

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
General Comment	<p>Commenter does not see the emphasis on STANDARD OF PRACTICE in these proposed regulations. Commenter opines that although the science of medicine is guided by medical research, not every condition has been studied to the level of publication. Commenter states that the reasons are many, most of the time being lack of funding and sometimes, it's just because no one has thought of it. However, many treatments have been routinely and successfully used in medical practice. For instance, Aspirin has been for treatment of cardiac chest pain for a long time until the studies actually demonstrated its value. CA Medical Board decisions are based on Standard of Practice. Commenter opines that the lack of literature should not be the reason of denying the treatment or testing. Medicine is not Black and White. "Take one and call me in the morning" still applies even today.</p> <p>Commenter recommends that the language in the CA MTUS should indicate that, when it is silent on specific treatment, the decision should</p>	<p>Michael Bazel, MD May 9, 2014 Written Comment</p>	<p>Reject. Standard of practice is not emphasized in these regulations because Labor Code section 5307.27 makes clear that the Medical Treatment Utilization Schedule “shall incorporate the evidence-based, peer-reviewed, nationally recognized standards of care”. If there is a topical gap and a medical treatment is not addressed by the MTUS, Labor Code section 4604.5 states authorized treatment “shall be in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.”</p> <p>Reject. For the same reason just stated.</p>	<p>None</p> <p>None.</p>

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9792.21(i)(3)	<p>be guided by standard of practice.</p> <p>Commenter references the requirement to “search for current studies, five years old or less that are scientifically based, peer-reviewed, and published in journals that are national recognized by the medical community to find a recommendation applicable to the injured worker’s specific medical condition.”</p> <p>Commenter notes that some classic articles are published before that time and the same study would not be necessarily repeated in the past five years due to the fact that the classic articles are so conclusive.</p>	Joyce Ho, M.D. Medical Director CompPartners, Inc. May 27, 2014 Written Comment	Accept: Agree this will be clarified because there may be seminal scientific studies that are older than five years old that are still the best available evidence. Although the definition for “Medical Treatment Guidelines” set forth in section 9792.20(g) will continue to contain the phrase “reviewed and updated within the last five years” because it is important that the most current versions of the guidelines are relied upon when a treatment request is made that is based on recommendations found outside of the MTUS or when MEEAC reviews guidelines to update the MTUS. The five year time period is necessary to give the phrase “most current version” context.	Section 9792.21(i)(3) is replaced with (g)(3) and the phrase “five years old or less” is deleted.
9792.25.1(a)(3)(C)	Commenter questions whether case-series, uncontrolled or observational study and case report can really be used knowing that conclusions cannot be drawn from those small studies.	Joyce Ho, M.D. Medical Director CompPartners, Inc. May 27, 2014 Written Comment	Reject: Although the studies questioned by the commenter are considered lower level evidence than the randomized controlled trials and systematic	None.

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	<p>Commenter states that there is a strong bias to publish positive outcomes and not negative ones; therefore, these studies cannot be relied upon. Commenter opines that many potentially harmful interventions would be “supported.”</p>		<p>reviews of several randomized controlled trials, they are still considered medical evidence. These regulations have provided a hierarchy of external evidence to assist in evaluating medical evidence.</p>	
9792.21(c)	<p>Commenter opines that the key principle underlying these rules is that clinical decisions are to be based on Evidence Based Medicine (EBM). Commenter notes that this section mandates that "health care professionals shall base clinical decisions on EBM." Commenter strongly supports the provision of the highest quality and most effective medical treatment for injured workers. Commenter opines that the practice of medicine is an art, and determining the proper treatment for every patient and condition is not simply a matter of finding the treatment option supported by the highest level of medical evidence.</p>	<p>Diane Worley Director of Policy Implementation California Applicants’ Attorneys Association June 30, 2014 Written Comment</p>	<p>Reject: The definition of Evidence-Based Medicine makes clear that the systematic approach to making clinical decisions integrates the best available research evidence with clinical expertise and patient values.</p>	None.
9792.20(e)	<p>Commenter supports this proposed definition of evidence-based medicine.</p> <p>Commenter states that this definition is consistent with the explanation of</p>	<p>Diane Worley Director of Policy Implementation California Applicants’</p>	<p>Agree. The article cited by commenter is one of the articles DWC relied upon to define “Evidence-Based Medicine”. See Initial</p>	None.

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	<p>EBM as set forth in an article¹ entitled "<i>Evidence based medicine: what it is and what it isn't; It's about integrating individual clinical expertise and the best external evidence,</i>" published by several of the originators of EBM, including Professor David Sackett [Commenter provided the Division with a copy for the rulemaking file.]:</p> <p>"Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient."</p> <p>Commenter states that this definition is also consistent with the requirement in Labor Code §5307.27 which mandates that the Administrative Director adopt a MTUS "that shall incorporate the evidence-based, peer-reviewed, nationally recognized</p>	<p>Attorneys Association June 30, 2014 Written Comment</p> <p>Robert McLaughlin California Applicants' Attorneys Association July 1, 2014 Oral Comment</p>	<p>Statement of Reasons, under the heading "Technical, Theoretical, or Empirical Studies, Reports or Documents," item (9) Sackett DL, Rosenberg WM, Gray JA, Haynes RB, and Richardson WS, "Evidence based medicine: what it is and what it isn't" <i>BMJ</i>, 1996; January 13, Volume 312, 71-72. The other article DWC relied upon is item (2) Akobeng AK, "Evidence-based child health. 1. Principles of evidence-based medicine" <i>Arch Dis Child</i>, 2005; Volume 90, 37-40. Nothing in these proposed regulations preclude the integration of clinical expertise and patient values. However, these proposed regulations clearly set forth a systematic approach to making clinical decisions which includes the process to evaluate and determine which recommendations are</p>	

¹ Available on the website of the Center for Evidence Based Medicine (<http://www.cebm.net/?o=1014>) which is affiliated with the University of Oxford.

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	<p>standards of care recommended by the commission pursuant to Section 77.5...." [Emphasis added.]</p> <p>Commenter opines that the use of the word "incorporate" in §5307.27 indicates that the Legislature intended that other factors should be included in the medical guidelines adopted as the MTUS. As explained in <i>Milpitas Unified School District v. Workers' Comp. Appeals Bd. (Guzman)</i> (2010) 187 Cal.App.4th 808:</p> <p>"To 'incorporate' is to 'unite with or introduce into something already existent, 'to 'take in or include as a part or parts, 'or to 'unite or combine so as to form one body. ' (Webster's Third New International Dict. p. 1145 (1993); Random House Dict. of the Eng. Lang. 2d ed. (1987) p. 968; American Heritage Dict. 3d ed., p. 588.) Section 4660, subdivision (b)(1), thus requires the physician to include the descriptions, measurements, and percentages in the applicable chapter of the <i>Guides</i> as part of the basis for determining impairment.</p> <p>"We cannot expand the statutory</p>		<p>supported with the best available medical evidence.</p> <p>The article cited by commenter and relied upon by DWC states it best. "Evidence based medicine is not 'cookbook' medicine...any external guideline must be integrated with individual clinical expertise in deciding whether and how it matches the patient's clinical state, predicament, and preferences..." Under these proposed regulations, physicians will continue to use his/her judgment and it will be integrated with the best available medical evidence.</p>	

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	<p>mandate by changing the word ‘incorporate ‘to ‘apply exclusively. ‘ Nor can we read into the statute a conclusive presumption that the descriptions, measurements, and percentages set forth in each chapter are invariably accurate when applied to a particular case. By using the word ‘incorporation, ‘the Legislature recognized that not every injury can be accurately described by the classifications designated for the particular body part involved. Had the Legislature wished to require every complex situation to be forced into preset measurement criteria, it would have used different terminology to compel strict adherence to those criteria for every condition. A narrower interpretation would be inconsistent with the clear provision that the Schedule -- which itself incorporates the <i>Guides</i> (PDRS p. 1-2)--is rebuttable (§ 4660, subd. (c)), and it would not comport with the legislative directive to construe the workers' compensation statutes liberally ‘with the purpose of extending their benefits for the protection of persons injured in the</p>			

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	<p>course of their employment.’ (§ 3202.)"</p> <p>Guzman, <i>supra</i> at 822.</p> <p>Commenter states that the practice guidelines of the American College of Occupational and Environmental Medicine (ACOEM) are also consistent with this proposed definition. ACOEM states in its practice guidelines that "decisions to adopt particular courses of actions must be made by trained practitioners on the basis of the available resources and the particular circumstances presented by the individual patient."</p> <p>Commenter notes that pursuant to the proposed definition of EBM, clinical decisions are not solely dependent upon evidence from population-based studies that may be inapplicable to an individual patient. Instead, in addition to the best available research evidence, the clinical expertise of the treating physician and the needs of the individual patient must also be taken into consideration in any treatment determination.</p>			

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9792.21.(e)	<p><u>Commenters recommend the following paragraph be added:</u></p> <p><u>“The MTUS’s presumption of correctness may be rebutted if medical evidence is cited that contains a recommendation applicable to the specific medical condition or diagnostic test requested by the injured worker and the recommendation is the same level of evidence as the medical evidence used to support the MTUS’s recommendation and the requesting physician documents the clinical justification for the treatment for this patient.”</u></p>	<p><u>Diane Worley</u> <u>Director of Policy</u> <u>Implementation</u> <u>California</u> <u>Applicants’</u> <u>Attorneys</u> <u>Association</u> <u>June 30, 2014</u> <u>Written Comment</u></p> <p><u>Robert McLaughlin</u> <u>California</u> <u>Applicants’</u> <u>Attorneys</u> <u>Association</u> <u>July 1, 2014</u> <u>Oral Comment</u></p>	<p><u>Reject: Labor Code section 4604.5(a) mandates a showing of the preponderance of the scientific medical evidence establishing that a variance from the MTUS is required, not the same level of evidence as commenters’ suggest. Please note, Robert McLaughlin either misspoke or his comments were incorrectly transcribed when he stated, “If the recommendation is the same level of medical evidence, you should support the MTUS recommendation” because that would not change section 9792.21 as he recommends.</u></p>	None.
9792.21(k)	<p>Commenter recommends that the last sentence of this subsection, as follows, should be deleted:</p> <p>..Medical care that is reasonably necessary to cure or relieve the injured worker from the effects of his or her injury shall be in accordance with the recommendation supported with the best available medical evidence.</p>	<p>Diane Worley Director of Policy Implementation California Applicants’ Attorneys Association June 30, 2014 Written Comment</p> <p>Robert McLaughlin</p>	<p>Accept in part. Reject in part: Accept: The provision has been deleted. Reject: Although the provision pointed out by commenter was deleted, it was deleted not for the reasons provided by commenter but to clarify that differing or competing recommendations cited shall be evaluated according to the</p>	Section 9792.21(k) will be re-lettered to (i) and revised deleting the provision pointed out by commenter for clarifying reasons and amended to include “MTUS Hierarchy of Evidence for

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	<p>Commenter opines that where valid medical evidence exists showing that a particular treatment is either beneficial or harmful, with rare exceptions, the clinical determination should conform to that evidence. Commenter states that the attached article from the Center for Evidence Based Medicine, "even excellent external evidence may be inapplicable to or inappropriate for an individual patient." Commenter states that in order to conform to both the authorizing statutes and the principles of EBM, she recommends that the last sentence of proposed §9792.21(k) be deleted.</p>	<p>California Applicants' Attorneys Association July 1, 2014 Oral Comment</p>	<p>MTUS Hierarchy of Evidence for Different Clinical Questions to determine which recommendation is supported with the highest level of evidence.</p>	<p>Different Clinical Questions".</p>
9792.21(f)	<p>Commenter opines that this subsection should be amended to make it clear that "medical care shall be in accordance with Evidence Based Medicine utilizing the best available medical evidence found in scientifically and evidenced-based medical treatment guidelines or peer-reviewed published studies that are nationally recognized by the medical community."</p>	<p>Diane Worley Director of Policy Implementation California Applicants' Attorneys Association June 30, 2014 Written Comment</p>	<p>Reject: Evidenced Based Medicine is defined in 9792.20(e) and further discussed in section 9792.21(c) and (d). (NOTE: Although this comment did not prompt any changes, section 9792.21(f) was re-lettered to 9792.21(e) and revised for clarifying and organizational reasons prompted by other comments).</p>	<p>None.</p>
9792.21(i)	<p>Commenter notes that this subdivision defines a process for conducting a</p>	<p>Diane Worley Director of Policy</p>	<p>Reject: The mandatory medical evidence search sequence</p>	<p>None.</p>

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	<p>medical literature search in order to identify the best available evidence. Commenter opines that if is the intent to locate the "highest" level of evidence, she does not believe establishing a mandatory search sequence is appropriate. Commenter recommends that this subdivision be amended to provide that the described search sequence "may" be followed. Commenter opines that another problem with this subdivision is that it assumes that there are scientific, evidence-based studies supporting every possible medical treatment recommendation. Commenter opines that although there appears to be a broad range of evidence available to a physician, the actual number of medical procedures for which high level medical evidence is available is limited. Commenter states that this is demonstrated by reviewing the 2011 version of the ACOEM Guidelines.</p> <p>ACOEM cites the level of evidence supporting its recommendations using four alphabet grades:</p> <p>A represents a "Strong evidence base"</p>	<p>Implementation California Applicants' Attorneys Association June 30, 2014 Written Comment</p> <p>Robert McLaughlin California Applicants' Attorneys Association July 1, 2014 Oral Comment</p>	<p>allows a physician to search broadly for medical evidence. This medical evidence search sequence is included for purposes of efficiency and consistency. (NOTE: Section 9792.21(i) was re-lettered to 9792.21(g) because of other changes made to this section).</p> <p>Reject: Commenter states that "the proposed rules require the treating physician to cite evidence that ACOEM has already determined is not</p>	<p>None.</p>

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	<p>B represents a "Moderate evidence base"</p> <p>C represents a "Limited evidence base"</p> <p>I represents "Insufficient" or irreconcilable evidence.</p> <p>Commenter provides the following example:</p> <p>Table 1 in the ACOEM chapter on Shoulder Disorders includes recommendations for diagnostic testing, covering 10 diagnostic categories with 30 separate treatment recommendations. Of the 30 recommendations, one is based on strong evidence/ Category A while the remaining 29 are based on insufficient evidence/Category I. Table 2 summarizes recommendations for treatment, separated into three categories: (1) Recommended; (2) No Recommendation; and (3) Not Recommended. There are 99 treatment options in Table 2 for which there is "No Recommendation" because there</p>		<p>available." Commenter incorrectly describes ACOEM's rating system. ACOEM will not generally support a recommendation for interventions that are not supported by randomized controlled trials. ACOEM may still recommend the intervention but they will indicate it is based on insufficient evidence.</p> <p>Labor Code section 4605.4 makes clear that the MTUS' presumption of correctness is rebuttable and may be controverted by a preponderance of the scientific medical evidence. These proposed regulations provide a process to evaluate medical evidence from high-level randomized controlled trials, systematic reviews of meta-analyses to what is considered lower level evidence. This evaluation process, transparently described, is necessary to determine medical</p>	

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	<p>is insufficient evidence/Category I, and 65 treatment options that are "Not Recommended" of which 54 – 7 out of every 8 – are based on insufficient evidence/Category I!</p> <p>Commenter states that this is not an isolated example. In the ACOEM chapter on Hip and Groin Disorders there are 25 treatment options that are "Not Recommended" and 24 are based on insufficient evidence/Category I. In the chapter on Cervical and Thoracic Spine Disorders 86 out of 110 treatment options that are "Not Recommended" are based on insufficient evidence/ Category I. A few chapters in ACOEM have a higher level of evidence supporting the "Not Recommended" treatment options, but in most Chapters the majority of "Not Recommended" treatment options are based on insufficient evidence/Category I. Furthermore, the same is true of "Recommended" treatment options – the majority are based on insufficient evidence/ Category I.</p> <p>Commenter opines that given the fact</p>		<p>care when competing recommendations are cited. Medical care shall be in accordance with the recommendation supported with the best available medical evidence.</p> <p>Reject: For the reasons stated</p>	<p>None.</p>

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	<p>that most treatment recommendations in ACOEM are based on insufficient or irreconcilable evidence, a comprehensive medical literature search will not locate a "higher" level of medical evidence unless new study is published. Commenter states that the proposed rules require the treating physician to cite evidence that ACOEM has already determined is not available. Commenter opines that these rules could significantly hamper the ability of the treating physician to rebut the MTUS, which is specifically authorized by Labor Code § 4604.5(a).</p> <p>Commenter recommends that a new paragraph (2) be added to §9792.21(e) to provide that:</p> <p>(2) The MTUS's presumption of correctness may be rebutted if medical evidence is cited that contains a recommendation applicable to the specific medical condition or diagnostic test requested by the injured worker and the recommendation is the same level of evidence as the medical evidence used to support the MTUS's</p>		<p>above. In addition, commenter's statement, "the ability of the treating physician to rebut the MTUS, which is specifically authorized by Labor Code § 4604.5(a)" is also rejected. Currently the process that needs to be applied to evaluate competing recommendations is set forth in section 9792.25(c)(1). The current process is significantly more onerous to apply and is limited to evaluating recommendations supported by randomized controlled trials.</p> <p>Reject: Labor Code section 4605.4 makes clear that the MTUS' presumption of correctness is rebuttable and may be controverted by a preponderance of the scientific medical evidence not the same level of evidence.</p>	None.

