

TITLE 8. INDUSTRIAL RELATIONS
DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
CHAPTER 4.5. DIVISION OF WORKERS' COMPENSATION
SUBCHAPTER 1. ADMINISTRATIVE DIRECTOR -- ADMINISTRATIVE RULES

Add the following new Article to Subchapter 1:

ARTICLE 5.5.2 MEDICAL TREATMENT UTILIZATION SCHEDULE

§ 9792.20. Medical Treatment Utilization Schedule—Definitions

As used in this Article:

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

(b) “ACOEM Practice Guidelines” means the American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines, 2nd Edition (2004). The Administrative Director incorporates the ACOEM Practice Guidelines by reference. A copy 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).

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

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

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

(f) “Medical treatment” is care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.23.

(g) “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.

(h) “MEDLINE” is the largest component of PubMed, the U.S. National Library of Medicine’s database of biomedical citations and abstracts that is searchable on the Web. Its website address is www.pubmed.gov.

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

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

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

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

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.21. Medical Treatment Utilization Schedule

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

(1) The American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines (ACOEM Practice Guidelines), Second Edition (2004). A copy 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).

(2) Acupuncture Medical Treatment Guidelines

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

(A) Definitions:

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

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

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

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

(i) Neck and Upper Back Complaints

(ii) Elbow Complaints

(iii) Forearm, Wrist, and Hand Complaints

(iv) Low Back Complaints

(v) Knee Complaints

(vi) Ankle and Foot Complaints

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

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

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

(ii) Frequency: 1 to 3 times per week

(iii) Optimum duration: 1 to 2 months

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

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

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

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

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.22. Presumption of Correctness, Burden of Proof and Strength of Evidence.

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

(b) For all conditions or injuries not addressed by the Medical Treatment Utilization Schedule, authorized treatment and diagnostic services shall be in accordance with other

scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community.

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

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

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

Criteria	Rating Explanation
<p>Randomization: Assessment of the degree that randomization was both reported to have been performed and successfully* achieved through analyses of comparisons of variables between the two groups.</p> <p>*Simply allocating individuals to groups does not constitute sufficient grounds to assess the success of randomization. The groups must be comparable; otherwise, the randomization was unsuccessful.</p>	<p>Rating is “0” if the study is not randomized or reports that it was and subsequent analyses of the data/tables suggest it either was not randomized or was unsuccessful.</p> <p>Rating is “0.5” if there is mention of randomization and it appears as if it was performed, however there are no data on the success of randomization, it appears incomplete, or other questions about randomization cannot be adequately addressed.</p> <p>Rating is “1.0” if randomization is specifically stated and data reported on subgroups suggests that the study did achieve successful randomization.</p>
<p>Treatment Allocation Concealed:</p>	<p>Rating is “0” if there is no description of how members of the research team or subjects would have not been able to</p>

<p>Concealment of the allocation scheme from all involved, not just the patient.</p>	<p>know how they were going to receive a particular treatment, or the process used would not be concealed.</p> <p>Rating is “0.5” if the article mentions how allocation was concealed, but the concealment was either partial involving only some of those involved or other questions about it are unable to be completely addressed.</p> <p>Rating is “1.0” if there is a concealment process described that would conceal the treatment allocation to all those involved.</p>
<p>Baseline Comparability: Measures how well the baseline groups are comparable (e.g., age, gender, prior treatment).</p>	<p>Rating is “0” if analyses show that the groups were dissimilar at baseline or it cannot be assessed.</p> <p>Rating is “0.5” if there is general comparability, though one variable may not be comparable.</p> <p>Rating is “1.0” if there is good comparability for all variables between the groups at baseline.</p>
<p>Patient Blinded</p>	<p>Rating is “0” if there is no mention of blinding of the patient.</p> <p>Rating is “0.5” if it mentions blinding, but the methods are unclear.</p> <p>Rating is “1.0” if the study reports blinding, describes how that was carried out, and would plausibly blind the patient.</p>
<p>Provider Blinded</p>	<p>Rating is “0” if there is no mention of blinding of the provider.</p> <p>Rating is “0.5” if it mentions blinding, but the methods are unclear.</p> <p>Rating is “1.0” if the study reports blinding, describes how that was carried out and would plausibly blind the provider.</p>

