Assessment of Public Comment

The 45-day public comment period with respect to Proposed Rule I.D. No. WCB-26-10-00013-P commenced on June 30, 2010, and expired on August 16, 2010. The Chair and the Workers' Compensation Board (Board) received and accepted formal written public comments on the proposed rule through September 10, 2010.

The Chair and Board received approximately 3,196 formal written comments. Approximately 3,110 were form letters from four groups: 1) chiropractors; 2) physical therapists; or 3) individuals stating they were claimants either receiving chiropractic or physical therapy treatment. The remaining 86 comments were submitted by the Business Council of New York State, American Insurance Association, New York State Insurance Fund, Property Casualty Insurers Association of America, Consolidated Edison Company of New York, Inc., Lovell Safety Management Co., LLC, POMCO Group, Hamberger & Weiss, Concentra, Coventry Health Care, Actors' Equity Association 1913, New York State Society of Orthopaedic Surgeons, Neuromodulation Therapy Access Coalition, Medtronic Neuromodulation, Synthes Spine, Pfizer, New York State Chiropractic Association, New York Chiropractic Council, New York Physical Therapy Association, New York State Occupational Therapy Association, claimants, physicians, chiropractors, and physical therapists.

All of the comments received were reviewed and assessed. The comments break down into three groups: 1) those addressing the regulations; 2) those addressing the medical treatment guidelines incorporated by reference; and 3) the form letters. This assessment will summarize and respond to the comments in that order after providing some background.

BACKGROUND

By letter dated March 13, 2007, former Governor Spitzer directed the Superintendent of Insurance, with the assistance of the Chair of the Board and Commissioner of Labor to complete four tasks. One task was to develop medical guidelines for the treatment of claimants. In 2007, the Governor appointed an advisory

committee to assist the Superintendent comprised of representatives from Insurance Department, the Board, and Labor Department, and highly qualified and respected medical professionals selected by labor, business, and the Insurance Department. After months of work, the advisory committee submitted to the Superintendent drafting medical treatment guidelines (Guidelines) for the neck, back, shoulder, and knee that all providers would be required to use when treating claimants with injuries to those body parts. On December 3, 2007, the Superintendent formally submitted the Guidelines to the Chair along with a proposed Medical Treatment Guidelines Education Plan, and in June 2008, proposed Implementation and Process Standards for the New York State Medical Treatment Guidelines.

In developing the Guidelines, the advisory committee performed a thorough review of available state-developed workers' compensation treatment guidelines, the American College of Occupational and Environmental Medicine (ACOEM) guidelines, and two commercially available guidelines, McKesson and Official Disability Guidelines. The advisory committee limited its consideration to guidelines that were used for treating work-related injuries. The advisory committee decided to use already existing guidelines for the body parts, with modifications. For the mid and low back, the advisory committee chose Chapter 12, Low Back Disorders (Revised 2007), of the Occupational Medicine Practice Guidelines, 2nd Edition published and copyrighted by the American College of Occupational and Environmental Medicine. For the neck, knee, and shoulder, the advisory committee chose the State of Colorado's treatment guidelines found in Exhibit 4 (Shoulder), Exhibit 6 (Lower Extremity), and Exhibit 8 (Cervical Spine Injury) of Rule 17, Medical Treatment Guidelines. Charts from the Washington State guidelines were used to supplement the Knee and Shoulder guidelines. The charts provided an easy mechanism to summarize treatment and surgical recommendations.

Soon after the recommended guidelines were submitted to the Chair, various entities began to submit comments and request meetings to discuss the guidelines. The Chair granted such requests. On January 26, 2009, the Chair issued a notice, which was posted on the Board's website, recommending that medical

providers and others become familiar with the Guidelines. During this time the Chair was working to obtain the medical services of a highly respected physician specializing in occupational medicine to serve as the Board's Medical Director. In June 2009, Stephen Levin, M.D. became the Board's Interim Medical Director. Thereafter on August 13, 2009, the Chair issued a notice advising the public that comments on the Guidelines would be accepted through September 9, 2009. The notice also stated that after that date the Medical Director and Board staff would evaluate all comments, as well as recent developments in medical treatment guidelines, and incorporate into the Guidelines those changes that are most important to patient well-being and supported by medical literature. Comments received after September 9th and comments received that were not incorporated, would be retained and considered during the regular process of review and updating of the Guidelines. The Medical Director and Board staff reviewed the comments, made revisions based on the comments and evidence received, and on January 19, 2010, revised guidelines were released. Final guidelines were released on June 30, 2010.

During this time period, regulations to implement the Guidelines, based in part on the implementation standards recommended by the Superintendent, were being drafted. Before finalizing the regulations, the Chair and Board sought comments and input from business, labor, and others. Many of the comments received during the public comment period were received and evaluated before the rule was proposed.

COMMENTS ON REGULATIONS

COMMENT:

Some comments expressed concern with the implementation schedule for the regulations and the medical treatment guidelines. Basically, there were concerns that the one month allotted for training and implementation of the new processes was not sufficient. One comment requested a six month implementation timeline.

RESPONSE:

In response to these comments, it was decided to delay the effective date of the regulations and Guidelines until December 1, 2010. This delay will provide everyone with an additional month to take the training and incorporate the new forms and processes into their operations. The Chair did not delay the effective date to allow for a six month implementation timeline because it is too long and not necessary. The training on the Guidelines and the processes will be available continuously and easily accessible through the Board's website. Therefore, the training can be complete within the two month period.

COMMENT:

One comment notes that the regulations include three different processes (variances, optional prior approval, and authorization of special services) which have different time frames, different credentials for those who can approve or deny requests, different appeals processes, and other issues. Further, it is unclear to the commentator which of the processes, if any, is to be used with regard to treatments excluded from the pre-authorized list or repeated surgeries. The commentator feels that the creation of these multiple processes will create confusion for claimants, treating physicians, carriers and other stakeholders, resulting in a more adversarial system, increased complaints and delay in care and suggests that it all be dealt with in one system. Finally, the commentator states that the relationship between the requirements in the proposed rule and utilization review programs already used by certified PPOs and IME programs operating under existing rules must be clarified.

RESPONSE:

No changes are warranted by these comments. First, the Board conducted a pilot program in which treating providers and insurance carriers agreed to use the Guidelines and the variance and optional prior approval processes. The major difference between the pilot program and these regulations is that all disputes were resolved by the Board's Medical Director in the pilot program. The participants in the pilot did not notify the Board of any confusion over the different time frames. Second, so that claimants, providers, insurance carriers,

and others know each of the processes, the Board has developed training that is available free of charge. The training is web based or eLearning so it can be taken at any time of the day from the comfort of a person's office or home. Third, the authorization for special services process is dictated by WCL §13-a (5) and should present no confusion as it remains basically the same. Fourth, the optional prior approval process is optional. There is no requirement that a provider opt-in or use the optional prior approval process and insurance carriers can opt-out of this process. This is intended to be a quick process that encourages providers to discuss issues with the insurance carrier and receive responses quickly so treatment can flow. When the provider and insurance carrier opt to participate in this process, part of that option is agreeing that any disputes will be resolved by the medical arbitrator as defined in the regulation. The medical arbitrator process enables review by medical professionals and final determinations to be issued quickly. The participants in the pilot support this dispute process. Fifth, the variance process is modeled after the process for the authorization of special services. Both require a response within 30 days and provide for the use of an IME. The variance process does differ in that if the insurance carrier does not intend to obtain a records review or IME, it must respond in 15 days, and must notify the Chair of this decision within five business days.

With respect to the assertion that the rule is unclear as to which process is to be used with regards to treatments excluded from the pre-authorized list; a reading of the regulation makes clear what process is to be used. Section §324.2 (d) (2) lists the medical procedures that cost more than $1,000 dollars and are not included in the pre-authorized procedures list; these procedures require authorization. As these procedures are excluded from the pre-authorized list and cost more than $1,000, the provider must request authorization, as stated in the regulation, using the process in §325-1.4. The excluded items are still within the Guidelines; they are just not pre-authorized.

Finally, certified Preferred Provider Organizations (PPOs) are authorized by WCL Article 10-A. Employers can elect to use a certified PPO to provide treatment to their workers who are injured on the job. If the

employer makes such an election, the employees must be notified of the PPO and must use a provider from within the PPO, but can elect to go outside the network 30 days after his or her first visit to a PPO provider. Section 325-8.6 of the regulations regarding PPOs provides that all rules and regulations of the Chair and Board are applicable to PPO arrangements except if they conflict with the WCL Article 10-A or Subpart 325-8. It is clear that the proposed regulations apply to PPOs. With respect to IME programs, the proposed rule provides for the use of IMEs and references the appropriate statute and rules. If an IME will be obtained to respond to a variance request then the claimant must receive seven business days notice, the report must conform to all of the requirements in the WCL and rules, and the report must be filed within ten business days of the IME. This is the same as currently required when an IME is obtained to respond to a request for authorization of special services and will be required under the amendments to §325-1.4 set forth in the proposed rule.

COMMENT:

One comment found the definition of "Insurance carrier or Special Fund's medical professional" to be unclear as to whether merely being employed by a URAC accredited company allows a non-medical professional to serve in the capacity outlined in the regulations and suggested the insertion of a colon after the word "practices."

RESPONSE:

The suggested insertion of the colon was accepted to clarify that a non-medical professional employed by a URAC accredited company does not qualify as an "Insurance carrier or Special Fund's medical professional."

COMMENT:

Three comments raised concerns about the definition of "Maximum Medical Improvement (MMI)." One comment expressed the following: 1) concern that the definition was vague and lacks any time parameter; 2) that the word "and" in the definition should be "or"; 3) that the goal should be for the doctor to state when further recovery or restoration of function is unlikely to occur; 4) that the committee working on impairment

guidelines developed a more refined definition of MMI; and 5) that more concise definitions are available from other states and one such definition (Texas) should be adopted. A second comment states the proposed definition is too subjective, will mean different things to different doctors, needs to be more uniform and objective, and provides a suggested alternative. Finally, the third comment sets forth that: 1) the proposed definition, and requiring it as a criteria for permanency, present serious obstacles to classification; 2) the proposed definition does not comport with the realities of the human condition and state of medical practice; 3) the definition should be reflective of the chronic, overall unchanging aspects of a medical condition as opposed to MMI; 4) the definition in this rule should not be used as a requirement for classification when the new rules and guidelines for impairment have been formulated and promulgated; and 4) the definition be consistent with current guidelines for non-schedule classification.

