

Revised Regulatory Impact Statement

1. Statutory Authority:

The Chair of the Workers' Compensation Board (Board) is authorized to amend § 300.23 (d) of Title 12 NYCRR, adopt a new Part 324 of Title 12 NYCRR, amend §§ 325-1.2, 325-1.3, 325-1.4, and the title and first paragraph of 325-1.24 of Title 12 NYCRR, and add a new §325-1.25. Workers' Compensation Law (WCL) § 117 (1) authorizes the Chair to make reasonable regulations consistent with the provisions of the WCL and the Labor Law. WCL § 141 authorizes the Chair to enforce all provisions of the chapter and make administrative regulations and orders providing in part for the receipt, indexing, and examining of all notices, claims and reports.

WCL § 13 of the WCL establishes employer liability for the provision of medical treatment and care for an injured employee and authorizes the Chair to prepare and establish a schedule for the state, or schedules limited to defined localities, of charges and fees for medical treatment and care, and including all medical, dental, surgical, optometric, or other attendance or treatment, nurse and hospital service, medicine, optometric services, crutches, eye-glasses, false teeth, artificial eyes, orthotics, prosthetic devices, functional assistive and adaptive devices and apparatus in accordance with and to be subject to change pursuant to rules promulgated by the Chair. Concomitant with an employer's liability to provide medical treatment and care for an injured employee and the Chair's authority to establish a medical fee schedule is the need for guidelines setting forth standards of appropriate treatment and care for injured or ill employees.

WCL §13-b requires individuals rendering medical care to, or conducting independent medical examinations (IMEs) of, claimants to be authorized by the Chair, except for six enumerated exceptions. This section also sets forth the process by which a physician becomes authorized to treat and/or conduct IMEs. The Chair has the authority to temporarily suspend or revoke a physician's authorization to treat or conduct IMEs for, among others, professional or other misconduct, exceeding the limits of his or her professional

competence in rendering medical care, failing to file medical reports, knowingly making a false statement, and failing to appear for testimony. WCL §§ 13-k, 13-l, and 13-m, respectively, give the Chair the power to authorize podiatrists, chiropractors, and psychologists to treat and/or conduct IMEs of claimants, and to temporarily suspend or revoke their authorizations for the same reasons as a physician.

WCL § 13-a (5) requires prior authorization from the insurance carrier or self-insured employer for operations, physical or occupational therapy, x-rays, or diagnostic tests costing more than \$1,000. The medical provider seeking to perform the special services costing more than \$1,000 must submit a request to the insurance carrier, who then has thirty days to respond to the request. A denial by the insurance carrier must be based upon a conflicting second opinion rendered by an authorized physician. Chapter 6 of the Laws of 2007, the 2007 workers' compensation reform legislation, amended this statutory provision to increase the threshold for prior authorization from \$500 to \$1,000. The reform legislation also amended the section to add a provision directing the Chair to issue and maintain a list of pre-authorized procedures costing more than \$1,000.

Section 80 of Chapter 6 of the Laws of 2007 specifically authorizes the Chair to adopt regulations to implement the reform legislation.

Although the statutes do not specifically require the adoption of guidelines, it is clear that the absence of them has resulted in an inefficient system. Because all medical practitioners do not have consistent, up-to-date standards on which to base treatment of occupational injuries and illnesses, claimants may not be receiving the high quality care they deserve. While some board certified physicians are required to engage in rigorous recertification processes demonstrating knowledge of the best treatments, the WCL does not require physicians to be board certified to treat claimants so all physicians are not subject to such recertification processes. Further, with no agreed upon standards on which to assess medical necessity, costly disputes and

unnecessary treatment delays occur. In his oversight of the workers' compensation system, the Chair has an obligation to recommend procedures to rectify these problems. These guidelines should help to do so.

