TITLE 8. INDUSTRIAL RELATIONS
DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
CHAPTER 4.5. DIVISION OF WORKERS' COMPENSATION
SUBCHAPTER 1. ADMINISTRATIVE DIRECTOR -- ADMINISTRATIVE RULES
ARTICLE 5.5.2 MEDICAL TREATMENT UTILIZATION SCHEDULE

§ 9792.20. Medical Treatment Utilization Schedule—Definitions

As used in this Article:

~~(a) "Acute" means a medical condition lasting less than 3 months.~~

(a~~b~~) "American College of Occupational and Environmental Medicine (ACOEM)" is a medical society of physicians and other health care professionals specializing in the field of occupational and environmental medicine, dedicated to promoting the health of workers through preventive medicine, clinical care, research, and education.

(b~~c~~) "ACOEM Practice Guidelines" means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, 2nd Edition (2004)~~, published by OEM Press~~. The Administrative Director incorporates the ACOEM Practice Guidelines by reference. A copy may be obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts 01915 (www.oempress.com).

~~(d) "Chronic" means a medical condition lasting 3 months or more.~~

(c~~e~~) "Claims administrator" is a self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator, or the California Insurance Guarantee Association.

(d~~f~~) "Evidence-based " means based, at a minimum, on a systematic review of literature published in medical journals included in MEDLINE.

(e) "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment.

~~(g) "Hierarchy of evidence" establishes the relative weight that shall be given to scientifically based evidence.~~

(f~~h~~) "Medical treatment" is care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-97~~2~~92.23.

(g~~i~~) "Medical treatment guidelines" means the most current version of written recommendations revised within the last five years which are systematically developed by a multidisciplinary process through a comprehensive literature search to assist in decision-making about the appropriate ~~health care~~ medical treatment for specific clinical circumstances.

~~(j) "Medical treatment provider" means a provider of medical services as well as related services or goods, including but not limited to an individual or facility, a health care service plan, a health care organization, a member of a preferred provider organization, or medical provider network as provided in Labor Code section 4616.~~

(h~~k~~) "MEDLINE" ~~commonly known as PubMed is the search engine for the National Library of Medicine.~~ is the largest component of PubMed, the U.S. National Library of Medicine's database of biomedical citations and abstracts that is searchable on the Web. Its website address is www.pubmed.gov.

(j~~l~~) "Nationally recognized" means published in a peer-reviewed medical journal; or developed, endorsed and disseminated by a national organization with affiliates based in two or more U.S. states; or currently adopted for use by one or more U.S. state governments or by the U.S. federal government; and is the most current version.

(j) "Peer reviewed" means that a medical study's content, methodology and results have been evaluated and approved prior to publication by an editorial board of qualified experts.

(k~~m~~) "Scientifically based" means based on scientific literature, wherein the body of literature is identified through performance of a literature search in MEDLINE, the identified literature is ~~graded~~ evaluated, and then used as the basis for the guideline.

(l) "Strength of Evidence" establishes the relative weight that shall be given to scientifically based evidence.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.21. Medical Treatment Utilization Schedule

(a) The Administrative Director adopts the Medical Treatment Utilization Schedule consisting of Sections 9792.20 through Section 9792.23. The Administrative Director adopts and incorporates by reference the following medical treatment guidelines into the Medical Treatment Utilization Schedule:

(1) T~~t~~he American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM Practice Guidelines), Second Edition (2004)~~, published by OEM Press, into the medical treatment utilization schedule~~. A copy may be

obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts 01915 (www.oempress.com).

(2) Acupuncture Medical Treatment Guidelines

The Acupuncture Medical Treatment Guidelines set forth in this subdivision shall supersede the text in the ACOEM Practice Guidelines, Second Edition, relating to acupuncture, except for shoulder complaints, and shall address acupuncture treatment where not discussed in the ACOEM Practice Guidelines.

(A) Definitions:

(i) "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm.

(ii) "Acupuncture with electrical stimulation" is the use of electrical current (micro-amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

(iii) "Chronic pain for purposes of acupuncture" means pain that persists for at least 30 days beyond the usual course of an acute disease or a reasonable time for an injury to heal or that is associated with a chronic pathological process that causes continuous pain (e.g., reflex sympathetic dystrophy). The very definition of chronic pain describes a delay or outright failure to relieve pain associated with some specific illness or accident.

