

## Revised Summary of Regulatory Impact Statement

### 1. Statutory Authority:

Workers' Compensation Law (WCL) § 117 (1) authorizes the Chair to make regulations consistent with the WCL and the Labor Law. WCL § 141 authorizes the Chair to enforce all provisions of the chapter and make administrative regulations.

WCL § 13 establishes employer liability for medical treatment and authorizes the Chair to establish a fee schedule for medical treatment. The Chair's authority to establish a fee schedule forms the basis for Medical Treatment Guidelines (Guidelines) which set the standards of appropriate treatment.

WCL §13-b requires individuals providing medical care or conducting independent medical examinations (IMEs) of claimants to be authorized by the Chair, except for six enumerated exceptions. The Chair has the authority to temporarily suspend or revoke a physician's authorization to treat or conduct IMEs. WCL §§ 13-k, 13-l, and 13-m, respectively, allow the Chair to authorize podiatrists, chiropractors, and psychologists to treat and/or conduct IMEs, and to temporarily suspend or revoke their authorizations.

WCL § 13-a (5) requires prior authorization from the carrier for special procedures costing more than \$1,000, increased by Chapter 6 of the Law of 2007 from \$500. A denial by the carrier must be within 30 days and must be based upon a conflicting second opinion rendered by an authorized physician. The 2007 reform legislation also added a provision directing the Chair to issue a list of pre-authorized procedures costing over \$1,000.

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, claimants may not be receiving the high quality care they deserve.

Further, with no agreed upon standards on which to assess medical necessity, costly disputes and unnecessary

treatment delays occur. In his oversight of 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 reform in chapter 6 of the Laws of 2007, effective March 13, 2007, was to increase benefits and improve delivery of services to injured workers while reducing costs. By letter dated March 13, 2007, the Governor directed the Superintendent of Insurance, with the assistance of the Board's Chair and the Commissioner of Labor, to design guidelines to account for modern diagnostic and treatment techniques and evidence-based standards of medical treatment in order to minimize litigation conflicts and speed return to employment. The Governor appointed an Advisory Committee of respected individuals in the industry to assist the Superintendent and who recommended to him proposed treatment guidelines for the shoulder, knee, neck, and back injuries that all providers would be required to use when treating injuries to those body parts. The Superintendent then recommended them to the Chair.

The goals of the Medical Treatment Guidelines (Guidelines) are three fold:

1. Improve the quality of treatment;
2. Improve the speed of delivery and reduce friction costs; and
3. Eliminate unnecessary medical treatments which do not contribute to a positive outcome.

These goals are consistent with the legislation and the Governor's directive in that they facilitate delivery of quality medical treatment to injured workers and provide a structure for that treatment based upon evidence-based standards and best practices.

WCL § 13-a (5), as amended by Chapter 6, increases the prior authorization threshold and requires a list of pre-authorized procedures. The pre-authorized list allows the Board appropriate regulatory flexibility to add or remove procedures depending on best practices, increases or decreases in costs, or various managed care approaches.

### 3. Needs and Benefits:

Because New York does not currently have treatment guidelines, all New York practitioners do not have up-to-date standards for the treatment of occupational injuries to the knee, shoulder, back and neck, which account for approximately 36% of the claims but nearly 60% of medical costs. Similarly, insurance carriers, self-insured employers, and the State Insurance Fund (“carriers”) do not have standards to assess the medical necessity of treatment, which results in disputes over treatment, delayed care, and increase frictional costs.

The Guidelines set the standard of treatment. Carriers will only pay for treatment consistent with the Guidelines or approved through a variance process. The Guidelines create criteria for timing and use of diagnostic testing and treatments, and controls utilization of some significant cost drivers such as chiropractic manipulations, physical therapy modalities, MRIs, therapeutic injections, and nerve blocks injections. It also places limitations on 12 procedures that are subject to abuse or are complex and invasive. It prohibits ineffective treatments such as use of Medex machines and electro-analgesic nerve blocks.

In other states, treatment guidelines have significantly reduced medical costs. In California, a 24 visit cap on chiropractic and physical therapy decreased chiropractic costs by 72% and physical therapy costs by 58% in 18 months.

The Guidelines will benefit participants by improving the quality of care. Treatment guidelines, grounded in evidence-based medicine and the sound clinical judgment of highly credentialed physicians, is a useable and practical tool for stakeholders.

Without treatment guidelines, biases may affect determinations of medically necessary care to the claimant’s detriment. While denial of care to reduce costs is harmful, overuse of medical services does not necessarily improve outcomes. Treatment guidelines minimize the effects of bias by addressing sound treatment practices, providing better care at lower cost.

Carriers use utilization management to assess appropriateness of care to control costs and ensure quality. However, lack of uniformity in UR standards may lead to variations in the treatment and adds frictional costs by producing needless disputes.

Uniform UR standards based on treatment guidelines should significantly reduce variation in treatment, increase the transparency of the medical claim and payment process, lead to decisions based on sound, evidence-based medicine, and reduce disputes. When disputes do arise, adjudicators will have a standard to resolve them.

Instances will occur where the Guidelines are not appropriate for a particular claimant. In such situations the treating medical provider may request approval for a variance by submitting information on the form prescribed for this purpose. The burden of proof for a variance is on the claimant and treating medical provider. Carriers have 30 days to review the request and respond. If the variance is denied, and the claimant requests review of the denial, a determination will be made at an expedited hearing or, if both the claimant and the carrier agree in writing, by a medical arbitrator appointed by the Chair. If the dispute is resolved by a medical arbitrator, there is no further appeal. The variance process provides flexibility to ensure that claimants receive necessary care.

