

## Assessment of Public Comment

The 45-day public comment period with respect to Proposed Rule I.D. No. WCB221400009 commenced on June 4, 2014, and expired on July 21, 2014. The Chair and the Workers' Compensation Board (Board) accepted formal written public comments on the proposed rule through July 25, 2014.

The Chair and Board received thirteen written comments. These comments were reviewed and assessed. The comments are discussed below.

One group of chiropractors commented that the Non-Acute Pain Medical Treatment Guidelines (NAP MTG) only address the issue of delayed recovery for patients with "non-complicated cases." The Board believes that this is an inaccurate reading of the NAP MTG. Specifically, the NAP MTG states that "therapy for non-acute pain can range from single modality approaches for the straightforward patient to comprehensive interdisciplinary care for the more challenging patient." Accordingly, no change has been made in response to this comment.

This group of chiropractors additionally commented that other factors such as disc pathology or disc degeneration should be included under the factor for delayed recovery. In the NAP MTG, delayed recovery specifically addresses the psychosocial factors that come into play when pain and functional impairment persist in spite of the apparent healing of the underlying pathology. It is a component of the biopsychosocial model that is key to the NAP MTG. The factor listed by this group are addressed in other sections under the evaluation and re-evaluation of NAP diagnosis. Accordingly, no change has been made in response to this comment.

The group of chiropractors also suggested that the language regarding self-management of pain be modified. Specifically, they objected to the statement that "non-acute pain must be managed, not cured." This sentence specifically addresses the patient who does not fully recover and would not apply in the situation where a patient fully recovers. As there was extensive discussion and agreement on this language by the Medical Advisory Committee to the Board (MAC), this sentence has not been changed. The issues of reasonable

expectations are addressed elsewhere in the NAP MTG as well and do not alter the need for non-acute pain to be managed.

This group of chiropractors also objected to the exclusion of chiropractors from the interdisciplinary teams used in functional restoration programs to assist patients with more complex conditions. This comment was presented and addressed in the Board's preliminary non-formal comment period. Specifically, it is noted that E.4 includes language for "additional professionals as indicated based upon the patient's needs" which would include a chiropractor if indicated by a patient's condition/needs. With respect to the functional restoration program described at C.1.e of the NAP MTG, the Board notes that a physician leads this team because the team leader needs broad expertise to evaluate and develop a treatment plan for all body parts (not just back/neck) and for medication management, areas that are outside of the chiropractor's scope of practice. Accordingly, no changes have been made in response to these comments.

The chiropractic group also commented that chiropractors should be added to H.1.a of the NAP MTG. The Board has not made any change in response to this comment as this section of the NAP MTG: Functional Maintenance Care includes the development and review of a Self-Directed Pain Management Program for the initiation of short-term medication use along with monitoring for adverse effects of the pain medications, which is outside the scope of practice for chiropractors.

Another group of chiropractors suggested changes to the language of Section D to clarify that all parts of the examination are not required for every patient. This section provides an overview and approach that covers all systems. The Board believes that it is clear that all components of the exam are not applicable in every clinical situation. The exam is modified depending upon the injury/condition under evaluation. For example, a straight leg raise would not be expected to be done when evaluating a patient with a shoulder injury. Language in the NAP MTG indicates "exam techniques and tests applicable to the area being examined... a more focused exam

may be performed based on clinical circumstances.” The intent and language of the section is clear and is consistent with clinical practice. Thus no change has been made.

Both groups of chiropractors objected to the NAP MTG’s inclusion of the maximum of 10 maintenance visits per year and to the fact that no variance from the maximum frequency is permitted. The Board responded to this objection in the Assessment of Public Comment to the 2013 MTG amendments. Ongoing Maintenance Care is a component of Functional Maintenance Care which consists of three parts. It emphasizes a clinically appropriate, independent self-management program. The chiropractic groups suggest that medical providers be able to request a variance following completion of ongoing maintenance care treatment. The Chair, in conjunction with the MAC, determined that when a claimant has reached maximum medical improvement, an ongoing maintenance program that includes patient self-management, periodic therapeutic withdrawal, and a self-directed pain management program is appropriate. Variance requests to allow additional passive therapy are not consistent with this recommendation. Accordingly, no change has been made to the NAP MTG.

A chiropractic group commented that the proposed NAP MTGs do not have treatment options available for the time between when acute-care guidelines cease and the time when a claimant is classified as having reached maximum medical improvement (MMI). This statement is in error. The MAC carefully discussed this and Section E.3 specifically reflects the MAC’s approach to the issue raised by referring to either a relevant MTG or standard of care for injuries not covered by an MTG: “The NAP MTG does not contain specific recommendations for other non-pharmacological treatment modalities such as physical medicine modalities or injection therapies. These other treatment options, when clinically indicated, should follow the recommendations in the relevant Medical Treatment Guidelines. When an injury not addressed by an existing Medical Treatment Guideline results in non-acute pain, the standard of care for that injury should be observed.” No change has been made to the NAP MTG in response to this comment.

