Section 300.19 of Title 12 NYCRR is hereby amended to read as follows:

Interest on an award of compensation or death benefits shall, except where an award is affirmed on appeal, as provided for in section 24 of the Workers' Compensation Law, be computed from 30 days after the date of filing of the award made by the Board until the date of payment of the award. The following shall apply solely to interest for medical bills rendered to an insurance carrier or an employer (or its third-party administrator), and shall be in lieu of any other interest provided for in the Workers' Compensation Law and rules promulgated thereunder. Medical bills, as referred to herein, shall mean any bills for treatment by an authorized medical provider or other legally permitted provider of Medical Care (as that term is defined in section 325-1.25 of this Chapter) [physician, podiatrist, chiropractor or psychologist, but shall not include hospital bills].

(a) Where a medical bill which identifies the injured employee, his or her employer and date of injury, was timely rendered for payment to an insurance carrier or an employer (or its third-party administrator) who has not timely requested an impartial examination of the fairness of such bill or timely raised any other questions as to the employer's liability for the payment of such bill as provided in section 13-g, 13-k, 13-l or 13-m of the Workers' Compensation Law, and the bill has not been paid within 60 days after the bill was rendered to the insurance carrier or an employer (or its third-party administrator), interest shall be paid in addition to the amount of the bill, computed commencing 30 days from the date the bill was rendered to the insurance carrier or an employer (or its third-party administrator), to the date of payment.

(b) Where a medical bill, which identifies the injured employee, his or her employer and date of injury, was timely rendered for payment to the insurance carrier or an employer (or its third-party administrator) who timely requested an impartial examination of the fairness of such bill or timely raised questions as to the employer's liability for the payment of such an amount as provided in section 13-g, 13-k, 13-l or 13-m of the Workers' Compensation Law and a decision was rendered granting the full amount demanded in the bill [by the physician, podiatrist, chiropractor or psychologist], interest shall be computed commencing 30 days from the date the bill was rendered to the insurance carrier or an employer (or its third-party administrator), to the date of payment.

(c) Where a medical bill which identifies the injured employee, his or her employer and date of injury, was timely rendered to the insurance carrier or an employer (or its third-party administrator) who timely requested an impartial examination of the fairness of such bill or timely raised questions as to the employer's liability for such amount and the [physician, podiatrist, chiropractor or psychologist] authorized medical provider or other legally permitted provider of Medical Care (as that term is defined in section 325-1.25 of this Chapter) is granted only part of the amount demanded in the bill, interest computed commencing 30 days from the date the award, which resolved the bill [of the physician, podiatrist, chiropractor or psychologist], is filed, to the date of the payment, shall be paid in addition to the amount found due and owing.

(d) In the event a decision or award made by a Workers' Compensation Law Judge, establishing the liability of the employer or carrier (or a third-party administrator) for the payment of a medical bill in whole or in part, is reviewed by a panel of the Board, and such decision or award is affirmed, and it is determined that the amount of the bill is due and owing [to the physician, podiatrist, chiropractor or psychologist] in whole or in part, interest computed, commencing 30 days after the filing of such award made by the Workers' Compensation Law Judge who originally decided the claim to the date of payment, shall be paid in addition to the amount found due and owing.

(e) In the case where a Workers' Compensation Law Judge finds that the employer is not liable for the payment of the medical bill and the Board on review established that the employer is liable, and the bill rendered is resolved in whole or in part in favor of the [physician, podiatrist, chiropractor or psychologist] authorized medical provider or other legally permitted provider of Medical Care (as that term is defined in section 325-1.25 of this Chapter), interest computed, commencing 30 days from the date of the filing of the award, establishing the amount due [to the physician, podiatrist, chiropractor or psychologist], to the date of payment, shall be paid in addition to the amount found due and owing.

(f) In the event the Workers' Compensation Law Judge and the Board find that the employer is not liable for the payment of the medical bill and the case is appealed to the courts, which reverse the Board, and the bill [of the physician, podiatrist, chiropractor or psychologist] is resolved in whole or in part in favor of the [physician, podiatrist, chiropractor or psychologist] authorized medical provider or other legally permitted provider of Medical Care (as that term is defined in section 325-1.25 of this Chapter), interest computed, commencing 30 days from the date of the filing of the final award establishing the amount due [to the physician, podiatrist, chiropractor or psychologist], to the date of payment, shall be paid in addition to the amount due and owing.

(g) Whenever a medical bill, which identifies the injured employee, his or her employer and date of injury, was timely rendered to the insurance carrier or an employer (or its third-party administrator) during the time while a case is closed, adjourned for failure to prosecute, or unduly delayed by the claimant, interest computed, commencing 30 days from the date the award is filed establishing the liability of the employer or carrier (or a third-party administrator) and the amount of the bill [of the physician, podiatrist, chiropractor or psychologist] in whole or in part, to the date of payment, shall be paid in addition to the amount found due and owing.

