



STATE OF NEW YORK
INSURANCE DEPARTMENT
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DAVID A. PATERSON
Governor

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Superintendent

September 15, 2010

Honorable Robert E. Beloten
Chair
NYS Workers' Compensation Board
20 Park Street
Albany, New York 12207

Dear Mr. Beloten:

The Workers' Compensation Reform Law of 2007 increased the maximum weekly indemnity benefit and introduced limitations on how long indemnity benefits will be paid for non-schedule permanent partial disability claims (PPD-NS). Under Section 15(3)(w) of the Workers' Compensation Law, as amended by the Reform Law, claims classified as PPD-NS, with a date of injury or illness on or after March 13, 2007, can receive compensation up to a specified maximum number of weeks depending on the percentage of loss of wage-earning capacity ("duration maximums").

In his March 13, 2007 letter that accompanied the Reform Legislation, former Governor Spitzer directed the New York State Department of Insurance to develop new guidelines that related to loss of wage-earning capacity. As part of the reform effort, the Workers' Compensation Reform Task Force (Task Force) was created in the Department to develop these guidelines. The March 13th letter provided for appointment by the Governor of an Advisory Committee to work with the Task Force.

At the outset, the Task Force and participating Advisory Committee members agreed that these guidelines (Disability Duration Guidelines) would be comprised of three inter-related segments: (a) Medical Impairment Guidelines; (b) Residual Functional Abilities/Losses Guidelines; and (c) Loss of Wage-Earning Capacity Guidelines. After some 60 meetings with the participating Advisory Committee members and their medical and other professional advisors, the Department through the Task Force has developed proposed Medical Impairment Guidelines and Residual Functional Abilities/Losses Guidelines numbering in excess of 100 pages. These Guidelines reflect a consensus of such Advisory Committee members, their medical and other advisors and the Task Force. After some 20 meetings and extensive consideration of several approaches for the third

segment -- Loss of Wage-Earning Capacity – the participating Advisory Committee members were unable to reach consensus on this third segment. Because a consensus could not be reached by the Advisory Committee, this third segment is referred to the Workers' Compensation Board (Board) for development and determination.

This letter contains an overview of the how the three segments should inter-relate to produce a percentage of loss of wage-earning capacity and a summary of the process used by the Task Force to develop the Guidelines. We enclose a draft of the proposed Medical Impairment Guidelines and Residual Functional Abilities/Losses Guidelines for consideration by the Board, the body in whose discretion promulgation of regulations is vested.

Overview of the Three Segments

Disability Duration Guidelines provide the basis for determining the percentage of loss of wage-earning capacity and related duration maximums for individuals who are subject to Section 15(3)(w) and are not working. They do not address temporary disabilities or schedule loss of use awards for PPD.

For an individual who has reached maximum medical improvement, the Medical Impairment Guidelines provide the physician with accurate and objective tools to document an individual's permanent impairment resulting from a medically documented work related injury or illness. By following the detailed steps outlined for a medical impairment analysis, the physician selects the appropriate Medical Impairment Class and related severity ranking which should inform the physician's evaluation of the impact of the injury or illness on the individual's functional status.

The Residual Functional Abilities/Losses Guidelines (Residual Functional Guidelines) provide a methodology for measuring an individual's residual functional abilities and losses in relation to the diagnosed work-related medical impairment and the likely functional requirements in the workplace. The physician assesses the individual's residual functional abilities according to a prescribed set of standard metrics and documents the findings on a newly designed Functional Assessment Form. In the event of material differences in the findings of the treating physician and the IME, an impartial medical professional will perform a functional capacity evaluation. The physicians may issue a new or modified Functional Assessment in light of the impartial functional capacity evaluation. The results from the Functional Guidelines are an input to and inform the determination of loss of wage-earning capacity.

Loss of wage-earning capacity guidelines should utilize the results from the Functional Guidelines together with vocational factors, such as education, skill level and age, to provide a framework for determining loss of wage-earning capacity. Information regarding vocational factors should be collected from the individual using the newly created Vocational Data Form and may be supplemented by the employer.

The procedural steps for utilizing Disability Duration Guidelines are illustrated by the flow chart incorporated in the enclosed Guidelines. The Guidelines envision three separate judicial decisions: (1) determination of whether the individual has reached MMI, (2) assignment of the Medical Impairment Class and severity ranking, and determination of residual functional abilities and losses, and (3) determination of loss of wage-earning capacity.