A chiropractic group commented that the term “non-acute pain” is poorly understood in the medical literature and suggests adding a note that “non-acute pain” is often referred to as “chronic pain.” The term NAP was carefully considered and selected by the MAC and the Board, the Board has not made this suggested change. Variance requests are based on documentation of specific clinical findings and/or specific criteria. The title NAP does not play a role in the required documentation necessary to support a variance request and has no impact on the approval and or denial of a request. In the current NAP MTG, the MAC and the Board were cognizant of references to chronic pain and will remain cognizant when updates to the NAP MTG are developed.

The same chiropractic group also had comments regarding profession specific language, requesting that the phrase “spinal manipulation and physical medicine” be changed to “passive therapy and active therapy.” This comment was addressed in the Board’s 2013 Assessment of Public Comment and in pre-publication comments. The Board notes that the MTG use of the terms PT and OT along with spinal manipulation are not intended to preclude any qualified provider from using active and passive therapies as a component of a qualified course of ongoing maintenance care. As the medical terms used in the MTG were carefully considered and selected by the MAC and the Board, the Board has not made this suggested change.

The Board received several comments from an individual chiropractor who suggested several language and/or phrasing revisions for the Key Concepts of the Diagnosis, Treatment and Management of Non-Acute Pain section. The definition of Non-Acute Pain was carefully considered by the MAC and the Board. Accordingly, no change was made as a result of this comment.

A compensation medical services provider sent in several comments. The first comment was that obtaining the source material for the NAP MTG was costly and could result in providers having conflicting courses of treatment from the different sources. The only document that is necessary is the New York Non-Acute Pain MTG. This document contains all the New York recommendations. The “Sources” section reflects the medical

literature used by the MAC in developing the NAP MTG. There is only one document, the NAP MTG itself, which must be utilized. No others MTGs need to be obtained or purchased.

This commenter also noted that the NAP MTG recommendations with respect to TENS Units/Sessions is inconsistent with the recommendations in the previously published Back MTG and that the language “at least one instructional session” is open-ended. The Back MTG was revised for consistency with the TENS recommendations in the Neck MTG. TENS instructional sessions are not open-ended, but rather are limited to a “Maximum Duration: 3 sessions.” Accordingly, no change has been made to the NAP MTG.

This commenter suggested that the rules governing use of spinal cord stimulators be modified to clearly indicate that a less invasive functional restoration program be attempted prior to use of a spinal cord stimulator. Whether or not to mandate participation in a Functional Restoration Program as a pre-requisite for Spinal Cord Stimulator implantation was carefully discussed by the MAC. The MAC decided not to make a functional restoration program a prerequisite. The NAP MTG have not been changed in response to this comment.

The commenter also suggested that tobacco use should be part of the evaluation for risk of substance abuse. This comment refers to the ORT tool, which is specifically identified as an instrument for the evaluation of risk of substance abuse, misuse or addiction which has been tested and validated for this purpose. Use of tobacco as an additional risk factor is addressed in the “History Taking” section of the NAP MTG. No change has been made in response to this comment.

The commenter also noted that the assessment section recommends for a medical provider to use an instrument (the PADT) that grades “better, same, worse” in evaluation of the claimant’s functional status and that this is not specific enough. Section F.3.a in the NAP MTG states: “patients on chronic opioid therapy need regular monitoring and re-evaluation to measure patient adherence and progress towards treatment goals, with documentation in the medical record at each patient visit. The PADT is provided as an example of a tool for systematically documenting each encounter and assisting in organizing the management and review of care.” It

is not mandated and was not meant as a tool for evaluating functional improvement or to replace standardized tools that are available for evaluating function. Accordingly, no change has been made to the NAP MTG.

The commenter stated that the facet injection section only includes the maximum number of treatments in the non-acute section. It is noted that D.6.f.i does include the same recommendations for a maximum of three joint levels for acute pain as for non-acute pain.

The commenter asked why smoking cessation was not included as a recommendation prior to lumbar fusion as it is in neck fusion. While it is clear that smoking cessation is generally medically recommended, the MAC and Board's research found that unlike cervical fusion, there is not sufficient medical evidence to currently support a change to this section.

This commenter also suggested that the NAP MTG be modified with respect to bone stimulators. Specifically, the commenter wishes the Board to address non-compliance with manufacturers' recommendations. The NAP MTG addresses clinical criteria and treatment recommendations but are not meant to be compliance criteria for the use of devices. Such criteria will be determined by manufacturers' recommendations for specific brands and professional expertise, not by the NAP MTG. No change has been made in response to this comment.

The commenter also suggested that shoulder replacement be included in the MTG as they are seeing more requests for this treatment. It is noted that hemiarthroplasty is addressed under proximal humeral fractures at D.9.b. Further recommendations may be developed by the MAC and the Board as clinically appropriate when the Shoulder MTG are updated. Variances are available when clinically appropriate.

The commenter noted that the recommendations regarding arthroscopic surgery for treatment of a meniscal tear of the knee does not distinguish between tears due to a traumatic injury and degenerative tears. While this is a valid point, the MTG addresses treatment for workplace injuries and such injuries are generally traumatic in

nature. Accordingly, the MTG for treatment of a meniscus tear is for a work-related traumatic injury.

