

THE TRUE COST OF THE MEDICAL TREATMENT GUIDELINES

On December 1, 2010, the New York State Workers' Compensation Board implemented Medical Treatment Guidelines that were recommended by a Task Force and Advisory Committee formed by the New York State Insurance Department. The Insurance Department did not recommend that the Guidelines be applied retroactively, nor did it recommend that they be applied to cases involving chronic treatment.

The Workers' Compensation Board has recognized the latter issue, and has issued a statement that it intends to form a new Task Force to address cases involving chronic care. See, Workers' Compensation Board Press Release, Workers' Compensation Board Chair to Appoint Medical Advisory Committee, May 31, 2011.¹ In the interim, however, it has continued to apply the Guidelines both retroactively and to cases involving chronic care, neither of which was recommended by the Insurance Department. This implementation has resulted in the termination of care for thousands of injured workers, and has flooded the workers' compensation system with applications for a variance from the Guidelines, preventing the agency from adjudicating other claims in a timely fashion.

S. 3741.

S.3741 is primarily intended to prevent the retroactive termination of symptomatic medical treatment that was authorized by stipulation or by decision of the Workers' Compensation Board. It is of course fundamentally unfair for the agency to withdraw its prior decisions or to undo stipulations between the parties simply because it has adopted a new regulation. The law disfavors retroactive application of statutes or regulations. See, e.g., McKinney's Statutes, Chapter 5, § 53.

The Business Council's Claim.

The Business Council of New York State, in opposing S.3741, has arbitrarily claimed that the cost of the Guidelines that went into effect on December 1, 2010, is \$100 million. This figure is entirely lacking in evidentiary support.

The Cost of Treatment Prohibited by the Guidelines.

The retroactive termination of symptomatic medical treatment generally involves workers who have been classified as having a "non-scheduled permanent partial disability." According to the Insurance Department and the Workers' Compensation Board, in 2003 there were 3,756 such classifications. Report to the Governor from the Superintendent of Insurance Summarizing Workers' Compensation Data and Recommending Improvements in Data Collection and Development of a Research Structure for Public Policy at p. 29, March 3, 2008.²

¹ <http://www.wcb.state.ny.us/content/main/PressRe/2011/AppointMedAdvisoryComm.jsp>

² <http://www.ins.state.ny.us/press/2008/nyisid-wcb080303.pdf>

Symptomatic treatment generally involves periodic chiropractic or physical therapy care. Under the workers' compensation / No-Fault fee schedule, the cost of each such visit is approximately \$33.³

If one were to assume (1) that there are 5,000 workers each year entitled to symptomatic treatment (25% more than the actual number of classified cases from 2003); and (2) that those workers averaged 12 visits per year, then the cost of the treatment at issue would be \$1,980,000 per year.

	\$33 per visit
X	12 visits

	\$396 per year
X	5,000 workers

	\$1,980,000 per year

If one were to further assume that there are ten years of claims involved, then the cost of the treatment at issue is \$19,800,000 – less than 20% of the Business Council claim. This would appear explain the lack of substantiation offered by the Business Council in support of its claim.

The Cost of Guidelines Implementation.

The cost of the medical treatment that is being terminated by retroactive application of the Medical Treatment Guidelines must be compared to the cost of implementing the Guidelines and the litigation that they have engendered.

In response to a request filed by the New York Committee for Occupational Safety and Health (NYCOSH) under the New York State Freedom of Information Act, the Workers' Compensation Board provided the following information regarding the number of "variance" hearings it has held as a result of its implementation of the Medical Treatment Guidelines.

