

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

**NOTICE OF MODIFICATION TO TEXT OF
PROPOSED RULEMAKING**

**Subject Matter of Regulations:
Workers' Compensation – Medical Treatment Utilization Schedule**

**TITLE 8, CALIFORNIA CODE OF REGULATIONS
Sections 9792.20 through 9792.26**

NOTICE IS HEREBY GIVEN that the Acting Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, and 5307.3, proposes to modify the text of the following proposed regulations contained in Article 5.5.2 of Chapter 4.5, Subchapter 1, Division 1, of Title 8, California Code of Regulations, sections 9792.20 through 9792.26, relating to the medical treatment utilization schedule (MTUS).

Adopted Section 9792.23	Clinical Topics
Adopted Section 9792.23.1	Neck and Upper Back Complaints
Adopted Section 9792.23.2	Shoulder Complaints
Adopted Section 9792.23.3	Elbow Disorders
Adopted Section 9792.23.4	Forearm, Wrist, and Hand Complaints
Adopted Section 9792.23.5	Low Back Complaints
Adopted Section 9792.23.6	Knee Complaints
Adopted Section 9792.23.7	Ankle and Foot Complaints
Adopted Section 9792.24.2	Chronic Pain Medical Treatment Guidelines
Adopted Section 9792.24.3	Postsurgical Treatment Guidelines

**PRESENTATION OF WRITTEN COMMENTS AND DEADLINE FOR SUBMISSION
OF WRITTEN COMMENTS**

Members of the public are invited to present written comments regarding these proposed modifications. **Only comments directly concerning the proposed modifications to the text of the regulations will be considered and responded to in the Final Statement of Reasons.**

Written comments should be addressed to:

Maureen Gray, Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

The Division's contact person must receive all written comments concerning the proposed modifications to the regulations no later than **5:00 p.m. on Friday, February 20, 2009**. Written comments may be submitted by facsimile transmission (FAX), addressed to the contact person at (510) 286-0687. Written comments may also be sent electronically (via e-mail), using the following e-mail address: dwcrules@hq.dir.ca.gov.

AVAILABILITY OF TEXT OF REGULATIONS AND RULEMAKING FILE

Copies of the original text and modified text with modifications clearly indicated, and the entire rulemaking file, are currently available for public review during normal business hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding legal holidays, at the offices of the Division of Workers' Compensation. The Division is located at 1515 Clay Street, 17th Floor, Oakland, California.

Please contact the Division's regulations coordinator, Ms. Maureen Gray, at (510) 286-7100 to arrange to inspect the rulemaking file.

If any member of the public is interested in obtaining a hard copy of the Chronic Pain Medical Treatment Guidelines (Part 1-Introduction and Part 2-Pain Interventions and Treatments), or Appendix D—Chronic Pain Medical Treatment Guidelines-Division of Workers' Compensation and Official Disability Guidelines References, please contact the Division's regulations coordinator, Ms. Maureen Gray, at (510) 286-7100 and arrangements will be made to make a copy available to the requesting party. Otherwise all the rulemaking documents, including the proposed Chronic Pain Medical Treatment Guidelines will be posted in the DWC website at <http://www.dwc.ca.gov>.

The specific modifications proposed include changes to the text of the proposed amendments Title 8, California Code of Regulations:

Adopted Section 9792.23	Clinical Topics
Adopted Section 9792.23.1	Neck and Upper Back Complaints
Adopted Section 9792.23.2	Shoulder Complaints
Adopted Section 9792.23.3	Elbow Disorders
Adopted Section 9792.23.4	Forearm, Wrist, and Hand Complaints
Adopted Section 9792.23.5	Low Back Complaints
Adopted Section 9792.23.6	Knee Complaints
Adopted Section 9792.23.7	Ankle and Foot Complaints
Adopted Section 9792.24.2	Chronic Pain Medical Treatment Guidelines
Adopted Section 9792.24.3	Postsurgical Treatment Guidelines

DOCUMENTS SUPPORTING THE RULEMAKING FILE

- Comments from various interested parties concerning the regulations have been added to the rulemaking file.
- Intervertebral disc disorder without myelopathy, October 23, 2008 ODG version.
- ODG Acetaminophen Guideline Update, January 21, 2009
- ODG Topical Analgesics and Topical Analgesics, compounded Guidelines Updates, January, 21, 2009
- ODG Updates Change Log, November, 2008
- ODG Updates Change Log, December, 2008

FORMAT OF PROPOSED MODIFICATIONS

Proposed Text Noticed for 45-Day Comment Period:

Deletions from the regulatory text, as proposed in June 2008, are indicated by single strike-through, thus: ~~deleted language~~.

Additions to the regulatory text, as proposed in June 2008, are indicated by underlining, thus: underlined language.

Proposed Text Noticed for The 1st 15-Day Comment Period on Modified Text:

Deletions from the regulatory text, as proposed in this comment period, are indicated by double strike-through, thus: ~~deleted language~~.

Additions to the regulatory text, as proposed in this comment period, are indicated by a double underline, thus: added language.

Proposed Text Noticed for This 2nd 15-Day Comment Period on Modified Text:

Deletions from the regulatory text, as proposed in this comment period, are indicated by single strike-through bold italicized language, thus: ~~*deleted language*~~.

Additions to the regulatory text, as proposed in this comment period, are indicated by a single underline bold italicized language, thus: *added language*.

