

Assessment of Public Comment

During the revised rule making period, the Chair and Board received approximately 282 unique formal written comments, and approximately 226 additional form letters, as well as approximately 100 postcards. The Board also received several comments and postcards after the close of the public comment period. Within the unique comments received, there were several requests for information. These communications have been responded to individually and are not summarized here. The comments received are summarized below.

Medical Fee Schedule

The Board received two comments concerning Ground Rule 11, opining that supervision of a PA or NP should be paid at 100%, not 80%. Because a physician is not actually providing the treatment, and because the requirements for supervision no longer require the physician to be on-site when treatment is rendered, no change has been made as a result of this comment. It is believed that the 80% reimbursement rate conforms to the method of reimbursement for other types of insurance.

The Board received three comments highlighting a typographical error in Physical Medicine Ground Rule 11, where CPT code 97101 should say 97010. This typo has been corrected.

The Board received a comment from a group expressing concern about the provision of the proposal applying the fee schedules to out of state providers. No comment was received on the Board's initial proposal regarding medical fees for out of state treatment and no changes were made to this section in the revised rule making. In its comment this group cited to a 1993 case *Conn v. Kotasek* (198 AD2d 600) to support its contention that the New York Workers' Compensation Medical Fee Schedule does not apply to out of state treatment. In the *Conn* case, the Appellate Division affirmed the Board's finding that the person injured in New York but living in Florida was entitled to medical treatment in Florida and the medical provider should be paid at the Florida fee schedule. The proposed Ground Rule does not change this holding, but rather addresses the fees that may be charged for out-of-state treatment when the injured worker lives in New York State: Payment shall be made to the medical provider using the regional conversion factor for the zip code where the claimant resides. Accordingly, no change has been made in response to this comment.

The Board received several comments concerning the changes to Ground Rule 12 to conform this Ground Rule to the requirements contained in the Board's Non-Acute Pain Medical Treatment Guidelines (NAP MTG). These commenters express concern about the sensitivity of immunoassays used for drug screening; about the urine drug test rules in the proposal generally; expressing disagreement with the limitation on confirmatory testing when there are red flags. As the in-office screening and circumstances available for confirmatory lab testing mirror the testing requirements and protocols set forth in the Board's NAP MTG, which sets forth the treatment standard for managing non-acute pain, the rules governing payment for this type of screening must conform to the NAP MTG. It is noted that contrary to some comments received, confirmatory lab testing is always available when the in-office screening reveals an unexplained positive or negative test and that immunoassay tests are available to screen for fentanyl. Finally,

several commenters want the fees for such testing to increase. As these fees reflect substantial increases over Medicare Fees for the same tests, no changes have been made in response to these comments.

The Board received a comment disagreeing with the removal of the words “at least” in Ground Rule 12, and cited concerns about the impact on No-Fault patients. To the extent that commenters believe that the Medical Fee Schedule proposal impacts No-Fault, those comments should be directed to DFS as to their application to the No-Fault system. The Board does not have jurisdiction over No-Fault and therefore may not make statements as to the applicability of any of its rules to the No-Fault system. No change has been made in response to this comment.

The Board received many comments from individuals, physicians, companies, and form letters disagreeing with physical medicine Ground Rule 2 – specifically, the 12 sessions/180-day limitation. Many of these comments opined that 12 visits or 180 days is not enough time for injuries to heal, and that the rule is not based on medical evidence, as well as concerns about continuing their business with this rule in place. Several comments also cited concerns about the impact on No-Fault insurance. In response to these comments, the Board has decided not to implement this change, so Ground Rule 2 will read as it did previously: “Physical medicine services in excess of 12 treatments or after 45 days from the first treatment, require documentation that includes physician certification of medical necessity for continued treatment, progress notes, and treatment plans. This documentation should be submitted to the insurance carrier as part of the claim.” This limitation has been removed wherever it appeared.

The Board also received one comment from an assembly member and several form letters requesting that the RVU cap for physical therapy be increased from 8 to 16 RVUs. The revised proposal reflects an increase from 8 RVUs to 12 RVUs per patient, and increased the available RVUs for initial evaluations and reevaluations. Accordingly, no change has been made in response to these comments.