(h) Where an [arbitration committee] arbitrator determined that an [physician, podiatrist, chiropractor or psychologist] authorized medical provider or other legally permitted provider of Medical Care (as that term is defined in section 325-1.25 of this Chapter) willfully exaggerated the amount of the bills submitted to arbitration or rendered excessive or unnecessary treatment to claimant, or rendered a bill without properly identifying the claimant and employer, interest shall not be paid.

(i) Where an [arbitration committee] arbitrator determines that an insurance carrier or an employer (or its third-party administrator) willfully failed to pay a reasonable portion of the medical bill being controverted, interest may be directed to be paid on that portion of the bill which should have been paid

by the employer or carrier (or a third-party administrator), computed commencing 30 days from the date the bill was rendered. Where an issue of proration of a bill is presented for arbitration, no interest shall be added unless the employer or its insurance carrier (or its third-party administrator) willfully failed to pay a reasonable portion of the medical bill at issue.

(j) In any circumstance, other than hereinabove described, when interest is due, it shall be paid [to a physician, podiatrist, chiropractor or psychologist] for medical bills timely rendered, computed commencing 30 days from the date an award, establishing the amount due [to the physician, podiatrist, chiropractor or psychologist] is filed.

(k) When paying a medical bill, the employer or insurance carrier (or its third-party administrator) shall separately identify any interest payment made pursuant to the provisions of this section.

(l) Interest referred to herein shall be simple interest computed at the rate of 1 1/2 percent for each 30-day period after the bill has become due and payable and in which the bill has not been paid. The interest shall become payable at the end of such 30-day period. Interest as herein provided shall be in lieu of any other interest provisions provided for in the Workers' Compensation Law and the rules promulgated thereunder.

(m) Wherever a bill is submitted by mail an additional five days from the date of mailing of said bill shall be allowed.

(n) [Interest shall be added for services rendered by a physician, podiatrist or chiropractor on or after January 1, 1980. Interest shall be added for services rendered by a psychologist on or after January 1, 1990.

(o) Notwithstanding the foregoing provisions of this section or any provisions of this Title to the contrary, any award made by the Chair, the Board or an arbitration committee appointed by the Chair to a physician, self-employed occupational or physical therapist, podiatrist, chiropractor or psychologist for the payment of medical bills for services rendered on or after October 1, 1994 shall include interest at the rate set forth in section 5004 of the Civil Practice Law and Rules but shall in any event not exceed 1-1/2 percent per month. Such interest shall be computed on the entire amount of the award from the 45th day after the bill was submitted to the insurance carrier or self-insured employer or from the 30th day after all other questions duly and timely raised in accordance with the provisions of the Workers' Compensation Law relating to the employer's liability for the payment of such amount shall have been finally determined adversely to the employer, whichever is later, until the date of payment of the award. For purposes of this subdivision, the date on which all other questions duly and timely raised in accordance with the provisions of the Workers' Compensation Law shall have been finally determined adversely to the employer shall mean:

(1) the date of filing a decision by a Workers' Compensation Law Judge establishing the employer's liability for the payment of a medical bill in whole or in part, if such decision is either not reviewed by a Board Panel or is affirmed by a Board Panel upon review; or

(2) the date of filing of a decision by the Board on review establishing the employer's liability for the payment of a medical bill, if the decision by the Workers' Compensation Law Judge did not establish the employer's liability for the payment of such bill; or

(3) the date of a decision by an appellate court establishing the employer's liability for the payment of a medical bill, if the decisions by the Workers' Compensation Law Judge and the Board did not establish the employer's liability for the payment of such bill.

(p)] The foregoing provisions relating to interest on medical bills shall not apply to the special fund for reopened cases until after a filing of liability for payment of compensation by such fund has been made in the case.

([q]o) The foregoing provisions in this rule shall be inapplicable to the Uninsured Employers' Fund until liability for payment of compensation by such fund has been established pursuant to section 26-a of the Workers' Compensation Law, and awards for such medical bills have been made by the Board and defaulted by the employer.

(p) Effective dates. This regulation shall be effective on January 1, 2020.

Section 325-1.24 of Title 12 NYCRR is hereby rescinded.

Section 325-1.25 of Title 12 NYCRR is hereby amended to read as follows:

Section 325-1.25. Payment of and objections to medical bills [for treatment or services performed on or after December 1, 2010]

Obligation and liability of employer or insurance carrier (or third-party administrator) to provide [m]Medical [c]Care.

(1) The employer or insurance carrier (or third-party administrator) is required to promptly provide the claimant with such [m]Medical [c]Care,[symptomatic, palliative, or maintenance treatment] for such period as the nature of the injury, illness, or occupational disease, or process of recovery may require. Medical Care means symptomatic, palliative, maintenance treatment, services, or supplies.