SUMMARY OF PROPOSED CHANGES

Modifications to § 9792.23. Clinical Topics

Subdivision 9792.23(b)(1) is modified to substitute the phrase “definitive treatment” with the word “cure.” The modification resulted from public comments requesting that the phrase “definitive treatment” be defined. Because the term “medical treatment” is already defined in the regulations in subdivision 9792.20(g) as “care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.26,” DWC found it pertinent not to add another definition to the regulations related to medical treatment but to extract from the definition of the term “medical treatment” the word which best described the phrase “definitive treatment” in the context of subdivision 9792.23(b)(1), which is making reference to the identification of a chronic condition. It was determined that the word “cure” was the appropriate word to substitute the phrase “definitive treatment” because when there is an “absence of any *cure* for the patient” and the patient “continues to have pain that persists beyond the anticipated healing,” that patient has a chronic condition and the chronic pain medical treatment guidelines apply. Moreover, the definition of “medical treatment” encompasses the concept of “cure” when it states “care which is reasonably required to cure or relieve.” (See also, Lab. Code, 4600(a).)

Subdivision 9792.23(b)(1) is further modified to add the phrase “and supersede any applicable chronic pain guideline in accordance with section 9792.23(b)”, in reference to the chronic pain medical treatment guidelines. This language was added clarify that the chronic pain medical treatment guidelines supersede other chronic pain treatment guidelines outside of the MTUS in accordance with section 9792.23(b). This avoids conflict between the MTUS and other guidelines as this subdivision makes it clear than when the injured worker is treating for chronic pain, the chronic pain medical treatment guidelines of the MTUS apply. Thus, subdivision 9792.23(b)(1), as modified provides, “In providing treatment using other guidelines pursuant to subdivision (b) above and in the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply and supersede any applicable chronic pain guideline in accordance with section 9792.23(b).”

Subdivision 9792.23(b)(2) is modified to add a sentence at the end of the subdivision which states, “The postsurgical treatment guidelines supersede any applicable postsurgical treatment guideline in accordance with section 9792.23(b).” This language was added clarify that the postsurgical treatment guidelines supersede other postsurgical treatment guidelines outside of the MTUS in accordance with section 9792.23(b). This avoids conflict between the MTUS and other

guidelines as this subdivision makes it clear than when the injured worker is receiving postsurgical treatment, the postsurgical treatment guidelines of the MTUS apply. Thus, subdivision 9792.23(b)(2), as modified provides, “In providing treatment using other guidelines pursuant to subdivision (b) above and if surgery is performed, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS or in accordance with section 9792.23(b). The postsurgical treatment guidelines supersede any applicable postsurgical treatment guideline in accordance with section 9792.23(b).”

Modifications to § 9792.23.1. Neck and Upper Back Complaints

Subdivision 9792.23(d) is modified to delete the phrase “or in accordance with section 9792.23(b)” at the end of the first sentence. The phrase is being deleted for clerical error as it is unnecessary to reference section 9792.23(b) in this subdivision because the treatment being provided under this subdivision is within the MTUS and it is unnecessary to reference guidelines outside of the MTUS.

Subdivision 9792.23.1(d) is further modified substitute the phrase “definitive treatment” with the word “cure” in the second sentence of the subdivision. The modification resulted from public comments requesting that the phrase “definitive treatment” be defined. Because the term “medical treatment” is already defined in the regulations in subdivision 9792.20(g) as “care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.26,” DWC found it pertinent not to add another definition to the regulations related to medical treatment but to extract from the definition of the term “medical treatment” the word which best described the phrase “definitive treatment” in the context of subdivision 9792.23.1(d), which is making reference to the identification of a chronic condition. It was determined that the word “cure” was the appropriate word to substitute the phrase “definitive treatment” because when there is an “absence of any *cure* for the patient” and the patient “continues to have pain that persists beyond the anticipated healing,” that patient has a chronic condition and the chronic pain medical treatment guidelines apply. Moreover, the definition of “medical treatment” encompasses the concept of “cure” when it states “care which is reasonably required to cure or relieve.” (See also, Lab. Code, 4600(a).) Thus, subdivision 9792.23.1(d), as modified provides, “If surgery is performed in the course of treatment for neck and upper back complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.”

Modifications to § 9792.23.2. Shoulder Complaints

Subdivision 9792.23.2(c) is modified to delete the phrase “or in accordance with section 9792.23(b)” at the end of the first sentence. The phrase is being deleted for clerical error as it is unnecessary to reference section 9792.23(b) in this subdivision because the treatment being provided under this subdivision is within the MTUS and it is unnecessary to reference guidelines outside of the MTUS.

Subdivision 9792.23.2(c) is further modified substitute the phrase “definitive treatment” with the word “cure” in the second sentence of the subdivision. The modification resulted from public comments requesting that the phrase “definitive treatment” be defined. Because the term “medical treatment” is already defined in the regulations in subdivision 9792.20(g) as “care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.26,” DWC found it pertinent not to add another definition to the regulations related to medical treatment but to extract from the definition of the term “medical treatment” the word which best described the phrase

“definitive treatment” in the context of subdivision 9792.23.2(c), which is making reference to the identification of a chronic condition. It was determined that the word “cure” was the appropriate word to substitute the phrase “definitive treatment” because when there is an “absence of any *cure* for the patient” and the patient “continues to have pain that persists beyond the anticipated healing,” that patient has a chronic condition and the chronic pain medical treatment guidelines apply. Moreover, the definition of “medical treatment” encompasses the concept of “cure” when it states “care which is reasonably required to cure or relieve.” (See also, Lab. Code, 4600(a).) Thus, subdivision 9792.23.2(c), as modified provides, “If surgery is performed in the course of treatment for shoulder complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.”

Modifications to § 9792.23.3. Elbow Disorders

Subdivision 9792.23.3(c) is modified to add the phrase “and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to chronic pain” at the end of the sentence. The phrase is added to clarify the chronic pain medical treatment guidelines apply and supersede ACOEM’s Elbow Disorders Chapter’s text on chronic pain. This clarification avoids internal conflict in the application of the MTUS. Thus, subdivision 9792.23.3(c), as modified provides, “If recovery has not taken place with respect to pain by the end of the Elbow Algorithm 10-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to chronic pain.”

