

Subparagraph (4) of subdivision (f) of section 300.22 of Title 12 of the NYCRR is amended as follows:

4. Reporting of other types of benefits. Upon submission of a subsequent report of injury required by subparagraphs (1) [or], (2)[,] or (3), the carrier, Special Fund, or TPA shall be responsible for reporting the total amount and type of payments made in connection with the claim, including: (i) all penalties paid to the claimant or New York State; (ii) all medical expenses including payments to physicians, chiropractors, physical therapists or other medical providers, payments to hospitals, payments for pharmaceuticals, payments for dental expenses, payments for durable medical goods, payments for medical and travel expenses reimbursed to the claimant, any other medical expenses; (iii) attorney fees or other legal fees; (iv) interest paid. Such reports shall be filed electronically in the format prescribed by the chair and shall contain the data elements prescribed by the chair.

Section 300.26 of Title 12 of the NYCRR is amended as follows:

§ 300.26 Information to be furnished with each payment of compensation

The employer or carrier paying compensation to a claimant shall specify with each payment the period for which such payment is made, and the rate[.] , and shall notify the Board of such payment and the period for such payment when prescribed in subdivision (f) of section 300.22 of this Part.

Section 300.29 of Title 12 of the NYCRR is amended as follows:

§ 300.29 Modification of distribution of payment in compliance with income execution or income deduction

Any party liable for the payment of a compensation award may modify the distribution of such payment without the necessity of a Workers' Compensation Law Judge hearing or notice of decision where such modification is made in order to comply with an income execution or income deduction issued pursuant to an order of support as defined in [CPLR 5241](#) and [CPLR 5242](#) which has been served upon said party. Where said party is otherwise required to [file a form C-8/8.6] file electronically a notice of payment modification pursuant to section 300.22, [a form C-8/8.6]the notice of payment modification and a copy of the income execution or income deduction shall be [filed with] submitted to the Chair with [proof of mailing of] copies thereof upon the claimant and his or her legal representative (if any). Any modification of payment made in compliance with an income execution or income deduction order for support enforcement issued pursuant to an order of support as defined in [CPLR 5241](#) and [CPLR 5242](#) shall not be grounds for imposition of a penalty under the Workers' Compensation Law, so long as the monies paid in compliance with the income execution or income deduction order are limited to those monies which would have been paid to the claimant, after payment of any liens for attorney or licensed representative fees, or for prior payment made by a disability benefits carrier, or for advance payments of compensation by an employer.

Subdivision (b) of section 300.33 of Title 12 of the NYCRR, is amended as follows:

(b) All cases in which a notice of controversy and a medical report referencing an injury are [~~filed~~]submitted shall be scheduled for a pre-hearing conference to be held as soon as practicable, but in no event more than 30 calendar days after receipt by the board of the notice of controversy and a medical report referencing an injury. Cases with outstanding issues, which cannot be processed through conciliation or administrative determination, shall be referred to a pre-hearing conference when necessary to complete any discovery.

Subdivision (d) of section 300.33 of Title 12 of the NYCRR, is amended as follows:

(d) All represented parties must file a pre-hearing conference statement in accordance with section 300.38(f) of this Part.

Subparagraph (1) of subdivision (f) of section 300.33 of Title 12 of the NYCRR, is amended as follows:

(f) If the claimant has not retained a legal representative on or before the date of the pre-hearing conference, the following provisions shall apply:

(1) Pre-hearing conferences shall be held before a Workers' Compensation Law Judge or Conciliator, who shall consider at the conference, with the parties or their authorized legal representatives, the following:

(i) confirmation that all appropriate information, forms or notices, including completed medical reports, have been submitted and a verification that all information on the forms and notices is accurate;

(ii) addition of any other necessary parties, where appropriate;

(iii) simplification and limitation of factual and legal issues, where appropriate;

(iv) presentation of a list of proposed witnesses, where appropriate;

(v) production of depositions of proposed witness, where appropriate;

(vi) scheduling the case for hearing; and

(vii) entering into a stipulation made in writing, in which case it shall be signed by all parties to the stipulation. All parties to the stipulation shall certify that they have been advised of the legal effect of the stipulation and that they have agreed to the stipulation of their own free will.

