

Revised Text

The opening paragraph of subdivision (d) of Section 300.23 of Title 12 NYCRR is amended to read as follows:

(d) Whenever an employer or carrier shall seek to terminate medical care or refuse authorization for special medical services, except when a request for variance is denied, the Chair prescribed form [C-8.1, Part A, Notice of Treatment Issue(s)/Disputed Bill Issue(s),] shall be completed and filed with the [chair] Chair within five days after such termination or refusal, together with:

Subchapter C of Title 12 NYCRR is amended to add a new Part 324 to read as follows:

Part 324. Medical Treatment Guidelines

Section 324.1 Definitions

Section 324.2 Medical Treatment Guidelines

Section 324.3 Variances

Section 324.4 Optional Prior Approval

Section 324.5 Conditions, treatments, or diagnostic tests not addressed by Medical Treatment Guidelines

Section 324.6 Incorporation into policies, procedures, and practices

Section 324.1. Definitions. For purposes of this Subchapter:

(a) The definitions of the terms in subdivision (a) of section 300.1 of Part 300 of this Chapter are applicable to this Subchapter.

(b) “Consistent with the Medical Treatment Guidelines” means within the criteria of the Medical Treatment Guidelines and based on a correct application of the Medical Treatment Guidelines.

(c) “Insurance carrier or Special Fund’s medical professional” means a physician, registered physician assistant, registered professional nurse, or nurse practitioner licensed by New York State, or the appropriate

state where the professional practices, who is: 1) employed by an insurance carrier or Special Fund; or 2) has been directly retained by the insurance carrier or Special Fund; or 3) is employed by a URAC accredited company retained by the insurance carrier or Special Fund through a contract to review claims and advise the insurance carrier or Special Fund.

(d) “Maximum Medical Improvement (MMI)” means an assessed condition of a claimant based on medical judgment that (1) the claimant has recovered from the work injury, illness, or occupational disease to the greatest extent that is expected and (2) no further improvement in his/her condition is expected. A finding of maximum medical improvement is a normal precondition for determining the permanent disability level of a claimant.

(e) “Medical arbitrator” means the Medical Director of the Board, the Assistant Medical Director of the Board, or a New York licensed physician designated by the Chair or his or her designee.

(f) “Medical care” means all care, treatment, and other attendance for an injured worker’s injury, illness or occupational disease as listed and provided in Workers’ Compensation Law Sections 13, 13-b, 13-k, 13-l, and 13-m.

(g) “Medical Treatment Guidelines” means the treatment guidelines for workers’ compensation injuries, illnesses, or occupational diseases to the parts of the body addressed in the guidelines incorporated by reference in subdivision (a) of section 324.2 of this Part.

(h) “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 has designated for this purpose to other persons, entities, or the Board.

(i) “Review of records” means the evaluation of a claimant without physical examination, by a medical provider authorized by the Chair to treat claimants or to conduct independent medical examinations or both, based on the review of reports and records, including treatment notes, diagnostic test results, depositions or hearing testimony, exhibits, and other records or reports from medical providers or independent medical examiners or both in the electronic case file maintained by the Board.

(j) “Special Fund” means any special fund maintained by the Board that is responsible for paying for medical treatment and care of injured workers, including but not limited to, the Special Fund for Reopened Cases created and governed by Workers’ Compensation Law Section 25-a and the Uninsured Employers’ Fund created and governed by Workers’ Compensation Law Section 26-a.

(k) “Treating Medical Provider” means any physician, podiatrist, chiropractor, or psychologist that is providing treatment and care to an injured worker pursuant to the Workers’ Compensation Law.

Section 324.2. Medical Treatment Guidelines

(a) Medical Treatment Guidelines. Regardless of the date of accident or date of disablement, on and after December 1, 2010, on the job injuries, illnesses, or occupational diseases to a worker’s lumbar, thoracic, or cervical spine, shoulder or knee covered by the Workers’ Compensation Law shall be treated consistent with the Medical Treatment Guidelines set forth in paragraphs (1) through (4) of this subdivision. On and after December 1, 2010, all Treating Medical Providers shall treat all existing and new workers’ compensation injuries, illnesses, or occupational diseases, except as provided in section 324.3 of this Part, in accordance with the following:

(1) for the lumbar and thoracic spine, the *New York Mid and Low Back Injury Medical Treatment Guidelines*, First Edition, June 30, 2010, which is herein incorporated by reference;

(2) for the cervical spine, the *New York Neck Injury Medical Treatment Guidelines*, First Edition, June 30, 2010, which is incorporated herein by reference;

(3) for the knee, with the *New York Knee Injury Medical Treatment Guidelines*, First Edition, June 30, 2010, which is incorporated herein by reference; and

(4) for the shoulder, the *New York Shoulder Injury Medical Treatment Guidelines*, First Edition, June 30, 2010, which is incorporated herein by reference.