Subdivision 9792.23.3(d) is modified to delete the phrase “or in accordance with section 9792.23(b)” at the end of the first sentence. The phrase is being deleted for clerical error as it is unnecessary to reference section 9792.23(b) in this subdivision because the treatment being provided under this subdivision is within the MTUS and it is unnecessary to reference guidelines outside of the MTUS.

Subdivision 9792.23.3(d) is further modified substitute the phrase “definitive treatment” with the word “cure” in the second sentence of the subdivision. The modification resulted from public comments requesting that the phrase “definitive treatment” be defined. Because the term “medical treatment” is already defined in the regulations in subdivision 9792.20(g) as “care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.26,” DWC found it pertinent not to add another definition to the regulations related to medical treatment but to extract from the definition of the term “medical treatment” the word which best described the phrase “definitive treatment” in the context of subdivision 9792.23.3(d), which is making reference to the identification of a chronic condition. It was determined that the word “cure” was the appropriate word to substitute the phrase “definitive treatment” because when there is an “absence of any *cure* for the patient” and the patient “continues to have pain that persists beyond the anticipated healing,” that patient has a chronic condition and the chronic pain medical treatment guidelines apply. Moreover, the definition of “medical treatment” encompasses the concept of “cure” when it states “care which is reasonably required to cure or relieve.” (See also, Lab. Code, 4600(a).) Thus, subdivision 9792.23.3(d), as modified provides, “If surgery is performed in the course of treatment for elbow complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.”

Modifications to § 9792.23.4. Forearm, Wrist, and Hand Complaints

Subdivision 9792.23.4(d) is modified to delete the phrase “or in accordance with section 9792.23(b)” at the end of the first sentence. The phrase is being deleted for clerical error as it is unnecessary to reference section 9792.23(b) in this subdivision because the treatment being provided under this subdivision is within the MTUS and it is unnecessary to reference guidelines outside of the MTUS.

Subdivision 9792.23.4(d) is further modified substitute the phrase “definitive treatment” with the word “cure” in the second sentence of the subdivision. The modification resulted from public comments requesting that the phrase “definitive treatment” be defined. Because the term “medical treatment” is already defined in the regulations in subdivision 9792.20(g) as “care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.26,” DWC found it pertinent not to add another definition to the regulations related to medical treatment but to extract from the definition of the term “medical treatment” the word which best described the phrase “definitive treatment” in the context of subdivision 9792.23.4(d), which is making reference to the identification of a chronic condition. It was determined that the word “cure” was the appropriate word to substitute the phrase “definitive treatment” because when there is an “absence of any *cure* for the patient” and the patient “continues to have pain that persists beyond the anticipated healing,” that patient has a chronic condition and the chronic pain medical treatment guidelines apply. Moreover, the definition of “medical treatment” encompasses the concept of “cure” when it states “care which is reasonably required to cure or relieve.” (See also, Lab. Code, 4600(a).) Thus, subdivision 9792.23.4(d), as modified provides, “If surgery is performed in the course of treatment for forearm, wrist, and hand complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient—who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.”

Modifications to § 9792.23.5. Low Back Complaints

Subdivision 9792.23.5(d) is modified to delete the phrase “or in accordance with section 9792.23(b)” at the end of the first sentence. The phrase is being deleted for clerical error as it is unnecessary to reference section 9792.23(b) in this subdivision because the treatment being provided under this subdivision is within the MTUS and it is unnecessary to reference guidelines outside of the MTUS.

Subdivision 9792.23.5(d) is further modified substitute the phrase “definitive treatment” with the word “cure” in the second sentence of the subdivision. The modification resulted from public comments requesting that the phrase “definitive treatment” be defined. Because the term “medical treatment” is already defined in the regulations in subdivision 9792.20(g) as “care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.26,” DWC found it pertinent not to add another definition to the regulations related to medical treatment but to extract from the definition of the term “medical treatment” the word which best described the phrase “definitive treatment” in the context of subdivision 9792.23.5(d), which is making reference to the identification of a chronic condition. It was determined that the word “cure” was the appropriate word to substitute the phrase “definitive treatment” because when there is an “absence of any *cure* for the patient” and the patient “continues to have pain that persists beyond the anticipated healing,” that patient has a chronic condition and the chronic pain medical treatment guidelines apply. Moreover, the definition of “medical treatment” encompasses the concept of “cure” when it states “care which is reasonably required to cure or relieve.” (See also, Lab. Code, 4600(a).) Thus, subdivision 9792.23.5(d), as modified provides, “If surgery is performed in the course of treatment for low back complaints, the postsurgical treatment

guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.”

Modifications to § 9792.23.6. Knee Complaints

Subdivision 9792.23.6(d) is modified to delete the phrase “or in accordance with section 9792.23(b)” at the end of the first sentence. The phrase is being deleted for clerical error as it is unnecessary to reference section 9792.23(b) in this subdivision because the treatment being provided under this subdivision is within the MTUS and it is unnecessary to reference guidelines outside of the MTUS.

Subdivision 9792.23.6(d) is further modified substitute the phrase “definitive treatment” with the word “cure” in the second sentence of the subdivision. The modification resulted from public comments requesting that the phrase “definitive treatment” be defined. Because the term “medical treatment” is already defined in the regulations in subdivision 9792.20(g) as “care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.26,” DWC found it pertinent not to add another definition to the regulations related to medical treatment but to extract from the definition of the term “medical treatment” the word which best described the phrase “definitive treatment” in the context of subdivision 9792.23.6(d), which is making reference to the identification of a chronic condition. It was determined that the word “cure” was the appropriate word to substitute the phrase “definitive treatment” because when there is an “absence of any *cure* for the patient” and the patient “continues to have pain that persists beyond the anticipated healing,” that patient has a chronic condition and the chronic pain medical treatment guidelines apply. Moreover, the definition of “medical treatment” encompasses the concept of “cure” when it states “care which is reasonably required to cure or relieve.” (See also, Lab. Code, 4600(a).) Thus, subdivision 9792.23.6(d), as modified provides, “If surgery is performed in the course of treatment for knee complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.”