RESPONSE:

No changes were made to this definition. It was noted in one of the comments that the committee developing impairment guidelines developed a definition of MMI that starts with the definition in this rule, but adds the following language: "The need for palliative or symptomatic treatment does not preclude a finding of MMI. In cases that do not involve surgery or fractures, MMI cannot be determined prior to 6 months from the date of injury or disablement, unless otherwise agreed to by the parties." The proposed definition in this rule is consistent with the recommended definition from the impairment committee. The entity that submitted the comment that the proposed definition is vague, lacks a time parameter, and the "and" should be an "or," was a member of the committee that developed the impairment guideline definition of MMI. It is unclear why it raises these points with respect to the definition in these regulations, but supports the same language with respect to impairment guidelines. Further, the definition developed by the impairment committee does not address the time parameters in a meaningful manner. It is also not clear how the example from Texas suggested by this entity is any more precise as it uses phrases such as "no longer reasonably be anticipated." The

suggested example in the second comment also uses words such as “not reasonably expected”. The suggestions and the proposed definition are actually similar. Finally, the decision was made not to be consistent with the current medical guidelines, which are impairment guidelines, as they will soon be replaced, and do not actually define MMI but rather provide parameters when classification, a legal determination by the workers’ compensation law judge, is appropriate for non-scheduled impairments of extremities. The definition in this rule is consistent with the recommended definition for the impairment guidelines.

COMMENT:

One comment requested that fax be removed as an option of same day transmission, leaving e-mail or other electronic means as the sole means for certain requests and responses.

RESPONSE:

This suggestion was made before the regulation was proposed and was rejected. First, not all medical providers have access to the internet in their office and some do not use computers at all. Second, fax is a legitimate means of transmission, as evidenced by the use of it by the Board for the submission of appeals and other claims forms. Third, the Board began a pilot program testing use of the guidelines and the processes implementing them in November 2009. In the pilot, transmissions had to be by fax or email. No issues arose out of the use of fax. This suggestion was not accepted.

COMMENT:

Some comments requested that physicial therapists be included in the definition of “Treating Medical Provider” and thereby be permitted to request variances directly. The comments expressed concern that without this ability there will be delays in treatment.

RESPONSE:

During the drafting of the regulations careful consideration and discussion was given to including physical therapists within the definition of “Treating Medical Provider” and allowing them to request variances.

Ultimately it was decided not to include them in the definition and not to permit them to request variances. WCL §13-a requires claimants to treat with physicians who are authorized by the Chair to treat injured workers. WCL §§13-k, 13-l, and 13-m require claimants to treat with podiatrists, chiropractors, and psychologists who are authorized by the Chair. Physical therapists are not authorized by the Chair to treat claimants, are not authorized under the WCL to diagnose, and their reports are not evidence of degree of disability or causal relationship. WCL §13-b (1) prohibits anyone who is not authorized by the Chair from rendering medical care under the WCL except in six instances. Paragraph (d) of WCL §13-b (1) provides that upon the referral of an authorized physician, which referral may be directive as to treatment, a claimant may receive physical therapy care from a licensed physical therapist. This paragraph requires that the physician maintain records of the claimant's condition and progress, along with records of instruction for treatment. Therefore, before a physical therapist can provide treatment, a physician must order physical therapy and may even specify the modalities to be provided.

Physical therapists are not authorized to request a variance because such request should not occur until after the physician has re-evaluated the claimant to insure that the claimant is receiving appropriate/adequate medical treatment and can, therefore, maximally participate in the recommended rehabilitation program. When a claimant is proceeding slower than expected, it is important for the physician to re-evaluate the patient to insure that any co-morbid medical conditions or any previously unidentified limiting medical problems are identified and actively treated, so that the claimant's ability to participate in rehabilitation is maximized. If a physical therapist could request a variance then such re-evaluation would probably not occur. The physician and physical therapist must act as team caring for the claimant. The physical therapist's scope of practice does not include the medical reassessment of the claimant and it is the physician's responsibility to insure that the patient receives maximal medical treatment in order to maximize participation in rehabilitation, and ultimately a more rapid return to work.

Physical therapists can request authorization for additional physical therapy costing more than $1,000 pursuant to WCL §13-a (5) and §325-1.4. In order to make such request the physical therapist must have a referral from the physician for additional therapy and state the medical necessity for the additional therapy. A request for a variance requires: 1) a medical opinion from the Treating Medical Provider, including the basis for such opinion, that the medical care that varies from the Guidelines is appropriate for the claimant and medically necessary; 2) a statement that the claimant agrees to the proposed medical care: 3) an explanation of why alternatives under the Guidelines are not appropriate or sufficient; 4) a description of any signs or symptoms which have failed to improve with previous treatments in accordance with the Guidelines, when appropriate; and 5) a description of the functional outcomes that have continued to demonstrate objective improvement from such treatment and are reasonably expected to further improve with additional treatment, when appropriate. The request for a variance requires more support and consideration than a request for authorization. Further, it requires more involvement of the physician. Before writing the referral for additional physical therapy, the physician must be of the opinion that additional physical therapy is needed and have a medical basis for this opinion, and be able to explain why alternatives under the Guidelines are not appropriate or sufficient. Therefore it is approriate to require the physician to request the variance. In addition, if the insurance carrier denies the variance request and the parties do not waive their right to an expedited hearing, it is the testimony of the physician that must be obtained, not the physical therapist.

COMMENT:

One comment asked if the regulations will apply to all claims or only new claims.

RESPONSE:

The regulations and Guidelines will apply to all claims.

COMMENT:

One comment requested that regulations be amended to include a provision exempting patients with injuries sustained prior to the effective date from applications of the Guidelines as it will be difficult to fit patients currently undergoing treatment into the Guidelines.

RESPONSE:

Careful consideration was given to which claims the Guidelines would apply and it was determined that if the Guidelines represent the standard of care for work related injuries then the same standard should apply to all claims. If a course of treatment was initiated, was not within the Guidelines, and the medical provider believes the treatment should continue, the medical provider has the option of requesting a variance. When treatment outside the Guidelines is necessary, the physician, podiatrist, or chiropractor can request permission from the insurance carrier to provide such treatment. If the insurance carrier denies the request, the Board will resolve the issue. Further it is not clear exactly what is meant by claim in the comment. Does it mean just the injuries under current treatment or all injuries for that date of accident or disablement? What about consequential injuries diagnosed and treated after the effective date of the rule? For these reasons the rule was not change.

COMMENT:

Three comments objected to the list of pre-authorized procedures in §324.2 (d) and one objected to the reference to this list in §325-1.4 (a) (1). One comment objected because: 1) the statutory language added by Chapter 6 of the Laws of 2007 to Workers' Compensation Law (WCL) §13-a (5) was never intended to allow every medical procedure as preauthorized but to provide limited authority to create a process so new medical procedures could be deemed pre-authorized with the approval of the Superintendent; 2) the language of WCL §13-a (5) is vague, as it does not say that the list of pre-authorized procedures will apply even when the procedures cost more than $1,000; 3) the proposed rule negates the due diligence implied in the bill memo to Chapter 6 of the Laws of 2007 that the language in WCL §13-a (5) would give "appropriate regulatory flexibility to add or remove procedures depending on best practices, increases or decreases in costs, or

opportunities presented by managed care approaches."; and 4) was objected to by the representatives of the entity during the development of the Guidelines.

The second comment believes that this provision is confusing as it does not actually provide a list of pre-authorized procedures, but instead includes a list of procedures that are not pre-authorized, so as to inappropriately authorize every procedure except those not on the list. The entity submitting this comment requests that a specific list of authorized procedures be maintained. Finally, the third comment objected to this provision on the basis it conflicts with WCL §13-a (5).

RESPONSE:

This provision was not changed as the Chair and Board disagree with the statutory interpretations in the comments. Chapter 6 of the Laws of 2007 added a second sentence to WCL §13-a (5) to authorize the issuance and maintenance of a list of pre-authorized procedures, with the approval of the Superintendent of Insurance. The only treatment that needs to be pre-authorized are specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, x-ray examinations or special diagnostic laboratory tests costing more than $1,000 as set forth in the first sentence. Reading the two sentences together it is clear that the authority exists for a list of pre-authorized special services costing more than $1,000. As stated in the memorandum in support of Chapter 6, the purpose of this change, along with the increase in the prior authorization dollar threshold, was "to remove impediments to prompt diagnostic and treatment measures and to better reflect current medical service costs." The creation of a pre-authorized list allows for regulatory flexibility to add and remove procedures based upon best practice. The Guidelines set up best practices for treatment to the neck, back, shoulder, and knee. The Guidelines will be updated regularly to remain current and reflect the best practices. The regulation establishes the pre-authorized list as all tests, procedures, and treatment consistent with the Guidelines, except for 12 specifically identified procedures. The term "consistent with the guidelines" is defined in the regulations. The advisory committee did not create a pre-authorized list.

In developing the regulations and implementation of the Guidelines, it was noted that if a provider is treating consistent with the Guidelines, and is following the best practices set by the Board it did not make sense to have him request approval for a test or procedure costing more than $1,000. The list established by the rule is consistent with the statute and has not been changed.

COMMENT:

One comment requested that surgeries involving non-union of bones and amputations be excluded from the pre-authorized list.

RESPONSE:

This comment was received during the drafting of the regulations and the decision was made not to exclude them from the pre-authorized list because the criteria in the Guidelines for such procedures is sufficient, these are procedures not subject to abuse, and a need for such exclusion has not been demonstrated.

COMMENT:

One comment requested that the rule let readers know that when the word “day” is not modified by the word “business” it means calendar days.

RESPONSE:

No change is indicated by this comment. Throughout the regulations adopted by the Chair or the Board there are many timeframes set forth in days. It is widely understood that if the word “business” does not appear before the word “days” it means “calendar days.” Therefore no change was made. However, this will be made clear in all training and information about the timeframes in the regulations.

