

Gas East Corporation d/b/a National Grid (KeySpan) to: (1) update its definition of weighted average cost of capacity; (2) add corresponding language to its Mandatory Capacity Program; and (3) eliminate the Capacity Release Surcharge Adjustment. The Commission may adopt, reject, or modify, in whole or in part, KeySpan’s proposal.

*Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann\_ayer@dps.state.ny.us*

*Data, views or arguments may be submitted to:* Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: Secretary@dps.state.ny.us

*Public comment will be received until:* 45 days after publication of this notice.

*Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis and Job Impact Statement*  
Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.  
(10-G-0278SP1)

**PROPOSED RULE MAKING  
NO HEARING(S) SCHEDULED**

**Weighted Average Cost of Capacity**

**I.D. No. PSC-26-10-00012-P**

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

**Proposed Action:** The Commission is considering a tariff filing by The Brooklyn Union Gas Company d/b/a National Grid (Brooklyn Union) to update its definition of weighted average cost of capacity and eliminate the Capacity Release Surcharge Adjustment.

**Statutory authority:** Public Service Law, section 66(12)

**Subject:** Weighted Average Cost of Capacity.

**Purpose:** To revise tariff language to allow KeySpan to update its definition of weighted average cost of capacity.

**Substance of proposed rule:** The Commission is considering whether to approve, modify or reject, in whole or in part, a proposal filed by The Brooklyn Union Gas Company d/b/a National Grid (Brooklyn Union) to: (1) update its definition of weighted average cost of capacity; (2) add corresponding language to its Mandatory Capacity Program; and (3) eliminate the Capacity Release Surcharge Adjustment. The Commission may adopt, reject, or modify, in whole or in part, Brooklyn Union’s proposal.

*Text of proposed rule and any required statements and analyses may be obtained by filing a Document Request Form (F-96) located on our website <http://www.dps.state.ny.us/f96dir.htm>. For questions, contact: Leann Ayer, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 486-2655, email: leann\_ayer@dps.state.ny.us*

*Data, views or arguments may be submitted to:* Jaclyn A. Brillling, Secretary, Public Service Commission, 3 Empire State Plaza, Albany, New York 12223-1350, (518) 474-6530, email: Secretary@dps.state.ny.us

*Public comment will be received until:* 45 days after publication of this notice.

*Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis and Job Impact Statement*  
Statements and analyses are not submitted with this notice because the proposed rule is within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.  
(10-G-0279SP1)

**Workers’ Compensation Board**

**PROPOSED RULE MAKING  
NO HEARING(S) SCHEDULED**

**Medical Treatment Guidelines**

**I.D. No. WCB-26-10-00013-P**

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

**Proposed Action:** Amendment of sections 300.23(d), 325-1.2, 325-1.3, 325-1.4, 325-1.24; repeal of section 325-1.6; and addition of Part 324 and section 325-1.25 to Title 12 NYCRR.

**Statutory authority:** Workers’ Compensation Law, sections 117, 141, 13, 13-a, 13-b, 13-k, 13-l, 13-m

**Subject:** Medical Treatment Guidelines.

**Purpose:** Requires use of Medical Treatment Guidelines to treat neck, back, knee and shoulder, and provides processes surrounding such use.

**Substance of proposed rule (Full text is posted at the following State website: [www.wcb.state.ny.us](http://www.wcb.state.ny.us)):** The proposed adopts and mandates the use of treatment guidelines for workers’ compensation injuries or illnesses to the neck, back, shoulder, and knee, and amends other provisions to support the guidelines.

Section 300.23 (d) is amended to state that it does not apply when a request for a variance is denied.

A new Part 324 is added to Subchapter C regarding Medical Treatment Guidelines.

Section 324.1 defines relevant terms used in this Part including “Maximum Medical Improvement,” “Medical Treatment Guidelines,” “Review of Records,” and “Treating Medical Provider.”

