

# California Medical Treatment Utilization Schedule (MTUS): Current Status, Map for the Future

DWC Educational Conference 2014

February 3-4, Los Angeles

February 10-11, Oakland

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Division of Workers' Compensation

## Medical Care in Workers' Comp

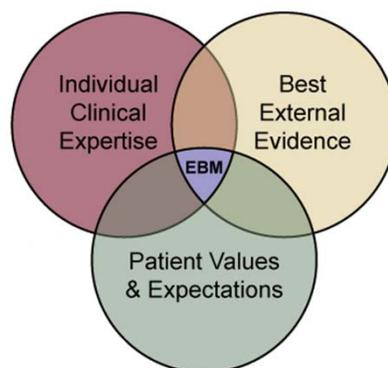
- Doctors in the California workers' compensation system are required to provide evidence-based medical treatments to workers that have been proven effective in providing the best medical outcomes
- The Medical Treatment Utilization Schedule (MTUS) lays out these treatments

## MTUS: Evidence-Based Medical Treatment Guidelines

- “Systematically developed by a multidisciplinary process through a comprehensive literature search to assist in decision-making about the appropriate medical treatment for specific clinical circumstances.”
- Proven to cure or relieve work-related injuries and illness
- Describe frequency, intensity, duration, appropriateness

8 CCR 9792.20 et seq.

## Evidence-Based Medicine



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

## MTUS Promotes Best Practices

- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Medically necessary

**MTUS is consistent with “Choosing Wisely”**

An initiative of the [ABIM Foundation](#), *Choosing Wisely* is focused on encouraging physicians, patients and other health care stakeholders to use evidence-based recommendations and to think and talk about medical tests and procedures that may be unnecessary, and in some instances can cause harm.

## MTUS Intended Audience

- Practicing clinicians
- Utilization review and management
- Independent Medical Review (IMR)



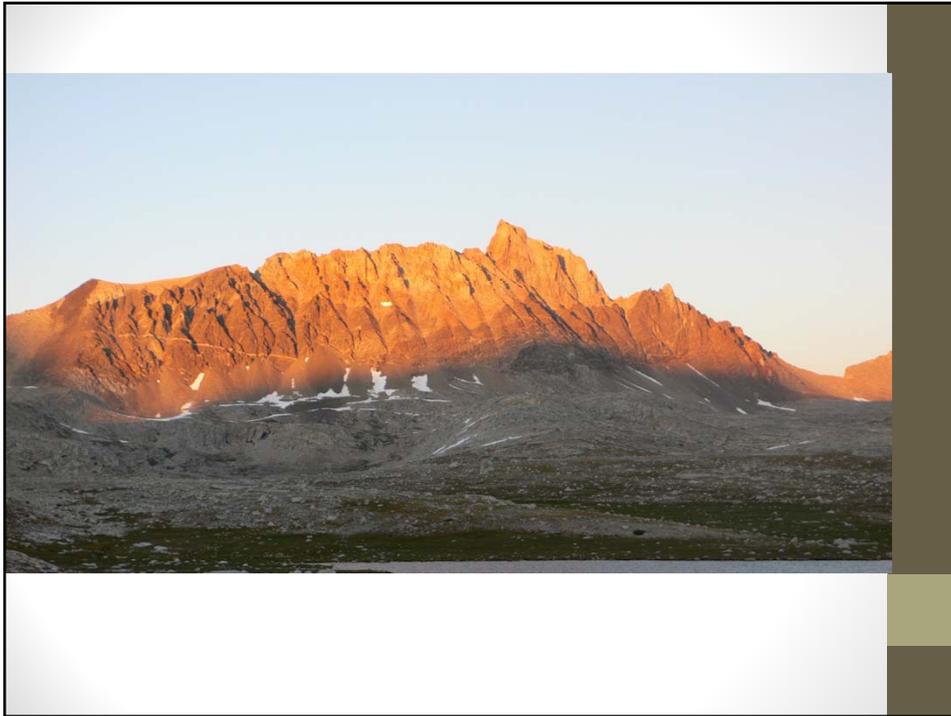
# IMR Decision Hierarchy

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- Medical Treatment Utilization Schedule  
Labor Code Section 5307.27
  - Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service
  - Nationally recognized professional standards
  - Expert opinion
  - Generally accepted standards of medical practice
  - Treatments likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious

