



STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

Eliot Spitzer
Governor

Eric R. Dinallo
Superintendent

December 3, 2007

Honorable Zachary Weiss
Chair
Workers' Compensation Board
20 Park Street
Albany, New York 12207

Dear Mr. Weiss:

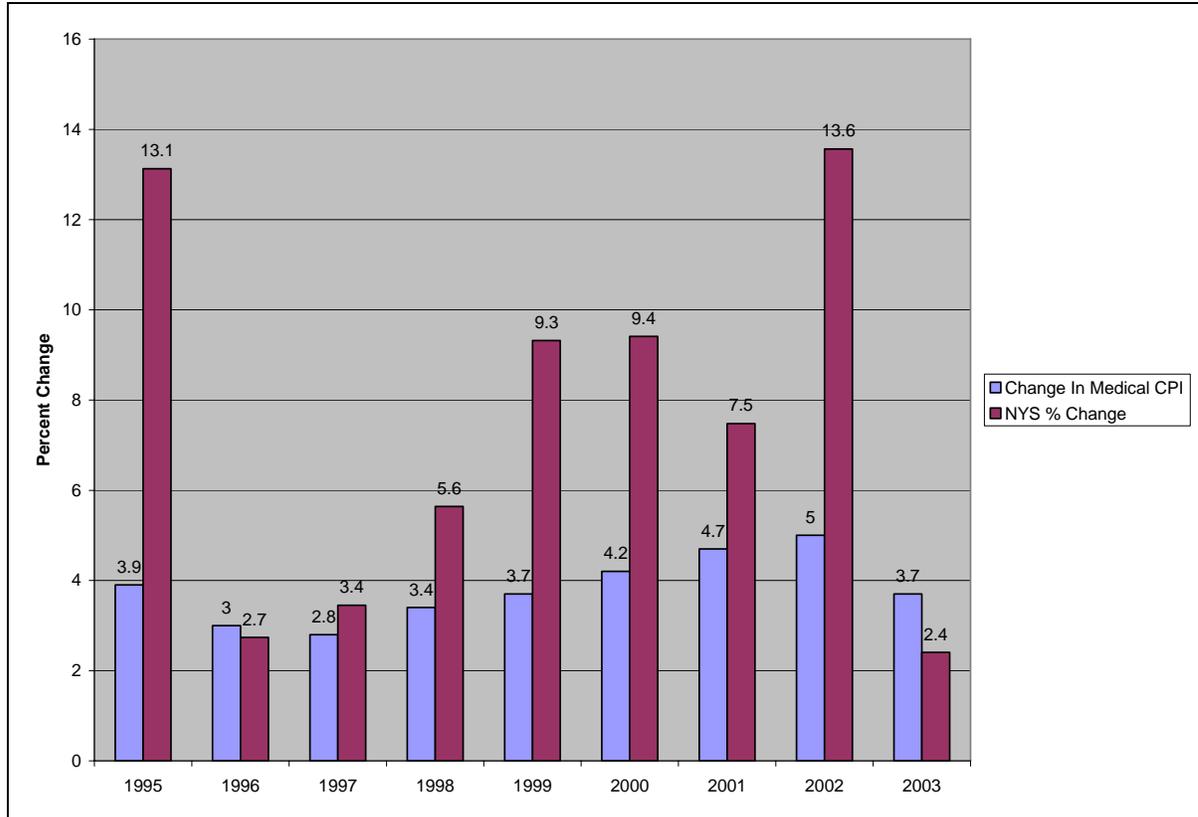
In his March 13, 2007 letter, Governor Spitzer directed the New York State Department of Insurance to develop medical treatment guidelines and training for Workers' Compensation law judges and other employees.

