

**General Principles
Medical Treatment Guidelines**

**Proposed by the
State of New York
Department of Insurance
to the
Workers' Compensation Board**



GENERAL GUIDELINE PRINCIPLES

The principles summarized in this section are key to the intended application of the New York State Medical Treatment Guidelines.

1. **MEDICAL CARE** and treatment required as a result of a work-related injury, should be focused on restoring functional ability required to meet the patient's daily and work activities and return to work, while striving to restore the patient's health to its pre-injury status in so far as is feasible.
2. **EDUCATION** of the patient and family, as well as the employer, insurer, policy makers and the community should be a primary emphasis in the treatment of work related injury or illness. Practitioners must develop and implement effective educational strategies and skills. An education-based paradigm should always start with communication providing reassuring information to the patient. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention of future injury.
3. **DIAGNOSTIC TIME FRAMES** for conducting diagnostic testing commence on the date of injury. Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document.
4. **TREATMENT TIME FRAMES** for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration may be impacted by disease process and severity, patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document.
5. **ACTIVE INTERVENTIONS** emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

6. **ACTIVE THERAPEUTIC EXERCISE PROGRAM** goals should incorporate patient strength, endurance, flexibility, range of motion, coordination, and education. This includes functional application in vocational or community settings.

7. **POSITIVE PATIENT RESPONSE:** Positive results are defined primarily as functional gains which can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion, strength, endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures which can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation.

8. **RE-EVALUATE TREATMENT:** If a given treatment or modality is not producing positive results, the treatment should be either modified or discontinued. The first evaluation of the treatment or modality should occur 2 to 3 weeks after the initial visit and 3 to 4 weeks thereafter. Reconsideration of diagnosis should also occur in the event of poor response to a rational intervention.

9. **SURGICAL INTERVENTIONS:** Contemplation of surgery should be within the context of expected functional outcome and not solely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s).

10. **DIAGNOSTIC IMAGING AND TESTING PROCEDURES:** Clinical information obtained by history taking and physical examination should be the basis for selection and interpretation of imaging procedure results. All diagnostic procedures have variable specificity and sensitivity for various diagnoses.

When a diagnostic procedure, in conjunction with clinical information, provides sufficient information to establish an accurate diagnosis, the second diagnostic procedure will become a redundant procedure. At the same time, a subsequent diagnostic procedure (that may be a repeat of the same procedure, when the rehabilitation physician, radiologist or surgeon documents the study was of inadequate quality to make a diagnosis) can be a complementary diagnostic procedure if the first or

preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis.

11. **SIX-MONTH TIME FRAME:** Since the prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months, the emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible.

12. **RETURN-TO-WORK:** For purposes of these guidelines, return-to-work is defined as any work or duty that the patient is able to perform safely. It may not be the patient's regular work. Ascertaining a return-to-work status is part of medical care, should be included in the treatment and rehabilitation plan, and normally addressed at every outpatient visit. A description of patient's status and task limitations is part of any treatment plan and should provide the basis for restriction of work activities. Early return-to-work should be a prime goal in treating occupational injuries given the poor return-to-work prognosis for a patient who has been out of work for more than six months.

13. **DELAYED RECOVERY:** For those patients who are failing to make expected progress 6-12 weeks after an injury, reexamination in order to confirm the accuracy of the diagnosis should be made. Thereafter, consideration for an alternate treatment program should be made. This may include an interdisciplinary rehabilitation program and may also include a psychosocial evaluation.

14. **FUNCTIONAL CAPACITY EVALUATION (FCE)/FUNCTIONAL DEMAND REPORT** is a comprehensive or modified evaluation of the various aspects of function as they relate to the patient's ability to return to work. Areas such as endurance, lifting (dynamic and static), postural tolerance, specific range-of-motion, coordination and strength, worker habits, employability, as well as psychosocial, cognitive, and sensory perceptual aspects of competitive employment may be evaluated. Components of this evaluation may include: (a) musculoskeletal screen; (b) cardiovascular profile/aerobic capacity; (c) coordination; (d) lift/carrying analysis; (e) job-specific activity tolerance; (f) maximum voluntary effort; (g) pain assessment/psychological screening; (h) non-material and material handling activities; (i) cognitive; (j) visual; and (k) sensory perceptual factors.

In most cases, the question of whether a patient can return to work can be answered without an FCE.

In the event that a carrier asks for further details regarding work capacities, but not to the level of definition or sophistication of an FCE, physicians may charge by report to complete a functional demand form supplied by the carrier and/or employer.

See Appendix for proposed modification of current New York Workers' Compensation Fee Schedule for Function Capacity Evaluations.

15. **JOB SITE EVALUATION:** The treating physician may communicate with the employer or his designee, either in person or by telephone, to obtain information regarding the demands of the patient's pre-injury job, including a description of the exertional demands of the job, the need for repetitive activities, load lifting, static or awkward postures, or any other factors that would pose a risk of re-injury or impedance of convalescence. When return to work at the patient's previous job task/setting is not feasible, given the clinically determined restrictions on the patient's activities, inquiry should also be made about modified duty work settings, and a similar set of questions should be posed by the physician about work activities/demands in modified duty jobs.

