TRAVELERS

2012 Update
New York State Workers Compensation 2007 Reform
Medical Treatment Guidelines
Permanent Disability and Loss of Wage Earning Capacity Guidelines

NY State WC Medical Treatment Guidelines
Effective December 1, 2010

The Medical Treatment Guidelines (MTGs) create standards of care for the back, neck, knee and shoulder applicable to all workers compensation treatment dates on or after December 1, 2010, excluding emergent care. These specific body parts account for 40% of all WC claims in NY and equate to approximately 60% of the payout. These guidelines apply to all private and municipal self-insured employers, group self-insured trusts, Special Funds, the State Insurance Fund, and private insurance carriers when an injured worker either lives or is treating in New York State. They are a compilation of guidelines from the state of Colorado, ACOEM, as well as input from the Workers' Compensation Reform Advisory Committee. The Workers' Compensation Board has vested their medical director's office with responsibility for promoting high quality care and outcomes for all injured workers, implementing and updating the NY WCB Medical Treatment Guidelines as well as educating and training users statewide

Highlights of Guidelines

- Pre-Authorization
- Variance process

Pre-Authorization

Treatment and testing administered in accordance with the MTGs no longer requires pre-authorization. There are, however, 12 specific procedures identified in the MTGs (listed below) that require pre-authorization. Additionally, subsequent surgery associated with an unsuccessful surgical procedure requires pre-authorization.

Lumbar fusions	Anterior acromioplasty of the shoulder
Artificial disk replacement	Chrondoplasty
Vertebroplasty	Osteochondral autograft
Kyphoplasty	Autologus chrondocyte implantation
Electrical bone growth stimulators	Meniscal allograft transplantation
Spinal Cord Stimulators	Knee arthroplasty (total or partial knee joint replacement)

Analysis of Impact

- Establishes a standard of medical care for injured workers.
- Expedites quality care for injured workers.
- Reduces ongoing, palliative treatment that may limit exposure.
- The application of the MTGs requires significant time commitment by all parties. The extensive guidelines must be reviewed when evaluating all treatment and bills.
- Requires the continual education of the provider community by our claim and medical professionals.

Variance Process

The Workers' Compensation Board recognizes the fact that individuals heal and respond to treatment differently. As a result, the variance process was created to allow for flexibility in how and when treatment is rendered when it is not consistent with the MTGs. Treatment inconsistent with the MTGs includes treatment not addressed, treatment outside the guidelines, and last, treatment beyond the duration limits set forth in the guidelines. These instances require the provider to obtain prior approval for the treatment/testing that is believed to be medically necessary. This request is made on the Workers' Compensation Board prescribed Form MG2 (Attending Doctor's Request for Approval of Variance and Carrier's Response). The form requires the following information as outlined by the Workers' Compensation Board:

- Necessary medical documentation to support the request.
- Medical provider's medical opinion why treatment is appropriate and medically necessary.
- Injured worker's agreement to the treatment.
- Explanation of why treatment consistent with MTG is not appropriate or sufficient.
- If appropriate, signs or symptoms that have failed to improve with treatment consistent with the MTG.
- If the medical provider is requesting treatment that exceeds the documented limits in the MTG, they must include the functional outcomes that continue to show objective improvement and are reasonably expected to further improve.
- Any citations or copies of relevant literature that support the request.

Upon receipt of the variance request, the carrier reviews the requests and must either grant, negotiate, or deny the requested treatment. To evaluate the medical necessity of the request, the carrier may elect to have an Independent Medical Examination (IME), a Records Review, or a review by a licensed medical professional who is either employed or retained by the carrier. The carrier must inform the WCB and the requester within 5 business days if it intends to secure an IME. If an IME is secured, the response to the variance request must be documented within 30 days. If the carrier does not secure an IME, the response to the request must be documented within 15 days.

Upon receipt of a denial, the medical provider may attempt resolution of the issue informally within 8 days, or the injured worker may request a formal review by the WCB within 21 days.

The formal review is conducted through one of two methods: an expedited hearing or review by the WCB's medical director. If both parties agree to the same method of review, that method is used. If there is no agreement, the default option is an expedited hearing.

Analysis of Impact

- Establishes process for medical providers to request treatment outside the MTGs.
- Affords carriers the flexibility to allow for treatment outside the MTGs.
- Reduces treatment disputes between carriers and medical providers.
- Process is paper intensive and burdensome.
- We have seen increased use of IMEs and Record Reviews due to this process.
- Timeframes associated with this process are stringent.
- Significant nurse resources are allocated to this process.
- Requires the continual education of the provider community by our claim and medical professionals.
- There are no limitations on the number of variance requests that are filed by providers.

NYS WC Permanent Disability and LWEC Guidelines
Effective January 1, 2012

The guidelines address the evaluation of both schedule loss of use awards and non-schedule permanent disabilities. The portion devoted to schedule loss of use awards (Chapters 2-8) is essentially unchanged from the 1996 Guidelines. The non-schedule permanent disability sections (Chapters 9-17) are largely based on the work of the Insurance Department's Workers' Compensation Reform Task Force and Advisory Committee (Task Force). The NY Impairment Guidelines include guidance for medical professionals on how to evaluate medical impairment and physical function as well as guidance for the Board on how to determine loss of wage earning capacity.

