CLIENT TESTIMONIAL

" I could not have asked for a better Workers' Compensation attorney to represent me than Adam Dombchik. He is very knowledgeable and was always willing to explain things to me throughout the entire process. I am also very grateful to his Spanish-speaking staff members for their support and patience."

- Pedro Aldape

Adam D. Dombchik

Adam D. Dombchik began advocating for the rights of the injured early in his career. He started working for the firm while attending night school at Southwestern University School of Law. He joined as a full-time lawyer after graduation and was named partner in 2005. Mr. Dombchik received the Exceptional Achievement Award in Workers' Compensation Law & Practice from his alma mater.

Recognized by the California State Bar as a Certified Specialist in Workers' Compensation, Mr. Dombchik is a Past President and Legislative Committee Chairperson of the California Applicants' Attorneys Association (CAAA). He currently serves on CAAA committees, including the American Medical Association Guidelines Committee and the Regulations Committee. Previously, he also served as president of CAAA's Southern California chapter.

Mr. Dombchik is very active on the legislative scene in Sacramento, fighting for the passage of fair and just legislation for injured workers. Such was the case when he offered input to help minimize the potential damage of Senate Bill 863, the latest Workers' Compensation "reform" law.

Mr. Dombchik has been named one of the Most Influential People in the Workers' Compensation Industry by the editors of *Workers' Comp Executive.* In 2016, he received the Marvin Shapiro Award for Excellence, presented by the Southern California Chapter of the California Applicants' Attorneys Association (CAAA). And, the Workers' Compensation Section of the State Bar of California named him its 2011 Applicants' Attorney of the Year.

Mr. Dombchik regularly speaks on Workers' Compensation issues to large groups of doctors, lawyers, public safety officers and others in the community.

Mr. Dombchik received a bachelor's degree in Speech Communication, with honors, from Pennsylvania State University. He is licensed to practice law in California and Florida. Mr. Dombchik has been selected for inclusion in The Best Lawyers in America® and *Super Lawyers* for 2012 and 2013. He has also been consistently named a "Rising Star" among Southern California lawyers by *Law & Politics* magazine.

How do we deal with treatment requests, delays and denials?

For injuries before January 1, 2013, treatment denials by Utilization Review were addressed only through the Agreed Medical, or Qualified Medical Examiner process, which often took months to resolve.

Because of the new Workers' Compensation "reform" law—Senate Bill 863— all Utilization Review disputes for injuries after January 1, 2013 will have to be resolved through the Independent Medical Review process. However, even injuries before January 1, 2013 will be processed the same way after July 1, 2013. And, the injured worker must object to treatment denials within 20 days, with a simultaneous request for Independent Medical Review. Failure to object timely and request review ends the process and all chances for that recommended treatment.

To make matters worse, the treating doctor has to use extreme caution, with the proper submission of a Request for Authorization form mandated by the State of California. This form has to be completed to the last detail, or the form can be returned as "incomplete." If treatment is denied by the employer's Utilization Review department, it is crucial to test the validity of that review as to timeliness and completeness.

Generally, the Utilization Review reply has to be done within five to 14 days, by a licensed physician "who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice." It is not uncommon for the responses to be unsigned by a doctor, or to be signed by a nurse or the adjuster.

What does the unrepresented injured worker do?

For injuries on or after January 1, 2013, and for all injuries after July 1, 2013, it becomes much more difficult to enforce treatment without a lawyer. The process of appeal and Independent Medical Review are very strict with regard to the forms and time limits, and it has never been more important for treating doctors to get the requests exactly right. Mistakes and omissions give the insurance company the justification they need to deny requests for care.

It has never been more important to contact a qualified Workers' Compensation attorney as soon as you receive the first denial, since there are only 20 days to object and request an Independent Medical Review. If you do not do so within 20 days, the treating doctor cannot request that treatment again for one year, unless there is a change in the patient's condition.

What about emergencies?

Obviously, if an injured worker is in need of emergency care, he or she should go straight to the emergency room, and worry about the insurance later. But, what if a medical condition puts the injured worker in an "imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function"? If the normal timeframe for the decision making process (five to 14 days) would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, the decision must be made in less than 72 hours.

Examples of expedited requests relate to spine injuries, internal injuries, brain injuries, and any situation where the delay would harm the injured worker. This can also include situations where the insurance company cuts off medication and the withdrawals from the sudden termination of treatment can be lethal.

The medical Utilization Review process is fraught with peril for the uninitiated, and it is essential that injured workers consult with a skilled Workers' Compensation attorney as early in the process as possible. If you would like to speak with a Workers' Compensation attorney from the firm of Gordon, Edelstein, Krepack, Grant, Felton & Goldstein, LLP, please call 213-739-7000.

Pursuant to Labor Code Section 5432(a), making a false or fraudulent workers' compensation claim is a felony subject to up to 5 years in prison or a fine of up to $50,000 or double the value of the fraud, whichever is greater, or by both imprisonment and fine.

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☐ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information			
Name (Last, First, Middle):			
Date of Injury (MM/DD/YYYY):		Date of Birth (MM/DD/YYYY):	
Claim Number:		Employer:	
Requesting Physician Information			
Name:			
Practice Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
Specialty:		NPI Number:	
E-mail Address:			
Claims Administrator Information			
Company Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)

Requesting Physician Signature: Date:

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

Instructions for Request for Authorization Form

Warning: Private healthcare information is contained in the Request for Authorization for Medical Treatment, DWC Form RFA. The form can only go to other treating providers and to the claims administrator.

Overview: The Request for Authorization for Medical Treatment (DWC Form RFA) is required for the employee's treating physician to initiate the utilization review process required by Labor Code section 4610. A Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment must be attached. The DWC Form RFA is not a separately reimbursable report under the Official Medical Fee Schedule, found at California Code of Regulations, title 8, section 9789.10 et seq.

Checkboxes: Check the appropriate box at the top of the form. Indicate whether:

- This is a new treatment request for the employee or the resubmission of a previously denied request based on a change in material facts regarding the employee's condition. A resubmission is appropriate if the facts that provided the basis for the initial utilization review decision have subsequently changed such that the decision is no longer applicable to the employee's current condition. Include documentation supporting your claim.
- Review should be expedited based on an imminent and serious threat to the employee's health. A request for expedited review must be supported by documentation substantiating the employee's condition.
- The request is a written confirmation of an earlier oral request.

Routing Information: This form can be mailed, faxed, or e-mailed to the address, fax number, or e-mail address designated by the claims administrator for this purpose. The requesting physician must complete all identifying information regarding the employee, the claims administrator, and the physician.

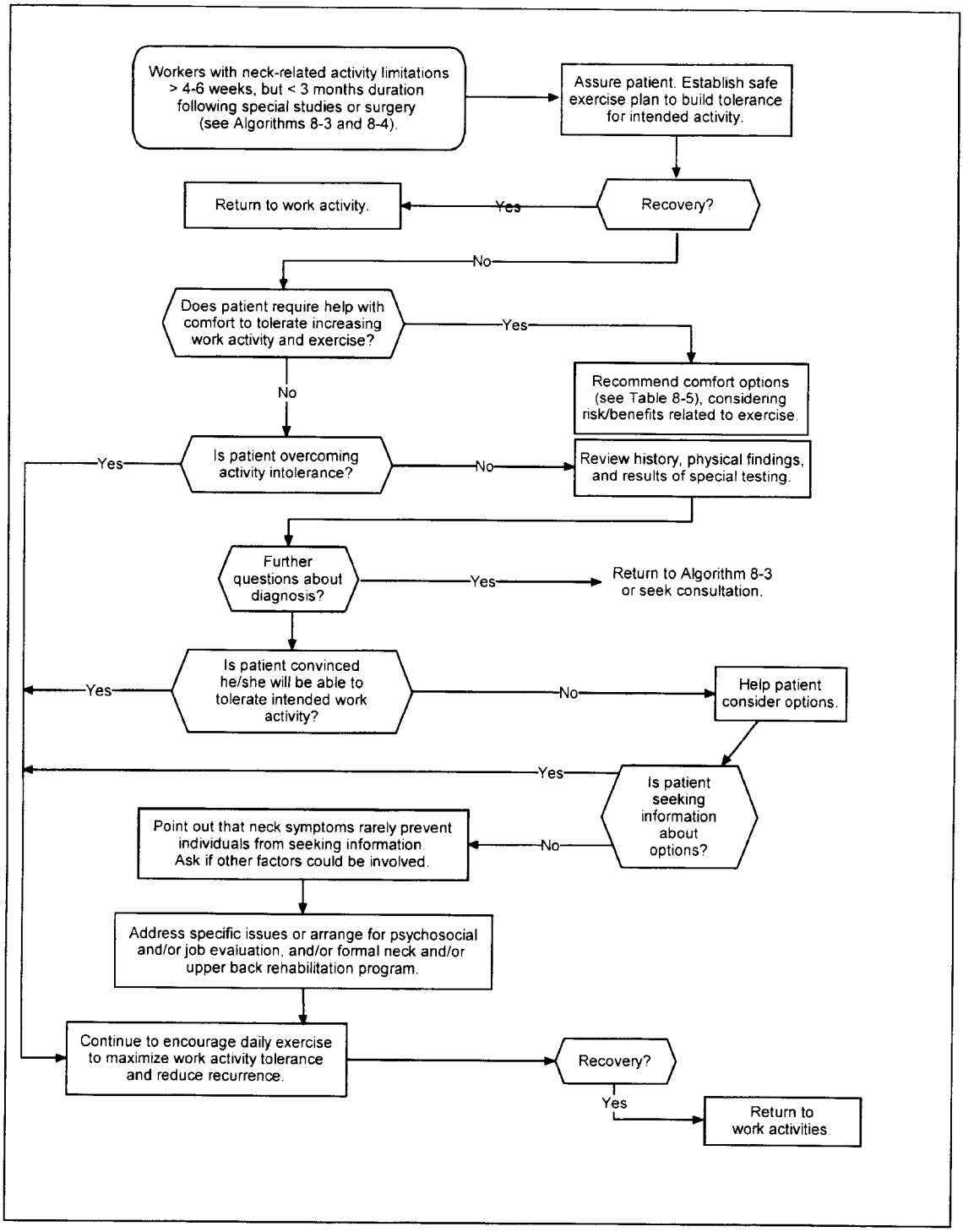
Requested Treatment: The DWC Form RFA must contain all the information needed to substantiate the request for authorization. If the request is to continue a treatment plan or therapy, please attach documentation indicating progress, if applicable.

- List the diagnosis (required), the ICD Code (required), the specific service/good requested (required), and applicable CPT/HCPCS code (if known).
- Include, as necessary, the frequency, duration, quantity, etc. Reference to specific guidelines used to support treatment should also be included.
- For requested treatment that is: (a) inconsistent with the Medical Treatment Utilization Schedule (MTUS) found at California Code of Regulations, title 8, section 9792.20, et seq.; or (b) for a condition or injury not addressed by the MTUS, you may include scientifically based evidence published in peer-reviewed, nationally recognized journals that recommend the specific medical treatment or diagnostic services to justify your request.

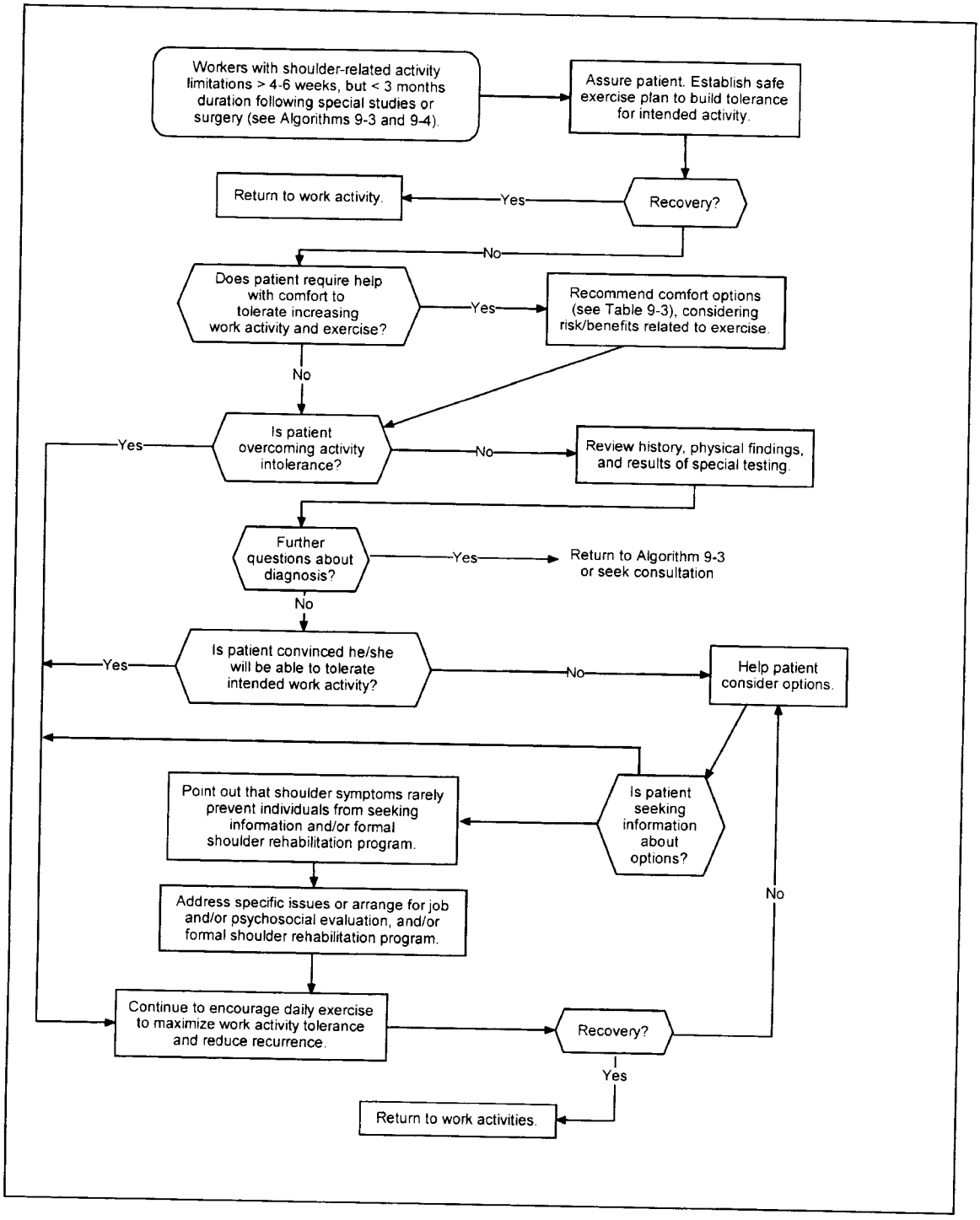
Requesting Physician Signature: Signature/Date line is located under the requested treatment box. A signature by the treating physician is mandatory.

Claims Administrator/URO Response: Upon receipt of the DWC Form RFA, a claims administrator must respond within the timeframes and in the manner set forth in Labor Code section 4610 and California Code of Regulations, title 8, section 9792.9.1. To communicate its approval on requested treatment, the claims administrator may complete the lower portion of the DWC Form RFA and fax it back to the requesting provider. (Use of the DWC Form RFA is optional when communicating approvals of treatment; a claims administrator may utilize other means of written notification.) If multiple treatments are requested, indicate in comments section if any individual request is being denied or referred to utilization review.

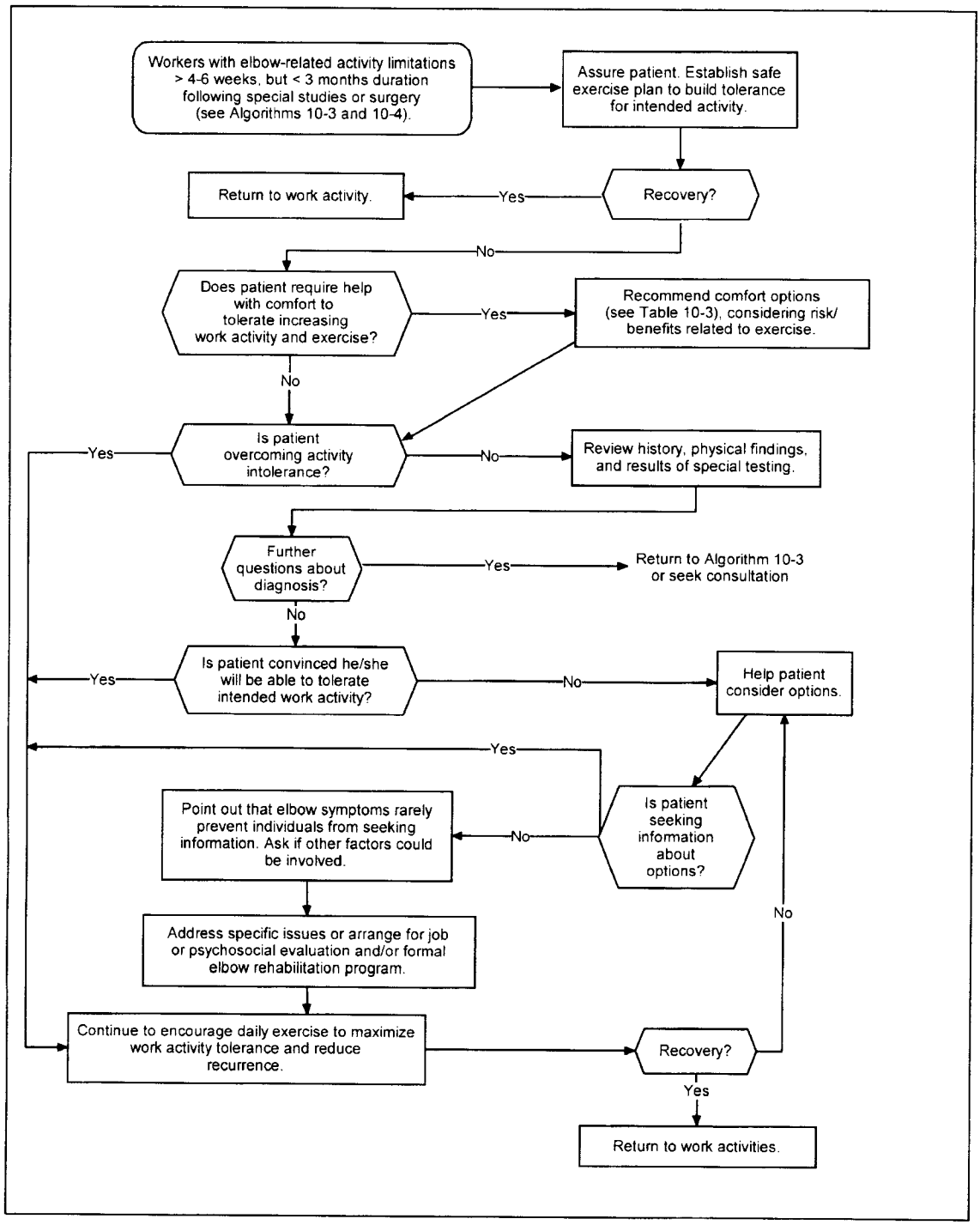
Algorithm 8-5. *Further Management of Occupational Neck and Upper Back Complaints*



