

Subsection (i) of section 324.1 of Title 12 of the New York Code Rules and Regulations is amended as follows:

§324.1 (i) "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. The Chair shall have discretion to mandate or prohibit any means of same day transmission. When the means of same day transmission is the electronic portal maintained by the Workers' Compensation Board for receipt of medical information and available to all parties of interest and Treating Medical Providers, the requesting Treating Medical Provider and parties shall only be required to submit the request, response or request for review to the portal maintained by the Board and shall not be required to transmit the request, response or request for review to other parties or the requesting Treating Medical Provider.

Section 324.3 of Title 12 of the New York Code Rules and Regulations is amended as follows:

#### § 324.3 Variances

##### (a) Treating Medical Providers

(1) 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, is appropriate for the claimant and medically necessary, he or she shall request a variance [from the insurance carrier or Special Fund] by submitting the request in the format prescribed by the Chair [for such purpose] as set forth in subsection (i) of section 324.1 herein. A variance must be requested and granted by the insurance carrier, Special Fund, the Board or order of the Chair before medical care that varies from the Medical Treatment Guidelines is provided to the claimant and a request for a variance will not be considered if the medical care has already been provided.

(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.

(3) The Treating Medical Provider requesting a variance shall submit the request in the format prescribed by the Chair [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] as set forth in subsection (i) of section 324.1 herein, 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 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. All questions on the variance request prescribed by the Chair must be answered completely, clearly setting forth information that meets the following requirements:

(i) for all variances:

(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 is appropriate for the claimant and medically necessary, and

(b) a statement 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 involves frequency or duration of a particular treatment, a description of the functional outcomes that, as of the date of the variance request, 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) (i) No variance 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, and New York Non-Acute Pain Medical Treatment Guidelines Section H.1.e.

(ii) The Treating Medical Provider may render or prescribe treatment in accordance with the ongoing maintenance care guidelines 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, and New York Non-Acute Pain Medical Treatment Guidelines Section H.1.e 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.

(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 variance from the Medical Treatment Guidelines, [he or she must request] such variance shall be requested from the insurance carrier 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 variance request.

(i) If a variance request for substantially similar treatment, procedure or test has been previously denied by the insurance carrier 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. A variance request that is substantially similar to any previous request may not be submitted until the insurance carrier or Special Fund has denied any previous variance request.

(ii) In the event that a variance request is submitted before a previous variance request for substantially similar treatment, procedure or test has been denied, the insurance carrier or Special Fund may submit the denial of the subsequent request without a medical opinion by its medical professional, a review of records, or independent medical examination.

(iii) In the event that a variance request, following denial of a request for substantially similar treatment, procedure or test, is submitted without additional documentation or justification beyond the prior variance request, the insurance carrier or Special Fund may deny the variance request 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, a review of records, or independent medical examination.

(b) Insurance carriers 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 thirty 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 ten [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.

(2) Review by insurance carrier or Special Fund.

(i) Without IME or review of records.

(a) The insurance carrier or Special Fund shall review the variance request and respond to the variance request [in the format prescribed by the Chair] as set forth in subparagraph

(4) of subdivision (a) herein within fifteen days of receipt, except as provided in subparagraph (ii) of this paragraph. Receipt is deemed to be the date submitted, if submitted by one of the prescribed methods of same day transmission, or, if sent by regular mail, five business days after the date the Treating Medical Provider requesting the variance certified that the form was sent to the insurance carrier or Special Fund.

(b) If the request for a variance was submitted after the medical care was rendered, a medical opinion by the insurance carrier or Special Fund's medical professional, a review of records, or independent medical examination is not required and the insurance carrier or Special Fund may deny the variance request on the basis that it was not requested before the medical care was provided.

(c) The insurance carrier 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 or Special Fund's medical professional, a review of records, or an independent medical examination. If the insurance carrier 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 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 or Special Fund must also assert any other basis for denial or such basis for denial will be deemed waived.

(e) The insurance carrier or Special Fund may deny a request for a variance on the basis that (i) the Treating Medical Provider seeks a variance 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 or Special Fund; or (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 or Special Fund may deny the variance request by specifying the basis for the denial. The carrier or Special Fund may submit the denial without a medical opinion by its medical professional, a review of records, or independent medical examination.

(f) A denial of the request for a variance for reasons other than those set forth in clauses (b), (c) and (e) of this subparagraph must be reviewed by the insurance carrier or Special Fund's medical professional, if an independent medical examination or review of records is not conducted as set forth in subparagraph (ii) of this paragraph.