2. Legislative Objectives:

The purpose of the workers' compensation reform in Chapter 6 of the Laws of 2007, effective March 13, 2007, was to increase benefits and improve delivery of services to injured and ill employees (claimants), while at the same time reducing costs. By letter dated March 13, 2007, then Governor Spitzer directed the Superintendent of Insurance to lead an effort with the necessary help and assistance of the Chair of the Board and the Commissioner of Labor to design new medical guidelines to account for modern diagnostic and treatment techniques and evidence-based standards of medical treatment and care with emphasis on “(1) guidelines that structure the information that the treating physician or other health care professionals is to report to the Board in order to minimize factual conflicts and the need for battles of experts before the Board, taking into consideration the appropriate use of impartial specialists and advances in imaging and diagnostic techniques; (2) a set of best practices for health care professionals who are providing treatment, taking into consideration the role of managed care and vocational rehabilitation; and (3) protocols and training for Workers' Compensation law judges and other employees.” In addition, the Governor placed emphasis on facilitating the employee's return to gainful employment. In 2007, the Governor appointed an Advisory Committee to assist the Superintendent comprised of representatives from Insurance, the Board, and Labor, 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 recommended Medical Treatment Guidelines (Guidelines) for the neck, back, shoulder, and knee that all providers would be required to use when treating 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.

The goals of the Guidelines are three fold:

1. Improve the quality of treatment and care provided;
2. Improve the speed of delivery of treatment and reduce friction costs (the costs involved in resolving disputes); and
3. Eliminate unnecessary medical treatments which do not contribute to a positive outcome.

These goals are consistent with the 2007 reform legislation in that they will facilitate delivery of quality medical treatment and care to workers' compensation claimants. These goals are also consistent with the directives of the Governor in that the Guidelines provide a structure for treatment and care, evidence-based standards of care, and provide a set of best practices for medical treatment and care.

As noted above, WCL § 13-a (5) was amended by Chapter 6 to increase the prior authorization threshold and require the establishment of a list of pre-authorized procedures. The Memorandum in Support of the 2007 workers' compensation reform legislation describes the purpose of these changes as follows, "to remove impediments to prompt diagnostic and treatment measures and to better reflect current medical service costs. The provision permitting the creation of a pre-authorized list allows the Board appropriate regulatory flexibility to add or remove procedures depending on best practices, increases or decreases in costs, or opportunities presented by managed care approaches."

3. Needs and Benefits:

Prior to the adoption of Chapter 6 of the Laws of 2007 and the Governor's directive to develop Guidelines, the Governor recognized the need to streamline practices and use existing resources in a better and smarter way through regulation. New York does not currently have treatment guidelines. In the absence of such guidelines, all New York practitioners do not have easily accessible up-to-date standards for treatment and

care. While some board certified physicians are required to engage in rigorous recertification processes demonstrating knowledge of the best treatments, the WCL does not require physicians to be board certified to treat claimants so all physicians are not subject to such recertification processes. In addition, such recertification only occurs every seven to ten years, whereas the Chair intends to update the guidelines every three to four years. Similarly, claims examiners at the insurance carriers and self-insureds (“carriers”) do not have agreed upon standards by which to assess the medical necessity of treatment and care. One result is the generation of substantial disputes about medical treatment and care that is detrimental to both employee and employer, as delivery of care is delayed and frictional costs increase.

The Guidelines determine the standard of treatment and care for workers’ compensation claimants. Carriers will only be required to pay for treatment and care that is consistent with the Guidelines or that has been approved through a variance process. The Guidelines create criteria for appropriate timing and use of diagnostic testing and medical treatments and will control utilization of treatment thereby reducing costs. It will control utilization of some significant cost drivers in New York:

- Limits chiropractic manipulation to 20-24 visits for neck and 6-12 visits for back injuries, depending on severity
- Limits various physical therapy modalities to 12-20 visits
- Provides that an MRI for back injuries is not appropriate in the first 6 weeks unless there are red flags
- Places limits on therapeutic injections in a 12 month period
- Prohibits repeated non-therapeutic nerve block injections
- Places additional limitations on 12 procedures that are subject to abuse or are complex and invasive : lumbar fusion, spinal cord stimulator, artificial disk replacement, vertebroplasty, kyphoplasty, electrical bone stimulation, anterior acromioplasty, chondroplasty, osteochondral autograft, autologus chondrocyte implantation, meniscal allograft transplantation, and knee arthroplasty

- Prohibits ineffective treatments (e.g. Medex machines, electro-analgesic nerve blocks, etc.).

Injuries involving the knee, shoulder, back, and neck account for approximately 36% of the claims but nearly 60% of system medical costs. Currently, many providers treat well in excess of the Guidelines. For example, it is not uncommon to see a claim with more than 50 or 100 chiropractic and/or physical therapy treatments.