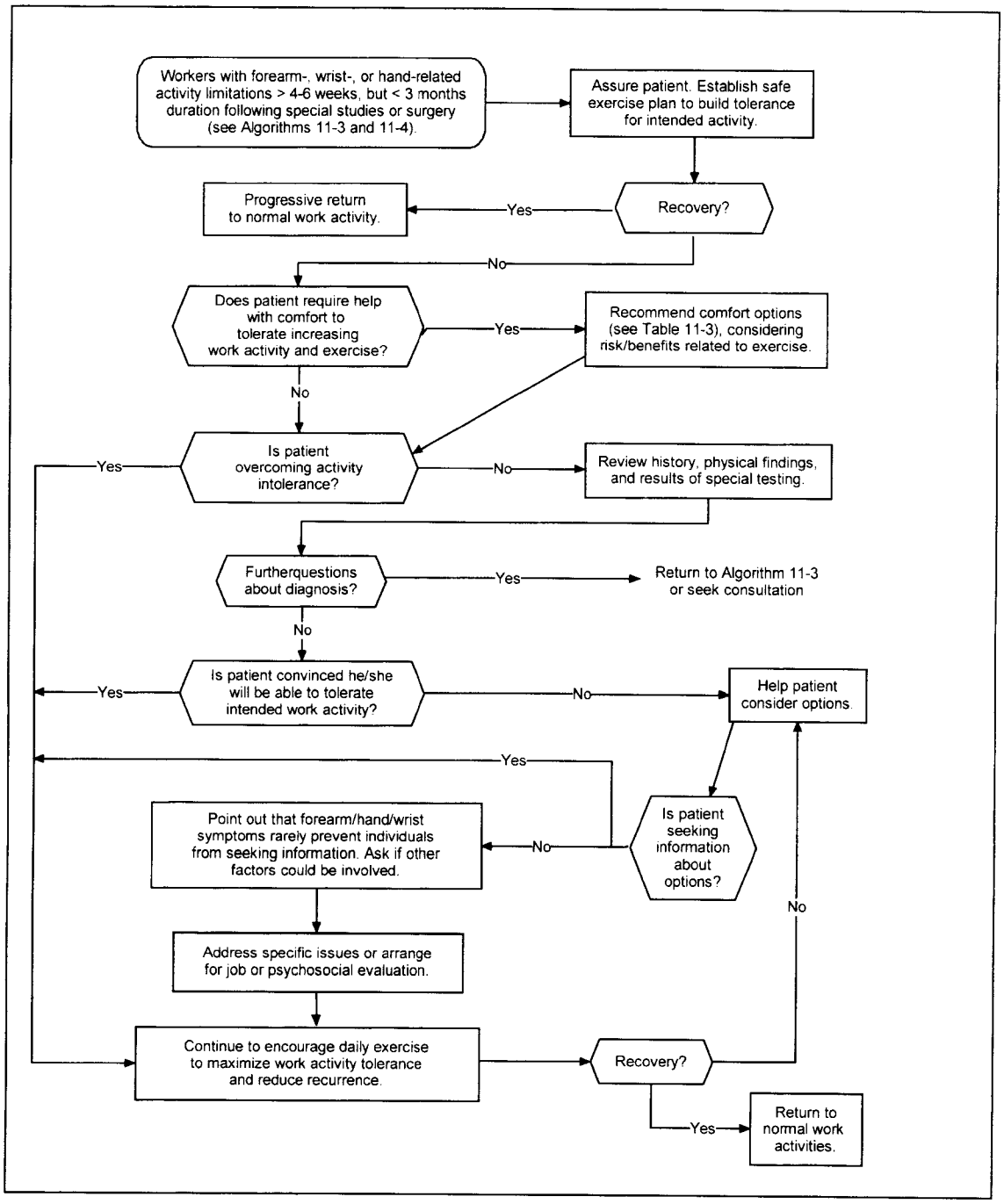
Algorithm 9-5. *Further Management of Occupational Shoulder Complaints*



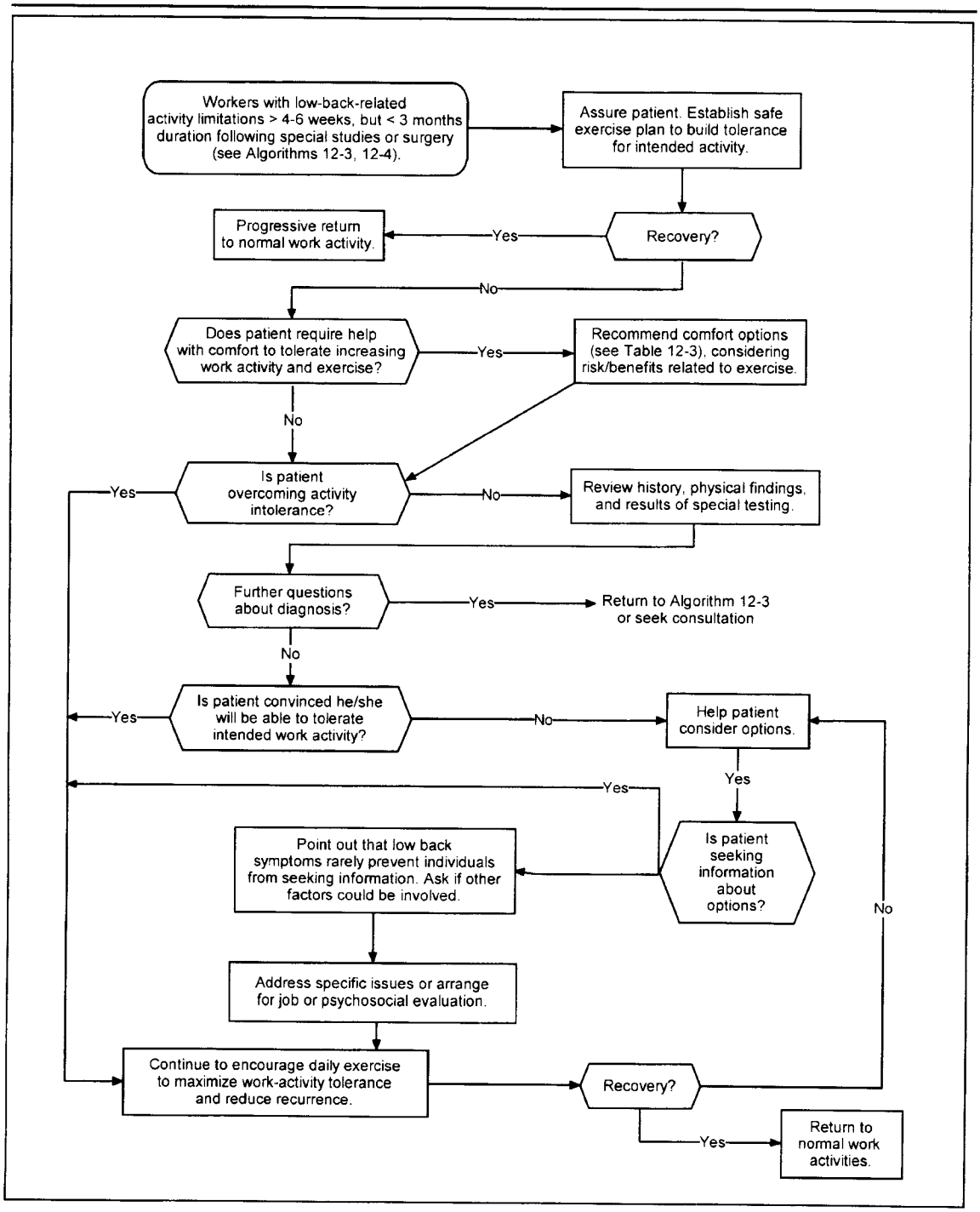
Algorithm 10-5. *Further Management of Occupational Elbow Complaints*



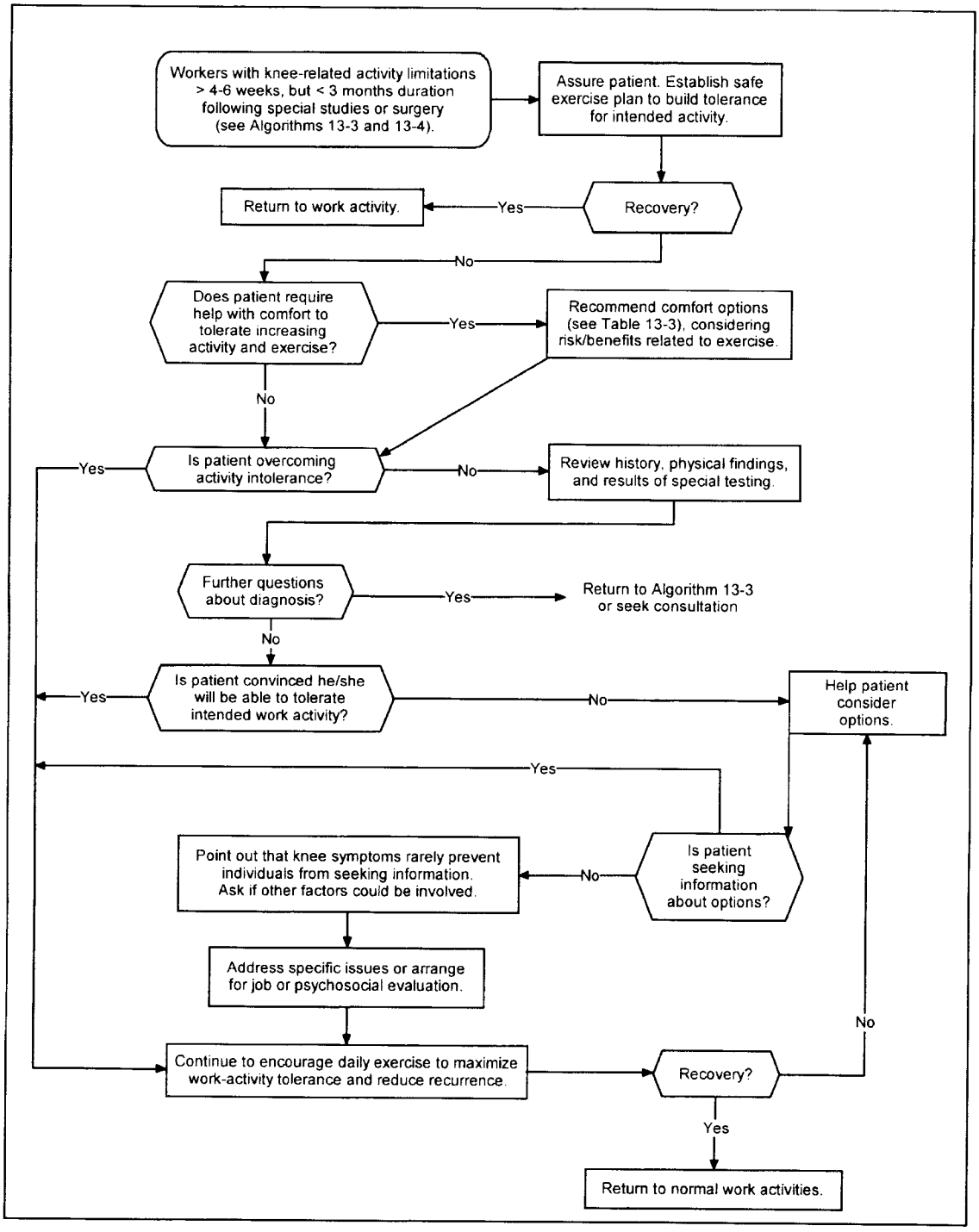
Algorithm 11-5. *Further Management of Occupational Forearm, Wrist, and Hand Complaints*



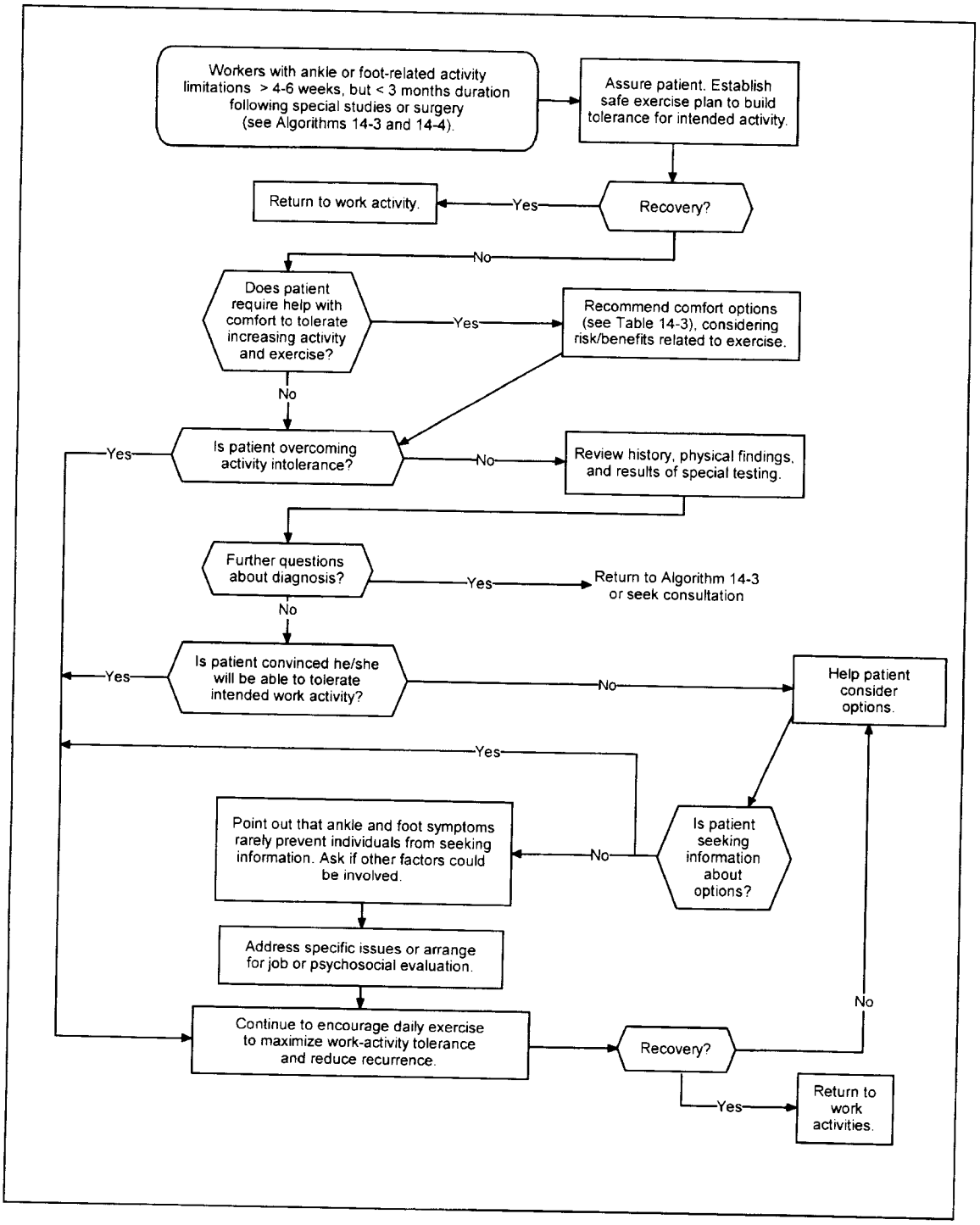
Algorithm 12-5. *Further Management of Occupational Low Back Complaints*



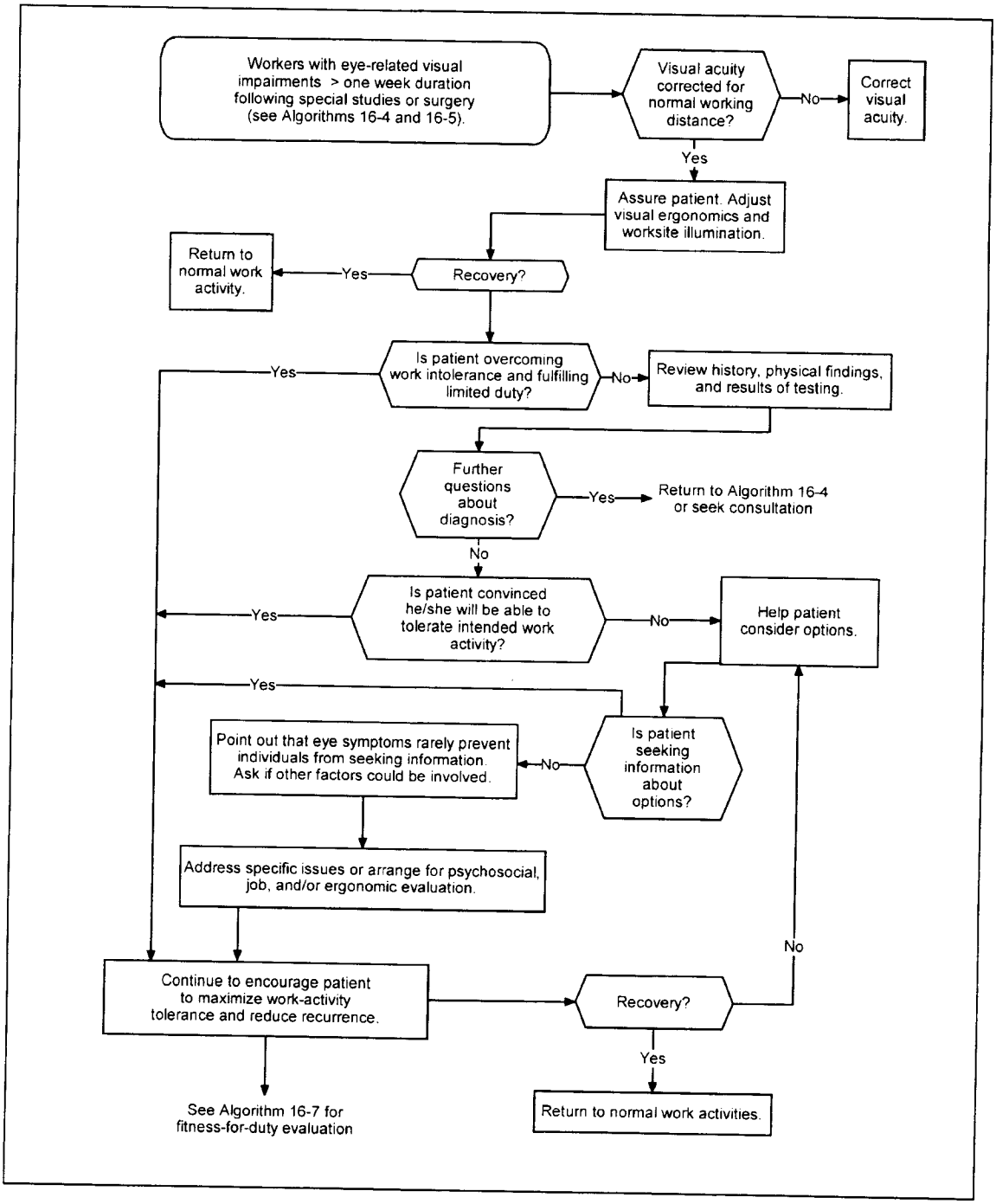
Algorithm 13-5. *Further Management of Occupational Knee Complaints*



Algorithm 14-5. *Further Management of Occupational Ankle and Foot Complaints*



Algorithm 16-6. *Further Management of Occupational Eye Complaints*



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Checkboxes: Check the appropriate box at the top of the form. Indicate whether:

- This is a new treatment request for the employee or the resubmission of a previously denied request based on a change in material facts regarding the employee's condition. A resubmission is appropriate if the facts that provided the basis for the initial utilization review decision have subsequently changed such that the decision is no longer applicable to the employee's current condition. Include documentation supporting your claim.
- Review should be expedited based on an imminent and serious threat to the employee's health. A request for expedited review must be supported by documentation substantiating the employee's condition.
- The request is a written confirmation of an earlier oral request.

