



MEDICAL TREATMENT GUIDELINES

WCB Forms and Processes

FOR NON-MEDICAL AND ADMINISTRATIVE STAFF

**NYS Workers' Compensation Board
March 1, 2013**

Medical Treatment Guideline eLearning is provided by the NYS Workers' Compensation Board for Treating Medical Providers, Medical Office staff, Carriers, and the Legal community at: <http://www.wcb.ny.gov/content/main/hcpp/MedicalTreatmentGuidelines/Training.jsp>

This manual is designed for the office staff of Treating Medical Providers and Carriers (claims examiners, medical professional staff, etc.).

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OBJECTIVES

After completing this course, the appropriate Medical Office Staff and Carrier staff will be able to:

- ✓ Determine when and know how to submit and/or respond to an Optional Prior Approval Request
- ✓ Properly fill out and submit appropriate form to correct parties
- ✓ Attach appropriate documentation when necessary
- ✓ Determine when and how to submit and/or respond to a Variance Request
- ✓ Properly fill out and submit appropriate form to correct parties
- ✓ Attach appropriate documentation when necessary.
- ✓ Determine when and know how to submit and/or respond to a Pre-Authorization Request
- ✓ Properly fill out and submit appropriate form to correct parties
- ✓ Attach appropriate documentation when necessary

After completing this course, the appropriate Medical Provider Staff will be able to:

- ✓ Follow time frames for filing of medical reports--90 days not 45
- ✓ Determine what treatment needs pre-authorization

After completing this course, the appropriate Carrier Staff will be able to:

- ✓ Identify required information to posted on the WCB website

INTRODUCTION

Medical Treatment Guidelines Defined

- ✓ The Medical Treatment Guidelines (MTG) developed by the NYS Workers' Compensation Board (WCB) are the standard of care for injured workers in New York State.
- ✓ The MTG are evidence-based, supported by the strongest medical studies when available; and, in the absence of strong medical evidence, they are based on the consensus of experienced medical professionals.
- ✓ The MTG apply to injuries or illnesses to the mid and low back (back), neck, knee, shoulder, and Carpal Tunnel Syndrome.
- ✓ The MTG are mandatory for all work-related injuries and illnesses experienced by employees who live in New York and/or are treated by medical providers in New York or who have offices in New York.
- ✓ The MTG do not apply to the treatment of urgent or emergent care. Care of work-related urgent and/or emergent injuries should continue in accordance with appropriate standards.
- ✓ Regardless of the date of injury, the MTG apply to all treatment (dates of service) on or after: December 1, 2010 for Back, Neck, Knee, and Shoulder version 1; March 1, 2013 for Back Neck, Knee, and Shoulder version 2, and Carpal Tunnel Syndrome.
- ✓ All treatment and procedures consistent with the MTG are pre-approved. Medical Providers who diagnose and treat patients consistent with the Guidelines do not need to obtain pre-authorization except in the following situations:

The ten specific procedures listed in the MTG that require pre-authorization.

Any second or subsequent performance because of the failure or incomplete success of the same procedure and the procedure is not addressed as a multiple procedure in the MTG. (A repeated procedure may be one of the 10 exception procedures or any other procedure or treatment.).

Note: **Consistent with the Guidelines** is defined as “within the criteria of the Medical Treatment Guidelines and based on a correct application of the Medical Treatment Guidelines.” Correct application of the MTG is achieved in combination with the General Principles.

WCB Medical Director

The WCB Medical Director's Office (MDO) has an important role in the administration of the MTG. The office is comprised of the co-medical directors, and nursing staff located in Albany and Brooklyn.

The responsibilities of the Medical Director's Office include the following:

- ✓ Promoting high quality care and outcomes for all injured workers.
- ✓ Implementing the MTG.
- ✓ Updating the MTG.
- ✓ Educating and training guideline users statewide.
- ✓ The medical director also oversees the Health Provider Administration (HPA) unit.

The chair has designated the Co-Medical Directors of the WCB of the WCB to serve as Medical Arbitrator.

GENERAL INFORMATION

There are changes as a result of the regulations associated with the Medical Treatment Guidelines that apply to many procedures both new and existing.

Electronic Submission of Documents

The Workers' Compensation Board (WCB) prefers documents be submitted electronically using email or faxes. Some forms are also available for submission from the WCB website. The WCB recognizes it is not always possible to do this and will continue to accept documents delivered or sent by the US Mail.

WCB fax number: 1.877.533.0337

WCB email address: wcbclaimsfilings@wcb.ny.gov

Timeliness of Filing

The receive date of a form (ex.: Variance Request) is the day the form is submitted by fax, email, or other electronic means. If sent by regular mail, the receive date is 5 days after the medical provider requesting the treatment certified that the form was sent to the carrier.

Multiple Submission of Same Form by Parties

In several instances, the Medical Treatment Guideline processes use the same WCB form multiple times. For example:

- ✓ the Medical Provider may request prior approval in the first section,
- ✓ the Carrier may grant or deny treatment in the second section; and
- ✓ the Medical Provider may request a review of a denial using yet another section of the form.

Note: For those who use eCase, some forms will appear with modified Form IDs. For example, the original Optional Prior Approval Request will appear as MG-1. When the Carrier responds, it will appear as MG-1G for request "granted" or MG-1D for request "denied." When the Medical Provider requests a review, the Form ID will be MG-1R for "review."

Carrier Information to be posted on WCB Website

Carriers will be required to put certain information on the WCB website. This will include contact information for each process and whether the Carrier is participating in the Optional Prior Approval process.

Medical Providers will be able to go to the website, enter the Carrier name, and find the necessary information. This is for *Carriers only*; Third Party Administrators (TPA) are not required to submit this information to the WCB.



Guideline Reference

The Guideline Reference is a field on WCB forms that indicates the location in the MTG that discusses the requested treatment. Correctly filling out this field will enable parties to quickly find the MTG section and respond to the request. An accurate Guideline Reference will facilitate the process; an inaccurate or incomplete Guideline Reference may delay the process and may even lead to an unnecessary denial of treatment.

The first character is the first letter of the body part: B = Back, N = Neck, S = Shoulder, K = Knee, and C = Carpal Tunnel Syndrome. The next characters are taken from the outline format of the Guidelines. An example of a Guideline Reference would be B-C.1.b.v.

There will not always be five characters for each Reference, but there must be **at least three characters** to be considered a complete reference.

An accurate Guideline Reference will facilitate the process; an inaccurate or incomplete Guideline Reference may delay the process and may even lead to an unnecessary denial of treatment.

If the Guideline Reference is incomplete, WCB will send Medical Providers a letter asking the request be resubmitted with a complete Guideline Reference in order for the WCB to process the form.

The medical provider should resubmit the request *if an approval by the Carrier has not been received.*

To request treatment(s) not covered in the Guideline recommendations, please use the following:

For the Back -- B-N O N E
For the Shoulder -- S-N O N E
For the Knee-- K-N O N E
For the Neck -- N-N O N E
For Carpal Tunnel Syndrome – C-NONE

Unestablished claims

Carriers must respond to all requests – Optional Prior Approval (if a participating carrier), Variance, and Pre-Authorization – on *medical necessity* if the case is controverted, the time to controvert has not yet expired, or the body part or condition has not been established.

Treating Medical Provider

The regulations define Treating Medical Provider as any physician, podiatrist, chiropractor, or psychologist that is providing treatment and care to an injured worker pursuant to the Workers' Compensation Law. A physical therapist and an occupational therapist are not included in this definition.

Only Treating Medical Providers can request Optional Prior Approval and Variances.

Note: A physical/occupational therapist may complete the MG-2/MG-2.1 form(s) including the Guideline reference codes and supportive documentation of objective findings, and submit it to the treating medical provider for review, approval, and signature. Once the treating medical provider approves and signs the form(s), the physical therapist may submit the completed MG-2/MG-2.1 form(s) on behalf of the treating medical provider.

PRE-TREATMENT: FORMS AND PROCEDURES

Optional Prior Approval Requests

As stated earlier, any treatment that is consistent with the MTG is pre-approved and requires no action on the part of the Medical Provider. Therefore, it is optional to request prior approval. However, WCB is aware that in some instances Medical Providers require or prefer to have written authorization before treating or testing. To accommodate this preference, the WCB designed an expedited approval process to allow Medical Providers to receive written authorization from participating Carriers.

★ Note: Because this procedure is optional, Carriers are allowed to determine whether they will participate. If they are not participating, they do not have to respond to an Optional Prior Approval Request. There is a list on the Board's website which tells which carriers are participating. **Watch the effective date!!** Carriers must reply to requests up to the day they no longer participate. **Carriers:** Directions for sending information to the Board regarding your decision on this procedure are available on the Board's website.

Forms

MG-1 (Attending Doctor's Request for Optional Prior Approval and Carrier's Response) Note: Form will be referred to as Optional Prior Approval Request in this manual.

MG-1.1 (Continuation to Attending Doctor's Request for Optional Prior Approval) Note: Form will be referred to as Continuation to the MG-1 in this manual.

Note: If requesting more than one treatment at a time, use the MG-1.1 (Continuation of the MG-1). **The MG-1.1 should NEVER be submitted by itself** - it must always be attached to an MG-1. You can request up to 5 treatments using the MG-1.1 Continuation with an MG-1.

Process

Step 1: Medical Provider

The Medical Provider orders treatment for an injured worker that is consistent with the Medical Treatment Guidelines. The treatment *does not* require prior approval. However, the Medical Provider wants written approval before treating.



First, determine whether the Carrier participates in the Optional Prior Approval process by checking the WCB website. **Only follow this process if the Carrier participates.**

If there is no information available for a Carrier, it is participating. The Carrier must inform the WCB if they are "opting out" of the Optional Prior Approval process.

Use Form MG-1 (Optional Prior Approval Request and Carrier Response) if only one treatment is being requested.

Note: If requesting more than one treatment at a time, use the MG-1.1 (Continuation of the MG-1). The MG-1.1 should NEVER be submitted by itself--it must always be attached to an MG-1. You can request up to 5 treatments using the MG-1.1

The first section of the form is filled out by the Medical Provider. It is shown below:

WCB Case Number:	Carrier Case Number:	Date of Injury:
------------------	----------------------	-----------------

A. Patient's Name: Social Security No.:

First MI Last

Patient's Address:

Employer's Name & Address:

Insurance Carrier's Name & Address:

Note: This form is used only if the employer/carrier participates in the Optional Prior Approval program. You can obtain participation status from the WCB Website.

B. Attending Doctor's Name & Address:

Individual Provider's WCB Authorization No.: - Telephone No.: Fax No.:

C. **DATE REQUEST SUBMITTED:**

The undersigned requests optional prior approval under the WCB Medical Treatment Guidelines as indicated below:

Treatment/Procedure Requested:

Guideline Reference: - (In first box, indicate body part: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)

Date of Service of Supporting Medical in WCB Case File: (if not already in file, please attach.)

Other Comments:

I certify that I am making the above request for optional prior approval and my affirmative statements are true and correct. I did / did not contact the carrier by telephone to discuss this request before making it. I contacted the carrier by telephone on (date) and spoke to (person spoken to or was not able to speak to anyone) .

A copy of this form was sent to the carrier/employer/self-insured employer/Special Fund by (fax number or e-mail address required)

A copy was sent to the Workers' Compensation Board (see the Board's email address and fax number on the reverse), and copies were provided to the claimant's legal counsel, if any, and to any other parties of interest on the date below.

Provider's Signature: Date:

It is important to completely fill out the form with all available information. The information facilitates the electronic matching of the document to its correct WCB case folder.

WCB Case Number—until a claim has been assembled, this number will not be available. This is also true of the **Carrier Case Number**. However, if you have the WCB Case Number, it is important to include it since this allows WCB to route the form to the correct Electronic Case Folder (ECF).

Date of Injury—some injured workers have more than one work-related injury or illness and this helps to identify the correct case folder.

The highlighted **Provider's WCB Authorization No.** is important for the WCB.

The highlighted **Guideline Reference** identifies the section of the MTG that discusses your request.

★ Note: This field identifies a location in the Medical Treatment Guidelines. A Guideline Reference of B-D.6.a.i is for a location in the Back Guidelines--the first letter indicates the body part. The guidelines are set up in an outline format and the rest of the Reference directs you to section D, part 6, letter a, and, then, i. Most references are very specific regarding diagnosis, symptoms, and treatment.

Date of Supporting Medical in WCB Case File—this is the date of service on the medical if you have already sent it to the WCB. Any new medical reports must be attached.

The **certification** indicates who has been contacted regarding this request, how, and when.

Provider's Signature and Date—MUST be signed—the WCB accepts stamped electronic signatures from providers. WCB does not accept signed or stamped signatures that are initialed.

The completed form is sent to the WCB and the Carrier using same day transmission such as fax or email or other electronic means.

Step 2: Carrier Responds to the Request

The Carrier has **8 business days** to respond by either granting or denying the request.

The Carrier refers to the Medical Treatment Guidelines using the Guideline Reference and information on the attached or existing medicals to make a decision on the request.

The Carrier fills out the Carrier's Response section.

D. CARRIER'S / EMPLOYER'S RESPONSE (Response is due 8 business days from receipt of this request or medical care is deemed approved (12 NYCRR 324.4(c)). The provider's request is:

Granted
 Granted without Prejudice (see item 7 on reverse)
 Denied IF DENIED, STATE THE BASIS FOR THE DENIAL IN THE SPACE PROVIDED BELOW. SEE IMPORTANT INFORMATION TO CARRIER ON REVERSE. Treatment Denied because not consistent with Guidelines. Patient must show measurable functional improvement

Name of the Medical Professional who Reviewed the Denial: **Marcus Welby, MD**

I certify that copies of this form were sent to the Treating Medical Provider requesting optional prior approval, the Workers' Compensation Board (see email address and fax number on the reverse), the claimant's legal counsel, if any, and any other parties of interest, on the date below.

