

**Implementation and
Process Standards for the
New York State
Medical Treatment Guidelines**

**Proposed by the
State of New York
Department of Insurance
to the
Workers' Compensation Board**



Proposed Implementation and Process Standards for the
New York State Medical Treatment Guidelines

Implementation Standards

1. The NYS Medical Treatment Guidelines (the “Guidelines”) are the standard for medical care for workers’ compensation injuries to the parts of the body addressed by the Guidelines. Variances from the Guidelines are permissible only as provided in these implementation standards.¹

2. For claims and medical conditions that have been accepted or established as compensable by workers’ compensation:
 - Under the applicable fee schedule, the insurer² shall be obligated to pay for all medical care that is (a) within the criteria of the Guidelines and is based on correct application of the Guidelines; (b) a proper variance from the Guidelines in accordance with paragraph 3; (c) agreed to by the insurer; or (d) as ordered by the Board pursuant to statutory or regulatory provision.

 - The insurer shall not be obligated to pay for any medical care, under the applicable fee schedule or otherwise, that is not within criteria of the Guidelines or is not based on correct application of the Guidelines, except as provided in paragraph 3 or as ordered by the Board pursuant to statutory or regulatory provision.

3. Variances from the criteria of the Guidelines by treating medical providers (for purposes of these Standards, this includes physicians, dentists, chiropractors and podiatrists) shall be governed by the following:
 - Requirements:
 - a. a medical opinion by the treating medical provider, including the basis for the opinion, that the proposed medical care which is the subject of the variance is medically necessary;
 - b. patient to agree to the proposed medical care;
 - c. an explanation why alternatives under the Guidelines are not appropriate or sufficient;
 - d. signs and/or symptoms which have failed to improve with previous treatment that was consistent with the Guidelines; and

¹ These implementation standards and the Guidelines do not establish a legal standard for determining professional liability for variances from the Guidelines.

²“Insurer” shall mean private insurance carriers, the State Insurance Fund (“SIF”), self-insureds, self-insured trusts and third-party-administrators.

- e. for a variance involving frequency or duration of a particular treatment: to the date of the variance request, functional outcomes have improved from that treatment and it is reasonably expected that future treatment will result in future functional improvement.
- Relevant literature published in recognized, peer-reviewed medical journals shall be considered in determining whether a variance is medically necessary, including satisfaction of the above requirements, other than (b).³
 - The burden of proof to establish a variance shall rest on the treating medical provider requesting the variance.
 - These criteria for variances shall be used by IME's or other medical reviewers in evaluating whether variances from the Guidelines are medically necessary.
 - A determination by the Board that a variance is or is not medically necessary for a particular patient⁴ shall have no precedential value.
4. If the Guidelines do not address a condition, treatment or diagnostic test for a part of the body covered by the Guidelines, then the factors in sub-paragraphs 3(a) – (c) and relevant medical literature as described in paragraph 3 shall be used to determine whether the insurer shall be obligated or not obligated to pay for the medical care at issue.
 5. Insurers may submit conflicting medical opinions, including the basis for the opinion, respecting issues addressed in paragraphs 2-4.
 6. The Board shall regularly review and update the Guidelines to reflect the current medical literature, best practices of medical providers, outcomes data as available and any other factors it deems appropriate.

Process Standards

1. The Board shall require insurers to incorporate the Guidelines standards into their policies, procedures and practices so that their utilization review and management criteria are consistent with the Guidelines. The insurers shall certify annually to the Board that they have done so. The Board and Department of Insurance (as to private insurance carriers and SIF) will conduct audits of insurers regarding the correctness of the certifications as

³ If relevant literature is part of the basis for a variance request, early submission of citation(s) to the literature may facilitate determination of the request.

⁴ In these Standards, injured workers are referred to as patients recognizing that in certain circumstances there is no doctor-patient relationship.

follows: at least once every 4 years, each insurer shall be required to submit those policies and procedures to the Board or Department of Insurance, as the case may be, which shall review them to insure that the certifications as to the policies and procedures are correct and if not, that the insurer rectifies any deficiencies.

2. With the objective of providing guidance to users of the Guidelines, the Board shall publish selected decisions of its judges and any related appellate Board decision that reflect principles and reasoning for applying the Guidelines, recognizing that privacy of patients must be preserved.

3. To promote efficient introduction of the Guidelines into the claims administration process, special calendar part(s) shall be created for exclusively determining disputes about whether specific medical care for a patient is: (a) within the criteria of the Guidelines; (b) based on correct application of the Guidelines; (c) a proper variance from the Guidelines in accordance with paragraph 3 of the implementation standards; or (d) agreed to by the insurer.
 - Judge(s) shall be assigned to the calendar part(s) on a full time basis.

 - The calendar part(s) shall be in effect for a period of at least 6 months from the effective date of the Guidelines, or such longer period as the Board shall determine.