In other states, treatment guidelines have significantly reduced medical costs. In California, the introduction of a 24 visit cap on chiropractic and physical therapy treatment led to a 72% decrease in chiropractic costs and a 58% decrease in physical therapy costs at 18 months. The utilization of chiropractic treatment in New York is roughly equivalent or slightly greater than it was in California before the cap.

The Guidelines will benefit everyone in the workers' compensation system, from claimant to employer, from treating physician to carrier, from lawyer to judge. It is generally recognized that use of evidence-based guidelines has the potential to improve the quality of care. Treatment guidelines grounded in evidence-based medicine and the sound clinical judgment of highly credentialed physicians translate the medical literature into a useable and practical tool that assists busy medical providers in delivering appropriate health care.

Without treatment guidelines, biases may affect determinations of medically necessary care to the claimant's detriment. Denial of medically necessary care simply to reduce costs is obviously harmful to the claimant. On the other hand, excessive utilization of medical services for the claimant does not improve outcomes. In fact, repeated unsuccessful procedures that are not clinically indicated may adversely affect the claimant. Treatment guidelines minimize the effects of bias in determining medically necessary care. By addressing these possible biases in treatment decisions, treatment guidelines deliver better care at lower cost.

Carriers (and their third- party administrators) use a variety of tools to assess appropriateness of care in an effort to control costs and ensure quality, a process that is called utilization management or review (UR). There is no requirement that carriers employ the same UR standards or processes, and this lack of uniformity may cause claimant-patients with the same conditions to be treated differently. This lack of standardization

may lead to variations in the treatment of claimants that are not explained by the nature of their injuries, so that some claimants may receive lower quality of care than others. Lack of standardization also adds to frictional costs by producing needless disputes.

Uniform UR standards based on treatment guidelines should significantly reduce this variation in treatment, increase the transparency of the medical claim and payment process, and lead to decisions based on sound, evidence-based medicine. Increased consistency in UR decisions will result in greater predictability for the medical provider and furnish a common ground for discussion between the treating physician and the UR physician or carrier about differences concerning appropriate treatment. A common standard used by all parties should reduce disputes and have a direct economic benefit to the system as a whole in the form of reduced costs. When disputes do arise, judges and arbitrators will have an acknowledged standard to use to resolve them, thereby promoting ease of resolution, more consistency and more timely decision making.

There may be instances where the Guidelines are not appropriate for a particular claimant. For example, there may be instances where the limit on physical therapy visits is reached but the claimant is still improving, or where a procedure needs to be earlier than set forth in the Guidelines. In such situations the treating medical provider may request approval for a variance from the Guidelines by submitting detailed information on the form prescribed for this purpose. The regulations require specific information and the burden of proof for a variance is on the claimant and treating medical provider. Variances are the exception to the rule and are to be requested only when clearly medically necessary. Carriers have up to 30 days to respond to a variance request and are provided with differing options if they feel that an additional medical opinion is needed to help them respond to the variance request. If the variance is denied, and the claimant requests review of the denial, a determination will be made by a Workers' Compensation Law Judge (WCLJ) at an expedited hearing or, if both the claimant and the carrier agree in writing, by a medical arbitrator appointed by the Chair which at this time will be the Board's Medical Director or Assistant Medical Director. If the dispute is referred to the

medical arbitrator there will be no hearing and no appeal pursuant to WCL §23, resulting in an expeditious resolution. The variance process, though it should be used infrequently, provides flexibility to ensure that claimants receive appropriate and medically necessary care.

The rule establishes the pre-authorized list required by WCL §13-a (5). Specifically, the pre-authorized list consists of all medical care recommended by the Guidelines, except for 12 procedures or treatments. The 12 procedures or treatments which are not on the pre-authorized list require prior authorization because they are subject to abuse or are complex and invasive. One of the complaints about the workers' compensation system is the delay in treatment. By adopting the Guidelines as the standard of care for the neck, back, shoulder, and knee, and making all but 12 procedures or treatments pre-authorized, medically sound, evidence based treatment will flow promptly to injured workers. Prompt medical care will greatly improve the claimant's recovery and the likelihood that he or she will return to work.

4. Costs:

The proposed rule will impose some additional costs on the regulated parties, the Board, the State or local governments which are expected to be offset by the savings from use of the medical treatment guidelines. Medical professionals, insurance carriers, self-insured employers, third party administrators, and the Board will be required to incorporate the Guidelines into their policies, practices, and procedures. There will be some cost to accomplish this incorporation which will vary depending on current practices, size of entity, familiarity and use of any treatment guidelines, and internal processes to amend policies, practices, and procedures. To assist in this process, the Board will be providing training to stakeholders and Board employees. There will be no charge for this training at this time. The training will not only cover the Guidelines, but provisions of this rule.

