



Workers' Compensation Board

Overview

The Board conducted a series of Business Process Re-engineering (BPR) roadshows in June and July to keep stakeholders informed and, most importantly, involved in the BPR project.

The BPR discussions began with a recap of the BPR project, presenting the goals of the project and the five areas targeted for change: Communication, Education and Outreach; Claims Management; Adjudication and Appeals; Medical Provider Management; and Monitoring and Compliance. The discussions continued with an update on the development and implementation of the medical authorization portal and payer compliance. New initiatives directed towards improving processes in claims and issue resolution rounded out the discussions.

Medical Authorization Portal

The Medical Authorization Portal is envisioned to ultimately be available to all stakeholders (health care providers, attorneys, payers, and injured workers) involved in the workers' compensation system.

The functionality of the Portal will be developed in several releases. Release 1 of the Portal will be a web-based application for Medical Authorizations that will be accessed via the Board's website. It is being built using Customer Relationship Management software. The only software the user will require is an Internet browser.

The Portal's user interface will be interactive. Health care providers will answer a series of questions, the answers to which will route them through the authorization process, enabling them to submit Treatment Authorization Request forms (MG-1, MG-2, and C-4 Auth). The Medical Portal will then notify the payer and other parties of interest that an authorization was submitted. Data will be input and stored within the Portal and access to information will be role-based.

There were concerns expressed during the sessions about the payers not responding timely to a health care provider's submitted medical treatment authorization request. There are no changes in current procedures—Orders of the Chair and Medical Director's Office Resolutions will be issued if the payer does not respond in a timely manner. This system will allow the Board to more closely monitor payer performance.

Release 1 will be available to New York workers' compensation authorized providers for Medical Authorization requests. Providers will still be allowed to submit the paper form as they do today, but their payer response will be timelier if they utilize the Portal. A major feature of the Portal will be the availability of the Medical Treatment Guidelines (MTG) codes to the provider and the applicable descriptions as they work through the request process.

Future releases will add functionality and will allow health care providers to submit medically related documentation to the Board and to payers. Release 1 is strictly medical authorizations; information on prescription abuse will not be available in Release 1. The feedback received on this issue will be considered for future releases.

A concern was raised about health care providers submitting an MG or a C-4 Auth form for a case that does not exist, which then results in the Board creating a new case. This could lead to duplicate cases being created if information on the MG or C-4 Auth form is incorrect. This issue will be rectified by combining the cases if it is later discovered that there was already a case in existence.

Please direct any question about the Medical Portal to the BPR mailbox: BPR@wcb.ny.gov

Compliance and Monitoring

The Compliance and Monitoring initiative from the Board's new Monitoring Unit supports a major theme of the BPR—Redefine the Board's role to refocus on its core mission to protect injured workers and employers.

Building on the foundation of the Board's eClaims project, which implemented electronic submission of accident and payment data, the Monitoring Unit has identified the first set of key performance indicators:

- Timeliness of the First Report of Injury Filing;
- Timeliness of Initial SROI showing Initial Payment;
- Timeliness of Initial Payment of Compensation; and
- Timeliness of Controversy; and Percentage of Claims Controverted.

Initially, the Monitoring Unit is using the eClaims FROI/SROI data to establish performance standards and collaborate with the payer community on how they can track and improve their performance. Future releases will focus on other aspects of stakeholder compliance.

Penalty Reports

Penalties for failure to file a required report within the specified time frame pursuant to WCL Section 25 (3)(e) will be based on the following:

- Timeliness of First Report of Injury (FROI) is based on the 18/10 Day Rule defined in NYCRR Section 300.22: "On or before the 18th day after the disability event OR within 10 days after the employer has knowledge of the disability event, whichever period is greater, the payer, Special Fund, self-insured employer or TPA shall file electronically a First Report of Injury (FROI) with the Board."

Timeliness of Subsequent Report of Injury showing Initial Payment and Timely Initial Payment is based on the 18/10 Day Rule defined in WCL Section 25(1)(c): If the employer or insurance payer does not controvert the injured worker's right to compensation such employer or insurance payer shall, either on or before the 18th day after disability, OR within 10 days after the employer first has knowledge of the alleged accident, whichever period is the greater, begin paying compensation and shall immediately notify the chair in accordance with a form prescribed by him, that the payment of compensation has begun, accompanied by the further statement that the employer or insurance payer, as the case may be, will notify the chair when the payment of compensation has been stopped.

