

Medical Treatment Guidelines March 2013 Revisions

The NYS Workers' Compensation Board implemented Medical Treatment Guidelines (MTG) for the back, neck, shoulder and knee in December 2010. Since then, the Board has been involved in developing new MTGs, first for carpal tunnel syndrome and currently for chronic pain. The Board also has the benefit of more than a year and a half of experience and extensive feedback from both internal and external stakeholders on the existing MTGs and processes. While the Board has already made some minor modifications administratively, it will undertake its first regulatory modification of the MTGs to be effective March 1, 2013. The new regulations will include the following:

- adoption of a new Carpal Tunnel Syndrome MTG,
- adoption of a new maintenance care program for chronic pain as part of the existing back, neck, shoulder and knee MTGs,
- minor clarifications/modifications to existing MTGs, and
- process and form changes recommended by stakeholders and detailed below.

Carpal Tunnel Syndrome (CTS)

The Governor's Workers' Compensation Task Force and Advisory Committee, which included the Board's Medical Director as a member, developed a comprehensive MTG for the treatment of CTS as its final task. The Task Force used the medical treatment guidelines of Washington and Colorado as its foundation. A hand surgeon from Albert Einstein Medical School/Montefiore Medical Center reviewed the draft guideline and suggested minor changes, which were incorporated by the Task Force. The Insurance Department forwarded the recommended MTG to the Chair in Fall 2011. The Board posted the proposed MTG and sought public comments. The comments were reviewed and changes made where appropriate.

The regulations will adopt the new CTS MTG as the standard of care for treatment of CTS and will preauthorize all recommended care that is performed consistent with the MTG. The MTG will apply to all claims involving CTS on and after February 1, 2013 regardless of date of accident or date of disablement. Carriers must certify that they have incorporated the MTG's standards in their utilization standards.

Maintenance Care

The four MTGs primarily address treatment for the acute/subacute phases of injury, with limited recommendations for the management of chronic conditions and chronic pain. In particular, the MTGs do not recommend maintenance care (i.e. ongoing manipulation or therapy modalities) for the treatment of chronic pain. Since introduction of the MTGs, nearly 80% of variance requests have been for maintenance care for patients with chronic pain.

A Medical Advisory Committee (MAC), appointed by the Chair in 2011, is developing a chronic pain MTG, which is not yet complete. However, the physician members of the

MAC agreed that some maintenance care (chiropractic, physical or occupational therapy) should be available for patients with chronic pain who have benefitted from treatment in the past. To address the large volume of variance requests, the Board is introducing the new maintenance care recommendations to take effect March 1, 2013.

The revised MTGs will authorize a program that includes up to 10 visits for maintenance care per year for those with chronic pain who have reached maximum medical improvement (MMI), have a permanent disability and meet the requirements of the maintenance program. No variance is allowed from the 10 visit annual maximum.

The maintenance care sections will apply to all claims on and after March 1, 2013 regardless of date of accident or date of disablement. Carriers must certify that they have incorporated the MTG's standards in their utilization standards.

Minor Changes to Existing MTGs

Minor changes to the MTG recommendations will also be incorporated. The knee, shoulder and back MTGs will be modified to state that kinesiotaping, taping or strapping, other than for acute joint immobilization (for example, acute ankle sprain), is not recommended for acute, subacute or chronic pain.

Process and Form Changes

Since the MTGs went into effect, the Board has actively engaged stakeholders to solicit feedback and recommendations to make the process work more smoothly for all. As a result of a series of meetings in 2011 and 2012, the Board has identified the following change that will be implemented by regulation, effective March 1, 2013:

- **Referral to Medical Director's Office (MDO):** The MTG variance process allows for dispute resolution by a medical arbitrator (currently the MDO). This resolution path has the advantages of quicker resolution by medical staff without the expense of litigation (hearings, depositions, etc.). Currently both parties must affirmatively request resolution by the MDO to be effective; this happens fewer than 20% of the time. The regulations change the default to resolution by the MDO unless one or both parties request a hearing. Based on current practice, we expect this to produce a modest increase in the use of the MDO while still allowing either party to have a hearing on the issue if desired.
- **Individual forum selection by carrier:** The original regulations required carriers to select by June 1, 2012 whether they want all variance disputes heard by hearing or Medical Director. This requirement has actually generated more work for Board staff. The revised regulations will allow both parties to select the preferred forum in each instance, which will streamline work for Board staff and enable the parties to choose the appropriate forum for the particular circumstances of the case.

- **Clarify timing of variance signature and fax transmission:** The current regulations require the medical provider to certify that it has served a copy of the variance request on the insurance carrier on the same date it sends the form to the Board. Due to medical office practices, the form was often faxed to the Board and the carrier the day after the physician signed the form, causing some variance requests to be rejected. The revised regulations and form will allow the provider to certify that the form will be submitted simultaneously to the Board and carrier within two business days to avoid rejecting requests based on when the office faxed the form.
- **Reduce number of procedures requiring C-4 Auth:** The existing MTGs pre-authorize all recommended care that is provided according to the guidelines, with the exception of 13 procedures that require prior authorization by the carrier. Two (chondroplasty and anterior acromioplasty) of the 13 procedures will no longer require prior authorization because the CPT (treatment) codes used for the related procedures that are pre-authorized have been amended by the AMA to include chondroplasty and anterior acromioplasty. As a result, there is no way to distinguish between the pre-authorized and non-pre-authorized procedures in the billing and no economic incentive for the provider to perform the chondroplasty and anterior acromioplasty unless indicated.
- **Limit on duplicate variance requests:** Currently, some providers repeatedly submit identical variance requests (same treatment and same patient) without justification. These duplicate submissions generate additional work and cost for all parties and generate confusion about which request is operative. The new regulations require the provider to certify that it has not submitted a similar variance request for the same patient without a clinical change or meaningful new information. Duplicate requests are not permitted and will not qualify for an order of the chair. Those who repeatedly violate this provision may be subject to sanction by the Board.
- **Allow partial granting of variance:** The regulations and forms do not currently allow a carrier to grant a portion of a variance request (e.g. approve 8 weeks of continued treatment instead of 16 weeks). This creates unnecessary litigation by forcing the carrier to deny the request completely. The revised regulations allow the carrier to partially grant the variance and give the provider and claimant the right to request review of any portion that was denied.
- **Minor regulation changes:**
 - **MMI definition:** The definition of Maximum Medical Improvement (MMI) is changed slightly to correspond to the definition recommended by the Workers' Compensation Reform Task Force and adopted as part of the 2012 Permanent Impairment and Loss of Wage Earning Capacity Guidelines.

"Maximum Medical Improvement (MMI)" means a medical judgment that (a) a claimant has recovered from the work injury to the greatest extent that is expected and (b) no further improvement in his or her condition is reasonably expected. The need for palliative or symptomatic treatment does not preclude a finding of MMI. In cases that do not involve surgery or fractures, MMI cannot be determined prior to 6 months from the date of injury or disablement, unless otherwise agreed to by the parties.

- The language describing submission of and response to variance requests is modified to allow it to be done electronically rather than by paper form, should that technology become available.
- **Miscellaneous form changes:** The Board avoids making frequent changes to forms because of the impact on stakeholders. Nevertheless, there have been numerous suggestions for form changes and the Board is taking this opportunity to make all suggested changes at one time. These include new checkboxes for denials based on burden of proof and duplicate submission. A complete description of the changes is attached and drafts of the new forms are available on the Board website. Final forms are available on the Board's website and may be used after February 2013.