Routing Information: This form can be mailed, faxed, or e-mailed to the address, fax number, or e-mail address designated by the claims administrator for this purpose. The requesting physician must complete all identifying information regarding the employee, the claims administrator, and the physician.

Requested Treatment: The DWC Form RFA must contain all the information needed to substantiate the request for authorization. If the request is to continue a treatment plan or therapy, please attach documentation indicating progress, if applicable.

- List the diagnosis (required), the ICD Code (required), the specific service/good requested (required), and applicable CPT/HCPCS code (if known).
- Include, as necessary, the frequency, duration, quantity, etc. Reference to specific guidelines used to support treatment should also be included.
- For requested treatment that is: (a) inconsistent with the Medical Treatment Utilization Schedule (MTUS) found at California Code of Regulations, title 8, section 9792.20, et seq.; or (b) for a condition or injury not addressed by the MTUS, you may include scientifically based evidence published in peer-reviewed, nationally recognized journals that recommend the specific medical treatment or diagnostic services to justify your request.

Requesting Physician Signature: Signature/Date line is located under the requested treatment box. A signature by the treating physician is mandatory.

Claims Administrator/URO Response: Upon receipt of the DWC Form RFA, a claims administrator must respond within the timeframes and in the manner set forth in Labor Code section 4610 and California Code of Regulations, title 8, section 9792.9.1. To communicate its approval on requested treatment, the claims administrator may complete the lower portion of the DWC Form RFA and fax it back to the requesting provider. (Use of the DWC Form RFA is optional when communicating approvals of treatment; a claims administrator may utilize other means of written notification.) If multiple treatments are requested, indicate in comments section if any individual request is being denied or referred to utilization review.

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

☐ Periodic Report (Required 45 days after last report) ☐ Change in treatment plan ☐ Release From Care

☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information

☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Request for authorization

☐ Other

Patient

Patient last name: Patient first name: MI

Patient Street Address/PO Box Patient City State Zip Code Sex

Occupation Phone Number Date of Birth

Claims Administrator Date of Injury

Claims Administrator Name Claim number

Claims Administrator Street Address/ Claims Administrator City State Zip Code

Phone Number Fax Number Employer Name Phone Number

Subjective Complaints (The information below must be provided. You may use this form or you may substitute or append a narrative report):

Objective findings: *(Include significant physical examination, laboratory, imaging, or other diagnostic findings.)*

Diagnoses:

1.		ICD-10		7.		ICD-10	
2.		ICD-10		8.		ICD-10	
3.		ICD-10		9.		ICD-10	
4.		ICD-10		10.		ICD-10	
5.		ICD-10		11.		ICD-10	
6.		ICD-10		12.		ICD-10	

Treatment Plan: Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any **changes** in treatment plan? If so, why?

Work Status: This patient has been instructed to:

☐ Remain off-work until _____

☐ Return to *modified* work on _____ with the following limitations or restrictions. (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

☐ Return to full duty on _____ with no limitations or restrictions.

Primary Treating Physician: *(original signature, do not stamp)* Date of Exam

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3.

Physician signature Cal. License Number: _____

Executed at: _____ Date *(mm/dd/yyyy)*: _____

Physician Name _____ Specialty: _____

Physician address: _____ Phone Number _____

PRIVACY NOTICE: A statement of current data collection and use policies and certain privacy rights of injured workers may be found at the following website: [illegible].

CAAA Bulletin

MTUS PRACTICE TIPS

1303 J Street, Suite 420, Sacramento, CA 95814 P: (916) 444-5155

1 MTUS Practice tip- Change in Material Facts

May 9, 2016

This is the first in a series of practice tips on the MTUS with "pearls" designed to educate the workers compensation community on the use of the Medical Treatment Utilization Schedule ("MTUS") in the Utilization Review ("UR") and Independent Medical Review ("IMR") processes.

In this context, a "pearl" is defined as "a morsel of information intended to highlight a legal or medical point to help practitioners represent injured workers."

CAAA successfully educated the community on the *AMA Guides* with the publication of the "Pearls of the AMA Guides, 5th Edition" after years of collaboration with the devoted members of CAAA's AMA Guides Committee and several very knowledgeable physicians. The "Pearls of the AMA Guides" were ultimately published in EBook form and introduced at CAAA's 2014 Winter Convention.[1]

We hope to have the same success with the "Pearls of the MTUS."

CAAA believes understanding the MTUS is the key for practitioners and physicians to get treatment approved for injured workers.

This tip will focus on how to define a "Change in Material Fact" for resubmission of a treatment request for approval.

[1] The "Pearls of the AMA Guides" are available for purchase at the CAAA online bookstore www.caaa.org/Pearls and can be accessed on an iPad, Mac or iPhone.

Defining "Change in Material Facts"

On the final version of the Request for Authorization DWC Form RFA there is a check box entitled "Resubmission—Change in Material Facts." This check box is underutilized by treating physicians combatting Utilization Review (UR) denials. If the facts warrant, checking this box, identifying a "Change in Material Facts" will **require** that the claims examiner resubmit a treatment request, made by the **same** physician, even though a year has not passed since the prior UR denial (see Labor Code Section 4610(g)(6)) and even if an Independent Medical Review (IMR) Appeal is pending on the initial request. (See *Melendez v Kohl's Department Store* 2015 Cal. Wrk. Comp P.D. LEXIS 535, stating the fact that the previous UR denial was upheld by IMR did not prevent the WCAB from ruling on medical necessity of the updated request.)

State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☐ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle):

Date of Injury (MM/DD/YYYY): | Date of Birth (MM/DD/YYYY):
Claim Number: | Employer:

So, what is a "Change in Material Facts?" There is **no** definition in the Labor Code or the Regulations for this phrase. This Pearl of the MTUS looks at the background and policy behind the RFA form, the mandate to resubmit a request if there is a change in material facts, and the importance of ensuring that UR and IMR review all of the *material facts* to approve MTUS compliant medical treatment requests.

A "change in material facts" is a phrase that requires a broad definition. The public policy behind the creation of the RFA was to *expedite* medical treatment requests by a uniform process. The supporting documentation to the RFA is intended to confirm that a treatment request is in fact MTUS (Medical Treatment Utilization Schedule) compliant. MTUS compliant medical treatment requests are by definition medical care intended to cure or relieve the injured worker of the effects of their injury (See *Labor Code Section 4600*). So it stands to reason that the law requires consideration of a resubmission request for treatment when previously *unknown,*

unaddressed, or new material facts exist. Here are some considerations that support a resubmission:

Change in medical condition documented by

- a change in the clinical examination and its findings, OR
- updated diagnostic testing, with a history from patient documenting a change in his or her functional capacity. **This change can be the result of either deterioration or an improvement in a patient's condition.**
  - An example of a potential improvement in a patient's condition:
    - In *Herring*[2], the WCJ suggests that an additional RFA requesting the same medication but a different dosage was sufficient to constitute a change of circumstances.
    - The first prescription request was for Cymbalta, a 6 month supply at 90mg and Buspirone at 5mg. The second request was changed to Cymbalta at 60mg and Buspirone at 6mg.
  - An example of a deteriorating condition constituting a change of circumstances:
    - In *Melendez*, the WCJ, which the Appeals Board adopted in part, stated that the additional medical report accompanying a new RFA claiming a Change of Circumstances did in fact constitute a "change of circumstances" because it was documented that the applicant's **pain level had significantly increased even with medication use.**
      - This "significant" pain increase was an increase from a 4/10 with medication and a 7/10 without medication to a 6/10 with medication and a 9/10 without medication.
    - We find another example in *Willis*[3] where a WCJ stated that if an applicant's "ability to participate in activities of daily living, most notably work, should deteriorate despite the use of a four wheeled walker, that would constitute a 'change in the facts material to the basis of the utilization review decision'
- The treatment now warrants an expedited request, and the treating physician fills out the RFA with the "Expedited Review" box checked; or in the alternative, if the initial request was an "Expedited Review" request, and the change in circumstances makes it now not urgent. As a result the treating physician issues a new, non-expedited request via a new RFA, OR
- A further explanation or change in medical opinion documented in a deposition of the treating physician

[2] Herring v Paradise Valley Hospital, 2015 Cal. Wrk. Comp. P.D. LEXIS 526

[3] Willis v State of California Department of Parks and Recreation, 2014 Cal. Wrk. Comp. P.D. LEXIS 210

Resubmission based on *new* material facts, presented after it is identified that the UR doctor

- denied the requested treatment based on a lack of information, OR
- the UR doctor failed to identify relevant information in the submitted medical documentation, OR
- the UR doctor concluded relevant information did not exist to support the treatment request, yet the information was in fact in the documents reviewed by the UR doctor, OR
- the UR doctor was not sent and did not have the opportunity to review relevant information to fully evaluate the medical treatment request.

Failure by the claims examiner to resubmit an RFA based on a change in material facts will render the UR untimely, evoking WCAB jurisdiction, and with substantial evidence there will be a basis for the Judge to issue an Award and Order directing that the medical care be provided.

Attached to this tip are two sample letters, a longer version and a shorter version, that you may consider when communicating a request to a physician to address the need for a supplemental report, and submission of a new RFA due to a change in material facts.

Conclusion

Future Pearls of the MTUS will focus on 1) how to navigate the Strength of Evidence guidelines, 2) how to identify MTUS guidelines routinely used to obtain approval of the top 20 treatment requests, and 3) how to address timeliness and other challenges to the UR and IMR process.

CAAA is a leader in education in the California workers' compensation community committed to making a better workers' compensation system for all while advocating for the rights of injured workers.

An educational program on the Pearls of the MTUS and how to get treatment approved will be at CAAA's Winter Convention scheduled for January 26 through 29, 2017 at the San Diego Sheraton Hotel & Marina.

We hope you put this on your calendar and can join us.

Note: This practice tip is intended to be advisory only, and does not define or establish any new standard or duty for practitioners.

URGENT:

PROMPT REPLY REQUESTED

NEED REBUTTAL TO UR DENIAL FOR IMR

April 25, 2016

Doctor MD

RE: Robert B. Test vs. TROUBLE CO.

WCAB No: ADJ123456

Dear Dr.:

Thank you for serving as treating physician in this matter. As noted on the enclosed IMR application, Defendant has denied/modified treatment that you requested, and I am concurrently filing for Independent Medical Review. This denial has created a "disputed medical fact" and "contested claim" between my client and the defendant. If you did not receive the utilization review (UR) denial/modification, please contact my office immediately. In order to resolve this dispute, please review the utilization review denial and any records in the patient chart and prepare a Medical Legal Report addressing the opinions expressed in the denial.

If you feel that there exists a "Change in Material Facts" – i.e. facts that were not considered by UR in their adverse determination, you can resubmit your request on a new RFA, and check the box "Resubmission – Change in Material Facts." This will trigger the insurance company to resubmit your request back through the UR process, and we hope will result in the necessary authorization so that you may proceed with your medical treatment plan.

Further, as you are aware, the task of IMR is to determine whether a particular treatment request is consistent with the Medical Treatment Utilization Schedule (MTUS) or other ranked criteria. Under California Labor Code 4610.5(j), "The requesting physician may join with or otherwise assist the employee in seeking an independent medical review, and may advocate on behalf of the employee." In light of the employer declaring a dispute over your treatment recommendations by denying/modifying treatment through utilization review, a supplemental report is immediately necessary which explains:

1. **Why the requested treatment is medically necessary, particularly:**
    a. **How your medical treatment request is supported by the MTUS, or**
    b. **How your request is supported by another medical standard and why every standard ranked higher in the below hierarchy (see below) is inapplicable to the employee's medical condition;**
2. **How the Utilization Reviewer erred in his or her analysis;**
3. **How the request is supported by any documentation or reporting that the utilization reviewer did not consider.**

Your analysis must adhere to the hierarchy of medical standards below; in other words, you must explain why the higher ranked standard was rejected by you in favor of a lower ranked standard and why the lower ranked standard is applicable in this case. The ranking is as follows:

1. The Medical Treatment Utilization Schedule (Regulations 9792.20 - 9792.24),
2. Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service,
3. Nationally recognized professional standards,
4. Expert opinion (including yours),
5. Generally accepted standards of medical practice.

In the event that the MTUS either does not address or does not adequately consider the applicant's condition or the treatment request that you have made, the law requires you to

provide a very specific analysis to support your treatment request.[4] For example, in the event that the MTUS does not (or does not adequately) address the treatment at issue, you must explain how it does not, and you must use the second-ranked standard: peer reviewed literature. If both the first- and second-ranked standards do not apply, the same analysis must be provided in regards to the third-ranked standard, and so on.

Please title your report "Record Review and Report to Assist Employee with Review of Medical Treatment Request," and send it to my office, to the defendant, and to the Independent Medical Review agency (Maximus Federal Services) either at fax number (916) 605-4270 or at the following address:

DWC-IMR, c/o MAXIMUS Federal Services
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009

Please issue the requested report promptly after receipt of your copy of the Notice of Assignment, as Maximus will only review reports received within 10 days of notice of assignment of the case. If Maximus upholds the UR denial, the decision is final and shall remain effective for 12 months from the date of the decision unless there is a documented change in the material facts. **Please be sure to include the Maximus Case Number in the heading of your report.**

As the need for this supplemental report was a consequence of a dispute raised by the employer, please be sure to bill for your professional services in response to this request. The foregoing is requested pursuant to Administrative Director Rules sections 9793, et seq.

Thank you for your attention to this matter and for your continuing attention to the needs of your patient and our client.

Very truly yours,

Enclosed: Independent Medical Review Application

[4] California Code of Regulations 9792.25.

URGENT:

PROMPT REPLY REQUESTED

TREATMENT DENIAL BY UR

April 25, 2016

Doctor MD

RE: Robert B. Test vs. TROUBLE CO.

WCAB No: ADJ123456

Dear Dr.:

Your request for [particular treatment] was **DENIED.** **However, there are still ways to get it approved.** If you believe there is a change of material facts including but not limited to:

1. **A change in medical condition either an improvement or deterioration**
   - This can include any changes in your clinical examination of the client
   - This can include an increase/decrease in pain level or a new request that the medication dosage needs to be increased/decreased in amount
2. **This delay in medical treatment has now made the request an urgent matter**
   - Or if the request was an expedited matter but the situation has been resolved to now consider it a regular request
3. **Utilization Review missed taking into account any or all of the relevant reporting and information**

If any of these apply, you can resubmit your request on a NEW RFA, and check the box "Resubmission – Change in Material Facts."

Thank you for your attention to this matter and for your continuing attention to the needs of your patient and our client.

Very truly yours,

CAAA Bulletin

MTUS PRACTICE TIPS

1303 J Street, Suite 420, Sacramento, CA 95814 P: (916) 444-5155

#2 MTUS Practice Tip – Strength of Evidence Guidelines

June 27, 2016

This is the second in a series of practice tips on the MTUS with "pearls" designed to educate the workers compensation community on the use of the Medical Treatment Utilization Schedule ("MTUS") in the Utilization Review ("UR") and Independent Medical Review ("IMR") processes.

In this context, a "pearl" is defined as "a morsel of information intended to highlight a legal or medical point to help practitioners represent injured workers."

CAAA successfully educated the community on the *AMA Guides* with the publication of the "Pearls of the AMA Guides, 5th Edition" after years of collaboration with the devoted members of CAAA's AMA Guides Committee and several very knowledgeable physicians. The "Pearls of the AMA Guides" were ultimately published in EBook form and introduced at CAAA's 2014 Winter Convention.

We hope to have the same success with the "Pearls of the MTUS."

CAAA believes understanding the MTUS is the key for practitioners and physicians to get treatment approved for injured workers.

This tip will focus on how to navigate the Strength of Evidence guidelines.

MTUS Strength of Evidence Guidelines

The Strength of Evidence guidelines provide the steps for evaluating evidence used by treating doctors and reviewing physicians in supporting treatment recommendations. However, as you will see, these guidelines are shockingly complex and require the reader to create a series of flowcharts to wade through the process. A lay person could not navigate this.

The purpose of the MTUS and Strength of Evidence Guidelines is to ensure the injured worker receives expeditious and appropriate treatment for her injury. The guidelines should not cause treating doctors and reviewing physicians to shy away from requesting the treatment because they do not understand how to perform the analysis required by the guidelines.

