

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
<p>Section 9792.20 (a) and 9792.20(d)</p>	<p>Commenter references §§ 9792.20(a) and (d), setting forth the definitions to “acute” as a medical condition lasting less than 3 months, and “chronic” as a medical condition lasting 3 months or more. Commenter states that CMA appreciates that legal challenges and emerging interpretations from ACOEM underlay these definitions. Commenter adds that it is important to note that there is no basis in science for an arbitrary divide at three months to separate acute and chronic conditions.</p> <p>Commenter states that there are often injuries that may remain in the acute stage longer than three months and may not necessarily be considered chronic for six months or longer. Commenter further states that the definition of acute or chronic really depends on the response to treatment and that the point in time that the condition becomes persistent is when the term chronic applies.</p> <p>Commenter argues that while ACOEM now asserts and the DWC now proposes that the guidelines apply equally well to acute and chronic conditions, ACOEM itself states that the few high quality studies address musculoskeletal and other disorders are at least partially subjectively defined. Commenter urges the DWC to be mindful of this limitation and urges the DWC to neither adopt nor reinforce the assumption that the lack of studies equates to an authorization to withhold treatment on the basis of the length of time the illness or injury has existed.</p>	<p>Nileen Verbeten, VP Center for Economic Services California Medical Association, August 22, 2006</p>	<p>Agree in part. See Response No. 11—Chronic Conditions</p>	<p>Sections 9792.20(a) and 9792.20(d) have been stricken from the proposed regulations. Further, the first sentence of Section 9792.22(a) has been amended to state that: “(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.”</p>

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Section 9792.20(c) and Section 9792.21(a)	Commenter states that ODG-TWC (on-line edition) is a living document that is updated at least once every three months, but usually more often. Commenter further states that should topical gaps exist or arise they can be dealt with in a timely fashion without contradictory recommendations. Commenter opines that this would be consistent with the third option (How should guidelines be updated) recommended by RAND, in its report, at page 70.	Dan Sheppard July 20, 2006	Disagree. See Response No. 1— Adoption by Incorporation by Reference an Existing Document and Any Future Updates	None.
Section 9792.20(c)	Commenter states that subdivision (c) defines “ACOEM Practice Guidelines” to mean the 2d edition, published in 2004. Commenter opines that in order to avoid rulemaking each time the guidelines are updated, it would be advisable to replace the specific reference with the phrase, “the most recent edition and version.” Commenter adds that both “edition” and “version” are used because updates may occur without release of an entirely new edition.	Steven Suchil, Assistant Vice President American Insurance Association August 22, 2006	Disagree. See Response No. 1— Adoption by Incorporation by Reference an Existing Document and Any Future Updates	None.
Section 9792.20(c)	Commenter states that the development of medical treatment guidelines is, and should be, a dynamic one. Commenter indicates that ACOEM has advised that it will be updating guidelines and individual chapters on an ongoing basis. Commenter further states that the medical treatment utilization schedule regulations should assure that the most current version of guidelines is in use at all times and that obsolete versions of guidelines are promptly eliminated. Commenter opines that including a specific reference to “the most current version” of the 2 nd Edition of the	Brenda Ramirez, Claims and Medical Director Michael McClain, General Counsel & Vice President California Workers’ Compensation Institute August 23, 2006	Agree in part. ACOEM has issued a news release informing the public that ACOEM is now the publisher of the ACOEM Practice Guidelines. See, News Release entitled: <i>ACOEM Becomes Publisher of Its Practice Guidelines</i> , dated August 25, 2006, added to the formal rulemaking file as a document relied upon. Thus, it is reasonable to delete the reference to the publisher as unnecessary as long as the edition is properly identified. With regard to the comment about a	Section 9792.20(c), now re-lettered Section 9792.20(b) has been amended to delete the phrased “published by OEM Press.” Further Section 9792.21(a)(1) has been amended to delete the phrase “published by OEM Press.”

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	<p>ACOEM Practice Guidelines will accomplish this. Commenter suggests deleting “published by OEM Press” because Commenter has learned that the American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines will be published by the American College of Occupational and Environmental Medicine’s Occupational Medicine on a going forward basis. Commenter recommends that section 9792.20(c) be amended as follows:</p> <p><i>“ACOEM Practice Guidelines” means <u>the most recent version of the American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines, 2ND Edition (2004)</u>, published by OEM Press. The Administrative Director incorporates the ACOEM Practice Guidelines by reference. A copy may be obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts, 01915 (www.oempress.com).</i></p>		<p>specific reference to “the most current version of the 2nd Edition of the ACOEM Practice Guidelines,” see Response No. 1— Adoption by Incorporation by Reference an Existing Document and Any Future Updates</p>	
<p>Section 9792.20(f) Section 9792.20(i)</p>	<p>Commenter states that according to RAND and DWC’s medical treatment utilization schedule, evidence-based means, based, at a minimum, on a systematic review of literature published in medical journals included in MEDLINE. However, also according to RAND, to remain evidenced-based the guideline must be developed, updated, or reviewed during the previous 3 years (page 24). It is 5 years according to National Guideline Clearinghouse. In any event, commenter suggests that DWC should address this so the WCAB does not rely on guidelines that have not been revised, updated or</p>	<p>Dan Sheppard July 20, 2006</p>	<p>Agree in part. We agree that guidelines should be reviewed against current literature within the last 5 years. Further, commenter’s suggested language is more on point to the definition of “medical treatment guidelines” contained in Section 9792.20(i). Section 9792.20(i) has been re-lettered Section 9792.20(g), and has been amended to reflect the time limit review requirement based on the inclusion criteria set forth by the National Guidelines Clearing House</p>	<p>Section 9792.20(i) has been re-lettered Section 9792.20(g). The section has been amended to state that “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</p>

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Section 9792.20(g)	<p>reviewed against current literature within the last 3 or at least 5 years.</p> <p>Commenter further states that the definition of evidence-based in the proposed regulations is taken in part and not in full from RAND. Commenter opines that if the definition is left as is, providers cannot only game the system by using 1980 guidelines (as long as they are the most current version) they can endanger patients by not relying on the best available evidence. Commenter opines that RAND's definition of evidence-based needs to be taken in full not in part.</p> <p>Commenter believes that the definitions noted in §9792.20 focus on an academic approach to the practice of medicine. Commenter argues that qualifying "evidence" as only derived from articles published in peer-reviewed journals dismisses medical texts, medical school training, developing technologies and procedures, unpublished studies and findings, and effectively negates community standards of care if they are not based or cannot be proven to be based on an analysis of peer-reviewed literature.</p> <p>Commenter states that physicians "practice" medicine, and not all medical practice is grounded in use of guidelines and even so, guidelines and medical literature are often conflicting. Commenter further states that payers in group health and Medicare pay benefits for many practices and community standards of care that would be effectively denied under this restrictive hierarchy of</p>	<p>Robert R. Thauer, President Alliance for Physical Therapy, Rehabilitation & Medical Technology August 23, 2006</p>	<p>found at www.guidelines.gov. The document will be incorporated as a document relied upon as part of the formal rulemaking file. Disagree with the remaining comment; the proposed regulations have been drafted to be more inclusive in order to meet the requirements of Labor Code section 5307.27.</p> <p>Disagree. See Response No. 2— Definition of term "Evidence-Based." Moreover, the definitions set forth in section 9792.20 are based on the context of the regulations which are based on the requirements of the statute. If information presented in medical texts and in medical school is evidence-based, the substantiating literature as found in MEDLINE can be submitted pursuant to Section 9792.22(c), and the recommendations can be considered through the strength of evidence. Moreover, unpublished studies and unpublished findings are neither peer-reviewed nor nationally recognized and therefore do not meet the standards of Section 9792.22(c) or the requirements of the statute. Furthermore, the intent of the statute is to move from a medical practice</p>	<p>search to assist in decision-making about the appropriate medical treatment for specific clinical circumstances.</p> <p>Section 9792.20(g) has been re-lettered Section 9792.20(1), and re-named "Strength of Evidence." The meaning of the term remains the same: "Strength of Evidence" establishes the relative weight that shall be given to scientifically based evidence.</p>

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Section 9792.20(f)	<p>evidence.</p> <p>Commenter recommends the following revised definition for the term “evidence-based,” which in his opinion would make the definition consistent with the clear intent of the legislature: <i>“Evidence-based” means based on a systematic review of rigorous, scientific medical studies to guide effective medical decision-making and ensure the consistent use of proven medical practices.</i></p> <p>Commenter opines that the revised definition is appropriate, stating that as explained in the Initial Statement of Reasons, the definition is derived from the 2005 RAND report. Commenter further states that the RAND study used “generous definitions in order to be inclusive.” Commenter states that the actual sentence in the RAND report concludes, “at this stage.” Commenter believes that the reason is quite simple—RAND wanted to assure that they were identifying every guideline that might meet additional screening criteria and the Labor Code requirements. However, commenter states, in its exhaustive survey, the study authors identified only 72 guidelines for workplace injuries and only 5 comprehensive guidelines sets that satisfied the Labor Code requirements.</p> <p>Commenter further states that as described by PubMed, “MEDLINE is the NLM’s premier bibliographic database covering the fields of medicine, nursing, dentistry, veterinary</p>	<p>Steven Suchil, Assistant Vice President American Insurance Association August 22, 2006</p>	<p>that is not evidence-based to a medical practice that is evidence-based.</p> <p>Disagree. See Response No. 2— Definition of term “Evidence-Based.”</p>	<p>Section 9792.20(f) has been re-lettered Section 9792.20(d).</p>

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Section 9792.20(f)	<p>medicine, the health care system, and the preclinical sciences. MEDLINE contains bibliographic citations and author abstracts from more than 4,800 biomedical journals published in the United States and 70 other countries. The database contains over 14 million citations dating back to the mid-1960s. Coverage is worldwide, but most records are from English-language sources or have English abstracts.” Commenter concludes that the quality of the journals in MEDLINE’s ever-expanding data base, as well as the standards for acceptance of articles by these journals, vary significantly. Some are far more rigorous than others. Thus, commenter believes that his recommended definition make the definition of the term consistent with the intent of the legislature.</p> <p>Commenter states that the reference to MEDLINE in the proposed regulation is misplaced. Commenter indicates that in the Initial Statement of Reasons, the Division cites innumerable sources and more precise definitions of evidence-based medicine but opts to use one of the “generous definitions” selected by RAND to accomplish a different purpose entirely. Commenter states that the 2005 RAND Report set out to evaluate the validity and reliability of a variety of medical treatment guidelines and defined the statutory criteria generously and even combined the terms “evidence-based” and “peer reviewed” to meet the needs of their study, i.e., “in order to be inclusive.”</p> <p>Commenter opines that the statutory terms</p>	<p>Brenda Ramirez, Claims and Medical Director Michael McClain, General Counsel & Vice President California Workers’ Compensation Institute August 23, 2006</p>	<p>Disagree. See Response No. 2— Definition of term “Evidence-Based.”</p>	<p>Section 9792.20(f) has been re-lettered Section 9792.20(d).</p>

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	<p>being defined by these regulations are essential to the overall definition of medical care in Labor Code 4600. When treatment is requested that is not addressed by the medical treatment utilization schedule, the statute requires that the request be supported by high quality medical evidence. "Evidence-based" guidelines and medical evidence will be required to determine the appropriateness of medical care and therefore, each element in the statute must be defined as precisely as possible. Commenter states that if beyond the medical treatment utilization schedule, the requested treatment will likely be disputed and that dispute will be decided by a workers' compensation administrative law judge, who will rely on the regulatory definitions to evaluate the supporting medical evidence.</p> <p>Commenter states that in the context of the Administrative Director's regulation defining a key statutory term, a review of journals found in MEDLINE is too generous and overly simplistic. Commenter further states that the Division cites several articles and definitional elements in the Statement of Reasons but then drops these elements in favor of a looser description. Commenter opines that their recommended language for the definition of "evidence-based" contained in Section 9792.20(f) more closely reflects the Division's discussion and provides the precision required to resolve disputes over what is the best medical care for the injured worker:</p> <p><i>"Evidence-based as used to describe medical</i></p>			

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Section 9792.20(f)	<p><i>treatment guidelines, means based, at a minimum, on a systematic review of literature published in medical journals included in MEDLINE published scientific medical studies that have been peer reviewed, and published in medical journals for national sale and distribution, to guide effective decision-making, to ensure the consistent use of proven medical practices, and to reduce ineffective medical care.”</i></p> <p>Commenter states that the requirement that medical treatment guidelines must be “evidence-based” is an essential standard for any medical treatment utilization schedule adopted pursuant to Labor Code Section 5307.27. Commenter opines that the proposed definition of “evidence-based” set forth in section 9792.20(f) falls short of the precision that the term requires. Commenter further opines that the proposed definition’s reliance on MEDLINE casts too broad a net.</p> <p>Commenter states that ACIC supports the comments of the California Workers Compensation Institute (CWCI) on the definition of “evidence-based”. Commenter recommends the definition put forth in the CWCI comments with a modification to describe the conduct of the review as follows:</p> <p><u>Evidence-based” as used to describe medical treatment guidelines, means based, at a minimum, on a systematic review, by a review panel of experts trained to review and critically evaluate the scientific medical literature, of literature published in medical</u></p>	<p>Samuel Sorich, President Association of California Insurance Companies August 23, 2006</p>	<p>Disagree. See Response No. 2— Definition of term “Evidence- Based.”</p>	<p>Section 9792.20(f) has been re-lettered Section 9792.20(d).</p>

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<p>Section 9792.20(f)</p> <p>Section 9792.20(f)</p>	<p>journals included in MEDLINE published scientific medical studies that have been peer reviewed, and published in medical journals for national sale and distribution to guide effective medical decision-making to ensure the consistent use of proven medical practices, and to reduce ineffective medical care.</p> <p>Commenter opines that §9792.20 (f) provides a very broad definition for “evidence based.” Commenter recommends that the reference to MEDLINE be deleted because it is a clearinghouse and lists everything without regard to validity.</p> <p>Commenter also recommends that DWC consider adopting the following definition of “evidence based: <i>“means expert-based, literature supported and outcomes validated from well-designed randomized trials when such information is available and which uses the best available evidence to support medical decision making.”</i></p> <p>Commenter inquires as to whether the claims administrators have the final authority on which treatment guidelines are accepted as alternatives to the ACOEM Practice Guidelines under Section 9792.20(f).</p>	<p>Tina Coakley, Legislative & Regulatory Analyst The Boeing Company August 23, 2006</p> <p>Linda White, Director EMPI, Inc. August 23, 2006</p>	<p>Disagree. See Response No. 2— Definition of term “Evidence-Based.”</p> <p>Disagree. Disagree. See Response No. 2—Definition of term “Evidence-Based.” Further, under the proposed regulations, claims administrators do not have the final authority on which treatment guidelines are accepted as alternatives to the ACOEM Practice Guidelines. The claims administrators may utilize a guideline they believe is appropriate but if that approach is contested, the dispute is resolved pursuant to the procedures of Labor Code section 4062.</p>	<p>Section 9792.20(f) has been re-lettered Section 9792.20(d).</p> <p>Section 9792.20(f) has been re-lettered Section 9792.20(d).</p>
<p>Section 9792.20(h)</p>	<p>Commenters opine that the draft regulations include a definition for “medical care” which could be interpreted to mean care which is insufficient to meet the statutory requirements and constitutional requirements imposed on</p>	<p>Liberty R. Sanchez, Legislative Advocate Law Offices of Barry Broad, on behalf of: Amalgamated Transit</p>	<p>Disagree. See Response No. 3— Definition of term “medical treatment.” It is noted that Section 9792.20(h), now re-lettered Section 9792.20(f) contains a clerical error.</p>	<p>Section 9792.20(h) has been re-lettered and it is now Section 9792.20(f). This section has been corrected for clerical</p>

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Section 9792.20(h)	<p>employers. Commenters state that Labor Code Section 4600 defines “medical treatment reasonably required to cure or relieve from the effects of injury” as the treatment specified in the medical treatment utilization schedule. The draft regulations define “medical treatment” as care which is reasonably required to cure the employee from the effects of the industrial injury consistent with the requirements of 9792.20-9792.23. In other words, the regulations define compliance with the regulations as appropriate medical treatment. Commenter opines that this could lead to interpretations of what is appropriate medical care which are narrower than what is interpreted under statutory law. Commenter’s recommend that the proposed regulations should instead include the following definition of appropriate medical care:</p> <p>“Appropriate medical treatment means treatment that meets both of the following requirements: (i) Treatment that is clinically appropriate, in terms of safety, type, frequency, extent, site, and duration, and considered effective for the patient’s injury, and (ii) The treatment is not primarily for the convenience of the patient, physician, or other health care provider and not more costly than an alternative service or sequence of services likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the injured worker’s injury.”</p> <p>Commenter states that the term “illness and injury” is an all-encompassing term to delineate industrial conditions requiring</p>	<p>Union, United Food and Commercial Workers’ Union, UNITE/HERE!, International Federation of Professional and Technical Engineers, Local 21, and Strategic Committee of Public Employees (Laborers’ International Union of North America) August 9, 2006</p> <p>Liberty R. Sanchez, Legislative Advocate, On behalf of California Teamsters Public Affairs Council August 9, 2006</p> <p>Angie Wei, Legislative Director, California Labor Federation, AFL-CIO August 21, 2006</p> <p>Brenda Ramirez, Claims and Medical Director Michael McClain,</p>	<p>The section will be corrected for clerical error.</p> <p>Disagree. The definition is based on Labor Code section 4600 which specifically makes reference to the</p>	<p>error, and it now states that “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,” and not 9792.20-9722.23.</p> <p>None.</p>

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	<p>medical care. Commenter opines that the use of the term “injury” alone could lead to ambiguity. Commenter recommends that section 9792.20(h) be amended as follows:</p> <p><i>“Medical treatment” is care which is reasonably required to cure or relieve the employee from the effects of the industrial illness or injury consistent with the requirements of sections 9792.20-9722.23.</i></p>	<p>General Counsel & Vice President California Workers’ Compensation Institute August 23, 2006</p>	<p>term “industrial injury.” It is common practice in workers’ compensation that the term “industrial injury” is all-encompassing and it includes the term “industrial illness” as well as “industrial condition.”</p>	
Section 9792.20(i)	<p>Commenters opine that the draft regulations contain an inappropriate definition of “medical treatment guidelines.” Commenter’s believe that a more appropriate definition of guidelines as used in Labor Code Section 4600 should make clear that the term guidelines means the entire MTUS, and cannot be interpreted to mean ACOEM alone. Commenters believe that it is important for the regulations to define the term “guidelines” as used in Labor Code Section 4600 to mean “the regulations adopting the medical treatment utilization schedule in accordance with Labor Code section 5307.27.” Commenters note that in Labor Code Section 4600, the word guidelines is not qualified by other terms such as “evidence based, peer reviewed or nationally recognized.” Additionally, the term guidelines is not found anywhere in 5307.27. Accordingly, commenters believe that the only logical conclusion which may be drawn is that the word guidelines in 4600 is meant to be the entire set of regulations as adopted by the Administrative Director, rather than any one set of guidelines found within those</p>	<p>Liberty R. Sanchez, Legislative Advocate Law Offices of Barry Broad, on behalf of: Amalgamated Transit Union, United Food and Commercial Workers’ Union, UNITE/HERE!, International Federation of Professional and Technical Engineers, Local 21, and Strategic Committee of Public Employees (Laborers’ International Union of North America) August 9, 2006</p> <p>Liberty R. Sanchez, Legislative Advocate, On behalf of California Teamsters Public Affairs Council August 9, 2006</p> <p>Angie Wei,</p>	<p>Agree in part. See, Response No. 4— Definition of term “medical treatment guidelines.”</p>	<p>Section 9792.20(i) has been re-lettered Section 9792.20(g), and has been amended to state that “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>Moreover, Sections 9792.21(a), (b), (c), and Sections 9792.22(a) and (b) have been amended to insert the term “Medical Treatment Utilization</p>

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Section 9792.20(i)	<p>regulations.</p> <p>Commenter states that subdivision (i) defining “medical treatment guidelines” again adopts a broad approach which does not serve the needs of the community nor implement effectively the legislature’s intent. Commenter further states that RAND reported that “new research evidence renders about 50% of guidelines out of date after 5.8 years and at least 10% out of date after 3.6 years.” (Citations omitted.) Failure to include periodic review within the definition would be inconsistent with utilization management requirements in Labor Code 4610(f) and conceivably could require authorization of treatment contrary to the requirements of that section.</p> <p>Commenter recommends that the definition be revised to read:</p> <p><i>“Medical treatment guidelines” means written recommendations systematically developed through a comprehensive literature search, supported by a hierarchy of evidence, reviewed and updated as necessary at least every three years, to guide decision-making about the appropriate health care for specific clinical circumstances.</i></p>	<p>Legislative Director, California Labor Federation, AFL-CIO August 21, 2006</p> <p>Steven Suchil, Assistant Vice President American Insurance Association August 22, 2006</p>	<p>Agree in part. We agree that it is important to limit the effective date of the treatment guideline in order to insure currency. Thus we have amended the definition of the term “Medical Treatment Guidelines” to require that the guidelines be revised within the last five years. This requirement is based on the National Guideline Clearinghouse (NGC)’s inclusion criteria at http://www.guideline.gov/about/inclusion.aspx. This document will be added to the rulemaking file under documents relied upon. We disagree with the remaining comments for the reasons set forth at Response No. 4— Definition of term “medical treatment guidelines.”</p>	<p>Schedule” instead of the term “ACOEM Practice Guidelines” for clarification purposes.</p> <p>Section 9792.20(i) has been re-lettered Section 9792.20(g), and has been amended to state that “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>
Section 9792.20(i)	<p>Commenter states that the definition for the term “medical treatment guidelines” makes no mention of the guidelines being evidence-</p>	<p>Stephen J. Cattolica AdvoCal Legislative and</p>	<p>Agree in part. See Response No. 4— Definition of term “medical treatment guidelines.” We disagree</p>	<p>Section 9792.20(i) has been re-lettered Section 9792.20(g), and has been</p>

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	<p>based as required by Labor Code Section 5307 27. Commenter further states that rather than utilizing a general reference to “appropriate health care,” a specific reference to “Medical Treatment” would better define the end result of applying the guidelines by use of a term already found within the definitions.</p>	<p>Administrative Agency Advocacy on behalf of California Society of Industrial Medicine and Surgery, U.S. Works, and the California Society of Physical Medicine and Rehabilitation</p>	<p>that the use of “evidence-based” is necessary in the definition of the term “Medical Treatment Guidelines.” This requirement is contained in Section 9792.21(c). We agree that the phrase “appropriate health care” should be replaced with the phrase “medical treatment” for clarity purposes because the regulations already contain a definition of the term medical treatment.</p>	<p>amended to state that “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>Section 9792.20(j)</p>	<p>Commenter states that the term “medical treatment provider” is used only in section 9792.21(b). Commenter further states that if the revision recommended for section 9792.21(b) is accepted, then the definition in (j) can be deleted and the subsequent definitions can be renumbered. If section 9792.21(b) remains intact, then commenter offers the two alternatives below:</p> <p>Commenter opines that the first alternate recommendation is appropriate because nothing is needed after the word “facility.” Commenter opines that the additional language is confusing and unnecessary. Thus, the first alternate recommendation is as follows:</p> <p><i>“Medical treatment provider’ means a provider of medical goods or services as well</i></p>	<p>Brenda Ramirez, Claims and Medical Director Michael McClain, General Counsel & Vice President California Workers’ Compensation Institute August 23, 2006</p>	<p>Agree that the definition is not necessary because the term is only used once in the regulations at Section 9792.21(b), and the sentence in that section can be easily changed as suggested by commenter without losing the contextual meaning in the section.</p>	<p>Section 9792.20(j), containing the definition of the term “medical treatment provider” has been stricken from the proposed regulations. Moreover, Section 9792.21(b) has been amended to state that 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</p>

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Section 9792.20(j)	<p>as related services or goods, including but not limited to an individual or a facility, health care service plan, a health care organization, a preferred provider organization, or medical provider network as provided in Labor Code section 4616.</p> <p>Commenter opines that the second alternate recommendation is appropriate because members of health care service plans and health care organizations provide the medical goods and services, not the health care service plans and health care organizations per se. Thus, the second alternate recommendation is as follows:</p> <p><i>“Medical treatment provider” means a provider of medical goods or services as well as related services or goods, including but not limited to an individual or a facility, including an individual or a facility participating in a health care service plan, a health care organization, a member of a preferred provider organization, or medical provider network as provided in Labor Code section 4616.</i></p> <p>Commenter states that the definition of the term “medical treatment provider” includes a “health care organization” among those considered providers of treatment. Labor Code Section 4600.5 established Health Care Organizations (HCOs). No HCOs, not even Knox-Keene entities, take on the actual risk of providing healthcare in the same meaning as a physician. They do not even take on financial risk as each HCO provider is mandated to</p>	<p>Stephen J. Cattolica AdvoCal Legislative and Administrative Agency Advocacy on behalf of California Society of Industrial Medicine and Surgery, U.S. Works, and the California Society of Physical</p>	<p>Agree in part. The definition is not necessary because the term is only used once in the regulations at Section 9792.21(b), and the sentence in that section can be easily changed without losing the contextual meaning in the section.</p>	<p>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.</p> <p>Section 9792.20(j), containing the definition of the term “medical treatment provider” has been stricken from the proposed regulations. Moreover, Section 9792.21(b) has been amended to state that the Medical Treatment</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	charge for medical services on a fee-for-service basis. Commenter suggests that the reference to health care organizations be stricken.	Medicine and Rehabilitation		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.
Section 9792.20(k)	Commenter recommends that the definition of “MEDLINE” in § 9792.20(k) be rescinded because it is a clearinghouse and lists everything without regard to validity.	Tina Coakley, Legislative & Regulatory Analyst The Boeing Company August 23, 2006	Disagree. See Response No. 2— Definition of term “Evidence-Based.” However, the term has been amended to be consistent with the definition contained in the U.S. National Library of Medicines website. The definition may be found at: http://www.nlm.nih.gov/pubs/factsheets/dif_med_pub.html	Section 9792.20(k), now re-lettered Section 9792.20(h) has been amended. The section now states: “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.
Section 9792.20(k)	Commenter states that the term “MEDLINE” is used only in section 9792.20(f). If the revision recommended for section 9792.20(f)	Brenda Ramirez, Claims and Medical Director Michael McClain,	Disagree. See Response No. 2— Definition of term “evidence-based.” However, the term has been amended	Section 9792.20(k), now re-lettered Section 9792.20(h) has been

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	is accepted, then the definition in (k) can be deleted and the subsequent definitions can be renumbered.	General Counsel & Vice President California Workers' Compensation Institute August 23, 2006	to be consistent with the definition contained in the U.S. National Library of Medicines website. The definition may be found at: http://www.nlm.nih.gov/pubs/factsheets/dif_med_pub.html	amended. The section now states: "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 .
Sections 9792.20(l), 9792.21(c) and 9792.22(b)	Commenter recommends that the language "generally recognized by the national medical community" contained in Sections 9792.21(c) and 9792.22(b) be replaced with the language contained in Section 9792.20(l) which provides the definition to the term "nationally recognized." Commenter believes that replacement of the term "generally recognized by the national medical community" that is undefined and subject to ambiguity with the term "nationally recognized" that is already appropriately defined in §9792.20(l) is more appropriate.	John Hernandez, PhD Advanced Bionics Corp. August 21, 2006	Agree. See Response No. 5— "Generally recognized by the national medical community" language and definition of term "nationally recognized."	Section 9792.20(l) has been re-lettered Section 9792.20(i). Sections 9792.21(c) and 9792.22(b) have been amended to delete the language "generally recognized by the national medical community" and to insert the language "nationally recognized by the medical community." Section 9792.21 (c) has been amended to state: 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

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Section 9792.20(1)	Commenter requests acknowledgement by the Division of Workers' Compensation that Medicare National Coverage Determinations (NCDs) are presumptively correct for treatments not addressed by the ACOEM	John Hernandez, PhD Advanced Bionics Corp. August 21, 2006	Disagree. It is not necessary for the Division of Workers' Compensation to "acknowledge" that certain guideline meets the definition of "nationally recognized." If a	<p>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.</p> <p>Section 9792.22(b) is amended as follows: (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.</p> <p>None.</p>

