

**Medical Treatment Guidelines - Understanding Variances Update 2013**

**Slide 1:**

Hello. My name is Dr. Elaine Sobel Berger. I am the Co-Medical Director of the New York State Workers' Compensation Board and Senior Policy Advisor. Our topic for today is: *Understanding Variances - 2013 Update*

**Slide 2:**

This module is intended for medical providers who are responsible for the diagnosis, treatment and management of patients with work-related injuries of the mid and low back, neck, shoulder, knee and carpal tunnel in New York State. This course is approximately 73 pages long. Estimated study time approximately one hour to complete. Original release date is November 21, 2012. Termination date, November 21, 2015.

**Slide 3:**

By the end of this course you will be able to:

- understand what a variance is and when it is appropriate to request one;
- learn the documentation necessary to support a variance request;
- learn how to request a variance and a review of a carrier's denial of a variance;
- learn the 2013 updates and revisions to the variance procedures

**Slide 4:**

- recognize the importance of the complete and accurate completion of the MG2 or variance request forms to ensure timely and appropriate care for patients;
- learn the differences between pre-authorization (C4-Auth), exacerbation and ongoing maintenance care, when each should be used and whether or not a variance is needed in a particular situation;
- and finally, identify Board resources that are available to assist with questions regarding variances.

**Slide 5:**

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**Slide 6:**

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**Slide 7:**

Let us begin our discussion with an introduction to the medical treatment guidelines themselves. The medical treatment guidelines were implemented by the New York State Workers' Compensation Board and are the standard of care for injured workers. The medical treatment guidelines are evidence-based and are supported by the strongest medical studies available and the consensus of experienced medical professionals.

**Slide 8:**

The medical treatment guidelines are mandatory for all work-related injuries. They, however, do not apply to urgent or emergent care where appropriate standards of care should be applied. They apply to all dates of treatment and whether the treatment occurred on or after the implementation date, all care provided for injuries to the relevant body parts will be according to the medical treatment guideline recommendations.

**Slide 9:**

Effective February 2013, the second edition of the medical treatment guidelines will be implemented and this update is going to reflect the changes that have come about as a result of the updating of the medical treatment guidelines. The original medical treatment guidelines for the low back, the neck, shoulder, and knee have been revised and now include a new ongoing maintenance care section for patients with a chronic pain who meet specified criteria. And in addition to the revisions of the original medical treatment guidelines, there is a new carpal tunnel syndrome guideline which has been developed. Training for that guideline will be available separately.

**Slide 10:**

In addition to the updates to the treatment guidelines themselves there are associated regulatory changes in the variance processes and procedures. In order to effectively care for injured workers it is key that physicians understand the medical treatment guidelines and associated regulatory processes as they apply to variances. Let me digress and provide a framework for understanding the relationship between the medical treatment guidelines and the variances. The approach or the framework is really two-pronged. There are the actual medical treatment guidelines and general principles. Then there are the implementing regulations which provide the basis for the processes and procedures. So variances represent the intersection of the actual guidelines and the implementing regulations. And as we move forward I think you'll begin to see the relationship between the two.

**Slide 11:**

To summarize or give you an overview, this training will address the following topics: defining variances and related processes, the medical treatment guideline general principles, objective functional improvement in

variances, regulatory changes to the variance process, variances and exacerbations, variances in ongoing maintenance care, variances in C4-Auth, case studies, and then we'll end up identifying resources.

**Slide 12:**

Let's start with what the update is all about. The 2013 regulatory revisions include changes that will enable parties to more easily choose the Medical Director's Office as the vehicle for resolving disputes regarding variances. The revisions also clarify and simplify certain types of transmission requirements that were resulting in rejection of thousands of variance requests for technical violations.

**Slide 13:**

Additionally, the revisions to the regulations will allow carriers to partially grant variance requests, thereby expediting care and hopefully, reducing litigation. And finally, and importantly, will assist in eliminating the submission of duplicate variance requests.

