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

§ 9792.20. Medical Treatment Utilization Schedule—Definitions

As used in this Article:

(a) "American College of Occupational and Environmental Medicine (ACOEM)" is a medical society of physicians and other health care professionals specializing in the field of occupational and environmental medicine, dedicated to promoting the health of workers through preventive medicine, clinical care, research, and education.

(b) "ACOEM Practice Guidelines" means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, 2nd Edition (2004). A copy 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).

(c) "Chronic pain" means any pain that persists beyond the anticipated time of healing.

(d) "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.

(e) "Evidence-based" means based, at a minimum, on a systematic review of literature published in medical journals included in MEDLINE.

(f) "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 evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment.

(g) "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.

(h) "Medical treatment guidelines" means the most current version of written recommendations revised within the last five years 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.

(i) “MEDLINE” is the largest component of PubMed, the U.S. National Library of Medicine’s database of biomedical citations and abstracts that is searchable on the Web. Its website address is www.pubmed.gov.

(j) “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; or currently adopted for use by one or more U.S. state governments or by the U.S. federal government; and is the most current version.

(k) “Peer reviewed” means that a medical study’s content, methodology and results have been evaluated and approved prior to publication by an editorial board of qualified experts.

(l) “Scientifically based” means based on scientific literature, wherein the body of literature is identified through performance of a literature search in MEDLINE, the identified literature is evaluated, and then used as the basis for the guideline.

(m) “Strength of Evidence” establishes the relative weight that shall be given to scientifically based evidence.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 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 intended to assist in the provision of medical treatment by offering an analytical framework for the evaluation and treatment of injured workers and to help those who make decisions regarding the medical treatment of injured workers understand what treatment has been proven effective in providing the best medical outcomes to those workers, in accordance with section 4600 of the Labor Code.

(c) Treatment shall not be denied on the sole basis that the condition or injury is not addressed by the MTUS. In this situation, the claims administrator shall authorize treatment if such treatment is in accordance with other scientifically and evidence-based, peer-reviewed, medical treatment guidelines that are nationally recognized by the medical community, in accordance with subdivisions (b) and (c) of section 9792.25, and pursuant to the Utilization Review Standards found in section 9792.6 through section 9792.10.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.22. General Approaches

(a) The Administrative Director adopts and incorporates by reference into the MTUS specific guidelines set forth below from the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM Practice Guidelines) for the following chapters. A copy 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).

(1) Prevention (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 1).

(2) General Approach to Initial Assessment and Documentation (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 2).

(3) Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3).

(4) Cornerstones of Disability Prevention and Management (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 5).

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 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 9792.25(b).

(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).

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.23.1. Neck and Upper Back Complaints

(a) The Administrative Director adopts and incorporates by reference the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8) into the MTUS from the ACOEM Practice Guidelines.

(b) In the course of treatment for neck and upper back complaints where acupuncture or acupuncture with electrical stimulation is being considered, the acupuncture medical treatment guidelines in section 9792.24.1 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to acupuncture.

(c) If recovery has not taken place with respect to pain by the end of algorithm 8-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

(d) If surgery is performed in the course of treatment for neck and upper back complaints, 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. 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.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.23.2. Shoulder Complaints

(a) The Administrative Director adopts and incorporates by reference the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) into the MTUS from the ACOEM Practice Guidelines.

(b) If recovery has not taken place with respect to pain by the end of algorithm 9-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

(c) If surgery is performed in the course of treatment for shoulder complaints, 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. 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.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.23.3. Elbow Disorders

(a) The Administrative Director adopts and incorporates by reference the Elbow Disorders Chapter (ACOEM Practice Guidelines, 2nd Edition (Revised 2007), Chapter 10) into the MTUS from the ACOEM Practice Guidelines.

(b) In the course of treatment for elbow complaints where acupuncture or acupuncture with electrical stimulation is being considered, the acupuncture medical treatment guidelines in section 9792.24.1 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to acupuncture.

(c) If recovery has not taken place with respect to pain by the end of the Elbow Algorithm 10-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to chronic pain.