The Guidelines will be available on the Board's website and anyone will be able to download and print them free of charge. If an individual or entity requests a hardcopy of one or more of the guidelines, the cost

will be \$10.00 per guideline or \$40.00 for all four. This charge is to cover the Board's cost in making the copies. The charge for one or more of the Guidelines on a compact disc is \$5.00.

Treating medical providers will incur some cost when requesting a variance due to the need to complete the required form and provide the required information. However, the variance process is very similar to the current process to request prior authorization under WCL §13-a (5). In fact, the form to request a variance was modeled after the form to request prior authorization, the C-4Auth. Upon receiving a variance request, the carrier has the option of having it reviewed by its own medical staff, either employees or contractors, or having an IME or records' review performed. If the carrier does not believe the variance request meets the burden of proof required, it may deny the variance request without a medical opinion; however, for all other denials where the burden of proof has been met, there must be a medical opinion. Carriers will incur the costs if an IME or records review is obtained. The Board does not know how much an IME costs the carriers. While IMEs are covered by the medical fee schedule, the fee for the applicable code is determined "BR" or by report. This means it depends on what the examiner charges for the examination and report. In addition, carriers may hire IME entities to perform administrative functions which results in an additional charge. The actual cost of an IME is not provided to the Board at this time. The cost for IMEs or records reviews to respond to variance requests will be offset by the reduction in number of IMEs required to respond to requests for prior authorization for the procedures and treatments on the pre-authorized list.

If a variance is denied, a WCLJ will resolve the issue at an expedited hearing or, if both parties consent, a medical arbitrator will resolve the issue. Carriers and claimants will incur costs if the denial is resolved through the hearing process; however, these costs are similar to the ones incurred for resolving denials of requests for prior authorization. These costs should be offset by the reduction in the number of denials, due to the reduction in the number of requests for prior authorization that need to be resolved. If the parties opt to use the medical arbitrator, the costs are nominal as there is no hearing or testimony. The medical arbitrator

resolves the dispute on the variance request and the denial on the documents submitted without testimony. Further, the medical arbitrator's decision is not subject to an administrative appeal which eliminates the cost of an appeal.

There will be some cost for those providers that opt-in and those carriers who do not opt-out of the optional prior approval process set forth in the rule. The optional prior approval process provides an opportunity for the treating medical provider to seek the carrier's agreement, prior to providing treatment that the treatment is consistent with the Guidelines. If the carrier agrees, the provider can treat the claimant knowing his or her bill will not be objected to on the grounds that the medical care was not consistent with the Guidelines. Through this process the carrier has the opportunity to discuss the treatment with the provider and come to a consensus that the treatment is consistent with the guidelines. There are costs to the treating medical provider associated with completing the form to request the optional prior approval and costs to the carrier in having the request reviewed by its staff medical professional that is either an employee or contractor. However, the cost is offset by the savings to the provider generated by prompt payment without waiting for resolution of a disputed medical bill. In addition, if the treatment is not consistent with the guidelines and this process is used, the provider does not perform treatment for which it is not paid. There are also costs to the carrier associated with reviewing the request. However, these costs are offset by savings from eliminating the need for hearings to resolve whether the treatment was consistent with the guidelines.

As noted in the needs and benefits section, use of the Guidelines means that providers and carriers are using the same standards to determine if medical treatment is necessary, which will result in a reduction in disputes over medical bills. Reductions in disputes will reduce the costs involved in resolving them and increase the speed of payment. Further, the Guidelines along with the pre-authorized list will reduce the delays in treatment and care and improve medical outcomes so that claimants may return to work faster.

The use of the Guidelines is expected to result in millions of dollars of savings. Because the Board does not receive payment information about medical bills and does not track the number of treatments a claimant receives, it cannot determine the actual savings to be realized. However, costs associated with unnecessary and excessive treatment and therapies will be eliminated or greatly minimized with implementation of the Guidelines. In short, use of the Guidelines should result in savings that are greater than the costs.