By: (print name) **Jane Doe** Title: **Examiner**
Signature: *Jane Doe* Date: 03/01/2013

Note: The Carrier is required to respond to all treatment requests; however, if the case or body part has not yet been established and/or the time to controvert has not yet expired and/or the body part or condition has not been established, this decision does not mean the Carrier is liable for payment of the bill. Authorization does not equal liability.

If the treatment is approved, the Carrier indicates Granted or Granted without Prejudice, enters its name and title, signs and dates the form, and sends the form to the Medical Provider and WCB by same day transmission.

If treatment is denied—denials must be reviewed by a medical professional and his or her name supplied on the form; however the medical professional does not have to sign the form. (See image above.)

Note: A **medical professional** for an insurance carrier or Special Fund is defined as: a physician, registered physician's assistant, registered professional nurse, or nurse practitioner licensed by New York State, or the appropriate state where the professional practices, who is employed by an insurance carrier or Special Fund, or has been directly retained by the insurance carrier or Special Fund or is employed by a URAC accredited company retained by the insurance carrier or Special Fund through a contract to review claims and advise the insurance carrier or Special Fund.

Some examples of reasons for denial:

- ✓ Treatment requested is not consistent with the MTG
- ✓ Guideline Reference is incorrect--confusion regarding what treatment is being requested
- ✓ Incorrect application of MTG

When denying treatment, the Carrier checks the box, states the basis for the denial in the space provided, enters the name of the medical professional who reviewed the case, adds the name, title, and signature of the person filling out the form, and the date. The form is sent to the Medical Provider and the WCB. See image above. Whenever denying a request, the Carrier should send any supporting medicals in its possession to the WCB with the denial.

Step 3: WCB Monitors the Response

WCB monitors for a timely response from the Carrier within 8 business days. If the response is not timely or there is no response from the Carrier, WCB will issue a Notice of Resolution of Treatment deeming the request approved.

WCB will also review the Form MG-1 request to determine if it is:

- ✓ a duplicate
- ✓ completely filled out --e.g. the Guideline Reference must be filled in, must have signature of medical provider
- ✓ proper form/process used for request—body part is covered by the Guidelines, injured worker lives in NYS and/or is being treated in NYS

The Medical Provider will be notified of any problems.

Step 4: Medical Provider Responds to Denial

If the request is approved, the Medical Provider treats the injured worker. However, since all treatment consistent with the Guidelines is pre-approved, it was not necessary to go through this process.

If the request is denied, Medical Provider can:

- ✓ accept the denial
- ✓ try to resolve dispute informally and/or
- ✓ request WCB review

The Medical Provider has up to **14 calendar days** from the date of the denial to request a review by the WCB Medical Director.

Since one of the goals of the MTG is the quick resolution of treatment disputes, trying to resolve a denial informally by contacting the Carrier during those 14 days is encouraged.

Informal Resolution--Carrier

If the informal resolution attempt is successful, the Carrier fills out the section on the same form labeled Carrier is Approving this Optional Prior Approval Request after an Initial Denial.

F. CARRIER / EMPLOYER IS APPROVING THIS REQUEST FOR OPTIONAL PRIOR APPROVAL AFTER AN INITIAL DENIAL	
<input type="checkbox"/> I certify that the provider's request for optional prior approval given above, which was initially denied on _____, is now granted.	
By: (print name) _____	Title: _____
Signature: _____	Date: _____

Check the box certifying the denial is now an approval, fill in date denied, fill in your name, title, and signature, and the date.

Carrier sends form to the WCB and the Medical Provider using same day electronic transmission or regular mail.

When a request is denied and informal resolution is either not attempted or is unsuccessful, the Medical Provider has **14 calendar days** from the denial to ask WCB for a review.

To request a review, the Medical Provider fills out the section--on the same form--labeled Medical Provider's Request for Review by Medical Arbitrator of Denial.

MEDICAL PROVIDER'S REQUEST FOR REVIEW BY MEDICAL ARBITRATOR OF DENIAL	
<input type="checkbox"/> I hereby request review by a medical arbitrator designated by the Chair of the carrier's decision to deny optional prior approval of the above request. I understand that resolution by the medical arbitrator is binding and is not appealable under Workers' Compensation Law §23. (Request is due within 14 calendar days of the date of denial.) Supporting medical report(s) dated _____ is/are attached or is/are available in the WCB case file.	
Provider's Signature _____	Date: _____

To fill out the form, check the box, attach the supporting medical if not in WCB file, fill in the date of service on the supporting medical, sign and date. (WCB accepts a stamped signature for a medical provider.)

The request is sent to WCB and the Carrier via same day submission.

If an Optional Approval Request is denied for not being consistent with the MTG, the Medical Provider may decide to submit a Variance Request. Please see the Module entitled Variance Requests in this course for more information.

Step 5: WCB

Upon receipt of the request for review, the Medical Director's Office (Medical Arbitrator) has **8 business days** to review the file and issue a Notice of Resolution of Treatment agreeing with the denial or approving the treatment. This decision is binding and cannot be appealed.

Requests for more than one Treatment/Procedure

Medical Provider

When the Medical Provider must request more than one treatment or procedure at the same time, he/she can attach an MG-1.1 to the MG-1.

Note: The MG-1.1 is NEVER submitted without an MG-1.

The Medical Provider fills out all available information and submits the form with the MG-1.

Carrier's Response to Multiple Requests

The Carrier responds to each request on the front of the form, checking the appropriate box.

If any requests are denied, transfer the request information--the **number** and the **Guideline Reference** to the section on the back that must be filled out. See the picture below.

CARRIER'S/EMPLOYER'S RESPONSE	
<i>(Carrier/employer must complete certification on reverse of this form.)</i>	
<input checked="" type="checkbox"/>	Granted
<input type="checkbox"/>	Granted without Prejudice
<input type="checkbox"/>	Denied

B. CARRIER'S /EMPLOYER'S RESPONSE (Response is due in 8 business days from receipt of this request or medical care is deemed approved (12 NYCRR 324.4(c)). IF ANY REQUESTS ARE DENIED, GIVE REASON(S) IN THE SPACE PROVIDED BELOW. Identify reasons according to Request No. 2-5 on the front of this form.

Guideline Reference B-E.6.a.i Denied because requested treatment is not consistent with the Guidelines.

Name of the medical professional who reviewed the denial(s): Nurse Ratched, RN

I certify that copies of this form were sent to the Treating Medical Provider requesting optional prior approval, the Workers' Compensation Board (see mailing and email addresses and fax number on Form MG-1), the claimant's legal counsel, if any, and any other parties of interest, on the date below.

By: Jane Doe Title: Examiner

Signature: Jane Doe Date: 12/05/10

State the reason for the denial, the medical professional who reviewed the request, your name, title, signature, and the date.

Send the completed form to the Medical Provider and the WCB by same-day transmission.

Variance Requests

Variances allow for flexibility in the Medical Treatment Guidelines (MTG).

Variances allow Medical Providers to provide treatment that may not conform to the MTG. The Medical Provider may seek a variance after discussing the proposed treatment with the claimant and the claimant agrees to have the treatment.

It is recognized there are legitimate reasons for not adhering to the MTGs--

- ✓ People heal at different rates
- ✓ Extenuating circumstances or co-morbid conditions may delay an individual's response to treatments or procedures
- ✓ Peer reviewed studies may provide evidence supporting new/alternative treatments

In those cases, the Medical Provider may submit a Variance Request.

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 MTG
- ✓ For treatment not recommended by the MTG
- ✓ For treatment not addressed by the MTG

Forms

MG-2 (Attending Doctor's Request for Approval of Variance and Carrier's Response)

Note: Referred to as Variance Request in this manual.

MG-2.1 (Continuation of MG-Variance Request) Referred to as Continuation of MG-2 in this manual.

Note: If more than one treatment or procedure is requested at a time, the MG-2.1 may be attached to the MG-2. **The MG-2.1 should NEVER be submitted without an MG-2.** You can request up to 5 treatments using the MG-2.1 Continuation with an MG-2.

Process

Step 1: Medical Provider Requests Variance

The Medical Provider requests treatment for an injured worker that is not consistent with the MTG; therefore, this is a Variance Request.

The Medical Provider fills out the first page of the MG-2 completely. The more information you are able to provide, the greater the chance the form will be electronically matched to the correct WCB case file. This ensures a faster response by the WCB.

WCB Case Number—until a claim has been assembled, this number will not be available. This is also true of the **Carrier Case Number**. However, if you have the WCB Case Number, it is important to include it since this allows WCB to route the form to the correct Electronic Case Folder (ECF).

Date of Injury—some injured workers have more than one work-related injury or illness and this helps to identify the correct case folder

WCB Case Number: 00000005	Carrier Case Number: W028905	Date of Injury: 11/11/10
A. Patient's Name: Joe L. Smith		Social Security No.:
<small>First</small>	<small>MI</small>	<small>Last</small>
Patient's Address: 1 Pond Hill Road Pleasantville, NY 12231		
Employer's Name & Address: Pleasantville Contracting, 1 Main Street, Pleasantville, NY		
Insurance Carrier's Name & Address: All Insurance Company, 1212 Main Street Pleasantville, NY 12231		

The highlighted **Provider's WCB Authorization No.** is important for the WCB.

B. Attending Doctor's Name & Address: Cristina Yang 17 River Street, Pleasantville, NY 12231		
Individual Provider's WCB Authorization No.:	0 0 6 4 7 0 - 3 8	Telephone No.: 877.555.1212 Fax No.: 800.555.1212

Remember, please fill the out completely with all available information.

The **Guideline Reference** identifies the section of the MTG that discusses your request. There must be at least three characters for the reference to be considered complete.

★ This field identifies a location in the Medical Treatment Guidelines. A Guideline Reference of B-D.6.a.i is for a location in the Back Guidelines-- the first letter indicates the body part. The guidelines are set up in a modified outline format and the rest of the Reference directs you to section D, part 6, letter a, and, then, i. Most references are very specific regarding diagnosis, symptoms, and treatment.

C. The undersigned requests approval to VARY from the WCB Medical Treatment Guidelines as indicated below:

Guideline Reference: - (In first box, indicate body part: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)

Approval Requested for: (one request type per form)

additional 8 weeks of therapeutic exercise

Date of Supporting Medical in WCB Case File—this is the date of service on the medical if you have already sent it to the WCB. Any new medical reports must be attached.

The **certification** indicates who has been contacted regarding this request, how, and when. If you indicated a fax number previously on this form, please do not check the box saying you cannot submit the form electronically.

Date(s) of Previously Denied Variance Request for Substantially Similar Treatment – If there are any previously denied variance requests for substantially similar treatment, you must indicate the dates.

Provider’s Signature and Date—MUST be signed—the WCB accepts stamped electronic signatures from providers. WCB does not accept signed or stamped signatures that are initialed.

STATEMENT OF MEDICAL NECESSITY - See item 4 on instruction page.

Your explanation must provide the following information:

- the basis for your opinion that the medical care you propose is appropriate for the claimant and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

If applicable, your explanation must also provide:

- the symptoms, signs, or lack of improvement that compel you to seek the proposed treatment, or
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment.
- the specific duration or frequency of treatment for which a variance is requested.

You have the option to submit citations or copies of relevant literature published in recognized, peer-reviewed medical journals as part of the basis in support of this variance request.

Date of service of supporting medical in WCB case file, if not attached: 02/20/2012

Date(s) of previously denied variance request for substantially similar treatment, if applicable:

See attached statement

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the claimant understands and agrees to undergo the proposed medical care. I did / did not contact the carrier by telephone to discuss this variance request before making the request. I contacted the carrier by telephone on (date) 02/28/2012 and spoke to (person spoke to or was not able to speak to anyone) Mary Jones

A copy of this form was sent to the carrier/employer/self-insured employer/Special Fund by (fax number or email address required) fax 877.555.5555

A copy was sent to the Workers' Compensation Board, and copies were provided to the claimant's legal counsel, if any, to the claimant if not represented, and to any other parties of interest within two (2) business days of the date below.

I am not equipped to send or receive forms by fax or email. This form was mailed to the parties indicated above on

In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: Christina Yang, MD

Date: 02/28/2012

In addition to the basic information at the top of the form, the Variance Request includes a **Statement of Medical Necessity**, located at the bottom of the form.

Providing the burden of proof is the Medical Provider's responsibility. The explanation must include:

- The basis for his or her opinion that the medical care he or she proposes is appropriate for the claimant and is medically necessary at this time.
- An explanation why alternatives set forth in the MTG are not appropriate or sufficient.
- Certification the injured worker agrees to the treatment (highlighted).

If applicable, he or she must provide:

- ✓ The symptoms, signs, or lack of improvement that compel you to seek the proposed treatment, or
- ✓ A description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment.

The Medical Provider may attach his or her explanation, along with any citations or copies of relevant literature, to this form.

The completed form is sent to the WCB and the Carrier using same day transmission such as fax or email or other electronic means.

According to the regulations, a Medical Provider must certify he/she cannot electronically submit this form. If the fax number field is filled out in Section A, please do not check the box indicating submission of the form cannot be done electronically.

Step 2: WCB Reviews and Monitors

The WCB reviews the original variance request for accuracy and monitors the Carrier's response for timeliness and completeness.

In some cases, a letter may be sent to the Medical Provider asking that they resubmit the request if the following criteria is met:

- ✓ the body part involved is not covered by the MTG,
- ✓ the injured worker is residing and being treated out of New York State,
- ✓ the form is incompletely filled out.