Section 324.2 mandates treatment in accordance with the Medical Treatment Guidelines for the mid and low back, neck, knee, and shoulder, which are incorporated by reference, for all work related injuries or illnesses on an after October 18, 2010, regardless of the date of accident or date of disablement. Establishes a list of pre-authorized procedures pursuant to Workers’ Compensation Law § 13-a (5), which includes all medical care consistent with the Medical Treatment Guidelines except for 12 treatments or procedures. Provides that variances from the Medical Treatment Guidelines are only allowed as provided in § 324.3.

Section 324.3 sets forth what is required to request a variance, that the burden of proof is on the treating medical provider that a variance is medically necessary and appropriate, the requirements related to a response to a variance, including the time period in which a response must be made, and how denials of variances are resolved.

Section 324.4 sets for an optional prior approval process whereby a treating medical provider can request approval from the insurance carrier or Special Fund that the treatment is consistent with the Medical Treatment Guidelines before it is performed. This section establishes how providers can opt-in to the program and makes a request, how insurance carriers can opt-out of the process, how insurance carriers who participate respond to a request, and how denials are resolved.

Section 324.5 provides that if the Medical Treatment Guidelines do not address a condition, treatment or diagnostic test for a part of the body covered by the Medical Treatment Guidelines, then the factors in necessary to request a variance shall be used to determine whether the insurance carrier or Special Fund is obligated to pay for the medical care at issue.

Section 324.6 requires insurance carriers and Special Fund to incorporate the Medical Treatment Guidelines and relevant regulatory provisions into their policies, procedures, and practices, and certify that this has been completed within 120 days of the effective date of Part 324.

Section 325-1.2 is amended to require specialists and consultants to file the same medical report forms used by treating providers.

Section 325-1.3 is amended to require medical reports of attending physicians be filed on the correct version of the form or forms prescribed by the chair for such purpose and that medical reports must be filed when a follow-up visit is necessary except the time between follow-up visits cannot exceed 90 days.

Section 325-1.4 regarding prior authorization for special services is amended to clarify and modify the procedure so it reflects the procedures actually used currently, make clear the ability of physical and occupational therapists to request prior authorization, clarify when prior authorization is necessary when multiple special services are to be performed, and incorporate the pre-authorized list from Section 324.2 (d) of this Title.

Section 325-1.6 is repealed.

Section 325-1.24 is amended to limit its applicability to bills for medical services provided on and after October 1, 1994, and before October 18, 2010.

Section 325-1.25 is added to set forth the process for the submission of medical bills, the time in which medical bills must be paid and/or objected to, the objections that can be raised, and the resolution of objections.

**Text of proposed rule and any required statements and analyses may be obtained from:** Cheryl M. Wood, NYS Workers' Compensation Board, 20 Park Street, Room 400, Albany, New York 12207, (518) 408-0469, email: regulations@wcb.state.ny.us

**Data, views or arguments may be submitted to:** Same as above.

**Public comment will be received until:** 45 days after publication of this notice.

#### 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 medical practitioners have no 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, New

York practitioners do not have up-to-date standards for treatment of 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 in 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:

Participants will be able to comply when the regulations take effect on October 18, 2010. During the one month between adoption and the effective date, participants will have time to finalize incorporation of the guidelines into their processes and undergo training.

#### *Summary of Regulatory Flexibility Analysis*

##### 1. Effect of rule:

Small businesses and local governments whose only involvement with the workers' compensation system is that they are employers and are required to have coverage will not be affected by this rule. Group self-insured trusts, third party administrators hired by private insurance carriers and group self-insured trusts, independent medical examination (IME) entities, and attorneys may be small businesses who will be impacted by this regulation. All health practitioners authorized by the Chair to treat or conduct independent medical examinations of claimants will have to comply with parts of this rule. Finally, local governments that own and/or operate a hospital will be effected by this rule.

