Section 324.1 of Title 12 NYCRR is hereby amended to read as follows:

Section 324.1. Definitions

For purposes of this Subchapter:

(a) The definitions of the terms in section 300.1(a) of this Title are applicable to this Subchapter.

(b) **Calendar day** means the time period from midnight to midnight. For the purposes of calculating calendar days, the day of submission is day zero and the first calendar day begins at midnight following the submission.

(c) Carrier's Physician means a physician or physicians, licensed by New York State, or the appropriate state where the professional practices, who is: 1. employed or contracted by the insurance carrier, self-insured employer, or third-party administrator; or 2. employed by a URAC accredited company retained by the insurance carrier, self-insured employer, or third-party administrator through a contract to review prior authorization requests and advise the insurance carrier, self-insured employer, or third-party administrator; and 3. is not employed or contracted by the carrier, self-insured employer, or third-party administrator's recommendation of care network.

([b]d) **Consistent with the Medical Treatment Guidelines** means within the criteria of the Medical Treatment Guidelines and based on a correct application of the Medical Treatment Guidelines.

([c]e) **Denial, deny** or **denies** means a denial[,] or a partial approval[grant or partial denial] by an insurance carrier, self-insured employer, or third-party administrator [or Special Fund] of a [variance request] Prior Approval Request, defined herein, made pursuant to section 324.3 of this Part or a[n optional] prior approval request made pursuant to section 324.4 of this Part.

[(d) **Insurance carrier or Special Fund's medical professional** means a physician, registered physician assistant, registered professional nurse, or nurse practitioner licensed by New York State, or the appropriate state where the professional practices, who is:

(1) employed by an insurance carrier or Special Fund; or

(2) has been directly retained by the insurance carrier or Special Fund; or

(3) is employed by a URAC accredited company retained by the insurance carrier or Special Fund through a contract to review claims and advise the insurance carrier or Special Fund.]

([e]f) **Maximum Medical Improvement (MMI)** means a medical judgment that

(1) a claimant has recovered from the work injury to the greatest extent that is expected and

(2) no further improvement in his or her condition is reasonably expected. The need for palliative or symptomatic treatment does not preclude a finding of MMI. In cases that do not involve surgery or fractures, MMI cannot be determined prior to six months from the date of injury or disablement, unless otherwise agreed to by the parties.

A finding of maximum medical improvement is a normal precondition for determining the permanent disability level of a claimant.

([f]g) **Medical [arbitrator] Director's Office** means the Medical Director of the Board, the Executive Medical Policy Director, the Assistant Medical Director of the Board, or [a New York licensed physician designated by the Chair or his or her] their designee.

([g]h) **Medical care** means all care, treatment, and other attendance for an injured worker's injury, illness or occupational disease as listed and provided in Workers' Compensation Law Sections 13, 13-b, 13-k, 13-l, and 13-m.

([h]i) **Medical Treatment Guidelines** means the treatment guidelines for workers' compensation injuries, illnesses, or occupational diseases to the parts of the body addressed in the guidelines incorporated by reference in section 324.2(a) of this Part.

([i]j) **Prior Authorization** means the carrier, self-insured employer, or third-party administrator's approval of a Prior Authorization request initiated by the medical provider.

[Prescribed method of same day transmission means:

(1) facsimile **transmission**, provided that the receiving party has designated a facsimile number for this purpose to other persons, entities, or the Board;

(2) electronic mail (email), provided that the receiving party has designated an electronic mail address for this purpose to other persons, entities, or the Board; or

(3) such other means of electronic delivery as the receiving party or the Chair has designated for this purpose to other persons, entities, or the Board]

([j]k) [**Review of records]** **Carrier's physician's medical report** means the evaluation of a claimant without physical examination, by the Carrier's physician [a medical provider authorized by the Chair to treat claimants or to conduct independent medical examinations or both], based on the review of reports and records, including treatment notes, diagnostic test results, depositions or hearing testimony, exhibits, and other records or reports from medical providers or independent medical examiners or both in the electronic case file maintained by the Board.

([k] l) **Prior Authorization Request** (PAR) shall mean any of the following: a variance request (PAR: MTG Variance) or a request for special services (PAR: Special Services) made pursuant to section 324.3 herein, or a request confirming consistency with Medical Treatment Guidelines (PAR: MTG Confirmation) or confirming medical necessity when there is no Medical Treatment Guideline that addresses treatment for the body part or condition and the treatment costs less

than $1000 (PAR: Non-MTG $1,000 or Under) as defined in 324.4. "Prior Authorization Request" or "PAR" may also mean a prior authorization request for medical care costing more than $1000 when there is no Medical Treatment Guideline that addresses treatment for the body part or condition (PAR: Non-MTG Over $1,000) made pursuant to section 325-1.4 of this Chapter.

[**Special Fund** means any special fund maintained by the Board that is responsible for paying for medical treatment and care of injured workers, including but not limited to, the Special Fund for Reopened Cases created and governed by Workers' Compensation Law Section 25-aand the Uninsured Employers' Fund created and governed by Workers' Compensation Law Section 26-a.]

([l]m) **Treating medical provider** means a duly licensed acupuncturist, chiropractor, nurse practitioner, occupational therapist, physical therapist, physician, physician assistant, podiatrist, psychologist, or social worker authorized by the chair, as such terms are defined in section 13-b of the workers' compensation law, or any provider not permitted to obtain authorization in New York State and who has not surrendered or had a Board authorization suspended or revoked, and (1) is licensed pursuant to the education law to provide medical care and treatment in the state of New York, or (2) is duly licensed pursuant to the laws of another state to provide medical care and treatment, who [that] is providing treatment and care to an injured worker pursuant to the Workers' Compensation Law.

Subdivision (d) of Section 324.2 of Title 12 NYCRR is hereby amended to read as follows:

Section 324.2. Medical treatment guidelines

(d) *Applicability and Pre-authorized procedures list.*

[(1)] All medical care consistent with the Medical Treatment Guidelines costing more than $1,000 is included on the pre-authorized procedures list, except as set forth in section 324.3 herein [for the medical care set forth in paragraph (2) of this subdivision]. Medical care costing more than $1,000 included [on the pre-authorized procedures list are] in a Medical Treatment Guideline is pre-authorized so Treating Medical Providers are not required to request prior authorization. Medical care that is not included in the applicable Medical Treatment Guidelines may only be provided in accordance with section 324.3 herein. A Treating Medical Provider may confirm that medical care is consistent with the Medical Treatment Guidelines or, when there is not an applicable Medical Treatment Guideline and the total cost for the aggregate of such medical care is less than $1000, may confirm the medical necessity of causally related medical care by submitting a request in accordance with section 324.4 herein.

[(2) The following medical care consistent with the Medical Treatment Guidelines costing more than $1,000 is not included on the pre-authorized procedures list set forth in paragraph (1) of this subdivision so that prior authorization is required:

(i) Lumbar fusion as set forth in E.4 of the New York Mid and Low Back Injury Medical Treatment Guidelines;

(ii) Artificial disc replacement as set forth in E.5 of the New York Mid and Low Back Injury Medical Treatment Guidelines, and in E.3 of the New York Neck Injury Medical Treatment Guidelines;

(iii) Vertebroplasty as set forth in E.6.a.i. of the New York Mid and Low Back Injury Medical Treatment Guidelines;

(iv) Kyphoplasty as set forth in E.6.a.i. of the New York Mid and Low Back Injury Medical Treatment Guidelines;

(v) Electrical bone stimulation as set forth in the New York Mid and Low Back Injury Medical Treatment Guidelines and the New York Neck Injury Medical Treatment Guidelines;

(vi) Osteochondral autograft as set forth in D.1.f and Table 4 of the New York Knee Injury Medical Treatment Guidelines;

(vii) Autologous chondrocyte implantation as set forth in D.1.f., Table 5, and D.1.g. of the New York Knee Injury Medical Treatment Guidelines;

(viii) Meniscal allograft transplantation as set forth in D.6.f., Table 8, and D.7. of the New York Knee Injury Medical Treatment Guidelines;

(ix) Knee arthroplasty (total or partial knee joint replacement) as set forth in F.2. and Table 11 of the New York Knee Injury Medical Treatment Guidelines;

(x) Spinal Cord Pain Stimulators as set forth in G.1 of the Non-Acute Pain Medical Treatment Guidelines; and,

(xi) Intrathecal Drug Delivery (Pain Pumps) as set forth in G.2 of the Non-Acute Pain Medical Treatment Guidelines.

