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The California Applicants' Attorneys Association ("CAAA") offers the following comments regarding the proposed Evidence Based Updates to the Medical Treatment Utilization Schedule (MTUS) that are currently posted for public comment.

The key principle underlying the Medical Treatment Utilization Schedule (MTUS) is that clinical decisions are to be based on Evidence Based Medicine (EBM).

Labor Code section 5307.27 requires the Administrative Director to adopt an MTUS that incorporates evidence-based, peer-reviewed, and nationally-recognized standards of care for all treatment procedures and modalities commonly performed in workers' compensation cases.

With regard to the amendments to Regulation § 9792.22. General Approaches, while these are updates to existing ACOEM chapters already incorporated into the MTUS, CAAA does have a continued concern that these "best practice" guidelines for physicians should not be included within the MTUS as they do not address "standards of care" nor the frequency, duration, and appropriateness of treatment procedures and modalities. The ACOEM chapters on Prevention, Initial Assessment and Documentation, and the Cornerstones of Disability Prevention and Management address report writing and other evaluation procedures. CAAA does see the potential benefit in the ACOEM chapter on Disability Prevention and Management, but we also don't want carriers to use the failure of physicians to follow these practice guidelines to be a basis to delay or deny medical treatment. To resolve this conflict with Labor Code section 5307.27 on what should be included in the adoption of the MTUS, we recommend that the following

introductory language in § 9792.22(a) be deleted " ~~The Administrative Director adopts and incorporates by reference into the MTUS specific guidelines set forth below from~~…" and the introduction now begin with the following existing language plus the language underlined " The American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines(ACOEM Practice Guidelines) for the following chapters shall be used by physicians evaluating workers' compensation patients."

With regard to the addition of § 9792.24.5. Traumatic Brain Injury Guideline, while there are many treatments on the recommended list, there are also several care classifications which are "recommended" but qualified with insufficient scientific support. We are concerned this may still pose a problem in obtaining approval for the treatment with this qualification. In addition, there are a number of treatments "not recommended" based on insufficient evidence. It is unclear how ACOEM made a determination to "not recommend" when other treatments are "recommended" with insufficient scientific support based on "consensus". For example, several attention deficit therapies are not recommended whereas behavioral, cognitive, intelligence, and neuro-psyche testing rank as "Recommended," although at best, they get a "C" level for evidence (or "B" in very few instances.) We support the "consensus" for diagnostic testing as testing is essential for understanding the extent of a TBI injury. However, the "consensus" also should be that biofeedback, imaging studies, anti-seizure/convulsant medications, NSAIDs for TBI patients, restorative functional skills training, occipital nerve blocks for migraine headaches, neuro-muscular re-education, and perceptual skills training are recommended; however, all these treatments are either not recommended or have no recommendation based on insufficient evidence.

It is inconceivable that the MTUS will cover all treatment requests to be reviewed in the workers' compensation system. There simply aren't scientific, evidence-based studies supporting every possible medical treatment recommendation. In fact, although there appears to be a broad range of evidence available to a physician, the actual number of medical procedures for which high level medical evidence is available is limited. This is demonstrated by reviewing the 2011 version of the ACOEM Guidelines for Shoulder Disorders.

Table 1 in the ACOEM chapter on Shoulder Disorders includes recommendations for diagnostic testing, covering 10 diagnostic categories with 30 separate treatment recommendations. Of the 30 recommendations, one is based on strong evidence/ Category A while the remaining 29 are based on insufficient evidence/Category I.

Table 2 summarizes recommendations for treatment, separated into three categories: (1) Recommended; (2) No Recommendation; and (3) Not Recommended. There are 99 treatment options in Table 2 for which there is "No Recommendation" because there is insufficient evidence/Category I, and 65 treatment options that are "Not Recommended" of which 54 – 7 out of every 8 – are based on insufficient evidence/Category I!

This is not an isolated example and can be found in many chapters of the ACOEM guidelines.

Given the fact that most treatment recommendations in ACOEM are based on insufficient or irreconcilable evidence, a comprehensive medical literature search will not locate a "higher" level of medical evidence unless a new study is published. In essence, the proposed rules require the treating physician to cite evidence that ACOEM has already determined is not available. The end result is that these rules significantly hamper the ability of the treating physician to rebut the MTUS, which is specifically authorized by Labor Code § 4604.5(a).

"In this era of widespread guideline development by private organizations, the American College of Occupational and Environment Medicine (ACOEM) has developed guidelines that evaluate areas of clinical practice well beyond the scope of occupational medicine and yet fail to properly involve physicians expert in these, especially those in the field of interventional pain management. As the field of guidelines suffers from imperfect and incomplete scientific knowledge as well as imperfect and uneven means of applying that knowledge without a single or correct way to develop guidelines, ACOEM guidelines have been alleged to hinder patient care, reduce access to interventional pain management procedures, and transfer patients into a system of disability, Medicare, and Medicaid." [A critical appraisal of the 2007 American College of Occupational and Environmental

Medicine (ACOEM) Practice Guidelines for Interventional Pain Management: an independent review utilizing AGREE, AMA, IOM, and other criteria.
Manchikanti L, Singh V, Helm S 2nd, Trescot AM, Hirsch JA.
Pain Physician. 2008 May-Jun;11(3):291-310.]

The goal of all stakeholders in the workers compensation system should be to get the most appropriate treatment to the worker as quickly as possible. It is less costly for the employer and carrier. More importantly, it improves the worker's outcome from the injury. However, we believe this goal will only be reached if the MTUS is designed to establish a process that truly "allows the integration of the best available research evidence with clinical expertise and patient values."

Even ACOEM states in its treatment guidelines that "decisions to adopt particular courses of actions must be made by trained practitioners on the basis of the available resources and the particular circumstances presented by the individual patient."

CAAA strongly supports the provision of the highest quality and most effective medical treatment for injured workers, but we don't support blind adherence to "evidence-based medicine" or "consensus" which denies access to procedures which are desperately needed to treat a worker's injury. Often these procedures must be sought elsewhere if the worker is fortunate enough to have another source of medical coverage through private group health, Medicare, Medicaid, or a union trust fund.

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