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Section 9792.20(1)	<p>Practice Guidelines, on the basis that Medicare NCDs meet the definition of “nationally recognized” in §9792.20 as “currently adopted by one or more U.S. state governments or by the U.S. federal government”. Commenter believes that recognizing Medicare NCDs as presumptively correct for treatments not addressed by the ACOEM Practice Guidelines is within the scope of this proposed regulation.</p> <p>Commenter also requests acknowledgement by the DWC that the American Society of Interventional Pain Physician (ASIPP) Practice Guidelines titled <i>Interventional Techniques in The Management of Chronic Spinal Pain: Evidence-Based Practice Guidelines</i> (enclosed) are presumptively correct for treatments not addressed by the ACOEM Practice Guidelines, on the basis that these ASIPP Practice Guidelines meet the definition of “nationally recognized” in §9792.20 as “published in a peer-reviewed medical journal.”</p> <p>Commenter references the definition of the term “nationally recognized” Commenter states that the American Occupational Therapy Association (AOTA) was founded in 1917 and is the national professional society for the occupational therapy profession. The Association is incorporated in the District of Columbia, with headquarters located in Bethesda, Maryland. Commenter further states that AOTA is affiliated with state occupational therapy associations in all 50 states, Puerto Rico and the District of</p>	<p>Charles Willmarth Director, State Affairs The American Occupational Therapy Association, Inc. August 18, 2006</p>	<p>guideline is being submitted to address treatment to a condition or injury not addressed in ACOEM, then the proper procedure is to follow the requirements of the proposed regulations. Moreover, the Medical Evidence Evaluation Advisory Committee can review the Medicare National Coverage Determinations (NCDs) and the ASIPP Medical Practice Guidelines to determine whether they are appropriate for inclusion in the MTUS.</p> <p>Agree. See Response No. 5— “Generally recognized by the national medical community” language and definition of term “nationally recognized.” It is noted that the previous language was unclear as to AOTA would meet the standards. The language was amended to allow AOTA to be considered nationally recognized as it has affiliates based on two or more states.</p>	<p>Section 9792.20(1) has been re-lettered Section 9792.20(i). Section 9792.20(i) now states that “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</p>

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Section 9792.20(1)	<p>Columbia. Commenter indicates that it is unclear whether AOTA meets the definition “nationally recognized” under the standard for being “based in two or more U.S. states” as required in the proposed definition. Commenter requests clarification.</p> <p>Commenter recommends that the definition of “nationally recognized” be revised to read: <i>“Nationally recognized” means developed by a multidisciplinary clinical panel, published in a peer-reviewed medical journal, endorsed and disseminated by a national organization based in two or more states and used nationwide.</i></p> <p>Commenter suggests the addition of the phrase “multidisciplinary clinical panel” to the definition of “nationally recognized,” as this reflects the findings of several studies showing that such panels are an important component of guideline quality. Commenter states that the definition proposed by DWC is broader than the statute and unauthorized by statute. Commenter opines that the mere publication of a guideline in a single journal does not confer upon it the widespread, general acceptance the term “nationally” implies. Commenter also states that adoption of a guideline by a single state government fails to satisfy the requirement that a guideline be “nationally” recognized.</p>	<p>Steven Suchil, Assistant Vice President American Insurance Association August 22, 2006</p>	<p>Agree in part. See, Response No. 5— “Generally recognized by the national medical community” language and definition of term “nationally recognized.” Agree with the comment that multidisciplinary clinical panels should be involved in the developing of the guidelines. (See ISOR at p. 20, and 2005 RAND Report at p. xviii.) DWC believes, however, that this requirement relates more appropriately to the definition of “medical treatment guidelines.” Thus, the definition of the term “medical treatment guidelines” has been amended to include the requirement that the guidelines be developed by a multidisciplinary process. Disagree with the comment that the definition is too broad. The definition is intended to be inclusive,</p>	<p>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.</p> <p>Section 9792.20(1) has been re-lettered Section 9792.20(i). Section 9792.20(i) now states that “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.</p> <p>Further Section 9792.20</p>

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Section 9792.20(1)	<p>Commenter states that because the term “nationally recognized” has one meaning when used in relation to medical journals and another when used in relation to medical treatment guidelines, she recommend separating and renumbering the two definitions.</p> <p>With reference to the first part of the definition, commenter indicates that a “nationally recognized” medical journal is not only peer reviewed, it is also published for national sale and distribution.</p> <p>With respect to the second part of the definition, commenter states that the reference in the proposed regulation to the adoption “by one or more U.S. state governments or by the U.S. federal government” should be removed.</p>	<p>Brenda Ramirez, Claims and Medical Director Michael McClain, General Counsel & Vice President California Workers’ Compensation Institute August 23, 2006</p>	<p>not restrictive. (See 2005 RAND report at p. xvi.)</p> <p>Agree in part. See, Response No. 5— “Generally recognized by the national medical community” language and definition of term “nationally recognized.” We do agree that a systematic screening is important when reviewing guidelines. In order to use a guideline, a governmental agency must process that guideline through rulemaking; therefore, the addition of the phrase “for use by” would ensure proper screening process.</p>	<p>(i) has been re-lettered Section 9792.20(g), and it now states: “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>Section 9792.20(1) has been re-lettered Section 9792.20(i). Section 9792.20(i) now states that “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.</p>

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	<p>Commenter indicates that too often governmental entities do not systematically screen submitted guidelines against a hierarchy of medical evidence. Commenter also states that it is unquestionably the intent of the statute and clearly the purpose of these regulations to consider medical evidence and treatment guidelines solely on the basis of scientific rigor, national acceptance, and proven utility for the care of injured workers. Commenter opines that her recommended revisions more directly express the statutory language and intent. Commenter adds that simply because a guideline is posted on the National Guideline Clearinghouse by a government entity, or a link to such a site is provided by a state or federal agency does not mean that it has attained national credibility.</p> <p>Commenter recommends that Section 9792.20(1) be amended as follows:</p> <p>(1) <i>“Nationally recognized”:</i> <i>(1) when used to describe a medical journal, means published in a peer-reviewed medical journal for national sale and distribution, or and developed, endorsed, and disseminated by a national medical organization based in two or more U.S. states; or currently adopted by one or more U.S. state governments or by the U.S. federal government; and is the most current version.</i></p> <p>(2) <i>when used to describe medical treatment guidelines, means developed, endorsed, and disseminated by a organization with a national scope; used nation-wide to assist</i></p>			

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Section 9792.20(1)	<p><u>medical decision makers; and the most current version.</u></p> <p>Commenter recommends that the definition of “nationally recognized” set forth in Section 9792.20(1) be amended as follows:</p> <p><i>“Includes, but not limited to, syntheses of clinical issues that may take the form of published reports in the scientific literature, national consensus documents, formalized documents addressing standards of practice, practice parameters from professional societies or commissions, and technology assessments produced by independent evidence-based practice centers.”</i></p>	<p>Tina Coakley, Legislative & Regulatory Analyst The Boeing Company August 23, 2006</p>	<p>Disagree. See, Response No. 5— “Generally recognized by the national medical community” language and definition of term “nationally recognized.” Disagree with proposed definition as too broad, for example it would allow a small group of people to name themselves as an independent evidence-based practice center and develop a guideline without proper credentials.</p>	<p>Section 9792.20(1) has been re-lettered Section 9792.20(i).</p>
Section 9792.20(1)	<p>Commenter inquires as to whether Medicare adoption qualifies as “adopted by one or more U.S. state governments or by the U.S. federal government”? Commenter further questions as to how is the “Burden of Proof” under 9792.22(c)(1), which comes from one or more U.S. state governments disseminated to the “claims administrator”? Commenter sets forth the example that many of the Treatment Guidelines in ACOEM are different from several State specific guidelines – Colorado and Washington are examples: http://www.coworkforce.com/dwc/Medical_Treatment.asp</p>	<p>Linda White, Director EMPI, Inc. August 23, 2006</p>	<p>Disagree. If Medicare adopts a national standard, that standard would qualify under this Section. The regulations as adopted give the MTUS the presumption and if the provider intends to use any other guideline outside of the MTUS the process by which the burden of proof is followed is set forth in the regulations.</p>	<p>Section 9792.20(1) has been re-lettered Section 9792.20(i).</p>
Section 9792.20(1)	<p>With regard to the definition of “nationally recognized,” ACIC recommends that the nature of “a peer-reviewed medical journal” be further restricted to those medical journals whether published in this country or abroad</p>	<p>Samuel Sorich, President Association of California Insurance Companies August 23, 2006</p>	<p>Disagree. See Response No. 5— “Generally recognized by the national medical community” language and definition of term “nationally recognized.” The</p>	<p>None.</p>

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	<p>whose studies are regularly cited in other peer-reviewed medical journals that are not published by the same specialty society and are regularly included in the health sciences collection of major teaching universities.</p>		<p>definition proposed by commenter would be impractical to use in any given situation. For instance, if a doctor wants to cite a journal article, that doctor would have to search the literature, and then find other journals from other specialties that cite that article then check that journal to see if it is regularly included in academic libraries. The goal of the MTUS is to make treatment accessible to the injured worker.</p>	
<p>Section 9792.20(m)</p>	<p>Commenter recommends that the definition of the term “scientifically based” set forth in Section 9792.20(m) be amended as follows:</p> <p><i>“involves the application of rigorous, systematic, and objective procedures to obtain reliable and valid knowledge relevant to medical testing, diagnoses and treatment; involves rigorous data analyses that are adequate to test the stated hypotheses and justify the general conclusions drawn; and, has been accepted by a peer-reviewed journal or approved by a panel of independent experts through a comparably rigorous, objective, and scientific review.”</i></p>	<p>Tina Coakley, Legislative & Regulatory Analyst The Boeing Company August 23, 2006</p>	<p>Agree in part. Agree that the definition of “scientifically based” should be clarified. DWC believes that the changes reflected in the definition of the term “scientifically based” make the definition more clear as it ties the definition with other elements of the proposed regulations. Furthermore, a definition of peer-reviewed has been added to the proposed regulations for clarification purposes. Further, the regulations included the concept of systematic review in the definition of medical treatment guidelines. We disagree that the addition of the term “rigorous” adds any substantial meaning to the definition. The process of reviewing articles to show that they are adequate to test the stated hypothesis and justify the general conclusion drawn is reflected in the Strength of Evidence in</p>	<p>Section 9792.20(k) formerly 9792.20(m) has been amended as follows: “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.</p> <p>Section 9792.20(j) now provides a definition for the term “peer reviewed,” which is defined to mean that a medical study’s content, methodology and results have been evaluated and approved</p>

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			9792.22(c).	prior to publication by an editorial board of qualified experts.
New Subdivision in Section 9792.20	<p>Commenter states that Labor Code Section 5307.27 requires the medical treatment utilization schedule to incorporate “evidence-based, peer-reviewed, nationally recognized standards of care.” Commenter notes that although the first and last terms are defined in these regulations, the term “peer reviewed” has been omitted. Commenter recommends that a new definition be added to section 9792.20 as follows:</p> <p><i>“Peer-reviewed” means that a medical study’s content, methodology and results have been evaluated by an editorial board of qualified experts before approval to publish the research has been granted.</i></p>	<p>Steven Suchil, Assistant Vice President American Insurance Association August 22, 2006</p>	<p>Agree. We agree that a definition of the term “peer reviewed” is necessary and the definition has been added in section 9792.20(j).</p>	<p>Section 9792.20(j) now provides a definition for the term “peer reviewed,” which is defined to mean that a medical study’s content, methodology and results have been evaluated and approved prior to publication by an editorial board of qualified experts.</p>
New Subdivision in Section 9792.20	<p>Commenter states that the statute requires a definition of key criteria and while it may have been appropriate for the purposes of the Commission’s review of treatment guidelines to combine some of these terms, it is not appropriate for the regulations to do so. Commenter states that the Administrative Director has defined only “evidence-based” and “nationally recognized,” and as these terms will be applied to the use of other treatment guidelines and medical evidence, there should be precise definitions for each of the statutory terms. Thus, commenter recommends that the term “peer reviewed” be defined as follows:</p>	<p>Brenda Ramirez, Claims and Medical Director Michael McClain, General Counsel & Vice President California Workers’ Compensation Institute August 23, 2006</p>	<p>Agree. We agree that a definition of the term “peer reviewed” is necessary and the definition has been added in section 9792.20(j).</p>	<p>Section 9792.20(j) now provides a definition for the term “peer reviewed,” which is defined to mean that a medical study’s content, methodology and results have been evaluated and approved prior to publication by an editorial board of qualified experts.</p>

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New Subdivision in Section 9792.20	<p><i>“Peer reviewed” means a medical study’s quality and importance were measured by a scholarly review of its methods and results, and approved prior to publication, by an editorial board of experts.</i></p> <p>Commenter recommends that a definition for the term “peer review” be added to the regulations to <i>“mean evaluation or review of the performance of colleagues by a panel with similar types and degrees of expertise.”</i></p>	<p>Tina Coakley, Legislative & Regulatory Analyst The Boeing Company August 23, 2006</p>	<p>Agree. We agree that a definition of the term “peer reviewed” is necessary and the definition has been added in section 9792.20(j).</p>	<p>Section 9792.20(j) now provides a definition for the term “peer reviewed,” which is defined to mean that a medical study’s content, methodology and results have been evaluated and approved prior to publication by an editorial board of qualified experts.</p>
Section 9792.21	<p>Commenter set forth excerpts from medical articles/studies stating that manual therapy is safer than medications. Commenter also points to a misleading study according to commenter on low back pain and bias of randomized control trials (RCT) on manual therapy and further bias against radiographs of spinal conditions, curtail use of research on manual therapy based on case reports or descriptive studies, thus purportedly justifying the reduction of use of manual therapy.</p> <p>Commenter further states that ACOEM does not consider case reports or descriptive studies to be scientific evidence worthy of inclusion in the ACOEM Guidelines as opposed to other guidelines. Commenter requests the continued use of case reports or descriptive studies to justify continued use of manual therapy.</p>	<p>Charles G. Davis, DC, QME July 10, 2006</p>	<p>Disagree. Areas such as the one referenced by the commenter will be considered by the advisory committee created under Section 9792.23. It is inappropriate to examine one study without reviewing the body of evidence in that subject. Further, case reports should not be given the same weight as randomized controlled studies. We agree with ACOEM that case reports should not be included under the Strength of Evidence.</p>	<p>None.</p>

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Section 9792.21	Commenter states ACOEM does not address the requirements of Labor Code section 5307.27, which requires the medical treatment utilization schedule to address, at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases.	Charles G. Davis, DC, QME July 10, 2006	Agree in part. See Response No. 6—ACOEM Meets the Requirements of Labor Code section 5307.27	None.
Section 9792.21(a) Requests for Adoption of Supplemental Guidelines	Commenters, providers of acupuncture treatment, have submitted form letters stating that Labor Code section 3209.3 lists acupuncturists in the definition of "physicians" for purposes of workers' compensation benefits. Commenters state that since the adoption of the ACOEM Practice Guidelines, many insurance companies have been denying all acupuncture services, ignoring the scientific evidence of the efficacy of acupuncture treatment. Commenters request that DWC adopt and incorporate their guideline entitled: "Acupuncture Treatment Guidelines," which has been developed by the Council of Acupuncture and Oriental Medicine Association.	Signature only/No Name N. California Health & Acupuncture, Inc. August 7, 2006 Xiaofen Shen Los Altos Acupuncture Center August 9 and 15, 2006 William Zhao Zhao Acupuncture CLC August 10, 2006 Yue-Fen Yue-Fen Natural Healthcare August 10, 2006 Allen M. Xu Xu's Acupuncture & Herbs August 10, 2006 Patrick Zhao Patrick Zhao Acupuncture Clinic	Agree in part. See Response No. 14—Acupuncture Medical Treatment Guidelines	New proposed Section 9792.21(a)(2) sets forth the Acupuncture Medical Treatment Guidelines as follows: § 9792.21. (a) (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

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		<p>August 10, 2006</p> <p>Aiming Huang Liu August 10, 2006</p> <p>Liling Z. Gao Golden Gate Acupuncture Center August 10, 2006</p> <p>Jun Yang August 10, 2006</p> <p>Dave Liu Chinese Medicine Clinic & Education Center August 10, 2006</p> <p>William Chang Dr. William Wang Acupuncture Clinic August 10, 2006</p> <p>Michael Chen and W.W. Chen's Acupuncture and Chinese Medicine Clinic August 10, 2006</p> <p>Signature only/No Name Haiyan's Acupuncture August 10, 2006</p> <p>Zhiwei Xu Xu's Acupuncture Clinic August 10, 2006</p>		<p>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.</p> <p>(ii) "Acupuncture with electrical stimulation" is the use of electrical current (micro- amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous</p>

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		<p>Andrew E. Yee Yee's Therapy with Acupuncture August 10, 2006</p> <p>Gwen Yee Yee's Therapy with Acupuncture August 10, 2006</p> <p>Li-Chun Ou Ou's Acupuncture, Massage and Herb Center August 11, 2006</p> <p>Yan-Xiang Li California Acupuncture Clinic August 11, 2006</p> <p>Lilian Huang California Acupuncture Clinic August 11, 2006</p> <p>Shen San Chen San Ling Acupuncture & Herbal Clinic August 15, 2006</p> <p>Jenny Shi California Health and Acupuncture August 15, 2006</p> <p>Liao Ping Wang</p>		<p>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.</p> <p>(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</p>

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		<p>Wang Ping Acupuncture Clinic August 15, 2006</p>		<p>specific illness or accident.</p> <p>(B) Indications for acupuncture or acupuncture with electrical stimulation include the following presenting complaints in reference to the following ACOEM Practice Guidelines Chapter Headings:</p> <p>(i) Neck and Upper Back Complaints</p> <p>(ii) Elbow Complaints</p> <p>(iii) Forearm, Wrist, and Hand Complaints</p> <p>(iv) Low Back Complaints</p> <p>(v) Knee Complaints</p> <p>(vi) Ankle and Foot Complaints</p> <p>(vii) Pain, Suffering, and the Restoration of Function</p> <p>(C) Frequency and duration of acupuncture or acupuncture with</p>

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Section 9792.21(a)	Commenter requests that DWC include	Jackson Chau	Agree in part. See Response No.	<p>electrical stimulation may be performed as follows:</p> <p>(i) Time to produce functional improvement: 3 to 6 treatments.</p> <p>(ii) Frequency: 1 to 3 times per week</p> <p>(iii) Optimum duration: 1 to 2 months</p> <p>(iv) Maximum duration: 14 treatments.</p> <p>(D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e).</p> <p>(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.</p> <p>New proposed Section</p>

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Section 9792.21(a)	<p>not been revised, updated or at least reviewed for potential updating against current literature since 1993 and therefore do not meet the definition of evidence-based. Commenter also states that, in fact, the Mercy guidelines have been removed from the National Guideline Clearinghouse because they are no longer evidenced-based. Commenter indicates that the sponsor of the Mercy guidelines (the Congress of Chiropractic State Associations) has commissioned CCGPP (not the 35-member commission initially sponsored by COCSA which developed Mercy) to write a completely new guideline. Commenter concludes that the Mercy guidelines are dead with no chance of ever being revised, updated, or reviewed; therefore are not evidenced-based.</p> <p>Commenters state that Section 5307.27 of the Labor Code states that: “the administrative director, in consultation with the Commission on Health and Safety and Workers’ Compensation, shall adopt, after public hearings, a medical treatment utilization schedule, that shall incorporate the evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission.”</p> <p>Commenters further state that the RAND report commissioned by CHSWC reviewed numerous evidence-based guidelines to identify which set was most appropriate for incorporation into the medical treatment utilization schedule. RAND concluded that ACOEM provided the best overall set of</p>	<p>Liberty R. Sanchez, Legislative Advocate Law Offices of Barry Broad, on behalf of: Amalgamated Transit Union, United Food and Commercial Workers’ Union, UNITE/HERE!, International Federation of Professional and Technical Engineers, Local 21, and Strategic Committee of Public Employees (Laborers’ International Union of North America) August 9, 2006</p>	<p>last 5 years. Thus, Section 9792.20(i) has been amended to include the requirement that the medical treatment guidelines be revised within the last five years.</p> <p>Agree in part. See Response No. 7—Adoption of Supplemental Guidelines. See also, Response No. 14—Acupuncture Medical Treatment Guidelines.</p>	<p>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>New proposed Section 9792.21(a)(2) sets forth the Acupuncture Medical Treatment Guidelines as set forth above.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>treatment guidelines, but AAOS offered a more clinically valid guideline for lumbar spinal surgeries.</p> <p>Commenters also state that based on the results of this study, CHSWC recommended that the AAOS guidelines be incorporated into the treatment utilization schedule. Pursuant to the statutory language that clearly allows the Commission to recommend more than one set of guidelines, the Commission concluded that the AAOS guideline should also be incorporated for lumbar spinal injuries.</p> <p>Commenters state that subsequently, AAOS removed its guidelines from consideration for this purpose. Accordingly, while the AAOS guidelines are no longer a viable alternative, the need for an alternate treatment protocol for lumbar spinal surgery still exists.</p> <p>Commenters add that adopting optimal standards in the area of lumbar spinal surgeries is critical given the frequency of this type of injury and the costs associated with it. A 2004 RAND study identified eight primary cost-drivers in workers compensation, and five of the eight were entirely or partially for spinal surgeries.</p> <p>Commenter states that an acupuncturist has treated him for several years. Commenter opines that if it were not for the acupuncture treatment, he would have had major back surgery again. The surgery would have meant 2 months bed rest and 7 months recuperation time. Commenter recommends that the DWC</p>	<p>Liberty R. Sanchez, Legislative Advocate, On behalf of California Teamsters Public Affairs Council August 9, 2006</p> <p>Angie Wei, Legislative Director, California Labor Federation, AFL-CIO August 21, 2006</p> <p>John C. Reclusado August 10, 2006</p>	<p>Agree in part. See, Response No. 14—Acupuncture Medical Treatment Guidelines.</p>	<p>New proposed Section 9792.21(a)(2) sets forth the Acupuncture Medical Treatment Guidelines as set forth above.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>adopt and incorporate “Acupuncture and treatment Guidelines” developed by the Council of Acupuncture and Oriental Medicine Associations</p> <p>Commenter states that according to the RAND study, the ACOEM guidelines were described as being inadequate in their coverage of numerous medical modalities, including Acupuncture, which has been a part of the Workers’ Compensation system for many years. Commenter states that guidelines that are comprehensive and inclusive of all medical modalities within the Workers’ Compensation system are vital to the best care and treatment of injured workers. Commenter requests that the proposed regulations be reviewed carefully and revised accordingly to ensure that they reasonably and adequately address each and every medical modality, especially Acupuncture, within the Workers’ Compensation system.</p>	<p>Judy Chu Assemblymember 49th District Assembly California Legislature August 21, 2006</p>	<p>Agree in part. See, Response No. 14—Acupuncture Medical Treatment Guidelines. See also, Response No. 7—Adoption of Supplemental Guidelines</p>	<p>New proposed Section 9792.21(a)(2) sets forth the Acupuncture Medical Treatment Guidelines as set forth above.</p>
Section 9792.21(a)	<p>Commenter addresses the prospective review of other medical protocols or treatment guidelines. Commenter states that there were two notable deficiencies in the RAND evaluation of treatment guidelines. Commenter further states that RAND only evaluated and compared “comprehensive” guideline sets. Commenter opines that to exclude medical specialty society guidelines or other narrowly focused guidelines is contrary to the benefits of specialized medicine. Commenter indicates that the guidelines from the North American Spine Society (NASS), which were supported by the</p>	<p>Robert R. Thauer, President Alliance for Physical Therapy, Rehabilitation & Medical Technology August 23, 2006</p>	<p>Agree in part. See Response No. 7—Adoption of Supplemental Guidelines</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>California Orthopedic Association and even Dr. Scott of RAND are a clear example of this exclusionary review. Commenter indicates that Dr. Scott said they were good guidelines and the only reason they were not included in RAND’s recommendations is that their charge was to evaluate general guidelines and NASS does not address extremities. Commenter opines that these guidelines would be good specialty society guidelines to fill in for chronic pain conditions that ACOEM does not cover.</p> <p>Commenter states that the mandate had been that guidelines be “updated” every three years. In his opinion, this is an unrealistic time frame because clinical studies and the development of new procedures and technologies often takes 5-10 years, to expect that guidelines be updated every 3 years is inconsistent with reality and the priorities of medical specialty societies. Commenter believes this is the primary reason the American Academy of Orthopedic Surgeons (AAOS) withdrew its guidelines from consideration. Commenter concludes that the two most prevalent and highest respected orthopedic medical societies (AAOS and NASS) are forced to follow algorithms developed by a relatively minor, specialty society representing less than 5% of the practicing orthopedic and spine surgeons in the United States.</p> <p>Commenter states that the RAND findings noted that all guideline sets had deficiencies. In particular to commenter’s interests, RAND concluded that ACOEM and the four other</p>	<p>Robert R. Thauer, President Alliance for Physical Therapy, Rehabilitation</p>	<p>Agree in part. See Response No. 7— Adoption of Supplemental Guidelines</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>sets of guidelines compared do not do a very good job addressing physical modalities. Commenter states that many physical modalities and medical devices used for many decades are not well-researched, or there is conflicting scientific evidence. Commenter opines that in cases where there is limited or conflicting evidence in the literature, standard of care and expert opinion should be given stronger weight.</p> <p>Commenter argues that the Administrative Director has ruled that interim physical therapy and occupational therapy treatment guidelines and the spinal surgery guidelines written by the American Academy of Orthopedic Surgery (AAOS) are to be ignored in order to adopt the entire treatment guidelines written by the American College of Occupational and Environmental Medicine (ACOEM). Commenter questions whether evidence-based medicine that may be superior to ACOEM's guidelines has been hijacked in the process. Commenter further states that the Administrative Director of DWC has rejected two recommendations made by the RAND Institute for Civil Justice and the California Commission on Health and Safety and Workers' Compensation (CHSWC). Commenter states that both groups recommended the ACOEM guidelines for physical and occupational therapy should be replaced by interim guidelines written elsewhere. Commenter opines that DWC's recommendation to implement the medical treatment guidelines written by ACOEM will severely restrict the type of care, including</p>	<p>& Medical Technology August 23, 2006</p> <p>Patrick Monette-Shaw August 23, 2006</p>	<p>Disagree. See Response No. 7— Adoption of Supplemental Guidelines. Moreover, it is noted that comments submitted by other commenters either in written form or orally at the August 23, 2006 hearing and quoted by commenter will be addressed independently in reference to those comments.</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>quality and quantity, which will be offered to California's injured workers. Commenter further states that the ACOEM guidelines are being utilized as a cookbook to be incorporated as the force of law, even though they have not been adopted or ratified by all medical specialty professional organizations as part of their clinical practice guidelines. Commenter cites to testimony presented at unrelated hearing, and also sets forth an alleged list of parties opposing adoption of the ACOEM Practice Guidelines. Commenter cites to testimony at the August 23, 2006 hearing on these regulations.</p> <p>Commenter states that controversy over medical treatment issues, particularly the presumption of correctness of the treating physician, played a significant role in the 2003 - 2004 legislation that changed the way healthcare is delivered to industrially injured workers. Commenter further states that it must be recognized that the purpose of a medical treatment guideline is, first and foremost, to insure that workers get the care that they need to cure and relieve from the effects of the injury. [See California Constitution, Article 14, §4]. Commenter indicates that the purpose of a medical treatment guideline is not, nor should it be, a cost-savings device. Commenter states that cost savings can and should occur when workers are provided the correct treatment in a timely manner, but cutting costs should only be a byproduct of the guidelines, not the central goal.</p> <p>Commenter indicates that it is important to</p>	<p>David Rockwell, President California Applicants' Attorneys Association August 23, 2006</p>	<p>Agree in part. See, Response No. 14—Acupuncture Medical Treatment Guidelines. See also, Response No. 7—Adoption of Supplemental Guidelines.</p>	<p>New proposed Section 9792.21(a)(2) sets forth the Acupuncture Medical Treatment Guidelines as set forth above.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>understand the intent of the Legislature in requiring the adoption of a medical treatment utilization schedule. Commenter states that the Legislature adopted the ACOEM Guidelines, sight unseen and prior to publication, only as an interim step. Commenter states that concurrently, Labor Code §77.5 was also enacted to require the Commission on Health & Safety & Workers' Compensation to conduct a survey and evaluation of evidence-based, peer-reviewed, nationally-recognized standards of care. Commenter states that on or before October 1, 2004 the Commission was required to report "its findings and recommendations to the administrative director for purposes of the adoption of a medical treatment utilization schedule." Commenter adds that the Legislature then adopted §5307.27 mandating that the interim ACOEM guidelines be replaced by a new treatment schedule on or before December 1, 2004.</p> <p>Commenter states that unfortunately, although the Commission contracted with the RAND Institute for Civil Justice to conduct the required study, and RAND issued a Working Paper in November, 2004, there were serious structural flaws in that study that limited its value. Specifically, commenter notes that the study stated that:</p> <p><i>"It is important to note that we are accomplishing these objectives in a very limited time frame and with limited resources; because of these constraints, we did not conduct an independent review of the clinical</i></p>			

