

Title 8. Industrial Relations
Division 1. Department of Industrial Relations
Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director -Administrative Rules
Article 5.5.2. Medical Treatment Utilization Schedule

8 CCR § 9792.20

§ 9792.20. Medical Treatment Utilization Schedule - Definitions.

As used in this Article:

- (a) "ACOEM " means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines published by the Reed Group containing evidenced-based medical treatment guidelines for conditions commonly associated with the workplace. ACOEM guidelines may be obtained from the American College of Occupational and Environmental Medicine, 25 Northwest Point Blvd., Suite 700, Elk Grove Village, Illinois, 60007-1030 (www.acoem.org).
- (b) "Chronic pain" means pain lasting three or more months from the initial onset of pain.
- (c) "Claims administrator" is a self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator, or the California Insurance Guarantee Association.
- (d) "Evidence-Based Medicine (EBM)" means a systematic approach to making clinical decisions which allows the integration of the best available research evidence with clinical expertise and patient values.
- (e) "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the medical evaluation and treatment; and a reduction in the dependency on continued medical treatment.
- (f) "Medical treatment" is care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.26.
- (g) "Medical treatment guidelines" means the most current version of written recommendations which are 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 reviewed and updated within the last five years .
- (h) "Nationally recognized" means published in a peer-reviewed medical journal; or developed, endorsed and disseminated by a national organization with affiliates based in two or more U.S. states and is the most current version.
- (i) "ODG" means the Official Disability Guidelines published by the Work Loss Data Institute containing evidenced-based medical treatment guidelines for conditions commonly associated with the workplace. ODG guidelines may be obtained from the Work Loss Data Institute, 169 Saxony, #101, Encinitas, California 92024 (www.ODG@worklossdata.com).

(j) "Peer reviewed" means that a study's content, methodology and results have been evaluated and approved prior to publication by an editorial board of qualified experts.

(k) "Scientifically based" means based on scientific literature, wherein the body of literature is identified through performance of a literature search, the identified literature is evaluated, and then used as the basis to support a recommendation.

(l) "Strength of Evidence" establishes the relative weight that shall be given to scientifically based evidence.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

Title 8. Industrial Relations

Division 1. Department of Industrial Relations

Chapter 4.5. Division of Workers' Compensation

Subchapter 1. Administrative Director -Administrative Rules

Article 5.5.2. Medical Treatment Utilization Schedule

8 CCR § 9792.21

§ 9792.21. Medical Treatment Utilization Schedule.

(a) The Administrative Director adopts the Medical Treatment Utilization Schedule (MTUS) consisting of section 9792.20 through section 9792.26.

(b) The MTUS is based on the principals of Evidenced-Based Medicine (EBM). EBM is a systematic approach to making clinical decisions which allows the integration of the best available evidence with clinical expertise and patient values. EBM is a method of improving the quality of care by encouraging practices that work and discouraging those that are ineffective or harmful. EBM asserts that intuition, unsystematic clinical experience, and pathophysiologic rationale are insufficient grounds for making clinical decisions. Instead, EBM requires the evaluation of medical evidence by applying an explicit systematic methodology to determine the quality and strength of evidence used to support the recommendations for a medical condition or injury. The best available evidence is then used to guide clinical decision making.

(c) The recommended guidelines set forth in the MTUS are presumptively correct on the issue of extent and scope of medical treatment. The MTUS constitutes 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. The MTUS shall be the primary source of guidance for treating physicians and physician reviewers for the evaluation and treatment of injured workers.

(d) Treatment shall not be denied on the sole basis that the condition or injury is not addressed by the MTUS. There are two limited situations that may warrant treatment based on recommendations found outside of the MTUS.

(1) First, if a medical condition or injury is not addressed by the MTUS, medical care shall be in accordance with other medical treatment guidelines or peer-reviewed studies found by applying the Medical Evidence Search Sequence set forth in section 9792.21.1.

(2) Second, if the MTUS' presumption of correctness is successfully challenged. The recommended guidelines set forth in the MTUS are presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof. Therefore, the treating physician who seeks treatment outside of the MTUS bears the burden of rebutting the MTUS' presumption of correctness by a preponderance of scientific medical evidence.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5, 4610.5 and 5307.27, Labor Code.

Title 8. Industrial Relations

Division 1. Department of Industrial Relations

Chapter 4.5. Division of Workers' Compensation

Subchapter 1. Administrative Director -Administrative Rules

Article 5.5.2. Medical Treatment Utilization Schedule

8 CCR § 9792.21.1

§ 9792.21.1. Medical Evidence Search Sequence.

(a) 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.

(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. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1. 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. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1. Medical treatment guidelines can be found in the National Guideline Clearinghouse that is accessible at the following website address: www.guideline.gov/. 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. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1. A search for peer-reviewed published studies may be conducted by accessing the U.S. National Library of Medicine's database of biomedical citations and abstracts that is searchable at the following website: www.ncbi.nlm.nih.gov/pubmed. Other searchable databases may also be used.

(b) After conducting the medical evidence search in the sequence specified above:

(1) Treating Physicians

(A) If the medical condition or injury is not addressed by the MTUS, then the treating physician may provide in the Request for Authorization (RFA) or in an attachment to the RFA a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

1. The citation provided by the treating physician shall be the primary source relied upon which he or she believes contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

2. If the treating physician provides more than one citation, then a narrative shall be included by the treating physician in the RFA or in an attachment to the RFA explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

(B) If the medical condition or injury is addressed by the MTUS but the treating physician is attempting to rebut the MTUS' presumption of correctness, then the treating physician shall provide in the RFA or in an attachment to the RFA the following: a clear and concise statement that the MTUS' presumption of correctness is being challenged; a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury; and a copy of the entire study or the relevant sections of the guideline containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

1. The citation and copy of the study or copy of the relevant sections of the guideline provided by the treating physician shall be the primary source relied upon which he or she believes contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

2. If the treating physician provides more than one citation, then a copy of the additional study(ies) or copy of the additional relevant sections of the guideline(s) along with a narrative shall be included by the treating physician in the RFA or in an attachment to the RFA explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is

applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

(2) Utilization Review Physicians

(A) If the RFA is being modified, delayed or denied, then the Utilization Review physician shall provide in the Utilization Review decision, in addition to the requirements set forth in section 9792.9.1(e), a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

1. The citation provided by the Utilization Review physician shall be the primary source relied upon which he or she believes contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

2. If the Utilization Review physician provides more than one citation, then a narrative shall be included by the reviewing physician in the Utilization Review decision explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

(3) Independent Medical Review Physicians

(A) If the Utilization Review Decision delays, denies or modifies an injured worker's request for treatment and review of that decision is requested through Independent Medical Review, then the Independent Medical Review physician shall provide in the Independent Medical Review decision, in addition to the requirements set forth in section 9792.10.6(d), a citation to the guideline or study containing the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

1. The citation provided by the Independent Medical Review physician shall be the primary source he or she relied upon which contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

2. If the Independent Medical Review physician provides more than one citation, then a narrative shall be included by the reviewing physician in the Independent Medical Review decision explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

(c) If the treating physician and/or the Utilization Review physician and/or the Independent Medical Review physician cited different guidelines or studies containing recommendations that are at variance with one another, the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1 shall be applied by the reviewing physician to determine which one of the recommendations is supported by the best available evidence.

