

## Summary of Assessment of Public Comment

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 associations representing business, insurance carriers, and medical providers, as well as one law firm, a labor union, individuals, medical professionals, and businesses.

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. The full Assessment of Public Comment summarized, analyzed, and responded to the comments received and it exceeds 2,000 words. This document is a summary of the full Assessment of Public Comment. A copy of the full assessment is posted on the Board's website at <http://www.wcb.state.ny.us/content/main/wclaws/newlaws.jsp>.

The comments on the regulations included numerous requests to delay the effective date of the regulations and the Guidelines, clarify provisions that were not interpreted the same by all readers, clarify provisions by explicitly stating black letter law implied by the provisions, and correct typographical errors. The following changes were made to the regulations: 1) a colon was added to the definition "Insurance carrier or Special Fund's medical professional" in §324.1 (c); 2) "subpart" was changed to "part" in the definition of "Medical Treatment Guidelines in §324.1(g); 3) changed the date from "October 18, 2010" to "December 1, 2010" in §§324.2 (a), 325-1.24, and 325-1.25; 4) clarified in §324.2 (b) that the fee for copies of the Guidelines must be included with request for the Guidelines, corrected the address where to send the request, clarified that the email address and telephone number are for information about the Guidelines as the fee cannot be sent with an email and the request must be in writing, and clarified that checks must be made payable to Chair, WCB; 5) clarified §324.3 (a) (1) by adding a statement that a variance is needed when treatment is not recommended by the

Guidelines; 6) corrected the cite in §324.3(b) (2) (i) (c) and in §324.5; 7) clarified in §324.3(b)(2)(ii)(a) that the only required action within five business days is to notify the chair; 8) added clarifying language to §§324.3(b)(4), 324.3(d)(7), 324.4 (d) & (h), 325-1.4(b)(2) & (3); 9) clarified §325-1.3 (b) (3) that during continuing treatment a progress report must be filed for follow-up visits, which are scheduled when medically necessary but no more than 90 days apart; 10) clarified §325-1.4 (a) (9) that receipt is by the Board; 11) added missing cite to §325-1.4 (d) and changed “excepted” to “excluded”; and 12) modified §325-1.25 (c) (7) so there is no confusion that occupational & physical therapists can not request a variance.

Comments were received requesting changes to definitions, time frames, the list of pre-authorized procedures, and who resolves disputes over variances. The regulations set forth the best processes based upon the statutory authority available and, other than as described above, were not modified by the comments. In part this is due to the experience and feedback obtained through the pilot program and comments received prior to finalizing the regulations. The most significant comments received from multiple commentators are discussed below, and all of the comments received are discussed in detail in the complete Assessment of Public Comments.

Some comments expressed a need for addition time before the regulations and medical treatment guidelines (Guidelines) took effect. In response the effective date of the regulations and Guidelines has been delayed until December 1, 2010.

Three comments raised concerns about the definition of “Maximum Medical Improvement (MMI).” The commentators found the definition, among other things, to be vague, too subjective, and lacking any time parameter, presents obstacles to classification, needs to be more uniform and objective, and that more concise definitions are available from other states and one such definition (Texas) should be adopted. No changes were made to this definition. The advisory committee developing impairment guidelines developed a definition of MMI that is basically the same as the definition in this rule. The recommended definition for the impairment

guidelines starts with the exact same language used in the definition in this rule and then adds additional language, but the definitions are still consistent. It is 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.”

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). The objections included the belief that the statutory language added to Workers’ Compensation Law (WCL) §13-a (5) was never intended to allow every medical procedure as preauthorized, the language of WCL §13-a (5) is vague or confusing, the proposed rule negates the due diligence implied in the bill memo to Chapter 6 of the Laws of 2007, and this provision conflicts with WCL §13-a (5).