When the [m]Medical [c]Care is to or for a part of the body or condition covered by the Medical Treatment Guidelines as set forth in section 324.2 (a) of this Title, the employer or insurance carrier (or third-party administrator) is required to provide such [m]Medical [c]Care which is consistent with the Medical Treatment Guidelines or, if applicable, an approved variance from such guidelines.

(2) The employer or insurance carrier (or third-party administrator) is liable for the payment of medically necessary care, services, and supplies to the claimant when it has accepted the claim or the claim has been established as compensable by the Board. When the [m]Medical [c]Care is to or for a part of the body covered by the Medical Treatment Guidelines and the claim has been accepted or established as compensable, the employer or insurance carrier (or third-party administrator) shall be obligated to pay for all [m]Medical [c]Care, in the amount set forth in the applicable fee schedule, or in any other amount as agreed to by the Treating Medical Provider and payor, that is:

(i) within the criteria of the Medical Treatment Guidelines incorporated by reference pursuant to section 324.2(a) of this Title and is based on correct application of such guidelines;
(ii) within a proper variance from the Medical Treatment Guidelines in accordance with the requirements of section 324.3 (a) (2), or has been authorized pursuant to section 325-1.4 or Part 441of this Title;
(iii) agreed to by the employer or insurance carrier (or third-party administrator); or
(iv) as ordered by the Board pursuant to statute or regulation.

The employer or insurance carrier (or third-party administrator) shall not be obligated to pay for any [m]Medical [c]Care that is not within the criteria of the Medical Treatment Guidelines or is not based on correct application of the Medical Treatment Guidelines, except if a variance has been approved by the employer, insurance carrier (or third-party administrator), or Board in accordance with section 324.3 of this Title or as ordered by the Board pursuant to statute or regulation.

(b) Submission of bills for Medical Care [treatment or services performed on or after December 1, 2010].

(1) Physicians, podiatrists, chiropractors, [or] psychologists, nurse practitioners, physician assistants, licensed clinical social workers, physical therapists, occupational therapists and acupuncturists authorized by the Chair to provide treatment and care under the Workers' Compensation Law to a claimant or [self-employed occupational or physical therapists] other legally permitted providers of Medical Care shall submit bills for Medical Care [services performed on or after December 1, 2010, on the appropriate forms and version]in the format prescribed by the Chair (which may be electronic) and as set forth in section 325-1.3 of this Subpart. Bills shall be submitted to the employer or insurance carrier (or third-party administrator) [either] within [9]120 days from the [last day of the month in which services were rendered, or 90 days from the last day of the month in which the claimant received the final treatment in a continuous course of treatment] day the Medical Care was rendered. Bills submitted in any other format or outside this time requirement shall not be eligible for an award by the Chair under the provisions of the Workers' Compensation Law as described herein. When Medical Care was rendered prior to January 1, 2020, the bill for such care shall be submitted within 120 days from January 1, 2020 (April 30, 2020).

(2) Hospitals shall submit bills for out-patient hospital services [performed on or after December 1, 2010,] to the employer or insurance carrier (or third-party administrator) using the New York State Universal Data Set specification as described in 10 NYCRR section 400.18 and Appendices C-2 and C-3 and such additional specifications as are approved by the Commissioner of Health. Bills shall be submitted within 120 days from the last day of [the month in which the treatment was provided]

Medical Care. Bills submitted in any other format or outside this time requirement shall not be eligible for an award by the Chair under the provisions of the Workers' Compensation Law as described herein.

(3) Notwithstanding the foregoing, upon an application in writing to the Chair [from the physician, self-employed occupational or physical therapist, podiatrist, chiropractor, psychologist, or hospital], the Chair may for good cause shown excuse a delay in the submission of the bill to the insurance carrier or employer (or third-party administrator).

[(4) Provisions of this section shall apply to all bills for treatment or services performed on or after December 1, 2010, regardless of the date of accident or occupational disease.]

(c) Payment of bills for Medical Care [treatment or services performed on or after December 1, 2010].