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	recommendation and the requesting physician documents the clinical justification for the treatment for this patient.			
9792.21 and 9792.25.1	<p>Commenter notes that the proposed regulations repeatedly refer to "the highest level of evidence." [See §§ 9792.21(g), (i)(1), (i)(2), (i)(3), (j), and (k).] Commenter states that the only reference to how "the highest level of evidence" is to be determined is in § 9792.21(k), which provides that:</p> <p>"if there is a discrepancy between the recommendations cited, the underlying medical evidence supporting the differing recommendations shall be evaluated according to the strength of evidence methodology set forth in section 9792.25.1 to determine which recommendation is supported with the highest level of evidence."</p> <p>Commenter opines that even if a treating physician has the expertise to conduct the evaluation required under § 9792.25.1, it is impractical to assume that such a time-consuming</p>	<p>Diane Worley Director of Policy Implementation California Applicants' Attorneys Association June 30, 2014 Written Comment</p>	<p>Reject in part. Accept in part.</p> <p>Reject: A transparent, systematic process must remain to evaluate medical evidence in order to determine the highest level of evidence.</p> <p>Accept: The provision requiring a "requesting physician" to find the recommendation supported with the highest level of evidence" is deleted and replaced with "Treating physician may apply the medical literature search sequence..."</p>	<p>Section 9792.21(g) is deleted and replaced with section 9792.21(f)(1) "Treating physicians may apply the medical literature search sequence...to find a recommendation that supports their Request for Authorization." This is now consistent with section 9792.21(h) which specifies Utilization Reviewers and Independent Medical Reviewers "shall cite" and treating physicians "may cite" the medical treatment guideline or peer-reviewed published study with the</p>

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	and complex evaluation will be done on a regular basis. Commenter recommends that these regulations be amended to provide a more practical methodology for determining the level of medical evidence.			recommendation supported with the highest level of evidence.
9792.21(j)	<p>Commenter notes that this section requires that UR and IMR decisions contain the citation of the medical treatment guideline or study used to support the determination, and permits the requesting physician to cite the medical treatment guideline or study used to support the treatment request. Paragraph I then requires that the citation include "at a minimum, information that clearly identifies the source of the recommendation." Commenter recommends that in addition to requiring that the citation include "the source of the recommendation," proposed § 9792.21(j) be amended to require that the level of evidence supporting the recommendation also be identified.</p> <p>Commenter opines that adding this requirement will allow all parties to easily determine the "highest level of evidence," and will eliminate potential</p>	<p>Diane Worley Director of Policy Implementation California Applicants' Attorneys Association June 30, 2014 Written Comment</p> <p>Robert McLaughlin California Applicants' Attorneys Association July 1, 2014 Oral Comment</p>	Reject: The documentation of the level of evidence supporting the competing recommendations cited is already required in these proposed regulations in section 9792.25.1(a)(5)(A).	None.

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	disputes and speed up the final determination where there are competing recommendations.			
9792.20(c)	<p>Commenter recommends that the DWC include a timeframe in the definition for chronic pain. For example, “Chronic pain means any pain that persists beyond three months from the date of injury.” Commenter opines that this recommendation adds clarity and a definitive description aimed at facilitating appropriate treatment of chronic pain, including initiating treatment at the earliest optimal time.</p> <p>Commenter notes that the U.S. National Library of Medicine/National Institutes of Health website: www.nlm.nih.gov/medlineplus, states “chronic pain is often defined as any pain lasting more than 12 weeks”.</p> <p>Commenter opines that a specific timeframe would encourage treating physicians to initiate appropriate and effective plans for treatment of chronic pain. Reasonable expectations of treatment outcomes should be established early. Not including a</p>	<p>Peggy Thill Claims Operations Manager</p> <p>Dinesh Govindarao Chief Medical Officer</p> <p>State Compensation Insurance Fund June 30, 2014 Written Comment</p>	Accept: A timeframe of three or more months will be incorporated into the definition of Chronic Pain.	Section 9792.20(c) is re-lettered to (b) and revised to state, “Chronic Pain” means pain lasting three or more months from the initial onset of pain.

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	length of time would create ambiguity and lead to inconsistencies in initiating the treatment of chronic pain, as well as possible delays or prolonged unnecessary treatment. Commenter states that the potential for causes of treatment delays or recovery must be eliminated whenever possible.			
9792.25.1(a)	<p>Commenter recommends that this section be deleted and requests that the DWC maintain the current method for evaluation and determination of strength of evidence.</p> <p>Commenter opines that the language in this section as proposed will open the door for ambiguity and misinterpretation of the DWC's intent to clarify and improve the way in which clinical decisions are made. Commenter predicts that evaluation of the Strength of Evidence on potentially every case will result in increased disputes and treatment delays.</p>	<p>Peggy Thill Claims Operations Manager</p> <p>Dinesh Govindarao Chief Medical Officer</p> <p>State Compensation Insurance Fund June 30, 2014 Written Comment</p>	Reject: The proposed method for evaluation and determination of strength of evidence is more comprehensive and allows for the evaluation of studies that is not randomized.	None.
9792.26(a)(2)	Commenter recommends that the DWC include a Physician Assistant on the MEEAC as Pas are recognized health care providers in the workers' compensation system pursuant to	Teresa Anderson Public Policy Director California Academy of Physician	Reject: Although PA's are clearly recognized and valued health care providers in the workers' compensation system, the most pressing	None.

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	<p>Labor Code 3209.10.</p> <p>Commenter states that physician assistants are valued members of the healthcare team and practice medicine across virtually every specialty of medicine recognized by the Medical Board of California. Commenter notes that as stated in the Initial Statement of Reason (ISOR) the purpose for expanding the MEEAC to include a representative from the pharmacology and nursing community is to provide the Medical Director with advisory input from these important medical fields. Further stated in the ISOR is the necessity for the regulatory changes which is based on the need to specify the process MEEAC will use to formulate its advisory recommendations to the Medical Director to ensure that the regulated community understands MEEAC's recommendations are based on the principals of Evidence-Based Medicine. Given the role PAs have in the Workers' Compensation healthcare system commenter opines that they would provide important advisory input and ensure the</p>	<p>Assistants June 30, 2014 Written Comment</p>	<p>matters concerning the MTUS will require additional input from the pharmacology field and the nursing field.</p>	

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	regulated community, as it pertains to PA practice, understands the MEEAC's recommendations are based on the principles of Evidence-Based Medicine.			
9792.20(g)	<p>Commenter recommends amending the definition of medical treatment to be consistent with, and clearer than LC 4600(a).</p> <p>Commenter states that the inclusion of a definition of "medical treatment" is an excellent idea. Commenter opines that without such a definition, there is a procedural default to considering anything requested by a physician on a DWC Form RFA to be medical treatment, even when that is clearly not the case. Real-life examples include vocational rehabilitation, TTD benefits or a new house.</p> <p>Commenter states that the definition in the current draft is probably not going to be acceptable to the WCAB. Commenter notes that in the draft, "medical treatment" is defined as any service that is consistent with the requirements of the MTUS. This means that any goods or services that</p>	Robert Ward July 1, 2014 Written Comment	Reject: The definition of "medical treatment" is not subject to this rulemaking because no changes are being proposed to the current regulatory definition.	None.

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	<p>are not mentioned within the MTUS; or which are inconsistent with the MTUS; are not medical treatment. Commenter opines that it is doubtful that this assertion would stand.</p> <p>Commenter recommends that a definition that is consistent with the terms found in LC 4600(a) would be superior. Commenter opines that a good operational definition of medical treatment would be something along the lines of services that must be provided by a licensed or certified health care professional; or goods for which there are defined HCPCS codes. Commenter states that this would result in appropriate medical goods and services not consistent with the MTUS still being considered as medical treatment; and would exclude services provided by lay persons (e.g., gardening) or goods for which there is no defined HCPCS code (e.g., a house).</p> <p>Commenter states that an operational definition of this type would reduce the level of confusion and dispute over which issues require settlement by a</p>			

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	physician reviewer; and which belong within the scope of persons other than health care professionals (e.g., judges).			
9792.21(c)	<p>Commenter recommends amending the discussion of evidence-based medicine to include consideration of outcomes of prior care for the specific patient.</p> <p>Commenter notes that the discussion of evidence-based medicine in this section does not contain any reference to evidence arising from the specific patient (e.g., outcomes of prior similar treatment). Commenter opines that without this consideration, any decision making process that is tied to guidelines must be based on guideline content only and that this can result in inappropriate treatment. For patients who technically meet guideline criteria for patient selection but have a history of the same treatment without benefit, authorization is likely to result. For patients who do not technically meet guideline criteria but have a history of the same treatment with excellent outcomes, adherence to 9792.21(c) could result in</p>	Robert Ward July 1, 2014 Written Comment	<p>Reject in part. Accept in part: Reject: The proposed definition of Evidence-Based Medicine allows the integration of the best available research evidence with clinical expertise and patient values. The consideration of outcomes of prior care for the specific patient falls under the categories of clinical expertise and patient values. Accept: For patients who do not technically meet guideline criteria but have a history of the same treatment with excellent outcome, section 9767.21(j) is added. Additionally, “functional improvement” has been defined to incorporate patient response to treatment. Therefore, a clinically significant improvement in activities of daily living or</p>	Section 9767.21(j) is added to state, “Employers, at their discretion, may approve medical treatment beyond what is covered in the MTUS or supported by the best available medical evidence in order to account for unique medical circumstances warranting an exception.”

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	inappropriate denial of care.		reductions in work restrictions are factors that must be considered.	
9792.21(h)	<p>Commenter recommends amending this section so that it does not mandate employers to reimburse treating physicians for opting to conduct a formal literature review.</p> <p>Commenter notes that the proposed section states, “Providers making treatment decisions may conduct a comprehensive medical literature search”. Commenter states that it is understood that the drafters of the regulations intended this as informational; however, he opines that the language may be interpreted by the courts as mandating the claims administrator to reimburse the treating physician for any and all costs claimed in association with the literature search (E/M service codes for time spent in obtaining and reading publications; fees for obtaining full text of relevant articles; etc.). Commenter opines that if the DWC did not intend for the creation of this potential cost to providers, he recommends that the language cited be</p>	Robert Ward July 1, 2014 Written Comment	Accept: This provision has been deleted and replaced with language that deletes the phrase “...may conduct a comprehensive medical literature search.”	Section 9792.21(h) is deleted and replaced with 9792.21(f) “To find the best available medical evidence requires a search of the large body of medical literature. Conducting a comprehensive medical literature search is resource-intensive. Therefore, in the interest of efficiency and consistency, the medical literature search sequence set forth in subdivision 9792.21(g) shall be sufficient and applies to all physicians.”

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9792.21(k)	<p>clarified or removed.</p> <p>Commenter recommends that the DWC define the process for settling a dispute over the quality of competing recommendation citations as discussed in the subsection.</p> <p>Commenter notes that this section very sensibly states that if a dispute hinges on conflicting cited recommendations, that the recommendation that is the highest quality of evidence as found in 9792.25.1 would be followed.</p> <p>Commenter states that there is a significant process issue left entirely unaddressed: Who shall decide which citation is of the highest quality?</p> <p>Commenter opines that if this question is not explicitly addressed within the regulations, then this issue will default to WCAB judges, who are unqualified to make that determination. This would result in improper decisions, as well as increased caseloads at the WCAB and increased dispute resolution costs for employers.</p>	Robert Ward July 1, 2014 Written Comment	Accept: Revisions to this section are made to clarify that Utilization Review and Independent Medical Review physicians decide which citation is of the highest quality if there is a dispute over the quality of competing recommendations citations.	Section 9792.21(k) is re-lettered to 9792.21(i) and revised to add additional subdivisions 9792.21(k)(1) and(2) to clarify that Utilization Review and Independent Medical Review physicians decide which citation is of the highest quality by applying 9792.25 if there is a dispute over the quality of competing recommendations cited.