Penalties for untimely first payment and notice of controversy will be based upon the following:

- When an employer reports that an employee was injured at work and is expected to have compensable lost time, and the employer does not dispute the claim, WCL Section 25(1)(c) requires the payer to begin payment either on or before the 18th day after disability, OR within 10 days after the employer first has knowledge of the alleged accident, whichever period is the greater, and immediately notify the chair that the payment of compensation has begun. A SROI-

IP filed after these time frames will be subject to a \$300 penalty pursuant to WCL Section 25 (2)(a).

- In accordance with WCL §25 (2)(a) when a payer fails to file a notice of controversy or begin payment within the prescribed period or within 10 days of claims administrator knowledge (whichever period is greater), the Board may impose a \$300 penalty payable to the injured worker, in addition to any other penalty.

Legacy cases with ongoing benefits will not be measured. These cases do not require a FROI/SROI filing until an event occurs. The semi-annual reporting that is required in claims with ongoing payments is considered an event. For these claims, a SROI-SA must be filed. To be able to file the SROI-SA, a FROI must first be submitted.

When there is an issue with information submitted on the SROI-SA by a specific payer, parties can email eClaims@wcb.ny.gov with the specific cases and the Board will work with the payer to resolve the issue.

It is important to note that the Board is currently not monitoring payers regarding the filling of prescriptions for injured workers. Future measurements are being considered.

Reports provide the number of filings for the quarter along with the number of timely and untimely filings. The report only lists the cases that are late. A request was made to include both the filings that were denied as well as those accepted. The Board will be reviewing this request to determine its feasibility.

Transitioning from the C-8

There were issues raised regarding the SROI and the transition from the C-8 form. It was stated that SROIs received from payers are inaccurate, which results in injured workers being unable to get unemployment benefits and/or social security benefits. Please note that the Board has done extensive outreach with Social Security and the Department of Labor, as well as other government agencies, regarding SROIs replacing Form C-8. If you find a specific office is still looking for a Form C-8, please contact eClaims@wcb.ny.gov. The Board has also done extensive outreach and statewide training with Trading Partners for proper SROI filing. If there is an issue with a specific payer and the information, parties can email eClaims@wcb.ny.gov with the specific cases and the Board will work with the payer to resolve the issue. An example of the letter sent to government agencies is located at: http://www.wcb.ny.gov/content/ebiz/eclaims/Updated_SROI_replaces_C_8_letter.pdf

It was also stated that the C-8 form was helpful but since changing the forms, it is difficult to understand what is being paid to the injured worker. The Board has held webinars and in-person training sessions across the state to present the changes incorporated on the FROI/SROI tab, which replace the C-8 form. The data on this tab floods from the FROI/SROI transactions. The SROI data is listed on the Summary of Benefits, which displays all of the “events” that have been submitted. A Cumulative tab displays all of the “sweep” benefit reporting, listing benefits paid to date based on the IAIABC Claims EDI requirements by Benefit Type Code. A summary of the IAIABC Claims EDI standard for event and sweep reporting is listed in the presentations located at:

<http://www.wcb.ny.gov/content/ebiz/eclaims/Presentations.jsp>

For assistance in interpreting a specific transaction, please send an email to eClaims@wcb.ny.gov, or call 1-877-632-4996 and select Option 7 to speak with an eClaims examiner.

Education

The need to educate employers was also discussed. Issues were raised regarding seasonal employers and the difficulties employers face in determining if a person is out on worker's compensation. Section 54(2) says that notice to the employer is notice and knowledge to a payer. It's in the best interest of the payer to educate their employers regarding timely notice. The Board regularly speaks with employers and will advise them on their obligation to timely notify payers of an injury. Initially, no penalties will be imposed against the employer.

This information is available for the stakeholders. The PowerPoint presentations as well as future webinars can be found at <http://www.wcb.ny.gov/content/main/Monitoring/Overview.jsp>

Administrative Determinations

Administrative Determinations (ADs) are decisions issued by a claims examiner after a judge has reviewed and approved the proposed decision. Regulation 300.5(c) requires that such decisions are issued if the Board finds that the disability exceeds seven days. The Workers' Compensation Law does not require decisions on claims with no lost time. In fact, there is no regulatory or statutory authority mandating an AD for claims with no lost time.