The approximately 2,511 political subdivisions that are self-insured for workers' compensation coverage in New York State will have to comply with the provisions of this proposal. Those local governments who are not self-insured and do not own and/or operate a hospital will not be affected by this rule.

##### 2. Compliance requirements:

The proposed rule imposes new compliance requirements on the small businesses and local governments described above.

Small businesses authorized to provide medical treatment to claimants will have to treat neck, back, shoulder, and knee injuries consistent with the Medical Treatment Guidelines (Guidelines) and self-insured local governments, third-party administrators, and group self-insured trusts who administer their own claims (hereafter referred to as "affected payers") will be required to pay only for such treatments. In order to vary from the Guidelines, the provider must request a variance using the prescribed form from the affected payer and file a copy with the Workers' Compensation Board (Board). The burden of proof for a variance rests on the treating provider. Affected payers must have the request reviewed by their own medical professional or obtain an IME or review of records. The affected payer must respond within fifteen business days if an IME is not obtained or thirty days if an IME is obtained. Denials of variance requests must be based on a medical opinion unless the denial is because the provider did not meet his burden of proof. The denial will be resolved by either a medical arbitrator or at an expedited hearing. Both the affected payer and claimant must choose to have the issue resolved by a medical arbitrator; otherwise it will be resolved at a hearing.

Providers who are small businesses and affected payers who participate in the optional prior approval process must complete the appropriate forms and respond within the required time frames. Affected payers must have its medical professional review the request for optional prior approval. If the affected payer has denied the optional prior approval, the dispute shall be resolved by the medical arbitrator and no further action is required.

Self-insured local governments and group self-insured trusts are required to certify that they have incorporated the Guidelines and this rule

into their policies, procedures, and practices. If they modify their policies, procedures, and practices, they must certify that the Guidelines and this rule are still incorporated.

Rather than submitting medical reports every forty-five days, the rule requires authorized providers who are small businesses to submit medical reports when a follow-up visit is necessary, except the interval between medical reports can be no greater than 90 days. This actually lessens an existing compliance requirement.

The rule now requires that the prescribed form be used to request and respond to prior authorizations. Throughout the rule, treating providers and affected payers are required to use specific methods to transmit forms. Specifically, those methods are facsimile, email, or some other method of electronic transmission. Exceptions are provided for those who do not have the capability.

The rule requires affected payers to use the Chair prescribed form for valuation objections to medical bills, except when the affected payer adjusts the amount billed so it conforms to the appropriate workers' compensation fee schedule.

3. Professional services:

Small businesses and local governments effected by the rule will not need any new professional services to comply with this rule. The Board will be providing training on the Guidelines and the processes surrounding them at no charge.

4. Compliance costs:

The proposed rule will impose some additional costs on the affected small businesses and local governments, which are expected to be more than offset by the savings from use of the Guidelines. Medical professionals and affected payers will be required to incorporate the Guidelines into their policies, practices, and procedures. There will also be a cost to self-insured local governments and group self-insured trusts associated with the requirement that it must certify within one hundred and twenty days of the effective date that it has completed such incorporation. To assist in this process, the Board will be providing training to small businesses and local governments, as well as all other stakeholders and the Board's employees at no charge.

The Guidelines will be available on the Board's website free of charge. The cost for a hardcopy will be \$10.00 per guideline or \$40.00 for all four. The charge for one or more of the Guidelines on a compact disc is \$5.00.

Small businesses that are treating medical providers will incur some cost when requesting a variance. Upon receiving a variance request, an affected payer may have the request reviewed by its own medical staff or having an IME or records review performed. If the affected payer 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 where the burden of proof has been met, there must be a medical opinion. Affected payers will incur costs if an IME or records review is obtained. The cost for IMEs or records reviews to respond to variance requests will be offset by the reduction in number of IMEs required to respond to requests for prior authorization for the procedures and treatments on the pre-authorized list.

