Medical Treatment Utilization Schedule (MTUS)

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MTUS - Overview

- The statutory groundwork for the Medical Treatment Utilization Schedule (MTUS) was established over a decade ago.
- Labor Code §5307.27 – Authorizing statute for the establishment of the MTUS.
- Labor Code §4600(b) – Medical treatment that is reasonably required to cure or relieve means treatment based on the MTUS.

MTUS - Overview

- Labor Code §4604.5(a) – The MTUS is presumed correct on the issue of extent and scope of medical treatment. Rebuttable and may be overcome by a preponderance of scientific medical evidence. Treating physicians bear the burden of proof.
- Labor Code §4604.5(d) – Treatment not covered by the MTUS shall be in accordance with other evidenced-based medical treatment guidelines that are recognized generally by the national medical community.

MTUS - Overview

- From 2004-2007 the American College of Occupational and Environmental Medicine's, 2nd edition was the standard for medical treatment.
- The MTUS was adopted by regulations in 2007 and in 2009 the MTUS was re-organized into chapters and the Chronic Pain Guidelines and Post-Surgical Guidelines were adopted.
- Patch-work approach to creating the MTUS.

MTUS - Overview

- Clinical Topics (ACOEM):
  - -Neck and upper back;
  - -Shoulder;
  - -Elbow disorders;
  - -Forearm, wrist, and hand;
  - -Low back;
  - -Knee;
  - -Ankle and foot;
  - -Stress related conditions;
  - -Eye;
- Special Topics:
  - -Acupuncture guidelines (Colorado's Guideline);
  - -Chronic treatment guidelines (ODG);
  - -Postsurgical treatment guidelines (DWC);
- Evaluating Medical Evidence: ACOEM's rating methodology

MTUS - Overview

- MTUS evaluating medical evidence.
- Opioid treatment guideline for non-cancer pain – rulemaking status.
- Chronic Pain Guideline – rulemaking status.
- Clinical Topics "body chapters" updates in progress.

MTUS – Evaluating Medical Evidence

- Current rulemaking clarifies the role of the MTUS.
- The MTUS is based on the principals of Evidence-Based Medicine (EBM). EMB is a systematic approach to making clinical decisions which allows the integration of the best available evidence with clinical expertise and patient values.

http://www.cochrane.org/about-us/evidence-based-health-care

MTUS – Evaluating Medical Evidence

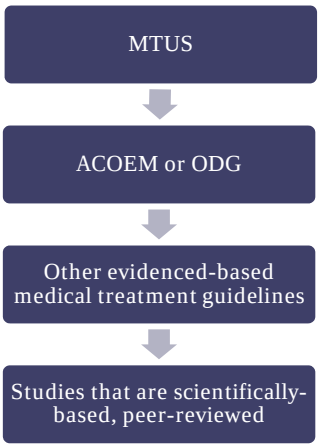
- MTUS shall be the primary source of guidance for treating physicians and physician reviewers for the evaluation and treatment of injured workers.
- There only two (2) limited situations that may warrant treatment based on recommendations found outside of the MTUS.

  1) If the medical condition or injury is not addressed by the MTUS.

  2) If the MTUS' presumption of correction is successfully challenged by the treating physician. The treating physician bears the burden of rebutting the MTUS'.

MTUS – Evaluating Medical Evidence

- Medical Literature Search Sequence:



MTUS – Evaluating Medical Evidence

After conducting the medical literature search, does a citation to the guideline or study need to be provided?

- Treating physicians – Request for Authorization:
  1) If the medical condition or injury is not addressed by the MTUS.
  2)If the MTUS' presumption is being rebutted.
- Utilization Review physicians – UR decision:
  1) If the RFA is being modified, denied, or delayed.
- Independent Medical Review physicians- IMR decision:
  1) If IMR is requested.

MTUS – Evaluating Medical Evidence

- If different guidelines or studies are cited that are at variance with one another, apply the MTUS Methodology for Evaluating Medical Evidence, set forth in section 9792.25.1.
- Currently, California Code of Regulations, title 8, section 9792.25 is the methodology that is to be applied if there are competing recommendations which was adopted from ACOEM's rating methodology.
- MTUS Methodology for Evaluating Medical Evidence was modeled after information from the Cochrane Diagnostic Testing Group and the Oxford Centre for Evidence-Based Medicine.