(b) Obtaining the medical treatment guidelines. The *New York Mid and Low Back Injury Medical Treatment Guidelines*, *New York Neck Injury Medical Treatment Guidelines*, *New York Knee Injury Medical Treatment Guidelines*, and *New York Shoulder Injury Medical Treatment Guidelines* incorporated by reference herein may be examined at the office of the Department of State, 99 Washington Avenue, Albany, New York, 12231, the Legislative Library, the libraries of the New York State Supreme Court, and the district offices of the Board. Copies may be downloaded from the Board's website or obtained from the Board by submitting a request in writing, with the appropriate fee, identifying the specific guideline requested and the choice of format to Publications, New York State Workers' Compensation Board, 20 Park Street, Room 301 Albany, New York 12207. Information about the Medical Treatment Guidelines can be requested by email at general_information@wcb.state.ny.us, or by telephone at 1-800-781-2362. The Medical Treatment Guidelines are available on paper or compact disc. A fee of ten dollars will be charged for each guideline requested in paper format, and a fee of five dollars will be charged for a compact disc containing all guidelines requested. Payment of the fee shall be made by check or money order payable to "Chair WCB."

(c) Limitations. The Medical Treatment Guidelines in subdivision (a) of this section and this Part are not intended to, and were not prepared with the expectation of, establishing a standard for determining professional liability.

(d) Pre-authorized procedures list.

(1) All medical care consistent with the Medical Treatment Guidelines costing more than one thousand dollars is included on the pre-authorized procedures list, except for the medical care set forth in paragraph (2) of this subdivision. Medical care costing more than one thousand dollars included on the pre-authorized procedures list are pre-authorized so Treating Medical Providers are not required to request prior authorization.

(2) The following medical care consistent with the Medical Treatment Guidelines costing more than one thousand dollars is not included on the pre-authorized procedures list set forth in paragraph (1) of this subdivision so that prior authorization is required:

(i) Lumbar fusion as set forth in E.4 of the *New York Mid and Low Back Injury Medical Treatment Guidelines*;

(ii) Artificial disc replacement as set forth in E.5 of the *New York Mid and Low Back Injury Medical Treatment Guidelines*, and in E.3 of the *New York Neck Injury Medical Treatment Guidelines*;

(iii) Spinal cord stimulators as set forth in E.8 of the *New York Mid and Low Back Injury Medical Treatment Guidelines*;

(iv) Vertebroplasty as set forth in E.6.a.i. of the *New York Mid and Low Back Injury Medical Treatment Guidelines*;

(v) Kyphoplasty as set forth in E.6.a.i. of the *New York Mid and Low Back Injury Medical Treatment Guidelines*;

(vi) Electrical bone stimulation as set forth in the *New York Mid and Low Back Injury Medical Treatment Guidelines* and the *New York Neck Injury Medical Treatment Guidelines*;

(vii) Anterior acromioplasty as set forth in D.6.f., Table 2, D.7.f., and Table 3 of the *New York Shoulder Injury Medical Treatment Guidelines*;

(viii) Chondroplasty as set forth in D.1.f. and Table 3 of the *New York Knee Injury Medical Treatment Guidelines*;

- (ix) Osteochondral autograft as set forth in D.1.f. and Table 4 of the *New York Knee Injury Medical Treatment Guidelines*;
- (x) Autologous chondrocyte implantation as set forth in D.1.f., Table 5, and D.1.g. of the *New York Knee Injury Medical Treatment Guidelines*;
- (xi) Meniscal allograft transplantation as set forth in D.6.f., Table 8, and D.7. of the *New York Knee Injury Medical Treatment Guidelines*; and
- (xii) Knee arthroplasty (total or partial knee joint replacement) as set forth in F.2. and Table 11 of the *New York Knee Injury Medical Treatment Guidelines*.