Navigating the Guidelines

Section 9792.21(c) provides that the guidelines set forth in the MTUS are presumptively correct on the issue of medical treatment. The MTUS is "the standard for the provision of medical care in accordance with Labor Code section 4600 for all injured workers diagnosed with industrial conditions because it provides a framework for the most effective treatment of work-related illness or injury to achieve functional improvement, return-to-work, and disability prevention." 9792.21(c). It is the primary source for treaters and physician reviewers.

The first step in the analysis is to determine whether or not the MTUS addresses the treatment request. This includes determining whether the physician reviewer has correctly determined that the MTUS does not apply.

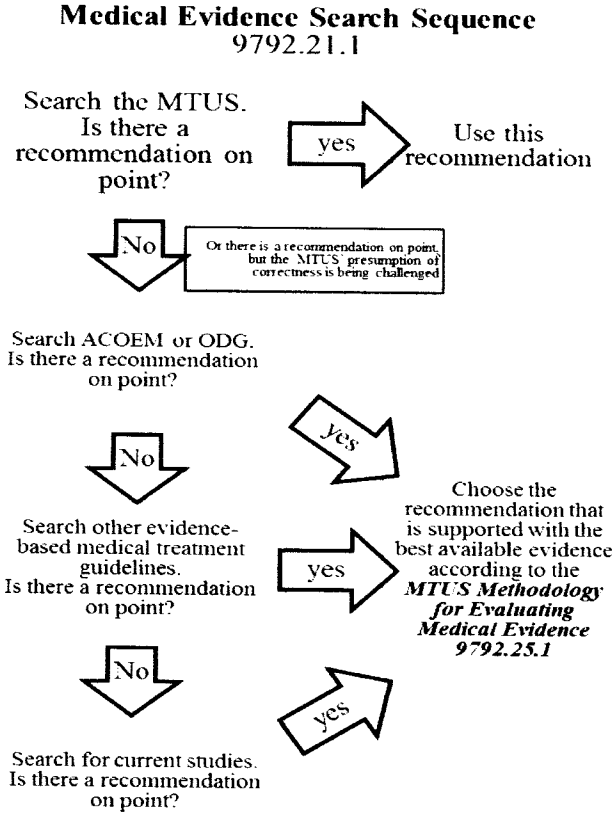
The rules provide two situations where treatment recommendations outside the MTUS can be used to support the treatment request. 9792.21(d).

1. "If a medical condition or injury is not addressed by the MTUS." Treatment cannot be denied if the primary source, the MTUS, does not address the medical issue. When this situation arises, the Medical Evidence Search Sequence must be applied to determine the guideline to be used. 9792.21.1
2. "If the MTUS' presumption of correctness is successfully challenged." This means, that if the treating physician is requesting authorization for treatment and the applicable MTUS guideline does not support authorization of that treatment, she must show by a preponderance of scientific medical evidence that the treatment is reasonably required.

Any evidence used to support a treatment recommendation outside the MTUS must be evaluated using the Strength of Evidence guidelines.

Medical Evidence Search Sequence

The medical evidence search sequence provides a hierarchy of resources to use if there is not an MTUS guideline on point. Section 9792.21.1.



Requesting treatment when the medical condition is not addressed by the MTUS

When the medical condition is not addressed by the MTUS the doctor can provide a citation to the guideline or study she believes guides or supports the reasonableness and necessity of the requested treatment. This should be done in the Request for Authorization or in an attachment to the RFA. 9792.21.1(b)(1)(A). The citation should be the primary source relied on by the physician, which she believes guides the injured worker's care. Further, if the PTP provides more than one citation, she must explain in narrative format how each guideline "provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable [...] but is not addressed by the primary source cited."

So, if the primary treating physician cannot find an applicable guideline in the MTUS, she must cite to an applicable guideline keeping in mind the Medical Evidence Search Sequence. If more than one citation is cited, the doctor must explain how each guideline supports the requested treatment.

Rebutting the MTUS

The second scenario in which a doctor can seek treatment outside the MTUS is when she successfully rebuts the MTUS' presumption of correctness.

In attempting to rebut the MTUS, the doctor must attach to the RFA:

1. A clear and concise statement that the MTUS' presumption of correctness is being challenged
2. A citation to the guideline or study containing the recommendation supporting the reasonableness and necessity of the treatment
3. A copy of the entire study or guideline

The guideline or study must be the doctor's primary source and if more than one citation is provided, the doctor must explain how each citation is applicable, but not addressed by the primary source. Utilization Review (and possibly IMR after that) then reviews the doctor's RFA and reasoning for rebutting the MTUS.

Because the doctor is trying to prove to the reviewing physician that the MTUS is not the correct guideline to be used and that the medical evidence she cited is the "best evidence," this is her one opportunity to persuade that reviewer. She should clearly explain *why* the alternative guideline should apply.

Who determines whether the PTP has successfully rebutted the MTUS?

In order to successfully rebut the MTUS, the physician seeking treatment bears the burden of rebutting the MTUS' presumption of correctness. This must be done by a "preponderance of scientific medical evidence." The specific burden, "preponderance of the evidence" is a legal term of art and whether a doctor has met that burden is a legal determination. Not a medical determination.

The WCAB has addressed the issue in two noteworthy panel decisions. In *McFarland v. The Permanente Medical Group*, 2015 Cal. Wrk. Comp. P.D. LEXIS 23, the panel concluded that this is a medical treatment dispute and thus, under *Dubon II*, must be dealt with in IMR unless the UR decision is untimely. However, Commissioner Marguerite Sweeney argues in her dissent in *McFarland*, that "[r]ebuttal is not a medical issue but a legal issue that must be determined by a court" and if UR has denied medical treatment based on the MTUS then the applicant is "entitled to present evidence that she has rebutted the MTUS." Her interpretation of the statutes is that determining whether the applicant has rebutted the MTUS is separate from the UR and IMR process addressed in *Dubon II.*

In another noteworthy panel decision, *Ly v. Loral Space Systems*, 2015 Cal. Wrk Comp. P.D. LEXIS 138, the Applicant filed a Declaration of Readiness to Proceed to Expedited Hearing after the Defendant failed to authorize Applicant's prescription. The WCJ ordered Applicant's Expedited Hearing off calendar stating that because the UR was timely, under *Dubon II*, it must be dealt with through IMR. However, the WCAB on reconsideration found that the Applicant

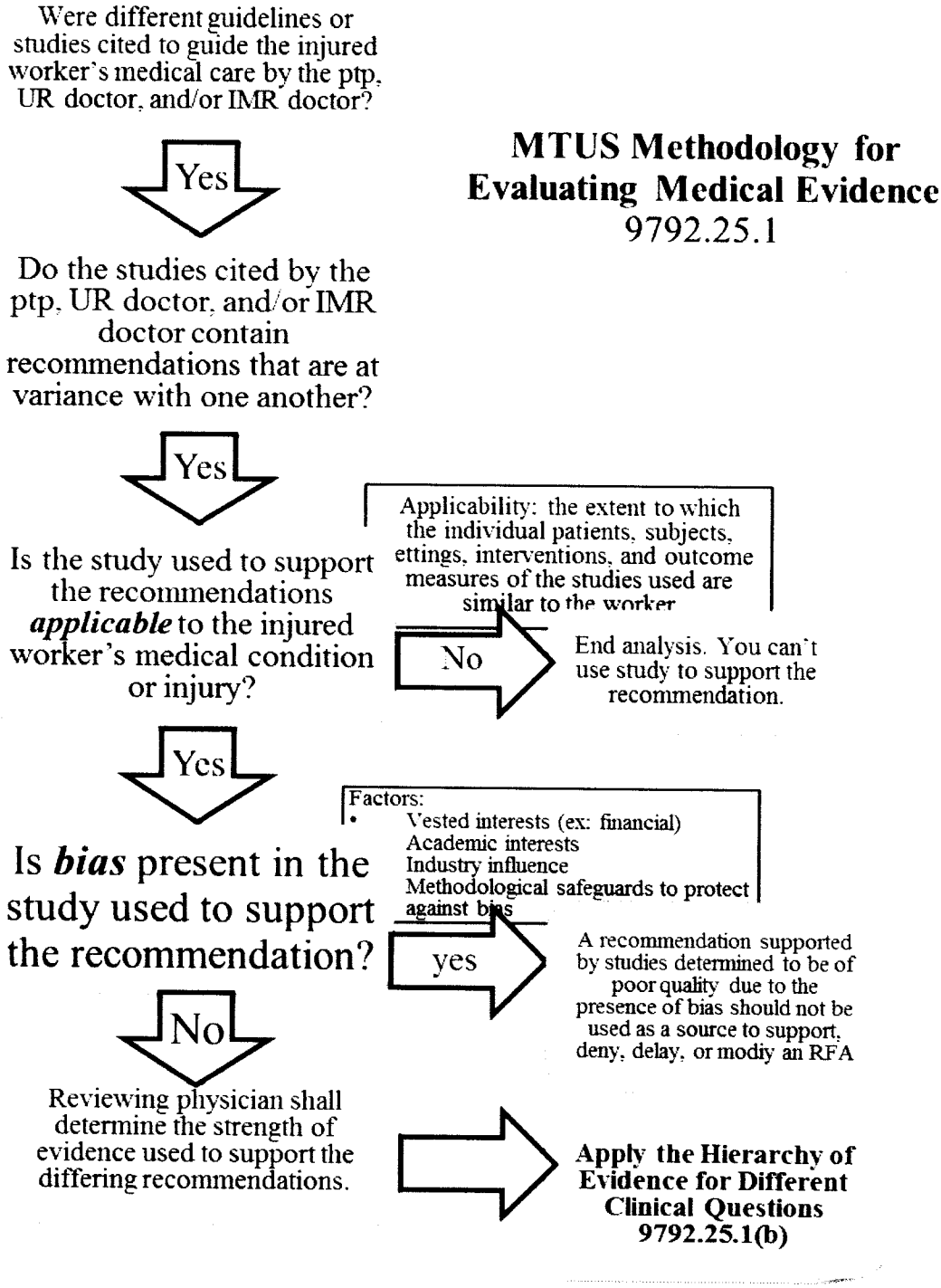
had a right to be heard and present evidence at an expedited hearing. Several issues can arise under these circumstances where evidence must be presented at an Expedited Hearing, including evidence rebutting the MTUS. The case was returned to the trial level for an expedited hearing.

These cases show that the issue is not yet settled. Our position is that the Board has jurisdiction to determine whether the requesting physician has successfully rebutted the MTUS as this is a legal issue, not a medical necessity issue.

What do reviewing physicians do when PTPs and UR/IMR physicians cite guidelines outside the MTUS?

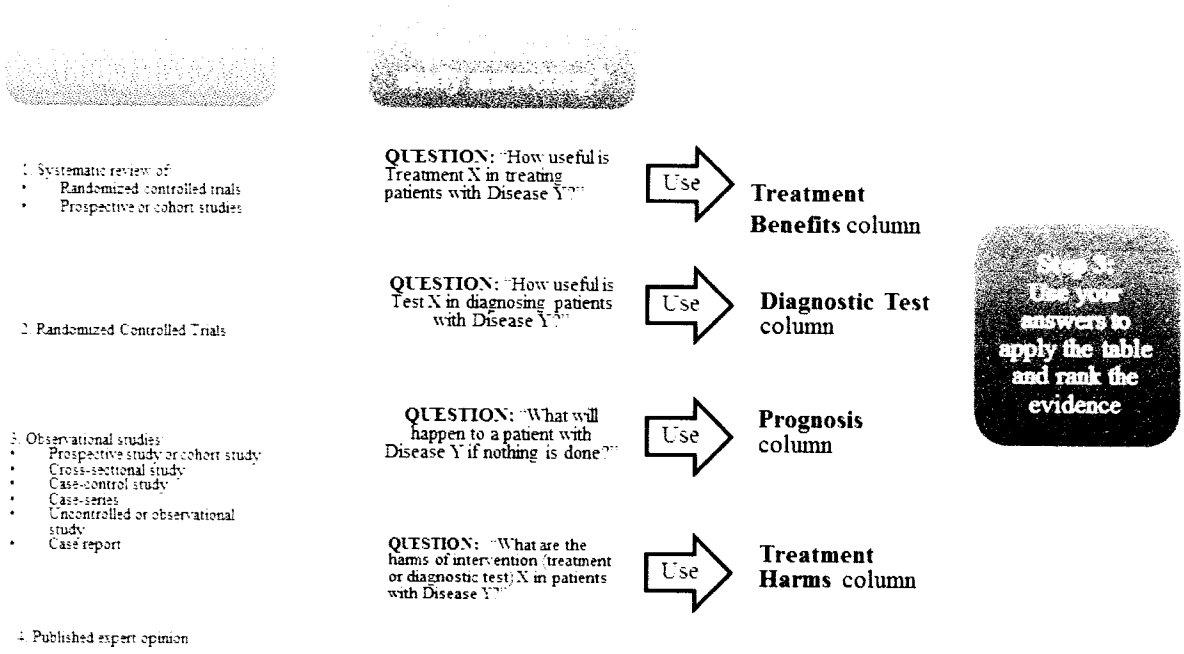
If more than one guideline is cited by the treating physician, UR physician, and/or IMR physician, the reviewer should choose the recommendation that is supported by the best evidence by applying the Methodology for Evaluating Medical Evidence. 9792.25.1. For example, if the PTP cites to some evidence based guideline in the RFA and the reviewing UR physician cites to another evidence based guideline and denies the PTP's request, then the IMR reviewer must use the Methodology for Evaluating Medical Evidence to determine which guideline is supported by the best evidence.

It is important to note that this methodology for evaluating evidence is to be applied to the underlying study supporting the guideline, not the guideline itself.


Were different guidelines or studies cited to guide the injured worker's medical care by the ptp, UR doctor, and/or IMR doctor?
Yes
MTUS Methodology for Evaluating Medical Evidence
9792.25.1
Do the studies cited by the ptp, UR doctor, and/or IMR doctor contain recommendations that are at variance with one another?
Yes
Applicability: the extent to which the individual patients, subjects, ettings, interventions, and outcome measures of the studies used are similar to the worker
Is the study used to support the recommendations applicable to the injured worker's medical condition or injury?
No
End analysis. You can't use study to support the recommendation.
Yes
Factors:
Vested interests (ex: financial)
Academic interests
Industry influence
Methodological safeguards to protect against bias
Is bias present in the study used to support the recommendation?
yes
A recommendation supported by studies determined to be of poor quality due to the presence of bias should not be used as a source to support, deny, delay, or modiy an RFA
No
Reviewing physician shall determine the strength of evidence used to support the differing recommendations.
Apply the Hierarchy of Evidence for Different Clinical Questions
9792.25.1(b)

Hierarchy of Evidence for Different Clinical Questions

If the reviewer determines that the guidelines cited are of good quality, then the reviewing physician must apply the Hierarchy of Evidence for Different Clinical Questions. 9792.25(b). The evidence with the highest ranking should be used.



Systematic review of randomized controlled trials with low risk of bias	Systematic review of high-quality prospective studies (homogeneous sample of patients, consecutively enrolled, all undergoing the index test and reference standard) or systematic review of randomized controlled trials with low risk bias	Systematic review of inception cohort studies or of control arms of randomized controlled trials with low risk of bias	Systematic review of randomized controlled trials with low risk of bias
Randomized controlled trials with low risk of bias	High-quality prospective study or cohort study or randomized controlled trials with low risk of bias	Inception cohort study or control arm from one randomized controlled trial with low risk of bias	Randomized controlled trials with low risk of bias
One or more randomized controlled trials with identified risks of bias (or systematic review of such trials)	Biased cross-sectional study	Cohort study or control arm of randomized controlled trials with identified risks of bias	Prospective study
Non-randomized cohort studies that include controls	Case-control study enrolling a broad spectrum of patients and controls with conditions that may be confused with the disease being considered	Case-series or case control studies	Randomized controlled trial(s) with identified risk of bias
Case-control studies or historically controlled studies	Case-control study using severe cases and healthy controls		Non-randomized controlled cohort/follow-up study

			(post-marketing surveillance)
Uncontrolled studies (case studies or case reports)		Uncontrolled studies (observational studies, case studies, or case reports)	Consistent case reports (for example, individual case safety reports from US Food and Drug Administration, which are available at the following website: www.fda.gov/For Industry/DataStandards/ IndividualCaseSafety Reports/default.htm
Published expert opinion	Published expert opinion	Published expert opinion	Toxicological or mechanistic data that demonstrate or support biologic plausibility

After making her way through the Strength of Evidence standards, the reviewing physician must make a determination to authorize, deny, or modify the medical treatment or uphold/overturn the UR determination. This must be based on the quality and strength of evidence.

Conclusion

What policy are we promoting by having such a complicated process? Correctly applying these guidelines is complicated and challenging for reviewing physicians, attorneys, and treating physicians alike. The PTP has to understand how to select and argue for quality evidence and the UR and IMR reviewing physicians have to correctly apply the complex analysis for choosing the guideline supported by the best evidence.

The result may be that physicians are not challenging the MTUS and injured workers are denied appropriate care simply because the participants are unable to navigate the evidence guidelines.

When more appropriate treatment is supported by other evidence based guidelines, why should the injured worker be bound by the restrictive MTUS guidelines and the complicated process for rebutting them? Instead, adopting a broader set of guidelines would make appropriate medical treatment more accessible to the injured worker.

CAAA is a leader in education in the California workers' compensation community committed to making a better workers' compensation system for all while advocating for the rights of injured workers.

An educational program on the Pearls of the MTUS and how to get treatment approved will be at CAAA's Winter Convention scheduled for January 26 through 29, 2017 at the San Diego Sheraton Hotel & Marina.

We hope you put this on your calendar and can join us.

Note: This practice tip is intended to be advisory only, and does not define or establish any new standard or duty for practitioners.

CAAA Bulletin

Formulary Practice Tip

1303 J Street, Suite 420, Sacramento, CA 95814 P: (916) 444-5155

#3 MTUS Practice Tip – MTUS Drug Formulary ACOEM Guidelines

January 31, 2018

This is the third in a series of practice tips on the MTUS and will focus on the new MTUS Drug Formulary and the relevant MTUS ACOEM Guidelines.

After two years of stakeholder meetings and public hearings hammering out the final details of the regulations, the CA Division of Workers' Compensation has now adopted a drug formulary to implement [redacted] (Perea), which was signed into law by Governor Brown on October 6, 2015. The new formulary went into effect January 1, 2018.

