

Section 442.2 of Title 12 NYCRR is hereby amended to read as follows:

§ 442.2 Fee schedule

- (a) (1) The maximum permissible charge for the purchase of durable medical equipment, medical/surgical supplies, and orthotic and prosthetic appliances shall be the fee payable for such equipment or supplies under the Official New York Workers' Compensation Durable Medical Equipment Fee Schedule, created February 19, 2020, prepared and published by the Board, which is hereby incorporated by reference. [under the New York State Medicaid program at the time such equipment and supplies are provided, except that the fee for bone growth stimulators (HCPCS codes E0747, E0748 and E0760) shall be paid in one payment and not split. For orthopedic footwear or if the New York State Medicaid program has not established a fee payable for the specific item, then the fee payable shall be the lesser of:

- a) The acquisition cost (i.e. the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations, mailing, shipping, handling, insurance costs or any sales tax) to the provider plus 50 percent; or
- b) The usual and customary price charged to the general public.]

(2) The maximum permissible monthly charge for the rental of durable medical equipment shall be the rental price listed in the Official New York Workers' Compensation Durable Medical Equipment Fee Schedule multiplied by the total number of months or weeks respectively for which the durable medical equipment is needed. In the event the total rental charge exceeds the purchase price, the maximum permissible charge for the durable medical equipment shall be the purchase price listed in the Official New York Workers' Compensation Durable Medical Equipment Fee Schedule, whether or not the claimant keeps the durable medical equipment or returns it when no longer needed.

(3) Within six months of the effective date of this section, all durable medical equipment and supplies shall be provided (a) by a New York State Medicaid Enrolled Supplier and (b) in accordance with the Ground Rules therefore as set forth in the Official New York Workers' Compensation Durable Medical Equipment Fee Schedule, except for durable medical equipment provided as part of medical treatment provided in conformity with the Ground Rules of the Official New York Workers' Compensation Medical Fee Schedule. A supplier's MMIS ID number must be submitted with every bill for durable medical equipment. The Official New York State Workers' Compensation Durable Medical Equipment Fee Schedule for durable medical equipment, medical/surgical supplies, and orthotic and prosthetic appliances incorporated by reference herein is available on the Board's website at wcb.ny.gov. [The maximum permissible monthly rental charge for such equipment, supplies and services provided on a rental basis shall not exceed the lower of the monthly rental charge to the general public or the price determined by the New York State Department of Health area office. The total accumulated monthly rental charges shall not exceed the fee amount allowed under the Medicaid fee schedule.]

- (b) (1) Prior authorization in accordance with section 442.4 must be obtained when indicated on the Official New York State Workers' Compensation Durable Medical Equipment Fee Schedule for any durable medical equipment prior to prescribing or supplying.
(2) When a medical provider recommends durable medical equipment that is not listed in the Official New York Workers' Compensation Durable Medical Equipment Fee Schedule, prior authorization, including a proposed purchase price or rental price for such equipment, must be obtained and provided within the prior authorization request prior to prescribing or supplying such durable medical equipment.
[The maximum permissible charge for the purchase of durable medical equipment, medical/surgical supplies, and orthotic and prosthetic appliances and the maximum permissible monthly rental charge for such equipment, supplies, and services provided on a rental basis as set forth in subdivisions (a) and (b) of this section are payment in full and there are no separate and/or additional payments for shipping, handling, and delivery.]
(d) Self-insured employers and insurance carriers, including their agents and designees, shall not direct a claimant to use a particular supplier of durable medical equipment, medical/surgical supplies, and orthotic and prosthetic appliances, except as part of a certified preferred provider organization in accordance with Workers' Compensation Law Article 10-A and Subpart 325-8 of this Title. Self-insured employers and insurance carriers, including their agents and designees, may recommend a supplier of durable medical equipment, medical/surgical supplies, and orthotic prosthetic appliances.
(e) [Notwithstanding any other provision to the contrary, the Chair may make other adjustments to the durable medical equipment fee schedule as he or she deems appropriate, upon a finding that the reimbursement provided for a particular piece of durable medical equipment, medical/surgical supply or other such item under the fee schedule is grossly inadequate to meet the suppliers' or pharmacies' costs, and following 30 days notice on its website and consideration of any comments provided in response to such notice. Requests for such adjustments to the fee schedule shall be submitted to the Bureau of Health Management, 100 Broadway, Menands, Albany, NY 12241. (f)]
[Hearing aids are not considered durable medical equipment for purposes of this fee schedule and the reimbursement is the provider's usual and customary price.
(g) The Medicaid provider manual and the policy guidance for durable medical equipment are not included as part of the durable medical equipment fee schedule used in workers' compensation cases except to the extent such documents contain the Medicaid durable medical equipment fee schedule.]