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>literature or develop guidelines ourselves.” [Page xiii].</i></p> <p>Commenter also notes that a decision was made to review sets of guidelines over multiple individual guidelines — not because sets of guidelines contain superior treatment recommendations, but because multiple guidelines “<i>may address the same injuries and treatments and make contradictory recommendations, which could foster litigation... “and “multiple guidelines may be more complex for the state to implement and administer...”[Page xiv]</i></p> <p>Commenter opines that these policy decisions— not to conduct any independent review of published guidelines and to limit the review to only a few comprehensive guideline sets - seriously compromised the RAND study. Commenter indicates that working within these limitations, RAND actually found that none of the guidelines it reviewed met the standards it had established. Commenter notes the conclusion of seven of the eleven panelists who reviewed excerpts of treatment guidelines from the five different guideline sets reviewed by RAND was that:</p> <p><i>“They do not meet or exceed standards, they barely meet standards,” and “California could do a lot better by starting from scratch.”</i></p> <p>Commenter states that in the face of the statutory report deadline of October 1, 2004, RAND concluded that ACOEM could be</p>			

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	<p>continued in the short term, but only because it happened to the best among those reviewed, although marginally so. Commenter also states that RAND added, to address the “<i>uneven quality</i>” of the comprehensive guideline sets, “<i>the state will need to patch multiple guidelines together into a coherent set.</i>”</p> <p>Commenter finds it both incomprehensible and unacceptable that although it is almost two years later, the proposed regulations still make no attempt to address the appalling shortcomings identified by RAND in each of the comprehensive guideline sets, including ACOEM. Commenter opines that the only way to achieve the intent of SB 228 is through the adoption of multiple guidelines. Commenter further opines that arguments that multiple guidelines will only create conflicts that will lead to unnecessary litigation are specious. Commenter states that the fact is that the much-larger world of group health operates beautifully with multiple guidelines. Commenter also states that there is no reason why the workers’ compensation system cannot, particularly given the fact that it was the stakeholders themselves who agreed on this point. Commenter indicates that if there is any conflict, the adoption of a hierarchy of medical evidence will quickly resolve these potential problems. Commenter adds that in those few situations where different guidelines include different recommendations, both based on the same level of medical evidence, the decision on which treatment is provided should be based on the medical needs of the</p>			

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>individual patient, not on an inflexible administrative rule that arbitrarily gives an undeserved presumption to one guideline.</p> <p>Commenter urges DWC to pursue, with all haste, identification of additional guidelines that will address the shortcomings of the ACOEM Practice Guidelines as identified by RAND.</p> <p>Commenter states that in order to avoid a new round of rulemaking each time ACOEM issues a new edition or version of its practice guidelines; he recommends that the reference to the Second Edition (2004) be replaced with the words, “the most recent edition or version.”</p>	<p>Steven Suchil, Assistant Vice President American Insurance Association August 22, 2006</p>	<p>Disagree. See Response No. 1— Adoption by Incorporation by Reference an Existing Document and Any Future Updates.</p>	<p>None.</p>
Section 9792.21(a)	<p>Commenter recommends that DWC add “or the most recent publication” to this section so that the regulations would not have to be updated later on, as new revisions are published.</p>	<p>Tina Coakley, Legislative & Regulatory Analyst The Boeing Company August 23, 2006</p>	<p>Disagree. See Response No. 1— Adoption by Incorporation by Reference an Existing Document and Any Future Updates.</p>	<p>None.</p>
Section 9792.21(a)	<p>Commenter indicates that although RAND states, there is no reason to switch to a different set of guidelines at this time, they also state that they are not confident that the ACOEM Guideline is valid for nonsurgical topics and deciding whether or not to continue using ACOEM for nonsurgical topics as an interim strategy remains a policy matter. Commenter states that this is probably because the ACOEM guidelines do not address the frequency and duration for nonsurgical topics. Commenter states that, for example, ACOEM recommends 1-2 visits of</p>	<p>Dan Sheppard July 20, 2006</p>	<p>Agree in part. See Response No. 6— ACOEM Meets the Requirements of Labor Code section 5307.27. We agree that ACOEM could be more expressive as noted in commenter’s examples. However, in some of commenter’s examples, a frequency or duration is not necessary. For instance, ACOEM recommends 1-2 visits of physical therapy for low back strains (at p. 299), duration is not necessary because only one visit may be required. Moreover, one of</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Physical Therapy, no duration. The guides recommend no more than 4 weeks of manipulation for low back pain, no frequency. The guides recommend as an option manipulation for neck pain early in care only, no duration or frequency. Acupuncture is recommended as an option for low back pain without any recommended frequency or duration. Nonoperative rehabilitation for medial collateral ligament injuries is recommended without frequency or duration. ESWT is recommended as an option for plantar fasciitis without any recommended frequency or duration. Postsurgical care and rapid reconditioning are recommended without frequency and duration. Also, ACOEM does not provide any treatment recommendations commonly performed for head injuries including headaches and injuries to the hip and pelvis. (Just to name a few) How is the OAL going to approve ACOEM for nonsurgical topics when they are not consistent with Labor Code section 5307.27? Commenter suggests that DWC should consider adopting chapters 1-5 and 7 of ACOEM as a philosophy and Official Disability Guidelines-Treatment in workers' compensation (ODG-TWC) 2006 edition for treatment recommendations. Chapters 1-7 of ACOEM are not diagnosis specific guidelines, they are just an approach and will therefore not overlap with ODG-TWC. Also ODG-TWC does not address chapters 1-5 and 7. ODG-TWC 2006 edition is far more comprehensive than its 2004 edition, which was reviewed by RAND in Oct of 2004. Or at the very least, commission RAND to address</p>		<p>the goals of the committee is to address this issue, and to supplement the MTUS as necessary. Furthermore, in accordance with RAND's and the Commission's recommendation, we are adopting the ACOEM Guideline instead of ODG.</p>	

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>the revised 2006 edition and advise if it would be better to use chapters 1-5 and 7 of ACOEM as a philosophy and ODG-TWC for treatment recommendations. ODG-TWC provides at a minimum, the frequency, duration, intensity and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases for acute and chronic conditions including head injuries/headaches and injuries to the hip and pelvis--ACOEM does not even come close. FYI, 14 states/provinces have adopted ODG for treatment and only one has adopted ACOEM, Nevada.</p> <p>Commenters opine that the draft MTUS regulations fail to adequately address commonly performed treatment procedures and modalities.</p> <p>Commenters state that a CWCI study found in 1997 that physical medicine services including chiropractic and physical therapy accounted for up to one third of total medical costs in workers compensation. The RAND study found that neither ACOEM nor the other guidelines reviewed adequately dealt with physical modalities. Commenters state that CHSWC recommended separate provisions for specific physical modalities that are based on demonstrable functional improvement. Commenter opines that by neglecting to include the CHSWC recommendations, the draft regulations fail to meet the statutory objective of “adequately address(ing)” these physical modalities. (Lab. Code, § 5307.27.) Commenters recommend</p>	<p>Liberty R. Sanchez, Legislative Advocate Law Offices of Barry Broad, on behalf of: Amalgamated Transit Union, United Food and Commercial Workers’ Union, UNITE/HERE!, International Federation of Professional and Technical Engineers, Local 21, and Strategic Committee of Public Employees (Laborers’ International Union of North America) August 9, 2006</p> <p>Liberty R. Sanchez, Legislative Advocate, On behalf of California</p>	Disagree. See Response No. 8—CHSWC’s Recommendations on Physical Modalities.	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	that the draft regulations should be revised to incorporate the CHSWC recommended provisions for these modalities.	<p>Teamsters Public Affairs Council August 9, 2006</p> <p>Angie Wei, Legislative Director, California Labor Federation, AFL-CIO August 21, 2006</p>		
Section 9792.21(a)	<p>Commenter is the regional component of the American College of Occupational and Environmental Medicine (ACOEM), and its 400 members include physicians who participate in California's Workers' Compensation system as treating physicians, medical directors, and providers of independent medical and utilization review. Commenter states that they use the ACOEM Practice Guidelines daily and appreciate their role in standardizing the quality of medical care provided to injured workers in California.</p> <p>Commenter testified at the public hearing and briefed on several ways that ACOEM is making its Practice Guidelines more easily and effectively used:</p> <p>D) ACOEM publishes APG Insights, a newsletter that offers supplemental material to the Guidelines. It includes updates from the medical literature, current analyses, and further explanations designed to help users understand the Guidelines and better use them in their practices.</p>	<p>Steven C. Schumann, M.D., Western Occupational & Environmental Medical Association, Chair, Legislative Affairs Committee August 23, 2006 Oral and Written Comment</p>	Agree.	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>2) ACOEM has also developed the Utilization Management Knowledgebase (UN'K). This easy-to-use electronic tool helps providers, case-managers, and reviewers make appropriate care management decisions and communicate clearly about the Guidelines.</p> <p>3) ACOEM is also moving forward with a regular and predictable updating process that includes review of new therapies and literature and expansion on the Guidelines where appropriate. This will be a progressive refinement of the Second Edition, with a "rolling" set of guideline updates to be issued over a three year period, The first updates will be published later this year or in early 2007, and will address the elbow and the spine.</p> <p>Commenter states that the updating process is the work of two bodies. ACOEM's Evidence Based Practice Committee, with its body-part sub panels, acquires and evaluates evidence, and brings forth recommendations to update the Guidelines. This group includes more than 50 physicians from appropriate specialty areas, as well as other healthcare professionals.</p> <p>A second committee — composed of 4 ACOEM members and 3 members from other major national specialty associations - is charged with watch dogging the evidence-based methodology and ensuring a collaborative effort among specialties and that all topical reviews adhere to the fundamental evidence-based principles.</p>			

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>Commenter states that ACOEM has listened carefully to the comments raised by various stakeholders in California, and are committed to addressing those issues in our update process. Commenter invites input from those who may have concerns that the recommendations found in the Second Edition are incorrect or not in keeping with the conclusions of current, high-grade medical literature. They request that the comments along with citations from the literature be sent to them for review.</p> <p>Commenter's organization, American Insurance Association (AIA), is a national trade association representing more than 435 property and casualty insurers that write insurance in every jurisdiction in the United States. Commenter states that AIA member companies offer all types of property and casualty insurance, including workers' compensation. Commenter also states that AIA member companies account for 21 percent of the workers' compensation premiums in California.</p> <p>Commenter notes that with the passage of SB 228 in early 2003, the legislature took control of the skyrocketing costs of providing medical treatment for injured workers and expressed its intent to limit inappropriate medical treatment and overutilization of medical services through a mandate to adopt medical treatment utilization guidelines and, in the interim, to rely on guidelines developed by the American College of Occupational and Environmental Medicine (ACOEM).</p>	<p>Steven Suchil, Assistant Vice President American Insurance Association August 22, 2006</p>	<p>Agree in part. It is important to distinguish the utilization review process (UR regulations) from the medical treatment utilization schedule (MTUS regulations) in their relationship to the provision of medical treatment. Essentially, utilization review is the process to determine the appropriateness of medical treatment requested as it relates to the medical treatment utilization schedule. The medical treatment utilization schedule and the utilization review process work together as complimentary parts to ensure provision of evidence-based medical care. However, the MTUS represents the process in which evidence-based medical treatment guidelines are formulated whereas utilization review represents how requests for treatment are handled. Thus, while the utilization review regulations (9792.6-9792.10) initially</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Commenter further states that the potential savings as well as the positive effects on employee health resulting from the legislature's decision to require adoption of treatment guidelines were discussed in an October 23, 2005 letter from Frank Neuhauser, UC Berkeley Survey Research Center, to CHSWC Executive Officer Christine Baker. Commenter states that after citing studies of the significant impact of guidelines in the group health setting, not only on costs but also on improved patient outcomes, Frank Neuhauser turned to a study of the use of guidelines in workers' compensation. Commenter cites the following extract from the October 23, 2005 letter: "Even more appropriate for this discussion, Elam, et. al., (1997) evaluated specifically the introduction of workers' compensation practice guidelines on lumbar-spinal fusion. Washington's Department of Labor and Industry introduced guidelines in 1988 for elective lumbar fusion. Evaluating the rate of lumbar fusion over the period 1987-1992, the authors found a decline of 33% in fusion rates, while non-fusion rates remained constant. Prior to the introduction of guidelines, the rate of fusion operations as a fraction of all lumbar surgeries was higher among the workers' compensation inpatient population than for a similar non-occupational inpatient population. After the introduction of guidelines, the rate declined below that for the non-occupational treatment population. This is particularly important because (1) spinal fusions are very expensive operations, (2) when compared to</p>		<p>incorporated the ACOEM Practice Guidelines in 2005 to govern the utilization review process as required by the statute (Labor Code section 4610(c)), the UR regulations also state that at section 9792.8(a)(1) that the criteria governing the utilization review process must be consistent with the MTUS after its adoption. Now the MTUS is being adopted and the ACOEM Practice Guidelines are incorporated as part of the schedule, but they are not the entire schedule. The schedule is composed of sections 9792.20-9792.23, and it will continue to be amended by formal rulemaking as ACOEM revises the guidelines or as supplemental guidelines are adopted into the schedule by the DWC.</p>	

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>non-fusion surgery, lumbar fusion is associated with higher rates of complications and longer hospital stays, and (3) Washington state data indicated that 2/3 of fusion surgery patients were totally disabled two years after surgery. Current and future costs were reduced, and injured worker outcomes were likely improved by the introduction of the lumbar-fusion guidelines.”</p> <p>Commenter further states that in 2004, following a CHSWC survey, report and recommendations prepared on its behalf by RAND regarding evidence-based, peer-reviewed, nationally recognized standards of care, the Administrative Director adopted the ACOEM guidelines on an emergency basis, and in 2005, incorporated the ACOEM guidelines into the Utilization Review Standards (Section 9792.6 et. Seq.).</p> <p>The rules which are now being proposed would readopt the ACOEM practice guidelines (the term used in the proposal is “incorporate”) as the California medical treatment utilization schedule and give effect to other provisions of law addressing circumstances in which an injury or condition is not covered by those guidelines.</p> <p>Commenter states that the Workers’ Compensation reforms of 2003 and 2004 mandated that comprehensive treatment guidelines be developed and adopted to address all medical modalities within the Workers Compensation system. Commenter further states that the ACOEM Practice</p>	<p>Judy Chu Assemblymember 49th District Assembly California Legislature August 21, 2006</p>	<p>Agree in part. Agree that supplementation of the ACOEM Practice Guidelines is important. See, Response No. 14—Acupuncture Medical Treatment Guidelines. See also, Response No. 7—Adoption of Supplemental Guidelines. Disagree</p>	<p>New proposed Section 9792.21(a)(2) sets forth the Acupuncture Medical Treatment Guidelines as set forth above.</p>

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Section 9792.21(a)	<p>Guidelines, which have been temporarily in place until now, were only to be deferred to in the absence of more complete and efficient set of guidelines. Commenter is concerned with DWC’s proposal that the ACOEM guidelines be adopted and incorporated into the medical treatment utilization schedule because according to commenter the ACOEM guidelines have been found to be deficient.</p> <p>Commenter’s organization objects to the use of ACOEM guidelines to guide treatment decisions. Commenter opines that the ACOEM Practice Guidelines have a variety of inconsistencies and shortfalls that are being used by Insurance companies to prevent many injured workers from receiving medically necessary care.</p> <p>Commenter states that in its statement of reasons, the DWC admits that ACOEM is flawed for chiropractic care but DWC claims it is not able to adopt other guidelines to address these problems because other guidelines in existence at this time also have serious flaws in the area of physical medicine. Commenter states that these proposed regulations ignore the serious problem identified by RAND that there is a pressing need to address some areas that are not addressed well in the comprehensive guideline sets (e.g., the physical modalities) and those that are addressed minimally or not at all (e.g., acupuncture). Commenter believes that the Administrative Director should follow RAND’s recommendation and adopt interim guidelines for chiropractic care to allow care</p>	<p>John Bueler, Jr., D.C., President California Chiropractic Association August 23, 2006</p>	<p>with comment that the ACOEM Practice Guidelines, 2nd Edition have been found to be deficient. See Response No. 9—Incorporation of ACOEM into the MTUS.</p> <p>Disagree. See Response No. 9—Incorporation of ACOEM into the MTUS; See also Response No. 7—Adoption of Supplemental Guidelines. Moreover, the Utilization Review Standards regulations (Sections 9792.6 through 9792.10) and proposed Utilization Review Enforcement regulations (Sections 9792.11 through 9792.15), which are undergoing formal rulemaking at the present time address the problem of the UR process in applying MTUS. For instance, the UR regulations prohibit denial of medical treatment because the condition is not addressed in the ACOEM Practice Guidelines. Furthermore, the Medical Evidence Evaluation Advisory Committee can address the topic of whether a trial of chiropractic care should be allowed or any other topics that fall under the same situation. As reflected in the proposed regulations, the committee would review the medical evidence about chiropractic care for different</p>	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>when medically necessary. Commenter states that interim guidelines can be simple and implemented immediately. Commenter suggests that for those areas where ACOEM's comprehensiveness or validity is questionable, a trial of chiropractic care should be allowed. Commenter then states that if the provider can demonstrate positive outcomes using standard validated outcome assessment tools (such as the "Neck Disability Index" and the "Rolland Moms Disability Questionnaire," etc.) in the patient, additional visits should be authorized. Commenter opines that this is a reasonable solution especially given the fact that chiropractic and physical therapy services are capped at 24 visits each.</p> <p>Commenter states that the members of the California Workers' Compensation Institute strongly support the Administrative Director's decision to anchor the statutory definition of medical care with the ACOEM guidelines. Commenter further states that this policy decision follows both the spirit and the letter of SB 228 and SB 899 in establishing evidence-based medicine as the cornerstone of proper medical care in the California workers' compensation system.</p> <p>Commenter indicates that the consequence of the Legislature's policy decision is to require reliance on evidence-based medicine and the ACOEM guidelines at every level of the workers' compensation system. Commenter opines that it must be very clear that treating physicians, claims administrators, injured workers, employers, and adjudicators must</p>	<p>Brenda Ramirez, Claims and Medical Director Michael McClain, General Counsel & Vice President California Workers' Compensation Institute August 23, 2006</p>	<p>conditions and make recommendations based on the scientific evidence.</p> <p>Agree.</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>adhere to the ACOEM guidelines, other evidence based, peer-reviewed, nationally recognized treatment guidelines, and the hierarchy of scientific medical evidence to determine whether any proposed treatment is safe, efficacious and therefore presumed to be appropriate. Commenter adds that the regulations supporting that determination must not drift from the statutory foundation of high-grade, evidence-based medicine and the ACOEM guidelines.</p> <p>Commenter indicates that since March 31, 2004, the ACOEM guideline has been implemented in the California workers' compensation system as presumptively correct on an interim basis. Commenter states that as has been cited on many occasions—by patients, providers, and by the RAND Corporation's evaluation of the guideline—acupuncture is among the topics that the guideline addresses, as the RAND study puts it, “minimally or not at all.” Commenter argues that this has resulted in widespread denials of acupuncture treatment and in the de facto elimination of acupuncture as a readily accessible treatment modality within the workers' compensation system.</p>	<p>Bill Mosca, LAc Executive Director California State Oriental Medical Association August 23, 2006</p>	<p>Agree in part. See, Response No. 14—Acupuncture Medical Treatment Guidelines.</p>	<p>New proposed Section 9792.21(a)(2) sets forth the Acupuncture Medical Treatment Guidelines as set forth above.</p>
Section 9792.21(a)	<p>Commenter states that as acknowledged by the RAND Study, current ACOEM guidelines are based on generally accepted principals rather than clinically based scientific evidence; and therefore, as stipulated by the Executive Director, Barry S. Eisenberg, of the American College of Occupational and Environmental Medicine in his March 22,</p>	<p>H. Purcell, Director of Operations Electrostim Medical Services, Inc. August 23, 2006</p>	<p>Agree in part. See Response No. 7—Adoption of Supplemental Guidelines. Disagree with commenter's request that DWC publish an opinion recognizing that the ACOEM Practice Guidelines are “not intended as mandates,” and “offer[ing] an official process for the</p>	<p>None</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>2004 memorandum to the state capital, the treatment guidelines should be recognized as "recommendations and not intended as mandates". Commenter urges the DWC to publish an opinion, which recognizes this, and offers an official process for the authorization of medically necessary services otherwise not covered.</p> <p>Commenter represents the members of the California Physical Therapy Association. Commenter states that the comments being made are from the perspective of physical therapists and for physical therapy services as recognized in California Labor Code and the California Business and Professions Code. Commenter states that there have been very serious delays in authorization to begin treatment, carriers stating that due to the regulations they can only speak with physicians and problems getting carriers to follow regulations that have been on the books for some time (i.e., those that detail when written confirmation of verbal authorization must be sent). Commenter offers her support and appreciation for the proposed utilization review penalties. Commenter opines that it is imperative for carriers to be held responsible</p>	<p>Tameka White, Executive Associate for Practice & Payment California Physical Therapy Association August 18, 2006</p>	<p>authorization of medically necessary services otherwise not covered." The regulations are clear that pursuant to Labor Code section 4604.5(a) the MTUS (and consequently the ACOEM Practice Guidelines) is presumed correct on the issue of extent and scope of medical treatment. Moreover, the regulations as proposed do set forth a procedure to be followed for "injuries or conditions" not covered by the MTUS. This procedure is delineated in proposed Sections 9792.22(b) and 9792.22(c)(1) and (c)(2). Thus, it is not necessary that DWC issue an opinion on this issue.</p> <p>Agree in part. See Response No. 7— Adoption of Supplemental Guidelines. Comments relating to the proposed Utilization Review Enforcement regulations (Sections 9792.11 through 9792.15) will be addressed during that formal rulemaking process which is taking place simultaneously with the present rulemaking.</p>	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>for following appropriate process and expedition of care for the injured worker.</p> <p>Commenters state that it is critically important that medical treatment provided to injured workers conforms to the constitutional requirements of “curing and relieving” [footnote omitted] from the effects of the injury. Commenters further state that the California workers’ compensation system has been employing the ACOEM Guidelines on an interim basis as the presumptively correct standard of medical treatment for the last year and a half, and prior to that for several additional months when they were used but not yet presumed correct. Commenter adds that this has given all stakeholders an opportunity to see how they have worked, and that litigation challenging the applicability of the guidelines has shed light on some of the relevant issues.</p> <p>Commenter states that the Division now proposes to permanently adopt ACOEM as the presumptively correct standard for treatment despite the lackluster evaluation from the Rand team who reported in November, 2004 that all of the guidelines reviewed “barely meet standards.” [Footnote omitted.] Commenters further allege that stakeholder interviews confirmed that the ACOEM guideline has “been applied to topics that it addresses only minimally or not at all, for example, chronic conditions, acupuncture, medical devices, home health care, durable medical equipment, and toxicology.”[Footnote omitted.]</p>	<p>Peggy Sugarman, Consultant for VIAW Mark Hayes, President VotersInjuredatWork.org August 22, 2006 Written and Oral Comment</p>	<p>Agree in part. See, Response No. 14—Acupuncture Medical Treatment Guidelines. See also, Response No. 7—Adoption of Supplemental Guidelines, Response No. 10—Incorporation of ACOEM into the Medical Treatment Utilization Schedule. Comments relating to the Utilization Review Enforcement regulations (Sections 9792.11 through 9792.15) will be addressed in that formal rulemaking process which is taking place simultaneously with the present rulemaking.</p>	<p>New proposed Section 9792.21(a)(2) sets forth the Acupuncture Medical Treatment Guidelines as set forth above.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
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	<p>Commenter indicates that in order to deal with the identified deficiencies, the RAND report suggested that ACOEM be adopted along with the AAOS guidelines for low back, and that the state proceed as quickly as possible to deal with certain areas where ACOEM did not perform well. Commenter states that this included priority areas of: Physical therapy of the spine and extremities; Chiropractic manipulation of the spine and extremities; Spinal and paraspinal injection procedures; Magnetic resonance imaging (MRI) of the spine; Chronic pain; Occupational therapy; Devices and new technologies; and Acupuncture.</p> <p>Commenters indicate that since that time, there have been many problems with the medical treatment delivery system in today's workers' compensation system. Commenter opines that some of the problems are the result of improper use of the ACOEM Guidelines while others stem from utilization review delays and deficiencies, the latter of which have either been addressed in the utilization review standards or will be addressed upon the adoption of the utilization review penalty regulations. Commenter states that many problems still exist with the ACOEM Guidelines. Commenter notes that those problems were reported by stakeholders to the Rand researchers in 2004 and are continuing today, and that these regulations do little to address the issues.</p>			
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Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(a)	<p>Commenter states that the unintended consequence of the Workers' Compensation reform legislation from 2003-2004 was the virtual removal of Acupuncture from the Workers' Comp System, thereby robbing injured workers, and the Workers' Compensation System, of this proven successful and cost effective medicine.</p> <p>Commenter states that the reform legislation mandated that the Administrative Director to adopt Treatment Utilization Schedules for all modalities utilized in the Workers' Compensation System, and that the reform legislation further directed that until these comprehensive guidelines were adopted, the ACOEM Guidelines would be considered presumptively correct.</p> <p>Commenter references the RAND Corporation study, and states that RAND found that the ACOEM Guidelines did not address Acupuncture, and other modalities, in a sufficient or comprehensive manner. Commenter alleges that the Administrative Director instructed the Council of Acupuncture and Oriental Medicine Associations (CAOMA) to develop peer reviewed, evidence-based treatment guidelines for Acupuncture, to confer with the RAND Corporation for guidance in achieving sufficiency in such guidelines, and to submit such guidelines to the Administrative Director by December, 2004.</p> <p>Commenter states that CAOMA, in partnership with numerous medical experts,</p>	<p>Sandra Carey Carey Associates Advocacy Group On behalf of Council of Acupuncture and Oriental Medicine Associations August 23, 2006 Oral and Written Comment</p>	<p>Agree in part. See, Response No. 14—Acupuncture Medical Treatment Guidelines.</p>	<p>New proposed Section 9792.21(a)(2) sets forth the Acupuncture Medical Treatment Guidelines as set forth above.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>developed the Acupuncture and Electroacupuncture Evidence-Based Treatment Guidelines, December 2004. Commenter alleges that these Guidelines are peer-reviewed, nationally recognized, research, evidence and results based.</p> <p>Commenter argues that the Administrative Director has not reviewed these Guidelines after almost 2 years, and unfortunately, the results of this inaction are widespread denial of Acupuncture for injured workers.</p> <p>Commenter states that the Administrative Director has proposed the status quo for injured workers, e.g., proposed to make the ACOEM Guidelines a permanent and sole treatment guidelines structure for this system, all the while knowing that these guidelines are not comprehensive. Commenter argues that under the proposed regulations the only way an injured worker can get the optimum medical procedure is to enter into a rebuttal process. Commenter states that Acupuncture has been an accepted medical protocol in the Workers' Compensation System for almost 20 years.</p> <p>Commenter states that the ACOEM Guidelines are not going to "help those who make medical treatment decisions regarding the care of injured workers understand what treatment has been proven effective in providing the best medical outcomes to those workers" pursuant to section 9792.21, because they do not include all the modalities that are supposed to be made available to the patient.</p>			

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Commenter state that she does not accept this and rejects the proposed regulations on the basis of the fact that they are inadequate, deficient and in violation of the word and the intention of California statute. Commenter requests that the Administrative Director and the Division of Workers' Compensation to remember that the purpose of the guidelines is to ensure that legitimate and proven health care is provided on the basis of results and on a cost effective basis.</p> <p>Commenter objects to the Administrative Director's determination that adoption of these regulations will not eliminate jobs or businesses within California, nor have a significant adverse economic impact on private persons or directly affected businesses. Commenter alleges that the regulations directly impact many practitioners of Acupuncture.</p> <p>Commenter also objects to the Administrative Director's determination in accordance with Government Code section 11346.5(a)(13) that no reasonable alternative (to the ACOEM Guidelines) has been identified or brought to her attention that would be more effective in carrying out the purpose of which the actions are proposed. Commenter states that the Administrative Director has had almost two years to respond to the mandate of the California Legislature for the development of truly comprehensive treatment guidelines.</p>			