COMMENT:

One comment expressed concern that claims administrators may confuse the 15 calendar day response period for a variance without an IME or record review with the eight business day response period for an optional prior approval.

RESPONSE:

No change is indicated by this comment. These are two separate procedures. The Board will make sure that the training on these procedures are clear.

COMMENT:

One comment requests that what constitutes burden of proof be defined in the regulations because without such definition there could be disputes over the appropriateness of the denial of a variance for this reason.

RESPONSE:

No change is necessary. Section 324.3(a) (2) states that the burden of proof to establish that a variance is appropriate for the claimant and medically necessary rests on the Treating Medical Provider requesting the variance. The term "burden of proof" has no special meaning for the proposed rule. It means that the Treating Medical Provider has the duty to establish by sufficient evidence to the insurance carrier and Board that the variance should be approved. What constitutes meeting the burden of proof is submitting evidence proving that the medical treatment that varies from the Guidelines is appropriate for the claimant and medically necessary. Paragraph (3) (i) and (ii) of §324.3 (a) sets forth the proof that must be submitted. All of this will be explained in the training provided by the Board free of charge.

COMMENT:

One comment requested that the regulations be amended to include a provision requiring requests from physicians for variances be reviewed by a physician in the same medical specialty as the treating physician so the requests will be properly evaluated.

RESPONSE:

This suggestion was made during the drafting of the regulations but was not incorporated. The regulation allows a carrier to have a variance request reviewed by the insurance carrier's medical professional or to obtain an independent medical examination (IME) or record review. To require the same medical specialty would

hinder the ability of some insurance carriers to use their own medical professional. Further, the provisions relating to an IME do not require the use of the same medical specialty. This suggestion was not incorporated.

COMMENT:

Similar to the comment above, another comment requested that the definition of "Insurance carrier or Special Fund's medical professional" be amended to conform to industry standards, as set forth by organizations such as URAC, by removing nurses and physician assistants.

RESPONSE:

This suggestion was not included. First, the commentator does not identify the industry. While an educated assumption would be the workers' compensation industry, it could be another as URAC has a number of different accreditation programs. Second, nurses and physician assistants were specifically included in recognition of the fact that not all workers' compensation insurance carriers and self-insured employers have physicians, or a sufficient number of them, on staff, but instead rely on nurses. During the pilot program, nurses responded to variance requests and no issues were identified.

COMMENT:

Two comments requested clarification that the requirement in §324.3(b) (2) (ii) (a) is only to notify the Chair that the insurance carrier will be obtaining an IME or record review and not to actually schedule the IME within five business days.

RESPONSE:

The text has been clarified as the provision only requires that the insurance carrier tell the Chair if it will be obtaining an IME within five business days. The insurance carrier does not need to schedule the IME within that time period.

COMMENT:

Two comments stated that the 30 day period to respond to a variance request when an IME or record review is obtained is too short and not realistic and request additional time for the insurance carrier to respond. One comment suggested a 45 day timeframe was more realistic.

RESPONSE:

It is important that claimants receive treatment in a timely manner so they can recover to the greatest extent possible. It is important that any interruptions or delays in treatment are minimal. Therefore it was determined that the timeframe to respond to variance requests be set at 30 days. This timeframe is the same as the period to respond to a request for prior authorization in WCL §13-a (5). Currently insurance carriers are able to obtain IMEs and respond to prior authorization requests within 30 days. Therefore, it is realistic and possible to respond within 30 days. Further, the regulations explicitly state that a record review, which does not require the physical exam of the claimant, can be obtained rather than an IME. This provision was not changed.

COMMENT:

One comment requests that the requirement in §324.3(b)(2) (ii) that a review of records be performed by a New York authorized doctor be changed to a physician licensed in the state where the physician practices and that the references to IMEs be removed.

RESPONSE:

These suggestions were not incorporated. First, while record reviews do not involve a physical examination of a claimant, it is still an evaluation of claimant through his or her medical records by someone hired by the insurance carrier to conduct this review. Therefore, it is similar in many respects to an IME. Additionally, if the records review were performed to respond to a request for authorization, then by statute the physician must be authorized to treat claimants or conduct IMEs. As stated elsewhere in this document, the variance request was designed to be as similar as possible to the process to request authorization for special services. An exception was made in cases where the insurance carrier wanted to rely upon its own staff and could therefore

provide a response more quickly, but if it retains outside physician to give an opinion, then such physician must be authorized by the Chair. A physician authorized by the Chair, has been recommended by the county medical society where he practices, is monitored by the Board, and agrees to act in accordance the WCL and regulations.

The suggestion that IMEs be removed as an option was not incorporated. If the IME was removed as an option, then denials would be based only on records review if the carrier did not use its own medical professional. This would eliminate the ability for an insurance carrier to have the claimant examined to determine if the variance is appropriate for the claimant and medically necessary. Historically and currently, IMEs are performed to obtain the required opinion for the insurance carrier to respond to a request for authorization. As discussed above, the intent was to have a variance process as similar as possible to the process for authorization of special services. While IMEs can be expensive, the rule offers two alternatives to insurance carriers that do not involve examinations. Further, the insurance carrier by statute (WCL §13-b [4]) has the right to have the claimant examined by an authorized physician so removing it from the regulation would be improper. Finally, there is no justification given, other than this is not how things operate in other states, to remove an option from the insurance carriers.

COMMENT:

One comment notes that §324.3 (b) (2) (ii) (b) provides that if a claimant fails to appear for an IME scheduled by the insurance carrier in order to response to a variance request, the insurance carrier may deny the request and if the Board determines that the failure to appear was due to reasonable grounds, the insurance carrier will have an additional 30 days to obtain the IME and respond to the request. The comment goes on to suggest that the regulation does not address when the carrier agrees that the reason for the failure to appear was reasonable, but requires rescheduling which will result in the exam being conducted beyond the 30 day limit. The comment proposes language to address this situation.

RESPONSE:

This comment was carefully considered but the suggested language was not adopted. It is important that the carrier respond within 30 days. If the carrier agrees that the claimant missed the IME for reasonable grounds, then it can indicate this on any denial. The Board will take this into consideration when determining whether to grant an additional 30 days for an IME, which could be done without the need for a hearing. To make sure cases move quickly it is important that the process as set forth in the proposed rule be implemented. At this time it is unknown how often the IME will be missed for reasonable grounds, and how often the insurance carrier will agree that there were reasonable grounds.

COMMENT:

One comment states that there is a typographical error in §324.3 (b) (3) (iv), specifically that the word "attached" in the first sentence should be "attach." This same comment notes a typographical error in the last sentence of §325-1.25 (c) (1), specifically that the word "the" should be removed before the phrase "such objections."

RESPONSE:

A review of the proposed text of the regulation text shows that the word in that subparagraph is "attach" and that the word "such" is no longer in the sentence, so no changes are necessary.

COMMENT:

One commentator suggested adding language to §§324.3 (b) (4), 324.3 (d) (7), 324.4(d) & (h), and 325-1.4(b) (2) & (3) to explicitly state that the insurance carrier is only liable for the cost of the treatment if the claim is established or the insurance carrier is found liable.

RESPONSE:

These paragraphs address the fact that insurance carriers must respond to requests even when the claim is controverted, or the time to controvert has not expired, but they are not liable for payment until the claim or

condition is established and they are found liable. One of the underlying tenets of workers' compensation is that an insurance carrier is only responsible for medical treatment for claims and conditions that are established as its liability and the statement made by the requested additional language is understood. However, for the sake of clarity this language has been added where requested to the text.

COMMENT:

Two comments recommended that all variance denials be reviewed by the medical director and that the expedited hearing process be a secondary process.

RESPONSE:

As explained in the Regulatory Impact Statement, the statutory authority does not exist for the medical arbitrator to review a variance denial absent the waiver by both parties of the right to a hearing. The WCL does not provide for resolution by the Medical Director or any other medical arbitrator. Further, if the Medical Director reviewed all variance denials before scheduling a hearing, it would delay the resolution of the issue and could result in the Medical Director having to testify. It is not feasible to expect this in additional to all the other duties the Medical Director performs.

COMMENT:

One comment suggests adding the language, "If the Treating Medical Provider believes" at the beginning of the second sentence in §324.3(c).

RESPONSE:

The sentence already contains that language so change is not necessary.

COMMENT:

One comment suggests changing §324.3 (d) to mandate that the Treating Medical Provider use the informal resolution process before requesting the denial of the variance be decided by the Board

RESPONSE:

This suggestion was not incorporated. The rule provides that if a variance request is denied, the Treating Medical Provider may elect to contact the insurance carrier or Special Fund's medical professional directly to resolve the issue. However, as set forth in subdivision (c) of §324.3, it is the claimant or claimant's legal representative who requests review of the denial by the Board. While use of the informal process is encouraged, there will be circumstances where it is clear that informal resolution will not be successful. In such cases, waiting until the end of the time period for that process for claimant to submit the request for review is just an unnecessary delay.

COMMENT:

One comment recommends that §324.3(d)(2)(iv) state how quickly the medical arbitrator is required to rule on the denial of a variance request and suggests that it be eight business days, the same time the medical arbitrator has to rule on denials of optional prior approval.

RESPONSE:

When drafting the regulations consideration was given to setting a maximum time within which the medical arbitrator had to rule. However, after such consideration it was determined that due to the various unknowns, such as the complexity of the some variance requests and the number received, a determination was made not to include a time frame at this time. The suggested time frame of eight business days is not appropriate as a variance request is more complex than an optional prior approval request. The issue for an optional prior approval is whether the treatment is consistent with the Guidelines, while a variance request is submitting detailed information on why the provider should be allowed to deviate from the Guidelines.

COMMENT:

One comment states that the timeframes in §324.3(d)(3)(ii) and in §325-1.4 (a) (9) do not provide sufficient time to obtain the depositions, do not provide accommodation if the deposition must be rescheduled for an emergency, and do not define complex medical issues, and that there should be guidance as to the amount of

time between the Notice of the Expedited Hearing and the hearing, and ignores how the parties will be notified if the testimony can be taken at the expedited hearing.