(3) Notwithstanding that a surgical procedure is consistent with the guidelines, a second or subsequent performance of such surgical procedure shall require prior approval if it is repeated because of the failure or incomplete success of the same surgical procedure performed earlier, and if the Medical Treatment Guidelines do not specifically address multiple procedures.]

Section 324.3 of Title 12 NYCRR is hereby amended to read as follows:

Section 324.3. Variances (PAR: MTG Variances)

(a) *Treating medical providers.*

(1) Applicability

(i) (*a*) When a treating medical provider determines that medical care that varies from the Medical Treatment Guidelines, such as when a treatment, procedure, or test is not recommended by the Medical Treatment Guidelines, appropriate for the claimant and medically necessary, he or she shall request a variance from the insurance carrier, self-insured employer, or third party administrator[, or Special Fund] by submitting [the request] a prior approval request (PAR: MTG Variance) (hereinafter "PAR") in the format prescribed by the chair for such purpose, which may be electronic.

(*b*) In addition, prior authorization for the following special services (PAR: Special Services) is required:

(*i*) Lumbar fusion as set forth in E.4 of the New York Mid and Low Back Injury Medical Treatment Guidelines;

(*ii*) Artificial disc replacement as set forth in E.5 of the New York Mid and Low Back Injury Medical Treatment Guidelines, and in E.3 of the New York Neck Injury Medical Treatment Guidelines;

(*iii*) Vertebroplasty as set forth in E.6.a.i. of the New York Mid and Low Back Injury Medical Treatment Guidelines;

(*iv*) Kyphoplasty as set forth in E.6.a.i. of the New York Mid and Low Back Injury Medical Treatment Guidelines;

(*v*) Electrical bone stimulation as set forth in the New York Mid and Low Back Injury Medical Treatment Guidelines and the New York Neck Injury Medical Treatment Guidelines;

(*vi*) Osteochondral autograft as set forth in D.1.f and Table 4 of the New York Knee Injury Medical Treatment Guidelines;

(*vii*) Autologous chondrocyte implantation as set forth in D.1.f., Table 5, and D.1.g. of the New York Knee Injury Medical Treatment Guidelines;

(*viii*) Meniscal allograft transplantation as set forth in D.6.f., Table 8, and D.7. of the New York Knee Injury Medical Treatment Guidelines;

(*ix*) Knee arthroplasty (total or partial knee joint replacement) as set forth in F.2. and Table 11 of the New York Knee Injury Medical Treatment Guidelines;

(*x*) Spinal Cord Pain Stimulators as set forth in G.1 of the Non-Acute Pain Medical Treatment Guidelines; and,

(*xi*) Intrathecal Drug Delivery (Pain Pumps) as set forth in G.2 of the Non-Acute Pain Medical Treatment Guidelines.

(*c*) Notwithstanding that a surgical procedure is consistent with the guidelines, a second or subsequent performance of such surgical procedure shall require a variance if it is repeated because of the failure or incomplete success of the same surgical procedure performed earlier, and if the Medical Treatment Guidelines do not specifically address multiple procedures.

(*d*) This section shall not apply to prior authorization requests from the formulary, as set forth in Part 441 of this chapter, or the durable medical equipment fee schedule, as set forth in Part 442 of this chapter.

(ii) A [variance] PAR must be requested and granted by the carrier, self-insured employer, or third-party administrator[Special Fund], the Board or order of the Chair before medical care that varies from the Medical Treatment Guidelines or special service is provided to the claimant and [a request for a variance will not be considered if the medical care has already been provided] the carrier, self-insured employer, or third-party administrator may deny the PAR and deny payment of the treatment requested if the treatment is rendered prior to the PAR being granted by the carrier, self-insured employer, third-party administrator, the Board or order of the Chair.

(iii) For the purposes of this section, a treating medical provider shall not include a physician assistant, acupuncturist, physical therapist, or occupational therapist, as defined in section 13-b.

(2) The burden of proof to establish that a variance is appropriate for the claimant and medically necessary shall rest on the Treating Medical Provider [requesting the variance] submitting the PAR.

(3) The Treating Medical Provider requesting a variance shall submit the [request] PAR in the format prescribed by the Chair which may be electronic [to the insurance carrier or Special Fund,

Board, claimant, and the claimant's legal representative, if any, on the same day. A variance request must be submitted within two business days of the date it is prepared and signed. The Treating Medical Provider shall submit the variance request to the insurance carrier or Special Fund and Board by one of the prescribed methods of same day transmission if equipped to do so, otherwise the Treating Medical Provider may send the form by regular mail with a certification that the Treating Medical Provider is not equipped to send and receive the variance request by one of the prescribed methods of same day transmission and the date the variance request was sent to the insurance carrier or Special Fund and Board]. The Treating Medical Provider shall [either] submit at the same time as the PAR [variance request or reference on the variance request, if already in the claim file maintained by the Board,] the necessary medical documentation to support the [variance request] PAR. All questions on the [variance request] PAR prescribed by the Chair must be answered completely, clearly setting forth information that meets the following requirements:

(i) for all variance[s] and special services requests (PAR: MTG Variance and PAR: Special Services):

(*a*) a medical opinion by the Treating Medical Provider, including the basis for the opinion that the proposed medical care that varies from the Medical Treatment Guidelines or special service is appropriate for the claimant and medically necessary; and

(*b*) a statement that the claimant has been informed that the variance request will be submitted and that the claimant agrees to the proposed medical care; and

(*c*) an explanation of why alternatives under the Medical Treatment Guidelines are not appropriate or sufficient; and

(ii) for appropriate claims:

(*a*) a description of any signs or symptoms which have failed to improve with previous treatments provided in accordance with the Medical Treatment Guidelines; or

(*b*) if the [variance] PAR involves frequency or duration of a particular treatment, a description of the functional outcomes that, as of the date of the [variance request]PAR, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment.

(4) Treating Medical Providers may submit citations or copies of relevant literature published in recognized, peer-reviewed medical journals in support of a variance request.

(5) Maintenance Care

(i) No [variance]PAR is permitted from the maximum frequency and duration of ongoing maintenance care contained in New York [Mid and Low Back Injury] Medical Treatment Guidelines [Sections D.10(a)(ii) and D.11, New York Neck Injury Medical Treatment Guidelines Sections D.11(d)(ii) and D.12, New York Shoulder Injury Medical Treatment Guidelines Section E.12, New York Knee Injury Medical Treatment Guidelines Section E.9, and New York Carpal Tunnel Syndrome Medical Treatment Guidelines Section E.4.g].

(ii) The Treating Medical Provider may render or prescribe treatment in accordance with the ongoing maintenance care guidelines contained in, and if not contained in, then consistent with applicable New York [Mid and Low Back Injury] Medical Treatment Guidelines [Sections D.10(a)(ii) and D.11, New York Neck Injury Medical Treatment Guidelines Sections D.11(d)(ii)

and D.12, New York Shoulder Injury Medical Treatment Guidelines Section E.12, New York Knee Injury Medical Treatment Guidelines Section E.9, and New York Carpal Tunnel Syndrome Medical Treatment Guidelines Section E.4.g] when:

(*a*) the Board has made a legal determination that the claimant has a permanent disability; or

(*b*) a medical provider submits a medical opinion evidencing that the claimant has reached maximum medical improvement and has a permanent impairment, in the format prescribed by the Chair for such purpose, and the Board has not yet made a legal determination on maximum medical improvement or permanent disability.

(iii) The maintenance care shall consist of a maximum of ten visits in any twelve-month period when objectively documented in order to maintain functional status, without which a deterioration of function has been previously observed and documented in the medical record. No PAR varying from this maximum frequency is permitted.

(6) If a claim is controverted or the time to controvert the claim has not expired and the Treating Medical Provider needs to request a PAR[variance from the Medical Treatment Guidelines], he or she must [request such variance from]submit the PAR to the insurance carrier, self-insured employer, or third-party administrator [or Special Fund] who would become responsible in the event the claim is established by complying with paragraphs (1) through (4) of this subdivision.

(7) Resubmission of a PAR [variance request].

(i) If a [variance request]PAR for substantially similar treatment, procedure or test has been previously denied by the carrier, self-insured employer, or third-party administrator

[or Special Fund], the Treating Medical Provider shall submit the date of such denial and additional documentation or justification in support of a new [variance request]PAR. A [variance request]PAR that is substantially similar to any previous request may not be submitted until the carrier, self-insured employer, or third-party administrator [or Special Fund] has denied any previous [variance request]PAR.