**Slide 14:**

Let's start with looking at the regulatory component. Variances are defined in the regulations. The 'regs' actually tell us who can request a variance, what is a variance, when is a variance permitted, what is required to obtain a variance, how to request a variance, how to obtain review of a variance denial.

**Slide 15:**

Who can request variance? The regulation defines a treating medical provider as a physician, a chiropractor, psychologist or podiatrist. Of note, physical therapists and occupational therapists are not considered treating medical providers under the variance regulations.

**Slide 16:**

What is a variance? Simply stated, a variance is an exception to or deviation from the medical treatment guideline recommendations. The variance recognizes that people heal at different rates, that there may be extenuating circumstances or comorbidities that may delay an individual's response to treatment, or that new evidence may become available that would support alternative treatments that either were not addressed in the original medical treatment guidelines or were not recommended.

**Slide 17:**

Variance is a process that allows for flexibility in care. The treating medical provider or the physician determines that care that varies from the medical treatment guideline is appropriate for a particular patient and is medically necessary.

**Slide 18:**

There are three circumstances that are identified as situations where a variance may be necessary. The first situation occurs when treatment beyond maximum duration may be indicated, when treating outside the recommendations in the medical treatment guidelines or where a condition or a treatment for a particular body part is not addressed in the medical treatment guidelines.

**Slide 19:**

All variances must start with the physician's documentation or statement that the patient requires this care and why. Why alternatives to the medical treatment guidelines are not appropriate or sufficient and a statement that the patient agrees to the proposed care.

**Slide 20:**

For certain variance requests the provider must describe the patient's signs and symptoms that did not improve when treatment was provided in accordance with the medical treatment guidelines. And finally, physicians and other providers may submit citations or copies of relevant literature from peer-reviewed journals in support of a variance request. One example that we saw in the Medical Director's Office was a request for treatment that was actually addressed in the medical treatment guidelines, and the physician provided a list of citations and references from cancer chemotherapy literature. The patient's diagnosis was low back strain or sprain and clearly the literature provided was not appropriate for the patient's condition and the variance in this situation would not have been approved.

**Slide 21:**

The most common type of variance that we see is a request for treatment or therapy beyond maximum durations recommended in the medical treatment guidelines. For this type of a variance request there are two documentation requirements. One, the injured worker must continue to show objective functional improvement as a result of the treatment and that it is reasonably expected that the patient will continue to improve with additional treatment.

**Slide 22:**

In looking at the documentation requirements in order to request a variance, one of the key issues is documenting objective functional improvement. The medical treatment guidelines general principles provides assistance in defining what is required to demonstrate objective functional improvement. There are 23 medical treatment guideline general principles. They are located in the front of each medical treatment guideline. And we're going to focus on four of them that are located in a section called, Medical Care: General Principles.

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Medical Care: General Principles is comprised of four general principles: medical care, rendering of medical services, positive patient response and reevaluate treatment.

**Slide 24:**

General principle number one, medical care, is an important one. It sets the overarching goals of treatment and basically says that the goal of treatment should be focused on restoring functional ability that is required to meet the patient's daily and work activities and ultimately return to work. So in documenting goals of objective functional improvement we need to target those goals that are necessary to have the patient function at home and in the work environment.

**Slide 25:**

General principle number two, rendering of medical services is simply a restatement of the fact that the medical treatment guidelines is the standard of care for injured workers.

**Slide 26:**

General principle number three addresses outcomes of treatment. We're going to monitor to see whether or not the patient is indeed improving as a result of the treatment. A positive patient response or positive results are defined as functional gains which can be objectively measured.

**Slide 27:**

The general principle goes on to further define some of the functional aspects that can be monitored in order to determine whether or not objective gains are occurring, and these include positional tolerances, range of motion, strength, endurance and so on. Of note, it is not uncommon for us to see a few degrees of change in range of motion being listed as objective functional improvement, as the sole measure of objective functional improvement, it would not be sufficient. The few degrees of range of motion need to be linked to actual functional gains. Second, pain is considered part of the clinical picture but not the sole indicator of a patient's response to treatment.