All the treatments outlined in the Guidelines comprise the pre-authorized list, except for 12 procedures which are subject to abuse or are complex and invasive. By adopting the Guidelines as the standard of care for the neck, back, shoulder, and knee, and making all but 12 procedures pre-authorized, medically sound, evidence based treatment will flow promptly which will improve recovery and expedite a return to work.

#### 4. Costs:

The proposed rule will impose some additional costs on the regulated parties, the Board, the State, and local governments which are expected to be offset by the savings from use of the guidelines. Medical professionals, insurance carriers, self-insured employers, third party administrators, and the Board will be required to

incorporate the guidelines into their procedures. Costs will vary depending on current practices, size of the entity, familiarity with and use of any treatment guidelines.

The Board will provide training on the Guidelines to stakeholders at no cost. Copies of the Guidelines will be available on the Board's website free of charge. The cost of a hard copy is \$10.00 per guideline or \$5.00 for a compact disc of the four Guidelines.

Treating providers will incur some cost when requesting a variance due to the need to complete the required form. Upon receiving a variance request, the carrier has the option of having it reviewed by its own medical staff, or seeking an IME opinion. 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 a medical opinion is necessary. Carriers will incur the costs if an IME or records review is obtained. The cost, however, will be offset by a reduction in IMEs due to the pre-authorized list.

If a variance is denied, the issue will be resolved at an expedited hearing or, if both parties consent, by a medical arbitrator. Parties will incur costs if the denial is resolved through the hearing process; however, these costs should be offset by the reduction in the number of denials. If the parties opt to use the medical arbitrator, the costs are nominal because there is no testimony or administrative appeal.

There will be some cost for providers who opt-in and those providers who do not opt-out of the optional prior approval process. This process provides an opportunity for the treating provider to seek the carrier's agreement, prior to providing treatment. If the carrier agrees that the treatment is consistent with the Guidelines, the provider can treat and bill, knowing that the carrier will not object. Providers will have costs associated with completing the optional approval form, and carriers will have costs associated with their responses. However, the cost is offset by the savings to the provider generated by prompt payment and fewer disputes. Carrier costs are offset by savings from eliminating the need for hearings to resolve treatment disputes.

Use of the Guidelines means that providers and carriers employ the same standards to determine if medical treatment is necessary, resulting in fewer disputes over medical bills which reduces costs and speeds payment. The pre-authorized list reduces delays in treatment and improves medical outcomes.

Use of the Guidelines is expected to result in millions of dollars of savings by eliminating unnecessary and excessive treatments and therapies which will offset any additional costs.

Except for adjustments to the proper fee schedule amount, the rule requires carriers to file with the Board on a prescribed form their valuation objections to medical bills. This submission will diminish disputes over whether an objection was filed and the timeliness of the objection. There will be nominal costs associated with filing the form which can be faxed, emailed, or filed by regular mail.

#### 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. Those entities 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 to the neck, back, shoulder, and/or knee be treated in accordance with the Guidelines. Self-insured local governments will be required to incorporate the Guidelines into their 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 respond to variance requests and 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 injured workers, to request a variance, and follow all of the other rules.

#### 6. Paperwork Requirements:

Treating medical providers, carriers, the State Insurance Fund, claimants, and others will have new paperwork requirements. Submissions relating to the Guidelines are on prescribed forms. Variance requests

and responses, and 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 participating in the optional prior approval process, the requests and responses require the use of one form. Use of prescribed forms ensures easy identification and processing.

In addition to the two new forms, the regulations require use of three existing forms.

Carriers are required to certify that they have incorporated the Guidelines into their procedures. If they modify their practices, they must re-certify that the Guidelines are still incorporated.

#### 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. With respect to the Guidelines, the Board solicited comments between August 13, 2009, and September 9, 2009. The Board's Medical Director reviewed the comments and incorporated some changes.

There are no practicable alternatives to adopting treatment guidelines. Currently, the Board has no treatment guidelines, which does not lend itself to uniform standards of quality treatment and containment of costs. A uniform system will encourage proper and timely treatment, and reduce unnecessary litigation and delay.

The rule provides that all treatment consistent with the Guidelines costing more than \$1,000, except for twelve procedures, is on the pre-authorized list. An alternative would be to not put medical care over \$1,000 on the pre-authorized list and require prior authorization. This was rejected because it impedes the delivery of care. Twelve procedures still require prior authorization because they are complex or high risk, invasive, or subject to abuse.

An alternative would be to require strict adherence to the Guidelines without the possibility of a variance. The ability to vary from the guidelines is necessary because claimants are different and all injuries do not always progress the same. Without a variance, some claimants would not receive the best medical care.

An alternative would be to have all denials reviewed by the Medical Director or medical arbitrator. However, as there is no statutory authority for such option, the rule allows the parties to opt-in to the arbitration process.

The rule requires that the claimant 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. This alternative was not chosen because the claimant may not want to proceed with the variance request and undergo that specific procedure.

Another alternative would be to eliminate the optional prior approval process. However, the pilot survey shows that the process improves communications and reduces bill disputes.

The rule amends §325-1.3 to increase the 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. However, 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 the rule was changed to exempt objections that merely adjust the fee so that it reflects the appropriate fee schedule.

#### 9. Federal Standards:

No federal standards are 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.