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	<p>Commenter states that it would be possible to resolve this process issue by stating that in instances where there is such a dispute between a UR physician and a treating physician, that this dispute is settled via the IMR process. Alternatively, the DWC could create its own internal process for this purpose; although how it would be resourced is unclear.</p>			
9792.25	<p>Commenter recommends limiting evidence of treatment efficacy and safety to publications at levels 1a, 1b, 1c and 2 on the hierarchy of evidence.</p> <p>Commenter recommends that the Medical Director reflect upon what levels within the hierarchy constitute meaningful evidence of clinical efficacy and safety; and which do not; and to disqualify any publications that do not constitute evidence.</p> <p>Commenter recommends that the DWC consider levels 1a, 1b, 1c and 2 as meaningful evidence; and consider levels 3, 4 and 5 as not constituting evidence sufficient for medical decision making. Commenter opines that materials at level 3, 4 and 5 more properly serve as indicators to clinical</p>	<p>Robert Ward July 1, 2014 Written Comment</p>	<p>Reject: Although medical evidence levels 3, 4 and 5 are lower levels than 1a, 1b, 1c and 2 on the hierarchy of evidence they are still considered medical evidence. The guidelines still require that the study be published, peer-reviewed and nationally recognized and that any expert opinion be published.</p>	<p>None.</p>

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	<p>researchers as to where evidence should be sought in future studies.</p> <p>Commenter opines that the hierarchy set forth is very sensible.</p> <p>Commenter states that as written, any form of publication within the past 5 years can constitute scientific evidence regarding medical treatment. Commenter opines that this sets the stage for abusive providers to run amok with expensive and questionable services for which there is no meaningful evidence, but for which there is a single publication that was funded by the manufacturer.</p>		<p>Accept: Agree.</p> <p>Reject: Disagree. Recommendations supported by questionable evidence such as a single publication that was funded by the manufacturer could be rejected as not credible because of the presence of bias. The presence of bias is one of the factors a reviewing physician shall consider when evaluating competing recommendations.</p>	<p>None.</p> <p>None.</p>
9792.21(f)	<p>Commenter recommends that the DWC amend this section to indicate what may/should occur when there is no evidence of any kind for or against the requested medical treatment.</p>	<p>Robert Ward July 1, 2014 Written Comment</p>	<p>Reject in part. Accept in part. Reject: This section is not amended as a result of this comment. Accept: Section 9767.21(j) is added to indicate employers have discretion to approve a requested medical treatment even if it's not covered by the</p>	<p>Section 9767.21(j) is added, "Employers, at their discretion, may approve medical treatment beyond what is covered in the MTUS or supported by the best available medical evidence in</p>

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			MTUS or the best available medical evidence.	order to account for unique medical circumstances warranting an exception.”
9792.20(b) and (h)	Commenter notes that 9792.20(b) defines "ACOEM Practice Guidelines" as specifically referring to the 2004 edition. Commenter states that this effectively excludes the ACOEM Practice Guidelines from the definition of "medical treatment guidelines" in 9792.20(h), owing to the age of the 2004 edition.	Robert Ward July 1, 2014 Written Comment	Reject: The MTUS remains valid even if it has not been updated in the last five years. Guidelines that have not been updated or reviewed within the last five years may not be up-to-date, but they are by no means expired or invalid. The phrase that guidelines be “reviewed and updated within the last five years” will remain because it is important that the most current versions of the guidelines are relied upon when MEEAC reviews guidelines to update the MTUS or when a treatment request is made that is based on recommendations found outside of the MTUS. However, as previously stated in a response to Joyce Ho, M.D.’s comment, “there may be seminal scientific studies that are older than five years	None.

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			old that are still the best available evidence” and the recommendations it supports may carry over to updated versions of the guideline.	
9792.21(d); 9721.21(e); 9792.21(e)(1); 9792.21(f); 9792.25(a)(1)	Commenter states that the phrase "medical condition or diagnostic test" appears in several instances in this sections. Commenter opines that the intended meaning is something along the lines of "medical treatment or diagnostic test for the injured worker's condition".	Robert Ward July 1, 2014 Written Comment	Accept in part. Reject in part. Accept: Revised sections 9721.21(e), 9792.21(e)(1), 9792.21(f) and 9792.25(a)(1) as commenter suggests. Reject: Section 9792.21(d).	Sections 9721.21(e), 9792.21(e)(1), 9792.21(f) and 9792.25(a)(1) the phrase “medical treatment or diagnostic test” replaces the phrase “medical condition or diagnostic test.” No change to section 9792.219(d).
9792.20(b)	Commenter recommends that the definition refer to the most current ACOEM guidelines in use. (Commenter refers to Section (k) and how ODG is referenced.)	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers’ Compensation July 1, 2014 Written Comment	Reject in part. Accept in part. Reject: The ACOEM guideline adopted and incorporated into the MTUS is the 2 nd Edition version. Accept: The definition for ACOEM will be revised to contain information consistent with the definition for ODG.	Section 9792.20(a) is re-lettered from (b) and is revised to delete “Practice Guidelines”, “2 nd Edition (2004)”, “A copy” and add the phrases “published by the Reed Group containing evidenced-based medical treatment

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				guidelines for conditions commonly associated with the workplace”, “ACOEM guidelines”.
9792.20(c)	<p>Commenter recommends deleting the phrase “the anticipated time of healing” and replacing it with the phrase “beyond three months.”</p> <p>Commenter states that most medical research (on which guidelines for chronic pain must be based), use a three month duration to define chronic pain. Commenter states that the definition must match the medical evidence. Commenter opines that the use of a specified period of time will eliminate potential litigation over what constitutes “the anticipated time of healing.”</p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers’ Compensation</p> <p>July 1, 2014 Written Comment</p>	Accept: A timeframe of three or more months will be incorporated into the definition of Chronic Pain.	Section 9792.20(c) is re-lettered to (b) and revised to state, “Chronic Pain” means pain lasting three or more months from the initial onset of pain.
9792.20(e)	Commenter recommends removing this proposed definition and adopting the most common definition of Evidence-Based Practice as defined by the Institute of Medicine, Evidence-Based Medicine. The Institute of Medicine defined EBM to mean that “to the greatest extent possible, the	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers’ Compensation</p>	Reject: The proposed definition for “Evidence-Based Medicine” was adopted from information from Sackett DL, Rosenberg WM, Gray JA, Haynes RB, and Richardson WS, “Evidence based medicine: what it is and what it	None.

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	<p>decisions that shape the health and health care of Americans—by patients, providers, payers, and policy makers alike—will be grounded on a reliable evidence base, will account appropriately for individual variation in patient needs, and will support the generation of new insights on clinical effectiveness” (IOM’s Roundtable on Evidence-Based Medicine, 2006). Commenter states that EBM is the framework for methodologically analyzing best evidence so that the care provided to each patient delivers the most value. Commenter opines that the benefits of EBM will be to reduce discrepancies in care of patients and improve value of the healthcare delivered. (IOM, Evidence-Based Medicine, 2009.) Commenter favors this second definition as it considers not just decision making as it relates to the patient, but suggests a public health perspective and takes into account “payer” perspective.</p> <p>Alternatively, commenter recommends changing the proposed language to read as follows:</p>	<p>July 1, 2014 Written Comment</p>	<p>isn’t” <i>BMJ</i>, 1996; January 13, Volume 312, 71-72. The other article DWC relied upon is Akobeng AK, “Evidence-based child health. 1. Principles of evidence-based medicine” <i>Arch Dis Child</i>, 2005; Volume 90, 37-40 see Initial Statement of Reasons, under the heading “Technical, Theoretical, or Empirical Studies, Reports or Documents,” items (9) and (2). Dr. David Sackett is widely regarded as one of the pioneers of evidence-based medicine and we believe the definition he has provided is sufficient.</p> <p>Reject: The definition proposed by commenter is</p>	<p>None.</p>

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	(e) "Evidence-Based Medicine (EBM)" means a systematic approach to making clinical decisions which allows the integration of the best available research.		very similar to the definition DWC has proposed. The commenter proposes a change in the regulatory definition of EBM that fails to include a very important concept from the definition he proposes, "...will account appropriately for individual variation of patient needs..."	
9792.20(h)	Commenter recommends removing "within the last five years." Medical treatment guidelines are already defined in statute and this definition should point to the most current version. Commenter opines that retaining the five year limitation in the regulations could lead to confusion and additional litigation and expense over whether or not MTUS remains valid since a self-imposed deadline has passed.	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation July 1, 2014 Written Comment	Reject: The MTUS remains valid even if it has not been updated in the last five years. Guidelines that have not been updated or reviewed within the last five years may not be up-to-date, but they are by no means expired or invalid. The phrase that guidelines be "reviewed and updated within the last five years" will remain because it is important that the most current versions of the guidelines are relied upon when MEEAC reviews guidelines to update the MTUS or when a treatment request is made that is based on recommendations found outside of the MTUS.	None.

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			However, as previously stated in a response to Joyce Ho, M.D.'s comment, "there may be seminal scientific studies that are older than five years old that are still the best available evidence" and the recommendations it supports may carry over to updated versions of the guideline.	
9792.20(j)	Commenter recommends retaining the existing language. Commenter states that "Nationally recognized" is applicable and appropriate if the most current version has been adopted for use by the United States federal government or a state government.	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation July 1, 2014 Written Comment	Reject: To eliminate some guidelines that are questionably evidence-based, the phrase "or currently adopted for use by one or more U.S. state governments or by the U.S. federal government" has been deleted.	None.
9792.21(c)	Commenter recommends that this definition mirror the definition under 9792.20(e).	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers' Compensation	Reject: It does but provides more details about the "systematic approach" to making clinical decisions.	None.

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		July 1, 2014 Written Comment		
9792.21(e)(1)	<p>Commenter does not support the addition of this proposed language. Commenter opines that this section is intended to establish the order of evidence to support medical treatment decisions, not establish presumptive correctness or rebuttal evidence. Merely a progression of what should be the order in which the guidelines are used for medical treatment.</p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers' Compensation</p> <p>July 1, 2014 Written Comment</p>	<p>Reject: Labor Code section 4604.5 clearly states the MTUS's presumption is "rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of his or her injury."</p>	None.
9792.21(f)	<p>Commenter recommends separating (f) into two sections because the requirement for an injury that is not addressed in the MTUS differs from that of an injury that is addressed in the MTUS but where the MTUS recommendation is successfully rebutted.</p> <p>Commenter states that the MTUS is presumptively correct unless the injury is not covered by the MTUS. Labor Code section 4604.5(d) specifies that authorized medical care for injuries not covered by the MTUS</p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers' Compensation</p> <p>July 1, 2014 Written Comment</p>	<p>Reject: The process in evaluating competing recommendations remains the same and medical care shall be in accordance with the best available medical evidence.</p> <p>Accept: Agree.</p>	<p>None.</p> <p>None.</p>

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	<p>must be in accordance with other evidence-based medical treatment guidelines that are nationally recognized and scientifically based.</p> <p>Commenter state that if the MTUS is being rebutted, authorized treatment is the treatment supported by the best available medical evidence.</p>		Accept: Agree.	None.
9792.21(g)	Commenter recommends replacing the term “shall” with “may” so that it is clear that a literature search is optional.	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers’ Compensation</p> <p>July 1, 2014 Written Comment</p>	<p>Reject in part. Accept in part.</p> <p>Reject: The medical literature search sequence shall be applied by physician reviewers.</p> <p>Accept: The medical literature search sequence may be applied by treating physicians.</p>	Section 9792.21(g) is re-lettered to (f) and (f)(1) makes clear treating physicians “may” apply the medical literature search sequence and sections (f)(2)(3) makes clear that Utilization Review and Independent Medical Review physicians “shall” apply the medical literature search sequence.
9792.25(a)(1)	Commenter states that AGREE II language for guideline developers such as the MEEAC is fine; however, he opines that adding AGREE II language in regulation with an	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer</p>	Reject: Section 9792.25(a)(1) does not mandate the use of AGREE II. The systematic methodology for evaluating medical evidence set forth in	None.

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	<p>expectation that it is to be used by physicians or other medical providers, or in the UR/IMR process is unrealistic. Commenter states that most of these practitioners will not use, and would not be experienced in how to use AGREE II, as extensive training is necessary. Commenter opines that its inclusion could have unintended consequences such as driving up medical and/or legal actions and costs. Commenter states that the added definitions in subsections (2)-(29) are already defined in AGREE II and would not need to be restated in this regulation.</p>	<p>California Coalition on Workers' Compensation July 1, 2014 Written Comment</p>	<p>section 9792.25(a)(1) was developed from information obtained from the Cochrane Group and the Oxford Centre for Evidence-based Medicine (see Initial Statement of Reasons, under the heading "Technical, Theoretical, or Empirical Studies, Reports or Documents," items (4) and (8). Medical and/or legal actions and costs will not be driven up because a similar systematic approach is already required pursuant to current section 9792.25(c)(1) which was adopted from ACOEM.</p>	
<p>9792.21; 9792.26(e)(1)(B) (1)</p>	<p>Commenter notes that section 9792.21, as amended, provides for use of ACOEM or ODG national guidelines for first-tier treatment recommendations for an injured worker's specific medical condition in those cases where the MTUS is silent on a particular proposed treatment regimen, and/or when the MTUS' rebuttable presumption has been overcome. Commenter notes that Section 9792.26(e)(1)(B)(1), also contains a requirement that the MTUS</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation Services July 1, 2014 Written Comment</p>	<p>Reject: Commenter has misquoted section 9792.26(e)(1)(B)(1) as a mandate that the MTUS is somehow expired or invalid if it has not been updated within 5 years and, therefore, paving the way for the use of ACOEM and ODG. That is incorrect. Section 9792.26(e)(1)(B)(1) describes a key item in the domain "Currency of Guideline" that must be</p>	<p>None.</p>

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	<p>guidelines be "...updated in a timely fashion...", recommended as no longer than 3 years, but in any case never to be more than 5 years, therefore, paving the way for the use of ACOEM and ODG as outlined above.</p> <p>Commenter is in support of these provisions, as they afford providers and utilization reviewers with alternative, standardized, evidence-based and nationally-recognized standards to back the application of the MTUS. Commenter states that both ACOEM and ODG are in use in other jurisdictions throughout the country, and many UR and physician reviewers are already accustomed to their use; commenter state that her company's UR reviewers have experience with both sets of guidelines.</p>		<p>considered by MEEAC when reviewing guidelines to update the MTUS. Guidelines adopted into the MTUS should be updated at least every five years. The MTUS remains valid even if it has not been updated in the last five years. Guidelines that have not been updated or reviewed within the last five years may not be up-to-date, but they are by no means expired or invalid. The phrase that guidelines be "reviewed and updated within the last five years" will remain because it is important that the most current versions of the guidelines are relied upon when MEEAC reviews guidelines to update the MTUS or when a treatment request is made that is based on recommendations found outside of the MTUS. However, as previously stated in a response to Joyce Ho, M.D.'s comment, "there may be seminal scientific studies that are older than five years</p>	

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			old that are still the best available evidence” and the recommendations it supports may carry over to updated versions of the guideline.	
9792.21(j)	<p>Commenter notes that the proposed language states that after a medical literature search, “...Utilization Review decisions and Independent Medical Review decisions shall contain the citation of the [selected] medical treatment guideline...” to support their decisions. Commenter supports the inclusion of this language in the proposed MTUS regulations, as UR decisions presently issued by her company contain such citations, and inclusion of the citation makes the UR decision more meaningful.</p> <p>Commenter opines that given the quasi-judicial nature of the IMR process, a greater level of responsibility should be placed on the IMRO reviewer to not only state the guideline(s) in immediate support of the IMR decision, but to also specifically distinguish the guidelines/medical evidence submitted by the treating physician and/or URO</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers’ Compensation Services July 1, 2014 Written Comment</p>	<p>Accept. Agree</p> <p>Accept. Agree. If competing recommendations are cited, both the Utilization Review and/or the Independent Medical Review physicians are required to indicate the level of evidence in their UR or IMR decisions.</p>	<p>None.</p> <p>None.</p>