**Slide 28:**

The next general principle addresses how to evaluate the effectiveness of treatment. Is the treatment actually working? There's two components. Number one is the requirement that the patient be reevaluated 2 to 3 weeks after the initial visit and 3 to 4 weeks thereafter to determine whether or not the patient is having a positive patient response or objective functional gains. Secondly, if the treatment is not producing positive response then one, the treatment should be modified or discontinued or two, perhaps the diagnosis is incorrect or inaccurate and there should be a reconsideration of the diagnosis.

**Slide 29:**

Tying this all together, there are three basic components to documenting objective functional improvement. And again, they derive from the general principles and can be stated as follows. There is the initial evaluation. Where was the patient at the time of the initial or previous assessment? The reevaluation: where is the patient now in the continuum of care? And finally: the goals. Based on the assessment of the patient's condition, where do you expect the patient to be at the next 'eval'? What type of treatment is planned to reach these goals and finally, the ultimate goals which will be based on the work activities and identified limitations and again, relate to general principle number one.

**Slide 30:**

The key documentation that's required of the provider is called the burden of proof. It is the provider's responsibility to demonstrate that the variance request is appropriate and medically necessary for this particular patient. The burden of proof simply means documentation that supports a statement of medical necessity.

**Slide 31:**

In order to request a variance, the provider must complete form MG2. If more than one treatment or modality is being requested then the addendum form MG 2.1 will also be completed and processed along with the MG2 form. There is a Medical Director's Office bulletin that provides instructions on the accurate completion of the form. In order to ensure timely care for a patient, the form should be completed in its totality with a particular emphasis on the medical documentation necessary to support the care requested. When the form is completed, the treating medical provider will send the form to the carrier and the Workers' Compensation Board.

**Slide 32:**

The treating medical provider sends the form to both the carrier and the Workers' Compensation Board. Currently a variance request must be submitted on the same day as it is prepared and signed. Effective February 2013, variance requests will be considered timely if submitted to the carrier and the Board within two business days of being prepared and signed.

**Slide 33:**

The carrier has 15 days to respond to a variance request. If the carrier decides to obtain an IME he must notify the parties within five days of the IME evaluation, and has 30 days to obtain the actual examination or record review.

**Slide 34:**

There are several changes that have occurred as a result of regulatory changes. They will be effective February 2013. The first is a clarification and simply stated a variance must be requested and granted before care that varies from the medical treatment guidelines is performed. There has been some confusion and the thought was that if I simply put the form in that was efficient. That is not sufficient. The form has to be submitted. The variance request has to be submitted, and granted before the care can proceed. The variance request will not be considered if medical care has already been provided.

**Slide 35:**

In the past, there was a mandatory period of time when the provider was supposed to try to resolve informally the variance request dispute. And there was a mandatory eight-day waiting period. This is no longer in effect. The treating medical provider is encouraged to resolve the variance dispute informally, directly with the carrier. But there's no longer the mandatory eight-day waiting period for the informal dispute resolution. Finally, the carrier was not given permission previously to partially grant variance requests. So when a provider has given a list of procedures, the carrier may now grant some and deny some. Again will be effective 2013.

**Slide 36:**

If the carrier denies the variance, the claimant or patient has 21 days to request a review of this denial. What's expected is that the treating physician will review the request, ensure that it's still medically necessary, complete the appropriate section requesting a review of the variance denial and the carrier may, as of 2013, partially grant a variance request. When there is a variance denial there are two mechanisms for requesting a review of this denial. One is an expedited hearing in front of a law judge and that can happen within 30 days or by medical arbitration in the Medical Director's Office.

**Slide 37:**

Currently, the default position for the review of a variance denial is the expedited hearing process. Effective 2013, variance review requests will be referred for medical arbitration through the Medical Director's Office unless the claimant or the carrier request an expedited hearing. So there's been a change to the Medical Director's Office, medical arbitration which is viewed as being faster and a less costly mechanism for review of a dispute.

**Slide 38:**

The Board and carriers have experienced large volumes of substantially similar or duplicate requests. A regulatory change that will occur effective 2013, will prohibit substantially similar requests and this means that if a review request is pending or a request is submitted without new medical documentations to support the request, the carrier may deny these substantially similar requests from the same provider without a medical opinion from its medical professional, record review or IME.

