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WORKERS' COMPENSATION BOARD
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ROBERT E. BELOTEN
CHAIR

December 1, 2010

Dear Medical Provider:

Effective today, the Medical Treatment Guidelines became the mandatory standard of care for the mid and low back, neck, shoulder, and knee **for dates of service on or after December 1, 2010**. Also effective today, there is a **30% increase to the Evaluation and Management services fee schedule**.

This letter provides:

- **Information on the Medical Fee Schedule Increase;**
- Information on the Medical Treatment Guidelines Implementation, and free training on the Guidelines and new processes;
- Reporting requirements;
- Definitions of Treating Medical Providers and Carriers;
- Information on how to determine the correct Carrier and that Carrier's Contact Person;
- An overview of the Medical Treatment Guideline's Optional Prior Approval, Treatment Pre-authorization, and Variance processes;
- New and revised forms that must be used; and
- Frequently Asked Questions regarding existing claims.

Medical Fee Schedule Increase

As previously announced, I have adopted a new fee schedule that includes an across-the-board **30% increase** to the Evaluation and Management services fees and a comprehensive revision of the chiropractic fee schedule, effective December 1, 2010. The new fee schedules are available for purchase from Ingenix, Inc., by writing to New York Workers' Compensation Medical Fee Schedule, c/o Ingenix, Inc., PO Box 27116, Salt Lake City, UT 84127-0116, or by telephone at 1-

800-464-3649, or online at <http://www.shopingenix.com/SearchResults.aspx?SearchTerm=1986>. The cost for all four fee schedules is \$85.00.

Over the next twelve months, the Board will also conduct a comprehensive review and revision of the physician fee schedule, as well as other health care provider fee schedules.

Medical Treatment Guidelines Implementation

This is the third letter that I have sent to you to advise you of this major change in providing medical care for injured workers under workers' compensation. My two previous letters are available on the Board's website under Medical Treatment Guidelines, References.

Currently, medical providers deal with 1,700 carriers and self-insured employers, each of which has its own process for determining what medical treatment is appropriate. The Medical Treatment Guidelines will create a uniform standard of care for all medical providers and carriers. The result is that both medical providers and carriers will deal with "clean claims", thereby speeding payments to medical providers and reducing disputed medical bills.

All stakeholders and Board staff will be expected to follow the Guidelines. In short, with the exception of certain procedures discussed below, treatment that is consistent with and a correct application of the Guidelines is authorized without requiring prior authorization from the carrier or self-insured employer. Treatment that is outside or in excess of the Guidelines will not be reimbursed unless the treating provider has obtained a variance from the carrier, self-insured employer or the Board.

Variety of Training Opportunities Offered

It is essential for medical providers and their staff to become familiar with the Guidelines and the new procedures and forms required to implement the Guidelines. Free training is available via the Board's website by selecting "Medical Treatment Guidelines, Training" or going to: <http://www.wcb.state.ny.us/content/main/hcpp/MedicalTreatmentGuidelines/Training.jsp> (case sensitive). Physicians are eligible for CME credits and chiropractors are eligible for CCE credits for completing these courses.

The Board continues to collaborate with stakeholder groups and provider associations to offer additional training opportunities, which will be posted on the Board's website. I encourage all system participants to take the available training to ensure a smooth transition into the new Medical Treatment Guideline process.

Reporting Requirements

- Medical Providers continue to be required to file medicals with the carrier using the forms prescribed by the Chair:
 - within 48 hours of first treatment (Form C-4);
 - a 15 day report, within 17 days of first treatment;
 - for each follow-up visit scheduled when medically necessary while treatment continues, but no more than 90 days apart (Form C-4.2 or EC-4Narr); and
 - when an injured worker reaches maximum medical improvement with an opinion on permanent impairment or loss of use (Form C-4.3).
- As of December 1, 2010, medical providers, excluding those in the provider shortage area, must use the current version of the appropriate form from the C-4 family. However, effective January 1, 2011, all medical providers, **including those in the**

provider shortage area must use the current version of the appropriate form from the C-4 family.

Definitions

For purposes of the regulations and description of processes in the regulations and this letter, we are using the following definitions:

- **Treating Medical Provider**

Treating Medical Provider, as defined by the regulations, means any physician, podiatrist, chiropractor, or psychologist that is providing treatment and care to an injured worker pursuant to the Workers' Compensation Law. The Medical Treatment Guidelines also require that physical therapists and occupational therapists adhere to Guideline requirements, although they are not included in the definition of Treating Medical Provider and therefore cannot request an optional prior approval or a variance.

- **Carrier**

Carrier, as defined by the regulations, means all private and municipal self-insured employers, group self-insured trusts, all Special Funds, the State Insurance Fund, and private insurance carriers.