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	reviewers that were <i>not</i> selected in support of the underlying IMRO decision. Commenter opines that this distinction should include a discussion of the relative weight of evidence used in arriving at the selected treatment recommendation.			
9792.20(b)	<p>Commenter recommends the following revised language:</p> <p>“ACOEM Practice Guidelines” means the American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines, 2nd Edition (2004). A copy <u>ACOEM Practice Guidelines</u> may be obtained from the American College of Occupational and Environmental Medicine, 25 Northwest Point Blvd., Suite 700, Elk Grove Village, Illinois, 60007-1030 (www.acoem.org).</p> <p>Commenter notes that DWC proposes to adopt a definition of ODG (Official Disability Guidelines) without specifying a particular dated version. Commenter opines that it is necessary to delete the reference to a particular version of the ACOEM Practice Guidelines in this definition so that</p>	<p>Brenda Ramirez Claims & Medical Director California Workers’ Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Accept in Part. Revisions are made to this section but the exact language suggested by commenter will not be adopted.</p> <p>Reject: The definition of ACOEM is revised to contain a</p>	<p>Section 9792.20(a) is re-lettered from (b) and is revised to delete “Practice Guidelines”, “2nd Edition (2004)”, “A copy” and add the phrases “published by the Reed Group containing evidenced-based medical treatment guidelines for conditions commonly associated with the workplace”, “ACOEM guidelines”.</p> <p>None.</p>

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	<p>treating physicians and reviewers can utilize the current version when searching or citing ACOEM Practice Guidelines. If a specific dated version is determined necessary, commenter recommends revising the definitions for ACOEM and ODG guidelines to reflect the most recent versions. Commenter opines that the definition of ACOEM Practice Guidelines specifies an outdated version and there will be confusion and disputes over whether the guideline cited is valid.</p>		<p>consistent format with the definition of ODG. Note, for the MTUS guidelines that adopt either ACOEM or ODG or Colorado, the citation to the frozen versions of those guidelines are provided for in their respective regulatory sections.</p>	
9792.20(c)	<p>Commenter recommends the following revised language:</p> <p>(c) “Chronic pain” means any pain that persists beyond the anticipated time of healing <u>three months</u>.</p> <p>Commenter states that most medical research (on which guidelines for chronic pain must be based) use a three-month duration to define chronic pain. Commenter opines that the definition must match the medical evidence and that the use of a specified period of time will eliminate potential litigation over what constitutes “the anticipated time of</p>	<p>Brenda Ramirez Claims & Medical Director California Workers’ Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Accept: A timeframe of three or more months will be incorporated into the definition of Chronic Pain.</p>	<p>Section 9792.20(c) is re-lettered to (b) and revised to state, “Chronic Pain” means pain lasting three or more months from the initial onset of pain.</p>

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9792.20(e)	<p>healing.”</p> <p>Commenter recommends the following revised language:</p> <p>“Evidence-Based Medicine (EBM)” means a systematic approach to making clinical decisions which allows the integration of the best available research evidence with clinical expertise and patient values.</p> <p>Commenter opines that clinical expertise and patient values are subjective and therefore inappropriate as standards to assess the appropriateness of medical care. Commenter state that it is necessary to delete “clinical expertise and patient values” from the proposed definition of EBM. Commenter opines that the MTUS has to be definitive in order to establish useful, clear, and scientific treatment guidelines as the statutes direct.</p> <p>Commenter states that the inclusion of the term “clinical expertise and patient values” contradicts the language now in section 9792.21(c) which accurately states: “EBM is a method of</p>	<p>Brenda Ramirez Claims & Medical Director California Workers’ Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Reject: The proposed definition for “Evidence-Based Medicine” was adopted from information from Sackett DL, Rosenberg WM, Gray JA, Haynes RB, and Richardson WS, “Evidence based medicine: what it is and what it isn’t” <i>BMJ</i>, 1996; January 13, Volume 312, 71-72. The other article DWC relied upon is Akobeng AK, “Evidence-based child health. 1. Principles of evidence-based medicine” <i>Arch Dis Child</i>, 2005; Volume 90, 37-40 see Initial Statement of Reasons, under the heading “Technical, Theoretical, or Empirical Studies, Reports or Documents,” items (9) and (2). Dr. David Sackett is widely regarded as one of the pioneers of evidence-based medicine. Sackett’s article states, “Evidence based medicine is not ‘cookbook’ medicine...any external guideline must be integrated with individual</p>	<p>None.</p>

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	<p>improving the quality of care by encouraging practices that work, and discouraging those that are ineffective or harmful. EBM asserts that intuition, unsystematic clinical experience, and pathophysiologic rationale are insufficient grounds for making clinical decisions.”</p> <p>Alternatively, commenter recommends using instead the definition of Evidence-Based Medicine (EBM) that the (IOM) adopted in 2009: “EBM is the framework for methodologically analyzing best evidence so that the care provided to each patient delivers the most value. The benefits of EBM will be to reduce discrepancies in care of patients and improve value of the healthcare delivered. (IOM, Evidence-Based Medicine, 2009.)”</p>		<p>clinical expertise in deciding whether and how it matches the patient’s clinical state, predicament, and preferences...” Under these proposed regulations, physicians will continue to use his/her judgment and it will be integrated with the best available medical evidence.</p>	
9792.20(f)	<p>Commenter recommends the following revised language:</p> <p>“Functional improvement” means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the</p>	<p>Brenda Ramirez Claims & Medical Director California Workers’ Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Reject: The recent 2014 regulatory revisions to the Official Medical Fee Schedule (OMFS) sufficiently detail what reports can and cannot be billed as an evaluation and management service and, therefore, commenter’s</p>	<p>None.</p>

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	<p>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 9789.10-9789.19-medical-evaluation and treatment; and a reduction in the dependency on continued medical treatment.</p> <p>Commenter opines that the evaluation and management (E/M) OMFS reference is useful because evaluation of functional improvement is a component of the evaluation and management service and should not be subject to duplicate payment. Commenter notes that this was originally added to the MTUS regulations as providers were beginning to bill for reporting functional improvement separately from the usual E & M codes. Commenter opines that if this is removed, the issue may resurface; therefore this language should be retained. Restoring the reference will avert disputes that will otherwise unnecessarily occur.</p>		<p>recommendation to re-instate the deleted phrase is unnecessary. Moreover, the definition of functional improvement relies on clinical and medical criteria, and is not based on administrative or fiscal criteria.</p>	
9792.20(h)	Commenter recommends the	Brenda Ramirez	Reject: The MTUS remains	None.

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	<p>following revised language:</p> <p>“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 medical treatment for specific clinical circumstances.</p> <p>Commenter states that it is not necessary to include a five-year limitation in the definition of medical treatment guidelines because the most current version of written recommendations should still be included in the definition of “medical treatment guidelines,” even if not revised within the last five years. For example, written MTUS, ACOEM and ODG recommendations that have not been revised within five years are still medical treatment guidelines. Commenter states that a guideline may be based on a definitive study for which there is no new evidence and therefore is not updated. That should</p>	<p>Claims & Medical Director California Workers’ Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>valid even if it has not been updated in the last five years. Guidelines that have not been updated or reviewed within the last five years may not be up-to-date, but they are by no means expired or invalid. The phrase that guidelines be “reviewed and updated within the last five years” will remain because it is important that the most current versions of the guidelines are relied upon when MEEAC reviews guidelines to update the MTUS or when a treatment request is made that is based on recommendations found outside of the MTUS. However, as previously stated in a response to Joyce Ho, M.D.’s comment, “there may be seminal scientific studies that are older than five years old that are still the best available evidence” and the recommendations it supports may carry over to updated versions of the guideline.</p>	

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	not render the guideline invalid after 5 years. Pursuant to Labor Code section 77.5, which is referenced in Labor Code section 5307.27, only a periodic review is required. Commenter states that the DWC can meet statutory review requirements to periodically update MTUS without imposing artificial deadlines. Commenter opines that retaining the five-year limitation in the regulations could lead to confusion, additional litigation and expense over whether or not MTUS remains valid since a self-imposed deadline has passed.			
9792.20(i)	<p>Commenter recommends that this subsection be deleted.</p> <p>Commenter opines that MEDLINE should be deleted because it no longer appears in the proposed regulations.</p>	<p>Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Accept: The definition for "Medline" is deleted.</p>	<p>Section 9792.20(i) is r-lettered to (h) and the definition for Medline has been deleted.</p>
9792.20(j)	<p>Commenter recommends the following revised language:</p> <p>"Nationally recognized" means published in a peer-reviewed medical journal; or <u>and either</u> developed, endorsed and disseminated by a</p>	<p>Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) July 1, 2014</p>	<p>Reject: To eliminate some guidelines that are questionably evidence-based, the phrase "or currently adopted for use by one or more U.S. state government or by the U.S. federal government"</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>national organization with affiliates based in two or more U.S. states; <u>or currently adopted for use by one or more U.S. state governments or by the U.S. federal government</u>, and is the most current version.</p> <p>Commenter states that “nationally recognized” is also applicable and appropriate if the most current version has been adopted for use by the federal government or a state government in the United States.</p>	Written Comment	has been deleted.	
9792.20(m)	<p>Commenter recommends the following revised language:</p> <p>“Scientifically based” means based on <u>objective, reproducible results in</u> scientific literature, wherein the body of literature is identified through performance of a literature search, the identified literature is evaluated, and then used as the basis to support a recommendation.</p> <p>Commenter opines that for a study to be considered scientifically based, its results must be objective and replicable.</p>	<p>Brenda Ramirez Claims & Medical Director California Workers’ Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	Reject: The phrase “scientific literature” necessarily includes the empirical techniques used that should allow reproducible, objective results. Therefore, commenter’s suggestion is unnecessary.	None.

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.21 - Title	<p>Commenter recommends deleting the reference to Medical Literature Search Sequence from the title. Commenter states that the whole section addresses MTUS and opines that this is unnecessary. Commenter opines that the sequence of review is established by Labor Code §4610.5 and will control the sequence of review.</p>	<p>Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Reject: Medical Literature Search Sequence is included in the title because this section also describes the process to find medical literature. Labor Code section 4610.5(c)(2)(A) begins the sequence of review with the MTUS, which is precisely what this rulemaking entails.</p>	None.
9792.21(a)	<p>Commenter recommends the following revised language:</p> <p>(a) The Administrative Director adopts the Medical Treatment Utilization Schedule (MTUS) consisting of section 9792.202 through section 9792.26<u>4.3</u>.</p> <p>Commenter notes that while the Medical Treatment Utilization Schedule regulations encompass sections 9792.20 through 9792.26, the Medical Treatment Utilization Schedule itself includes only sections 9792.22 through 9792.24.3. The remainder of the sections includes information that pertains to the Schedule, but is not part the schedule, including procedures to follow when</p>	<p>Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Reject: The MTUS consist of sections 9792.20 through 9792.26. The recommended guidelines set forth in the MTUS consist of sections 9792.22 through 9792.24.3.</p>	None.

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>the MTUS does not apply. Commenter opines that if the sections that identify circumstances when the MTUS does not apply are within the MTUS as currently proposed, the MTUS does apply and she finds herself as Alice in Wonderland. Commenter opines that such confusion can be avoided by adopting only sections 9792.22 through 9792.24.3 as the MTUS.</p>			
9792.21(b)	<p>Commenter recommends the following revised language:</p> <p><u>Medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury is treatment based on the MTUS.</u> The MTUS provides a framework for the most effective treatment of work-related illness or injury to achieve functional improvement, return-to-work, and <u>to minimize</u> disability-prevention.</p> <p>Commenter states that the recommended additional language sets out clearly the heart of the statutory requirements for the MTUS in Labor Code sections 4600, 4604.5, and</p>	<p>Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Reject: The language suggested by commenter is unnecessary because it is covered in section 9792.21(d). Section 9792.21(d) states, "The recommended guidelines set forth in the MTUS...shall constitute the standard for the provision of medical in accordance with Labor Code section 4600 for all injured workers diagnosed with industrial conditions."</p>	None.

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	<p>5307.27. See introduction.</p> <p>Commenter recommends using “minimize disability” as this term is broader and more accurate in this context than “disability prevention.”</p>		<p>Reject: Disagree. Commenter’s suggested language will not be adopted because it is not accurate. An injured worker is not necessarily entitled to disability indemnity benefits.</p>	<p>None.</p>
<p>9792.21(c)</p>	<p>Commenter recommends the following revised language:</p> <p>Evidence-Based Medicine (EBM) is a systematic approach to making clinical decisions which allows the integration of based on the best available research evidence with clinical expertise and patient values. EBM is a method of improving the quality of care by encouraging practices that work, and discouraging those that are ineffective or harmful. EBM asserts that intuition, unsystematic clinical experience, and pathophysiologic rationale are insufficient grounds for making clinical decisions. Instead, EBM requires the evaluation of medical evidence by applying an explicit systematic methodology to determine the strength of evidence used to</p>	<p>Brenda Ramirez Claims & Medical Director California Workers’ Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Reject: The proposed definition for “Evidence-Based Medicine” was adopted from information from Sackett DL, Rosenberg WM, Gray JA, Haynes RB, and Richardson WS, “Evidence based medicine: what it is and what it isn’t” <i>BMJ</i>, 1996; January 13, Volume 312, 71-72. The other article DWC relied upon is Akobeng AK, “Evidence-based child health. 1. Principles of evidence-based medicine” <i>Arch Dis Child</i>, 2005; Volume 90, 37-40 see Initial Statement of Reasons, under the heading “Technical, Theoretical, or Empirical Studies, Reports or Documents,” items (9) and (2). Dr. David Sackett is widely</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>support the recommendations for a medical condition. The best available evidence is then used to guide clinical decision making. In order to effectively promote health and well-being, health care professionals shall base clinical decisions on EBM.</p> <p>Commenter states that EBM is based on the best available medical evidence. See her comments on section 9792.20(e). Commenter states that this section also introduces a duplicate definition. Commenter opines that to avoid confusion and disputes over which definition controls, a single definition of Evidence-Based Medicine should be included in the regulation and thereafter Evidence-Based Medicine should be used as a term that simply refers back to the definition. Commenter recommends deleting the last portion of this section because it is not necessary and may be misconstrued, thereby setting up a potential conflict with the code. Commenter recommends that the Administrative Director consider moving the contents of (c) (as</p>		<p>regarded as one of the pioneers of evidence-based medicine. Dr. Sackett’s article relied upon by DWC states it best. “Evidence based medicine is not ‘cookbook’ medicine...any external guideline must be integrated with individual clinical expertise in deciding whether and how it matches the patient’s clinical state, predicament, and preferences...” Under these proposed regulations, physicians will continue to use his/her judgment and it will be integrated with the best available medical evidence. However, in order to determine the best available medical evidence, a methodology needs to be provided to evaluate medical evidence.</p>	