**Slide 39:**

The variance request forms have been modified to reflect the regulatory changes that will take effect. These are important for physicians and providers to be aware of. Section C requires the provider to certify that he indeed, submitted the variance request within two days of preparing and signing the form. Basically, this may sound trivial but it is an important mechanism to ensure that all parties have the same information at the same time and are aware that there needs to be a response. In addition, section C has another certification that the provider must sign. The provider is certifying that he or she does not have a substantially similar request pending, meaning that there's not one that has not gone through the system and been completed or two, one that does not have additional information available.

**Slide 40:**

Another change on the form affects the carrier and it actually brings some clarity to the other parties who have to review the form. There's now a new check-off box which allows the carrier to identify clearly the reason for denying and/or granting a variance. Here you'll see a sample of the new box. There may be some nips and tucks to this box still, but at this point in time it will be very similar and you will note that the carrier has the opportunity to clearly define what actions they are taking.

**Slide 41:**

Next we will go on and look at several processes and define them and put them in context as far as whether or not they require a variance. The first concept that we will deal with is exacerbation. Basically, an exacerbation is defined as a temporary worsening of a prior condition by some event, an exposure, an injury. The expectation is that after a transient increase in symptoms and decrease in function that the patient will recover to a baseline status or what that patient would have been if the exacerbation had not occurred.

**Slide 42:**

There are criteria for the exacerbation and there is also a Medical Director's Office bulletin that adds further definition to an exacerbation. In order to meet the criteria for an exacerbation, the physician must document when and how the exacerbation occurred, objective findings from the baseline, what type and frequency of treatments are anticipated and the patient's response documented through objective functional improvement,

**Slide 43:**

An exacerbation that meets the criteria defined does not require a variance. The medical treatment guideline recommendations are applicable and the provider simply can follow those treatment guideline recommendations providing the criteria are met. And again, one of the key criteria is that there be objective functional improvement documented showing that the patient is moving along the continuum of his treatment to his baseline. In the event that a patient has reached the maximum frequency permitted in a recommendation then a variance would be required to treat beyond the maximum recommendation. This would hold for a variance as well as the general care of a patient.



**Slide 44:**

The next concept that we will talk about is ongoing maintenance care. This is a new program. It will be effective as of February 2013. Ongoing maintenance care is a course of treatment that may be PT, OT or spinal manipulation depending upon the body part involved. This care may be indicated or permitted under certain circumstances in order to maintain a patient's functional status providing there has been a previously documented objective deterioration in functional status without the treatment. We will clarify what this means as we move along in the discussion on ongoing maintenance care.

**Slide 45:**

Who is eligible for ongoing maintenance care? A patient with chronic pain who has reached MMI, has demonstrated a decline in function without the identified treatment and who meets the requirements for ongoing maintenance care.

**Slide 46:**

In order to be eligible for the ongoing maintenance care, the provider must establish or show in the medical record the following: that the patient has participated in a self-management program, that in spite of that self-management program the patient has gotten worse in terms of function and pain, that there is previous treatment that has been identified that has maintained functional status and that in the past without that treatment the patient has declined.

**Slide 47:**

The initiation of the ongoing maintenance program would require the identification of specific objective goals that are identified, measured and must be met as a result of the maintenance program. And there has to be a trial of therapeutic withdrawal to determine if the function can be maintained without the maintenance care. And what do we mean by this therapeutic withdrawal?

**Slide 48:**

Once a patient is receiving ongoing maintenance care, there needs to be progressively longer periods between each treatment, an attempt to extend the treatment and manage longer periods without the care. Within a year, and annually thereafter, a trial without the maintenance care should be instituted. And finally and importantly, if deterioration of ability to maintain function is documented then reinstatement of the maintenance care may be acceptable.