Highlights of Guidelines

- Maximum Medical Improvement (MMI) definition and timing
- Outlines the three-step process for determining non-schedule permanency:
  - MMI is determined by a physician.
  - Medical Impairment and functional loss is determined by a physician.
  - Loss of Wage Earning Capacity (LWEC) is determined by the Judge.

Maximum Medical Improvement

- **MMI as defined by the Workers Compensation Board**

  "A finding of maximum medical improvement is based on a medical judgment that (a) the claimant has recovered from the work related injury to the greatest extent that is expected and (b) no further improvements in his or her condition is reasonably expected. The need for palliative care or symptomatic treatment does not preclude a finding of MMI. In cases that do not involve surgery or

fractures, MMI cannot be determined prior to six months from the date of injury or disablement, unless otherwise agreed to by the parties."

- **MMI Timing**
  - Injured worker must be at MMI before assessing permanency.
  - MMI cannot be determined until 6 months after injury, unless parties stipulate.
  - MMI can be determined at any time for cases involving surgery or fracture.

Analysis of Impact

- MMI can be established by attending physician or Independent Medical Examiner.
- Allows for expedited determination of MMI.
- We anticipate increased litigation surrounding this issue.

Medical Impairment and Functional Loss

To determine non-scheduled permanency, the physician must consider the severity of the injured worker's medical impairment as well as the functional loss.

- **Medical Impairment**

  When the injured worker is at MMI, a physician must conduct an impairment evaluation based on the tables contained in the guidelines. These tables provide the physician with guidelines to determine an impairment ranking between A and Z. Once the A to Z ranking is identified, the physician will use the crosswalk table to convert this into a 0 to 6 severity ranking. The results of this impairment evaluation are reported on the Doctor's Report of MMI/Permanent Impairment, Form C4.3.

Analysis of Impact

- Medical Impairment can be evaluated by the attending physician or Independent Medical Examiner.
- The tables contain a level of medical complexity that requires education and training for all providers, carriers, and Judges.
- The crosswalk table allows for a singular severity ranking between 1 (least severe) and 6 (most severe) for each body part. This allows for a relative comparison across body parts.
- It is not uncommon to have injuries involving multiple body parts, however, the 2012 Guidelines do not provide a mathematical formula for combining medical impairment.
- We anticipate the need to have medical professionals review and calibrate evaluations of medical impairment rankings.
- The medical impairment ranking is not to be used as a direct translation to LWEC.

- Due to the complexity and time commitments required to comply with the guidelines, some providers may be reluctant to accept WC patients.
- We anticipate increased litigation surrounding this issue.

- **Functional Loss**

  The functional assessment is completed by a physician and describes the injured worker's capability to perform various work-related functions such as sitting, standing, and reaching overhead (not limited to the at-injury job activities). The physician will also evaluate the worker's residual exertional capacity based on the standard classification of physical demand requirements on a scale of Sedentary to Very Heavy.

  Analysis of Impact

  - Functional capacity exams can be performed by the attending physician or Independent Medical Examiner.
  - Obtaining a pre-injury job description will be necessary on all claims.
  - We may consider surveillance to corroborate a physician's findings.
  - We anticipate increased litigation surrounding this issue.

Loss of Wage Earning Capacity (LWEC)

Loss of wage earning capacity is the reduction in an injured worker's earning capacity due to a work-related injury or disease. To determine LWEC, the Judge must review the physician's assessment of the injured worker's medical impairment and functional capacity. In addition, the Judge must consider various vocational factors.

- **Vocational Factors**

  The guidelines discuss other factors that the Judge must consider when determining LWEC. These factors include: education/training; skills; age; literacy and English proficiency. In addition, the Judge may consider any other aspects that may affect the worker's ability to perform paid employment.

The determination of LWEC is a legal issue and differs depending on whether or not the injured worker has returned to work. The Judges will consider the medical impairment, functional ability and vocational factors to determine the appropriate LWEC.

Determining LWEC for Non-Working Claimants:

If the injured worker is not working, the Judge establishes a LWEC based on the medical and vocational factors outlined above. There is no formula for the Judges to follow. It should be noted that an LWEC finding of greater than 80% allows an injured worker to request a reclassification to permanent total disability or total industrial disability within a year prior to the expiration of capped indemnity benefits if they can demonstrate "extreme hardship."

Determining LWEC for Working Claimants:

In situations where the IW has returned to work, the calculation of LWEC is determined by calculating the actual earnings as compared to their prior earnings. The injured worker must demonstrate that the reduction in earnings is due to a work-related injury or disease.

Analysis of Impact

- The effects of the vocational factors on LWEC will vary by industry and job classification. For example, education or training that qualifies a worker to perform work they are physically capable of while earning similar wages may result in a lower LWEC. Conversely, limited English proficiency, coupled with an inability to perform manual work, may result in a higher LWEC.
- We anticipate vocational factors will be weighted heavily in the Judge's LWEC determination.
- How the Judges and the WCB will arrive at the LWEC determination will become clearer as cases develop.
- "Extreme hardship" has not been clearly defined in the law.
- We anticipate injured workers will pursue classifications greater than 80% to be afforded the safety net consideration.
- We anticipate increased litigation surrounding LWEC.