

Section 325-1.4 of Title 12 of the New York Code Rules and Regulations is amended as follows:

§ 325-1.4 Authorization for special services

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

(1) When it is necessary for the attending physician to engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or occupational therapy or physical therapy or special diagnostic laboratory tests costing more than one thousand dollars, or when it is necessary for a self-employed physical or occupational therapist to continue physiotherapeutic or occupational therapy procedures prescribed by an attending physician costing more than one thousand dollars, he or she must request and secure authorization from the employer or insurance carrier or the Chair, by setting forth the medical necessity of the special services required and submitting the request in the format prescribed by the Chair.[on the Chair prescribed form for such purpose]. Such requests are not required in an emergency or for pre-authorized procedures as set forth in subdivision (d) of this section and section 324.2(c) of this Subchapter. Requests shall be submitted by one of the prescribed methods of same day transmission as set forth in subsection (i) of section 324.1. When the Treating Medical Provider is not equipped to send and receive the authorization request by one of the prescribed methods of same day transmission, he or she may send the request by regular mail with a certification that the Treating Medical Provider is not equipped to send and receive the authorization request by one of the prescribed methods of same day transmission and the date the authorization request was sent to the insurance carrier or Special Fund and Board.

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

(3) The attending physician or self-employed physical or occupational therapist seeking authorization shall submit the request in accordance with subparagraph (1) herein [file the form prescribed by the Chair for this purpose with the Board and also on the same day serve a copy on the insurance carrier by one of the prescribed methods of same day transmission set forth in section 324.1(h) of Part 324 of this Subchapter or by regular mail with confirmation of delivery]. All questions [on the form prescribed by the Chair for this purpose] shall be answered completely, clearly setting forth the medical necessity of the special services requested. The attending physician or self-employed physical or occupational therapist shall not request authorization for the same special service multiple times without any change of the claimant's medical condition.

(4) In order to process such requests expeditiously and within the time limits specified hereunder, the insurance carrier shall designate a qualified employee or employees in its office, and the self-insured employer shall designate a qualified employee or employees in its office or an authorized employee or employees of its licensed representative, to receive and act upon such requests.

(5) In response to requests for authorization for treatment related to an established body part or illness, the self-insured employer or insurance carrier may have the claimant

examined within four business days if the claimant is hospitalized or thirty days if the patient is not hospitalized, by an appropriate specialist who is authorized by the Chair, to conduct independent medical examinations of workers' compensation claimants. If such specialist is not available or where the claimant resides outside of state, consultation may be rendered by a qualified provider who may conduct the independent medical examination as provided in Workers' Compensation Law section 137(3)(a) and section 300.2 (b)( 9) and (d)([7] 10) of this Chapter.

(6) The self-insured employer or insurance carrier shall respond to the authorization request orally and in writing by one of the prescribed methods of same day transmission as defined in section 324.1 ([h] i) of this Subchapter or by regular mail with confirmation of delivery within thirty days. The thirty day time period begins to run from the date of receipt [the completed form prescribed by the Chair for this purpose was sent] if sent by one of the prescribed methods of same day transmission or five days after it was sent if sent by regular mail with confirmation of delivery. The [written] response shall be [on a copy of the form] in the format prescribed by the Chair [completed by the attending physician seeking authorization] and shall clearly state whether the authorization request has been granted or denied. If the authorization has been denied, the insurance carrier shall submit with the [written response]denial a report offering a conflicting opinion from an independent medical examiner, a qualified medical professional as defined in section 300.2(b)(9) and (d)([7] 10) of this Chapter, or, if the report was made upon review of the records without a physical examination, in accordance with 300.2(b)(12)[a physician authorized to treat workers' compensation claimants]. If the report offering a conflicting opinion is already contained in the Board file, the insurance carrier shall not submit the report but shall identify the report [on the form prescribed by the Chair] by providing the name of the independent medical examiner, qualified medical professional as defined in section 300.2(b)(9) of this Chapter, or physician authorized to treat workers' compensation claimants who gave the conflicting opinion, the date of the report, and the date it was received by the Board. Nothing herein shall relieve the carrier from complying with the provisions of section 300.23 of this Title.

(7) The oral response to the authorization request shall be to the attending physician or self-employed physical or occupational therapist who requested the authorization. The written response to the authorization request shall be to the attending physician or self-employed physical or occupational therapist with a copy to the Board, claimant, claimant's legal counsel, if any, and to any other parties of interest.

(8) If such authorization or denial has not been sent by one of the prescribed methods of transmission in section 324.1 ([h] i) of this Subchapter to the attending physician or self-employed physical or occupational therapist with copies to the Board, the claimant's legal representative, if any, and to any other parties within thirty calendar days, such request shall be deemed authorized and the employer or insurance carrier shall be liable for payment for such special service. The Chair may issue an order stating that such request is deemed authorized or requiring the employer or carrier to provide written authorization, if such documentation is required by the claimant to secure necessary medical treatment. Such order of the Chair is not appealable under Workers' Compensation Law section 23.