RESPONSE:

Sufficient time is provided. If the claimant is not represented then the testimony will always be taken at a hearing. If the claimant is represented, then the testimony will be taken by deposition or at a hearing. If the testimony is not taken because the provider is not deposed or fails to testify, the workers' compensation law judge will weigh the medical evidence and reach a determination. What constitutes a complex medical condition will change over time and be determined by workers' compensation law judges and Board panels in individual cases. Notice of the hearing will be in accordance with the WCL and existing regulations and will provide information informing the parties of what will transpire. The Board will be providing training on these processes.

COMMENT:

One commentator takes issue with the provisions in §§ 324.3 (d) (6), 325-1.4 (a) (8), and 325-1.4 (a) (9) (ii) that states if the insurance carrier fails to timely deny or approve the variance request or request for prior authorization it is deemed approved and an Order of the Chair will be issued that cannot be appealed pursuant to WCL §23. The commentator believes this provision is improper as the insurance carrier should have the right to dispute the finding or to explain why the regulations were not followed, such as due to surprise or inadvertence.

RESPONSE:

If an insurance carrier fails to respond, there is no contrary medical evidence and all defenses have been waived. There is nothing to appeal. Further, an Order of the Chair is memorializing that the insurance carrier has failed to respond to the request so such request is deemed approved. An Order of the Chair is not a decision of a workers' compensation law judge, a board panel or the full board. No change is warranted.

COMMENT:

One commentator requests that §324.4(a) be amended to specify that providers can obtain information about which insurance carriers are participating in the optional prior approval process through a website or other means.

RESPONSE:

This suggestion was not incorporated as it is not necessary. The Board intends to maintain this information on its website and will notify everyone to that effect. This does not need to be included in the proposed rule for the Board to provide this information.

COMMENT:

One commentator requests that the term "receipt" be defined in §324.4 (c), the same as it is defined elsewhere.

RESPONSE:

A definition is not necessary here as the optional prior approval request must be sent by one of the methods of same day transmission, which are email, fax, or other electronic means. These are methods that allow the document to be received the same day it is sent. The date of receipt is assumed to be the same day as transmission.

COMMENT:

One commentator requests that the eight business days for a response by the insurance carrier or Special Fund be extended to ten business days.

RESPONSE:

This process was part of the pilot program conducted by the Board. Participants in the pilot had to respond within four business days and they were able to meet this deadline. In the regulations, the time was doubled to eight business days. Based upon experience there is no need to extend the time to respond beyond eight

business days. Further, the issue is solely whether the treatment which is the subject of the optional prior approval is consistent with the Guidelines.

COMMENT:

One commentator suggested adding eight days to the 14 days the Treating Medical Provider has from the date of the denial of the optional prior approval to request review by the medical arbitrator in order to maximize the number of informal resolutions.

RESPONSE:

With an optional prior approval request, the Treating Medical Provider is seeking agreement from the insurance carrier or Special Fund that his or her understanding and application of the Guidelines is correct and that the insurance carrier or Special Fund will pay for the service. It is important that this process proceed quickly so treatment is not unduly delayed or interrupted. When reviewing the timeline for this process, the insurance carrier or Special Fund has eight business days from receipt to respond to the request. Then the Treating Medical Provider has 14 days from the date of the denial to request review by the medical arbitrator, who has eight business days to issue a decision. Therefore, as set forth in the proposed rule, when there is a denial the process will take, from original request to decision, between 37 and 39 days. Adding an additional eight days before the Treating Medical Provider must request review by the medical arbitrator will only extend this process. While more time may result in more informal resolutions, adequate time is already provided and does not offset the additional time before a decision is issued by the medical arbitrator when informal resolution is not successful.

COMMENT:

One comment requests that the informal resolution process in §324.4(d) be mandatory for the treating medical provider.

COMMENT:

One commentator takes issue with the provision in §324.4(f) that the Notice of Resolution issued by the medical arbitrator to resolve the denial of an optional prior approval request is not appealable. The commentator submits that the parties should have the option to cross-examine the Treating Medical Provider and the medical arbitrator on the basis of his or her determination, and possibly appeal the medical arbitrator's decision to ensure the medical arbitrator is not arbitrary and capricious and preserves each party's due process rights.

RESPONSE:

As stated above, the optional prior approval process provides the Treating Medical Provider with the option to request approval from the insurance carrier or Special Fund that the treatment to be provided is consistent with the Guidelines. This is an optional process, in that the Treating Medical Provider has to affirmatively decide to use it or "opt-in," and the Treating Medical Provider only uses the process when he or she wants to. Its use is not mandatory. Insurance carriers and Special Funds are deemed to have opted-in to the process, meaning they will accept and respond to such requests, unless they affirmatively opt-out of the process. By opting-in and not opting-out, the parties are agreeing to be bound by the determination of the medical arbitrator as to whether the treatment, test, or procedure is consistent with the Guidelines. The optional prior approval process does not provide for an appeal so that the treatment, test, or procedure is not unduly delayed. This process does not violate each party's due process rights as it provides an opportunity for each side to agree to participate, there is notice of the process, and each party has an opportunity to present his or her position with supporting documentation. Further, it is not clear why the medical arbitrator would be subject to cross-examination. The medical arbitrator is a making a determination. Judges, referees and arbitrators are not usually subject to cross-examination.

COMMENT:

One commentator notes that the reference in §324.5 to subdivision (c) (4) of §324.3 should actually be to subdivision (d) (5).

RESPONSE:

The commentator is correct that the reference to subdivision (c) (4) in §324.5 is incorrect. However, the correct cite is subdivision (a) (4). This typographical error has been corrected.

COMMENT:

One comment suggests that the regulation be clarified to make clear that if a provider wants to pursue a treatment, test, or procedure that is not recommended in the Guidelines a variance is required.

RESPONSE:

This clarification has been made in §324.3 (a) (1).

COMMENT:

Two comments requested clarification as to whether the requirement to incorporate the Guidelines and the procedures in the regulations into an insurance carrier's policies and procedures extends to third party administrators (TPAs) who are hired by self-insured employers and insurance carriers to process and administer their claims.

RESPONSE:

Section 324.6 of the regulations requires insurance carriers and Special Funds to incorporate into their policies and procedures the Guidelines and the processes and procedures in the regulations relating thereto. If an insurance carrier, which includes a self-insured employer, hires or contracts with a TPA to process and administer its claims, the insurance carrier must require the TPA to incorporate the Guidelines and the regulations into its (the TPAs) policies and procedures and certify that it has been done. The insurance carrier should submit the certification by the TPA and the insurance carrier to the Board.

COMMENT:

Four comments were received objecting to the amendment in §325-1.3 extending the period between which reports on follow-up visits must be filed from 45 days to 90 days. One comment notes that an additional six weeks of indemnity benefits will be provided during the additional 45 days. This comment also states that the timeframe for medical reporting is for claimants who should be under active treatment, not receiving palliative care. In addition this comment states that by lengthening this timeframe, limits the ability of a case manager to ensure the care regimen is appropriate so the current 45 day report requirement should remain. Finally, the comment indicates the provision needs clarification as it could be interpreted to mean that the provider has 90 days from the date of treatment to submit a report. The second comment notes that medical reports are essential for evaluating claims, facilitating recovery, returning claimants to work, and properly compensating claimants. This comment states that the 90 day reporting period would prevent meaningful application of the medical guidelines, and recommends that medical reports be submitted sooner than the current 45 days. Finally, this comment notes that it is in the physician's interest to submit the medical report as soon as possible. The Third comment states that increasing the time between progress reports will unnecessarily drive up indemnity benefits and expense costs and require the scheduling of more independent medical examinations so carriers can have necessary and current information on degree of disability and return to work. This commentator recommends retaining the current 45 day period. The fourth comment states that the current time period should be retained as increasing it to 90 days is likely to delay return to work.

RESPONSE:

It was not the intent of this provision to state that physicians have 90 days after the examination of a claimant to submit a medical report. Rather, the intent was to require follow-up visits with the physician at medically necessary intervals, for which the physician would submit a medical report, except that the intervals between follow-up visits can be no more than 90 days. To ensure the provision is not misinterpreted, it has been revised. As stated in the Regulatory Impact Statement, physicians have complained that they are forced to

examine claimants when it is not medically necessary in order to file a medical report every forty-five days. This results in a medical report that is no different than the previous report, because nothing has changed medically. In addition, the provider is entitled to a fee for the office visit, which increases costs. By requiring reports only when a visit is medically necessary, but no more than ninety days apart, fewer unnecessary office visits will be scheduled and costs reduced. The Guidelines set time frames for examinations by physicians and other providers; by setting the time period for follow-up visits as medically necessary, as long as there is a visit every 90 days, it allows a physician to follow the Guidelines without adding a visit for the sole purpose of filing a medical report at least every 45 days, even if one is not warranted.

Two comments indicate that without the medical report at least every 45 days, payment of unwarranted indemnity payments will result. This must be based on the theory that claimants will now only be seen every 90 days and that under the 45 day rule, the second report would indicate that the claimant's condition has improved so he or she can return to work thus warranting a reduced indemnity payment. This is an erroneous. First, this change sets an outer limit of 90 days. Therefore, medical reports could be received for visits that are 21, 45, 60, or 80 days apart. Second, in all cases the medical report submitted after 45 days would not indicate that the claimant could return to work or had improved. Third, in order to stop or reduce indemnity payments, based upon an award made by the Board, the insurance carrier must produce medical evidence supporting that action. If the treating physician has not indicated such improvement, the insurance carrier must obtain an IME. Currently, many medical reports are submitted every 45 days in a claim that do not reflect any change in the claimant's condition and insurance carriers obtain IMEs on the degree of impairment in order to determine if the level of indemnity benefits should remain the same. This will not change.

COMMENT:

One commentator believes there is a grammatical error in last sentence of §325-1.4 (a) (5) and suggested a revision.

RESPONSE:

The sentence is correct as the word “who” is necessary for the sentence be correct as a qualified provider is one who may conduct an IME pursuant statute and regulation.

COMMENT:

One comment requests that the time periods for a request for authorization for special medical services costing more than $1,000 run from the date that the carrier receives the request.

