THE MEDICAL TREATMENT GUIDELINES

I. INTRODUCTION

A. About the Medical Treatment Guidelines.

On December 1, 2010, the NYS Workers' Compensation Board is implementing new regulations and Medical Treatment Guidelines. These guidelines (known as "MTG") will set the standard of care for injured workers in New York State. The Board has made the following statements about these guidelines:

- The MTG are **evidence-based**, supported by the strongest medical studies when available; and, in the absence of strong medical evidence, they are based on the consensus of experienced medical professionals.

- The MTG apply to injuries or illnesses to the **mid and low back, neck, knee,** and **shoulder.**

- The MTG are **mandatory** for all work-related injuries and illnesses experienced by employees who live in New York and/or are treated by medical providers in New York or who have offices in New York.

- The MTG **do not apply to the treatment of urgent or emergent care**. Care of work-related urgent and/or emergent injuries should continue in accordance with appropriate standards.

- The MTG apply to all treatment on or after December 1, 2010 regardless of the date of injury for the relevant body parts.
-

B. Background of the Medical Treatment Guidelines.

The MTG are a result of the March 2007 Workers' Compensation Reform Act. A governor's task force and advisory committee consisting of medical professionals and representatives of business and labor worked together to develop the Guidelines. Their goal was to identify and ensure the best possible medical care for injured workers in New York State.

The advisory committee members reviewed available medical treatment guidelines and used guidelines from the American College of Occupational Environmental Medicine (ACOEM) and the States of Colorado and Washington to develop New York State's Medical Treatment Guidelines.

After the task force and advisory committee developed a draft of the MTG, the WCB published them and sought input from all interested parties. Those who wished to provide input were encouraged to submit medical evidence in support of their positions.

The WCB reviewed the many comments and new scientific literature, and ultimately made modifications to the original MTG based on the evolving scientific evidence.

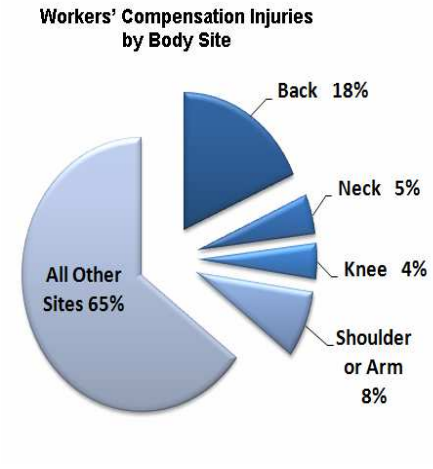
C. Why the Neck, Back, Knee and Shoulder are Covered.

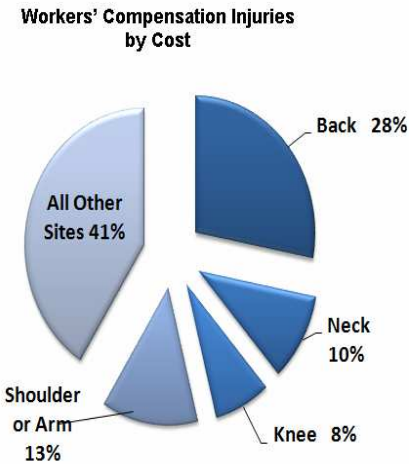
In New York State, injuries to the back, shoulder, neck, and knee are the most common in the workplace. They result in substantial pain and suffering for injured workers, significant lost work time, and are the most costly workplace injuries in New York State.

According to a July 2007 report from the Workers' Compensation Research Institute, in New York State, work-related back injuries account for:

- About 18 percent of all workers' compensation claims.
- Almost 28 percent of all medical payments for work-related injuries.

Injuries to the neck, knee, and shoulder follow as the most frequent and costly work-related injuries in New York. Taken together, the back, neck, shoulder, and knee account for nearly 40 percent of workers' compensation claims and almost 60 percent of workers' compensation costs.





II. GOALS OF THE MEDICAL TREATMENT GUIDELINES.

A. General Goals of the Guidelines.

The NYS Workers' Compensation Medical Treatment Guidelines are intended to:

- Set a **single standard** of medical care for injured workers.
- **Expedite quality care** for injured workers.
- **Improve the medical outcomes** for injured workers.
- **Speed up return to work** by injured workers whenever possible.
- **Reduce disputes** between carriers and medical providers over treatment issues.
- Achieve **timely payments** to medical providers.
- **Reduce overall system costs**.