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
<p>Section 9792.21(a)</p>	<p>Commenter states that focusing the Schedule’s language on the ACOEM Guidelines and tailoring specific reference to them throughout the Article will require extensive re-writing in the future when new or additional Medical Treatment Guidelines are adopted. Commenter suggests shortening § 9792.21, and adding a new § 9792.22 as indicated below and subsequently renumbering of the remaining sections. Commenter states that by adopting this structure and language, the Division will facilitate future additions and build-in some much-needed flexibility to the Schedule as it matures.</p> <p>Commenter further states that if consensus is not accepted as evidence at some level, (proposed regulation §9792.22) then guidelines based on consensus cannot be proof and do not deserve a presumption of correctness. Commenter suggests the word “found” or perhaps ACOEM’s own words, “most likely” rather than “proven” in recognition of this conclusion plus the fact that the ACOEM Guidelines recommendations are in many cases, actually consensus-based and thus should be disallowed by statute or excluded by the very definitions of evidence found within this Article. Commenter’s revisions to this section are as follows:</p> <p>§ 9792.21. <u>Medical Treatment Utilization Schedule</u></p> <p>(a) <i>The Administrative Director adopts and</i></p>	<p>Stephen J. Cattolica AdvoCal Legislative and Administrative Agency Advocacy on behalf of California Society of Industrial Medicine and Surgery, U.S. Works, and the California Society of Physical Medicine and Rehabilitation</p>	<p>Agree in part. Commenter is correct that the language of the regulations should be re-focused to reference the adoption of the MTUS, and the regulations should make it clear that the ACOEM Practice Guidelines, although the foundation of the MTUS, is just a component of the MTUS as the MTUS is expected to evolve based on revisions of the ACOEM Practice Guidelines themselves (e.g., new editions), based on the results of work performed by the Medical Evidence Evaluation Advisory Committee (e.g., new guidelines added into the MTUS), and due to the proposed Acupuncture Medical Treatment Guidelines. Thus Section 9792.21(a) has been amended to clarify the adoption of the MTUS, and a new subdivision (a)(1) has been added to the regulations to incorporate the ACOEM Practice Guidelines into the schedule. Moreover, Section 9792.21(a)(2) has been added to the regulations setting forth the Acupuncture Medical Treatment Guidelines. Sections 9792.21(b), 9792.21(c), 9792.22(a), and 9792.22(b) have been amended to delete the phrase “ACOEM Practice Guidelines” and to insert the phrase “Medical Treatment Utilization Schedule” instead. Disagree with commenter’s statement on the consensus issue; the ACOEM</p>	<p>Section 9792.21(a) has been amended to read as follows: “[t]he 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 guideline into the Medical Treatment Utilization Schedule:</p> <p>New Section 9792.21(a)(1) has been added to state: “[t]he American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines (ACOEM Practice Guidelines), Second Edition (2004). A copy may be obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts 01915 (www.oempress.com).”</p> <p>New Section 9792.21(a)(2) contains the Acupuncture Medical Treatment Guidelines as</p>

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	<p><i>incorporates by reference, the following Medical Treatment Guidelines:</i></p> <p><i>i) American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines (ACOEM Practice Guidelines), Second Edition (2004), published by OEM Press, into the medical treatment utilization schedule. A copy may be obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts 01915 (www.oempres.com).</i></p> <p><i>ii) (Additional guideline #2 and so on.)</i></p> <p><i>§ 9792 22 (new) Medical Treatment Utilization Schedule Intent and Use of the Schedule</i></p> <p><i>(a) The ACOEM Practice Guidelines The Medical Treatment Guidelines found within this Article are intended to assist medical treatment providers 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 found effective in providing the best medical outcomes to those workers, in accordance with section 4600 of the Labor Code.</i></p> <p><i>(b) Treatment shall not be denied on the sole basis that the condition or injury is not addressed by <u>any of the ACOEM Practice Medical Treatment Guidelines</u> found in Section 9792.21 found in Section 9792.21. In</i></p>		<p>Practice Guidelines is evidence-based as it uses a systematic review of literature published in medical journals as its basis.</p>	<p>set forth above. Moreover, Sections 9792.21(b), 9792.21(c), 9792.22(a), and 9792.22(b) have been amended to delete the phrase “ACOEM Practice Guidelines” and to insert the phrase “Medical Treatment Utilization Schedule” instead.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<i>this situation, the claims administrator shall authorize treatment if such treatment is in accordance with other scientifically and evidence-based medical treatment guidelines that are generally recognized by the national medical community, in accordance with subdivisions (b) and (c) of section 9792.223.</i>			
Section 9792.21(b)	<p>Commenter states that the medical treatment utilization schedule will have a broader application and the regulation should reflect that. Commenter further states that as a guide to all medical decision makers, the treatment schedule will prevent some disputes and resolve others. Commenter opines the more inclusive statement set forth below states in a more clear manner the statutory purpose of the treatment schedule:</p> <p><i>The ACOEM Practice Guidelines are intended to assist medical treatment <u>and authorization providers decision makers</u> 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.</i></p>	<p>Brenda Ramirez, Claims and Medical Director Michael McClain, General Counsel & Vice President California Workers' Compensation Institute August 23, 2006</p>	<p>Disagree. The language of section 9792.21(b) is language directly from the statute (Lab. Code, §4604.5(b)). The regulations may clarify the statute but cannot expand or detract from the meaning of the language in the statute.</p>	<p>None.</p>
Section 9792.21(b)	<p>Commenter inquires as to whether Section 9792.21(b) mean ACOEM is no longer mandated for medical treatment, but to be utilized as an analytical guide for treatment. Commenter inquires as to whether other evidence-based medical treatment guidelines may be used as long as they are in accordance</p>	<p>Linda White, Director EMPI, Inc. August 23, 2006</p>	<p>Disagree. The MTUS is presumed correct pursuant to the statute (Lab. Code, §4604.5(c)). The phrase as stated in the regulations is direct language from the statute (see, Labor Code § 4604.5(b)). Together with the presumption of correctness, this</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(b)	<p>with subdivisions (b) and (c) of section 9792.22. Commenter inquires as to how and who makes the decision the information is in accordance with these subdivisions? Does the Division make this decision? Does the Claims Administrator? Or the Medical Evidence Evaluation Advisory Committee as outlined in 9792.23?</p> <p>Commenter makes reference to § 9792.21(b), and indicates that CMA has received hundreds of complaints from physicians outraged about the cookbook application of the ACOEM guidelines by individuals who lack the clinical qualifications to render informed evaluations of requested treatment and companies that apply a literal interpretation of the guidelines for their economic gain. Commenter applauds the reminder by the DWC of the intent of the law. Commenter states that claims administrators require a deeper understanding that guidelines as developed by ACOEM are a way to think about rendering care, not a literal order or rigid standard. Commenter further adds that the guidelines are not written for application by the lay-person (occurrences of which continue to be reported). Commenter looks forward to the finalization of the UR penalty regulations that will significantly discourage the improper application of these</p>	<p>Nileen Verbeten, VP Center for Economic Services California Medical Association, August 22, 2006</p>	<p>phrase means that the MTUS is mandated to be used to determine appropriate medical treatment. Thus commenter's interpretation of this section is incorrect. Moreover, the medical provider and the claims administrator can decide on an individual case whether to apply other evidence-based medical treatment guidelines. If a dispute arises, the matter will be resolved using the provisions of Labor Code section 4062, and subsequently before a workers' compensation administrative law judge.</p> <p>Agree in part. DWC agrees that it is important to remind the public of the intention of the statute (Labor Code section 4604.5(b)) as reflected in Section 9792.21(b). However, we disagree we disagree with comment that individuals who lack clinical qualifications are rendering evaluations of requested treatment. Pursuant to the UR regulations, a non-physician reviewer may be used to initially apply specified criteria to requests for authorization of medical services, a non-physician reviewer may approve requests for authorization of medical services, a non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria.</p>	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	guidelines.		However, a non-physician reviewer cannot deny a request for authorization as that is the exclusive province of the physician. (See California Code of Regulations, Title 8, section 9792.7.)	
Section 9792.21(c)	Commenter states that the draft regulations refer to injuries not covered by ACOEM, however it does not address treatment modalities not covered by ACOEM. Commenter states that there are numerous cases in which the ACOEM guidelines discuss injuries, but do not cover all potential treatment options. Commenter opines that it is feasible that an insurer could deny treatment based on this provision. Commenter urges the Division of Workers' Compensation to modify the language to include treatment not covered by ACOEM.	Joseph A. Zammuto, DO Chair, Osteopathic Physicians & Surgeons of California August 16, 2006	Disagree. See Response No. 10—“Medical Treatment” Not Addressed in the Medical Treatment Utilization Schedule as Opposed to “Condition or Injury” not Addressed in the Medical Treatment Utilization Schedule.	None.
Section 9792.21(c)	Commenter is a company that designs and manufactures implantable medical devices, including implantable spinal cord stimulation systems for the treatment of chronic intractable pain. Commenter commends the Division for including language in §9792.21(c) that clearly instructs claims administrators to authorize treatments that are not addressed by ACOEM Practice Guidelines as opposed to denying treatments on that basis.	John Hernandez, PhD Advanced Bionics Corp. August 21, 2006	Agree in part. See Response No. 10—“Medical Treatment” Not Addressed in the Medical Treatment Utilization Schedule as Opposed to “Condition or Injury” not Addressed in the Medical Treatment Utilization Schedule.	None.
Sections 9792.21(c) and 9792.22(b)	Commenter applauds the DWC for including provisions which state that treatment shall not be denied on the sole basis that a condition or	Charles Willmarth Director, State Affairs The American	Agree.	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Sections 9792.21(c) and 9792.22(b)	<p>injury is not addressed by the ACOEM Practice Guidelines, and that for all conditions or injuries not addressed by the ACOEM Practice Guidelines, authorized treatment and diagnostic services shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are generally recognized by the national medical community.</p>	<p>Occupational Therapy Association, Inc. August 18, 2006</p>		
	<p>Commenter is concerned about how these provisions will be interpreted and implemented in practice. Commenter questions as to who will decide if “authorized treatment and diagnostic services” are “in accordance with other scientifically and evidence-based medical treatment guidelines that are generally recognized by the national medical community?” Commenter requests that these provisions be clarified to explicitly state who will make these determinations and how disputes will be handled.</p>	<p>Charles Willmarth Director, State Affairs The American Occupational Therapy Association, Inc. August 18, 2006</p>	<p>Disagree. The medical provider and the claims administrator can decide on an individual case whether to apply other evidence-based medical treatment guidelines. If a dispute arises, the matter will be resolved using the provisions of Labor Code section 4062, and subsequently before a workers’ compensation administrative law judge.</p>	<p>None.</p>
	<p>Commenter notes there are some workers’ compensation payors who inappropriately use or interpret ACOEM and other treatment guidelines. Commenter offers the example that when a guideline indicates that a treatment may not be appropriate for one presenting condition or body part, many carriers are using this reference to deny treatment for other conditions or body parts that the guidelines do not address. Commenter states that sometimes payors use a fragment of a sentence, without guideline reference bibliography, to broadly deny treatment. Commenter states that the DWC is</p>	<p>Charles Willmarth Director, State Affairs The American Occupational Therapy Association, Inc. August 18, 2006</p>	<p>Disagree. See Response No. 9— Incorporation of ACOEM into the MTUS; See also Response No. 7— Adoption of Supplemental Guidelines. Moreover, the Utilization Review Standards regulations (Sections 9792.6 through 9792.10) and proposed Utilization Review Enforcement regulations (Sections 9792.11 through 9792.15), which are undergoing formal rulemaking at the present time and address the problem of misapplication of the ACOEM Practice Guidelines. For instance, the</p>	<p>None.</p>

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<p>Sections 9792.21(c), 9792.22(b)</p>	<p>addressing in §9792.21 the denial of coverage when a treatment or condition is not addressed in the guidelines. We would ask that the DWC also address this inappropriate misapplication and generalization of particulars in the guidelines.</p> <p>Commenter states that his organization, OTAC, appreciates the acknowledgement in this regulation that the ACOEM Practice Guidelines do not fully address the full range of issues associated with rehabilitation services in Workers' Compensation. Commenter further states that the proposed regulation raises questions of interpretation and implementation. Commenter seeks clarification, and sets forth the following questions: 1) Who would make the determination of whether the requested treatment falls within scientifically and evidenced-based medical treatment guidelines; and 2) through what process will disputes regarding evidence issues between providers and claims administrators be resolved?</p> <p>Commenter states that right now, most requests for authorization that go through utilization review have a lag time of about 1-2 weeks, precious time in the rehabilitation of an injured worker and costly for the employer as well. As the patient waits for continuation of treatment, an inevitable regression in their progress towards return to work occurs, and the employer incurs the expenses associated with replacement of the injured worker and/or replacement wages for modified duty.</p>	<p>Richard Bookwalter, MS, OTR, President Occupational Therapy Association of California August 23, 2006</p>	<p>UR regulations prohibit denial of medical treatment because the condition is not addressed in the ACOEM Practice Guidelines.</p> <p>Agree in part. See Response No. 10—"Medical Treatment" Not Addressed in the Medical Treatment Utilization Schedule as Opposed to "Condition or Injury" not Addressed in the Medical Treatment Utilization Schedule. Moreover, the medical provider and the claims administrator can decide on an individual case whether to apply other evidence-based medical treatment guidelines. If a dispute arises, the matter will be resolved using the provisions of Labor Code section 4062, and subsequently before a workers' compensation administrative law judge.</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(c)	<p>Commenter states that from the Statement of Reasons explaining this section, it is clear that the Division only wants to ensure that when an injury or condition is not addressed by the medical treatment utilization schedule, the claims administrator supports its decision with the rationale demanded by the statute — other evidence-based, nationally recognized, peer reviewed medical treatment guidelines or medical evidence that is generally recognized by the national medical community.</p> <p>Commenter states that as drafted and without reference to the Statement of Reasons, the proposed regulation is not clear whether the claims administrator is required to support its treatment utilization review decision with other medical treatment guidelines or is required to “prove a negative,” i.e., that the requested treatment is not supported by any other medical treatment guideline or medical evidence. Commenter indicates that the former reflects current utilization review practices and the latter process would impose an impossible burden that, as the regulation is currently drafted, would entail a review of all medical evidence contained in MEDLINE.</p> <p>Commenter opines that the recommended revisions to Section 9792.21(c) as set forth below would clarify the obligations of the utilization reviewer and the physician requesting the treatment to support their decisions:</p> <p><i>Treatment shall not be denied on the sole</i></p>	<p>Brenda Ramirez, Claims and Medical Director Michael McClain, General Counsel & Vice President California Workers’ Compensation Institute August 23, 2006</p>	<p>Agree in part. These regulations do not change the current Utilization Review practice. We agree that the insurer is not required “to prove a negative.” Decisions to approve, modify or deny treatment are controlled by the Utilization Review Standards regulations (Section 9792.6 through Section 9792.10). We agree that clarification in this regard is appropriate. Disagree with proposed language; it is believed that a reference to the UR regulations in Section 9792.21(c) is sufficient to clarify this process.</p>	<p>Section 9792.21(c) has been amended to state that 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 generally recognized by the national medical community, in accordance with subdivisions (b) and (c) of section 9792.22, and pursuant to the Utilization</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(c)	<p><i>basis that the condition or injury is not addressed by the ACOEM Practice Guidelines. In this situation, the claims administrator shall authorize treatment if such treatment is Authorization decisions to approve, modify or deny treatment for a condition or injury not addressed by the ACOEM Practice Guidelines shall be made in accordance with other a set of scientifically and evidence-based medical treatment guidelines that addresses the condition or injury and that are is generally recognized by the national medical community, in accordance with subdivisions (b) and (c) of section 9792.22.</i></p> <p><i>When medical treatment in a request for authorization has been modified or denied in accordance with the ACOEM Practice Guidelines or other nationally recognized, scientifically and evidence-based medical treatment guidelines that address the condition or injury, and the requesting physician disagrees with the modification or denial, the physician shall support that request with specific references to and excerpts from other nationally recognized, scientifically and evidence-based medical treatment guidelines.</i></p> <p>With regard to Section 9792.2.1(c), ACIC agrees with CWCI that once a denial has been made based on the ACOEM Practice Guidelines or, if not covered in those guidelines, other nationally recognized, scientifically and evidence-based medical treatment guidelines, then it is the</p>	<p>Samuel Sorich, President Association of California Insurance Companies August 23, 2006</p>	<p>Agree in part. See Response No. 10—"Medical Treatment" Not Addressed in the Medical Treatment Utilization Schedule as Opposed to "Condition or Injury" not Addressed in the Medical Treatment Utilization Schedule.</p>	<p>Review Standards found in Section 9792.6 through Section 9792.10.</p> <p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(c)	<p>responsibility of the requesting provider to support his request with citations to the nationally recognized, scientifically and evidence-based guidelines which support his proposed treatment.</p> <p>Commenter applauds the DWC's efforts to create a mechanism for rebutting the presumptive correctness of the ACOEM guideline. Commenter further states that he also applauds the draft regulations for prohibiting denials of treatment on the sole basis that the condition is not addressed by the ACOEM guideline.</p>	<p>Bill Mosca, LAc Executive Director California State Oriental Medical Association August 23, 2006</p>	Agree.	None.
Section 9792.21(c)	<p>Commenter states that during the public hearing, evidence was presented to suggest that treatment modalities including physical therapy and the delivery of some types of medical devices (TENS/interferential) have been denied coverage for <u>chronic</u> care based on acute or sub-acute algorithms. Commenter urges the DWC to publish an opinion, which nullifies this practice.</p>	<p>H. Purcell, Director of Operations Electrostim Medical Services, Inc. August 23, 2006</p>	<p>Disagree. Section 9792.21(c) specifically provides that treatment shall not be denied on the sole basis that the condition or injury is not addressed by the Medical Treatment Utilization Schedule. The section further provides an approach for this stating that 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 9792.6-9792.10. Moreover, these claimed denials of medical treatment must be examined on an individual basis. For example,</p>	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(c)	Commenter makes reference to section 9792.21(c), and indicates that parallel to the comment submitted pursuant to section 9792.21(b) above, CMA greatly appreciates the DWC’s clear expectation that ACOEM’s silence on a condition or injury is an insufficient basis for denial of requested treatment.	Nileen Verbeten, VP Center for Economic Services California Medical Association, August 22, 2006	some denials may be based on the 24 chiropractic, occupational therapy, and physical therapy cap imposed by Labor Code section 4604.5(d)(1) while others may be entitled to penalties under the proposed Utilization Review Enforcement regulations (Sections 9792.11 through 9792.15), which are undergoing formal rulemaking at the present time, and are intended to address the problem of misapplication of the ACOEM Practice Guidelines. Agree.	None.
Section 9792.21(c)	Commenter states that the proposed regulations state that treatment shall not be denied on the sole basis that the condition or injury is not addressed by the ACOEM guidelines. Commenter states that the Utilization Review Standards in §9792.8, however, state that “Treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Guidelines”. Commenter opines that there is a huge difference between condition or injury and specific treatment. Commenter suggests that DWC conform §9792.21(c) to existing	David Rockwell, President California Applicants’ Attorneys Association August 23, 2006	Agree in part. See Response No. 10—“Medical Treatment” Not Addressed in the Medical Treatment Utilization Schedule as Opposed to “Condition or Injury” not Addressed in the Medical Treatment Utilization Schedule. Agree in part that the Utilization Review Standards regulations, at Section 9792.8(a)(2), and proposed section 9792.21(c) need to be harmonized. The Utilization Review Standards regulations, at Section 9792.8(a)(2)	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.21(c)	<p>§9792.8 — not just for clarity and consistency but to insure that newer treatments that may not have been included in large guideline sets are not automatically rejected simply because they are not specified in ACOEM. The sections should be harmonious.</p> <p>Commenter indicates that §9792.21(c) states that treatment shall not be denied on the sole basis that the condition or injury is not addressed by the ACOEM Practice Guidelines. Commenter states that this is inconsistent with existing language in §9792.8 that states that treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Guidelines or medical treatment utilization schedule adopted by the Administrative Director. Commenter suggests that the proposed §9792.21(c) should be changed to reflect the existing rule.</p>	<p>Peggy Sugarman, Consultant for VIAW Mark Hayes, President VotersInjuredatWork.org August 22, 2006 Written and Oral Comment</p>	<p>states “Treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Guidelines until adoption of the medical treatment utilization schedule pursuant to Labor Code section 5302.27.” This language will be corrected through formal rulemaking in the near future to conform to the MTUS regulations.</p> <p>Agree in part. See Response No. 10—“Medical Treatment” Not Addressed in the Medical Treatment Utilization Schedule as opposed to “Condition or Injury” not addressed in the Medical Treatment Utilization Schedule. Agree in part that the Utilization Review Standards regulations, at Section 9792.8(a)(2), and proposed section 9792.21(c) need to be harmonized. The Utilization Review Standards regulations, at Section 9792.8(a)(2) states “Treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Guidelines until adoption of the medical treatment utilization schedule pursuant to Labor Code section 5302.27.” This language will be corrected through formal rulemaking in the near future to conform to the MTUS regulations.</p>	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.22(a)	Commenter states that ACOEM is mainly for acute injuries, and its chapter on chronic pain does not address the neurophysiologic aspects of chronic pain. Commenter further states that on page 287, the ACOEM Guidelines state that low back pain conditions are addressed for the first 90 days.	Charles G. Davis, DC, QME July 10, 2006	Disagree. See Response No. 11— Chronic Conditions	None.
Section 9792.22(a)	Commenters state that the provision in Section 9792.22 (a) which provides that the ACOEM Practice Guidelines “are presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addresses in those guidelines for both acute and chronic medical conditions,” is not medically sound, and is not in the best interest of successful treatment of the injured worker. Commenter argues that there is currently no consensus amongst medical providers regarding whether application of the ACOEM guidelines for chronic care is appropriate under any circumstances. To the contrary, there are some members of the provider community who contend that ACOEM is never appropriate for any treatment other than for acute treatment. Further, commenters contend that application of the ACOEM guidelines is actually advised against for chronic care under specified circumstances. Specifically, Chapter 12, page 1, paragraph 2, of ACOEM states “[r]ecommendations on assessing and treating adults with potentially work-related low back problems (i.e. activity limitations due to symptoms in the low back of less than three months duration) are presented in this clinical practice guideline.” By way of example, (also derived from Chapter 12, page 1), imaging	Liberty R. Sanchez, Legislative Advocate Law Offices of Barry Broad , on behalf of: Amalgamated Transit Union, United Food and Commercial Workers’ Union, UNITE/HERE!, International Federation of Professional and Technical Engineers, Local 21, and Strategic Committee of Public Employees (Laborers’ International Union of North America) August 9, 2006 Liberty R. Sanchez, Legislative Advocate , On behalf of California Teamsters Public Affairs Council August 9, 2006 Angie Wei, Legislative Director , California Labor Federation, AFL-CIO	Disagree. See Response No. 11— Chronic Conditions	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.22(a)	<p>(i.e. MRI) and other tests are not usually helpful during the first four to six weeks of low back symptoms. Commenters argue that under the proposed regulations this could be interpreted to mean that via application of the ACOEM guidelines to chronic as well as acute conditions, an injured worker with a low back injury with a duration of 6 months, would never be able to get an MRI because ACOEM does not recommend such a procedure during the first three months of care. Commenters conclude that it is inappropriate, within the confines of these regulations, to provide for blanket applicability of the ACOEM guidelines for chronic conditions.</p> <p>Commenter objects to the proposed regulations. Commenter is a licensed sports massage therapist. Commenter states that she treats some patients who have on the job injuries and who have chronic conditions, some still able to work, some that cannot. Commenter opines that the proposed regulations do not apply to chronic conditions; and to put this in regulation as the presumptively correct standard of care for injured workers is medically wrong and inappropriate. Commenter states that reasonably accepted treatment modalities and a multidisciplinary approach help keep these chronically injured people functional.</p>	<p>August 21, 2006</p> <p>Carol McManus, LMT August 21, 2006</p>	<p>Disagree. See Response No. 11— Chronic Conditions</p>	<p>None.</p>
Section 9792.22(a)	<p>Commenter states that the ACOEM guidelines are focused on the first 90 days. Commenter believes that alluding to occasional reference within the guidelines to extrapolate that they</p>	<p>Robert R. Thauer, President Alliance for Physical Therapy, Rehabilitation</p>	<p>Disagree. See Response No. 11— Chronic Conditions</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
<p>Section 9792.22(a)</p> <p>Section 9792.22(a)</p>	<p>are clearly definitive for chronic conditions is a broad leap. Commenter cautions the DWC as commenter envisions legal challenge to this broadening of the scope of the ACOEM guidelines.</p> <p>Commenter states that Section 9792.22(a) reiterates the presumptive weight Labor Code Section 4604.5(a) accords the MTUS as well as the proof required to rebut the presumption. The subdivision duplicates the statute and is not needed.</p> <p>Commenter states that while the proposed regulatory action provides an ostensible mechanism for rebutting the presumptive correctness of the ACOEM guideline, CSOMA has concerns with the July 2006 draft regulations.</p> <p>Commenter states that CSOMA has profound concerns regarding the presumptive correctness of the ACOEM guideline, especially with respect to chronic conditions and with respect to acupuncture. Commenter indicates that the RAND Corporation’s evaluation of the ACOEM guidelines found them to be deficient in a number of areas. Chronic care, pain management, and acupuncture were among the specific “priority topic areas” that were only addressed, according to RAND, “minimally or not at all.” Commenter argues that to endow the guidelines with permanent presumptive correctness without first addressing these</p>	<p>& Medical Technology August 23, 2006</p> <p>Steven Suchil, Assistant Vice President American Insurance Association August 22, 2006</p> <p>Bill Mosca, Lac Executive Director California State Oriental Medical Association August 23, 2006</p>	<p>Disagree. The reiteration from the statute of the presumption and burden of proof allows all of the requirements pursuant to the statute and under the MTUS to be in one set of regulations thus making it easier for the regulated public to comply with the requirements of the statute.</p> <p>Agree in part. See, Response No. 14—Acupuncture Medical Treatment Guidelines. Disagree with comment that ACOEM does not apply to chronic conditions. See Response No. 11—Chronic Conditions. In addition, is noted that the presumption of correctness is required by the statute. (Lab. Code, §4604.5(a).)</p>	<p>None.</p> <p>New proposed Section 9792.21(a)(2) sets forth the Acupuncture Medical Treatment Guidelines as set forth above.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
<p>Section 9792.22(a)</p> <p>Section 9792.22(a)</p>	<p>deficiencies will only serve to perpetuate the lack of access to appropriate treatment for injured workers. Commenter requests that for this reason, DWC address the priority deficiencies of the guideline before finalizing this regulation.</p> <p>Commenter further adds that the explicit extension of the presumptive correctness of the ACOEM guideline to chronic medical conditions [Section 9792.22(a)] defies both ACOEM's own statements with respect to the appropriate use of the guideline as well as RAND's analysis of them. Commenter states that there is no medical evidence to substantiate a three-month cutoff for acute conditions as defined in the draft. Commenter opposes the use of the ACOEM guideline for chronic conditions and urges the DWC to remove the extension of presumptive correctness for chronic medical conditions to ACOEM guideline from the draft regulation</p> <p>Commenter states that although the ACOEM guidelines clearly define acute, sub-acute, and chronic pain, he opines that the current parameters pertain solely to treatment of injuries within the first 90 days of onset. Commenter recommends that specific treatment protocols be drafted to include standards that allow for the delivery of care to chronic pain patients.</p> <p>Commenter objects to the presumption of correctness attributed to the ACOEM Practice Guidelines under Labor Code section 4604.5(a). Commenter indicates that the</p>	<p>H. Purcell, Director of Operations Electrostim Medical Services, Inc. August 23, 2006</p> <p>Patrick Monette-Shaw August 23, 2006</p>	<p>Disagree. See Response No. 11—Chronic Conditions.</p> <p>Disagree. See Response No. 7—Adoption of Supplemental Guidelines. It is noted also that the presumption of correctness is</p>	<p>None.</p> <p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.22(a)	<p>injured workers and their treating clinician(s) should not have to bear the burden of proving that the ACOEM guidelines written for preventive care that are incorrect, nor should they be required to have to appeal denial of care by having to present other treatment guidelines to prove their rebuttals. Commenter argues that instead, the Division of Worker’s Compensation should be required, at minimum, to adopt treatment guidelines written by clinical specialists who have experience in writing guidelines for rehabilitative and restorative medical care to reduce the burden on injured workers and their treating professionals. Commenter recommends that DWC reject the recommendation to incorporate the ACOEM Practice Guidelines as presumptively correct.</p> <p>Commenter discusses at length his objections to the decision of the DWC not to incorporate the AAOS Guidelines and/other specialty guidelines into the proposed MTUS schedule at this time. Commenter recommends that DWC go back to the drawing board and start all over again by acknowledging that rehabilitative medicine, not preventive medicine, is the medical model that should be followed in treating injured workers after they have been injured.</p> <p>Commenter, representative of First Health, proposes that a statement be included in the regulations clarifying that the use of the ACOEM guidelines is not restricted to the first 90 days after injury. Many practitioners’ believe that the guidelines are restricted to this</p>	<p>Kelly M. Weigand, Managing Attorney First Health August 23, 2006</p>	<p>required by the statute. (Lab. Code, §4604.5(a).) Commenter further disregards discussion in ISOR regarding justification for incorporating the ACOEM Practice Guideline into the proposed MTUS (See ISOR at pp. 17-36 discussing necessity for Section 9792.21(a).) Disagree with commenter’s suggestion that the MTUS does not contain a rehabilitative component. The ACOEM Practice Guidelines which have been incorporated into the MTUS address rehabilitation and functional restoration. See Chapter 5-Cornerstones of Disability Prevention and Management.</p> <p>Agree. This requirement is already addressed in section 9792.22(a). See also, Response No. 11—Chronic Conditions.</p>	<p>Section 9792.22(a) has been amended to state that the Medical Treatment Utilization Schedule is presumptively correct on the issue of extent and</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.22(a)	<p>90 day period.</p> <p>Commenter states that the shortcomings of the ACOEM Practice Guidelines include problems with the validity of the guidelines for non-surgical treatment. Commenter states that in RAND's interviews of stakeholders, payors themselves questioned whether the guidelines were specific enough to determine appropriateness of care and suggested that acupuncture, chronic conditions, and other topics may not be covered well. Commenter states he opposes the proposal to apply the guidelines to both acute and chronic conditions.</p> <p>Commenter believes that such a regulation is outside the scope of DWC's authority.</p>	<p>David Rockwell, President California Applicants' Attorneys Association August 23, 2006</p>	<p>Disagree. See Response No. 11—Chronic Conditions.</p>	<p>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.</p> <p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Commenter states that the regulations cannot apply a medical guideline to a chronic condition where the guideline itself states that the recommended treatment is for acute injuries. Commenter opines that if the evidence on which a guideline is based looks only at specific symptoms within a specific time frame, it is irresponsible and could be physically damaging to an injured worker to extend the application of that guideline to other symptoms or other time frames.</p> <p>Commenter offers examples: Consider the following statement in Chapter 12, page 287 of ACOEM:</p> <p><i>“Recommendations on assessing and treating adults with potentially work-related low back problems (i.e., activity limitations due to symptoms in the low back of less than three months duration) are presented in this clinical practice guideline.”</i> [Emphasis in comment.]</p> <p>Commenter states that this statement prefaces the entire chapter. Commenter further states that no regulation can change this basic fact. Commenter restates that these recommendations apply only where the symptoms last less than three months. Commenter opines that implicit within this statement is that where the symptoms last more than three months, additional testing and/or treatment may be warranted. Commenter indicates that arbitrarily extending the testing and treatment recommendations, where the underlying evidence shows these tests and treatment are efficacious only within</p>			