The MTUS Drug Formulary applies to all drugs dispensed on or after January 1, 2018, regardless of the date of injury.

For injuries on or after January 1, 2018 the treating physician should submit their RFA for medications based upon the new MTUS Drug Formulary ACOEM Guidelines.

However, for injuries occurring prior to January 1, 2018, with existing drug treatment plans the MTUS Drug Formulary is to be phased in to ensure that injured workers who are receiving ongoing drug treatment are not harmed by an abrupt change to the course of treatment. **Section 9792.27.3(b) (1)**

To accomplish this, the treating physician is now responsible for submitting a progress report pursuant to section 9785 and a Request for Authorization which addresses the injured worker's ongoing drug treatment plan. **Section 9792.27.3(b) (2)**

The report must be submitted **no later than April 1, 2018** and is required to either:

(A) Include a treatment plan setting forth a medically appropriate weaning, tapering, or transitioning of the worker to a drug pursuant to the MTUS, or

(B) Provide supporting documentation, as appropriate, to substantiate the medical necessity of, and to obtain authorization for, the Non-Exempt drug, unlisted drug, or compounded drug, pursuant to the MTUS (via guidelines, Medical Evidence Search Sequence, and/or Methodology for Evaluating Medical Evidence.) **Section 9792.27.3(b) (2)**

CAAA's #2 MTUS Practice Tip on the Strength of Evidence Guidelines will serve as a refresher on how to conduct a Medical Evidence Search Sequence and the Methodology for Evaluating Medical Evidence .

The progress report, including the treatment plan and Request for Authorization , should be submitted at the time the next progress report is due under section 9785, subdivision (f)(8), however if that is not feasible, **no later than April 1, 2018. Section 9792.27.3(b) (3)**

In order to help treating physicians understand what is required of them with the new drug formulary a letter that outlines the treater's new responsibilities is attached to this tip.

We recommend that you print out this letter, amend it as you see fit, and send it out to physicians who treat workers' compensation patients in your area.

Dr. Steven Feinberg, a CAAA associate member, has also authored the article entitled "THE DWC MTUS ACOEM GUIDELINES & FORMULARY" which is included with this practice tip.

We believe this document needs to be widely distributed to physicians who treat injured workers. It includes a wealth of information that is critically important to treating physicians in dealing with the new MTUS drug Formulary. CAAA will also make this document available to the general public on its website.

Note: This practice tip is intended to be advisory only, and does not define or establish any new standard or duty for practitioners.

THE DWC MTUS ACOEM GUIDELINES[1] & FORMULARY[2]

STEVEN D. FEINBERG, MD, MPH

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[1] http://www.dir.ca.gov/dwc/MTUS/MTUS-Guidelines.html
[2] http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/MTUS-Formulary.htm

Table of Contents

SUMMARY TABLES

SUMMARY OF IMPORTANT MTUS FORMULARY METHODOLOGY POINTS

- Formulary does not limit access to any FDA-approved drug, all non-exempt and unlisted medications are available through the usual prospective review process.
- **MTUS Drug List**
  - **Exempt drugs – No Prospective Review if in accord with MTUS**
    - Being noted as a first line therapy weighs in favor of being Exempt.
    - Recommended for most acute and or acute/chronic conditions addressed in clinical guidelines weighs in favor of being Exempt.
    - A safer adverse effects (risk) profile weighs in favor of being Exempt.
    - Drugs listed for the treatment of more common work-related injuries and illnesses weighs in favor of being Exempt.
  - **Non-Exempt & Unlisted Drugs – Prospective Review required**
  - **"Special Fill" & "Perioperative Fill"** of specified Non-Preferred drugs
    - 4-day supply of certain nonexempt drugs in limited situations
    - No prospective review of certain nonexempt drugs during the perioperative period
- Ancillary Formula Rules: Intended to support the provision of appropriate, cost effective, high-quality medical care.
  - Access to non-preferred and unlisted drugs.
  - Off-label use allowed as recommended by the MTUS guidelines.
  - Generic drug preference; requirements for brand name drug.
  - Compounded drugs must be authorized through prospective review prior to being dispensed.
  - Physician dispensing:
    - Must be authorized through prospective review prior to being dispensed.
    - May dispense up to a 7-day supply of an exempt drug on a one-time basis as long as drug treatment is in accordance with the MTUS treatment guidelines.
- Structure of MTUS Drug List
  - Organized by active drug ingredient
  - Reference Brand
  - Exempt / Non-Exempt status
  - Special Fill & Perioperative Fill
  - Drug class
  - Reference in Guideline "legend"
    - (✓) Recommended
    - (✕) Not Recommended
    - (⊘) No Recommendation
  - Dosage Form, Strength, Product ID

PHYSICIAN STEPS TO FORMULARY USE

1. Go to MTUS Formulary Drug List:
   a. Excel spreadsheet version: http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/Final-Regulations/DRUG-LIST.xls
   b. PDF version: http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/Final-Regulations/DRUG-LIST.pdf
   c. **Drug MUST be used in conjunction with MTUS Guidelines** (i.e., the MTUS must support use of the drug for the diagnosis/body part – see column 8, Reference in Guidelines)
   d. See links to MTUS Guidelines on page 8
   e. See information on page 8 re: purchase of electronic access to MDGuidelines
2. **Look up drug** in column 2, Drug Ingredient from Formulary Drug List
   a. **If Exempt** (column 3), go to #3
   b. If **Non-Exempt** (column 3) or if **Unlisted** (not listed in the Formulary) go to #4
   c. **Special Fill** (column 5) go to #5
   d. **Perioperative Fill** (column 6) go to #6
3. **Exempt** (always prescribed/dispensed in accordance with MTUS)
   a. May be prescribed without authorization
   b. Physician dispensed drugs limited to one 7-day supply at initial visit within 7 days of injury
   c. Must get authorization to use Brand name if generic available
4. **Non-Exempt** or **Unlisted** (requires authorization prior to prescribing or dispensing)
5. **Special Fill** (drug may be prescribed/dispensed without prior authorization/prospective review)
   a. Prescription at initial visit within 7 days of injury, and
   b. supply not to exceed #days indicated, and
   c. is a generic or single source brand, or brand where physician substantiates medical necessity, and
   d. if in accord with MTUS
6. **Perioperative Fill** (drug may be prescribed/dispensed without prior authorization/prospective review)
   a. Rx issued during the perioperative period (2-4 days before through 4 days after surgery), and
   b. supply not to exceed #days indicated, and
   c. is a generic or single source brand, or brand where physician substantiates medical necessity, and
   d. if it is in accord with MTUS.
7. **Ancillary Formula Rules**
   a. Off-label use: allowed as recommended by the MTUS guidelines
   b. Generic drugs preferred
   c. Compounded drugs must be preauthorized
   d. Physician dispensing
      i. Must be authorized through prospective review prior to being dispensed
      ii. May dispense up to a 7-day supply of an exempt drug on a one-time basis as long as drug treatment is in accordance with the MTUS treatment guidelines

SUMMARY OF IMPORTANT OPIOID & TAPERING POINTS

- **DWC MTUS** Opioid Guidelines and Chronic Pain Guidelines are **presumptively correct**.
- Physician must provide quality review of records, medical history and physical examination with recommendations that meet evidence-based medicine (EBM) guidelines.
- **Transition** (for injured workers receiving ongoing drug treatment for injury prior to 1/1/18):
  - Formulary should be phased in to avoid harm from abrupt change to drug treatment.
  - Physician responsible for requesting medically appropriate & safe treatment in accordance with MTUS.
  - Treatment may include Non-Exempt/Unlisted drug if necessary for injured worker condition, or for safe weaning/tapering/transition to different drug.
  - Physician must submit RFA with ongoing drug treatment plan including tapering, weaning, transitioning to drug pursuant to MTUS or provide documentation supporting medical necessity for Non-Exempt/Unlisted/compounded drug per MTUS.
  - Previously approved drug treatment shall not be terminated/denied except as may be allowed by MTUS, and in accord with applicable UR/IMR regulations.
- Opioid use is moderately not recommended for treatment of subacute and chronic nonmalignant pain.
- The maximum daily opioid dose recommended for opioid naïve, acute or postoperative or subacute and chronic pain patients based on risk of overdose/death is 50 mg MED[3] (morphine equivalent dose).
- Opioid prescription should be patient specific, and limited to cases in which other treatments are insufficient and criteria for opioid use are met.
- The use of an opioid trial is recommended when other evidence based approaches for functional restorative pain therapy have been used, and documented to have provided inadequate improvement in function.
- While opioids may be effective in moderate doses in certain individuals, they also carry significant risks of harm.
- Opioid tapering/weaning must be medically safe - the goal is to safely reduce medications that are not efficacious while monitoring negative effects of withdrawal symptoms.
- It is medically unsafe and risky for the injured worker to abruptly stop taking certain medications - this is especially true in the medically compromised individual.
- While opioid tapering/weaning or detoxification may be appropriate, the real issue is the injured workers well-being and function (activities of daily living).
- Physicians who feel uncomfortable or are unsuccessful with managing an opioid taper or wean, should refer to the appropriate chronic pain specialist or addictionologist.
- The frequency/duration of a taper is dependent on multiple factors and is patient specific.
- The most common taper is 10% per week; again, tapering needs to be patient specific.[4]
- Guidelines support patient engagement in tapering with provision of education by the physician or others along with involvement in other active therapies including cognitive behavioral therapy and progressive physical reactivation.
- The taper should be stopped if there is objective worsening of function, excessive withdrawal, and/or intolerance. After stabilization, resumption of the taper should be attempted.
- Not all patients can be completely tapered off opioids and in specific cases, continuation of the opioid may be a consideration as well as the substitution of buprenorphine or methadone.
- The CA DWC MTUS Formulary Drug List needs to be understood by the treating physician to be used effectively.
- Treatment alternatives are supported by the CA DWC MTUS.

CA DWC MTUS DRUG FORMULARY[5]

On January 1, 2018, the MTUS Drug Formulary takes effect for all drugs dispensed regardless of the date of injury.

According to Section 9792.27.3, the MTUS Drug Formulary should be phased in to ensure that injured workers who are receiving ongoing drug treatment are not harmed by an abrupt change to the course of treatment. The physician is responsible for requesting a medically appropriate and safe course of treatment for the injured worker in accordance with the MTUS, which may include use of a Non-Exempt drug or unlisted drug, for an extended period where that is necessary for the injured worker's condition or necessary for safe weaning, tapering, or transition to a different Preferred drug.

For dates of injury prior to 1/1/18, if the injured worker has been receiving treatment that includes a nonexempt drug, an unlisted drug, or a compounded drug, the physician shall submit a progress report and a Request for Authorization (RFA) that shall address the injured worker's ongoing drug treatment plan. The plan should 1) set forth medically appropriate weaning/tapering/transitioning to a drug pursuant to the MTUS, or 2) provide supporting documentation to substantiate the medical necessity of, and to obtain authorization for, the nonexempt drug, unlisted drug, or compounded drug, pursuant to the MTUS.

The MTUS Drug List must be used in conjunction with 1) the MTUS Guidelines, which contain specific treatment recommendations based on condition and phase of treatment and 2) the drug formulary rules.

"Reference in Guidelines" indicates guideline topic(s) which discuss the drug. In each guideline there may be conditions for which the drug is Recommended (✓), Not Recommended (✗), or No Recommendation (⊘). Consult guideline to determine the recommendation for the condition to be treated and to assure proper phase of care use.

"Exempt" indicates drug may be prescribed/dispensed without seeking authorization through Prospective Review if in accordance with MTUS.

1. Physician dispensed "Exempt" drugs limited to one 7-day supply at initial visit within seven days of the date of injury without Prospective Review.
2. Prescription/dispensing of Brand name "Exempt" drug where generic is available requires authorization through Prospective Review.

"Non-Exempt" or "Unlisted" drug requires authorization through Prospective Review prior to prescribing or dispensing.

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[3] A morphine equivalent dose (MED) is the amount of opioid prescription drugs, converted to a common unit (milligrams of morphine)

[4] While expeditious for communication purposes, this can lead to a prolonged tapering plan as the endpoint is only reached asymptomatically–practical management would suggest a tapering of 10% of the number of tablets of usual dose size each week - sdf

[5] hhttp://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/MTUS-Formulary.htm

Special Fill - Indicates the Non-Exempt drug may be prescribed/dispensed without Prospective Review:

1. Prescription at initial visit within 7 days of injury, and
2. supply not to exceed #days indicated, and
3. is a generic or single source brand, or brand where physician substantiates medical necessity, and
4. if in accord with MTUS.

Perioperative Fill – Indicates the Non-Exempt drug may be prescribed/dispensed without Prospective Review:

1. Rx issued during the perioperative period (2-4 days before through 4 days after surgery), and
2. supply not to exceed #days indicated, and
3. is a generic or single source brand, or brand where physician substantiates medical necessity, and
4. if it is in accord with MTUS.

NAVIGATING THE CA DWC FORMULARY–SPECIFIC APPROACHES

Staying within the California DWC Formulary:

1. Follow the MTUS recommendations for evaluation and treatment.
2. Use alternate "Exempt" drugs.
3. Use generics, when available.
4. Use MTUS to the injured worker's advantage.
    a. Use the MTUS for the specific condition and the MTUS Formulary as a guide to getting specific medications authorized.
    b. Monitor past utilization review (UR) and independent medical review (IMR) decisions to better understand what is denied and what is approved.

DWC MTUS GUIDELINES

The DWC MTUS is based on the ACOEM Guidelines.

- **ACOEM Guidelines**
  - **Initial Approaches to Treatment Guideline** (ACOEM June 30, 2017)
  - **Cervical and Thoracic Spine Disorders Guideline** (ACOEM May 27, 2016)
  - Shoulder Disorders Guideline (ACOEM August 1, 2016)
  - Elbow Disorders Guideline (ACOEM 2013)
  - **Hand, Wrist, and Forearm Disorders Guideline** (ACOEM June 30, 2016)
  - **Low Back Disorders Guideline** (ACOEM February 24, 2016)
  - **Knee Disorders Guideline** (ACOEM October 28, 2015)
  - **Ankle and Foot Disorders Guideline** (ACOEM September 2015)
  - **Eye Disorders Guideline** (ACOEM April 1, 2017)
  - **Hip and Groin Guideline** (ACOEM May 1, 2011)
  - **Occupational/Work-Related Asthma Medical Treatment Guideline** (ACOEM January 4, 2016)
  - **Occupational Interstitial Lung Disease Guideline** (ACOEM January 4, 2016)
  - **Chronic Pain Guideline** (ACOEM May 15, 2017)
  - **Opioids Guideline** (ACOEM April 20, 2017)

MDGUIDELINES

The ACOEM Occupational Medicine Practice Guidelines are published by ReedGroup and are and are accessible electronically through a subscription to the MDGuidelines website (http://www.mdguidelines.com/) and includes the ACOEM Formulary and a searchable interface with chapters that are updated with ACOEM's evidence-based methodology. This online tool also provides users with first access to chapters as they are updated.

California medical providers who are new subscribers may obtain an click on the link to obtain the discounted license) to the ACOEM guidelines and formulary at a discounted rate of $100/year. Other users will need to obtain license information by contacting ReedGroup / Joe Guerriero: via email to jguerriero@reedgroup.com or by phone (720) 456-4387.

MTUS SEARCH SEQUENCE: STRENGTH (OR HIERARCHY) OF EVIDENCE GUIDELINES

The DWC MTUS search sequence to be followed can be found at Medical Evidence Search Sequence.

Treating physicians and medical reviewers shall conduct the following medical evidence search sequence for the evaluation and treatment of injured workers.