RESPONSE:

The time period runs from the date of receipt. If the request is sent by email, fax, or other electronic means, which are the methods of same day transmission, then the request is received on the date sent. Therefore, the date sent is the same as the date received so the time period is running from the received date. If the request is sent by regular mail, it is deemed received five days after it was sent to account for mailing. Further, when it is sent by regular mail, it must be sent with confirmation of delivery. Therefore, the time period is running from received date and no change is warranted.

COMMENT:

One comment discusses the qualifications required for physicians to perform peer review of requested treatments during the utilization review process. The comment states that it does not seem to the commentator “that the isolated peer review portion of the utilization review process was contemplated in the current utilization review system.” To assist in an understanding of their comments, the term peer review is explained to be “that portion of the process in which a provider reviews the treating provider’s request on the basis of medical necessity.” The commentator notes that the Chair and Board regulations do not specifically require New York medical licensure or Chair authorization in order to review requested medical treatments for medical necessity; however, a denial of treatment must be based on a conflicting second opinion or an IME by a medical professional authorized by the Chair. This has caused utilization review companies to require physician peer

reviews to obtain Chair authorization because without it their reports are not admissible as evidence in support of a denial. Further, Chair authorization is limited to treating physicians or physicians conducting independent medical examinations (IMEs), as there is no category for peer review/utilization review. It is also noted that Chair authorization is not required for all other practitioners, such as dentists. The commentator states that the proposed rule is a beginning to correct the situation with the definition in §324.1 of "Insurance carrier or Special Fund's medical professional" used with respect to the variance process. However, as noted in the comment, a request for authorization is governed by §325-1.4 (a) (6), which requires that a denial be supported by a report from an IME, qualified medical professional as defined in §300.2, or a physician authorized to treat claimants. The commentator opposes requiring same-state licensure for peer reviewers for reasons such as it is an undue burden, overly restrictive, antiquated, and increases health care costs. In addition, having the two different standards, one for situations involving treatment guidelines and another for situations that do not, is an unwarranted administrative burden. Further, Chair authorization appears arbitrary because membership in professional societies is required.

RESPONSE:

In adopting rules, the Chair must abide by the WCL. It is the WCL that sets forth who may treat claimants and requires authorization by the Chair for physicians (WCL §13-b), podiatrists (WCL §13-k), chiropractors (WCL §13-l), and psychologists (WCL §13-m). These sections of the WCL also set forth the process to be authorized. For physicians, WCL §13-b (1) requires that the physician be recommended by the medical society of the county in which his or her office is located. Membership in the medical society is not required to receive such recommendation. The physician must complete an application and submit it to the society, who then must review and submit it with an application to the Chair. WCL §13-a (4) (b) authorizes insurance carriers to have a claimant examined by a physician of its choice, but the physician must be authorized to treat or perform IMEs. Further, the WCL sets forth that physicians, podiatrists, chiropractors, and psychologists can only be authorized

to treat claimants, conduct IMEs, or both; there is no mention of “peer review” or “utilization review”. Section 325-1.4 of Title 12 NYCRR provides the process to comply with WCL §13-a (5), which requires a treating provider to request authorization for special services, such as surgery or physical therapy, costing more than $1,000. Section 13-a (5) requires that a denial of such a request “must be based on a conflicting second opinion rendered by a physician authorized by the board.” Therefore, the requirement in §325-1.4 (a) (6) is taken from the statute and cannot be changed absent a statutory change. The only change that could be made to the rule would be to change the definition of “Insurance carrier or Special Fund’s medical professional” to require Chair authorization, which is the opposite of what is requested. Therefore, no changes were made based upon this comment.

COMMENT:

One comment requests that §325-1.4 (a) (9) be clarified to state that the expedited hearing shall be scheduled within 30 days of the Board’s receipt of the denial.

RESPONSE:

This suggestion has been accepted and the text of the regulation so modified.

COMMENT:

One comment notes that §325-1.4 (a) (9) indicates that the workers’ compensation law judge may request the opinion of an impartial specialist when ruling on the denial of authorization for one of the items excluded from the list of pre-authorized procedures. If the opinion of an impartial specialist is obtained, this comment states that the parties must be permitted to cross-examine the impartial specialist.

RESPONSE:

The parties will have the opportunity to cross-examine the impartial specialist in accordance with WCL §13 (e).

COMMENT:

One comment requests clarification regarding when special services are to be considered individually or together when determining if the cost is greater than $1,000 and therefore requiring the medial provider to request authorization from the carrier in §325-1.4 (c).

RESPONSE:

The text is clear as to when special services are to be considered as a single request and does not require further clarification. If the special services are part of a series of related treatment or care or part of a battery of related tests, then they are considered as a single request. The regulation already includes examples. Litigation already exists on this issue. While this provision will not end the litigation in its entirety, it will be greatly reduced.

COMMENT:

One comment states that the words “symptomatic,” “palliative,” and “maintenance” in §325-1.25 (a) (1) are vague and will generate significant amounts of litigation.

RESPONSE:

The statement in §325-1.25 (a) (1) that uses such terms is stating a basic understanding of the provision of medical benefits under the WCL. These terms have no special meaning beyond their usual definitions. Therefore they should not generate any new litigation and no change is warranted.

COMMENT:

One comment takes issue with §325-1.25 (d) (6) which provides that a decision will be made on the timely written objection to the Chair’s proposed administrative award for a bill for medical care and states that the parties’ due process rights to a hearing must be preserved.

RESPONSE:

Subdivision (d) of §325-1.25 relates to the administrative award process when a medical bill is not paid and the carrier does not submit a valuation objection within 45 days after the submission of the medical bill.

Paragraph (6) of this subdivision addresses the ability of the insurance carrier to object to the administrative award before the filing date of such award which will be at least 30 days. If an objection is received, the objection is reviewed by the Chair or the Chair's designee and a decision is issued. This process is the same as currently exists in §325-1.24 (f), which has existed since October 1, 1984, and is based on WCL §13-g, which authorizes the Chair to issue such awards. The Chair is further authorized to issue these rules. Due process requires notice and an opportunity to be heard, and both are part of this process. First, the insurance carrier receives the medical bill and, pursuant to statute and regulation, has 45 days to pay, in whole or in part, or object to the bill in whole or in part. If the insurance carrier takes no action, pursuant to WCL §13-g, it is liable for the bill at the reimbursement level provided in the appropriate fee schedule. Second, when the insurance carrier fails to pay the bill or object within 45 days, the medical provider is authorized by §13-g to request an administrative award. Third, if the request is in compliance with the rules, a notice of decision will be sent to all parties notifying them of the proposed administrative date, the proposed filing date, and that an objection must be received before the filing date. Any objection, which is the opportunity to be heard, is reviewed and a decision entered. The only objections to the administrative award are that the bill was paid, an objection was filed, or the bill was never received. If an objection is not filed timely it is not considered. There is no need for a hearing and the statute does not require one. The parties are afforded due process under this long standing process.

COMMENT:

One commentator objects to the provisions in §325-1.25 (f) (1) and (g) (1) (i) because they do not provide for a hearing before a workers' compensation law judge and therefore do not afford the parties due process.

RESPONSE:

Section §325-1.25 (f) (1) provides that if the self-insured employer or insurance carrier submits an objection to a medical bill raising legal issues and/or Guideline objections, such objection shall be reviewed by

the Board. This review will either be through the hearing or conciliation process. The Board will determine the path for resolution, which are provided in the WCL and afford all parties due process. There is no subdivision (g) in §325-1.25 in the proposed rule and therefore there is no need to respond to the rest of this comment. This is also true for the comment on §325-1.25 (g) (2) (iv).

COMMENT:

One comment was received regarding the Summary Regulatory Impact Statement. The commentator took issue with the statements under "Statutory Authority" and "Needs and Benefits" in that there are no treatment guidelines or up-to-date standards for providers. It is noted that orthopedic surgeons are required to go through a process called Maintenance of Certification in order to continue to be certified by the American Board of Othopaedic Surgery on a seven to ten year cycle.

RESPONSE:

The WCL does not require treating physicians, including orthopaedic surgeons, to be certified by a specialty board of the American Board of Medical Specialties. In addition, not all providers are physicians who can be board certified. Therefore, all providers do not have treatment guidelines or up-to-date standards. Further, the Guidelines adopted by this rule are for work place injuries. However, the Regulatory Impact Statement and Summary of Regulatory Impact Statement have been revised to clarify this point.

COMMENTS ON THE GUIDELINES

COMMENT:

A few comments expressed disagreement with the statement that the Guidelines are evidence-based and made specific comments as why they believe the Guidelines are not evidence based. First, the comments raise issues with the guidelines upon which the New York Guidelines are based. Specifically, one comment states that the Guidelines are a comprised of pieces taken from existing guidelines of "questionable merit and value."

A second comment states that the Guidelines come from two un-named commercial guideline sets and because they are un-named there is no way to verify that the Guidelines are evidence based or follow the best available evidence.

RESPONSE:

As stated above, in developing the Guidelines, the Insurance Department and the Advisory Committee performed a thorough review of available state-developed workers' compensation treatment guidelines, the American College of Occupational and Environmental Medicine (ACOEM) guidelines, and two commercially available guidelines, McKesson and Official Disability Guidelines. Consideration was limited to guidelines used for treating work-related injuries and illnesses. For the mid and low back, the advisory committee chose Chapter 12, Low Back Disorders (Revised 2007), of the Occupational Medicine Practice Guidelines, 2nd Edition published and copyrighted by the American College of Occupational and Environmental Medicine. For the neck, knee, and shoulder, the advisory committee chose the State of Colorado's treatment guidelines found in Exhibit 4 (Shoulder), Exhibit 6 (Lower Extremity), and Exhibit 8 (Cervical Spine Injury) of Rule 17, Medical Treatment Guidelines. Charts from the Washington State workers' compensation guidelines were used to supplement the New York Knee and Shoulder Guidelines as the charts provided an easy mechanism to summarize care and treatment recommendations. The guidelines chosen are nationally recognized medical treatment guidelines used for treating individuals with workplace injuries. Both Colorado and Washington have prominent workers' compensation medical directors who hold faculty positions at the respective state medical universities and are recognized for their workers' compensation expertise.