Labor Code Section 4610.5(c)(2)

# MTUS: Evolution and Development

- 
- 2004 Legislature makes ACOEM 2<sup>nd</sup> ed. the standard for medical treatment
  - 2007 DWC adopts MTUS guidelines, establishes Medical Evidence Evaluation Advisory Committee (MEEAC)
  - 2009 DWC organizes MTUS into chapters, adopts chronic pain guideline
  - 2012 MEEAC re-established after 4-year hiatus



## MEEAC

- DWC Medical Director appoints members and chairs committee

[http://www.dir.ca.gov/dwc/MTUS/MTUS\\_DisclosureOfConflictOfInterest.html](http://www.dir.ca.gov/dwc/MTUS/MTUS_DisclosureOfConflictOfInterest.html)

### Members of the 2013 Division of Workers' Compensation Medical Evidence Evaluation Advisory Committee

- Lesley Anderson, M.D. – Orthopedic
- Melvin Belsky, M.D. – Physical Medicine and Rehabilitation
- Rajiv Das, M.D., M.P.H. – Occupational Medicine/Physical Medicine and Rehabilitation/Pain Medicine
- Mark Diaz, M.D. – Occupational Medicine (Subject Matter Expert)
- Mary Foto, O.T.R. – Occupational Therapy
- Gary Franklin, M.D., M.P.H. – Neurology
- Leslie Israel, D.O., M.P.H. – Occupational and Environmental Medicine
- Dong Ji, Ph.D., L.A.C. – Acupuncture
- Claire Johnson, D.C., M.S.Ed. – Chiropractic
- Frank Kase, D.P.M. – Podiatry
- Joshua Kirz, Ph.D. – Psychology
- Michel Kliot, M.D. – Neurosurgery
- Ronald Koretz, M.D. – Internal Medicine
- Robert Larsen, M.D., M.P.H. – Psychiatry
- Sean Mackey, M.D., Ph.D. – Pain Medicine
- Nancy Morioka-Douglas, M.D., M.P.H. – Family Medicine
- Lori Reisner, Pharm.D. – Pharmacology (Subject Matter Expert)
- Anne Searcy, M.D. – Family Medicine (Subject Matter Expert)
- Lee Snook, M.D., M.P.H. – Pain Medicine
- Leslie Torburn, D. P.T., M.S. – Physical Therapy

[http://www.dir.ca.gov/dwc/MTUS/MTUS\\_DisclosureOfConflictOfInterest.html](http://www.dir.ca.gov/dwc/MTUS/MTUS_DisclosureOfConflictOfInterest.html)

## MEEAC

- DWC Medical Director appoints members and chairs committee  
[http://www.dir.ca.gov/dwc/MTUS/MTUS\\_DisclosureOfConflictOfInterest.html](http://www.dir.ca.gov/dwc/MTUS/MTUS_DisclosureOfConflictOfInterest.html)
- Reviews the latest scientific guidelines and medical evidence
- Applies Strength of Evidence methodology
- Provides advisory recommendations to Medical Director on revisions, updates, supplements to MTUS

# MEEAC Meetings

- Meets four times a year as required
- Meetings are closed to public as they are considered part of pre-rule making deliberative process

# MEEAC Meetings



## Current MTUS Guidelines

- General approaches
  - Clinical topics (Body Chapters)
    - Neck and upper back
    - Shoulder
    - Elbow disorders
    - Forearm, wrist, and hand
    - Low back
    - Knee
    - Ankle and foot
    - Stress related conditions
    - Eye
  - Special topics
    - Acupuncture guidelines
    - Chronic pain treatment guidelines
    - Postsurgical treatment guidelines
- 2004, ACOEM 2<sup>nd</sup> edition
  - 2004, ACOEM 2<sup>nd</sup> ed.
  - 2007, ACOEM 2<sup>nd</sup> ed. update
  - 2004, ACOEM 2<sup>nd</sup> ed.
  - 2007 (State of Colorado)
  - 2009 (ODG\*, “frozen edition”)
  - 2009 (MEEAC)
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\*Work Loss Data Institute's Official Disability Guidelines