(d) If surgery is performed in the course of treatment for elbow complaints, 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. 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.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792. 23.4. Forearm, Wrist, and Hand Complaints

(a) The Administrative Director adopts and incorporates by reference the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11) into the MTUS from the ACOEM Practice Guidelines.

(b) In the course of treatment for forearm, wrist, and hand complaints where acupuncture or acupuncture with electrical stimulation is being considered, the acupuncture medical

treatment guidelines in section 9792.24.1 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to acupuncture.

(c) If recovery has not taken place with respect to pain by the end of algorithm 11-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

(d) If surgery is performed in the course of treatment for forearm, wrist, and hand complaints, 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. 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.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792. 23.5. Low Back Complaints

(a) The Administrative Director adopts and incorporates by reference the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) into the MTUS from the ACOEM Practice Guidelines.

(b) In the course of treatment for low back complaints where acupuncture or acupuncture with electrical stimulation is being considered, the acupuncture medical treatment guidelines in section 9792.24.1 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to acupuncture.

(c) If recovery has not taken place with respect to pain by the end of algorithm 12-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

(d) If surgery is performed in the course of treatment for low back complaints, 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. 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.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792. 23.6. Knee Complaints

(a) The Administrative Director adopts and incorporates by reference the Knee Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 13) into the MTUS from the ACOEM Practice Guidelines.

(b) In the course of treatment for knee complaints where acupuncture or acupuncture with electrical stimulation is being considered, the acupuncture medical treatment guidelines in section 9792.24.1 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to acupuncture.

(c) If recovery has not taken place with respect to pain by the end of algorithm 13-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

(d) If surgery is performed in the course of treatment for knee complaints, 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. 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.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792. 23.7. Ankle and Foot Complaints

(a) The Administrative Director adopts and incorporates by reference the Ankle and Foot Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 14) into the MTUS from the ACOEM Practice Guidelines.

(b) In the course of treatment for ankle and foot complaints where acupuncture or acupuncture with electrical stimulation is being considered, the acupuncture medical treatment guidelines in section 9792.24.1 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to acupuncture.

(c) If recovery has not taken place with respect to pain by the end of algorithm 14-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

(d) If surgery is performed in the course of treatment for ankle and foot complaints, 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. 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.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792. 23.8. Stress Related Conditions

(a) The Administrative Director adopts and incorporates by reference the Stress Related Conditions Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 15) into the MTUS from the ACOEM Practice Guidelines.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792. 23.9. Eye

(a) The Administrative Director adopts and incorporates by reference the Eye Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 16) into the MTUS from the ACOEM Practice Guidelines.

(b) If recovery has not taken place with respect to pain by the end of algorithm 16-6, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.24. Special Topics

(a) Special topics refer to clinical topic areas where the Administrative Director has determined that the clinical topic sections of the MTUS require further supplementation.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 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~~f).

(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.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.24.2. Chronic Pain Medical Treatment Guidelines

(a) The Chronic Pain Medical Treatment Guidelines (May, 2009), consisting of two parts, are adopted and incorporated by reference into the MTUS. Part 1 is entitled Introduction. Part 2 is entitled Pain Interventions and Treatments. These guidelines replace Chapter 6 of the ACOEM Practice Guidelines, 2nd Edition (2004). Where the clinical topic sections of the MTUS in the series of sections commencing with 9792.23.1 et seq., make reference to Chapter 6 or when there is a reference to the "pain chapter," or "pain assessment," the chronic pain medical treatment guidelines will apply instead of Chapter 6. A copy of the chronic pain medical treatment guidelines 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.

(b) The chronic pain medical treatment guidelines apply when the patient has chronic pain as determined by following the clinical topics.

(c) When a patient is diagnosed with chronic pain and the treatment for the condition is covered in the clinical topics sections but is not addressed in the chronic pain medical treatment guidelines, the clinical topics section applies to that treatment.

(d) When the treatment is addressed in both the chronic pain medical treatment guidelines and the specific guideline found in the clinical topics section of the MTUS, the chronic pain medical treatment guideline shall apply.

