NEW YORKERS FOR FAIR AUTOMOBILE INSURANCE REFORM • NYFAIR

Dedicated to protecting access to quality healthcare for automobile accident victims

November 1, 2018

Via email to regulations@wcb.ny.gov

Heather MacMaster, Esq.
Deputy General Counsel
Workers' Compensation Board
328 State Street
Schenectady, NY 12305-2318

Dear Ms. MacMaster:

On behalf of New Yorkers for Fair Automobile Insurance Reform, I respectfully request review and consideration of the following comments submitted in response to the Notice of Revised Rule Making (Medical Fee Schedules I.D. No. WCB-23-18-00005-RP) published in the New York State Register on October 3, 2018 and October 17, 2018.

As you are aware, the proposed revision to the Medical Fee Schedule was announced in April of 2018 as part of a series of "Proposals to Improve Medical Care for Injured Workers." The stated goal was to "[t]o increase provider participation in the workers' compensation system and improve injured workers' access to timely, quality medical care…" The announcement asserted "[a]ccess to quality medical care for injured workers is of utmost importance for a healthy workers' compensation system." The Board indicated it was undertaking a "multipronged approach to address provider concerns" with regard to the workers' compensation system.[1]

[1] The providers' have numerous concerns. For more than two decades, the reimbursement available under the Workers Compensation Fee Schedule remained relatively unchanged. Even after the announcement of a long overdue fee increase, we have been contacted by providers indicating an increasing impatience with the workers' compensation system. Providers are frustrated that they have no official standing before the Board and are dependent upon the injured worker taking affirmative action to initiate proceedings. This is exacerbated by the Board's July 2018 decision to remove the requirement for the filing of a Form C-8.1 Part A where the insurer denies the request for authorization. Many providers have indicated they just refuse to participate in the workers'

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On June 6, 2018 the Workers Compensation Board released a proposal to, among other things, increase reimbursement for the vast majority of services provided by nearly every class of heath care provider. However, there are notable exceptions that threaten to reduce available care and treatment options: Procedure codes were removed from the Chiropractic Fee Schedule; Reimbursement for electrodiagnostic testing was sharply curtailed; Psychologists were prohibited from providing care through the use of licensed social workers.

On October 3, 2018 the Chair of the Workers' Compensation Board published a Revised Rule Making Statement that identified only one major substantive modification unrelated to the changes from the initial proposal: Increasing from 8 to 12 units, the per day therapy limitation.

However, the actual text of the new proposed Fee Schedule contains an unprecedented and seemingly arbitrary limitation on physical treatment: limiting physical therapy to 12 sessions within the first 180 days. This limitation was engineered via a modification to Physical Medicine Ground Rules 2 and 5. Chiropractic Physical Medicine Ground Rule 3 was also altered to limit chiropractic treatment to 180 days. None of these proposed changes were discussed in the State Register notice published on October 3, 2018 or October 17, 2018.[2]

The current Physical Medicine Ground Rule 2 permits reimbursement for physical therapy beyond 12 visits if there is documentation that includes a doctor's certification of the need for continued treatment:

> Physical medicine services in excess of 12 treatments or after 45 days from the first treatment, require documentation that includes provider certification of medical necessity for continued treatment, progress notes, and treatment plans.

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compensation system. Others that still do question the wisdom of continuing to participate in a system beset by delay and one that hampers their ability to provide the care they feel their patients need.

[2] On October 17, 2018 the Chair published another Notice of Revised Rule Making, (I.D. No. WCB-23-18-00005-RP), pertaining to Medical Fee Schedules, indicating that the Noticed published in the October 3, 2018 issue of the State Register was published with the incorrect Assessment of Public Comment. And further providing a "correct assessment for the revised rule: Subject: Medical Fee Schedules". The Notice concluded with the following language: As a result of these comments and the Board internal review, the proposed Medical Fee Schedules have been revised throughout. The Board will receive public comments to the revised rule-making for an additional thirty days. In subsequent communications, the Board has indicated that the period for comment was not extended by the October 17. 2018 publication. This decision is contrary to the plain language published in the State Register.