## MTUS Updates in Progress

- Strength of Evidence
- Opioids for treatment of non-cancer pain



## Strength of Evidence Methodology: Uses

- To evaluate literature/guidelines to update the MTUS (e.g., MEEAC has to abide by it)
  - See 8 CCR 9792.26(c)(1)-(3)
- To overcome the “presumption of correctness” of the MTUS
- To evaluate treatments for conditions not addressed in the MTUS

8 CCR §9792.25 Presumption of Correctness, Burden of Proof and Strength of Evidence: [http://www.dir.ca.gov/t8/9792\\_25.html](http://www.dir.ca.gov/t8/9792_25.html)

## Presumption of Correctness

- The MTUS is presumed to be correct
- If individual practitioners want to overcome the presumption, they need to use the strength of evidence methodology to choose the best treatment abased on evidence
  - (1) when the condition is not addressed in the MTUS, or
  - (2) When the condition is addressed in the MTUS, but there is newer data available that meets the requirements of the hierarchy

## Opioids for the treatment of non-cancer pain

- Currently part of MTUS Chronic Pain Chapter
  - 8 CCR §§9792.20 – 9792.26
- Why a separate chapter?

### CHRONIC PAIN MEDICAL TREATMENT GUIDELINES

#### Opioids

This topic is covered under multiple headings. See more specific entries, as follows: Opioids, criteria for use; Opioids for chronic pain; Opioids for neuropathic pain; Opioids for osteoarthritis; Opioids, cancer pain vs. nonmalignant pain; Opioids, dealing with misuse & addiction; Opioids, differentiation dependence & addiction; Opioids, dosing; Opioids, indicators for addiction; Opioids, long-term assessment; Opioids, pain treatment agreement; Opioids, psychological intervention; Opioids, screening for risk of addiction (tests); Opioids, state medical boards guidelines; Opioids, steps to avoid misuse/addiction; Detoxification; Substance abuse (tolerance, dependence, addiction); Weaning of medications; Implantable drug-delivery systems (IDDS); Methadone; Rapid detox; Testosterone replacement for hypogonadism (related to opioids); Opioid hyperalgesia & Opioids, specific drug list. Opioid drugs are also referred to as opiate analgesics, narcotic analgesics, or schedule C (II-IV) controlled substances. Opioid analgesics are a class of drugs (e.g., morphine, codeine, and methadone) that have a primary indication to relieve symptoms related to pain. Opioid drugs are available in various dosage forms and strengths. They are considered the most powerful class of analgesics that may be used to manage chronic pain. These medications are generally classified according to potency and duration of dosage duration.

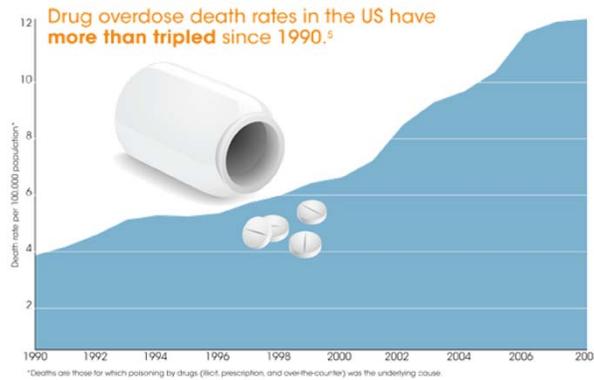
#### Overall Classification:

**Pure agonists:** include natural and synthetic opioids such as morphine sulfate (MS Contin®), hydromorphone (Dilaudid®), oxycodone (Numorphan®), levorphanol (Levo-Dromoran®), codeine (Tylenol w/Codeine 3®), hydrocodone (Vicodin®), oxycodone (OxyContin®), methadone (Dolophine HCl®), and fentanyl (Duragesic®). This group of opioids does not have a ceiling effect for their analgesic efficacy nor do they antagonize (reverse) the effects of other pure opioids. (Baumann, 2002) Morphine is the most widely used type of opioid analgesic for the treatment of moderate to severe pain due to its availability, the range of doses offered, and its low cost.