(3) Notwithstanding that a surgical procedure is consistent with the guidelines, a second or subsequent performance of such surgical procedure shall require prior approval if it is repeated because of the failure or incomplete success of the same surgical procedure performed earlier, and if the Medical Treatment Guidelines do not specifically address multiple procedures.

(e) Variances from the Medical Treatment Guidelines are permissible only as provided in section 324.3 of this Part.

(f) Maximum medical improvement shall not preclude the provision of medically necessary care for claimants. Such care shall be medically necessary to maintain function at the maximum medical improvement level or to improve function following an exacerbation of the claimant's condition. Post-maximum medical improvement medical services shall conform to the relevant Medical Treatment Guidelines, except as provided in section 324.3 of this Part.

Section 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 form prescribed by the Chair for such purpose. A variance must be requested 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 send the form 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. The Treating Medical Provider shall send the form to the insurance carrier or Special Fund and Board by one of the prescribed methods of same day transmission if equipped to do so, 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 form by one of the prescribed methods of same day transmission and the date the form was sent to the insurance carrier or Special Fund and Board. The Treating Medical Provider shall either attach to the form or reference on the form, if already in the claim file maintained by the Board, the necessary medical documentation to support the variance request. All questions on the form 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) 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 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.

(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 send a response to the variance request in writing within fifteen days of receipt, except as provided in subparagraph (ii) of this paragraph. 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 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) A denial of the request for a variance for reasons other than those set forth in clauses (b) and (c) 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 of this decision by completing the appropriate section of the form prescribed by the Chair and sending such form to the Treating Medical Provider and the Board 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 in writing on the prescribed form and sent 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 deemed denied. The insurance carrier or Special Fund shall send 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 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 on the same form as the request for a variance and shall clearly state whether the variance has been granted or denied.

(ii) The variance response shall be sent to the Treating Medical Provider who requested the variance, the Board, claimant, claimant's legal representative, if any, and to any other parties on the same day.

(iii) The variance response shall be sent by one of the prescribed methods of same day transmission to the Treating Medical Provider, 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 form to such individual or individuals by regular mail with a certification of the date and to whom the form was sent.

(iv) 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, attach 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 filed with the Board and sent to all other parties. The denial shall identify the independent medical examination report or review of records report, if already filed with 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 approves a variance request, such approval 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 sending the written 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 made 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 on a form prescribed by the Chair for such purpose and provide all information requested, unless the claimant is unrepresented. Simultaneous with requesting review of the insurance carrier or Special Fund's denial of the request for a variance, a represented claimant or such claimant's legal representative shall notify the Chair if he or she agrees to waive his or her right to an expedited hearing and requests resolution by the medical arbitrator in accordance with paragraph (2) of subdivision (d) of this section. If a represented claimant or such claimant's legal representative does not notify the Chair of his or her agreement and request, the request for review of the denial of the variance request will be resolved through the expedited hearing

process set forth in paragraph (3) 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 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) Resolution of request for review of denial of variance.

(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 expedited hearing process set forth in paragraph (3) of this subdivision or medical arbitrator process set forth in paragraph (2) of this subdivision. The Treating Medical Provider has eight business days from receipt of the denial by the insurance carrier or Special Fund to try to resolve the dispute informally as provided in this subdivision. 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 Treating Medical Provider.

(ii) If the dispute is resolved, the insurance carrier or Special Fund confirms the resolution by submitting the form 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 form through one of the prescribed methods, by regular mail to such recipient .

(iii) If the discussion fails to resolve the dispute within eight business days of receipt of the denial, 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 expedited hearing process set forth in paragraph (3) of this subdivision or medical arbitrator process set forth in paragraph (2) of this subdivision.

(2) Medical arbitrator process. (i) The request for review of a denial of a variance shall be resolved by a medical arbitrator if the claimant and the insurance carrier or Special Fund state in writing that they waive their right to an expedited hearing and request that the issue be decided by a medical arbitrator.

