Assessment of Public Comment

During the public comment period, the Board received approximately 68 unique written comments and two copies of a form letter.

Comments on the proposal generally

The Board received several comments disagreeing with the proposals generally, with no suggestions or specific points of concern. Therefore, the Board has made no changes in response to these comments.

Many of the comments from providers, attorneys, and associations disagreed with the proposed guidelines as far as limiting the number of therapy visits and applying a “one size fits all” approach to treatment. It should be noted that the Medical Treatment Guidelines do not set hard and fast limits on the number and duration of therapy visits in a "one size fits all" manner. Rather, it is stated repeatedly that treatment plans are derived on a case-specific basis. Therefore, no change has been made in response to these comments. However, it should be noted that the case-specific nature of care was further reiterated throughout the guideline in order to underscore this point.

The Board received several comments from providers taking issue with the statement in the proposed guidelines that the WCB and medical advisory committee have not independently evaluated/vetted scientific medical literature but have relied on methodology by developers of various guidelines. The Board relies on evidence-based guidelines, medical literature, subject matter experts, and expert opinion received during public comment periods that have basis in the evidence-based medical literature. Accordingly, no change has been made as a result of this comment.

The Board received several comments from individual providers providing personal anecdotes of patients illustrating disagreement with the proposal generally. Because these comments did not express specific concerns or suggestions, no change was made in response to these comments.

Several comments expressed concern that the proposed guidelines seem to push medication when behavioral treatment should be considered more effective, as well as that the proposal focuses on symptom reduction instead of functional ability. The MTGs do not inherently favor pharmacologic interventions over behavioral interventions. Such determinations are typically based on the specific facts of any given case. The guidelines focus on both clinical and functional improvement. Therefore, no change has been made in response to these comments.

One comment recommended including mood stabilizers and stimulation medications in the proposal. The Board believes, based on the medical evidence, expert guidance, and public comment that the recommended pharmacologic interventions represent best practice. Requests for other interventions may be sought through the prior authorization process, provided there is appropriate medical justification. Therefore, no change has been made in response to this comment.
One comment also requested that a wider variety of benzodiazepines be available. The Board believes, based on the medical evidence, expert guidance, and public comment that the recommended pharmacologic interventions represent best practice. Requests for other interventions may be sought through the prior authorization process, provided there is appropriate medical justification. Therefore, no change has been made in response to this comment.

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The Board received a comment opining that supportive therapy should be included as a recommended treatment. The Board believes, based on the medical evidence, expert guidance, and public comment that the recommended array of therapeutic interventions represents best practice. Requests for other interventions may be sought through the prior authorization process, provided there is appropriate medical justification. Therefore, no change has been made in response to this comment.

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One comment expressed concern that fraud and administrative burdens would be increased with the proposal. The Board believes that by promoting clinical best practices, administrative burden should be reduced, and sees no connection with an assertion of increased fraud. Therefore, no change has been made in response to this comment.

One comment expressed concern that there is not enough time being spent before the proposals are set to be effective. The Board believes that the formal public notice and comment period, revised rulemaking in response to public comment, and subsequent effective date should provide ample time for providers to reinforce clinical best practices, so no change has been made in response to this comment.

The Board also received several comments expressing confusion and/or frustration about the implementation of the drug formulary. As the drug formulary is not part of this proposal, the Board has not made any change to this proposal in response to these comments.

One comment also recommended delaying all psychiatry MTGs until there is a psychiatric formulary released simultaneously. The Board notes that updates to the existing formulary, incorporating the recommendations in these guidelines, will be made prior to the effective date of the guidelines, so no change has been made in response to these comments.

One comment from several providers requested that the Board acquire and publish data accurately reflecting the scope of work-related mental illness, as well as an accurate statewide accounting of resources available to treat mental health issues. While the Board appreciates this suggestion, which raises important questions, this is beyond the scope of this review, comment and response related to the medical treatment guidelines, so no change has been made in response to this comment. The comment also stated that the proposed guidelines are well-researched and clearly written, but contain insufficient emphasis on issues related to suicidal thoughts and prevention. The guidelines do encourage providers to be vigilant for any
indications that an individual might pose a threat to self or to others, and recommend escalation of the type and intensity of clinical services or interventions when indicated.