The rule requires carriers to file with the Board their objections to medical bills submitted by providers for payment. Under existing rules the valuation objection is only sent to the provider. However, this makes it difficult for the Board to independently determine if the carrier objected to a bill and if that objection was timely before it issues an administrative award, which designates that the carrier is responsible for payment because it did not timely object to the amount of the bill. This change will provide the Board with evidence that the objection was made and, assuming the carrier follows the requirement to send the objection to the Board and provider on the same day, evidence of whether the objection was made timely. Such evidence will improve the processing of administrative award by reducing the number that are issued incorrectly or based on submission of incorrect information. Additionally, once carriers start filing objections with the Board, it can start collecting data about such objections. Currently allegations are made about the validity of objections and medical bills by the providers and carriers. The data gathered from the objections will help the Board to research these allegations and work to solve them. The rule also requires the objection, except for adjustments to the proper fee schedule amount, to be filed on the Chair prescribed form. The form on which to make valuation objections currently exists, but its use is not mandatory. There will be a cost associated with having to use and file the prescribed form with the Board, which should be nominal. The form can be filed by fax, email, or regular mail. As the fax number is toll free there should be only nominal costs in filing by fax and email. The cost to file by regular mail is the cost of postage. The Board is also developing an electronic

version of the form so that carriers can fill in basic identifying information and attach an explanation of benefits.

The *Mid and Low Back Injury Medical Treatment Guidelines* are based upon Chapter 12, Low Back Disorders, of the American College of Occupational and Environmental Medicine's (ACOEM) *Occupational Medicine Practice Guidelines, 2nd Edition*. The Advisory Committee then undertook a line by line analysis of the base guideline and the medical professional members suggested modifications based on their clinical judgment, professional experience based on general medical principles, and knowledge, review, and research of literature to produce the best guidelines for New York. In addition, the medical professionals reviewed the state guidelines of Colorado and Washington for work-related injuries and incorporated the best and relevant portions. In addition the *Neck Injury Medical Treatment Guidelines*, *Knee Injury Medical Treatment Guidelines*, and *Shoulder Injury Medical Treatment Guidelines* include aspects of the relevant chapters of the *Occupational Medicine Practice Guidelines, 2nd Edition*, which is copyrighted by ACOEM. The Board has received permission from ACOEM to use these portions of its guidelines in its guidelines, which includes making the New York Guidelines available for downloading, copying, and use for educational and informational purposes. There is no cost to the Board for such use. However, an entity that seeks to use the New York Guidelines for commercial use, such as creating software to help use the guidelines, will need to obtain permission directly from ACOEM.

5. Local Government Mandates:

The rule only imposes a mandate on local governments that are self-insured or that own and/or operate a hospital. The mandates on local governments are the same as those imposed on private self-insured employers, insurance carriers, the State Insurance Fund, third party administrators, medical professionals, private hospitals. Self-insured local governments and those that own and/or operate a hospital will need to

comply with the requirements in the rule the same as a private self-insured employer or insurance carrier or private hospital.

On and after October 18, 2010, the rule requires that all claimants with injuries, illnesses or occupational diseases to the neck, back, shoulder, and/or knee be treated in accordance with the Guidelines adopted by the regulation. Self-insured local governments will be required to incorporate the Guidelines and the rule into their policies, procedures and practices and certify that this has been done. Local governments who are self-insured will be required to pay for medical treatment that is consistent with the Guidelines, to review and respond to variance requests, and to respond to optional prior approval requests if they do not opt-out. Physicians employed by public hospitals will be required to use the Guidelines to treat workers' compensation claimants, the same as physicians employed by private hospitals. Such physicians will also need to request a variance for treatment that deviates from the guidelines and to follow all of the other rules.

6. Paperwork Requirements:

Treating medical providers, self-insured employers, insurance carriers, the State Insurance Fund, claimants, and others who participate in the system will have new paperwork requirements. A number of the submissions relating to the Guidelines are on prescribed forms promulgated by the Chair and all but two of the forms are already in use. Variance requests and responses, as well as requests for review of a denial and the election to opt-in to the medical arbitrator process require the use of one form. For those providers and carriers participating in the optional prior approval process, the requests and responses require the use of one form prescribed for this purpose. The use of prescribed forms ensures that everyone can identify the request and response when it is received and that the Board can track the process and intervene when necessary.