MTUS – Evaluating Medical Evidence

- MTUS Methodology for Evaluating Medical Evidence
- Step #1 – Determine if recommendations cited are at variance with one another.
- Step #2 – Evaluate the quality of evidence by determining if the studies used to support the recommendations are applicable to the injured worker and his or her medical condition. End?
- Step #3 – Evaluate the quality of evidence by determining what factors, if any, bias may have had in the studies used to support the recommendations. End?
- Step #4 – Hierarchy of Evidence for Different Clinical Questions. Ranking of Evidence.

MTUS – Evaluating Medical Evidence

SUMMARY

- MTUS is the primary source of guidance.
- Two limited situations that may warrant treatment based on recommendations found outside the MTUS.
  1) When the MTUS is silent.
  2) When the MTUS' is rebutted.
- Medical Evidence Search Sequence is provided for efficiency and consistency purposes.
- Systematic, transparent methodology that shall be used to evaluate medical evidence when there are competing recommendations.

CHRONIC PAIN TREATMENT GUIDELINES

MEDICAL TREATMENT UTILIZATION SCHEDULE

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NURSE CONSULTANT, MEDICAL UNIT
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CHRONIC PAIN MEDICAL TREATMENT GUIDELINES MTUS

WHY A GUIDELINE FOR CHRONIC PAIN?

- Public Health problem
- Significant factor in delayed recovery
- Main reason for medical treatment disputes in the workers' compensation system

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*"A **key goal** of these guidelines is to incentivize a multidisciplinary approach to chronic pain treatment to **restore function** and **reduce pain** and ultimately to **encourage return to work** following injury.*

*The guidelines promote an **evidence-based**, **comprehensive approach** to treating pain, emphasizing measures that prevent or reduce chronic pain, suffering. and disability."*

Rupali Das, M.D., DWC Executive Medical Director

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CHRONIC PAIN MEDICAL TREATMENT GUIDELINES

Current Guidelines:

Based on "frozen" 2009 adaptation of Official Disability Guidelines (ODG), published by Work Loss Data Institute

- 2009 ODG (published October 31, 2007)

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CHRONIC PAIN MEDICAL TREATMENT GUIDELINES

2014 Version

- Based on edited version of ODG "Treatment in Workers' Compensation—Chapter on Pain (Chronic)"
- ODG modified to include introduction based on MEEAC* input and other changes
- Changes made in conjunction with MEEAC
- Based on best medical evidence & scientific studies

**Medical Evidence Evaluation Advisory Committee (MEEAC)*

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CHRONIC PAIN MEDICAL TREATMENT GUIDELINES

Modified ODG adopted 2009

MEEAC recommends re-adoption of ODG with modifications

DWC obtains permission from ODG/WLDI to make specific modifications

Revised chronic pain guidelines posted to forum, December 2014

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CHRONIC PAIN MEDICAL TREATMENT GUIDELINES

Part 1: Introduction

- Definitions
- Overview
- Risk Stratification
- Assessment Approaches
- Functional Restoration Approach
- Pain Outcomes and Endpoints

Part 2: Pain Interventions and Treatments

Bibliography, Reference Summaries

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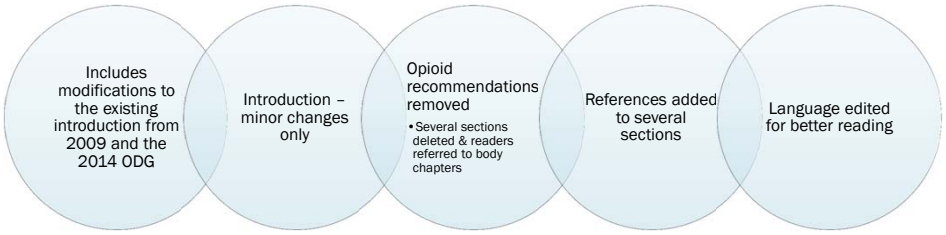
CHRONIC PAIN: MODIFICATIONS MADE TO ODG 2014