(d) The format of the citations provided by the treating physician, Utilization Review physician, and Independent Medical physician, shall include the following

(1) When citing the MTUS:

- (A) Indicate the MTUS is being cited and the effective year of the guideline;
- (B) Title of chapter (e.g., Low Back Complaints); and
- (C) Section of chapter (e.g., Surgical Considerations).
- (2) When citing other medical treatment guidelines:
 - (A) Title of organization publishing the guideline (e.g., ACOEM or ODG);
 - (B) Year of publication;
 - (C) Title of chapter; and
 - (D) Section of chapter.
- (3) When citing a peer-reviewed study:
 - (A) First author's last name and first name initial;
 - (B) Published article title;
 - (C) Journal title (standard abbreviations may be used);
 - (D) Volume number;
 - (E) Year published; and
 - (F) Page numbers.
- (e) Employers and their representatives, at their discretion, may approve medical treatment beyond what is covered in the MTUS or supported by the best available medical evidence in order to account for medical circumstances warranting an exception. The treating physician should provide clear documentation of the clinical rationale focusing on expected objective functional gains afforded by the requested treatment and impact upon prognosis.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5, 4610.5 and 5307.27, Labor Code.

Title 8. Industrial Relations

Division 1. Department of Industrial Relations

Chapter 4.5. Division of Workers' Compensation

Subchapter 1. Administrative Director -Administrative Rules

Article 5.5.2. Medical Treatment Utilization Schedule

8 CCR § 9792.23

§ 9792.23. Clinical Topics.

- (a) The Administrative Director adopts and incorporates by reference into the MTUS specific clinical topic medical treatment guidelines in the series of sections commencing with 9792.23.1 et seq. Clinical topics apply to the initial management and subsequent treatment of presenting complaints specific to the body part.
- (b) For all conditions or injuries not addressed in the MTUS, the authorized treatment and diagnostic services in the initial management and subsequent treatment for presenting complaints shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community pursuant to section 9792.21(d)(1).
- (1) In providing treatment using other guidelines pursuant to subdivision (b) above and 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 in

section 9792.24.2 shall apply and supersede any applicable chronic pain guideline in accordance with section 9792.23(b).

(2) In providing treatment using other guidelines pursuant to subdivision (b) above and if surgery is performed, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS or in accordance with section 9792.23(b). The postsurgical treatment guidelines supersede any applicable postsurgical treatment guideline in accordance with section 9792.23(b).

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

Title 8. Industrial Relations

Division 1. Department of Industrial Relations

Chapter 4.5. Division of Workers' Compensation

Subchapter 1. Administrative Director -Administrative Rules

Article 5.5.2. Medical Treatment Utilization Schedule

8 CCR § 9792.24.1

§ 9792.24.1. Acupuncture Medical Treatment Guidelines.

(a) As used in this section, the following definitions apply:

(1) "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm.

(2) "Acupuncture with electrical stimulation" is the use of electrical current (micro-amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

(3) "Chronic pain for purposes of acupuncture" means chronic pain as defined in section 9792.20(c).

(b) Application

(1) These guidelines apply to acupuncture or acupuncture with electrical stimulation when referenced in the clinical topic medical treatment guidelines in the series of sections commencing with 9792.23.1 et seq., or in the chronic pain medical treatment guidelines contained in section 9792.24.2.

(c) Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows:

- (1) Time to produce functional improvement: 3 to 6 treatments.
- (2) Frequency: 1 to 3 times per week
- (3) Optimum duration: 1 to 2 months
- (d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e).
- (e) It is beyond the scope of the Acupuncture Medical Treatment Guidelines to state the precautions, limitations, contraindications or adverse events resulting from acupuncture or acupuncture with electrical stimulations. These decisions are left up to the acupuncturist.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

Title 8. Industrial Relations

Division 1. Department of Industrial Relations

Chapter 4.5. Division of Workers' Compensation

Subchapter 1. Administrative Director -Administrative Rules

Article 5.5.2. Medical Treatment Utilization Schedule

8 CCR § 9792.24.3

§ 9792.24.3. Postsurgical Treatment Guidelines.

(a) As used in this section, the following definitions apply:

- (1) "General course of therapy" means the number of visits and/or time interval which shall be indicated for postsurgical treatment for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section.
- (2) "Initial course of therapy" means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section.
- (3) "Postsurgical physical medicine period" means the time frame that is needed for postsurgical treatment and rehabilitation services beginning with the date of the procedure and ending at the time specified for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section. For all surgeries not covered by these guidelines the postsurgical physical medicine period is six (6) months.
- (4) "Surgery" means a procedure listed in the surgery chapter of the Official Medical Fee Schedule with follow-up days of 90 days.
- (5) "Visit" means a date of service to provide postsurgical treatment billed using the physical medicine section of the Official Medical Fee Schedule.

(b) Application

- (1) The postsurgical treatment guidelines apply to visits during the postsurgical physical medicine period only and to surgeries as defined in these guidelines. At the conclusion of the postsurgical physical medicine period, treatment reverts back to the applicable 24-visit limitation for chiropractic, occupational and physical therapy pursuant to Labor Code section 4604.5(d)(1).

(c) Postsurgical Patient Management

(1) Only the surgeon who performed the operation, a nurse practitioner or physician assistant working with the surgeon, or a physician designated by that surgeon can make a determination of medical necessity and prescribe postsurgical treatment under this guideline.

(2) The medical necessity for postsurgical physical medicine treatment for any given patient is dependent on, but not limited to, such factors as the comorbid medical conditions; prior pathology and/or surgery involving same body part; nature, number and complexities of surgical procedure(s) undertaken; presence of surgical complications; and the patient's essential work functions.

(3) If postsurgical physical medicine is medically necessary, an initial course of therapy may be prescribed. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period.

(4) Patients shall be reevaluated following continuation of therapy when necessary or no later than every forty-five days from the last evaluation to document functional improvement to continue physical medicine treatment. Frequency of visits shall be gradually reduced or discontinued as the patient gains independence in management of symptoms and with achievement of functional goals.

(A) In the event the patient sustains an exacerbation related to the procedure performed after treatment has been discontinued and it is determined that more visits are medically necessary, physical medicine treatment shall be provided within the postsurgical physical medicine period.