One comment requested that the WCB Psychology Practice Committee be consulted for the proposed guidelines and going forward. The Board has utilized widely accepted, evidence-based medical guidelines, as well as input from acknowledged subject matter experts in the generation of this MTG. While it may not be the specific function of the WCB Psychology Practice Committee to consult on the development of such guidelines, the Board always welcomes the comments of Committee members on these or related guidelines.

A form letter received from individual providers summarized perceived deficiencies in the proposal, including cultural awareness and competence, that issues of chronic pain and disability, as well as suicidality were not addressed, as well as psycho-social impact. The Board believes that all parties engaged in the Workers' Compensation System should comport themselves with cultural awareness and competence, and that such considerations should not be confined to any one MTG. Issues of chronic pain, disability, psycho-social impact and suicidality are addressed in the MTGs, so no change has been made in response to this form letter.

The Board received a comment from a provider opining that many of the evaluation sections and timelines are not supported by research and clinical practice. The comment did not include any evidence from the medical literature to support this assertion, and failed to recognize the multiple areas of the MTGs in which it is clearly stated that there may be variability in responses to treatment and treatment durations, so no change has been made in response to this comment.

The Board received a comment from an association generally agreeing with the addition of the proposed guidelines, but recommending the addition of duration, frequency, and specific types of alternative treatment (like yoga and exercise) to the proposal. The Board believes, based on the medical evidence, expert guidance, and public comment that the recommended array of therapeutic interventions represents best practice. Requests for other interventions may be sought through the prior authorization process, provided there is appropriate medical justification, so no change has been made in response to this comment.

The Board received a comment from an attorney requesting that the proposal be changed to allow providers to treat and allow carriers to challenge recommendations for treatment with an IME rather than MTGs. The MTG is designed to promote clinical best practices, and the mechanism by which claims are administered or adjudicated is beyond the scope of this MTG, so no change has been made in response to this comment.

PTSD
Two comments supported the inclusion of an atypical antipsychotic as a treatment option but suggested including several other medications as well. The Board believes, based on the medical evidence, expert guidance, and public comment that the recommended pharmacologic interventions represent best practice. Requests for other interventions may be sought through the prior authorization process, provided there is appropriate medical justification, so no change has been made in response to this comment.
One comment expressed concern that delayed onset PTSD is not included in the proposal. The Board has modified the MTG to include this in response to this comment.

The Board received a comment from a provider on the patient response section of the proposal stating that it takes much longer than 2-4 weeks for someone with PTSD to improve. The entirety of Section A (General Guideline Principles) has been reviewed by the Board's Medical Advisory Committee, and updates and modifications have been made throughout Section A which address this concern about PTSD, as well as other conditions.

The Board received a comment from a provider disagreeing with the diagnostic timeframes in the proposal, opining that it does not allow for clinical judgment. The entirety of Section A (General Guideline Principles) has been reviewed by the Board's Medical Advisory Committee, and updates and modifications have been made throughout Section A which address this concern about PTSD, as well as other conditions.

The Board received a comment from a provider disagreeing with the psychological and psychiatric evaluations sections of the proposal, stating that the majority of workers with PTSD have more than one diagnosis. The entirety of Section A (General Guideline Principles) has been reviewed by the Board's Medical Advisory Committee, and updates and modifications have been made throughout Section A which address this concern about PTSD, as well as other conditions.

The Board received a comment from a provider indicating that the statistics are misleading and disagreeing with the proposal, and that the timelines are not supported by literature or clinical practice. The Board would comment that the statistics provided come from the medical literature, and the MTG clearly states that a significant percentage of patients develop chronic PTSD, so no change has been made in response to this comment.

The Board received a comment from a provider opining that a PTSD assessment scale should be administered and reviewed by the examiner for their validity. The MTG supports the use of appropriately administered diagnostic testing, so no change has been made in response to this comment.

**Depression**

One comment expressed concern that “depressive disorder due to another condition” is not included in the proposal. The Board has modified the MTG accordingly to include this and other diagnoses.