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CHRONIC PAIN MEDICAL TREATMENT GUIDELINES

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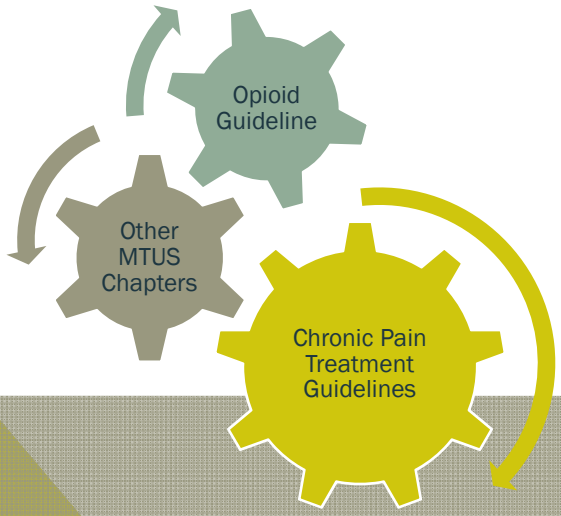
CHRONIC PAIN MEDICAL TREATMENT GUIDELINES
INTEGRATE WITH OTHER MTUS CHAPTERS



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for the Use of Opioids to Treat Work-Related Injuries

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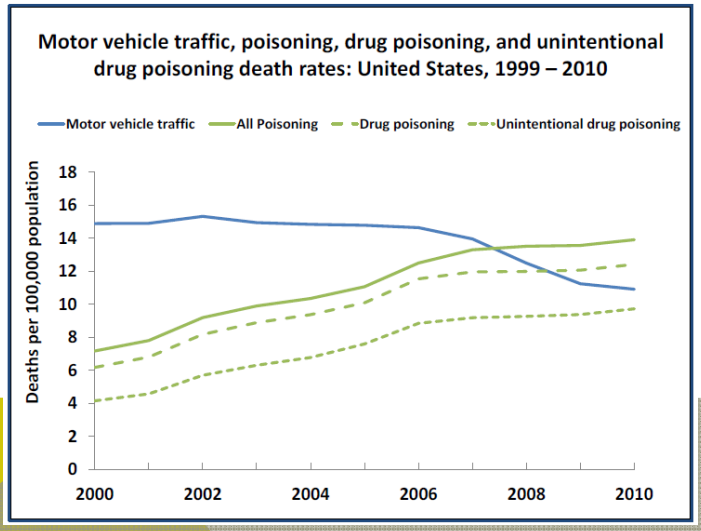
UNINTENTIONAL DRUG DEATHS RISE



NCHS 2012

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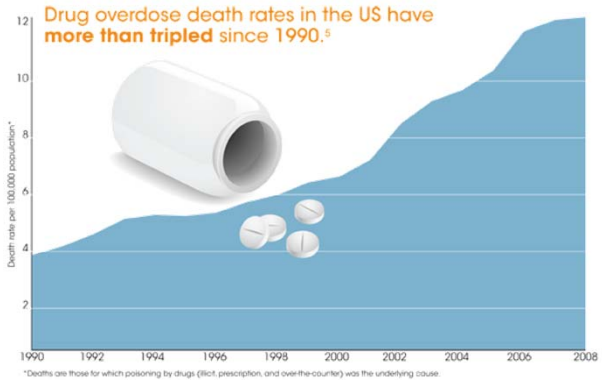
CDC DECLARES "NATIONAL EPIDEMIC"



CDC. Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008. MMWR 2011; 60: 1-6

100 people die from drug overdoses every day in the United States.