**Slide 49:**

The actual recommendation for ongoing maintenance care is as follows. The frequency is a maximum of up to 10 visits a year after the determination of maximum medical improvement, or MMI according to objectively documented maintenance of functional status. And a variance is not required for ongoing maintenance care provided the criteria are met. So clearly, this was an attempt to provide care that would maintain function and not have to go through any additional process. The last point as far as ongoing maintenance care, a variance is not permitted from the maximum frequency of treatment. You get 10 treatments a year. You don't need a variance and when you've had your 10 treatments during the year you are not able to get a variance thereafter.



**Slide 50:**

Let's move into another area where there's been some confusion. The preauthorization and variance is an ongoing issue. Let's talk about when do we need a C4-Auth? The C4-Auth is required when any of the identified procedures that require preauthorization are contemplated. What do we mean by this? Currently, if you treat according to the medical treatment guidelines, you do not need to get that treatment request authorized or preauthorized. You can go ahead and treat as long as you're treating consistent with the medical treatment guidelines. The variance request, the MG2 is used when you want to treat outside of the medical treatment guideline recommendations. You want to treat in a manner that may not be consistent with the medical treatment guidelines.

**Slide 51:**

So once more, to summarize, the C4-Auth is only used for procedures that are specifically listed on the list of procedures, that require preauthorization. Treating medical providers who treat according to the guidelines do not need to complete a C4-Auth.

**Slide 52:**

Currently there are 12 procedures that require preauthorization and an additional 13th exception for repeat surgery. Effective 2013, anterior acromioplasty and chondroplasty will be removed from the list of procedures requiring pre-auth.

**Slide 53:**

The next two slides contain the list of procedures that do require preauthorization. It is notable that some of the procedures, for example, lumbar fusion can have adverse outcomes without appropriate criteria in place. You will note that the two procedures that have been removed, one from the shoulder and one from the knee, are indicated as well.

**Slide 54:**

On the next slide are the remaining list of procedures that require preauthorization. Autologous chondrosyte implantation, for example, osteochondral autograph, meniscal allograft transplantation, neo-thyroplasty, full or partial, and then finally, the one that I alluded to was what we commonly call repeat surgeries.

**Slide 55:**

Next we're going to go into some case studies which I think will help you understand how the variance procedure works and what the various steps might be in terms of requesting a review. Let's look at case number 1. By the way, these cases are real. They've been modified and simplified for this discussion but they do come out of cases that the Medical Director's Office has been asked to review. The first case looks at a request to continue PT and acupuncture. We have a 46-year-old man with a six-year old low back injury who's been receiving physical therapy and acupuncture for years and is not working.

**Slide 56:**

The statement of medical necessity that the doctor completed stated that modalities are to continue and that there was abdominal pain and low back pain. The PT progress notes are essentially unchanged when comparing notes from 2006 through 2011. PT three times a week, acupuncture three times a week, the goals: decrease pain, increase range of motion and strength. Treatment plan was simply a long laundry list of modalities that would be performed.

**Slide 57:**

And you'll see that list on this slide.

**Slide 58:**

Let's go back and review what we should be looking for in terms of objective functional improvement, the information that comes that out of our general principles. Our positive patient response, we should be looking at objective measurements which may include physiological and anatomical changes and the functional impact or outcomes that are related to these objective findings. Basically, these become the goals of the treatment and the plan of care.

**Slide 59:**

And once more, there's the three components. Where was the patient? Where is the patient? And what is the end point for this patient; both short term and long term goals?

**Slide 60:**

In the case at hand, the burden of proof or the documentation to support a variance request to continue PT and acupuncture has not been met by the provider. Generic statements about improvement and goals to increase range of motion and strength are not end points that are measurable. In essence we need to have clear stated objective goals that reflect the patient's activities of daily living and work needs. These are generic and are not focused on the general principal number 1: goals that need to be definitive and objective.

**Slide 61:**

Case study number 2 is a variance request to continue PT. We have a 62-year-old man, 11-year-old, low back injury. The patient's working and has received PT for years.

**Slide 62:**

The statement of medical necessity to continue PT is as follows. The patient is making slow progress. Keeping in mind that slow progress is now an 11-year old slow progress: able to reduce medication usage, should continue PT before considering alternative treatments such as injections.