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	modified) into the definition of Evidence-Based Medicine (EBM) in Section 9792.20(e), and simply stating here in (c) “Medical Necessity decisions shall be based on Evidence-Based Medicine.”			
9792.21(d)	<p>Commenter recommends the following revised language:</p> <p>(d) The MTUS is based on the principals of EBM. The MTUS is presumptively correct on the issue of extent and scope of medical treatment and diagnostic services for the duration of the medical condition. The MTUS shall constitute the standard for the provision of medical care in accordance with Labor Code section 4600 for all injured workers diagnosed with industrial conditions.</p> <p>Commenter states that the MTUS is based on EBM, not only on its principles; therefore she recommends deleting “the principals of” for a more accurate, clearer statement.</p>	Brenda Ramirez Claims & Medical Director California Workers’ Compensation Institute (CWCI) July 1, 2014 Written Comment	<p>Reject in part. Accept in part: Reject: Commenter’s suggested changes are unnecessary. Accept: Although commenter is correct, the recommended guidelines set forth in the MTUS are based on EBM, the phrase “the principals of” EBM will remain because the MTUS, which includes the transparent, systematic approach to making clinical decisions are based on the principals of EBM. The clarification will be made to add “recommended guidelines set forth in the...”</p>	Section 9792.21(d) is amended the state, “The recommended guidelines set forth in the MTUS are presumptively correct...”
9792.21(e) and 9792.21(e)(1)	<p>Commenter recommends the following revised language:</p> <p>(e) The MTUS does not address</p>	Brenda Ramirez Claims & Medical Director California Workers’	Reject in part. Accept in part. Reject: Commenter’s suggested changes will not be adopted.	Section 9792.21(e)(1) is deleted and section 9792.21(e) is revised to state, “When the

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	<p>every medical condition or diagnostic test and the MTUS's presumption of correctness may be successfully rebutted.</p> <p>(1)The MTUS's presumption of correctness <u>is one affecting the burden of proof. It</u> may be rebutted if medical evidence is cited <u>in a request for authorization that</u> that contains a recommendation applicable to the specific injury medical condition and to the treatment or diagnostic test requested by the injured worker treating physician, and the recommendation is supported with a higher level of evidence than the medical evidence used to support the MTUS's recommendation. the medical evidence establishes by a preponderance of the evidence that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury.</p> <p>Commenter recommends clarifying the nature of the presumption.</p> <p>Commenter states that the request for</p>	<p>Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Accept: Section 9792.21(e) is revised to clarify the two limited situations that may warrant treatment based on recommendations found outside of the MTUS.</p> <p>Reject: Commenter's</p>	<p>MTUS's presumption of correctness is challenged pursuant to Labor Code section 4604.5 or when there is a topical gap and a medical treatment or diagnostic test is not addressed by the recommended guidelines set forth in the MTUS, medical care shall be in accordance with the best available medical evidence found in scientifically and evidenced-based medical treatment guidelines or peer-reviewed published studies that are nationally recognized by the medical community."</p> <p>None.</p>

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	<p>authorization form (Section 9785.5) instructs the treating physician to include all information needed to substantiate the request and states:</p> <p>“For requested treatment that is:</p> <p>(a) inconsistent with the Medical Treatment Utilization Schedule (MTUS) found at California Code of Regulations, title 8, section 9792.20, et seq.; or</p> <p>(b) for a condition or injury not addressed by the MTUS, you may include scientifically based evidence published in peer-reviewed, nationally recognized journals that recommend the specific medical treatment or diagnostic services to justify your request.”</p> <p>Commenter opines that instructing treating physicians to include citations to relevant supporting medical evidence when requesting authorization for services that are inconsistent with the MTUS will be helpful, will avoid unnecessary delays, and will conform to Section 9785.5.</p>		<p>suggestion is already covered by section 9792.21(i). Treating physicians, however, are not required but may cite the medical treatment guideline or peer-reviewed published study that contains the recommendation supported with the highest level of evidence in the chart notes or Request for Authorization.</p>	

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>The treatment is being requested by the treating physician rather than by the injured worker.</p> <p>Commenter opines that the presumption and burden of proof as stated conflicts with Labor Code 4604.5 and 4610.5. Labor Code 4610.5 states that the MTUS is the highest standard and lower standards can only be considered if “every higher ranked standard is inapplicable to the employee’s medical condition.” Labor Code 4604.5 states that the “presumption may be rebutted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of this or her injury.” Commenter notes that the original regulation language from 9792.25 correctly stated this and she opines that this language should be retained for the purpose of rebutting the MTUS.</p>		<p>Accept: Agree</p> <p>Reject: Disagree that proposed section 9792.21 conflicts with Labor Codes section 4604.5 and 4610.5. Our proposed regulations make it clear that the MTUS constitutes the standard for the provision of medical care in accordance with Labor Code section 4600. Our proposed regulations also make it clear that the MTUS’ presumption of correctness is rebuttable or may not cover all injuries. This is consistent with Labor Code section 4605.4. Labor Code section 4610.5 sets forth a hierarchy for any dispute over a Utilization Review decision. On top of the hierarchy is the MTUS which is the subject of this rulemaking.</p>	<p>Section 9792.21(e)(1) is deleted.</p> <p>None.</p>
9792.21(f)	Commenter recommends the following revised language:	Brenda Ramirez Claims & Medical	Reject: The commenter’s recommended language will	None.

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	<p>(f) When The MTUS does not address every injury. For injuries not covered by the MTUS, is silent on a particular medical condition or diagnostic test or when the MTUS is successfully rebutted, authorized medical care shall be in accordance with the best available medical evidence found in other scientifically and evidenced-based, nationally recognized medical treatment guidelines or peer reviewed published studies that are nationally recognized by the medical community.</p> <p>(g) When the MTUS is silent on a particular medical condition or diagnostic test or when successfully rebutted, medical care shall be in accordance with the best available medical evidence found in scientifically and evidenced based medical treatment guidelines or peer reviewed published studies that are nationally recognized by the medical community.</p> <p>Commenter recommends separating (f) into two sections because the requirement for an injury that is not</p>	<p>Director California Workers' Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>not be adopted. However, this section is revised to clarify when treatment based on recommendations found outside of the MTUS may be warranted.</p> <p>Reject: When the MTUS is silent on a particular medical condition or injury, medical care shall be in accordance with the best available medical evidence. There is no disagreement about this. However, what if the MTUS is silent and competing recommendations are cited by the treating physician and the reviewing physician? If the MTUS is silent or if there is an attempt to rebut the MTUS, the process of evaluating competing recommendations</p>	<p>None.</p>

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	<p>addressed in the MTUS differs from that of an injury that is addressed in the MTUS, but where the MTUS recommendation is successfully rebutted.</p> <p>Commenter states that the MTUS is presumptively correct unless the injury is not covered by the MTUS. Labor Code section 4604.5(d) specifies that authorized medical care for injuries not covered by the MTUS must be in accordance with other evidence-based medical treatment guidelines that are nationally recognized and scientifically based.</p> <p>Commenter states that if the MTUS is being rebutted, authorized treatment is the treatment supported by the best available medical evidence.</p>		remains the same.	
9792.21(g)	<p>Commenter recommends the following revised language:</p> <p><i>(gh) In situations described in subdivision (f), a A medical literature search shall may be conducted by the treating physician or medical reviewers making treatment decisions and should be conducted by the</i></p>	<p>Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Reject: For consistency and efficiency purposes a medical search sequence is set forth in the proposed regulations. Conducting a proper and comprehensive medical literature search is time consuming and expensive; the proposed regulatory search</p>	None.

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	<p><i>requesting provider</i>, to find the recommendation supported with the highest level of evidence applicable to the injured worker’s specific medical condition.</p> <p>Commenter strongly recommends replacing “shall” with “may” so it is clear that a literature search is optional. Commenter states that there is no statutory basis or necessity for requiring the treating physician or utilization reviewer to conduct a literature search, although either may choose to do so. If an injury or condition is not covered by the MTUS, Labor Code section 4604.5 requires authorized treatment to be in accordance with other scientifically-based, nationally recognized guidelines. When an injury is addressed in the MTUS but the MTUS recommendation is successfully rebutted, authorized treatment must be treatment supported by the best available medical evidence. Commenter opines that the treating physician and/or the utilization reviewer may wish to perform a literature search, but none is required.</p>		<p>sequence ensures that California providers first look for medical evidence in the MTUS, then two reputable guidelines (ACOEM or ODG), then other medical guidelines and finally peer-reviewed studies. As a result, treating physicians, Utilization Reviewers and Independent Medical Reviewers will consistently search for medical evidence from the same sources. Making the medical literature search optional will not result in the anticipated gains in consistency and efficiency.</p>	

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>If an IMR is requested, the independent medical reviewer can compare the strength of evidence that supports the service recommended in the MTUS or other guideline (if applicable) and the evidence cited to support the requested service, and can perform a complete literature search where appropriate.</p> <p>Commenter states that requiring a medical literature search ignores the very tight statutory and regulatory time constraints on utilization review. Commenter opines that if the requirement remains, it will become another fertile field for disputes and allegations of procedural defects fueling the jurisdictional battle between the WCAB and UR/IMR. Applicant's attorneys will argue over whether or not the literature search was required, whether it was complete and properly performed, and whether it was done in a timely manner. Under Dubon, any of these issues will shift the case from a prompt evaluation of the best medical care to litigation at the Board as to whether the UR decision contains "material procedural</p>		<p>Reject: DWC is aware of these concerns and the very tight statutory and regulatory time constraints on Utilization Review. UR and IMR reviewers make determinations on the reasonableness and necessity of medical treatment requests by the treating physician. Their decisions must be supported by the best available medical evidence. A medical search sequence will make the process more efficient and consistent.</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	defects that undermine the integrity of the UR decision.” Commenter opines that this will simply become a new way to divert decisions by medical professionals, flood the Board with questionable disputes, and increase the cost of utilization reviews.			
9792.21(h)	<p>Commenter recommends the following revised language:</p> <p>Conducting a comprehensive medical literature search is resource-intensive. <i>A treating physician or reviewer Providers-making-treatment-decisions</i> may conduct a comprehensive medical literature search, but for purposes of this section and in the interest of efficiency and consistency, the medical literature search sequence set forth in subdivision (i) shall be sufficient.</p> <p>This guidance on the level and type of literature search is helpful and appreciated. The minor language</p>	<p>Brenda Ramirez Claims & Medical Director California Workers’ Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Accept in part. Reject in part. Accept: Clarifying changes will be made to the medical literature search sections to make it clear that treating physicians may conduct a medical literature search. Reject: Clarifying change will be made to the medical literature search sections to make it clear that a Utilization Reviewer and Independent Medical Reviewer shall conduct a medical literature search.</p>	<p>Section 9792.21(f) is revised to state, “To find the best available medical evidence requires a search of the large body of literature. Conducting a comprehensive medical literature search is resource-intensive. Therefore in the interest of efficiency and consistency, the medical literature search sequence set forth in subdivision</p>

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	modification is suggested for simplicity and clarity.			9792.21(g) shall be sufficient and applies to the following physicians.” Section 9792.21(g) is deleted and replaced with “Medical literature search sequence to find the best available medical evidence.”
9792.21(i)(1) – (3)	<p>Commenter recommends the following revised language:</p> <p>(i) When conducting a medical literature search of the large body of available medical evidence, the following search sequence, may at a minimum, shall be followed:</p> <p>(1) Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker’s specific medical condition. Choose the recommendation that is supported with the highest level of evidence according to the strength of evidence methodology set forth in section 9792.25.1. If the current version is</p>	<p>Brenda Ramirez Claims & Medical Director California Workers’ Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Reject: The commenter’s suggested language will not be adopted. However, changes are made to this section to make it clear that treating physicians may conduct a medical literature search. Clarifying change will be made to the medical literature search sections to make it clear that a Utilization Reviewer and Independent Medical Reviewer shall conduct a medical literature search.</p> <p>Reject: The five year timeline will remain to give the phrase “most current version” context.</p>	<p>None.</p> <p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>more than five years old, or if no applicable recommendation is found, or if the medical reviewer or treating physician believes there is another recommendation supported by a higher level of evidence, then</p> <p>(2) Search the most current version of other evidence-based medical treatment guidelines that are nationally recognized and by the national medical community and are scientifically based to find a recommendation applicable to the injured worker’s specific medical condition. Choose the recommendation that is supported with the highest level of evidence according to the strength of evidence methodology set forth in section 9792.25.1. Medical treatment guidelines can be found in the National Guideline Clearinghouse that is accessible at the following website address: www.guideline.gov/. If the current version is more than five years old, or if no applicable recommendation is found, or if the medical reviewer or treating physician believes there is another</p>		<p>Reject: The proposed language is taken directly from labor code section 4604.5(d).</p> <p>Reject: The five year timeline will remain to give the phrase “most current version” context.</p>	<p>None.</p> <p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>her comments regarding section (gh), that there is no statutory basis or necessity for requiring the treating physician or utilization reviewer to conduct a literature search, although either may choose to do so.</p> <p>Commenter states that if an injury or condition is not covered by the MTUS, Labor Code section 4604.5 requires authorized treatment in accordance with other scientifically based nationally recognized guidelines. When an injury is addressed in the MTUS, but the MTUS recommendation is successfully rebutted, authorized treatment is treatment supported by the best available medical evidence. Commenter states that the treating physician and/or the utilization reviewer may wish to perform a literature search, but should not be required to do so. If an IMR is requested, the independent medical reviewer can compare the strength of the evidence supporting the competing guidelines/studies, and can perform a complete literature search if appropriate.</p>		<p>Reject: For the same reasons stated above. In addition, a Utilization Reviewer is also required to evaluate the medical evidence used to support competing recommendations. Note, this comment "...and can perform a complete literature search if appropriate" is inaccurate. The medical evidence search sequence is applied if the MTUS does not apply because the recommended guidelines set forth in the MTUS are silent or when there is an attempt to rebut the MTUS' presumption of correctness.</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Commenter states that the term “recognized by the national medical community” is not defined. Commenter recommends instead using the term “nationally recognized” which is defined in Section 9792.20(j).</p> <p>Commenter opines that it is not necessary to limit studies that are five years old or less. Labor Code section 77.5, which is referenced in Labor Code section 5307.27, only requires periodic updates without establishing a time frame that would call into question the validity of the MTUS after a period of time passed. Commenter states that an older study is still a valid study and may have definitively determined the issue, making it the best or the only available medical evidence.</p>		<p>Reject: The proposed language is taken directly from labor code section 4604.5(d).</p> <p>Reject: The MTUS remains valid even if it has not been updated in the last five years. Guidelines that have not been updated or reviewed within the last five years may not be up-to-date, but they are by no means expired or invalid. The phrase that guidelines be “reviewed and updated within the last five years” will remain because it is important that the most current versions of the guidelines are relied upon when MEEAC reviews guidelines to update the MTUS or when a treatment request is made that is based on recommendations found outside of the MTUS. However, as previously stated</p>	<p>None.</p> <p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			in a response to Joyce Ho, M.D.'s comment, "there may be seminal scientific studies that are older than five years old that are still the best available evidence" and the recommendations it supports may carry over to updated versions of the guideline.	
9792.21(j)	<p>Commenter recommends the following revised language:</p> <p><i>After conducting</i> If a medical literature search <i>has been conducted</i>, Utilization Review decisions and Independent Medical Review decisions shall contain the citation of the medical treatment guideline or peer-reviewed published study with the recommendation supported with the highest level of evidence, <i>and t-</i> Treating physicians <i>may-shall</i> cite the medical treatment guideline or peer-reviewed published study that contains the recommendation supported with the highest level of evidence in the <i>chart notes or</i> Request for Authorization, <i>particularly if barriers to getting authorization are</i></p>	<p>Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Reject: For consistency and efficiency purposes a medical search sequence is set forth in the proposed regulations. Conducting a proper and comprehensive medical literature search is time consuming and expensive; the proposed regulatory search sequence ensures that California providers first look for medical evidence in the MTUS, then two reputable guidelines (ACOEM or ODG), then other medical guidelines and finally peer-reviewed studies. As a result, treating physicians, Utilization Reviewers and Independent Medical Reviewers will</p>	None.