Subparagraph (4) of subdivision (f) of section 300.33 of Title 12 of the NYCRR, is amended as follows:

(4) Ten days before the pre-hearing conference, the insurance carrier shall file with the board a pre-hearing conference statement, on a form prescribed by the chair, noting all of the specific issues in dispute. The employer's or carrier's statement shall be accompanied by the carrier or

employer's first report of injury, [(C-2)]and any medical reports, from a treating health provider(s) or consultants, which the employer or carrier has in its possession.

Section 300.37 of Title 12 of the NYCRR is amended as follows:

§ 300.37 Case file creation and indexing of claims that may be controverted

(a) Case File. Upon receiving any document or notice regarding a claim or potential claim for workers' compensation benefits for which a case number has not been assigned and a case file has not been created, the Board shall assign a unique case number and create a case file. The assignment of a case number and creation of a case file is not the indexing of a claim for purposes of filing a notice of controversy in accordance with paragraph (b) of subdivision (2) of [section 25 of the Workers' Compensation Law](#). The Board shall assign the case number and create the case file within five business days of receipt of said document for which a case file does not exist. Nothing in this section changes existing law with respect to the filing of a claim for purposes of the limitations period set forth in [Workers' Compensation Law section 28](#).

(b) Indexing.

(1) The Board will index a claim for compensation only upon the receipt of these notices or forms:

(i) a [completed] notice or form prescribed by the Chair for an employee, dependent or beneficiary, volunteer firefighter, volunteer ambulance worker, or a volunteer who meets the definition set forth in subdivision (1) of [section 161 of the Workers' Compensation Law](#) for a participant in World Trade Center rescue, recovery or cleanup operations to make a claim for compensation, death benefits or volunteer benefits (hereinafter referred to as Employee Claim form) pursuant to the Workers' Compensation Law, Volunteer Firefighters' Benefit Law or Volunteer Ambulance Workers' Benefit Law, or a [completed] notice or form prescribed by the Chair for an employer or political subdivision to report an injury or illness of an employee, volunteer firefighter or volunteer ambulance worker as required by [Workers' Compensation Law section 110](#) and/or [Volunteer Firefighters' Benefit Law section 42](#) and [section 57](#) or [Volunteer Ambulance Workers' Benefit Law section 42](#) and [section 57](#) (hereinafter referred to as Employer's Report);

(ii) a completed report or form as prescribed by the Chair for a medical provider treating an injured employee to report on medical treatment which references an injury (hereinafter referred to as Medical Report), except that the Medical Report need not be [on the prescribed form] in the prescribed format where (a) the treating medical provider is based out of state; (b) the claimant was treated in an emergency room; or (c) the claimant is deceased; and

(iii) a completed and executed limited authorization to obtain relevant medical records regarding the prior medical history of the body part or illness at issue (hereinafter referred to as Limited Release). The Limited Release is only required if the claimant files a completed Employee Claim form and indicates on the form that he or she had a prior injury to the same body part or similar illness to the one(s) listed on the form. It shall be part of the Employee Claim form and compliant with the Health Insurance Portability and Accessibility Act.

(2) Notwithstanding paragraph (1) of this subdivision, if the Chair obtains information that a worker was killed due to injuries or illness sustained in a work related accident, the Chair may direct that a claim be indexed if the alleged employer has either failed or refused to [file] submit an Employer's Report as described in paragraph (1) of this subdivision and neither a beneficiary nor representative of the worker's estate has filed a claim or can be identified to file a claim.

(3) Within five business days of receiving the notices or documents required for indexing as set forth in paragraph (1) of this subsection, except as set forth in subsection (c) of this section, the Board shall index the claim and electronically make available to the insurance carrier and, if applicable, the Uninsured Employers' Fund created by [Workers' Compensation Law section 26-a](#), all documents which the Board has received to date.

