Evidence Based Medicine

WCJ Noah Tempkin

Sacramento

DISCLAIMER

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- The materials are intended to be a reference tool only and are not to be relied upon as legal advice.

Evidence Based Medicine in CA W/C

- Labor Code 4600(a):
  - Medical, surgical, chiropractic, acupuncture, hospital treatment, etc. …that is **reasonably required to cure or relieve** the injured worker from the effects of the injury shall be provided by the employer.
- Labor Code 4600(b):
  - Medical treatment that is reasonably required to cure or relieve the injured worker from the effects of the injury **means treatment that is based upon the guidelines adopted by the A.D. pursuant to L.C. sec. 5307.27 (MTUS)**.
    - MTUS runs from Reg. 9792.20 through 9792.26

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(MTUS see Reg. 9792.20 – Reg. 9792.26)

- Reg. 9792.21(b) states:
  - 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.

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- Reg. 9792.21(c) – the recommended guidelines set forth in the MTUS are **presumptively correct** on the issue of extent and scope of medical treatment.
- Reg. 9792.21(d) – two limited situations when treatment found outside of the MTUS may be warranted:
  - The medical condition or treatment not covered by MTUS.
  - Presumption is successfully challenged.
    - Physician has the burden of proof in rebutting the MTUS
- Reg. 9792.21.1(a)- when MTUS does not address treatment or when the presumption being challenged, the physician and reviewers need to search the most current ACOEM, ODG, nationally recognized guidelines and studies.
  - Medical Evidence Search Sequence….(don't ask)

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(MTUS see Reg. 9792.20 – Reg. 9792.26)

MTUS adopts certain chapters from ACOEM:

- Reg. 9792.23.1 (a)– adopts Chapter 8 from ACOEM Practice Guidelines, 2nd Edition (2004) for **neck and upper back** complaints.
- Reg.9792.23.2(a) – adopts Chapter 9 from ACOEM Practice Guidelines, 2nd Edition (2004) for **shoulder complaints**.
- Reg.9792.23.3(a) – adopts Chapter 10 from ACOEM Practice Guidelines, 2nd Edition (Revised 2007) for **elbow disorders**.
- Reg.9792.23.4(a) – adopts Chapter 11 from ACOEM Practice Guidelines, 2nd Edition (2004) for **forearm, wrist, and hand complaints**.
- Reg.9792.23.5(a) – adopts Chapter 12 from ACOEM Practice Guidelines, 2nd Edition (2004) for **low back complaints**.
- Reg.9792.23.6(a) – adopts Chapter 13 from ACOEM Practice Guidelines, 2nd Edition (2004) for **knee complaints**.
- Reg.9792.23.7(a) – adopts Chapter 14 from ACOEM Practice Guidelines, 2nd Edition (2004) for **ankle and foot complaints**.
- Reg. 9792.23.8(a) – adopts Chapter 15 from ACOEM Practice Guidelines, 2nd Edition(2004) for **stress related conditions**.
- Reg. 9792.23.9(a) – adopts Chapter 16 from ACOEM Practice Guidelines, 2nd Edition (2004) for treating the **eye**.
- Reg. 9792.24(a) – is entitled "**Special Topics**" and refers to clinical topics areas where the A.D. has determined that the clinical topic sections of the MTUS require further supplementation.
- Special Topics included:
  - Reg. 9792.24.1 – **Acupuncture** Medical Treatment Guidelines.
  - Reg. 9792.24.2 – **Chronic Pain** Medical Treatment Guidelines.
  - Reg. 9792.24.3 – **Postsurgical** Treatment Guidelines

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- Understanding the limitations of the presumptively correct MTUS:
  - The presumption only applies if the treatment is specifically covered under the MTUS.
  - "***Evidence-based Medicine: What Does It Mean? Why Do We Care***?" (Appendix at page 491 of the ACOEM Guidelines (2nd Edition):
    - "…To the extent that the literature has adequate high-quality studies of a given topic, it is possible to develop guidelines or conclusions regarding treatment and causation that are truly based on scientific evidence. Unfortunately many, if not most, of the treatments and tests we provide, and many of the hypotheses on which we base concerns regarding risk and exposure, have not been rigorously evaluated. Budget constraints and the absence of sponsors who would benefit from study results are only two of the reasons that there is a lack of funding for research in this area. Interventions that as yet have not been satisfactorily proven (or disproven) to be of value or relevance are continuously being introduced, and often integrated into clinical practice…."

EBM: a movement in crisis?

- On June 13, 2014, the BMJ (originally called the British Medical Journal) published an article entitled: "**Evidence based medicine: a movement in crisis**?" (BMJ 2014; 348: g3725).
  - http://www.bmj.com/content/348/bmj.g3725.long
- The authors identify that:
  - Critics of EBM were concerned that emphasis on experimental evidence could devalue basic science and the tacit knowledge that accumulates with clinical experience; and also questioned whether findings from average results in clinical studies could inform decisions about real patients, who seldom fit the textbook description of disease and differ from those included in the research trials.
  - Proponents argued that evidence based medicine, if practiced knowledgably and compassionately, could accommodate basic scientific principles, the subtleties of clinical judgement, and the patient's clinical and personal idiosyncrasies.
  - In acknowledging the numerous successes for EBM, they note a wide variation in implementing evidence based practice remains a problem.