A new section 442.4 of Title 12 NYCRR is added as follows:

442.4 Prior Authorization Process for Durable Medical Equipment

- (a) When identified as requiring Prior Authorization in the Official New York State Durable Medical Equipment Fee Schedule incorporated by reference in section 442.2 herein, a medical provider must obtain Prior Authorization for the durable medical equipment.
1. For purposes of this section and section 442.5 herein, medical provider shall mean a physician, nurse practitioner, physician assistant, podiatrist, chiropractor, dentist, optometrist and audiologist.

2. The medical provider must obtain prior authorization before such durable medical equipment may be supplied to the claimant.
 3. In the event of a medical emergency, requiring immediate use of durable medical equipment following an accident or injury, exacerbation of an earlier accident or injury or unanticipated results following surgery:
 - i. Such durable medical equipment may be dispensed without prior authorization.
 - ii. The medical provider shall submit the bill for the durable medical equipment together with a description of the emergency and justification of the need for the durable medical equipment together with submission of the CMS-1500.
 - iii. The carrier, self-insured employer or third-party administrator may deny payment for the durable medical equipment on the basis of medical necessity.
 - iv. Inappropriate identification of a need for emergency durable medical equipment by a medical provider, or inappropriate denial by a carrier, self-insured employer or third-party administrator, may result in imposition of penalties by the Board.
- (b) When a durable medical equipment is not listed in the Official New York State Durable Medical Equipment Fee Schedule incorporated by reference in section 442.2 herein, a medical provider must obtain Prior Authorization for the durable medical equipment, including a purchase or rental price for such equipment. The medical provider must obtain prior authorization before such durable medical equipment may be supplied to the claimant.
 - (c) When the Chair identifies durable medical equipment by HCPCS code or purchase/rental price threshold as requiring prior authorization, such equipment shall require prior authorization before being supplied to the claimant.
 - (d) A medical provider may request prior authorization for any durable medical equipment listed on the Official New York State Durable Medical Equipment Fee Schedule. The carrier or self-insured employer may not object to payment for such durable medical equipment unless it has made a timely denial of the prior authorization request.
 - (e) When responsibility for payment is apportioned between more than one carrier or self-insured employer, the medical provider shall seek Prior Authorization from the primary carrier or self-insured employer on the claim (as identified by the Board). Approval by such carrier or self-insured employer shall be deemed approval by all responsible carriers or self-insured employers.
 - (f) Insurance carriers and self-insured employers 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 Prior Authorization review. Such contact information shall include the contacts' email address(es).
 1. If the designated point(s) of contact changes at any time for any reason, the insurance carrier or self-insured employer 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 and self-insured employer shall be maintained by the Board electronically. When a treating medical provider submits a Prior Authorization request electronically, he or she shall be directed to the appropriate contact person. Any change in the designated contact shall not be effective until the carrier, self-insured employer or third-party administrator has updated the designated contact information in the Board's electronic records.
 3. In the event that a carrier or self-insured employer fails to provide the Chair or his or her designee with such name and contact information (in the manner prescribed) within six months of the effective date of this Subpart, or provides incorrect or incomplete contact information during initial registration or when updating pursuant to subparagraph (1) of this subdivision, such carrier may be subject to:
 - i. Orders of the Chair approving Prior Authorizations 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 Prior Authorization was requested.
- (g) To initiate the Prior Authorization process, the medical provider shall submit a request for Prior Authorization to the insurance carrier, self-insured employer, or third-party administrator to the designated contact as described in subdivision (d) herein. Such request shall be submitted in the manner prescribed by the Chair.
1. The carrier, self-insured employer, or third-party administrator shall approve, partially approve or deny a Prior Authorization request within four calendar days of submission by a provider. The carrier, self-insured employer or third-party administrator shall send the claimant notice of the approval, partial approval or denial of the prior authorization request. 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
 - i. A partial approval means the carrier, self-insured employer or third-party administrator: (A) authorizes durable medical equipment with a different HCPCS code than was requested; or, (B) when a rental was requested, authorizes rental of the requested durable medical equipment for less than the requested duration; or (C) authorizes durable medical equipment not listed on the Official New York State Durable Medical Equipment Fee Schedule at a lesser purchase price than requested by the medical provider; or when the carrier approves rental of durable medical equipment instead of purchase of such equipment.
 - ii. A request for Prior Authorization that is not responded to within four calendar days (by an approval, denial or partial approval) may be approved upon issuance of an Order of the Chair 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. A carrier may not object to payment in accordance with section 325-1.25 of this Chapter for Durable Medical Equipment approved by an Order of the Chair and any such objection or non-payment may be subject to penalties pursuant to section 114-a (3) of the Workers' Compensation Law.