(4) Notice of Indexing. (i) The Board shall send the claimant, the claimant's legal representative, if any, the insurance carrier and if applicable, the Uninsured Employers' Fund, the notice of indexing on the form prescribed by the Chair. The Board shall also make available to the insurance carrier and, if applicable, the Uninsured Employers' Fund, the completed Limited Release executed by the claimant required by subdivision (b)(1)(iii) of this section.

(ii) The notice of indexing shall include notification that if the insurance carrier [files] submits a notice of controversy:

(A) any independent medical examination report as provided in section 300.2(d)(3) of this Part (hereinafter referred to as IME Report) shall be filed with the Board and served as required by [Workers' Compensation Law section 137\(a\)\(1\)](#) at least three days before the date set for the Initial Expedited Hearing; and

(B) the failure to so file and serve an IME Report shall be a waiver, as provided in section 300.38(g)(8) of this Part, of the insurance carrier's right to examine the claimant and to have filed on its behalf or otherwise have considered an IME Report on the threshold issue of causal relationship.

(c) When claim is not indexed. (1) Notwithstanding subdivision (b) (1) of this section, if the insurance carrier [files with] submits to the Board a [form] notice that serves one of the purposes described in this paragraph before the Board receives all of the notices or forms required to index a claim as provided in subdivision (b) (1) of this section, the Board is not required to index a claim. The Board may take appropriate action without indexing a claim to address any issue(s) or dispute(s) raised by one of the parties in a form that serves one of the purposes described below that has been filed with the Board by the insurance carrier. If the Board does not index a claim in accordance with this subdivision, the date the Board received the [form filed] notice submitted by the insurance carrier that serves one of the purposes described in this paragraph shall be considered the date of indexing for purposes of [Workers' Compensation Law sections 25\(2-b\)](#) and [32](#). The [forms]notices are those [prescribed by the Chair or the Board] required by section 300.22 of this Part and that:

(i) accept the claim or show that the claim has been accepted; or

(ii) agree to make temporary payment of compensation, payment for medical treatment, and payment for prescribed medicine without prejudice and without admitting liability pursuant to [Workers' Compensation Law section 21-a](#); or

(iii) controvert the claim.

(2) If the insurance carrier [files a form] submits notice controverting the claim before the claim is indexed in accordance with subdivision (b)(1) of this section and the Board has not received a medical report referencing an injury, the Board shall:

(i) contact the claimant, the claimant's legal representative if applicable, and the claimant's treating medical provider or providers if known, in writing to advise of the need for and how to file a Medical Report;

(ii) attempt to contact the claimant, claimant's representative if applicable, and the claimant's treating medical provider or providers, if known, by telephone to explain the need for and how to file a Medical Report; and

(iii) if the claimant is unrepresented and a Claimant Information Packet has not been sent in accordance with subdivision (d)(2)(ii), send a Claimant Information Packet as described in subdivision (d)(2)(ii) of this section to the claimant.

(d) Provisions applicable to all claims that have been or may be controverted.

(1) If the claimant has retained a legal representative at the time the Employee Claim form is filed with the Board, the legal representative shall file with the Employee Claim form:

(i) a written certification, signed by the legal representative, that to the best of the legal representative's knowledge, information and belief, formed after an inquiry reasonable under the circumstances, the allegations and other factual matters asserted on the Employee Claim form have evidentiary support or if specifically so identified, are likely to have evidentiary support after a reasonable opportunity for further investigation or discovery; and

(ii) a list of all documents in the possession, custody or control of the claimant that may be used to support the claim.

(2) If the claimant has not retained a legal representative, the Board shall do the following with respect to a claim that has a case number but has not been indexed, has not been accepted by the insurance carrier, or does not have an Employee Claim form and a Medical Report in the case file:

(i) make readily available, to the employee, assistance in: A) complying with the indexing requirements in subdivision (b)(1) of this section when applicable; B) completing the Employee Claim form; and C) obtaining a Medical Report. Such assistance shall include information about the need for a Medical Report, the services of the Office of the Advocate for Injured Workers, a Board employee electronically completing the Employee Claim form based on information

provided by the claimant through a recorded telephone conversation and sending the completed form to the claimant for review, and a telephone hotline exclusively dedicated to these purposes;

