

California Coalition on Workers' Compensation  
California Chamber of Commerce  
California Manufacturers & Technology Association  
California Association of Joint Powers Authorities  
Association of California Insurance Companies  
California Restaurant Association  
California Grocers Association  
Schools Insurance Group  
Sedgwick Claims Management Services, Inc.  
Employers Compensation Insurance Fund  
Republic Indemnity  
GSG Associates  
Healthcare Solutions  
Marriott International  
Nordstrom  
Safeway

August 30, 2013

Division of Workers' Compensation  
P.O. Box 420603  
San Francisco, CA 94142  
Attn: DWC Forums

RE: DWC Forums – Medical Treatment Utilization Schedule

To Whom It May Concern:

The organizations listed above thank you for the opportunity to provide feedback to the draft changes to the Medical Treatment Utilization Schedule (MTUS). Combined, our organizations represent tens of thousands of insured and self-insured public and private sector California employers, as well as dozens of insurance companies.

The MTUS is a vitally important component in the machinery that makes up California's workers' compensation system. The effectiveness of Utilization Review and Independent Medical Review are directly linked to the quality of the guidelines in the MTUS and the strength of evidence regulations. Considering the importance of the MTUS, we offer the following comments:

**Functional Restoration**

The draft regulations strike the definition of "functional improvement" which, because there is no explanation such as the one that would typically be included in an ISOR, is concerning to our coalition members.

In fact, in June 2007, in the Final Statement of Reasons (FSOR) for revisions to the MTUS Regulations, the DWC included the following reasons for including a definition for functional restoration:

*The definition of “functional improvement” was adapted from the medical treatment philosophy that is incorporated in the ACOEM Practice Guidelines. For example, the ACOEM Practice Guidelines state at page 77:*

*In order for an injured worker to stay at or return successfully to work, he or she must be physically able to perform some necessary job duties. This does not necessarily mean that the worker has fully recovered from the injury, or is pain-free: it means that the worker has sufficient capacity to safely perform some job duties. Known as functional recovery, this concept defines the point at which the worker has regained specific physical functions necessary for reemployment. (See, ACOEM Practice Guidelines, at p. 77.)*

The next ACOEM quote included in that 2007 FSOR specifically addresses over-treating pain, and over-medicating with Opioids and Pain Meds.

*Another example is contained at ACOEM Practice Guidelines, page 106:*

*Pain in today’s work place presents a challenge to the occupational physician. Although mistreating or undertreating pain is of concern, an even greater risk for the physician is overtreating the chronic pain patient, especially with opioids and other medications. Overtreatment often results in irreparable harm to the patient’s socioeconomic status, home life, personal relationships, and quality of life in general. However, because opioids are “easy” and represent a path of little resistance, they may prevent the patient, the physician, or both from vesting in a difficult and uncomfortable rehabilitation course. A physician’s choice to palliate and not rehabilitate is a profound clinical, ethical, and medico-economic decision not to be taken lightly or be based on unfounded dogma. A patient’s complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self-actualization. (See, ACOEM Practice Guidelines, at p. 106.)*

In 2007, the prescience to recognize the possibility of over-medicating was evident. Now in 2013, when we recognize there exists an epidemic of over-medicating, we should not eliminate one of the definitions that will give us a tool to guide treatment to recovery of function as opposed to “treatment” to addiction.

Is “functional improvement” and the elimination of disability and barriers to return to work not the entire point of the Work Comp System? Unfortunately, we know in some cases, we may never make someone pain-free, but we can allow them to return to work. Further, functional improvement is also a criterion in many sections of the MTUS used to determine whether ongoing treatment is appropriate. Without the definition of functional improvement, when should treatment stop, or go into “maintenance mode?”

**RECOMMENDATION:** *Maintain the definition of functional improvement in the regulations to ensure that proper consideration is given to the restoration of functionality.*

### **Definition of “Evidence Based Medicine”**

The definition of “Evidence Based Medicine” contained in § 9792.20(e) of the draft regulations is problematic because it expands the scope of what can be considered as “evidence based” to include subjective factors into what should be a purely objective decision-making process. The inclusion of “patient

and community standards” in the definition of “evidence based medicine” is a significant diversion away from the objective evaluation of medical treatment and opens the door to virtually any kind of treatment.

**RECOMMENDATION:** *Remove references to “patient and community standards” from the definition of “evidence based medicine”.*

### **MEEAC Process**

Our coalition would respectfully request that the DWC reconsider the current MEEAC process, which unfortunately provides very little opportunity for input from stakeholders. We understand that the MEEAC was intentionally designed to be private in order to provide doctors with an opportunity to provide the unvarnished truth that may not be appreciated by their colleagues; however, we believe that a more open and inclusive process would yield better results.

Consider, for example, the [Oregon Medical Advisory Committee](#) that has been in existence since 1965. This body has by-laws, established processes, and public meeting schedules, agendas, and notes.