(1) Search the recommended guidelines set forth in the current MTUS to find a recommendation applicable to the injured worker's medical condition or injury. *(NB: If a treater agrees with and follows the treatment guidelines as documented in the current CA MTUS, there is no need to proceed further).*

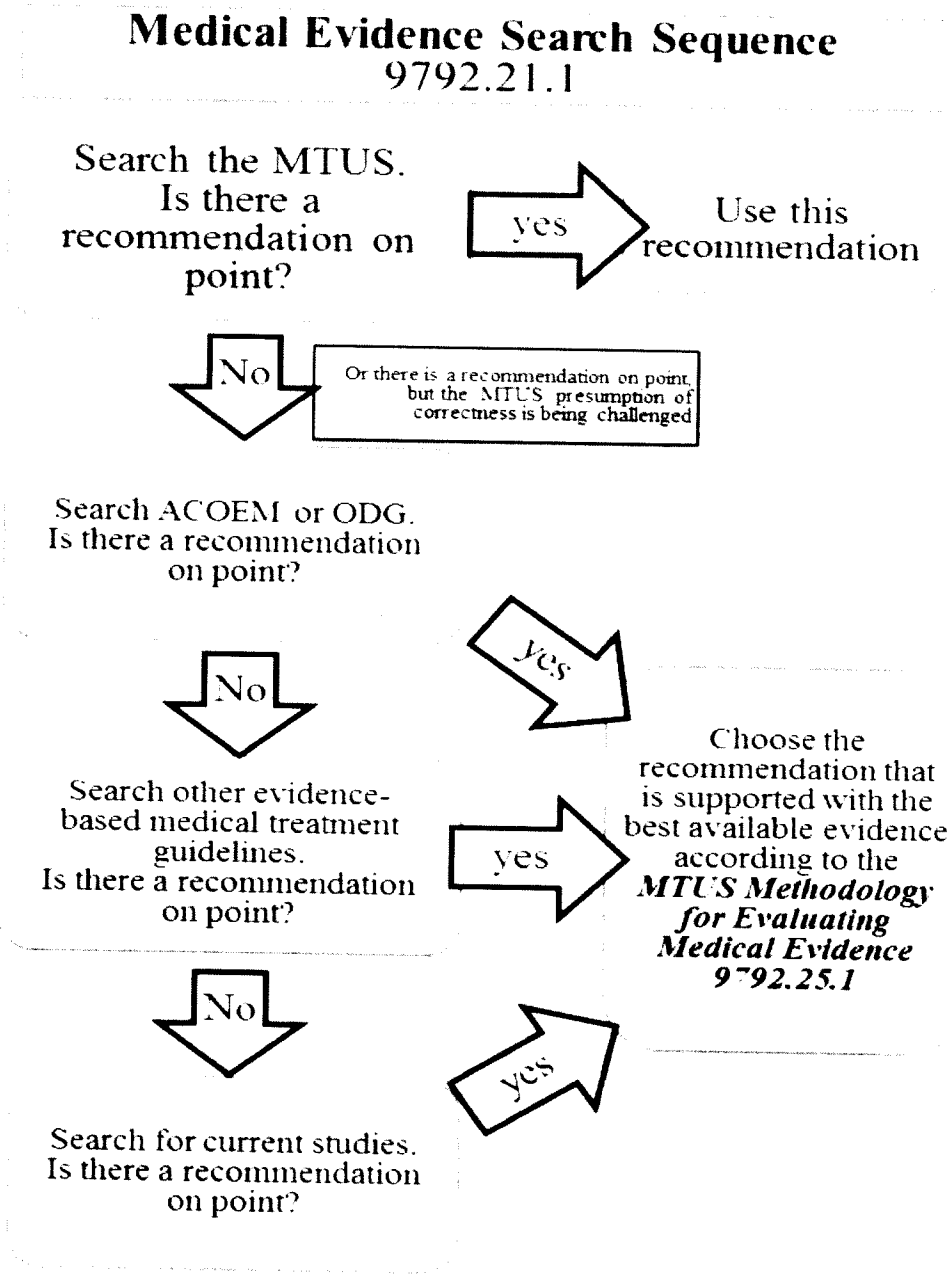
(2) In the limited situation where a medical condition or injury is not addressed by the MTUS or if the MTUS' presumption of correctness is being challenged, then:

A. Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then

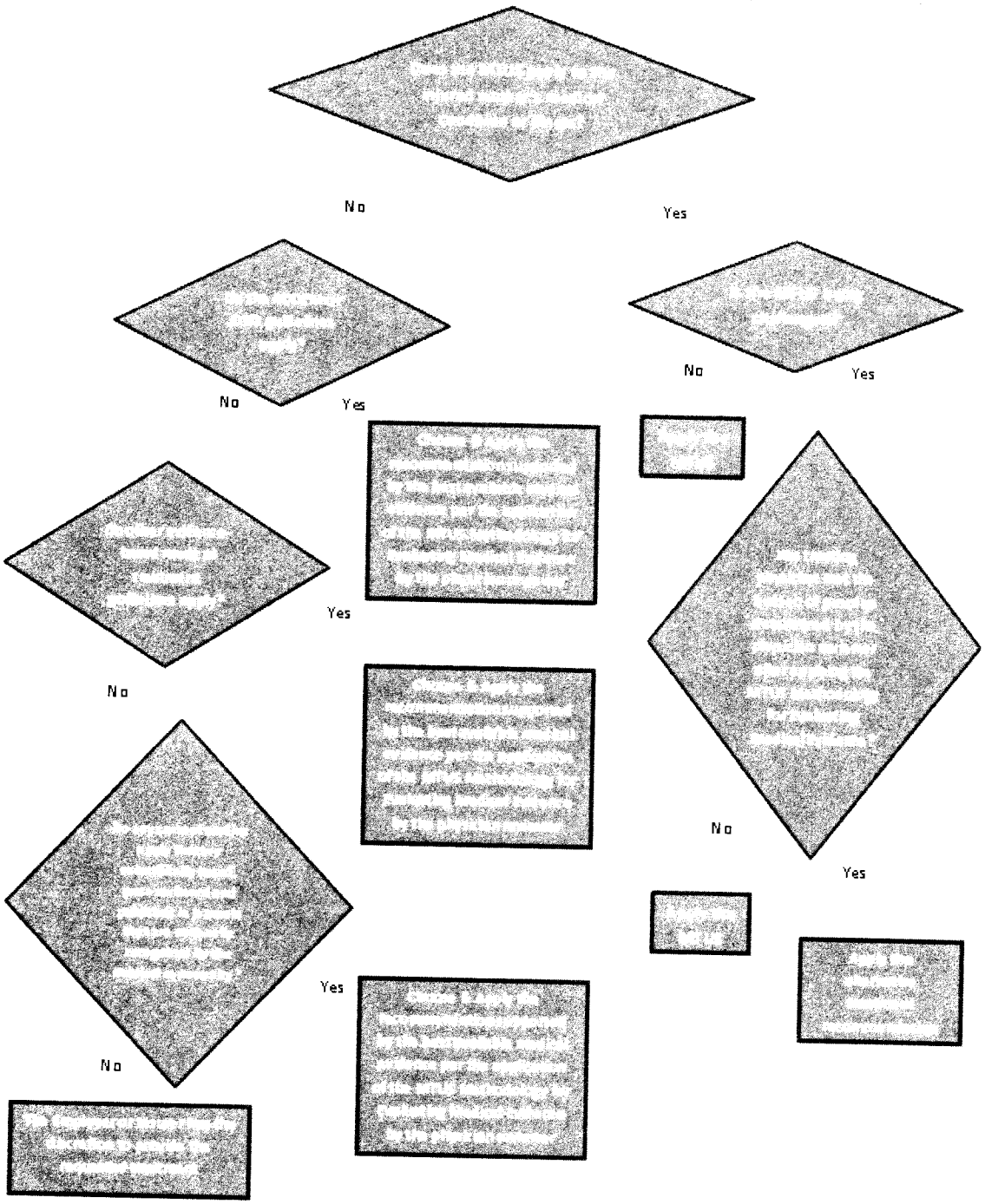
B. Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then

C. Search for current studies that are scientifically-based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury.

The following chart is provided permission from the California Applicants' Attorneys Association (CAAA), an explanatory graphic of the **Medical Evidence Search Sequence** is provided. CAAA has graciously also provided a Link to a CAAA Bulletin, MTUS Practice Tips, at #2 MTUS Practice Tips - Strength of Evidence Guidelines which I highly recommend to you.


Medical Evidence Search Sequence
9792.21.1
Search the MTUS. Is there a recommendation on point?
yes
Use this recommendation
No
Or there is a recommendation on point, but the MTUS presumption of correctness is being challenged
Search ACOEM or ODG. Is there a recommendation on point?
yes
No
Search other evidence-based medical treatment guidelines. Is there a recommendation on point?
yes
Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence 9792.25.1
No
Search for current studies. Is there a recommendation on point?
yes

The following chart was developed by the DWC during rulemaking process and can also be found at



PHYSICAN INTEGRITY - STANDARD OF CARE/MALPRACTICE ISSUES

The physician has a moral, ethical and legal obligation to practice safe and effective medicine and to do no harm (primum non nocere). The physician may find himself or herself in a quagmire when prescribed medically necessary recommended treatment is denied. If evidence based medicine guidelines truly are in contrast to the physician's treatment recommendations, then the injured worker should not suffer or be less functional. The ACOEM and CDC Opioid Guidelines are very clear in noting that each patient is unique, should have input into decision making, and that tapering/weaning/detoxification is not "one size fits all" and that the end result is quality patient care and pain management leading to life satisfaction and the highest level of function possible.

The DWC MTUS provides a search sequence to get treatment authorized (see page 9). If the physician believes that the prescribed treatment is medially necessarily and within the standard of care, when there is a denial of care, the physician should follow the MTUS search sequence.

Here are some quotes regarding the standard of practice:

- National Association for Healthcare Quality
    - Healthcare quality professionals' primary commitment is to the health, well-being, and safety of patients.
- NOLO
    - Most medical malpractice cases hinge on whether a health care professional was negligent in treating (or failing to treat) a patient. And medical negligence is always measured by the medical standard of care that applied in the specific treatment setting in which the patient was harmed. The "medical standard of care" is typically defined as the level and type of care that a reasonably competent and skilled health care professional, with a similar background and in the same medical community, would have provided under the circumstances that led to the alleged malpractice.
- Judicial Council of California; Standard of Care for Healthcare Professionals,
    - A [insert type of medical practitioner] is negligent if [he/she] fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful [insert type of medical practitioners] would use in the same or similar circumstances. This level of skill, knowledge, and care is sometimes referred to as "the standard of care." [You must determine the level of skill, knowledge, and care that other reasonably careful [insert type of medical practitioners] would use in the same or similar circumstances, based only on the testimony of the expert witnesses [including [name of defendant]] who have testified in this case.][6]

[6] Judicial Council of California; Standard of Care for Healthcare Professionals, http://www.thelaw.net/download/CCA_CIVIL-JURY.pdf

OPIOID ISSUES

MTUS (ACOEM) OPIOID GUIDELINES

The CA DWC MTUS is using the ACOEM Opioid Guidelines[7]. It is important to understand these guidelines if the physician is going to recommend and get authorization for the prescription of opioids in the treatment of injured workers.

1. Appropriate pain management is a responsibility of those treating pain.

2. It requires adequate knowledge about, and assessment of, a patient's pain and function.

3. Pain management often requires multiple pharmacological and nonpharmacological methods to appropriately control pain that should be evaluated.

4. A comprehensive history and physical examination and documentation is required.

5. A clear diagnosis is critical with treatment recommendations that are evidence-based.

6. When considering prescribing opioid, the treating physician should have a clear, quantified treatment plan and functional goals. These goals should be Specific, Measurable, Achievable, Realistic and Time-based (SMART).

7. The documentation should include a discussion and plan for the 5As:

    1. Analgesia (reduction in pain);
    2. Activity increase (improved level of functional and meaningful activities, and especially in work-related injuries, returning to work);
    3. Adverse effects (any side effects, especially constipation, dizziness, confusion and inability to function due to opioids);
    4. Aberrant behaviors (self-dose escalation, poor compliance, continued 'pain behaviors' despite use of opioids); and
    5. Affect (mood changes such as worsening of depression).

8. Documentation should include informed consent including an agreed-on opioid treatment agreement and monitoring results (urine drug testing, questionnaire screening tools, the California CURES prescription database, etc.).

9. Due to the greater than 10-fold elevated risks of adverse effects and death, considerable caution is warranted among those using other sedating medications and substances including:

    i. Benzodiazepines,
    ii. Anti-histamines (H1-blockers), and or

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[7]

iii. Illicit substances.

10. Considerable caution is also warranted among those who (are/have):

i. Older (>65 years),
ii. Pregnant,
iii. Sleep apnea, psychiatric/mental health disorders (anxiety, depression, personal salivary disorder, suicidal),
iv. Drug-seeking behavior,
v. current or past substance abuse,
vi. Consuming alcohol in combination with opioids,
vii. Renal insufficiency,
viii. Hepatic insufficiency, and who are
ix. Unemployed (10-fold risk of death).

11. Due to elevated risk of death and adverse effects, caution is also warranted when considering prescribing opioid for patients with any of the following characteristics:

i. Other psychotropic medications,
ii. Current tobacco use,
iii. Attention deficit hyperactivity disorder (ADHD),
iv. PTSD,
v. Impulse control problems,
vi. Thought disorders,
vii. COPD, or
viii. Recurrent pneumonia.

12. Additional risks and/or adverse effects thought to be present from other medical comorbidities.

13. Opioids are not indicated for MILD injuries (e.g., strains, tendinitis, nonspecific pain, mild to moderate low back pain).

14. Opioids MAY BE indicated for MODERATE injuries (e.g., Severe sprains of moderate or large joints, moderate trauma, moderate to severe low back pain).

15. Opioids ARE indicated for SEVERE injuries (e.g., fractures, major trauma, large burns).

16. Post-operative pain (up to 4 weeks, there is limited use of opioids as an objective therapy to more effective treatments.[8]

17. Opioid use is moderately not recommended for treatment of **subacute and chronic nonmalignant pain**.

1. Opioid prescription should be patient specific, and limited to cases in which other treatments are

[8] Most current recommendations include provision of a three-day prescription followed by weekly prescriptions and concurrent recommendations for daily dose tapering as an active part of the postoperative recovery plan - sdf.

insufficient and criteria for opioid use are met.

2. The use of an opioid trial is recommended when other evidence based approaches for functional restorative pain therapy have been used, and documented to have provided inadequate improvement in function.
3. Screening of patients is recommended prior to initiating a trial of opioids for treatment of subacute or chronic pain.

18. The **maximum daily opioid dose** recommended for opioid naïve, acute or postoperative or subacute and chronic pain patients based on risk of overdose/death is **50 mg MED** (morphine equivalent dose).

19. Rotation of opioids is selectively recommended but should be an infrequent requirement.

20. **Buprenorphine** is selectively recommended for adjunctive treatment and opioid tapering.[9] Most patients are weaned without use of controlled substance medication. Buprenorphine is sometimes used for detoxification from high-dose opioids and is recommended for selected cases with opioid use at over 50–90 MG MED for at least 3 months duration as well as for the treatment of addiction. As treatment of these conditions is behaviorally and medically challenging, most are treated by an addiction specialist (e.g., high-dose patients, prior withdrawal problems, complex psychosocial confounders, complicating medical conditions). When there are complex medical issues (e.g., significant cardiovascular disease), inpatient treatment may be indicated. Buprenorphine is not generally recommended for those with no demonstrated functional gains; noncompliance; use of illicit substances; use of alcohol with opioids; and/or adverse effects of opioids (e.g., cognitive impairment, falls, poor judgment, untreated sleep apnea, psychological disorders, use of benzodiazepines). Transitioning to only an NSAID or acetaminophen for complete cessation of analgesics is/are generally preferable to substitution with buprenorphine.

21. **Breakthrough Pain (BTP)** is a transient increase in pain to greater than moderate intensity, which occurred on baseline pain of moderate intensity or less. It is also defined as "the transient exacerbation of pain occurring in a patient with otherwise stable, persistent pain." Opioids are not recommended for routine treatment of breakthrough superimposed on chronic pain in the absence of overt trauma or acute nociceptive pathology (e.g., fracture, myocardial infarction, tooth abscess).

22. **Intrathecal Drug Delivery Systems** are not recommended for the treatment of chronic nonmalignant pain.

[9] Buprenorphine is not well tolerated by all patients and therefore needs to be considered only as a potential tool in the management of Chronic Opioid Therapy and or Chemical Dependence disorder - sdf

MEDICALLY SAFE TAPERING/WEANING OFF PAIN MEDICATIONS

The ability for opioids to cause physical dependence means that when withdrawn, discomforting physical symptoms occur. To reduce the severity of withdrawal symptoms (e.g., drug craving, anxiety, vomiting/diarrhea, increased heart rate and blood pressure; sweating; tremors, anxiety), discontinuation of opioid therapy should be done through a gradual dose reduction (i.e., wean/ taper).

Each injured worker is unique when he comes to weaning/detoxification. Some injured workers can just stop abruptly without side effects and others go into severe withdrawal. The focus needs to be on function and not on the medication. Medications that increase function with little or no untoward side effects are medically reasonable.

Questions to ask: Are the medications actually making a difference? Are they making the person's life better and improving function? Are the benefits worth any side effects and negative effects? In other words, taking pain medications is a choice that each person must make by weighing the benefits vs. the risks.

When there is lack of efficacy and/or the risks appear to outweigh the benefits of taking a pain medication, reducing the dose and ultimately discontinuing the medication should be considered. This is called weaning or tapering particularly when the individual has become dependent on the medication. The term "detoxification" is sometimes used interchangeably but should be limited to cases with opioid addiction.

The goal of tapering/weaning down the dose is to safely discontinue medications that do not seem helpful in reducing pain while allowing the body to adjust while monitoring for negative effects of withdrawal symptoms. Oftentimes, people discover they feel better taking lower doses, fewer medications, or not taking medications at all.

It is dangerous to abruptly stop taking some medications (sometimes referred to as going "cold turkey"). Because the body develops physical dependence to some medications when they are taken regularly, abrupt withdrawal or too rapid a reduction in the dose of these medications can be very uncomfortable or even hazardous to one's health. It depends on the type of medication, how much, and for how long the medication has been taken.

MTUS (ACOEM) OPIOID GUIDELINE RECOMMENDATIONS

Discontinuance of opioids is recommended by the ACOEM Opioid Guidelines for acute and postoperative patients who have reached meaningful functional recovery. Discontinuance is also recommended for subacute and chronic pain patients who i) use opioids on a chronic basis, and ii) [any one of] no demonstrated function gain, noncompliance, aberrant drug screening results and/or diversion, adverse effects (e.g., cognitive impairment, falls, poor judgment, untreated sleep apnea, psychological disorders, and concurrent use of depressant medications such as benzodiazepines and diphenhydramine).

Immediate discontinuation without tapering is recommended for those who have a urine drug screen (UDS) showing unexpected absence of the prescribed drug. Among those with urine drug testing results showing nonprescribed licit or illicit substance(s) use, discontinuation is recommended, although tapering may be

advisable if the opioid is thought to be taken as prescribed (e.g., rather than partially diverted) and the doses over 50 mg MED.

Tapering is recommended if the opioid was used at a moderate or high level (e.g., above 50–90 milligram MED) on a chronic basis. Consultation with an addiction specialist or psychiatrist as recommended for complex patients (e.g., high-dose patients, prior withdrawal problems, complex psychosocial confounders, complicating medical conditions).

Transitioning to only an NSAID or acetaminophen or complete cessation of opioids is/are generally indicated.

The frequency/duration of a taper is empirical, dependent on dose, prior opioid use duration, and informed patient decision-making. Rates of the taper vary. The following are options:

- 10% per day
- 20% every 3-5 days
- 10% per week
- 25% per week
- 20–50 percent per day until lower doses reached
- Faster tapers over a few days have been safely accomplished

The speed of the taper should generally be an informed choice involving the patient, as some well prefer a faster or slower taper.

- The slowest taper in common use is 10% per week, thus lasting 10 weeks.
- A faster taper is 25% per week for 4 weeks.
- Some will opt to taper over, e.g., 10 days.

(Clear communication in tapering may be achieved by reducing the number of tablets of the chosen drug by one per day over each tapering interval. In this way the patient can have a predetermined number of tablets for that day's use described on a tapering calendar to assist in providing clear education regarding the process. If there is concern about overuse during the tapering process, weekly refills of decreasing amounts may reduce the opportunity for that overuse - sdf).

The ACOEM Opioid Guidelines offers a recommended process:

1. Develop a taper planned. Elements of the plan include: 1) agreement to taper, 2) education on expected symptoms during the taper, 3) return visits for intolerable symptoms with consideration of a pause in the taper, and 4) other treatments to be changed or substituted.
2. The provider should be supportive and engaged in the patient's care, management and concerns. 'Do not abandon' the patient. Considering engaging the patient in other active therapies during taper (e.g., progressive active exercises, cognitive behavioral therapy, education, psychiatric consultation, psychiatric medication). Consider judicious use of passive therapies (e.g., acupuncture, TENS, manipulation) as adjuncts in assisting tapering.
3. Rate of tapering is not critical, rather the direction of the doses. A typical wean is 10%/week to 10%/month in chronic pain patients and outpatient settings. Tapers may be faster in inpatient and more controlled

settings, or when use has been for short a period of time. Brief negotiated pauses in the rate of taper is acceptable.