If a variance is denied, a Workers' Compensation Law Judge will resolve the issue at an expedited hearing or, if both parties consent, a medical arbitrator will resolve the issue. Affected payers will incur costs if the denial is resolved through the hearing process; but they should be offset by the reduction in the number of prior authorization denials that need to be resolved. If the parties opt to use the medical arbitrator the costs are nominal as there is no hearing or testimony.

There will be some cost for those providers who are small businesses and those affected payers who participate in the optional prior approval process, which provides an opportunity for the treating medical provider to seek the payer's agreement that the treatment is consistent with the Guidelines. The treating medical provider will incur costs completing the form to request the optional prior approval and the affected payer will incur costs having the request reviewed by its staff medical professional.

By mandating use of the Guidelines, providers and payers are using the same standards to determine if medical treatment is necessary, which will result in a reduction in disputes over medical bills. Reductions in disputes will reduce the costs involved in resolving them and increase the speed of payment. Further, the Guidelines along with the pre-authorized list will reduce the delays in treatment and care and improve outcomes so that claimants may return to work faster.

The use of the Guidelines is expected to result in millions of dollars of savings. Costs associated with unnecessary and excessive treatment and therapies will be eliminated or greatly minimized with implementation of the Guidelines as they:

- o Limit chiropractic manipulation to 20-24 visits for neck and 6-12 visits for back injuries, depending on severity
- o Limit various physical therapy modalities to 12-20 visits
- o Provide that an MRI for back injuries is not appropriate in the first 6 weeks unless there are red flags

- o Place limits on therapeutic injections in a 12 month period
- o Prohibit repeated non-therapeutic nerve block injections
- o Place additional limitations on 12 procedures that are subject to abuse or are complex and invasive
- o Prohibit ineffective treatments (e.g. Medex machines, electro-analgesic nerve blocks, etc.).

Injuries involving the knee, shoulder, back and neck account for approximately 36% of the claims but nearly 60% of system medical costs. Currently, many providers treat well in excess of the Guidelines.

The rule requires affected payers to file with the Board their objections to medical bills submitted by providers for payment on the Chair prescribed form, except for adjustments to the proper fee schedule amount. There will be a cost associated with having to use and file the prescribed form with the Board, which should be minimal. The form can be filed by fax, email, or regular mail.

5. Economic and technological feasibility:

It is economically and technologically feasible for small businesses and local governments to comply with this rule. The rule relies on existing technological capabilities and services already provided to affected payers.

6. Minimizing adverse impact:

As stated above, the implementation of Guidelines is expected to save millions of dollars.

To minimize possible adverse impacts, the regulations provide some flexibility by allowing for variances from the Guidelines. Variances are allowed in limited circumstances because claimants are different and all injuries or illnesses do not always progress in the same manner. Without the ability to request a variance, when it is appropriate and medically necessary, some claimants would not receive the best medical care.

The rule requires the claimant or his or her legal representative to request review of the denial of a variance rather than automatically scheduling an expedited hearing, or if the parties both opt-in, referring the dispute to the medical arbitrator without any further action by the claimant or affected payer. By requiring the claimant to request review after consulting with his or her treating provider, the claimant has the opportunity to decide if he wants to move forward with the variance request. Further, as the burden of proof is on the claimant to show that the variance is medically necessary and appropriate, having the claimant request review provides an opportunity for him or her to evaluate whether the burden has been met.

Medical professionals who are small businesses and affected payers will be required to incorporate the Guidelines into their policies, practices, and procedures. To assist in this process, the Board will be providing training to stakeholders and Board employees at no charge.

The rule requires self-insured local governments and group self-insured trusts to certify that they have incorporated the Guidelines and the provisions of the rule into their policies, procedures, and practices within one hundred and twenty days after the rule is effective and upon modification of such policies, procedures, and practices.