**Partial agonists/antagonists:** agents that stimulate the analgesic portion of opioid receptors while blocking or having little or no effect on toxicity. This group of opiates includes buprenorphine (Suboxone®). Partial agonist-antagonists have lower abuse potential than pure agonists, however the side effects of this class of analgesics include hallucinations and dysphoria. **Opioid antagonists** such as naloxone are included in this class. They are most often used to reverse the effects of agonists and agonist-antagonist derived opioids. (Baumann, 2002)

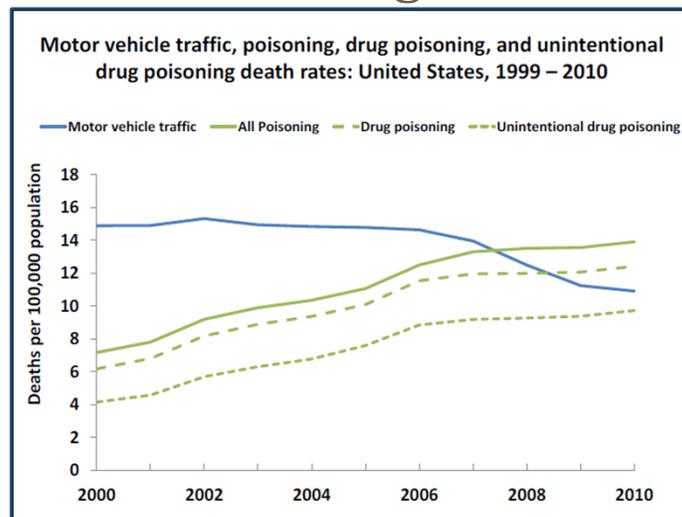
**Mixed agonist-antagonists:** another type of opiate analgesics that may be used to treat pain. They include such drugs as bupropionol (Stadol®), dezocine (Dalgan®), nalfuprine (Noban®) and pentazocine (Talwin®).

## CDC declares “national epidemic”



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

## Unintentional Drug Deaths Rise



NCHS 2012

# Unintentional Drug Deaths Rise

Sunday  
**Los Angeles Times**

## Canada comes calling in quest for U.S. workers

As the country struggles to fill its production, 34 new U.S. workers are a prime target for the nation's laborers.



**What makes this election pivotal**  
A growing number of voters are looking for a change in leadership in the White House.

## TERRY SMITH COLLAPSED FACE-DOWN

*Ohio introduces opioid prescribing guidelines*

## Gupta: Let's end the prescription drug death epidemic



## Opioids for Chronic Non-Cancer Pain

- One of many tools available for treating pain
- Not first-line option
- Successful models for opioid usage exist
- MTUS will create separate guidelines on opioids to treat non-cancer pain for work-related injuries

# Choose Wisely: Pain management Interventions or tests commonly performed don't always have evidence behind them

## Five things physicians and patients should question\*

1. Don't prescribe opioid analgesics as first-line therapy to treat non-cancer pain.
2. Don't prescribe opioid analgesics as long-term therapy to treat chronic non-cancer pain until the risks are considered and discussed with the patient.
3. Avoid imaging studies (MRI, CT or X-rays) for acute low back pain without specific indications.
4. Don't use intravenous sedation for diagnostic and therapeutic nerve blocks, or joint injections as a default practice.
5. Avoid irreversible interventions for non-cancer pain that carry significant costs and/or risks.

