NYS 2010 Worker Compensation Medical Treatment Guidelines

Ronald V. Musto MD, MPH, MBA, CIME
Executive Vice President and Director of Occupational Health Services
Community Care Physicians, P.C.
Table of Contents

- Resources 3, 66
- Principles 6 - 15
- Back Injuries (reference) 19 - 28
- Neck Injuries (reference) 29 - 36
- Knee Injuries (reference) 37 - 46
- Shoulder Injuries (reference) 47 - 53
- Mechanics 54 – 66
- Insights 65 - 69
Dr. Musto’s Slide Presentation
- www.communitycare.com/cha

Dr. Musto’s E-mail address
- rmusto@communitycare.com

NYS WCB Medical Guidelines
- http://www.wcb.state.ny.us/content/main/hcpp/MedicalTreatmentGuidelines/MTGOverview.jsp

Office of the WCB Medical Director
- www.WCBMedicalDirectorsOffice@wcb.state.ny.us
How the Guidelines Were Developed
General Principles Underlying the Guidelines
Specific Conditions to which Guidelines Apply
  - Back
  - Neck
  - Knee
  - Shoulder
Mechanics of Compliance
March 2007 Worker Compensation Reform Act
Governor’s Task Force and Advisory Committee
Evidence Based
- The Workers Compensation Board [the Department and its Advisors including medical and other professionals] have not independently evaluated or vetted the scientific medical literature used in support of the guidelines, but have relied on the methodology used by the developers of various guidelines utilized and referenced in these Guidelines.
  - ACOEM Guidelines
  - Colorado Guidelines
  - Washington State Guidelines
Publication and Comment Period
Pilot Project
General Principles

- Apply to injuries and illnesses affecting
  - Mid and Low Back
  - Neck
  - Knees
  - Shoulders
- Do NOT apply to urgent / emergent care
- Mandatory for applicable conditions effective 12-1-2010 (regardless of injury date)
Attributable Effect
(Of Selected Conditions)

**Workers’ Compensation Injuries by Body Site**
- All Other Sites 65%
- Back 18%
- Neck 5%
- Knee 4%
- Shoulder or Arm 8%

**Workers’ Compensation Injuries by Cost**
- All Other Sites 41%
- Back 28%
- Neck 10%
- Shoulder or Arm 13%
- Knee 8%
Objectives

- Single standard of medical care
- Expedite Quality
- Improve Outcomes
- Hasten Return to Work
- Reduce Disputes
- Enhance Payment Timeliness
- Reduce Overall Cost
No Prior Authorization Required when Evaluation and Treatment Conforms to Guidelines EXCEPT:

- Twelve Specific Procedures
- Second or Subsequent Procedure when the First Procedure Was Wholly or Partly Unsuccessful
The Twelve Procedures (Requiring Prior Authorization)

- Lumbar Fusion
- Artificial Disc Replacement
- Vertebroplasty
- Kyphoplasty
- Electrical Bone Growth Stimulators
- Spinal Cord Stimulators
- Anterior Shoulder Acromioplasty
- Chondroplasty
- Osteochondral Autograft
- Autologous Chondrocyte Implantation
- Meniscal Allograft Transplantation
- Knee Arthroplasty (Total or Partial)
Focus on Restoring Functional Work Ability
  - Pre-injury Health Status in so far as is Feasible

Treatment must produce Positive Results or else be Modified or Stopped
  - Positive Results Are Functional Gains, Objectively Measured
    - Consider Subjective Reports of Pain or Function when Anatomically and Physiologically Correlated
General Principles

- Educate Stakeholders
  - Facilitate Self – Management of Symptom
  - Prevent Future Injury
- Utilize Active Interventions
  - Emphasize Patient Responsibility
- Clinical Findings Govern Imaging
- Choose Operative Intervention within Context of Clinical Findings and Expected Functional Outcome
  - “Cure” after surgery generally a misnomer
General Principles

