| **EVIDENCE-BASED UPDATES TO THE MEDICAL TREATMENT SCHECULE (MTUS)** | **RULEMAKING COMMENTS**  **30 DAY COMMENT PERIOD**  **PROPOSED OPIOID UPDATE** | **NAME OF PERSON/ AFFILIATION** | **RESPONSE** | **ACTION** |
| --- | --- | --- | --- | --- |
| General comment | Commenter has reviewed the proposed updates and has no comment at this time. | Alma D. Del Real  Claims Regulatory Director  State Compensation Insurance Fund  March 13, 2025  Written Comment | Agree. | None. |
| 9792.24.2  Chronic Pain Guideline – Functional Restoration Program (FRP) | Commenter is concerned regarding the adverse impact the recent changes to the ACOEM treatment guidelines for patients entering a Functional Restoration Program (FRP) will have on injured California workers and their families, and of the exacerbation of wage, living, and housing gaps (at least) in the state. Commenter opines that stricter criteria will significantly limit access for injured workers who require this essential treatment. If adopted by the  state of California through the Medical Treatment Utilization Schedule (MTUS), commenter states that these guidelines would create additional barriers for patients, particularly those with complex chronic pain conditions who benefit most from  comprehensive, multidisciplinary care. Rather than imposing restrictive criteria that could deny necessary treatment, the guidelines should focus on directing patients to CARF-certified centers, which have demonstrated superior patient outcomes. CARF-certified programs ensure adherence to high standards of care, delivering evidence-based, multidisciplinary treatment that improves functional recovery, reduces disability, and facilitates a successful return to work. By directing to CARF certified centers, there is a guarantee about the  strict focus on quality of care and positive patient outcomes, versus organizations that do not meet this high standard and have poor outcomes. Commenter opines that restricting access based on arbitrary new criteria is counterproductive when  a more effective solution is to steer patients toward high-quality programs with proven success rates. Commenter requests that the MTUS prioritize patient access to CARF-accredited FRP centers rather than create unnecessary  hurdles that may ultimately compromise care and patient recovery.  Commenter states that the proposed modifications to the ACOEM Chronic Pain Guidelines, particularly those related to Tertiary Pain Programs, appear to be designed to facilitate insurance denials rather than ensure appropriate patient access to effective care. The addition of vague eligibility criteria, such as requiring an absence of other  evidence-based treatments with potential clinical benefit, serves as a loophole for insurers to repeatedly deny treatment. Existing criteria already mandate that patients must have attempted and failed appropriate medical  and therapeutic interventions, making the new language redundant and potentially obstructive. Commenter opines that the requirement to track functional improvements using specific tables lacks supporting evidence and could be misapplied by utilization review (UR) providers, leading to inappropriate denials. The stipulation for weekly  progress reports and potential denial of care after a brief plateau ignores the reality of chronic pain treatment, where initial setbacks often precede progress.  Commenter states that the revised eligibility criteria now require "individualized" psychological or behavioral services before approving a Tertiary Pain Program, contradicting ACOEM's own guidelines on Cognitive Behavioral  Therapy (CBT). The guidelines recognize that CBT can be effective both as a standalone treatment and when integrated with physical therapy in a multidisciplinary setting. The insistence on exhausting individualized psychological treatments before program approval grants insurers excessive power to dictate treatment  modalities, potentially overruling clinical judgment. Rather than implementing these restrictive modifications, commenter states that a more effective approach would be to mandate accreditation by independent national bodies, such as CARF, to ensure quality and effectiveness in Tertiary Pain Programs. This would ensure that patients receive appropriate,  evidence-based care without undue barriers imposed by insurers. | Bajeet Singh Sangha, MPH, FACHE  Commission Chair  Hospital Diversity Commission  Department of Health Care Access and Innovation  State of CA Health and Human Services Agency  March 13, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Mandating specific treatment facilities is outside the scope of this rulemaking. | None. |
| General  Comment | Commenter appreciates the Department of Workers' Compensation efforts in proposing regulations to better align with the requirements of SB 1160 and AB 1124. Commenter notes that this has been a significant undertaking, and recognizes the challenges presented. Commenter recognizes the need for continued changes to the regulatory environment to ensure the overall process aligns with both the legislative and regulatory intent.  Commenter is supportive of the changes proposed and has some clarifying questions to ensure ongoing compliance with the requirements set forth by the DWC. | Ben Roberts  Vice President  Utilization Review  Genex  March 14, 2025  Written Comment | Agree. | None. |
| 9792.24.2  Chronic Pain Guidelines – Functional Restoration Program (FRP) | Commenter references the following language:  Indications: Functional restoration programs are recommended for patients with failed trials of evidenced-based conservative treatments, lack other evidence-based treatment options, and remain significantly incapacitated. Both program specific and patient specific criteria should be met prior to referring the patient and initiating such a program.  Commenter questions if the program specific criteria is defined under “15. Other Program Criteria.” If so, commenter questions if a proven track record of returning patients to work considered part of the criteria. Commenter recommends the inclusion for “significantly incapacitated” in measurable terms.  Commenter notes that for tertiary pain programs, treatment is generally a minimum of 5 hours/day, 5 days/week, 4-6; 160 hour maximum.  Commenter requests that the trial period (or minimum number of hours) be specifically defined.  Commenter seeks clarification as to whether the injured worker has to meet ALL criteria outlined under #1 a), b) and c) in the indications section for a functional restoration program before requesting a multidisciplinary evaluation.  Commenter requests clarification if initiation into a functional restoration program is acceptable based on MDE finding alone, as he notes that there are often discrepancies between the MDE and medical records and history of care available.  Commenter notes that the second bullet point (page 419) states:  *“Other appropriate evidence-based medical and/or invasive care has been attempted (if indicated) and proved to be inadequate to restore functional status*.”  Commenter seeks clarification if the time frame for exhausting conservative care efforts depends on the relevant, specific evidence-based guideline recommendations for the recommended treatment of the diagnosis of the injured body part.  Commenter questions, that under Functional Restoration Program continuation (page 421), if the payer is obligated to pay for continuation of the program up to the 160 hours even if continuation is denied.  Commenter notes that FRP timeframe expectation (page 422) states “minimum of 5 hours/day.” Commenter questions if this indicates that partial day programs less than 5 hours/day would not be supported.  Regarding Functional Restoration Program costs (page 422), commenter notes that recommended charges are not part of the ACOEM guideline; however, he questions if there is still a consideration to establish a standardized fee schedule for these programs given that most providers bill under an unlisted procedure code. Commenter opines that it would be helpful for employers/insurers to have a consistent code and/or a consistent fee schedule for reimbursement purposes. Commenter recommends providing direction to medical providers regarding how to appropriately bill for these programs.  Regarding Functional Restoration Program #15 Other Program Criteria (page 422), commenter questions how the medical providers/facilities are required to provide measurable evidence of success. Commenter wants to know how this information is obtained and how the record of success is measured given that it is the most important criterion for the program. Commenter requests elaboration on the method of tracking this. | Ben Roberts  Vice President  Utilization Review  Genex  March 14, 2025  Written Comment | Disagree.  Commenter is directed to the guideline and is cautioned to utilize the more detailed indications, specific appropriate diagnoses, temporal sequencing, preceding testing or conservative treatment, and contraindications that are elaborated in more detail for each test or treatment in the body of the guideline in using the recommendations in clinical practice or medical management. These recommends are not simple “yes/no” criteria.  Reimbursement of treatment and the official medical fee schedule is not the subject of this rulemaking. | None. |
| 9792.24.8  Cannabis Guideline | Commenter states that there are no long-term randomized comparative trials for treating common work-related conditions that assessed the potential for superiority of cannabinoids to: 1) NSAIDs, 2) functional restoration programs (especially the gold standard of combining aerobic/strengthening exercises with either cognitive behavioral therapy or emotional awareness therapy), and 3) other comparators of known efficacy.  Commenter recommends removal of the specific treatments numerically outlined above and replacement with the following verbiage: *There are no long-term randomized comparative trials for treating common work-related conditions that assessed the potential for superiority of cannabinoids to other guideline recommended form(s) of treatment for chronic pain of known efficacy.* | Ben Roberts  Vice President  Utilization Review  Genex  March 14, 2025  Written Comment | Disagree.  The scope of this evidence-based guideline on cannabis is focused on treatment of pain ensuing from disorders that have a reasonable probability of being work-related (e.g., spin pain, chronic radicular pain, osteoarthritis). A review of the evidence and treatment recommendations for chronic pain, acute pain, postoperative pain and for safety-critical workers appears reasonable.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline. | None. |
| 9792.24.8  Cannabis Guideline | Commenter states that she has been a California-licensed physician since 1991. Commenter worked in the field of pediatrics and emergency medicine for many years before transitioning to the specialty of cannabinoid medicine in 2008. Commenter has written two books on medical cannabis,  published numerous peer-reviewed articles for scientific journals, spoken at dozens of conferences nationally and  internationally, and is considered an expert in cannabis therapeutics. After 17 years and 18,000 patients, commenter attests to the benefits and safety of medical cannabis for many difficult-to-treat conditions, including chronic pain.  Commenter requests that the DWC reconsider potential policies prohibiting injured workers under workers' compensation from accessing medical cannabis as a treatment for chronic pain. Compelling scientific evidence supports the use of medical cannabis as both an alternative and adjunct to opioids and other medications in pain management.  Commenter notes that opioids are widely prescribed for chronic pain, but their long-term efficacy is unsupported, and they carry significant risks of addiction, overdose, and other serious consequences, including increased risk of fractures, infections, cardiovascular complications, sleep-disordered breathing and bowel dysfunction.[[1]](#footnote-1) The Centers for Disease Control (CDC) guidelines published in 2022 explicitly warn against long-term opioid therapy, emphasizing that the harms often outweigh the  benefits.[[2]](#footnote-2) According to the National Institute on Drug Abuse (NIDA), opioid overdose deaths remain alarmingly high, and  many patients prescribed opioids for chronic pain eventually develop dependence or addiction.[[3]](#footnote-3) Commenter states that non-opioid alternatives are often ineffective and come with various risks that are not associated with medically supervised cannabis use.  Medical cannabis, particularly formulations containing both THC and CBD, has demonstrated analgesic and anti-inflammatory  properties that provide meaningful relief for chronic pain sufferers. In 2017, the National Academies of  Science, Engineering and Medicine published a report, “The Health Effects of Cannabis and Cannabinoids,” concluding,  “there is substantial evidence that cannabis is an effective treatment for chronic pain in adults.”[[4]](#footnote-4)  Commenter states that numerous additional studies highlight the ability of medical cannabis to reduce pain and reduce the use of opioids and other medications:  <!--[if !supportLists]-->· <!--[endif]-->A 2014 *JAMA Internal Medicine* study found that states with medical cannabis laws saw a 25% reduction in opioid overdose deaths compared to those without.[[5]](#footnote-5)  <!--[if !supportLists]-->· <!--[endif]-->A 2019 study in the *Journal of Pain* found that cannabis use was associated with a 64% reduction in opioid use among chronic pain patients.[[6]](#footnote-6)  <!--[if !supportLists]-->· <!--[endif]-->A 2022 systematic review in *Pain Physician Journal* confirmed that medical cannabis reduces opioid prescription rates and overall opioid consumption in pain patients.[[7]](#footnote-7)  <!--[if !supportLists]-->· <!--[endif]-->A 2025 published review of cannabinoids used for chronic pain concluded, “This review has provided scientific evidence supporting the use of cannabis as an adjuvant in the treatment of  chronic pain which could also lead pain reduction to the point of minimizing other pharmacological treatments.”[[8]](#footnote-8)  Commenter states that the report on cannabis published by the American College of Occupational and Environmental Medicine does not make any distinction between medical and non-medical use of cannabis. Commenter opines that this conflation is misguided and detrimental to patients who may benefit from medical use and is not in line with published research investigating the differences in use. One particular study published in 2021 reported that medical cannabis patients, “demonstrated significant improvements on measure of executive function and clinical state over the course of 12 months.” These patients also had significantly decreased total mood disturbance, anxiety ratings and better sleep quality.[[9]](#footnote-9) These findings are not documented with any other pain medications.  Commenter states that in her extensive clinical practice, she’s observed firsthand the positive impact of medical cannabis on chronic pain patients. They frequently achieve a reduction or cessation of opioid and other pain medication use, alongside consistent improvements in sleep, anxiety levels, and overall quality of life. As a result, they regain the ability to fully engage in their  personal and professional lives while using cannabis responsibly as part of their treatment.  Commenter requests that policymakers recognize the distinction between medical and non-medical use and ensure access to medical cannabis for injured workers dealing with chronic pain. | Bonni Goldstein MD  Medical Director  Canna-Centers  February 19, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline. | None. |