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>anticipated.</i></p> <p>Commenter notes that her suggested changes support an optional literature search. Commenter state that when a literature search is performed, it is reasonable for the treating physician to cite the guideline or study that supports the requested treatment in the Request for Authorization, and for the reviewer to cite the guideline or study supporting the review decision. Commenter opines that striking the last part of the sentence removes unnecessary language that encourages the perception that the medical necessity process creates barriers and creates an adversarial system.</p>		consistently search for medical evidence from the same sources. Making the medical literature search optional will not result in the anticipated gains in consistency and efficiency.	
9792.21(k)	<p>Commenter recommends the following revised language:</p> <p>Finally, if there is a discrepancy between the recommendations cited, <i>and an Independent Medical review has been properly requested, the Independent Medical Reviewer shall evaluate the</i> underlying medical evidence supporting the differing recommendations shall be evaluated according to the strength of evidence</p>	<p>Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Reject: The application of the strength of evidence methodology set forth in section 9792.25.1 must be applied by both the Utilization Reviewer and/or the Independent Medical Reviewer if competing recommendations are cited. If the treating physician's provides a citation and the Utilization Reviewer denies, modifies or delays the</p>	None.

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>methodology set forth in section 9792.25.1 to determine which recommendation is supported with the highest level of evidence. Medical care that is reasonably necessary to cure or relieve the injured worker from the effects of his or her injury shall be in accordance with the <i>MTUS, or if applicable, the</i> recommendation supported with the best available medical evidence.</p> <p>Commenter states that if IMR is requested, the independent medical reviewer can compare the strength of the medical evidence supporting the competing guidelines/studies, and can perform a complete literature search if appropriate. Commenter opines that without this modification, the section as written sets up a battle of experts and litigation for any medical necessity determination which would increase administrative and legal expense for all parties.</p>		treating physician's request for authorization, then the Utilization Reviewer shall evaluate the evidence supporting the competing recommendations according to the methodology set forth in section 9792.25.1.	
9792.25(a) 9792.25(a)(1)	<p>Commenter recommends the following revised language:</p> <p>(a) For purposes of sections 9792.25-9792.26, the following definitions</p>	Brenda Ramirez Claims & Medical Director California Workers' Compensation	Accept in part. Reject in part. Accept: The AGREE II Instrument definition is revised to specify the <u>date of publication of the frozen</u>	<u>Section 9792.25(a)(1) is revised to include the phrase, "The Administrative Director adopts and</u>

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	<p><i>shall apply:</i></p> <p>(1) “Appraisal of Guidelines for Research & Evaluation II (AGREE II) Instrument, <i>published September 2013</i>” means a tool designed primarily to help guideline developers and users assess the methodological rigor and transparency in which a guideline is developed. The AGREE II Instrument can be found in the following website: www.agreetrust.org</p> <p>Commenter recommends retaining the current methodology for evaluating criteria and determining strength of evidence. Commenter opines that using AGREE II protocols will not limit MTUS recommendations to those supported by peer-reviewed, and nationally recognized scientific medical evidence as Sections 4604.5 and 5307.27 require. Commenter states that extensive training is necessary for all those who will use the protocols and that applying the protocols is much more time consuming than the existing standards.</p> <p>Commenter states that if the</p>	<p>Institute (CWCI) July 1, 2014 Written Comment</p>	<p>version that is adopted by these regulations.</p> <p><u>Reject: The May 2009 version is being adopted rather than the “September 2013” version as suggested by commenter because the May 2009 version of the AGREE II Instrument was the version the Division and the MEEAC reviewed and relied upon to draft these proposed regulations. The 2013 version had not yet been published when preliminary rulemaking activities began in 2011.</u></p> <p>Reject: Commenter recommends retaining the current methodology for evaluating medical evidence because the proposed methodology is “is much more time consuming than the existing standards.” The existing standard is currently set forth in section 9792.25(c)(1) and is an eleven step evaluation process adopted from ACOEM. The</p>	<p><u>incorporates by reference the Appraisal of Guidelines for Research & Evaluation II (AGREE II) Instrument, May 2009 in the MTUS from” the following website: www.agreetrust.org. A copy of the Appraisal of Guidelines for Research & Evaluation II (AGREE II) Instrument, May 2009 version may be obtained from the Medical Unit, Division of Workers’ Compensation, P.O. Box 71010, Oakland, CA 94612-1486, or from the DWC web site at http://www.dwc.ca.gov.</u></p>

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	<p>Administrative Director decides to adopt the AGREE II Instrument and methodology, it is necessary to identify the specific version adopted in this regulation.</p> <p>Commenter states that the appraisal guidelines were developed to assist MEEAC perform their duties, not for casual users. Commenter opines that this should be made clear so that lay people do not attempt to use these to individually assess MTUS guidelines that are adopted.</p>		<p>proposed methodology is just a five step process and is much more comprehensive because evidence supported by non-randomized controlled trials can be evaluated. Commenter mistakenly refers to our proposed methodology to evaluate medical evidence as AGREE II. A modified AGREE II instrument will only be used by MEEAC when evaluating medical treatment guidelines for consideration in revising the MTUS. This is clearly laid out in proposed section 9792.26(e). On the other hand, the proposed systematic methodology for evaluating medical evidence set forth in section 9792.25(a)(1) was developed from information obtained from the Cochrane Group and the Oxford Centre for Evidence-based Medicine (see Initial Statement of Reasons, under the heading “Technical, Theoretical, or Empirical Studies, Reports or</p>	None.

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9792.25(a)(2) through (a)(29)	<p>Commenter recommends that these subsections all be deleted.</p> <p>Commenter notes that the Administrative Director intends to adopt the AGREE II protocols, and provides the AGREE II web site address. Commenter opines that if Administrative Director adopts the AGREE II methodology, including details such as definitions (2) through (29) in this section does not appear necessary since the AGREE II Instrument and AGREE II Training Tools and related resources are available on that web site. Commenter states that including these details also adds complexity that is not necessary and which will lead to additional disputes and confusion.</p> <p>Note: Commenter states that AGREE II protocols are complex and time-consuming. Commenter opines that correctly applying the AGREE II tool will require thorough training. If the Administrative Director adopts the AGREE II tool, commenter strongly</p>	<p>Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Documents," items (4) and (8). Reject: Again, a modified AGREE II instrument will only be used by MEEAC (see above response). In addition, a Utilization Reviewer must also apply the methodology for evaluating medical evidence when a treating physician has provided a citation to a guideline or study which contains a recommendation that is contrary to the recommendation a Utilization Reviewer believes is the best evidence to determine the medical necessity and the treatment request has been denied, modified or delayed.</p>	<p>None.</p>

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	<p>recommends that the Administrative Director not require their use by treating physicians and utilization reviewers, and require that:</p> <ol style="list-style-type: none"> 1) IMR reviewers and MEEAC members are thoroughly trained on applying the AGREE II tool before the effective date of these regulations. 2) The MTUS include the strength of evidence for each recommendation. 		<p>Reject: See previous response. In addition, MEEAC members have already been trained and will continue to be trained to apply the modified AGREE II.</p> <p>Reject: No body part or special topic guideline is being considered with these proposed regulations. Although for future MTUS guideline revisions, the DWC is considering adding the level of evidence to each recommendation where relevant to the extent possible.</p>	<p>None.</p> <p>None.</p>
9792.25.1	<p>Commenter recommends deleting this proposed section.</p> <p>Commenter recommends retaining the current methodology for evaluating criteria and determining strength of evidence. See her comment on section 9792.25(a).</p>	<p>Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Reject: See previous response.</p>	<p>None.</p>
9792.26(d)	<p>Commenter recommends the</p>	<p>Brenda Ramirez</p>	<p>Reject: Although levels 3, 4</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>following revised language:</p> <p>The advisory MEEAC recommendations shall be supported by the best available <i>medical-scientific</i> evidence found in scientifically and evidenced-based medical treatment guidelines or peer-reviewed published studies that are nationally recognized by the medical community.</p> <p>Commenter notes that according to the Initial Statement of Reasons, the Division proposes to remove from the current regulations the Strength of Evidence methodology adopted from ACOEM because that methodology is designed to identify the strength of scientific evidence, which ACOEM believes is limited to randomized controlled trials.</p> <p>Commenter notes that the Initial Statement of Reasons states: “DWC takes the position that the MTUS shall be supported by the current best available evidence in making clinical decisions.” Commenter notes that the DWC wishes to include other evidence including published expert</p>	<p>Claims & Medical Director California Workers’ Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>and 5 are lower levels, they are still considered medical evidence. The best available medical evidence may currently be supported by evidence lower than a randomized controlled trial. However, it is still evidence because we still require that the study or expert opinion be published, peer-reviewed and nationally recognized.</p>	

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	<p>opinion and case reports. Commenter states that published expert opinion and case reports are not scientific evidence and Labor Code sections 4604.5 and 5307.27 require the Administrative Director to adopt a Medical Treatment Utilization Schedule (MTUS) that is evidence and scientifically based, nationally recognized, and peer-reviewed. Commenter opines that the MTUS recommendations must be based on the best scientific evidence that has been peer-reviewed and is nationally recognized. To comply with the statutory requirements, commenter urges the DWC to modify its position to require that recommendations in the MTUS shall be supported by the best available scientific evidence.</p>			
9792.26(e)	<p>Commenter recommends the following revised language:</p> <p>To assess the quality and methodological rigors used to develop a medical treatment guideline, members of MEEAC shall use a modified version of the Appraisal of Guidelines for Research & Evaluation II (AGREE II) Instrument, <i>published</i></p>	<p>Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Accept in part. Reject in part. Accept: Section 9792.26(e) is revised to cite the frozen regulatory version of the AGREE II Instrument that will be used by MEEAC. Reject: Commenter recommends retaining the current methodology for evaluating medical evidence</p>	<p>Section 999792.26(e) is revised to state, "To assess the quality and methodological rigors used to develop a medical treatment guideline, members of MEEAC shall use a modified version of the</p>

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	<p><i>September 2013.</i> The AGREE II Instrument consisting of 23 key items organized within six domains followed by two global rating items and can be found in the following website: www.agreetrust.org</p> <p>To comply with statutory requirements, as discussed in her comments regarding 9792.26 (d), commenter believes it is better for the MEEAC to utilize the current methodology including the criteria and strength of evidence in recommendations to develop or update the MTUS. Commenter opines that AGREE II is much more complex than the current methodology, and requires extensive training and is very time-consuming to properly apply.</p> <p>Commenter states that if the Administrative Director decides to retain the requirement for MEEAC to use AGREE II, it is not necessary to modify the AGREE II Instrument.</p> <p>Commenter states that the specific AGREE II version adopted in this regulation must be identified in these</p>		<p>because the proposed methodology is “is much more time consuming than the existing standards.” The existing standard is currently set forth in section 9792.25(c)(1) and is an eleven step evaluation process adopted from ACOEM. The proposed methodology is just a five step process and is much more comprehensive because evidence supported by non-randomized controlled trials can be evaluated. Commenter mistakenly refers to our proposed methodology to evaluate medical evidence as AGREE II. A modified AGREE II instrument will only be used by MEEAC when evaluating medical treatment guidelines for consideration in revising the MTUS. This is clearly laid out in proposed section 9792.26(e). On the other hand, the proposed systematic methodology for evaluating medical evidence set forth in section</p>	<p>Appraisal of Guideline for Research & Evaluation II (AGREE II) Instrument, May 2009. The AGREE II Instrument, May 2009, consisting of 23 key items organized within six domains followed by two global rating items was found in the following website: www.agreetrust.org. A copy of the AGREE II Instrument, May 2009 version may be obtained from the Medical Unit, Division of Workers’ Compensation, P.O. Box 71010, Oakland, CA 94612-1486, or from the DWC website at http://www.dwc.ca.g</p>

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	regulations.		9792.25(a)(1) was developed from information obtained from the Cochrane Group and the Oxford Centre for Evidence-based Medicine (see Initial Statement of Reasons, under the heading “Technical, Theoretical, or Empirical Studies, Reports or Documents,” items (4) and (8).	ov.”
9792.26(e)(B)	<p>Commenter recommends the following revised language:</p> <p>1. Key Item in this domain - The guideline is being updated in a timely fashion (typically at least every three years and, if the guideline is <i>has not been reviewed and updated if necessary in</i> more than five years old, it should <i>may</i> be considered to be out of date).</p> <p>While the guideline (MTUS) should be updated timely, it should not be rejected if it is not. Individual recommendations can be challenged with stronger evidence if any.</p>	<p>Brenda Ramirez Claims & Medical Director California Workers’ Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>Reject: The MTUS remains valid even if there may be guidelines incorporated into the MTUS that are older than five years old. As previously stated, in a response to Joyce Ho, M.D’s comment, “there may be seminal scientific studies that are older than five years old that are still the best available evidence.” The inclusion of the phrase that guidelines be “reviewed and updated within the last five years” will remain because guidelines need to reflect current research. Guidelines that have not been updated or reviewed within the last five years may not be up-do-date,</p>	None.

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			but they are in no means expired or invalid. When MEEAC reviews guidelines to update the MTUS or when a treatment request is made that is based on recommendations found outside of the MTUS it is important that the most current versions of the guidelines are relied upon.	
9792.26(f)	<p>Commenter recommends the following revised language:</p> <p>Recommendations in guidelines that have a low AGREE II overall score may still be considered, provided that the evidence supporting the recommendations is the best available <i>peer-reviewed, and nationally recognized scientific</i> medical evidence.</p> <p>Commenter states that guidelines and medical evidence must still comply with the Labor Code section 4604.5 and 5307.27 requirements</p>	Brenda Ramirez Claims & Medical Director California Workers' Compensation Institute (CWCI) July 1, 2014 Written Comment	Reject: Commenter once again incorrectly refers to the proposed methodology to evaluate medical evidence as AGREE II. Built into the MTUS Hierarchy of Evidence for Different Clinical Questions is a requirement that the lower level evidence be published, peer-reviewed and nationally recognized.	None.
9792.26(g)	<p>Commenter recommends the following revised language:</p> <p>To determine the best available</p>	Brenda Ramirez Claims & Medical Director California Workers'	Reject: Commenter's suggested language will not be adopted because built into the MTUS Hierarchy of Evidence	None.