This documentation should be submitted to the insurance carrier as part of the claim.

The Proposed Ground Rule 2 and 5 impose a hard limit of 12 sessions/visits and specify that the treatment must occur within 180 days.

Proposed Ground Rule 2 provides:

2. Physical Medicine Utilization

Physical medicine services may not exceed 12 sessions/visits per patient per accident or illness or be rendered more than 180 days from the first session/visit.

Proposed Ground Rule Chiropractic Physical Medicine Ground Rule 3 also limits treatment to 180 days.

These proposals do not appear to be in accord with the overall goal of the Workers' Compensation Law to provide a swift and sure source of benefits to injured employees. We are concerned that these new proposed limitations were not based upon any medical assessment and appear to have been chosen in an arbitrary manner. In contrast to the approach adopted herein, before the Board adopted the Medical Treatment Guidelines in 2010, it engaged in lengthy consideration, after public notice and review of accepted medical practices. We ask the Board to disclose the medical justification for limiting all treatment to 12 visits or 180 days.

Furthermore, the proposed limitations would only apply to those body parts not subject to the Medical Treatment Guidelines. Here again, it seems arbitrary to impose a hard limitation unsupported by medical evidence merely because the worker sustained an injury to a body part that was not covered by the Medical Treatment Guidelines. Additionally, even without adoption of these proposed Ground Rules, pre-authorization is already required for non-urgent care in excess of $1,000.

In sum, it appears that adopting the proposed changes to Physical Medicine Ground Rules 2 and 5, and Chiropractic Physical Medicine Ground Rule 3 would only affect the treatment provided to a small number of injured workers: Those having an injury to a body part not covered by the Medical Treatment Guidelines and who require treatment below the $1,000 pre-authorization threshold. This begs the question: What is the point?

While material to only a small number of injured workers, these Ground Rule modifications would have a profound effect on virtually every automobile accident victim seeking physical therapy or chiropractic care under the no-fault insurance policy.

The No-Fault insurance system was designed to permit only those who sustain serious injury to pursue negligence claims while ensuring that all accident victims are promptly compensated for economic injury, including health care expenses. The No-Fault statute specifically provides that payment for all necessary physical therapy is to be made "without limitation as to time, provided that within one year after the date of the accident causing the injury it is ascertainable that further expenses may be incurred as a result of the injury." Ins. Law 5102(a)(1).

As you are aware, Insurance Law 5108 limits reimbursement under the No-Fault policy to the amounts allowed in the NY Workers' Compensation Medical Fee Schedule for the treatment of work related injuries. Department of Financial Services Regulation 11 NYCRR 68.1(b)(1) provides that, other than in limited circumstances not applicable herein, the "ground rules in the workers' compensation fee schedules apply" to the payment of No-Fault claims.

These proposed Ground Rules should not be applied to automobile accident victims. First, these ground rules eliminate the current standard of medical necessity. They are arbitrary limitations made without regard to the patient's needs, and without any examination of the patient or the patient's records and without reference to accepted medical practice. These Ground Rules effectively take medical decision making out of the hands of the medical professionals, without any regard for the needs of the individual patient, or the professional judgment of their health care provider, or reference to accepted medical standards.

Currently, physical therapy beyond 12 visits is only permitted if there is documentation that includes a doctor's certification of the need for continued treatment. Not only is the documentation subject to the no-fault insurer for review, but the insurer may itself conduct an examination of the patient to verify the need for further treatment. Thus, decisions regarding the need for treatment are made by medical professionals, not a line in a regulation based upon arbitrarily imposed limitations.

Under the proposed Ground Rule, a patient who prudently delayed receiving reconstructive surgery while receiving conservative treatment could easily find herself in a situation where the surgery is covered, but the physical therapy necessary to recover from the surgery is not. There is no medical justification for such a rule. In fact, it seems to promote medical malpractice.