- iii. If the insurance carrier, self-insured employer or third-party administrator concedes the medical necessity of the medical care, it may approve the durable medical equipment prior authorization request 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 durable medical equipment 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.
- iv. In the event the prior authorization request is submitted prior to creation of a workers' compensation case by the Board in accordance with 300.37(a) of this Chapter, the prior authorization request will be promptly reviewed by the Board to identify the proper carrier, self-insured employer or third-party administrator. Upon such identification, the prior authorization request will be directed by the Board to the proper carrier, self-insured employer, or third-party administrator, who shall have 4 calendar days to approve, partially approve or deny the request. In the event the prior authorization request 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 4 calendar days to approve, partially approve or deny the request. In the event the prior authorization request 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.

v.

- 2. A partial approval or denial of a request for Prior Authorization must:
 - i. Be issued by the Carrier's Physician (defined in subdivision (g) of section 441.1 of this Subchapter) unless: (A) such request is for durable medical equipment that is the subject of an earlier prior authorization request that has been denied or has not yet been acted upon; (B) such request for durable medical equipment for a case that is closed, disallowed or cancelled, settled via section 32 of the Workers' Compensation Law, or controverted in accordance with section 300.22 (b)(1)(ii) or (c)(1) of this

Chapter. Such prior authorization requests for durable medical equipment may be denied without review by the Carrier's Physician;

- ii. Provide a specific reason for the denial or partial approval with reference to the specific Prior Authorization request made by the medical provider;
 - iii. When the partial approval reduces the durable medical equipment price requested by the medical provider, the partial approval must: (A) identify two sources of the adjusted price, including the address and phone number of the source, and the reason for such adjustment; and, (B) the durable medical equipment must be available at a supplier located within 15 miles of the claimant's place of residence or employment if the claimant resides in a rural area as that term is defined in section 440.2 of this chapter, or within five miles of the claimant's place of residence or employment if the claimant resides in a municipality which is an incorporated city or village having a population of 2,500 or more, or the durable medical equipment must be delivered to the claimant's residence; and (C) such durable medical equipment must be delivered or supplied completely assembled and useable without further fittings within 48 hours.
 - iv. Provide information regarding how to request review of the denial from the Board's Medical Director's Office.
3. 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 durable medical equipment at the fee schedule rate and any such objections will be rejected by the Board and applicable penalties imposed.
- (h) All communications regarding Prior Authorization, including communications pursuant to sections 442.4 and 442.5 of this Part, shall be by the means of electronic delivery the Chair has designated for this purpose.

442.5 Review by the Board of a Prior Authorization Denial.

- (a) If the Carrier's Physician issues a denial or a partial approval, the medical provider may seek review by the Board's Medical Director's Office. The medical provider may not seek review by the Board's Medical Director's Office unless the medical provider has received a denial or partial approval by the Carrier's Physician.
- (b) All requests for review of denials or partial approvals of a Prior Authorization request shall be submitted to the Medical Director's Office in the format prescribed by the Chair. The Chair or Medical Director may designate private entities to evaluate such requests for review of denials by a Carrier's Physician provided that the entity has:
 - 1. the appropriate URAC accreditation or such accreditation/certification as designated by the Chair,
 - 2. other demonstrated expertise and criteria established by the Board; and
 - 3. no conflict of interest exists in resolving the subject dispute.

- (c) When a prescribing medical provider wishes to request review of a denial or partial approval of a Prior Authorization request, 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 Prior Authorization request, and the denial or partial approval issued by the Carrier's Physician.
- (d) A decision by the Medical Director's Office (or designated accredited entity) is final and binding on the medical provider, the carrier, self-insured employer or third-party administrator. Such decision shall be binding and not appealable under Workers' Compensation Law section 23.
- (e) Notwithstanding paragraph (d) herein, a claimant may request review of a Medical Director's Office decision, by filing a Request for Further Action, that demonstrates that such durable medical equipment is medically necessary and denial of the Prior Authorization request adversely impacts the claimant's interests. 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. Such decisions shall be binding and not appealable under Workers' Compensation Law section 23.
- (f) In the event that a Prior Authorization request is denied on the merits, the medical provider may not submit a request for Prior Authorization for the same durable medical equipment unless he or she submits evidence that there has been a change in the claimant's medical condition that renders the denial of the request for Prior Authorization no longer applicable to the claimant's current medical condition.