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	<p>medical evidence, members of MEEAC shall rank the medical evidence used to support recommendations found in either guidelines or peer-reviewed published studies by applying the strength of evidence methodology set forth in section 9792.25.2 and shall choose the recommendations supported by the best available <i>peer-reviewed, and nationally recognized scientific</i> medical evidence.</p> <p>Commenter states that guidelines and medical evidence must still comply with the Labor Code section 4604.5 and 5307.27 requirements.</p>	<p>Compensation Institute (CWCI) July 1, 2014 Written Comment</p>	<p>for Different Clinical Questions is a requirement that the lower level evidence be published, peer-reviewed and nationally recognized.</p>	
General Comment	<p>Commenter appreciates the proposed amendments to the MTUS by which evidence-based clinical decisions are made for injured workers' diagnosed with industrial conditions. Commenter opines that the proposed process used to determine reasonable and necessary medical care when the MTUS is silent on a particular medical condition or therapeutic procedure is fair and appropriate based on available evidenced-based literature.</p>	<p>Richard Katz, PT, DPT Payment Policy Committee Chairperson California Physical Therapy Association July 1, 2014 Written Comment</p>	<p>Accept: Agree.</p> <p>Reject: The MTUS remains valid even if there may be guidelines incorporated into the MTUS that are older than five years old. As previously stated, in a response to Joyce Ho, M.D's comment, "there may be seminal scientific studies that are older than five years old that are still the best available evidence." The</p>	<p>None.</p> <p>None.</p>

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	<p>Commenter has some minor concern with the proposed regulations requiring that all studies must be five years old or less however he does agree with the option to search current evidence-based treatment guidelines for treatment recommendations as appropriate.</p> <p>Commenter recommends that the Division of Workers' Compensation perform its own outcome to ensure that injured workers are demonstrating better outcomes upon implementation of the new regulations.</p>		<p>inclusion of the phrase that guidelines be "reviewed and updated within the last five years" will remain because guidelines need to reflect current research. Guidelines that have not been updated or reviewed within the last five years may not be up-do-date, but they are in no means expired or invalid. When MEEAC reviews guidelines to update the MTUS or when a treatment request is made that is based on recommendations found outside of the MTUS it is important that the most current versions of the guidelines are relied upon.</p>	
9792.21	<p>Commenter discusses the legislative history of the MTUS (see original correspondence).</p> <p>Commenter acknowledges that the Division of Workers' Compensation is constrained by its authorizing statutes when constructing the MTUS; however he opines that the proposed regulations unnecessarily continue to</p>	<p>Mark Webb Vice-President & General Counsel Pacific Comp July 1, 2014 Written Comment</p>	<p>Reject: SB863 did not amend Labor Code section 4605.4(a) which states the MTUS' "presumption of correctness is rebuttable and may be controverted by a</p>	None.

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	<p>emphasize the legal aspects of the MTUS with equal strength as it does the medical aspects of it. Commenter opines that it is up to the Legislature to revisit statutory language that is now anachronistic when applied to IMR, but it is also up to all of us to realize that the continued infusion of legalese into the MTUS will prompt the same wasteful adversarial situation that Legislature so articulately loathed when sending SB 863 to the Governor with better than two-thirds of both the Senate and Assembly in support.</p> <p>Commenter states that it is not outside the scope of the Division to adopt a regulation that is, " ... consistent and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute." (Government Code§ 11342.2, supra) Commenter opines that this iteration of the MTUS should acknowledge that formal rules regarding burden of proof and the presentation of evidence must be viewed differently post-SB 863. Commenter questions that if the legal effect of the MTUS was intended to curb the discretion of the Appeals</p>		<p>preponderance of the scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of his or her injury. The presumption creates is one affecting the burden of proof.”</p> <p>Reject: The proposed regulations with formal rules regarding burden of proof and the presentation of evidence pertain to treating physicians, Utilization Reviewers and Independent Medical Reviewers and not the Appeals Board. These proposed regulations provide a transparent, systematic approach to evaluating medical evidence that shall be applied by reviewing physicians if recommendations to support a</p>	None.

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	<p>Board, what need is there to continue that emphasis when the Legislature has, effectively, taking the discretion, and indeed the entire decision, away from the Board²?</p> <p>Commenter opines that the definition of evidence based medicine should be consistent with Dr. Sackett's definition as follows:</p> <p>"Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient</p>		<p>medical treatment request compete with recommendations to deny, modify, or delay a medical treatment request.</p> <p>Accept. The DWC relied on the article cited by commenter and agrees that evidence based medicine should be consistent with Dr. Sackett's definition.</p>	<p>None.</p>

² Commenter notes that the WCAB has taken the position that it is still a force to be reckoned with on issues of medical necessity. See: Jose Dubon v. World Restoration, Inc. (State Compensation Insurance Fund), (2014) 79 Cal. Comp. Cases 313.

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	<p>diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer." <i>Sackett, supra</i></p> <p>Commenter requests that the Division reconsider its approach to the MTUS in light of the changes in the medical dispute resolution process created in SB 863. Rather than trying to tip evidentiary scales, commenter opines that the MTUS should be the catalyst</p>		<p>Reject: Again, the transparent, systematic approach to evaluate medical evidence as set forth in these proposed regulations are intended for treating physicians, Utilization Review physicians and</p>	<p>None.</p>

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	<p>to prompt a dialogue between the physician and the reviewer on what is best for the injured worker. Also, the more prescriptive the MTUS the more utilization review (UR) decisions may be subject to collateral attack under Jose Dubon v. World Restoration, Inc. (State Compensation Insurance Fund), (2014) 79 Cal. Comp. Cases 313. Commenter opines that this may be unavoidable given the requirements of Labor Code § 4610.5(c)(2), but that it is not a foregone conclusion.</p>		Independent Medical Review physicians and not the Appeals Board.	
9792.25.1	<p>Commenter notes that the Division's Initial Statement of Reasons (ISOR) accompanying the proposed regulations states in relevant part:</p> <p>“...The proposed regulations explain and clarify the scientific process by which evidence-based clinical decisions are made for injured workers. The role of the MTUS as the standard for the provision of medical care in accordance with Labor Code section 4600 for all injured workers is established. The proposed regulations <u>set forth the process used to determine when medical care is reasonable and necessary when the MTUS is silent on</u></p>	<p>Stephen J. Cattolica AdvoCal June 26, 2014 Written Comment July 1, 2014 Oral Comment</p>	<p>Reject: Section 9792.25.1(a)(5)(A) and (B) provide a prescription to Utilization Reviewers and Independent Medical Reviewers when communicating their decisions to treating physicians.</p>	None.

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	<p><u>a particular medical condition or diagnostic test or when the MTUS is <i>successfully</i> rebutted pursuant to Labor Code section 4604.5. The scientific process begins with a medical literature search sequence to guide those making treatment decisions find recommendations applicable to the injured worker's medical condition.</u> Recommendations shall be evaluated according to the explicit, systematic, strength of evidence methodology set forth in the proposed regulations to determine which recommendation is supported with the best available evidence. The recommendation supported with the best available medical evidence shall be used to determine what is reasonably required to cure or relieve the injured worker from the effects of his or her injury.” (emphasis added)</p> <p>Commenter states that the proposed regulations provide no prescription for the content, form and format of the communication from the expert reviewer to the treating physician when a request is denied. Commenter recommends that the Division require</p>			

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>that utilization review experts provide specific references in their written response regarding any deficiencies and an explanation of specifically how the evidence offered and the evidence to which it was compared, stacked up against each other. Commenter states that presently the proposed regulations require no such specificity.</p> <p>Commenter opines that without the requirement for specific feedback from the UR physician, the result will likely be business as usual. That is, the current practice of check-box responses and “canned” language that often bears no relationship to the actual request will be perpetuated.</p> <p>Commenter notes that the burden of proof is on the requesting physician when either the MTUS is silent or the requesting physician seeks authorization for a course of treatment or a test that may not be addressed by the MTUS. Commenter opines that if a treating physician is required to go to the literature to painstakingly and successfully support his/her request (proposed section 9792.25.1(f)), then the burden shifts to the expert</p>		<p>Reject: The burden of proof is on the treating physician when rebutting the MTUS but there is no similar requirement on the treating physician when the MTUS is silent on a particular medical condition or injury. Section 9792.25.1(a)(5)(A) and (B) provide a prescription to Utilization Reviewers and Independent Medical Reviewers when</p>	<p>None.</p>

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	<p>reviewer to properly deny the request.</p> <p>Commenter requests that this requirement be enforced by mandatory penalties and rapid enforcement for noncompliance.</p>		<p>communicating their decisions to treating physicians.</p>	
9792.21	<p>Commenter notes that page six of the Division’s ISOR - the specific purpose for proposed Section 9792.21 - it states in relevant part, “...the recommendation applicable to the injured workers that is supported with the highest level of evidence shall be cited in either the Utilization Review decision or the Independent Medical Review decision...” (emphasis added).</p> <p>Commenter recommends that this requirement be placed on both UR and IMR, rather than one or the other. Later on page 6 of the ISOR, the Division speaks of transparency when describing the need for citations of the recommendation’s source by both UR and IMR. Commenter opines that without the requirement of a citation being placed on both programs, transparency is illusory.</p>	<p>Stephen J. Cattolica AdvoCal June 26, 2014 Written Comment July 1, 2014 Oral Comment</p>	<p>Agree: The proposed regulations require the citation to the guideline or study that contains the recommendation applicable to the injured worker that is supported with the highest level of evidence in the Utilization Review and Independent Medical Review decision pursuant to section 9792.21(j) which has been re-lettered to (h).</p>	None.

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	<p>Commenter recommends that the Division explicitly refer to, and place requirements on, the content, form and format of both the UR and IMR response back to the requesting physician.</p>			
9792.20(f)	<p>Commenter states that ever since use of the term “functional improvement” became part of the language within the MTUS Chronic Pain Guidelines, he has urged the Division to also include a definition for the term “Functional Maintenance.”</p> <p>Commenter opines that with these proposed regulations, the Division has yet another opportunity to recognize that not every injured or ill individual “improves” as the Division currently defines “improvement.” Commenter notes that regardless of the amount of time that passes or the therapies used in their treatment program, maintaining one’s ability to function may be as good as it gets.</p> <p>Commenter opines that UR decisions to deny or delay treatment should not be made when the medical record clearly shows that a course of</p>	<p>Stephen J. Cattolica AdvoCal June 26, 2014 Written Comment July 1, 2014 Oral Comment</p>	<p>Reject: The term “functional maintenance” is good in concept and is used more in lay language but scientific references to and definition of this term were found to be lacking. There is certainly value in ensuring that level of good function at home and work is maintained. However, there is inadequate evidence to show if and what types of treatment is necessary to achieve this. Thus, at this time, there is not a strong evidence basis for its inclusion in the MTUS and there is no scientific basis to define what constitutes a maintenance program.</p> <p>Accept: For patients who do not technically meet guideline criteria or their clinical</p>	<p>None.</p> <p>Section 9767.21(j) is added to state, “Employers, at their discretion, may</p>

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>treatment can maintain the injured worker's ability to function at a job that provides them with a living and in their daily lives.</p> <p>Commenter recommends that the Division develop a definition that will assist those on maintenance programs to continue to be eligible for that treatment.</p>		<p>diagnostic and therapeutic situations are not covered by evidence-based medicine, section 9767.21(j) is added.</p>	<p>approve medical treatment beyond what is covered in the MTUS or supported by the best available medical evidence in order to account for unique medical circumstances warranting an exception. The treating physician shall provide clear documentation of the clinical rationale focusing on objective functional gains afforded by the requested treatment and impact upon prognosis.”</p>
9792.21	<p>Commenter is concerned that the UR regulations, taken as a whole, may be a burden on small practices, which are generally of high quality and are precisely the practices least able to afford increased time and research on documentation beyond what is already needed. Commenter states that this issue is also relevant for large</p>	<p>Robert C. Blink Steven D. Feinberg Constantine Gean Stephen Levit Bill Lewis Paul Papanek Bernyce Peplowski Occupational & Environmental</p>	<p>Reject: Labor Code section 5307.27 mandates the administrative director adopt a medical treatment utilization schedule that is evidence based. Moreover, Labor Code section 4604.5 states the MTUS shall be presumptively correct on the issue of extent</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>practices.</p> <p>Commenter is concerned that there is a serious risk of forcing high-quality practitioners out of the workers' compensation system, especially if they are in small practices. Commenter opines that this is particularly worrisome for non-procedure-oriented specialties where the economic realities of these practices may not allow increases in the time and resources needed to comply with the proposed MTUS changes. Commenter opines that the strategy of waiting to watch for that to happen may create serious permanent damage to the pool of quality providers available and recommends that proactive analysis and preventive action be taken to prevent this.</p> <p>Commenter is concerned about the additional burden of the practitioner having to purchase reference resources such as ODG or ACOEM Guidelines as the MTUS refers to these.</p>	<p>Medical Group (OEM) June 28, 2014 Written Comment</p>	<p>and scope of medical treatment and that the MTUS' presumption is rebuttable by a preponderance of medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of his or her injury. The statutes require an evidence-based system. If a treating physician requests treatment outside of the MTUS, then he or she will need to support the reasonableness and necessity of the treatment request with medical evidence. If there are competing recommendations, then a transparent, systematic methodology must be in place to evaluate medical evidence. This concept is already in place in our existing regulations in 9792.25(c)(1). However, our proposed methodology allows for the evaluation of non-randomized studies and requires fewer steps to apply.</p>	

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			Reject: Currently the MTUS has already adopted numerous chapters from ACOEM and ODG that requires the practitioner to purchase proprietary guidelines.	None.
9792.21(f)	<p>Commenter notes that this section refers to those situations where the MTUS is silent on a particular medical condition or diagnostic test that clinical decisions should be made “<i>in accordance with the best available medical evidence found in scientifically and evidenced-based medical treatment guidelines or peer-reviewed published studies</i>”.</p> <p>Commenter agrees with this position; however, commenter opines that this is not always possible. Commenter states that when peer-reviewed evidence is not available or applicable, it should be recognized that allowing physicians latitude on decision-making is prudent if done in accordance with standards of practice. This latitude of course needs to be supported by disciplined physician judgment. Commenter opines that</p>	<p>Robert C. Blink Steven D. Feinberg Constantine Gean Stephen Levit Bill Lewis Paul Papanek Bernyce Peplowski Occupational & Environmental Medical Group (OEM) June 28, 2014 Written Comment</p>	<p>Reject in part. Accept in part. Reject: It is clear from the definition of “evidence-based medicine” that clinical decisions allow for the integration of the best available research evidence with clinical expertise and patient values. Therefore, physicians will still be using his or her judgment. As stated in the previous response, the statutes require an evidence-based system.</p> <p>Accept: For patients who do not technically meet guideline criteria or their clinical diagnostic and therapeutic situations are not covered by evidence-based medicine, section 9767.21(j) is added.</p>	<p>None.</p> <p>Section 9767.21(j) is added to state, “Employers, at their discretion, may approve medical treatment beyond what is covered in the MTUS or supported by the best available</p>

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	<p>formal allowances for the application of such judgments in practice need to be made. Commenter states that these allowances for physician judgment are needed because a large percentage of clinical diagnostic and therapeutic situations are not covered by evidence-based medicine research as applicable to specific clinical situations. Documenting this concern, research exists showing the wide variation in the percentage of medical treatment decisions that are based on “evidence-based medicine” [Cochrane Collaboration].</p>			<p>medical evidence in order to account for unique medical circumstances warranting an exception. The treating physician shall provide clear documentation of the clinical rationale focusing on objective functional gains afforded by the requested treatment and impact upon prognosis.”</p>
9792.21	<p>Commenter states that in forming a clinical judgment, physicians must invoke tools such as clinical experience, intuition and pathophysiologic rationale to match the patient to the clinical need and to fill in the gaps that EBM does not cover. For example, factoring in comorbid conditions, prior treatments, age, religious and cultural beliefs, psychiatric status, etc. frequently change the recommendations made by physicians - unfortunately, studies with populations that match all of</p>	<p>Robert C. Blink Steven D. Feinberg Constantine Gean Stephen Levit Bill Lewis Paul Papanek Bernyce Peplowski Occupational & Environmental Medical Group (OEM) June 28, 2014 Written Comment</p>	<p>Accept: For patients who do not technically meet guideline criteria or their clinical diagnostic and therapeutic situations are not covered by evidence-based medicine, section 9767.21(j) is added.</p>	<p>Section 9767.21(j) is added to state, “Employers, at their discretion, may approve medical treatment beyond what is covered in the MTUS or supported by the best available medical evidence in order to account for unique medical circumstances warranting an</p>