(B) In cases where no functional improvement is demonstrated, postsurgical treatment shall be discontinued at any time during the postsurgical physical medicine period.

(5) Treatment is provided to patients to facilitate postsurgical functional improvement.

(A) The surgeon who performed the operation, a nurse practitioner or physician assistant working with the surgeon, or physician designated by that surgeon, the therapist, and the patient should establish functional goals achievable within a specified timeframe.

(B) Patient education regarding postsurgical precautions, home exercises, and self-management of symptoms should be ongoing components of treatment starting with the first visit. Intervention should include a home exercise program to supplement therapy visits.

(C) Modalities (CPT [as defined in section 9789.10(d)] codes 97010 through 97039) should only be performed in conjunction with other active treatments. Although these modalities are occasionally useful in the post surgical physical medicine period, their use should be minimized in favor of active physical rehabilitation and independent self-management.

(d) Postsurgical Physical Medicine Treatment Recommendations

(1) The postsurgical physical medicine treatment recommendations, as listed below, indicate frequency and duration of postsurgical treatment for specific surgeries. The specified surgeries in these guidelines are not all inclusive. Requests for postsurgical

physical medicine treatment not included in these guidelines shall be considered pursuant to section 9792.21(d)(1). The physical medicine treatment recommendations (listed alphabetically) are adapted from the Official Disability Guidelines (ODG) except where developed by the Division of Workers' Compensation and indicated as "[DWC]." The postsurgical physical medicine period is identified by an asterisk [*] as developed by DWC.

Postsurgical Treatment Guidelines

Ankle & Foot

Ankle & Foot

Exercise program goals should include strength, flexibility, endurance, coordination, and education. Patients can be advised to do early passive range-of-motion exercises at home by a therapist. (Colorado, 2001) (Aldridge, 2004) This RCT (randomized controlled trial) supports early motion (progressing to full weight-bearing at 8 weeks from treatment) as an acceptable form of rehabilitation in surgically treated patients with Achilles tendon ruptures. (Twaddle, 2007)

Achilles tendon rupture (ICD9 727.67):

Postsurgical treatment: 48 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Ankle Sprain (ICD9 845.0):

Postsurgical treatment: 34 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Anterior tibial tendon [DWC]:

Postsurgical treatment: 8 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Amputation of foot (ICD9 896):

Post-replantation surgery: 48 visits over 26 weeks

*Postsurgical physical medicine treatment period: 12 months

Post-amputation treatment [DWC]: 48 visits over 26 weeks

*Postsurgical physical medicine treatment period: 12 months

Amputation of toe (ICD9 895):

Post-replantation surgery: 20 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Dislocation of the peroneal tendons [DWC]:

Postsurgical treatment: 8 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Enthesopathy of ankle and tarsus (ICD9 726.7):

Postsurgical treatment: 9 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of ankle (ICD9 824):

Postsurgical treatment: 21 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of ankle, Bimalleolar (ICD9 824.4):

Postsurgical treatment (ORIF): 21 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Postsurgical treatment (arthrodesis): 21 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of ankle, Trimalleolar (ICD9 824.6):

Postsurgical treatment: 21 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of one or more phalanges of foot (ICD9 826):

Postsurgical treatment: 12 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Special Consideration [DWC]: Postsurgical physical medicine is rarely needed for ganglionectomy.

Fracture of tibia and fibula (ICD9 823):

Postsurgical treatment (ORIF): 30 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Hallux rigidus (ICD9 735.2):

Postsurgical treatment: 9 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Hallux valgus (ICD9 735.0):

Postsurgical treatment: 9 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Hallux varus (ICD9 735.1):

Postsurgical treatment: 9 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Metatarsal stress fracture (ICD9 825):

Postsurgical treatment: 21 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Other hammer toe (ICD9 735.4):

Postsurgical treatment: 9 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Peroneal tendon repair [DWC]:

Postsurgical treatment: 8 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Posterior tibial tendonitis [DWC]:

Postsurgical treatment: 8 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Posterior tibial tenosynovitis (partial or complete rupture) [DWC]:

Postsurgical treatment: 8 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Burns

Recommended. Occupational therapy and physical therapy for the patient with burns may include respiratory management, edema management, splinting and positioning, physical function (mobility, function, exercise), scar management, and psychosocial elements. (Simons, 2003) As with any treatment, if there is no improvement after 2-3 weeks the protocol may be modified or re-evaluated.

Burns (ICD9 949):

Postsurgical treatment: 16 visits over 8 weeks

*Postsurgical physical medicine treatment period: 6 months

Cardiopulmonary [DWC]:

Coronary Stenting [DWC]:

Postsurgical treatment: 36 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Heart Valve repair/replacement [DWC]:

Postsurgical treatment: 36 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Percutaneous transluminal coronary angioplasty (PTCA) [DWC]:

Postsurgical treatment: 36 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Carpal Tunnel Syndrome

Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT (physical therapy) or OT (occupational therapy) for CTS (carpal tunnel syndrome). The evidence may justify 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is a relatively simple operation that also should not require extended multiple therapy office visits for recovery. Of course, these statements do not apply to cases of failed surgery and/or misdiagnosis (e.g., CRPS (complex regional pain syndrome) I instead of CTS). (Feuerstein, 1999) (O'Conner-Cochrane, 2003) (Verhagen-Cochrane, 2004) (APTA, 2006) (Bilic, 2006) Post surgery, a home therapy program is superior to extended splinting. (Cook, 1995) Continued visits should be contingent on documentation of objective improvement, i.e., VAS (visual analog scale) improvement greater than four, and long-term resolution of symptoms. Therapy should include education in a home program, work discussion and suggestions for modifications, lifestyle changes, and setting realistic expectations. Passive modalities, such as heat, iontophoresis, phonophoresis, ultrasound and electrical stimulation, should be minimized in favor of active treatments.