- Time Frames
  - Diagnostic Time Frames Begin on Date of Injury
  - Treatment Time Frames Begin When Treatment Begins
  - No Progress over 6-12 weeks or Non-Physiologic Findings May Merit Psychological Evaluation
  - Target Return to work by within 3-6 Months
At 12 weeks, employees have only a 50% chance of ever returning to work.
General Principles

- History of Present Illness
  - Mechanism
  - Symptoms
  - Psychological Reaction
  - Functional Effect (Work and ADL’s)

- “Comprehensive” Past History

- Physical Exam
  - General Elements
  - Site Specific Elements

- Causality

- Red Flags
  - Fracture
  - Dislocation
  - Infection
  - Tumor
  - Degenerative Disease
Laboratory Tests – for suspicion of systemic illness
  - CBC, ESR, RF, ANA, CRP, CMP

Imaging Tests
  - “abnormal” findings on x-rays, magnetic resonance images, and other diagnostic tests are frequently seen by age 40 even in asymptomatic individuals.
  - Correlate Imaging with Clinical Findings
# BACK INJURY – IMAGING*

<table>
<thead>
<tr>
<th></th>
<th>Acute (&lt;6 weeks)</th>
<th>Subacute (6-12 weeks)</th>
<th>Chronic (&gt;12 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray</td>
<td>Not Recommended</td>
<td>Acceptable</td>
<td>Acceptable</td>
</tr>
<tr>
<td>MRI**</td>
<td>Not Recommended</td>
<td>Acceptable</td>
<td>Acceptable</td>
</tr>
<tr>
<td>CT</td>
<td>Not Recommended</td>
<td>Acceptable</td>
<td>Acceptable</td>
</tr>
<tr>
<td>Myelogram</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Bone Scan</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
</tbody>
</table>

*Absent Red Flags
** Acceptable for severe persistent radiculopathy pending surgery or ESI
Not Recommended: Fluoro, SPECT, Ultrasound, Discography, Myeloscopy, Thermography
Acceptable for radiculopathy when imaging studies are equivocal
Must include BOTH nerve conduction and electromyography
“Surface” NCV/EMG is not recommended
## Back Injury - Treatments

<table>
<thead>
<tr>
<th>Condition</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture - adjunct</td>
<td>Chronic LBP</td>
</tr>
<tr>
<td></td>
<td>12 sessions</td>
</tr>
<tr>
<td>Foot Orthotics</td>
<td>Leg Length</td>
</tr>
<tr>
<td></td>
<td>Discrepancy</td>
</tr>
<tr>
<td></td>
<td>No Comment</td>
</tr>
<tr>
<td>Biofeedback - adjunct</td>
<td>Chronic LBP</td>
</tr>
<tr>
<td></td>
<td>16 sessions</td>
</tr>
<tr>
<td>TENS - adjunct</td>
<td>Chronic LBP</td>
</tr>
<tr>
<td></td>
<td>No comment</td>
</tr>
</tbody>
</table>

**Not Recommended:** Taping, Magnets, Beds, Bed rest, Inferential, Iontophoresis
# Back Injury – Injection Treatments

<table>
<thead>
<tr>
<th></th>
<th>Acute</th>
<th>Subacute</th>
<th>Chronic</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESI – Radiculopathy</td>
<td>Acceptable</td>
<td>Acceptable</td>
<td>Acceptable</td>
</tr>
<tr>
<td>ESI – Back Pain</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>ESI – Spinal Stenosis</td>
<td>Acceptable</td>
<td>Acceptable</td>
<td>Acceptable</td>
</tr>
<tr>
<td>Trigger Points</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Acceptable</td>
</tr>
<tr>
<td>SI Joint</td>
<td>Acceptable</td>
<td>Acceptable</td>
<td>Acceptable</td>
</tr>
<tr>
<td>Diagnostic Facet</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Acceptable</td>
</tr>
<tr>
<td>Therapeutic Facet</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Acceptable</td>
</tr>
<tr>
<td>Intradiscal</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Chemonucleolysis</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
</tbody>
</table>