| 9792.24.8  Chronic Pain Guideline – Functional Restoration Program (FRP) | Commenter opines that the recent changes to the ACOEM treatment guidelines for patients entering a Functional Restoration Program  (FRP) introduce stricter criteria that may significantly limit access for injured workers who require this essential treatment. If adopted by the state of California through the Medical Treatment Utilization Schedule (MTUS), these  guidelines could create additional barriers for patients, particularly those with complex chronic pain conditions who benefit most from comprehensive, multidisciplinary care. Commenter recommends that rather than imposing restrictive criteria that could  deny necessary treatment, the guidelines should focus on directing patients to CARF-certified centers, which have  demonstrated superior patient outcomes. CARF-certified programs ensure adherence to high standards of care,  delivering evidence-based, multidisciplinary treatment that improves functional recovery, reduces disability, and  facilitates a successful return to work. Restricting access based on arbitrary new criteria is counterproductive when a more effective solution is to steer patients toward high-quality programs with proven success rates. Commenter requests that the MTUS prioritize patient access to CARF-accredited FRP centers rather than create unnecessary hurdles that may ultimately compromise care and patient recovery. | Callum Eastwood, PsyD, QME  Chief of Behavioral Medicine, Pain & Rehabilitative Consultants Medical Group  March 13, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Mandating specific treatment facilities is outside the scope of this rulemaking. | None. |
| 9792.24.8  Chronic Pain Guideline – Tertiary Pain Programs | Commenter is concerned that the new ACOEM Chronic Pain Guidelines, and specifically the guideline regarding Tertiary Pain Programs, have been intentionally modified in such a way to  provide insurers and utilization reviewers with an increased basis to deny access to effective care rather than to ensure that appropriate patients are being referred to quality programs with proven outcomes.  1. As the guidelines have been rewritten, commenter opines that they appear to be actively focused on providing a basis for the insurer to deny rather than consider authorization. For instance, the addition of the following new catch-all eligibility criteria:   * There is an absence of other evidence-based medical, physical medicine, behavioral or interventional treatment options for the given disorder with potential to provide significant clinical improvement   This addition appears to be giving insurers one more opportunity to deny access to treatment, as there are already eligibility requirements that require:   * Other appropriate evidence-based medical and/or invasive care has been attempted (if indicated) and proved to be inadequate to restore functional status, and * The patient is not responding to less costly interventions, including evidence-based individualized medical care, physical or occupational therapy (e.g., including active graded exercise programs), and psychological/behavioral services.   Commenter states that the inclusion of the new catch-all criteria appears to only serve the purpose of providing insurers the opportunity to get a “do-over” for treatments they have already denied, have already been attempted, or the patient has opted out of by asserting their right to choose (e.g. surgical procedures, individual psychotherapy, injections, etc.). Such a criteria creates a circuitous path of request for treatment and denials, causing undue delays in patient access to  medical care and delaying their recovery to MMI status in as timely fashion as medically indicated.  2. Another concern is that no evidence or citation is provided for the requirement to use the recommended functional improvement tracking tables (tables 9 & 10). These tables can be readily misused/misinterpreted by UR providers as “required” in their entirety, when they may not be totally relevant to all patients, or only partially relevant. Clarification should be delineated that they are examples but should be modified to correspond to relevant presenting concerns identified in the MDE, not simply through adding items, but also through deleting those found not relevant to a patient’s presenting concerns.  3. Additionally, while progress tracking is absolutely a critical component of guiding quality care and supporting optimal outcomes, the requirement for weekly progress reporting with a recommendation of denying  continuation after a two-week plateau in progress appears to ignore a critical reality for most chronic pain patients that have failed conservative treatments. As maladaptive coping/avoidance behaviors, deconditioning,  and disability mindset concerns are unpacked and addressed in a program, patients almost always experience an increase in pain or psychosocial symptom escalation. Functional improvements are very frequently not observed in the first two to three weeks of treatment as adaptive coping skills are taught and physical reconditioning efforts start and stall due to some increased pain before resuming progress. Weekly reporting  that does not explicitly allow for a temporary decline in functioning, especially early in a program, is a set-up for denial of a continuation of care that often will not manifest positive outcomes until the later stages of treatment.  4. Finally, returning to the revision of the following eligibility criteria:   * The patient is not responding to less costly interventions, including evidence-based individualized medical care, physical or occupational therapy (e.g., including active graded exercise programs), and psychological/behavioral services.   Commenter notes that the above criterion has been revised to include the term “individualized” and to add “psychological/behavioral  services.” While it is true that many chronic pain syndrome patients can benefit from individualized psychotherapy, it is not always indicated as an individual, stand-alone modality of psychological/behavioral treatment for chronic pain patients based upon the nature of their presenting concerns. Some patients may benefit from group CBT  interventions, and some from interventions integrated into a multidisciplinary program.  Commenter notes that this reality appears to be acknowledged elsewhere in the ACOEM Chronic Pain Guidelines, as those for Cognitive Behavioral Therapy state that CBT can be “provided either independently (Lamb SE, 2010) or as a component therapy integrated into a program that includes physical or occupational therapy, such as an interdisciplinary or  other functional restoration program (Monticone et al., 2013), especially where the primary complaint is LBP.” Also, these same guidelines state, “Cognitive behavioral therapy has been shown to be effective in most studies for the treatment of chronic pain (see evidence table). There are many moderate quality trials of CBT and combinations of CBT with physical therapy and other interventions”; and that in regards to evidence of efficacy of CBT, “One trial suggested significant reduction in disability attributed to a combination of CBT and physical therapy (Linton, 2005),  and another trial suggested better development of muscles in the physical therapy exercises plus CBT group compared with physical therapy exercises alone (Bagheri et al., 2020).”  The implications of the ACOEM Guidelines for CBT, then, indicate that CBT in combination with physical therapy, whether in a group or individual modality, and as a part of a multidisciplinary program where both  psychological/behavioral and physical therapies can be integrated and coordinated, may be better indicated for  some patients than individualized CBT alone. The revision to the Tertiary Pain Program Guidelines to require individualized psychological/behavioral treatments to be exhausted is contradictory to the ACOEM guidelines for CBT, and thus runs the risk of again giving insurers, utilizing utilization review physicians without the necessary  credentials or scope of practice to determine the appropriate modality of psychological/behavioral treatment that a patient may most benefit from, the excuse to deny access to a tertiary pain program that an evaluating psychologist  has determined would best address a patient’s presenting concerns (e.g. fear-avoidance behaviors, pain catastrophizing, kinesiophobia). Commenter recommends that when it comes to the Tertiary Pain Program eligibility criteria regarding psychological/behavioral treatments that ACOEM be consistent with their other guidance associated with those  treatments to prevent misuse of the Tertiary Pain Program guidelines by insurers to unreasonably delay or deny  access to timely treatment and utilize the MDE to determine which modality of psychological/behavioral treatment  is best indicated for a given patient; individual CBT, group CBT, and either of these modalities integrated with physical therapy in a Tertiary Pain Program.  The valid concern of Tertiary Pain Programs adhering to quality treatment goal, progress, and outcomes tracking to optimize patients' attainment of desired functional improvements, return to work, and attainment of MMI appears to have been subsumed by eligibility criteria that instead support the denial or severe restriction of access to a modality of treatment for chronic pain that is optimal for a notable number of chronic pain syndrome patients. As  opposed to adopting these revised ACOEM Guidelines, instead commenter recommends requiring Tertiary Pain Programs  providing services to California injured workers to be accredited by a national accrediting body (e.g. CARF) that is independent of bias regarding restricting access to treatments and instead is focused on quality assurance and  best practices for such programs. | Callum Eastwood, PsyD, QME  Chief of Behavioral Medicine, Pain & Rehabilitative Consultants Medical Group  March 13, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury. Please see Labor Code section 4604.5 and title 8 California Code of regulations section 9792.21.1. | None. |
| 9792.24.8  Cannabis Guidelines | Commenter notes that is proposed guideline attempts to align with the American College of Occupational and Environmental Medicine’s (ACOEM) chronic pain recommendations, which ban the use of cannabis for treating chronic pain, acute pain, and post-operative pain; this proposal ignores the extensive amount of scientific research and real-world evidence demonstrating that cannabis is an effective alternative to opioids and other pharmaceuticals. Commenter states that this proposed guideline also disregards the experiences of countless patients, doctors, and pain management specialists who have found medical cannabis to be an important lifeline for treating intractable chronic pain. Commenter notes that the scope for this guidelines recommendations does not include multiple common symptoms such as Alzheimer's disease, cancer, terminal care, post-traumatic stress disorder, epilepsy, nausea/vomiting related to chemotherapy, sleep disturbance, multiple sclerosis, and amyotrophic lateral sclerosis.  Cannabis has long been prescribed to cancer patients and those with severe chronic conditions for pain management, nausea relief, and improved quality of life—especially during chemotherapy. Many physicians consider cannabis a safer alternative to opioids, which have higher addiction risks and devastating societal consequences. While ACOEM cites workplace safety concerns, commenter opines that its rigid stance does not acknowledge that many injured workers are already using cannabis responsibly under medical supervision. This proposal would force injured workers into fewer and often more harmful longer-term treatment options, limiting access to pain relief that can significantly improve their quality of life.  Commenter is concerned that this proposed treatment ban could set a concerning precedent for limiting medical cannabis access in other areas of healthcare. Commenter requests that the workers’ compensation system not adopt outdated, anti-science policies that will harm existing and future patients. | Caren Woodson  Director, Compliance & Licensing  Kiva Brands, Inc.  March 10, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury. Please see Labor Code section 4604.5 and title 8 California Code of regulations section 9792.21.1. | None. |
