

Section 324.4 of Title 12 of the New York Code Rules and Regulations is amended as follows:

§ 324.4 Optional prior approval

(a) Insurance carriers and Special Funds that participate in the optional prior approval process shall designate a qualified employee or employees in its office, if it handles its own claims, or a qualified employee or employees in the office of its representative licensed pursuant to Workers' Compensation Law Section 50 (3-b) and (3-d) as a point of contact for the Board and Treating Medical Providers regarding optional prior approval.

Insurance carriers and Special Funds that participate in the optional prior approval process must notify and provide all requested information to the Chair or his or her designee and shall provide the Chair or his or her designee with the name and contact information for the point(s) of contact, including, his, her, or their direct telephone number(s), facsimile number(s), and email address(es), within thirty days of the effective date of this paragraph. An insurance carrier or Special Fund may opt-out of the optional prior approval process by notifying the Chair or his or her designee in writing before final authorization to write workers' compensation insurance, before final authorization to be self-insured, or at least sixty days before the last day of participation. An insurance carrier or Special Fund that has opted-out of this process may opt-in by providing notice to the Chair or his or her designee in writing sixty days prior to beginning participation.

(b) The Treating Medical Provider has the option of requesting prior approval from the insurance carrier or Special Fund to confirm that the proposed medical care is consistent with the Medical Treatment Guidelines. To request the optional prior approval, the Treating Medical Provider shall submit the optional prior approval request to the insurance carrier or Special Fund and Board by one of the prescribed methods of same day transmission. The optional prior approval request shall be in a format prescribed by the Chair for such purpose. In addition to submitting the optional prior approval request in a format prescribed by the Chair, the Treating Medical Provider may also contact the insurance carrier, self-insured employer or Special Fund by telephone.

(c) The insurance carrier, self-insured employer or Special Fund has eight [business] days from submission of the optional prior approval request to approve or deny the medical care. Any prior approval request must be reviewed by the insurance carrier, self-insured employer or Special Fund's medical professional before it may be denied.

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

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

(3) If the insurance carrier, self-insured employer or Special Fund fails to respond to a request for optional prior approval within eight [business] days, the medical care is deemed approved on the ground that approval was unreasonably withheld and the medical arbitrator will issue an order stating that the request is approved.

(d) If a claim is controverted or the time to controvert the claim has not expired, and the insurance carrier, self-insured employer or Special Fund agrees that the medical care for which optional prior approval is requested is consistent with the Medical Treatment Guidelines, such agreement shall not be construed as an admission that the condition for which the optional prior approval 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.

(e) If the insurance carrier or Special Fund denies that the medical care for which optional prior approval is requested is consistent with the Medical Treatment Guidelines, the Treating Medical Provider may elect to try to resolve the dispute by discussing the optional prior approval request directly with the insurance carrier or Special Fund's medical professional prior to commencing the review provided in subdivision (f) of this section.

(1) If the dispute is resolved, the insurance carrier or Special Fund shall confirm the resolution in the format prescribed by the Chair and shall submit the resolution to the Treating Medical Provider and Board by using one of the prescribed methods of same day transmission.

(2) If the discussion fails to resolve the dispute, the Treating Medical Provider may request review of such denial by submitting the request for review in the format prescribed by the Chair by using one of the prescribed methods of same day transmission. The request for review of the denial of the optional prior approval will be reviewed in accordance with subdivision (f) of this Section.

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

(g) An insurance carrier or Special Fund shall not dispute a bill for medical care on the basis that it was not consistent with the Medical Treatment Guidelines if it has approved a request for optional prior approval for such medical care or the medical arbitrator has issued a notice of resolution approving the medical care.

(h) When the medical arbitrator issues a resolution as provided in subdivisions (b)(3) and (e) of this section in a claim that has been controverted or the time to controvert the claim has not expired, the insurance carrier or Special Fund shall not be responsible for the payment of such services until the question of compensability is resolved and then only if the claim or condition is established.