(ii) In the event that a [variance request] PAR is submitted before a previous [variance] request for substantially similar treatment, procedure or test has been denied, the carrier, self-insured employer, or third-party administrator [or Special Fund] may submit the denial of the subsequent request without a [medical opinion by its medical professional,] Carrier's Physician's medical report, [a review of records,] or independent medical examination.

(iii) In the event that a [variance request] PAR, following denial of a request for substantially similar treatment, procedure or test, is submitted without additional documentation or justification beyond the prior [variance request] PAR, the carrier, self-insured employer, or third-party administrator [or Special Fund] may deny the [variance request] PAR by specifying that a prior [variance] request for substantially similar treatment, procedure or test has been denied, and the subsequent [variance] request does not contain any additional documentation or justification. Such denial may be submitted without a medical opinion by its [medical professional,] Carrier's Physician's medical report, [a review of records,] or independent medical examination.

(b) *Insurance carriers, self-insured employers, and third-party administrators [and Special Fund].*

(1) [Insurance carriers and Special Fund shall designate a qualified employee or employees in its office, if it handles its own claims, or a qualified employee or employees in the office of its representative licensed pursuant to Workers' Compensation Law Section 50 (3-b) or (3-d) as a point of contact for the Board and Treating Medical Providers regarding variance requests. Insurance carriers and Special Fund shall provide the Chair or his or her designee with the name and contact information for the point(s) of contact, including his, her, or their direct telephone number(s), facsimile number(s), and email address(es), within 30 days of the effective date of this paragraph. If the designated point(s) of contact changes at any time for any reason, the insurance carrier or Special Fund shall notify the Chair or his or her designee within 10 business days of the change. The list of designated points of contact for each insurance carrier and Special Fund shall be posted on the Board's website.] Insurance carriers, self-insured employers, or third-party administrators shall provide the Chair or his or her designee in the manner prescribed by the Chair with the name and contact information for the point(s) of contact for PAR review. Such contact information may include the contacts' direct telephone number(s) and email address(es).

(i) If the designated point(s) of contact changes at any time for any reason, the insurance carrier, self-insured employer, or third-party administrator shall notify the Chair or his or her designee of such change in the manner prescribed by the Chair.

(ii) The list of designated points of contact for each insurance carrier, self-insured employer, or third-party administrator shall be maintained by the Board electronically. When a treating medical provider submits a PAR electronically, it shall be directed to the appropriate contact person. Any change in the designated contact shall not be effective until the designated contact information has been updated in the Board's electronic records.

(iii) In the event that a carrier, self-insured employer, or third-party administrator fails to so provide the Chair or his or her designee with such name and contact information (in the manner prescribed), or provides incorrect or incomplete contact information during initial registration or when updating pursuant to paragraph (1) of this subdivision, such carrier may be subject to:

(*a)* Orders of the Chair granting any PAR submitted during such time when the name and contact information is missing, incomplete or incorrect; and

(*b)* Penalties issued pursuant to section 114-a (3) of the Workers' Compensation Law for every case, where a PAR was submitted.

(2) Review by insurance carrier, self-insured employer, or third-party administrator [, or Special Fund]. When an insurance carrier, self-insured employer, or third-party administrator denies or partially approves a PAR, the insurance carrier, self-insured employer, or third-party administrator must also assert any other basis for denial or such basis for denial will be deemed waived. Except as set forth in subdivision (b) below, all denials or partial approvals must be made by the Carrier's Physician. A partial approval limits the length of time or frequency of the treatment, or authorizes a related but different treatment than that requested in the PAR.

(i) Without IME or review of records.

(*a*) The insurance carrier, self-insured employer, or third party administrator[, or Special Fund] shall review the [variance request]PAR and respond to the [variance] request in the format prescribed by the chair within 15 calendar days of receipt, except as provided in subparagraph (ii) of this paragraph. Receipt is deemed to be the date submitted.

(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.

(*b*) In the following circumstances a PAR may be denied without an opinion by the Carrier's Physician or an IME or review of records.

(1) If the [request for a variance] PAR was submitted after the medical care was rendered, a medical opinion by the [insurance carrier, third party administrator, or Special Fund's medical professional,] Carrier's Physician, a review of records, or independent medical examination is not required and the insurance carrier, self-insured employer or third party administrator[, or Special Fund] may deny the [variance request] PAR on the basis that it was not requested before the medical care was provided.

[(*c*) The insurance carrier, third party administrator, or Special Fund may deny a request for a variance on the basis that the treating medical provider did not meet the burden of proof that a variance is appropriate for the claimant and medically necessary as set forth in subdivision (a) of this section without review by the insurance carrier, third party administrator, or Special Fund's medical professional, a review of records, or an independent medical examination. If the insurance carrier, third party administrator, or Special Fund also wishes to obtain a medical opinion, a review of records, or independent medical examination, it must also comply with the timeframes set forth in subparagraph (ii) of this paragraph.(*d*) When an insurance carrier, third party administrator, or Special Fund denies a variance request on the basis that the treating medical provider did not meet the burden of proof, the insurance carrier, third party administrator, or Special Fund

must also assert any other basis for denial or such basis for denial will be deemed waived.]

([*e]2*) The insurance carrier, self-insured employer, or third-party administrator [, or Special Fund] may deny a [request for a variance] PAR on the basis that:

([*1]i*) the treating medical provider seeks a [variance] PAR for a treatment, procedure or test that is substantially similar to a prior [variance] request from the treating medical provider that has not yet been denied by the carrier, self-insured employer or third party administrator[, or Special Fund]; or

([*2]ii*) that a prior substantially similar [variance] request has been denied, and the subsequent [variance] request does not contain any additional documentation or justification to the previous [variance] request. The carrier self-insured employer or third-party administrator [, or Special Fund] may deny the [variance request] PAR by specifying the basis for the denial. The carrier self-insured employer or third-party administrator [, or Special Fund] may submit the denial without a medical opinion by [its medical professional,] Carrier's Physician's [a review of records,] or independent medical examination.

(3) If a case is closed, disallowed or cancelled, where ongoing medical treatment is resolved by an agreement pursuant to section 32 of the Workers' Compensation Law, subject to an offset pursuant to an approved third-party settlement in accordance with section 29 of the Workers' Compensation Law, or controverted in accordance with section 300.22 (b)(1)(ii) or (c)(1) of this Chapter, or when a claimant fails to appear for a scheduled IME as set forth in (b)(ii)(2) herein, the insurance carrier, self-insured

employer or third-party administrator may deny a PAR without review by the Carrier's Physician, or an independent medical examination.

(i) Nothing herein shall prohibit a carrier from seeking review of a PAR by a Carrier's Physician or independent medical examiner.

(ii) When a PAR is denied without review by Carrier's Physician in accordance with subdivision (b) herein, there shall be no review by the Medical Director's Office. A claimant may request review by the Board by filing a Request for Further Action, that demonstrates that the basis for denial is factually inaccurate. The Board may respond to such requests for review by letter or by referral to adjudication, as appropriate in the discretion of the Chair or his or her designee.

([*f*]*c*) A denial or partial approval of the request for a variance for reasons other than those set forth in clause (a)[s (b), (c) and (e)] of this subparagraph, including a denial for failure of the medical provider to meet the burden of proof that the PAR was appropriate for the claimant and medically necessary, or an approval that concedes medical necessity but does not affirm that the approved medical care will be paid at the fee schedule rate, must be reviewed by the [insurance carrier, third party administrator, or Special Fund's medical professional] Carrier's Physician, if an independent medical examination or review of records is not conducted as set forth in [subparagraph (ii) of] this paragraph. A denial or partial approval issued by other than a Carrier's Physician is not valid and may be deemed approved by the Board. Invalid denials may be subject to penalties pursuant to sections 13-a(6)(a) and 114-a (3) of the Workers' Compensation Law.

(*d*) The carrier, self-insured employer or third-party administrator shall send the claimant notice of the approval, partial approval or denial of the PAR. Failure to send the claimant such notice

may result in penalties under section 25(3)(e), for failure to file a required report with the Board, and section 13-a (6)(a) of the Workers' Compensation Law

(ii) Review with IME or review of records.

(*a*) If the insurance carrier, self-insured employer, or third party administrator[, or Special Fund] wants an independent medical examination conducted of the claimant or a review of records in order to respond to the variance request, it shall provide notification [notify the chair and the treating medical provider] of this decision in the format prescribed by the Chair which may be electronic within five business days of receipt of the PAR [variance request by one of the prescribed methods of same day transmission]. A final response to the [variance request] PAR shall be submitted in the format prescribed by the Chair which may be electronic [in the same manner as the notice in the preceding sentence] within 30 calendar days of receipt of the request. [Receipt is deemed to be the date sent.]

