Moving Forward 2013-Medical Treatment Guidelines

Slide 1:
Hello. My name is Dr. Elaine Sobel Berger. I am the Co-Medical Director and Senior Policy Advisor at the New York State Workers’ Compensation Board. Our topic for discussion today is: Moving Forward-2013 Medical Treatment Guidelines.

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 syndrome in New York State. This course is approximately 56 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:
• learn about the updates and revisions to the New York State medical treatment guidelines in order to effectively care for injured workers;
• learn what the ongoing maintenance program is and the requirements and documentation necessary to support ongoing maintenance care;
• understand the difference between ongoing maintenance care and the treatment of an exacerbation;
• learn the exacerbation criteria and when a variance is required to treat a patient with an exacerbation.

Slide 4:
• understand function as a key medical treatment guideline concept and learn the applicable general principles that provide a framework for evaluating and monitoring objective functional improvement as a treatment goal;
• learn the significant regulatory and associated process and procedure changes to the medical treatment guidelines;
• effectively use the associated process, procedures and forms necessary to ensure timely, appropriate care for patients and timely reimbursements for practitioners;
• identify Board resources that are available to assist with questions, regarding updates and revisions to the medical treatment guidelines.

Slide 5:
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Slide 6:
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Slide 7:
Let us begin by looking at an overview of the changes to the 2013 Medical Treatment Guidelines and the topics that we will address today. The first development is a new carpal tunnel syndrome medical treatment guideline which we will not address in this training. There will be a separate training available. We will focus on updates and revisions to the current medical treatment guidelines. This includes the ongoing maintenance care program which has been added to all four current medical treatment guidelines, a new recommendation, kinesio taping and strapping, changes in procedures requiring preauthorization, and then we will move on to the related medical treatment guideline issues such as the exacerbation function and finally, the regulatory and associated process changes.

Slide 8:
Let us begin with the first important update to medical treatment guidelines which is the ongoing maintenance care. The ongoing maintenance care is generally described as a course of treatment for chronic pain that includes, or may include PT, OT or spinal manipulation, depending upon the body part involved. The program may be indicated under certain circumstances in order to maintain a patient's functional status.

Slide 9:
The ongoing maintenance care program can be identified in the existing guidelines in the new sections listed on this slide and includes the low back, the neck, the shoulder, and the knee.

Slide 10:
What has changed? The previous recommendations in the neck and the low back stated that there was no efficacy for chronic treatment i.e. manipulation several times a month for years and chronic treatment is not recommended. The new recommendation states that a maximum of up to 10 visits per year for ongoing maintenance care may be permitted after the determination of MMI, according to objectively documented maintenance of functional status. No variance from the maximum frequency is permitted.

Slide 11:
Why has this change occurred? There is a Medical Advisory Committee that has been meeting regularly for a year and addressing the chronic pain medical treatment guidelines. In their review of the topic of maintenance care, the MAC members found that the evidence for maintenance care, although not definitive, might be a benefit to certain patients. So in essence, the ongoing maintenance care program will eventually be part of a much bigger medical treatment guideline, the chronic pain medical treatment guideline which will, hopefully, be issued sometime in 2013.
Slide 12:
Who might be eligible for the ongoing maintenance care program? The criteria that have been developed with the purpose of identifying the patient population that could benefit from this treatment and, in a nutshell, the patient with chronic pain who has reached MMI, has a demonstrated decline in function without the identified treatment, and who subsequently meets the requirements of the program.

Slide 13:
The provider or the physician must establish in the medical record that the patient has participated in a self-management program. And again, this comes out of a larger chronic pain medical treatment guideline. The self-management program has basically two components: a home exercise program and an interim pain medication plan. So the patient is participating in the self-management program, and in spite of this participation has a worsening of symptoms, function and pain. There is previous treatment that has been identified that helped to maintain functional status in the past and that documentation supports the fact that without that treatment the functional status deteriorated.