Carpal tunnel syndrome (ICD9 354.0):

Postsurgical treatment (endoscopic): 3-8 visits over 3-5 weeks

*Postsurgical physical medicine treatment period: 3 months

Postsurgical treatment (open): 3-8 visits over 3-5 weeks

*Postsurgical physical medicine treatment period: 3 months

Elbow & Upper Arm

Arthropathy, unspecified (ICD9 716.9):

Postsurgical treatment, arthroplasty, elbow: 24 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Cubital tunnel release [DWC]:

Postsurgical treatment: 20 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Dislocation of elbow (ICD9 832):

Unstable dislocation, postsurgical treatment: 10 visits over 9 weeks

*Postsurgical physical medicine treatment period: 4 months

ECRB / ECRL debridement [DWC]:

Postsurgical treatment: 10 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

ECRB / ECCRL tenotomy [DWC]:

Postsurgical treatment: 10 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Elbow diagnostic arthroscopy and arthroscopic debridement [DWC]:

Postsurgical treatment: 20 visits over 2 months

*Postsurgical physical medicine treatment period: 4 months

Elbow collateral ligament repair [DWC]:

Postsurgical treatment: 14 visits over 6 months

*Postsurgical physical medicine treatment period: 8 months

Enthesopathy of elbow region (ICD9 726.3):

Postsurgical treatment: 12 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of humerus (ICD9 812):

Postsurgical treatment: 24 visits over 14 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of radius/ulna (ICD9 813):

Postsurgical treatment: 16 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Lateral epicondylitis/Tennis elbow (ICD9 726.32):

Postsurgical treatment: 12 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Medial epicondylitis/Golfers' elbow (ICD9 726.31):

Postsurgical treatment: 12 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Muscle or tendon transfers for elbow flexion [DWC]:

Postsurgical treatment: 30 visits over 5 months

*Postsurgical physical medicine treatment period: 8 months

Rupture of biceps tendon (ICD9 727.62):

Postsurgical treatment: 24 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Sprains and strains of elbow and forearm (ICD9 841):

Postsurgical treatment/ligament repair: 24 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Traumatic amputation of arm (ICD9 887):

Post-amputation treatment: without complications, no prosthesis [DWC]: 18 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Post-amputation treatment: without complications, with prosthesis [DWC]: 30 visits over 6 months

*Postsurgical physical medicine treatment period: 9 months

Post-amputation treatment: with complications, no prosthesis [DWC]: 30 visits over 5 months

*Postsurgical physical medicine treatment period: 7 months
Post-amputation treatment: with complications and prosthesis [DWC]: 40 visits over 8 months

*Postsurgical physical medicine treatment period: 12 months

Post-replantation surgery: 48 visits over 26 weeks

*Postsurgical physical medicine treatment period: 12 months

Triceps repair [DWC]:

Postsurgical treatment: 24 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Ulnar nerve entrapment/Cubital tunnel syndrome (ICD9 354.2):

Postsurgical treatment: 20 visits over 10 weeks

*Postsurgical physical medicine treatment period: 6 months

Forearm, Wrist, & Hand

(Not including Carpal Tunnel Syndrome - see separate post surgical guideline.)

Used after surgery and amputation. During immobilization, there was weak evidence of improved hand function in the short term, but not in the longer term, for early occupational therapy, and of a lack of differences in outcome between supervised and unsupervised exercises. Post-immobilization, there was weak evidence of a lack of clinically significant differences in outcome in patients receiving formal rehabilitation therapy, passive mobilization or whirlpool immersion compared with no intervention. There was weak evidence of a short-term benefit of continuous passive motion (post external fixation), intermittent pneumatic compression and ultrasound. There was weak evidence of better short-term hand function in patients given therapy than in those given instructions for home exercises by a surgeon. (Handoll-Cochrane, 2002) (Handoll-Cochrane, 2006)

Amputation of arm, below the elbow [DWC]:

Post-amputation treatment: without complications, no prosthesis: 18 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Post-amputation: without complications, with prosthesis: 30 visits over 6 months

*Postsurgical physical medicine treatment period: 9 months

Post-amputation: with complications, no prosthesis: 30 visits over 5 months

*Postsurgical physical medicine treatment period: 7 months

Post-amputation: with complications and prosthesis: 40 visits over 8 months

*Postsurgical physical medicine treatment period: 12 months

Amputation of hand (ICD9 887):

Post-amputation treatment: without complications, no prosthesis [DWC]: 18 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Post-amputation treatment: with complications, no prosthesis [DWC]: 24 visits over 5 months

*Postsurgical physical medicine treatment period: 7 months

Post-replantation surgery: 48 visits over 26 weeks

*Postsurgical physical medicine treatment period: 12 months

Amputation of thumb; finger (ICD9 885; 886):

Post-replantation surgery: 36 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Post-amputation: Amputation of fingers without replantation [DWC]: 14 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Post-amputation: Amputation of thumb without replantation [DWC]: 16 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Arthropathy, unspecified (ICD9 716.9):

Postsurgical treatment, arthroplasty/fusion, wrist/finger: 24 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Contracture of palmar fascia (Dupuytren's) (ICD9 728.6):

Postsurgical treatment: 12 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Digital nerve repair [DWC]:

Postsurgical treatment: 8 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

DIP joint intraarticular fracture at middle or distal phalanx [DWC]:

Postsurgical treatment: 14 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Dislocation of finger (ICD9 834):

Postsurgical treatment: 16 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Dislocation of wrist (ICD9 833):

Postsurgical treatment (TFCC reconstruction): 16 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Extensor tendon repair or tenolysis [DWC]:

Postsurgical treatment: 18 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Extensor tenosynovectomy [DWC]:

Postsurgical treatment: 14 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Flexor tendon repair or tenolysis Zone 2 and other than Zone 2 [DWC]:

Postsurgical treatment: Flexor tendon repair or tenolysis Zone 2: 30 visits over 6 months

*Postsurgical physical medicine treatment period: 8 months

Postsurgical treatment: Other than Zone 2: 20 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Flexor tenosynovectomy [DWC]:

Postsurgical treatment: 14 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Flexor tendon repair (forearm) [DWC]:

Postsurgical treatment: 12 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Fracture of carpal bone (wrist) (ICD9 814):

Postsurgical treatment: 16 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of metacarpal bone (hand) (ICD9 815):

Postsurgical treatment: 16 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of one or more phalanges of hand (fingers) (ICD9 816):

Postsurgical treatment: Complicated, 16 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of radius/ulna (forearm) (ICD9 813):

Postsurgical treatment: 16 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Ganglion and cyst of synovium, tendon, and bursa (ICD9 727.4):

Postsurgical treatment: 18 visits over 6 weeks

*Special Consideration: Postsurgical physical medicine is rarely needed for ganglionectomy.