4. A pilot program for facilitating access to medical care is attached as an Appendix.

5. Preparation by the Board of a report that describes: (a) implementation of the Guidelines, including education efforts for users of the Guidelines; (b) use of the Guidelines by treating medical providers, insurers and the Board's judges; (c) effects of the Guidelines on the provision and cost of timely medical care; and (d) effect of the pilot program referenced above.

6. Maximum medical improvement (MMI) shall not preclude the provision of medically necessary care for patients. Such care shall be medically necessary to stabilize function at the MMI level or to improve function following an exacerbation of the patient's condition. Post-MMI medical services shall conform to the medical treatment guidelines employed.

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“Medical care” in these Standards shall mean all the care, treatment and other items for the employee’s injury as listed in WCL §§ 13, 13-k, 13-l and 13-m.

APPENDIX

Proposed Pilot Program
To Facilitate Access to Medical Care¹

The Workers Compensation Law does not require prior authorization for medical treatment costing \$1,000 or less. Often times medical providers are reluctant to provide services for these treatments because payment is not guaranteed by the insurer. As a result, medical care for the patient is sometimes delayed until there is an assurance of payment by the insurer.

This uncertainty of payment and delays in medical care can also slow recovery and return to work, thereby increasing payments for lost wages, and can increase administrative adjudication and defense costs. It is the goal of the pilot program described below to provide faster and better medical care, minimize disputes about medical care and related friction costs and improve recovery and return to work time tables.

Establish a voluntary pilot program applicable to requests for medical care that are \$1,000 or less under the applicable fee schedule and are not subject to the authorization requirement of WCL §13-a(5):

- The treating medical provider shall have the option of requesting a decision from the insurer as to whether proposed medical care is (a) within the criteria of the Guidelines and is based on correct application of the Guidelines; or (b) a proper variance from the Guidelines in accordance with paragraph 3 of the implementation standards (“request”). The request may be made by a person in the office of the treating medical provider who preferably is a nurse, physician’s assistant or other health professional. The request (which must include the Board’s claim number) shall be made by telephone with a confirming email, and a copy to the Board (“requesting email”). Although not required, inclusion of the insurer’s case number could expedite the insurer’s response to the request.
- The insurer shall make available by telephone a person to discuss the request with the medical provider’s office, provided that the person is authorized to approve the request or initially disapprove it. It is preferable that the person be a nurse, physician’s assistant or other health professional.
- The insurer shall have 4 business days from the requesting email to email its decision in response, with a copy to the Board. If the request is made in connection with a claim that is not accepted or established, agreement to the request shall not be an admission that the claim is compensable and shall be without prejudice to the insurer controverting the claim.

¹Terms defined in the implementation standards have the same meaning in this pilot program.

- If the insurer does not respond by email within the allotted time, the proposed medical care shall be deemed to be within the Guidelines and based on a correct application of the Guidelines or a proper variance from the Guidelines in accordance with paragraph 3 of the implementation standards, as the case may be, provided however, that this shall not establish or be considered an acceptance of the claim or medical condition.
- Each insurer shall provide the Board with an email address and telephone number to which treating medical providers shall submit their requests; the address and telephone number shall be posted by the Board on its website.
- This program shall have no effect on the Board's determination of the medical necessity of care or the right to payment for care furnished, except if the insurer is deemed to have agreed by failing to timely respond to a request or has agreed to such care. (Any agreement as to care shall not be an admission that the claim is compensable and shall be without prejudice to the insurer controverting the claim.)
- Optional procedures to facilitate this process:
 - a. the treating medical provider may submit information in support of a request. The information may include the patient's history, findings on physical examination, diagnosis, and specific items in the Guidelines supporting the proposed medical care or specific items supporting a variance.
 - b. if the person engaged by the insurer initially denies the request, then the treating medical provider may personally seek a telephone conference doctor-to-doctor with a doctor in a relevant (but not necessarily the same) specialty who is engaged by the insurer for review of the denial.
- Communications and discussions under this program which are limited to whether specific medical care requested is:
 - a. within the criteria of the Guidelines,
 - b. based on correct application of the Guidelines, or
 - c. a proper variance from the Guidelines in accordance with paragraph 3 of the implementation standards,
 are encouraged and are not in violation of WCL §13-a (6) (improperly influencing a treating physician's medical opinion) or the related WCB Chairman's Announcement, dated November 24, 2003, Subject No. 046-124. The insurer's response to a request that is not a violation based on the above, is not subject to the requirement in the Chairman's Announcement that written communications with health care providers be copied to opposing parties and their legal representatives.
- Participation in the pilot program by insurers shall be voluntary. The pilot program shall begin within 3 months of the effective date of the Guidelines and

shall be for a period of 1 year. The Board, in its discretion, may extend the period of the pilot program.

- An insurer's election to participate in the pilot program must be made prior to commencement of the program. If an insurer seeks to participate in the program after its commencement, participation by that insurer shall be at the discretion of the Board. An insurer that is participating in the pilot program may opt-out of the program at any time by notifying the Board, provided that such opt-out shall be deemed effective at the beginning of the month following the month in which the Board is notified of the opt-out.
- The WCB shall maintain on its website a current list of insurers participating in the pilot program.