| 9792.24.8  Cannabis Guideline | Commenter requests that the DWC reconsider the proposed removal of medicinal cannabis from workers' compensation coverage in California by adopting this guideline. Commenter opines that this decision could have severe consequences, particularly given the ongoing opioid epidemic that continues to devastate our state. Removing cannabis as a treatment option would not only limit access to a safer alternative for pain management but could also lead to an increase in opioid  prescriptions—exacerbating addiction, overdose rates, and healthcare costs.  Commenter notes that in 2021 alone, 7,175 Californians died from opioid overdoses, a figure that has been rising (National Institute on  Drug Abuse, 2023). The opioid crisis has placed an enormous burden on California’s healthcare system, law enforcement, and social services, with treatment and response efforts costing billions annually (CalMatters, 2023). Many opioid addictions begin with legally prescribed pain medications, often after a workplace injury.  When workers are not given safer alternatives, they may develop dependencies that spiral into long-term addiction (SHADAC, 2023).  Multiple peer-reviewed studies have demonstrated that access to medicinal cannabis can significantly reduce opioid use, dependency, and overdose rates. A federally funded study published in 2022 found that opioid  prescriptions dropped in states that legalized medicinal cannabis—suggesting that pain patients prefer cannabis when it is available (McMichael et al., 2022). Research published by the American Medical Association (AMA) concluded that long-term medical marijuana use is associated with a reduction in opioid dosages among pain  patients (Lake et al., 2023). Another study found that patients who have access to medicinal cannabis report lower pain levels and reduced dependence on both opioids and psychiatric medications (Shover et al., 2023). A new study published in *Exploration in Medicine* found that patients using cannabis for chronic pain reported a significant  reduction in the use of opioids, benzodiazepines, antidepressants, and nonsteroidal anti-inflammatory drugs (NSAIDs) (Marijuana Moment, 2024). Given this compelling body of research, commenter opines that it is clear that cannabis is an effective and science-backed alternative for pain management, offering a pathway for injured workers to recover without the high risk of addiction associated with opioids.  Beyond its public health benefits, medicinal cannabis has been shown to reduce healthcare and prescription drug costs. Studies suggest that in states where medicinal cannabis is legal, Medicare and Medicaid spending  on opioid prescriptions has declined significantly (Bradford & Bradford, 2019). Commenter states that when workers have access to cannabis, they are less likely to require expensive, long-term opioid treatment, reducing costs for both insurers and the state.  Commenter opines that if medicinal cannabis is removed from workers' compensation coverage, it could lead to higher overall medical expenses—as injured workers may require prolonged opioid prescriptions, addiction treatment, and emergency care for overdose-related incidents.  Commenter opines that restricting access to medicinal cannabis for injured workers would be a step backward in California’s fight against the opioid epidemic. The evidence is clear: medicinal cannabis reduces opioid use, prevents addiction, and saves lives. Instead of removing it from coverage, California should be expanding access to cannabis as  part of a comprehensive, harm-reduction approach to pain management.  Commenter requests that the Division of Workers’ Compensation prioritize science, public health, and economic sustainability by  maintaining medicinal cannabis coverage in workers' compensation cases, as this decision will not only protect  injured workers but also contribute to a safer, healthier California. | Chelsea Haskins  Director of State and Local Licensing  March 11, 2025  Written Comment | Disagree.  The cannabis guideline marks the first instance of a cannabis-related guideline being adopted into the MTUS. This is not a removal of coverage. This is an evidence-based guideline on cannabis focused on the treatment of pain ensuing from disorders that have reasonable probability of being work-related.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury. Please see Labor Code section 4604.5 and title 8 California Code of regulations section 9792.21.1. | None. |
| 9792.24.8  Cannabis Guideline | Commenter is writing to express his objection to adopting the proposed Cannabis Regulation (Sec. 9792.24.8) recommended by the American College of Occupational and Environmental Medicine (Jan 25 2025), which classifies medicinal cannabis as “not recommended” for treating chronic pain.  Commenter states that this report flies in the face of extensive evidence that cannabis is effective in treating chronic pain and reducing dependency on opioids and other prescription drugs, ignoring scores of published scientific studies[[10]](#footnote-10) and the experience of countless chronic pain patients and physicians in California. **[Note that a list of studies supporting the use of cannabis for chronic pain, submitted by commenter is available upon request.]**  Commenter states that the report’s recommendation conflicts with a comprehensive expert review by the National Academy of Sciences, which concluded: “There is substantial evidence that cannabis is an effective treatment for chronic pain in adults”[[11]](#footnote-11) (2017).  Commenter states that it also conflicts with the findings of California’s Center for Medicinal Cannabis Research, which was established by the legislature to investigate the medicinal efficacy of cannabis, Five out of five of the CMCR’s initial studies found cannabis effective in reducing pain, especially chronic neuropathic pain, leading CMCR Director Dr. Igor Grant to declare “There is good evidence now that cannabinoids may be either an adjunct or first line treatment [for pain and neuropathy]”[[12]](#footnote-12) (2012).  Commenter has been informed that the CMCR has recommended that DWC reject the ACOEM’s proposed guideline and instead list cannabis as “Recommended class C” for chronic pain and he concurs.  In the weeks since publication of the ACOEM report, commenter states that more new studies have appeared showing medical cannabis effective for chronic pain and reducing use of prescription pain killers.[[13]](#footnote-13)  Commenter opines that the ACOEM report suffers badly from a lack of informed input from experienced medical cannabis practitioners and patients. Cal NORML has heard from hundreds of patients and medical cannabis practitioners over the years who report cannabis is uniquely effective in treating otherwise intractable chronic pain, especially neuropathic pain.[[14]](#footnote-14) Many report they have been able to reduce or even eliminate their usage of opioids and other prescription drugs by substituting cannabis.  Commenter states that chronic pain accounts for some 42% of all recommendations for medical marijuana.[[15]](#footnote-15) The number of medical cannabis users in California may be fairly estimated at around 2-3% of the population, or ~ 800,000-1.2 million users[[16]](#footnote-16) (the proportion is grossly understated in the ACOEM report at 0.01%, apparently based on the state’s rarely-used voluntary ID Card program). A Kaiser Health survey of pain patients in California found that 30% are using cannabis to help control their pain.[[17]](#footnote-17)  The adjunctive use of cannabis has been shown to augment the analgesic effects of opioids synergistically, reducing opioid usage and abuse liability.[[18]](#footnote-18) Cannabis appears to be uniquely beneficial in cases of chronic neuropathic pain, which is resistant to standard opioid therapy. Multiple studies have linked legal cannabis access with reduced rates of opioid use and abuse, opioid hospitalizations, accidents and overdose deaths.[[19]](#footnote-19) Multiple studies have likewise linked cannabis access to reductions in overall prescription drug activity.[[20]](#footnote-20)  Commenter states that the ACOEM report neglects to cite over 100 published studies involving thousands of subjects that show medicinal benefits from cannabis in reducing chronic pain and opioid use.[[21]](#footnote-21) Perhaps the ACOEM judged that these studies did not meet its criteria for “critically-appraised higher-quality” evidence; however the footnoted citations show no evidence that they were ever reviewed. It should be noted that a large quantity of lower quality studies can statistically compensate for a scarcity of higher quality ones.  Commenter notes that the ACOEM report dwells at length on a host of adverse effects that are not relevant to the medicinal use of cannabis to treat injured workers – e.g. usage by children, recreational abuse problems, schizophrenia, etc. The report dwells at length on cannabis use disorder, despite the fact that neither medicinal use of cannabis nor chronic pain are risk factors for CUD.  Commenter opines that the ACOEM report displays an unscientific bias in its discussion of adverse effects. Rather than limit its discussion to “critically-appraised higher-quality” studies, it cites many weakly established study results that are contradicted or refuted by other studies it fails to mention. For example, reports of increased aggression,[[22]](#footnote-22) violence,[[23]](#footnote-23) crime,[[24]](#footnote-24) COPD,[[25]](#footnote-25) cardiovascular disease[[26]](#footnote-26), pre-diabetes,[[27]](#footnote-27) negative operative outcomes,[[28]](#footnote-28) oral cancer (applicable only to smoked marijuana)[[29]](#footnote-29), neonatal effects,[[30]](#footnote-30) and traffic accidents[[31]](#footnote-31) are all disputed or flatly contradicted by other studies not mentioned in the report. All of this raises serious questions about the objectivity of the report.  Commenter notes that the report mentions that cannabis potency has increased in recent years. Yet higher THC potency means higher purity, which can be medically beneficial insofar as it eliminates other potentially harmful contaminants such as smoke toxins from the medicine. What is more important than THC potency is the actual dosage delivered. Electronic vaporization devices, which use 80-90% THC concentrates, are typically designed to deliver moderate doses of THC per puff, reducing users’ exposure to harmful smoke toxins. Before being outlawed in 1937, the medicinal cannabis tinctures sold in U.S. pharmacies were highly potent, with dosages measured in droplets.  In an issue of particular concern to workers’ comp policy, the ACOEM report distorts the evidence regarding cannabis and workplace injuries. For example, it cites a 1990 study by Zwerling et al. finding that postal workers who used marijuana suffered increased industrial accidents and injuries. However, it fails to mention a larger, follow-up study of postal workers by Normand et al. which found no such link.[[32]](#footnote-32) Likewise, it cites a study by Carnide et al. that showed an increased risk of injury from cannabis use on the job – *but no risk for use off the job,* where injured workers would normally use medical cannabis.[[33]](#footnote-33) The report fails to mention other studies finding no increased risk of workplace injuries due to cannabis,[[34]](#footnote-34) as well as one showing medical cannabis laws are associated with *fewer* workplace fatalities.[[35]](#footnote-35)  Commenter notes that several other states now allow worker’s compensation payments for cannabis.[[36]](#footnote-36) The Colorado Division of Workers’ Compensation recently created an Alternative Pain Management Program aimed at assessing whether medicinal cannabis can improve health safety and outcomes. The program effectively met its primary goals and determined that worker’s compensation insurers can safely support medical cannabis reimbursement and improve treatment outcomes and quality of life. Commenter opines that California, the first state to recognize the medicinal value of cannabis, should do likewise.  Commenter states that the ACOEM recommendations are poorly informed, biased, and ill-advised. Cannabis is substantially less dangerous and addictive than the prescription opioids commonly recommended to treat chronic pain. The evidence overwhelmingly suggests that injured California workers would benefit by the use of cannabis as a substitute or supplement for other, more dangerous and costly prescription analgesics available through workers’ comp.  Commenter endorses the recommendation of the California Center for Medicinal Research, as submitted separately to DWC**.** California should reject the ACOEM guideline dis-recommending use of cannabis, and instead adopt a guideline of **“Recommended C level” for chronic pain**. Commenter agrees that the cannabis guidelines for both acute pain and postoperative pain should be changed from “not recommended” to “Insufficient – No Recommendation.” | Dale Gieringer, Ph.D,  Director, Cal NORML  March 10, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury. Please see Labor Code section 4604.5 and title 8 California Code of regulations section 9792.21.1. | None. |
| 9792.24.8  Cannabis Guideline | Commenter opines that is not ok to remove cannabis from workers’ compensation and state that cannabis in not an effective tool or treatment for chronic pain. | Dylan Buratovich  March 4, 2025  Written Comment | Disagree.  The cannabis guideline marks the first instance of a cannabis-related guideline being adopted into the MTUS. This is not a removal of coverage. This is an evidence-based guideline on cannabis focused on the treatment of pain ensuing from disorders that have reasonable probability of being work-related.    Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline. | None. |