COMMENT:

Second, one comment states that the Guidelines do not meet the principles of good guideline development, such as the AGREE collaboration standards for evidence review. A few comments stated there was no appraisal of evidence used and no reference to the evidence or bibliography or evidence tables.

RESPONSE:

In the general principles at the beginning of each of the Guidelines, there is a clear statement that the scientific medical literature was not independently vetted. Rather, the members of the Advisory Committee relied upon the methodology used by the developers of the various guidelines to develop the New York State Guidelines. All three guidelines chosen by the Advisory Committee are evidence-based according to the methodology used by the developers of the various guidelines. ACOEM is the treatment guideline chosen for the New York Mid and Low Back Injury Medical Treatment Guideline. Their guidelines apply to working age adults with work-related medical conditions. ACOEM has an organizational structure and methods for the development of recommendations for evidence-based practice that is outlined on its website at www.acoem.org. Evidence-based Practice Panels are appointed and are responsible for developing or updating evidence-based practice recommendations. The development or updating of practice recommendations is based upon a literature review using the AGREE methodology. Research staff carry out a literature review for each guideline (using a transparent screening process) to identify studies that meet inclusion criteria for studies to be considered as adequate evidence for review. The quality of the individual treatment studies are scored and the aggregate of studies or levels of evidence on a given topic are rated to develop the evidence-based recommendations. The methodology used by ACOEM is a systematic review that meets the standard of good guideline development. The scientific medical literature listed in ACOEM's References is the bibliography for the New York Mid and Low Back Injury Medical Treatment Guidelines. Colorado's guidelines are the primary guidelines used for the New York Neck Injury Medical Treatment Guidelines, New York Knee Injury Medical Treatment Guidelines, and New York Shoulder Injury Medical Treatment Guidelines. The states of Colorado and Washington (Industrial Insurance Medical Advisory Committee – IIMAC) have medical advisory committees to update and develop treatment guidelines. In both states, literature searches are performed, reviewed, and critiqued (graded) by a research methodologist in Colorado and epidemiologist in Washington

and the material provided to the committee members. The bibliography from Colorado and Washington are references for the related New York Guidelines. ACOEM, Colorado, and Washington have either external review and/or consultant/public comments as a mechanism for obtaining feedback on the guidelines recommendations. Although the Advisory Committee did not vet the scientific medical literature, it relied on developers whose methodology was an evidence-based approach.

COMMENT:

Third, the comments stated that the development of the Guidelines was not an integrated, multidisciplinary process.

RESPONSE:

As stated above, the Advisory Committee relied upon the methodology of the developers of the various guidelines. ACOEM's evidence-based Spine Panel consisted of physicians and a physical therapist. Additional panel consultants included chiropractors and psychologists. Finally, feedback was obtained from professional societies including physical therapy, occupational therapy, and psychology. Colorado's Medical Advisory Committee consists of physicians (medical doctors, osteopaths, occupational medicine, surgeons, and physical medicine and rehabilitation), physical therapists, occupational therapists, chiropractors, psychologists, and acupuncturists. Washington's IIMAC consists of physicians (medical doctors, osteopaths, neurologists, physical medicine and rehabilitation, occupational medicine, and surgeons). The various developers of the medical treatment guidelines used by the Advisory Committee utilize an integrated, multidisciplinary process for developing their practice recommendations.

COMMENT:

Of the approximately 70 comments received requesting changes to the Guidelines, about half suggested changes based on literature and offered evidence in support.

RESPONSE:

As noted above, the Chair and Board accepted comments regarding the content of the guidelines from the time they were received in December 2007. Between August 13, 2009, and September 9, 2009, a formal comment period was held where anyone was invited to submit comments on the Guidelines. If changes were suggested, evidence supporting such change needed to be submitted with the comments. The Board's Medical Director and his staff, along with an epidemiologist, reviewed the comments and the evidence submitted. Revised Guidelines were released for review on January 19, 2010. Based on additional work by the Medical Director and his staff further revised Guidelines were released on June 30, 2010. It is recognized that medical science and practice will change over time. Guidelines must keep pace with these changes. ACOEM, Colorado, and Washington all have processes in place to review and update the scientific medical literature and revise their treatment guideline recommendations to reflect new medicine. The Chair will implement a process to review and critique available medical literature and update the Guidelines as indicated. The comments that requested changes to the Guidelines recommendations based upon literature provided will necessitate appropriate analysis and grading of the studies to determine whether the evidence reaches the standard for a change in practice recommendations. This will be performed through the process established by the Chair. In addition, some of the requested changes were submitted and considered for the revised Guidelines released on January 19, 2010. Specific suggestions will also be addressed below.

COMMENT:

Two comments states that the Guidelines do not address whether any therapeutic procedures can be appropriately performed concurrently with other therapeutic procedures and request that the Guidelines be clarified as to what treatments have similar rehabilitative benefits and are considered duplicative.

RESPONSE:

The Guidelines set forth the standard of care for work-related injuries. Treating medical providers must treat in accordance with the Guidelines. The Guidelines set forth the treatment that can be provided, which

includes therapeutic procedures. Which procedure can be provided concurrently is set forth in the Guidelines. Some of the therapeutic procedures can properly be performed by multiple providers, such as physicians, physical therapists, or chiropractors. However, a specific therapeutic procedure can only be performed by one provider at a time. For example, if the Guidelines provide for 6 sessions of a modality they cannot be performed by two providers, such as a chiropractor and physical therapist, at the same time. If they are provided by two providers at the same time, the carrier is only responsible for payment to one of the providers.

COMMENT:

One comment requests that the terms “acute,” “subacute,” “chronic,” and “experimental” be defined in the Guidelines.

RESPONSE:

These terms are widely understood in the medical community so definitions are not necessary.

COMMENT:

One commentator suggests that the Guidelines clearly require causally related and pre-existing conditions be carefully documented with respect to the psychological or psychosocial testing discussed in general principles A.15 and A.16 because reports for psychological or psychosocial testing are *prima facie* evidence for establishing these conditions as causally related.

RESPONSE:

It is standard practice for a medical provider to document the history of any condition so there is no need to require it in the Guidelines. Further, pre-existing conditions would also be documented in order to properly diagnose and discuss the relationship between any psychological or psychosocial factors and any impediment to the claimant’s recovery.

COMMENT:

One commentator states that the general principles suggest consideration of psychological referrals are premature and should await specific, detailed evidence-based examination of the issue, and therefore should be removed.

RESPONSE:

Psychology evaluation and treatment are accepted approaches for the evaluation and management of clinical concerns related to personality, psychological and psychosocial problems. Therefore, it is appropriate to include these general principles to address when a medical provider feels that psychological factors or issues may be impeding the effectiveness of treatment.

COMMENT:

Comments were submitted that took issue with the fact that the Guidelines do not provide coverage for chronic care, in particular manipulation, which limits the ability of practitioners, such as chiropractors, to provide medically necessary care. Currently claimants are receiving chiropractic manipulation two times a month. Further, chronic chiropractic care is less costly than medication and more effective.

RESPONSE:

The current practice of chronic manipulation is custom and is not based on evidence. In the past the Board included in its decisions that a claimant who has been classified is entitled to symptomatic treatment to note that medical coverage is not terminated. Over time these decisions became custom and were interpreted to mean chiropractic treatments two times a month. However, this interpretation has never been based on medical evidence. The Advisory Committee carefully reviewed the recommendations in each of the medical treatment guidelines chosen and made changes where appropriate. Further, this was not changed in response to the comments and evidence received before the Guidelines were revised. Finally, if a claimant needs additional treatment beyond what is recommended in the Guidelines, his or her provider can request a variance and provide evidence that such variance is appropriate.

COMMENT:

At least two commentators state that the recommendation that routine x-rays are not indicated is a standard of care treatment issue for chiropractors because the standard of care requires that before any treatment begins, x-rays should be done to rule out contraindications for treatment such as manipulation.

RESPONSE:

X-rays that are performed based upon the medical provider's clinical assessment of the claimant and the identified needs of that patient, (i.e., not automatically performed) it is not considered routine. Therefore, if there are clinical indications that x-rays are needed, then they are not considered routine.

COMMENT:

A number of comments stated that the global fee schedule for chiropractors is unfair.

RESPONSE:

This rule does not address the reimbursement fees for treatment provided to claimants.

COMMENT:

Comments were submitted with evidence and cites for other literature that manipulation under anesthesia should be recommended.

RESPONSE:

The Advisory Committee reviewed and discussed underlying guideline recommendations including, but not limited to, recommendations relating to manipulation under anesthesia. Changes were made when they determined it was appropriate. The Advisory Committee did not change these recommendations and they were not changed based upon comments and evidence received during the comment period in 2009.

COMMENT:

Comments were submitted requesting changes to the Guideline's recommendations regarding electrical stimulation, myofascial release, diathermy, and traction in low back and to allow manipulation under anesthesia in the neck and low back.

RESPONSE:

The Advisory Committee reviewed and discussed underlying guideline recommendations including, but not limited to, recommendations related to manipulation under anesthesia and use of TENS units making changes where they determined it was appropriate. The Advisory Committee did not change these recommendations and they were not changed based upon the comments and evidence received during the August 13, 2009, through September 9, 2009, comment period. Similarly, the general principles were discussed in detail and consensus reached on these important underlying principles to the Guidelines, and they were not changed

COMMENT:

Some comments requested that other providers duly trained and certified in electrodiagnostic testing be allowed to perform such testing.

RESPONSE:

The Guidelines do not prohibit providers other than physicians board certified in neurology and physical medicine and rehabilitation from performing these tests. Rather it is recommended and preferred. Therefore, no change is necessary.

COMMENT:

Some comments requested that chronic back pain be added as recommended under manipulation in the Guidelines with treatment frequency as twice per week or less to maintain function.

RESPONSE:

As noted above, the Advisory Committee carefully studied the recommendations in the Guidelines and made changes where they determined it was appropriate. Further, the Board's medical director and his staff

reviewed all comments and evidence submitted and where appropriate made revisions to the Guidelines. After both reviews the determination was made not to change this recommendation.