(1) The employer or insurance carrier (or third-party administrator), within 45 days after the bill has been submitted shall pay the bill or shall notify the physician, [self-employed] occupational or physical therapist, podiatrist, chiropractor, psychologist, nurse practitioner, physician assistant, licensed clinical social worker, acupuncturist, [or] hospital, or other provider of Medical Care, and the Board [on a form] in the format prescribed by the Chair (which may be electronic) for such purpose that the bill is not being paid and the reasons for non-payment. If the employer or insurance carrier (or third-party administrator) objects to payment of all or part of the bill for reasons concerning its legal liability for payment, the legal objections shall be placed on the Chair prescribed form for such purpose and submitted to the physician, [self-employed] occupational or physical therapist, podiatrist, chiropractor, psychologist, nurse practitioner, physician assistant, licensed clinical social worker, acupuncturist, [or] hospital, or other provider of Medical Care, and the Board. If the employer or insurance carrier (or third-party administrator) objects to payment of all or part of the bill for reasons concerning the value of the treatment performed or the amount billed, the valuation objections shall be placed on the Chair prescribed form for that purpose and submitted to the physician, [self-employed] occupational or physical therapist, podiatrist, chiropractor, psychologist, nurse practitioner, physician assistant, licensed clinical social worker, acupuncturist, [or] hospital, or other provider of Medical Care, and the Board, except if the only objection is that the amount billed for the particular Current Procedural Terminology (CPT) code is in excess of the appropriate fee schedule for the region where the services were provided then the insurance carrier or employer (or third-party administrator) may file its explanation of benefits form. If the employer or insurance carrier (or third-party administrator) objects to payment of all or part of the bill for one or more of the Medical Treatment Guidelines objections set forth in paragraph (7) of this subdivision, the objections shall be placed [on the Chair prescribed form for such purpose] in the format prescribed by the Chair (which may be electronic), along with the basis for the objection, and submitted to the physician, [self-employed] occupational or physical therapist, podiatrist, chiropractor, or psychologist, nurse practitioner, physician assistant, licensed clinical social worker, acupuncturist, [or] hospital, or other provider of Medical Care, and the Board.

(2) If the employer or insurance carrier (or third-party administrator) objects to only a portion of the bill submitted, it shall pay the uncontested portion within 45 days and file objections to the remaining portion as indicated herein.

(3) If the employer or insurance carrier (or third-party administrator) has not objected in the manner described herein to the payment of the bill within 45 days of submission, it shall be liable for payment of the full amount billed up to the maximum amount established in applicable fee schedule. The Board

shall not review any objection made thereafter.

(4) Legal, valuation, and Medical Treatment Guidelines objections shall be made [on the appropriate Chair prescribed form or forms]in the format prescribed by the Chair (which may be electronic).

(5) Valuation objections as to the amount of the bill include, but are not limited to, contentions that the bill is excessive and not in accordance with the pertinent fee schedule; has not been properly pro-rated or apportioned between providers; involves concurrent, duplicative, or overlapping services; uses improper current procedural terminology codes; is not in accordance with the Ground Rules limitation in the appropriate official workers' compensation fee schedule; is rendered too frequently; involves unnecessary or excessive hospitalization; or involves a physician, [self-employed] occupational or physical therapist, podiatrist, chiropractor, [or] psychologist, nurse practitioner, physician assistant, licensed clinical social worker or acupuncturist treating outside the scope of practice.

(6) Legal objections as to the liability of the employer or insurance carrier (or third-party administrator) to pay include, but are not limited to, contentions that the claim has been controverted and liability has not been resolved; prior authorization for the special medical service was not granted; treatment was not causally related to the compensable injury; treatment provided was outside of the preferred provider organization; the medical report was not timely filed or was legally defective; the medical appliance, program, or provider is not authorized under the Workers' Compensation Law; or the bill is for evidentiary purposes and not for treatment. Pursuant to Workers' Compensation Law section 13(a), raising the issue of liability under Workers' Compensation Law section 25-a is not a valid legal objection to payment of a bill for treatment.

(7) The Medical Treatment Guidelines objections as to the liability of the employer or insurance carrier (or third-party administrator) to pay are:

(i) the treatment is not consistent with the Medical Treatment Guidelines and a variance was not requested or approved by the employer or insurance carrier (or third-party administrator), or the Board before the [m]Medical [c]Care was rendered;

(ii) the physician, [self-employed occupational or physical therapist,] podiatrist, chiropractor, psychologist, nurse practitioner, licensed clinical social worker, or hospital varied from the Medical Treatment Guidelines, the physician, podiatrist, chiropractor, [or] psychologist, nurse practitioner, licensed clinical social worker, [or] hospital, or other provider of Medical Care, requested and received approval for a variance from the employer or insurance carrier (or third-party administrator) or the Board before the [m]Medical [c]Care was rendered but provided [m]Medical [c]Care other than what was covered by the variance; or

(iii) the physician, [self-employed] occupational or physical therapist, podiatrist, chiropractor, psychologist, nurse practitioner, physician assistant, licensed clinical social worker, acupuncturist, [or] hospital or other legally permitted Medical Care provider misapplied the Medical Treatment Guidelines.

(d) Administrative award: a remedy for non-payment of bills when no timely valuation objections are raised.