Slide 14:
The ongoing maintenance program, when initiated, has to have specific objective goals that are measurable, and met as a result of the program, and a trial of therapeutic withdrawal will be done to determine if function can be maintained without maintenance care. In the next slide I’ll go into the details of what is meant by a trial of therapeutic withdrawal.

Slide 15:
Once initiated, progressively longer periods of time should be attempted between treatments and within a year and annually thereafter, discontinuation of the maintenance care should be attempted. If after the therapeutic withdrawal or during the therapeutic withdrawal periods, deterioration of ability to maintain function is documented, then a reinstatement of maintenance care may be acceptable.

Slide 16:
The recommendation reads as follows: there is a maximum of up to 10 visits per year that is permissible in the ongoing maintenance care program, after the determination of MMI according to objectively documented maintenance of functional status. Please note, there’s been some discussion and questions asked about what do we mean about MMI. In the circumstances of ongoing maintenance care MMI will be defined as 1) a provider who documents that MMI has been reached or 2) a Board decision that MMI has been reached. In other words, a legal determination that MMI has been reached and in the setting of MMI, ongoing maintenance care may be appropriate. No variance from the maximum frequency is permitted.

Slide 17:
A question that has arisen: what is the difference between ongoing maintenance care versus exacerbation? Exacerbation is a temporary worsening of a prior condition. There is an increase in symptoms including a decrease in function and an increase in pain, and/or an increase in pain. Ultimately, the patient recovers to baseline status or what the status would have been had the exacerbation not occurred. An exacerbation is initially treated as an acute episode with treatment according to the existing medical treatment guideline recommendations.
Slide 18:
In order to establish an exacerbation, the physician must document the following: when and how the exacerbation occurred, what the objective changes from baseline function are, the type and frequency of treatments that are expected to bring the patient back to baseline function, and importantly, the patient’s response to treatment through documented measures of objective functional improvement. Of note, there is a Workers’ Comp Board panel that made a legal decision on this issue of exacerbation, an interesting intersection of medical and legal issues, and basically, it’s an example of where the Board’s decision helps define exacerbation and the medical and legal issues do come together very well in this situation.

Slide 19:
So again, the initial treatment of an exacerbation does not require a variance. But if there’s continued improvement that’s progressing somewhat more slowly than anticipated, the physician can request a variance.

Slide 20:
In the next few slides I’m going to focus on function. In the 2 1/2 years since the implementation of the medical treatment guidelines, objective functional improvement is a key concept that seems to be misunderstood or confused, and I’d like to share some insight on what we mean by function. Function is a key concept and it shows up in exacerbations, in ongoing maintenance care, in variances and in all five medical treatment guidelines. So we hear about function as a baseline, objective functional improvement as a treatment goal, functional deterioration or decline in the ongoing maintenance of functional status. So let’s explore a little more detail what these mean and how we can define and support the concept of function.

Slide 21:
Let’s take a very brief refresher course on the general principles. General principle A1 provides us with overall goals or endpoints of treatment which are to restore functional ability required to meet daily and work-related activities. So it gives us goals. It gives us endpoints of treatment. A3 tells us what we should be measuring and what we ought to look at in terms of seeing whether or not a patient is moving along toward endpoint goals. We talk about a positive patient response defined primarily as functional gains which can be objectively measured. The objective measurements may include physiological and anatomic changes, range of motion, positional tolerances and other items that are also identified in the general principles.

Slide 22:
Positive patient response is a two-pronged approach. We look at the objective measurements such as the physiological and anatomic changes and the functional impact or outcomes related to the objective findings. What activities can the patient perform or not perform?