(B) Indications for acupuncture or acupuncture with electrical stimulation include the following presenting complaints in reference to the following ACOEM Practice Guidelines Chapter Headings:

(i) Neck and Upper Back Complaints

(ii) Elbow Complaints

(iii) Forearm, Wrist, and Hand Complaints

(iv) Low Back Complaints

(v) Knee Complaints

(vi) Ankle and Foot Complaints

(vii) Pain, Suffering, and the Restoration of Function

(C) Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows:

(i) Time to produce functional improvement: 3 to 6 treatments.

(ii) Frequency: 1 to 3 times per week

(iii) Optimum duration: 1 to 2 months

(iv) Maximum duration: 14 treatments.

(D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e).

(E) It is beyond the scope of the Acupuncture Medical Treatment Guidelines to state the precautions, limitations, contraindications or adverse events resulting from acupuncture or acupuncture with electrical stimulations. These decisions are left up to the acupuncturist.

(b) The ~~ACOEM Practice Guidelines are~~ Medical Treatment Utilization Schedule is intended to assist ~~medical treatment providers~~ in the provision of medical treatment by offering an analytical framework for the evaluation and treatment of injured workers and to help those who make decisions regarding the medical treatment of injured workers understand what treatment has been proven effective in providing the best medical outcomes to those workers, in accordance with section 4600 of the Labor Code.

(c) Treatment shall not be denied on the sole basis that the condition or injury is not addressed by the ~~ACOEM Practice Guidelines~~ Medical Treatment Utilization Schedule. In this situation, the claims administrator shall authorize treatment if such treatment is in accordance with other scientifically and evidence-based, peer-reviewed, medical treatment guidelines that are ~~generally~~ nationally recognized by the ~~national~~ medical community, in accordance with subdivisions (b) and (c) of section 9792.22, and pursuant to the Utilization Review Standards found in Section 9792.6 through Section 9792.10.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.22. Presumption of Correctness, Burden of Proof and ~~Hierarchy of Scientific Based Evidence~~ Strength of Evidence.

(a) The ~~ACOEM Practice Guidelines are~~ Medical Treatment Utilization Schedule is presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addressed in ~~those guidelines~~ the Medical Treatment Utilization Schedule for ~~both acute and chronic~~ the duration of the medical condition~~s~~. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof.

(b) For all conditions or injuries not addressed by the Medical Treatment Utilization Schedule ~~ACOEM Practice Guidelines~~, authorized treatment and diagnostic services shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are ~~generally~~ nationally recognized by the ~~national~~ medical community.

(c)(1) For conditions or injuries not addressed by either subdivisions (a) or (b) above; for medical treatment and diagnostic services at variance with both subdivisions (a) or (b) above; or where a recommended medical treatment or diagnostic service covered under subdivision (b) is at variance with another treatment guideline also covered under subdivision (b), the following ~~hierarchy of~~ ACOEM's strength of evidence rating methodology is adopted and incorporated as set forth below, and shall be used to evaluate scientifically based evidence published in peer-reviewed, nationally recognized journals ~~shall apply to determine the effectiveness of~~ to recommend ~~different~~ specific medical treatment ~~and~~ or diagnostic services:

~~(A) **Level A.** Strong research-based evidence provided by generally consistent findings in multiple (more than one) high quality randomized control studies (RCTs).~~

~~(B) **Level B.** Moderated research-based evidence provided by generally consistent findings in one high-quality RCT and one or more low quality RCTs, or generally consistent findings in multiple low quality RCTs.~~

~~(C) **Level C.** Limited research based evidence provided by one RCT (either high or low quality) or inconsistent or contradictory evidence findings in multiple RCTs.~~

(A) Table A – Criteria Used to Rate Randomized Controlled Trials

Studies shall be rated using the following 11 criteria. Each criterion shall be rated 0, 0.5, or 1.0, thus the overall ratings range from 0-11. A study is considered low quality if the composite rating was 3.5 or less, intermediate quality if rated 4-7.5, and high quality if rated 8-11.