Ideally, the physician would gain the most information from an on-site inspection of the job settings and activities; but it is recognized that this may not be feasible in most cases. If job videos/CDs/DVDs are available from the employer, these can contribute valuable information.

Frequency: 1 or 2 calls

- 1st call: Patient is in a functional state where the patient can perform some work.
- 2nd call: Patient has advanced to state where the patient is capable of enhanced functional demands in a work environment

The physician shall document the conversation on a form prepared by the Workers' Compensation Board.

16. **PERSONALITY/PSYCHOLOGICAL/PSYCHOSOCIAL EVALUATIONS:** In select patients, diagnostic testing procedures may be useful when there is a discrepancy between diagnosis, signs, symptoms, clinical concerns or functional recovery. Psychological testing should provide differentiation between pre-existing depression versus injury-caused depression, as well as post-traumatic stress disorder, and other psychosocial issues that may include work or non-work related issues.

For those patients who fail to make expected progress 6-12 weeks after an injury and whose subjective symptoms do not correlate with objective signs and tests, reexamination in order to confirm the accuracy of the

diagnosis should be made. Formal psychological or psychosocial evaluation may be considered.

A professional fluent in the primary language of the patient is strongly preferred. When such a provider is not available, services of a professional language interpreter must be provided.

Frequency: One time visit for evaluation. If psychometric testing is indicated as a portion of the initial evaluation, time for such testing should not exceed an additional two hours of professional time.

17. **PERSONALITY/PSYCHOLOGICAL/PSYCHOSOCIAL INTERVENTION:** Following psychosocial evaluation, when intervention is recommended, such intervention should be implemented as soon as possible. This can be used alone or in conjunction with other treatment modalities.
 - Time to produce effect: 2 to 8 weeks
 - Optimum duration: 6 weeks to 3 months
 - Maximum duration: 3 to 6 months. Counseling is not intended to delay but to enhance functional recovery. For select patients, longer supervision may be required, and if further counseling is indicated, extensive documentation addressing which pertinent issues are pre-existing versus aggravated versus causative, as well as projecting a realistic functional prognosis, should be provided by the authorized treating practitioner every 4 to 6 weeks during treatment.

18. **GUIDELINE RECOMMENDATIONS AND MEDICAL EVIDENCE:** 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.

19. **SCOPE OF PRACTICE:** These Guidelines do not address scope of practice or change the scope of practice.

20. **EXPERIMENTAL TREATMENT:** Medical treatment that is experimental and not approved for any purpose, application or indication by the FDA is not permitted under these Guidelines.

21. **INJURED WORKERS AS PATIENTS:** In these Guidelines, injured workers are referred to as patients recognizing that in certain circumstances there is no doctor- patient relationship.

APPENDIX

PROPOSED MODIFICATION OF CURRENT WCB FUNCTIONAL CAPACITY EVALUATIONS

14. FUNCTIONAL CAPACITY EVALUATIONS

Indications

The FCE is utilized for the following purposes:

- A) To determine the level of safe maximal function at the time of maximum medical improvement.
- B) To provide a pre-vocational baseline of functional capabilities to assist in the vocational rehabilitation process.
- C) To objectively set restrictions and guidelines for return to work.
- D) To determine whether specific job tasks can be safely performed by modification of technique, equipment, or by further training.
- E) In some limited situations FCE may be indicated to determine if a work hardening program is appropriate.

- 1) Claimant is preparing to return to previous job or
- 2) Claimant has been offered a new job (verified) or
- 3) Claimant is working with a rehabilitation provider and a vocational objective is established.

D) Reports will include the following information:

- 1) Patient demographics including work history.
- 2) Indication for evaluation.
- 3) Type of evaluation performed.
- 4) Raw and tabulated data.
- 5) Normative data values.
- 6) Narrative cover sheet with recommendations.

General Requirements

- A) The FCE may be prescribed only by a licensed physician in NYS, or may be requested by the carrier when indicated.
- B) The FCE does not require prior authorization by the carrier.
- C) The attending physician must justify the Indication for each at the request of the carrier (see Eligibility Criteria).
- D) The FCE shall be performed by a physical or occupational therapist currently holding a valid license in NYS, or other licensed provider qualified by scope of practice. Constant supervision by the licensed provider is required.

- E) The bill for services provided must be Attached to the report to be processed by the carrier.
- F) All evaluation tools must be standardized, and normative data and interpretive guidelines must be attached to the report.
- G) Charges for psychometric testing performed as part of the FCE by providers other than psychologists or psychiatrists are inclusive and may not be billed separately.
- H) Testing and/or treatment provided by licensed psychologists or psychiatrists must be performed in accordance with the Psychology or Medicine fee schedules, and should be billed separately.

97800 Functional Capacity Evaluation:

Region I	378.00	Region III	455.00
Region II	400.00	Region IV	495.00

Specific Requirements

- A) The FCE, when medically necessary and indicated, may be performed only at the point of maximum medical improvement in the opinion of the attending physician.
- B) The FCE should not be prescribed prior to three (3) months post-injury unless there is a significant documented change in the claimant's status which justifies earlier utilization.
- C) One or more of the following eligibility criteria is required for all claimants:

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