(*b*) If the claimant fails to appear without reasonable cause for an independent medical examination scheduled by the insurance carrier, self-insured employer or third-party administrator [, or Special Fund] in order to respond to a [request for a variance] PAR, the request for a variance shall be denied. The insurance carrier, self-insured employer or third-party administrator [, or Special Fund] shall submit the response to the [variance request] PAR within 30 calendar days of receipt of the request. Receipt is determined as provided in clause (a) of this subparagraph. If the claimant requests review of the denial of the [variance request] PAR based on his or her failure to appear, such request for review shall be reviewed by the Board in the manner prescribed by the Chair. Such

request for review of the denial of the [variance]PAR shall be submitted in the manner prescribed by the Chair within 21 business days of receipt of the insurance carrier, self-insured employer or third-party administrator [, or Special Fund]'s denial by the claimant. If the claimant requests review of the denial of the [variance request]PAR and it is determined that the failure to appear was for reasonable grounds, the insurance carrier, self-insured employer or third party administrator[, or Special Fund] will have 30 calendar days from the date of the filing of the decision to obtain an independent medical examination or 15 calendar days if proceeding in accordance with paragraph (i) herein, and provide a further response to the [request for a variance}PAR.

(3) Insurance carrier, Self-insured employer or Third-party administrator [, or Special Fund] response to [variance request] PAR.

(i) The [variance]PAR response shall be in the format prescribed by the Chair and shall clearly state whether the [variance]PAR has been granted, denied, granted with respect to medical necessity but liability for payment is withheld, or partially granted. If a [variance request] PAR has been partially granted, the [variance] response shall specify the medical treatment, procedure or test that has been granted.

(ii) [The variance response shall be submitted by one of the prescribed methods of same day transmission to the treating medical provider who requested the variance, the Board, claimant, claimant's legal representative, if any, or any other parties.

(iii)] If the insurance carrier, self-insured employer or third party administrator[, or Special Fund] denies a [variance request]PAR, it shall state the basis for the denial in detail and, if for reasons other than those set forth in clause (2)(i)(b) or (c) or (2)(ii)(b) of

this subdivision, submit with its response the written report of the Carrier's Physician [insurance carrier, third party administrator, or Special Fund's medical professional] that reviewed the [variance request or the review of records, if it has not already been submitted to the board and to all other parties] PAR. When the denial is based on an independent medical examination, t[T]he denial shall identify the independent medical examination report or review of records report, if already submitted to the Board, by the document identification number in the electronic case folder and date received by the Board. The insurance carrier, self-insured employer or third-party administrator [, or Special Fund] may submit citations or copies of relevant literature published in recognized, peer-reviewed medical journals in support of a denial of a [variance request] PAR. If the insurance carrier, self-insured employer or third-party administrator concedes the medical necessity of the medical care, it may grant without liability, only if the case has been controverted in accordance with section 300.22 (b)(1)(ii) or (c)(1) of this Chapter, or the medical care is for a body part or condition that has not been accepted by the insurance carrier, self-insured employer or third-party administrator or established by the Board.

iii. When a PAR is denied without review by Carrier's Physician in accordance with subdivision (b) herein, there shall be no review by the Medical Director's Office. A claimant may request review by the Board by filing a Request for Further Action, that demonstrates that the basis for denial is factually inaccurate. The Board may respond to such requests for review by letter or by referral to adjudication, as appropriate in the discretion of the Chair or his or her designee.

(4) If a claim is controverted or the time to controvert the claim has not expired, and the insurance carrier, self-insured employer, or third party administrator[, or Special Fund] grants or partially grants a [variance request]PAR, such grant is limited to the question of appropriateness for the claimant and medical necessity, and it shall not be construed as an admission that the condition for which the [variance]PAR is requested is compensable and the insurance carrier, self-insured employer or third party administrator[, or Special Fund] is not liable for the cost of such treatment unless the claim or condition is established.

(5) Unless the insurance carrier, self-insured employer, or third-party administrator has properly denied or granted as to medical necessity but withheld liability for the claim, the carrier may not thereafter object to payment for such medical care at the fee schedule rate and any such objections will be rejected by the Board and applicable penalties imposed [Prior to submitting the response, the insurance carrier or Special Fund may initially respond orally to the Treating Medical Provider about the variance requested by such provider].

(c) *Request for review of denial of [variance] a PAR.* Upon receipt of the denial of [the] a PAR [variance request, the claimant or claimant's legal representative, if any, shall consult with] by Carrier's Physician or by an Independent Medical Examination, the treating medical provider [who requested the variance to determine if such variance is still appropriate and medically necessary. If the treating medical provider still believes it is appropriate and medically necessary, the claimant or claimant's legal representative, if any,] may request review of the denial [of the variance] by the Medical Director's Office as set forth in subdivision (d) herein. A request for review of the denial of the [variance]PAR shall be submitted within [21 business] 10 calendar

days of [receipt of] the insurance carrier, self-insured employer or third-party administrator [, or special fund]'s denial [by the claimant. Receipt is deemed to be the date sent, if sent by one of the prescribed methods of same day transmission, or, if sent by regular mail, five business days after the date the insurance carrier, third party administrator, or Special Fund certified that the variance response was sent to the claimant or the claimant's legal representative, if any]. The request shall be made in the format prescribed by the Chair and provide all information requested [, unless the claimant is unrepresented]. When a denial is not based on a claimant's failure to appear for an independent medical examination pursuant to subparagraph [(b)(2)(ii)](2)(ii)(b) of this section and the [claimant] treating medical provider seeks review of such denial, [a represented claimant or such claimant's legal representative shall notify the chair if he or she requests resolution by adjudication, including an expedited hearing if necessary, and in accordance with paragraph (d)(3) of this section simultaneous with requesting review of the insurance carrier, third party administrator, or Special Fund's denial of the request for a variance. If a represented claimant or such claimant's legal representative does not notify the Chair of his or her request for resolution by adjudication, including an expedited hearing, the] the treating medical provider may request [for] review of the PAR denial [of the variance request will be resolved] through the [medical arbitration] process set forth in paragraph (d)[(2)] of this section. If the request is not received by the Board within [21 business] 10 calendar days of receipt of the denial, the denial of the [request for the variance] PAR will be deemed final. [If the claimant or claimant's legal representative, if any, is informed or knows that the treating medical provider is trying to informally resolve the denial of the variance request in accordance with subdivision (d) of this section, the claimant or claimant's legal representative shall not request review of the denial until advised that attempts at informal resolution have been unsuccessful or the informal

resolution period has expired. If the claimant or claimant's legal representative submits a timely request for review of the denial of the variance, such request will be resolved in accordance with paragraph (d)(2) or (3) of this section.] A claimant may request review of a denial of a PAR by an independent medical examination in accordance with paragraph (d)(3) herein.

(d) *Process for requesting review of denial of [variance]PARs except denials based on the claimant's failure to appear for an IME.*

1. All requests for review of denials or partial approvals of a PAR by a Carrier's Physician shall be submitted to the Medical Director's Office in the format prescribed by the Chair.
2. When a denial is based on a reason set forth in (b)(2)(i)(*b*), in addition to a Carrier's Physician review, the request for review shall be submitted to the Medical Director's Office.
3. When a denial or partial approval is based upon an independent medical examination, the medical provider may request review by the Medical Director's Office unless a request for further action through adjudication is filed by the claimant. In the event a decision is rendered by the Medical Director's Office, the claimant retains the rights set forth in subparagraph (7) herein.
4. The Chair or Medical Director may designate private entities to evaluate such requests for review of denials by the carrier's physician provided that the entity has:

    i. the appropriate URAC accreditation or such accreditation/certification as designated by the Chair,

    ii. other demonstrated expertise and criteria established by the Board; and

iii. no conflict of interest exists in resolving the subject dispute.

5. When a medical provider wishes to request review of a denial or partial approval of a PAR, the medical provider shall submit the request to the Medical Director's Office in the format prescribed by the Chair within 10 calendar days of the denial date together with all documentation submitted in support of its initial request, and the denial or partial approval issued following request.
6. A decision by the Medical Director's Office (or designated accredited entity) is final and binding on the medical provider, and upon the carrier for issues related to medical necessity. Such decision shall be binding and not appealable under Workers' Compensation Law section 23.
7. Notwithstanding paragraph (5) and (6) herein, a claimant may request review of a Medical Director's Office decision or a denial by Carrier's Physician by filing a Request for Further Action that demonstrates that such treatment is medically necessary. A Request for Further Action following denial by a Carrier's Physician shall render a request for review by the Medical Provider to the Medical Director's Office moot. Decision on the denial will be made in Adjudication. The Board may respond to such requests for review by letter or by referral to adjudication, including the expedited hearing process, as appropriate in the discretion of the Chair or his or her designee.