(e) Appendix D—Chronic Pain Medical Treatment Guidelines-Division of Workers' Compensation and Official Disability Guidelines References (May, 2009)—is incorporated by reference into the MTUS as supplemental part of the Chronic Pain Medical Treatment Guidelines. A copy of Appendix D 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.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 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(c). 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

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

Osteoarthrosis 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 (Osteoarthrosis; 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.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.25. Presumption of Correctness, Burden of Proof and Strength of Evidence.

(a) The MTUS is presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addressed in the MTUS for the duration of the medical condition. 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.

(b) For all conditions or injuries not addressed by the MTUS, authorized treatment and diagnostic services shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community.

(c)(1) For conditions or injuries not addressed by either subdivisions (a) or (b) above; for medical treatment and diagnostic services at variance with both subdivisions (a) and (b) above; or where a recommended medical treatment or diagnostic service covered under subdivision (b) is at variance with another treatment guideline also covered under subdivision (b), the following ACOEM's strength of evidence rating methodology is adopted and incorporated as set forth below, and shall be used to evaluate scientifically based evidence published in peer-reviewed, nationally recognized journals to recommend specific medical treatment or diagnostic services:

(A) Table A – Criteria Used to Rate Randomized Controlled Trials

Studies shall be rated using the following 11 criteria. Each criterion shall be rated 0, 0.5, or 1.0, thus the overall ratings range from 0-11. A study is considered low quality if the composite rating was 3.5 or less, intermediate quality if rated 4-7.5, and high quality if rated 8-11.

Criteria	Rating Explanation
Randomization: Assessment of the degree that randomization was both reported to have been performed and successfully* achieved through analyses of comparisons of variables between the two groups.	Rating is "0" if the study is not randomized or reports that it was and subsequent analyses of the data/tables suggest it either was not randomized or was unsuccessful. Rating is "0.5" if there is mention of randomization and it appears as if it was performed, however there are no data on the success of randomization, it appears incomplete, or other questions about randomization cannot be adequately addressed. Rating is "1.0" if randomization is specifically stated and

*Simply allocating individuals to groups does not constitute sufficient grounds to assess the success of randomization. The groups must be comparable; otherwise, the randomization was unsuccessful.	data reported on subgroups suggests that the study did achieve successful randomization.
Treatment Allocation Concealed: Concealment of the allocation scheme from all involved, not just the patient.	Rating is "0" if there is no description of how members of the research team or subjects would have not been able to know how they were going to receive a particular treatment, or the process used would not be concealed. Rating is "0.5" if the article mentions how allocation was concealed, but the concealment was either partial involving only some of those involved or other questions about it are unable to be completely addressed. Rating is "1.0" if there is a concealment process described that would conceal the treatment allocation to all those involved.
Baseline Comparability: Measures how well the baseline groups are comparable (e.g., age, gender, prior treatment).	Rating is "0" if analyses show that the groups were dissimilar at baseline or it cannot be assessed. Rating is "0.5" if there is general comparability, though one variable may not be comparable. Rating is "1.0" if there is good comparability for all variables between the groups at baseline.
Patient Blinded	Rating is "0" if there is no mention of blinding of the patient. Rating is "0.5" if it mentions blinding, but the methods are unclear. Rating is "1.0" if the study reports blinding, describes how that was carried out, and would plausibly blind the patient.

Provider Blinded	Rating is “0” if there is no mention of blinding of the provider. Rating is “0.5” if it mentions blinding, but the methods are unclear. Rating is “1.0” if the study reports blinding, describes how that was carried out and would plausibly blind the provider.
Assessor Blinded	Rating is “0” if there is no mention of blinding of the assessor. Rating is “0.5” if it mentions blinding, but the methods are unclear. Rating is “1.0” if the study reports blinding, describes how that was carried out and would plausibly blind the assessor.
Controlled for Co-interventions: The degree to which the study design controlled for multiple interventions (e.g., a combination of stretching exercises and anti-inflammatory medication or mention of not using other treatments during the study).	Rating is “0” if there are multiple interventions or no description of how this was avoided. Rating is “0.5” if there is brief mention of this potential problem. Rating is “1.0” if there is a detailed description of how co-interventions were avoided.
Compliance Acceptable: Measures the degree of non-compliance.	Rating is “0” if there is no mention of non-compliance. Rating is “0.5” if non-compliance is briefly addressed and the description suggests that there was compliance, but a complete assessment is not possible. Rating is “1.0” if there are specific data and the non-compliance rate is less than 20%.