COMMENT:

Some comments requested changes to the general principles so that: 1) the Guidelines are general recommendations and not prescriptive; 2) care under the Guidelines is for treatment before maximum medical improvement is reached and does not limit post-maximum medical improvement care; and 3) enhanced sleep and decrease in pain medications would be signs of positive patient response. In addition, some comments requested that yellow flags be added to refer to accepted indicators of chronicity, delayed recovery, and delayed return to work.

RESPONSE:

The purpose in developing the Guidelines was to develop standards of care for work-related injuries. Only by mandating them is there assurance that all claimants will receive this standard of care. With respect to the general principles, the Advisory Committee spent a great deal of time discussing them in detail until consensus was reached on these important underlying principles to the Guidelines. The general principles include principles on Personality, Psychological and Psychosocial Evaluation and Intervention to address concerns about recovery and return to work delays.

It is important that standards of care exist not just prior to maximum medical improvement but afterwards as well. If the guidelines did not apply to post-maximum medical improvement the potential exists for treatment that is not appropriate to be provided to the claimant. If the Guidelines to not address a condition or treatment for one of the four body parts, such as a chronic condition, §324.5 of the regulations sets forth how a determination will be made as to whether the treatment is appropriate. Subdivision (f) of §324.2 of the regulations makes clear claimant can still receive medically necessary care after maximum medical improvement is reached. Additional guidelines will be developed that will address chronic conditions.

Enhanced sleep and decrease in pain medications may be considered as indicators of a positive patient response. General Principle 3, "Positive Patient Response" defines a positive response and gives examples, which is not an all inclusive list as indicated by the language, "but are not limited to" before the examples. If the commentator can meet the requirements of this principle and demonstrate how his suggested markers objectively impact functional gains, they may well be potential indicators of a positive patient response.

Yellow flags have not been added to the Guidelines as suggested. "Red flags" is a phrase that is generally accepted and understood, with a clear clinical meaning. Yellow flags do not fall into the same category. The important thing is to insure that the concepts of chronicity, delayed recovery and delayed return to work are recognized and addressed in the Guidelines which they are. The use of "yellow flags" will not clearly identify the extent and depth of these essential concepts and the general principles which address them (A8, A9, A15, A16, A17, A18 and A19).

COMMENT:

A comment was received regarding the lack of assessment of pain in the Guidelines such as with the Visual Analog Scale (VAS) and pain drawing.

RESPONSE:

This comment is incorrect. The history and physical exam section of the Guidelines contains the following statement, "The use of an accepted pain assessment tool (e.g. the Visual analog Scale {VAS} is highly recommended, especially during the first two weeks following injury, to assure that all work-related symptoms, including pain, are being addressed." Additionally, certain recommendations in the Guidelines discuss documenting the impact of treatment on pain and specifically address the use of a pain assessment tool. Further, tools other than the VAS can be utilized. Any accepted pain tool can be utilized; however, the VAS is a common and simple one to use.

COMMENT:

Comments were received requesting changes to allow the performance of x-rays and other tests based on history and physical examination, and the doctor's clinical determination that further investigation is necessary. The comment also states that in some urgent situations a CT may need to be performed either prior to or instead of an MRI.

RESPONSE:

Based on comments received during the comment period, the general principle "Diagnostic Imaging and Testing Procedures" and the section called "Follow-up Diagnostic Imaging/Testing" were revised for the Guidelines released on January 19, 2010.

COMMENT:

One comment raised an issue about the fact no surgeons were involved in the development of the Guidelines.

RESPONSE:

As set forth above, surgeons were involved in the development of ACOEM's Colorado's, and Washington's medical treatment guidelines which were used to develop the Guidelines.

COMMENT:

Comments were received requesting changes to surgical procedures and allowing experimental treatment for FDA/IRB approved trials. It was suggested that surgical procedures should be changed to allow corpectomy at three levels and lower back fusion before the third discectomy.

RESPONSE:

As noted above, the Advisory Committee carefully studied the recommendations in the Guidelines and made changes where they determined it was appropriate. Further, the Board's Medical Director and his staff reviewed all comments and evidence submitted and where appropriate made revisions to the Guidelines. After both reviews the determination was made not to change these recommendations. The Advisory Committee

specifically discussed experimental treatment, which is addressed in the general principles section. The consensus was that medical treatment that is experimental and not approved for any purpose, application, or indication by the Federal Drug Administration is not permitted. This was based in part of the fact that while a treatment is experimental there are no studies or information on which to base its efficacy and safety. During the comment period in 2009 comments were received that this should be changed to permit the use of experimental treatment. After careful review, the decision was not to change the general principles. Another suggestion to change the recommendations for vertebroplasty and kyphoplasty from "may be considered" to "are recommended" was accepted based upon review of the literature and the comments.

COMMENT:

Comment was received requesting that providers be allowed to perform epidural injections without fluoroscopy.

RESPONSE:

As noted above, the Advisory Committee carefully studied, reviewed and discussed the recommendations in the Guidelines, including those related to the use of fluoroscopy in performing epidural injections, and made changes where they determined it was appropriate. Further, the Board's Medical Director and his staff reviewed all comments and evidence submitted and where appropriate made revisions to the Guidelines. After both reviews the determination was made not to change this recommendation.

COMMENT:

A few comments were received requesting the cap on diagnostic injections be changed to two and the cap on therapeutic injections be changed to four to six.

RESPONSE:

As noted above, the Advisory Committee carefully studied, reviewed and discussed the recommendations in the Guidelines, including those related to the maximum number of diagnostic and therapeutic injections, and

made changes where they determined it was appropriate. Further, the Board's Medical Director and his staff reviewed all comments and evidence submitted and where appropriate made revisions to the Guidelines. After both reviews the determination was made not to change this recommendation.

COMMENT:

A few comments raised the issue that the Guidelines do not contain any diagnostic transforaminal procedures.

RESPONSE:

Diagnostic transforaminal injections are permitted, please see section C.2.b. and D.3.a.i. of the New York Neck Injury Medical Treatment Guidelines.

COMMENT:

A number of comments were received regarding the criteria that must be met in order for a spinal cord stimulator to be recommended. Specifically, the comments requested removal of the required criteria that there is no other treatment option available and that there is a blinded trial period to determine if effective. One suggestion was that the language about there being no other treatment option be changed to it being considered a late or last resort.

RESPONSE:

As noted above, the Advisory Committee carefully studied, reviewed and discussed the recommendations in the Guidelines, including those related to use of spinal cord stimulators, and made changes where they determined it was appropriate. The Guidelines recommended by the Advisory Committee did not recommend spinal cord stimulators at all. However, after the Board's Medical Director and his staff reviewed all comments and evidence submitted the Guidelines were revised to permit spinal cord stimulators when certain criteria were met, such as no other treatment option available and after a blinded trial period. Based upon the evidence

submitted and review performed the requirement that no other treatment option is available merited no change. The requirement that the trail be blind has been removed because it is not possible to perform a blind trial.

COMMENT:

Comments were received requesting that lumbar fusion be recommended as a treatment for Degenerative Disc Disease / “Discogenic Back Pain” / “Black Disc Disease” in the Mid and Low Back Injury Medical Treatment Guideline.

RESPONSE:

Based upon comments received during the comment period in 2009 and literature reviewed the recommendation regarding treatment for De Degenerative Disc Disease / “Discogenic Back Pain” / “Black Disc Disease” in the Mid and Low Back Injury Medical Treatment Guideline was changed as suggested. The June 30, 2010, edition of the Guideline recommends lumbar fusion as treatment for Degenerative Disc Disease / “Discogenic Back Pain” / “Black Disc Disease.”

COMMENT:

Some comments requested that the language for cervical and lumbar artificial discs be replaced to reflect FDA language.

RESPONSE:

The language for cervical and lumbar artificial discs does reflect FDA language.

COMMENT:

One comment was received requesting that the language in the Guidelines regarding NSAIDs be changed to reflect FDA recommendations.

RESPONSE:

Based upon comments and evidence received during the comment period in 2009, the Guidelines were revised to reflect the FDA language. The Guidelines also include additional background language based on the

literature available when the Guidelines were drafted. Changes to this language in the Guidelines will be subject to periodic review and will be modified as the scientific evidence warrants.

COMMENT:

Numerous comments were received noting concerns with the limits on physical therapy visits. Some comments stated that capping physical therapy visits will discourage conservative care and is not a reasoned approach to control cost. Further, arbitrary visit limits of 12 – 20 will restrict potentially needed care.

RESPONSE:

As noted above, the Advisory Committee carefully studied, reviewed and discussed the recommendations in the Guidelines, including those related to the number and types of modalities to be performed for physical therapy, and made changes where they determined it was appropriate. Further, the Board's medical director and his staff reviewed all comments and evidence submitted and where appropriate made revisions to the Guidelines. After both reviews the determination was made not to change these recommendations to add additional modalities or treatments. However, the Advisory Committee recognized the need to have a process that would allow for situations where a claimant's care might vary from the recommendations in the Guidelines. The variance process was developed with the goal of allowing for individualizing care under circumstances such as those identified by the commentators. The variance process provides the flexibility for medical providers to treat outside of the Guidelines, when indicated.

COMMENT:

A number of comments noted that while the variance process was conceptually good, clarification was needed to provide timeframes to respond to a variance request so large gaps in treatment do not occur.

RESPONSE:

Section 324.3 of the proposed regulation sets forth in detail the variance process, including how to request a variance, how much time the insurance carrier has to respond, the use of independent medical examinations

(IMEs) and records review, and the resolution of a denial of a variance request by the insurance carrier. The timeframes to respond to a variance request are fifteen days if the insurance carrier does not intend to obtain an IME or records review report and thirty days if the insurance carrier obtains such report. The insurance carrier has five business days from receipt of the request to inform the Chair if it will be obtaining an IME or records review. These comments do not require a change because it has already been addressed in the regulations.

COMMENT:

A number of comments were received requesting that the recommendation that electrodiagnostic studies (EDS), which include needle electromyelogram (EMG), performed in an out-patient setting be performed and interpreted by physicians board certified in Neurology or Physical Medicine and Rehabilitation be amended to include additional providers such as physical therapists, chiropractors, and physicians in other specialties.