[(1) Informal resolution.

(i) If the insurance carrier, third party administrator, or Special Fund denies the variance request in accordance with subdivision (b) of this section, the treating medical provider who requested the variance may elect to try to resolve the dispute by discussing the variance request directly

with the insurance carrier, third party administrator, or Special Fund's medical professional prior to the resolution of the dispute through the medical arbitrator process set forth in paragraph (2) of this subdivision or the expedited hearing process set forth in paragraph (3) of this subdivision.

(ii) If the dispute is resolved, the insurance carrier, third party administrator, or Special Fund confirms the resolution by submitting notice of resolution in the format prescribed by the Chair for this purpose reflecting the resolution to the treating medical provider, Board, claimant, claimant's legal representative, if any, and to any other parties, by one of the prescribed methods of same day transmission or, if one of the recipients is not equipped to receive the notice of resolution through one of the prescribed methods, by regular mail to such recipient.

(iii) The parties shall make every effort to resolve the dispute, however, if the discussion fails to resolve the dispute the treating medical provider shall notify the claimant and the claimant's legal representative, if any, that the dispute was not resolved so that the claimant or claimant's legal representative, if any, may request review of the denial of the request for a variance and have the dispute resolved through the medical arbitrator process set forth in paragraph (2) of this subdivision or expedited hearing process set forth in paragraph (3) of this subdivision.

(2) Medical arbitrator process.

(i) If the claimant or claimant's legal representative requests review of the denial of a variance, the Chair shall order the claim into the medical arbitrator process, when:

(*a*) the treating medical provider and insurance carrier, third party administrator, or Special Fund have attempted and failed to resolve the denial of the variance informally; and

(*b*) the claimant or insurance carrier, third party administrator or Special Fund has not requested that the issue be decided by expedited hearing as provided in paragraph (3) of this subdivision.

(ii) The request for review, variance request, and denial will be reviewed by the medical arbitrator. Such review will not commence if the treating medical provider and insurance carrier, third party administrator, or Special Fund resolve the denial of the variance informally and the insurance carrier, third party administrator, or Special Fund confirms the resolution by submitting the notice of resolution in the format prescribed by the Chair for this purpose as provided in subparagraph (1)(ii) of this subdivision. The medical arbitrator shall rule on the request for review of the denial of the variance and issue a notice of resolution setting forth the ruling and the basis for such ruling. If the basis for the insurance carrier, third party administrator, or Special Fund's denial of the variance request was that the treating medical provider failed to meet the burden of proof that the variance was appropriate for the claimant and medically necessary, and the medical arbitrator rules that the treating medical provider did meet his or her burden of proof, the medical arbitrator shall then immediately rule on whether the variance request is approved or denied. The notice of resolution issued by the medical arbitrator is binding and not appealable under Workers' Compensation Law section 23.

(3) Expedited hearing process.

(i) Upon request of a party, the case may be referred to adjudication, and if necessary, set for an expedited hearing for review of the denial. A request for referral to adjudication, and if necessary, set for an expedited hearing is applicable only to the specific variance denial under review. Subsequent requests for review of a variance denial shall be referred to the medical arbitrator process unless a party requests referral for an expedited hearing.

(ii) Claims referred to the expedited hearing process to resolve the request for review of the denial of a variance may be heard by a Workers' Compensation Law judge designated to hear such issues. Notice of the expedited hearing shall provide that the parties may take the testimony

of the claimant's treating medical provider and the insurance carrier, third party administrator, or Special Fund's medical professional, independent medical examiner, or records reviewer who wrote the written report upon which the denial of the variance request was based at or prior to the hearing, unless the denial was solely based on the failure of the treating medical provider to meet his or her burden of proof as provided in clause (b)(2)(i)(c) of this section. If the medical professionals are deposed, transcripts shall be provided to the board on or before the hearing and within 30 days of the request for the expedited hearing. If the claimant is unrepresented the testimony of claimant's attending physician and the independent medical examiner shall be taken at a hearing. For good cause shown, the Workers' Compensation Law Judge may grant an adjournment if one or both of the medical professionals cannot be deposed and transcripts filed with the board at or prior to the hearing, or if one or both of the medical professionals cannot appear to testify at the expedited hearing. The Workers' Compensation Law Judge shall issue his or her decision on the request for review of the denial of the variance at the expedited hearing, including the reasons and evidence supporting the decision, and a notice of decision will be sent after the close of the hearing, unless the Workers' Compensation Law Judge determines on the record that there are complex medical issues, in which case he or she will reserve his or her decision and the written decision shall be issued shortly after the expedited hearing. The case shall not be continued for further development of the record except where there are complex medical issues of diagnosis, treatment or causation present and then it shall be continued for no more than 30 days.

(4) The claimant and the treating medical provider who requested the variance shall have the burden of proof that such variance is appropriate for the claimant and medically necessary.

(5) The Board shall consider relevant literature published in recognized, peer-reviewed medical journals cited by the treating medical provider or the insurance carrier, third party administrator, or Special Fund or both, and may consider relevant literature not previously cited, in determining whether a variance is medically necessary, including satisfaction of the relevant requirements in paragraph (a)(3) of this section.

(6)](8) If the insurance carrier, self-insured employer, or third party administrator[, or Special Fund]fails to respond to the [variance request] PAR, fails to timely deny the [variance request] PAR in accordance with subdivision (b) of this section, or, except if the basis for the denial is one of the reasons set forth in clause (b)(2)(i)(*b*) or (c) or subdivision ([e] a) of this section, fails to submit the written report, or identify the report in the electronic case folder, the variance may be deemed approved on the ground that such approval was unreasonably withheld and the Chair will issue an order stating that the request is approved and the carrier, self-insured employer or third-party administrator shall be subject to a penalty pursuant to section 25(3)(e) of the Workers' Compensation Law. Such order of the Chair is not appealable under Workers' Compensation Law section 23. When a substantially similar [variance] PAR has been submitted in violation of paragraph (a)(7) of this section, the failure of the carrier, self-insured employer or third party administrator[, or Special Fund] to timely deny such request shall not result in the [variance] PAR being deemed approved and the Chair is not required to issue an order stating that the request is approved.

([7] 9) When the Chair issues an order as provided in paragraph ([6]8) of this subdivision in a claim that is controverted or the time to controvert the claim has not expired, the insurance carrier, self-insured employer or third party administrator[, or Special Fund]shall not be responsible for the payment of such medical care until the question of compensability is resolved

and then only if that insurance carrier, , self-insured employer or third party administrator[, or Special Fund]is found liable for the claim.

Section 324.4 of Title 12 NYCRR is hereby amended to read as follows:

Section 324.4.[Optional prior approval] PARs confirming consistency with MTG or medical necessity when no MTG

(a) Every [I]insurance carrier[s], self-insured employer and third-party administrator [and Special Funds that participate in the optional prior approval process] shall designate a qualified employee or employees [in its office, if it handles its own claims, or a qualified employee or employees in the office of its representative licensed pursuant to Workers' Compensation Law Section 50 (3-b) and (3-d)]as a point of contact for the Board and Treating Medical Providers regarding PARs to confirm consistency with the Medical Treatment Guidelines or medical necessity. [Insurance carriers and Special Funds that participate in the optional prior approval process must notify and provide all requested information to the Chair or his or her designee and shall provide the Chair or his or her designee with the name and contact information for the point(s) of contact, including, his, her, or their direct telephone number(s), facsimile number(s), and email address(es), within 30 days of the effective date of this paragraph] Insurance carriers, self-insured employers and third-party administrators shall provide the Chair or his or her designee in the manner prescribed by the Chair with the name and contact information for the point(s) of contact for PARs to confirm consistency with the Medical Treatment Guidelines (PAR: MTG Confirmation) or review for medical necessity (PAR: Non-MTG $1,000 or Under).

Such contact information may include the contacts' direct telephone number(s) and email address(es).

1. If the designated point(s) of contact changes at any time for any reason, the insurance carrier, self-insured employer or third-party administrator shall notify the Chair or his or her designee of such change in the manner prescribed by the Chair.