The Advisory Committee members participating in the development of the Disability Duration Guidelines were:

Colleen Gardner
Commissioner
NYS Department of Labor

Mark Humowiecki
Deputy Executive Director, Policy and Program Development
Workers' Compensation Board

Margaret Moree
Director of Federal Affairs
The Business Council of New York

Kenneth J. Pokalsky
Senior Director of Government Affairs
The Business Council of New York

Arthur N. Wilcox, Jr.
Director, Public Employees Division
NYS AFL-CIO

Development of the Medical Impairment Guidelines

Participating Professionals

Development of medical impairment guidelines required input from medical professionals. The Governor's designees from Labor and Business carefully selected professional advisors who were well qualified for the task. The Department also retained a highly qualified physician as its consultant.

Pamela Caggianelli RN, C.C.M., C.D.M.S., COHN-S, LNCC, CIPP
Manager, Corporate Health and Global Privacy
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David Deitz, M.D., Ph.D
Vice President, National Medical Director

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Avital Fast, M.D.
Chairman and Professor
Department of Rehabilitation Medicine
Montefiore Medical Center and
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Robert Goldberg, D.O.
Past-President, Medical Society of the State of New York
Dean, Touro College of Osteopathic Medicine
Associate Dean of Community Medical Affairs and Advocacy and
Professor of Physical Medicine & Rehabilitation
Clinical Associate Professor of Rehabilitation Medicine, New York Medical College

Stephen Levin, M.D.
Co-Medical Director
Mount Sinai - IJ Selikoff Center for
Occupational & Environmental Medicine and
Former Interim Medical Director of the Workers' Compensation Board

James McCarthy, Esq.
Injured Workers' Bar Association

Alexander Rosado, Esq.
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Jaime Szeinuk, M.D.
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James Tacci, M.D., J.D., M.P.H.
Manager of Medical Services
Xerox Corporation
Assistant Professor and Residency Program Director
Department of Community & Preventive Medicine
University of Rochester Medical Center

Guideline Development Process

These credentialed professionals have regularly met over some 20 months to provide advice and participate in drafting the guidelines. They voluntarily gave their time, effort

and expertise and personally received no compensation other than knowing they were rendering a public service to the State of New York.¹ Participating in these meetings and completing the “working group” were the Task Force and Advisory Committee members.

The working group reviewed medical impairment guidelines from states including Utah, Washington, Oregon, Florida and Minnesota, and from the American Medical Association in developing specific sections of these new Medical Impairment Guidelines. The working group, and especially the medical professionals, drafted these new Medical Impairment Guidelines on a line-by-line basis. The relative severity rankings of the Medical Impairment Guidelines were initially developed by a sub-committee of medical professionals from the working group in meetings with the Task Force and were tested successfully for ease of use and inter-rater reliability using hypothetical cases.

The Medical Impairment Guidelines reflect the consensus of the medical and other professionals, as well as the Advisory Committee members and the Task Force.

The Medical Impairment Guidelines provide a standard framework and methodology for physicians to evaluate and report an individual's permanent medical impairment. Specific guidelines have been developed for injuries to body parts commonly encountered in Workers' Compensation clinical practice, including the spine (cervical, thoracic and lumbar), pelvis, cardiovascular, respiratory, and the brain. For impairments to parts of the body not covered by specific Chapters within these Guidelines, Chapter 8 entitled "Other Injuries and Occupational Diseases (Default Guideline)" establishes the method for proceeding.

The Guidelines provide objective criteria for determining the level of medical impairment. As detailed in the Guidelines, the impairment analysis should include an accurate history and objective test measurements, with greater weight given to objective clinical findings. The methodology of the Guidelines is intended to foster consistency, predictability and inter-rater reliability for determining impairment.

Development of Residual Functional Abilities/Losses Guidelines

Participating Professionals

The same professionals who participated in developing the Medical Impairment Guidelines also participated, together with Kenneth Eichler of Reed Group, in creating the Residual Functional Guidelines.

Guideline Development Process

These professionals together with the Task Force and Advisory Committee members have regularly met as working group over a seven month period to craft the Residual Functional Guidelines. These Guidelines reflect the consensus of the medical and other

¹ The hospitals that employ the Task Force's consultant and the Board's Interim Medical Director are compensated for their employee's time.

professionals, as well as the participating Advisory Committee members and the Task Force.

The working group reviewed and discussed various approaches to performing functional assessments, including available standardized programs. They also considered presentations and views of various experts, including Ellen Bodner, PT, DPT, who assisted the Task Force, and reviewed the U.S. Department of Labor's system for analyzing the functional requirements of jobs.

These Residual Functional Guidelines provide a methodology for measuring an individual's residual functional abilities in relation to the diagnosed work-related medical impairment and the likely functional requirements in the workplace. The treating physician and the IME (if applicable) assess the individual's residual functional abilities according to a prescribed set of standard metrics and document their findings on a newly created Functional Assessment Form.