Intersection syndrome [DWC]:

Postsurgical treatment: 9 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Median Nerve Repair: Forearm - Wrist [DWC]:

Postsurgical treatment: 20 visits over 6 weeks

*Postsurgical physical medicine treatment period: 6 months

PIP and MCP capsulotomy/capsulectomy [DWC]:

Postsurgical treatment: 24 visits over 2 months

*Postsurgical physical medicine treatment period: 4 months

PIP and MCP collateral ligament reconstruction [DWC]:

Postsurgical treatment: 18 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

PIP and MCP collateral ligament repairs [DWC]:

Postsurgical treatment: 12 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

PIP joint intraarticular fracture and or dislocation at proximal or middle phalanx [DWC]:

Postsurgical treatment: Postsurgical treatment: 20 visits over 6 months

*Postsurgical physical medicine treatment period: 8 months

Proximal row carpectomy [DWC]:

Postsurgical treatment: 20 visits over 6 months

*Postsurgical physical medicine treatment period: 8 months

Nerve Repair: Elbow - Wrist [DWC]

Postsurgical treatment: 20 visits over 6 weeks

*Postsurgical physical medicine treatment period: 8 months

Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04):

Postsurgical treatment: 14 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Sprains and strains of elbow and forearm (ICD9 841):

Post-surgical treatment/ligament repair: 24 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Synovitis and tenosynovitis (ICD9 727.0):

Postsurgical treatment: 14 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Tendon transfer forearm, wrist or hand [DWC]:

Postsurgical treatment: 14 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Tendon transfers - thumb or finger [DWC]:

Postsurgical treatment: 26 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

TFCC injuries-debridement (arthroscopic) [DWC]:

Postsurgical treatment: 10 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Trigger finger (ICD9 727.03):

Postsurgical treatment: 9 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Ulnar nerve entrapment/Cubital tunnel syndrome (ICD9 354.2):

Postsurgical treatment: 20 visits over 10 weeks

*Postsurgical physical medicine treatment period: 6 months

Wrist - intercarpal ligament reconstruction or repair [DWC]:

Postsurgical treatment 20 visits over 6 months

*Postsurgical physical medicine treatment period: 8 months

Head

Patient rehabilitation after traumatic brain injury is divided into two periods: acute and subacute. In the beginning of rehabilitation therapist evaluates patient's functional status, later he uses methods and means of treatment, and evaluates effectiveness of rehabilitation. Early ambulation is very important for patients with coma. Therapy consists of prevention of complications, improvement of muscle force, and range of motions, balance, movement coordination, endurance and cognitive functions. Early rehabilitation is necessary for traumatic brain injury patients and use of therapy methods can help to regain lost functions and to come back to the society. (Colorado, 2005) (Brown, 2005) (Franckeviciute, 2005) (Driver, 2004) (Shiel, 2001)

Fracture of skull (ICD9 801):

Postsurgical treatment: 34 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Hernia

Not recommended. No evidence of successful outcomes compared to surgery.

Hip, Pelvis and Thigh (femur)

A therapy program that starts immediately following hip surgery allows for greater improvement in muscle strength, walking speed and functional score. (Jan, 2004) (Jain, 2002) (Penrod, 2004) (Tsauo, 2005) (Brigham, 2003) (White, 2005) (National, 2003) A weight-bearing exercise program can improve balance and functional ability to a greater extent than a non-weight-bearing program. (Expert, 2004) (Binder, 2004) (Bolgla, 2005) (Handoll, 2004) (Kuisma, 2002) (Lauridsen, 2002) (Mangione, 2005) (Sherrington, 2004) Patients with hip fracture should be offered a coordinated multidisciplinary rehabilitation program with the specific aim of regaining sufficient function to return to their pre-fracture living arrangements. (Cameron, 2005) Accelerated perioperative care

and rehabilitation intervention after hip and knee arthroplasty (including intense therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008)

Arthrodesis [DWC]:

Postsurgical treatment: 22 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Arthropathy, unspecified (ICD9 716.9):

Postsurgical treatment, arthroplasty/fusion, hip: 24 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of neck of femur (ICD9 820):

Postsurgical treatment: 24 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of pelvis (ICD9 808):

Postsurgical treatment: 24 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Osteoarthritis and allied disorders (ICD9 715):

Post-surgical treatment: 18 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Synovectomy [DWC]:

Postsurgical treatment: 14 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Knee

Controversy exists about the effectiveness of therapy after arthroscopic partial meniscectomy. (Goodwin, 2003) Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. (Minns Lowe, 2007) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008)

Amputation of leg (ICD9 897):

Post-replantation surgery: 48 visits over 26 weeks

*Postsurgical physical medicine treatment period: 12 months
Post-amputation [DWC]: 48 visits over 6 months

*Postsurgical physical medicine treatment period: 8 months

Arthritis (Arthropathy, unspecified) (ICD9 716.9):

Postsurgical treatment, arthroplasty, knee: 24 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella (ICD9 836; 836.0; 836.1; 836.2; 836.3; 836.5):

Postsurgical treatment: (Meniscectomy): 12 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of neck of femur (ICD9 820):

Postsurgical treatment: 18 visits over 8 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of other and unspecified parts of femur (ICD9 821):

Postsurgical treatment: 30 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of patella (ICD9 822):

Postsurgical treatment: 10 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of tibia and fibula (ICD9 823):

Postsurgical treatment (ORIF): 30 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Manipulation under Anesthesia (knee) [DWC]:

Postsurgical treatment: 20 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Old bucket handle tear; Derangement of meniscus; Loose body in knee;

Chondromalacia of patella; Tibialis tendonitis (ICD9 717.0; 717.5; 717.6; 717.7; 726.72):

Postsurgical treatment: 12 visits over 12 weeks

*Postsurgical physical medicine treatment period: 4 months

Sprains and strains of knee and leg; Cruciate ligament of knee (ACL tear) (ICD9 844; 844.2):

Postsurgical treatment: (ACL repair): 24 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Low Back

As compared with no therapy, therapy (up to 20 sessions over 12 weeks) following disc herniation surgery was effective. Because of the limited benefits of therapy relative to massage, it is open to question whether this treatment acts primarily physiologically, but psychological factors may contribute substantially to the benefits observed. (Erdogmus, 2007)

Artificial Disc [DWC]:

Postsurgical treatment: 18 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Fracture of vertebral column with spinal cord injury (ICD9 806):

Postsurgical treatment: 48 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of vertebral column without spinal cord injury (ICD9 805):

Postsurgical treatment: 34 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Intervertebral disc disorder with myelopathy (ICD9 722.7):

Postsurgical treatment: 48 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):

Postsurgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

*Postsurgical physical medicine treatment period: 6 months

Postsurgical treatment (arthroplasty): 26 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Postsurgical treatment (fusion): 34 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Spinal stenosis (ICD9 724.0):

See 722.1 for postsurgical visits

*Postsurgical physical medicine treatment period: 6 months

Neck & Upper Back

Displacement of cervical intervertebral disc (ICD9 722.0):

Postsurgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

*Postsurgical physical medicine treatment period: 6 months

Postsurgical treatment (fusion, after graft maturity): 24 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Degeneration of cervical intervertebral disc (ICD9 722.4):

See 722.0 for postsurgical visits

*Postsurgical physical medicine treatment period: 6 months

Fracture of vertebral column without spinal cord injury (ICD9 805):

Postsurgical treatment: 34 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of vertebral column with spinal cord injury (ICD9 806):

Postsurgical treatment: 48 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Shoulder

Acromioclavicular joint dislocation (ICD9 831.04):