B. Authorization.

Treating medical providers who diagnose and treat patients consistent with the Guidelines will not need to obtain pre-authorization except in the following situations:

- The twelve specific procedures listed in the MTG that require pre-authorization.

PROCEDURES REQUIRING PRE-AUTHORIZATION

PROCEDURE	APPLICABLE GUIDELINE
Lumbar Fusion	Back
Artificial Disc Replacements	Back, Neck
Vertebroplasty	Back
Electrical Bone Growth Stimulators	Back, Neck
Kyphoplasty	Back
Anterior Acromioplasty of the Shoulder	Shoulder
Spinal Cord Stimulators	Back
Autologous Chondrocyte Implantation	Knee
Chondroplasty	Knee
Meniscal Allograft Transplantation Knee Repair with Tissue Transplant	Knee
Osteochondral Autograft	Knee
Knee Arthroplasty (Total or Partial Knee Joint Replacement)	Knee

- Any second or subsequent performance because of the failure or incomplete success of the same procedure.

C. Variances.

The Guidelines allow for some flexibility through a "variance" process. The variance process allows workers to get treatment that is not covered by the Guidelines or at a different time than the one set by the Guidelines. Some factors that may lead to a variance request are:

- People heal at different rates.
- Extenuating circumstances or comorbidities may delay an individual's response to treatments or procedures.
- Peer reviewed studies may provide evidence supporting new/alternative treatments. (If the evidence is strong enough, this particular reason might result in a change of recommendation in the MTG.)

The treating doctor determines when a variance is requested. A treating doctor requests a variance by filing Form MG-2. The employer or carrier can respond to a request for a variance in one of two ways: by requesting an "independent medical exam" (IME) within 5 days, or by responding without an IME within 15 days.

If the employer or carrier opts for an IME exam, it has 30 days to produce the report and to authorize or deny the variance request based on the IME's opinion.

If the employer or carrier does not want an IME exam, then it can authorize or deny the variance request within 15 days.

In general, if the employer or carrier denies the variance request, the injured worker can either ask the WCB Medical Director's office to rule on the request, or can request a hearing before a judge. Decisions by the judge can be appealed; decisions by the Medical Director's office cannot.

III. GENERAL PRINCIPLES OF THE MEDICAL TREATMENT GUIDELINES.

Principle 1: Medical Care

Medical care and treatment required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient's daily and work

activities and return to work, while striving to restore the patient's health to its pre-injury status in so far as is feasible.

Principle 2: Rendering of Medical Services

The Medical Treatment Guidelines establish the standard of care for injured workers. Medical Providers rendering care to workers' compensation patients must use the MTG as provided for work related injury or illness.

Principle 3: Positive Patient Response

Positive results are defined primarily as functional gains which can be objectively measured. Objective functional gains include, but are not limited to:

- Positional tolerances.
- Range of motion.
- Strength.
- Endurance.
- Activities of daily living.

When evaluating a patient's response, subjective complaints of pain and function should be considered and given relative weight when the pain has an anatomic and physiologic correlation.

Principle 4: Re-Evaluate Treatment

Efficacy of the treatment or modality should be evaluated and documented by the provider:

- 2-3 weeks after the initial visit; *and*
- 3-4 weeks thereafter.

If a treatment is not producing positive results, the provider should:

- Modify or discontinue the treatment regime; *or*
- Reconsider the diagnosis in the event of a poor response to a rational intervention.

Principle 5: Education

Education of the patient, family, employer and other parties involved in the injured worker's recovery and return to work is an essential element of treating work related injuries.

- Medical Providers must develop and implement effective educational strategies and skills.

- Education should always start with communicating reassuring information to the patient.

- No treatment plan is complete without addressing patient education as a means of facilitating self-management of symptoms and prevention of future injury.

Principle 6: Diagnostic Time Frames

Time frames for conducting diagnostic testing commence at the time of injury.

Principle 7: Treatment Time Frames

Time frames for specific interventions commence once treatments have been initiated.

For diagnostic and treatment time frames, clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed. For example, a co-morbidity such as a heart condition may slow down the course of active therapy.

Principle 8: Six Month Time Frame

Research shows that injured workers who are out of work for more than six months, return to work at a much lower rate than other workers.

The emphasis within the Guidelines is to move injured workers along a continuum of care and return-to-work within a six-month time frame, whenever possible.