Upon receipt of this letter, if the Medical Provider has not yet received an approval of the request from the Carrier, he or she should resubmit the request.

If there is no response or the response by the Carrier is untimely (the Carrier has 15 calendar days if they do not get an IME; 30 calendar days to obtain an IME), the WCB will issue an Order of the Chair deeming the request approved.

If there is no supporting medical documentation attached or documentation in the case file referenced to and it necessary to complete the denial, the WCB will issue an Order of the Chair deeming the request approved.

Step 3: Carrier's Response

The Carrier reviews the request. Before deciding whether to approve or deny the request, the Carrier has the option of getting an IME or records review. The Carrier has **5 business days** to notify WCB and the Medical Provider if it is getting an IME or records review.

If the Carrier opts for the IME or records review, it has **30 calendar days** to respond to the request; if no IME or records review, it has **15 calendar days** to respond.

D. CARRIER'S / EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW	
<input type="checkbox"/> The self-insurer/carrier hereby gives notice that it will have the claimant examined by an Independent Medical Examiner or the claimant's medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the variance request.	
By: (print name) _____	Title: _____
Signature: _____	Date: _____

To notify the WCB of an IME or records review, the Carrier fills out the section labeled Carrier's/Employer's Notice of Independent Medical Examination (IME) or Medical Records Review and sends the form to WCB and the Medical Provider, injured worker and injured worker's attorney, if any.

Within 15 or 30 days, the Carrier submits its response to the request. The Carrier must check the appropriate box for approving or denying the request. If denying the request, an explanation must be included along with a selection for resolution.

E. CARRIER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST																	
Carrier's response to the variance request is indicated in the checkboxes on the right. Carrier denial, when appropriate, should be reviewed by a health professional. (Attach written report of medical professional.) If request is approved or denied, sign and date the form in Section E.	<table border="1"> <tr> <td colspan="2">CARRIER'S / EMPLOYER'S RESPONSE</td> </tr> <tr> <td colspan="2">If service is denied or granted in part, explain in space provided.</td> </tr> <tr> <td><input type="checkbox"/> Granted</td> <td><input type="checkbox"/> Without Prejudice</td> </tr> <tr> <td><input type="checkbox"/> Granted in Part</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Denied</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Burden of Proof Not Met</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Substantially Similar</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Request Pending or Denied</td> <td></td> </tr> </table>	CARRIER'S / EMPLOYER'S RESPONSE		If service is denied or granted in part, explain in space provided.		<input type="checkbox"/> Granted	<input type="checkbox"/> Without Prejudice	<input type="checkbox"/> Granted in Part		<input type="checkbox"/> Denied		<input type="checkbox"/> Burden of Proof Not Met		<input type="checkbox"/> Substantially Similar		<input type="checkbox"/> Request Pending or Denied	
CARRIER'S / EMPLOYER'S RESPONSE																	
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<input type="checkbox"/> Denied																	
<input type="checkbox"/> Burden of Proof Not Met																	
<input type="checkbox"/> Substantially Similar																	
<input type="checkbox"/> Request Pending or Denied																	
Name of the Medical Professional who reviewed the denial, if applicable: _____																	
I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal counsel, if any, and any other parties of interest, with the written report of the medical professional in the office of the carrier/employer/self-insured employer/Special Fund attached, within two (2) business days of the date below.																	
(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made _____ by the Medical Arbitrator designated by the Chair or _____ at a WCB Hearing. I understand that if either party, the carrier or the claimant, opts in writing for resolution at a WCB hearing, the decision will be made at a WCB hearing. I understand that if neither party opts for resolution at a hearing, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.																	
By: (print name) _____	Title: _____																
Signature: _____	Date: _____																

The completed form is sent to the WCB, the Medical Provider, the injured worker, and the injured worker's representative, if any. The form is submitted by same-day transmission or regular mail.

Note: The default for resolution is Medical Arbitration. One or both parties must select resolution by hearing. This selection is made on a case by case basis.

Step 3: Carrier's Response, continued

Reasons for Variance Request Denials by Carriers

- ✓ Request submitted after treatment rendered
 - No review by medical professional necessary
 - No review of records necessary
 - No IME or records review necessary

- ✓ Request did not meet burden of proof (appropriateness and medical necessity)
 - No review by medical professional necessary
 - No review of records necessary
 - No IME or records review necessary
 - Must assert any other basis for denial

- ✓ Injured worker did not appear for IME appointment
 - No reasonable grounds for no-show

- ✓ For other denial reasons
 - State basis in detail
 - Attach written report of medical professional who reviewed request or review of records IME or refer to report in case folder by Document ID and Receive Date
 - Optional to add citations and copies of relevant literature

Whenever denying a request, the Carrier should send any supporting medical reports in its possession to the WCB with the denial unless the documents are already in the WCB's file.

The Carrier's response should focus on reasons of medical necessity for the requested treatment. Authorization of this request, if the case or body part is not established, does not mean liability is accepted.

Injured Worker No-Show for IME Appointment

If the injured worker fails to appear for the scheduled IME, the Variance Request is automatically denied. The injured worker may request a review of this denial. When a review is requested, the case is sent to adjudication for a ruling on the reasonableness of the non-appearance. (There is no option to waive his or her right to a hearing.)

Step 4: Medical Provider Response to Denial

Upon receipt of denial of variance request, the Medical Provider:

- ✓ Determines if request is still appropriate and medically necessary
- ✓ May attempt to resolve informally via discussions with Carrier

Upon receipt of a denial of a variance request, the injured worker may request a review of the denial.

The Medical Provider has **8 business days** from the receipt of the denial to attempt an informal resolution with the Carrier; the injured worker has **21 business days** from the receipt of the denial to request a review by WCB. (These timeframes are concurrent.)

If the Medical Provider resolves the dispute informally, Carrier submits MG-2 form to all parties with the section below filled out.

CARRIER'S / EMPLOYER'S GRANTING OF ATTENDING DOCTOR'S VARIANCE REQUEST AFTER INITIAL DENIAL.	
I certify that the provider's variance request initially denied above is now granted.	
By: (print name).....	Title:.....
Signature:.....	Date:.....

If the informal attempt is unsuccessful, the injured worker may request a review by submitting the same form indicating his or her request. At the same time, the injured worker indicates if he or she requests hearing. See the highlighted text below:

G. CLAIMANT'S / CLAIMANT REPRESENTATIVE'S REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S / CARRIER'S DENIAL
NOTE to Claimant's / Claimant Licensed Representative's: The claimant should only sign this section after the request is fully or partially denied. This section should not be completed at the time of initial request.
YOU MUST COMPLETE THIS SECTION IF YOU WANT THE BOARD TO REVIEW THE CARRIER'S DENIAL OF THE PROVIDER'S VARIANCE REQUEST.
<input type="checkbox"/> I request that the Workers' Compensation Board review the carrier's denial of my doctor's request for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made by the Medical Arbitrator designated by the Chair or at a WCB Hearing. I understand that if either party, the carrier or the claimant, opts in writing for resolution at a WCB hearing, the decision will be made at a WCB hearing. I understand that if neither party opts for resolution at a hearing, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

The default method of resolution is medical arbitration by the Medical Director; at least one party must request a hearing for the decision to be made at a WCB hearing.

The WCB will inform unrepresented injured workers of their rights regarding a review and their option to select a resolution of the Variance Request by a WCLJ at a hearing or by the Medical Director when a denial of a Variance Request is received by WCB.

When the WCB receives a request for a review when the reason for the denial is no-show for an IME appointment by the injured worker, Adjudication will rule whether the reason for the no-show is reasonable and a second IME should be scheduled.

Step 5: Resolution of Request for Review of Denial

If neither party requests an expedited hearing, the Medical Director reviews the denial and issues a Notice of Treatment Resolution. This is a binding decision.

If at least one of the two parties requests a hearing, an expedited hearing will be scheduled within 30 days.

The Hearing Notice will inform parties that depositions from the medical professional, independent medical examiner, or records reviewer are due before or at the hearing. In the case of an unrepresented injured worker, testimony will be taken at the hearing.

At the hearing, the judge can:

- ✓ Issue a decision
- ✓ Continue the case up to 30 days due to complex medical issues
- ✓ Issue a reserved decision a few days later

Medical Provider Requests More than Two Variances

Medical Provider

When the Medical Provider must request more than one treatment or procedure at the same time, he/she can attach an MG-2.1 to the MG-2.

Note: The MG-2.1 is NEVER submitted without an MG-2.

The Medical Provider fills out all available information and submits the form with the MG-2.

The Medical Provider attaches his or opinion and the supporting documentation.

Carrier Responds to Multiple Requests

The Carrier must indicate the requests it will seek an IME or record review for when it fills out the Carrier's/Employer's Notice of Independent Medical Examination (IME) or Medical Records Review.

B. CARRIER'S/EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

The carrier/employer hereby gives notice that it will have the claimant examined by an Independent Medical Examiner and submit Form IME-4 within 30 calendar days of the Variance Request, with respect to: Request No. 2 Request No. 3 Request No. 4 Request No. 5

By: (print name): _____ Title: _____
Signature: _____ Date: _____

The Carrier responds to each request by checking the appropriate box for the corresponding request number.

C. CARRIER'S/EMPLOYER'S RESPONSE TO ADDITIONAL VARIANCE REQUEST(S)

Carrier's response to the variance request is indicated in the checkboxes below. If any additional request(s) are denied, give reason(s) for denial or partial granted below. Identify reasons according to Request No. 2-5. (Attach written report of medical professional for each denial as explained on Form MG-2.)

Request No. 2: Granted Granted in Part Denied Burden of Proof Not Met Substantially Similar Request Pending or Denied Without Prejudice

Request No. 3: Granted Granted in Part Denied Burden of Proof Not Met Substantially Similar Request Pending or Denied Without Prejudice

Request No. 4: Granted Granted in Part Denied Burden of Proof Not Met Substantially Similar Request Pending or Denied Without Prejudice

Request No. 5: Granted Granted in Part Denied Burden of Proof Not Met Substantially Similar Request Pending or Denied Without Prejudice

Name of the Medical Professional who reviewed the denial, if appropriate: _____

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal counsel, if any, and any other parties of interest, with the written report of the medical professional in the office of the carrier/employer/self-insured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made _____ by the Medical Arbitrator designated by the Chair or _____ at a WCB Hearing. I understand that if either party, the carrier or the claimant, opts in writing for resolution at a WCB hearing, the decision will be made at a WCB hearing. I understand that if neither party opts for resolution at a hearing, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name): _____ Title: _____
Signature: _____ Date: _____

State the reason for the denial, the medical professional who reviewed the request, your name, title, signature, and the date.

If the Medical Provider is successful in resolving the treatment dispute informally, the Carrier fills out the section below and files the form with all parties.

The Carrier must be careful to check the correct request.

D. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND CARRIER
I certify that the provider's variance request initially denied above is now granted or partially granted for the following requests:
 Request No. 2 Request No. 3 Request No. 4 Request No. 5

By: (print name): _____ Title: _____
Signature: _____ Date: _____

Injured Worker Responds

And, if the injured worker requests a review of a denial, he/she must check the correct checkbox and select medical arbitration or hearing.

E. CLAIMANT'S/CLAIMANT'S REPRESENTATIVE REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S/CARRIER'S DENIAL
NOTE to Claimant/Claimant's Attorney or Licensed Representative: The claimant should only sign this section after the request is denied. This section should not be completed at the time of initial request.

I request that the Workers' Compensation Board review the carrier's denial of my doctor's Request No. 2 Request No. 3 Request No. 4 Request No. 5
for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made by the Medical Arbitrator designated by the Chair or at a WCB Hearing. I understand that if either party, the carrier or the claimant, opts in writing for resolution at a WCB hearing; the decision will be made at a WCB hearing. I understand that if neither party opts for resolution at a hearing, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: _____ Date: _____

Required Pre-Authorization

The Medical Treatment Guideline (MTG) regulations designate that certain procedures require pre-authorization. These requests will follow the existing procedures for acquiring pre-authorization for treatment costing more than \$1,000. You will use the same form--the C-4AUTH.

The procedures requiring Pre-Authorization are:

Artificial Disc replacement	Kyphoplasty
Lumbar fusion	Osteochondral autograft
Spinal cord stimulators	Meniscal allograft transplantation
Vertebroplasty	Autologus chondrocyte implantation
Electrical bone stimulation	Knee arthroplasty (full or partial knee joint replacement)

And

- ✓ Second or subsequent performance of surgical procedure due to failure or lack of success of the same procedure performed earlier and not addressed in the MTG as multiple procedures.

Forms

C-4AUTH (Attending Doctor's Request for Authorization and Carrier Response) Not Available Yet

Note: As of the date of the implementation of the MTG, the Board will no longer act on a pre-authorization request that is on any other form than the C-4AUTH. This includes correspondence, an authorization reference on a narrative medical report, and the old version of the attending doctor's report (C-4) which has a checkbox to check for authorization. This form has been replaced by Form C-4.0 which does not have a checkbox. However, WCB will continue to act on requested indicated by checkbox on the OT/PT-4, and other forms that are prescribed by the Board and continue to have to the checkbox available.

Process

Step 1: Medical Provider Requests Authorization

When the Medical Provider needs to perform one of the Medical Treatment Guideline (MTG) procedures on the list that requires pre-authorization, a C-4AUTH (Attending Doctor's Request for Authorization and Carrier Response) is submitted to the Carrier, the WCB, the injured worker, and the injured worker's representative, if any.

The Medical Provider fills out the front of the form with all available information. The **WCB Case Number** may not be available if the case has not been assembled yet.

