# NOTICE OF MAINTENANCE CARE PROGRAM

**Patient Name** _____ **Date of Injury** _____

**WCB#** _____ **Carrier Case#** _____ **SS#** _____

This patient is seeking maintenance care relative to a work-related injury as permitted by the NYS WCB Medical Treatment Guidelines (MTGs). The NYS WCB has directed that "A maintenance program of ... spinal manipulation ... may be indicated in certain situations, after the determination of MMI, when tied to maintenance of functional status." The Guidelines allow for up to 10 visits per calendar year of maintenance therapy per injured body part. They have also directed that a completed C-4.2, Doctor's Progress Report, or EC-4NARR, Doctor's Narrative Report, which contains all the required documentation, would be sufficient to fulfill the MTG requirements.

Significant objective deterioration in function has been previously observed during periods of therapeutic withdrawal, resulting in the need for periodic supervised intervention. The goals of treatment are to maintain the patient's functional ability and reduce the frequency and/or intensity of exacerbations or functional regression. The need for ongoing maintenance care shall be evaluated by progressively longer trials of therapeutic withdrawal of maintenance care.

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**Qualification:**

1. **This patient has reached maximum medical improvement and has a permanent disability.** ☐**Yes** ☐**No**
2. **This patient suffers from chronic pain.** ☐**Yes** ☐**No**
3. **This patient has demonstrated a decline in their functional status in the absence of the proposed maintenance treatment.** ☐**Yes** ☐**No**
4. **The treatment plan is consistent with the applicable Medical Treatment Guideline.** ☐**Yes** ☐**No**

**If you answered 'no' to any of the above, this patient may not qualify for maintenance treatment. If yes, the following criteria must be met and documented. If the patient suffered an exacerbation, please follow the requirements outlined in MDO 2012#1.**

**Criteria:**

1. A self-management program has been developed with this patient, consisting of the following: ☐ See Attached

   _____

   _____

2. Is the patient compliant with their self-management program? ☐Yes ☐No, the patient has not complied for the following reason(s): _____

   _____

3. Describe the subjective and objective functional regression upon withdrawal of care despite self-management ☐ See Attached

   _____

   _____

4. Specific objective functional goals to be measured and met as a result of maintenance treatment ☐ See Attached

   _____

   _____

I have reviewed the aforementioned with my patient, who has advised me that a maintenance care program has not been requested or established by another health care provider for this region of the body.

Provider's Signature: _____ Date _____


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