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.22(a)	<p>the first three months, completely contradicts the fundamental goal of providing evidenced-based care in a timely manner. Commenter opines that there is absolutely no medical or legal basis to assume that a test or treatment is efficacious at six months after the injury simply because evidence showed it was efficacious at three months after the injury.</p> <p>Commenter recognizes that a statement made in an ACOEM newsletter suggests that the guidelines can be used to guide treatment for chronic conditions in some instances. Commenter opines that this statement is far from a declaration that the guidelines should be mandatory, applied as presumptively correct for all chronic conditions. Commenter believes that ACOEM would agree that treatment decisions must be made by a physician based on the physician's review of the guideline when supporting a specific treatment plan or recommending diagnostic testing. Commenter urges DWC to leave the practice of medicine to physicians, and delete the unjustified proposal to make the ACOEM guidelines presumptively correct for chronic conditions.</p> <p>Commenter references section 9792.22 (a), which states that ACOEM Practice Guidelines are presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addressed in those guidelines for both acute and chronic medical conditions. Commenter states that while it is true that Labor Code 4604.5(a) states that, "American College of Occupational and</p>	<p>Peter Mandell, Chair Workers' Compensation Committee California Orthopedic Association August 15, 2006</p>	<p>Disagree. See Response No. 11—Chronic Conditions. Also, it is noted that an orthopedist contributed to the first edition of the ACOEM Practice Guidelines. (See, Occupational Medicine Practice Guidelines, 1st Edition, Preface page <i>xxvii</i>, Dr. John Lavorgna, Clinical Professor, Orthopedic Surgery, UCSF.) The</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Environment Medicine’s Occupational Medicine Practice Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment, regardless of date of injury,” the Labor Code does not state that the guidelines apply to both acute and chronic medical conditions.</p> <p>Commenter believes there is little scientific evidence to show that the ACOEM guidelines apply to chronic conditions. Commenter states that for reasons beyond the control of ACOEM the guidelines received no formal input from the national musculoskeletal professional organization, orthopaedic or neurosurgery. Commenter states that the guidelines themselves call for referrals to specialists when red flags are identified by the treating physician. Commenter further states that if the guidelines were all inclusive and covered chronic conditions, the guidelines would refer the treating physicians to another section in the guidelines to address the chronic condition, not just indicate that a referral to a specialist is in order. Commenter opines that this further confirms that the guidelines do not specifically address all conditions, particularly surgical conditions.</p> <p>Commenter indicates that CHSWC recommended that, “the ACOEM guidelines should be used as the primary basis for medical treatment utilization schedule because their flexibility allows medical decisions to take into consideration the full range of valid considerations and thus to provide optimal care for individual patients.” Commenter</p>		<p>second edition was updated by review of the literature based on the first edition. Further, it is noted that the American Association for Hand Surgery was involved in the Second Edition, which includes orthopedic sub-specialists. Thus, the comment that there was no orthopedic involvement in the second edition of the ACOEM Practice Guidelines is erroneous.</p> <p>Furthermore, it is important to identify red flags as this helps to identify cases in need of immediate medical intervention. The ACOEM Practice Guidelines do appropriately call for referrals to specialists in case red flags are identified. For instance, a pulsatile midline abdominal mass found in dissecting abdominal aortic aneurysms should be referred to a specialist and should fall outside of the ACOEM Practice Guidelines. (See, ACOEM Practice Guidelines, at p. 290.) Indeed, the role of the ACOEM Practice Guidelines is to help treating physicians identify these potentially serious conditions, many of which are not caused by musculoskeletal conditions. Also, the proposed regulations indicate that the ACOEM Practice Guidelines are presumed to be correct on the issue of extent and scope of medical treatment and diagnostic services addressed in the MTUS (including</p>	

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.22(a)	<p>opines that in theory this may be valid, but in practice, the literal interpretation of the ACOEM guidelines has not provided timely and optimal care. Commenter states that a further statement by the DWC that the guidelines apply to all conditions will only further reinforce the literal interpretations that have been problematic.</p> <p>Commenter commends ACOEM for their efforts in putting together these practice guidelines, but cannot agree that the guidelines address all chronic conditions. Commenter believes that by adding that the guidelines apply to both acute and chronic medical conditions, the regulations go beyond the statute and urges the Division to delete, “for both acute and chronic medical conditions” phrase from the regulations.</p> <p>Commenters oppose §9792.22 stating that ACOEM is applicable to chronic conditions. Commenters indicate that they have seen the newsletter from ACOEM that suggests that the guidelines are applicable to chronic conditions. Commenter opines that there is a big difference between using ACOEM as a guideline to suggest possible medical approaches to a work-related injury and making it the presumptively correct standard of care for chronic conditions. Commenters believe that these are two entirely separate concepts.</p> <p>Commenter states that the RAND research highlighted problems with ACOEM being applied to chronic conditions. Commenter also</p>	<p>Peggy Sugarman, Consultant for VIAW Mark Hayes, President VotersInjuredatWork.org August 22, 2006 Written and Oral Comment</p>	<p>the ACOEM Practice Guidelines). (Section 9792.22(a).) However, if the condition is not addressed by the MTUS (including the ACOEM Practice Guidelines), the proposed regulations provide that “authorized treatment and diagnostic services shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are generally recognized by the national medical community.” (Section 9792.22(b).)</p> <p>Disagree. See Response No. 11—Chronic Conditions. Further, it is not appropriate for DWC to discuss a specific medical case. However, if a condition such as severe burns or facial fractures is not included in ACOEM, a claims administrator may not deny treatment based on ACOEM. In that regard, the proposed regulations give clear instructions as to the proper procedure to obtain treatment. (See, Sections 9792.22(a) and 9792.22(b).)</p>	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>states that there are also current cases where the applicability of ACOEM was successfully challenged in the courts. Commenter states that in <i>Hamilton v. State Compensation Insurance Fund, STK 189211</i>, Sept. 16, 2004 the WCAB denied reconsideration of a judicial award of medical treatment alleged by defendants to be contrary to ACOEM. Commenter states that the trial judge determined, and the WCAB denied reconsideration, that ACOEM guidelines apply only to the treatment of acute injuries. They based their decision on the language of the ACOEM guidelines.</p> <p>Commenter states that in <i>Hamilton</i>, the judge referred to the statement in Chapter 12: Low Back that clearly states that the “<i>Recommendations on assessing and treating adults with potentially work-related low back problems (‘i.e., activity limitations due to symptoms in the low back of less than three months duration) are presented in this clinical practice guideline.</i>”</p> <p>Commenter states that ACOEM makes a similar statement in Chapter 13 governing knee complaints:</p> <p>“<i>Recommendations on assessing and treating adults with potentially work-related knee problems are presented in this clinical practice guideline. Topics include the initial assessment and diagnosis of patients with acute and subacute knee complaints. . .</i>” [page 329].</p>			

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Commenter also states that the same language exists for Chapter 14: Ankle and Foot Complaints. [page 361]</p> <p>Commenter further states that in Chapter 15: Stress-related Conditions, ACOEM states in the very first sentence:</p> <p><i>“This guideline is intended to help occupational physicians and primary care practitioners manage employed patients with acute stress-related conditions of relatively short duration.”</i> [Page 387.] Commenter opines that clearly, this chapter should not be used as a standard of care for workers who are losing time due to a stress-related condition.</p> <p>Commenter also states that the application of ACOEM to patients with serious, chronic conditions particularly those with multiple injuries that overlap with one another can limit necessary care. Commenter requests that DWC consider the difficult medical problems of VIAW board member Steven Duncan.</p> <p>Commenter states that Mr. Duncan is a survivor of the 1999 explosion at Tosco Oil Refinery where four of his co-workers were killed in an explosion. Mr. Duncan survived by leaping off the fractionator tower while on fire. He landed on the roof of a building after falling some fifty-plus feet. He has had 50 surgeries, lost part of one hand, suffered severe facial injuries, broke untold number of bones in his legs and sports the after effects caused by severe burns. Today, he has been diagnosed with hetatopical ossification--</p>			

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.22(a)	<p>meaning that he has calcium deposits (bones growing) in his muscle tissue. This may require another surgery. He also has increasing problems with sleep apnea as a consequence of the facial injuries where his face was depressed by an inch and a half. As a result of the sleep apnea, he gets only minimal sleep at night. ACOEM says nothing about sleep apnea, care for severe burns, heterotopic ossification, facial fractures, nor does ACOEM discuss the need for support services as might be necessary to manage chronic, long-term medical problems.</p> <p>Commenters urge the Division to reconsider its position in this matter. Commenters opine that to promulgate such a regulation may endanger the health of injured workers and prevent or delay access to medical treatment that may assist workers with their overall functioning. Commenter states that by attempting to make the guideline applicable to conditions where it clearly is not - by virtue of a regulation - DWC will make these problems much worse, increase litigation and further delay necessary treatment for the people who need it the most.</p> <p>Commenter objects to Section 9792.22(a) stating that the ACOEM Practice Guidelines are presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addressed in those guidelines for both acute and chronic medical conditions. Commenter offers the following references to ACOEM to support his position that the ACOEM Practice Guidelines do not</p>	<p>Stephen J. Cattolica AdvoCal Legislative and Administrative Agency Advocacy on behalf of California Society of Industrial Medicine and Surgery, U.S. Works, and the California</p>	<p>Agree in part. See Response No. 11—Chronic Conditions. Agree that DWC is not adopting the advisory guidelines (e.g., ACOEM Practice Guidelines Insights or APGs) at this time. DWC believes that it is important to vet any guideline adopted into the MTUS through a formal process such as that one done</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>apply to chronic conditions:</p> <p><i>Consider the following statement in Chapter 12, "Low Back Complaints," page 287 of ACOEM:</i></p> <p><i>(1) "Recommendations on assessing and treating adults with potentially work-related low back problems (i.e., activity limitations due to symptoms in the low back of less than three months duration) are presented in this clinical practice guideline." [Emphasis added]</i></p> <p><i>(2) Chapter 13, Knee Complaints, page 352. On this page is a chart representing an algorithm for "Further Management of Occupational Knee Complaints" The entry-level circumstance for use of the algorithm is stated as, "Workers with knee-related activity limitations > (greater than) 4-6 weeks, but < (less than) 3 months duration."</i></p> <p><i>(3) Chapter 15, "Stress-related Conditions." It states, "This guideline is intended to help occupational physicians and primary care practitioners manage employed patients with acute stress-related conditions of relatively short duration..." Of particular note is the fact that this set of 'guidelines' are not aimed at specialists care nor chronic conditions.</i></p> <p>In reference to the first example, commenter believes that this statement is succinct and unequivocal in its meaning that all of the ACOEM Guidelines for treatment of low back complaints are applicable to symptoms of less</p>	<p>Society of Physical Medicine and Rehabilitation</p>	<p>by RAND or the process that will be utilized by the Medical Evidence Evaluation Advisory Committee pursuant to proposed Section 9792.23. Any revisions of the MTUS will go through formal rulemaking, and commenter will have the opportunity to comment on any proposed changes.</p>	

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>than three months duration. Commenter opines that there is no other interpretation possible. Commenter believes the Division is overstepping its authority to extend a presumption to these and similarly designated guidelines, in order to address chronic conditions, which are clearly beyond their evidence-based and, in many cases, consensus-based origins.</p> <p>Commenter emphasizes that regardless of subsequently written advisories that attempt to address the issue of applicability to chronic conditions, any such documents, separately published after the fact, are not incorporated into the Guidelines by statute and thus are excluded. Commenter adds that if the Division decides to include such separate documents into the Schedule through these regulations, because such advisories are not themselves evidence-based, they cannot be considered.</p> <p>Based on the argument above, commenter recommends the following revisions to the proposed section:</p> <p><u>§ 9792.223. Presumption of Correctness, Burden of Proof and Hierarchy of Scientific Based Evidence</u></p> <p>(a) The <u>ACOEM Medical Practice Guidelines listed in this Article</u> are presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addressed in those guidelines for both acute and chronic medical conditions. The presumption is rebuttable and may be controverted by a</p>			

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	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.			
Section 9792.22(b)	Commenter states that subdivision (b) reiterates the requirements of Labor Code Section 4604.5 (e) as well as Subdivision (b) of Section 9792.21 and, in somewhat different form, Section 9792.8. The duplicative and varying restatements of the same directive fail to meet the non-duplication and consistency requirements for administrative rules. If this subdivision is retained, it should not be exempt from application of the hierarchy of scientific evidence, a hierarchy critical to determining the rigor applied in guideline development and the relative effectiveness of a given treatment.	Steven Suchil, Assistant Vice President American Insurance Association August 22, 2006	Disagree. The reiteration from the statute for all condition or injuries not addressed by the ACOEM Practice Guidelines, authorized treatment shall be in accordance with other scientifically and evidence-based, peer reviewed, medical treatment guidelines allows all of the requirements pursuant to the statute and under the MTUS to be in one set of regulations thus making it easier for the regulated public to comply with the requirements of the statute. Moreover, it is not necessary to apply the strength of evidence pursuant to Section 9792.22(c) to this section because the statute already provides for the level of scientific evidence necessary by requiring that the treatment provided pursuant to the guideline be scientifically and evidence-based, peer reviewed, and pursuant to a nationally recognized guideline.	None.
Section 9792.22(b)	Commenter states that the recommended changes below more directly reiterate the statutory standards, as the treatment guidelines apply to injuries and conditions, not treatment. Commenter opines that the changes in syntax clarify that medical treatment and	Brenda Ramirez, Claims and Medical Director Michael McClain, General Counsel & Vice President California Workers'	Disagree. The language contained in proposed Section 9792.22(b) clearly reflect and statutory standard as set forth in Labor Code section 4604.5(e).	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Cochrane Review uses four categories, though there is no reason why further categorization could not occur. However, the hierarchy of evidence noted directly below the above quote on page 501 is not the one adopted by the AHRQ, the Cochrane Review or the one used by ACOEM and in commenter's opinion it should not be the one adopted by the state of California. Commenter further states that for example, 1a of the AHRQ's hierarchy of evidence allows for a systematic review and meta-analysis of RCTs and the Cochrane Review is based on systematic reviews and meta-analyses. However, systematic reviews and meta-analyses are never considered "no research-based evidence" and levels A-C on page 501 only allow for RCTs. Commenter also states that in the "Summary of Recommendations and Evidence" throughout ACOEM, they did not rely on levels A-D noted on page 501. If they had, they would not have been able to address the systematic reviews and meta-analyses located in the "References" section throughout ACOEM.</p> <p>Commenter notes that the quality of a RCT is determined by several factors: sample size, conflict of interest, study design and statistical significance. Commenter questions how are practitioners or the WCAB going to figure out whether a RCT is high quality or low quality? Commenters recommend that DWC should consider changing the proposed regulations to the AHRQ's hierarchy of evidence (absent case reports, case series and expert committee reports or opinions and/or clinical experience).</p>			<p>strength of evidence rating methodology to evaluate scientifically based evidence to recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22((a)(2) has been amended to state that "evidence shall be given the highest weight in the order of the strength of evidence."</p>

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Section 9792.22(c)	<p>Commenters state that although the amount of medical research available is immense, it is generally recognized that not all medical cases have been studied. Any physician treating workers' compensation cases will likely encounter an illness or injury for which no study has been published nor panel of medical experts convened. Unfortunately the draft regulations fail to take this situation into account. Under these regulations, a physician who is treating an injury that has not been the subject of a published study or medical expert panel has no option to pursue his or her recommended course of treatment. This would leave an injured worker without adequate and appropriate medical treatment, in direct violation of statutory law and the California Constitution.</p> <p>Commenters recommend that in order to address this situation, the "hierarchies" of evidence proposed should give some weight to the judgment of a single, treating physician. Including this as the "bottom rung" in the hierarchy of evidence would allow the physician to follow his or her best clinical judgment in a situation in which no published empirical evidence exists. A broad consensus of participants in the March 15, 2005 advisory group meeting convened by the Division of Workers' Compensation expressed the necessity of allowing treating physicians reasonable discretion when no applicable guidelines exist. Commenters state that to achieve this purpose, commenters believe that the regulations should be amended to provide for the following alternative hierarchy:</p>	<p>Liberty R. Sanchez, Legislative Advocate Law Offices of Barry Broad, on behalf of: Amalgamated Transit Union, United Food and Commercial Workers' Union, UNITE/HERE!, International Federation of Professional and Technical Engineers, Local 21, and Strategic Committee of Public Employees (Laborers' International Union of North America) August 9, 2006</p> <p>Liberty R. Sanchez, Legislative Advocate, On behalf of California Teamsters Public Affairs Council August 9, 2006</p> <p>Angie Wei, Legislative Director, California Labor Federation, AFL-CIO August 21, 2006</p>	Disagree. See, Response No. 12—ACOEM's Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings.	Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM's updated strength of evidence rating methodology to evaluate scientifically based evidence to recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22((a)(2) has been amended to state that "evidence shall be given the highest weight in the order of the strength of evidence.

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Section 9792.22(c)	<p>“For conditions or injuries not addressed by 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 medical necessity of treatment to cure or relieve from the effects of an injury shall be determined by the specific medical needs of the employee and any of the following:</p> <p>(1)Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.</p> <p>(2)Nationally recognized professional standards</p> <p>(3)Expert opinion.</p> <p>(4)Generally accepted standards of medical practice.</p> <p>(5)Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.</p> <p>In instances where no empirical evidence exists to guide a physician’s treatment determination, the physician shall follow his best clinical judgment.”</p> <p>Commenter requests that the hierarchy of scientific based evidence include case reports and/or clinical examples in the determination of effectiveness. Commenter recognize that the Division of Workers’ Compensation is under pressure to establish strict standards for scientific based evidence However, commenter opines that the vast majority of</p>	<p>Joseph A. Zammuto, DO Chair, Osteopathic Physicians & Surgeons of California August 16, 2006</p>	<p>Disagree. See, Response No. 12—ACOEM’s Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings.</p>	<p>Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM’s updated strength of evidence rating methodology to evaluate scientifically based evidence to</p>

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Section 9792.22(c)	<p>viable medical treatment options would not qualify under the proposed A-C designation. Even the commonly identified early proponent of evidence-based medicine, D. L. Sackett, MD quoted on page 9 of the Initial Statement of Reasons (July 2006), recognized that physician experience and case study are viable forms of evidence-based medicine.</p> <p>Commenter understands that evidence will be “given the highest weight in the order of the hierarchy of evidence” when decisions are made about medical treatment and diagnostic services. Commenter opines that it is unclear what level of evidence will be required and it is unclear who will make the decision about the level of evidence needed so that treatment may be provided. Commenter requests that these provisions be clarified to explicitly state who will make these determinations and how disputes will be handled.</p>	<p>Charles Willmarth Director, State Affairs The American Occupational Therapy Association, Inc. August 18, 2006</p>	<p>Disagree. See, Response No. 12—ACOEM’s Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings.</p>	<p>recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22((a)(2) has been amended to state that “evidence shall be given the highest weight in the order of the strength of evidence.”</p> <p>Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM’s updated strength of evidence rating methodology to evaluate scientifically based evidence to recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled</p>

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Section 9792.22(c)	<p>Commenter states that he understands the importance of the hierarchy of evidence in decision-making about medical treatment and diagnostic services. Commenter further states that in rehabilitation services, randomized control studies related to Workers' Compensation injuries may not be available or conclusive. Commenter states that this is especially true with regard to complex injuries involving behavioral as well as physiological problems (both of which occupational therapists are uniquely qualified to evaluate and treat) and new techniques under study that may hold promise, but may not yet be in a stage of development that permits the completion of randomized control studies. Commenter argues that in such cases, it is unclear what level of evidence may be required and who will make the decision about the level of evidence needed so that treatment may be provided. Commenter requests that these provisions be clarified to state explicitly who will make these determinations and how disputes will be handled.</p>	<p>Richard Bookwalter, MS, OTR, President Occupational Therapy Association of California August 23, 2006</p>	<p>Disagree. See, Response No. 12—ACOEM's Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings. Moreover, under the proposed regulations, claims administrators do not have the final authority on which treatment guidelines are accepted as alternatives to the ACOEM Practice Guidelines. The claims administrators may utilize a guideline they believe is appropriate but if that approach is contested, the dispute is resolved pursuant to the procedures of Labor Code section 4062.</p>	<p>Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22((a)(2) has been amended to state that “evidence shall be given the highest weight in the order of the strength of evidence.</p> <p>Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM's updated strength of evidence rating methodology to evaluate scientifically based evidence to recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22((a)(2) has been amended to state that “evidence shall be given the highest weight in the order of the strength of</p>

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Section 9792.22(c)	<p>Commenters support the suggestion of the California Labor Federation to add a physician’s clinical judgment to the hierarchy of evidence to allow for medical treatment to proceed where no published empirical evidence exists to address the treatment. Commenters state that this is particularly important for those workers who have serious but rare complications or diseases and for whom experimental treatment is recommended. Commenters add that this is an option in the group health arena, supported by the Department of Managed Care’s Independent Medical Review program.</p>	<p>Peggy Sugarman, Consultant for VIAW Mark Hayes, President VotersInjuredatWork.org August 22, 2006 Written and Oral Comment</p>	<p>Disagree. See, Response No. 12—ACOEM’s Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings.</p>	<p>evidence.” Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM’s updated strength of evidence rating methodology to evaluate scientifically based evidence to recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22((a)(2) has been amended to state that “evidence shall be given the highest weight in the order of the strength of evidence.</p>
Section 9792.22(c)	<p>Commenter believes that an additional level of evidence should be included in the Hierarchy of Scientific Based Evidence. This level should be included pursuant to C.F.R. Title 21 – Food and Drugs. Commenter believes that U.S. federal government approval to market a medical device as safe and effective provides prima facie evidence that the device is</p>	<p>Robert R. Thauer, President Alliance for Physical Therapy, Rehabilitation & Medical Technology August 23, 2006</p>	<p>Disagree. See, Response No. 12—ACOEM’s Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings.</p>	<p>Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM’s updated strength of evidence rating methodology to evaluate scientifically based evidence to</p>

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	<p>appropriate when prescribed for the indications for use. Commenter opines that FDA approval for medical devices clearly meets the standard in SB 228 as nationally recognized, scientifically based, medical evidence and therefore should be highly ranked in the hierarchy of evidence described in §9792.22.</p> <p>In support of his commenter, commenter states that pursuant to Section 860.7 the U.S. Food and Drug Administration’s Center for Devices and Radiological Health reviews devices for safety and efficacy. Commenter notes that the reviewers are scientists with the appropriate scientific credentials to make determinations regarding the devices submitted to the panel for FDA approval. Commenter believes that the FDA protocol clearly demonstrates that the federal government evaluates the scientific evidence to make a determination of safety and efficacy for the benefit to health from use of the device for its intended use and conditions of use.</p> <p>Commenter attached the below addendum from the Code of Federal Regulations as reference:</p> <p>C.F.R. Title 21 – Food and Drugs Chapter I – Food and Drug Administration Department of Health and Human Services Subchapter H – Medical Devices Part 860 – Medical Device Classification Procedures Subpart A – General Sec. 860.7 Determination of safety and</p>			<p>recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22((a)(2) has been amended to state that “evidence shall be given the highest weight in the order of the strength of evidence.</p>

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Section 9792.22(c)	<p>effectiveness.</p> <p>Commenter states that if the ACOEM guidelines, which by its own admission were/are often consensus based are to be given presumption, then other consensus based or non-scientific evidence e.g. standard of care in the community, expert opinion, payor approval for treatment, etc. should have credence in the hierarchy of evidence.</p> <p>Commenter urges DWC to be cautious about accepting FDA approval of a medical device as being tantamount to a “guideline” that is evidence and scientifically based, nationally recognized, and peer-reviewed.</p> <p>Commenter states that the opinions expressed are his own and do not represent findings or opinions of the Commission on Health and Safety and Workers’ Compensation. Commenter states that his opinions are based primarily on the documents he is submitting attached to his comments. Commenter recommends that these issues should be carefully reviewed before DWC accepts as definitive either his opinions or the testimony of the witnesses at the hearing.</p> <p>Commenter states that it was asserted at the hearing that FDA approval of a medical device means that the device has been found to be safe and effective. Commenter states that this assertion perpetuates a misconception about the meaning of FDA approval. Commenter states that an article in the Journal of the American Board of Family Practice</p>	<p>D. Lachlan Taylor, WCALJ Commission on Health and Safety and Workers’ Compensation, August 23, 2006</p>	Agree.	None.