District	Variance Hearings held							
	Dec, 2010	Jan, 2011	Feb, 2011	Mar, 2011	Apr, 2011	May, 2011	June, 2011*	Total*
Albany	0	0	4	10	51	81	134	280
Binghamton	0	1	3	15	34	52	48	153
Brooklyn	0	0	7	52	39	86	97	281
Buffalo	0	0	8	80	113	251	358	810
Hauppauge	0	0	16	47	79	143	156	441
Hempstead	0	0	5	22	36	58	89	210
Manhattan	0	0	10	36	64	49	90	249
Peekskill	0	0	16	37	86	154	179	472
Queens	0	3	7	39	64	104	154	371
Rochester	0	2	5	35	66	85	75	268
Syracuse	0	3	23	122	131	237	235	751
Total	0	9	104	495	763	1,300	1,615	4,286

*As of 6/26/2011

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³ <http://www.wcb.state.ny.us/content/main/hcpp/MedFeeSchedules/medfee.jsp>

Because the Guidelines did not go into effect until December 1, there was little impact from the process until May, 2011. It is difficult to project the number of variance hearings that will be required each month in the future, as the chart provided by the Board shows an increasing number each month (note that the figure for June, 2011 does not even represent a full month). It appears, however, that a conservative estimate is that the Board will be required to schedule at least 1,700 variance hearings per month.

Each variance hearing is scheduled in response to a carrier's denial of a treating physician's variance application. The least expensive method a carrier may use to deny a variance application is to have the application reviewed by a non-physician (such as a nurse case manager) or by a non-examining physician (such as a "peer review" company). It is estimated that the cost to the carrier (including administrative costs) of this method is approximately \$200. In some instances, the carrier may choose to have an independent medical examination; this would increase the cost of the variance denial.

If the carrier denies the variance application, then it must typically take testimony from the treating physician in support of the application. If the treating physician is a chiropractor, then the statutory fee to the physician for his or her appearance is \$300; if the treating physician is a medical doctor, then the statutory fee is \$400. The carrier will also typically incur at least \$750 in defense costs for its attorney and a stenographer.

The Board will ultimately schedule a hearing regarding the variance, which will result in an additional cost to the carrier, estimated to be \$250.

Thus, in the least expensive case, a variance denial leading to a hearing results in a cost to the carrier of approximately \$1,500:

\$200 variance receipt, review by nurse or peer review, denial issued
+ \$300 testimony fee to attending chiropractor
+ \$750 deposition costs
+ 250 hearing costs

\$1,500

If the carrier conducts an independent medical examination and multiple depositions are required, the cost of a variance denial may be double the figure shown. As shown above, these denials typically involve treatment requests that would cost a small fraction of the expense of litigation. We also note that even if the carrier approves the variance request, it has still expended approximately \$200 as a result of the process.

If we assume hypothetically that there is zero cost to approved variances, and that every variance hearing is conducted at the minimum expenditure of \$1,500, then the Medical Treatment Guidelines result in costs to employers and carriers of \$2,550,000 per month, or \$30,600,000 per year.

⁴ Letter dated July 8, 2011 from New York State Workers' Compensation Board by Patrick J. Cremo, Associate Attorney and Records Access Officer, to Joel Shufro, Executive Director, New York Committee for Occupational Safety and Health

	1,700 variance hearings per month
X	\$1,500 minimum cost per hearing

	\$2,550,000
X	12 months

	\$30,600,000 per year

Of course, the true cost of the variance process is significantly higher than this figure, because the cost per hearing in this calculation assumes that each variance hearing is conducted at a minimum cost, and the cost to employers and carriers of approving variance applications is not considered.⁵ It is reasonable to assume that the true cost of the variance process exceeds \$40 million per year.

The Cost of Guidelines Implementation is More than Double
the Cost of the Treatment Prohibited by the Guidelines.

It is therefore apparent that the cost to employers and carriers of implementing the Medical Treatment Guidelines is more than twice the cost of the medical treatment that is being denied by those Guidelines. This is, of course, additional to the financial and human cost paid by injured workers who are arbitrarily denied treatment due to the Board's unilateral decision to apply these Guidelines in a retroactive fashion.

Passage of S.3741 would therefore result in cost efficiencies for employers, administrative efficiencies for the Workers' Compensation Board, and improved access to benefits and medical treatment for injured workers.

⁵ These costs would include the costs of the Workers' Compensation Board associated with implementing, processing, and holding hearings in connection with variances. The Board's operations are funded by employers through assessments.