RESPONSE:

This issue was discussed at length by the advisory committee. During the comment period in 2009, comments were submitted regarding which providers are appropriately trained to conduct EDS. The information submitted, which was reviewed the Medical Director and his staff, from the professional and accrediting organizations for EDS, such as the American Association of Neuromuscular & Electrodiagnostic Medicine, agree that only neurologists and physiatrists receive sufficient training during their residency programs to assure competence in the performance and interpretation of EDS. Based upon this information, the language was added that it is preferred that such tests be performed by board certified neurologists and physiatrists. This language was shared with the advisory committee, which supported this change. However, this preference does not prohibit other properly trained and certified providers from performing EMGs. Therefore no change is necessary.

COMMENT:

Numerous comments were received raising issues with the amount of reimbursement for physical therapy. Specifically, in addition to the amount of reimbursement, the comments stated that high quality physical therapy visits should be about 45 minutes, not the current 23 minutes of care. The comments recommended increasing the current maximum of 8 relative value units (RVUs) to 12 – 16 per visit.

RESPONSE:

The proposed regulation and the Guidelines do not place limits on the number of RVUs per visit. These limits are in the physical medicine section of the Medical Fee Schedule. No changes to the regulation or Guidelines are warranted based on these comments.

COMMENT:

One comment asked, in response to two of the general principles, about a standardized method of measurement and documentation for functional ability.

RESPONSE:

This will be addressed in the Disability Duration Guidelines (Section 11 – Functional Ability) that the Superintendent of Insurance just submitted to the Chair.

COMMENT:

A few comments indicated that the Guidelines do not distinguish the level of training and athleticism required by professional performing artists, such as dancers.

RESPONSE:

The Advisory Committee recognized the need to have a process that would allow for situations where a claimant's care might vary from the recommendations in the Guidelines. The variance process was developed with the goal of allowing for individualizing care under circumstances such as those identified by the commentators. The variance process provides the flexibility for medical providers to treat outside of the Guidelines, when indicated. The information provided by the medical providers in their comments, clinical

information that describes what makes a patient different, and objective documentation of a positive response by the patient to treatment modalities, is exactly the rationale for requesting and obtaining a variance. The variance is the path to an exception, not the exemption of certain professions, occupations or patient populations. Therefore, this change was not made.

FORM LETTERS

Of the 3,110 form letters, approximately 2,096 were from individuals stating they were claimants receiving chiropractic treatment. The first comment in the letter is concern that the signers will not be able to obtain the treatment they need to fully recover and return to work because the guidelines are for typical, uncomplicated cases. This issue has been addressed through the inclusion of the variance process. If additional chiropractic manipulation or modalities are needed then the chiropractor can request a variance in accordance with §324.3. This is also true for treatment that is not recommended by the Guidelines. The second comment is support for the comments and recommendations of the chiropractic profession which have been discussed above.

Approximately 364 of the form letters were from individuals stating they were chiropractors authorized to treat claimants. The letters first state that there are unanswered questions about the implementation and applicability of the Guidelines. These questions are answered by the regulations which sets forth the implementation and applicability and the training which is free of charge. As stated above, the regulations set forth the variance process in detail in §324.3. If the Guidelines are not appropriate for a claimant, then the chiropractor may request a variance. The second issue raised is that the Guidelines may limit a chiropractor's ability to perform medically necessary services for which he or she is qualified, trained and licensed to perform. However, no example is provided. The Guidelines do not prohibit a particular provider from performing treatment that is within his or her scope of practice. The third issue raised relates to how chiropractors bill for services provided to claimants. How chiropractors bill is governed by the Chiropractic Fee Schedule, which is

not part of this rule. However, a rule has been proposed to amend the Chiropractic Fee Schedule so that chiropractors can bill by modalities rather than through a global fee. This change is expected to take effect on December 1, 2010, the same date as this rule. Finally, the letter expresses support for the comments of the New York State Chiropractic Association, which have been addressed above.

Approximately 548 of the 3,110 form letters were submitted by individuals who stated they were patients receiving physical therapy services. The letters express two main concerns; reimbursement and access. The first concern regarding reimbursement is not the subject of this rule. The limits on number of relative value units (RVUs) provided in a session is set forth in the physical medicine section of the Medical Fee Schedule, which is the subject of a separate rule making and therefore will not be addressed in this document. The second concern relates to the maximum number of visits or modalities and the concern it will limit potentially needed care. If additional visits or modalities are needed, the treating physician may request a variance. The last point in the letter urged the Board to meet with the New York Physical Therapy Association. The meeting was held during the public comment period.

Approximately 102 of the form letters were submitted by physical therapists and discussed three main concerns. The first concern identified was omission of the physical therapy profession's current evidence based practice patterns. This omission the letters assert will guarantee that claimants do not receive high-quality care. Further, the lack of quality care is not due to treatment techniques but reimbursement patterns. As stated above, the Guidelines are based upon the ACOEM low back guidelines and the State of Colorado neck, knee, and shoulder guidelines. These guidelines were chosen as the best of the guidelines available for work related injuries. The second concern relates to the reimbursement for physical therapy services and the RVU cap. As stated above, the reimbursement and RVU cap are in the physical medicine section of the Medical Fee Schedule, which is not part of this rule. The third concern relates to the limits on visits or modalities set forth in

the Guidelines. As mentioned above, if additional visits or modalities are necessary, then a variance can be requested by the treating physician ordering such additional visits or modalities.

CHANGES TO TEXT OF REGULATION:

1. §324.1 (c) – amended definition of "Insurance carrier or Special Fund's medical professional" to add colon
2. §324.1(g) – amended definition of Medical Treatment Guidelines" to change "subpart" to "part"
3. §324.2 (a) – changed date from "October 18, 2010" to "December 1, 2010"
4. §324.2 (b) – amended to make clear that the fee must be sent with request; corrected the address where requests for guidelines must be sent; clarified that email address and telephone number are for information about the guidelines, as it is not possible to send a fee with an email and that request must be in writing; and clarified that checks should be made payable to "Chair, WCB" as the word "Guidelines" is not needed
5. §324.3 (a) (1) – added language to clarify that a variance is needed when treatment is not recommended by Guidelines
6. §324.3(b) (2) (i) (*c*) – changed the cite at end from paragraph 2 of this subsection to "subparagraph (ii) of this paragraph"
7. §324.3(b) (2) (ii) (*a*) – clarified only have to notify chair within 5 business days.
8. §324.3(b) (4) – added clarifying language that the insurance carrier is not liable unless claim or condition is established.
9. §324.3(d) (7) – added clarifying language "and then only if the carrier on notice is found liable for the claim."
10. §324.4 (d) – added clarifying language "and the insurance carrier or Special Fund is not liable for the cost of such treatment unless the claim or condition is established."

11. §324.4 (h) – added clarifying language "and then only if the claim or condition is established."

12. §324.5 – corrected cite from "subdivision (c) (4)" to "subdivision (a) (4)."

13. §325-1.3 (b) (3) – clarified provision

14. §325-1.4 (a) (9) – clarified that it is receipt by the Board.

15. §325-1.4 (b) (2) – added clarifying language, "and the self-insured employer or insurance carrier is not liable for the cost of said treatment unless the claim or condition is established as compensable."

16. §325-1.4 (b) (3) – added clarifying language, "and then only if the claim is established as compensable."

17. §325-1.4 (d) – added missing cite to paragraph (3) of §324.2 (d) and changed "excepted' to "excluded"

18. §325-1.24 – p. 31 – changed date from "October 18, 2010" to "December 1, 2010"

19. §325-1.25 – p. 31 – 33 – changed date from "October 18, 2010" to "December 1, 2010"

20. 325-1.25 (c) (7) – clarified provision so consistent with §324.3 that occupational & physical therapists can not request a variance.

CHANGES TO GUIDELINES:

1. In the New York Mid and Low Back Injury Medical Treatment Guidelines (Back Guideline) the words "Low Back" or letters "LB" were changed to *"back"* to reflect the change in the name of the Guidelines from Low Back to Mid and Low Back. The change in the name of this Guideline occurred before the publication date but "LB" was mistakenly left in the document.

2. In the New York Neck Injury Medical Treatment Guidelines (Neck Guideline) there were several places where "LB" or "Low Back" mistakenly appeared. Any reference to LB was changed to *"neck"*.

3. In the Electrical Bone Stimulator sections of the Back Guideline (E.5.) and the Neck Guideline (E.3.) several words inadvertently left out of the last sentence in the section were added, "as evidenced by serial x-rays over *a course of 3 months during the latter portion of the 6 month period."*

4. In the Electrical Bone Stimulator section (E.3.) of the Neck Guideline, two BMI values are listed: Morbid Obesity > 40 and Obese= BMI $\geq$ 30 We say > 40. The second was to have been removed. This was corrected so it now reads, *"Morbid obesity >40"*

5. In the Back Guideline, the Spinal Cord Stimulator section, the language as existed was not clinically feasible. The language has been changed by removing the words, "with the patient blinded to the on/off status."

6. In the Back Guideline, at the end of the document, after the ACOEM and State of Washington source information, and before the Index, the following words should appear: "*Recommendations modified from ACOEM's Occupational Medicine Treatment Guidelines for Low Back Disorders are indicated by (WCB)"*. This sentence was inadvertently left out of the Back Guideline.

7. In the Neck Guideline, transforaminal injections was removed from "C.2.b. Injections-Diagnostic" for internal consistency. The recommendation under "C.2.b. Injections-Diagnostic" is "not recommended" however another section, D.3.a.i. permits transforminal diagnostic injections. The section now reads:

C.2.b. Injections-Diagnostic

Including median branch blocks, atlanto-axial/atlanto-occipital

Not recommended.

8. In the Back Guideline Section C.1.b.vi. has been corrected to complete phrase in the last sentence by adding "*and/or*" between "manipulation" and "acupuncture".

9. In the New York Knee Injury Medical Treatment Guidelines (Knee Guideline), in Table 3 the reference to "see Table 5, following page" was removed as there is no Table 5 on the following page.

10. In the Knee Guideline, in Table 5, there was a reference to Table 9, which was corrected to "Table 6."

11. The remaining changes in all the Guidelines were spelling (for example: myelgram spelled wrong and corrected to myelogram), grammar, and formatting changes (bullets, spacing, etc).