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Section 9792.22(c)	<p>explains the limitations of FDA approval. See Deyo, Richard A., <i>Gaps, Tensions, and Conflicts in the FDA Approval Process: Implications for Clinical Practice</i>, JABFP March-April 2004, Vol. 17, No. 2, pp 142-149.</p> <p>Commenter states that according to the article, “Most new devices are approved by demonstrating ‘substantial equivalence’ to a product that was marketed more than 25 years ago (before 1976).” That was when the FDA first acquired jurisdiction over medical devices. A guideline for treatment of injured workers should not authorize treatment with a device just because it is substantially equivalent to something that was on the market when such devices were unregulated. Commenter attaches a copy of the cited article as well as an example of the FDA approval of a device with some explanation of its safety but no evidence of its effectiveness.</p> <p>Commenter states that subdivision (c) establishes a hierarchy of evidence in three circumstances: (1) when the condition or injury is not addressed by ACOEM or any other evidence and scientifically based, nationally recognized medical treatment guidelines; (2) when treatment or services vary from either ACOEM or other nationally recognized guidelines and (3) when there is a conflict among the multiplicity of nationally recognized guidelines about recommended treatment or services.</p> <p>Commenter further states that while he</p>	<p>Steven Suchil, Assistant Vice President American Insurance Association August 22, 2006</p>	<p>Disagree. See, Response No. 12—ACOEM’s Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings. See also, Response No. 10—“Medical Treatment” Not Addressed in the Medical Treatment Utilization Schedule as Opposed to “Condition or Injury” not Addressed in the Medical Treatment Utilization Schedule.</p>	<p>Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM’s updated strength of evidence rating methodology to evaluate scientifically based evidence to recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate</p>

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Section 9792.22(c)	<p>supports the use of a hierarchy of evidence to resolve any disputes that may arise, the reference to conditions or injuries that are not addressed by either ACOEM or other nationally recognized guidelines is confusing. The possibility is not addressed in Labor Code Section 4604.5. If the Administrative Director is aware of specific injuries or conditions that are not addressed by either of the possibilities covered by the statute, the rule should at the very least provide examples.</p> <p>Commenter offers the following grammatical changes to Section 9792.22 (c)(1).</p> <p>Add the word “either” for clarification to the first part of section 9792.22 (c)(1): e.g., “<i>For conditions or injuries not addressed by <u>either</u> subdivisions (a) or (b) above;</i>”</p> <p>Commenter also suggests two alternatives for correction of the section as follows: “for medical treatment and diagnostic services at variance with <u>either</u> subdivisions (a) or (b) above” or as “for medical treatment and diagnostic services at variance with both subdivisions (a) <u>and</u> (b) above”?</p>	<p>Peggy Hoertz, Regulatory Compliance Analyst Fair Isaac Corporation August 23, 2006</p>	<p>Agree. The suggestion is appropriate and it clarifies the requirements of the section. Thus, Section 9792.22(c)(1) has been amended to insert the word “either” before the words “subdivisions (a) or (b).”</p>	<p>Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22((a)(2) has been amended to state that “evidence shall be given the highest weight in the order of the strength of evidence.”</p> <p>Section 9792.22(c)(1) has been amended to insert the word “either” before the words “subdivisions (a) or (b).” The section now states: “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</p>

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Section 9792.22(c)	<p>Commenter states that the hierarchy of evidence [Section 9792.22(c)(1)(A-C)] in the draft regulations appears to omit the fourth level (i.e., “Level D”) of the Agency for Healthcare Research and Quality’s (AHRQ) evidence grading scale. Commenter further states that this level includes case-based evidence without research-based evidence or randomized control trials. Commenter opines that its exclusion from the draft regulation seems to imply that such evidence will not be permitted any weight in determining the preponderance of evidence. Commenter opines that this is a stricter standard than ACOEM itself applies to medical evidence. Commenter argues that in considering refutations of the ACOEM guideline, the committee should be permitted to evaluate the entire evidence base, including clinical evidence, in making its recommendations. Commenter further argues that such a strict academic and mechanical approach to evidence negates any consideration of community-based standards of care. Commenter urges DWC to restore this fourth</p>	<p>Bill Mosca, Lac Executive Director California State Oriental Medical Association August 23, 2006</p>	<p>Disagree. See, Response No. 12—ACOEM’s Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings.</p>	<p>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.</p> <p>Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM’s updated strength of evidence rating methodology to evaluate scientifically based evidence to recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22((a)(2) has been amended to state that “evidence shall be given the highest weight in the order of the strength of</p>

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Section 9792.22(c)	<p>level of evidence to the draft regulations as doing so would acknowledge the infantile nature of evidence-based medicine, the lack of any evidence basis in many areas of the standard of care, and would permit consideration of other consensus-based evidence.</p> <p>Commenter references § 9792.22 and requests that Level D as set forth in the ACOEM Practice Guidelines at page 501 be restored to the hierarchy of evidence and amended. Commenter also requests that consensus statements receive recognition when no higher-level guideline is available. Commenter’s recommendation is as follows:</p> <p><i>“(D) Level D. No research-based evidence, no RCTs. Published consensus statements by nationally recognized specialties exist.”</i></p> <p>Commenter offers the following explanation for her suggestion. Commenter states that data documenting excessive utilization in the Workers’ Compensation program in California fueled the intense focus on reforming the program in 2003 and 2004. Commenter acknowledges the harm imposed by runaway utilization and appreciates the need to focus precious resources on care that offers the greatest value. That said, Commenter expresses significant concern that the unbridled embrace of “evidence based care” precedes the existence of research to establish evidence for the treatment of many conditions.</p>	<p>Nileen Verbeten, VP Center for Economic Services California Medical Association, August 22, 2006</p>	<p>Disagree. See, Response No. 12—ACOEM’s Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings. Moreover, the proposed regulations adopt the ACOEM Practice Guidelines by incorporation which has been determined to be evidence-based. The guidelines include treatment guidelines for foreign bodies to the eye (at Table 16-10, p. 446), and to treatment of fractures (e.g., p. 258 for fracture forearm, wrist, or hand).</p>	<p>evidence.”</p> <p>Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM’s updated strength of evidence rating methodology to evaluate scientifically based evidence to recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22((a)(2) has been amended to state that “evidence shall be given the highest weight in the order of the strength of evidence.”</p>

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	<p>Commenter states that taken to an absurd level, there are no clinical trials that evidence a superior result of removal of a foreign body in the eye to leaving it there or the repair of a broken bone contrasted to inaction, yet there is no dispute against the preference to remove the foreign body or fix the broken bone. Commenter further states that the very fact that there are not resounding complaints about the ability to receive treatment for emergency conditions suggests there is ample appreciation that immediate intervention is important whether there have been randomized studies or not. Commenter adds that in fact, the belief that immediate attention to these things is so pervasive in our society that law requires this attention.</p> <p>Commenter indicates that perhaps, as a society, we so quickly accept these interventions without a thought to the contrary because we can readily identify with the suffering and need for immediate relief associated with these conditions. Of course we should respond. To do otherwise is unconscionable.</p> <p>Commenter states that CMA appreciates the increasing call for reducing variation and the goal of improving outcomes. Commenter adds that CMA has endorsed the ACOEM guidelines in previous communication to the DWC and continues to support them. Commenter also states that CMA has advocated for the DWC's adoption of other nationally recognized, peer reviewed, and scientifically based guidelines and was</p>			

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>disappointed with the refusal of the Administrative Director (“AD”) to adopt these guidelines as supplemental to ACOEM.</p> <p>Commenter states that the Initial Statement of Reasons accompanying the proposed regulations clearly spell out the concerns of the DWC regarding the inconsistency created by multiple guidelines. Commenter appreciates the desire of the AD to avoid legal confusion about what standard to apply. Commenter also notes the poor evaluation rendered by the RAND study to the sufficiency of all the available guidelines, including ACOEM and offers the DWC’s own discussion in the Initial Statement of Reasons as evidence for the limitations in the science of guideline development as we know it today.</p> <p>Commenter restates the Hierarchy of Evidence as recommended by ACOEM at page 501, and states that ACOEM is clear in its conclusions statement which discuss the use of guidelines. Commenter quotes the ACOEM Conclusions statement in the Appendix to their guidelines discussing Evidence-Based Medicine below [at p. 505]:</p> <p><i>“Despite an overall trend toward the use of “evidence-based” practice parameters, it is difficult to achieve this goal when evaluating treatments, tests, and causes of musculoskeletal and other disorders that are defined, at least in part, subjectively. While there are clear guidelines for the identification of high-quality studies, there is a dearth of such studies available for review.</i></p>			

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	<p><i>“Of equal importance in reaching decisions regarding practice parameters is comparison of a new test or treatment (with regard to both efficacy and cost) to those that are already available. Regardless of whether or data support a given intervention, a guideline generally should not be adopted if it does not provide clinical benefit above and beyond that provided from those currently in existence. This is particularly so when the new intervention increases direct or indirect costs.</i></p> <p><i>“Hence, though we may endeavor to make “evidence-based medicine” the source of our conclusions, the available evidence often is not of the highest quality and the applicability of the evidence is not necessarily clear. Under such circumstances the use of lower quality scientific evidence is necessary. Guideline recommendations then are based on the analysis of less than ideal data, an inventory of current practices, and a discussion of both that will hopefully produce a consensus conclusion regarding the ‘best clinical practices.’” [Emphasis added by commenter.]</i></p> <p>Commenter states that by eliminating Level D, the DWC is ruling out consideration of physicians’ knowledge, expert consensus, best clinical practices or the legally defined standard of care. Commenter opines that this is unacceptable. Commenter indicates that while CMA appreciates the imperative of pursuing the appropriate use of guidelines, CMA holds that published consensus statements by nationally recognized</p>			

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Section 9792.22(c)	<p>specialties represent a national consensus of experts that should also be considered. Commenter believes this is consistent with the law and in the best interest of injured workers.</p> <p>Commenter submits Attachment B to exemplify the danger of an overzealous reliance on randomized clinical trials rather than the acceptance of strong consensus where it exists. http://fbmj.bmjournals.com/cgi/content/full/327/742911459</p> <p>Commenter makes reference to the hierarchy of evidence set forth in section 9792.22(c), and the evidence required to refute ACOEM in situations where a physician believes an alternative treatment for a low back problem is required. Commenter states that this has been an area of consistent concern as commenter has heard complaints about ACOEM from many California spinal surgeons over the past two years. Commenter states that the spinal surgeons repeatedly state that ACOEM does not sufficiently address many low back conditions and have noted that when they request approval of a procedure they have an extremely difficult time getting approval, even with the submission of valid clinical evidence.</p> <p>Commenter states that in section 9792.22, the proposed language includes a hierarchy of evidence to determine the “effectiveness of different medical treatment and diagnostic services” to refute ACOEM for variance</p>	<p>Dena Scearce, JD Director State Government Relations Medtronic August 23, 2006</p>	<p>Disagree. See, Response No. 12—ACOEM’s Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings.</p>	<p>Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM’s updated strength of evidence rating methodology to evaluate scientifically based evidence to recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22(a)(2) has been amended to state that “evidence shall be given</p>

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	<p>treatments and conditions. Commenter indicates that all of the levels of evidence require the use of randomized controlled studies (RCTs). Commenter states that she believes it would be more accurate to require the hierarchy of evidence to be consistent with the hierarchy of evidence used to establish the specific treatments recommended in ACOEM for a given chapter. Commenter states that there are other levels of studies that are recognized as providing valid evidence of efficacy and that illustrate appropriate clinical outcomes, other than RCTs. Commenter offers that looking at the references listed in Chapter 12, "Low Back Complaints", of the most recent version of ACOEM, there is only one study referenced that used RCTs. Commenter is concerned that when a spinal surgeon attempts to use alternative medical treatment guidelines to refute ACOEM they will be denied by the carrier due to not meeting the threshold set in the hierarchy listed in the proposed regulations. Commenter states that both the North American Spine Society (NASS) and the American Academy of Orthopaedic Surgeons (AAOS) have adopted levels of evidence for primary research questions that allow for case controlled studies and case studies to be used. Commenter suggests that an additional hierarchy level of studies, that does not require the use of RCTs, be allowed for surgeons requesting care outside the scope, or not covered by ACOEM, be included. Commenter argues that this hierarchy level would allow a provider to submit medical treatment guidelines with additional clinical</p>			<p>the highest weight in the order of the strength of evidence."</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.22(c)(1)(B)	<p>studies and information to refute ACOEM.</p> <p>Commenter recommends that 9792.22(c)(1)(B) be revised to reflect a required word usage revision as follows:</p> <p><i>Level B. Moderated Moderate research-based evidence provided by generally consistent findings in one high-quality RCT and one or more low quality RCTs, or generally consistent findings in multiple low quality RCTs.</i></p>	<p>Brenda Ramirez, Claims and Medical Director Michael McClain, General Counsel & Vice President California Workers' Compensation Institute August 23, 2006</p>	<p>Disagree. See, Response No. 12—ACOEM's Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings.</p>	<p>Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM's updated strength of evidence rating methodology to evaluate scientifically based evidence to recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22((a)(2) has been amended to state that “evidence shall be given the highest weight in the order of the strength of evidence.”</p>
Section 9792.22(c)	<p>Commenter recommends that Section 9792.22(c)(1) be amended as follows: For conditions or injuries not addressed by subdivisions (a) or (b) above; 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</p>	<p>Stephen J. Cattolica AdvoCal Legislative and Administrative Agency Advocacy on behalf of California Society of Industrial Medicine and Surgery, U.S. Works,</p>	<p>Disagree. See, Response No. 12—ACOEM's Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings.</p>	<p>Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM's updated strength of evidence rating methodology to evaluate scientifically based evidence to</p>

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Section 9792.22(c)	<p>with another treatment guideline also covered under subdivision (b), the following hierarchy of scientifically based evidence published in peer-reviewed, nationally recognized journals shall apply to determine the effectiveness of different medical treatment and diagnostic services:</p> <p>Commenter states that the initial reference in the first sentence of (C) (1) would appear no longer necessary because the instructions provided in (a) and (b) no longer only apply to the ACOEM <i>Guidelines</i>, but to all guidelines within the Schedule.</p> <p>Commenter suggests that the next two paragraphs be added to the hierarchy of evidence set forth in Section 9792.22(c):</p> <p><u>(d) The presumption of correctness does not exist unless a specific Medical Treatment Guideline is directly applicable to the injured worker’s injury and condition. In this situation, the claims administrator shall authorize treatment if such treatment is in accordance with scientifically and evidence-based medical treatment guidelines that are generally recognized by the national medical community, in accordance with subdivisions (b) and (c) of section 9792.223.</u></p>	<p>and the California Society of Physical Medicine and Rehabilitation</p> <p>Stephen J. Cattolica AdvoCal Legislative and Administrative Agency Advocacy on behalf of California Society of Industrial Medicine and Surgery, U.S. Works, and the California Society of Physical Medicine and Rehabilitation</p>	<p>Disagree. See, Response No. 12—ACOEM’s Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings. See also, Response No. 10—“Medical Treatment” Not Addressed in the Medical Treatment Utilization Schedule as Opposed to “Condition or Injury” not Addressed in the Medical Treatment Utilization Schedule. Moreover, see Response No. 11—Chronic Conditions, wherein the case of <i>Sierra Pacific Industries v. WCAB (Chatham)</i> (2006) 140 Cal. App. 4th 1498; 45 Cal. Rptr. 3d 550; 71 Cal. Comp. Cas 714; Review denied 2006 Cal.</p>	<p>recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22(a)(2) has been amended to state that “evidence shall be given the highest weight in the order of the strength of evidence.”</p> <p>Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM’s updated strength of evidence rating methodology to evaluate scientifically based evidence to recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets</p>

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	<p><u>(e) The presumption of correctness does not exist for any Medical Treatment Guideline or specific recommended clinical measure that is based on evidence other than the three levels of evidence defined in this Section. In this situation, the claims administrator shall authorize treatment if such treatment is in accordance with medical treatment guidelines or literature that is generally recognized by the national medical community.</u></p> <p>Commenter explains that the purpose of these two suggested new paragraphs is to address the too-common situation where the claims administrator applies a treatment guideline to a condition to which the guideline is not applicable. Commenter opines that this language intends to assure that the timeliest dialogue takes place to consider both the specific Medical Treatment Guideline, clinical measure and any appropriate alternatives on a level playing field.</p> <p>Commenter further quotes from a letter to State Senator, Richard Alarcon, Chairman of the Senate Labor and Industrial Relations Committee, dated June 13, 2004, concerning the use and misuse of the Guidelines, Barry S. Eisenberg, Executive Director of ACOEM:</p> <p><i>“We (ACOEM) have delivered a consistent message at ACOEM-sponsored training sessions in California, and our intent is to reinforce these concepts at future training sessions.”</i></p> <p><i>“We have emphasized two key points:</i></p>		<p>LEXIS 12464 (Cal., Oct. 11, 2006) is addressed.</p>	<p>forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22((a)(2) has been amended to state that “evidence shall be given the highest weight in the order of the strength of evidence.”</p>

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	<p><i>1) Our guidelines are recommendations, and are not intended as mandates; and 2) Most cost savings will come from workers getting the care that is most likely to help them, as close as possible in time to their first need for that care, versus applying the guidelines as mandates.”</i></p> <p>Commenter further states that Mr. Eisenberg goes on to quote: <i>“We believe it is vital for those who use our guidelines to understand that the guidelines are not intended to serve as mandates or decrees...that when a physician’s request does not meet guidelines, it does not automatically mean that the request is inappropriate.”</i></p> <p>Commenter states that a corollary to Mr. Eisenberg’s last statement is also true. Notwithstanding <u>Chatham</u>, which is under appeal, when an ongoing course of treatment (such as for a chronic condition) is compared to the Guidelines and found not to meet them, it does not automatically mean the treatment is inappropriate.</p> <p>Commenter states that an expeditious adoption of the ACOEM Guidelines alone is problematic at best. Commenter applauds the formation of an adequately staffed Advisory Committee, but believes that this group will take months to be effective. Commenter opines that the Division can quickly remedy a great deal of problematic issues by denying the presumption of correctness to consensus guidelines applied prospectively or</p>			

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Section 9792.22(c)	<p>retroactively or applied to conditions, acute or chronic, to which they were not originally intended. Commenter suggests that in so doing, the Division will enable a timely dialogue between professionals in order to determine the best treatment available.</p> <p>Commenter recommends that meta-analysis of randomized controlled studies be included as the highest level of evidence in the proposed hierarchy of evidence. Commenter states that the proposed regulations have randomized controlled studies as the highest level of evidence but that meta-analysis of randomized controlled studies constitute the highest level of evidence and should be specifically listed first under "Level A." Commenter states that this is an important point because some meta-analyses of random controlled studies of traditional allopathic interventions have found medical procedures to be unsafe when compared to chiropractic procedures. Commenter indicates that one would not necessarily come to the same conclusion looking at individual studies. Commenter adds that this is important information that is necessary when determining which procedures are effective and should be provided to the injured worker.</p>	<p>John Bueler, Jr., DC, President California Chiropractic Association August 23, 2006</p>	<p>See, Response No. 12—ACOEM's Criteria Used to Rate Randomized Controlled Trials and Strength of Evidence Ratings.</p>	<p>Section 9792.22(c)(1) has been amended to adopt and incorporate ACOEM's updated strength of evidence rating methodology to evaluate scientifically based evidence to recommend specific medical treatment or diagnostic services. Section 9792.22(c)(1)(A) sets forth Table A—Criteria Used to Rate Randomized Controlled Trials and Section 9792.22(c)(1)(B) sets forth Table B—Strength of Evidence Ratings. Moreover, Section 9792.22((a)(2) has been amended to state that "evidence shall be given the highest weight in the order of the strength of evidence."</p>

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Section 9792.23	Commenter states that family physicians should have a permanent seat on the Advisory Committee because there are more family physicians treating injured workers than any other specialty.	Peter Swann Concentra July 18, 2006	Agree. See Response No. 13— Composition of Medical Evidence Evaluation Advisory Committee	Section 9792.23(a)(2)(J) has been added to the proposed regulations to require that the medical evidence evaluation advisory committee shall have a representative from the family physician field.
Section 9792.23	Commenter opines strongly that the medical evidence advisory committee should include an osteopathic physician. Commenter states that pages 48-52 of the Initial Statement of Reasons (July 2006) for the draft regulations specify the reasons that representatives from branches of medicine covering physical medicine should be included on the medical evidence advisory committee. In many cases, the reason for designating a specific type of practitioner relates to inadequate/ incomplete information in the ACOEM guidelines or inconsistencies between the ACOEM guidelines and specialty guidelines. Osteopathic manipulative treatment is only peripherally addressed in the current ACOEM guidelines. In addition, osteopathic physicians are uniquely trained and qualified to consider physical medicine treatment options as part of total patient care. Commenter concludes that it is particularly important that an osteopathic physician is designated as a member of the medical evidence advisory committee. Great value may be derived by including a physician with this broad scope of training and experience.	Joseph A. Zammuto, DO Chair, Osteopathic Physicians & Surgeons of California August 16, 2006	Agree. See Response No. 13— Composition of Medical Evidence Evaluation Advisory Committee	Section 9792.23(a)(2) has been amended to require that the medical evidence evaluation advisory committee have a representative from the osteopathy field.

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Section 9792.23	Commenter commends the Division of Workers' Compensation for establishing a medical evidence evaluation advisory committee in §9792.23 to provide recommendations to the Administrative Director on matters concerning the medical treatment utilization schedule.	John Hernandez, PhD Advanced Bionics Corp. August 21, 2006	Agree.	None.
Section 9792.23	Commenter supports the development of the Medical Evidence Evaluation Advisory Committee and expects that the process will be transparent and include all stakeholders with the opportunity for input and interface. As noted by RAND, California needs to develop its own treatment guidelines that promote effective and comprehensive care, and some flexibility for the physician to practice according to community standards of care for injured workers.	Robert R. Thauer, President Alliance for Physical Therapy, Rehabilitation & Medical Technology August 23, 2006	Agree. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee. Moreover, any changes to the MTUS resulting from input from the medical evidence evaluation advisory committee will go through formal rule-making which will afford the public notice and opportunity to comment on the proposed changes.	None.
Section 9792.23	<p>Commenter states that his organization is pleased with the Division's proposal to convene an advisory committee charged with recommending possible enhancements to the guidelines. Commenter agrees that the issues involved require expert handling, and believes that the committee, which will include representatives from across the provider committee, is an appropriate venue for deliberating on medical research, hierarchies of evidence, clinical efficacy, and data on treatment outcomes.</p> <p>Commenter suggests that the advisory committee include two additional dedicated positions, either through expansion of the committee or through assignment of the</p>	Steven C. Schumann, M.D., Western Occupational & Environmental Medical Association, Chair, Legislative Affairs Committee August 23, 2006	Agree in part. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee. We disagree with the comment that the committee should have an expert on clinical research as the function of reviewing evidence will be done prior to the committee meetings. DWC will be either adding staff or subcontracting with necessary resources to address this need.	Section 9792.23(a)(2)(K) has been added to the proposed regulations to require that the medical evidence evaluation advisory committee have a representative from the family physician field.

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Section 9792.23	<p>unspecified seats: 1) an expert on clinical research, of no particular affiliation, who could help guide the committee through its deliberations on standards of evidence and the relative scientific integrity of various guideline sets; and 2) a family physician. Commenter states that many family physicians concentrate on treating workplace illness and injury. Many more of them devote a small but significant portion of their practices to Workers' Compensation cases, often treating the same patients they see for general healthcare needs. Commenter further states that family physicians serve as Primary Treating Physicians for a substantial number of California's Workers' Compensation cases and their perspective would be invaluable to the committee.</p> <p>Commenter states that CSOMA has concerns about the operation of the Medical Evidence Evaluation Advisory Committee (MEEAC) that would be created by this regulation. Commenter further states that chief among the concerns is the apparent absence of any mechanism for submitting rebuttals of the ACOEM guideline for review by the MEEAC. Commenter states that in refuting the presumptive correctness of the ACOEM guideline, the burden of proof for establishing appropriateness of care lies with injured workers and their care providers, not with the DWC Medical Director. Commenter opines that there must be some mechanism for initiating rebuttals by entities other than the DWC itself.</p>	<p>Bill Mosca, Lac Executive Director California State Oriental Medical Association August 23, 2006</p>	<p>Disagree. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee. See also Response No. 9—Incorporation of ACOEM into the Medical Treatment Utilization Schedule. Also, the regulations are clear that the Medical Evidence Evaluation Advisory Committee will be created for continuous study of the medical treatment utilization schedule and to provide advice to the Administrative Director from experts in various fields for revisions and/or supplementation of the schedule as necessary in order to comply with the requirements of Labor Code section 5307.27. Moreover, the regulations</p>	<p>None.</p>

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	<p>Commenter further states that his association also has concerns with the timeliness of the MEEAC. Commenter argues that a medical treatment utilization schedule should have been in place, per a statutorily mandated timeline, nearly two years ago. Only now is the schedule being adopted, and this schedule is the same unmodified, non-comprehensive interim schedule imposed by the legislature more than two years ago. Given the lack of action to date, commenter argues he has profound concerns that this regulatory mechanism for rebutting the ACOEM guideline could amount to an indefinite de facto suspension of access to acupuncture within the workers' compensation system. Commenter urges the DWC to impose some assurance of timely consideration through this regulation.</p> <p>Commenter further expresses confusion regarding the DWC's plan to manage revisions, updates, and supplementations made to the ACOEM guideline by the DWC Administrative Director (AD) as ACOEM issues revised editions of its guideline. Commenter questions whether the AD's piecemeal modifications to the schedule become presumptively correct until successfully rebutted? Commenter also questions whether these piecemeal modifications would be sustained following revisions to the guideline by ACOEM, or will any new edition of the ACOEM guideline become the new baseline schedule where it starts with a "clean slate?" Commenter believes that this area requires additional</p>		<p>are clear that the medical treatment utilization schedule is presumed to be correct and therefore the presumption will attach to any supplementation of the MTUS. Furthermore, any revisions to the schedule will be processed through formal rulemaking which will provide the public with notice and an opportunity to comment on the proposed changes. Regarding any future revisions of ACOEM, see Response No. 1- Adoption by incorporation by reference to an existing document and any future updates. Thus, any revisions to the MTUS either by way of the committee or by way of ACOEM updates will go through formal rulemaking. It is important to note that the MTUS will control the provision of medical treatment until it is changed by way of formal rulemaking.</p>	

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Section 9792.23	<p>detail in the proposed regulations.</p> <p>Commenter states that the proposed regulations to create a medical evidence evaluation advisory committee to advise the Administrative Director on matters concerning the medical treatment utilization schedule is a resourceful way of allowing practitioners to provide reasonably required medical treatment to injured workers.</p>	<p>Tameka White, Executive Associate for Practice & Payment California Physical Therapy Association August 18, 2006</p>	<p>Agree.</p>	<p>None.</p>
Section 9792.23	<p>Commenter strongly supports DWC forming a Medical Evidence Evaluation Advisory Committee (MEEAC) creating a body of experts to assist the Division in refining and updating the ACOEM Practice Guidelines. Commenter states that the Advisory Committee will be able to make recommendations on procedures not covered by the Guidelines, or to provide input on problem areas that are identified. Commenter agrees that, due to the number of musculoskeletal injuries, that an orthopaedic surgeon should be appointed to this Committee.</p> <p>Commenter proposes a restructuring of the Committee to pattern it after the Medicare California Carrier Advisory Committee (CCAC) formed by the Centers for Medicare and Medicaid Services to allow carrier interaction with providers within their respective states and to assist them in developing local medical policies. Commenter opines that their structure would work well for DWC.</p>	<p>Peter Mandell, Chair Workers' Compensation Committee California Orthopedic Association August 15, 2006</p>	<p>Agree in part. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee. We have reviewed the Medicare Carrier Advisory Committee (CCAC) and have determined that we cannot structure our committee entirely as the CCAC has been structured. After consultation with their medical director, we have decided to increase the number of specialists in the committee. As previously stated, the medical evidence evaluation advisory committee will be addressing the requirements of the statute to develop a MTUS that addresses “the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers’ compensation cases” as required by the statute, and not billing procedures. We agree that the committee should include members from allied health</p>	<p>Section 9792.23(a)(2) has been amended to add eight more members to the medical evidence evaluation advisory committee.</p>

