, I  
4 don't think that he would have been able to come up, to  
5 perform, put on a uniform and make that last play for San Jose  
6 State.

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

18           I wish that you would know to just look at this and do  
19 something about it, because I am not the only one. It has  
20 caused a lot of adversities in my personal life as well.  
21 Financially. To sit back and can't get paid is -- well, I'm  
22 not harping on the money. But had there not been delays, I  
23 wouldn't be in that kind of position like others, wherein they  
24 have lost their families, lost their home, lost their job, or  
25 even lost their own life.

1 Behind what you're trying to do, the intent, I take it  
2 is good. But the actuality and the way it's handled, the  
3 application of it and process of it, is not. It really is not.

4 And I want to thank you for giving me this time.

5 MS. OVERPECK: Thank you for your comments.

6 Diane Przepiorski?

7 **DIANE PRZEPIORSKI**

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

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

24 I really just have a couple of comments this morning.

25 It seems like what we don't want to do in these

1 regulations is just exchange a problem that we had with  
2 legislated, 24-visit postsurgical guidelines or physical  
3 therapy treatments, to problems with guidelines. And when we  
4 were working on the legislation, we realized that not even  
5 judges had the discretion -- or it is at least a gray area that  
6 judges had discretion to authorize additional rehab visits if  
7 they felt that it was necessary. We really feel strongly that  
8 the guidelines need to contain some sort of a statement that  
9 says just because the procedure is not listed on your list of  
10 procedures that could potentially need rehabilitative  
11 surgeries, that it doesn't mean that never would a patient that  
12 had a particular surgery would need some postsurgical  
13 rehabilitation following the surgery. And we also think as  
14 part of that is -- realization is that not all patients are  
15 going to fit into, you know, X-number of visits for a rotator  
16 cuff repair. I think we realized that when we were gathering  
17 information for the Division, that even with good surgeons,  
18 their practice patterns are very different, and we want to make  
19 sure that we have optimal outcome. So patients with  
20 co-morbidities, multiple injuries, there is going to be  
21 exceptions to these rules. And we feel strongly that in this  
22 particular set of guidelines, even though it's inherent in all  
23 guidelines that they're just guidelines, that there be a clear  
24 statement that Division did not intend that there not be any  
25 postsurgical rehabilitation, of procedures that aren't listed,

1 or you couldn't go beyond what is recommended by ODG or MEEAC  
2 for certain situations.

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

22           So those are our comments. Overall, we're supportive  
23 of the Division moving forward with the postsurgical treatment  
24 guidelines, and we just don't want to go back to a situation  
25 where we had problems with the legislation and then we're just

1 shifting now to problems with the guidelines. So I think you  
2 have an opportunity to make the Division's intent clear here,  
3 and we have some language that we would suggest that you could  
4 add to the regulations.

5 Thank you.

6 MS. OVERPECK: Thank you.

7 **TIM MADDEN**

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

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

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

1 down the road.

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

5 "Only the surgeon who performed the  
6 operation,"

7 Comma,

8 "a nurse practitioner,"

9 Comma,

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

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

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

24 MS. OVERPECK: Thank you.

25 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

1 about chronic low back pain due to sacroiliac joint dysfunction  
2 and to incorporate this knowledge into their evaluations.

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

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

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

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

24           I'm willing to advise others about these matters  
25 and thereby help to improve the rehabilitation of thousands

1 of injured workers who currently suffer total disability and  
2 ongoing neglect within the current system of workers'  
3 compensation medical care.

4 Thank you.

5 MS. OVERPECK: Thank you.

6 Dr. Steven Schumann.

7 **DR. STEVEN SCHUMANN**

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

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

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

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

24 An online newsletter covering workers' comp issues  
25 attributed comments to several of those who testified

1 yesterday, which are flatly wrong and need to be corrected for  
2 the record. I won't spend a lot of time on this, but because  
3 the speakers misrepresented ACOEM's guidelines yesterday, I  
4 think it's very important that you have the facts.

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

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

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

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

24 Let me begin by saying that we appreciate the State of  
25 California's leadership in implementing evidence-based medical

1 treatment guidelines to ensure that injured workers receive  
2 quality medical care in a timely and appropriate manner. ACOEM  
3 has worked closely with California in the past, and we look  
4 forward to an ongoing relationship dedicated to providing the  
5 best care possible for injured workers and the best guidelines  
6 for physicians.