Modifications to § 9792.23.7. Ankle and Foot Complaints

Subdivision 9792.23.7(d) is modified to delete the phrase “or in accordance with section 9792.23(b)” at the end of the first sentence. The phrase is being deleted for clerical error as it is unnecessary to reference section 9792.23(b) in this subdivision because the treatment being provided under this subdivision is within the MTUS and it is unnecessary to reference guidelines outside of the MTUS.

Subdivision 9792.23.7(d) is further modified substitute the phrase “definitive treatment” with the word “cure” in the second sentence of the subdivision. The modification resulted from public comments requesting that the phrase “definitive treatment” be defined. Because the term “medical treatment” is already defined in the regulations in subdivision 9792.20(g) as “care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.26,” DWC found it pertinent not to add another definition to the regulations related to medical treatment but to extract from the definition of the term “medical treatment” the word which best described the phrase “definitive treatment” in the context of subdivision 9792.23.7(d), which is making reference to the identification of a chronic condition. It was determined that the word “cure” was the appropriate word to substitute the phrase “definitive treatment” because when there is an “absence of any *cure* for the patient” and the patient “continues to have pain that persists beyond

the anticipated healing,” that patient has a chronic condition and the chronic pain medical treatment guidelines apply. Moreover, the definition of “medical treatment” encompasses the concept of “cure” when it states “care which is reasonably required to cure or relieve.” (See also, Lab. Code, 4600(a).) Thus, subdivision 9792.23.7(d), as modified provides, “If surgery is performed in the course of treatment for ankle and foot complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.”

Modifications to § 9792.24.2. Chronic Pain Medical Treatment Guidelines

As previously noticed, Subdivision 9792.24.2(a) informs the public the Division of Workers’ Compensation (DWC) proposes to adapt the Chronic Pain Medical Treatment Guidelines, Part 1: Introduction and Part 2-Interventions and Treatments. The DWC Chronic Pain Medical Treatment Guidelines as adapted from the Work Loss Data Institute’s Official Disability Guidelines (ODG) Treatment in Workers’ Comp – Chapter on Pain, is based on an ODG **version dated October 23, 2008**. As previously noticed, the Chronic Pain Medical Treatment Guidelines, Section 9792.24.2, et al., consists of two parts. Part 1: Introduction, and Part 2: Pain Interventions and Treatments. The chronic pain medical treatment guidelines replace the ACOEM’s Practice Guidelines’ Chapter 6—*Pain, Suffering, and the Restoration of Function* (Chapter 6) relating to chronic pain.

The following are modifications made to the Chronic Pain Medical Treatment Guidelines, based on the ODG version dated October 23, 2008 following the 1st 15-day comment period.

The Chronic Pain Medical Treatment Guidelines are modified as follows:

Part 1: Introduction

1. The first paragraph, fifth sentence of the Introduction, at page 1, is modified to delete the word “definitive” and to insert the word “curative.” This modification is intended to harmonize the language in the Introduction with the language in the regulations. The clinical topics sections of the MTUS have been modified to delete the word “definitive” and substitute it with the word “cure” as this word better describes treatments which serve to restore the patient back to health. Comments were submitted by the public requesting that the phrase “definitive treatment” be defined. Because the term “medical treatment” is already defined in the regulations in subdivision 9792.20(g) as “care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.26,” DWC found it pertinent not to add another definition to the regulations related to medical treatment but to extract from the definition of the term “medical treatment” the word which best described the phrase “definitive treatment” in the context of subdivision 9792.23(b)(1), which is making reference to the identification of a chronic condition. It was determined that the word “cure” was the appropriate word to substitute the phrase “definitive treatment” because when there is an “absence of any *cure* for the patient” and the patient “continues to have pain that persists beyond the anticipated healing,” that patient has a chronic condition and the chronic pain medical treatment guidelines apply. Moreover, the definition of “medical treatment” encompasses the concept of “cure” when it states “care which is reasonably required to cure or relieve.” (See also, Lab. Code, 4600(a).) It is appropriate, therefore, to use the term “curative” in the context in this sentence in the Introduction. Thus, as modified, the sentence states, “If the patient continues to have pain that persists beyond the anticipated time of healing, without plans for curative treatment, such as surgical options, the chronic pain medical treatment guidelines apply.”

2. The third paragraph, third sentence, under the subject *Acute vs. Chronic Pain Model*, at page 4, is modified to insert the word “may” before the word “involve” and to strike the “s” at the end of the word “involves.” This sentence is modified based on public comment that persistent, inadequately treated acute pain does not always result in changes in the nervous system giving rise to neuropathic pain, hence the word “may involve” is more accurate than the word “involves. Thus, as modified, the sentence states, “Evidence suggests that generation and subsequent maintenance of chronic pain, as opposed to acute pain, may involve changes in central pain processing mediated through mechanisms of neural plasticity and ultimately leading to hyper-excitability of central structures in the spinal cord and brain.”