The rule amends § 325-1.3 to increase the maximum length of time between the submission of medical reports from forty-five days to ninety days. 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. This results in a medical report that is 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 medically necessary visit is required, but no more than ninety days apart, fewer unnecessary office visits will be scheduled and costs reduced.

Originally, the rule required that all valuation objections of medical bills be on the Chair prescribed form. In response to legitimate concerns, the rule was changed to exempt objections that merely adjust the fee so that it reflects the appropriate amount under the workers' compensation fee schedule. Some providers bill using their usual and customary rate, which is greater than the fee schedule. When the affected payers process and pay the bills they must adjust for the fee schedule and object to that portion of the bill that is above the fee schedule. As there is no dispute for the Board to resolve in these situations, the benefit of using the prescribed form was outweighed by the cost and burden to the affected payers.

7. Small business and local government participation:

The Board shared a draft of the regulations with the AFL-CIO, Business Council of New York State, 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. In addition, the Board either met with or had conference calls with representatives from most of these entities. Changes were made to the regulations in response to the comments. With respect to the Guidelines themselves, the Board solicited comments on them between August 13, 2009, and September 9, 2009. Those seeking revisions to the guidelines were instructed to provide medical evidence supporting such changes. The Board received numerous comments which were reviewed

by the Board's Medical Director and some changes were made to the guidelines.

#### **Summary of Rural Area Flexibility Analysis**

##### **1. Types and estimated numbers of rural areas:**

This rule will apply to all insurance carriers, the State Insurance Fund self-insured employers, self-insured local governments, local governments that own and/or operate hospitals, attorneys, medical providers, group self-insured trusts, third party administrators and claimants across the state. These individuals and entities exist in all rural areas of the state.

##### **2. Reporting, recordkeeping and other compliance requirements:**

Medical providers in rural areas authorized to treat claimants will have to treat neck, back, shoulder, and knee injuries consistent with the Medical Treatment Guidelines (Guidelines) and insurance carriers, self-insured employers, self-insured local governments, third-party administrators, group self-insured trusts who administer their own claims, and the State Insurance Fund in rural areas (hereafter referred to as "affected payers") will be required to pay only for such treatments. If the provider wants to vary from the Guidelines, he or she will have to request a variance submitting the prescribed form to the Workers' Compensation Board (Board) and affected payer. The burden of proof for the variance rests on the treating provider. Affected payers respond to the request and determine if it will have the request reviewed by its own medical professional or obtain an IME or review of records. The affected payer must respond within fifteen business days if an IME is not obtained or thirty days if an IME is obtained. Denials of variance requests must be based on a medical opinion unless the denial is because the provider did not meet his burden of proof. The denial will be resolved by either a medical arbitrator or at an expedited hearing. Both the affected payer and claimant must choose to have the issue resolved by a medical arbitrator; otherwise it will be resolved at a hearing.

Treating providers in rural areas who participate in the optional prior approval process must complete the appropriate forms and respond within the required time frames. Affected payers must have its medical professional review the request for optional prior approval. If the affected payer has denied the optional prior approval, the dispute shall be resolved by the medical arbitrator and no further action is required.

Insurance carriers, self-insured employers, self-insured local governments, group self-insured trusts, and the State Insurance Fund are required to certify that they have incorporated the Guidelines and this rule into their policies, procedures, and practices. If they modify their policies, procedures, and practices, they must certify that the Guidelines and this rule are still incorporated.

Rather than submitting medical reports every forty-five days, the rule requires authorized providers, including those in rural areas, to submit medical reports when a follow-up visit is necessary, except the interval between medical reports can be no greater than 90 days. This actually lessens an existing compliance requirement.

The rule now requires that the prescribed form be used to request and respond to prior authorizations. Throughout the rule, treating providers and affected payers are required to use specific methods to transmit forms. Specifically, those methods are facsimile, email, or some other method of electronic transmission. Exceptions are provided for those who do not have the capability.

The rule requires affected payers to use the Chair prescribed form for valuation objections to medical bills, except when the affected payer adjusts the amount billed so it conforms to the appropriate workers' compensation fee schedule.