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

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

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

1 medicine, including those developed by AMA and AGREE.

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

21           Now, some comments about the chronic pain guidelines.

22           The Division is to be commended for its decision to  
23 expand MTUS to include a more detailed approach to chronic  
24 pain. Chronic pain in today's workplace represents a challenge  
25 to physicians caring for injured workers, but it should be

1 noted that reaching agreement on an evidence-based guideline  
2 for treatment of chronic pain is an exceedingly complex,  
3 difficult, and often controversial effort.

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

11         ACOEM has just completed the chronic pain update to  
12 its comprehensive practice guidelines. As we have all -- as we  
13 have completed all research, evidence evaluation, synthesis and  
14 peer review of the ACOEM chronic pain update, we are in a  
15 unique position to assess DWC's proposed treatment guideline.  
16 After thorough review, we believe that the Division's proposal  
17 would benefit from inclusion of added content on this update.  
18 Our chronic pain panel members, trained in our evidence-based  
19 methodology, found some shortcomings in the proposed treatment  
20 guideline that we would like to share with the DWC in order to  
21 make the most informed decisions going forward. Of particular  
22 note is what we believe to be a lack of specificity in  
23 treatment options and the potential for confusion among  
24 providers and payers that could result from combining treatment  
25 recommendations authored by the Division and adapted from ODG.

1 Combining recommendations in this way utilizes two completely  
2 different article-grading methods and methods to develop  
3 guidance while presenting recommendations on two different  
4 formats in a given topic. We believe it's worth taking a  
5 second look at this part of the proposed proposal to ensure no  
6 inconsistency is introduced to the overall system.

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

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

18           Let me conclude by reiterating that, beyond these  
19 specific issues, ACOEM is an enthusiastic supporter of  
20 California's efforts to shape an effective guideline system,  
21 and would be pleased to offer any additional analysis, review  
22 or recommendations to improve the current proposal. We are  
23 delighted that the Division proposes to adopt updated  
24 guidelines for elbow disorders developed by ACOEM, and we  
25 look forward to our continued collaboration with the Division

1 and the State of California to ensure that injured workers  
2 receive quality medical care.

3 Thank you for the opportunity to speak.

4 MS. OVERPECK: Thank you for your comments.

5 Dr. Matthew Hughes.

6 DR. HUGHES: I'd like to withdraw.

7 MS. OVERPECK: Sure.

8 Frank Navarro.

9 **FRANK NAVARRO**

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

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

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

24 One more statement has to do with the ODG. CMA TAC  
25 technical -- excuse me -- Workers' Compensation Technical

1 Advisory Committee has looked at ODG and ACOEM, and we lean  
2 towards ODG, particularly on these -- this set of proposed  
3 regs. One thing that we would ask -- and we don't want to  
4 delay these anymore. We really want these regs out there. But  
5 since there is a revision to the ODG chronic pain guidelines,  
6 what we would ask for you to consider would be integrating the  
7 proposed language from the MEEAC, M-E-E-A-C -- I should call it  
8 "MEEAC", I guess -- incorporating those recommendations and  
9 looking at ODG and incorporating the rest of the  
10 recommendations that are in there. So we don't want to confuse  
11 it, but we want -- what we want is the reference to the studies  
12 that ODG refers to in this most recent update.

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

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

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

1 want to thank you and close with that.

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

4 MS. OVERPECK: No. Thank you, though.

5 MR. NAVARRO: Okay.

6 MS. OVERPECK: Tom Waldorf.

7 **TOM WALDORF**

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

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

17 "To Whom It May Concern, please consider  
18 this my formal professional objection to the  
19 DWC's proposal to effectively abolish the  
20 use of compounded topical medications. As a  
21 full-time PM&R physician, the majority of  
22 my practice consists of the management of  
23 both acute and chronic work-related injuries.  
24 I have innumerable examples of cases in my  
25 practice in which the use of compounded

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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,

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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

1 the lack of well-designed controlled trials  
2 supporting functional improvement, yet side  
3 effects, dependency, hormonal balance and  
4 addiction are known complications and encountered  
5 on a daily basis. I have yet to encounter such  
6 issues with topical compounded medication."