Answer all questions fully on this report

WCB Case Number:	Carrier Case Number:	Date of Injury:
------------------	----------------------	-----------------

A. Patient's Name: Social Security No.:

.....
Address:
.....
Employer's Name:
Address:
.....
Insurance Carrier's Name:
Address:
.....

B. Attending Doctor's Name:
Address:
.....
Provider's Authorization No.: Telephone No. Fax No.

DO NOT FILE

The **Date of Injury** is important since some injured workers have more than one claim. The **Provider's Authorization No.** is important to the WCB.

The Medical Provider checks the appropriate MTG treatment/procedure.

C. AUTHORIZATION REQUEST

The undersigned requests written authorization for the following special service(s) costing over \$1,000 or requiring pre-authorization pursuant to the Medical Treatment Guidelines. Do NOT use this form for injuries/illnesses involving the Mid and Low Back, Neck, Knee, and Shoulder; except for the treatment/procedures listed below under Medical Treatment Guideline Procedures Requiring Pre-Authorization. Please use the appropriate Medical Treatment Guideline form if any other procedure/test is being requested.

Authorization Requested: **Carrier Response: if any service is denied, explain on reverse.**

Diagnostic Tests:

Radiology Services (X-Rays, CT Scans, MRI) indicate body part: _____ Granted Granted w/o Prejudice Denied

Other _____ Granted Granted w/o Prejudice Denied

Therapy (including Post Operative):

Physical Therapy: _____ (___ times per week for ___ weeks) Granted Granted w/o Prejudice Denied

Occupational Therapy: _____ (___ times per week for ___ weeks) Granted Granted w/o Prejudice Denied

Other: _____ Granted Granted w/o Prejudice Denied

Surgery:

Type of Surgery (Describe, include use of hardware/surgical implants) _____ Granted Granted w/o Prejudice Denied

_____ Granted Granted w/o Prejudice Denied

Treatment:

Other: _____ Granted Granted w/o Prejudice Denied

Medical Treatment Guidelines Procedures Requiring Pre-Authorization (Complete Guideline Reference for each item checked, if necessary. In first box, indicate body part: K=Knee, S=Shoulder, B=Mid and Low Back, N=Neck. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)

1. Lumbar Fusions B - E 4 a _____ 1. Granted Granted w/o Prejudice Denied

2. Artificial Disk Replacement B - E 6 a i _____ 2. Granted Granted w/o Prejudice Denied

3. Vertebroplasty B - E 7 a i _____ 3. Granted Granted w/o Prejudice Denied

4. Kyphoplasty B - E 7 a i _____ 4. Granted Granted w/o Prejudice Denied

5. Electrical Bone Growth Stimulators - E a _____ 5. Granted Granted w/o Prejudice Denied

6. Spinal Cord Stimulators B - E 10 a i _____ 6. Granted Granted w/o Prejudice Denied

7. Anterior Acromioplasty of the Shoulder S - D 6 _____ 7. Granted Granted w/o Prejudice Denied

8. Chondroplasty K - D 1 f _____ 8. Granted Granted w/o Prejudice Denied

9. Osteochondral Autograft K - D 1 f _____ 9. Granted Granted w/o Prejudice Denied

10. Autologus Chondrocyte Implantation K - D 1 _____ 10. Granted Granted w/o Prejudice Denied

11. Meniscal Allograft Transplantation K - D _____ 11. Granted Granted w/o Prejudice Denied

12. Knee Arthroplasty (total or partial knee joint replacement) K - F 2 _____ 12. Granted Granted w/o Prejudice Denied

13. Second or Subsequent Procedure - - - - - 13. Granted Granted w/o Prejudice Denied

Note: The Guideline Reference may need more information. For some of the procedures, there is more than one reason or diagnosis. For example, there are several diagnoses that may lead to a lumbar fusion; therefore, the last box in the Guideline Reference must be filled in.

Step 2: WCB Monitors and Reviews Process

WCB reviews all C-4AUTHs for accuracy and, if certain criteria are not met, sends a letter to the Medical Provider, Carrier, injured worker, and injured worker's representative, if any.

Note: WCB will no longer read through Medical Narratives for pre-authorization requests. Medical Providers must use the C-4AUTH for all pre-authorization requests.

Request will not be processed if:

- ✓ Correct form C-4AUTH is not used
- ✓ Cost of treatment is under \$1000
- ✓ No medical report in case file or attached
- ✓ Incomplete information
- ✓ Duplicate form
- ✓ Not signed by medical provider
- ✓ Services requested not covered
- ✓ Authorization not necessary for treatment consistent with Guidelines

Request is processed but if the Carrier's name is incorrect, WCB notifies Medical Provider and the correct Carrier.

WCB also monitors for a timely Carrier response. The WCB will issue an Order of the Chair deeming the authorization request approved if the carrier has not timely responded or if the response is deficient.

Note: The checkboxes to request pre-authorization will still be on the OT/PT-4, PS-4, and C-5.

Step 3: Carrier Response

The Carrier has **30 calendar days** to respond to the request. It must have an IME already or must obtain one. Exceptions:

The Carrier checks the appropriate box(s) on the front of the form, indicating it is granting or denying the request(s).

If the Carrier grants the request, the form is sent to the Medical Provider, the WCB, the injured worker, and the injured worker's representative, if any.

If the request(s) is denied, the appropriate box(s) is checked on the front of the form and the section on the back pictured below is filled out.

Note: The Carrier must submit the C-4AUTH, a C-8.1 Part A, and a supporting medical for the denial to be complete.

The form must be signed by the Medical Provider. WCB accepts a stamped signature for Medical Providers.

REASON FOR DENIAL(S), IF ANY. (ATTACH OR REFERENCE CONFLICTING SECOND MEDICAL OPINION AS EXPLAINED ABOVE.)	
.....	
.....	
.....	
.....	
.....	
Date of service of supporting medical in WCB case file:	
<i>I certify that the self-insured employer/carrier telephoned the office of the health care provider listed above within the response time-frame indicated above and advised that the self-insured employer/carrier had either granted or denied approval for the special services for which authorization was sought, as indicated above, on the date below.</i>	
and	
<i>I certify that copies of this form were e-mailed, faxed, or mailed to the health care provider, the claimant, the claimant's legal counsel, if any, the Workers' Compensation Board and all parties of interest on the date below:</i>	
By:	Title:
(Please print name)	
Signature:	Date:

Injured Worker No-Show for IME Appointment

If the injured worker fails to appear for the scheduled IME, the Carrier may file a C-4AUTH documenting the injured worker's failure to appear and WCB will schedule an expedited hearing.

Carrier must respond to the request on medical necessity grounds when the claim is controverted and the controversy has not yet been resolved, or the injury to that specific body part or condition has been controverted and the controversy has not yet been resolved. An authorization of treatment in an unestablished claim or for unestablished body part does not automatically mean the carrier is liable for payment.

Step 4: WCB Responds to the Denial

When the WCB receives a complete denied Pre-Authorization Request, an expedited hearing is scheduled.

Step 5: WCB Resolution of Issue(s)

The Hearing Notice will state that depositions must be submitted to WCB before or at the hearing. In the case of an unrepresented injured worker, the physicians must be present to testify.

At the expedited hearing, the WCB Law Judge may:

- ✓ Issue a reserved decision a few days later
- ✓ Order a record review by an Impartial Specialist
- ✓ Continue the case up to 30 days due to complex medical issues

Pre-Treatment Quiz

1. How many days does a Carrier have to respond to an Optional Prior Approval Request?

- A. 21 calendar days
- B. 8 business days
- C. 4 business days

2. A timely denied Required Pre-Authorization request always goes to WCB Adjudication for resolution.

- A. True
- B. False

3. What happens if an injured worker fails to show up for an IME appointment?

- A. It is an automatic denial with no recourse.
- B. The appointment is immediately rescheduled.
- C. It is an automatic denial and an expedited hearing is scheduled.

4. Who can request a review of a denial variance request?

- A. The injured worker
- B. The Employer
- C. The Medical Provider

Answers

1. B. Per the regulations, the Carrier has 8 business days to respond to the request.
2. A. This is the normal WCB pre-authorization process for special services and denials always go to Adjudication per regulation.
3. C. Per the regulations, the judge will determine if the reasons for the no-show are reasonable. If they are, the judge will set a date the IME will be due so the appointment can be rescheduled.
4. A. It is the responsibility of the injured worker, after discussion with the Medical Provider, to request a review of a denial variance request.

POST-TREATMENT PROCEDURES

The regulations that are being implemented in conjunction with the Medical Treatment Guidelines (MTG) require that WCB modify some existing processes. This course will discuss the processes and the changes.

The Medical Provider is required to submit an accurate bill for treatment within a specific timeframe; and the Carrier is required to pay the bill within a specific time frame. However, there are legitimate reasons to object to a bill. These objections may involve legal issues or valuation issues. Any objection(s) a Carrier has must be filed accurately and correctly within a specific timeframe.

Depending upon the carrier's response to the bill, the Medical Provider may request an Administrative Award or Arbitration, depending upon the circumstances.

Administrative Award

When the Medical Provider has submitted a timely bill and the Carrier has not responded or has sent an invalid response, the Medical Provider's recourse is to request an Administrative Award.

Forms

HP-1 (Health Provider's Request for Decision on Unpaid Medical Bill)

HP-2 (Determination of Administrative Award) (Computer-generated form)

HP-3 (Carrier Objection—Award Rescinded) (Computer-generated form)

HP-3.1 (Carrier Objection—Award Upheld) (Computer-generated form)

Process

Step 1: Medical Provider

Medical Provider determines he or she has no response or an invalid response from the Carrier 45 days after submitting a bill. The Medical Provider fills out the HP-1 (Health Provider's Request for Decision on Unpaid Medical Bill), attaches the bill in question, and submits to WCB via regular mail.

EXCEPTION to electronic submission: The HP-1 should always be mailed or delivered directly to the Health Provider Administration, 100 Broadway-Menands, Albany, NY 12241.

Note: The HP-1 must have the medical provider's original signature.

There are three sections on the front and back of the HP-1 that need to be filled out for an Administrative Award request.

A. Since the HP-1 is used for Administrative Award Requests and Arbitration requests, you must put a check in the box marked A. REQUEST FOR ADMINISTRATIVE AWARD. See picture below.



<input checked="" type="checkbox"/>	<p>A. REQUEST FOR ADMINISTRATIVE AWARD Carrier did not reply with nonpayment explanation or pay for medical services submitted on the attached bill. More than 45 days have passed since the date of the medical bill submission or more than 30 days from the receipt of a related notice establishing carrier/employer liability. Complete the front of this form and Section A on the reverse. FILING FOR AN AWARD PRIOR TO THE RESOLUTION OF ISSUES RELATED TO C-7, C-8.1 OR RB-89 IS PROHIBITED. <i>FEE IS NOT REQUIRED.</i> DO NOT SUBMIT MORE THAN ONE BILL WITH THIS FORM.</p>
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B. The second section is on the bottom of the first page. The information provided here must match the information on the bill in question. (Exceptions to this may occur when an office has changed locations or a provider has left a practice.)

TYPE OF CARE:		<input type="checkbox"/> Medical	<input type="checkbox"/> Outpatient Hospital	<input type="checkbox"/> Inpatient Hospital	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Psychology	<input type="checkbox"/> Podiatry	<input type="checkbox"/> Osteopathic
Name and Mailing Address of Health (MAXIMUM 30 CHARACTERS)						5 WCB Case Number		WCB Authorization Number		
Name										
Lines 1&2										
Address	1					Provider's WCB Rating Code				
City	State	Zip Code					Provider's Telephone Number			
Name and Billing Address of Health Provider (MAXIMUM 30 CHARACTERS)						Carrier Case Number				
Name										
Lines 1&2	2					Carrier or Self-Insured Employer I.D. #		Date of Accident		
Address						W		M M / D D / Y Y		
City	State	Zip Code					County Where Service Was Rendered			
Name and Mailing Address of Carrier (MAXIMUM 30 CHARACTERS)						Claimant's Social Security Number				
Name										
Lines 1&2	3									
Address								Name of Claimant (First, Middle Initial, Last Name)		
City	State	Zip Code								
Name and Mailing Address of Employer (MAXIMUM 30 CHARACTERS)						I affirm, under penalty of perjury, that the conditions indicated above are true.				
Name								Health Provider's Signature		
Lines 1&2	4							Date: _____		
Address										
City	State	Zip Code								
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.										

C. Fill in the (1) Name and Mailing Address, the (2) Name and Billing Address, (3) Carrier, and the (4) Employer on the left-hand side. This information in boxes 3 and 4 must be the same as the information on the bill you are requesting an award for. There may be exceptions for sections 1 and 2 since a practice may have moved or someone has left the practice.

Fill in (5) **WCB Case Number, WCB Authorization Number, Date of Accident, Claimant's Name**, and any other available information requested.

On the back of the form, complete Section A.

SECTION A: REQUEST FOR ADMINISTRATIVE AWARD - PLEASE COMPLETE THE FOLLOWING

1. Federal Tax I.D. Number	SSN	EIN	2. Patient's Account No.	3. Total Charge	4. Amount Paid	5. Amt. in Dispute
				\$	\$	\$

The HP-1 should be sent by regular mail or delivered to WCB Health Provider Administration.

Step 2: Health Provider Administration (HPA)

HPA reviews the request for compliance, accuracy, and completeness. The most common mistakes found are:

- ✓ The request is submitted more than 120 days from the date the carrier was required to pay the bill.
- ✓ The bill is not in the claimant's (or injured worker's) electronic case file. Copies of the C-4 bills were not sent to WCB.
- ✓ The attached bill is not the original with the original bill dates and treatment codes.
- ✓ No original signature by the treating medical provider or other authorized official is on the form.
- ✓ 45 days have not elapsed since the bill was sent to the carrier (or 30 days after date of decision resolving a legal issue).
- ✓ Form is not adequately completed; insufficient information to match to WCB claim or other documents.