4. Educate the patient that taper will produce symptoms. These include anxiety, emotional distress, hyperalgesia, experiencing pain in new areas. These are expected and not contraindications to taper, although if intolerable, may be a rationale for a brief pause in a taper.
5. The taper should be stopped if there is objective worsening of function, excessive withdrawal, and/or intolerance. After stabilization, resumption of the taper should be attempted. However, if there is a plateau level where function is achieved, that dose should be noted in the records and maintained for an ongoing basis. There is consideration for reattempting taper in subsequent years.

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN — UNITED STATES, 2016[10]

When opioids are reduced or discontinued, a taper slow enough to minimize symptoms and signs of opioid withdrawal (e.g., drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, diaphoresis, mydriasis, tremor, tachycardia, or piloerection) should be used. A decrease of 10% of the original dose per week is a reasonable starting point; experts agree that tapering plans must be individualized based on patient goals and concerns.

In theory, the longer a patient has been on opioid therapy, the slower the taper may need to be. Additionally, tapers may need to be paused and restarted again per patient response and be more gradual once patients reach low dosages. According to these guidelines, "tapers may be considered successful as long as the patient is making progress."

The idea behind these guideline statements is to allow patients to drive the process of weaning as much as possible because the decision to wean, after years of use, requires a significant commitment from the patient. It is important to consider that opioid weaning is not a discontinuation of care.

Once the smallest available dose is reached, the interval between doses can be extended. Opioids may be stopped when taken less frequently than once a day. More rapid tapers might be needed for patient safety under certain circumstances (e.g., for patients who have experienced overdose on their current dosage).

In many ways, opioid weaning requires as much attention, treatment, and care as opioid initiation.

Patients who are not taking opioids (including patients who are diverting all opioids they obtain) do not require tapers. Clinicians should discuss with patients undergoing tapering the increased risk for overdose on abrupt return to a previously prescribed higher dose.

Collaboration among relevant health providers and psychosocial support is needed to ensure success. While acute withdrawal symptoms may subside, depressive-like symptoms may persist for weeks or months. This is referred to as "protracted abstinence syndrome." Protracted abstinence syndrome presents risk of relapse and continual care may be necessary to manage this risk.

Some medications may be safe to stop abruptly.

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a. For instance, a medication that is taken for just a few days or only taken once in a while (e.g., once a week).
b. Medications that are prescribed when necessary (prn - as needed, not taken regularly).
c. Some medications that do not produce physical dependence (e.g., acetaminophen, nonsteroidal anti-inflammatory drugs [NSAIDs – like aspirin, ibuprofen and others]).

Some medications always require medical supervision when stopped:

a. Opioids that have been taken in regular daily doses for several days or longer.
b. Benzodiazepines, muscle relaxants, antidepressants, and anticonvulsant medications that have been taken in regular daily doses for several days or longer.
c. Barbiturates taken frequently for headache (butalbital).

Weaning off medications may be complicated by the potential for increased levels of pain that may accompany dose reduction, but can be done safely under medical supervision. The health care professional determines the rate at which the dose is reduced and adjustments can be made as necessary.

For example, reasonable opioid weaning protocols suggest decreasing pill intake by 10-20 percent per week, as tolerated. Hydration (drinking water), relaxation, and emotional support are all important to enhance the likelihood of success.

Sometimes weaning or discontinuing medication (especially opioids) is most safely accomplished under the close supervision of a specialist (such as a pain or addiction medicine specialist) in a medically-supervised program to prevent complications and severe withdrawal symptoms.

Symptoms of withdrawal from opioids can include:

a. worsening of pain
b. rapid heart beat
c. high blood pressure
d. sleeplessness
e. agitation and anxiety
f. stomach cramps, nausea, vomiting, diarrhea
g. body aches (flu-like symptoms) and muscle cramps
h. runny nose, sweating, tearing, yawning, goose bumps

Prescription medications that can help diminish symptoms of opioid withdrawal include:

a. Alternative opioids:
    i. Methadone
    ii. Buprenorphine
b. Non-opioid detoxification
    iii. alpha-2 agonists (clonidine) – blood pressure needs to be monitored while taking this medication
    iv. anti-nausea medications (e.g. ondansetron, metoclopramide)

v. anti-diarrheal (loperamide)
vi. muscle relaxants (e.g., tizanidine, methocarbamol, carisoprodol)
vii. stomach relaxants (dicyclomine)
viii. anti-inflammatory pain relievers (e.g. ibuprofen, naproxen, others)
ix. sleep aids (e.g. trazodone, amitriptyline)
x. anti-anxiety agents (e.g. diazepam, lorazepam) may be used for short periods (5-7 days)

c. On occasion, alternative detoxification with phenobarbital may be offered.

MEDICAL BOARD OF CALIFORNIA GUIDELINES FOR PRESCRIBING CONTROLLED SUBSTANCES FOR PAIN[11]

Discontinuing or tapering of opioid therapy may be required for many reasons and ideally, an "exit strategy" should be included in the treatment plan for all patients receiving opioids at the onset of treatment. Reasons may include:

- Resolution or healing of the painful condition;
- Intolerable side effects;
- Failure to achieve anticipated pain relief or functional improvement (although ensure that this failure is not the result of inadequate treatment);
- Evidence of non-medical or inappropriate use;
- Failure to comply with monitoring, such as urine drug screening (although ensure that this failure is not the result of a cost issue);
- Failure to comply with pain management agreement;
- Exhibition of drug-seeking behaviors (although ensure this behavior is not a result of inadequate treatment) or diversion, such as:
  - Selling prescription drugs;
  - Forging prescriptions;
  - Stealing or borrowing drugs;
  - Aggressive demand for opioids;
  - Injecting oral/topical opioids;
  - Unsanctioned use of opioids;
  - Unsanctioned dose escalation;
  - Concurrent use of illicit drugs;
  - Getting opioids from multiple prescribers and/or multiple pharmacies; or
  - Recurrent emergency department visits for chronic pain management.

If opioid therapy is discontinued, the patient whom has become physically dependent should be provided with a safely-structured tapering regimen. Opioid withdrawal symptoms are uncomfortable, but generally not life threatening.

Opioids can be stopped abruptly when the risks outweigh the benefits (in very limited situations, e.g., an example would be pending organ failure or death from respiratory depression - sdf). This is not true for benzodiazepine withdrawals, which can be life-threatening. Withdrawal can be managed either by the prescribing physician or by referring the patient to an addiction specialist.

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Approaches to weaning range from a slow 10% reduction per week for more aggressive 25-50% reduction every few days. In general, a slower taper will produce fewer unpleasant symptoms of withdrawal. The termination of opioid therapy should not mark the end of treatment, which should continue with other modalities, either through direct care or referral to other healthcare specialist, as appropriate.

WASHINGTON STATE GUIDELINE ON PRESCRIBING OPIOIDS FOR PAIN

The Washington State Agency Medical Directors' Group Interagency Guideline on Prescribing Opioids for Pain[12] is an excellent resource. The following is from their 2006 **Strategies for Tapering and Weaning** (Appendix 15):

Strategies for tapering:

From a medical standpoint, weaning from opioids can be done safely by slowly tapering the opioid dose and taking into account the following issues:

- A decrease by 10% of the original dose per week is usually well tolerated with minimal physiological adverse effects. Some patients can be tapered more rapidly without problems (over 6 to 8 weeks).
- If opioid abstinence syndrome is encountered, it is rarely medically serious although symptoms may be unpleasant.
- Symptoms of an abstinence syndrome, such as nausea, diarrhea, muscle pain and myoclonus can be managed with clonidine 0.1 – 0.2 mg orally every 6 hours or clonidine transdermal patch 0.1mg/24hrs (Catapres TTS-1™) weekly during the taper while monitoring for often significant hypotension and anticholinergic side effects. In some patients it may be necessary to slow the taper timeline to monthly, rather than weekly dosage adjustments.
- Symptoms of mild opioid withdrawal may persist for six months after opioids have been discontinued.
- Consider using adjuvant agents, such as antidepressants to manage irritability, sleep disturbance or antiepileptics for neuropathic pain.
- Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids.
- Referral for counseling or other support during this period is recommended if there are significant behavioral issues.
- Referral to a pain specialist or chemical dependency center should be made for complicated withdrawal symptoms.

Recognizing and managing behavioral issues during opioid weaning: Opioid tapers can be done safely and do not pose significant health risks to the patient. In contrast, extremely challenging behavioral issues may emerge during an opioid taper. Behavioral challenges frequently arise in the setting of a prescriber who is tapering the opioid dose and a patient who places great value on the opioid he/she is receiving. In this setting, some patients will use a wide range of interpersonal strategies to derail the opioid taper. These may include:

- Guilt provocation ("You are indifferent to my suffering")
- Threats of various kinds
- Exaggeration of their actual suffering in order to disrupt the progress of a scheduled taper

There are no fool-proof methods for preventing behavioral issues during an opioid taper, but strategies implemented at the beginning of the opioid therapy are most likely to prevent later behavioral problems if an opioid taper becomes necessary.

[12] Washington State Agency Medical Directors' Group Interagency Guideline on Prescribing Opioids for Pain

GETTING TO YES WITH UR & IMR

Efficient use of the California MTUS ACOEM Guidelines and the MTUS Drug Formulary Drug List requires:

1. First identifying the **body part**,
2. A specific **diagnosis** to find out what treatment or drug is recommended/no recommendation/not recommended.
    a. It turns out that the same diagnosis with a different adjective (i.e., severe or neuropathic), can make a difference in what is recommended/no recommendation/not recommended.
3. Finding what is MTUS Treatment compliant
    a. Go to MTUS ACOEM Guidelines http://www.dir.ca.gov/dwc/DWCPropRegs/Medical-Treatment-Utilization-Schedule/Medical-Treatment-Utilization-Schedule.htm.
        i. Go to the Summary of Recommendations.
    b. Go to the ReedGroup MDGuidelines (http://www.mdguidelines.com/).
        i. Click on Resources (top right on screen to the right of Print and to the left of your name)
        ii. Click on ACOEM Guidelines
        iii. Click on Disorders
        iv. Click on the body part (i.e., Knee Disorders or Shoulder Disorders, etc.) or on Chronic Pain
        v. Click on Summary of Recommendations
        vi. You can scroll down and see a chart with the treatments listed on the left, more specificity in the middle column, and then the 3rd column notes whether it is recommended or not.

PREFERRED CHRONIC PAIN TREATMENT APPROACHES & ALTERNATIVES

In the California workers' compensation arena, we are charged with providing the best medical care possible to "cure or relieve" from the effects of the industrial injury. Transitioning away from unnecessary and sometimes harmful medications, by itself, will be beneficial, but the real issue is assisting the injured worker in having a productive and happy life and returning to gainful employment if possible. The MTUS strongly supports a functional restoration approach.

There are a host of treatment approaches that are recommended by the MTUS and as listed in the 2017 ACOEM Chronic Pain Guidelines Update[13]. The emphasis is on active patient participation, psychological approaches including cognitive behavioral therapy, physical reactivation and functional restoration approaches using a biopsychosocial model. These approaches when utilized concurrently with weaning/tapering, provide the injured worker tools to avoid relapse and instead, to achieve a successful outcome.

[13]

REPORT WRITING

You can avoid utilization review (UR) denials by excellence in report writing. Here are some bullet point recommendations.

- Physician needs to provide a clear, legible and concise history and physical examination followed by diagnoses and then recommendations for evidence-based medicine (EBM) care.
- Timely submitted reports will help expedite proposed treatment and avoid unnecessary delays unrelated to the UR process.
- Avoid boilerplate paragraphs especially with an electronic medical record (EMR).
- State how the medical treatment is supported by EBM.
- In your written report, "walk" the claims examiner, attorney, UR Reviewer through the treatment course and document how the treatment request meets EBM standards.
- The medical reporting should document that the injured individual is educated about, and understands the diagnoses. Additionally, the treater should outline the specific goals to be achieved. For example:
    - Less discomfort (pain)
    - Reduced medication usage
    - Improved activities of daily living function
        - Improved sleep
        - Increased ADLs such as personal hygiene, dressing, walking, cleaning, mowing the lawn, etc.
    - Staying at or returning to work modified or full duty.

REPORT WRITING TEMPLATE

Many physicians now use electronic medical record templates, but they often include, extraneous, repeated information, and worse, erroneous information. The record must be accurate.

The following is a report writing template which includes information which can help avoid denials.

Brief/Concise History: *Provide a brief history and keep it short and concise.*
Current (relevant) Symptoms: ☐ Stable ☐ Improving ☐ Worsening *Don't just repeat the symptoms from the last visit unless still relevant.*
Physical Findings (pertinent): *Don't just repeat the same findings every visit. List only pertinent and relevant positive or changing findings.*
Current Medications: *List the actual medications, dose and frequency – be specific as to how may pills taken a day, week or month. Clarify any changes, reason for changes, etc. Ask yourself each visit whether the medication prescribed is truly needed and efficacious.*
Activities of Daily Living (ADLs): *Note +/- or no changes related to treatment. What has changed in a positive way to support the current treatment regimen? Were the goals set at the last visit met?*
ADL Goals (for next visit): *Use this section to note what goals are set in terms of ADLs, medication reduction and other activities.*
Diagnoses (include ICD): *Be careful and be specific. While the diagnoses may not change from visit to visit, make sure each visit that they are accurate.*
Disability Status: ☐ MMI/P&S or ☐ TD (Temporary Disability)
Work Abilities/Restrictions[14]**:** ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐Very Heavy (☑ one and elaborate as appropriate – what are the specific restrictions that would allow the IW to return to modified work?)
Work Status Capability: ☐ Stay at Work (SAW) ☐ Return to Work (RTW) ☐ Full duty ☐ Modified duty (with above restrictions) ☐ Cannot work in any capacity (Total Temporary Disability - TTD)
Treatment Plan: *Use some common sense. Explain your rationale in simple terms. Make it understandable to the patient, NCM, claims examiner, attorney, UR & IMR reviewers, etc.*
Prescription/Request (RFA): *Start simple and conservative before requesting complex and invasive treatments - justify those requests.*
Request Justification/Support per EBM: *How will the request for treatment make a positive difference? Is it diagnostic? Will the requested procedure/treatment results in less pain, less medication usage and increased function while avoiding complications? Is the risk-benefit ratio acceptable? How does the request for treatment meet EBM guidelines? Reference the specific guideline here by page number or even copy or attach the specific supporting guideline or scientific evidence.*

[14] Physical Demand Definitions from the Dictionary of Occupational Titles (Department of Labor)

PHYSICAL DEMAND DEFINITIONS FROM THE DICTIONARY OF OCCUPATIONAL TITLES (DEPARTMENT OF LABOR)

Physical Demand Level	Occasional 0-33⅓ of the workday	Frequent 34⅓-66⅔ of the workday	Constant 67⅓-100⅓ of the workday	Typical Energy Required
Sedentary	10 lbs.	Negligible	Negligible	1.5 - 2.1 METS
Light	20 lbs.	10 lbs.	Negligible	2.2 - 3.5 METS
Medium	20 to 50 lbs.	10 to 25 lbs.	10 lbs.	3.6 - 6.3 METS
Heavy	50 to 100 lbs.	25 to 50 lbs.	10 to 20 lbs.	6.4 - 7.5 METS
Very Heavy	Over 100 lbs.	Over 50 lbs.	Over 20 lbs.	Over 7.5 METS

Sedentary Work – Exerting up to 10 pounds of force occasionally (Occasionally: activity or condition exists up to 1/3 of the time) and/or a negligible amount of force frequently (Frequently: activity or condition exists from 1/3 to 2/3 of the time) to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Light Work - Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force frequently, and/or a negligible amount of force constantly (Constantly: activity or condition exists 2/3 or more of the time) to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may be only a negligible amount, a job should be rated Light Work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.

Medium Work - Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.

Heavy Work - Exerting 50 to 100 pounds of force occasionally, and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work.

Very Heavy Work - Exerting in excess of 100 pounds of force occasionally, and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Heavy Work.

Getting to YES with UR & IMR

A Guide to Successful use of the MTUS

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This document is meant to help physicians and others better serve injured workers. Understanding how to write requests for treatment that meet evidence-based medicine (EBM) guidelines will more often result in approved authorization for medical care through Utilization Review (UR) and Independent Medical Review (IMR). This approach requires a little extra work at the front end, but it saves having to deal with and respond to denials of care which clog up the physician's office, take valuable time, leaving the injured worker upset and without treater recommended medical care.

I take full responsibility for this document and any errors or omissions are mine. Your input to improve this document would be greatly appreciated. Please email me at stevenfeinberg@hotmail.com.

How to Use this Document

This document, if viewed on your computer, has embedded Internet Links (blue underlined titles) which you can click on to go to the actual document on the DWC or other web sites.

This document is not meant to replace the detailed information found on the DWC Workers' Compensation Web Site, the Medical Treatment Utilization Schedule (MTUS) or the Guide to the MTUS Regulations.

Other Educational Materials

The Division of Workers' Compensation (DWC) provides a free online education course for physicians treating patients in the California workers' compensation system. It covers: 1) What the MTUS is and how to use it; 2) How to navigate the MTUS treatment guidelines and apply recommendations via case scenarios; 3) When to consider recommendations outside of the MTUS guidelines for the care of your patient; and 4) The role of utilization review (UR) and independent medical review (IMR) physicians.

The DWC also offers a newly edited and rewritten Physician's Guide to Medical Practice in the California Workers' Compensation System (Physician's Guide). It assists physicians in understanding the many complexities in the California workers' compensation system and is the basis for the QME exam.

Avoid UR & IME Denials by using the MTUS

As a treating physician, you can avoid UR & IMR denials by prescribing medical care that is supported by and consistent with, the MTUS. The Medical Treatment Utilization Schedule (MTUS) **is presumptively correct on the issue of extent and scope of medical treatment** (Section 9792.21(c)).

The DWC medical treatment utilization schedule (MTUS) outlines the most effective treatment of injured and ill workers, based upon the "best" EBM. The Strength (or Hierarchy) of Evidence Search Sequence uses EBM-based principles to guide appropriate clinical decision making when new evidence is produced or when the MTUS does not address a clinical condition or a diagnostic test.