**RECOMMENDATION:** *The DWC should consider modifications to the MEEAC process that increases transparency, accountability, and stakeholder involvement.*

### **MTUS and Independent Medical Review**

The draft regulations would create an odd interaction between the Medical Treatment Utilization Schedule (established by the DWC under authority granted in LC Section 5307.27) and the Independent Medical Review (IMR) process established pursuant to LC Section 4610.5. LC Section 4610.5(c)(2) contains a definition for the term “medically necessary” that creates a hierarchy of medical evidence to be used when making decisions about medical treatment. The hierarchy, in which standards must be applied in order and reliance on a lower-ranked standard is only applicable when every higher-ranked standard is inapplicable, is as follows:

1. The guidelines adopted by the administrative director pursuant to Section 5307.27 (MTUS).
2. Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
3. Nationally recognized professional standards.
4. Expert opinion.
5. Generally accepted standards of medical practice.

Our coalition believes that the scope of the draft MTUS regulations essentially integrates all of the lower-ranked standards in the hierarchy established in LC Section 4610.5. The result, as far as we can tell, is to consolidate the entire decision-making process inside of the MTUS. If this was the intent of the draft MTUS regulations, then the DWC should make that clear and ensure that the decision-making processes established in the draft MTUS regulations are consistent with the hierarchy established in 4610.5(c)(2).

**RECOMMENDATION:** *Clarify the intent of the approach being taken by the MEEAC and the DWC with respect to the draft MTUS regulations. If the MTUS is now a substitute for the hierarchy established in LC Section 4610.5(c)(2) then that should be clearly stated.*

## **AGREE II Process**

Our coalition is unified in our concern that the Appraisal of Guideline for Research & Evaluation (AGREE) II medical guideline evaluation tool is too complex and cumbersome. We do not believe that a process that requires a ten page worksheet and requires that 27 “key items” be scored from 1 to 7 and then plugged into a complex calculation is conducive to dispute-free and timely decision-making.

*RECOMMENDATION: Identify and pursue alternative decision-making processes that are less cumbersome and more conducive to dispute-free and timely medical treatment decisions.*

## **Application of Guidelines to all Providers**

For maximum effectiveness, the ODG guidelines must apply to all providers. All entities including physician dispensers, clinics, pharmacies, and mail order pharmacies must be held to the same standard under the guidelines. This includes enforcing prospective and retrospective review guidelines across all providers.

*RECOMMENDATION: Require all providers handling a claimant’s prescription drug treatment program to follow the ODG guidelines.*

## **Treatment Guidelines as Presumptively Correct**

We are supportive of language identifying the MTUS as presumptively correct, meaning in order to treat outside the guidelines, clinically compelling evidence must be provided. Considering the guidelines presumptively correct places the burden on the provider to justify treating outside of evidenced-based medicine, which is considered the best pathway for positive outcomes for claimants.

*RECOMMENDATION: Maintain the language identifying the MTUS as presumptively correct.*

## **Adoption of Nationally Accepted Treatment Guidelines**

We urge adoption of nationally accepted guidelines that are evidence-based. The Official Disability Guidelines (ODG) are robust and have been adopted by a majority of states that utilize treatment guidelines. There are two significant advantages of adopting nationally accepted guidelines versus state-specific guidelines. First, there are no administrative costs for creating or maintaining the guidelines. Second, it circumvents political pressure to modify guidelines for special interest groups.

*RECOMMENDATION: Replace the current California-specific MTUS guidelines with the Official Disability Guidelines (ODG)*

## **Mandatory Pre-Authorization and/or Utilization Review**

Pre-authorization and/or utilization review must be mandatory. Mandating pre-authorization and/or utilization review on certain procedures and/or medications is a valuable tool to assist in the improvement of medical outcomes for injured workers. Utilization review should occur prior to the procedure or dispensing of medication in order to achieve the best results. Mandatory pre-authorization on specific medications or combinations of medications would be beneficial in the following situations:

- a) Any non-FDA approved medication, including compounds;
- b) Opioids over 120 mg/day morphine equivalents; and,
- c) ODG N-Drugs. (These are not considered first line medications)

RECOMMENDATION: *Mandate pre-authorization and/or utilization review for certain procedures and/or dispensations of medication.*

Thank you once again for providing our coalition with an opportunity to provide comments on the draft MTUS regulations. We urge the DWC to consider the recommendations offered above, and would be happy to meet with the DWC staff if there are any questions.

Sincerely,



Jason Schmelzer  
CCWC



Jeremy Merz  
CalChamber

Cc: David Lanier, Chief Deputy Legislative Secretary, Office of Governor Edmund G. Brown  
Christine Baker, Director, Department of Industrial Relations  
Destie Overpeck, Acting Administrative Director, Division of Workers' Compensation