Part 2 – Pain Interventions and Treatments: All of the following (listed alphabetically) treatment recommendations are adapted from ODG except those labeled “[DWC]”

The individual treatment topic guideline for Acetaminophen (APAP), at pp. 11-12, is modified to strike the last two sentences of the guideline, wherein ODG discusses two Manchikanti et al. articles. The text provides commentary which is off-topic and not pertinent to ODG’s recommendations in the specific treatment guideline on Acetaminophen. Moreover, because DWC is deleting this language in the guideline, DWC notes that ODG via its internal updating process, completed on November 4, 2008, has expanded its evidence base in this guideline although this does not change the basic recommendation for Acetaminophen. (See, ODG Updates Change Log, November, 2008, added to the Rulemaking file.) In order to properly update this guideline, the entire updated guideline is being adapted into the current version of these regulations (See, ODG Acetaminophen Guideline Update, January 21, 2009, added to the rulemaking file). Thus, the individual treatment topic guideline for Acetaminophen (APAP), as modified provides, as follows:

Acetaminophen (APAP)

~~See Medications for Acute Pain Recommended *as an initial choice* for treatment of chronic pain & acute exacerbations of chronic pain. *A Cochrane review of the literature on drug relief for low back pain (LBP) suggests that the popular nonsteroidal anti-inflammatory drugs (NSAIDs) are no more effective than acetaminophen, but NSAIDs had more adverse effects than acetaminophen. The results of this study support recommending NSAIDs as a treatment option after acetaminophen. (Roelofs-Cochrane, 2008) See NSAIDs. Long-term administration of moderate to high doses of acetaminophen should not be considered safer than NSAIDs from the perspective of the risk for developing hypertension or kidney failure. In addition this drug is one of the most common causes of severe drug-induced liver injury. Risk factors include supratherapeutic doses (> 4g a day), and use in patients with a history chronic alcohol ingestion. With new information questioning the use of NSAIDs, acetaminophen should be recommended on a case-by-case basis. The side effect profile of NSAIDs may have been minimized in systematic reviews due to the short duration of trials. On the other hand, it now appears that acetaminophen may produce hypertension, a risk similar to that found for NSAIDs.*~~

~~*Osteoarthritis (hip, knee, and hand): Recommended as an initial treatment for mild to moderate pain, in particular, for those with gastrointestinal, cardiovascular and renovascular risk factors. (Laine, 2008) If pain is inadequately treated or there is evidence of inflammation, alternate pharmacologic treatment should be considered. In patients with moderate to severe disease, initial treatment with an NSAID may be warranted. The decision to use either class of drugs should be made on a case-by-case basis, incorporating factors including side effect profile and patient preferences. Current guidelines note that evidence is limited to make an initial recommendation with acetaminophen, and that NSAIDs may be more efficacious for treatment. In terms*~~

of treatment of the hand it should be noted that there are no placebo trials of efficacy and recommendations have been extrapolated from other joints. (Zhang, 2007) The selection of acetaminophen as a first-line treatment appears to be made primarily based on side effect profile in osteoarthritis guidelines. (Zhang, 2008) The most recent Cochrane review on this subject suggests that non-steroidal anti-inflammatory drugs (NSAIDs) are more efficacious for osteoarthritis than acetaminophen in terms of pain reduction, global assessments and improvement of functional status. No significant difference was found between overall safety, although patients taking NSAIDs were more likely to experience an adverse GI event. It is important to note that the median trial duration was only 6 weeks. (Towheed, 2008) See NSAIDs; NSAIDs, GI symptoms & cardiovascular risk; & NSAIDs, hypertension and renal function.

Low back pain (acute and chronic): Both acetaminophen and NSAIDs have been recommended as first-line therapy for low back pain. There is insufficient evidence to recommend one medication over the other. Selection should be made on a case-by-case basis based on weighing efficacy vs. side effect profile. In the past many low back pain guidelines recommended acetaminophen as a first-line treatment but recent systematic reviews either failed to find evidence to support the view that acetaminophen was effective for the treatment of non-specific low back pain (Davies, 2008) or found that there was only "fair" quality evidence to support use vs. "good" quality evidence for NSAIDs. (Chou, 2007) Problems with research in this area include a lack of large high quality trials, inadequate reporting of methods and results, and choice of treatment contrasts. Further research on this topic has been suggested. It appears that part of the reason that acetaminophen was recommended as a first-line treatment over NSAIDs in most guidelines, in part, was that acetaminophen appeared to have less adverse effects. (Roelofs-Cochrane, 2008) See adverse effects below.

Adverse effects: Hepatotoxicity: Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. (Hunt, 2007) A warning is given on all acetaminophen products that patients that consume ≥ 3 alcoholic drinks a day should discuss use with their physician, although a systematic review of acetaminophen use in alcoholic subjects concluded that there was little credible evidence to implicate therapeutic doses as a cause of fulminant hepatotoxicity in alcoholics. (Dart, 2007) Recent RCTs found that short-term treatment (3-5 days) of acetaminophen in newly abstinent alcoholic patients did not cause hepatic injury. (Kuffner, 2007) (Bartels, 2008) Acetaminophen, when used at recommended maximum doses, may induce ALT elevations $>3\times$ ULN in up to nearly 40% of subjects. Renal toxicity: Renal insufficiency occurs in 1 to 2% of patients with overdose. (Mazer, 2008) Hypertension and cardiovascular risk: Cohort analysis reveals that acetaminophen use is associated with hypertension but evidence from randomized controlled trials is limited. This risk is similar to that found for NSAIDs. (Forman, 2007) (Montgomery, 2008) An increased cardiovascular risk was found in the Nurse's Health Study. (Chan, 2006) (Laine, 2007) (Laine, 2008)

Dose: The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day.

(Laine, 2007) These ODG recommendations are contrary to the recently released update to the ACOEM Practice Guidelines, which say NSAIDs are recommended for treatment over acetaminophen, and they conclude that acetaminophen is modestly less efficacious. (ACOEM, 2008) But an independent review of these guidelines utilizing the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument concluded that they scored below 30% with a recommendation from AGREE, "not recommended or suitable for use in practice." (Manchikanti, 2008) (Manchikanti, 2008)

The individual treatment topic guideline for Topical Analgesics, at pp. 116-118, is modified based on review of the public comments received during the 1st 15-day comment period. After reviewing the public comments, ODG was consulted to evaluate the scientific evidence pertaining to Topical Analgesics and more specifically to the compounding pharmacy practice of preparing topically applied analgesics by mixing more than one active ingredient. ODG conducted its own evidence-based reviews, and determined that it was appropriate to modify its Topical Analgesics guidelines to include clarifying language that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Moreover, the clarifying language was added to state that there is no evidence for use of any other muscle relaxant as a topical product, and that there is no evidence for use of any other antiepilepsy drug as a topical product. (See, ODG Topical Analgesics Guideline Update, January, 21, 2009, and ODG Updates Change Log, December, 2008, added to the Rulemaking file.) Thus, the individual treatment topic guideline for Topical Analgesics, compounded, as modified provides, as follows:

Topical Analgesics

Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, α -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, γ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many these agents. **Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended.** The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. [Note: Topical analgesics work locally underneath the skin where they are applied. These do not include transdermal analgesics that are systemic agents entering the body through a transdermal means. See Duragesic® (fentanyl transdermal system).]