When an acceptable HP-1 is received, HPA issues an **HP-2 (Determination of Administrative Award)** which is sent to the Medical Provider and the Carrier. The Carrier has 30 days to object.

When an unacceptable HP-1 is received, HPA returns the form with a rejection letter.

Step 3: Final Resolution

The Carrier has **30 days** to object to the HP-2. Sufficient justification to rescind the award must also be submitted.

If there is no timely and/or sufficient objection from the Carrier, the Administrative Award is final as of the date issued.

If the Carrier objects to the Award, the HPA reviews the objection and then makes a determination.

An **HP-3 (Carrier Objection—Award Rescinded)** is issued if the HPA decides in favor of the Carrier and rescinds the Award.

An **HP-3.1 (Carrier Objection—Award Upheld)** is issued if the HPA upholds the original Award. Payment is past due and should be made immediately with interest.

Objection to Payment of Bill Due to Guideline Issues

The Medical Provider submits his or her bill for services rendered.

The Carrier has **45 days** in which to pay the bill or to object to payment. Objections are in two categories--legal liability objection for which the C-8.1 Part B is used or valuation for which the C-8.4 is used.

The existing C-8.1 form has been modified to include Medical Treatment Guideline issues.

The three reasons for objecting associated with the MTG are as follows:

- ✓ Treatment provided was not based on correct application of the Guidelines.
- ✓ Treatment deviates from the Guidelines without securing a Variance.
- ✓ Treatment not consistent with the approved Variance.

Form

C-8.1 Part B (Notice of Treatment Issue(s)/Disputed Bill Issue(s))

Process

Step 1: Carrier

Carrier fills out a **C-8.1 Part B (Notice of Treatment Issue(s)/Disputed Bill Issue(s))**, and submits it to WCB and the Medical Provider.

The Carrier fills out all available information in top of Part B.

CHECK TYPE OF CASE:					
<input type="checkbox"/>	WORKERS' COMPENSATION	<input type="checkbox"/>	VOLUNTEER FIREFIGHTER	<input type="checkbox"/>	VOLUNTEER AMBULANCE WORKER
ANSWER ALL QUESTIONS FULLY					
ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS					
1. W.C.B. Case Number	2. Carrier Case Number	3. Carrier Code	4. Date of Injury	5. Social Security Number	
Name			Address to which notices should be sent		
6. Claimant				Apt. No.	
7. Employer*					
8. Carrier					
9. Claimant's Doctor					
<small>*In volunteer firefighters' and volunteer ambulance workers' benefit cases, the liable political subdivision (or unaffiliated ambulance service as defined in Sec. 30 VAWBL) is deemed to be the "EMPLOYER."</small>					

The highlighted reasons at the bottom were added for the Medical Treatment Guidelines.

Treatment provided was not based on correct application of the Guidelines.

An example would be continuing physical therapy past the maximum allowed when the patient does not demonstrate a positive response or an automatic series of three steroid injections. (These would not be approved if submitted as a variance.)

Treatment deviates from the Guidelines without securing a variance. Medical Provider provided treatment outside the Guidelines without getting approval.

Treatment not consistent with the approved Variance. Medical Provider did not act within the approved variance.

Variance denied without claimant timely requesting review or variance denied by board decision filed.

Claimant failed to timely request review of denied variance.

**PART B
NOTICE OF OBJECTION TO PAYMENT OF A BILL
FOR TREATMENT PROVIDED**

(Notice must be properly completed and filed within 45 days of submission of bill. Failure to pay undisputed portion of bill may subject carrier to interest on that portion).

Bill pertains to treatment: in New York State out of New York State denial

Date of C-4/Bill _____ WCB Document ID# of C-4/Bill _____
(Note: If C-4/Bill is not in the Board's file, it must be submitted with this form.)

Date of Treatment _____ Amount of Bill \$ _____

Amount in Dispute \$ [_____]

The carrier raises the following legal objections to the above cited bill for treatment rendered:

- Claim has been controverted by Form C-7 dated _____ and liability has not been resolved.
- Prior authorization was not granted for treatment over \$1,000.
- Request for treatment has been denied, withdrawn, or refused.
- Treatment Provided was not causally related to the compensable injury.
- Treatment provided within 30 days of initial treatment was outside of preferred provider organization (PPO).
- Medical Report for treatment was not timely filed or is legally defective.
- Medical appliance or program is not covered under the WCL.
- Provider is not authorized under the Workers' Compensation Law.
- Bill is not for treatment but for an evidentiary opinion.
- Amount of bill for dental treatment or treatment outside of NYS exceeds community standard.
- Diagnostic test was performed outside of network.
- Other (Specify): _____

Compliance with Medical Treatment Guidelines: (ONLY applies to body parts covered by Medical Treatment Guidelines)

- Treatment provided was not based on correct application of the Guidelines.
- Treatment deviates from the Guidelines without securing a Variance.
- Treatment not consistent with the approved Variance.
- Variance denied without claimant timely requesting review or variance denied by Board Decision filed: _____

Explain Reason(s)/MTG Reference: _____

The bottom section, pictured below, must be filled out completely.

IT IS HEREWITH CERTIFIED THAT A COPY OF THIS FORM WAS SENT THIS DATE TO THE HEALTH PROVIDER.

Dated: _____ Prepared By: _____

Tel. No. & Ext.: _____ Official Title: _____

Prescribed by Chair

Step 2: WCB

WCB reviews the C-8.1 Part B. If the form is filled out completely, WCB will resolve the objection either through the hearing or the conciliation process.

Objection to Payment of Bill Due to Valuation Issues

The Carrier may object to a bill on valuation issues within the 45-day initial payment period or within 30 days following a decision by WCB resolving legal objection(s) in favor of the Medical Provider. In turn, the Medical Provider may request arbitration to settle the dispute.

Forms

C-8.4 (Notice to Health Care Provider and Injured Worker of a Carrier's Refusal to Pay All (or a Portion) of a Medical Bill Due to Valuation Objection(s))

HP-1 Health Provider's Request for Decision on Unpaid Medical Bill(s), Part B)

Process

Step 1: Carrier

The Carrier determines it has objections on Valuation issues. It files a **C-8.4 (Notice to Health Care Provider and Injured Worker of a Carrier's Refusal to Pay All (or a Portion) of a Medical Bill Due to Valuation Objection(s))** with the WCB and the Medical Provider.

This must be done within 45 days of receipt of the bill or within 30 days following a decision by WCB resolving legal objection(s) in favor of the Medical Provider.

The form is sent by regular mail, fax, email, or other means and is scanned into the Electronic Case Folder (ECF).

The reasons for objecting are as follows:

- ✓ Amount of Bill
 - Is excessive or not in accordance with pertinent NYS Medical Fee Schedule
 - Has not been properly pro-rated or apportioned between medical providers
 - Uses improper CPT codes
 - Is not in accordance with Ground Rules limitations
- ✓ Treatment
 - Is inappropriate
 - Involves concurrent or overlapping services
 - Is duplicative, excessive or rendered too frequently
 - Involves unnecessary or excessive hospitalization
 - Involves a medical provider treating outside scope of practice

The Carrier provides all known information requested on the form, checks the appropriate box to indicate its reason for objecting and completes the certification at the bottom.

NOTICE TO HEALTH CARE PROVIDER AND INJURED WORKER OF A CARRIER'S REFUSAL TO PAY ALL (OR A PORTION OF) A MEDICAL BILL DUE TO VALUATION OBJECTION(S)				
1. WCB Case Number	2. Carrier Case Number	3. Carrier Code	4. Date of Injury	5. Social Security Number
Name		Address to which notices should be sent (give Number and Street, City, State and Zip Code)		
6. Injured Person				Apt. No.
7. Employer*				
8. Carrier				
9. Volunteer Fire or Ambulance Company, if applicable				
10. Injured Person's Doctor				
<small>* In volunteer firefighters' and volunteer ambulance workers' benefit cases, the liable political subdivisions (or unaffiliated ambulance service as defined in Sec. 30 VAWBL) is deemed to be the "EMPLOYER."</small>				
MEDICAL BILL INFORMATION:		11. Date of Medical Bill	12. Date Bill Received	13. Treatment Date(s)
		14. Amount of Medical Bill \$	15. Amount Paid \$	16. Amount in Dispute \$
REASON(S) FOR OBJECTION TO MEDICAL BILL: Please check all that apply.				
Amount of Bill:				
<input type="checkbox"/> is excessive or not in accordance with pertinent NYS Medical Fee Schedule				
<input type="checkbox"/> has not been properly pro-rated or apportioned between providers				
<input type="checkbox"/> uses improper CPT codes				
<input type="checkbox"/> is not in accordance with Ground Rules limitation				
Treatment:				
<input type="checkbox"/> is inappropriate				
<input type="checkbox"/> involves concurrent or overlapping services				
<input type="checkbox"/> is duplicative, excessive or rendered too frequently				
<input type="checkbox"/> involves unnecessary or excessive hospitalization				
<input type="checkbox"/> involves a provider treating outside scope of practice				
FAILURE TO PAY UNDISPUTED PORTION OF BILL WITH THIS NOTIFICATION SHALL NOT BE CONSIDERED A TIMELY NOTIFICATION.				
IT IS HEREWITH CERTIFIED THAT A COPY OF THIS FORM WAS SENT THIS DATE TO THE HEALTH CARE PROVIDER, THE WORKERS' COMPENSATION BOARD, THE CLAIMANT AND HIS/HER REPRESENTATIVE, IF ANY.				
Date		Prepared By		
Tel. No. & Ext.		Official Title		

The C-8.4 may be faxed, emailed, sent via regular mail, or delivered to the WCB. It is scanned into the Electronic Case Folder (ECF).

Step 2: Medical Provider

When the Medical Provider receives the C-8.4, he or she may file an HP-1 (Health Provider's Request for Decision on Unpaid Medical Bill(s)), filling out Part B to request arbitration.

1. Since the HP-1 is used for Administrative Award requests and Arbitration requests, you must put a check in the box marked **B. REQUEST FOR ARBITRATION**.

X	B. REQUEST FOR ARBITRATION Carrier has not satisfactorily paid for services rendered as shown on the attached medical bill(s). A copy of the carrier's payment explanation must be attached. If you wish to submit other documents to be considered by the Committee, attach them to this form. Complete the front and reverse of this form. FILING FOR AN AWARD PRIOR TO THE RESOLUTION OF ISSUES RELATED TO C-7, C-8.1 OR RB-89 IS PROHIBITED. <i>SEE TABLE OF ARBITRATION FEES ON REVERSE. CHECK FOR APPROPRIATE FEE, PAYABLE TO CHAIR, WCB, MUST ACCOMPANY EACH REQUEST.</i>		
NUMBER OF MEDICAL BILLS ATTACHED			
FEE SUBMITTED	\$	CHECK/M.O. NO.	

The section below needs to be filled out.

TYPE OF CARE:		<input type="checkbox"/> Medical	<input type="checkbox"/> Outpatient Hospital	<input type="checkbox"/> Inpatient Hospital	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Psychology	<input type="checkbox"/> Podiatry	<input type="checkbox"/> Osteopathic
Name and Mailing Address of Health (MAXIMUM 30 CHARACTERS)						WCB Case Number		WCB Authorization Number		
Name	[]					[]		[]		
Lines 1&2	[]					[]		[]		
Address	[]					[]		[]		
City	[]	[]	[]	[]	[]	[]		[]		
Name and Billing Address of Health Provider (MAXIMUM 30 CHARACTERS)						Provider's WCB Rating Code		[]		
Name	[]					[]		[]		
Lines 1&2	[]					[]		[]		
Address	[]					[]		[]		
City	[]	[]	[]	[]	[]	[]		[]		
Name and Mailing Address of Carrier (MAXIMUM 30 CHARACTERS)						Carrier Case Number		[]		
Name	[]					[]		[]		
Lines 1&2	[]					[]		[]		
Address	[]					[]		[]		
City	[]	[]	[]	[]	[]	[]		[]		
Name and Mailing Address of Employer (MAXIMUM 30 CHARACTERS)						Carrier or Self-Insured Employer I.D. #		Date of Accident		
Name	[]					[]		[] / [] / []		
Lines 1&2	[]					[]		[] / [] / []		
Address	[]					[]		[] / [] / []		
City	[]	[]	[]	[]	[]	[]		[] / [] / []		
						County Where Service Was Rendered		[]		
						Claimant's Social Security Number		[] - [] - []		
						Name of Claimant (First, Middle Initial, Last Name)		[]		
						I affirm, under penalty of perjury, that the conditions indicated above are true.				
						_____ Health Provider's Signature				
						Date: _____				
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.										

Check a box at the top to indicate the **Type of Care**.

2. Fill in the (1) **Name and Mailing Address of the Health Provider**, the (2) **Health Provider** and/or **Facility**, the (3) **Carrier**, and the (4) **Employer** on the left-hand side.

This information in boxes 3 and 4 must be the same as the information on the bill you are requesting arbitration. The information in boxes 1 and 2 may not match.

Fill in (5) **WCB Case Number**, **Hospital's WCB Authorization Number**, **Date of Accident**, **Claimant's Name**, and any other available information requested.