Principle 9: Delayed Recovery

When injured workers fail to make expected progress 6-12 weeks after an injury:

- Re-examination should be done to confirm the accuracy of the diagnosis.
- Thereafter, an alternate treatment program should be considered.
- An alternate treatment program may include an interdisciplinary rehabilitation program and may also include a psychosocial evaluation.

Principle 10: Active Interventions

Active interventions emphasize patient responsibility and are generally preferred over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in active rehabilitation programs and to achieve objective functional improvement.

Principle 11: Active Therapeutic Exercise Program

The focus of active therapeutic exercise programs should be objective functional improvement in strength, endurance, flexibility, range of motion, and coordination.

Active vs. Passive Therapy

Active therapy requires effort or energy expenditure by the injured worker to complete a specific exercise or task. It requires supervision from a therapist or medical provider. Passive therapy includes those treatment modalities that do not require energy expenditure on the part of the patient, such as manipulation, massage and mobilization. Passive modalities should be used along with active therapies.

Principle 12: Diagnostic Imaging and Testing Procedures

Clinical information obtained by history taking and physical examination should be the basis for the selection and interpretation of imaging procedure results.

Subsequent diagnostic procedures:

- When a diagnostic procedure, in conjunction with clinical information, establishes an accurate diagnosis, a second diagnostic procedure will be redundant if it is performed only for diagnostic purposes.

- May be a repeat of the same procedure, when the rehabilitation physician, radiologist or surgeon documents the study was of inadequate quality to make a diagnosis.

- Can be a complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis.

Repeat imaging studies, diagnostic procedures and other tests may be warranted during the course of care to follow the progress of treatment in some cases, to reassess or stage the pathology when there is progression of symptoms or findings, prior to surgical interventions and therapeutic injections when warranted, and post-operatively to follow the healing process.

Principle 13: Surgical Interventions

- All operative interventions must be based upon positive correlation of clinical findings, clinical course and imaging and other diagnostic tests.

- Surgery should be within the context of expected functional outcome.

- For surgery to be performed to treat severe pain there should be clear correlation between the pain symptoms and objective evidence of its cause.

Principle 14: Pre-Authorization

This principle is one of the most significant changes in the way medical care will be delivered to injured workers in New York State.

All diagnostic imaging, testing procedures, non-surgical and surgical therapeutic procedures within the criteria of the medical treatment guidelines and based on a correct application of the medical treatment guidelines are considered authorized with the exception of the 12 procedures listed on the next page.

This means a Medical Provider may begin treatment immediately:

- for the body parts covered by the guidelines.
- as long as the treatment is within the criteria of the Medical Treatment Guidelines and based on a correct application of the Medical Treatment Guidelines.

This is true even if the procedure or test costs more than $1,000.

Principle 15: Personality/Psychological/Psychosocial Evaluations *and*
Principle 16: Personality/Psychological/Psychosocial Interventions

An evaluation is an assessment of the injured workers psychological and psychosocial clinical issues. An intervention is the treatment of the injured worker.

- A psychological evaluation may be useful when there is a discrepancy between diagnosis, signs, symptoms, clinical concerns or functional recovery.

- If the evaluation recommends intervention, such intervention should be implemented as soon as possible to enhance functional recovery.

Principle 17: Functional Capacity Evaluation (FCE)
Principle 18: Return-to-Work
Principle 19: Job Site Evaluation

These three principles address the very important issue of return-to-work. Return-to-work is defined as any work or duty the injured worker is able to perform safely. It may not be the injured worker's regular work.

According to the Principles, the medical provider plays an active role in assisting the injured worker to return to work safely. This includes contacting the employer to discuss accommodations and/or light duty, working with the injured worker to plan for return to work, and, when warranted, using FCEs or job site evaluations to ensure that return to work is safe and appropriate.

Early return-to-work should be a primary goal in treating occupational injuries given the poor return-to-work prognosis for an injured worker who has been out of work for more than six months.

Principle 20: Guideline Recommendations and Medical Evidence

The Workers' Compensation Board [the Department and its Advisors including medical and other professionals] has not independently evaluated or vetted the scientific medical literature used in support of the guidelines, but has relied on the methodology used by the developers of various Guidelines utilized and referenced in these Guidelines.

Principle 21: Experimental Treatment

Medical treatment that is experimental and not approved for any purpose, application or indication by the FDA is not permitted under these Guidelines.

Principle 22: Injured Workers as Patients

Injured workers are referred to as patients recognizing that in certain circumstances there is no doctor-patient relationship.

Principle 23: Scope of Practice

The Medical Treatment Guidelines do not address scope of practice or change the scope of practice.