Dropout Rate: Measures the drop-out rate.	Rating is "0" if there is no mention of drop-outs or it cannot be inferred from the data presented. Rating is "0.5" if the drop-out issue is briefly addressed and the description suggests that there were few drop-outs, but a complete assessment is not possible. Rating is "1.0" if there are specific data and the drop-out rate is under 20%.
Timing of Assessments: Timing rates the timeframe for the assessments between the study groups.	Rating is "0" if the timing of the evaluations is different between the groups. Rating is "0.5" if the timing is nearly identical (e.g., one day apart). Rating is "1.0" if the timing of the assessments between the groups is identical.
Analyzed by Intention to Treat: This rating is for whether the study was analyzed with an intent to treat analysis.	Rating is "0" if it was not analyzed by intent to treat. Rating is "0.5" if there is not mention of intent to treat analysis, but the results would not have been different (e.g., there was nearly 100% compliance and no drop-outs). Rating is "1.0" if the study specifies analyses by intention to treat.
Lack of Bias: This rating does not enter into the overall rating of an article. This is an overall indication of the degree to which biases are felt to be present in the study.	Rating is "0" if there are felt to be significant biases that are uncontrolled in the study and may have influenced the study's results. Rating is "0.5" if there are felt to be some biases present, but the results are less likely to have been influenced by those biases. Rating is "1.0" if there are few biases, or those are well controlled and unlikely to have influenced the study's results.

(B) Table B – Strength of Evidence Ratings

Levels of evidence shall be used to rate the quality of the body of evidence. The body of evidence shall consist of all studies on a given topic that are used to develop evidence-based recommendations. Levels of evidence shall be applied when studies are relevant to the topic and study working populations. Study outcomes shall be consistent and study data shall be homogeneous.

A	**Strong evidence-base**: One or more well-conducted systematic reviews or meta-analyses, or two or more high-quality studies.
B	**Moderate evidence-base**: At least one high-quality study, a well-conducted systematic review or meta-analysis of lower quality studies or multiple lower-quality studies relevant to the topic and the working population.
C	**Limited evidence-base**: At least one study of intermediate quality.
I	**Insufficient Evidence**: Evidence is insufficient or irreconcilable.

(2) Evidence shall be given the highest weight in the order of the strength of evidence.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.26. Medical Evidence Evaluation Advisory Committee

(a)(1) The Medical Director shall create a medical evidence evaluation advisory committee to provide recommendations to the Medical Director on matters concerning the MTUS. The recommendations are advisory only and shall not constitute scientifically based evidence.

(A) 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 medical evidence evaluation advisory committee shall be appointed by the Medical Director, or his or her designee, and shall consist of 17

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.); or Doctor of Podiatric Medicine (DPM), 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) Two additional members shall be appointed at the discretion of the Medical Director or his or her designee.

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

(b) The Medical Director, or his or her designee, shall serve as the chairperson of the medical evidence evaluation advisory committee.

(c) To evaluate evidence when making recommendations to revise, update or supplement the MTUS, the members of the medical evidence evaluation advisory committee shall:

(1) Apply the requirements of subdivision (b) of section 9792.25 in reviewing medical treatment guidelines to insure that the guidelines are scientifically and evidence-based, and nationally recognized by the medical community;

(2) Apply the ACOEM's strength of evidence rating methodology to the scientific evidence as set forth in subdivision (c) of section 9792.25 after identifying areas in the guidelines which do not meet the requirements set forth in subdivision (b) of section 9792.25;

(3) Apply in reviewing the scientific evidence, the ACOEM's strength of evidence rating methodology for treatments where there are no medical treatment guidelines or where a guideline is developed by the Administrative Director, as set forth in subdivision (c) of section 9792.25.

(d) The members of the medical evidence evaluation advisory committee, except for the three subject matter experts, shall serve a term of two year period, 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 four (4) times a year.

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

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.