| 9792.24.8  Cannabis Guideline | Commenter states that she has grave concerns regarding California adopting Cannabis Regulation (Sec. 9792.24.8) as recommended by the American College of Occupation and Environmental Medicine.  Commenter states that it didn’t take much digging to uncover disturbing connections between the ACOEM and the worker’s compensation insurance  industry. For example, ACOEM’s **[REDACTED]**, a worker’s compensation insurance provider. Also, the organization offers a “comprehensive professional liability insurance program” from  **[REDACTED]** which provides workers’ compensation insurance for health care workers, and (interestingly) for the cannabis and hemp industries.  Most troubling is that, according to the organization’s website, **in 2022 their Mid-Atlantic chapter opposed legislation in**  **New Jersey that would have required workers’ compensation carriers to “cover the cost of dispensary-purchased**  **‘medical’ [their quotes] cannabis and cannabis-derived products.”**  Commenter opines that for a scientific-based organization to take a political stand with obvious benefits to the workers’ compensation insurance industry is deeply disturbing, especially since their recommendation to California ignored extensive evidence that cannabis is effective in treating chronic pain, as outlined in Cal NORML’s letter to you from their director Dale Gieringer.  ACOEM also offers a course for Medical Review Officers who review workplace drug tests, and their leadership has ties to that  industry also. Commenter’s primary fear is that injured Californians will be subjected to drug testing and denied benefits if the ACOEM recommendations are adopted.  Commenter recommends that the DWC side with science and injured workers, and not with insurance companies, when deciding whether or not to exclude medical cannabis as an accepted treatment. | Ellen Komp  Deputy Director  California NORML  March 12, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  The cannabis guideline marks the first instance of a cannabis-related guideline being adopted into the MTUS. This is not a removal of coverage. This is an evidence-based guideline on cannabis focused on the treatment of pain ensuing from disorders that have reasonable probability of being work-related. | None. |
| 9792.24.8  Cannabis Guideline | Commenters state that their organization, the University of California, San Diego Center for Medicinal Cannabis Research (CMCR) was established by the Legislature and Governor of the State of California to conduct research into the possible benefits, and risks of cannabinoids as medicines. As such, they have conducted numerous clinical trials and have reviewed the literature on this topic. Commenter states that their purpose is not to  advocate for or against medicinal cannabis, but to provide facts to the public, policy makers, and  the health care community.  Commenters have recently become aware that the California Division of Workers Compensation (DWC) plan to introduce new treatment guidelines regarding medicinal cannabis in pain  based on the recommendations of the American College of Occupational and Environmental Medicine (ACOEM).  Commenters respectfully  disagree with some of the recommendations, and particularly those related to chronic pain  management. Based on our their two decades of experience in serving the State of California, and their understanding of the current literature, commenter offers comments on the ACOEM  Recommendations, as follows:  1. The proposal that the use of cannabinoids in chronic pain management is “not recommended” is not consistent with the evidence. For example, the 2017 report of the National Academies of Sciences, Engineering, and Medicine stated, “There is conclusive or substantial evidence that cannabis or cannabinoids are effective for the treatment of chronic pain in adults” (National Academies of Sciences, Engineering, and Medicine: The  Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research. Washington, DC: The National Academies Press.  <https://doi.org/10.17226/24625>)  . While this conclusion was made in 2017, they are not aware of a mass of new research to refute this conclusion. In fact, more recent reviews, e.g., conducted by the American Society of Pain and Neuroscience in 2023, concluded:  “Level I evidence from several randomized controlled trials supports the use of cannabis  for neuropathic pain. However, because of a lack of additional large-scale randomized controlled trials, the use of cannabis for the treatment of neuropathic pain yields a grade C recommendation at this time.” (<https://pmc.ncbi.nlm.nih.gov/articles/PMC10716240/>)  Therefore, we believe that it is appropriate in instances of chronic pain management, for DWC to  adopt a change to ACOEM’s chronic pain guideline to **Recommended C level**. This  recommendation can be usefully augmented by including the Medical Board of California  recommended decision tree regarding cannabinoids in persisting conditions, including chronic  pain: <https://www.mbc.ca.gov/Download/Publications/guidelines-cannabis-recommendation.pdf>  2. Furthermore, based on our understanding of the literature, they believe that for DWC’s  purposes the recommendations for the management of **acute pain** should be changed to  **Insufficient** - **No Recommendation (consensus based) “I” level.**  3. The recommendation in regard to **Postoperative Pain** is more accurately **Insufficient - Not Recommended (consensus-based) “I” level**, due to insufficient studies.  4. The recommendation for critical safety workers should be consistent with whatever  recommendations the DWC has in regard to other medications with potential sedative effects, including antihistamines, antispasmodic agents such as baclofen, and others such as lamotrigine, and some antidepressants.  In reviewing the ACOEM’s recommendations, commenters experienced some disquiet in the fact that ACOEM included in their review issues that are not directly pertinent to the management of  injuries by workers. Examples included discussions of rates of cannabis use, students’  perceptions of marijuana risk, marijuana and hallucinogen use among young adults, possible  connections of cannabis and schizophrenia, etc. These data have little relevance to the matter of possible uses of cannabinoids in the management of workplace injuries, and caused them to wonder if the ACOEM panel’s substantial focus on these topics might have colored recommendations on potential medicinal cannabis indications. Commenter opines that these broader topics deserve continued public discussion, but not in the context of management or worker injuries. | Igor Grant, MD  Director  Mary Gilman Marston, Distinguished Professor  Center for Medicinal Cannabis Research (CMCR) – UC San Diego, Department of Psychiatry  March 4, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury. Please see Labor Code section 4604.5 and title 8 California Code of regulations section 9792.21.1. | None. |
| 9792.24.8  Cannabis Guideline | Commenter was injured at work on December 4, 1992 and has had five back surgeries (removing 3 disks) and anticipates needing more in the future. Commenter once used Oxycontin and other drugs for years until replacing his prescriptions 20 years ago with a strong cannabis medicine, which saved his life. Commenter states that he makes his own medicine since the workers’ compensation insurance does not cover the cost. Commenter submitted a link to an article about his experience:  [Daily Dose: John Prinz - Vegas Cannabis Magazine](https://www.vegascannabismag.com/home-featured/daily-dose-john-prinz/)  Commenter requests that the DWC allow for reimbursement for medical cannabis for workers’ compensation patients. Commenter states that Health Safety Code 11362.785(d) prevents medical marijuana from CA workers’ compensation patients. | John Prinz  California Injured Worker – Chronic Pain Patient  March 13, 2025  Written Comment | Disagree.  Reimbursement of medical expenses is not the subject of this rulemaking.  The cannabis guideline marks the first instance of a cannabis-related guideline being adopted into the MTUS. This is not a removal of coverage. This is an evidence-based guideline on cannabis focused on the treatment of pain ensuing from disorders that have reasonable probability of being work-related.    Recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury. Please see Labor Code section 4604.5 and title 8 California Code of regulations section 9792.21.1. | None. |
| 9792.24.8  Cannabis Guideline | Commenter is concerned about changes being proposed that would remove medical marijuana as a suitable treatment for workers’ compensation patients. Commenter understand that this based upon a recent study, but he opines that this is just the same old tired fear mongering regarding marijuana. Commenter states the many other studies have proven that there are fewer side effects. | Joshua McGrew  March 4, 2025  Written Comment | Disagree.  The cannabis guideline marks the first instance of a cannabis-related guideline being adopted into the MTUS. This is not a removal of coverage. This is an evidence-based guideline on cannabis focused on the treatment of pain ensuing from disorders that have reasonable probability of being work-related.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline. | None. |
| 9792.24.2  Chronic Pain Guidelines – Tertiary Pain Programs | Commenter opines that the proposed guidelines appear to favor insurers by granting them greater authority to deny functional restoration treatment. For example, the addition of the following criterion is concerning:  - The patient is not responding to less costly interventions, including evidence-based individualized medical care, physical or occupational therapy (such as active graded exercise programs), and psychological/behavioral services.  Commenter is concerned that insurance companies and Utilization Review (UR) will likely use this criterion to disregard patients' rights to choose their  preferred treatment options. Surgical procedures and psychotherapy are common treatments that patients often resist. Additionally, many insurance companies reject requests for psychological/behavioral services because "psych" is not  recognized as an accepted body part. As a result, even with multiple requests for psychological treatment, these will likely  not pass through the UR process. Given the strict nature of this criterion, patients may find it challenging to access tertiary  program treatments.  Commenter opines that the requirement to track patient progress within two weeks seems unrealistic. Noticeable improvement typically does  not occur until the third week of the program. Based on his experience and knowledge, the first week is often a challenging start, as they have many questions about the program and its benefits, and whether it will indeed help with  their chronic pain. By the second week, their mindset usually shifts to a willingness to give the program another chance,  albeit with some hesitation. It’s in the third week that genuine progress begins to emerge. Patients become more  motivated and comfortable with the supportive group around them, which fosters mutual encouragement. | Kalvin Pespitro  NCFRP Authorizations & Reports Supervisor  Northern CA Functional Restoration Program – Pain & Rehabilitative Consultants Medical Group  March 14, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline. | None. |
| 9792.24.8  Cannabis Guideline | Commenter doesn’t agree with eliminating cannabis as a medical avenue for those who are injured or crippled by the workforce. Cannabis has had many studies  around the world, indicating that it does cure or help certain illnesses, and conditions. Commenter opines that many would prefer this option over a man-made chemical that is created in a lab. Cannabis should not be considered as a street drug because it has been discovered and documented to benefit cancer, patients, Alzheimer’s patients, MS patients, and more. Commenter understands that cannabis is extremely hard to control since there is no concrete laws on the plant, but because the laws don’t support its existence, doesn’t it mean that it doesn’t have a place in society. Commenter requests that the DWC consider patients who do depend on this plant as a medicine. | Mckaelyn Tennison  March 4, 2025  Written Comment | Disagree.  The cannabis guideline marks the first instance of a cannabis-related guideline being adopted into the MTUS. This is not a removal of coverage. This is an evidence-based guideline on cannabis focused on the treatment of pain ensuing from disorders that have reasonable probability of being work-related.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline. | None. |
| 9792.24.2  Chronic Pain Guideline – Functional Restoration Program – Tertiary Program | Commenter opines that the revised guidelines have been rewritten to prioritize providing insurers with reasons to deny authorization rather than consider it.  Commenter notes that the new catch-all eligibility criterion states that there has to be an absence of other evidence based medical, physical medicine, behavioral, or interventional treatment options for the given disorder that have the potential to provide significant clinical improvement.  Commenter opines that this addition appears to give insurers another opportunity to deny access to treatment. The inclusion of this new catch-all criterion seems designed to allow insurers a "do-over" for treatments they have previously denied, those that have already been attempted, or those the patient has opted out of by asserting their right to choose (e.g., surgical procedures, individual psychotherapy, injections, etc.). This criterion creates a circular path of treatment requests and denials, causing unnecessary delays in patient access to medical care  and prolonging their recovery to maximum medical improvement (MMI) as medically indicated.  Commenter agrees that progress tracking is a critical component of guiding quality care and supporting optimal outcomes; however, she opines that the requirement for weekly progress reporting—along with the recommendation of denying continuation after a two-week plateau—overlooks a crucial reality for most chronic pain patients who have failed conservative treatments. As maladaptive coping/avoidance behaviors, deconditioning, and a disability mindset are addressed in a program, patients often experience increased pain or psychosocial symptom  escalation. Functional improvements are frequently not observed in the first two to three weeks of treatment, as adaptive coping skills are taught and physical reconditioning efforts may stall due to temporary increases in pain before resuming progress. Weekly reporting that does not explicitly allow for a temporary  decline in functioning, particularly early in a program, sets the stage for denying continued care that often will not yield positive outcomes until later stages of treatment.  Commenter states that there is a revision of the following eligibility criterion: The patient is not responding to less costly interventions, including evidence-based individualized medical care, physical or occupational therapy (such as active graded exercise programs), and psychological/behavioral services.  