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	<p>these different parameters and permutations often do not exist. While physician judgment should not substitute for proven and applicable evidence, when such evidence is lacking, or only marginally applicable, there should be latitude to allow a physician to explain why a course of action is needed and to have such explanations given serious consideration (i.e., not summarily dismissed as "not in the guidelines"). Commenter recommends that if a therapy or diagnostic test is denied, the requesting physician's explanation should be specifically addressed by the reviewer in a logical analysis.</p>			<p>exception. The treating physician shall provide clear documentation of the clinical rationale focusing on objective functional gains afforded by the requested treatment and impact upon prognosis.”</p>
9792.21	<p>Commenter is concerned that the proposed MTUS changes appear to require a search of the medical literature to counter adverse decisions made by utilization review (there seems to be uncertainty on this: although Section § 9792.21 (g) seems to imply that this research requirement only applies to physicians doing UR or IMR; other sections seem to refer to the treating physician, e.g., § 9792.21 (f) <u>“a medical literature search ...should be conducted by the</u></p>	<p>Robert C. Blink Steven D. Feinberg Constantine Gean Stephen Levit Bill Lewis Paul Papanek Bernyce Peplowski Occupational & Environmental Medical Group (OEM) June 28, 2014 Written Comment</p>	<p>Accept: Clarification is made to section 9792.21(f) to make clear treating physicians “may” apply the medical literature search sequence while “utilization review physicians and “independent medical review physicians” shall apply the medical literature search sequence.</p>	<p>Section 9792.21(g) is deleted and replaced with section 9792.21(f)(1) “Treating physicians may apply the medical literature search sequence...to find a recommendation that supports their Request for Authorization.”</p>

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>requesting provider” and § 9792.21 (h) “Providers making treatment decisions may conduct a comprehensive medical literature search...”). Commenter opines that this research-like process involving comparing and contrasting applicable guidelines is very burdensome for a practitioner trying to squeeze such research into the day-to-day crush of patient care tasks. If this only applies to UR and IMR, commenter recommends that this be explicitly clarified. If it applies to the requesting/treating physician commenter opines that the process outlined could easily take a busy clinic provider 1 to 2 hours to complete. Commenter states that this would not be clinically or financially feasible regardless of the size of the practice or practice group.</p>			<p>Section 9792.21(f)(2) states, “Utilization Review physicians shall apply the medical literature search sequence..” and section 9792.21(f)(3) states, “Independent Medical Review physicians shall apply the medical literature search sequence...”</p>
General	<p>Commenter notes that MPN’s were originally conceived as a vehicle for streamlining care, and opines that the concept should be revisited to bolster its benefits. Commenter opines that due to the advent of the Affordable Care Act, with its emphasis on electronic health record (EHR) and the</p>	<p>Robert C. Blink Steven D. Feinberg Constantine Gean Stephen Levit Bill Lewis Paul Papanek Bernyce Peplowski Occupational &</p>	<p>Reject: Goes beyond the scope of this proposed rulemaking.</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>measurement of clinical outcomes, the timing may be ideal for allowing more stringent MPN selection accompanied by relaxed administrative requirements, and a safe harbor for MPN's to remove physicians who demonstrate unacceptable clinical practice. Such selection might favor providers who have better outcomes, and who incorporate strength of evidence into their practice parameters, and are thus are given favored status.</p> <p>Commenter states that there are also software solutions involving the electronic health record systems that attach guidelines automatically to diagnosis(es) when the treating physician is actually seeing the patient. Commenter notes that small practices don't always have the wherewithal to design and implement in-house software solutions; however, commenter recommends that the DWC consider the possibility of giving small practices advice, and/or referring such practices to appropriate federal government agencies that are involved with Affordable Care Act</p>	<p>Environmental Medical Group (OEM) June 28, 2014 Written Comment</p>	<p>Reject: Goes beyond the scope of this proposed rulemaking.</p>	<p>None.</p>

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9792.21	<p>EHR initiatives.</p> <p>Commenter seeks clarification of exactly who is responsible for ranking evidence and at what juncture in the claims process that the evidence should be ranked. Commenter provides an example that a treating physician needs to submit a request for authorization (RFA) if the physician needs to take the time to rank the evidence when they submit the RFA. Commenter opines that the treating physician should not have to rank the evidence on the first line. If they do, commenter opines that there would be significant pushback from treating physicians and that would provoke them to stop treating workers' compensation patients. Commenter states that he would like to know that when the treatment raises to the next level of dispute resolution, the UR process, whether or not the UR doctor is required to rank the evidence of the treating physician and their own evidence and then contrast the two evidence models to determine who meeting the higher ranking of evidence standard. Commenter wonders when it goes up to the next</p>	<p>Ken Eichler, Director Regulatory Outcomes and Initiatives Work Loss Data Institute (WLDI) July 1, 2014 Written and Oral Comment</p>	<p>Accept: Clarification is made to section 9792.21(f) to make clear treating physicians “may” apply the medical literature search sequence while “utilization review physicians and “independent medical review physicians” shall apply the medical literature search sequence. In addition, if there is a discrepancy between the recommendations cited, Utilization Review physicians and Independent Medical Review physicians are responsible for evaluating the medical evidence by applying the MTUS Hierarchy of Evidence for Different Clinical Questions set forth in section 9792.25.1.</p>	<p>Section 9792.21(g) is deleted and replaced with section 9792.21(f)(1) “Treating physicians may apply the medical literature search sequence...to find a recommendation that supports their Request for Authorization.” Section 9792.21(f)(2) states, “Utilization Review physicians shall apply the medical literature search sequence..” and section 9792.21(f)(3) states, “Independent Medical Review physicians shall apply the medical literature search sequence...” Section 9792.21(k) is re-lettered to (i) and</p>

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	<p>level, the IMR process, there is a question of ranking and what evidence trumps the other. Commenter would like to know if the IMR physician reviewer has the responsibility and is mandated to rank the evidence from the treating physician, the UR physician and any new evidence that the IMR physician may have.</p> <p>Commenter recommends that triggers for requiring citations of Guidelines or assignment of evidence ranking be more clearly defined along with the parties responsible for performing said rankings at specific junctures.</p> <p>Commenter opines that although it would be beneficial for treating medical providers to submit Guideline citations and/or Strength of Evidence Rankings for any evidence provided with the submission of an RFA or IMR, he recommends that such submissions and rankings not be mandatory at present.</p> <p>Commenter states that if the treating medical provider is not citing Guidelines or ranking the evidence,</p>		<p>Accept: See previous response and action.</p> <p>Accept: Agree, see previous response and action.</p> <p>Accept: Agree, see previous response and action.</p>	<p>states, “Finally, if there is a discrepancy between the recommendations cited, the underlying medical evidence supporting the differing recommendations shall be evaluated according to the MTUS Hierarchy of Evidence for Different Clinical Questions set forth in section 9792.25.1 to determine which recommendation is supported with the highest level of evidence. Section 9792.21(k)(1) states, “Utilization Review physicians shall apply the MTUS Hierarchy of Evidence for Different Clinical Questions...” Section 9792.21(k)(2) states,</p>

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	<p>then he can deduce (as it is unstated in the proposed regulations) that ranking will not come into play until an UR or IMR is triggered. Commenter recommends that the DWC require the UR Profession to cite Guidelines and/or assign Strength of Evidence Rankings for all evidence (provided by the Treating Medical Provider and the UR Professional) which is considered in issuing any adverse UR decision. No citation of Guidelines and/or assignment of Strength of Evidence Rankings should be required if issuing an approval.</p> <p>Commenter opines that if a request is elevated to IMR, the IMR Reviewer should be required to review all Guidelines citations and/or subjective assigned Strength of Evidence Ranking of the Treating Medical Provider and/or the UR Reviewer. Commenter states that the validity of such citations and rankings should be addressed by the IMR Reviewer and included in the IMR decision. Commenter recommends that all IMR decisions include Guidelines citations and/or assignment of Strength of</p>		<p>Accept in part. Reject in part. Accept: Agree, see previous response and action. Reject: Utilization Review and Independent Medical Review physicians are already required to do this pursuant to section 9792.25.1(a)(5)(A).</p>	<p>“Independent Medical Review physicians shall apply the MTUS Hierarchy of Evidence for Different Clinical Questions...”</p> <p>None.</p>

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	<p>compensation setting.</p> <p>Commenter opines that five years is far too long of a period between reviews of the available literature and medical evidence to consider a Guideline current.</p>		<p>version of the guideline is cited.</p> <p>Reject: The timeline provided by our proposed regulations of 5 years will remain. A guideline that has not been reviewed and or updated within the last five years is considered to be out dated. However, it does not mean that it is expired or invalid. As stated in a previous response to Joyce Ho, M.D. there may be seminal scientific studies that are older than five years old that are still the best available evidence. Therefore, recommendations and the evidence that supports those recommendations may carry-over to updated newer versions of the guideline.</p>	None.
9792.21	<p>Commenter represents a group of 20-plus occupational clinics in California. Commenter states that his member physicians are confused regarding the proposed regulations as to exactly what is being required, why, and when the hierarchy of evidence is required.</p>	<p>Tim Madden California Occupational Medicine Physician's Association July 1, 2014 Oral Comment</p>	<p>Accept: Clarification is made to section 9792.21(f) to make clear treating physicians "may" apply the medical literature search sequence while "utilization review physicians and "independent medical review physicians" shall apply</p>	<p>Section 9792.21(g) is deleted and replaced with section 9792.21(f)(1) "Treating physicians may apply the medical literature search sequence...to</p>

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	<p>Commenter states that half of his membership feel that the proposed regulations apply for a Request for Authorization (RFA) to justify the treatment that they are prescribing for their patients and are expressing concern about the amount of time needed to perform a medical literature search and they are considering ceasing to treat workers' compensation patients because of this. The rest of his group didn't read it that way. Commenter requests clarification on exactly what is required.</p>		<p>the medical literature search sequence. In addition, if there is a discrepancy between the recommendations cited, Utilization Review physicians and Independent Medical Review physicians are responsible for evaluating the medical evidence by applying the MTUS Hierarchy of Evidence for Different Clinical Questions set forth in section 9792.25.1.</p>	<p>find a recommendation that supports their Request for Authorization.” Section 9792.21(f)(2) states, “Utilization Review physicians shall apply the medical literature search sequence..” and section 9792.21(f)(3) states, “Independent Medical Review physicians shall apply the medical literature search sequence...” Section 9792.21(k) is re-lettered to (i) and states, “Finally, if there is a discrepancy between the recommendations cited, the underlying medical evidence supporting the differing recommendations</p>

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				<p>shall be evaluated according to the MTUS Hierarchy of Evidence for Different Clinical Questions set forth in section 9792.25.1 to determine which recommendation is supported with the highest level of evidence. Section 9792.21(k)(1) states, "Utilization Review physicians shall apply the MTUS Hierarchy of Evidence for Different Clinical Questions..." Section 9792.21(k)(2) states, "Independent Medical Review physicians shall apply the MTUS Hierarchy of Evidence for Different Clinical Questions..."</p>
9792.25	Commenter strongly supports the	Bob Plank	Accept: Clarification is made	Section 9792.21(g) is

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	<p>revisions to the hierarchy of evidence. However, commenter is concerned about the additional burden of documentation that is being required by the system of both small and large medical practices.</p> <p>Commenter opines that there are times when evidence-based medicine is either not applicable or very difficult to apply because of differences in patient age, co-morbidities, genetic predispositions, past medical history, etc. and that then the art of medicine must be applied. Commenter states that the Cochrane people have estimated that this happens 80 to 90 percent of the time.</p> <p>Commenter requests that the Division consider decreasing the complexity for medical practices to justify a request when there is a denial for treatment from UR or IMR in order to support logical conclusions rather than cold standards.</p>	<p>Occupational Medicine Physician July 1, 2014 Oral Comment</p>	<p>to section 9792.21(f) to make clear treating physicians “may” apply the medical literature search sequence.</p> <p>Accept: For patients who do not technically meet guideline criteria or their clinical diagnostic and therapeutic situations are not covered by evidence-based medicine, section 9767.21(j) is added.</p> <p>Reject: Labor Code section 5307.27 mandates the administrative director adopt a medical treatment utilization schedule that is evidence based. Moreover, Labor Code section 4604.5 states the MTUS shall be presumptively correct on the issue of extent and scope of medical treatment and that the MTUS’ presumption is rebuttable by a preponderance of medical evidence establishing that a variance from the guidelines</p>	<p>deleted and replaced with section 9792.21(f)(1) “Treating physicians may apply the medical literature search sequence...to find a recommendation that supports their Request for Authorization.”</p> <p>Section 9767.21(j) is added to state, “Employers, at their discretion, may approve medical treatment beyond what is covered in the MTUS or supported by the best available medical evidence in order to account for unique medical circumstances warranting an exception. The treating physician shall provide clear</p>

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			reasonably is required to cure or relieve the injured worker from the effects of his or her injury. The statutes require an evidence-based system. If a treating physician requests treatment outside of the MTUS, then he or she will need to support the reasonableness and necessity of the treatment request with medical evidence.	documentation of the clinical rationale focusing on objective functional gains afforded by the requested treatment and impact upon prognosis.” None.
General Comment	<p>Commenter states that the MTUS is excellent and is designed to bring a patient all the way up to permanent and stationary status, the most functional state.</p> <p>Commenter opines that the problem is that no one is required to know or implement the MTUS. Commenter states that in his experience that insurance companies, representatives, board members, etc. are not familiar with the MTUS.</p> <p>Commenter states that currently UR and IMR reviewers don't follow the MTUS, they follow ACOEM and cut and paste medical excerpts to deny</p>	<p>Robert Kutzner M.D. Anesthesia Interventionist, PMR, Addiction Medicine July 1, 2014 Oral Comment</p> <p>Patrick “Joe Public” July 1, 2014 Oral Comment</p>	<p>Agree. Accept.</p> <p>Reject: Disagree. Currently, section 9792.25 makes clear the MTUS is presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addressed in the MTUS for the duration of the medical condition. Our proposed regulations are intended to clarify this and to make clear the transparent, systematic</p>	<p>None.</p> <p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>treatment.</p> <p>Commenter requests that the DWC add a sentence to these regulations requiring doctors that want to be included in a provider network to acknowledge that they will follow the MTUS.</p>		<p>methodology that should be applied by the UR and IMR physicians if there is a dispute about the applicable medical recommendation.</p> <p>Reject: Goes beyond the scope of this proposed rulemaking. Although recent revisions to the Medical Provider Network regulations already include this requirement.</p>	None.