EBM: a movement in crisis?

- The authors identify the problems with EBM and offered some solutions:
  - Problems:
    - The evidence based “quality mark” has been misappropriated by vested interests.
    - The volume of evidence, especially clinical guidelines, has become unmanageable.
    - Statistically significant benefits may be marginal in clinical practice.
    - Inflexible rules and technology drive prompts may produce care that is management driven rather than patient centered.
    - Evidence based guidelines often map poorly to complex multimorbidity.

EBM: a movement in crisis?

- The authors identify the problems with EBM and offered some solutions (cont.):
  - Authors suggest a return to real evidence based medicine. Real evidence based medicine:
    - Makes the ethical care of the patient its top priority.
    - Demands individualized evidence in a format that clinicians and patients can under stand.
    - Is characterized by expert judgment rather than mechanical rule following.
    - Share decisions with patients through meaningful conversations.
    - Builds on a strong clinician-patient relationship and the human aspects of care.
    - Applies these principles at community level for evidence based public health.

EBM: a movement in crisis?

- The authors identify the problems with EBM and offered some solutions (cont.):
  - Suggested actions to deliver real EBM:
    - Patients must demand better evidence, better presented, better explained, and applied in a more personalized way.
    - Clinical training must go beyond searching and critical appraisal to hone expert judgement and shared decision making skills.
    - Producers of evidence summaries, clinical guidelines, and decision support tools must take account of who will use them, for what purposes, and under what constraints.
    - Publisher must demand that studies meet usability standards as well as methodological ones.
    - Policy makers must resist the instrumental generation and use of "evidence" by vested interests.
    - Independent funders must increasingly shape the production, synthesis, and dissemination of high quality clinical and public health evidence.
    - The research agenda must be broader and more interdisciplinary, embracing the experience of illness, the psychology of evidence interpretation, the negotiation and sharing of evidence by clinicians and patients, and how to prevent harm from over diagnosis.

It is a Process…

"Lather, rinse, repeat"

1) Request for Authorization
   - Checklists, Guidelines, and posted IMR determinations…
2) Review UR denial/modification
   - Review denial/modification for the analysis
   - Untimely…applicant still has burden (*Dubon II*)
3) Utilize UR internal appeals process
   - Short time frame
4) Request Independent Medical Review
5) Appeal the Final Determination of A.D.

It is a Process…

"Lather, rinse, repeat"

- The physician can re-request the treatment with the additional documentation.
  - Labor Code sec. 4610(g)(6) and Reg. 9792.9.1(h) state that the UR decision shall remain effective for 12 months with regard to any further recommendation by the same physician **UNLESS** "the further recommendation is support by **a documented change in the facts material to the basis of the utilization review decision**."
    - » Could this be as simple as providing/identifying medical records that the UR reviewer did not see or was unaware of?
    - » Could this be as simple as pointing out the UR review did not follow/apply the correct guidelines?
    - » If the physician documents a "*change in the facts material to the basis of the utilization review decision*" and defendant does not put back through UR relying on Labor Code sec. 4610(g)(6)…is it untimely under *Dubon II*?

PERSPECTIVE

- “We look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line. There is science in what we do, yes, but also habit, intuition, and sometimes plain old guessing. The gap between what we know and what we aim for persists. And this gap complicates everything we do.”
  — Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science*

  - Atul Gawande is author of three bestselling books: *Complications*, a finalist for the National Book Award; *Better*, selected by Amazon.com as one of the ten best books of 2007; and *The Checklist Manifesto*. His latest book is *Being Mortal: Medicine and What Matters in the End.* He is also a surgeon at Brigham and Women’s Hospital in Boston, a staff writer for *The New Yorker*, and a professor at Harvard Medical School and the Harvard School of Public Health. He has won the Lewis Thomas Prize for Writing about Science, a MacArthur Fellowship, and two National Magazine Awards

THE END

STP	Secondary Treating Physician
Strikes	Represented EE, injury o/a 1/1/05, Lab. Code, § 4062.2 (c), each "side" strikes 1 of 3 doctors & Dr. left is the "Panel or PQME"
Sub Rosa	Private investigation, usually a video of employee's activities
Subrogation	CA's claim for payment from 3rd party which is alleged to have caused injury; Lab. Code, §§ 3850–3864; Ins. Code, § 11662
Summary Rating	Cal. Code Regs., tit. 8, §§ 10160–10165; one of several ratings done by DEU
SWAG	Scientific Wild-Assed Guess {See Lab. Code, § 4663 & EBM}
SX	Symptoms
Take Nothing	"… used to indicate a finding of no entitlement to any benefits at all …." Editorial in Title Records, Inc. vs WCAB (Shahbazian) 25 CWCR 205, 206
TBI	Traumatic Brain Injury
TD, TTD or TDI	Temporary Total Disability Indemnity