Individuals and entities in rural areas affected by the rule will not need any new professional services to comply with this rule. The Board will be providing training on the Guidelines and the processes surrounding them at no charge.

##### **3. Costs:**

The proposed rule will impose some additional costs on the individuals and entities identified above, which are expected to be more than offset by the savings from use of the Guidelines. Medical professionals and affected payers, including those in rural areas, will be required to incorporate the Guidelines into their policies, practices, and procedures. There will also be a cost to insurance carriers, self-insured employers, and group self-insured trusts associated with the requirement that it must certify within one hundred and twenty days of the effective date that it has completed such incorporation. To assist in this process, the Board will be providing training to small businesses and local governments, as well as all other stakeholders and the Board's employees at no charge.

The Guidelines will be available on the Board's website free of charge. The cost for a hardcopy will be \$10.00 per Guideline or \$40.00 for all four to cover the Board's cost. The charge for one or more of the Guidelines on a compact disc is \$5.00.

Treating medical providers in rural areas will incur some cost when requesting a variance. Upon receiving a variance request, an affected payer in a rural area may have the request reviewed by its own medical staff or

having an IME or records review performed. If the affected payer 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 where the burden of proof has been met, there must be a medical opinion. Affected payers will incur costs if an IME or records review is obtained. The cost for IMEs or records reviews to respond to variance requests will be offset by the reduction in number of IMEs required to respond to requests for prior authorization for the procedures and treatments on the pre-authorized list.

If a variance is denied, a Workers' Compensation Law Judge will resolve the issue at an expedited hearing or, if both parties consent, a medical arbitrator will resolve the issue. Affected payers and claimants will incur costs if the denial is resolved through the hearing process; but they should be offset by the reduction in the number of prior authorization denials that need to be resolved. If the parties opt to use the medical arbitrator the costs are nominal as there is no hearing or testimony.

There will be some cost for those providers in rural areas and those affected payers who participate in the optional prior approval process, which provides an opportunity for the treating medical provider to seek the affected payer's agreement that the treatment is consistent with the Guidelines. The treating medical provider will incur costs completing the form to request the optional prior approval and the affected payer will incur costs having the request reviewed by its staff medical professional.

By mandating use of the Guidelines, providers and affected payers across the State are using the same standards to determine if medical treatment is necessary, which will result in a reduction in disputes over medical bills. Reductions in disputes will reduce the costs involved in resolving them and increase the speed of payment. Further, the Guidelines along with the pre-authorized list will reduce the delays in treatment and care and improve outcomes so that claimants may return to work faster.

The use of the Guidelines is expected to result in millions of dollars of savings. Costs associated with unnecessary and excessive treatment and therapies will be eliminated or greatly minimized with implementation of the Guidelines as they:

- o Limit chiropractic manipulation to 20-24 visits for neck and 6-12 visits for back injuries, depending on severity
- o Limit various physical therapy modalities to 12-20 visits
- o Provide that an MRI for back injuries is not appropriate in the first 6 weeks unless there are red flags
- o Place limits on therapeutic injections in a 12 month period
- o Prohibit repeated non-therapeutic nerve block injections
- o Place additional limitations on 12 procedures that are subject to abuse or are complex and invasive
- o Prohibit ineffective treatments (e.g. Medex machines, electro-analgesic nerve blocks, etc.).

Injuries involving the knee, shoulder, back and neck account for approximately 36% of the claims but nearly 60% of system medical costs. Currently, many providers treat well in excess of the Guidelines.

The rule requires affected payers to file with the Board their objections to medical bills submitted by providers for payment on the Chair prescribed form, except for adjustments to the proper fee schedule amount. There will be a cost associated with having to use and file the prescribed form with the Board, which should be minimal. The form can be filed by fax, email, or regular mail.