(ii) For the six months following the effective date of this section, when an insurance carrier or Special Fund denies a variance request it shall simultaneously notify the Chair if it agrees to waive its right to an expedited hearing and requests resolution by the medical arbitrator by following the process prescribed by the Chair. If the insurance carrier or Special Fund does not notify the Chair of its agreement and request, the request for review of the denial of the variance request will be resolved through the expedited hearing process set forth in paragraph (3) of this subdivision. By the end of the six months following the effective date of this section or at the time a new insurance carrier or Special Fund is authorized or created, whichever is later, each insurance carrier and Special Fund shall notify the Chair, in the manner prescribed by the Chair, whether it waives its right to an expedited hearing and requests resolution by the medical arbitrator for all claims for which it is liable. An insurance carrier or Special Fund that waived its right to an expedited hearing and requested resolution by the medical arbitrator may withdraw such waiver with thirty days notice to the Chair or his or her designee. An insurance carrier or Special Fund that did not waive its right to an expedited hearing within six

months following the effective date of this section or at the time of authorization or creation may subsequently waive such right and request such resolution with thirty days notice to the Chair or his or her designee.

(iii) When the insurance carrier or Special Fund waives its right to an expedited hearing and requests that the request for review of the denial of the variance be decided by the medical arbitrator, the Board shall contact the claimant if unrepresented and request that the claimant state in writing whether he or she waives his or her right to an expedited hearing and requests resolution by the medical arbitrator. The claimant shall respond within fourteen days of contact by the Board in writing. If the claimant does not respond within fourteen days or responds and declines to waive his or her right to an expedited hearing, the claim shall be transferred to the expedited hearing process as provided in paragraph (3) of this subdivision.

(iv) If the claimant responds within fourteen days and waives his right to an expedited hearing and requests resolution by the medical arbitrator in writing, the request for review, variance request, and denial will be reviewed by the medical arbitrator. Such review shall not commence until the period for informal resolution in paragraph (1) of this subdivision has ended and 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 form 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) If the claimant or claimant's legal representative requests review of the denial of a variance, the Chair shall order the claim into the expedited hearing process wherein an expedited hearing shall be scheduled within thirty days, when:

(a) the period for informal resolution provided in paragraph (1) of this subdivision has ended; and

(b) the Treating Medical Provider and insurance carrier or Special Fund failed to resolve the denial of the variance informally; and

(c) the claimant or insurance carrier or Special Fund have not waived their right to an expedited hearing and requested that the issue be decided by a medical arbitrator as provided in paragraph (2) of this subdivision.

(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. 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 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 will reserve his 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 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 send the denial of 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) or (c) of this section, fails to attach the written report to, or identify the report in the electronic case folder on, the Chair prescribed form as required by subdivision (b) (3) (iv), 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.

(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.

324.4 Optional Prior Approval.

(a) Insurance carriers and Special Fund 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 or Special Fund 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 the effective date of this paragraph, 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 send 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 on a form or in a format prescribed by the Chair for such purpose. In addition to sending the optional prior approval request in writing, the Treating Medical Provider may also contact the insurance carrier or Special Fund by telephone.

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

(1) If the insurance carrier or Special Fund agrees that the medical care for which optional prior approval is requested is consistent with the Medical Treatment Guidelines, it shall complete the appropriate section of the prescribed form or respond using the prescribed format and send 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 or Special Fund denies that the medical care for which optional prior approval is requested is consistent with the Medical Treatment Guidelines, it shall complete the appropriate section of the prescribed form or respond using the prescribed format, stating the basis for its denial, and send 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 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 or Special Fund agrees that 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 by completing the appropriate section of the form prescribed by the Chair or using the Chair prescribed format to reflect the resolution and shall send 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 completing the appropriate section of the form prescribed by the Chair or using the Chair prescribed format and submitting the form to the Board 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 as set forth on the form 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.

Section 324.5. Conditions, treatments, or diagnostic tests not addressed by Medical Treatment Guidelines.

If the Medical Treatment Guidelines do not address a condition, treatment or diagnostic test for a part of the body covered by the Medical Treatment Guidelines, then the factors in subdivision (a) (3) of section 324.3 of this Part and relevant medical literature as described in subdivision (a) (4) of section 324.3 of this Part shall be used to determine whether the insurance carrier or Special Fund shall be obligated or not obligated to pay for the medical care at issue.

Section 324.6. Incorporation into policies, procedures and practices.