\* Evidence-based recommendations for all patients; consistent with the MTUS

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## Choosing Wisely

An initiative of the ABIM Foundation

American Society of Anesthesiologists - Pain Medicine

American Society of  
Anesthesiologists

### Five Things Physicians and Patients Should Question

- 1 Don't prescribe opioid analgesics as first-line therapy to treat chronic non-cancer pain.**  
Physicians should consider multimodal therapy, including non-drug treatments such as behavioral and physical therapies prior to pharmacological intervention. If drug therapy appears indicated, non-opioid medication (e.g., NSAIDs, anticonvulsants, etc.) should be tried prior to commencing opioids.
- 2 Don't prescribe opioid analgesics as long-term therapy to treat chronic non-cancer pain until the risks are considered and discussed with the patient.**  
Patients should be informed of the risks of such treatment, including the potential for addiction. Physicians and patients should review and sign a written agreement that identifies the responsibilities of each party (e.g., urine drug testing) and the consequences of non-compliance with the agreement. Physicians should be cautious in co-prescribing opioids and benzodiazepines. Physicians should proactively evaluate and treat, if indicated, the nearly universal side effects of constipation and low testosterone or estrogen.
- 3 Avoid imaging studies (MRI, CT or X-rays) for acute low back pain without specific indications.**  
Imaging for low back pain in the first six weeks after pain begins should be avoided in the absence of specific clinical indications (e.g., history of cancer with potential metastases, known acute neuritis, progressive neurologic deficit, etc.). Most low back pain does not need imaging and doing so may reveal incidental findings that divert attention and increase the risk of having unhelpful surgery.
- 4 Don't use intravenous sedation for diagnostic and therapeutic nerve blocks, or joint injections as a default practice.**  
Intravenous sedation, such as with propofol, midazolam or ultrashort-acting opioid infusions for diagnostic and therapeutic nerve blocks, or joint injections, should not be used as the default practice. Ideally, diagnostic procedures should be performed with local anesthetic alone. Intravenous sedation can be used after evaluation and discussion of risks, including interference with assessing the acute pain relieving effects of the procedure and the potential for false positive responses. American Society of Anesthesiologists Standards for Basic Anesthetic Monitoring should be followed in cases where moderate or deep sedation is provided or anticipated.
- 5 Avoid irreversible interventions for non-cancer pain that carry significant costs and/or risks.**  
Irreversible interventions for non-cancer pain, such as peripheral chemical neurolytic blocks or peripheral radiofrequency ablation, should be avoided because they may carry significant long-term risks of weakness, numbness or increased pain.

\*This recommendation does not apply to pediatric patients.

These items are provided solely for educational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their physician.

<http://www.choosingwisely.org/doctor-patient-lists/american-society-of-anesthesiologists-pain-medicine/>

## What's a Medical Provider to do ?

- Apply the principles of EBM when treating patients
  - <http://www.cebm.net/>
- Document history, objective findings, test results, treatments, and functional status initially and at each visit
- When treating CA workers, base treatment on MTUS
  - [http://www.dir.ca.gov/dwc/mtus/mtus\\_regulationsguidelines.html](http://www.dir.ca.gov/dwc/mtus/mtus_regulationsguidelines.html)
- If recommending test/treatment not in the MTUS, provide high quality scientific evidence to justify
  - Strength of Evidence guidelines
- Help your patient navigate the medical care process



## What's Next?

- Strength of Evidence Regulations formal public comment period
- Opioid treatment guidelines initial public comment period
- Other “Body Chapters” updates in progress



# California Medical Treatment Utilization Schedule (MTUS): Strength of Evidence

DWC Educational Conference 2014  
February 3-4, Los Angeles  
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John G. Cortes, Industrial Relations Counsel  
Division of Workers' Compensation

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## Discussion Outline

### I. Overview of our Rulemaking Progress

### II. Proposed Changes to MTUS regulations

- Clarifying the process in which clinical decisions are made for injured workers diagnosed with industrial conditions.
- Adding a medical literature search sequence.
- Revising the methodology to evaluate Strength of Evidence.
- Making slight changes to the Medical Evidence Evaluation Advisory Committee (MEEAC) regulations.

### III. Rulemaking Timeline –What's next?

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## I. Overview of our Rulemaking Progress

- MEEAC provided its recommendations to DWC's Executive Medical Director June 2013.
- DWC conducted its 10 day Public Forum at the end of August 2013.

1. The text of the proposed regulations and the forum comments can be found in DWC's website:

<http://www.dir.ca.gov/dwc/DWCWCABForum/MTUSRegs.htm>

- Formal rulemaking will begin soon.

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## II. Proposed Changes to MTUS Regulations

### 1. Clarifying the process in which clinical decisions are made for injured workers diagnosed with industrial conditions:

- Clinical decisions shall be made using the principals of Evidence-Based Medicine (EBM).
- EBM is a systematic approach to making clinical decisions which allows the integration of the best available research evidence with clinical expertise and patient values.
- EBM requires the evaluation of medical evidence by applying an explicit systematic methodology to determine the strength of evidence used to support the recommendation for a medical condition.