##### **4. Minimizing adverse impact:**

As stated above, the implementation of Guidelines is expected to save millions of dollars.

To minimize possible adverse impacts, the regulations provide some flexibility by allowing for variances from the Guidelines. Variances are allowed in limited circumstances because claimants are different and injuries or illnesses do not always progress in the same manner. Without the ability to request a variance, when it is appropriate and medically necessary, some claimants would not receive the best medical care.

The rule requires the claimant or his or her legal representative to request review of the denial of a variance rather than automatically scheduling an expedited hearing, or if the parties both opt-in, referring the dispute to the medical arbitrator without any further action by the claimant or affected payer. By requiring the claimant to request review after consulting with his or her treating provider, the claimant has the opportunity to decide if he wants to move forward with the variance request. Further, as the burden of proof is on the claimant to show that the variance is medically necessary and appropriate, having the claimant request review provides an opportunity for him or her to evaluate whether the burden has been met. Such review and required action will ensure the claimant truly wants the treatment requested in the variance before the affected payer must defend the denial at a hearing.

Medical professionals and affected payers will be required to incorporate the Guidelines into their policies, practices, and procedures. To assist in this process, the Board will be providing training to stakeholders and Board employees. There will be no charge for this training at this time.

The training will not only cover the Guidelines, but all provisions of this rule.

The Superintendent of Insurance in his recommended implementation standards for the Guidelines included the requirement that affected payers certify annually that they have incorporated the Guidelines and this rule into their policies, procedures, and practices. The recommendation was modified as it was deemed to be too burdensome when compared to the benefit received. Rather, the rule requires an initial certification and then a new certification when the policies, procedures, and practices are modified.

The rule amends § 325-1.3 to increase the maximum length of time between the submission of medical reports from forty-five days to ninety days. 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. This results in a medical report that is 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 medically necessary visit is required, but no more than ninety days apart, fewer unnecessary office visits will be scheduled and costs reduced.

Originally, the proposed rule required all valuation objections to medical bills be on the Chair prescribed form. In response to legitimate concerns, the rule was changed to exempt objections that merely adjust the fee so that it reflects the appropriate amount under the workers' compensation fee schedule. Some providers do not adjust their billing systems to bill workers' compensation treatments at the appropriate fee schedule. Rather these providers bill using their usual and customary rate. When the affected payers process and pay the bills they must adjust for the fee schedule and object to that portion of the bill that is above the fee schedule. As there is no dispute for the Board to resolve in these situations, the benefit of using the prescribed form was outweighed by the cost and burden to the affected payers.

#### 5. Rural area participation:

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. In addition, the Board either met with or had conference calls with representatives from most of these entities. Changes were made to the regulations in response to the comments. With respect to the Guidelines themselves, the Board solicited comments on them between August 13, 2009, and September 9, 2009. Those seeking revisions to the guidelines were instructed to provide medical evidence supporting such changes. The Board received numerous comments which were reviewed by the Board's Medical Director and some changes were made to the guidelines.

#### *Job Impact Statement*

The proposed rule will not have an adverse impact on jobs. Pursuant to the directive of former Governor Eliot Spitzer, the Superintendent submitted recommended treatment guidelines for workers' compensation injuries and illnesses to the neck, back, shoulder, and knee (Medical Treatment Guidelines) to the Chair of the Workers' Compensation Board (Board) in December 2007, and submitted recommended implementation standards in June 2008. This rule adopts and mandates use of the Medical Treatment Guidelines, as modified by the Chair, and establishes the necessary processes to support the use of such guidelines.

The rule does not eliminate any existing process, procedure, or program. While the adoption of the Medical Treatment Guidelines and the establishment of a pre-authorized list of procedures should reduce medical disputes and the need for prior approval for special services costing more than \$1,000, such reductions will not result in an adverse impact on jobs. Further, the full implementation of the Medical Treatment Guidelines should result in savings that are greater than any costs that the rule may impose.