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	<p>Commenter sets forth the CCAC structure as follows:</p> <p><i>Each state medical specialty organization appoints one representative to attend the CCAC meeting. For the MEEAC, the Division could limit the representatives to only those medical specialties involved in treating injured workers, but may want to add slots for allied health professionals, involved in treating injured workers, who may not be represented on the Medicare CCAC. We would also recommend a slot for a medical director from one of the Workers' Compensation carriers. The California Medical Association also appoints one representative.</i></p> <p>Commenter states that any party can raise an issue. Commenter further states if Bruce Quinn, M.D., the Medical Director for National Heritage Insurance, the Medicare fiscal intermediary for California, believes the issue has merit and has not already been addressed in some other CMS policy, he drafts a policy for consideration by CCAC members. Commenter adds that prior to the CCAC review, the draft policy is sent to the medical specialty representatives who are directly affected by the policy and they provide input and recommended changes. Then, once those directly affected medical specialists have reached agreement on the policy or should they reach an impasse in their discussions, Dr. Quinn then presents the draft policy to the entire CCAC for their input. Commenter</p>		<p>professionals and have thus included an acupuncturist, a physical therapist, and an occupational therapist. Moreover, the agency is the entity responsible for developing the regulations with the input of the community. The agency's goal is to keep the advisory committee manageable and effective. The committee will advise the Administrative Director, but ultimately the agency, as represented by its Administrative Director, is responsible for the final decisions regarding the MTUS, not the members of the committee. DWC does expect that the committee will function in a very similar way the CCAC in that the DWC Medical Director will submit a draft of treatment recommendations to the committee for their review.</p>	

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.23	<p>states that the CCAC members ultimately vote to adopt or reject the policy. Commenter indicates that if adopted, a Local Coverage Determination (LCD) is created which gives providers and carrier representatives direction on clinical indications as to when the procedure is medically indicated, allowable ICD-9 and CPT codes, and any other special billing considerations. LCDs adopted by the CCAC can be found at the following URL: http://www.medicarenhic.com/cal..prov/policies.shtml</p> <p>Commenter states that this CCAC structure has been in place for a number of years and the LCDs they have developed have been very helpful in streamlining the billing process. Commenter opines that for Workers' Compensation treatment, the LCDs could also help clarify when medical services are medically indicated and UR decisions. Commenter urges the Division to consider adopting an advisory committee patterned after the CCAC. Commenter requests that the Division ask their advisory committee to give a high priority to refining chapters within the ACOEM guidelines dealing with treatments for shoulder, knee, hand, back and neck injuries. Commenter concludes that these are the areas that his organization's members have particularly noted need some refinement.</p> <p>Commenters support the creation of a Medical Evidence Advisory Committee to evaluate other guidelines and new treatments. Commenter suggests that the Medical Director be required to select from a list of physicians</p>	<p>Peggy Sugarman, Consultant for VIAW Mark Hayes, President VotersInjuredatWork.org August 22, 2006</p>	<p>Agree in part. We agree that the members of the committee who are medical doctors or doctors of osteopathy should be board certified by an American Board of Medical</p>	<p>Section 9792.23(2) has been amended to require that the members of the committee who are medical doctors or</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
<p>Section 9792.23</p> <p>Section 9792.23(a)(2)</p>	<p>who are board-certified providers and members in their specialty societies, as appropriate, and who actively practice in those fields. Commenter states that it makes sense to have the committee begin work immediately on the first of priority items identified by the Rand report and listed earlier in this response.</p> <p>Commenter references Section 9792.23-Medical Evidence Evaluation Advisory Committee, indicating that by definition; the Advisory Committee’s recommendations will be based on a consensus. Commenter urges the Division to re-define the role and potential effectiveness of this body to recommend needed revisions to the Schedule. The welfare of California’s injured workers provided by the California Constitution suffers when an administrative body cannot effectively implement change.</p> <p>Commenter states that the function of the expert panel will be to advise the administrative director regarding the augmentation of the medical treatment utilization schedule with additional guidelines. Commenter opines that expertise in developing evidence-based treatment guidelines would be very beneficial for the</p>	<p>Written and Oral Comment</p> <p>Stephen J. Cattolica AdvoCal Legislative and Administrative Agency Advocacy on behalf of California Society of Industrial Medicine and Surgery, U.S. Works, and the California Society of Physical Medicine and Rehabilitation</p> <p>Brenda Ramirez, Claims and Medical Director Michael McClain, General Counsel & Vice President California Workers’ Compensation Institute August 23, 2006</p>	<p>Specialties (ABMS). We disagree that they should be members of a specialty society because this does not assure better qualifications for membership. Moreover, we disagree with the requirement that the members of the committee actively practice in those fields because this might exclude otherwise qualified members such as researchers.</p> <p>Disagree. The committee will be structured to have a researcher do a systematic evidence-based search on the subject being evaluated. In some cases, a previously written evidence-based guideline or a review such as a Cochrane review may be submitted to the committee for review. Thus, the basis of any recommendation to the Administrative Director will be evidence-based.</p> <p>Disagree. DWC will consider expertise in developing treatment guidelines when forming the committee. However, DWC does not want to make this a requirement because otherwise exceptionally qualified individuals may be excluded from participating on the</p>	<p>doctors of osteopathy should be board certified by an American Board of Medical Specialties (ABMS), or American Osteopathic Association approved specialty boards (AOA) respectively.</p> <p>None.</p> <p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.23(a)(2)	<p>participants. Commenter recommends that Section 9792.23(a)(2) be amended as follows:</p> <p><i>The members of the medical evidence evaluation advisory committee shall be appointed by the Medical Director, or his or her designee, and shall consist of 10 members of the medical community with <u>experience in developing evidence-based treatment guidelines</u>, representing the following specialty fields:</i></p> <p>Commenter recommends that Section 9792.23 (a)(2) be amended to add “one member shall be from the neurology field.”</p>	<p>Tina Coakley, Legislative & Regulatory Analyst The Boeing Company August 23, 2006</p>	<p>committee.</p> <p>Agree in part. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee.</p>	<p>Section 9792.23(a)(2)(K) has been added to the proposed regulations to require that the medical evidence evaluation advisory committee have a representative from the neurology field.</p>
Section 9792.23(a)(2)	<p>Commenter states that CMA has participated in the quarterly Medicare Carrier Advisory Committee (CAC) for many years and finds it a useful means of exchanging information and advice between the Medicare program and providers. Commenter further states that although the Advisory Committee proposed is not identical in purpose to the CAC, there is sufficient similarity in purpose that CMA urges the DWC to converse with Medicare and learn from this structure. Commenter indicates that the description and purpose of the CAC, as described in the Medicare Carriers Manual is provided as an attachment to these comments. Commenter states that while some of the provisions may not be</p>	<p>Nileen Verbeten, VP Center for Economic Services California Medical Association, August 22, 2006</p>	<p>Agree in part. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee. We have reviewed the Medicare Carrier Advisory Committee (CCAC) and have determined that we cannot structure our committee entirely as the CCAC has been structured. After consultation with their medical director, we have decided to increase the number of specialists in the committee. As previously stated, the medical evidence evaluation advisory committee will be addressing the requirements of the statute to develop</p>	<p>Section 9792.23(a)(2)(L) has been added to the proposed regulations to require that the medical evidence evaluation advisory committee have a representative from the neurology field.</p> <p>Section 9792.23(a)(2)(J) has been added to the proposed regulations to require that the medical evidence evaluation advisory committee have a representative from the</p>

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	<p>relevant to this work, the experience gained from this process could inform the DWC of the structure and process it should consider.</p> <p>Commenter recommends that section 9792.23(a)(2) be amended as follows:</p> <p>Section 9792.23(a)(2)(H) to state “one member shall be from the field or neurology or neurosurgery;”</p> <p>New Section 9792.23(a)(2)(I) to state “one member shall be from the state medical association;”</p> <p>New Section 9792.23(a)(2)(J) to state “one member shall be a physician from the medical research community with experience in the evaluation of the strength of medical literature in terms of the hierarchy as set forth in this regulation;”</p> <p>New Section 9792.23(a)(2)(K) (formerly (H)) to state “two (as opposed to three as stated in draft) members shall be appointed at the discretion of the Medical Director or his or her designee.”</p>		<p>a MTUS that addresses “the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers’ compensation cases” as required by the statute, and not billing procedures. We agree that the committee should include members from allied health professionals and have thus included an acupuncturist, a physical therapist, and an occupational therapist. Moreover, the agency is the entity responsible for developing the regulations with the input of the community. The agency’s goal is to maintain the advisory committee as manageable and effective. The committee will advise the Administrative Director, but ultimately the agency and its Administrative Director is responsible for the final decisions regarding the MTUS, not the members of the committee. DWC does expect that the committee will function in a very similar way the CCAC in that the DWC Medical Director will submit a draft of treatment recommendations to the committee for their review. Commenter requests that “one member shall be from the state medical association, we disagree. DWC wants to designate the specialty of the physician rather than association membership. We disagree</p>	<p>neurosurgery field.</p> <p>Section 9792.23(a)(2)(P) (formerly proposed section 9792.23(a)(2)(H)) has been amended to reduce the number from 3 to 2.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.23(a)(2)	ACIC recommends that at least one member of the Advisory Committee be a representative of one of the federal Agency For Healthcare Research and Quality's (AHRQ) designated evidence-based practice centers. Commenter also requests that the committee members should be the most qualified professionals available, whether those professionals are in California or reside outside California. The regulations should make it clear that location or residence in California is not a criterion for membership on the Advisory Committee.	Samuel Sorich, President Association of California Insurance Companies August 23, 2006	with the comment that the committee should have an expert on clinical research as the function of reviewing evidence will be done prior to the committee meetings. DWC will be either adding staff or subcontracting with necessary resources to address this need. Agree in part. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee. Further, we agree that residence in California is not necessary for participation in the committee but we do not find it necessary to specify this in the regulations. Disagree that specific requirement regarding AHRQ be put into the regulations. Experience such as AHRQ membership will certainly be considered during the selection of the members of the committee.	None.
Section 9792.23(a)(2)	Commenter states that she is encouraged to see the proposed regulations regarding the development of the Medical Evidence Evaluation Advisory Committee and believe the Committee will serve as a vital resource to the Division. Commenter believes that it would be helpful to include an orthopedic surgeon that specializes in spinal procedures. Commenter states that spinal procedures have specific requirements that differentiate them from other orthopedic procedures such as	Dena Scearce, JD Director State Government Relations Medtronic August 23, 2006	Agree in part. See Response No. 14—Composition of Medical Evidence Evaluation Advisory Committee. We agree that having a member in the committee with spinal surgery expertise is important when dealing with spinal surgery conditions. Therefore, a spinal surgeon will be added to the committee as a subject matter expert when reviewing topics related to the	Section 9792.23(a)(2)(J) has been added to the proposed regulations to require that the medical evidence evaluation advisory committee have a representative from the neurosurgery field.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.23(a)(2)	<p>shoulder, knee, and elbow complaints. Commenter opines that this point is highlighted by the fact that ACOEM has a specific chapter addressing only low back complaints. Commenter believes the unique needs of spinal surgery patients warrant the inclusion of a spinal surgeon on the Committee. In the alternative, commenter suggests that the Medical Director appoint a spinal surgeon to one of the non-specialty specific spots on a permanent basis, who will round out the 10 person Medical Evidence Evaluation Committee. Commenter states that her organization would be more than happy to work with the Division to nominate two or three spinal surgeons in California that would act as experts for the committee.</p> <p>Commenter states that section 9792.23 establishes a Medical Evidence Evaluation Advisory Committee consisting of 10 members representing specific specialty fields of medicine, plus an additional three members as subject matter experts for a given topic. With regard to section 9792.23(a)(2), commenter suggests that a neurologist be added to the standing committee because of the prominence of this specialty in workers' compensation cases. Commenter also suggests that the committee should include two orthopedists, a spine specialist certified by the American Board of Spine Surgery and a hand/upper extremity specialist.</p>	<p>David Rockwell, President California Applicants' Attorneys Association August 23, 2006</p>	<p>spine. Furthermore, DWC will attempt to fill the neurosurgeon position with someone with spinal surgery expertise.</p> <p>Agree in part. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee. Disagree with commenter's request that the committee include two orthopedists, a spine specialist certified by the American Board of Spine Surgery and a hand/upper extremity specialist. Affiliation with the American Board of Spine Surgery is not necessary to meet the core requirements of the committee. We agree that having a member in the committee with spinal surgery expertise is important when dealing with spinal surgery conditions. Therefore, a spinal surgeon will be added to the committee as a subject</p>	<p>Section 9792.23(a)(2)(L) has been added to the proposed regulations to require that the medical evidence evaluation advisory committee have a representative from the neurology field.</p>

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9792.23(a)(2)	<p>Commenter states that the proposed regulations provide that the members of the medical evidence evaluation advisory committee shall have one member from “the physical or occupational therapy field,” (§9792.23(a)(2)(E)).</p> <p>Commenter states that occupational therapy is a unique and separate profession from physical therapy and that these fields are not interchangeable. Commenter further indicates that many health professions promote or facilitate “functional” through their interventions with consumers. The term “function” has many meanings. Physical therapists have traditionally focused on motor impairments and related functional limitations, with an approach to intervention based on therapeutic exercise. Occupational therapists assess all dimensions of the patient’s functional skills, including physical, cognitive, sensorimotor, and psychosocial aspects of performance. Occupational therapy is the therapeutic use of everyday life activities (occupations) to maximize an individual’s level of independence within the</p>	<p>Charles Willmarth Director, State Affairs The American Occupational Therapy Association, Inc. August 18, 2006</p>	<p>matter expert when reviewing topics related to the spine. Furthermore, DWC will attempt to fill the neurosurgeon position with someone with spinal surgery expertise. Moreover, the Medical Director can appoint an extra orthopedist or a hand/upper extremity specialist as a subject matter expert if required by the specific topic being reviewed.</p> <p>Agree in part. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee.</p>	<p>Section 9792.23(a)(2)(E) has been amended to require that the medical evidence evaluation advisory committee have a representative from the physical therapy field. New Section 9792.23(a)(2)(H) has been added to the proposed regulations to require that the medical evidence evaluation advisory committee have a representative from the occupational therapy field.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.23(a)(2)	<p>context of the patient’s home, work, and community environment.</p> <p>Commenter also indicates that the background to the regulatory proceedings in the initial statement of reasons cited a study which found that “California has more visits per claim—in total for physicians, chiropractors, and physical/occupational therapists—than any other states studied.” This study finds that occupational therapists contributed to high utilization. Commenter states that he believes that an occupational therapist will provide the committee with the expertise needed to identify practice guidelines that will yield the appropriate utilization of medical treatments. Commenter respectfully requests that the committee be expanded to specifically include one member of occupational therapy specialty field.</p> <p>Commenter requests that the committee specifically include one member from the occupational therapy field, rather than one physical therapist or one occupational therapist. Commenter states that occupational therapy is a unique and separate profession from physical therapy, and the therapies are not interchangeable</p> <p>Commenter states that occupational therapists have a unique and significant role in the rehabilitation of injured workers in the state. Commenter states that they use work-related activities in the assessment, treatment, and management of individuals whose ability to work has been impaired by physical,</p>	<p>Richard Bookwalter, MS, OTR, President Occupational Therapy Association of California August 23, 2006</p>	<p>Agree in part. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee.</p>	<p>Section 9792.23(a)(2)(E) has been amended to require that the medical evidence evaluation advisory committee have a representative from the physical therapy field. New Section 9792.23(a)(2)(H) has been added to the proposed regulations to require that the medical evidence evaluation advisory committee have a representative from the</p>

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	<p>emotional, or developmental illness or injuries such as in the work environment. Commenter states that their focus is restoring function by using actual functional activities as treatment modalities — an approach that has proven to be effective in producing positive outcomes and lowering overall treatment costs. Commenter describes at length the purpose/functions of occupational therapy. Commenter also states that occupational therapy practitioners are highly trained in subspecialties as Certified Hand Therapists and Ergonomic Specialists. Certified Hand Therapists, 80 percent of whom are occupational therapists, are looked upon by insurance companies and surgeons as the most qualified professional in managing upper extremity injuries. Commenter indicates that they are recognized in ensuring that the patient will receive the highest level of care and be able to return to work in a timely manner.</p> <p>Commenter states that the background to the regulatory proceedings in the initial statement of reasons cited a study which found that “California has more visits per claim—in total for physicians, chiropractors, and physical/occupational therapists—than any other states studied.” Commenter opines that since this study finds that occupational therapists contributed to high utilization, we believe that an occupational therapist will provide the committee with the expertise needed to identify practice guidelines that will yield the appropriate utilization of medical treatments.</p>			occupational therapy field.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.23(a)(2)	<p>Commenter states that the Division should expand the size of the Committee in recognition of the role and contribution of other specialties in the treatment of workplace injuries. Commenter states that the added recommended positions are indicated in Section 9792.23(a)(2)(A), (C), (H-K). Commenter further suggests that in lieu of an increased number of specific appointees, the Division may choose to decrease or eliminate “at-large” appointments or increase the overall size of the Committee to conform. Commenter’s recommendations are as follows:</p> <p>Section 9792.23(a)(2)(A): Commenter recommends two members from the orthopedic field instead of one as set forth in the proposed regulations;</p> <p>Section 9792.23(a)(2)(C): Commenter recommends two members from the occupational medicine field instead of one as set forth in the proposed regulations;</p> <p>Commenter also suggests the following new positions:</p> <p>(H) One member shall be from the Physical Medicine and Rehabilitation field;</p> <p>(I) One member shall be from the Neurology field;</p> <p>(J) One member shall be a specialist in spinal conditions;</p> <p>(K) One member shall be a specialist in hand/upper extremity conditions.</p>	<p>Stephen J. Cattolica AdvoCal Legislative and Administrative Agency Advocacy on behalf of California Society of Industrial Medicine and Surgery, U.S. Works, and the California Society of Physical Medicine and Rehabilitation</p>	<p>Agree in part. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee. It is not necessary to have two members from any field. In the event that two members from the same specialty are necessary for the evaluation of a guideline, one of the subspecialty members can be appointed by the Medical Director as subject matter specialist under Section 9792.23(a)(3). A neurosurgeon has been added to the committee to satisfy the recommendation for a specialist in spinal conditions. Moreover, when necessary a hand surgeon may be appointed for the subject matter under Section 9792.23(a)(3).</p>	<p>Section 9792.23(a)(2) has been amended to add eight more members to the medical evidence evaluation advisory committee. Section 9792.23(a)(2)(P) (formerly proposed section 9792.23(a)(2)(H)) has been amended to reduce the number from 3 to 2. Section 9792.23(a)(2)(N) has been added to the proposed regulations to require that the medical evidence evaluation advisory committee have a representative from the physical medicine and rehabilitation field. Section 9792.23(a)(2)(L) has been added to the proposed regulations to require that the medical evidence evaluation advisory committee have a representative from the neurology field. Section 9792.23(a)(2)(J) has been added to the proposed regulations to require that the medical evidence evaluation advisory committee have a</p>

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9792.23(a)(2)	<p>In sum, commenter suggests that a total of 8 positions relating to the specialty field he represents be assigned to the committee.</p> <p>Commenter recommends that Section 9792.23(a)(2)(H) be amended to require that the three members of the advisory committee appointed at the discretion of the Medical Director and the three additional members who serve as subject matter experts not have ties to the workers' compensation industry. In support of his recommendation, commenter states that this advisory committee will recommend changes to the utilization schedule and its review should be an unbiased evaluation of the scientific evidence supporting a given treatment, rather than factoring in financial or other potentially conflicting considerations. Commenter adds that even the appearance of a conflict of interest can undermine the legitimacy of this advisory committee and should be avoided.</p> <p>Commenter also states that he is concerned that the composition of the committee as proposed has potentially eight representatives from allopathic disciplines and only two representatives from alternative/complementary health care providers. Commenter states that if the committee membership is not altered, the resulting recommendations from this committee may inadvertently recommend more expensive, invasive treatment options over alternative care. Commenter states that unfortunately, most alternative therapies are</p>	<p>John Bueler, Jr., DC, President California Chiropractic Association August 23, 2006</p>	<p>Disagree. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee. The composition of the medical evidence evaluation advisory committee is defined by the requirements of the statute that the Administrative Director adopts a MTUS that addresses “the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers’ compensation cases.” We disagree with the request that the members of the committee not have ties with the workers’ compensation industry. It is important that at least some of the members have experience in treating the unique issues that arise when treating workers’ compensation cases. One such issue is addressing return to work. Also, diagnosis and treatment of workers presenting with work-related health problems represent an opportunity to prevent recurrences in those workers, to mitigate the effects of current work related hazards so as to reduce the duration of the problem, and to prevent the same problem in coworkers and those in similar jobs.</p>	<p>representative from the neurosurgeon field.</p> <p>None.</p>

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Section 9792.23(a)(3)	<p>not taught in medical school and many forms of alternative care that are supported by the scientific literature continue to not be accepted by the medical community. Commenter again recommends that the language be amended to require the three members appointed by the medical director that as described in 9792.23(a)(2)(H) be members of the public with no ties to the workers' compensation industry.</p> <p>Commenter references Section 9792.23(a)(3), and suggests that instead of adding "three subject matter experts" to the medical evidence evaluation advisory committee as proposed in the regulations, the number of these experts should be flexible. Commenter states that CMA supports the addition of subject matter experts to support the work of the Advisory Committee. Commenter strongly suggests that number of subject matter experts be more flexible and urges the DWC to assure the inclusion of as many clinical specialties as are relevant to consideration of the clinical matter under review. Commenter acknowledges that while the limitation proposed most likely follows on the intent to keep the process from being unwieldy, if all specialties have not been properly heard in the development of guidelines, the arguments to be considered will just be delayed until later in the process.</p> <p>Commenter states that CMA requests that the DWC support the work of this Advisory Committee. To perform this task properly will require significant work to review the</p>	<p>Nileen Verbeten, VP Center for Economic Services California Medical Association, August 22, 2006</p>	<p>Decisions will be made based on a systematic review of the literature. Recommendation of the committee will not be based on a democratic role. Having more representatives from allopathic disciplines will not override the opinions of alternative health care providers.</p> <p>Agree in part. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee. Moreover, it is noted that the proposed regulations are flexible in the appointment of the subject matter specialists by the Medical Director under Section 9792.23(a)(3). The regulations envision the use of the subject matter specialists for the time necessary to complete the evaluation of the guideline in which they are experts but after a new guideline is selected for evaluation, the subject matter specialists will change to reflect the appropriate subject. Moreover, DWC is committed to support the work of the advisory committee by either adding research staff or subcontracting with necessary resources to address this need. Also, any proposed changes to the MTUS will go through formal rulemaking, providing the public with notice and an opportunity to comment.</p>	<p>Section 9792.23(a)(2) has been amended to add eight more members to the medical evidence evaluation advisory committee.</p>

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Section 9792.23(a)(3)	<p>literature. Commenter inquires whether DWC will be adding researchers to its staff or contracting with appropriately qualified individuals to assist with this work. Commenter also requests that more process be spelled out for the work of the Advisory Committee, that the meetings be open and that minutes be published. Commenter further requests that the DWC, prior to the review of a clinical matter seek input from the state medical association and relevant specialties for subject matter experts. Commenter further requests that the proposed guidelines resulting from this work be submitted back to the medical community for comment prior to issuance. Additionally, commenter requests more detail on what triggers the activity of the Advisory Committee and sets forth the following questions: How are areas of review selected? Can a medical society or an individual physician petition the DWC for this review? Is it performed in conjunction with ACOEM updates?</p> <p>Commenter requests that the DWC to consider issues related to chronic/persistent pain to be</p>	Nileen Verbeten, VP Center for Economic	<p>It is not necessary to include the level of detail in the regulation as suggested by commenter. The committee will be utilizing the time in the first meeting prioritizing the subjects that will be covered. The Medical Director will keep informed of ACOEM's updates and those updates will be taken into consideration when prioritizing the subjects to be reviewed. Any group can recommend any topics to the committee. Disagree that the meetings of the medical evidence evaluation advisory committee should be open to the public. See, Response No. 15—Meetings of the Medical Evidence Evaluation Committee are not Subject to the Bagley-Keene Open Meeting Act. Moreover, Labor Code section 138.2(c) provides that “[a]ll meetings held by the Administrative Director shall be open to the public.” However, the meetings of the Medical Evidence Evaluation Committee will be held by the Medical Director of the Medical Unit, not the Administrative Director. Thus, Labor Code section 138.2(c) is not applicable to the meetings of the committee.</p> <p>Agree in part. See Response No. 13—Composition of Medical</p>	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>at the top of its agenda for review. Commenter states that a consistent thread among the many complaints received from physicians is the denial of care for individuals suffering with pain. Commenter further states that unlike the earlier example of society's embrace of the importance of immediate treatment for an injury, there is less appreciation for the reality and impact of persistent pain and the significant harm resulting from neglect of those who experience it.</p> <p>Commenter indicates that medicine has been slow in developing the science of persistent pain. Commenter states that this year, the American Medical Association adopted a report on neuropathic pain (maldynia). This report was drawn from the review of 706 articles. Its conclusion states:</p> <p><i>“Neuropathic pain is distinct from normal, nociceptive pain triggered by noxious stimuli. Nociceptive pain serves as an alerting/warning mechanism to decrease further harm. Neuropathic pain states are triggered by persistent nociceptive stimuli or frank nerve injury. These conditions activate a series of adaptive and eventually, maladaptive, changes in the function and properties of pain-carrying fibers and other sensory neurons, including phenotypic changes and alterations in gene expression, as well as the fundamental properties of specific neurons and sensory pathways. Effective management often requires a biopsychosocial approach. Comprehensive treatments aim to eliminate maladaptive pain-related behaviors,</i></p>	<p>Services California Medical Association, August 22, 2006</p>	<p>Evidence Evaluation Advisory Committee. Section 9792.23(a)(2)(G) provides that a pain specialties is included in the medical evidence evaluation advisory committee. Moreover, her request that the subject of pain be one of the first subjects to be considered will be submitted to the committee at the time they are prioritizing the subjects.</p>	

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>achieve pain control, and improve coping through use of an interdisciplinary team approach to improve psychological functioning, reduce disability, and achieve rehabilitation. Nonpharmacologic approaches include ice massage, heat or ultrasound therapy, relaxation techniques with biofeedback, exercise, massage, hypnosis, transcutaneous electrical nerve stimulation (TENS), physical therapy, acupuncture, or other ancillary techniques. Cognitive, rehabilitative, behavioral, and, at times, invasive neuromodulatory or neurosurgical interventions may be needed as well. Despite recent advances in understanding of the pathology related to nervous system injury, the pharmacologic management of neuropathic pain states remains a challenge.</i> [Citation Omitted.]</p> <p>Commenter states that while many would assert that the lack of “evidence” to direct treatment of persistent pain is sufficient to refuse treatment in the Workers’ Compensation Program, there is ample evidence that pain conditions inflict a significant cost in the US workforce. Commenter also states that a study published in the Journal of the American Medical Association in 2003 [footnote omitted] offers clear evidence that more attention is warranted in this area.</p> <p>Commenter states that the study, analyzing the results of 28,902 interviews of randomly selected working adults in the United States, found lost productive time from common pain</p>			