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## II. Proposed Changes to MTUS Regulations

- The MTUS is based on the principals of EBM.
- The MTUS constitutes the standard of care for the provision of medical care in accordance with Labor Code section 4600.
- However, the MTUS has its limitations:
  1. MTUS cannot address every conceivable medical condition.
  2. MTUS may be successfully rebutted if there is a recommendation applicable to the injured workers' medical condition which is supported by a higher level of evidence than the medical evidence used to support the MTUS's recommendation - see Labor Code §4604.5(a).

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## II. Proposed Changes to MTUS Regulations

2. Adding a medical literature search sequence:
  - If the MTUS is silent on a medical condition or when attempting to rebut the MTUS's presumption of correctness, a medical literature search shall be conducted by the providers making treatment decisions.
  - Conduct a medical literature search to find the recommendation supported by the best available medical evidence.
  - Medical care shall be in accordance with the recommendation supported by the best available medical evidence.

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## II. Proposed Changes to MTUS Regulations

- Conducting a comprehensive literature search is resource-intensive. Therefore, in the interest of efficiency and consistency, DWC will propose in its regulations a minimum medical literature search sequence as follows:
- Search the most current version of ACOEM or ODG and choose the recommendation supported by the highest level of evidence. If no relevant recommendations are found....
- Search other evidence-based medical treatment guidelines that are recognized by the national medical community. If no relevant recommendations are found....
- Search for studies that are scientifically based, peer-reviewed and published in journals that are nationally recognized by the medical community.

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## II. Proposed Changes to MTUS Regulations

- After conducting a medical literature search, UR decisions and IMR decisions shall contain the citation of the recommendation supported by the best available medical evidence. Treating physicians should cite the recommendation supported by the best available medical evidence in the chart notes or Request for Authorization, particularly if they anticipate barriers to getting authorization.
- If there is a discrepancy between the recommendations cited, the underlying medical evidence supporting the differing recommendations shall be evaluated to determine which recommendation is supported with the best available medical evidence.
- DWC is proposing a new methodology to evaluate the strength of medical evidence.

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## II. Proposed Changes to MTUS Regulations

### 3. Revising the methodology to evaluate strength of evidence:

- Current Strength of Evidence methodology is set forth in 8 CCR section 9792.25.
- Adopted from ACOEM but it only sets forth a methodology to evaluate studies that are supported by Randomized Controlled Trials (RCTs).
- Although RCTs are generally considered scientific studies of the highest quality, there are many medical interventions that are not supported by RCTs.
- Medical recommendations supported by other types of study designs should be considered provided that it is the best available medical evidence.

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## II. Proposed Changes to MTUS Regulations

### 3. Revising the methodology to evaluate strength of evidence:

- The MTUS Hierarchy of Evidence for Different Clinical Questions.
  1. Determine if the recommendation is applicable to the specific medical condition or diagnostic test requested by the injured worker.
  2. Determine what factors, if any, bias may have had in the study used to support a recommendation.
  3. Determine the design of the study used to support the recommendation.

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## II. Proposed Changes to MTUS Regulations

4. Determine which of the four clinical questions the study is answering to determine which hierarchy to apply:
  - “How useful is Treatment X in treating patients with Disease Y?”
  - “How useful is Test X in diagnosing patients with Disease Y?”
  - “What will happen to a patient with Disease Y if nothing is done?”
  - “What are the harms of intervention X in patients with Disease?”
5. In each clinical question category, the levels of evidence are listed from highest to lowest, as defined by the principals of Evidence-Based Medicine. Levels of evidence shall be applied in the order listed.

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## II. Proposed Changes to MTUS Regulations

4. Making slight changes to the Medical Evidence Evaluation Advisory Committee (MEEAC):
  - Adding two additional members – Pharmacologist and representative from the nursing field.
  - Clarifying and making transparent the methodologies that will be used to select medical evidence incorporated into the MTUS:
    1. Modified Agree II
    2. MTUS Hierarchy of Evidence for Different Clinical Questions

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### III. Rulemaking Timeline – What's Next?

- DWC expects to submit its rulemaking documents to the Office of Administrative Law (OAL) by this month.
- OAL will have 10 days to review the documents and then the regulations will be publicly posted and the 45 – Day Comment period will begin.