<p>Assessor Blinded</p>	<p>Rating is “0” if there is no mention of blinding of the assessor.</p> <p>Rating is “0.5” if it mentions blinding, but the methods are unclear.</p> <p>Rating is “1.0” if the study reports blinding, describes how that was carried out and would plausibly blind the assessor.</p>
<p>Controlled for Co-interventions: The degree to which the study design controlled for multiple interventions (e.g., a combination of stretching exercises and anti-inflammatory medication or mention of not using other treatments during the study).</p>	<p>Rating is “0” if there are multiple interventions or no description of how this was avoided.</p> <p>Rating is “0.5” if there is brief mention of this potential problem.</p> <p>Rating is “1.0” if there is a detailed description of how co-interventions were avoided.</p>
<p>Compliance Acceptable: Measures the degree of non-compliance.</p>	<p>Rating is “0” if there is no mention of non-compliance.</p> <p>Rating is “0.5” if non-compliance is briefly addressed and the description suggests that there was compliance, but a complete assessment is not possible.</p> <p>Rating is “1.0” if there are specific data and the non-compliance rate is less than 20%.</p>
<p>Dropout Rate: Measures the drop-out rate.</p>	<p>Rating is “0” if there is no mention of drop-outs or it cannot be inferred from the data presented.</p> <p>Rating is “0.5” if the drop-out issue is briefly addressed and the description suggests that there were few drop-outs, but a complete assessment is not possible.</p> <p>Rating is “1.0” if there are specific data and the drop-out rate is under 20%.</p>

<p>Timing of Assessments: Timing rates the timeframe for the assessments between the study groups.</p>	<p>Rating is “0” if the timing of the evaluations is different between the groups.</p> <p>Rating is “0.5” if the timing is nearly identical (e.g., one day apart).</p> <p>Rating is “1.0” if the timing of the assessments between the groups is identical.</p>
<p>Analyzed by Intention to Treat: This rating is for whether the study was analyzed with an intent to treat analysis.</p>	<p>Rating is “0” if it was not analyzed by intent to treat.</p> <p>Rating is “0.5” if there is not mention of intent to treat analysis, but the results would not have been different (e.g., there was nearly 100% compliance and no drop-outs).</p> <p>Rating is “1.0” if the study specifies analyses by intention to treat.</p>
<p>Lack of Bias: This rating does not enter into the overall rating of an article. This is an overall indication of the degree to which biases are felt to be present in the study.</p>	<p>Rating is “0” if there are felt to be significant biases that are uncontrolled in the study and may have influenced the study’s results.</p> <p>Rating is “0.5” if there are felt to be some biases present, but the results are less likely to have been influenced by those biases.</p> <p>Rating is “1.0” if there are few biases, or those are well controlled and unlikely to have influenced the study’s results.</p>

(B) Table B – Strength of Evidence Ratings

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

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

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

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.23. Medical Evidence Evaluation Advisory Committee

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

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

(2) The members of the medical evidence evaluation advisory committee shall be appointed by the Medical Director, or his or her designee, and shall consist of 17 members of the medical community holding the following licenses: Medical Doctor (M.D.) board certified by an American Board of Medical Specialties (ABMS) approved specialty board; Doctor of Osteopathy (D.O.) board certified by an ABMS or American Osteopathic Association (AOA) approved specialty board; M.D. board certified by a Medical Board of California (MBC) approved specialty board; Doctor of Chiropractic (D.C.); Physical Therapy (P.T.); Occupational Therapy (O.T.); Acupuncture (L.Ac.); Psychology (PhD.); or Doctor of Podiatric Medicine (DPM), and representing the following specialty fields:

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

- (B) One member shall be from the chiropractic field;
- (C) One member shall be from the occupational medicine field;
- (D) One member shall be from the acupuncture medicine field;
- (E) One member shall be from the physical therapy field;
- (F) One member shall be from the psychology field;
- (G) One member shall be from the pain specialty field;
- (H) One member shall be from the occupational therapy field;
- (I) One member shall be from the psychiatry field;
- (J) One member shall be from the neurosurgery field;
- (K) One member shall be from the family physician field;
- (L) One member shall be from the neurology field;
- (M) One member shall be from the internal medicine field;
- (N) One member shall be from the physical medicine and rehabilitation field;
- (O) One member shall be from the podiatrist field;
- (P) Two additional members shall be appointed at the discretion of the Medical Director or his or her designee.

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

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

(c) To evaluate evidence when making recommendations to revise, update or supplement the medical treatment utilization schedule, the members of the medical evidence evaluation advisory committee shall:

(1) Apply the requirements of subdivision (b) of Section 9792.22 in reviewing medical treatment guidelines to insure that the guidelines are scientifically and evidence-based, and nationally recognized by the medical community;

(2) Apply the ACOEM's strength of evidence rating methodology to the scientific evidence as set forth in subdivision (c) of Section 9792.22 after identifying areas in the guidelines which do not meet the requirements set forth in subdivision (b) of Section 9792.22;

(3) Apply in reviewing the scientific evidence, the ACOEM's strength of evidence rating methodology for treatments where there are no medical treatment guidelines or where a guideline is developed by the Administrative Director, as set forth in subdivision (c) of Section 9792.22.

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

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

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.