2. The list of designated points of contact for each insurance carrier, self-insured employer and third-party administrator shall be maintained by the Board electronically. When a treating medical provider submits a PAR electronically, it shall be directed to the appropriate contact person. Any change in the designated contact shall not be effective until the designated contact information has been updated in the Board's electronic records.

3. In the event that an insurance carrier, self-insured employer or third-party administrator fails to so provide the Chair or his or her designee with such name and contact information (in the manner prescribed), or provides incorrect or incomplete contact information during initial registration or when updating pursuant to subparagraph (1) of this subdivision, such insurance carrier, self-insured employer or third-party administrator may be subject to:

i. Orders of the Chair granting any PAR submitted during such time when the name and contact information is missing, incomplete or incorrect; and

ii. Penalties issued pursuant to section 114-a (3) of the Workers' Compensation Law for every case, where a PAR was requested.

[An insurance carrier or Special Fund may opt-out of the optional prior approval process by notifying the Chair or his or her designee in writing before final authorization to write workers'

compensation insurance, before final authorization to be self-insured, or at least 60 days before the last day of participation. An insurance carrier or Special Fund that has opted-out of this process may opt in by providing notice to the Chair or his or her designee in writing 60 days prior to beginning participation].

(b) Submission by Medical provider

(1) The Treating Medical Provider has the option of [requesting prior approval from] submitting a PAR to the insurance carrier, self-insured employer or third-party administrator [or Special Fund] to confirm that the proposed medical care is consistent with the Medical Treatment Guidelines.

(2) If there is no applicable Medical Treatment Guideline and the cost of the requested treatment is less than $1000 in the aggregate, the Treating Medical Provider has the option of submitting a PAR to the insurance carrier, self-insured employer or third-party administrator for such causally related medically necessary treatment and care. To request [the optional prior approval] to confirm consistency with the Medical Treatment Guidelines (PAR: MTG Confirmation) or medical necessity (PAR: Non-MTG $1,000 or Under), the Treating Medical Provider shall submit the [optional prior approval] request [to the insurance carrier or Special Fund and Board] in the manner prescribed by the Board [by one of the prescribed methods of same day transmission]. The [optional prior approval request] PAR to confirm consistency with the Medical Treatment Guidelines or medical necessity request shall be in [a] the format prescribed by the Chair which may be electronic [for such purpose. In addition to submitting the optional prior approval request

in a format prescribed by the Chair, the Treating Medical Provider may also contact the insurance carrier or Special Fund by telephone].

(c) The insurance carrier, self-insured employer or third-party administrator [or Special Fund] has eight business days from submission of the [optional prior approval] PAR to confirm consistency with the Medical Treatment Guidelines or medical necessity, and to approve or deny the medical care. The carrier, self-insured employer or third-party administrator shall send the claimant notice of the approval, partial approval or denial of the PAR. Failure to send the claimant such notice may result in penalties under section 25(3)(e), for failure to file a required report with the Board, and section 13-a (6)(a) of the Workers' Compensation Law. In the event the PAR is submitted prior to creation of a workers' compensation case by the Board in accordance with 300.37(a) of this Chapter, the PAR will be promptly reviewed by the Board to identify the proper carrier, self-insured employer or third-party administrator. Upon such identification, the PAR will be directed by the Board to the proper carrier, self-insured employer, or third-party administrator, who shall have 15 calendar days (or 30 calendar days in the event of an IME) to approve, partially approve or deny the request.
In the event the PAR is submitted after creation of a workers' compensation case by the Board in accordance with 300.37(a) of this Chapter but prior to filing the mandatory first report of injury pursuant to

section 300.22(b) of this Chapter that identifies a third-party administrator responsible for handling the claim, the request may be directed to a third-party administrator that has been designated by the carrier or self-insured employer as handling all or a portion of its workers' compensation claims and identified by the Board as the third-party administrator where such requests will be directed. Such third-party administrator shall have 8 business days to approve, partially approve or deny the request. 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 or Notice of Resolution granting the requested treatment.

. Unless the PAR is made in a case that has been closed, disallowed or cancelled, where ongoing medical treatment is resolved by an agreement pursuant to section 32 of the Workers' Compensation Law, or controverted in accordance with section 300.22 (b)(1)(ii) or (c)(1) of this Chapter, [A]any [prior approval request]PAR must be reviewed by the insurance carrier, self-insured employer or third-party administrator[or Special Fund's medical professional] Carrier's Physician before it may be denied or partially approved. When an insurance carrier, self-insured employer, or third-party administrator denies or partially approves a PAR, the insurance carrier, self-insured employer, or third-party administrator must also assert any other basis for denial or such basis for denial will be deemed waived. Except as set forth in subparagraph (2) below, all denials or partial approvals must be made by the Carrier's Physician. A partial approval limits the length of time or frequency of the treatment, or authorizes a related but different treatment than that requested in the PAR.

(1) If the insurance carrier , self-insured employer or third-party administrator[or Special Fund] agrees that the medical care for which [optional] [prior approval]a PAR is requested is consistent with the Medical Treatment Guidelines or is medically necessary, it shall respond in the format prescribed by the Chair [using the prescribed format and submit the approval to the Treating Medical Provider and the Board by using one of the prescribed methods of same day transmission].

(2) The insurance carrier, self-insured employer or third-party administrator may deny a PAR without review by the Carrier's Physician when a case is closed, disallowed or cancelled, where ongoing medical treatment is resolved by an agreement pursuant to section 32 of the Workers' Compensation Law, or controverted in accordance with section 300.22 (b)(1)(ii) or (c)(1) of this Chapter.

(i) Nothing herein shall prohibit an insurance carrier, self-insured employer or third-party administrator from obtaining an opinion from an independent medical examiner.

(ii) When a PAR is denied without review by Carrier's Physician there shall be no review by the Medical Director's Office. A claimant may request review by the Board by filing a Request for Further Action, that demonstrates that the basis for denial is factually inaccurate. The Board may respond to such requests for review by letter or by referral to adjudication, as appropriate in the discretion of the Chair or his or her designee.

(3) A denial of the PAR for reasons other than those set forth in subparagraph (2) of this subdivision, or an approval that concedes medical necessity but does not affirm that the

approved medical care will be paid at the fee schedule rate, must be reviewed by the Carrier's Physician. A denial issued by other than a Carrier's Physician is not valid and may be deemed approved by the Board. Invalid denials may be subject to penalties pursuant to sections 13-a(6)(a) and 114-a(3) of the Workers' Compensation Law.

[If the insurance carrier or Special Fund denies that the medical care for which optional prior approval is requested is consistent with the Medical Treatment Guidelines, it shall respond using the prescribed format, stating the basis for its denial, and submit the denial to the Treating Medical Provider and the Board by using one of the prescribed methods of same day transmission].

(4) If the insurance carrier, self-insured employer or third-party administrator concedes the medical necessity of the medical care, it may grant without liability, only if the case has been controverted in accordance with section 300.22 (b)(1)(ii) or (c)(1) of this Chapter, or the medical care is for a body part or condition that has not been accepted by the insurance carrier, self-insured employer or third-party administrator or established by the Board.

(5) If the insurance carrier, self-insured employer or third-party administrator[or Special Fund] fails to respond to a PAR [request for optional prior approval] within eight business days, the medical care [is] may be deemed approved on the ground that approval was unreasonably withheld and the [medical arbitrator] Chair will issue an order stating that the request is approved. In addition, the carrier, self-insured employer or third-party administrator shall be subject to a penalty pursuant to section 25(3)(e) of the Workers' Compensation Law.

(d) If a claim is controverted or the time to controvert the claim has not expired, and the insurance carrier, self-insured employer or third-party administrator[or Special Fund] agrees that the medical care for which [optional prior approval]a PAR is requested is consistent with the Medical Treatment Guidelines or is medically necessary, such agreement shall not be construed as an admission that the condition for which the [optional prior approval]PAR is requested is compensable and the insurance carrier, self-insured employer or third-party administrator[or Special Fund]is not liable for the cost of such treatment unless the claim or condition is established.