(ii) Review with IME or review of records.

(a) If the carrier 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 notify the Chair and the Treating Medical Provider of this decision in the format prescribed by the Chair as set forth in subparagraph (4) of subdivision (a) herein within five [business] days of receipt of the variance request by one of the prescribed methods of same day transmission, except if the Treating Medical Provider has certified he or she is not equipped

to send and receive by one of such methods, then by regular mail to the requesting Treating Medical Provider. A final response to the variance request shall be submitted in the format prescribed by the Chair in the same manner as the notice in the preceding sentence within thirty days of receipt of the request. 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 Treating Medical Provider requesting the variance certified that the form was sent to the insurance carrier or Special Fund.

(b) If the claimant fails to appear without reasonable cause for an independent medical examination scheduled by the insurance carrier or Special Fund in order to respond to a request for a variance, the request for a variance shall be denied. The insurance carrier or Special Fund shall submit the response to the variance request within thirty 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 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 shall be submitted in the manner prescribed by the Chair as set forth in subparagraph (4) of subdivision (a) herein within twenty-one [business] days of receipt of the insurance carrier or Special Fund's denial by the claimant. If the claimant requests review of the denial of the variance request and it is determined that the failure to appear was for reasonable grounds, the insurance carrier or Special Fund will have thirty days from the date of the filing of the decision to obtain an independent medical examination and provide a further response to the request for a variance.

(3) Insurance carrier or Special Fund response to variance request.

(i) The variance response shall be in the format prescribed by the Chair and shall clearly state whether the variance has been granted, denied, or partially granted. If a variance request 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. However, if the Treating Medical Provider certified he or she is not equipped to send and receive by one of the prescribed methods of same day transmission, and/or if the claimant, claimant's legal representative, if any, or any other party is not capable of receiving the response by one of the prescribed methods of same day transmission or has not provided the insurance carrier or Special Fund with the necessary contact information, the insurance carrier or Special Fund shall send the response to such individual or individuals by regular mail with a certification of the date and to whom the response was sent.

(iii) If the insurance carrier or Special Fund denies a variance request, it shall state the basis for the denial in detail and, if for reasons other than those set forth in paragraph (2) (i) (b) or (c) or (2) (ii) (b) of this subdivision, submit with its response the [written] report of the insurance carrier 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. The 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 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.

(4) If a claim is controverted or the time to controvert the claim has not expired, and the insurance carrier or Special Fund grants or partially grants a variance request, 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 is requested is compensable and the insurance carrier or Special Fund is not liable for the cost of such treatment unless the claim or condition is established.

(5) 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. Upon receipt of the denial of the variance request, the claimant or claimant's legal representative, if any, shall consult with 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. A request for review of the denial of the variance shall be submitted within twenty-one [business] days of receipt of the insurance carrier 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 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 (ii) of paragraph (2) of subdivision (b) herein and the claimant 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 an expedited hearing in accordance with paragraph (3) of subdivision (d) of this section simultaneous with requesting review of the insurance carrier 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 an expedited hearing, the request for review of the denial of the variance request will be resolved through the medical arbitration process set forth in paragraph (2) of subdivision (d) of this section. If the request is not received by the Board within twenty-one [business] days of receipt of the denial, the denial of the request for the variance 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 subdivision (d) (2) or (3) of this section.

(d) Process for requesting review of denial of variance except denials based on the

claimant's failure to appear for an IME.

(1) Informal resolution.

[(i)] If the insurance carrier 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 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. In the event the Treating Medical Provider and insurance carrier or Special Fund informally resolve the denial of the variance request, the insurance carrier or Special Fund shall update its response to the variance request in accordance with subdivision (a)(4) herein, identifying in the updated response whether the request has been granted or partially granted.

[(ii) If the dispute is resolved, the insurance carrier or Special Fund confirms the resolution by submitting notice of the 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 or Special Fund have attempted and failed to resolve the denial of the variance informally; and

(b) the claimant or insurance carrier 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 or Special Fund resolve the denial of the variance informally and the insurance carrier 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 paragraph (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 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 for an expedited hearing for review of the denial. A request for referral 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 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 subdivision (b) (2) (i)(c). If the medical professionals are deposed, transcripts shall be provided to the Board on or before the hearing and within thirty 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 thirty 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 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 subdivision (a)(3) of this section.

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

(7) When the Chair issues an order as provided in paragraph (6) of this subdivision in a claim that is 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 medical care until the question of compensability is resolved and then only if that insurance carrier or Special Fund is found liable for the claim.