After extensive meetings with the Governor's designated Advisory Committee and its medical and other professionals, a review of treatment guidelines used in various states, and discussions with leading medical directors of state workers' compensation systems, the Department has developed a set of medical treatment guidelines that reflect a consensus of the medical professionals designated by the Advisory Committee and the Department. The Guidelines, which contain quality standards for medical care of injured workers, should encourage accelerated delivery of quality medical services to injured workers and reduce disputes and costs. To achieve these benefits, education and training of the parties who will be using the guidelines will be needed. Accordingly, the Department has formulated a plan for educating and training the guideline users. This letter contains a summary of the process used by the Department to develop the Guidelines, the Guidelines, and the related training plan. We have enclosed a draft of the Guidelines developed by the Department for consideration by the Workers' Compensation Board, the body in whose discretion promulgation of regulations is vested, and a draft of the training plan.

The Current New York System

New York's medical costs per indemnity claim from 1995 to 2003 increased each year, with 2002 increasing by 13.6%.¹ Medical costs as a share of total benefits increased from 1994 (34%) to 2003 (38%).² With the exception of 1996 and 2003, these increases for lost-time claims have been substantially above the medical consumer price index (CPI), and in a number of years, increases have been almost twice the medical CPI.

Change in Medical CPI versus Change in Medical Costs Per New York Lost-Time Claim



Sources: Bureau of Labor Statistics, CIRB data at 30-month development.

In 2003, lost-time claims comprised 89% of total medical costs³ and were vastly more expensive in terms of medical costs per claim than medical-only claims: \$15,668 vs. \$790.⁴

Given New York's fixed medical fee schedule, the increases in New York's medical costs are generally not the result of price inflation. Because prices have been stable over the past ten years, the increase in costs per claim can be attributed to substantial increases in utilization of medical services.

¹ New York Compensation Insurance Rating Board (CIRB) data showing average medical cost per indemnity claim at 30 months of development.

² *Ibid.*

³ *Ibid.*

⁴ National Council on Compensation Insurance. *Annual Statistical Report 2007 Edition*.

Overall, New York has been a moderate cost state in comparison to other states; in 2003/2004, New York had the 18th highest medical costs per case out of 46 states. However, New York had the 5th lowest medical costs per permanent partial disability case, and the 9th lowest medical costs per total temporary disability case.⁵

New York does not currently have medical treatment guidelines.⁶ A number of states, however, have adopted medical treatment guidelines.

In the absence of medical treatment guidelines, New York practitioners do not have easily accessible up-to-date standards for care. Similarly, claims examiners at the insurance carriers and self-insureds (“carriers”) do not have agreed upon standards by which to assess the medical necessity of care. One result is the generation of substantial disputes about medical care that is harmful to both employee and employer, as delivery of care is delayed and frictional costs increase.

Benefits of Medical Treatment Guidelines For New York

It is generally recognized that use of evidence-based guidelines has the potential to improve the quality of care. Medical treatment guidelines grounded in evidence-based medicine and the sound clinical judgment of highly credentialed physicians translate the medical literature into a useable and practical tool that assists busy medical providers in delivering appropriate health care.

Without medical treatment guidelines, biases may affect determinations of medically necessary care to the injured worker’s detriment. Denial of medically necessary care simply to reduce costs is obviously harmful to the injured worker. On the other hand, excessive utilization of medical services for the injured worker does not improve outcomes. In fact, repeated unsuccessful procedures that are not clinically indicated may adversely affect the injured worker. Treatment guidelines minimize the effects of bias in determining medically necessary care. By addressing these possible biases in treatment decisions, medical treatment guidelines deliver better care at lower cost.

Carriers (and their administrative third-party payors) use a variety of tools to assess appropriateness of care in an effort to control costs and ensure quality, a process that is called utilization management or review (UR). There is no requirement that carriers employ the same UR standards or processes and this lack of uniformity may cause injured worker-patients with the same conditions to be treated differently. This lack of standardization may lead to variations in the treatment of injured workers that are not explained by the nature of their injuries, so that some workers may receive lower quality of care than others. Lack of standardization also adds to frictional costs by producing needless disputes.

⁵ *Ibid.* New York’s moderate ranking for overall medical costs per case compared to its lower ranking for PPD and TTD cases may be due to New York’s apparently having more higher-cost cases relative to other states.

⁶ New York’s existing medical guidelines, published in 1996, do not focus on treatment and care issues, but rather on percentage of impairment from work related injuries.