In addition to the two new forms, the regulations require the use of three existing forms, two of which are already mandatory. The form to request prior authorization and the form to terminate treatment or to raise a

non-valuation objection to a medical bill are already required forms that are in use. There will be changes to the forms to reflect the implementation of the Guidelines.

The rule requires carriers to use the Chair prescribed form for valuation objections to medical bills. The current rule only requires the objection to be in writing and explain in detail the reasons for non-payment. However, what carriers send to providers varies greatly and in many cases does not clearly provide the reason for the objection. Use of the prescribed form will ensure providers know the reasons their bills were not paid. The rule does not require use of the form if the carrier adjusted the amount billed so it conforms to the appropriate fee schedule.

Insurance carriers, self-insured employers and the State Insurance Fund are required to certify that they have incorporated the Guidelines and this rule into their policies, procedures, and practices. Further, if they modify their policies, procedures, and practices, they must certify that the Guidelines and this rule are still incorporated. This is a new paperwork requirement and was one of the implementation recommendations from the Advisory Committee that included representatives of the Business Council of New York State. The recommendation actually calls for an annual certification which is not included in the rule as it was deemed to be too burdensome when compared to the benefit received. Rather, the rule requires an initial certification and then a new certification when the policies, procedures, and practices are modified.

7. Duplication:

The proposed regulation does not duplicate or conflict with any state or federal requirements.

8. Alternatives:

The Board shared a draft of the regulations with the AFL-CIO, Business Council of New York State, State Insurance Fund, New York Insurance Association, American Insurance Association, Property Casualty Insurers Association of America, Medical Society of the State of New York, New York Conference of Mayors, New York State Association of Counties, and the Association of Towns of the State of New York,

and requested comments. In addition, the Board either met with or had conference calls with representatives from most of these entities. With respect to the Guidelines themselves, the Board solicited comments on them between August 13, 2009, and September 9, 2009. Those seeking revisions to the guidelines were instructed to provide medical evidence supporting such changes. The Board received numerous comments which were reviewed by the Board's Medical Director and some changes were made to the guidelines.

There are no practicable alternatives to adopting treatment guidelines. Currently, the Board is operating without treatment guidelines, which does not lend itself to uniform standards of quality treatment and care and containment of costs. As stated above, this presents administrative and practical problems. Administratively, a uniform system with standards of medical treatment and care will encourage proper and timely treatment and care, and reduce unnecessary litigation and delay, and, in turn, improve the efficacy and efficiency of the workers' compensation system. Practically, the proposed regulation will cause participants to utilize the Guidelines and regulatory processes.

The Guidelines adopted by this rule are specific to New York in that the Advisory Committee started with already existing treatment guidelines and then modified them based upon their experience, expertise, literature, and the guidelines not chose as the base, either ACOEM or state of Colorado or Washington. Specifically, the *Mid and Low Back Injury Medical Treatment Guidelines*, as noted above, are based upon the Chapter 12 of ACOEM's *Occupational Medicine Practice Guidelines, 2nd Edition*. The other three guidelines are based upon the treatment guidelines created and adopted by the State of Colorado for its workers' compensation claims. All four base guidelines were then modified. An alternative would have been to adopt one of the already existing treatment guidelines without any modifications. For example, treatment guidelines were developed by Colorado and Massachusetts for use in those states, while other states use the American College of Occupational and Environmental Medicine (ACOEM) or Official Disability Guidelines (ODG) treatment guidelines. However, the medical professionals tasked with drafting the Guidelines felt that the

existing treatment guidelines were not sufficient for New York State without modifications. As the guidelines were developed by medical professionals appointed by business and labor and reflect the consensus of the Advisory Committee, adoption of these guidelines is best for New York as it reflects the practice of medicine and the treatment of work-related injuries in New York.

The rule provides that all medical care consistent with the Guidelines costing more than \$1,000, except for twelve procedures or treatment, is on the pre-authorized list authorized by WCL §13-a (5). An alternative would be to not put medical care consistent with the Guidelines costing more than \$1,000 on the pre-authorized list and require prior authorization. This alternative was rejected because it is unnecessary and impedes the quick delivery of medical care. The Guidelines are the standard of care for injuries, illnesses, or occupational diseases to the mid and low back, neck, shoulder, and knee. If providers are treating claimants consistent with the Guidelines, they are providing the medical care that the Board has established, upon the recommendation of medical professionals on behalf of business and labor, as the best and most appropriate. To require prior authorization on whether the treatment costing more than \$1,000 that is required by the guidelines is medically necessary is redundant in most cases. If prior authorization were required in these situations, it would slow the treatment of claimants and could result in a delay in or less than optimal recovery. Twelve treatments or procedures in the Guidelines still require prior authorization because they are complex or high risk, invasive procedures or are procedures subject to abuse. Once performed a number of these procedures, such as a total knee replacement, cannot be undone and may result in a worsening of the claimant's condition.