(1) Chair authorized physicians, podiatrists, chiropractors, [or] psychologists, nurse practitioners, physician assistants, licensed clinical social workers, acupuncturists, [or self-employed] occupational or physical therapists, and other legally permitted providers of Medical Care, [who provide medical

care] or hospitals providing services to claimants who have timely submitted bills for payment to the insurance carrier or employer (or third-party administrator) and who have not been paid in full or in part or received notice in the [form] format prescribed by the Chair (which may be electronic) for the purpose of advising of a valuation reason for non-payment within the time prescribed above, may apply to the Chair [on] the prescribed [form] format (which may be electronic) for an administrative award pursuant to the provisions of Workers' Compensation Law sections 13-g (1), 13-k (6), 13-l (6) and 13-m (7). Such request shall be submitted no earlier than 45 days from the date of the submission of the bill or 30 days from the date of the Workers' Compensation Law Judge or conciliation decision, or if appeal, Board Panel decision establishing the insurance carrier's or employer's (or third-party administrator's) liability for the bill, and [no later than] within 120 days from the later of:

(i) the date of receipt of notification of nonpayment; or

(ii) the expiration of the time within which the insurance carrier or employer (or third-party administrator) is required to notify the physician, self-employed occupational or physical therapist, podiatrist, chiropractor, psychologist, or hospital of nonpayment [; or

(iii) the date of expiration of any continuous course of treatment of the claimant].

(2) Notwithstanding the foregoing, upon a written application of the physician, [self-employed] occupational or physical therapist, podiatrist, chiropractor, psychologist, nurse practitioners, physician assistants, licensed clinical social workers, acupuncturists, [or] hospital, or other provider of Medical Care, the Chair may for good cause shown excuse a delay in the submission of the request for an administrative award.

(3) (i)The Board will not accept any request for an administrative award until all issues duly and timely raised by the employer or insurance carrier (or third-party administrator) with respect to its legal liability for payment and/or any Medical Treatment Guidelines objections set forth in paragraph (c)(7) of this section have been finally determined adversely to it. (ii) A provider may only submit one request for an administrative award for each date of service. A request for administrative award that includes a date of service that was included on a previously submitted request for administrative award will be rejected.

(4) All requests for administrative awards shall be submitted to the Chair or his or her designee [on the form] in the format prescribed for such purpose and [contains] certifies the following information [affirmed under penalty of perjury]:

(i) the bill was timely submitted to the employer or insurance carrier (or third-party administrator) and the bill was not returned [by postal authorities];

(ii) the employer or insurance carrier (or third-party administrator) did not submit payment within 45 days after the bill was submitted or within 30 days after all questions duly and timely raised related to the employer or insurance carrier (or third-party administrator)'s liability therefore was finally determined adversely to it;

(iii) the employer or insurance carrier (or third-party administrator) did not [submit the Chair prescribed form raising] raise valuation issues in the format prescribed by the Chair objecting to [the] payment of the bill;

(iv) the bill conforms to the fee schedule, if any, promulgated by the Chair for treatment rendered; and

(v) the bill was submitted [on the appropriate forms and version] in the format prescribed by the Chair (which may be electronic) and as set forth in section 325-1.3 of this Subpart, or the form prescribed for outpatient hospital bills by the Commissioner of Health.

(5) The Board will reject incomplete requests for an administrative award. When information regarding a workers' compensation claim that is included on a request for administrative award does not match the information in the Board's electronic case system, the request may be rejected by the Board and the provider will be directed to review such information with his or her patient.

([5] 6) Upon receipt by the Chair or his or her designee of a completed request for an administrative award, the request shall be examined to determine if it is in compliance with the requirements of this section. If the request is not in compliance with the requirements of this section, the request will be rejected by the Board [shall be returned to the physician, self-employed occupational or physical therapist, podiatrist, chiropractor, psychologist, or hospital] with an explanation of why the request is being rejected[has been returned]. If the request is in full compliance with the requirement of this section, a notice of decision on the Chair prescribed form signed by the Chair or the Chair's designee will propose an administrative award for the [m]Medical [c]Care rendered not in excess of the fee schedule, if any, to the authorized physician, podiatrist, chiropractor, [or] psychologist, [self-employed] occupational or physical therapist, nurse practitioner, physician assistant, licensed clinical social worker, acupuncturist, [or] hospital or other provider of Medical Care. The Chair prescribed form for the notice of decision will be sent to all parties of interest, notifying them of the proposed administrative award and the proposed filing date. The proposed filing date shall be at least 30 days after the date of the proposed administrative award.

(6) Any party in interest may submit a written objection [on the form] in the format prescribed by the Chair (which may be electronic) to the proposed award on or before the proposed filing date. All documents or other evidence supporting the objection shall be submitted together with the written objection. If there is no written objection received prior to the proposed filing date, the proposed award will become final on the proposed filing date. If an objection is received from any party before the proposed filing date, the objection shall be reviewed by the Chair or the Chair's designee, who shall make a decision on the request for an award based upon the documents and other evidence submitted. Upon review, a determination on reconsideration shall be sent to all parties in interest.

(7) Interest on any administrative award made to a physician, self-employed occupational or physical therapist, podiatrist, chiropractor, [or] psychologist, nurse practitioner, physician assistant, licensed clinical social worker, acupuncturist, or other provider of Medical Care, [other than a hospital,] pursuant to this section shall be paid in accordance with the provisions of section 300.19[(o)] of this Title.