Insurance carriers and Special Fund shall incorporate the Medical Treatment Guidelines set forth in section 324.2 (a) and (b) and the provisions in sections 324.3 (b), 324.4 (a), and 324.5 of this Part, and section 325-1.25 of Subpart 325-1 into their policies, procedures, and practices so that their utilization review and management criteria are consistent with the Medical Treatment Guidelines. Insurance carriers and Special Fund shall certify to the Chair within one hundred and twenty days of the effective date of this Part that they have done so and shall re-certify to the incorporation of the Medical Treatment Guidelines and the regulatory provisions cited in the previous sentence within sixty days of any changes to their policies, procedures, and practices. The Chair and Department of Insurance will conduct audits of insurance carriers and Special Fund with respect to the accuracy of the certifications. Each insurance carrier shall submit the policies and procedures incorporating the Medical Treatment Guidelines incorporated by reference in section 324.2 (a) and (b) and the provisions in

sections 324.3 (b), 324.4 (a), and 324.5 of this Part, and section 325-1.25 of Subpart 325-1 to the Chair or Department of Insurance in connection with such audit.

Section 325-1.2 of Title 12 NYCRR is amended to read as follows:

All specialists[,] and consultants, [etc.] except independent medical examiners, shall [submit a report of their findings in triplicate, one copy to the chair, one to the attending physician and one to the employer or insurance carrier. If the specialist acts as attending physician, he or she shall] file the reports prescribed for attending physicians under section 325-1.3 of this Subpart with the Board, claimant, the claimant's attending physician, the claimant's legal representative, if any, and the employer or insurance carrier.

Section 325-1.3 of Title 12 NYCRR is amended to read as follows:

325-1.3 Reports of attending physicians.

In order to expedite the processing of claims and to avoid, so far as possible, the appearance of physicians in contested bill proceedings, the rules with respect to filing of medical reports by attending physicians are here stated:

(a) All medical reports filed by attending physicians and specialists must be on the most recent version, or such other version mandated by the Chair, of the forms prescribed by the Chair, must be fully completed and must contain the provider's authorization certificate number and code letters.

(b) Every physician shall file [the following reports] all medical reports directly with the Chair, and also with the employer or the employer's carrier, if known, in the following intervals:

(1) within 48 hours following first treatment, [a 48-hour preliminary report];

(2) within 15 days after filing the medical report filed within 48-hours after the first treatment [preliminary report, and in no event later than 17 days after first treatment, a 15-day report giving a complete report of injury and treatment];

(3) thereafter [and] during continuing treatment and without further request, a progress report [at intervals of 45 days or less] for each follow-up visit to be scheduled when medically necessary except the intervals between follow-up visits shall be no more than 90 days;

(4) when a claimant reaches maximum medical improvement, which must include an opinion whether there is any permanent impairment, if any;

(5) immediately upon termination of treatment, a final report regardless of the date the last previous report was filed, except that where treatment is terminated within 48 hours following first treatment, the [48-hour preliminary report] medical report filed within 48 hours of the initial treatment shall constitute the final report if so noted thereon. In case of a herniotomy, a final report by the operating surgeon must be filed immediately following final examination of the injured person made not less than eight weeks after operation in case of a single hernia and not less than 12 weeks in case of a double hernia;

~~(5)~~ additional or more frequent reports when requested by the Chair and within three workdays after such request is made.

(c) Whenever a report is filed with the Chair by an attending physician after the time period for filing, as provided herein and in subdivision (4) of section 13-a of the Workers' Compensation Law, has elapsed, the physician shall attach thereto a signed and verified statement giving the true reason for which he requests excuse for late filing.

(d) [The following forms are prescribed for the use of physicians in filing the required reports:

(1) form C-4 for attending physician's 48-hour preliminary reports, 15-day reports, progress reports and final reports;

(2) form C-27 for medical report in support of application for reopening a closed case;

(3) form C-64 for final report in a death case.] All medical reports of attending physicians must be filed on the form or forms prescribed by the Chair for such purpose. A prescribed form is identified by the assigned alpha-numeric combination and a date. Further, all forms must be submitted only in the manner authorized by the Chair. Failure to use the correct prescribed form or to submit the form in the proper manner may result in disciplinary action by the Chair.

Section 325-1.4 of Title 12 NYCRR is amended to read as follows:

Section 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 [\$1,000] 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]Chair, by setting forth the medical necessity of the special services required on the Chair prescribed form for such purpose. [For example, when the total fees for occupational or physical therapy treatment approach the sum of \$1,000, the physician must file an additional C-4 report and request authorization as prescribed in subdivision (5) of section 13-a of the Workers' Compensation Law.] 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.