Criteria	Rating Explanation
Randomization: Assessment of the degree that randomization was both reported to have been performed and successfully achieved through analyses of comparisons of variables between the two groups.	Rating is "0" if the study is not randomized or reports that it was and subsequent analyses of the data/tables suggest it either was not randomized or was unsuccessful. Rating is "0.5" if there is mention of randomization and it appears as if it was performed, however there are no data on the success of randomization, it appears incomplete, or other questions about randomization cannot be adequately addressed. Rating is "1.0" if randomization is specifically stated and data reported on subgroups suggests that the study did achieve successful randomization.
Treatment Allocation Concealed: Concealment of the allocation scheme from all involved, not just the patient.	Rating is "0" if there is no description of how members of the research team or subjects would have not been able to know how they were going to receive a particular treatment, or the process used would not be concealed. Rating is "0.5" if the article mentions how allocation was concealed, but the concealment was either partial involving only some of those involved or other questions about it are unable to be completely addressed. Rating is "1.0" if there is a concealment process described that would conceal the treatment allocation to all those involved.
Baseline Comparability: Measures how well the baseline groups are comparable (e.g., age, gender, prior treatment).	Rating is "0" if analyses show that the groups were dissimilar at baseline or it cannot be assessed. Rating is "0.5" if there is general comparability, though one variable may not be comparable. Rating is "1.0" if there is good comparability for all variables between the groups at baseline.
Patient Blinded	Rating is "0" if there is no mention of blinding of the patient. Rating is "0.5" if it mentions blinding, but the methods are

	unclear. Rating is “1.0” if the study reports blinding, describes how that was carried out, and would plausibly blind the patient.
Provider Blinded	Rating is “0” if there is no mention of blinding of the provider. Rating is “0.5” if it mentions blinding, but the methods are unclear. Rating is “1.0” if the study reports blinding, describes how that was carried out and would plausibly blind the provider.
Assessor Blinded	Rating is “0” if there is no mention of blinding of the assessor. Rating is “0.5” if it mentions blinding, but the methods are unclear. Rating is “1.0” if the study reports blinding, describes how that was carried out and would plausibly blind the assessor.
Co-interventions Avoided: The degree to which the study design avoided multiple interventions (e.g., a combination of stretching exercises and anti-inflammatory medication).	Rating is “0” if there are multiple interventions or no description of how this was avoided. Rating is “0.5” if there is brief mention of this potential problem. Rating is “1.0” if there is a detailed description of how co-interventions were avoided.
Compliance Acceptable: Measures the degree of non-compliance.	Rating is “0” if there is no mention of non-compliance. Rating is “0.5” if non-compliance is briefly addressed and the description suggests that there was compliance, but a complete assessment is not possible. Rating is “1.0” if there are specific data and the non-compliance rate is less than 20%.

Dropout Rate: Measures the drop-out rate.	Rating is "0" if there is no mention of drop-outs or it cannot be inferred from the data presented. Rating is "0.5" if the drop-out issue is briefly addressed and the description suggests that there were few drop-outs, but a complete assessment is not possible. Rating is "1.0" if there are specific data and the drop-out rate is under 20%.
Timing of Assessments: Timing rates the timeframe for the assessments between the study groups.	Rating is "0" if the timing of the evaluations is different between the groups. Rating is "0.5" if the timing is nearly identical (e.g., one day apart). Rating is "1.0" if the timing of the assessments between the groups is identical.
Analyzed by Intention to Treat: This rating is for whether the study was analyzed with an intent to treat analysis.	Rating is "0" if it was not analyzed by intent to treat. Rating is "0.5" if there is not mention of intent to treat analysis, but the results would not have been different (e.g., there was nearly 100% compliance and no drop-outs). Rating is "1.0" if the study specifies analyses by intention to treat.
Lack of Bias: This rating does not enter into the overall rating of an article. This is an overall indication of the degree to which biases are felt to be present in the study.	Rating is "0" if there are felt to be significant biases that are uncontrolled in the study and may have influenced the study's results. Rating is "0.5" if there are felt to be some biases present, but the results are less likely to have been influenced by those biases. Rating is "1.0" if there are few biases, or those are well controlled and unlikely to have influenced the study's results.