Non-steroidal antiinflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. In this study the effect appeared to diminish over time and it was stated that further research was required to determine if results were similar for all preparations. (Biswal, 2006) These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. (Mason, 2004) Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. FDA-approved agents: Voltaren® Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per

day in the lower extremity). The most common adverse reactions were dermatitis and pruritus. (Voltaren® package insert) For additional adverse effects: See NSAIDs, GI symptoms and cardiovascular risk; & NSAIDs, hypertension and renal function. *Non FDA-approved agents: Ketoprofen:* This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. (Diaz, 2006) (Hindsen, 2006) Absorption of the drug depends on the base it is delivered in. (Gurol, 1996). Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. (Krummel 2000)

Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). ~~This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia.~~ Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. (Argoff, 2006) (Dworkin, 2007) (Khaliq-Cochrane, 2007) (Knotkova, 2007) (Lexi-Comp, 2008) ***Non-neuropathic pain:*** Not recommended. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. (Scudts, 1995)

Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. ***Formulations:*** Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. ***Indications:*** There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. The number needed to treat in musculoskeletal conditions was 8.1. The number needed to treat for neuropathic conditions was 5.7. (Robbins, 2000) (Keitel, 2001) (Mason-BMJ, 2004) See also **Capsaicin**.

~~Other agents: Topical ketamine has only been studied for use in non-controlled studies for CRPS I and post-herpetic neuralgia, and both studies showed encouraging results. Topical clonidine has published reports in animal studies only. Topical gabapentin has no published reports.~~

Baclofen: Not recommended. There is currently one Phase III study of Baclofen-Amitriptyline-Ketamine gel in cancer patients for treatment of chemotherapy-induced peripheral neuropathy. There is no peer-reviewed literature to support the use of topical baclofen.

Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product.

Gabapentin: Not recommended. There is no peer-reviewed literature to support use.

Other antiepilepsy drugs: There is no evidence for use of any other antiepilepsy drug as a topical product.

Ketamine: Under study: Only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. Topical ketamine has only been studied for use in non-controlled studies for CRPS I and post-herpetic neuralgia and both have shown encouraging results. The exact mechanism of action remains undetermined. (Gammaitoni, 2000) (Lynch, 2005) See also **Glucosamine (and Chondroitin Sulfate); & Topical analgesics, compounded.**

~~Non-neuropathic pain (soft tissue injury and osteoarthritis):~~

~~NSAIDs: The efficacy in clinical trials for this treatment modality have been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. In this study the effect appeared to diminish over time and it was stated that further research was required to determine if results were similar for all preparations. (Biswal, 2006) These medications may be useful for chronic musculoskeletal pain, but there are no long term studies of their effectiveness or safety. Ketoprofen is under study in a patch formulation for treatment of ankle strain and for tendonitis/bursitis of the elbow, shoulder and knee in phase II clinical trials in Europe.~~

~~Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. See also Capsaicin.~~

~~Lidocaine: There are no randomized controlled trials evaluating the use of topical lidocaine for treatment of low back pain or osteoarthritis, and treatment with this modality is not currently recommended.~~

~~Other agents: Topical glucosamine, chondroitin and camphor showed significant pain relief for osteoarthritis of the knee after 8 weeks compared to placebo. (Cohen, 2003) See also Glucosamine (and Chondroitin Sulfate). For non-neuropathic low back and myofascial pain there are few published studies. (Argoff, 2006)~~

The individual treatment topic guideline for Topical Analgesics, compounded, at pp 118-119, is modified to reference the individual treatment topic guideline Topical Analgesics, and by striking the entire text of the guideline. During the 15-day comment period, many comments were received from the regulated public arguing that the guideline would completely ban all topical compounded drug treatments. This was not the intention of the guideline. After reviewing the comments, ODG was consulted to evaluate the scientific evidence pertaining to the compounding pharmacy practice of mixing more than one active ingredient. From this evidence-base review, as conducted through its formal internal review, ODG determined that it was appropriate to modify its Topical Analgesics guidelines to include language addressing compounding more than one topical analgesics, as set forth above. (See, ODG Topical Analgesics, compounded Guideline Update, January, 21, 2009.) Thus, the individual treatment topic guideline for Topical Analgesics, compounded, as modified provides, as follows:

Topical Analgesics, —~~Compounded [DWC]~~

~~*See Topical analgesics. Not recommended. There is no mixed evidence that about whether compounding topical medications, such as adding an anti-inflammatory agent to capsaicin, is more efficacious than the single medication. Furthermore, the a recent FDA has issued warnings warning on about the potential dangers of compounding topical medication containing local anesthetics supersedes any recommendation (U.S. Food and Drug Administration, FDA News, December 5, 2006, FDA Warns Five Firms to Stop Compounding Topical Anesthetic Creams. (<http://www.fda.gov/bbs/topics/NEWS/2006/NEW01516.html>) The FDA warns, that Exposure to high concentrations of local anesthetics, like those in compounded topical anesthetic creams, can cause grave reactions (including seizures, and irregular heartbeats and death). At least two deaths have been connected to compounded topical anesthetic creams. (FDA Advisory 12/05/06) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, α -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, γ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many [of] these agents. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required.*~~

The text of the individual treatment topic guideline for Interferential Current Stimulation (ICS) is modified, at page 126, for clerical error, to insert the phrase “as an isolated intervention” at the second full paragraph. The phrase was left out from the October 23, 2008 ODG version due to inadvertence, and it was brought to the attention of DWC by public comment during the 1st 15-day comment period. Thus, the revised text of the individual treatment topic guideline for Interferential Current Stimulation (ICS), as modified at page 126, second paragraph, provides, as follows:

~~While not generally~~ recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway:

Modifications to §9792.24.3. Postsurgical Treatment Guidelines

Subdivision 9792.24.3(d)(1)

The following modifications are made to the Postsurgical Treatment Guidelines as adapted from the ODG’s Postsurgical Treatment Guidelines Chapters, version dated October 23, 2008.

