

HOW ARE THE WORKER'S COMPENSATION CHANGES GOING TO HURT YOU?

If you have been injured in the past, your benefits are no longer guaranteed!

This article is presented to the Suffolk County Police Conference

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During a recent meeting, between your President Tom Tatarian and Vice President William Tricarico, your President and Vice President suggested I write an article in your recent police conference publication to highlight the changes in your Worker's Compensation system.

It seems that the President and Vice President have been receiving various comments and concerns by membership regarding the current changes which can adversely effect any prior decisions made in your case. More over, any honest and legitimate claim to total disability in the future, under the current system, will be difficult if not impossible to obtain because of the changes of the current guidelines.

Unless your case is managed competently you are going to get hurt procedurally and so it is important for your case to be worked up properly.

I recently attended an exhaustive conference given by the New York Chiropractic College, post graduate program and although the details are provided below are still in a state of evolution, the basic structure is provided below.

PAST HISTORY:

In the past you received a work related injury and you went to the emergency room. After documenting your injury you went to a doctor that you wanted to see for a particular injury. But the guidelines have now changed severely for injuries sustained to the neck, low back, knee and shoulder. Why? It seems these are the major areas that require the most treatment and rehabilitation, not only by physical therapists and orthopedists but chiropractors as well.

Those of you who have been injured in these areas are well aware of the fact that even though you returned to work, you continued to have pain in these areas which require periodic care. It is exactly under the old system you could have symptomatic treatment and under the new system, you cannot.

If you have been certified totally disabled and/or partially disabled and the judge ruled on your case and you believe these regulations do not pertain to you, **you are wrong, they do**. They are probably designed to focus on and limit any care that you receive in the future and in fact after the end of January of this year (2011), they essentially eliminate any care that you can have on an as needed basis. If you were regularly scheduled with

any chiropractic, orthopedic or pain doctor or physical therapist the days of chronic treatment for periodic pain that you get while directing traffic, spending long periods of time in the car, wearing your heavy gun belt, chasing a perpetrator that may flare up an old injury will not be covered under the new guidelines unless proper documentation exists, because they might be considered old and chronic. Uncovered!

THE CHANGES:

Starting December 1, 2010 anyone who had injuries to the neck or low back could obtain treatment 3 times a week for 4 weeks and then in January 2 times a week for 4 weeks. After that period of time you have to request a variance. Now here is the kicker on this and you tell me if you think this is fair. The variances are sent to the insurance company and depend on your insurance company reviewing and determining your additional need for care.

The doctor must submit details about your care in narrative format and supporting documentation which the carrier evaluates and then decides if the request that you are making is necessary. Remember, that under the new changes only acute care is covered, chronic care is not covered and therefore periodic care to you has been eliminated. Those of you who have enjoyed or have benefited from symptomatic care (going to the doctor when you felt an increase in your symptoms that impaired you and created pain) do not have that benefit any longer.

After your doctor submits a variance, at some point in your care if the response to the variance is denied or modified by the insurance company **you must be active in the protection of your benefits!**

You have two choices:

1. You sign a denied variance at the doctors office and you go to what is called a fast track hearing (we estimate a fast track hearing to be 30 days but we suspect it will be much longer).
2. It goes to the medical director, who can make a binding decision without any choice of appeal on what the amount of care you can have is. If they deny, then no care.

We have estimated that the treatment guidelines have changed to allow not only manipulation and/or physical therapy to you but also to allow therapeutic exercise and massage therapy so that your treatment program can be modified and we believe, that if the carrier is fair in their evaluations of our documentation, that we will be able to get you sufficient care to return to the job and restore function and reduce pain. For many of you that have multi-level herniated discs, history of orthopedic fractures to the spine, permanent contracture of soft tissue which creates on going impairment your treatment of any residual pain does not exist. So you will need all the help and support you can get!

So you can see that the management and maintenance of you to be able to perform your function in the job is actually discouraged under these guidelines. Only acute care is reimbursable.

We understand that the compensation board is going to work on symptomatic and/or chronic guidelines but we suspect they will be deficient as well and it may be years before they get to it.

Ok, this sounds bad and unfair! It is. Well it is if you are totally disabled and can not return to work. There is, in my opinion a concerted effort to discourage any type of disability and potentially not enough therapeutic access to prevent it. Once a person reaches a pain profile of greater than 6 months they are usually considered chronic and after 12 months permanent. Acute treatments without variance (insurance) approval peak out around 5 months.

Under the current guidelines it will be nearly impossible to treat a patient for a year without substantially modifying your treatment program and in my opinion it is going to be more expensive for the insurance carriers. Treatment modalities which have been inexpensive are now going to be cost shifted to other medical treatment earlier such as epidural steroid injections, trigger point modalities, concurrent acupuncture and other modalities of care that historically have not been integral to your treatment. These other modalities are going to have to be tried because the doctor is going to have difficulty giving you continuous care for the amount of time you need to get completely back to work without functional restriction and enough resolution of pain.