## BACK INJURY - MEDICATION

<table>
<thead>
<tr>
<th></th>
<th>Acute</th>
<th>Subacute</th>
<th>Chronic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Recommended</td>
</tr>
<tr>
<td>NSAID’s</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Recommended</td>
</tr>
<tr>
<td>Muscle Relaxants*</td>
<td>Second Line</td>
<td>Bedtime</td>
<td>Bedtime</td>
</tr>
<tr>
<td>Opiates</td>
<td>With Caution</td>
<td>With Caution</td>
<td>With Caution</td>
</tr>
<tr>
<td>Tramadol</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Recommended</td>
</tr>
<tr>
<td>TCA’s</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Recommended</td>
</tr>
<tr>
<td>SSRI’s**</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Topiramate</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Acceptable but not for radiculopathy</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Acceptable</td>
</tr>
<tr>
<td>Oral Steroids</td>
<td>Radiculopathy 5-14 day course</td>
<td>Not recommended</td>
<td>Not Recommended</td>
</tr>
</tbody>
</table>

*Cyclobenzaprine preferred  
** Except as indicated for concomitant depression
## Exercise

<table>
<thead>
<tr>
<th>Exercise</th>
<th>Frequency (Max)</th>
<th>Duration (Max)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Exercise</td>
<td>5 X / Week</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Aerobic Exercise</td>
<td>Recommended</td>
<td>Recommended</td>
</tr>
<tr>
<td>Strengthening Exercise*</td>
<td>Recommended</td>
<td>Recommended</td>
</tr>
<tr>
<td>Aquatic Exercise</td>
<td>Subacute/Chronic</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Yoga</td>
<td>5 X / Week</td>
<td>8 weeks</td>
</tr>
</tbody>
</table>

Exclusive abdominal strengthening not recommended.
BACK INJURY – PHYSICAL THERAPY

**Passive Modalities**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Frequency (Max)</th>
<th>Duration (Max)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manipulation</td>
<td>3X / Week</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Massage</td>
<td>2X / Week</td>
<td>6 weeks optimum</td>
</tr>
<tr>
<td>Joint Manipulation</td>
<td>3X / Week</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Soft Tissue Mobilization</td>
<td>3X / Week</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>3X / Week</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Infrared (acute LBP)</td>
<td>Not Stated</td>
<td>4 treatments</td>
</tr>
<tr>
<td>Hot/Cold Application (Adjunct)*</td>
<td>5X / Week</td>
<td>8 weeks</td>
</tr>
</tbody>
</table>

*May be used at home.
Not Recommended: Diathermy, Laser, Myofascial Release, Traction
BACK INJURY - INTERVENTIONAL TREATMENT

- Facet Rhizotomy
  - Last resort
  - Chronic low back pain
  - Responded well to facet injection

- Not Recommended
  - Dorsal Root Lesioning
  - IDET
  - PIRFT
BACK INJURY PAIN – OPERATIVE TREATMENT

- Lumbar Diskectomy
  + For radiculopathy
    + Unresolved after 6-12 weeks
    + Consistent clinical picture
- Spinal Decompression
  + For intractable symptomatic spinal stenosis
- Spinal Fusion
  + Requires prior authorization
  + Instability

Operative procedures not stated here require prior authorization.
NECK INJURY - IMAGING

- MRI ("useful")
  - Suspected Nerve Root Compression
  - Myelopathy
  - Exclude tumor, infection

- CT
  - Where MRI contraindicated or inaccurate

- Myelography/CT Myelography
  - Multiple previous neck surgeries
  - Pre operatively
  - MRI/CT unavailable or not feasible

- Bone Scan
  - Inflammation/tumor/occult fracture

- Gallium Scan
  - Inflammation/tumor

- Diagnostic Injection / Discography / Thermography
  - Not Recommended
# NECK INJURY – TREATMENTS*