AC separation, type III+: 8 visits over 8 weeks

*Postsurgical physical medicine treatment period: 6 months

Adhesive capsulitis (ICD9 726.0):

Postsurgical treatment: 24 visits over 14 weeks

*Postsurgical physical medicine treatment period: 6 months

Arthritis (Osteoarthritis; Rheumatoid arthritis; Arthropathy, unspecified) (ICD9 714.0; 715; 715.9; 716.9):

Postsurgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks

*Postsurgical physical medicine treatment period: 6 months

Brachial plexus lesions (Thoracic outlet syndrome) (ICD9 353.0):

Postsurgical treatment: 20 visits over 10 weeks

*Postsurgical physical medicine treatment period: 6 months

Complete rupture of rotator cuff (ICD9 727.61; 727.6):

Postsurgical treatment: 40 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Dislocation of shoulder (ICD9 831):

Postsurgical treatment (Bankart): 24 visits over 14 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of humerus (ICD9 812):

Postsurgical treatment: 24 visits over 14 weeks

*Postsurgical physical medicine treatment period: 6 months

Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):

Postsurgical treatment, arthroscopic: 24 visits over 14 weeks

*Postsurgical physical medicine treatment period: 6 months

Postsurgical treatment, open: 30 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Sprained shoulder; rotator cuff (ICD9 840; 840.4):

Postsurgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks

*Postsurgical physical medicine treatment period: 6 months

(2) Appendix C - Postsurgical Treatment Guidelines Evidence-Based Reviews (May, 2009)- is incorporated by reference into the MTUS as supplemental part of the Postsurgical Treatment Guidelines. A copy of Appendix C may be obtained from the Medical Unit, Division of Workers' Compensation, P.O. Box 71010, Oakland, CA 94612-1486, or from the DWC web site at <http://www.dwc.ca.gov>.

(3) Appendix E - Postsurgical Treatment Guidelines Work Loss Data Institute-Official Disability Guidelines References (May, 2009) - is incorporated by reference into the MTUS as supplemental part of the Postsurgical Treatment Guidelines. A copy of Appendix E may be obtained from the Medical Unit, Division of Workers' Compensation, P.O. Box 71010, Oakland, CA 94612-1486, or from the DWC web site at <http://www.dwc.ca.gov>.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

Title 8. Industrial Relations

Division 1. Department of Industrial Relations

Chapter 4.5. Division of Workers' Compensation

Subchapter 1. Administrative Director -Administrative Rules

Article 5.5.2. Medical Treatment Utilization Schedule

8 CCR § 9792.25

§ 9792.25. Quality and Strength of Evidence - Definitions.

(a) For purposes of sections 9792.25-9792.26, the following definitions shall apply:

(1) "Appraisal of Guidelines for Research & Evaluation II (AGREE II) Instrument" means a tool designed primarily to help guideline developers and users assess the methodological rigor and transparency in which a guideline is developed. The Administrative Director adopts and incorporates by reference the Appraisal of Guidelines for Research & Evaluation II (AGREE II) Instrument, May 2009 into the MTUS from the following website: www.agreetrust.org. A copy of the Appraisal of Guidelines for Research & Evaluation II (AGREE II) Instrument, May 2009 version may be obtained from the Medical Unit, Division of Workers' Compensation, P.O. Box 71010, Oakland, CA 94612-1486, or from the DWC web site at <http://www.dwc.ca.gov>.

(2) "Bias" means any tendency to influence the results of a trial (or its interpretation) other than the experimental intervention. Biases include but are not limited to vested interests such as financial interests, academic interests, and industry influence; confounding variables, inadequate generation of the randomization sequence, inadequate concealment of allocation, selection, lack of blinding, selective outcome reporting, failure to do intention-to-treat analysis, early stopping, and publication.

(3) “Biologic plausibility” means the likelihood that existing biological, medical, and toxicological knowledge explains observed effect.

(4) “Blinding” means a technique used in research to eliminate bias by hiding the intervention from the patient, clinician, and any others who are interpreting results.

(5) “Case-control study” means a retrospective observational epidemiologic study of persons with the disease (or other outcome variable) of interest and a suitable control (comparison, reference) group of persons without the disease. The relationship of an attribute to the disease is examined by comparing the diseased and non-diseased with regard to how frequently the attribute is present or, if quantitative, the levels of the attribute, in each of the groups.

(6) “Case report” means a detailed report of the symptoms, signs, diagnosis, treatment, and follow-up of an individual patient. Case reports usually describe an unusual or novel occurrence.

(7) “Case-series” means a group or series of case reports involving patients who were given similar treatment. Reports of case series usually contain detailed information about the individual patients. This includes demographic information (for example, age, gender, ethnic origin) and information on diagnosis, treatment, response to treatment, and follow-up after treatment. This may be done prospectively or retrospectively.

(8) “Cohort study” (also known as “follow-up study” or “prospective study”) means an epidemiologic study in which two or more groups of people that are free of disease and that differ according to the extent of exposure to a potential cause of the disease are compared with respect to the incidence (occurrence of the disease) in each of the groups. This may include a comparison of treated and non-treated patients. The main feature of cohort study is observation of large numbers of people over a long period of time (commonly years) with comparison of incidence rates in groups that differ in exposure levels.

(9) “Concealment of allocation” means precautions taken to ensure that the groups to which patients or subjects are assigned as part of a study are not revealed prior to definitively allocating them to their respective groups.

(10) “Confounding variable” means extrinsic factor associated with the exposure under study and cause of the outcome.

(11) “Cross-sectional study” means a study that examines the relationship between diseases (or other health-related characteristics) and other variables of interest as they exist in a defined population at one particular time. Note that disease prevalence rather than disease incidence is normally recorded in a cross-sectional study. The temporal sequence of cause and effect cannot necessarily be determined in a cross-sectional study.

(12) “Diagnostic test” means any medical test performed to confirm, or determine the presence of disease in an individual suspected of having the disease, usually following the report of symptoms, or based on the results of other medical tests. Some examples of diagnostic tests include performing a chest x-ray to diagnose pneumonia, and taking skin biopsy to detect cancerous cells.

(13) “Disease incidence” means new cases of disease or condition over a period of time.

(14) “Disease prevalence” means rate of a disease or condition at any particular point in time.

(15) “Expert opinion” means a determination by experts, through a process of evidenced-based thinking, that a given practice should or should not be recommended, and the opinion is published in a peer-reviewed medical journal.

(16) “Inception cohort study” means a group of individuals identified for subsequent study at an early, uniform point in the course of the specified health condition, or before the condition develops.

(17) “Index test” means the diagnostic procedure or test that is being evaluated in a study.

(18) “Intention to treat” means a procedure in the conduct and analysis of randomized controlled trials. All patients allocated to a given arm of the treatment regimen are included in the analysis whether or not they received or completed the prescribed regimen. Failure to follow this step defeats the main purpose of random allocation and can invalidate the results.