3. On the back of the form, the MP fills out **Section B**.

SECTION B: REQUEST FOR ARBITRATION - PLEASE COMPLETE THE FOLLOWING:							
1. Federal Tax I.D. Number	SSN	EIN	2. Patient's Account No.	3. Total Charge	4. Amount Paid	5. Amount in Dispute	6. Amount of Fee Submitted
				\$	\$	\$	\$

4. And, the section at the bottom of the form. The information on the form must match the information on the bill.

A. Date you first treated claimant <input type="text"/> / <input type="text"/> / <input type="text"/> <small>M M / D D / Y Y</small>	B. Was first treatment rendered by you? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>IF "NO," Complete Items C. through L. IF "YES," Complete Only Items G. through L.</small>								
C. Name and Address of provider that rendered first treatment (MAXIMUM 30) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">Name</td><td style="width: 90%;"></td></tr> <tr><td style="padding: 2px;">Lines 1&2</td><td></td></tr> <tr><td style="padding: 2px;">Address</td><td></td></tr> <tr><td style="padding: 2px;">City</td><td style="padding: 2px;">State <input type="text"/> Zip Code <input type="text"/></td></tr> </table>	Name		Lines 1&2		Address		City	State <input type="text"/> Zip Code <input type="text"/>	D. Diagnosis rendered by provider indicated in Item C. <div style="border: 1px solid black; height: 50px;"></div>
Name									
Lines 1&2									
Address									
City	State <input type="text"/> Zip Code <input type="text"/>								
E. Treatment rendered by provider indicated in Item C. <div style="border: 1px solid black; height: 30px;"></div>	F. Date provider in Item C. last treated or discharged claimant <input type="text"/> / <input type="text"/> / <input type="text"/> <small>M M / D D / Y Y</small> IF "YES," Move to Item J. IF "NO," Give date and condition of patient when discharged Date <input type="text"/> / <input type="text"/> / <input type="text"/> <small>M M / D D / Y Y</small>								
H. Total number of treatments from first treatment to current date <input type="text"/>	I. Are you still treating this claimant? <input type="checkbox"/> YES <input type="checkbox"/> NO								
J. Total amount of bill(s) including amount in dispute \$ <input type="text"/>	K. Amount previously paid to you on this case, if any. \$ <input type="text"/>	L. Amount previously paid to you on disputed bill(s), if any. \$ <input type="text"/>							
G. Your diagnosis <div style="border: 1px solid black; height: 40px;"></div> Condition <div style="border: 1px solid black; height: 60px;"></div>									
<p><i>I certify that the foregoing bill(s) was originally submitted on Form C-4, UB-92 or HCFA-1500 to the responsible carrier/self-insured employer for payment. Acceptable payment has not been received, arbitration is required. In the event I fail to appear at the scheduled hearing, I will abide by the decision of the Committee.</i></p>									
<hr style="width: 80%; margin: 0 auto;"/> Health Provider's Signature	<hr style="width: 80%; margin: 0 auto;"/> Date								

5. **Sections A, B, G, and Condition** must be completed.

Section D is filled out only when the answer is **Yes** to **Section B**.

It is not necessary to calculate J, K, and L.

The Health Provider's signature must be ORIGINAL on both the front and back of the HP-1 — no stamps or initialed signing will be accepted.

The C-8.4 filed by the Carrier must be attached.

This form must be mailed to the WCB Health Provider Administration, 100 Broadway Menands, Albany, NY 12241. A check, payable to the Chair of the WCB, for the appropriate amount as determined using the rate chart on the back of Form HP-1, must be included.

Step 3: HPA

The HPA reviews the HP-1 for accuracy and compliance.

The most common mistakes found are:

- ✓ No original signature by the treating physician or other authorized provider is on the form
- ✓ 45 days have not elapsed since the bill was sent to the carrier (or 30 days after date of decision resolving a legal issue)
- ✓ Total amount in dispute does not agree with bill(s)
- ✓ Filing fee check for incorrect amount
- ✓ Submitted without Carrier's objection (C-8.4) attached
- ✓ Carrier's objection (C-8.4) does not raise valid arbitration issue(s)
- ✓ Request from hospital does not include required documentation (OR report, implant invoice, nurses' notes, etc.).
- ✓ If the form is compliant and accurate, the HPA schedules an Arbitration Hearing. If there is a problem, the Medical Provider will receive a letter from the HPA.

Arbitration Hearing Notices are sent to the Medical Provider and the Carrier.

Step 4: Resolution

Following the Arbitration Hearing the WCB issues the Arbitration Committee's decision.

The decision is binding on the parties.

The Carrier must pay the Medical Provider within 30 days or the Medical Provider can file an HP-1J (Request for Judgment).

When would a Carrier file a C-8.4?

Scenario 1

Judy is receiving physical therapy for her wrist and elbow. After an initial 12 weeks of treatment, the physical therapist continues the treatment for an additional 8 weeks.

The physical therapist submits his or her bill to the Carrier and WCB.

The Carrier feels the treatment has been excessive and files a timely C-8.4 indicating treatment was duplicative, excessive or rendered too frequently.

The Medical Provider files an HP-1 Part B requesting arbitration with the appropriate fee.

Scenario 2

The Medical Provider submits his or her bill for payment for services rendered.

The Carrier files a C-8.4 indicating use of incorrect CPT codes. The Carrier pays the bill for the lesser amount.

Unless the Medical Provider files a timely HP-1 Part B asking for arbitration, no action will be taken by the Health Provider Administration.

Did you know?

The Carrier must respond with its own form (EOB) and is not required to file a C-8.4 when the Medical Provider bills at his or her usual and customary charges and the carrier reimburses the Provider at the proper Workers' Compensation fee schedule amount. A copy of the EOB must also be sent to WCB.

Post-Treatment Quiz

1. When a Carrier files a C-8.4 (Notice to Health Care Provider and Injured Worker of a Carrier's Refusal to Pay All (or a Portion) of a Medical Bill Due to Valuation Objection(s)), what recourse does a Medical Provider have?

- A. The Medical Provider may request Arbitration.
- B. The Medical Provider may request an Administrative Award.

2. Once the HPA has issued an HP-2 (Determination of Administrative Award), the decision is final.

- A. Yes.
- B. No

3. If a Carrier believes a Medical Provider has incorrectly applied the Medical Treatment Guidelines in a case, is there anything the Carrier can do?

- A. No, the treatment in the Guidelines is authorized.
- B. Yes.

Answers:

1. A. When a Carrier has filed a C-8.4, the Medical Provider may file an HP-1 filling out Part B which requests Arbitration.

2. B. The Carrier has 30 days to object and submit sufficient justification for the HPA to reconsider. The HPA may then rescind or uphold its decision.

3. B. The Carrier may file a C-8.1 Part B objecting to the treatment because it was not based on correct application of the Guidelines.

GUIDELINE REFERENCES

One of the most important skills you will need to know is how to find information you need in the New York State Workers' Compensation Board Medical Treatment Guidelines for each specific body part. Every section of the guidelines has a reference code based on an outline. This reference code is used on WCB forms to facilitate all of the MTG processes.

Please refer to copies of the Medical Treatment Guidelines while going through this section.

Whenever you see the "blue key"  graphic what follows is the Guideline Reference. The first letter of the reference refers to which Guideline the reference is in and is added on—it does not appear in the Guidelines.

The sample guideline reference below refers to **B** the back guideline, **Section B** which is the introduction, **Part 3** (Laboratory Testing), **Sub-section a** which is (Complete Blood Count or CBC)



B: B.3.a

Introduction

Each Guideline begins with General Guideline Principles in Section A followed by an introduction to the specific body part in Section B.

The Knee, Neck, and Back continue with History Taking and Physical Examination, Imaging, Laboratory Testing, and Follow-up Diagnostic Imaging and Testing Procedures in Section B.

For the Shoulder, History Taking and Physical Examination make up Section C.

The remainder of each Guideline is body part specific.

Note: To request treatment(s) not covered in the Guideline recommendations, please use the following:

For the Back -- **B-N O N E**

For the Shoulder -- **S-N O N E**

For the Knee-- **K-N O N E**

For the Neck -- **N-N O N E**

For Carpal Tunnel Syndrome – **C-NONE**

Back and Neck Guidelines

The organization of the Back and Neck Guidelines is based on testing and treatment procedures. To navigate the back and neck Guidelines, start with the type of test or treatment procedure being recommended by the Medical Provider.

Back Example

For example, to find out if the use of X-rays are a consistent application of the Medical Treatment Guidelines for a patient with a new low back injury, you would look in the table of contents for X-rays which are found under **B for Back, Section C (Diagnostic Studies), 1 (Imaging Studies), a (Roentgenograms)**, written as:



There are 4 topics listed under the reference above on Roentgenograms (X-rays)—**B-C.1.a.i through B-c.1.a.iv**

From the Guidelines: (Note that the **B** for Back is added in front of the reference in the Guidelines.)

B-C.1.a.i Routine x-rays are not recommended for acute non-specific back pain. In the absence of red flags (indicators of potentially serious disease, such as fever or major trauma), imaging tests are not recommended in the first 4-6 weeks of back pain symptoms.

Neck Example

To find out if the use of X-rays is consistent for neck pain, you would look in the table of contents for MRI which are found under section **N for Neck, C Diagnostic Studies, 1 Imaging Studies, and a Magnetic Resonance Imaging (MRI)**.



From the Guidelines:

N-C.1.a Magnetic Resonance Imaging (MRI)
MRI is useful in suspected nerve root compression, in myelopathy to evaluate the spinal cord and/or differentiate or rule out masses, infections such as epidural abscesses or disc space infection, bone marrow involvement by metastatic disease, and/or suspected disc herniation or cord contusion following severe neck injury. MRI should be performed immediately if there is a

question of infection or metastatic disease with cord compression. MRI is contraindicated in patients with certain implanted devices.

In general, the high field, conventional, MRI provides better resolution. A lower field scan with lower magnetic intensity may be indicated when a patient cannot fit into a high field scanner or is too claustrophobic despite sedation.

Inadequate resolution on the first scan may require a second MRI using a different technique. A subsequent diagnostic MRI may be a repeat of the same procedure when the rehabilitation physician, radiologist or surgeon documents that the study was of inadequate quality to make a diagnosis. All questions in this regard should be discussed with the MRI center and/or radiologist.

Ferrous material/metallic objects present in the tissues is a contraindication for the performance of an MRI.

Knee Guidelines

The knee guideline is the most complicated guideline to navigate. Similar to the shoulder guideline, you need to refer first to the diagnosis which is in section D, but you may need to also refer to one of three other sections.

Section C-Diagnostic Studies

Section E-Therapeutic Procedures Non-Operative

Section F-Therapeutic Procedures Operative

Section D includes the most common work related injuries/diagnosis to the knee. Each diagnosis contains a minimum of the following sub-topics:

Description/Definition

Mechanism of Injury

Specific Physical Findings

Diagnostic Testing Procedures

Non-Operative Treatment

Surgical Indications/Operative Treatment

Post-Operative Therapy

Note: Some diagnoses have additional topics addressed.

If you are looking for information on diagnostic testing you must refer to Section C. This will provide additional information on when the tests are most appropriate.

If you need information on non-operative therapeutic procedures, you again start with the diagnosis in Section D and then refer to Section E which provides you with information on how the procedures should be utilized such as limits on frequency and duration as well as other criteria.

Section F contains information for Operative Therapeutic Procedures. Again this must be used in combination with the information in Section D.

Knee Example

Where would you look to find information on non-operative treatment for tendonitis (inflammation of the lining of the tendon sheath or of the enclosed tendon)?

Start with Section D. Locate tendonitis using the Table of Contents or a Search.



K.D.10.e Non-Operative Treatment

Active and/or passive therapy, including ergonomic changes at work station(s), NSAIDs, therapeutic injections.

In order to find more information on what is recommended for therapeutic injections you need to go to



K.E.3 Injections Therapeutic

Description: Therapeutic injections involve the delivery of anesthetic and/or anti-inflammatory medications to the painful structure. Therapeutic injections have many potential benefits. Ideally, a therapeutic injection will: (a) reduce inflammation in a specific target area; (b) relieve secondary muscle spasm; (c) allow a break from pain; and (d) support therapy directed to functional recovery. Diagnostic and therapeutic injections should be used early and selectively to establish a diagnosis and support rehabilitation. If injections are overused or used outside the context of a monitored rehabilitation program, they may be of significantly less value.

Contraindications: General contraindications include local or systemic infection, bleeding disorders, allergy to medications used and patient refusal. Specific contraindications may apply to individual injections.

This information is followed by a list of different types of therapeutic injections—



K-E.3.a through  **K-E.3.e.**

Shoulder Guidelines

Due to the physical nature of the Shoulder and its injuries, the Guidelines for the Shoulder are organized in a different manner.

To fully understand the Guideline recommendations for non-therapeutic procedures for shoulder injuries, you must look at both at the specific diagnosis in Section D and the more detailed explanation of the non-operative therapeutic procedure in Section E.

Section D: Includes the most common work related injuries to the Shoulder. Each diagnosis contains the following sub-topics:

Mechanism of Injury.

Medical History.

Physical Examination Findings.

Diagnostic Studies (Testing Procedures).

Non-Operative Therapeutic Procedures (Treatment Procedures).

Operative Therapeutic Procedures.

Post-Operative Procedures

Section E: Contains more information on Non-Operative Therapeutic Procedures.

Example:

Where would you look to find information on non-operative therapeutic procedures for a **frozen shoulder**?



S-D.2.e Non-Operative Treatment Procedures (Adhesive Capsulitis/Frozen Shoulder) ...address the goal to restore and maintain function and may include:

S-D.2.e.i. Physical medicine interventions are the mainstay of treatment and may include thermal treatment, ultrasound, TENS, manual therapy, and passive and active range-of-motion exercises; as the patient progresses, strengthening exercises should be included in the exercise regimen.