Slide 23:
In terms of monitoring the effectiveness of treatment, A4 talks about evaluation and reevaluation of the treatment by the healthcare provider, 2 to 3 weeks after the initial visit and 3 to 4 weeks thereafter, and gives us guidance as to what we should be doing when there is not a positive objective functional response. It says the provider should either modify or discontinue the treatment which is basic common sense medicine or reconsider the diagnosis in the event of a poor response to the intervention. Finally, the general principle A5 and, in particular, the section of A5 that addresses education: education of patient, family as a means of facilitating self-management of symptoms and prevention of future injury. This particular general principle
was brought to mind in a recent case that the Medical Director’s Office saw. In this case, the patient had recurrent exacerbations each time he bent over and performed a certain activity, over and over again. No attempt to try to educate and identify a mechanism to avoid the injury and so this principle brings to mind the importance of trying to prevent injuries in injured workers.

Slide 24:
I’m now going to focus on a couple of case examples that particularly apply to looking at function, and then after this we’ll go into some more of the medical treatment guideline and regulatory changes. The first case that we have is a 61-year-old male with a low back injury. The date of injury was 10/5/2000. The carrier was objecting, in this case it was a chiropractic bill, but I can tell you it could just as easily have been a bill from a physical therapist or a rehab physician. And again, these cases are real. They come out of what we see in medical arbitration or at the Board when we are asked to provide some medical opinions. The question that’s raised is, does the chiropractor meet the criteria for an exacerbation and, in particular, does the documentation support the patient’s objective functional improvement in response to treatment?

Slide 25:
The provider further goes on to document goals. The goal is to restore function and health to pre-exacerbation abilities within two months.

Slide 26:
These are the questions that I pose and that we will answer as we continue to work through this case. How many degrees of change in range of motion is required to document objective functional improvement? What is the standard of comparison for exam findings or function in order to establish a patient’s baseline function? And the last question, what is the patient’s pre-exacerbation health and function?

Slide 27:
So let’s go on and look at some of the examination, in fact, probably the only examination that we have. We have an exam of the low back and we have active range of motion and this is documentation from 2011. We have post treatment values compared to normal values, and looking at this it seems as if, or the implication is that somehow we will be able to bring this patient from the post treatment to the normal at some point in the therapy.

Slide 28:
In this slide, documentation from the same provider. This time we fast forward to 2012 and here we have the results pre-treatment, post-treatment and again, we have the normal response, what the normal person would have. Again, what we’re talking about is pre-and post chiropractic, as I said, it could have been physical therapy or whatever the modality was. What is interesting to note is that pre-and post-therapy, the change is minimal.

Slide 29:
So let’s go to our first question. How many degrees of range of motion is required to document objective functional improvement? And the answer: it is not simply degrees of range of motion but the associated functional impact of a limitation. So, although we have an increase of 1° we’re not told in the documentation of what the impact might be on the person’s actual function.
Slide 30:
So range of motion may be a factor in an evaluation but does not equal objective functional improvement.

Slide 31:
What is the standard of comparison for exam findings or function in order to establish a patient’s baseline function? And the answer: the patient’s own baseline, pre-injury, post MMI, pre-exacerbation or previous visit findings, not general population norms. As in the 2011 exam findings the implication was that the goal was the general population norm and no patient baseline was identified.

Slide 32:
The last question for this case is what is the patient’s pre-exacerbation health and function? In this case, the patient’s baseline findings or function is not clearly defined. The goals of restoring function and health to pre-exacerbation abilities are not specific or objective. So basically, we have the use of certain terms without any medical evidence to really identify or support the terminology.

Slide 33:
In example number 2, we have a 53-year-old male with a shoulder injury and his date of injury is September 2008. The variance request was received in September of 2012. And the question that we are posing: has the provider documented objective functional improvement? And a little side note is that the patient has had conservative treatment for three years.

Slide 34:
Under medical necessity the provider documents: patient demonstrates 5% of objective functional improvement compared to last visit as evidenced by attached progress report, continues to improve with therapy, able to continue work, and the VAS, the pain scale, has decreased from 8/10 to 5/10.

Slide 35:
The provider documents goals to improve functional outcome by 70% and restore patient to pre-injury status, keeping in mind that pre-injury status would be four years earlier.