Commenter notes that this criterion has been revised to include the term "individualized" and add "psychological/behavioral  services." While it is true that many patients with chronic pain can benefit from individualized psychotherapy, such therapy is not always indicated as a standalone modality based on the nature of their presenting concerns. Some patients may benefit from group cognitive behavioral therapy (CBT), while others may  benefit from interventions integrated into a multidisciplinary program.  Commenter notes that the ACOEM Chronic Pain Guidelines acknowledge this reality elsewhere, as the guidelines for cognitive behavioral therapy state that CBT can be “provided either independently (Lamb SE, 2010) or as a component therapy  integrated into a program that includes physical or occupational therapy, such as an interdisciplinary or other  functional restoration program (Monticone et al., 2013), especially when the primary complaint is low back pain (LBP).” Additionally, these guidelines indicate that “Cognitive behavioral therapy has been shown to be effective in most studies for the treatment of chronic pain (see evidence table). There are many moderate quality trials of CBT and combinations of CBT with physical therapy and other interventions.” Regarding the  efficacy of CBT, it is noted that “one trial suggested significant reductions in disability attributed to a combination of CBT and physical therapy (Linton, 2005), and another trial indicated better muscle development in the physical therapy exercises plus CBT group compared to the physical therapy exercises alone (Bagheri et al., 2020).”  The implications of the ACOEM Guidelines for CBT suggest that combining CBT with physical therapy— whether through group sessions or individual modalities and as part of a multidisciplinary program where psychological/behavioral and physical therapies can be integrated and coordinated—may be better suited for some patients than individualized CBT alone. The revision in the Tertiary Pain Program Guidelines requiring  the exhaustion of individualized psychological/behavioral treatments contradicts the ACOEM guidelines.  Quoting the revision of the following eligibility criteria: The patient is not responding to less costly interventions, including evidence-based individualized medical care, physical or occupational therapy (e.g.,  including active graded exercise programs), and psychological/behavioral services.  The revision to the Tertiary Pain Program Guidelines to  require individualized psychological/behavioral treatments to be exhausted is contradictory to the ACOEM  guidelines for CBT, and thus runs the risk of again giving insurers, utilizing utilization review  physicians without the necessary credentialsor scope of practice to determine the appropriate modality of  psychological/behavioral treatment that a patient may most benefit from, the excuse to deny access to a tertiary pain program that an evaluating psychologist has determined would best address a patient’s presenting concerns (e.g. fear-avoidance behaviors, pain catastrophizing, kinesiophobia). I suggest when it comes to the Tertiary Pain Program eligibility criteria regarding psychological/behavioral treatments that ACOEM be consistent with their other guidance associated with those treatments to prevent misuse of the Tertiary Pain Program guidelines by insurers to unreasonably delay or deny access to timely treatment and  utilize the MDE to determine which modality of psychological/behavioral treatment is best indicated for a given patient; individual CBT, group CBT, and either of these modalities integrated with physical therapy in a Tertiary Pain Program.  Commenter states that the valid concern of Tertiary Pain Programs adhering to quality treatment goal, progress, and outcomes tracking to optimize patients' attainment of desired functional improvements, return to work, and attainment of MMI appears to have been subsumed by eligibility criteria that instead support the denial or severe restriction of access to a modality of treatment for chronic pain that is optimal for a notable number of chronic pain syndrome patients. As opposed to adopting these revised ACOEM Guidelines, commenter recommends  instead requiring Tertiary Pain Programs providing services to California injured workers to be accredited by a national accrediting body (e.g. CARF) that is independent of bias regarding restricting access to treatments  and instead is focused on quality assurance and best practices for such programs. | Nina Kintanar  Director of Operations – Tertiary Programs – Pain & Rehabilitative Consultant Medical Group – Northern CA Functional Restoration Program  Center for Brain Injury  March 14, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury. Please see Labor Code section 4604.5 and title 8 California Code of regulations section 9792.21.1.  Mandating specific treatment facilities is outside the scope of this rulemaking. | None. |
| 9792.24.8  Cannabis Guideline | Commenter notes that the proposed regulations classify medical cannabis as “not recommended” for the treatment of chronic pain in patients currently on disability. Commenter opines that this stance is detrimental to patient welfare, violates a patients’ rights to choose their course of holistic treatment, and overlooks substantial scientific evidence well documented to the mainstream public supporting the efficacy of medical cannabis in managing chronic and intractable pain, especially here within the legal framework of California. With the over whelming passage of Prop 215 in 1996 and Prop 64 in 2016, both constitutional propositions with a 72% approval by the voters of California it was clear that patients have the right choose their course of medical treatment as well as the ability for Adult consumption without persecution or discrimination for such use or denying a patients’ right to choose their medical treatment in the pursuit of happiness while living with intractable chronic pain. Commenter states that denying these patients their rights to use medical cannabis in the treatment of chronic pain would only set these patients back years and would put their health at ricks not to mention setting back research decades.  Commenter notes that as stated by NIH library of Medicine “Prescription drug overdoses are the leading cause of accidental death in the United States. Alternatives to opioids for the treatment of pain are necessary to address this issue. Cannabis can be an effective treatment for pain, greatly reduces the chance of dependence, and eliminates the risk of fatal overdose compared to opioid-based medications. Medical cannabis patients report that cannabis is just as effective, if not more, than opioid-based medications for pain.” <https://pmc.ncbi.nlm.nih.gov/articles/PMC5569620/>  Commenter states that patients with conditions such as multiple sclerosis (MS) have reported relief from spasticity and pain with the use of medical cannabis. A systematic review by the American Academy of Neurology found that oral cannabis extract is effective for reducing patient-centered measures of spasticity and pain in MS patients.  Commenter notes that the United States Department of Health and Health services currently holds Patent #US6630507-B1” Cannabinoids as a neuroprotectants and Antioxidant”. He questions that if cannabis has no medical or pain-relieving value, why would our government be holding a patent saying so.  Commenter states that there is a substantial body of evidence supporting the efficacy and safety of medical cannabis for chronic pain management and he requests that the Dept. of Workers Compensation reconsider the proposed ACOEM regulations under Section 9792.2 4.8. and vote NO! Commenter states that denying patients access to a legal and potentially life-improving treatment contradicts both scientific evidence and the principles of compassionate care. Commenter advocates for policies that empower physicians and patients to make informed decisions about pain management, including the use of medical cannabis where appropriate. Commenter requests that the ACOEM proposed regulations under section 9792.24 be rejected.  Commenter’s organization, American Alliance for Medical Cannabis (AAMC) was founded in 2001 and is operated by volunteer Medical Cannabis patients with active members in the medical professions & concerned citizens promoting safe, responsible legal access to medical cannabis for its therapeutic use and scientific research with members throughout California and across the united states and has no financial interest in the cannabis space. | Richard G. Miller,  California Executive Director, American Alliance for Medical Cannabis (AAMC)  March 11, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury. Please see Labor Code section 4604.5 and title 8 California Code of regulations section 9792.21.1. | None. |
| 9792.24.2  Chronic Pain Guideline – Functional Restoration Program – Tertiary Program | Commenter opines that the recent changes to the ACOEM treatment guidelines for patients entering a Functional Restoration Program (FRP) amount to the proverbial action of “throwing the baby out with the bathwater.” Quality Functional Restoration Programs  produce exceptional patient outcomes, particularly for those with complex chronic pain conditions that benefit most.  These programs achieve Maximum Medical Improvement (MMI) for the vast majority of patients that enter and complete  them, and in an expedited manner, compared to an endless cycle of piecemeal activities that fail to provide the holistic approach that is required. Given that, there is no doubt that the comprehensive, multidisciplinary care provided in quality certified programs is a more patient-centered and more cost-effective solution for patients that require this essential treatment. Rather than punishing patients with unnecessary restrictions to care, commenter recommends that the MTUS prioritize access to quality-certified programs and transparent reporting of patient outcomes. | Ryan Joyner, PhD, MPH, EMBA  March 14, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury. Please see Labor Code section 4604.5 and title 8 California Code of regulations section 9792.21.1. |  |
| 9792.24.8  Cannabis Guideline | Commenter requests that the adoption of the ACOEM Guidelines **be rejected,** for the reasons outlined below.  Commenter states that the American College of Occupational and Environmental Medicine (ACOEM) bases its recommendation on fatally  flawed, inaccurate findings, often citing outdated studies. To give you some idea of how biased the studies that were chosen are, commenter submitting as Addendum No. 1 NORM L's list of more recent studies [**list available upon request]**, all of which conform to the scientific  standards for such reports.  Commenter opines that the ACOEM carefully chose its' participants to **exclude** all medical cannabis experts, including those whose research and findings support cannabis as a viable alternative for pain mitigation.  The report also excluded information on long-standing and endorsed medical use of cannabis by doctors and state programs as well as the current federal stance, which has found that cannabis has currently accepted medical use1 and is in the process of moving cannabis on the Controlled Substances Act Schedule from Schedule I to Schedule Ill.  Commenter states that if adopted, ACOEM's position is in opposition even with the Federal Government's stance on this  issue as the Federal Department of Health and Human Sciences has found that cannabis has currently accepted medical  use.  Its abstract states: "We study the effect of state recreational marijuana laws (RM Ls) on workers' compensation {WC)  benefit receipt among adults 40-62 years. We find that WC receipt declines in response to RML adoption both in terms  of the propensity to receive benefits and benefit amount. We estimate complementary declines in non-traumatic workplace injury rates and the incidence of work limiting disabilities. We offer evidence that the primary driver of these reductions is an improvement in work capacity, likely due to access to an additional form of pain management therapy."  Commenter opines that as this study indicates, therapeutic use of cannabis **reduces** claims both in terms of propensity and benefit  amounts. It would seem not only cruel, but in opposition to good management, to exclude from use a substance which is beneficial not only to the patient but to the Workman's Compensation Program as well.  Commenter and her organization opposes the exclusion of cannabis as a therapeutic alternative relating to Workers' Compensation Claims and asks that Department of Industrial Relations reject the adoption of the ACOEM  Guidelines by the Department of Workman's' Compensation which would classify Cannabis as "not recommended" for treating chronic Pain.  Commenter states that her organization has 150,000 active supporters in all 50 states, Americans for Safe Access (ASA) is the largest national member based organization of patients, medical professionals, scientists, and concerned citizens working to overcome political, social, and legal barriers to improve access to medical cannabis for patients and researchers through legislation,  education, litigation, grassroots empowerment, advocacy and services for patients, governments, medical professionals, and medical cannabis providers. More information regarding their organization can be accessed at: https:ljwww.safeaccessnow.org/ | Sarah Armstrong JD  California, Legislative Coordinator  Americans for Safe Access (ASA)  March 10, 2025  Written Comment | Disagree.  The cannabis guideline marks the first instance of a cannabis-related guideline being adopted into the MTUS. This is not a removal of coverage. This is an evidence-based guideline on cannabis focused on the treatment of pain ensuing from disorders that have reasonable probability of being work-related.    Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury. Please see Labor Code section 4604.5 and title 8 California Code of regulations section 9792.21.1. |  |