**Slide 63:**

The accompanying documentation to support the variance request shows the patient is worse. The MD progress note states worsening pain. The treatment plan reflects: needs new MRI because of worsening symptoms, EMG, added narcotic to pain regimen, refer for lumbar epidural steroid injection or ESI. Clearly there's a 'disconnect' between the statement of medical necessity and the documentation to support it.

**Slide 64:**

The burden of proof for a variance request to continue with physical therapy has not been met by the provider.

**Slide 65:**

Case study number 3 is a variance request to continue physical therapy. In this case we have a 60-year-old woman with a low back injury six months ago. She's not working. She had a discectomy performed in May 2011, one month before the variance request.

**Slide 66:**

In the variance request dated 6/11 the primary care physician requests continuation of physical therapy. The statement of medical necessity states: back pain continues and patient needs to continue PT for strength and stability. There's no mention of surgery in May of 2011. The patient has not received any physical therapy since surgery.

**Slide 67:**

In this case, a variance would not be required for physical therapy after surgery. The therapy would be consistent with the medical treatment guidelines and therefore, a variance not needed. However, if the patient was progressing slowly, and was reaching the maximum duration of therapy and was continuing to demonstrate objective functional improvement, a variance might be needed. The variance should be requested as soon as the physician believes that recovery is proceeding at a slower pace than anticipated.

**Slide 68:**

In summary, variances allow for flexibility of care. When a treating medical provider determines that medical care that varies from the guideline is appropriate and necessary, a variance should be requested. The documentation to support the need for a variance or the burden of proof rests with the treating medical provider.

**Slide 69:**

Medical care and treatment should be focused on restoring functional ability and a positive patient response.

**Slide 70:**

There should be a reevaluation of the treatment to determine the efficacy. If treatment is not demonstrating a positive result or positive functional improvement, the provider needs to either modify or discontinue the treatment regimen as it exists or reconsider the diagnosis.

**Slide 71:**

And finally, the Board has resources available to assist in helping stakeholders understand the medical treatment guidelines, the changes and to be available for questions. Questions can be directed to the Medical Director's Office mail box. The Board's website has copies of the treatment guidelines, training, frequently asked questions and the Medical Director Office bulletins.

**Slide 71:**

Thank you for taking Understanding Variances 2013 Update. To receive your certificate of completion and your continuing medical education credits, you must complete the program evaluation. Please fill out the form below and please enter your first name, last name and email address and press "continue".

MEDICAL SOCIETY OF THE STATE OF NEW YORK

**NYS Medical Treatment Guidelines - Understanding Variances Update 2013**

**Program Evaluation**

Please take a minute to evaluate this course

**Please describe yourself:**

- Physician
- Non-Physician

**1. The content of this program was:**

- Excellent
- Good
- Fair
- Poor

**2. The instructional methods/tools were:**

- Excellent
- Good
- Fair
- Poor

**3. The stated objectives of this program were:**

- Met
- Not met

**4. Were faculty disclosures made?:**

- Yes
- No

**5. Was the presentation free of commercial bias?**

Yes

No

*If not, please provide additional information:*

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*Do you want us to contact you to discuss?:*

Yes

No

**6. Will the knowledge from this training program help you to better understand the updates to the Variances?**

Very much

Moderately

Minimally

Not at all

**7. Based on your participation in this training program, describe what a variance is and when it is appropriate to request a variance.**

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**8. Did this training program help you to better understand the reasons a variance is denied?**

Yes

No

**Did this training program help you to better understand and recognize the importance of the accurate completion of the MG2 or variance request forms?**

Yes

No

**Did this training program help you to learn the differences between pre-authorization, exacerbation and ongoing maintenance care and when it is appropriate to use for each?**

Yes

No

**9. Based on your participation in this program, have you identified any barriers to requesting a variance or your completion of the forms?**       Yes     No

*If yes, please provide additional information:*

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**10. Topics for future programs:**

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***Thank you for assisting us in evaluating this activity!***