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Frequency (Max)</th>
<th>Duration (Max)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>3X / week</td>
<td>10 treatments</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>2X / week</td>
<td>12 sessions</td>
</tr>
<tr>
<td>Cervical ESI (Radicular Pain)</td>
<td>NA</td>
<td>3/year/side/2 levels</td>
</tr>
<tr>
<td>Facet Injections</td>
<td>NA</td>
<td>3 / year / 2 levels</td>
</tr>
<tr>
<td>Intradiscal Injections</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Occipital Nerve Blocks</td>
<td>NA</td>
<td>3 injections</td>
</tr>
<tr>
<td>Trigger Point Injections</td>
<td>4 sites / week</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Facet Rhizotomy</td>
<td>If failed Rx over 12 weeks and</td>
<td>Repeat after 6-18 months prn after</td>
</tr>
<tr>
<td></td>
<td>effective nerve block</td>
<td>repeat nerve block effective</td>
</tr>
<tr>
<td>Prolotherapy</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Platelet Rich Plasma Injection</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
</tbody>
</table>

*Continuing treatment contingent on response to initial treatment*
NECK INJURY - MEDICATION

- See “Mid and Low Back Injury – Medication”
### Neck Injury - Orthoses

<table>
<thead>
<tr>
<th>Orthosis</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soft Cervical Collar</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Rigid Cervical Collar</td>
<td>Recommended Post op and Emergently</td>
</tr>
<tr>
<td>Postural Appliances</td>
<td>Not Recommended for Sprains</td>
</tr>
<tr>
<td>Cervico-thoracic Orthoses</td>
<td>Not Recommended for Sprains</td>
</tr>
<tr>
<td>Halo</td>
<td>Recommended Post Op</td>
</tr>
</tbody>
</table>
# Neck Injury – Physical Therapy

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency (Max)</th>
<th>Duration (Max)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities of Daily Living</td>
<td>5X / week</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Aquatic</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Functional Activities</td>
<td>5X / week</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Functional Electrical Stimulation</td>
<td>3X / week</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Neuromuscular Reeducation</td>
<td>3X / week</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Spinal Stabilization</td>
<td>5X / week</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Therapeutic Exercise</td>
<td>5X / week</td>
<td>8 weeks</td>
</tr>
<tr>
<td><strong>NECK INJURY – PHYSICAL THERAPY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Frequency (Max)</strong></td>
<td><strong>Duration (max)</strong></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Electrical Nerve Block</strong></td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td><strong>Electrical Stimulation</strong></td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td><strong>Iontophoresis</strong></td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td><strong>Manipulation</strong></td>
<td>3X / week</td>
<td>12 weeks</td>
</tr>
<tr>
<td><strong>Massage</strong></td>
<td>2X / week</td>
<td>8 weeks</td>
</tr>
<tr>
<td><strong>Joint Mobilization</strong></td>
<td>3X / week</td>
<td>6 weeks</td>
</tr>
<tr>
<td><strong>Soft Tissue Mobilization</strong></td>
<td>3X / week</td>
<td>6 weeks</td>
</tr>
<tr>
<td><strong>Diathermy</strong></td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td><strong>Heat/Cold Application</strong></td>
<td>5X / week</td>
<td>8 weeks</td>
</tr>
<tr>
<td><strong>Traction – Manual</strong></td>
<td>3X / week</td>
<td>4 weeks</td>
</tr>
<tr>
<td><strong>Traction - Mechanical</strong></td>
<td>3X / week</td>
<td>4 weeks (then +/- purchase)</td>
</tr>
<tr>
<td><strong>Transcutaneous Nerve Stimulation</strong></td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td><strong>TENS</strong></td>
<td>Variable</td>
<td>3 sessions then +/- buy</td>
</tr>
<tr>
<td><strong>US / Phonophoresis</strong></td>
<td>3X / week</td>
<td>8 weeks</td>
</tr>
</tbody>
</table>
NECK INJURY – OPERATIVE TREATMENT

- Fractures
  - Instability
  - Neurologic Deficit
  - Spinal Canal Compromise
- Disc Herniation
  - Myelopathy
  - Radiculopathy with deficit or incapacitating pain
    - One year surgical outcome = non operative outcome
- Non-Radicular Cervical Pain
  - Failed 6-12 weeks ACTIVE treatment
  - Serious functional limitations
  - Disc pathology or instability limited to 2 levels
  - Psychosocial issues addressed
“Radiographic imaging should not be routinely performed. The mechanism of injury and specific indications for the radiograph should be listed on the request form to aid the radiologist and x-ray technician.”