These Guidelines also provide for creation of an impartial Panel of designated health care professionals (DHCP) comprised of physicians (MD, DO) registered physical therapists and occupational therapists (DHCP) qualified to perform a Functional Capacity Evaluation (FCE). In the event of material differences between the findings of the treating physician and the IME, the parties or the Judge may request an FCE by a DHCP, who shall be selected by the Board from the Panel. The FCE by the DHCP shall follow a standard protocol, be performance-based and actually calculate, during an examination of the injured worker, functional abilities according to metrics from the U.S. Department of Labor Dictionary of Occupational Titles. There shall be an audio-video recording of the examination in order to record objectively the precise basis for the FCE, thereby assisting the parties and the Judge in assessing residual function as well as reducing friction costs. The physicians may issue a new or modified Functional Assessment in light of the impartial FCE.

The results from the Residual Functional Guidelines are an input to and inform the determination of loss of wage-earning capacity.

Development of Loss of Wage Earning Capacity

Participating Professionals

Development of loss of wage-earning capacity (LWEC) guidelines required the knowledge and experience of professionals who have been involved with the determination of PPD-NS claims. The Advisory Committee members from Labor and Business selected such professionals who could help craft LWEC guidelines. The professionals participated without compensation.²

Frederic J. Buse, CPCU

² The Board's Interim Medical Director also participated. The hospital that employs him was compensated for its employee's time.

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Guideline Development Process

These credentialed professionals along with the Task Force and participating Advisory Committee members formed a working group that met some 20 times for as long as 8 hours, including one Sunday, to attempt to develop the guidelines. Despite extensive efforts over some 9 months that is briefly summarized below, the working group was not able to achieve consensus on LWEC guidelines.

LWEC guidelines should utilize the results from the Residual Functional Guidelines together with vocational factors, such as the education, skill level and age of the injured worker to determine loss of wage-earning capacity. Information regarding vocational factors should be collected from the individual using the attached, newly created Vocational Data Form, and may be supplemented by the employer.

The working group reviewed the methods used by other states for determining earning capacity and heard presentations by vocational experts. The working group then considered four approaches for determining loss of wage-earning capacity, the first two of which were discussed and developed extensively: (1) Grid Approach: formulate a grid that assigned percentage points of loss of wage-earning capacity depending on various factors, including the difference in the injured worker's functional exertional capacity after the injury as compared to the exertional capacity requirements of the at-injury job; the age, skill level, and education of the injured worker; (2) Vocational Specialist Approach: use of an impartial vocational specialist to provide an expert opinion on the injured worker's residual wage-earning capacity, based on standard methodology and metrics; (3) Hybrid Approach: the use of a combination of the two preceding approaches; and (4) Litigation Approach: the injured worker and insurer would submit such evidence regarding the injured worker's earning capacity and loss of wage-earning capacity as they deem relevant for the Judge's consideration.

Because a consensus could not be reached by the participating Advisory Committee members about the approach for determining loss of wage-earning capacity, this third segment of the Guidelines is referred to the Board for development and determination.

Other Considerations

Education

To enhance the effective use of the Disability Duration Guidelines, education and training of the Guideline users are recommended. One possibility for jumpstarting this is for the Board to focus on educating its Judges, using internal resources. Once the Judges are comfortable with the Guidelines and consistently use them, the ripple effect on other

participants in the system, such as attorneys, medical providers and carriers, will provide a form of on-the-job training. Another important aspect of the education program should focus on the physicians who complete the Functional Assessment Forms and the DHCPs who perform the FCEs.

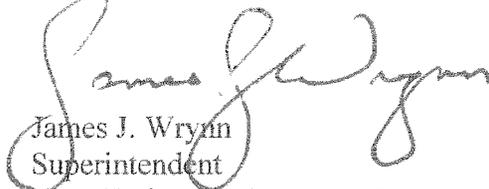
Data

Currently, the available data for determining the impact of medical impairments, residual functional abilities/losses and various vocational factors on LWEC is not robust. It is recommended that the Board design, with the assistance of an expert consultant, a data collection system that will provide the Board with additional data in this regard.

* * * *

The Advisory Committee members, and particularly the participating medical and other professionals, have generously and diligently given their time to this effort and the Department is most appreciative.

Sincerely,



James J. Wrynn
Superintendent
New York State Insurance Department

- cc: Honorable David A. Paterson
- Honorable Malcolm A. Smith
- Honorable Sheldon Silver
- Honorable George Onorato
- Honorable Susan John
- Labor Commissioner Colleen Gardner
- Kenneth Adams
- Denis M. Hughes
- Mark Humowiecki
- Margaret Moree
- Kenneth J. Pokalsky
- Arthur N. Wilcox, Jr.
- Ellen Bodner, DPT
- Frederic J. Buse, CPCU
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