The Board also received a number of comments from an insurance companies requesting that the Board decrease the proposal from 12 RVUs back to the 8 in place in the original proposal. As the Board noted in its original Assessment of Public Comment, the Board received over 600 comments objecting to the 8 RVUs in the previous proposal. Accordingly, no change has been made in response to these comments. To the extent that commenters believe that the medical fee schedule proposal impacts No-Fault, those comments should be directed to DFS as to their application to the No-Fault system. The Board does not have jurisdiction over No-Fault and therefore may not make statements as to the applicability of any of its rules to the No-Fault system.

The Board received one comment opining that allowing physical therapists to do acupuncture or acupuncture modalities is dangerous. The Medical Fee Schedule does not permit any provider to perform services for which they do not possess the appropriate licensing and/or certification. The presence of acupuncture codes within the Physical Medicine section of the Medical Fee Schedule means that physicians and physical therapists who are trained in acupuncture and have proper accreditation may bill for administering these techniques when medically necessary. These codes

have always been present in the Medical Fee Schedule. Accordingly, no change has been made as a result of this comment.

Two commenters suggest that CPT codes 97161-97163 and 97165-97167 should not be available for self-employed physical therapists and occupational therapists as this treatment is redundant when a referral has been made by a physician. While the CPT codes have been updated in this proposal, the services that may be billed remain un-changed from the 2101 MFS. Such evaluations may be performed by self-employed physical and occupational therapists as medically necessary and consistent with the MTG.

The Board received a number of comments and form letters objecting to the change in CPT codes that will result in reductions in reimbursement for EDX studies and testing. Needle EMG tests have received a proportionate increase. Surface EMGs are not recommended under the Medical Treatment Guidelines and therefore do not have a fee associated with this service. Fees for NCV reflect changes to the CPT codes themselves, as created by the American Medical Association (“AMA”), and the method for billing for such services. It is noted that NCV studies under the proposed Medical Fee Schedule will still be reimbursed at 200% of the Medicare level. Accordingly, no change to the proposal has been made in response to these comments.

The Board received comments seeking to limit the types of providers who may perform EDX testing under the WCL and describing when an EDX may be performed. The purpose of Medical Fee Schedule is to identify the fee for medical services. The Medical Fee Schedule does not limit how treatment may be rendered under the Workers’ Compensation Law and other relevant New York State statutes, the MTG or other regulations. Accordingly, no change has been made in response to these comments.

The Board also received a comment from a group requesting clarification about changes to the Biofeedback Ground Rule and whether evaluation reports are no longer required. The proposed Biofeedback Ground Rule was modified to reflect updates from the Medical Treatment Guidelines. The evaluation report sentence was excluded as reports are due for any medical treatment under the Workers’ Compensation Law. No change has been made as a result of this comment.

The Board received a comment requesting CPT code 95941 or G codes be included, and objecting to requiring her presence in the operating room for 1:1 supervision. The Workers’ Compensation Law does not permit remote monitoring of surgery by a supervising physician and the Board Medical Fee Schedule does not use G codes or any other CMS Hcpcs codes. The Medical Fee Schedule uses CPT codes. Accordingly, no change has been made in response to this comment.

The Board received a comment from an insurance company requesting that the Board clarify in its proposal what percent each provider would be reimbursed when there are co-surgeons, and recommend that the Board adopt the Medicare guidelines for this. The Medical Fee Schedule sets forth the maximum reimbursement when more than one surgeon participates in a surgery. Under the Workers’ Compensation Law, the surgeons should determine what proportion of this maximum reimbursement is payable to each. In the event the surgeons cannot agree as to the

amount of the apportionment, then such bill for services is subject to arbitration under the Workers' Compensation Law. These arbitration services are presently available to co-surgeons but are used rarely. Accordingly, no change has been made a result of this comment. To the extent that commenters believe that the medical fee schedule proposal impacts No-Fault, those comments should be directed to DFS as to their application to the No-Fault system. The Board does not have jurisdiction over No-Fault and therefore may not make statements as to the applicability of any of its rules to the No-Fault system.