Then, in order to find more information on what is recommended for TENS therapy, you need to go to S (shoulder); E (Therapeutic Procedures: Non-Operative); 6 (Transcutaneous Electrical Nerve Stimulation[TENS]) which says:



S-E.6 Transcutaneous Electrical Nerve Stimulation (TENS)

TENS treatment should include at least one instructional sessions for proper application and use. Indications include muscle spasm, atrophy and control of concomitant pain in the office setting. Minimal TENS unit parameters should include pulse rate, pulse width and amplitude modulation. Consistent, measurable, functional improvement must be documented and determination

of the likelihood of chronicity prior to the provision of a home unit. TENS treatment should be used in conjunction with active physical therapy.

Time to produce effect: Immediate

Frequency: variable

Optimum duration: 3 sessions

Maximum duration: 3 sessions. Purchase or provide with home unit if effective.

CASE STUDIES

The following case study has been designed to demonstrate how all of the pieces fit together –the Medical Treatment Guidelines, the General Guideline Principles, and the Forms and Processes.

All parties involved in the process should:

- ✓ know what the medical provider and the injured worker's options are when a request is denied, and
- ✓ know what the role of the WCB and the Medical Director's Office is in the process.

These case studies were designed to be a source of information that can be referred to when questions arise in the future.

Knee

Carmella is a 42 year old waitress with a well-documented history of osteoarthritis and other degenerative changes in her left knee. While serving a customer she slipped and twisted her left knee.

Employer: files a C-2 with its Carrier and the WCB.

Carrier: files C-669 accepting the claim.

Day 1

Carmella visits her Medical Provider complaining of increased pain and decreased range of motion in her left knee. She says that putting full weight on her knee aggravates the pain. She has tried NSAIDs and physical therapy in the past with a positive result. She has not gone to physical therapy in about 2 years because her symptoms have been manageable with medication.

The Medical Provider wants to write her a script to begin physical therapy, three times a week, but Carmella does not want to try physical therapy because she has a vacation coming up. She also doesn't want to attend the therapy sessions because she doesn't like the exercises they make her do.

She advises her doctor that she has been taking an NSAID, but it only helps for short periods of time and she has to take it more frequently than the recommended dosage to keep the pain bearable.

The doctor discusses options for her care including viscosupplementation (intracapsular acid salt injections). He describes the risks and benefits. Carmella states that she would like to try Synvisc, a brand of intracapsular acid salt injections.

Quiz

1. Is a viscosupplementation (intracapsular acid salt injection) at this point in Carmella's care consistent with the Guidelines?

A. Yes

B. No

Answer

B. No

The MTG's recommend injections as a therapeutic alternative in patients who have failed non-pharmacological treatment for this knee injury. Carmella is choosing not to participate in physical therapy because of personal reasons and not because of medical issues or contraindications.



K.E.3.e Intra-Capsular Acid Salts

Intra-Capsular Acid Salts (also known as Viscosupplementation) is a form of treatment for osteoarthritis and associated degenerative changes in the knee joint. It is recommended that these injections be considered a therapeutic alternative in patients who have failed non-pharmacological and analgesic treatment, and particularly, if non-steroidal anti-inflammatory drug treatment is contraindicated or surgery is not an option. The utility of viscosupplementation in severe osteoarthritis and its efficacy beyond 6 months is not well known.

Case Study continues:

Since these injections are not consistent with the Guidelines, the Medical Provider needs to request a Variance in order for the treatment to be reimbursed.

Quiz

1. The first step in the Variance Request process is the responsibility of the Medical Provider. What *must* he or she include in a Variance Request? (choose all that apply)

- A. Injured worker's consent to the treatment.
- B. Reasons why the treatment consistent with the Guidelines is not the correct treatment for this injured worker.
- C. Citations from current medical studies that support this request.

Answer:

A. The Medical Provider must certify on the request form that the injured worker consents to this treatment per the regulations.

B. This should be the medical justification why the treatment recommended in the Guidelines is not appropriate for this patient at this time.

Citations and relevant literature are optional.



Case Study continues:

Medical Provider: submits MG-2 to WCB, the Carrier, the injured worker, and the injured worker's attorney, if any. MG-2 includes the reasons why the patient does not want to participate in physical therapy.

Day 3

WCB receives the MG-2.

The Carrier receives the MG-2.

Quiz

1. Upon receiving the MG-2, what is the first thing the Carrier must do?

- A. Send its response to the request to the Medical Provider and WCB.
- B. Determine whether it needs to get an IME. If yes, then it must notify WCB and the Medical Provider within 5business days.

Answer:

B. The Carrier must decide if it wants an IME in the first 5 business days. If it chooses to obtain an IME it must notify all of the appropriate parties and the timeframe for its review is extended to 30 days from the date of receipt of the variance request.

Case Study continues:

Day 4 (First day following Receive Date of MG-2)

The Carrier decides to get an IME.

Carrier: notifies the Medical Provider and WCB that it will get an IME by filling out the appropriate section of the MG-2 and sending it to all appropriate parties by same-day submission or regular mail.

Day 33 (29 days following Receive Date of MG-2)

The Carrier receives the IME report which states: The injury is consistent with the mechanism of the injury. Recommends denial because there is no medical justification why the patient can not participate in the physical therapy recommended by the guidelines.

Carrier: denies the Variance Request and submits form MG-2 to WCB, Medical Provider, injured worker, and injured worker's representative, if any. At the same time, the Carrier waives its right to a hearing to resolve the issue.

Day 34 (30 days following the Receive Date of the MG-2)

The WCB, the Medical Provider and all other appropriate parties receive the denial by same-day transmission.

Quiz

1. When the Medical Provider receives the denial, what are his or her options?

- A. He or she must now provide treatment consistent with the Guidelines.
- B. Contact the Carrier and try to resolve the issue informally.
- C. Request a review of the denial by the WCB Medical Director's Office.

Answer:

B Per the regulations, the Medical Provider may attempt an informal resolution with the Carrier.

Case Study continues:

The Medical Provider fails to come to an informal resolution with the Carrier. The Medical Provider discusses the situation with the injured worker. The treatment is still a viable treatment for Carmella.

Carmella discusses the issue with her attorney and decides to request a review by WCB. Her attorney tells her NOT to waive her rights to a hearing.

Injured Worker: (with her attorney) files the appropriate section of the MG-2 within in 21 business days of receiving the denial and submits it to the WCB and the Medical Provider, requesting a review of the denial and NOT waiving her rights to a hearing.

Quiz

1. The Carrier has waived its right to a hearing. The injured worker has not waived his or her right to a hearing. What happens next?

- A. WCB schedules an expedited hearing to review the denial.
- B. The issue goes to the WCB Medical Director for resolution.
- C. The denial stands.

Answer:

A. Both the Carrier and the injured worker must waive rights to a hearing for the review of the denial to be resolved by the WCB Medical Director. In this case, the injured worker did not waive his or her right to a hearing.

Issues Addressed in this Case Study:

- ✓ When a Medical Provider prescribes treatment that is not consistent with the Guidelines, a Variance Request must be approved before the treatment can be provided.
- ✓ If both parties waive their right to a hearing, a review of a variance denial can be done by the WCB Medical Director.
- ✓ If the injured worker or the Carrier does not waive its right to a hearing, a review of a variance denial is done via an expedited hearing.

Neck

Day 1 (Thursday)

Jennifer, a 42-year old sales clerk, works in a small department store. While stacking packages of paper towels on the top shelf in the storeroom, she fell from a stepladder, landing on her upper back and hyper-flexing her neck. A co-worker heard Jennifer fall and called the store manager who drove Jennifer to the Emergency Room.

At the Emergency Room, Jennifer complained of pain in her neck and upper back. She explained she had fallen at work.

Note: Workers' Compensation covers treatment in Emergency Rooms but the Medical Treatment Guidelines do not apply.

The medical provider took a history which revealed no prior neck injuries.



Guideline Reference-- Section B or C of each MTG recommendations is given for history taking and physical examination. For Guideline purposes, documentation should include a history including detailed symptoms, functional levels, etc. History and examination should address red flags.

A neurological exam was within normal limits. The medical provider ordered an X-ray of her neck which ruled out a fracture or dislocation.

Diagnosis -- acute cervical strain with Quebec Classification of Grade 1.

Treatment--The medical provider prescribed appropriate analgesics and told Jennifer to see her medical provider the next day.

Emergency Room: submits Medical Narrative to WCB and Carrier.

WCB: receives and files document.

Day 2

The next day, at the medical provider's office, Jennifer's pain was much worse and she had limited ability to turn her head. Jennifer couldn't turn her head right to left, couldn't look up, and had difficulty raising her arms. The pain was localized to her

neck. She had no numbness, tingling or weakness. A neurological exam was within normal limits. Her medical provider agreed with the Emergency Room’s diagnosis.

Diagnosis: acute cervical strain.

Treatment: Medical Provider continues NSAIDs to manage the pain and refers Jennifer to a physical therapist for evaluation and treatment 3 times a week for 4 weeks with evaluation at 3 weeks. Jennifer is to return to work at light duty—with no heavy lifting --after one week of physical therapy.



General Guideline Principle N.A.8 Complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation.

Medical Provider: submits C-4.0 to WCB and Carrier.

WCB: receives and files document.

The physical therapist initiates a program that begins with passive therapy which includes ultrasound, massage and progresses to active therapy which includes therapeutic exercise and a home exercise program.

This treatment is consistent with the Guidelines.



Guideline Reference N.D.10.g Therapeutic exercise—maximum duration 8 weeks.
and



General Guideline Principle N-A.10 Active Interventions—use passive therapy to facilitate active therapy.

Day 12 (Monday)

Jennifer returns to work at light duty.

After 3 weeks of physical therapy:

Jennifer returns to her medical provider.



General Guideline Principle A-4 Reevaluate treatment at 3-4 weeks.

Jennifer has decreased pain, increased range of motion (ROM), and increased strength in her neck. She still has room for improvement and she has not reached her pre-injury status.



General Guideline Principle N-A.3 Positive Patient

Response--Positive results are defined primarily as functional gains which can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion, strength, endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures which can be quantified.

The physical therapist feels therapy should continue with the goal of return to pre-injury baseline function. He consults with Jennifer's primary care doctor who agrees to order 4 additional weeks of PT for therapeutic exercise and heat and cold.



Guideline Reference N.D.10.g Therapeutic exercise. Therapeutic Exercise with or without mechanical assistance or resistance, may include isoinertial, isotonic, isometric and isokinetic types of exercises. Indications include the need for cardiovascular fitness, reduced edema, improved muscle strength, improved connective tissue strength and integrity, increased bone density, promotion of circulation to enhance soft tissue healing, improvement of muscle recruitment, improved proprioception and coordination, increased range of motion and are used to promote normal movement patterns.

and



Guideline Reference N.D.11.k Superficial heat and cold are thermal agents applied in various manners that lower or raise the body tissue temperature for the reduction of pain, inflammation, and/or effusion resulting from injury or induced by exercise. It includes application of heat just above the surface of the skin at acupuncture points. Indications include acute pain, edema and hemorrhage, need to increase pain threshold, reduce muscle spasm, and promote stretching/flexibility. May be used in conjunction with other active therapy and may be self-administered by the patient.

Quiz

1. What is the Guideline Reference for physical therapy for the neck?

- A. N-D.10.g
- B. N-B.1.f.i
- C. N-A.8

2. If the Medical Provider decides to obtain Optional Prior Approval, what is the first step in the process?

- A. Check the WCB website to see if the Carrier involved participates in the Optional Prior Approval process.
- B. Fill out Form MG-2.

3. Is the medical provider required to obtain optional prior approval from the carrier for an additional 4 weeks of physical therapy for Jennifer?

- A. Treatment costing more than \$1000 must be pre-authorized. When several successive courses of treatment, such as physical therapy, reach the \$1000 threshold, pre-authorization must be obtained.
- B. A medical provider is never required to obtain optional prior approval. They may use this process if they are uncertain whether or not a procedure is a consistent application of the Guidelines. So if they are uncertain if 4 additional weeks of physical therapy are consistent with the Guidelines, they may choose to use the optional prior approval process.

Answers:

1. B. The Guideline Reference for acute cervical strain is N-B.1.f.i which is the diagnosis; the Guideline Reference for Therapeutic Exercise--the treatment that is being requested--is N-D.10.g. In this case, as in most cases, the Reference for the treatment is used.
2. A. Carriers have been given the choice to opt out of the Optional Prior Approval process because it is optional. You should always check the website first. If there is no Carrier information available, the Carrier participates in the process.
3. B. All treatment consistent with the Medical Treatment Guidelines is pre-approved--regardless of the cost--except for the 12 procedures on the exception list plus any repeated procedures due to failure or lack of success the first time. Therefore, the Medical Provider does not have to request Optional Prior Approval for treatment that is consistent with the Guidelines.

Case Study continues:

Medical Provider: submits Optional Prior Approval Request to WCB and Carrier. The attached or referenced medical must document the objective functional gains.

Carrier: has 8 business days to reply.

WCB: receives MG-1 and assembles a case.

WCB: monitors for a timely Carrier response.

Carrier refers to the Guideline Reference and the documentation submitted in the supporting medical and approves treatment since it is consistent with the Guidelines.

Carrier: submits MG-1 to Medical Provider and WCB with the Carrier's Response section of Optional Prior Approval Request completed.

3 weeks later

After completing a total of 6 weeks of physical therapy, Jennifer's functional levels are at pre-injury baseline levels.

Medical Provider: (physical therapist) documents functional levels on Form OT/PT and sent to WCB and the Carrier.

The physical therapist continues the therapy for the final 2 weeks (for a total of 8 weeks of physical therapy).

Quiz

1. A total of 8 weeks of physical therapy is consistent with the Guidelines. In the situation described above, does the Carrier have any reason to deny payment?

