Assessment of Public Comment

During the public comment period, the Board received approximately 11 unique written comments.

Comments on the proposal generally

The Board received two comments from the same individual expressing concern that the Board dismissed previous comments made by the individual in the original proposal, quoting part of the previous assessment of public comment. Because the quoted part of the assessment of public comment was not referring to this individual’s comments, and these comments do not deal with the substance of the revised proposal, no change has been made in response to these comments.

The Board received two additional comments from the same individual opining that the administrative requirements for filing reports and treatment plans, etc. will dilute time needed to treat patients and is overwhelming and unnecessary. The Board believes that the requirements outlined in the MTGs are reasonable and necessary to ensure quality care for injured workers, so no change has been made in response to this comment. Nowhere in the MTGs is it suggested that providers should reduce clinically indicated time spent in the treatment of injured workers in order to address administrative tasks, so no change has been made in response to these comments.

The Board received a comment from the same individual opining that enabling insurance carriers to be the first to decide if a request for additional care is necessary is a conflict of interest, as well as further concerns about insurance companies. This comment is a commentary on the systems and processes that are presently in place under existing Workers’ Compensation law, and does not address any of the clinical recommendations that are made in the MTGs, and therefore no change was made in response to this comment.

The Board received a comment from the same individual and another individual expressing concerns that many patients will not have access to the care they need with these proposed medical treatment guidelines, especially requiring existing patients to be bound to the MTGs. The MTGs represent the evidence-based standard of care for ill and injured workers in the NYS WC System. Implementation of new MTGs has always defined the evidence-based standard of care for workers with new and existing diagnoses, and have been clinically applicable to all patients with corresponding diagnoses, even those whose dates of injuries predate the implementation of the MTG. To do otherwise would be to deny ill and injured workers whose dates of injuries predate the MTG the benefit of having the most up-to-date, evidence-based standard of care, and by definition would relegate such ill and injured workers to a substandard of care. The MTGs are not intended to, and nor should they, deny ill/injured workers appropriate care. The MTGs should, however, give providers the opportunity to take measure of the care they are providing to each patient and assure that the care meets the evidence-based standard. The Board believes the MTGs accomplish these goals, so no change has been made in response to these comments.
One comment expressed concerns about the system for submitting requests being a barrier to treatment. This comment is a commentary on the systems and processes that are presently in place under existing Workers' Compensation law, and do not address any of the clinical recommendations that are made in the MTGs, so no change has been made in response to this comment.

One of the comments received requested no testing limit for the initial intake and assessment and a three-hour testing limit for reassessment. The request for unlimited testing for initial intake and assessment is inconsistent with the evidence-based medical literature, comparable medical treatment guidelines, and expert consensus opinion, so no change has been made in response to this comment.

The Board received several comments requesting that the session lengths, frequency, and duration should be determined by the psychologist with the patient, not the MTGs, and that it should not be a one-size-fits-all approach. The guidelines do not set hard and fast limits on the number, frequency and duration of clinical engagements. Rather, they set evidence-based guidance for the duration and frequency of treatment, allowing for expected variability on a case-by-case basis. The WC system gives providers ample opportunity to articulate the need for such variability for any given patient, on a case-by-case basis, so no change has been made in response to these comments.

The Board received a comment expressing concern that the proposed guidelines do not have a process for obtaining additional time for treatment if it's necessary beyond the limits in the guidelines. Because the prior authorization process already exists to address situations where treatment may necessarily differ from the MTGs, no change has been made in response to this comment.

One of the comments requested a brief reassessment for Degree of Disability every four months be added to the MTGs. The commenter provides no evidence basis for requiring a reassessment of "Degree of Disability" every four months. Providers are required to comment on degree of disability at the time of each clinical encounter. Absent a significant change in a patient's clinical/functional status, there is no evidence basis for requiring a "formal" reassessment of a patient's functional status every four months, beyond the assessments that can and should be made as part of routine follow-up care, without requiring additional, extensive and unnecessary batteries of tests. Therefore, no change has been made in response to this comment.