| 9792.24.8  Cannabis Guideline | Commenter representing her organization, which she states is the nation’s oldest and largest organization for medical cannabis, requests that the DWC rejects the adoption of the proposed guideline.  Commenter opines that the American College of Occupational and Environmental Medicine (ACOEM) bases its recommendation on fatally  flawed, inaccurate findings, often citing outdated studies. Commenter provides examples of studies to illustrate ACOEMs bias in the use of their studies. **[Addendum No. ! is available upon request.]** Commenter states that Addendum No. 1 NORM L's list more recent studies, all of which conform to the scientific  standards for such reports.  Commenter opines that ACOEM carefully chose its' participants to **exclude** all medical cannabis experts, including those whose  research and findings support cannabis as a viable alternative for pain mitigation. The report also excluded information on long-standing and endorsed medical use of cannabis by doctors and state programs as well as the current federal stance, which has found that cannabis has currently accepted medical use[[37]](#footnote-37) and is  in the process of moving cannabis on the Controlled Substances Act Schedule from Schedule I to Schedule Ill.  Commenter opines that the adoption of this ACOEM's report is in opposition with the Federal Government's stance on this  issue as the Federal Department of Health and Human Sciences has found that cannabis has currently accepted medical  use.  Commenter opines that by adopting the ACOEM's cruel and inaccurate findings will inflict immense suffering on workers who find medical cannabis to be a viable, non-addictive alternative to addictive painkillers; most likely face protracted litigation;  and will be in opposition to state and federal medicinal cannabis programs which have for years made cannabis and cannabis products available to the sick and dying in recognition of their therapeutic use, after appropriate scientific inquiries were made.  Currently, all states and territories, save one state and one territory have medical cannabis programs. These programs were adopted after careful consideration of the value of cannabis for therapeutic use and are supported by the  Federation of State Medical Boards (FSMB) model guidelines.  Today, there are over six million patients across the country utilizing the state medical cannabis programs. These programs, taken altogether, have identified, through expert review, 65 qualifying conditions for which cannabis can be used for treatment via their state programs.[[38]](#footnote-38) Commenter has attached this list as an addendum to this letter **[Copy available upon request]**.  Commenter opines that adoption of this proposed ACOEM Guidelines would create a de facto ban on the therapeutic use of cannabis by a discrete class, those injured in the workplace and pursuing legitimate workman  compensation claims. In contrast, most any other injured party not pursuing a workman's compensation claim is free to  use cannabis for relief without economic censure as cannabis is a legal substance in California.  This de facto ban impacts workers all over the state who have viable worker's compensation claims, and have a legitimate expectation that the Department of Industrial Relations will follow current valid science, and existing state  law and regulations, as well as taking a reasoned and compassionate stance to their pain and injury issues.  In California, therapeutic use of cannabis has been a part of state law since 1996, a period of 29 years, well over a quarter of a century. Commenter opines that by adopting the flawed, biased findings of one entity as the basis for a cruel and comprehensive  ban on the use of therapeutic cannabis as a valid treatment for pain, you are forcing patients to either forgo Workman's  Compensation assistance or face potentially hideous side effects, including opiate addiction relating to the medications that you do find acceptable. Commenter states that even long term use of non-addictive substances such as prescription level painkillers  like Ibuprofen can do serious damage to the body.  Mitigating any enlargement of the Opioid Crisis, particularly when cannabis has proven helpful in curtailing this national  epidemic is of great interest to our organization. You can link to commenter’s organization’s report on this matter at:  <https://www.safeaccessnow.org/opioidblueprint>  The National Bureau of Economic Research Paper published in 2021 (NBER Working Paper Series, Working Paper No.  28471) definitively demonstrates the efficacy of cannabis for therapeutic use, even when the source of the therapeutic  cannabis arises from adult use providers.[[39]](#footnote-39)  Its abstract states: "We study the effect of state recreational marijuana laws (RM Ls) on workers' compensation {WC)  benefit receipt among adults 40-62 years. We find that WC receipt declines in response to RML adoption both in terms  of the propensity to receive benefits and benefit amount. We estimate complementary declines in non-traumatic workplace injury rates and the incidence of work limiting disabilities. We offer evidence that the primary driver of these reductions is an improvement in work capacity, likely due to access to an additional form of pain management therapy."  As the above cited study indicates, therapeutic use of cannabis **reduces** claims both in terms of propensity and benefit amounts. Commenter opines that is would be cruel, and in opposition to good management, to exclude from use a substance which is beneficial not only to the patient but to the Workman's Compensation Program as well.  For the reasons stated above, Commenter opposes the exclusion of cannabis as a therapeutic alternative relating to  Workers' Compensation Claims and asks that Department of Industrial Relations reject the adoption of the ACOEM  Guidelines by the Department of Workman's' Compensation which would classify Cannabis as "not recommended" for treating chronic pain. | Sarah Armstrong, JD  Legislative Coordinator, Americans for Safe Access (ASA)  March 30, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline. | None. |
| 9792.24.8  Cannabis Guideline | Commenter is Chair of the San Diego Chapter of American’s for Safe Access, a national nonprofit organization advancing safe access to cannabis for therapeutic use and research, requests that the DWC reject adoption of the Medical Treatment Utilization Schedule (MTUS) concerning cannabis.  Commenter notes that both the U.S. Department of Health and Human Services (HHS) and the Department of Justice (DOJ) have acknowledged that cannabis has "accepted medical use in treatment in the United States." Furthermore, the National Academies of  Sciences has provided substantial evidence supporting cannabis as an effective treatment for chronic pain in adults. Cannabis also has a lower risk of problematic use than other medicines used for pain, including opioids, and no lethal dose has ever been identified in humans. Commenter opines that given this body of research, the current guidelines within the MTUS are in alignment with scientific consensus, and it is imperative that cannabis use continues to be available for injured workers.  Commenter requests that the Division reconsider these proposed changes, ensuring that injured workers retain access to a  valuable treatment option backed by substantial evidence. | Shelby L. Huffaker, MPH, Chair  San Diego Chapter of Americans for Safe Access  March 4, 2025  Written Comment | Disagree.  The cannabis guideline marks the first instance of a cannabis-related guideline being adopted into the MTUS. This is not a removal of coverage. This is an evidence-based guideline on cannabis focused on the treatment of pain ensuing from disorders that have reasonable probability of being work-related.    Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury. Please see Labor Code section 4604.5 and title 8 California Code of regulations section 9792.21.1. | None. |
| 9792.24.2  Chronic Pain Guidelines – Chronic Persistent Section | Commenter notes that it appears the Chronic Pain Chapter Chronic Persistent section is being phased in this proposed update.  Commenter notes that the Chronic Pain Chapter Chronic Persistent Pain section, Medications subsection is one of the more widely cited MTUS guidelines at present.  Commenter states that the Clinical Topics guidelines do not discuss all of the items currently addressed in the Chronic Pain Chapter Chronic Persistent Pain section and opines that omission of the Chronic Pain Chapter Chronic Persistent Pain section may reduce the applicability of the MTUS.  Commenter recommends retaining the Chronic Pain Chapter Chronic Persistent Pain section (ACOEM May 15, 2017). | Siva Ayyar, MD  February 15, 2025  Written Comment | Disagree.  This guideline does not address guidance for numerous specific disorders, including chronic phases of those conditions, please see recommendations available in other ACOEM guidelines. | None. |
| 9792.24.2  Chronic Pain Guideline –– Tertiary Pain Programs | Commenter opines that the  guideline modifications in regarding to tertiary pain programs seem to coincide with the insurance companies and utilization review (UR) and increasing their authority to  deny, without consideration, the patients access to effective care which results in treatment delay essential to their recovery. Commenter opines that the authority this gives to the insurers would allow them to push for treatment that was already attempted by the patient which was unsuccessful, or the patient opted out of. Instead of restricting access to quality care, commenter recommends that the guidelines focus on ensuring that patients are referred to accredited programs that demonstrate high quality care focused on the patient and their needs. | Sofia Perena  CBI Department Manager, Center for Brain Injury, Pain & Rehabilitative Consultants Medical Group  March 14, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury. Please see Labor Code section 4604.5 and title 8 California Code of regulations section 9792.21.1. | None. |
| 9792.24.8  Cannabis Guideline | Commenter opines that this proposal is nothing more than a blatant attempt to protect Big Pharma’s profits at the expense of workers’ lives. Commenter states that the DWC is willing to let injured people become addicted to opioids—drugs that have killed thousands—while denying them access to a safer, non-lethal alternative. Commenter opines that this is not about health; it’s about money, and everyone can see it.  Commenter requests that the DWC stop pretending to care about workers while sentencing them to a lifetime of addiction and overdose risk and asks the DWC to do the right thing—cover medical cannabis now. | Tim Balmer  Medical Cannabis Activist  March 4, 2025  Written Comment | Disagree.  The DWC adopts medical treatment utilization schedule that is based on the principals of evidence based medicine which is a systematic approach to making clinical decisions which allows the integration of the best available evidence with clinical expertise and patient values. | None. |
| 9792.24.2 Chronic Pain Guideline –Tertiary Pain Programs | Commenter notes that in relation to denials based on the lack of other evidence-based medical, physical medicine, behavioral, or interventional treatment options for a specific disorder that could provide significant clinical improvement, this restriction undermines a patient's right to choose a treatment modality that may be more beneficial for them. For some patients, denying access to a multidisciplinary program could mean the difference between life and death. Suicide is one of the leading causes of death in the United States, and chronic pain patients express suicidal ideation. Social isolation is detrimental for those struggling with such thoughts. Multidisciplinary programs have been shown to offer an environment where patients can feel supported and not alone. Removing this option eliminates the opportunity for patients in this vulnerable situation to receive the peer support they need while dealing with depression and suicidal ideation.  Regarding the revision of the eligibility criteria stating that "The patient is not responding to less costly interventions, including evidence-based individualized medical care, physical or occupational therapy (e.g., active graded exercise programs), and psychological/behavioral services," we must acknowledge that individualized therapy may not suffice for all patients based on their specific concerns. We should not overlook the ACOEM Chronic Pain Guidelines, which indicate  that Cognitive Behavioral Therapy (CBT) can be "provided either independently (Lamb SE, 2010) or as a component therapy  integrated into a program that includes physical or occupational therapy, such as an interdisciplinary or other functional  restoration program (Monticone et al., 2013), especially when the primary complaint is low back pain (LBP)."  The ACOEM Guidelines suggest that CBT, combined with physical therapy—whether delivered in a group or individual setting and as part of a multidisciplinary program—may be more beneficial for some patients than individualized CBT alone. Commenter opines that the success of treatment should not be measured solely by the effectiveness of individual CBT. Instead, the success outcomes for chronic pain patients should also include the option of physical therapy within a multidisciplinary  framework, allowing those who desire this approach to receive a more comprehensive treatment modality. | Veronica Davis  Behavioral Medicine Department Manager  Pain & Rehabilitative Consultants Medical Group  March 14, 2025  Written Comment | Disagree.  Commenter is encouraged to submit any studies to ACOEM through the following web address:  <https://acoem.org/Practice-Resources/Practice-Guidelines-Center>  ACOEM conducts comprehensive updates to all of its guidelines every 3 to 5 years. However, ACOEM accepts submissions of evidence from any source. All literature is reviewed following the same process (i.e., quality scoring, critiquing, and critical appraisal) for the development of evidence-based guidance. If there are major changes in literature, it may necessitate a focused update to the ACEOM guideline.  Recommendations found in the MTUS guidelines are presumed correct on the issue of extent and scope of treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of the injury. Please see Labor Code section 4604.5 and title 8 California Code of regulations section 9792.21.1. | None. |