Imaging Indications

- Inability to bear weight
- History of significant trauma
- Age > 55 years
- Persistent pain > 2 weeks
- History or exam suggesting infection
- Pain/Swelling/Limited ROM at prior fracture/surgery site
KNEE INJURY - IMAGING

- Acceptable Procedures
  - Plain Films
  - MRI
  - CT
  - Bone Scan
  - Indium/Gallium Scans

- Arthrogam
  - Acceptable when MR/CT not feasible

- Not Recommended
  - Linear Tomography
KNEE INJURY - DIAGNOSTICS

- Arthroscopy Indications
  + Persistent symptoms despite
    - Medical Treatment
    - Physical Therapy
  + Inconclusive imaging

- Acceptable Diagnostics*
  + Electrodiagnostics
  + Doppler Ultrasonography
  + Venogram / Arteriogram
  + Joint Aspiration

*Presumes clinical indications are present.
## Knee Injury - Treatments

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Frequency (Max)</th>
<th>Duration (Max)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>3X / Week</td>
<td>10 treatments</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Viscosupplementation</td>
<td>One Series</td>
<td>Repeat in 6 months contingent on symptoms and response</td>
</tr>
<tr>
<td>Trigger point injection, Prolotherapy, Platelet Rich Plasma</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
</tbody>
</table>
KNEE INJURY - MEDICATION

- Acetaminophen
- NSAIDS
- Tramadol
- Topicals
- Opiates (with caution)
# Knee Injury - Orthotics

<table>
<thead>
<tr>
<th></th>
<th>Frequency (Max)</th>
<th>Duration (Max)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fabrication</td>
<td>2X / week</td>
<td>4 sessions</td>
</tr>
<tr>
<td>Training</td>
<td>3X / week</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Splints</td>
<td></td>
<td>3 sessions</td>
</tr>
</tbody>
</table>
## KNEE INJURY – PHYSICAL THERAPY

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency (Max)</th>
<th>Duration (Max)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities of Daily Living</td>
<td>3X / week</td>
<td>3 weeks</td>
</tr>
<tr>
<td>Functional Electric Stim</td>
<td>3X / week</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Gait Training</td>
<td>3X / week</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Therapeutic Exercise</td>
<td>5X / week</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Wheelchair Management</td>
<td>3X / week</td>
<td>2 weeks</td>
</tr>
<tr>
<td>CPM (post-op)</td>
<td>4X / day</td>
<td>3 weeks</td>
</tr>
<tr>
<td>Fluidotherapy</td>
<td>3X / week</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Manipulation</td>
<td>5X / week</td>
<td>10 treatment</td>
</tr>
<tr>
<td>Manual Electric Stim</td>
<td>7X / week</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Joint Mobilization</td>
<td>3X / week</td>
<td>10 treatments</td>
</tr>
<tr>
<td>Soft Tissue Mobilization</td>
<td>3X / week</td>
<td>10 treatments</td>
</tr>
<tr>
<td>Superficial Heat/Cold</td>
<td>5X / week</td>
<td>8 weeks</td>
</tr>
<tr>
<td>TENS</td>
<td></td>
<td>3 treatments then buy</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>3X / week</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Whirlpool</td>
<td>5X / week</td>
<td>8 weeks</td>
</tr>
</tbody>
</table>
KNEE INJURY - PHYSICAL THERAPY