Uniform UR standards based on medical treatment guidelines should significantly reduce this variation in treatment, increase the transparency of the medical claim and payment process, and lead to decisions based on sound, evidence-based medicine. Increased consistency in UR decisions will result in greater predictability for the medical provider and furnish a common ground for discussion between the providing physician and the UR physician about differences concerning appropriate treatment.

A common standard used by all parties should reduce disputes and have a direct economic benefit to the system as a whole in the form of reduced costs. When disputes do arise, judges and arbitrators will have an acknowledged standard to use to resolve them, thereby promoting ease of resolution, more consistency and more timely decision-making.

In short, medical treatment guidelines benefit everyone in the workers' compensation system, from employee to employer, from treating physician to carrier, from lawyer to judge.

Development of NYS Medical Treatment Guidelines

Participating Professionals

Development of medical treatment guidelines should include input from medical professionals. The Governor's designees from labor and business carefully selected professionals who were well qualified for the task. The Department also retained a highly qualified physician as its consultant.

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Since August 2007, these credentialed professionals met on a regular basis for as long as ten hours at a time to provide advice to the Department respecting its development of the guidelines.⁷

Guideline Development Process

Two alternative approaches for guideline development were considered: (1) choose a single comprehensive guideline set that covers all parts of the body that are commonly injured at work; or (2) choose the single best guideline for each part of the body, assembling several guidelines into a patchwork.

The first approach permits broad coverage, but a comprehensive guideline set may very well have strengths and weaknesses in different parts of the guidelines. From a practical standpoint, a single guideline set would have to be chosen based on a selective, in depth review of only a narrow range of procedures and body parts covered by the guidelines.

The second approach—that of a guideline patchwork—was chosen, but with some variation. The patchwork approach permitted selection of the preferred guideline for each part of the body. While patchwork guidelines may not be as comprehensive as a single guideline set initially, continuous development of the patchwork will evolve into an equally broad group of guidelines, but with the advantage that each component will have

⁷ Participating in these meetings and completing the “working group” were the Advisory Committee members: Chair of the Assembly’s Labor Committee; representatives of the Senate Majority Leader, Speaker of the Assembly, NYS AFL – CIO, NYS Business Counsel, Workers’ Compensation Board and Department of Labor; and members of the Workers’ Compensation Reform Task Force that was created as a result of the Governor’s March 13th letter.

been individually selected and reviewed as the preferred one. In an effort to further enhance the chosen guidelines, the working group, including the group's medical professionals, reviewed the guidelines on a line-by-line basis. The guidelines were then modified in light of the suggestions primarily by the medical professionals based on various factors, including the medical professionals' clinical judgment, experience and knowledge of the medical literature.

The working group elected to develop guidelines for the parts of the body that were high medical cost drivers: low back, cervical spine, knee and shoulder. For every policy year from 1999 to 2004, the percentage of total medical costs and number of claims was the highest for back injuries.⁸ The Workers Compensation Research Institute (WCRI) recently reported that nearly 30% of medical costs were for treatment of back conditions, with claims involving disc conditions and/or radicular symptoms costing an average of nearly \$10,000 per case. Treatment for shoulder/arm (13%) and cervical spine (10%) accounted for the two next largest percentages of medical payments. Medical costs for the knee were fourth highest at 7.6% of total medical costs.⁹

The working group limited its consideration to guidelines for work-related injuries. It considered guidelines from the American College of Occupational and Environmental Medicine (ACOEM), two commercial guideline sets, and three state developed guidelines. Generally, ACOEM and the state guidelines of Colorado and Washington were selected for development of the NYS guidelines and are all nationally recognized. These states have prominent medical directors who hold faculty positions at their respective state medical universities. All three guidelines are evidence-based, supplemented by consensus of medical professionals.

For low back, cervical spine, shoulder and knee guidelines, a foundation guideline was selected considering the advice of the medical professionals that reflected the above factors as well as ease and friendliness of use of the guidelines. The foundation guideline was then modified in light of input primarily from the medical professionals including consideration of the other two guidelines.¹⁰ The medical professionals also reviewed various medical literature and applied their own professional experience based on general medical principles in providing their best advice to the Department. They recognize that medical science and practice may change over time and that medical opinions may differ on various subjects. The guidelines should keep pace with these changes.