Although there is no requirement to issue ADs in claims with no lost time, the Board nonetheless issues them. To streamline the AD process, the Board conducted an analysis to determine how much of its resources were devoted to issuing ADs on claims with no lost time.

To provide some background, ADs are grouped into the following types:

Type 1: cases with no pending issues that would require a formal hearing

Type 2: cases with certain penalty issues, e.g., failure to timely file a required form

Type 3: cases that have more complex issues, e.g., Special Funds accepts liability

Claims with no lost time fall under Type 1. In 2013 a total of 69,219 Administrative Determinations were issued. Of these decisions, 58,024 were Type 1 ADs and merely recited what was already in the electronic case folder. Of that number, 48% were for cases with no compensable lost time.

To redirect both examiners' and judges' time on matters that would be of more direct benefit to injured workers, the Board will be making the following changes:

1. Focus the Board's limited resources on disputed issues.
2. Provide information to injured workers through eCase access and better communication and outreach.

Claims with no lost time will be electronically closed upon receipt of the claim information. If an issue should arise, action will be taken as soon as the Board is notified of the issue.

The Notices of Assembly and Indexing have been revised. The language is clearer and the mailing of each notice will be included in the Claimant Information Packet.

The Board will not request payroll for cases with no lost time unless a permanency issue arises at a later time. Cases that result in permanency will continue to be followed by the Board, and the notices will clearly state this. In those cases, the Board will review the medical opinions regarding permanency and follow the process for making schedule loss of use awards.

Claimants can use eCase as a way to see important information about their claim. An AD does not provide any additional information than that contained in eCase. All information for newly assembled claims is in the eCase FROI/SROI tab. The FROI/SROI latest values tab has a section that displays the Nature of Injury, Part of Body, Cause of Injury and Accident/Injury Description. These fields clearly identify the body sites injured. The codes used for the Part of Body field are part of the data standard, so there is no flexibility in reporting. Payer submissions are not based on the ICD code.

Section 32s

Section 32 waiver agreements settle compensation and/or medical benefits.

Today all section 32 waiver agreements are scheduled for a hearing; 98% of all waiver agreements are approved as submitted at the hearing. To reduce the time it takes to complete the review and approve a waiver agreement, the Board intends to use its authority in the regulations (12 NYCRR 300.36) to issue desk decisions for certain types of waiver agreements.

Desk decisions will be issued for waiver agreements for represented claimants that are settling only their indemnity benefits, and/or agreements where represented claimants and opposing parties mutually agree to a desk decision. The chair's designees will review these cases. Hearing notices will be issued for cases not having desk processing. Issuing desk decisions for these types of waiver agreements should reduce the approval time by up to two months.

In order to fully inform injured workers, Section 32 form revisions will make it clear to injured workers what the effect of the Section 32 agreement is and how important it is that they understand each provision. An attorney attestation is required to ensure that the represented injured workers are fully informed and are provided knowledge-based consent. The attorney will certify what communication they have completed with their injured worker in order to assure the Board that the injured worker has been fully informed about their decision to file for a section 32. Should an injured worker notify the Board that he or she has decided not to proceed with the Section 32, the Board will follow the legal requirements of WCL §32 and 300.36. Section 32s will continue to be screened and fully approved. The statute does compel that a Section 32 offer be made within two years of indexing, or within six months of a Permanent Partial Disability (PPD) classification or death [see § 32(a)]. Other than that, there are no legal requirements for parties to consider a Section 32 agreement.

A Subject Number will be issued to announce the changes to the Section 32 waiver agreement process. Online training materials will also be available to enable stakeholders to learn the new processes.

Voluntary Binding Review

Voluntary Binding Review (VBR) is an alternative appeal resolution process that will result in more expeditious appeals. Today appeals take an average of 270 days to resolve. It is anticipated that VBR will reduce the time to approximately 60 days. Appeals that distill down to defined dollar amounts, can take six to nine months for resolution. VBR will be voluntary, and binding. Parties who choose the VBR path will receive decisions faster, but those decisions will not be subject to further appeal.

VBR is designed for certain types of claims. Generally speaking VBR will work for any dispute that involves a numerical finding. Issues that fall into this category include: temporary rates versus set rates, degree of disability, and disputes over proper awards. VBR will have a great impact on the current and future inventory of appeals. It is estimated that if only 5% of the current inventory of claims were VBR decisions, the inventory would be reduced by 55 decisions per month or 660 decisions per year. The Board will go through existing inventory to find cases that are eligible, but the parties need to initiate the VBR.