7 Thank you.

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

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

12 MS. OVERPECK: Robert Seik.

13 **ROBERT SEIK**

14 MR. SEIK: Hello. My name is Robert Seik. I am a  
15 pharmacist. I am the compounded pharmacist that Tom referred  
16 to. And I am here just to make a couple of remarks, you know,  
17 having a short amount of time to review some of the comments  
18 that were made in the recent ACOEM guidelines and the denial to  
19 actually recommend some of the compounded creams based on what  
20 is evidence-based medicine. And I am bringing these comments  
21 from two perspectives where I've spent, you know, my career  
22 bifurcated in two different places. And for ten years I worked  
23 in the pharmaceutical industry actually managing clinical  
24 trials, writing documentation for new drug applications that  
25 have actually been submitted to the FDA. And I do note that

1 there is great deal of importance to evidence-based medicine,  
2 and what constitutes that evidence, you know, is clear to me  
3 that it is very important. However, what I notice from the  
4 guidelines and the references that were used to the application  
5 of transdermal or topically applied compounded creams or  
6 variations of different ingredients that can be utilized, is  
7 that there is quite a bit of information that I felt was left  
8 out, in other words, referenced in that material. So rather  
9 than read to you my nicely assembled 12-page document which you  
10 can do in your free time -- I jest -- there are 35 references  
11 that I have given you that talk about, you know, very  
12 specifically the application of these products and the clinical  
13 utility that they give the practitioner.

14           The other part of my career has been actually, you  
15 know, becoming a compounding pharmacist, leaving the drug  
16 industry and actually pursuing, you know, my own business.  
17 So I am here representing, you know, the fact that I do provide  
18 that type of services to doctors that want access to these  
19 products. And there is -- although there is a great deal of  
20 evidence-based medicine that I submit exists in 35 references  
21 that I have given, a lot of the importance of clinical trials  
22 and I think how different ranking systems may or may not affect  
23 people with various disease types such as chronic pain based  
24 are on these large randomized placebo controlled trials. It  
25 may not always be financially feasible for companies to engage

1 in these because there is a great deal of issue with regard to  
2 the patentability of products and the actual mechanics involved  
3 for small companies, like compounding pharmacies that provide  
4 these things, that do not have the ability to submit these for  
5 such, you know, large randomized clinical controlled trials,  
6 but does not, you know, take away from the clinical utility of  
7 that practitioner, like Dr. Jeffrey Scott and many other  
8 practitioners that my company works with and my colleagues in  
9 compounding pharmacy that -- that are accredited and certified  
10 by independent organizations and sometimes by the state. The  
11 guidelines in which we function to provide high quality product  
12 for utilization, their patients allows us to take a look at  
13 what may not be, you know, very large randomized clinically  
14 controlled trials which, statistically speaking, we --  
15 remember, these are trials that are designed to detect small  
16 differences between a placebo and an active drug or, God  
17 forbid, if pharmaceutical companies go head to head to look at  
18 -- at one therapeutic application, one drug, and compare it  
19 against another, you need large numbers of patients to detect  
20 small differences in order to gain FDA approval. And even with  
21 FDA approval we are not always assured of the drug's safety,  
22 and I can list on one hand at least a handful of withdrawals  
23 including Vioxx, most recently from the market, drugs that are  
24 made through what is a very rigorous and grotesquely expensive  
25 process to get medications approved, unfortunately for many of

1 the large drug companies, only to have them later on withdrawn  
2 because of toxicities that may not have been identifiable or  
3 easily identifiable in, you know, still what are relatively  
4 large clinical trial populations in the studies that were  
5 submitted for approval of the drug. And that being said, even  
6 with the drug approved and the lack of toxicity being  
7 identified, you know, follow on trials as we've seen recently  
8 in the press for stories on Vitorin with absolutely no effect,  
9 you know, for some of the major applications and cardiovascular  
10 disease as well.

