Assessment of Public Comment

During the public comment period, the Board received approximately five unique written comments and received one comment after the public comment period ended.

The Board received a comment from an association opining that the proposed changes would negatively impact the ability to respond to denials of medical treatment and for objections to be adequately addressed in hearings. The proposal removes the burden from the claimant to make arguments about the clinical necessity of treatment, but there is a path to a hearing for the claimant if one is needed, so no change has been made in response to this comment.

Board received two comments opposing removing notification of the claimant's legal representative from notices of approval, denial, or partial denial. While these parties will no longer receive copies of the letters themselves, they will receive notification that something has changed, and they have system access. Therefore, no change has been made in response to this comment.

The Board received a comment from a law firm opining that the statement about job impacts from the Board is inaccurate, stating that because the proposed amendments would not allow for the use of medical professionals to review variance requests, many will become obsolete. While carrier physicians are required to review and sign off on a denial, the file may be reviewed or approved by other medical professionals, so the Board believes there is still a robust role for other medical professionals. The medical care for injured workers is the primary focus of this requirement and requiring review by a physician prior to denial of medical treatment is an important component of this regulation. Therefore, no change has been made in response to this comment.

This comment also opposed penalties in the proposal, opining that they disproportionately impact carriers, self-insured employers, and third-party administrators. These sections in the proposal make penalties explicit in the regulations that already exist or are implicit. Workers' Compensation Law 25(3)(e) provides for a $50 penalty if the employer or carrier fails to file a notice or report requested or required within the specified time frame (or 10 days if not specified). These penalties are rational, because a provider who has complied with the law and received an approval on a PAR should not be subject to an objection based on the approval, so no change has been made in response to this comment.

The comment also requested that the proposal be amended to allow carriers, self-insured employers, and third party administrators to argue that a treating provider did not meet the burden of proof without the need for a contrary medical opinion. The Board has not made a change in response to this comment – the proposal provides for a level 2 review in this situation, which includes denial by the carrier's physician.

One comment also opposed strict timeframes for filing an RFA-1 after a request for review of a denial or partial approval by the medical provider has been denied. The Board has removed this language to make it consistent with the other regulations regarding time restrictions for filing of an RFA-1.

The comment also opposed language stating that the Board *may* respond to such request for review by letter or referral to adjudication and requested clearer language. The Board has not made a change in response to this comment to maintain consistency with other existing regulations processes.

The Board received two comments opposed to allowing the Medical Director's Office to render decisions on requests for review of medical decisions filed by the medical provider when there has not been an IME, without an option for appeal or a hearing. One of the comments from a law firm also raised concerns about due process with the Medical Director's Office making decisions of this sort. Claimants maintain the right to seek review through adjudication if the claimant is dissatisfied with the decision of the Medical Director's Office. Carriers may preserve objections to causal relationship in the Level 1 denial of the PAR. Accordingly no change has been made as a result of this comment.

The Board received a comment from a society agreeing with the goal of the proposal, but disagreeing with excluding physician assistants from the proposal. This proposal did not change the current rules. Accordingly, no change has been made in response to this comment.

The Board received a comment from an attorney requesting that an objection due to burden of proof issues remain a level 1 denial only in the PAR system to allow the treating provider to resubmit the PAR with the burden of proof met. Because the determination as to whether a burden of proof has been met requires medical knowledge, a Carrier's physician review is needed to deny the request. It is noted that the portal by which PARs are submitted will indicate when necessary fields and information are missing thus providing medical providers with greater certainty when submitting a claim. Accordingly, no change has been made as a result of this comment.

The Board received a comment from an association supporting modernization of the prior approval process, but expressing concern that the proposal restricts the carrier's ability to handle several types of denials, especially ones that would be considered "administrative." The carrier's physician must make a substantive denial, but it may be part of the same denial – this prevents piecemeal denials, and because the Board believes this rule's merits outweigh any concerns, no change has been made in response to this comment.

This comment also recommended increasing the timeframe for carriers to obtain IMEs from 30 to 45 days. The 30-day timeframe has not changed from the existing rules with this proposal, and no change has been made in response to this comment.

The comment also requested clarification about whether a PAR is required for treatment that costs exactly $1,000. The Board has amended the language to make clear that a PAR is not required for treatment that costs exactly $1,000.

The Board received a comment from a law firm opposing the eight business day timeframe to respond to PARs. The Board believes that eight business days to respond to routine treatment

consistent with the Medical Treatment Guidelines is appropriate, so no change has been made in response to this comment.

The Board received one comment after the public comment period closed. This comment highlighted some typographical errors, which the Board has fixed.

Changes made:

- Fixed typographical errors throughout
- Section 324.3(b)(2)(i)(a)(1) and (2) are combined into one paragraph: (1) In the event the PAR is submitted after the mandatory first report of injury pursuant to section 300.22(b) of this Chapter shall become due and no such report has been filed, the Board may issue an Order of the Chair granting the requested treatment.
- Make clarifying change removing timeline language for filing RFA-1s.
- Modified language to clarify that prior authorization is not required for treatment costing exactly $1,000.
- Removed references to May 1, 2021 deadline for contact designee compliance for clarity; will be explained thoroughly in Board communications.