(e) For requests made pursuant to (b)(1) herein, [I]if the insurance carrier, self-insured employer or third-party administrator[or Special Fund]denies that the medical care for which [optional prior approval] a PAR is requested is consistent with the Medical Treatment Guidelines, the Treating Medical Provider may elect to submit a PAR (PAR: MTG Variance) in accordance with section 324.3 of this Part or submit a request for[try to resolve the dispute by discussing the optional prior approval request directly with the insurance carrier or Special Fund's medical professional prior to commencing the] review [provided in subdivision (f) of this section].
[(1) If the dispute is resolved, the insurance carrier or Special Fund shall confirm the resolution in the format prescribed by the Chair and shall submit the resolution to the Treating Medical Provider and Board by using one of the prescribed methods of same day transmission.
(2) If the discussion fails to resolve the dispute, the Treating Medical Provider may request review of such denial by submitting the request for review in the format by using one of the

prescribed methods of same day transmission. The request for review of the denial of the optional prior approval will be reviewed in accordance with subdivision (f) of this Section.

(f) Whether or not the Treating Medical Provider attempts to informally resolve the denial of the optional prior approval with the insurance carrier or Special Fund as provided in paragraph (e)(1) of this section, he or she] The Treating Medical Provider may request review [by the medical arbitrator]of the denial of [optional prior approval] the PAR within 10[4] calendar days of the date of the denial by submission of the request in the format prescribed by the Chair which may be electronic[for such purpose]. [Upon the request of the Treating Medical Provider, the optional prior approval request and denial will be reviewed by a medical arbitrator.] The [medical arbitrator] Medical Director's Office shall rule on whether the medical care is consistent with the Medical Treatment Guidelines and issue a notice of resolution setting forth the ruling and the basis for such ruling [within eight business days of receipt of the request for review by the Board]. Such notice of resolution is binding and not appealable under Workers' Compensation Law Section 23. [This notice of resolution does not preclude, where applicable, a subsequent request for a variance as provided in section 324.3 of this Part.]

(f) For requests made pursuant to (b)(2) herein, if the insurance carrier , self-insured employer or third-party administrator denies that the medical care for which prior approval is requested is causally related or medically necessary, the Treating Medical Provider may submit a request for review in the format prescribed by the Chair. Upon the request of the Treating Medical Provider, the PAR and denial will be referred to conciliation for a determination as to whether the medical care is causally related and medically necessary. Conciliation shall issue a proposed conciliation decision setting forth the ruling and the basis for such ruling. The claimant and insurance carrier,

self-insured employer or third-party administrator may object to the proposed conciliation decision within thirty calendar days in accordance with part 312 of this Chapter. The Treating Medical Provider may not object to the proposed conciliation decision.

(g) An insurance carrier, self-insured employer or third-party administrator [or Special Fund shall] may not dispute a bill for medical care on the basis that it was not consistent with the Medical Treatment Guidelines or that it was not causally related or medically necessary, if it has approved a request for [optional] prior approval for such medical care or [the medical arbitrator has issued a notice of resolution approving the medical care] the Board has issued a decision approving the treatment or an Order of the Chair.

(h) An insurance carrier, self-insured employer, or third-party administrator may not object to or deny payment of a medical bill solely because the treating medical provider did not submit a PAR under this section prior to rendering treatment. Denial of a medical bill solely for this reason may result in a penalty pursuant to sections 13-a(6) and 114-a(3). [When the medical arbitrator issues a resolution as provided in paragraph (b)(3) and subdivision (e) of this section in a claim that has been controverted or the time to controvert the claim has not expired, the insurance carrier or Special Fund shall not be responsible for the payment of such services until the question of compensability is resolved and then only if the claim or condition is established.]

Section 325-1.4 of Title 12 NYCRR is hereby amended to read as follows:

Section 325-1.4. Authorization for special services

(a) Authorization for medical care in accepted or established claims.

(1) When it is necessary for the attending provider to provide or prescribe medical care or supplies [engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or occupational therapy or physical therapy or special diagnostic laboratory tests] costing more than $1,000, he or she must request and secure authorization from the [employer or]insurance carrier, self-insured employer or third-party administrator [or the Chair], by setting forth the medical necessity of the special services required in the electronic format prescribed by the Chair. Such requests are not required in an emergency or for pre-authorized procedures as set forth in subdivision (d) of this section and section 324.2(d) of this Title.

(2)

(i) This section also applies to hospitals, specialists, consultants and surgeons, who are actually engaged to perform such services.

(ii) For the services of a physician assistant, the supervising physician shall make the request for authorization for special services.

(3) The [attending] treating provider seeking authorization shall [file the form] inform the claimant of the request for prior authorization (PAR: Non-MTG Over $1,000) (hereinafter "PAR") and submit the PAR in the manner prescribed by the Chair, which may be electronic.[the same day serve a copy on the insurance carrier by one of the prescribed methods of same day transmission set forth in section 324.1(i) of this Title or by regular mail with confirmation of delivery. All questions on the form prescribed by the Chair for this purpose shall be answered completely, clearly setting forth the medical

necessity of the special services requested.] The treating provider [attending physician or self-employed physical or occupational therapist] shall not [request authorization] submit a PAR for the same special service multiple times without any change of the claimant's medical condition.

(4) [In order to process such requests expeditiously and within the time limits specified hereunder, the insurance carrier shall designate a qualified employee or employees in its office, and the self-insured employer shall designate a qualified employee or employees in its office or an authorized employee or employees of its licensed representative, to receive and act upon such requests.] Insurance carriers, self-insured employer or third-party administrators shall provide the Chair or his or her designee in the manner prescribed by the Chair with the name and contact information for the point(s) of contact for PAR review. Such contact information may include the contacts' direct telephone number(s) and email address(es).

i. If the designated point(s) of contact changes at any time for any reason, the insurance carrier, self-insured employer or third-party administrator shall notify the Chair or his or her designee of such change in the manner prescribed by the Chair.

ii. The list of designated points of contact for each insurance carrier, self-insured employer and third-party administrator shall be maintained by the Board electronically. When a treating medical provider submits a PAR electronically, it shall be directed to the appropriate contact person. Any change in the designated

contact shall not be effective until the designated contact information has been updated in the Board's electronic records.

iii. In the event that a carrier, self-insured employer or third-party administrator fails to provide the Chair or his or her designee with such name and contact information (in the manner prescribed), or provides incorrect or incomplete contact information during initial registration or when updating pursuant to subparagraph (1) of this subdivision, such carrier, self-insured employer or third-party administrator may be subject to:

(a) Orders of the Chair granting any PAR submitted during such time when the name and contact information is missing, incomplete or incorrect; and

(b) Penalties issued pursuant to section 114-a (3) of the Workers' Compensation Law for every case, where a PAR was requested.

(5) In response to [requests for authorization for treatment]a PAR related to an established or accepted body part or illness, the [self-insured employer or] insurance carrier, self-insured employer or third-party administrator may have the claimant examined within four business days if the claimant is hospitalized or 30 days if patient is not hospitalized, by an appropriate specialist who is authorized by the Chair, to conduct independent medical examinations of workers' compensation claimants. In the event the PAR is submitted prior to creation of a workers' compensation case by the Board in accordance with 300.37(a) of this

Chapter, the PAR will be promptly reviewed by the Board to identify the proper carrier, self-insured employer or third-party administrator. Upon such identification, the PAR will be directed by the Board to the proper carrier, self-insured employer, or third-party administrator, who shall have 15 calendar days (or 30 calendar days in the event of an IME) to approve, partially approve or deny the request. In the event the PAR is submitted after creation of a workers' compensation case by the Board in accordance with 300.37(a) of this Chapter but prior to filing the mandatory first report of injury pursuant to section 300.22(b) of this Chapter that identifies a third-party administrator responsible for handling the claim, the request may be directed to a third-party administrator that has been designated by the carrier or self-insured employer as handling all or a portion of its workers' compensation claims and identified by the Board as the third-party administrator where such requests will be directed. Such third-party administrator shall have 30 calendar days to approve, partially approve or deny the request. 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 or Notice of Resolution granting the requested treatment.

(i) If such specialist is not available or where the claimant resides outside of state, consultation may be rendered by a qualified provider who may conduct the independent

medical examination as provided in Workers' Compensation Law section 137 (3) (a) and section 300.2(b)(9) and (d)(7) of this Title.

(ii) When a case is closed, disallowed or cancelled, where ongoing medical treatment is resolved by an agreement pursuant to section 32 of the Workers' Compensation Law, the carrier, self-insured employer or third-party administrator may deny the prior authorization request within 15 days without an independent medical examination; however, nothing herein shall prohibit a carrier, self-insured employer or third-party administrator from obtaining an opinion from an independent medical examiner. When a PAR is denied without an IME, there shall be no review by the Medical Director's Office. A claimant may request review by the Board by filing a Request for Further Action, that demonstrates that the basis for denial is factually inaccurate. The Board may respond to such requests for review by letter or by referral to adjudication, as appropriate in the discretion of the Chair or his or her designee.