(19) “Low risk of bias” means those trials or studies that contain methodological safeguards to protect against biases related to vested interests such as financial interests, academic interests, industry influence, or other biases related to the generation of the randomization sequence, concealment of allocation, selection, blinding, selective outcome reporting, early stopping, and intention to treat.

(20) “Meta-analysis” means a mathematical process whereby results from two or more studies are combined using a method that provides a weight to each study that reflects the statistical likelihood (variance) that its results are more likely to be closer to the truth.

(21) “Post-marketing surveillance” means a procedure implemented after a drug has been licensed for public use. The procedure is designed to provide information on the actual use of the drug for a given indication and on the occurrence of side effects, adverse reactions, etc. This is a method for identifying adverse drug reactions, especially rare (< 1% incidence) ones.

(22) “Prognosis” means the prospect of survival and recovery from a disease as anticipated from the usual course of that disease or indicated by special features of the case.

(23) “Randomized trial” means a clinical experiment in which subjects in a population are allocated by chance into groups, usually called study and control groups, to receive or not receive an experimental diagnostic, preventive, or therapeutic procedure, maneuver, or intervention. The results are assessed by comparison of rates of disease, death, recovery, or other appropriate outcome in the study and control groups.

(24) “Reference standard” means the gold standard to which an index test is being compared.

(25) “Risk of bias” means a term that refers to the advertent or inadvertent introduction of bias into trials because of methodological insufficiencies to protect against biases related to vested interests such as financial interests, academic interests, industry influence, or other biases related to the generation of the randomization sequence, concealment of allocation, selection, blinding, selective outcome reporting, early stopping, and intention to treat.

(26) “Selective outcome reporting” means the failure to report all of the outcomes that are assessed in a trial, including a post hoc change in the primary outcome.

(27) “Systematic review” means the application of strategies that limit bias in the assembly, critical appraisal, and synthesis of all relevant studies on a specific topic. Systematic reviews focus on peer-reviewed publications about a specific health problem and use rigorous, standardized methods for selecting and assessing articles. A systematic review differs from a meta-analysis in not including a quantitative summary of the results. However, a meta-analysis may be part of a systematic review.

(28) “Treatment benefits” means positive patient-relevant outcome associated with an intervention, quantifiable by epidemiological measures such as absolute risk reduction and number needed to treat.

(29) “Treatment harms” means an adverse patient-relevant outcome associated with an intervention, identifiable by epidemiological measures such as absolute increased risk of occurrence or number needed to harm if possible, but also identifiable by post-marketing surveillance.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

Title 8. Industrial Relations

Division 1. Department of Industrial Relations

Chapter 4.5. Division of Workers' Compensation

Subchapter 1. Administrative Director -Administrative Rules

Article 5.5.2. Medical Treatment Utilization Schedule

8 CCR § 9792.25.1

§ 9792.25.1. MTUS Methodology for Evaluating Medical Evidence.

(a) When competing recommendations are cited to guide medical care, Utilization Review and Independent Medical Review physicians shall apply the MTUS Methodology for Evaluating Medical Evidence to evaluate the quality and strength of evidence used to support the recommendations that are at variance with one another. The MTUS Methodology for Evaluating Medical Evidence provides a process to evaluate studies, not guidelines. Therefore, the reviewing physician shall evaluate the underlying study or studies used to support a recommendation found in a guideline. Medical care shall be in accordance with the recommendation supported by the best available evidence. The MTUS Methodology for Evaluating Medical Evidence shall be applied as follows:

(1) The reviewing physician shall determine if different guidelines or studies were cited to guide the injured worker's medical care by the treating physician, the Utilization Review physician and/or the Independent Medical Review physician that contain recommendations that are at variance with one another.

(2) If different guidelines or studies were cited to guide the injured worker's medical care containing recommendations that are at variance with one another, the reviewing physician shall evaluate the quality of evidence by determining if the studies used to support the recommendations are applicable to the injured worker and his or her medical condition or injury. Applicability refers to the extent to which the individual

patients, subjects, settings, interventions, and outcome measures of studies used to support a recommendation are similar to the worker and his or her medical condition or injury. A recommendation supported by inapplicable studies should not be used as the source to support, deny, delay or modify an RFA. Reviewing physicians shall provide an explanation of their rationale in the Utilization Review or Independent Medical Review decision if they conclude a recommendation is supported by studies inapplicable to the worker and his or her medical condition or injury.

(A) The evaluation of medical evidence can end after this step if a citation to a guideline or a study contains a recommendation supported by inapplicable studies and the other citation contains a recommendation that is supported by studies applicable to the injured worker's medical condition or injury.

(3) If the guidelines or studies cited contain recommendations supported by studies applicable to the worker and his or her medical condition or injury, then the reviewing physician shall continue to evaluate the quality of evidence by determining what factors, if any, bias may have had in the studies used to support the recommendations. Factors to consider include, but are not limited to, vested interests such as financial interests, academic interests, industry influence, and the methodological safeguards to protect against biases related to the generation of the randomization sequence, concealment of allocation, blinding, selective outcome reporting, early stopping, intention to treat, and confounding bias. A recommendation supported by studies determined to be of poor quality due to the presence of bias should not be used as the source to support, deny, delay or modify an RFA. Reviewing physicians shall provide an explanation of their rationale in the Utilization Review or Independent Medical Review decision if they conclude a recommendation is supported by studies determined to be of poor quality due to the presence of bias.

(A) The evaluation of medical evidence can end after this step if a citation to a guideline or a study contains a recommendation supported by studies determined to be of poor quality due to the presence of bias and the other citation contains a recommendation that is supported by studies determined to be of good quality due to the absence of bias.

(4) If the guidelines or studies cited contain recommendations supported by studies applicable to the worker and his or her medical condition or injury and if the recommendations are supported by studies that are determined to be of good quality due to the absence of bias, then the reviewing physician shall determine the strength of evidence used to support the differing recommendations by applying the Hierarchy of Evidence for Different Clinical Questions set forth in 9792.25.1(b). To apply the Hierarchy of Evidence for Different Clinical Questions, the following steps shall be taken:

(A) Determine the design of the study used to support the recommendation. Study designs are categorized as one of the following categories:

1. Systematic Review of:

- (aa) Randomized Controlled Trials

- (bb) Prospective or Cohort Studies

2. Randomized Controlled Trials

3. Observational studies:

- (aa) Prospective study or Cohort Study
- (bb) Cross-sectional study
- (cc) Case-control study
- (dd) Case-series
- (ee) Uncontrolled or observational study
- (ff) Case report

4. Published expert opinion

(B) Determine which of the four clinical questions in the MTUS Hierarchy of Evidence for Different Clinical Questions as set forth in Section 9792.25.2(b) the study is answering and then apply the corresponding hierarchy(ies) of evidence. The sequence to be followed for each of the four clinical questions is as follows:

1. If the original study answers the question “How useful is Treatment X in treating patients with Disease Y?” then the hierarchy of evidence set forth under Treatment Benefits shall apply.
2. If the original study answers the question “How useful is Test X in diagnosing patients with Disease Y?” then the hierarchy of evidence set forth under Diagnostic Test shall apply.
3. If the original study answers the question “What will happen to a patient with Disease Y if nothing is done?” then the hierarchy of evidence set forth under Prognosis shall apply.
4. If the original study answers the question “What are the harms of intervention (treatment or diagnostic test) X in patients with Disease Y?” then the hierarchy of evidence set forth under Treatment Harms shall apply.