The Board received form letters that expressed concern that fees are adjusted under a diagnostic testing network testing "DTN" contract. Such fees are contractual in nature, the contracts are permitted by statute, and physicians are not compelled to join DTNs. Thus, the terms of DTN contracts are not within the Board's purview and no change has been made in response to this form letter.

The Board received a comment requesting that Ground Rule 10 be amended to permit a 50% testimony fee to the provider if a deposition is cancelled on short notice. While the Chair has authority to set fees for medical services rendered, neither the Chair nor the Board has authority to impose fees on carriers when no service has been rendered such as when a telephone deposition or medical appointment is cancelled or rescheduled. Accordingly, no change has been made as a result of this comment.

The Board received a comment requesting that chiropractors be paid for medical testimony at the same rate as physicians. The Chair increased testimony fees for all providers by 50 dollars. Accordingly, no change has been made in response to this comment.

Chiropractic Fee Schedule

The Board received a number of comments from chiropractors and associations who want higher fees. This proposal increased fees for all providers including chiropractors. No change has been made a result of this comment.

The Board received a comment objecting to the removal of CPT code 97750, and says that the reasoning in the Board's original assessment explaining the removal is incorrect. The comment also opines that CPT code 95999 should not have an RVU of 0. These comments were fully considered in the initial review of public comments and addressed in the Assessment of Public Comment for the first proposal. Accordingly, no change has been made in response to this comment.

The Board received many comments objecting to the limitation of 180 days in chiropractic Ground Rule 3. Several of these comments also expressed concerns about physical medicine Ground Rule 2, discussed above. Some of the comments also provided suggested language changes. In response to these comments, the Board has decided not to implement this change, so the 180-day limitation has been removed.

The Board received a comment opining that surface EMG should be permitted. As discussed above, surface EMGs are not recommended under the Medical Treatment Guidelines. Accordingly, no change has been made in response to this comment.

The Board received a comment from a group supporting the proposed changes to chiropractic Ground Rule 11.

The Board received several comments disagreeing with the removal of some specific CPT codes from the Chiropractic Fee Schedule, and reduction in reimbursement rates generally. As the Board mentioned in its original Assessment of Public Comment, the Board did not decrease reimbursement rates and increased the RVUs for chiropractors. To the extent that any fees have declined, it is due to modification of the CPT codes themselves since 2012 and earlier, so no change has been made in response to these comments.

The Board received several comments from chiropractors and individuals objecting to the proposed changes impacting manipulation under anesthesia (MUA). As the Board stated in its original Assessment of Public Comment, MUA is not recommended under the Medical Treatment Guidelines. Accordingly, no change has been made as a result of these comments.

The Board received several comments from chiropractors opining that spinal decompression treatment should not be limited. As the Board noted in its original Assessment of Public Comment, spinal decompression is not recommended under the medical treatment guidelines. Accordingly, no change has been made as a result of these comments.

The Board received several comments objecting to chiropractic Ground Rule 10. Ground Rule 10 clarifies that chiropractors must bill using the Chiropractic Fee Schedule, and this clarification has been added to the podiatry and psychology fee schedules as well. Under the Workers' Compensation law, chiropractors have never been permitted to bill using codes that do not appear in the Chiropractic Fee Schedule, and such bills will not be enforced by the Board's Disputed Medical Bills Unit or the arbitration committees. This statement was included only for clarification of this existing rule. Accordingly, no change has been made as a result of these comments.

The Board received comments disagreeing with the limitations on manual clinical muscle testing systems. As noted in the Board's first Assessment of Public Comment, such manual testing is included in the fee for E & M services. Accordingly, no change has been made as a result of these comments.

The Board received a comment from a group requesting clarification in proposed Ground Rule 11 about whether unit-limitation reviews (15-unit and 18-unit rules) apply across the Board to all providers or if each provider is subject to their own rules. Under the Workers' Compensation Law, each provider is subject to his or her own rules – no change has been made in response to this comment.