(6) The [self-insured employer or] insurance carrier, self-insured employer or third-party administrator shall respond to the PAR[authorization request orally and in writing by one of the prescribed methods of same day transmission as defined in section 324.1(h) of this Title or by regular mail with confirmation of delivery] in the format prescribed by the Chair within 30 days. **[The 30 day time period begins to run from the date the completed form prescribed by the Chair for this purpose was sent if sent by one of the prescribed methods of same day transmission or five days after it was sent if sent by regular mail with confirmation of delivery. The written response shall be on a copy of the form prescribed by the Chair completed by the attending physician seeking authorization and shall clearly state whether the authorization

request has been granted or denied.] If the [authorization]PAR has been denied, the insurance carrier, self-insured employer or third-party administrator shall submit with the written response a report offering a conflicting opinion from an independent medical examiner, a qualified medical professional as defined in section 300.2(b)(9) of this Title, or, if the report was made upon review of the records without a physical examination, a physician authorized to treat workers' compensation claimants. If the report offering a conflicting opinion is already contained in the Board file, the insurance carrier, self-insured employer or third-party administrator shall not submit the report but shall identify the report on the form prescribed by the Chair by providing the name of the independent medical examiner, qualified medical professional as defined in section 300.2(b)(9) of this Title, or physician authorized to treat workers' compensation claimants who gave the conflicting opinion, the date of the report, and the date it was received by the Board. Nothing herein shall relieve the carrier, self-insured employer or third-party administrator from complying with the provisions of section 300.23 of this Title. The carrier, self-insured employer or third-party administrator shall send the claimant notice of the approval, partial approval or denial of the PAR. Failure to send the claimant such notice may result in penalties under section 25(3)(e), for failure to file a required report with the Board, and section 13-a (6)(a) of the Workers' Compensation Law

(7) [The oral response to the authorization request shall be to the attending provider who requested the authorization. The written response to the authorization request shall be to the attending provider with a copy to the Board, claimant, claimant's legal counsel, if any, and to any other parties of interest. (8)] If such authorization or denial [has not been sent by one of the prescribed methods of transmission in section 324.1(h) of this Title] is not submitted to the

[attending] treating provider [with copies to the Board, the claimant's legal representative, if any, and to any other parties] within 30 calendar days, such request [shall] may be deemed authorized and the [employer or] insurance carrier, self-insured employer or third-party administrator shall be liable for payment for such special service. The Chair may issue an order stating that such request is deemed authorized or requiring the [employer or]carrier, self-insured employer or third-party administrator to provide written authorization, if such documentation is required by the claimant to secure necessary medical treatment and the carrier, self-insured employer or third-party administrator shall be subject to a penalty pursuant to section 25(3)(e) of the Workers' Compensation Law. Such order of the Chair is not appealable under Workers' Compensation Law section 23.

([9]8)

(i) Upon the timely receipt [by the Board of the form prescribed by the Chair denying] of a denial of [authorization of the special medical service] a PAR and a report offering a conflicting opinion from an independent medical examiner, a qualified medical professional as defined in section 300.2(b)(9) of this Title, or, if the report was made upon review of the records without a physical examination, a physician authorized to treat workers' compensation claimants, the Board shall order the claim into the Expedited Hearing Process wherein an expedited hearing shall be scheduled within 30 days. Notice of the expedited hearing shall provide that the parties may depose the claimant's [attending physician] treating provider and the independent medical examiner, qualified medical professional, or physician authorized to treat workers' compensation claimants who submitted the conflicting medical report at or prior to the hearing. If the physicians

are deposed, transcripts shall be provided to the Board on or before the hearing. If the claimant is unrepresented the testimony of claimant's [attending physician] treating provider and the independent medical examiner shall be taken at a hearing. For good cause shown, the Workers' Compensation Law Judge may grant an adjournment if one or both of the medical professionals cannot be deposed and transcripts prior to the Board at or prior to the hearing, or if one or both of the medical professionals cannot appear to testify at the expedited hearing. [If authorization is denied for one of the procedures listed in section 324.2(d)(2) of this Title, the Workers' Compensation Law Judge may require examination of the claimant or a review of the claimant's records and submission of a report of such examination or review by an impartial specialist pursuant to Workers' Compensation Law Section 13 (e) as additional evidence to consider in rendering a decision.] The Workers' Compensation Law Judge shall rule on the [authorization]PAR at the expedited hearing and file a subsequent decision, or shall issue a reserved decision on the issue within 15 days of the expedited hearing date. The case shall not be continued for further development of the record except where there are complex medical issues of diagnosis or causation present and then it shall be continued for no more than 30 days.

(ii) If the form prescribed by the Chair denying the [authorization]PAR is untimely or does not reference or have attached a conflicting medical report from an independent medical examiner, a qualified medical professional as defined in section 300.2(b)(9) of this Title, or, if the report was made upon review of the records without a physical examination, a physician authorized to treat workers' compensation claimants, the Chair will issue an order stating that such [request] PAR is deemed authorized. Such order of the Chair is not appealable under Workers' Compensation Law section 23.

([10]9) Pursuant to Workers' Compensation Law section 13-a (4)(b), claimants shall cooperate in an examination by the insurance carrier, self-insured employer or third-party administrator's independent medical examiner. If a claimant fails to attend an examination scheduled in accordance with Workers' Compensation Law section 137 and section 300.2 of this Title at a medical facility convenient to the claimant during the 30 day authorization time period, the insurance carrier, self-insured employer or third-party administrator may file the form prescribed by the Chair along with contemporaneous supporting evidence that claimant failed to attend a scheduled medical examination pursuant to the provisions of Workers' Compensation Law section 137. Upon receipt of the form prescribed by the Chair for this purpose and the contemporaneous supporting evidence of failure to attend the scheduled medical examination, the Board shall order the claim into the Expedited Hearing Process wherein an expedited hearing shall be scheduled within 30 days on the request for prior authorization and the claimant's failure to attend the independent medical examination.

(10[1]) Such authorization is not required in an emergency under the provisions of Workers' Compensation Law section 13-a (5).

(b) Authorization for medical care when the right to compensation is controverted or the body part or condition has not been established.

(1) When it is necessary for the [attending] treating provider to secure specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, x-ray examinations or special diagnostic laboratory tests costing more than $1,000, or when it is necessary for a physical or occupational therapist to continue physiotherapeutic or occupational therapy procedures prescribed by a[n attending] treating provider costing

more than $1,000, and the claim is controverted or the time to controvert the claim has not expired or the body part or condition has not been established, the [attending] treating provider shall [request and obtain authorization from]submit a PAR to the [employer or]insurance carrier, self-insured employer or third-party administrator who would become responsible in the event the claim is adjudicated compensable by following the procedures in subdivision (a) of this section. All such procedures are applicable to such requests.

(2) The authorization herein referred to, if granted by the [self-insured employer or] insurance carrier, self-insured employer or third-party administrator, is limited to the question only of medical necessity of the services requested, and such authorization shall not be construed as an admission that the condition for which these services are required is compensable.

(3) When the Chair issues an order, pursuant to paragraph (a)(7[8]) of this section in a controverted case, the carrier, self-insured employer or third-party administrator shall not be responsible for the payment of such services until the question of compensability is resolved and then only if the claim is established as compensable.

(c) Multiple special services. If a[n attending] treating provider provides medical treatment or special services to more than one body part or more than one medical treatment or special service to the same body part, such treatment or special services shall be considered separate and shall not require a [request for prior authorization]PAR pursuant to Workers' Compensation Law section 13-a (5) or this section if the medical treatments or special services individually costs less than $1,000. Notwithstanding the previous sentence, if the medical treatment or special services

are a series of related treatment or care, such as physical or occupational therapy, or part of a battery of related tests, such as electro-diagnostic tests, the aggregate amount of such treatment, care, or tests shall be considered as a single request and shall require a [request for prior authorization]PAR pursuant to Workers' Compensation Law section 13-a (5) or this section if the aggregate amount is more than $1,000.

[(d) Workers' Compensation Law section 13-a (5) authorizes the creation of a list of preauthorized procedures costing more than $1,000. Prior authorization pursuant to Workers' Compensation Law section 13-a (5) and this section is not required for procedures on the pre-authorized list set forth in section 324.2 (d)(1) of this Title. Prior authorization is required for the procedures excluded from that list as set forth in section 324.2 (d)(2) and (3) of this Title.]