(e) Arbitration award: a remedy for non-payment of bills when timely valuation objections are raised.

(1) Chair authorized physicians, podiatrists, chiropractors, or psychologists, [self-employed] occupational or physical therapists [who provide medical care], nurse practitioners, physician assistants, licensed clinical social workers, acupuncturists, [or] hospitals or other legally permitted providers of Medical Care providing services to claimants who have timely submitted bills for payment to the employer or insurance carrier (or third-party administrator) in compliance with the provisions herein and have received [the Chair prescribed form] a response in the format prescribed by the Chair (which may be electronic) from the employer or insurance carrier (or third-party administrator) advising of a valuation reason for non-payment of the bill in full or in part within the time prescribed in this section, may apply to the Chair for arbitration [on] the format prescribed [form] if the parties cannot agree as to the value of the services rendered.

(2) Arbitration shall be requested solely at the option of the authorized physician, podiatrist, chiropractor, [or] psychologist, [or self-employed] occupational or physical therapist, nurse practitioner, physician assistant, licensed clinical social worker, acupuncturist, [or] hospital or other provider of Medical Care [and shall be conducted in accordance with the provisions of Parts 327, 328, 332, 342, 347, or Subpart 349-2 of this Title, as applicable].

(3) Notwithstanding the foregoing, upon a written application of the authorized physician, podiatrist, chiropractor, [or] psychologist, [or self-employed] occupational or physical therapist, nurse practitioner, physician assistant, licensed clinical social worker, acupuncturist, [or] hospital or other provider of Medical Care, the Chair may for good cause shown excuse a delay in the submission of the request for arbitration.

(4) The Chair will not accept any request for an arbitration award until all issues duly and timely raised by the employer or insurance carrier (or third-party administrator) with respect to its legal liability for payment and/or any Medical Treatment Guidelines objections set forth in paragraph (c)(7) of this section have been finally determined adversely to it.

(f) Adjudication decision: a resolution for non-payment of bills when legal objections and Medical Treatment Guidelines are raised.

(1) If the employer or insurance carrier (or third-party administrator) objects to payment of all or part of the bill for [m]Medical [c]Care rendered for reasons concerning its legal liability for payment and/or the Medical Treatment Guidelines as set forth in paragraph (c)(7) of this section and raises legal and/or Medical Treatment Guidelines objections [on the Chair prescribed form] in the format prescribed by the Chair (which may be electronic) for such purpose as indicated herein, the objection will be reviewed by the Board and a decision rendered on the issue of legal liability and/or the Medical Treatment Guidelines objections. The decision shall be filed with the parties including the authorized physician, podiatrist, chiropractor, [or] psychologist, [self-employed] occupational or physical therapist, nurse practitioner, physician assistant, licensed clinical social worker, acupuncturist, [or] hospital or other provider of Medical Care [that provided the service].

(2) If legal liability and/or Medical Treatment Guidelines objection for the service is found in favor of the physician, podiatrist, chiropractor, [or] psychologist, [self-employed] occupational or physical therapist, nurse practitioner, physician assistant, licensed clinical social worker, acupuncturist, [or] hospital or other provider of Medical Care, the employer, insurance carrier (or third-party administrator) shall pay the bill within 30 days from the filing of the Notice of Decision or may raise valuation issues as to all or part of the bill within 30 days [by filing the Chair prescribed form] in the format prescribed by the Chair (which may be electronic) for such purpose as indicated herein.

(3) If the employer or insurance carrier (or third-party administrator) files an application for review pursuant to Workers' Compensation Law section 23 from the Notice of Decision finding legal liability and/or Medical Treatment Guidelines objection in favor of the physician, podiatrist, chiropractor, [or] psychologist, [self-employed] occupational or physical therapist, nurse practitioner, physician assistant, licensed clinical social worker, acupuncturist, [or] hospital or other provider of Medical Care, the employer or insurance carrier (or third-party administrator) may withhold payment of the bills up to the amount in dispute until a Workers' Compensation Law Judge or conciliation decision, or if appealed, a Board Panel decision is rendered by the Board. If a Workers' Compensation Law Judge or conciliation decision, or if appealed, a Board Panel decision is filed finding legal liability and/or Medical Treatment Guidelines objection in favor of the physician, podiatrist, chiropractor, [or] psychologist, [self-employed] occupational or physical therapist, nurse practitioner, physician

assistant, licensed clinical social worker, acupuncturist, [or] hospital or other provider of Medical Care, the employer or insurance carrier (or third-party administrator) shall pay the bill within 30 days from the filing of the Workers' Compensation Law Judge or conciliation decision, or if appealed, Board Panel decision or may raise valuation issues as to all or part of the bill within 30 days by [filing the form] submitting such valuation issues in the format prescribed by the Chair (which may be electronic) for such purpose as indicated herein. A subsequent application to the Full Board, except for review by the Full Board of a Board Panel decision which one member dissented from, or to the Appellate Division of the Supreme Court, Third Department, or to the Court of Appeals on the issue of legal liability and/or Medical Treatment Guidelines objection shall not operate as a stay of the payment of the bills for medical or hospital services.