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

(3) [Such requests for authorization should be by telephone to the employer or carrier and confirmed by letter.] The attending physician or self-employed physical or occupational therapist seeking authorization shall 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. [To ensure compliance within the time limits prescribed, qualified persons shall be specially designated, within each office of the board, to deal with complaints relative to 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 [patient] claimant examined within four business days if the [patient] claimant is hospitalized or [30] thirty days if patient is not hospitalized, by an appropriate [medical board-certified] specialist who is [also] authorized [in such specialty,] by the [chair,] Chair to [treat] 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 [an authorized physician who is acceptable to both the self-insured employer or insurance carrier and the physician requesting authorization, or in the event the parties cannot agree, a physician may be selected by the chair] 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) of this Chapter.

(6) The self-insured employer or insurance carrier shall [grant or deny the requested authorization within four working days if the claimant is hospitalized, or within 30 days if the claimant is not hospitalized, by orally notifying the physician or hospital of its action. It shall confirm such action in writing by sending a notice to the physician, claimant's attorney or licensed representative and/or hospital within five days after the examination of the claimant when the four-day provision applies. When the 30-day provision applies the written confirmation shall be mailed within such period. Written notice of denial must be based on a conflicting second opinion rendered by a physician authorized to treat workers' compensation claimants.] 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) 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 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 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 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. 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 Chapter.

(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 [is not forthcoming] has not been sent by one of the prescribed methods of transmission in section 324.1 (h) 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 [four working days if the patient is hospitalized, the chair may issue an order, after investigation, authorizing the special services, on the ground that such authorization has been unreasonably withheld and the employer or carrier shall be liable for the payment for such special services and investigation. If such authorization or denial is not forthcoming within 30] thirty calendar days [if the patient is not hospitalized], 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 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 the authorization is untimely or does not reference or have attached a conflicting medical report 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 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 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.

([8]11) Such authorization is not required in an emergency under the provisions of [subdivision (5) of section 13-a of the] 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[ever medical care or special services are required in cases when the right to compensation is controverted or the time to controvert has not expired,] it is necessary for the attending physician [or the hospitals, specialists, consultants and surgeons engaged to perform such services] 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[: and all provisions of] by following the procedures in subdivision (a) of this section [are applicable to such requests]. 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 [c]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.

Section 325-1.6 of Title 12 NYCRR is repealed.

The title and the opening paragraph of section 325-1.24 of Title 12 NYCRR are amended to read as follows:

325-1.24. Payment of bills for treatment or services performed on or after October 1, 1994 and before December 1, 2010.

The making of an administrative award, pursuant to the provisions of subdivision 1 of section 13-g, subdivision 6 of section 13-k, subdivision 6 of section 13-1 and subdivision 7 of section 13-m of the Workers' Compensation Law, for any unpaid bill submitted to a self-insured employer or carrier by a physician, hospital, self-employed physical or occupational therapist, podiatrist, chiropractor or psychologist for treatment or services performed on or after October 1, 1994, and before December 1, 2010 shall be subject to the following:

A new section 325-1.25 is added to Title 12 NYCRR 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.

(a) Obligation and liability of employer or insurance carrier to provide medical care.

(1) The employer or insurance carrier is required to promptly provide the claimant with such medical care, including symptomatic, palliative, or maintenance treatment, for such period as the nature of the injury, illness,

or occupational disease, or process of recovery may require. When the medical care is to or for a part of the body covered by the Medical Treatment Guidelines as set forth in section 324.2 (a) of this Subchapter, the employer or insurance carrier is required to provide such medical care which is consistent with the Medical Treatment Guidelines or an approved variance from such guidelines.

(2) The employer or insurance carrier is liable for the payment of medically necessary care to the claimant when it has accepted the claim or the claim has been established as compensable by the Board. When the medical 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 shall be obligated to pay for all medical 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 Subchapter 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) of this Subchapter; (iii) agreed to by the employer or insurance carrier; or (iv) as ordered by the Board pursuant to statute or regulation. The employer or insurance carrier shall not be obligated to pay for any medical 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 Board in accordance with section 324.3 of this Subchapter or as ordered by the Board pursuant to statute or regulation.