What's the answer? My opinion is that if you go to your doctor's office tomorrow and they don't have the new treatment guidelines down, the new billing procedures down and the new therapeutic parameters designed and laid out for you then I think you could be at risk.

With each submission, every month to your compensation carrier, the office must document in detail the improvement in your function and pain indexes with monthly re-examinations. If the doctors office does not have sufficient diagnostic information such as range of motion equipment, muscle testing equipment to measure weakness, nerve damage testing which can tell you whether or not a patient has an acute nerve lesion versus a chronic one, it is my opinion that you will be at risk of losing treatment benefits. More over, if the office is not set up to get you your MRI's when they are necessary or PET scans then the documenting of an acute inflammatory lesion is again going to be difficult.

WHAT TO LOOK FOR TO MAKE SURE THAT YOU ARE BEING MANAGED CORRECTLY:

Again, it is my opinion that the doctor has to have adequate staffing to take care of all of this paperwork, since we have 9 girls and 2 dedicated specifically to worker's

compensation, I have made it a point to organize the patient's charts, variance needs and indexes and protocols to highlight the patient's acute manifestation of pain.

It is also my experience in private practice that even if I discharge you from a compensation situation, it is not un-common for you to come back several months later or another acute episode or while performing your activities of daily living and routine job activities. Some aspect of your work or daily living inflames the area acutely again.

Proper documentation of that event allows you to have care again but the documentation is critical.

Even with documentation it is my opinion that you are unlikely to be treated fairly. Being given an option of non-payment, carriers will send you to hearings to preserve your benefit and the board will be jammed with hearings when your treatment should have been approved due to proper documentation. They will have you examined and your benefits cut-off by insurance exams!

Remember, you have to be actively involved with your case. If the carrier should deny you your right to acute care we will request a hearing for you. You will sign the variance (and there is a time limit to sign the document and submit it) and you will be able to obtain your benefits through a worker's compensation judge (assuming that he rules for you, and we believe he will be fairer to you than the medical reviewer). We believe we are properly suited to adjust all of your worker's compensation needs because of our diagnostic infrastructure, which includes digital x-rays (and under the new protocols even x-rays are not covered unless the need for them is properly documented).

How can this system hurt you? You've been injured on the job. You have damaged discs, fractured bone, damaged nerves and while restraining a perpetrator or being involved in a MVA this system has already devised a plan, in my opinion, to circumvent the treatment time you actually, really need care, and be careful if you have gone to a doctor before me, the amount of treatment you received there is used against the profile of care that the State has outlined for you.

Is My Physical Therapy Affected?

Yes and what is worse your therapist cannot file a variance which can help you get the care you need.

THE SOLUTION:

The program is still constantly evolving and we have had dialogue between by office managers JoAnn and Brittany and the worker's compensation board who is going to monitor the program. We have been told that if various insurance companies, yours or any others routinely deny your request for variances or seem to severely limit them they are going to monitor that company. I would not discourage complaints from the patients against any particular carrier when they feel that they need the treatment and are not obtaining the care that they need.

Nevertheless, we are bound by the system and have to respect it to the extent that it's respecting your needs. I believe a patient can be adequately treated with the parameters that I have laid out regarding acute care. Our office staff is completely up and running with respect to all forms, all documentation, all diagnostic requests and all therapeutic interventions that are necessary to get our neck and back patients well.

Since this system is continuing to evolve and many of the insurance companies don't know exactly how to handle the current paperwork you can be sure there are going to be many errors unless you get started with your paperwork correctly. If you are under treatment in a office that is under staffed and cannot manage the degree of paperwork than I believe that you are going to be discharged before you have achieved full therapeutic and diagnostic benefit because of the burden of administrative aspects that will occur. I will not let that happen to you and when you come to my office I will introduce you to the three people I have helping to manage the compensation benefits, one of which is fully employed now to address these concerns. **Do not panic and do not worry.** For those of you who are adamant that the judge ruled that you have 18 years of compensation and you have a total disability and you believe you can get care whenever you wanted, those days are technically over, like it or not.

If you need help and are worried and concerned because you haven't been to the doctor in months or years for your case but still have acute therapeutic needs or if you have recently injured yourself in the neck, mid and lumbar spine and need advice and evaluation do not be afraid to give us a call since we have been here for you for over 26 years.

Joanne, Brittany or Krissy will be happy to answer any questions and I will be happy to answer any questions personally ... even if you are not yet a patient.

My personal regards,

Raymond A. Semente D.C., P.C.