Strength (or Hierarchy) of Evidence Guidelines

The DWC MTUS sequence to be followed can be found at Medical Evidence Search Sequence.

Treating physicians and medical reviewers shall conduct the following medical evidence search sequence for the evaluation and treatment of injured workers.

(1) Search the recommended guidelines set forth in the current MTUS to find a recommendation applicable to the injured worker's medical condition or injury. *(NB: If a treater agrees with and follows the treatment guidelines as documented in the current CA MTUS, there is no need to proceed further).*

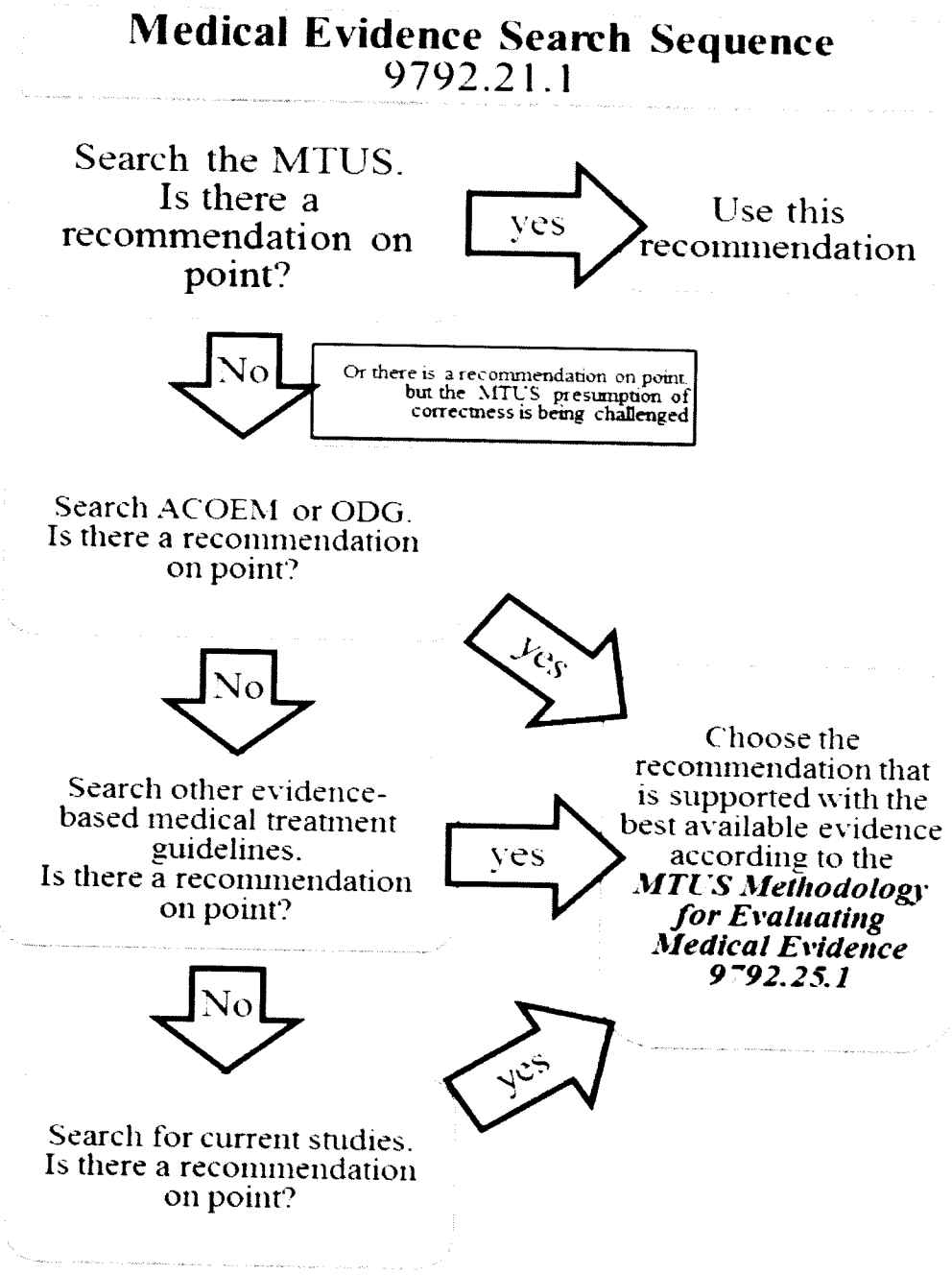
(2) In the limited situation where a medical condition or injury is not addressed by the MTUS or if the MTUS' presumption of correctness is being challenged, then:

A. Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then

B. Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then

C. Search for current studies that are scientifically-based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury.

On the following page, with permission from the California Applicants' Attorneys Association (CAAA), an explanatory graphic of the **Medical Evidence Search Sequence** is provided. CAAA has graciously also provided a Link to a CAAA Bulletin, MTUS Practice Tips, at #2 MTUS Practice Tip – Strength of Evidence Guidelines which I highly recommend to you.


Medical Evidence Search Sequence
9792.21.1
Search the MTUS. Is there a recommendation on point?
yes
Use this recommendation
No
Or there is a recommendation on point, but the MTUS presumption of correctness is being challenged
Search ACOEM or ODG. Is there a recommendation on point?
Yes
No
Search other evidence-based medical treatment guidelines. Is there a recommendation on point?
yes
Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence 9792.25.1
No
yes
Search for current studies. Is there a recommendation on point?

DWC Draft MTUS Guidelines

The DWC is in the process of updating many of the Guidelines and recommendations and has issued Draft MTUS Guidelines Updates which are accessible now on the DWC website (see Links below). While not the official "current" Guidelines, as treaters, we are instructed to use the most current evidence-based medicine (EBM). A draft of the MTUS Guidelines are available at no charge at the internet link below.

The DWC has proposed Draft MTUS Guidelines Updates from American College of Occupational and Environmental Medicine (ACOEM) guidelines (published by Reed Group, Ltd.) are accessible as listed below.:

- Ankle and Foot Disorders
- Cervical and Thoracic Spine Disorders
- Elbow Disorders
- Eye Disorders
- Hand, Wrist, and Forearm Disorders
- Hip and Groin Disorders
- Knee Disorders
- Low Back Disorders
- Shoulder Disorders

The MTUS also contains chapters known as **Special Topics** and these are accessible through the links below:

- Acupuncture medical treatment guidelines
- Chronic Pain Medical Treatment Guidelines
- Opioids Treatment Guidelines – Executive Summary, Introduction, and Recommendations (Part 1)
- Opioids Treatment Guidelines – Supplementary Materials (Part 2)
- Postsurgical treatment guidelines

Current Medical Treatment Utilization Schedule (MTUS)

While the following MTUS Guidelines are "current" and still in effect, they are "outdated" and use of the above noted "Draft" and Special Topics is recommended. You can Click on the word "**algorithm**" to be taken to that page.

- Neck and upper back complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8)
  - b. In the course of treatment for neck and upper back complaints where acupuncture or acupuncture with electrical stimulation is being considered, use the Acupuncture medical treatment guidelines
  - c. If recovery has not taken place with respect to pain by the end of **algorithm 8-5**, use the Chronic Pain Medical Treatment Guidelines
  - d. If surgery is performed in the course of treatment for neck and upper back complaints, the Postsurgical treatment guidelines for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the Chronic Pain Medical Treatment Guidelines shall apply.

- Shoulder complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9)
  - b. If recovery has not taken place with respect to pain by the end of **algorithm 9-5**, use the Chronic Pain Medical Treatment Guidelines
  - c. If surgery is performed in the course of treatment for shoulder complaints, the Postsurgical treatment guidelines for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the Chronic Pain Medical Treatment Guidelines shall apply.

- Elbow disorders (ACOEM Practice Guidelines, 2nd Edition (Revised 2007), Chapter 10)
  - b. In the course of treatment for neck and upper back complaints where acupuncture or acupuncture with electrical stimulation is being considered, use the Acupuncture medical treatment guidelines
  - c. If recovery has not taken place with respect to pain by the end of **algorithm 10-5**, use the Chronic Pain Medical Treatment Guidelines
  - d. If surgery is performed in the course of treatment for elbow complaints, the Postsurgical treatment guidelines for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the Chronic Pain Medical Treatment Guidelines shall apply.

- Forearm, wrist, and hand complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11)
  - b. In the course of treatment for forearm, wrist and hand complaints where acupuncture or acupuncture with electrical stimulation is being considered, use the Acupuncture medical treatment guidelines
  - c. If recovery has not taken place with respect to pain by the end of **algorithm 11-5**, use the Chronic Pain Medical Treatment Guidelines
  - d. If surgery is performed in the course of treatment for forearm, wrist and hand complaints, the Postsurgical treatment guidelines for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the Chronic Pain Medical Treatment Guidelines shall apply.

- Low back complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12)
  b. In the course of treatment for low back complaints where acupuncture or acupuncture with electrical stimulation is being considered, use the Acupuncture medical treatment guidelines
  c. If recovery has not taken place with respect to pain by the end of **algorithm 12-5**, use the Chronic Pain Medical Treatment Guidelines
  d. If surgery is performed in the course of treatment for low back complaints, the Postsurgical treatment guidelines for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the Chronic Pain Medical Treatment Guidelines shall apply.

- Knee complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 13)
  b. In the course of treatment for knee complaints where acupuncture or acupuncture with electrical stimulation is being considered, use the Acupuncture medical treatment guidelines
  c. If recovery has not taken place with respect to pain by the end of **algorithm 13-5**, use the Chronic Pain Medical Treatment Guidelines
  d. If surgery is performed in the course of treatment for knee complaints, the Postsurgical treatment guidelines for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the Chronic Pain Medical Treatment Guidelines shall apply.

- Ankle and foot complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 14)
  b. In the course of treatment for ankle and foot complaints where acupuncture or acupuncture with electrical stimulation is being considered, use the Acupuncture medical treatment guidelines
  c. If recovery has not taken place with respect to pain by the end of **algorithm 14-5**, use the Chronic Pain Medical Treatment Guidelines
  d. If surgery is performed in the course of treatment for ankle and foot complaints, the Postsurgical treatment guidelines for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the Chronic Pain Medical Treatment Guidelines shall apply.

- Stress related conditions (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 16)

- Eye (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 16)
  b. If recovery has not taken place with respect to pain by the end of **algorithm 16-6**, use the Chronic Pain Medical Treatment Guidelines

American College of Occupational and Environmental Medicine (ACOEM)

The ACOEM Occupational Medicine Practice Guidelines are published by Reed Group and are available electronically through MDGuidelines and includes a searchable interface with chapters that are updated with ACOEM's evidence-based methodology. This online tool also provides users with first access to chapters as they are updated. For physicians handling work comp cases in the state of California, a special discounted rate of $100 per year is available for a period of 3 years. This offer will be good through 12/31/2017.

Work Loss Data Institute Official Disability Guidelines (ODG)

The current Official Disability Guidelines (ODG) rate is $599 annually. ODG has a generic coupon code, ODGSTATE, which will take 25% off. The California Orthopaedic Association (COA) and The California Society of Industrial Medicine & Surgery (CSIMS) have negotiated coupon codes available in the membership areas of those sites.

REPORT WRITING

You can avoid UR & IMR denials by excellence in report writing. Here are some bullet point recommendations.

- Physician needs to provide a clear, legible and concise history and physical examination followed by diagnoses and then recommendations for evidence-based medicine (EBM) care consistent with the MTUS.

- Timely submitted reports will help expedite proposed treatment and avoid unnecessary delays unrelated to the UR process.

- Avoid boilerplate paragraphs especially with an electronic medical record (EMR).

- State how the medical treatment is supported by the MTUS first. If the treating physician wishes to appeal a denial based upon inconsistency with the CA MTUS, the treating physician can use ACOEM or ODG second, and then with other guidelines or EBM following the MTUS Medical Evidence Search Sequence.

- In your written report, "walk" the claims examiner, attorney, UR or IMR Reviewer through the treatment course and document how the treatment request meets the MTUS EBM standards.

- The medical reporting should document that the injured worker is educated about, and understands the diagnoses. Additionally, the treater should outline the specific goals to be achieved. For example:

    - Less discomfort (pain)
    - Reduced medication usage
    - Improved activities of daily living function
        - Improved sleep
        - Increased ADLs such as personal hygiene, dressing, walking, cleaning, mowing the lawn, etc.
    - Staying at or returning to work modified or full duty.

Report Writing Template

Many physicians now use electronic medical record templates but they often include, extraneous, repeated information, and worse, erroneous information. The record must be accurate.

The following is a report writing template which includes information which can help avoid denials.

Brief/Concise History: *Provide a brief history and keep it short and concise.*
Current (relevant) Symptoms: ☐ Stable ☐ Improving ☐ Worsening *Don't just repeat the symptoms from the last visit unless still relevant.*
Physical Findings (pertinent): *Don't just repeat the same findings every visit. List only pertinent and relevant positive or changing findings.*
Current Medications: *List the actual medications, dose and frequency – be specific as to how may pills taken a day, week or month. Clarify any changes, reason for changes, etc. Ask yourself each visit whether the medication prescribed is truly needed and efficacious.*
Activities of Daily Living (ADLs): *Note +/- or no changes related to treatment. What has changed in a positive way to support the current treatment regimen? Were the goals set at the last visit met?*
ADL Goals (for next visit): *Use this section to note what goals are set in terms of ADLs, medication reduction and other activities.*
Diagnoses (include ICD): *Be careful and be specific. While the diagnoses may not change from visit to visit, make sure each visit that they are accurate.*
Disability Status: ☐ MMI/P&S or ☐ TD (Temporary Disability)
Work Abilities/Restrictions: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐Very Heavy (☑ one and elaborate as appropriate – what are the specific restrictions that would allow the IW to return to modified work?)
Work Status Capability: ☐ Stay at Work (SAW) ☐ Return to Work (RTW) ☐ Full duty ☐ Modified duty (with above restrictions) ☐ Cannot work in any capacity (Total Temporary Disability - TTD)
Treatment Plan: *Use some common sense. Explain your rationale in simple terms. Make it understandable to the patient, NCM, claims examiner, attorney, UR & IMR reviewers, etc.*
Prescription/Request (RFA): *Start simple and conservative before requesting complex and invasive treatments - justify those requests.*
Request Justification/Support per MTUS EBM: *How will the request for treatment make a positive difference? Is it diagnostic? Will the requested procedure/treatment results in less pain, less medication usage and increased function while avoiding complications? Is the risk-benefit ratio acceptable? How does the request for treatment meet EBM guidelines? Reference the specific MTUS or other guideline (see Medical Evidence search sequence) here by page number or even copy or attach the specific supporting guideline or scientific evidence.*

Explanation of the Request for Initial Authorization

- The report should contain an explanation that the request/prescription for treatment is to achieve and will result in a positive outcome (and therefore be efficacious) by way of less pain, reduced medication usage and improved activities of daily living - ADLs (including staying at work or returning to work - SAW/RTW) which are measured and documented at the next visit.
- The report should clearly state that the prescription/request is supported by the MTUS or whatever scientific article or guideline you are using and is supported by evidence-based medicine or is otherwise justified. If the offered alternative evidence is not of high quality, it may be ignored or rejected.
- A "bullet-proof" report would be one that clearly notes that the injured worker has failed prior treatments and shows why the current recommended treatment is appropriate for the injured and, when possible, clearly indicates the negative ramifications of not receiving the recommended treatment.
- Even if the prescription/recommendation doesn't quite fit the MTUS guidelines; make sure further details are provided with regards to your request. For example: *While the patient has attempted PT in the past without lasting benefit and the prescription is in excess of what the MTUS recommends for this diagnosis, previous PT notes show care consisted primarily of passive modalities. The newly recommended PT will consist of (list active therapies) that will medically probably result and functional gains and thus should be considered for this specific patient.* The more patient specific the treatment plan can be along with justification that treatment will cure or relieve from the effects of the industrial injury and resultant improved ADLs, less medication usage and overall functional improvement, the better chance to obtain authorization.

Explanation of the Request for Additional/Continued Treatment Authorization

- To justify additional or continued treatment you will have to clearly document how the initial similar treatment resulted in a positive outcome (less pain, less medication usage, increased ADLs, etc.) and why additional similar care will result in a further benefit.

Post-UR & IMR Denial

- If there has already been a UR denial, a polite reply/appeal should be submitted further explaining your rationale for the request. If you made a mistake and left something out originally, correct and explain the deficiency.
- What documentation or evidence or report did the Utilization Reviewer miss or not consider.
- Learn from your UR mistakes - If the UR physician has pointed out legitimate errors in your reporting, correct the deficiency prior to IMR, and in all future similar requests. The most common errors are failure to document the appropriate findings and failure to outline the specific reason a particular treatment is appropriate in this individual case.

Documentation is #1

- It doesn't really matter where you are in the process – UR, IMR, or expedited hearing – every treatment request must be properly documented, fully substantiating the need for the treatment. A treatment request absent adequate documentation = UR or IMR Denial. Getting it right in the first place is the only viable, repeatable strategy.

Documentation Specifics

- Note progression of treatment: Simple/conservative to complex/invasive.
- Document timeline (how many weeks have passed?).
- Note failure/lack of improvement with lower level of treatment to date.
- Distinguish 1st, 2nd, 3rd, and 4th, line treatment options.
- Document history, mechanism of injury (MOI), physical findings, tests and imaging studies that support diagnosis and treatment requested.
- List red flags that demand treatment and risks associated with denial of care.
- Document improved ADLs and functional improvement.
- Document medication reduction.
- Use the MTUS first and then ODG or ACOEM as a Checklist: If the prescription/requested is supported in the guideline, describe how the injured worker meets the requirements for that treatment.

IMR Denials and Approvals

- Denial if too early in treatment course for the specific request without documentation in support of variance from the guidelines, simple diagnosis (sprain, etc.) does not warrant treatment request, no conservative treatment, no red flags, negative physical exam, test will not alter treatment course.
- Approval if delayed recovery, neurological deficit, chronic condition, conservative treatment didn't help, positive physical findings.

IMR Denial: Remains in effect for 12 months unless:

- Has there been a substantial change in the patient's condition - a change in the facts and/or clinical status?
- Was the IMR determination the result of a plainly erroneous expressed or implied finding of fact?
- If an IMR denial is in place, are there other alternative treatment options?