An alternative would be to require strict adherence to the Guidelines without the possibility of a variance. The Superintendent of Insurance recommended to the Chair, based upon the recommendation of the Advisory Committee that variances be allowed in limited circumstances. The ability to vary from the treatment guidelines is necessary in some limited circumstances because claimants are different and all injuries or

illnesses do not always progress in the same manner. Without the ability to request a variance, when it is appropriate and medically necessary, some claimants would not receive the best medical care.

Another alternative would be to allow physical and occupational therapists to request a variance for additional physical or occupational therapy treatment. However, because any physical or occupational therapy can only be performed based upon a referral from a treating physician, who must maintain records of the therapy treatment pursuant to WCL §13-b, the treating physician is in a better position to understand a claimant's overall progress and the need for a variance.

Before finalizing these regulations and adopting the Guidelines, the Board operated a pilot program in which authorized physicians and chiropractors and insurance carriers, self-insured employers, and the State Insurance Fund participated and agreed to use the guidelines and follow specified processes. As part of the pilot program, all denials of variance requests were resolved by the Board's Medical Director without a hearing or medical testimony. A survey of pilot participants resulted in 90% agreeing or strongly agreeing that the Medical Director's office is a fair and efficient method of resolving medical guideline disputes. An alternative would be to have all requests for review of the denial of a variance request reviewed by the Medical Director or through the medical arbitrator process established as an option in the rule. However, as there is no statutory authority for such option, the rule cannot mandate use of the medical arbitrator to resolve variance disputes but instead provides it as an option that the claimant and carrier can choose to exercise. The medical arbitrator, for now, is the Board's Medical Director or Assistant Medical Director, or New York licensed physicians designated by the Chair. If the claimant and carrier do not both opt-in, the variance is resolved through the expedited hearing process.

The rule requires the claimant or his or her legal representative to request review of the denial of a variance. An alternative would be to automatically schedule an expedited hearing, or if the parties both opt-in to refer the dispute to the medical arbitrator, without any further action by the claimant or carrier. The Chair

chose not to adopt this alternative because, after consulting with his or her treating medical provider, the claimant may not want to proceed with the variance request and undergo that specific procedure. Further, as the burden of proof is now on the claimant to show that the variance is medically necessary and appropriate, having the claimant request review provides an opportunity for him or her to evaluate whether the burden has been met.

Another alternative would be to eliminate the optional prior approval process. However, based upon results from the pilot survey, such process improves communications between carriers and treating providers and reduces medical bill disputes. Improving communication and reducing the number of medical bill disputes results in faster access to care for claimants.

The rule amends §325-1.3 to increase the maximum length of time between the submission of medical reports from forty-five days to ninety days. An alternative would be to leave the time period at forty-five days. 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 medically necessary visit is required, but no more than ninety days apart, fewer unnecessary office visits will be scheduled and costs reduced.

Another alternative would be to require that the prescribed form be used for all valuation objections. Originally, the rule had such a requirement, but based upon legitimate concerns, the rule was changed to exempt objections that merely adjust the fee so that it reflects the appropriate fee schedule. Some providers do not adjust their billing systems to bill workers' compensation treatments at the appropriate fee schedule. Rather these providers bill using their usual and customary rate. When the carriers process and pay the bills, they must adjust for the workers' compensation fee schedule and object to that portion of the bill that is above

the fee schedule. As there is no dispute for the Board to resolve in these situations, the benefit of using the prescribed form was outweighed by the cost and burden to the carriers.

9. Federal Standards:

There are no federal standards applicable to this proposed regulation.

10. Compliance Schedule:

The effected date of the regulation has been changed to December 1, 2010, from the original date of October 18, 2010, to provide participants with two additional months to comply with the regulation and take the training. This change was made based upon comments from some participants that the extra time was needed. Participants will now have two months in which to take the training and finalize the incorporation of the Guidelines and the processes in the regulations into their policies, procedures and practices.