Slide 36:
Let’s go to our questions. What are the findings to support the provider statements of 5% improvement or goal of 70% functional improvement? What is the endpoint of treatment? In other words, what are the identified functional goals?

Slide 37:
This slide contains the attached documentation that the provider alludes to. As we can see, we have post treatment and the normal. We have no pretreatment value and here too, we have some difference from normal but the implication is that somehow that normal is our goal.
Slide 38:
What are the findings to support the provider statement of 5% improvement or goals of 70% functional improvement? The answer is there is no medical documentation to support the provider statement of functional improvement and in fact, if you look at the documentation record, ultimately we could add them all up and have more than 100% improvement in this patient’s condition just by the numbers without any functional documentation support.

Slide 39:
Next question: what is the endpoint of treatment? What are the identified functional goals? The end point or goals of treatment should be specific functional activities required to meet daily and work-related activities. In this case, we have no endpoint goals. We have nothing to support what the improvements to pre-injury status would look like. What was the person able to do pre-injury? Where is the person now in the continuum, and where do we want the person to end up when treatment is over and done with?

Slide 40:
So, what is not objective functional improvement? It’s not just subjective reports of pain. It’s not a sentence or a statement that the patient improved or had some percent of functional improvement. We have seen diagnostic physical exam findings such as a straight leg raise used as an objective functional improvement. A few degrees of change in range of motion and we have even seen a list of therapy dates as evidence for objective functional improvement.

Slide 41:
Let’s summarize what it is that we are looking for in documenting objective functional improvement. There are three basic components. There is an initial evaluation. What was a patient’s baseline? And that could be the initial or previous assessment, the pre-injury or pre-exacerbation depending upon the circumstances of the case. There should be the reevaluation and what are the objective functional findings and gains at the re-eval? Has the patient returned to baseline? If the person has returned to baseline, then the goals of been reached; if not, then we go to three. What are the goals? What are the endpoint goals? So we have short-term and long-term goals that need to be identified and monitored.

Slide 42:
Let’s now look at two additional changes to the medical treatment guidelines themselves before we move on to look at the regulatory changes. The first important change is the removal of two procedures from the preauthorization list: anterior acromioplasty and chondroplasty in the knee are being removed from the list of procedures that require preauthorization. And essentially this has been done because the billing codes do not really allow differentiation for these procedures alone.
Slide 43:
The other medical treatment guideline change is the addition of strapping recommendations to kinesio-taping, taping or strapping. We’ve recently seen an increase of a variance request for strapping which is nothing more than immobilizing a body part. We’ve seen it in a variance request for people who have long-term injuries and in response to the inappropriate immobilization of various body parts. This recommendation has been revised to reflect the appropriate criteria for the use of immobilizing, kinesio-taping, taping or strapping. And in essence, other than for acute joint immobilization, kinesio-taping, taping or strapping are not recommended for acute, sub-acute or chronic pain. The language that reflects these changes can be found in the low back, knee and shoulder medical treatment guidelines, in the sections that have been identified.

Slide 44:
Now, let’s look at the regulatory and associated process changes that will be occurring in 2013. The changes to the variance process were precipitated by two reasons. One, there were requests from Board staff and external stakeholders to address issues and concerns that had been identified in the variance process. And two, the large number of variances that are duplicates.

Slide 45:
The regulatory revisions were initiated to enable parties to more easily choose resolution of variance denial reviews by the Medical Director’s Office, which provides faster and less costly dispute resolution. Many of the variance requests were denied for technical violations such as the provider not preparing, signing and transmitting the variance request within one day to all involved parties. And there’s been a process to simplify the preparation and submission of the forms.

Slide 46:
Carriers will be allowed to partially grant variance requests thereby expediting care and reducing litigation costs. The regulations will eliminate the submission of duplicate variance requests.