Accordingly, no change has been made.

The commenter also stated that following the removal of chondroplasty from the list of pre-authorized procedures, there seems to have been an increase in this procedure without evidence of efficacy. The change referenced by the commenter occurred in a 2013 revision and is not part of the current 2014 update. The Workers' Compensation Reform Task Force Advisory Committee, composed of medical professionals who developed the Knee MTG, recognized that chondroplasty may be a treatment option for certain conditions when criteria are met. With or without inclusion on the Pre-authorization list, chondroplasty requires adherence to the MTG criteria in order for a physician to perform the procedure. Additionally, the WCB has not identified trends towards an increase in this procedure. Therefore, the Board will not make the requested changes at this time.

A pharmacy benefits management company provided several comments. Initially, it stated that it did not appear that the Board and MAC included some of the more current medical evidence in developing the NAP MTG. The Board utilized Colorado's Chronic Pain MTG, effective Feb, 2012 and only utilized the Introduction to California's Chronic Pain MTG, which addressed key concepts but did not address treatment recommendation. The State of Connecticut is listed as one of 60 references in the NAP bibliography, not a source of many citations in the NAP MTG, as stated. Of note, the State of Connecticut's Opioid Medical Protocols were updated and became effective July 2012.

The commenter stated that some of the specific drug recommendations may be outdated by the time the NAP MTG are adopted, offering specific and differing drug regimens than those included in the NAP MTG. As the MAC and the Board carefully considered the medical literature and FDA recommendations in developing the NAP MTG, no changes to these recommendations will be included.

Three commenters expressed concern that while the NAP MTG makes specific recommendations regarding Urine Drug Testing protocols, the medical providers are prohibited from releasing the results of Urine Drug

Tests to carriers and employers. No change has been made in response to these comments. The MAC had extensive discussions regarding all the NAP MTG Urine Drug Testing recommendations. It is noted that medical providers must report non-compliance with prescribed medications in their reports to the carrier and the Board. The Patient Understanding for Opioid Treatment Form, which must be reviewed and signed by the physician and the patient initially and when any change in medical conditions and/or medications occur, contains criteria that reflect compliance. These criteria are surrogates for documenting adherence to or non-compliance with the treatment plan and are mandated components of the ongoing medical record that must be released to the carriers and the Board.

The Board received a lengthy comment from a company that creates Medical Treatment Guidelines for industrial accident boards contending that the Board should have used its offerings instead of the Board's MTG. The Board reviewed many medical treatment guidelines in developing all of its MTG, including this company's offering. In summary, the MAC and the Board ultimately made the determination to create its own MTG. The extensive bibliography lists source material reviewed in the development of the NAP MTG.

The Board received several comments from an insurance carrier. These comments are really questions about specific application of the MTG and will be included in FAQs prior to the effective date of the NAP MTG. In addition, any questions may always be submitted [WCBMedicalDirectorsOffice@wcb.ny.gov](mailto:WCBMedicalDirectorsOffice@wcb.ny.gov)

The Board received one comment from a claimant expressing concern that she would not receive necessary treatment as a result of the adoption of the NAP MTGs. As the NAP MTGs were specifically developed to ensure that all claimants receive necessary and appropriate treatment, the Board has not made any change in response to this comment.

The Board received a comment from a physician stating that in his professional opinion the Board should not adopt the NAP MTG. The MAC and Board have carefully considered all aspects of the NAP MTG prior to its publication. Accordingly, no change was made as a result of this comment.

## CHANGES TO THE REGULATION:

The Regulation that is being adopted contains the following insubstantial changes from the proposed rule published in the June 4, 2014, State Register:

- In section 324.2(d), Intrathecal Drug Delivery (Pain Pumps) has been added to the list of procedures that require pre-authorization to conform this text to the requirements in the NAP MTG themselves and in accordance with other Board announcements on the subject of NAP MTG.
- In section 324.2 (d), Spinal Cord Pain Stimulators have been moved from the list as a procedure in the New York Mid and Low Back Injury Medical Treatment Guidelines requiring pre-authorization to a procedure in the NAP MTG requiring pre-authorization. This conforms section 324.2 (d) to the language in the published text of the NAP MTG and New York Mid and Low Back Injury Medical Treatment Guidelines.
- In section D.11 of the New York Mid and Low Back Injury Medical Treatment Guidelines, section D.12 of the New York Neck Injury Medical Treatment Guidelines, section E.9 of the New York Knee Injury Medical Treatment Guidelines, section E.12 of the New York Shoulder Injury Medical Treatment Guidelines, and section E.4.g of the New York Carpal Tunnel Syndrome Medical Treatment Guidelines, the following sentence is added “Ongoing Maintenance Care is a component of the Functional Maintenance Care recommendations detailed in the *New York Non-Acute Pain Medical Treatment Guidelines*.”
- In section F.1.c of the NAP MTG, this clarifying text has been added “Therefore, brand name medications are generally not recommended except in specific situations with supporting medical documentation.”