1. Kotlińska-Lemieszek, Aleksandra, and Zbigniew Żylicz. "Less well-known consequences of the long-term use of opioid

   analgesics: a comprehensive literature review." *Drug Design, Development and Therapy* (2022): 251-264. [↑](#footnote-ref-1)
2. <https://www.cdc.gov/overdose-prevention/hcp/clinical-guidance/index.html> [↑](#footnote-ref-2)
3. <https://nida.nih.gov/publications/research-reports/misuse-prescription-drugs/overview> [↑](#footnote-ref-3)
4. National Academies of Sciences, et al. "The health effects of cannabis and cannabinoids: the current state of evidence and

   recommendations for research." (2017). [↑](#footnote-ref-4)
5. Bachhuber, Marcus A., et al. "Medical cannabis laws and opioid analgesic overdose mortality in the United States, 1999-

   2010." *JAMA internal medicine* 174.10 (2014): 1668-1673. [↑](#footnote-ref-5)
6. [↑](#footnote-ref-6)
7. Benedict, Gregory, Annas Sabbagh, and Till Conermann. "Medical Cannabis Used as an Alternative Treatment for

   Chronic Pain Demonstrates Reduction in Chronic Opioid Use–A Prospective Study." *Pain Physician* 25.1 (2022): E113. [↑](#footnote-ref-7)
8. Cortez-Resendiz, Alonso, et al. "The Pharmacology of Cannabinoids in Chronic Pain." *Medical Cannabis and*

   *Cannabinoids* (2025). [↑](#footnote-ref-8)
9. Sagar, Kelly A., et al. "An observational, longitudinal study of cognition in medical cannabis patients over the course of

   12 months of treatment: preliminary results." *Journal of the international neuropsychological society* 27.6 (2021): 648-