The result of this extensive process was the following compilation of quality guidelines that include suggested modifications by the participating professionals. These guidelines

⁸ Calculations provided by CIRB, derived from Unit Statistical Reports.

⁹ Workers' Compensation Research Institute. *WCRI FlashReport: What are the Most Important Medical Conditions in New York Workers' Compensation*, July, 2007.

¹⁰ The working group did not review the specific medical literature that the guidelines cited as their bases.

reflect a consensus among all the medical professionals:

- (1) Low back – adopted primarily from ACOEM, supplemented by Colorado¹¹;
- (2) Cervical spine – adopted primarily from Colorado, supplemented by ACOEM;
- (3) Shoulder – adopted primarily from Colorado, supplemented by Washington and ACOEM;
- (4) Knee – adopted primarily from Colorado, supplemented by Washington and ACOEM; and
- (5) General Principles for all Guidelines – adopted primarily from Colorado.

A draft of these five NYS Medical Treatment Guidelines as proposed by the Department for consideration of the Board is enclosed.

The working group will now begin consideration of process issues related to implementation of the treatment guidelines, including the evidentiary weight they are to be accorded, treatment variances from the guidelines and development of a pre-authorized list of treatments as provided by the recent reform legislation.

Education and Training of Guideline Users

For the treatment guidelines to be effective, the users of the guidelines should receive education and training about the guidelines' proper use and application. There will be three principal groups of guideline users: treating physicians and other medical providers; UR personnel of the carriers, including physicians; and the Workers' Compensation Board personnel, including judges, Board members who decide appeals and other employees involved in processing medical issues. The Department's proposed education and training plan, a copy of which is enclosed, addresses the content and delivery of the educational effort, recommendations for encouraging or requiring participation in the program, and evaluation regarding use of the guidelines.

Future Considerations

Updating Guidelines

Newly published medical literature reflects developments in the field of medicine; moreover, medical best practices change over time. The Department recommends that the Board review and update its medical treatment guidelines as the Board deems appropriate, taking into consideration such literature, best practices, outcomes data as available, as well as the guidelines' ease of use for practitioners.

¹¹ The pre-publication draft of the ACOEM's low back guideline was available to the working group. The published version, due out today, is not expected to have any substantive changes. The evidentiary back-up and discussion are more than 300 pages and have not been attached.

Medical Director

Medical care for injured workers is a major component of the system and affects all workers who file a claim. Some 65% of filed claims are medical only (no lost-time).¹² The Board currently authorizes approximately 21,000 physicians to practice before the Board and render care to injured workers. Oversight of the medical component of the system by a qualified, independent and impartial physician is essential. Indeed, the Workers' Compensation statute contemplates a medical director by its express reference to one. However, since 1998, there has been no Medical Director at the Board. The Department recommends that the Board retain a Medical Director who is a well-credentialed, experienced and impartial physician. However, the Department does not believe that the Medical Director's experience or practice should primarily be treating patients under the workers' compensation law – either as a treating physician or IME retained by the carriers, since that could affect the perception of independence and impartiality. The Medical Director's responsibilities should be general oversight of all medical issues at the Board, including promoting high quality care and outcomes for all injured workers, implementation and updating of the medical treatment guidelines and the education and training of the guideline users.

Additional Guidelines

The Department expects to develop a draft of additional medical treatment guidelines, two of which will be for chronic pain and wrist injuries (including carpal tunnel syndrome).

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All of the Advisory Committee members, and particularly the medical professionals, have generously and diligently given their time to this effort and the Department is most appreciative. We trust that the highly collegial process and professional dialogue amongst the medical professionals will continue and enable the Department to meet its continuing challenges.

Sincerely,



Eric Dinallo
Superintendent
New York State Insurance Department

cc: Honorable Eliot L. Spitzer
Honorable Joseph L. Bruno
Honorable Sheldon Silver

¹² CIRB data based 30-month development period. For the period 1994 – 2003, CIRB data shows that medical-only claims range from 63.4% to 65.4% of total claims.

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