How to Determine the Correct Carrier and Locate the Designated Contact Person

In our experience with the Medical Treatment Guidelines pilot, good communication between medical providers and carriers is key to a smooth implementation and the ability to resolve unique situations without a lot of unnecessary litigation or delay. To find out who your patient's insurance carrier is, you can consult the Workers' Compensation Board's website www.wcb.state.ny.us. Select "Does an Employer Have Coverage" (the button with the blue question mark at the bottom of the Board's homepage) or go to <http://www.wcb.state.ny.us/icpocinq/icpocsearch.jsp> (case sensitive). Upon searching, if the system lists several Carriers for that employer, choose the one who provided coverage during the injured worker's date of accident.

Occasionally, the system will identify the Carrier for the date of accident as "**SELFINS**". If this occurs, please call **(518) 402-0247** to identify the actual Carrier.

If you have questions regarding the employer coverage search, please contact (866) 298-7830.

Each Carrier is required to designate at least one contact for the variance, pre-authorization, and optional prior approval (if they participate) processes. If you need to speak to someone about a particular treatment or one of these requests, you can locate the Carrier's designated contacts on or after December 1, 2010 on the Board's web site www.wcb.state.ny.us. Select "Health Care Information, Medical Treatment Guidelines, Carrier Contacts and Participation, Search for Carrier Contacts and Participation (grey box)." If your search yields no results, please contact (877) 632-4996.

Optional Prior Approval

The optional prior approval process allows a Treating Medical Provider to request a determination from a participating Carrier that the planned medical treatment is consistent with the Guidelines. Carriers that participate in the optional prior approval process must designate a qualified employee as a point of contact for the Board and Treating Medical Providers. Carriers are allowed to opt-out of the Optional Prior Approval process completely if they notify the Board. The Board's website will contain the list of designated contacts for participating carriers (see section above for instructions to locate contacts on Board's website).

The new forms for the Optional Prior Approval process are:

- MG-1, Attending Doctor's Request for Optional Prior Approval and Carrier's/Employer's Response; and
- MG-1.1, Continuation to Form MG-1, Attending Doctor's Request for Optional Prior Approval.

Carriers must respond to an Optional Prior Approval request on the same form used by the Treating Medical Provider to request the approval. The Carrier has eight business days to respond. The Carrier may grant authorization without prejudice when the compensation case is controverted or the body part has not yet been established. Such authorization shall not be an admission that the condition for which these services are required is compensable or the employer/carrier is liable. If the request is denied, the Treating Medical Provider has 14 calendar days to request a review by the medical arbitrator. The medical arbitrator will render a decision within eight business days of the Treating Medical Provider's request for review. This decision is binding and may not be appealed. If the Carrier fails to respond to the request within the eight business days, the medical care is deemed approved.

The Optional Prior Approval Request Process Flow can be found on the Board's website by selecting "Medical Treatment Guidelines, References" or going to: <http://www.wcb.state.ny.us/content/main/hcpp/MedicalTreatmentGuidelines/Training/opaflow.pdf> (case sensitive)

Treatment Pre-authorization

With few exceptions, all treatment in accordance with the Guidelines is pre-authorized, **whether the cost exceeds \$1,000 or not**, and therefore do not require the use of Form C-4AUTH. The exceptions include twelve specific procedures listed in the Medical Treatment Guidelines and any second or subsequent performance of a surgery due to the failure or incomplete success of the same surgical procedure performed earlier. These procedures require the use of Form C-4AUTH to obtain authorization.

The regulations require Carriers to pay providers for services rendered in accordance with the Guidelines. Treatment that is outside the Guidelines will not be reimbursed unless a variance request is first approved by the Carrier or the Board.

Variances

Variances provide flexibility by allowing Treating Medical Providers to request approval for treatment that varies from the Guidelines. Variance requests are used in the following circumstances:

- To extend duration of treatment when an injured worker is continuing to show objective functional improvement;
- To treat outside the Medical Treatment Guidelines; or
- For treatment not addressed by the Medical Treatment Guidelines.

Carriers must designate a qualified employee as a point of contact for the Board and Treating Medical Providers for Variances. Information on each Carrier's contacts will be available on December 1, 2010 on the Board's web site. For more information on locating the contacts, see [How to Determine the Correct Carrier and Locate the Designated Contact Person](#) above.

The new forms for the Variance process are:

- MG-2, Attending Doctor's Request for Approval of Variance and Carrier's/Employer's Response; and

- MG-2.1, Continuation to Form MG-2, Attending Doctor's Request for Approval of Variance

The Treating Medical Provider must provide medical justification for a variance. The Carrier must respond to a variance request on the same form used by the Treating Medical Provider to request the variance within 15 calendar days if the Carrier does not intend to obtain an IME or a medical records review. If the Carrier intends to obtain an IME or a medical records review, the Carrier must notify the Chair and Treating Medical Provider within five business days, and then approve or deny the variance request within 30 calendar days.