- Not Recommended
  - Neuromuscular Reeducation
  - Contrast Baths
  - Electrical Stimulation
  - Infrared
  - Iontophoresis
  - Massage
  - Paraffin Baths
  - Diathermy
  - Traction
  - Vasopneumatic Devices
Surgery may preempt non-operative care
- Ligament Rupture – LCL, ACL, PCL
- Meniscus tear with knee “locking”

Symptoms persist despite non operative care
- Patellar Subluxation (4-6 months)
- Chondromalacia Patella (6-9 months)
- Manipulation under Anesthesia (3 months)
- Bursitis
- Osteoarthritis
- Osteotomy
- Hardware Removal
- Contracture Release
- Tendonitis ("surgery rarely indicated")
- Amputation (non viable, non functional extremity)
- Knee Fusion ("last resort")

Prior Authorization Always Required
- Knee Replacement
- Chondroplasty
- Osteochondral Autograft
- Autologous Chondrocyte Implant
- Meniscal Allograft Transplant
SHOULDER INJURY

“As shoulder injuries frequently involve a complex of problems, it is always necessary to consider the possible interaction of the various parts of the shoulder mechanism when proceeding with a diagnostic workup and a therapeutic treatment plan.”
SHOULDER INJURY

- A-C Joint Sprain / Dislocation
- Adhesive Capsulitis (Frozen Shoulder)
- Biceps Tendonitis
- Nerve Injuries (Brachial Plexus / Peripheral Nerves
- Bursitis
- Impingement
- Rotator Cuff Tears
- Rotator Cuff Tendonitis
- Fractures
- SLAP Lesions
- Shoulder Instability
SHOULDER INJURY - DIAGNOSTICS

- Plain X-ray Films
- MRI
- Arthrography
- Electrodiagnostic Testing (for nerve injuries)
SHOULDER INJURIES - TREATMENTS

- Steroid Injection (3 per year maximum)
- Immobilization (1 -12 weeks)
- Medication
  - NSAID’s and APAP
  - Opiates (with caution)
  - Tramadol
  - Anticonvulsants for nerve injuries
  - **Muscle Relaxants not recommended**
## Shoulder Injuries - Physical Therapy

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Frequency (Max)</th>
<th>Duration (Max)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Exercise</td>
<td>3X / week</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Superficial Heat/Cold</td>
<td>5X / week</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>3X / week</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Electric Therapeutic Modalities</td>
<td>3X / week</td>
<td>4 weeks</td>
</tr>
<tr>
<td>TENS</td>
<td></td>
<td>3 sessions then buy</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
</tbody>
</table>
SHOULDER INJURIES – OPERATIVE TREATMENT

- Generally after failure of non-operative treatment for 4-6 weeks except:
  - Open nerve injuries
  - Full thickness rotator cuff tears (2 weeks)
  - Fractures for which surgery is indicated
Mechanics - Definitions

- **Medical Providers**
  - Physicians
  - Podiatrists
  - Chiropractors
  - Psychologists

- **Pre – Authorization**
  - For the “Twelve” procedures
  - For Tests or Treatments not addressed by the Guidelines
  - Carrier has 30 days to respond or obtain IME

- **Optional Prior Approval**
  - Not Required for tests or treatments addressed by the guidelines
  - Carrier must participate in Approval Process (list on WCB Website)
  - “Is the test or treatment a consistent application of the Guidelines?”
  - Carrier has 8 days to respond
  - Disputes subject to binding decision by WCB Medical Director

- **Variance**
  - Request to perform test or procedure that does not conform to the guidelines or is not addressed by the guidelines and exceeds $1000
  - Can only be requested by a medical provider
# ATTENDING DOCTOR’S REQUEST FOR APPROVAL OF VARIANCE AND CARRIER’S RESPONSE

**State of New York - Workers' Compensation Board**

For additional variance requests in this case, attach Form MG-2.1. Answer all questions where information is known.