(C) In each Clinical Question category, the levels of evidence are listed from highest to lowest, as defined by the principles of Evidence-Based Medicine. Levels of evidence shall be applied in the order listed. Recommendation for or against medical treatment based on a lower level of evidence shall be permitted only if every higher ranked level of evidence is inapplicable to the employee's medical condition.

1. The level of evidence for each published study (e.g. 1a, 1b, 2, etc.) shall be documented and included with the citation in the Utilization Review or Independent Medical Review decisions.
2. When relying on lower levels of evidence, a written statement shall be provided that states higher levels of evidence are absent.

(b) MTUS Hierarchy of Evidence for Different Clinical Questions shall apply:

MTUS Hierarchy of Evidence for Different Clinical Questions

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5, 4610.5 and 5307.27, Labor Code.

Title 8. Industrial Relations

Division 1. Department of Industrial Relations

Chapter 4.5. Division of Workers' Compensation

Subchapter 1. Administrative Director -Administrative Rules

Article 5.5.2. Medical Treatment Utilization Schedule

§ 9792.26. Medical Evidence Evaluation Advisory Committee.

(a) The Medical Director shall create a Medical Evidence Evaluation Advisory Committee (MEEAC) to provide recommendations to the Medical Director on matters concerning the MTUS. The recommendations are advisory only and shall not constitute scientifically based evidence.

(1) If the Medical Director position becomes vacant, the Administrative Director shall appoint a competent person to temporarily assume the authority and duties of the Medical Director as set forth in this section, until such time that the Medical Director position is filled.

(2) The members of the MEEAC shall be appointed by the Medical Director, or his or her designee, and shall consist of 19 members of the medical community holding the following licenses: Medical Doctor (M.D.) board certified by an American Board of Medical Specialties (ABMS) approved specialty board; Doctor of Osteopathy (D.O.) board certified by an ABMS or American Osteopathic Association (AOA) approved specialty board; M.D. board certified by a Medical Board of California (MBC) approved specialty board; Doctor of Chiropractic (D.C.); Physical Therapy (P.T.); Occupational Therapy (O.T.); Acupuncture (L.Ac.); Psychology (PhD.); Doctor of Podiatric Medicine (DPM); Pharmacologist (PharmD); Nurse Practitioner (NP) or Registered Nurse (RN), and representing the following specialty fields:

(A) One member shall be from the orthopedic field;

(B) One member shall be from the chiropractic field;

(C) One member shall be from the occupational medicine field;

(D) One member shall be from the acupuncture medicine field;

(E) One member shall be from the physical therapy field;

(F) One member shall be from the psychology field;

(G) One member shall be from the pain specialty field;

(H) One member shall be from the occupational therapy field;

(I) One member shall be from the psychiatry field;

(J) One member shall be from the neurosurgery field;

(K) One member shall be from the family physician field;

(L) One member shall be from the neurology field;

(M) One member shall be from the internal medicine field;

(N) One member shall be from the physical medicine and rehabilitation field;

(O) One member shall be from the podiatrist field;

(P) One member shall be from the pharmacology field;

(Q) One member shall be from the nursing field;

(R) Two additional members shall be appointed at the discretion of the Medical Director or his or her designee.

(3) In addition to the nineteen members of MEEAC appointed under subdivision (a)(2) above, the Medical Director, or his or her designee, may appoint an additional three members to MEEAC as subject matter experts for any given topic.

(b) The Medical Director, or his or her designee, shall serve as the chairperson of MEEAC.

(c) Members of MEEAC shall make advisory recommendations to the Medical Director or his or her designee to revise, update or supplement the MTUS.

(d) The advisory MEEAC recommendations shall be supported by the best available medical evidence found in scientifically and evidenced-based medical treatment guidelines or peer-reviewed published studies that are nationally recognized by the medical community.

(e) To assess the quality and methodological rigors used to develop a medical treatment guideline, members of MEEAC shall use a modified version of the Appraisal of Guidelines for Research & Evaluation II (AGREE II) Instrument, May 2009. The AGREE II Instrument, May 2009, consisting of 23 key items organized within six domains followed by two global rating items was found in the following website: www.agreetrust.org. A copy of the AGREE II Instrument, May 2009 version may be obtained from the Medical Unit, Division of Workers' Compensation, P.O. Box 71010, Oakland, CA 94612-1486, or from the DWC web site at <http://www.dwc.ca.gov>.

(1) Members of MEEAC shall use a modified AGREE II that uses the same six domains and two global rating items as the AGREE II Instrument, May 2009 version but includes two additional domains and additional key items:

(A) Additional domain in the modified AGREE II Instrument - Conflict of Interest

1. Key Item in this domain - All conflicts of interest of each guideline development group member were reported and discussed by the prospective group prior to the onset of his or her work.

2. Key Item in this domain - Each panel member explained how his or her conflict of interest could influence the clinical practice guideline development process or specific recommendation.

3. Key Item in this domain - The chairperson of the guideline development group had no conflicts of interest.

(B) Additional domain in the modified AGREE II Instrument - Currency of Guideline

1. Key Item in this domain - The guideline is being updated in a timely fashion (typically at least every three years and, if the guideline is more than five years old, it should be considered to be out of date).

(f) Recommendations in guidelines that have a low AGREE II overall score may still be considered, provided that the evidence supporting the recommendations is the best available medical evidence.

(g) To determine the best available medical evidence, members of MEEAC shall rank the medical evidence used to support recommendations found in either guidelines or peer-reviewed published studies by applying the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1 and shall choose the recommendations supported by the best available medical evidence.

(h) The members of MEEAC, except for the three subject matter experts, shall serve a two-year term, but shall remain in that position until a successor is selected. The subject matter experts shall serve as members of the medical evidence evaluation advisory committee until the evaluation of the subject matter guideline is completed. The members of the committee shall meet as necessary, but no less than three (3) times a year.

(i) The Administrative Director, in consultation with the Medical Director, may revise, update, and supplement the MTUS as necessary.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.