This comment also requested a full battery reassessment and reevaluation report to be completed at 12 months to determine if MMI has been reached. The commenter provides no evidence basis for requiring a "full battery reassessment and reevaluation report to be completed at 12 months to determine MMI". Providers are required to comment on degree of disability at the time of each clinical encounter. Individuals will reach MMI at different rates and at different times during the course of their care. The extent of testing required to determine MMI (and permanent impairment, if any) is determined on a case-by-case basis. For many, a "full battery reassessment" is not required. Providers routinely make assessments of disability, impairment and MMI status as part of routine follow-up care, without requiring additional, extensive and unnecessary batteries of tests. Therefore, no change has been made in response to this comment.
The comment also opined that patients continue to get IMEs per the insurance carrier. Because this comment is a commentary on the systems and processes that are presently in place under existing Workers’ Compensation law, and does not address any of the clinical recommendations that are made in the MTGs, no change has been made in response to this comment.

The comment also requested that brief reassessments with objective assessments associated with the presenting diagnosis and patients given measures to assess impact of pain on psychological functioning if needed, based on clinical examination findings. The MTGs address the interaction between pain and psychological functioning. Therefore, no change to the MTGs has been made in response to this comment.

The Board received a comment from an association expressing concern that the Psychology Practice Committee was not consulted in drafting the proposed MTGs. The NYS WCB recognizes the knowledge and experience of the members of the WCB Psychology Practice Committee. To that end, as with any providers whose expertise is recognized by the Board, they were/are encouraged to submit comments during the public comment periods of these MTGs. Therefore, no change has been made in response to this comment.

**Comments on the PTSD MTG proposal**

The Board received a comment requesting clarification if sertraline, venlafaxine, and paroxetine explicitly first-line for PTSD treatment, or are they only preferred before a trial of mirtazapine, and if sertraline, venlafaxine, and paroxetine are first-line across the board, then is fluoxetine also first-line for PTSD, or if it in a lower tier than sertraline, venlafaxine, and paroxetine. Typically in the MTGs, the Board does not classify recommended medications as "first-line". The Board does specifically identify "second line" medications, along with conditions that would typically have to be met prior to the use of the second line medication (e.g. trial of first line medications). No change has been made in response to this comment.

The comment also requested clarification about sections I.1.e Escitalopram and I.1.f Citalopram, specifically whether the recommendation is also true for patients who have not responded to paroxetine and venlafaxine (and fluoxetine), or is a failed trial of sertraline the only prerequisite to a trial of escitalopram or citalopram. These sections of the MTGs are intended to be implemented as written. Escitalopram and Citalopram are considered second-line medications in the treatment of PTSD, and should only be prescribed in instances where patients have not responded to sertraline. That said, the MTGs do not state that sertraline is the only medication that should be tried prior to the use of escitalopram or citalopram, as many providers will try multiple, different first-line medications prior to utilizing a second-line medication. Such clinical decision-making is typically made on a case-by-case basis, based on the clinical situation. No change has been made in response to this comment.

One of the comments requested a change to allow frequency of treatment to be based on the treating therapist’s idea of the degree of disability. The MTGs provide evidence-based guidelines for the frequency of treatment that is based on clinical necessity and efficacy, so no change has been made in response to this comment.
The Board received two comments requesting that every patient be allowed 6-9 months of weekly treatment, continuing on differing schedules based on MMI and/or degree of disability. The MTGs provide evidence-based guidelines for the frequency and duration of treatment that is based on clinical necessity and efficacy. Therefore, no change has been made in response to these comments.

The Board received a comment from an individual stating that they suffer from PTSD and do not want their treatment stopped. Because the comment does not reference any specific concern with the proposed regulation, no change has been made in response to this comment.

Changes made:
- Changed effective date in the text from July 7, 2021 to November 1, 2021
- Clarifying change in the text for where to obtain copies of the MTGs (added the Board’s website URL)
- Clarifying change in the preauthorization section of the MTGs to reference the section of the regulation where the list of Special Services is found