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

(1) Physicians, podiatrists, chiropractors, or psychologists authorized by the Chair to provide treatment and care under the Workers' Compensation Law to a claimant or self-employed occupational or physical therapists shall submit bills for services performed on or after December 1, 2010, on the appropriate forms and version as set forth in section 325-1.3 of this Subpart. Bills shall be submitted to the employer or insurance carrier either

within ninety days from the last day of the month in which services were rendered, or ninety days from the last day of the month in which the claimant received the final treatment in a continuous course of treatment. 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.

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

(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 treatment or services performed on or after December 1, 2010.

(1) The insurance carrier within forty-five 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, or hospital and the Board on a form prescribed by the Chair for such purpose that the bill is not being paid and the reasons for non-payment. If the employer or insurance carrier 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, or hospital and the Board. If the employer or insurance carrier 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, or hospital 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 may file its explanation of benefits form. If the employer or insurance carrier 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, along with the basis for the objection, and submitted to the physician, self-employed occupational or physical therapist, podiatrist, chiropractor, or psychologist, or hospital and the Board.

(2) If the insurance carrier objects to only a portion of the bill submitted, it shall pay the uncontested portion within forty-five days and file objections to the remaining portion as indicated herein.

(3) If the insurance carrier has not objected in the manner described herein to the payment of the bill within forty-five 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.

(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 treating outside the scope of practice.

(6) Legal objections as to the liability of the insurance carrier 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 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 the Board before the medical care was rendered; (ii) the physician, self-employed occupational or physical therapist, podiatrist, chiropractor, psychologist, or hospital varied from the Medical Treatment Guidelines, the physician, podiatrist, chiropractor, or psychologist requested and received approval for a variance from the employer or insurance carrier or the Board before the medical care was rendered but provided medical care other than what was covered by the variance; or (iii) the physician, self-employed occupational or physical therapist, podiatrist, chiropractor, psychologist, or hospital 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, or self-employed occupational or physical therapists, who provide medical care or hospitals providing services to claimants who have timely submitted bills for payment to the insurance carrier and who have not been paid in full or in part or received the

form prescribed by the Chair 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 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 forty-five days from the date of the submission of the bill or thirty days from the date of the Workers' Compensation Law Judge or conciliation decision, or if appeal, Board Panel decision establishing the insurance carrier's liability for the bill, and no later than one hundred twenty days from (i) the date of receipt of notification of nonpayment, or (ii) the expiration of the time within which the insurance carrier 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, or hospital, the Chair may for good cause shown excuse a delay in the submission of the request for an administrative award.

(3) The Board will not accept any request for an administrative award until all issues duly and timely raised by the insurance carrier with respect to its legal liability for payment and/or any Medical Treatment Guidelines objections set forth in subdivision (c) (7) of this section have been finally determined adversely to it.

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

(i) the bill was timely submitted to the employer or insurance carrier and the bill was not returned by postal authorities;

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

(iii) the employer or insurance carrier did not submit the Chair prescribed form raising valuation issues 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 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) 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 shall be returned to the physician, self-employed occupational or physical therapist, podiatrist, chiropractor, psychologist, or hospital with an explanation of why the request 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 medical 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, or hospital. 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 thirty days after the date of the proposed administrative award.

(6) Any party in interest may submit a written objection on the form prescribed by the Chair 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, other than a hospital, pursuant to this section shall be paid in accordance with the provisions of section 300.19(o) of this Chapter.

(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 or hospitals providing services to claimants who have timely submitted bills for payment to the employer or insurance carrier in compliance with the provisions herein and have received the Chair prescribed form from the insurance carrier 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 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, or hospital and shall be conducted in accordance with the provisions of Parts 327, 328, 332, 342, 347, or 349-2 of this Chapter, 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, 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 insurance carrier with respect to its legal liability for payment and/or any Medical Treatment Guidelines objections set forth in subdivision (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 insurance carrier objects to payment of all or part of the bill for medical care rendered for reasons concerning its legal liability for payment and/or the Medical Treatment Guidelines as set forth in subdivision

(c) (7) of this section and raises legal and/or Medical Treatment Guidelines objections on the Chair prescribed form 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, or hospital 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, or hospital, the insurance carrier shall pay the bill within thirty days from the filing of the Notice of Decision or may raise valuation issues as to all or part of the bill within thirty days by filing the Chair prescribed form for such purpose as indicated herein.

(3) If the employer or insurance carrier 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, or hospital, the employer or insurance carrier 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, or hospital, the employer or insurance carrier shall pay the bill within thirty 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 thirty days by filing the form prescribed by the Chair 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.