This is an innovative new policy that separates us from other states. No state has the volume of litigation and appeals that New York has. There are other court systems with similar programs. For example, the appellate division has a Civil Appeals Settlement Program. This program, like all appeals, is a statewide initiative, through a centralized workgroup. A pilot was not necessary as it is anticipated that the initial volume of VBRs will be relatively small.

The Board plans to publish a proposed change to regulation 12 NYCRR 300.36 to include the ability to issue a decision that covers "range of determination of compensation." This regulation change will not have an impact on other appeals. A Subject Number will be issued, followed up with training from the Workers' Compensation Board.

Virtual Hearings

Virtual hearings enable all parties of interest to participate from wherever they are without the need to travel to a Board office. If they have the required technology (i.e., an Internet enabled computer, smart phone, etc.), injured workers may attend their hearing from home, or from their attorney's office, or wherever is most convenient for them.

The technology used to implement virtual hearings will be a vast improvement over the Board's current video capability, which has issues with both lag time and video quality. Other states are currently utilizing this technology.

Full training will be provided with the initial roll out. Participants will access virtual hearings via the Board's network. The only requirements for access will be an Internet connection to any device with video capability. Privacy and security will be taken into consideration during the development of our virtual hearing sites.

The technology is expected to improve the quality of digital audio recording (DAR). The recording capability of the technology is high, so no additional microphones or other equipment will be needed.

Call Center Transition to New York State Human Services Call Center (HSCC)

The Call Center Transition to HSCC has been moving ahead. New York State is moving towards centralized call centers that are capable of handling calls from multiple state agencies. These centers of excellence will be equipped with the latest technology, allowing them to respond to incoming calls in a timely, high-quality manner. The Board anticipates that HSCC will answer virtually all incoming calls.

HSCC will handle all Level 1 calls: those calls that can be answered by a customer service representative with agency-specific training and access to well-written scripts and agency documentation. In some cases the customer service representative will be able to access IC2 or CIS to answer questions. Level 2 and 3 calls are more complex, and will be routed back to the Board to be handled by Board staff.

The transition of Level 1 calls has been taking place in waves. The first wave was completed in April 2015. The Board anticipates that all Level 1 calls will be transitioned over to HSCC by the end of 2015.

Board Customer Service Representatives who currently take calls will still answer calls to varying degrees, and will be performing other functions that will maximize their skills and knowledge.

GovDelivery

The Board has implemented new email distribution functionality, GovDelivery, to enhance communication with our stakeholders. GovDelivery is a communications platform that enables stakeholders to subscribe

to the types of email communications they want to receive. Subscribers to GovDelivery can receive the following notifications from the Board:

- Board Announcements
- Business Process Re-engineering Project Director Update
- Education and Training Opportunities
- Social Media (Twitter)
- Press Releases
- Policy Subject Numbers
- Subject Numbers Concerning Health Care Provider Authorization
- eCase and System Availability
- Publications
- eClaims
- Medical Fee Schedule
- Medical Treatment Guidelines
- Monitoring and Compliance
- Special Fund Update
- Proof of Coverage
- Assessment Rate Changes
- Assessment Quarterly Reminders
- GA-2 Form Updates (Insurance Carriers Only)
- GA-3 Form Updates (Active Private Self-Insurers Only)
- GA-4 Form Updates (Active Political Subdivisions or Municipalities Only)
- GA-5 Form Updates (Active and Terminated Private Self-Insurers Only)
- GA 1.6 Form Updates (Active and Terminated Private Self-Insurers Only)
- Quarterly 505 Assessment Apportionment Rate (Active and Terminated Private Self-Insurers Only)
- Location Alerts (Email and Text Messaging)

These emails enable subscribers to stay informed with updates, recent changes, and news on their chosen topics. Based upon personal preferences, subscribers will receive email updates on the selected topics either immediately, daily, or weekly. Additionally, subscribers have the option to supply the county in which they are employed and their affiliation with the Board. This allows the Board to send emails regarding specific locations and affiliations should any such information need to be communicated directly to these demographics. Subscriptions can be changed at any time. Subscribers may add or remove topics, or completely unsubscribe from topics. Subscribers are in control of the frequency with which they receive Board emails via GovDelivery.

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