This provision was not changed as the Chair and Board disagree with the statutory interpretations in the comments. WCL §13-a (5) was amended in 2007 to authorize the issuance and maintenance of a list of pre-authorized procedures, with the approval of the Superintendent of Insurance. Under this section, the only treatment that needs to be pre-authorized is special services costing more than \$1,000. Reading the whole subdivision it is clear that the authority exists for a list of pre-authorized special services costing more than \$1,000. The purpose of this change is to speed access to care. 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 and will be updated regularly to remain current. 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. If a provider is treating consistent with the Guidelines, so he 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.

Four comments objected 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. The comments state that an additional six weeks of

indemnity benefits will be provided during the additional 45 days, this change will prevent proper case management and meaningful application of the Guidelines, will prevent return to work, and will result in additional IMEs. Suggestions were received to retain the current 45 day time period and to reduce it to 30 days.

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 reworded. 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, which results in medical reports that are 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.

Numerous comments were received about the medical treatment guidelines (Guidelines) themselves. The only changes to the Guidelines were to correct typographical errors, misspellings, and formatting, insert words that were accidentally left out, and to correct one section so it is now clinically feasible. Details on the changes to the Guidelines are set forth in the full assessment.

A number of the comments received challenged the statement that the Guidelines are evidence-based or took issue with the treatment guideline chosen as the base document. The Guidelines were developed by an advisory committee comprised of representatives from the Insurance Department, Board, and Labor Department, and highly qualified and respected medical professionals selected by labor, business, and the Insurance Department. The advisory committee was created to develop the Guidelines as directed by former Governor Spitzer in a letter dated March 13, 2007. On December 3, 2007, medical treatment guidelines for the

neck, back, shoulder, and knee that all providers would be required to use when treating injuries to those body parts were sent to the Chair.

When 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. 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, 2<sup>nd</sup> Edition published and copyrighted by the ACOEM. For the neck, knee, and shoulder, the advisory committee chose the State of Colorado's treatment guidelines with charts from the Washington State guidelines to supplement the Knee and Shoulder guidelines. The guidelines chosen are nationally recognized medical treatment guidelines used for treating individuals with workplace injuries.

After the recommended guidelines were submitted to the Chair, various entities submitted comments and met with the Chair to discuss the guidelines. 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 Board's Medical Director and 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 9<sup>th</sup> 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, and on January 19, 2010, revised guidelines were released. Final guidelines were released on June 30, 2010.

Many of the comments requested changes to the Guidelines based on literature and offered evidence in support. However, as just explained a formal comment period on the Guidelines was conducted in 2009, which resulted in revisions to the Guidelines. It is recognized that medical science and practice will change over time

and the Guidelines must keep pace with these changes. 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 be considered at that time. In addition, some of the requested changes were submitted and considered for the revised Guidelines released on January 19, 2010. The specific suggestions are addressed in the full assessment of public comment.

#### FORM LETTERS

Of the 3110 form letters, approximately 2096 were from individuals stating they were claimants receiving chiropractic treatment. These letters expressed concern about needing treatment outside the Guidelines which is addressed through the Variance process, and support for the comments and recommendations of the chiropractic profession which are fully discussed in the full assessment.

Approximately 364 of the form letters were from individuals stating they were chiropractors authorized to treat claimants. The letters expressed: 1) concern about perceived unanswered questions about the implementation and applicability of the Guidelines, which are actually addressed in the regulations; 2) 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, but no example is provided; and 3) concern about the manner in which chiropractors must bill for services provided to claimants, which is not the subject of this regulation. Finally, the letters express support for the comments of the New York State Chiropractic Association.

Approximately 548 form letters were submitted by 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 second concern relates to the maximum number of visits or modalities and the concern it will limit potentially needed care, which is addressed through the variance process.

Approximately 102 of the form letters were submitted by physical therapists and discussed three main concerns: 1) omission of the physical therapy professions current evidence based practice patterns; 2)

reimbursement for physical therapy services and the RVU cap, which is not part of this regulation; and 3) the limits on visits or modalities set forth in the Guidelines. As stated above, the guidelines chosen were picked because they were the best of the guidelines available for work related injuries. 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.