(g) Effective date. This regulation shall be effective on January 1, 2020.

Section 440.8 of Title 12 NYCRR is hereby amended to read as follows:

Section 440.8. Payment of bills [and reimbursement requests]

(a) Bills for prescribed medicine shall be paid in accordance with the fee schedule established by section 440.5 of this Part and section 325-1.25 of Part 325 of this Chapter. Objections to a bill for prescribed medicine shall be filed in accordance with section thirteen-g of the Workers' Compensation Law and section 325-1.25 of Part 325 of this Chapter. [Upon receipt of a bill or reimbursement request for prescription medicine, the self-insured employer or insurance carrier shall pay or reimburse the claimant, pharmacy, pharmacy benefit manager, pharmacy processing agent or third party within 45 days of receipt of the bill or reimbursement request in accordance with section 440.5 of this Part, unless:

(1) the liability of the self-insured employer or insurance carrier for the claim has not been established; or

(2) the prescribed medicine is not for a causally related condition; or

(3) the prescribed medicine was not prescribed consistent with the medical treatment guidelines set forth in section 342.2 (a) of Part 342 of this Title.

(b) Where the liability of the self-insured employer or insurance carrier for the claim has not been established, or the prescribed medicine is not for a causally related condition, or the prescribed medicine was not prescribed consistent with the medical treatment guidelines set forth in section 342.2 of this title, the self-insured employer or insurance carrier shall pay any undisputed amount of the bill or reimbursement request and notify the claimant, the claimant's representative, if any, as well as the pharmacy, or pharmacy benefit manager, pharmacy processing agent, or third party which submitted the bill or reimbursement request, as appropriate. A notice to the pharmacy, pharmacy benefits manager, pharmacy processing agent, or third party must be made for each claim; denial of multiple claims in a single notice are not in compliance with this Section. Such notice shall be made to all parties on the same day within 45 days of receipt of the claim or reimbursement request and shall state:

(1) that the claim is not being paid and the reason for non-payment of the claim; or

(2) that additional information is needed to reasonably determine the self-insured employer's or insurance carrier's liability for the claim, whether the medicine is causally related to the injury, or whether the prescribed medicine was prescribed in accordance with the medical treatment guidelines and to request

such information Upon receipt of the information reasonably requested by this paragraph, the self-insured employer or insurance carrier shall have 20 days to pay the bill or reimbursement request or provide a written explanation why the bill is not being paid, with copies of the additional information requested attached to the explanation to support the determination. The written explanation shall be sent by the self-insured employer or insurance carrier to the claimant, pharmacy, pharmacy benefit manager, pharmacy processing agent or third party that submitted the bill or reimbursement request, the claimant's legal representative, if any, and the Board on the same day.

(c) Where the self-insured employer or insurance carrier has failed to pay a bill or reimbursement request or make reasonable request for additional information within 45 days of receipt of the bill or reimbursement request, the self-insured employer or insurance carrier is deemed to have waived any objection to liability for the bill or reimbursement request and shall upon the expiration of such period pay the bill or reimbursement request to the claimant, pharmacy, pharmacy benefit manager, pharmacy processing agent, or third party that submitted it, in accordance with the fee schedule or written agreement with the pharmacy, pharmacies, pharmacy benefit manager or pharmacy processing agent.

(d) When a self-insured employer or insurance carrier, receives a bill or reimbursement request from a pharmacy, third party, pharmacy benefit manager or pharmacy processing agent that has not been designated by the self-insured employer or insurance carrier to dispense prescription medicines, it must notify such pharmacy and its billing agent, if any, third party, or pharmacy benefit manager by the method used to pay and receive bills and reimbursement requests, that the self-insured employer or carrier requires the claimant to obtain his or her prescription medicines from an independent pharmacy or pharmacy chain designated by, or affiliated with a pharmacy benefit manager designated by, such employer or carrier and the claimant was provided with the notification required by section 440.4 of this Part. Notwithstanding any provisions to the contrary in this Part, the self-insured employer or insurance carrier shall pay a bill or reimbursement request submitted by a pharmacy or third party at the fee schedule rate where the prescription was dispensed before the pharmacy and its billing agent, if any, or the third party that submits the bill or reimbursement request received notification that the self-insured employer or insurance carrier requires the claimant to use a designated independent pharmacy, pharmacy chain or pharmacy benefit manager. The pharmacy and its billing agent, if any, or the third party that submits the bill or reimbursement request is deemed to have received the notification required by this subdivision five business days after the date of the notice. The self-insured employer or insurance carrier is not obligated to pay any bill or reimbursement request for a prescription medicine dispensed after the date the pharmacy and its billing agent, if any, or the third party that submitted the bill or reimbursement request is deemed to have received the notification required by this subdivision. In the event the prescription was dispensed more than 90

days following such individual notification of the claimant for controlled substances and 60 days following individual notification of the claimant for non-controlled substances, the carrier or self-insured employer shall not be liable.