One comment disagreed with Venlafaxine and Bupropion only being included in the immediate release formulation. The Board believes, based on the medical evidence, expert guidance, and public comment that the recommended pharmacologic interventions represent best practice. Requests for other interventions may be sought through the prior authorization process, provided there is appropriate medical justification, so no change has been made in response to this comment.
One comment also recommended classifying trazodone as a medication for insomnia. The Board believes, based on the medical evidence, expert guidance, and public comment that the recommended pharmacologic interventions represent best practice. Requests for other interventions may be sought through the prior authorization process, provided there is appropriate medical justification, so no change has been made in response to this comment.

One comment pointed out that the PTSD guidelines provide for 3-12 months for PTSD psychological intervention, but the Depression guideline does not contain a similar provision, and questioned whether this was intentional. The Board believes that this represents an oversimplification and mischaracterization of the content of the guidelines. That notwithstanding, an effort has been made to clarify certain elements of both guidelines in response to this comment.

One comment supported the proposal generally, but suggested a modification to section A16, changing three hours to five hours for a follow-up assessment at a minimum. The entirety of Section A (General Guideline Principles) has been reviewed by the Board's Medical Advisory Committee, and updates and modifications have been made throughout Section A, including A16.

The Board received a comment from a provider opining that psychological testing is necessary as part of the intake process to identify issues. This is an incorrect interpretation of the MTGs as nowhere in either MTG does it state that psychological testing should not be part of the "intake." Accordingly, no change has been made in response to this comment.

The Board received a comment from a provider stating they believe a test assessing the severity of depression should be administered and reviewed. The Board appreciates the comment, and points out that such testing is already included, so no change has been made in response to this comment.

Changes made:
- Corrected a typographical error to clarify treatment of carpal tunnel syndrome before and after the Hand, Wrist and Forearm MTG becomes effective
- The entirety of Section A (General Guideline Principles) has been reviewed by the Board's Medical Advisory Committee, and updates and modifications have been made throughout Section A
- Language was added to both the Depression and PTSD guidelines warning about the inherent risks of polypharmacy. In addition, language was added to both guidelines advising that for long-term, chronic patients who are clinically and functionally stable, prescription refills and follow-up dates should be coordinated by both providers and insurers/PBMs to assure that there is continuity of treatment between follow-up visits.
- The effective date of the new MTGs changed to July 7, 2021 in the text of 324.2.
- Amended subdivision (b) of section 324.2 to clarify where copies of the New York MTGs may be obtained

Depression MTG Changes
• Changed name of MTG from New York Major Depressive Disorder Medical Treatment Guideline to New York Work-Related Depression and Depressive Disorders Medical Treatment Guideline
• Added DSM-5 diagnoses: depressive disorder due to another medical condition, adjustment disorder, and substance/medication-induced depression
• Added DSM-5 diagnostic criteria tables
• Added treatment and overview sentence reading: “For DDD due to other medical conditions, substances or medications, it is critical that the underlying cause of the DDD be addressed.”
• Added Cognitive Behavioral Therapy (CBT) paragraph reading: “Treatment frequency and duration may vary, based on case-specific circumstances. The healthcare provider must provide medical explanation and/or justification for deviation in frequency/duration from these guidelines. While this documentation is typically provided on a monthly basis during the acute phase of illness, for patients who have transitioned to a long-term, chronic phase of illness, and who are stable on existing treatment, this medical documentation can be provided every two to three months, in conjunction with regular clinical follow-up at those intervals. Care should be taken that such longer periods between clinic visits and reporting do not result in gaps in care.”
• Added notes regarding Pharmacotherapy to section B.3.b.ii
• Changed reference to MDD (Major Depressive Disorder) to Work-Related Depression and Depressive Disorders (DDD) throughout
• Modified medications sentence to read: “Discontinuation of Antidepressant Therapy – Should be done with a slow taper since [withdrawal] discontinuation done too rapidly may result in adverse withdrawal symptoms.”
• Clarified that Antipsychotics in section B.5.b.iii and electroconvulsive therapy (ECT) in section B.5.c. are only appropriate for Major Depressive Disorder and not all diagnoses addressed in the modified MTG

Post-Traumatic Stress Disorder MTG Changes

• Treatment Overview Sentence added reading “There may be occasional, subtle variations to treatment approaches, on a case-specific basis, when the provider can justify such variation with a medically evidence-based rationale.”
• Medication notes regarding medications added to Work-Related Depression and Depressive Disorders were also added to PTSD