If the Carrier denies the request, the injured worker may request a review of the denial within 21 business days of receipt of the denial. Upon receiving the injured worker's timely request for review, the Board will schedule an expedited hearing within 30 days, unless both the Carrier and the injured worker agree to have the dispute resolved by a binding decision of the medical arbitrator. The decision of the medical arbitrator cannot be appealed.

The Variance Request Process Flow can be found on the Board's website by selecting "Medical Treatment Guidelines, References" or at: <http://www.wcb.state.ny.us/content/main/hcpp/MedicalTreatmentGuidelines/Training/varianceflow.pdf>

New and Revised Forms

Samples of the new and revised Medical Treatment Guideline forms are available on the website by selecting "Medical Treatment Guidelines, Forms" or at <http://www.wcb.state.ny.us/content/main/hcpp/MedicalTreatmentGuidelines/MTGForms.jsp> (case-sensitive). Providers in the temporary shortage area ([Subject Number 046-398](#)) will be required to use the Medical Treatment Guideline forms. This includes Form C-4 AUTH. Providers and Carriers will be expected to use the forms on or after December 1, 2010, unless the revisions to the existing forms were instructional only.

Please contact the Board's Bureau of Health Management at (800) 781-2362 if you have any questions. Additional information and free e-learning ([Subject Number 046-445](#)) on the Guidelines may also be found on the Board's web site under Board Announcements at www.wcb.state.ny.us.

Existing Claims – Frequently Asked Questions

We have received many questions about how the Guidelines will impact existing claims and previously scheduled or approved treatments. The questions and answers below reflect the Board's current guidance and are posted on the Board's website.

What if the claim is several years old and the injured worker has already received more than the recommended amount of physical therapy treatment? Do the Guidelines apply?

Yes, however the Guidelines will be applied prospectively. Therefore, the Guidelines' recommended limits will apply to treatments on, or after, December 1, 2010. For example, if the doctor prescribes six weeks of physical therapy two times per week in mid-November, the portion of that therapy that occurs before December 1, 2010 is not subject to the Medical Treatment Guidelines. Beginning December 1, 2010, physical therapy may continue for up to three weeks and then, as required in the general principles of the Guidelines, the injured worker must be re-evaluated to determine if there is continuing objective functional improvement. Subsequent physical therapy must be consistent with the Guidelines or be approved through the variance process.

What if the claim is several years old and the injured worker has already received more than the recommended amount of chiropractic treatment? Do the Guidelines apply?

Yes. All existing cases will not have the full documentation on objective functional improvement, therefore medical providers and Carriers must follow the general principles and the Treatment Guidelines as if it is a new case. For example, an injured worker has been receiving chiropractic treatment two times per month for over a year prior to December 1, 2010. As of December 1, 2010, the Medical Treatment Guidelines apply, therefore the injured worker must be evaluated at the end of a three week period to determine if there is continuing objective functional improvement. If the injured worker shows no objective functional improvement, additional chiropractic treatment would not be consistent with the Medical Treatment Guidelines.

If a procedure or test that requires pre-authorization was approved by the insurance Carrier prior to December 1, 2010, but the procedure or test cannot be scheduled until after December 1, 2010, does the procedure or test have to comply with the Medical Treatment Guidelines?

No. Any procedure or test that has been pre-authorized by the Carrier, by an Order of the Chair, or deemed authorized due to an untimely response from the Carrier, before December 1, 2010, can be performed and will be compensated, even if it does not comply with the Guidelines.

If a Workers' Compensation Law Judge had previously rendered a decision authorizing ongoing or symptomatic treatment, would the treatment have to follow the Medical Treatment Guidelines?

Yes. The Medical Treatment Guidelines will apply to cases with orders for ongoing or symptomatic treatment as necessary. If such treatment is not consistent with the Medical Treatment Guidelines, the Carrier may object. If treatment exceeds the amount recommended under the Guidelines, the treating medical provider must show that there is a need for continuing treatment through the variance process.

Questions and Additional Information

Please contact the Board's Bureau of Health Management at (800) 781-2362 if you have any questions. Additional information on the Guidelines may also be found on the Board's web site www.wcb.state.ny.us Select "Health Care Information" on the Board's home page and then select "Medical Treatment Guidelines."

For ease of use in opening the links, this letter is available in electronic format on the Board's website. Select "Health Care Information, Medical Treatment Guidelines, References."

I strongly encourage you and your staff to review the information on the Board's web site regarding the Guidelines and to take advantage of the available training. Thank you for your cooperation in this critically important initiative.

Yours truly,

Robert E. Beloten

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Chair