Behavioral Health Fee Schedule

The Board received a number of comments objecting to the rule about supervision of non-authorized mental health professionals, opining that it does not make sense. As the Board noted in its original Assessment of Public Comment, this change was to clarify an area of confusion in the community. The Workers' Compensation Law (WCL) only permits supervision of non-authorized providers by *physicians*, in accordance with WCL § 13-b. There is no corollary

provision in WCL §13-m that permits psychologists to supervise non-authorized providers. Because only the legislature may amend the WCL, no change has been made in response to these comments.

The Board received a comment from a group objecting to the use of CPT code 97127, citing confusion. As this is the current CPT code in use for cognitive function testing, no change has been made in response to this comment.

General Comments

The Board received a number of comments from individuals and associations generally supporting the proposal.

The Board also received several comments and approximately 100 postcards disagreeing with any changes to the medical fee schedules at all, and offered no suggested changes. No changes have been made to the proposal in response to these comments and postcards.

The Board received a comment from an individual who requested that the medical fee schedules be published on the website instead of requiring hard copies to be published. The Medical Fee Schedule has always been published by an outside publisher. The Medical Fee Schedule is available for public review at Board offices, Supreme Court Libraries and Legislative Libraries in accordance with Rules governing materials Incorporated by Reference.

The Board received several comments and form letters expressing concerns about possible conflicts between the proposal and No-Fault statute and/or Insurance Law or DFS rules generally, and some of these comments request an amendment to the Ground Rules explicitly stating that they apply to Workers' Compensation but not No-Fault. To the extent that commenters believe that the medical fee schedule proposal impacts No-Fault, those comments should be directed to DFS as to their application to the No-Fault system. The Board does not have jurisdiction over No-Fault and therefore may not make statements as to the applicability of any of its rules to the No-Fault system.

The Board received a comment from an insurance company requesting that the Board make explicit in its proposal that out of state treatment rules do not apply to No-Fault. To the extent that commenters believe that the medical fee schedule proposal impacts No-Fault, those comments should be directed to DFS as to their application to No-Fault. The Board does not have jurisdiction over No-Fault and therefore may not make statements as to the applicability of any of its rules to the No-Fault system. No change has been made in response to this comment.

The Board received comments from insurance companies and one individual requesting the Board develop an acupuncture fee schedule with RVUs for cupping, moxibustion, and acupressure, as well as a massage therapy fee schedule. The Workers' Compensation Law does not permit treatment by acupuncturists or massage therapists accordingly there is no need for separate fee schedules for these types of treatment. No change has been made in response to these comments.

The Board also received comments from insurance companies requesting that a ground rule be written differentiating strapping and kinesio taping. The distinction between the two are contained within the descriptions in the CPT codes themselves. Strapping is a surgery code and may not be billed in Workers' Compensation by a physical therapist or chiropractor. As this rule is unchanged and has not been a problem in prior years, no change has been made a result of this comment. To the extent that commenters believe that the medical fee schedule proposal impacts No-Fault, those comments should be directed to DFS as to their application to the No-Fault system. The Board does not have jurisdiction over No-Fault and therefore may not make statements as to the applicability of any of its rules to the No-Fault system.

The Board received comments from insurance companies requesting that generic BR codes be eliminated. The Medical Fee Schedule has always used BR codes. In the event that there is a dispute over the amount of a bill or the proper usage of this code, the Workers' Compensation Law has the ability to resolve these disputes. Accordingly, no change has been made as a result of this comment. To the extent that commenters believe that the medical fee schedule proposal impacts No-Fault, those comments should be directed to DFS as to their application to the No-Fault system. The Board does not have jurisdiction over No-Fault and therefore may not make statements as to the applicability of any of its rules to the No-Fault system.

Summary of Changes

- The Board fixed a typographical error in Medical Fee Schedule Ground Rule 11, CPT code 97101 has been fixed to say 97010.
- The Board deleted an extra word ("is") from Physical Medicine Ground Rule 11 in the Medical Fee Schedule, which inadvertently read "the patient is may not..."
- The Board reverted back to the original language in Physical Medicine Ground Rule 2 in the Medical Fee Schedule. This reversion is also reflected in Physical Medicine Ground Rule 5 of the Medical Fee Schedule.
- The Board has also removed the 180-day limitation in the Chiropractic Fee Schedule Ground Rule 3.
- The Board has also corrected some errors in heading titles.