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NATIONALLY, DEATH RATES FROM PRESCRIPTION OPIOID PAIN RELIEVER (OPR) OVERDOSES QUADRUPLED DURING 1999–2010…

CENTERS FOR DISEASE CONTROL AND PREVENTION, MMWR, VOL. 63, NO. 39, OCT. 3, 2014

GUIDELINE FOR THE USE OF OPIOIDS TO TREAT WORK-RELATED INJURIES

MEEAC Work Begins December 2012

Guidelines Drafted

DWC Forum Posting April 2014
http://www.dir.ca.gov/dwc/dwcwcabforum/Opioids.htm

Next: Posting for Public Comment

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DWC OPIOID GUIDELINES BASED ON REVIEW OF EXISTING GUIDELINES

American College of Occupational and Environmental Medicine (ACOEM) (2011, 2014)

American Pain Society—
American Academy of Pain Medicine

American Society of Interventional Pain Physicians

Jurisdictions: Canada; Utah; Washington

Veterans Administration/Department of Defense

Work Loss Data Institute: Official Disability Guidelines

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OPIOID GUIDELINES: THREE GOALS

GUIDELINE FOR THE USE OF OPIOIDS TO TREAT WORK-RELATED INJURIES

- Provide best practices and universal precautions for safe and effective prescribing
- Prevent and reduce opioid-related long-term disability, mortality, and substance misuse/abuse
- Recommend opioid prescribing practices that promote functional restoration

Intended audience is primary care and specialty clinicians, providers of UR and IMR, and insurers

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OPIOID GUIDELINES: FOUR PARTS

GUIDELINE FOR THE USE OF OPIOIDS TO TREAT WORK-RELATED INJURIES

Part A: Executive Summary and Introduction

Part B: Recommendations

Part C: Findings

Part D: Comparison of Recommendations from Existing Guidelines

http://www.dir.ca.gov/dwc/dwcwcabforum/Opioids.htm

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RECOMMENDED PRACTICES

Not first line of treatment

- Use of non-opioid modalities

Use for acute pain when severity warrants

- Lowest dose, limited time, and no refill
- Taper to zero within two weeks as possible

Consult CURES (Controlled Substance Utilization Review and Evaluation System)

No simultaneous use of CNS depressants

Caution on potential adverse effects

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OPIOIDS BEYOND THE ACUTE PHASE

1 – 3 MONTHS (SUBACUTE)

- No contraindicated comorbidities
- Non-opioid treatments should be continued
- Urine drug testing should be performed and reveal no aberrant results
- Patients should be carefully monitored, both for improvement in pain and function, as well as indications for discontinuing opioids

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PATIENTS WITH CHRONIC PAIN

3 MONTHS OR MORE

- As above for Subacute
- Assess pain management and functional improvement
- Perform comprehensive evaluation
- Patients informed about risks, benefits, alternatives
- Treatment agreement/informed consent
- Opioid trial prior to committing to chronic opioids
- CURES results documented

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PATIENTS ON CHRONIC OPIOID TREATMENT

- Require careful management
- Use of questionnaire tools
- Periodic UDT
- Assess for clinically meaningful reduction in pain and functional improvement

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CONSULT / REFER TO A PAIN SPECIALIST

- To assess the risk-benefit of opioids in complex patients or those at high risk of adverse effects
- At the time of a trial of chronic opioid treatment
- When significant tolerance to opioids is suspected
- To assist with the management of aberrant behavior or patients who have opioid use disorder
- To assist with tapering or weaning regimens
- To assist with other complex issues

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METHODS FOR TAPERING OPIOIDS

TWO-STEP METHOD

Step 1: Outpatient setting

- 10%—25% per week taper
- May require pain medicine specialty and psychological support

Step 2: Inpatient setting

- Patients at higher risk who fail step one
- Offered inpatient detox with a multidisciplinary pain program
- Additionally, patients who have co-existing cardio-respiratory or other co-morbid conditions that may make outpatient tapering dangerous should be tapered in an inpatient setting

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DOSE THRESHOLD

No safe opioid dose has been demonstrated

For acute, subacute, chronic pain, doses for opioid-naïve patients should not exceed 80 mg/day MED

- Dunn 2010, Bohnert 2011, Gomes 2011

http://www.dir.ca.gov/dwc/dwcwcabforum/Opioids.htm

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DOSE THRESHOLD

Consistent recommendations across State agencies:

- Medical Board of California Guidelines for Prescribing Controlled substance for Pain
- DWC Guidelines for the Use of Opioids to Treat Work-Related Injuries

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