<table>
<thead>
<tr>
<th>WCB Case Number</th>
<th>Carrier Case Number</th>
<th>Date of Injury</th>
</tr>
</thead>
</table>

## A. Patient’s Information

- **Patient’s Name:**
- **Social Security No.:**
- **Patient’s Address:**
- **Employer’s Name & Address:**
- **Insurer’s Name & Address:**

## B. Attending Doctor’s Information

- **Attending Doctor’s Name & Address:**
- **Individual Provider’s WCB Authorization No.:**
- **Telephone No.:**
- **Fax No.:**

## C. Date and Method of Transmission

- **Date Variance Request Submitted:**
- **Method of Transmission:**

The undersigned requests approval to vary from the WCB Medical Treatment Guidelines as indicated below:

- **Guideline Reference:**
  - (In first box, indicate body part: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck)
  - (In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)

- **Approval Requested For:** (Choose one request type per form)

### CARRIER’S / EMPLOYER’S RESPONSE

- If service is denied, explain on reverse.
  - **Granted**
  - **Granted without Prejudice**
  - **Denied**

### STATEMENT OF MEDICAL NECESSITY — See Item 4 on instruction page for requirements.

Date of Service of Supporting Medical in WCB Case File:

I certify that I am making the above request for approval of the variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before enrolling in any medical care that varies from the Guidelines. I certify that the claimant understands and agrees to undergo the proposed medical care. I (Did/ Did not) contact the carrier by telephone to discuss this variance request before making the request. I contacted the carrier by telephone on (date), and spoke to (person spoken to or was not able to speak to anyone).

- **A copy of this form was sent to the carrier/employer/insured employer/Special Fund by (fax, email):**
- **A copy was sent (as an address or instruction page) to the Workers’ Compensation Board, if any, to the claimant if not represented, and to any other parties of interest on the date below:**
- **I am not equipped to send or receive forms by fax or email. This form was mailed to the parties indicated above on:**

Provider’s Signature: 

**Derek Shepherd, MD**

Date: _3/20/11_

## D. CARRIER’S / EMPLOYER’S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

- The self-insurer/employer hereby gives notice that it will have the claimant examined by an Independent Medical Examiner or the claimant’s medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the Variance Request.

By: (print name): 

Signature: 

Date: 

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DECEIVE PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINE AND IMPRISONMENT.**

---

*MG-2 [1-1] Page 1 of 2*
**CONTINUATION TO FORM MG-1, ATTENDING DOCTOR’S REQUEST FOR OPTIONAL PRIOR APPROVAL**

**Doctor’s Name**

**WCB Case Number**

**Carrier Case Number**

**Date of Accident**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Patient’s Social Security Number</th>
<th>Doctor’s WCB Authorization Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INSTRUCTIONS TO ATTENDING DOCTOR:** This form is not to be filed separately. Attach to completed Form MG-1 if requesting optional prior approval for additional treatment(s) or procedure(s) in the same case.

**A.** The undersigned requests additional optional approval under the WCB Medical Treatment Guidelines as indicated below:

<table>
<thead>
<tr>
<th>2. Treatment/Procedure Requested:</th>
<th>CARRIER/EMPLOYER’S RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline Reference: X X X X X</td>
<td>(Carrier/employer must complete certification on reverse of this form.)</td>
</tr>
<tr>
<td>In first box, indicate body part: K=Knee, S=Shoulder, B=Mid and Low Back, N=Neck</td>
<td>Granted</td>
</tr>
<tr>
<td>In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.</td>
<td>Granted without Prejudice</td>
</tr>
<tr>
<td>Date of Supporting Medical in WCB Case File:</td>
<td>Denied</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Treatment/Procedure Requested:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline Reference: X X X X X</td>
<td></td>
</tr>
<tr>
<td>In first box, indicate body part: K=Knee, S=Shoulder, L=Low and Mid Back, N=Neck</td>
<td></td>
</tr>
<tr>
<td>In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.</td>
<td></td>
</tr>
<tr>
<td>Date of Supporting Medical in WCB Case File:</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Treatment/Procedure Requested:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline Reference: X X X X X</td>
<td></td>
</tr>
<tr>
<td>In first box, indicate body part: K=Knee, S=Shoulder, L=Low and Mid Back, N=Neck</td>
<td></td>
</tr>
<tr>
<td>In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.</td>
<td></td>
</tr>
<tr>
<td>Date of Supporting Medical in WCB Case File:</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Treatment/Procedure Requested:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline Reference: X X X X X</td>
<td></td>
</tr>
<tr>
<td>In first box, indicate body part: K=Knee, S=Shoulder, L=Low and Mid Back, N=Neck</td>
<td></td>
</tr>
<tr>
<td>In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.</td>
<td></td>
</tr>
<tr>
<td>Date of Supporting Medical in WCB Case File:</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