   660. [↑](#footnote-ref-9)
10. See attached appendix for references. [↑](#footnote-ref-10)
11. “The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research” National Aacdemy of Sciences, (2017): Conclusion 4-1 p. 90 [↑](#footnote-ref-11)
12. “California research shows marijuana can ease muscle spasms and pain,” by Lisa Leff, AP Press release 17 Feb 2010. “’Gold Standard’ Studies Show That Inhaled Marijuana Is Medically Safe and Effective” Cal NORML Press Release 18 Feb 2010. [↑](#footnote-ref-12)
13. Reduced opioid use in 440 chronic pain subjects: “Comparative effectiveness of medicinal cannabis for chronic pain versus prescription medication treatment” Ajay Wasan et al, *Pain* 24 Jan 2025. Substitution of cannabis for traditional pain medications increases as legal availability of recreational cannabis increases: “Recreational Cannabis Laws and Fills of Pain Prescriptions in the Privately Insured,” Shelby Steuart et al, *Cannabis* Vol 8#1 (2025). “UK Medical Cannabis Registry: An Analysis of Clinical Outcomes of Medicinal Cannabis Therapy for Cancer Pain” Madhur Varadpande et al, *J Pain Palliative Care Pharmacotherapy* 8 Feb 2025; [↑](#footnote-ref-13)
14. Cal NORML first reported on medical cannabis usage in California in 1999, based on records of 2480 patients of Dr. Tod Mikuriya, 45.7% of whom had a primary indication for analgesia or painful inflammation. In subsequent years, Cal NORML heard personally from hundreds of chronic pain patients through our hotline, at conferences, and at medical cannabis dispensaries. “Medical Use of Cannabis: Experience in California,” Dale Gieringer in Franjo Grotenhermen and Ethan Russo, ed. *Cannabis and Cannabinoids: Pharmacology, Toxicology and Therapeutic Potential* (Haworth Press, 2003). [↑](#footnote-ref-14)
15. “Medical Reasons for Marijuana Use, Forms of Use, and Patient Perception of Physician Attitudes Among the US Population,” Patrick M Azcarate et al, *J Gen Intern Med* 6 April 2020. [↑](#footnote-ref-15)
16. Cal NORML estimated the population of medical marijuana users in California as between 2-3% of the population, or 750,000 to 1,125,000, based on a survey of California medical marijuana dispensaries plus patient registries in other states, (Press release, May 31, 2011). Five per cent of Californians surveyed report ever using marijuana for medicine: “Prevalence of medical marijuana use in California, 2012” Suzanne Ryan-Ibarra et al, *Drug Alcohol Rev.* 2015 Mar 34(2). [↑](#footnote-ref-16)
17. “Cannabis Use for Medical Reasons Among Patients in a Large California Health Care System After Legalization for Nonmedical Use,” Ruchir Karmali et al, *Journal of Studies on Alcohol and Drugs* :84, (Sep 2023) [↑](#footnote-ref-17)
18. **“**Opioid-sparing effect of cannabinoids for analgesia: an updated systematic review and meta-analysis of preclinical and clinical studies”: Suzanne Nielsen et al., *Neuropsychopharmacology* 2022. “Impact of co-administration of oxycodone and smoked cannabis on analgesia”: Ziva Cooper et al, *Neuropsychopharmacology 43*, 2018. [↑](#footnote-ref-18)
19. “The clouded debate: A systematic review of comparative longitudinal studies examining the impact of recreational cannabis legalization on key public health outcomes” Maria Athanassiou et al, *Front Psychiatry* 11 Jan 2023;

    “Medical Cannabis Legalization and Opioid Prescriptions: Evidence on US Medicaid Enrollees during 1993-2014” Di Liang, Yuhua Bao, Mark Wallace, Igor Grant, Yuyan Shi, *Addiction* 10 July 2018.

    “Medical Marijuana Legalization and Opioid- and Pain-Related Outcomes Among Patients Newly Diagnosed With Cancer Receiving Anticancer Treatment” Yuhua Bao et al, *JAMA Oncology*, Dec 2022. [↑](#footnote-ref-19)
20. “Recreational cannabis and opioid distribution.” Shyam Raman et al, *Health Economics* 32(4) Apr 2023; “Healthcare provider and medical cannabis patient communication regarding referral and

    medication substitution: the Canadian context.” Alexis Holman et al., *J. Cannabis Research* 2022:4(1) Jun 2022;

    “Recreational cannabis legalizations associated with reductions in prescription drug utilization among Medicaid enrollees,” Shyam Raman and Ashley Bradford, *Health Economics* 15 Apr 2022; “Medical use among older adults in Canada: Self-reported data on types and amount used, and perceived effects,” Shankar Tumati et al, Drugs and Aging 39, 2022;

    “Perceived Efficacy, Reduced Prescription Drug Use, and Minimal Side Effects of Cannabis in Patients with Chronic Orthopedic Pain”: Ari Greis et al, Cannabis and Cannabinoid Research Vol 7#6 Dec 2022;

    “Medical cannabis treatment for chronic pain: Outcomes and prediction of response”: Joshua Aviram et al, Eur J Pain 25(2) Feb 2021. [↑](#footnote-ref-20)
21. ACOEM footnotes #130-141 reference just 12 studies on cannabis in treatment of chronic pain; 56 are listed in the attached appendix, and over 120 are listed at NORML’s website. https://norml.org/marijuana/fact-sheets/relationship-between-marijuana-and-opioids/ [↑](#footnote-ref-21)
22. Aggressive responses are typically reduced by cannabis: “Subjective aggression during alcohol and cannabis intoxication before and after aggression exposure,” EB De Sousa Fernanda Perna et al. *Psychopharmacology (Berl)* 233(18): Sept 2016. [↑](#footnote-ref-22)
23. Same day marijuana use not associated with intimate partner violence: “Alcohol, Marijuana and Dating Abuse Perpetration by Young Adults: Results of a Daily Call Study” Emily Rothman et al, *Violence Against Women* 24(10) Aug 2018.

    “Couples’ marijuana use is inversely related to their intimate partner violence over the first 9 years of marriage,” Philip Smith et al *Psychology of Addictive Behaviors,* Aug 2014. [↑](#footnote-ref-23)
24. “Crime in a Time of Cannabis: Estimating the Effect of Legalizing Marijuana on Crime Rates in Colorado and Washington Using the Synthetic Control Method,” Alexis J Harper et al, *Journal of Drug Issues* 53(4) 2 Nov 2022 [↑](#footnote-ref-24)
25. COPD not linked to marijuana smoking: “Impact of Marijuana Smoking on COPD Progression in a Cohort of Middle-Aged and Older Persons,” Igor Barjatarevic et al, *Chornic Obst Pulm Dis*. 10(3) Jul 2023. [↑](#footnote-ref-25)
26. No association between marijuana use and cardiovascular disease: “Association Between Marijuana Use and Cardiovascular Disease in US Adults” Dhaval Jivanji et al. *Cureus* 12(12) 3 Dec 2020.

    No association between marijuana use and atherosclerotic cardiovascular risk: “Comparison of Atherosclerotic Cardiovascular Risk Factors and Cardiometabolic Profiles Between Current and Never Users of Marijuana,” Hassan A Alhassan et al, *Circ Cardiovasc Qual Outcomes* 16(11) Nov 2023;

    “Cumulative Lifetime Marijuana Use and Incident Cardiovascular Disease in Middle Age: The Coronary Artery Risk Development in Young Adults (CARDIA) Study”, Jared P Reis et al, *Am J Public Health* 107(4) April 2017. [↑](#footnote-ref-26)
27. Cannabis users show reduced risk of type 2 diabetes: “Association between cannabis use and risk of diabetes mellitus type 2: A systematic review and meta-analysis” Seyed Ehsan Mousavi et al, *Phythother Res.* 37(11) Nov 2023. [↑](#footnote-ref-27)
28. “Self-Reported Cannabis Use is Associated with a Lower Rate of Persistent Opioid Use After Total Joint Arthoplasty,” Vishal Hegde et al, *Arthoplasty Today* 5: 2023. History of cannabis use associated with lower use of opioids after spinal surgery: “Effect of cannabis use history on postoperative opioid utilization in lumbar fusion patients: an American retrospective study,” Pranav Mirpurio et al, *Asian Spine Journal* 19(5) Oct 2024. [↑](#footnote-ref-28)
29. No association between pot use and oral cancer, large-scale population study finds: “Marijuana Use and Risk of Oral Squamous Cell Carcinoma,” Karin Rosenblatt et al. *Cancer Research* 1 Jun 2004. [↑](#footnote-ref-29)
30. Prenatal marijuana exposure not associated with adverse birth outcomes: “Evaluation of the Association Between Prenatal Cannabis Use and Risk oof Developmental Delay” Dana Watts et al. *JAACAP Open.* 2(4) May 2024; [↑](#footnote-ref-30)
31. No changes in crash fatalities due to legalized cannabis: “Crash fatality Rates After Recreational Marijuana Legalization in Washington and Colorado,” Jayson D Aydelotte et al, *American Journal of Public Health* Aug 2017;

    Canadian study finds slight decrease in traffic crashes post legalization: “Did the cannabis recreational use law affect traffic crash outcomes in Toronto?” by Jose Ignacio Nazif-Munoz et al, *Drug and Alcohol Review* 19 Jul 2022. [↑](#footnote-ref-31)
32. Zwerling C, Ryan J, Orav EJ: The efficacy of preemployment drug screening for marijuana and cocaine in predicting employment outcome. *JAMA*. 1990;264(20; vs Normand J, Salyards S and Mahoney J, "An Evaluation of Preemployment Drug Testing," *Journal of Applied Psychology* 75(6) 629-39 1990. [↑](#footnote-ref-32)
33. “Workplace and non-workplace cannabis use and the risk of workplace injury” N Carnide et al, *Can J Public Health* Dec 2023. [↑](#footnote-ref-33)
34. ”Comparison of random and postaccident urine drug tests in southern Indiana coal miners” J.W. Price, *J. Addict Med* (2012); “Testing for cannabis in the workplace: a review of the evidence,” S Macdonald et al, *Addiction* 2010. [↑](#footnote-ref-34)
35. Legalizing medical marijuana correlated with improved workplace safety among workers 25-44: “Medical marijuana laws and workplace fatalities in the United States” D Mark Anderson, Daniel I Rees, Erdal Tekin, *Int J Drug Policy* 60: Oct 2018. [↑](#footnote-ref-35)
36. States that allow WCI reimbursement for cannabis are said to include Connecticut, New Hampshire, New Jersey, New Mexico, New York, Pennsylvania and Missouri: “Review of cannabis reimbursement by workers’ compensation insurance in the U.S. and Canada,” John Howard et al, *Am J Ind Med.* 64(12): Dec 2021 (et al.) [↑](#footnote-ref-36)
37. DOA, DOJ: Notice of Proposed Rulemaking: Schedules of Controlled Substances: Rescheduling of Marijuana, May 21,2024 [↑](#footnote-ref-37)
38. Among the qualifying conditions are many chronic diseases of which chronic pain is a component. Pain is specifically cited multiple

    times including: Pain: Chronic of Visceral Origin, Pain: Any Condition for Which Opioids are Prescribed, Pain Chronic: Chronic Related

    to Musculoskeletal Disorder, Neuropathic & Severe Debilitating & Intractable. [↑](#footnote-ref-38)
39. See: http://www.nber.ar/papers/w2847l. [↑](#footnote-ref-39)