11           So the existence of literature is one thing. The  
12 existence of the clinical significance is another, and, you  
13 know, I encourage the panel to take a look at the antithesis of  
14 that and evaluate on the practitioner's bases and hear the  
15 words of those who, through use some of the products that my  
16 company would provide and get their feedback from the patients  
17 that have been benefited from them and look at the value of,  
18 you know, single patient clinical trials which have been done.  
19 And some of these references do include that, and there is a  
20 large body of literature that supports that, because when --  
21 when you have a disease or a condition that is relatively  
22 stable, and you can detect an enormous difference in the  
23 functionality or the perceived pain for the patient in this  
24 sense that we're talking about, then the randomized placebo  
25 controlled trial may mislead -- what you want to consider, may

1 not necessarily dictate what is ultimately, umm, you know, the  
2 list of products or the armamentarium that the practitioner has  
3 access to.

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

7 DR. SEARCY: Thank you.

8 MR. SEIK: Thank you.

9 MS. OVERPECK: Gerald Rogan, M.D.

10 **GERALD ROGAN, M.D.**

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

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

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

25 I recognize that in the future you are going to be

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

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

20           So that's our emphasis going forward, that we would  
21 like to see some review of the evidence that we would bring  
22 forward to you to show that an artificial disk treatment for  
23 certain selected patients who would otherwise get surgery,  
24 who would otherwise get fusion surgery, may be an appropriate  
25 alternative to fusion.



1 issues we identified in the Division's proposed chronic pain  
2 guidelines.

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

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

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

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

1 quality of life.

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

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

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

22 As a general observation, the proposed rule appears to  
23 be limited and lacks specificity in expressing recommendations.  
24 We have some concern about the potential for restriction on  
25 access of care by injured workers. For example, in our update

1 we have 221 recommendations we have come up with, which is more  
2 than there are in the proposed rule.

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

7 I may now turn to a few specific issues.

8 We spoke of the draft document. Seems a bit unclear.  
9 There are some recommendations that come up that do not seem to  
10 be particularly relevant directly to chronic pain. For  
11 example, acute pain is mentioned, and postmastectomy patients  
12 are mentioned. Although chronic pain is now almost universally  
13 accepted as a biopsychosocial condition, there is little  
14 guidance to help the provider as far as how to adapt and  
15 implement that.

16 The lack of treatment algorithms is also an area for  
17 potential improvement. Algorithms provide further guidance  
18 about the sequence of treatment, and some providers very much  
19 like those algorithms, although admittedly some do not.  
20 Nevertheless, for those who like them, they do help to provide  
21 a quick, accurate guidance for busy clinicians.

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

25 In addition to these general issues, there are a

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

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

1 in fact efficacious interventions.

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

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

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

18 Thank you.

19 MS. OVERPECK: Thank you.

20 Nancy Chance.

21 **NANCY CHANCE**

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

23 I don't represent any group. I'm here on behalf of my  
24 husband, Richard Chance, who is a live, breathing person, who  
25 is trapped in the workers' compensation system. I'm here to

1 tell you our story. I'm here to tell you about utilization  
2 review and how it doesn't work, and I don't have any other  
3 forum. I went to my legislators; they suggested I come here.  
4 I wrote a letter and testified last time, and I got a response,  
5 so I just want to tell you a little bit about our -- our  
6 situation and tell you what we've been through since  
7 December 11th of 2006.

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

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

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

25 There are people, real, live people, that are part of

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

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

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

20           So when you're considering guidelines, when you're  
21 considering the things that you're doing, please remember him  
22 and the many, many, many people like him, because the other  
23 part I want you to remember is Richard has me. I don't take  
24 "no" for an answer. Every time they said "no" to me, I fought  
25 back.

1 I happen to know of people who have the same exact  
2 injuries that have permanent brain damage because they didn't  
3 have somebody that fought back when they were told "no," when  
4 they were denied; and they were. Denial, denial, fight back,  
5 denial. It's ridiculous. It really is.

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

10 Thank you.

11 MS. OVERPECK: Thank you.

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

14 **KRISTINE SHULTZ**

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

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

24 We also are concerned that -- about the DWC adopting  
25 an older version of the ODG guidelines. There have been some

1 changes to ODG in the spring, and that they're significant. We  
2 believe that if for some reason, for legal reasons, you can't  
3 adopt the most current version, at the very least, if you're  
4 doing another 15-day revision, to adopt this spring -- that  
5 spring version rather than the October.

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

11           Thank you very much.

12           MS. OVERPECK: Thank you.

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

15           (No response.)

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

20           Thank you all for participating.

21           (The public hearing was then adjourned.)

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