- A. Yes, the Carrier can object to the last 2 weeks of physical therapy.
- B. The Carrier can request a hearing.
- C. No, injured workers are entitled to all treatment that is consistent with the Guidelines for their injury.

2. If the Carrier wants to object to the last two weeks of physical therapy, what does it do?

- A. The carrier pays for the first two weeks of therapy and writes a note to the Medical Provider explaining why it is not paying the total amount.
- B. The Carrier files a C-8.1 Part B with WCB and the Medical Provider.

Answers:

1. A. Once the injured worker has reached pre-injury baseline levels, additional treatment is not consistent with the Guidelines.
2. B. The C-8.1 is used to object to treatment for Guideline issues.



Case Study continues:

Carrier: files a C-8.1 Part B objecting to the last two weeks of physical therapy.

WCB: receives the form, WCB Adjudication resolves the issue.

Issues Addressed in this Case Study

- ✓ When optimum or pre-injury baseline levels are reached, physical therapy treatment should end. The carrier may object to treatment once optimum improvement levels are reached.

Shoulder

Day 1

After two days of lifting and moving heavy boxes over his head, a 35-year-old warehouse worker named John experienced right shoulder pain and decreased range of motion.

Day 4

John went to his Medical Provider.

History: Pain has worsened and is aggravated when John tries to perform activities reaching over his head. He notes some weakness when he tries to elevate his arm and also complains of pain at night which interferes with his sleep.

He has not had a previous injury to the shoulder.

The review of systems is negative, without history of fever or other illnesses. He is a non-smoker.

Physical examination: John did not have a fever. Right shoulder tender to palpation. There is right shoulder pain with passive movement, which is worsened with active movement and decreased strength in the right arm.

Note: The medical history and physical examination findings are the foundation and dictate the subsequent stages of the treatment plan. Guidelines for history taking and physical examination are found in the History and Physical Examination sections of each shoulder diagnosis and include the history and mechanism of injury and relevant physical findings.

Diagnostic Test: Plain X-rays were within normal limits and negative for fracture. The history (review of systems) and examination also address red flags which may indicate serious underlying disease such as fracture; infection or inflammation; subdiaphragmatic problems; and cardiac disease.

Diagnosis: The findings were consistent with rotator cuff tendonitis.

Treatment plan: The medical provider directed John to stay out-of-work 3 days, prescribed NSAIDs, and referred him to an orthopedist.

Medical Provider: files a C-4.0 (Initial Report of Attending Doctor) to the Carrier and WCB.

Day 10

John goes to an orthopedist.

John's symptoms and physical exam findings are unchanged.

Diagnosis: The orthopedist agrees with the diagnosis of rotator cuff tendonitis and considers an impingement syndrome as well.

Treatment plan: John is referred to a physical therapist for evaluation and treatment three times a week for 4 weeks, a re-evaluation at 3 weeks and continue NSAIDs.



General Principles S.A.4: The medical provider should re-evaluate the patient and change approach to treatment if the patient is not having a positive response or reconsider the diagnosis.

Work status: To remain out-of-work for three weeks.

Medical Provider: (orthopedist) submits a C-4.0 (Initial Report of Attending Doctor) to the Carrier and the WCB.

The physical therapist sets up a program that moves from passive to active modalities and includes exercise, ultrasound, and heat/cold.



General Guideline Principle S.A.10: Active interventions-- Generally, passive and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

Medical Provider: (physical therapist) submits an OT/PT-4 (Report of Occupational Therapist and/or Physical Therapist) to WCB and the Carrier.

Injured Worker: files a C-3 (Employee Claim).

WCB: receives two C-4.0s, an OT/PT-4, and a C-3 and assembles a case; sends Notice of Indexing to the Carrier and the injured worker.

3 weeks later

John continues to experience pain and have restricted motion. He returns to the orthopedist who suggests a subacromial space anesthetic injection to confirm the diagnosis combined with a therapeutic steroid injection. John reports 90 percent relief from the injection immediately.

Results: Pain is immediately relieved and the diagnosis is confirmed



General Guideline Principle S-A.4: The first evaluation of the treatment or modality should occur 2 to 3 weeks after the initial visit and 3 to 4 weeks thereafter.



Guideline Reference S.D.8.d.iii Subacromial space injection can be used as a diagnostic procedure by injecting an anesthetic, such as sensorcaine or xylocaine solutions, into the space. If the pain is alleviated with the injection, the diagnosis is confirmed.

The therapeutic steroid injection ,which was given in combination with the diagnostic injection continues to provide ongoing relief in his pain and function. John is now beginning to participate in an active therapy program.



Note 6: Guideline Reference S-D.8.e.ii Subacromial space injection with steroids may be therapeutic if the patient responded positively to a diagnostic injection of an anesthetic. Steroid injections directly into the tendons are not recommended.

Frequency: Not more than 2-3 times annually. Usually 1 or 2 injections adequate. A minimum of 3 weeks interval between injections is recommended.

Time to produce effect: Immediate with local anesthetic, or within 3 days with corticosteroids.

Maximum duration: Limited to 3 injections annually to the same site.

Medical Provider: Orthopedist submits a C-4.2 (Report of Continuing Care by Attending Doctor) to the Carrier and WCB.

8 weeks later

The pain returns. John goes back to the orthopedist. The orthopedist gives John a second injection.

Medical Provider: Orthopedist submits a C-4.2 (Report of Continuing Care by Attending Doctor) to the Carrier and WCB.

5 days later

The right shoulder pain returns along with decrease range of motion. The doctor now wants to administer a third subacromial steroid injection.

Quiz

1. Is the third injection the medical provider wants to give John consistent with the Shoulder Guidelines?

- A. No, a minimum of three weeks between steroid injections is recommended. Payment may be denied by the carrier.
- B. Yes, the second injection was not successful so John needs another one.

2. The medical provider sends an Optional Prior Approval Request (MG-1) to the carrier and WCB. How many days does the carrier have to respond to this request?

- A. 5 business days
- B. 8 business days
- C. 15 calendar days

Answers:

1. A. Guideline Reference D.8.e.ii says regarding subacromial injections: Frequency: Not more than 2-3 times annually. Usually 1 or 2 injections adequate. A minimum of 3 weeks interval between injections is recommended.
2. B. The WC regulations specify 8 business days.



Guideline Reference S-A.4 Re-evaluate Treatment

If a given treatment or modality is not producing positive results, the provider should either modify or discontinue the treatment regime. The provider should evaluate the efficacy of the treatment or modality 2 to 3 weeks after the initial visit and 3 to 4 weeks thereafter. Reconsideration of diagnosis should also occur in the event of poor response to a rational intervention.

Case Study continues:

Medical Provider: Orthopedist submits an MG-1 (Optional Prior Approval Request) for the third injection (after checking to make sure the carrier is participating). Copies are sent to the Carrier and WCB. The C-4.2 for the visit is attached to the MG-1.

Carrier: denies the request, filling out the appropriate section of the MG-1, and sends the form to the Medical Provider and WCB.

The carrier denies because the second shot did not work and there needs to be at least 3 weeks between shots; therefore, the third shot is not recommended and would not be consistent with the Guidelines.

Quiz

1. What are the medical provider's options now?

- A. Call the Carrier and resolve the issue on the phone.
- B. Within 14 days, John, the injured worker, can request a review of the denial by the WCB Medical Director.

Answer:

1. A. Medical providers are encouraged to resolve these issues informally.



Case Study continues:

An attempt to resolve the issue informally fails.

Medical Provider: requests a review of the denial by the WCB Medical Director by filling out the appropriate section of the MG-1 and submitting to WCB and the Carrier.

WCB Medical Director: agrees with the denial of treatment and sends an EC-70 (Notice of Resolution of Treatment) to all parties.

Quiz

1. How many days does the WCB Medical Director have to respond to the request for a review?

- A. 8 business days
- B. 14 days
- C. 4 business days

Answer:

1. A. The regulations state the WCB Medical Director has 8 business days to respond.

Issues Addressed in this Case Study

- ✓ Timeframe for carrier to respond to Optional Prior Approval Request -- 8 business days.
- ✓ Party who requests review of Optional Prior Approval Request denial -- the medical provider.
- ✓ Timeframe WCB Medical Director's Office has to respond to request for review of Optional Prior Approval denial -- 8 business days.
- ✓ Automatic series of 3 shots--each needs to be scheduled separately and need to take into consideration the effectiveness of each previous shot.

Shoulder

Fall 2010

Janie hurt her shoulder stocking shelves with wallpaper at Home Depot. Janie went to her Medical Provider who sent her to a Physical Therapist for six weeks of treatment.

Injured Worker: filed a C-3 (Employee's Claim) with the WCB and Carrier.

Medical Provider: filed a C-4.0 (Attending Doctor's Initial Report) with the Carrier and WCB.

Carrier: filed a C-7 (Notice That Right to Compensation is Controverted) with Causally Related Accident and Accident Arising Out of and in the Course of Employment checked with the WCB and the Medical Provider.

WCB: receives the C-3, C-4.0, and C-7, assembles a case, and schedules an expedited hearing.

At the expedited hearing, the WCB Law Judge ruled the injury was work-related and established ANCR to the right shoulder. The judge authorized treatment. Subsequently, Janie's Medical Provider prescribed 12 additional weeks of physical therapy. Janie completes 2 weeks of physical therapy by December 1, 2010.

December 1, 2010--Medical Treatment Guidelines go into effect.

Quiz

1. Do the Medical Treatment Guidelines affect Janie's case?

- A. Yes, Janie can have up to 4 weeks of physical therapy without a re-evaluation after 3 weeks.
- B. No, because the Date of Accident is prior to December 1, 2010.
- C. No, because Janie's injured body part is not covered by the MTG.

Answer:

1. A is correct. As of December 1, Janie's treatment must be consistent with the MTG. The MTG allow 4 weeks of physical therapy to be prescribed at a time and require re-evaluations at 3-4 weeks. Any physical therapy previous to December 1 is not counted.



General Guideline Principle S:A.4: If a given treatment or modality is not producing positive results, the provider should either modify or discontinue the treatment regime. The provider should evaluate the efficacy of the treatment or modality 2 to 3 weeks after the initial visit and 3 to 4 weeks thereafter. Reconsideration of diagnosis should also occur in the event of poor response to a rational intervention.

Applying the Principle above, Janie would be re-evaluated at 3 weeks. As long as there is measureable functional improvement, Janie can continue with another 4 weeks of physical therapy.

Therefore, the medical provider must re-evaluate on a regular basis to determine whether treatment is producing positive results.

The **Date of Accident** has no bearing on whether the Medical Treatment Guidelines apply, only **Dates of Service** on or after December 1, 2010.

Issues Addressed in this Case Study

- ✓ For all cases which involve injuries to the back, neck, knee, and shoulder, treatment authorized by a WCB Law Judge may have to be re-evaluated after December 1, 2010.

Back

Frank is a 38 year old man, who is seen in the orthopedist's office for follow up of a work related injury that occurred when he lifted a 100 pound sack at work.

He continues to complain of severe low back pain that radiates down the outer part of his left leg into his foot, with numbness and tingling in his left foot. Walking aggravates the pain.

Frank had a course of physical therapy 2-3 times a week over the last 4 weeks. He reported at his re-evaluation that the physical therapy did not help, and aggravated his symptoms.

The orthopedist ordered a lumbar epidural steroid injection. Frank reports the injection did not relieve his pain.

Physical examination: unchanged and is consistent with L5 radiculopathy. MRI of the lumbar spine reveals bilateral facet spurring with no significant central canal narrowing seen. Mild to moderate foraminal narrowing bilaterally encroaching upon the left exiting nerve root. (i.e. spinal stenosis)

Medical Provider: determines a lumbar fusion (posterior lumbar interbody fusion (PLIF) w/PEEK cage and BMP (bone morphogenic protein) is needed because of the presence of spinal stenosis on MRI.

Quiz

1. What is the orthopedist's next step?

- A. Schedule Frank's surgery because it is consistent with the Medical Treatment Guidelines.
- B. Submit a pre-authorization request to the WCB and the Carrier.
- C. Submit an Optional Prior Approval Request to the WCB and the Carrier.

Answer

1. B. Lumbar fusion, while consistent with the Medical Treatment Guidelines, is one of the procedures that requires pre-authorization. The orthopedist must file a C-4AUTH with the WCB and the Carrier

Case Study continues:

Medical Provider: Orthopedist fills out and submits a C-4AUTH to WCB and the Carrier. The Guideline Reference on the form is B-E.4.a.i.



Guideline Reference B-E.4.a.i Lumbar fusion is recommended as treatment for spinal stenosis when concomitant instability has been proven. Lumbar fusion is not recommended for spinal stenosis without instability.

Carrier: receives the C-4AUTH.

The Carrier's medical professional reviews the medical records—there is nothing in the file to support the instability necessary for performing a lumbar fusion in the presence of spinal stenosis.

Carrier: submits his or her medical report to deny the request.

Note: Instability would be reported on the flexion and extension x-ray reports.

Quiz

1. When a pre-authorization request is denied by a Carrier, what is the next step?

- A. The medical provider who submitted the request must ask for a review of the denial.
- B. The injured worker may ask for a review of the denial by the WCB Medical Director.
- C. WCB schedules an expedited hearing within 30 days.

Answer

1. C. At the hearing the judge may order an impartial specialist's report, render a decision on the treatment, or continue the case for complex medical issues of diagnosis or causation present and then it shall be continued for no more than thirty days.

Issues Addressed in this Case Study:

- ✓ Although consistent with the Medical Treatment Guidelines, the 12 procedures listed as exceptions must receive pre-authorization before being performed.
- ✓ No party needs to request a review of the denial of a pre-authorization request; it is automatically scheduled for an expedited hearing by WCB.