Second, the proposed rules directly contradict the statutory provision that all necessary No-Fault benefits are available without time limitation, as long as the need for treatment is determinable within one year. Applied to an automobile accident victim, this proposal brings us from the current universe where the statute permits all necessary treatment without regard to time, based upon the actual needs of the patient, to a world where physical therapy--the most effective and commonly prescribed recuperative treatment regime--is arbitrarily limited to 12 visits within the first 180 days. It represents a shocking reversal that violates the express intent and language of the No-Fault law.

Third, the most draconian effects of these rule falls directly upon the accident victim seeking the No-Fault benefits from the insurance policy he was required to purchase.

Injured workers, unlike auto accident victims, may receive treatment in excess of the 12 session/180 day limitation as long as it comports with the Treatment Guidelines for services rendered to body parts covered by the Guidelines. Furthermore, injured workers may seek a variance authorizing treatment in excess of that recommended by the guidelines. In contrast, automobile accident victims will be subject to a harsh arbitrary rule denying necessary treatment without consideration of their own condition, without exception, and without recourse.

We respectfully request that the Board not adopt the proposed changes to Physical Medicine Ground Rules 2 and 5 and Chiropractic Physical Medicine Ground Rule 3. Alternatively, we ask that the Ground Rules be modified in a manner that would preclude their application to treatment provided to automobile accident victims.

Proposal to amend Ground Rule 11: While the addition of 4 units of modality treatment per treatment visit appears to benefit the patient, the text of Ground Rule 11 may create a conflict between providers of modality therapy and procedures with those who can also provide chiropractic manipulation therapy. The codes used for chiropractic manipulation, while listed within the physical medicine modalities subject to the daily 12 unit limitation (now 8 units) are not included within the general physical medicine section of the schedule. Accordingly, there may be confusion as to whether the units of manipulation only a licensed Chiropractor can provide, will serve to offset the total physical medicine units a patient can receive per day, from all providers. This rule could serve to limit the total care a patient receives based on a false equivalency between providers who cannot perform the same modalities and or treatment, i.e., chiropractic manipulation vs typical physical therapy modalities.

Chiropractic manipulations are the best available treatment for spinal subluxations. Physical therapists are not licensed or qualified to perform chiropractic manipulations. Therefore, an injured patient who has spinal subluxation as well as other symptoms that are amenable to physical therapy modalities, such as pain, weakness, stiffness, muscle spasm and loss of function, may not have access to all the modalities that they require and are entitled to under the current law.

It is respectfully submitted that this Ground Rule be clarified as follows: “When a patient received physical medicine procedures and/or modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per accident or illness from all providers. This limitation will apply only to modalities listed in the physical medicine sections of all providers”.

Ground Rule 10: The response to the initial comment period relating to the addition of ground rule 10 (within the Chiropractic fee schedule) addressed issues also relating to; the omission of CPT codes for massage therapists, non-surgical decompression tables, reduction in fees for injections, elimination of scope of practice for drug testing, and objection to chiropractic ground rule 10 generally. The omnibus response merely dismisses the objections as not relating to codes that were included in the Chiropractic fee schedule, yet indicates the need for the ground rule as a "clarification". The clarification fails to recognize existing mechanisms already in place that contemplate deviations from the available fee schedule codes in workers' compensation cases via the request for variance, and via Insurance Law §5108 which contemplate the "establishment of schedules for all such services for which schedules have not been prepared".

It is respectfully submitted that this Ground Rule be clarified as follows: "Subject to the issuance of a variance, a chiropractor may only use CPT codes contained in the Chiropractic Fee Schedule for billing of treatment for work related injuries. Subject to the issuance of a variance, a chiropractor may not use codes that do not appear in the Chiropractic Fee Schedule for work related injuries."

In closing we ask you to consider the following: Many of the practitioners that provide care to injured workers also provide care to automobile accident victims. If the Board's goal is to "increase provider participation" and "address provider concerns" adopting these Ground Rule proposals risks alienating the very provider pool it is trying to court. More importantly, physical therapy and chiropractic care are commonly utilized and effective treatment regimens that promote healing, increase flexibility and reduce pain. Arbitrarily terminating such treatment only increases the risk that injured people denied treatment will turn to dangerous and addictive drugs for pain relief.

Respectfully submitted,

William Purdy