(e) Any medical provider authorized to treat injured workers under Workers' Compensation Law Section 13-b shall indicate, in clear and legible print, on any prescription given to any worker whom he or she reasonably believes to have injuries or illness that are covered by workers' compensation insurance, that the prescription is for a workers' compensation injury or illness.

(f) Prior to such time as a self-insured employer or insurance carrier has given notice to claimant that it will provide medication, or that it will not do so pursuant to subdivision (a) of this section, if such claimant:

(1) provides a pharmacy with direct payment for any medication, either at his or her own expense or via

a third party other than a self-insured employer or insurance carrier; and

(2) presents either a prescription containing the notification set forth under subdivision (e) of this section, pharmacy benefit card or other comparable document issued under this Part, or other proof that the medication is needed for an injury or illness for which he has filed, or has a colorable basis for filing a claim for workers' compensation, the pharmacy shall not charge the claimant more than the fee schedule set forth in section 440.5 of this Part for non-controverted claims.

(g) A pharmacy's persistent failure to comply with this Section shall be sufficient grounds for the Chair to remove that pharmacy from any designation under this Part, or to bar that pharmacy from being designated under this Part.]

(b) Effective date. This regulation shall be effective on January 1, 2020.

Section 442.3 of Title 12 NYCRR is hereby amended to read as follows:

Section 442.3. Payment of bills [and reimbursement requests]

(a) Bills for durable medical equipment, medical/surgical supply, or orthotic or prosthetic appliance shall be paid in accordance with the fee schedule established by section 442.2 of this Part and section 13-g of the Workers' Compensation Law. Objections to and resolution of billing disputes shall be in the format and according to the process prescribed by the Chair and as set forth in section 13-g of the Workers' Compensation Law and section 325-1.25 of Part 325 of this Chapter. [Upon receipt of a bill or reimbursement request for durable medical equipment, medical/surgical supplies, or orthotic or prosthetic appliances, the self-insured employer or insurance carrier shall:
    (1) pay or reimburse the claimant or supplier in accordance with the fee schedule established by section 442.2 of this Part; and
    (2) pay or reimburse the claimant or supplier within 35 days of receipt of the bill or reimbursement request unless:
        (i) the liability of the self-insured employer or carrier for the claim has not been established; or
        (ii) the durable medical equipment, medical/surgical supply, or orthotic or prosthetic appliance is not for a causally related condition.

(b) Where the liability of the self-insured employer or insurance carrier has not been established, or the durable medical equipment, medical/surgical supply, or orthotic or prosthetic appliance is not for a causally related condition, the self-insured employer or insurance carrier shall pay any undisputed amount of the bill or reimbursement request and notify the claimant or supplier, as appropriate, in writing within 45 days of receipt of the claim or reimbursement request:
    (1) that the claim is not being paid and the reason for non-payment of the claim on the form prescribed by the Chair for such purpose and file a copy of the notice sent to the claimant or supplier with the Board and send a copy to the claimant, if the claimant did not submit the bill or reimbursement request for payment, and the claimant's legal representative, if any, on the same day; or
    (2) that additional information is needed to reasonably determine the self-insured employer's or insurance carrier's liability for the claim or whether the durable medical equipment, medical/surgical supply, or orthotic or prosthetic appliance is causally related to the injury. The request for additional information shall be filed with the Board and if the claimant submitted the bill or reimbursement request a copy shall be sent to the claimant's legal representative, if any, on the same day. Upon receipt of the information reasonably requested by this paragraph, the self-insured employer or

insurance carrier shall have 20 days to pay the bill or reimbursement request or provide a written explanation why the bill is not being paid, on the form prescribed by the Chair for such purpose, with copies of the additional information requested attached to the explanation to support the determination. The written explanation shall be sent to the claimant or supplier that submitted the bill or reimbursement request, the claimant if the claimant did not submit the bill or request, the claimant's legal representative, if any, and the Board on the same day.

(c) Where the self-insured employer or insurance carrier has failed to pay a bill or reimbursement request or make reasonable request for additional information within 45 days of receipt of the bill or reimbursement request, the self-insured employer or insurance carrier is deemed to have waived any objection to liability for the bill or reimbursement request and shall upon the expiration of such period pay the bill or reimbursement request to the claimant or supplier, in accordance with the fee schedule.

(d) Any self-insured employer or insurance carrier that fails to reimburse the claimant or pay the supplier, as appropriate and as required in this section, shall be obligated to pay to the claimant or supplier the amount prescribed on the fee schedule established by section 442.2 of this Part plus simple interest at the rate set forth in section 5,004 of the civil practice law and rules.]

Effective date. This regulation shall be effective on January 1, 2020.