The introductory text leading to the specific postsurgical physical medicine guidelines in the Ankle & Foot topic is corrected for clerical error to delete the word “physical” immediately preceding the word “therapist” in the second sentence of the introductory text. The modification is to clarify that a therapist can be either a “physical therapist” or an “occupational therapist” because “physical medicine” in these regulations encompasses both physical therapy and occupational therapy. Thus, the introductory text leading to the specific postsurgical physical medicine guidelines in the Ankle & Foot topic, as modified provides, as follows:

Ankle & Foot

Exercise program goals should include strength, flexibility, endurance, coordination, and education. Patients can be advised to do early passive range-of-motion exercises at home by a physical therapist. (Colorado, 2001) (Aldridge, 2004) This RCT supports early motion (progressing to full weightbearing at 8 weeks from treatment) as an acceptable

form of rehabilitation in surgically treated patients with Achilles tendon ruptures. (Twaddle, 2007)

The introductory text leading to the specific postsurgical physical medicine guidelines in the Carpal Tunnel Syndrome topic is corrected for clerical error to delete the word “physical” immediately preceding the word “therapy” in three instances in the introductory text. The modification is to clarify that “therapy” in these guidelines can be either a “physical therapy” or “occupational therapy” because “physical medicine” in these regulations encompasses both, physical therapy and occupational therapy. Thus, the introductory text leading to the specific postsurgical physical medicine guidelines in the Carpal Tunnel Syndrome topic, as modified provides, as follows:

Carpal Tunnel Syndrome

Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT or OT for CTS. The evidence may justify 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple *physical* therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, Carpal tunnel release surgery is a relatively simple operation that also should not require extended multiple *physical* therapy office visits for recovery. Of course, these statements do not apply to cases of failed surgery and/or misdiagnosis (e.g., CRPS I instead of CTS). (Feuerstein, 1999) (O’Conner-Cochrane, 2003) (Verhagen-Cochrane, 2004) (APTA, 2006) (Bilic, 2006) Post surgery, a home *physical* therapy program is superior to extended splinting. (Cook, 1995) Continued visits should be contingent on documentation of objective improvement, i.e., VAS improvement greater than four, and long-term resolution of symptoms. Therapy should include education in a home program, work discussion and suggestions for modifications, lifestyle changes, and setting realistic expectations. Passive modalities, such as heat, iontophoresis, phonophoresis, ultrasound and electrical stimulation, should be minimized in favor of active treatments.

The post-replantation surgery specific postsurgical physical medicine guideline under Traumatic Amputation of Arm (ICD9 887), Elbow & Upper Arm topic has been modified for clerical error to delete the abbreviations “ODG” in the brackets (i.e., [ODG]) as only the guidelines developed by DWC are the ones identified in brackets in the postsurgical guidelines. Thus, the post-replantation surgery specific postsurgical physical medicine guideline, as modified provides, as follows:

Elbow & Upper Arm

Traumatic amputation of arm (ICD9 887):

Post-replantation surgery ~~10DG~~: 48 visits over 26 weeks
*Postsurgical physical medicine treatment period: 12 months

The introductory text leading to the specific postsurgical physical medicine guidelines in the Forearm, Wrist, & Hand topic is corrected for clerical error to delete the word “physical” immediately preceding the word “therapist” in the introductory text. The modification is to clarify that a therapist can be either a “physical therapist” or an “occupational therapist” because “physical medicine” in these regulations encompasses both, physical therapy and occupational therapy. Thus, the introductory text leading to the specific postsurgical physical medicine guidelines in the Forearm, Wrist, & Hand topic, as modified provides, as follows:

Forearm, Wrist, & Hand

(Not including Carpal Tunnel Syndrome –see separate post surgical guideline.)

Used after surgery and amputation. During immobilization, there was weak evidence of improved hand function in the short term, but not in the longer term, for early occupational therapy, and of a lack of differences in outcome between supervised and unsupervised exercises. Post-immobilization, there was weak evidence of a lack of clinically significant differences in outcome in patients receiving formal rehabilitation therapy, passive mobilization or whirlpool immersion compared with no intervention. There was weak evidence of a short-term benefit of continuous passive motion (post external fixation), intermittent pneumatic compression and ultrasound. There was weak evidence of better short-term hand function in patients given **physical** therapy than in those given instructions for home exercises by a surgeon. (Handoll-Cochrane, 2002) (Handoll-Cochrane, 2006) ~~Hand function significantly improved in patients with rheumatoid arthritis after completion of a course of occupational therapy (p<0.05). (Rapoliene, 2006)~~

The post-replantation surgery specific postsurgical physical medicine guideline under the Amputation of Hand (ICD9 887) surgery, Forearm, Wrist, & Hand topic has been modified for clerical error to delete the abbreviations “ODG” in the brackets (i.e., [ODG]) as only the guidelines developed by DWC are the ones identified in brackets in the postsurgical guidelines. Thus, the post-replantation surgery specific postsurgical physical medicine guideline, as modified provides, as follows:

Forearm, Wrist, & Hand

Amputation of hand (ICD9 887):