(9) (i) Upon the timely receipt by the board of [the form prescribed by the Chair denying] a denial by the employer or carrier of a request for authorization of the special medical service and a report offering a conflicting opinion from an independent medical examiner, a

qualified medical professional as defined in section 300.2(b)(9) and (d)(7) of this Chapter, or, if the report was made upon review of the records without a physical examination, a physician authorized to treat workers' compensation claimants, the Board shall order the claim into the Expedited Hearing Process wherein an expedited hearing shall be scheduled within thirty days. Notice of the expedited hearing shall provide that the parties may depose the claimant's attending physician and the independent medical examiner, qualified medical professional, or physician authorized to treat workers' compensation claimants who submitted the conflicting medical report at or prior to the hearing. If the physicians are deposed, transcripts shall be provided to the Board on or before the hearing. If the claimant is unrepresented the testimony of claimant's attending physician and the independent medical examiner shall be taken at a hearing. For good cause shown, the Workers' Compensation Law Judge may grant an adjournment if one or both of the medical professionals cannot be deposed and transcripts prior to the Board at or prior to the hearing, or if one or both of the medical professionals cannot appear to testify at the expedited hearing. If authorization is denied for one of the procedures listed in Section 324.2 (d) (2) of this Subchapter, the Workers' Compensation Law Judge may require examination of the claimant or a review of the claimant's records and submission of a report of such examination or review by an impartial specialist pursuant to Workers' Compensation Law Section 13 (e) as additional evidence to consider in rendering a decision. The Workers' Compensation Law Judge shall rule on the authorization at the expedited hearing and file a subsequent decision, or shall issue a reserved decision on the issue within fifteen days of the expedited hearing date. The case shall not be continued for further development of the record except where there are complex medical issues of diagnosis or causation present and then it shall be continued for no more than thirty days.

(ii) If the [form prescribed by the Chair denying]denial of the authorization request is untimely or does not reference or [have attached]include a conflicting medical report in accordance with subdivision (7) herein, [from an independent medical examiner, a qualified medical professional as defined in section 300.2 (b) (9) of this Chapter, or, if the report was made upon review of the records without a physical examination, a physician authorized to treat workers' compensation claimants,] the Chair will issue an order stating that such request is deemed authorized. Such order of the Chair is not appealable under Workers' Compensation Law Section 23.

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

(11) Such authorization is not required in an emergency under the provisions of Workers'

Compensation Law Section 13-a(5).

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

(1) When it is necessary for the attending physician to secure specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, x-ray examinations or special diagnostic laboratory tests costing more than one thousand dollars, or when it is necessary for a physical or occupational therapist to continue physiotherapeutic or occupational therapy procedures prescribed by an attending physician costing more than one thousand dollars, and the claim is controverted or the time to controvert the claim has not expired or the body part or condition has not been established, he or she shall request and obtain authorization from the employer or insurance carrier who would become responsible in the event the claim is adjudicated compensable by following the procedures in subdivision (a) of this section. All such procedures are applicable to such requests.

(2) The authorization herein referred to, if granted by the self-insured employer or insurance carrier, is limited to the question only of medical necessity of the services requested, and such authorization shall not be construed as an admission that the condition for which these services are required is compensable and the self-insured employer or insurance carrier is not liable for the cost of said treatment unless the claim or condition is established as compensable.

(3) When the Chair issues an order, pursuant to subdivision (a) (8) of this section in a controverted case, the carrier shall not be responsible for the payment of such services until the question of compensability is resolved and then only if the claim is established as compensable.

(c) Multiple special services. If an attending physician provides medical treatment or special services to more than one body part or more than one medical treatment or special service to the same body part, such treatment or special services shall be considered separate and shall not require a request for prior authorization pursuant to Workers' Compensation Law Section 13-a (5) or this section if the medical treatments or special services individually costs less than one thousand dollars. Notwithstanding the previous sentence, if the medical treatment or special services are a series of related treatment or care, such as physical or occupational therapy, or part of a battery of related tests, such as electro-diagnostic tests, the aggregate amount of such treatment, care, or tests shall be considered as a single request and shall require a request for prior authorization pursuant to Workers' Compensation Law Section 13-a (5) or this section if the aggregate amount is more than one thousand dollars.

(d) Workers' Compensation Law Section 13-a (5) authorizes the creation of a list of preauthorized procedures costing more than one thousand dollars. Prior authorization pursuant to Workers' Compensation Law Section 13-a (5) and this section is not required for procedures on the pre-authorized list set forth in paragraph (1) of section 324.2 (d) of this Subchapter. Prior authorization is required for the procedures excluded from that list as set forth in paragraphs (2) and (3) of section 324.2 (d) of this Subchapter.