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.23(a)(3)	<p>conditions among active workers costs an estimated \$61.2 billion per year. Commenter further states that the majority (76.6%) of the lost productive time was explained by reduced performance while at work as opposed to work absence. Commenter adds that this is over and above the lost productive time of injured workers unable to return to work. Commenter believes this is a matter of significant importance.</p> <p>Commenter quotes Charles E. Argoff, MD, Assistant Professor of Neurology, New York University Medical School:</p> <p><i>“Neuropathic pain occurs because the nervous system is altered by injury and is essentially permanently changed. It should be treated as aggressively and as assertively as any other neurological disorder, and as assertively as any other medical disorder, as opposed to thinking it’s just a symptom of a problem that can be ‘sprinkled’ with whatever provides short-term relief.”</i></p> <p>Commenter indicates that a presentation providing the clinical underpinnings of this finding is http://www.medscape.com/viewarticle/453496 1. A copy of this presentation is provided in Appendix C.]</p> <p>Commenter states that First Health would like to propose that “experts on a given topic” be mandatory members rather than selected at the discretion of the Medical Director.</p>	<p>Kelly M. Weigand, Managing Attorney First Health August 23, 2006</p>	<p>Agree in part. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee. By stating in the</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.23(a)(3)	<p>Commenter states that according to the Notice of Proposed Rulemaking, the purpose for creating the advisory committee is for the committee to provide recommendations to the Administrative Director. Commenter states that to allow providers other than experts to participate on the committee would hinder the Administrative Director's ability to make an informed decision on whether the Medical Treatment Utilization Schedule should be modified. Commenter states that the requirement that all members of the committee be experts is further supported by CHSWC's recommendation that "the DWC and CHSWC jointly establish an ad hoc advisory group to receive expert advice in assembling a comprehensive set of guidelines" and statements in the ISOR that "...the Medical Director...will create an advisory committee composed of various experts from specified specialty fields." Commenter opines that the proposed section is not supported by the above statements.</p> <p>Commenter references Section 9792.23(c), and states that a simple advisory capacity will likely frustrate the "best and brightest" who will comprise the Medical Director's Committee. Commenter urges that the Division build a better role for these individuals.</p>	<p>Stephen J. Cattolica AdvoCal Legislative and Administrative Agency Advocacy on behalf of California Society of Industrial Medicine and Surgery, U.S. Works, and the California Society of Physical Medicine and Rehabilitation</p>	<p>proposed regulations that the three members appointed pursuant to 9792.23(a)(3) are subject experts, does not imply that the remaining members of the committee are not experts in their particular fields.</p> <p>Disagree. See Response No. 13—Composition of Medical Evidence Evaluation Advisory Committee. DWC by way of the medical evidence evaluation advisory committee will be addressing the requirements of the statute to develop a MTUS that addresses "the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases" as required by the statute. The</p>	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			agency is the entity responsible for developing the regulations with the input of the community. The agency's goal is to maintain the advisory committee manageable and effective. It is necessary to have the committee on an advisory capacity as it is Administrative Director of the DWC the party ultimately responsible for the final decisions regarding the MTUS. Furthermore, the three members appointed under Section 9792.23(a)(3) will be engaged in the committee as long as necessary depending on the topic at hand.	
9792.23(f)	<p>Commenter recommends that language be added to Section 9792.23(f) to require the Medical Evidence Advisory Committee to meet "as necessary, but at least once a year."</p> <p>ACOEM Guidelines utilize very dated studies to support some treatments. Commenter further states that this is very evident in the low back section of the treatment guideline where the latest study cited is one from 2002. Most of the studies cited are from the mid to late 1990s. Medical Technology is advancing at a rapid pace and clinical evidence from 4-10 years ago is considered by some to be very outdated.</p> <p>Commenter further states that in another instance, ACOEM states that artificial discs</p>	<p>Dena Scearce, JD Director State Government Relations Medtronic August 23, 2006</p>	<p>Agree. The regulations will be modified to inform the public about the number of meetings. The committee will meet as necessary, but no less than four (4) times a year.</p>	<p>Section 9792.23(d) has been amended to 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</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>are to be considered “experimental.” Currently two lumbar discs have been approved by the FDA and are being used by spine surgeons across the country. Commenter indicates that additional lumbar discs and cervical discs are expected on the market soon and they Commenter states that specific sections are showing good clinical outcomes. Commenter opines that unless the Medical Evidence Advisory Committee meets regularly, new technologies and more relevant studies will not be considered. Commenter adds that there must be a frequent opportunity to revise the Guidelines and reconsider classifications of treatments and therapies that are no longer applicable, like in the case of artificial discs. Commenter indicates that if updates are not made frequently, it will negatively affect the injured workers’ in California because the guidelines will not reflect the latest studies and technologies. Commenter concludes that as rapidly as technology is changing, it would only make sense to require, at the least, a yearly meeting of the Medical Evidence Advisory Committee to review the latest studies and clinical evidence.</p>			<p>completed. The members of the committee shall meet as necessary, but no less than four (4) times a year.</p>
<p>Sections 9792.20-9792.23</p>	<p>Commenter set forth the hypothesis that the workers’ compensation reform legislation providing the basis for this rulemaking had less to do with workers’ compensation medical costs and utilization, and more to do with the confluence of a dubious reinsurance scheme, stock market losses and blatant high-end financial cheating.</p>	<p>Charles G. Davis, DC, QME July 10, 2006</p>	<p>Disagree. Comment does not address the substance of the proposed regulations. Objections to the reform legislation should be presented to the legislature.</p>	<p>None.</p>
<p>Sections 9792.20-</p>	<p>Commenter states that the present rule</p>	<p>Larry Rose,</p>	<p>Disagree. Comment does not address</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.23	<p>requiring that evaluating physicians strictly use ACOEM guidelines to determine disability ratings has unfairly, and adversely impacted many severely ill, and injured California employees. Commenter further states that decision as to what level of disability, and whether or not a given injury, or illness is temporary, or permanent, must be left up to the discretion of the evaluating physician. Health care professionals should continue to make these important decisions based on science, and the presented facts. The insurance industry should not be setting regulations that interfere with this basic medical process. Commenter further states that in addition it is important that employees continue to have the right to pre-designate their present primary care physician as the evaluating physician if they are injured, or ill from their workplace, or job tasks.</p>	August 9, 2006	<p>the substance of the proposed regulations. The ACOEM Practice Guidelines are intended to assist medical treatment providers by offering an analytical framework for the evaluation and treatment of injured workers. The ACOEM Practice Guidelines are not intended to determine disability ratings and/or disability status; they are intended to assist in the provision of medical treatment. The proposed regulations do not relate to the pre-designation of personal physician regulations, which were approved by OAL and filed with secretary of state March 14, 2006, and became effective on that date. The comment that “the insurance industry should not be setting regulations that interfere with this basic medical process” is not responsive as the insurance industry is not promulgating the proposed regulations.</p>	
Sections 9792.20-9792.23	<p>Commenter, an injured worker, provides a lengthy history of her industrial injury in 1984 and subsequent medical treatment during the past 22 years. Commenter summarizes her comments by indicating that the system is entirely corrupted, and that medical physicians are in collusion with insurance companies to not treat patients properly or write reports when necessary. Commenter also opines that the medical guidelines are merely guidelines</p>	<p>Sharifah Rosso August 22, 2006</p>	<p>Disagree. Comment does not address the substance of the proposed regulations. The proposed regulations specifically state that the ACOEM Practice Guidelines are intended to assist medical treatment providers by offering an analytical framework for the evaluation and treatment of injured workers.</p>	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Sections 9792.20-9792.23	<p>and cannot possibly accommodate the extraordinary nature of her injuries to her head, neck, spine, and back.</p> <p>Commenter states that it is his understanding that DWC needs input on how well the 2003 changes worked. Commenter opines that they did not work. Commenter further states that as someone in chronic pain, it took far too much time for his worker's compensation insurance representative to return approvals for medical treatment. Commenter offers that they also had an Advisory Committee of their own, making the treatment guidelines so the person in pain suffered, but yet the insurance company saved money. Commenter states that the insurance company sent a list of treating doctors and clinics in his area, so he called these doctors, and when he explained to them what medicines and treatment he was receiving, they said they were not able to match the standard of care he was receiving. Commenter adds that the doctors did not even know the type of treatment that he was receiving, and when he tried to explain it to them, they had no idea what he was talking about. Commenter further states that the doctor that he sees now, for the last 4 to 5 years, might not be able to continue to treat him after the end of a year and that leaves him with no place to go.</p>	<p>Rande Rudinger-Fealy August 23, 2006</p>	<p>Disagree. Comment does not address the substance of the proposed regulations.</p>	<p>None.</p>
Sections 9792.20-9792.23	<p>Commenter sets forth the theory that partisan politics are being used to stimulate California's economy by denying treatment under workers' compensation. Commenter states that the Governor's workers'</p>	<p>Patrick Monette-Shaw August 23, 2006</p>	<p>Disagree. Comment does not address the substance of the proposed regulations. Objections to the reform legislation should be presented to the legislature.</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Sections 9792.20-9792.23	<p>compensation reform has allowed insurance companies to reap historic profits at the expense of injured workers. Commenter makes references to insurance companies' profits. Commenter states that injured workers want access to medical care, not a vigorous state economy that is stimulated on the backs of injured workers. Commenter further states that the purpose of treatment guidelines authored by various medical specialty boards and commissions were never designed simply to invigorate state, local, or national economies; instead they were designed to treat injuries and return patients to their highest level of functioning.</p> <p>Commenter states that the American Academy of Physical Medicine and Rehabilitation has noted in its "Practice Guideline Resources Disclaimer" that the practice guidelines are not intended to "dictate" specific treatments for specific patients. Commenter argues that the California Division of Workers' Compensation is attempting to dictate that the treatment guidelines of ACOEM must be implemented, restricting treatments available to injured California workers. Commenter quotes ACOEM's Executive Director stating that ACOEM's guidelines are recommendations, not mandates.</p>	<p>Patrick Monette-Shaw August 23, 2006</p>	<p>Disagree. Comment does not address the substance of the proposed regulations. Moreover, it is noted that the proposed regulations provide at section 9792.21(b) that the ACOEM Practice Guidelines are intended to assist medical treatment providers 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. The requirement that the MTUS be presumptive on the issue of extent and scope of medical treatment and diagnostic services is required by statute.</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Sections 9792.20-9792.23	<p>Commenter states that the ISOR acknowledges that CHSWC recommends considering the ACOEM guidelines as the “primary” medical utilization schedule. Commenter alleges that acknowledgment in the ISOR implies that a “secondary” utilization schedule may be also valid in order to consider a full range of valid considerations. Commenter criticizes both DWC and CHSWC for failing to detail or shed light on just what drawbacks in the ACOEM guidelines need to be “ameliorated.”</p> <p>Commenter objects stating that there is no explanation throughout the 53-page “Statement of Reasons” document that describes why Bickmore Risk Services was engaged to study effects of legislative reform of the workers’ compensation system. (A Study of the Effects of Legislative Reforms on California Workers’ Compensation Insurance Rates, State of California, Department of Industrial Relations, Division of Workers’ Compensation, Bickmore Risk Services (BRS), January 2006).</p>	Patrick Monette-Shaw August 23, 2006	Disagree. Comments do not address the substance of the proposed regulations. The ISOR, at pp. 45-52 does discuss the areas which will be evaluated for purposes of revision/supplementation of the MTUS.	None.
Sections 9792.20-9792.23	Commenter recommends that the workers’ compensation system must be “re-regulated.” Commenter states that efforts to “re-regulate” workers’ compensation insurance companies must be addressed immediately, or the crisis of injured workers being denied medical treatment will never be solved and the crisis will only worsen.	Patrick Monette-Shaw August 23, 2006	Disagree. Comment does not address the substance of the proposed regulations. Comment relating to deregulation of workers’ compensation system is outside the scope of these regulations as it is a subject which should be brought before the legislature.	None.
Sections 9792.20-	Commenter states that her doctor requested	Vicki Kohler	Disagree. Comment does not address	None.

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.23	<p>that she go to a gym to help strengthen the muscles around her lower back and neck area. Commenter was denied the gym membership and was advised she could learn all of this with Physical Therapy. Commenter further states that the doctor then requested Physical Therapy and was denied. Commenter states that the reason for the denial was because the first Utilization Review and the second Utilization Review Doctors were different doctors. Commenter opines that one doctor did not know what the other doctor requested or suggested. Commenter states that she is in the process of settling her case and had her doctor write a very demanding letter to the UR committee about Octagon Risk, and the Physical Therapy and the Gym membership were approved. Commenter adds that the problem she is having now with her settlement is getting what she should be getting after Perata's bill goes through. Commenter questions whether Perata could make this all retroactive even for those that have already settled or is this part of his bill. Commenter states that she has already been given her paperwork to go over for settlement and has found some discrepancies in the billing. Commenter states that she has been billed over \$5500 for Physical Therapy that was supposed to have been done in San Francisco and some other bills from other companies that she does not know who they are. Commenter states that she will be giving this to her attorney because she does not want the other side to pay for something they should not.</p>	August 23, 2006	the substance of the proposed regulations. This rulemaking does not relate to the Utilization Review Standards regulations which became effective on September 22, 2005.	

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
<p>Sections 9792.20-9792.23</p>	<p>Commenter, an injured worker, states that his injuries date back to July of 1987. He committed to a stipulated agreement in 1992 with SCIF.</p> <p>Commenter states that like many other workers who thought they had medical treatment guaranteed by virtue of what was a legally binding contract, he was disabused of that notion the beginning of last year when he was first refused medical care and continue to be so denied. Commenter states that he was denied physical therapy and gym membership as well as subsequent X-rays and an MRI. Commenter further states that he was also denied all prescribed medications and had to appeal through the utilization review process of the insurer, and eventually he received the medications.</p> <p>Commenter describes at length his emergency medical services and medical condition during the past months allegedly caused by denial of his physical therapy. Commenter opines that the monies wasted on utilization review could have paid for much of his therapy and would not have to be spent on hospital services. Commenter submits an article in support of the theory that the California Workers' Compensation system is dominated by companies whose economic interests are better protected than those of the injured workers.</p> <p>Commenter states that, like a significant number of workers faced with a denial of necessary medical care, his quality of life has</p>	<p>Stephen Kessler August 23, 2006</p>	<p>Disagree. Comment does not address the substance of the proposed regulations. This rulemaking does not relate to the Utilization Review Standards regulations which became effective on September 22, 2005. Comments relating to the Utilization Review Enforcement regulations (Sections 9792.11 through 9792.15) may be submitted in connection with that regulation which is undergoing formal rulemaking process.</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
<p>Sections 9792.20-9792.23</p>	<p>been seriously compromised. Commenter states that he is faced with pain and discomfort that disrupts his sleep, undermines his ability to gainfully support himself and his family, and limits his capacity to be productive as a worker and as an engaged citizen. Commenter argues that his experience and that of thousands of workers will reveal the inadequacy of the ACOEM guidelines as they pertain to chronic conditions of ill health.</p> <p>Commenter states that the American College of Occupational and Environmental Medicine in a letter to State Senator Richard Alarcon states that “when a physician’s request does not meet guidelines, it does not automatically mean that the request is inappropriate.” Commenter further states that, nevertheless, the ACOEM guidelines are applied as law since passage of enabling legislation. Commenter alleges that major clinical organizations have declined endorsement of this use of the ACOEM guidelines. Commenter further states that one of the current restrictions on treatment pertains to physical therapy and chiropractic in that treatment for an injury is limited to 24 sessions even though there is no evidence-based study showing that this number of treatments is optimal. Commenter argues that this number of treatments, 24, was unilaterally, arbitrarily, and capriciously chosen, and that the ACOEM guidelines are being applied in a unilateral, arbitrary, and capricious manner.</p> <p>Commenter further urges that reliance on</p>	<p>Robert L. Weinmann, M.D., President Union of American Physicians and Dentists August 23, 2006 Oral and Written Comment</p>	<p>Disagree. Comment does not address the substance of the proposed regulations. Both sections 9792.21(c), and 9792.22(b) prohibit “arbitrary” use of the ACOEM Practice Guidelines as alleged by commenter. This rulemaking does not relate to the Utilization Review Standards regulations which became effective on September 22, 2005. Moreover, the Utilization Review Enforcement regulations (Sections 9792.11 through 9792.15) are undergoing formal rulemaking process. The regulations assess penalties for violations of ACOEM applications. Regarding commenter’s comment on the 24 visit cap, limitations on chiropractic, occupational therapy and physical therapy visits are required by statute (Lab. Code, § 4604.5(d)(1)). These limitations are a policy matter for the legislature and objections should be addressed to the legislature. Regarding commenter’s comment</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>ACOEM guidelines be rescinded since the current use of these guidelines is not evidence-based and has become an added burden to impede recovery and return to work of injured workers.</p> <p>Commenter discusses at length that utilization review has been used to delay and deny care by throwing road-blocks into the best intentions of even the most experienced clinicians, and that the result has been harmful denials of care to injured workers. Commenter states that corporate interests have been enriched in this manner by money that should have been spent on patient care was not spent on patient care. Commenter gives examples of out-of-state physicians conducting UR reviews. Commenter argues that DWC now seeks to reduce or eliminate payments to physicians who dispense medications from their offices.</p> <p>Commenter quotes from a section in ACOEM, at page 83, entitled “Payer’s Role” as follows:</p> <p>“Payers must act expeditiously in evaluating responsibility for a claim. If the claim is accepted, worker payments must be timely in accordance with applicable statutes. Claims should be monitored for indicators of delayed recovery and, if necessary, trigger early case management to support providers in their efforts. They should play a nonadversarial role and work with the employer to define their approach.”</p>	<p>Stephen J. Cattolica AdvoCal Legislative and Administrative Agency Advocacy on behalf of California Society of Industrial Medicine and Surgery, U.S. Works, and the California Society of Physical Medicine and Rehabilitation</p>	<p>rescinding reliance on the ACOEM Practice Guidelines, see Response No. 9—Incorporation of ACOEM into the MTUS.</p> <p>Disagree. Comment does not address the substance of the proposed regulations.</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Sections 9792.20-9792.23	<p>Commenter states that this recommendation should be presumed correct.</p> <p>Commenter states that ACOEM is at best HMO treatment, not treatment for fixing an injury. Commenter objects to Labor Code section 4604.5(d)(1) which states that “not withstanding the medical treatment utilization schedule ..., an employee shall not be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury.” Commenter states that the trend in California, as in other states, is more visits to non-medical doctors.</p>	<p>Charles G. Davis, DC, QME July 10, 2006</p>	<p>Disagree. Comment does not address the substance of the proposed regulations. As pointed by commenter, limitations on chiropractic, occupational therapy and physical therapy visits are required by statute (Lab. Code, § 4604.5(d)(1)). These limitations are a policy matter for the legislature and objections should be addressed to the legislature.</p>	<p>None.</p>
Sections 9792.20-9792.23	<p>Commenter objects to Labor Code section 4604.5, stating that 24 visits per injury is inadequate as it does not allow doctors to follow an aggressive regime of therapy in order to facilitate a return to post operative range of motion and strengthening of injured parties. Commenter opines that because each injury and patient are different it should be left in the doctors hands as to how much therapy is needed for each individual. Commenter further states that the Labor Code requires that a doctor request any visits over 24. Commenter states that her doctor requested 6 visits which is what he thought would be approved by the insurer, and he was proved right when he requested 12 more visits and was turned down even after 2 requests. Commenter opines that the lack of aggressive therapy due to visit limitations in her case contributed to an increase in her permanent disability rating of 23%. Commenter further opines that the laws for workers compensation</p>	<p>Mary Rule August 18, 2006</p>	<p>Disagree. Comment does not address the substance of the proposed regulations. As pointed by commenter, limitations on chiropractic, occupational therapy and physical therapy visits are required by statute (Lab. Code, § 4604.5(d)(1)). These limitations are a policy matter for the legislature and objections should be addressed to the legislature.</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Sections 9792.20-9792.23	<p>regarding rehabilitation interfere with her right to medical treatment under the guidelines required under the surgeon generals office.</p> <p>Commenter objects to the statute setting forth limitations in chiropractic care, requesting that DWC take into account that there are 250 different types of chiropractic treatments and the Blair upper cervical chiropractic treatment is alleviating her serious neurological interference causing a brain stem compression.</p>	<p>Sharifah Rosso August 22, 2006</p>	<p>Disagree. Comment does not address the substance of the proposed regulations. As pointed by commenter, limitations on chiropractic, occupational therapy and physical therapy visits are required by statute (Lab. Code, § 4604.5(d)(1)). These limitations are a policy matter for the legislature and objections should be addressed to the legislature.</p>	<p>None.</p>
Sections 9792.20-9792.23	<p>Commenter states that State Fund has no further comments regarding the proposed Medical Treatment Utilization Schedule regulations. Commenter thanks the Division for considering its prior recommendations and offers their ongoing support in the development of these regulations.</p>	<p>Helen Resalvo, Legislative & Regulatory Analysis & Implementation Consultant Jose Ruiz, Claims Operation Manager State Compensation Insurance Fund August 23, 2006</p>	<p>Agree.</p>	<p>None.</p>
Sections 9792.20-9792.23	<p>Commenter states that many small business owners who care about their employees are not pleased with a system that does not provide adequate coverage to employees injured at work. Commenter states that owners who care about their staff are displeased and disappointed with a system that does not adequately ensure that their employees are taken care of. Commenter states that businesses purchase workers'</p>	<p>Rahel Smith August 23, 2006 Written and Oral Comment</p>	<p>Disagree. Disagree. See Response No. 9—Incorporation of ACOEM into the MTUS. See also, Response No. 11—Chronic Conditions. Further, some of commenter’s arguments do not address the substance of the proposed regulations. Limitations on chiropractic, occupational therapy</p>	<p>None.</p>

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>compensation insurance not only because they are mandated to do so but also because it gives peace of mind to those who want to take responsibility for injuries caused within their workplaces.</p> <p>Commenter is also an employee injured at work. Commenter states that she was injured in 1997, and the case settled in 2001 included future medical treatment. Commenter indicates that her condition requires ongoing treatment. Commenter further indicates that in 2004 the insurance company stopped approving ongoing treatment which had been enabling her to continue working pain free and with reduced symptoms. Commenter states that the justification for stopping was that treatment was not outlined in ACOEM. Commenter states that since 2001 the insurance company, State Compensation Insurance Fund, has repeatedly quoted ACOEM as justification for denial of treatment despite the fact that ACOEM is clearly designed for treatment only during the first 90 days. Commenter states that both her treating physician and the QME have repeatedly recommended the treatment, and the insurance company continues to seemingly blindly quote ACOEM. Commenter presents specific citations of the ACOEM Guidelines provided to her which she believes frequently do not apply to the appropriate areas. Commenter states that the insurance company will quote from low back area, but she has no low back injuries. Commenter states that the insurance company will quote things out of context, and will quote things that when she</p>		<p>and physical therapy visits are required by statute (Lab. Code, § 4604.5(d)(1)). These limitations are a policy matter for the legislature and objections should be addressed to the legislature. Moreover, this rulemaking does not relate to the Utilization Review Standards regulations which became effective on September 22, 2005. Comments relating to the Utilization Review Enforcement regulations (Sections 9792.11 through 9792.15) may be submitted in connection with that regulation which is undergoing formal rulemaking process.</p>	

Medical Treatment Utilization Schedule	RULEMAKING WRITTEN COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>checks them against the ACOEM Practice Guidelines; the guidelines suggest that the treatment is entirely appropriate.</p> <p>Commenter adds that if one looks at the guidelines and algorithms in ACOEM, they clearly do not apply to someone in her condition with a chronic injury and a permanent disability. Commenter opines that the guidelines are being abused and misused. Commenter offers the following example: Algorithm 8-2 on page 188 of ACOEM recommends treatment for <i>"Workers with neck-related activity limitations greater than four to six weeks but less than three months duration."</i> Commenter states her condition is clearly beyond the three month duration so this does not apply. Commenter further states that in the bottom right of that algorithm ACOEM's only answer to <i>"Recovery"</i> is <i>"Yes"</i>, and commenter opines this does not apply to a patient with ongoing disability of 36 percent.</p> <p>Commenter believes that presumption of correctness of a treating physician is more appropriate as the system used to indicate.</p> <p>Commenter states that if DWC adopts ACOEM, DWC would be doing a great justice to set parameters limiting ACOEM as applicable to injuries only for the first 90 days. Commenter opines that while there is a chapter on chronic pain, the chapter is primarily about how to prevent pain. Commenter indicates that that chapter does not address chronic injuries, or how to handle</p>			

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	<p>ongoing medical treatment for a patient who has a permanent disability. Commenter requests that DWC clearly issue appropriate recommendations that clarify insurance companies are obligated to continue providing medical treatment to permanently disabled workers, and that this treatment will frequently fall outside of ACOEM.</p> <p>Commenter further states that there are three other points she would like to make. First, commenter states that it has literally taken years since the insurance company denied treatment (on the basis of ACOEM) until a hearing occurred. Commenter states that these delays are difficult for patients who need treatment to keep functioning. Commenter adds that the delays, in her experience, have been much worse since ACOEM was adopted.</p> <p>The second point is that commenter believes she is in a distinct bind regarding chiropractic treatment. Commenter states that regulations prevent chiropractors from accepting payment directly from a patient, if the provider knows that there is a worker's compensation case involved. Commenter states that this means that even though my treating physician, and the QME believe that chiropractic treatment is helpful in preventing flare-ups (and in treating flare-ups that do arise), she has no access to this helpful treatment on her own. Commenter states that if she did want to get chiropractic treatment and pay for it herself, she would need to go to a different provider, and mislead them as to the source of her injury. Commenter states that patients should be</p>			

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	<p>allowed to get treatment that is helpful, and pay for it themselves if they wish. Commenter states that the current system not only refuses to pay for treatment, but also prevents patient's independent access to treatment.</p> <p>The third point that commenter wants to address is the submission of a copy of an insurance utilization review (UR), and her response to it. Commenter states that the UR uses ACOEM as a justification for denial of coverage, but the UR use of ACOEM is completely out of line with her case. Commenter states that they cite irrelevant sections; they take ACOEM quotes out of context, and are thoroughly illogical. Commenter states that it is frustrating and disappointing that the insurance company is allowed to behave this way, and that patients have no recourse. Commenter requests that DWC take into account the misuse of ACOEM when considering whether to implement it, as presumptively correct.</p> <p>Commenter adds that the Information and Assistance officers have been absolutely inaccessible and unavailable to workers. Commenter opines that that piece of the system is not functioning to provide resources to unrepresented workers.</p>			
Notice of Proposed Rulemaking	<p>Commenter references the Notice of Proposed Rulemaking, at page 8, Fiscal Impacts, fourth bullet point, wherein it reads in part: "...The proposed regulations do not apply to any local agency or school district."</p>	<p>Stephen J. Cattolica AdvoCal Legislative and Administrative Agency Advocacy on behalf of California Society of</p>	<p>Agree in part. Government Code section 11346.5(a)(6) requires the notice of proposed adoption of regulations include, in pertinent part, "other nondiscretionary costs or savings imposed on local agencies.</p>	<p>None.</p>

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	<p>Commenter states that the context of this statement is with respect to fiscal impact, but the statement must be clarified Commenter states that taken at its plain meaning, this statement appears to throw the medical treatment of public agency and school district employees injured on the job into complete disarray.</p> <p>Commenter states that the language in question refers the reader to the Local Mandate paragraph directly above it. Referring to that language, one could conclude that there are no new mandates created by these regulations. Commenter acknowledges that taken together, the two sections create an understanding. Commenter continues that, however, the statement quoted above is not necessary and, as it did in his reading, can throw readers off track, creating confusion. Commenter suggests the sentence be struck so that the fourth bullet would now read:</p> <p>Other nondiscretionary costs/savings imposed upon local agencies: None. The proposed regulations do not apply to any local agency or school district (See “Local Mandate” section above.)</p> <p>Commenter opines that the modified language loses neither meaning nor context by excluding the unclear reference while solving the confusion that this sentence engenders.</p>	<p>Industrial Medicine and Surgery, U.S. Works, and the California Society of Physical Medicine and Rehabilitation</p>	<p>That is, Government Code section 11346.5(a)(6) requires the agency proposing the regulations to consider other nondiscretionary costs or savings imposed by the regulations on local agencies that are in addition to the cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4.</p> <p>DWC considered the above requirement and determined that there would be no “other nondiscretionary costs or savings imposed on local agencies.” To clarify this point the notice makes reference to the subsection above on Local Mandate, which states that the proposed regulations do not impose any new mandate programs or increased service levels that are unique to local agencies or school districts. This section also makes reference to <i>County of Los Angeles v. State of California</i> (1987) 43 Cal.3d 46, wherein the California Supreme Court determined that an increase in workers’ compensation benefit levels does not constitute a new state mandate for the purpose of local mandate claims because the increase does not impose unique requirements on local governments. In this instance, the potential costs imposed on all public agency employers and</p>	

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			<p>payors by these proposed regulations, although not a benefit level increase, are similarly not a new state mandate because the regulations apply to all employers and payors, both public and private, and are not unique to local governments.</p> <p>Although DWC can see where the sentence "[t]he proposed regulations do not apply to any local agency or school district," might be confusing when read in isolation, this is the very reason why courts adhere to the fundamental rule that a statute (and in this case the "Fiscal Impacts" section of the notice) should be construed by looking at the language of the statute (or "Fiscal Impacts" section of the notice) read as a whole. (See <i>Anne Muller v. Automobile Club of Southern California</i> (1998) 61 CA4th 431, 440-441; <i>County of Yolo v. Los Rios Community College District</i> (1992) 5 CA4th 1242, 1248-1249). When the sentence at issue is construed by looking at the Fiscal Impacts section of the notice as a whole, and in particular, with the referred to "Local Mandate" subsection, the meaning is clear even to the commenter. Therefore, the issue raised by the commenter is moot.</p> <p>Because the notice has already issued, and as admitted by</p>	

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			<p>commenter when read in “context ... with respect to fiscal impact... it is clear that the sentence refers ... the reader to the local mandate section directly above it[, and] one can become relatively clear that there would be no new mandates, so the two sections taken together create an understanding,” there is no need to re-issue the notice. (See, Government Code section 11346.5(c)).</p> <p>Commenter’s suggested language will be taken into consideration in issuing future notices.</p>	