Post-replantation surgery ~~IODG~~: 48 visits over 26 weeks

*Postsurgical physical medicine treatment period: 12 months

The introductory text leading to the specific postsurgical physical medicine guidelines in the Head topic is corrected for clerical error to delete the word “physical” immediately preceding the word “therapy” in three instances in the introductory text. The modification is to clarify that “therapy” in these guidelines can be either “physical therapy” or “occupational therapy” because “physical medicine” in these regulations encompasses both, physical therapy and occupational therapy. Further, letter “t” in the word “therapy” has been changed to higher case because it is now in the beginning of the sentence. Thus, the introductory text leading to the specific postsurgical physical medicine guidelines in the Head topic, as modified provides, as follows:

Head

Patient rehabilitation after traumatic brain injury is divided into two periods: acute and subacute. In the beginning of rehabilitation **physical** therapist evaluates patient's functional status, later he uses methods and means of treatment, and evaluates effectiveness of rehabilitation. Early ambulation is very important for patients with coma. **Physical T**herapy consists of prevention of complications, improvement of muscle force, and range of motions, balance, movement coordination, endurance and cognitive functions. Early rehabilitation is necessary for traumatic brain injury patients and use of **physical** therapy methods can help to regain lost functions and to come back to the society. (Colorado, 2005) (Brown, 2005) (Franckeviciute, 2005) (Driver, 2004) (Shiel, 2001)

The introductory text leading to the specific postsurgical physical medicine guidelines in the Hip, Pelvis and Thigh (femur) topic is corrected for clerical error to delete the word “physical” immediately preceding the word “therapy” in two instances in the introductory text. The modification is to clarify that “therapy” in these guidelines can be either “physical therapy” or “occupational therapy” because “physical medicine” in these regulations encompasses both, physical therapy and occupational therapy. Thus, the introductory text leading to the specific postsurgical physical medicine guidelines in the Hip, Pelvis and Thigh (femur) topic, as modified provides, as follows:

Hip, Pelvis and Thigh (femur)

A **physical** therapy program that starts immediately following hip ~~injury or~~ surgery allows for greater improvement in muscle strength, walking speed and functional score. (Jan, 2004) (Jain, 2002) (Penrod, 2004) (Tsauo, 2005) (Brigham, 2003) (White, 2005) (National, 2003) A weight-bearing exercise program can improve balance and functional ability to a greater extent than a non-weight-bearing program. (Expert, 2004) (Binder, 2004) (Bolglia, 2005) (Handoll, 2004) (Kuisma, 2002) (Lauridsen, 2002) (Mangione, 2005) (Sherrington, 2004) Patients with hip fracture should be offered a coordinated ~~a~~ multidisciplinary rehabilitation program with the specific aim of regaining sufficient function to return to their pre-fracture living arrangements. (Cameron, 2005) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense **physical** therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008)

The introductory text leading to the specific postsurgical physical medicine guidelines in the Knee topic is corrected for clerical error to delete the word “physical” immediately preceding the word “therapy” in three instances in the introductory text. The modification is to clarify that “therapy” in these guidelines can be either “physical therapy” or “occupational therapy” because “physical medicine” in these regulations encompasses both, physical therapy and occupational therapy. Thus, the introductory text leading to the specific postsurgical physical medicine guidelines in the Knee topic, as modified provides, as follows:

Knee

Controversy exists about the effectiveness of **physical** therapy after arthroscopic partial meniscectomy. (Goodwin, 2003) Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term **physical** therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. (Minns Lowe, 2007) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense **physical** therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008)

The introductory text leading to the specific postsurgical physical medicine guidelines in the Low Back topic is corrected for clerical error to delete the word “physical” immediately preceding the word “therapy” in two instances in the introductory text. The modification is to clarify that “therapy” in these guidelines can be either “physical therapy” or “occupational therapy” because “physical medicine” in these regulations encompasses both, physical therapy and occupational therapy. Moreover the description of “sham therapy” to refer to “massage” was removed from the guideline pursuant to public comments voicing concern that it is incorrect to refer to massage therapy as sham therapy. Thus, the introductory text leading to the specific

postsurgical physical medicine guidelines in the Low Back topic, as modified provides, as follows:

Low Back

As compared with no therapy, *physical* therapy (up to 20 sessions over 12 weeks) following disc herniation surgery was effective. Because of the limited benefits of *physical* therapy relative to "*sham*" therapy (massage), it is open to question whether this treatment acts primarily physiologically, but psychological factors may contribute substantially to the benefits observed. (Erdogmus, 2007)

The postsurgical physical medicine guideline for Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8) is corrected for clerical error to add a specific postsurgical physical medicine guideline for arthroplasty, which was inadvertently left out from the October 23, 2008 ODG version. A document entitled "Intervertebral disc disorder without myelopathy" has been added to the rulemaking file as a document relied upon, reflecting that this surgery was originally contained in the ODG October 23, 2008 version. Thus the postsurgical physical medicine guideline for Intervertebral disc disorders without myelopathy for arthroplasty, as modified provides, as follows:

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):

Postsurgical treatment (arthroplasty): 26 visits over 16 weeks
**Posturgical physical medicine treatment period: 6 months*

Modifications to Appendix D—Chronic Pain Medical Treatment Guidelines-Division of Workers' Compensation and Official Disability Guidelines References

Appendix D is modified to delete references to two *Manchikanti, et al.* articles in Appendix D. The reason for deleting these references is set forth in the explanation for the modifications to the individual treatment topic guideline for Acetaminophen (APAP), above. (See, pp. 342, 343, and 344.)

Appendix D is further modified to add new references relating to the expansion of evidence base in the individual treatment topic guideline for Acetaminophen (APAP) as set forth above, at pages 93, 94, 157, 181, 182, 207, 208, 271, 307, 357, 371, 490, and 548.