I certify that I am making the above request(s) for optional prior approval and my affirmative statements are true and correct. I did / did not contact the carrier by telephone to discuss this request(s) before making it. I contacted the carrier by telephone on (date) and spoke to (person spoke to) or was not able to speak to anyone.

- A copy of this form was sent to the self-insured employer/carrier/Special Fund by (fax, email) __________________________, a copy was sent (see address and fax number on Form MG-1) to the Workers' Compensation Board, and copies were provided to the claimant's legal counsel, if any, and to any other parties of interest on the date below.
- I am not equipped to send or receive forms by fax or email. This form was mailed to the parties indicated above on __________________________.

**Provider’s Signature:** __________________________

**Date:** __________________________

**NY-WCB**
Apply Previous WC Pre-Auth Rules

NO

Guidelines Apply?

YES

One of "The Twelve"?

NO

Service Conforms to Guidelines?

YES

Carrier Participates in Optional Pre-Auth?

YES

Seek Optional Prior Approval?

NO

Submit C-4 Request for Authorization

Submit Variance Request MG-2

Submit Optional Prior Approval Form MG-1

YES

Binding Decision by WCB Medical Director

YES

Optional Prior Approval?

NO

Approved?

NO

WCB Med Director Decision Selected?

YES

Informal Appeals Process

Litigation

Resolved?

NO

YES

Proceed

Submit Request for Decision on Unpaid Medical Bills Form HP-1

Payment Delayed?

YES

End

NO
Insights - Metrics

- Expedited care
  - Number of variances
  - Anecdotal Evidence – question the stakeholders
  - There is still a learning curve
  - There is still a “trust” curve

- Timely Payment
  - HP1 Filings from providers

- Early return to work
  - Prefer “improved medical outcome”
  - Reflected by the severity of SLOU and Classification

- Reduced cost
  - Annual WC insurance rates
  - Studied by WCB, DOL, Insurance Department

- Time Frame
  - 2 to 5 years to collect reliable data
Requests exceeded expectations
- 90,000 in the first 10 months
- About 12,000 per month currently

80% -90% are requests for extended PT or Chiropractic
Very few requests for treatment outside the Guidelines
About 60% of requests are approved before appeal
Of the other 40%
- Almost all denials justified in the opinion of WCB medical directors
  - Poor documentation
  - Poor care

Options for appeal
- Insurers usually opt for Medical Director Review
  - 8 day turnaround
- Providers usually opt for litigation
  - 30 or more days’ turnaround
  - MG-2 form has check box to select Medical Director review
    - Patient must agree
  - Litigation by default unless Medical Director Review selected
Three physicians selected by the WCB
Three physicians selected by AFL/CIO
Three physicians selected by the Business Council
Insights – What’s Coming

- Guidelines on managing chronic pain
  - Advisory panel convening in October to deliberate
- 2011 Medical Guidelines for Evaluation of Permanent Disability
  - Will replace 1996 Guidelines
Help!
Resources

- Dr. Musto’s Slide Presentation
  - www.communitycare.com/cha
- Dr. Musto’s E – mail address
  - rmusto@communitycare.com
- NYS WCB Medical Guidelines
  - http://www.wcb.state.ny.us/content/main/hcpp/MedicalTreatmentGuidelines/MTGOverview.jsp
- Office of the WCB Medical Director
  - www.WCBMedicalDirectorsOffice@wcb.state.ny.us