(B) Table B – Strength of Evidence Ratings

Levels of evidence shall be used to rate the quality of the body of evidence. The body of evidence shall consist of all studies on a given topic that are used to develop evidence-based recommendations. Levels of evidence shall be applied when studies are relevant to the topic and study working populations. Study outcomes shall be consistent and study data shall be homogeneous.

A	**Strong evidence-base**: One or more well-conducted systematic reviews or meta-analyses, or two or more high-quality studies.
B	**Moderate evidence-base**: At least one high-quality study, a well-conducted systematic review or meta-analysis of lower quality studies or multiple lower-quality studies relevant to the topic and the working population.
C	**Limited evidence-base**: At least one study of intermediate quality.
I	**Insufficient Evidence**: Evidence is insufficient or irreconcilable.

(2) Evidence shall be given the highest weight in the order of the ~~hierarchy of evidence~~ strength of evidence.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.23. Medical Evidence Evaluation Advisory Committee

(a)(1) The Medical Director shall create a medical evidence evaluation advisory committee to provide recommendations to the Medical Director ~~Administrative Director~~ on matters concerning the medical treatment utilization schedule. The recommendations are advisory only and shall not constitute scientifically based evidence.

(A) If the Medical Director position becomes vacant, the Administrative Director shall appoint a competent person to temporarily assume the authority and duties of the Medical Director as set forth in this section, until such time that the Medical Director position is filled.

(2) The members of the medical evidence evaluation advisory committee shall be appointed by the Medical Director, or his or her designee, and shall consist of ~~10~~17 members of the medical community, holding a Medical Doctor (M.D.), Doctor of Osteopathy (D.O.), who are board certified by an American Board of Medical Specialties

(ABMS) or American Osteopathic Association approved specialty boards (AOA) respectively, Doctor of Chiropractic (D.C.), Physical Therapy (P.T.), Occupational Therapy (O.T.), Acupuncture (L.Ac.), Psychology (PhD.), or Doctor of Podiatric Medicine (DPM) licenses, and representing the following specialty fields:

(A) One member shall be from the orthopedic field;

(B) One member shall be from the chiropractic field;

(C) One member shall be from the occupational medicine field;

(D) One member shall be from the acupuncture medicine field;

(E) One member shall be from the physical ~~or occupational~~ therapy field;

(F) One member shall be from the psychology ~~or psychiatry~~ field;

(G) One member shall be from the pain specialty field;

(H) One member shall be from the occupational therapy field;

(I) One member shall be from the psychiatry field;

(J) One member shall be from the neurosurgery field;

(K) One member shall be from the family physician field;

(L) One member shall be from the neurology field;

(M) One member shall be from the internal medicine field;

(N) One member shall be from the physical medicine and rehabilitation field;

(O) One member shall be from the podiatrist field;

(P) ~~Three~~ Two additional members shall be appointed at the discretion of the Medical Director or his or her designee.

(3) In addition to the ~~ten~~ seventeen members of the medical evidence evaluation advisory committee appointed under subdivision (a)(2) above, the Medical Director, or his or her designee, may appoint an additional three members to the medical evidence evaluation advisory committee as subject matter experts for any given topic.

(b) The Medical Director, or his or her designee, shall serve as the chairperson of the medical evidence evaluation advisory committee.

(c) The members of the medical evidence evaluation advisory committee shall use the hierarchy of evidence set forth in subdivision (c)(1) of section 9792.22 to evaluate evidence when making recommendations to revise, update or supplement the medical treatment utilization schedule.

(d) The members of the medical evidence evaluation advisory committee, except for the three subject matter experts, shall serve a term of ~~one~~ two year period, but shall remain in that position until a successor is selected. The subject matter experts shall serve as members of the medical evidence evaluation advisory committee until the evaluation of the subject matter guideline is completed. The members of the committee shall meet as necessary, but no less than four (4) times a year.

(f) The Administrative Director, in consultation with the Medical Director ~~medical evidence evaluation advisory committee~~, may revise, update, and supplement the medical treatment utilization schedule as necessary.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.