Slide 47:
Currently, the review of variance request denials will fall to the expedited hearing process. Arbitration by the Medical Director’s Office can be chosen if both the carrier and the claimant agree to having arbitration by the Medical Director’s Office. As noted earlier, to expedite the process and to make it less costly, the Medical Director’s Office will be the default for review of a variance denial or request. If the claimant and/or the carrier wishes to go to a hearing, they may request that and then that would be the mechanism of choice. As I mentioned previously, the variances are considered timely now if they are submitted within one business day. Effective February 2013, as part of the new regulatory process, the variance will be considered timely if it is submitted within two business days of the date that it is prepared, signed and submitted to all parties.

Slide 48:
Carriers will be allowed to partially grant variance reviews. And this will allow appropriate care to be identified more quickly. This is an important change because it gives more flexibility to the carrier and makes the process run a little more smoothly. There has been some confusion about when care that’s requested in the variance may be performed. And there will be clarification in the regulation that the care requested in a variance cannot be performed until the variance has been granted. So it has to be requested and granted.
Slide 49:
Another important change addresses substantially similar variance requests. The regulation will limit or, hopefully, eliminate the number of substantially similar requests that are submitted either before the time for review of the original request has expired or without additional medical documentation to support the request. The carrier does not have to go through the normal review process for a substantially similar request. The carrier can deny the request without having to get a medical opinion from its own medical professional, a record review or an IME. The implication also extends to orders of the chair which may be limited when substantially similar requests are involved.

Slide 50:
I’m going to just identify some important form changes that I think impact the physician and reflect the discussion that we have had. The MG2 and the MG 2.1 have been revised based on the regulatory changes. There’s a section C which is new and the provider has to certify that the variance is being submitted within two days of preparation and signing. For those who are involved in this process, many times there are questions. Did you send it? Did we get it? Did the carrier get it? And this kind of documentation wants to ensure that the physician has done his or her part in getting the variance to the people who need to review it and has done it in a timely matter. Another revision in section C, the provider has to certify that he or she does not have a substantially similar request pending and that if there is a substantially similar request, that there new medical documentation to support the request.

Slide 51:
Section E is a carrier box and it’s a check box that allows the carrier to quickly identify either the fact that there’s been a grant, a grant in part or a denial and why. And I think it will be much easier for those who are reviewing the form to know quickly what the carrier’s position is, what the result is of the review and will move things along more quickly and more clearly.

Slide 52:
So in summary, the changes to the medical treatment guidelines for 2013 cover a variety of topics both directly in the medical treatment guidelines, issues related to the medical treatment guidelines, and regulatory and associated process changes. The updates and revisions, specifically the ongoing maintenance, an important new section, the new recommendations for strapping, and changes in the preauthorization process. The related medical treatment guideline issues focus on learning what objective functional improvement means. It will enhance the ability to identify appropriate care and provide the documentation necessary to obtain appropriate care for a patient.

Slide 53:
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.

Thank you for taking the training on Moving Forward - 2013 is Medical Treatment Guidelines.

Slide 54:
To receive a certificate of completion and your continuing medical education credits you must complete the program evaluation. Please fill out the form below and press ‘continue’ to complete the evaluation and receive your certificate.
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:

________________________________________________________________________________________

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 Medical Treatment Guidelines?

☐ Very much
☐ Moderately
☐ Minimally
☐ Not at all

7. Based on your participation in this training program, describe the ways that you will change the way you determine the difference between ongoing maintenance care and the treatment of exacerbation:

________________________________________________________________________________________

8. Did this training program help you to better understand the exacerbation criteria?

☐ Yes
☐ No

Did this training program help you to better understand when a variance is required to treat a patient with an exacerbation?

☐ Yes
☐ No

Did this training program help you to learn the significant regulatory and associated processes and procedure changes to the guidelines?

☐ Yes
☐ No
9. Based on your participation in this program, have you identified any barriers to your use of the process, procedures and forms?

☐ Yes
☐ No

*If yes, please provide additional information:*

________________________________________________________________________________________

10. Topics for future programs:

________________________________________________________________________________________

________________________________________________________________________________________

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