(ii) provide to the claimant by mail or other effective means the following information and documents (hereinafter referred to as the Claimant Information Packet):

A) an Employee Claim form;

B) instructions for completing said form that shall include notice of the availability of assistance in completing the form by calling a toll free telephone number;

C) notice of the necessity of a Medical Report, including the requirement that a medical report referencing an injury must be received in order to schedule a pre-hearing conference if the claim is controverted;

D) notice of the requirement that the employee complete and execute a Limited Release if the employee indicates on the Employee Claim form that he or she had a prior injury to the same body part or similar illness as the one(s) listed on such form;

E) notice that the employee has the right to a legal representative in proceedings before the Board, accompanied by information about access to an attorney or licensed representative which contains contact information for the State and local bar associations and information on how to obtain a list of licensed representatives; and,

F) notice regarding medical treatment for work related injuries, including that:

(1) the employee is entitled to medical treatment and prescription drugs for the work related injury and should not pay for such medical treatment; and

(2) the insurance carrier may have contracted with a designated pharmacy or pharmacies from which the employee may be required to obtain his or her prescription drugs and the insurance carrier must send notice to the employee about the designated pharmacy or pharmacies; and

(3) the insurance carrier may have contracted with a diagnostic network to perform x-rays, computed tomography scans (also known as computerized axial tomography scans)(CT or CAT scans) and/or magnetic resonance imagings (MRI), the employee may be required to obtain such diagnostic tests from a provider that is part of the network, and the insurance carrier must send notice to the employee about such network.

(iii) inform the claimant of all available resources in a meaningful fashion, using plain language. All forms, instructions and notices shall be available in English and Spanish; and

(iv) notify the claimant semi-annually in writing for two years after the filing of any document with the Board of the claimant's right to file a claim, the statute of limitations for doing so, and the assistance available for indexing a claim so long as the Board has a valid address for the claimant.

(3) The Employer's Report shall require the employer or its designee to certify that the employer or its designee has delivered to the injured or ill employee the Claimant Information Packet. The contents of the Claimant Information Packet are set forth in paragraph (2)(ii) of this subdivision except that the notices described in clause (F) of such paragraph shall also include specific information about the designated pharmacy or pharmacies and diagnostic networks claimants must utilize. (i) The information about the designated pharmacy or pharmacies must be in the form of a pharmacy benefit card and include (A) either the identity of all pharmacy chains and independent pharmacies designated by the insurance carrier, or where more than one pharmacy chain or independent pharmacy is so designated, the identity and contact information of a pharmacy benefits manager or other party, who shall provide a list of all pharmacies in the employee's state to the employee in writing or electronically upon and in accordance with an employee's request, and (B) a toll-free number and website where the employee may access information regarding the procedures by which the employee must fill and refill prescriptions through a remote pharmacy or other means, and may obtain a list of such pharmacies including their name, address and phone number, searchable by geographic location and fully updated as of the date at issue, in that employee's state. (ii) The information about the diagnostic network must include (A) the identity and contact information for the diagnostic network with which the insurance carrier has contracted; and (B) a toll-free number and website where the employee may access information about providers who are part of the diagnostic network and how to schedule an appointment. The contents of the Claimant Information Packet will be available to employers on the Board's website except for the information about the specific designated pharmacy or pharmacies and/or diagnostic network(s).

(4) A Medical Report shall set forth facts and opinions responsive to the questions on the form. A separate narrative or office notes of an authorized medical provider shall not be sufficient to serve as a Medical Report, although they may be used to supplement information in the Medical Report. Separate narrative or office notes may serve as a Medical Report if (i) the treating medical provider is based out of state; (ii) the claimant was treated in an emergency room; or (iii) the claimant is deceased. A medical provider shall not be paid for examining the claimant and filing a Medical Report unless the Medical Report is completed in accordance with this paragraph. The Medical Report may be filed electronically.

(5) A claimant who has not satisfied the indexing requirements may amend the required documents and resubmit them.

Section 312.2 of Title 12 of the NYCRR is amended as follows:

§ 312.2 Referral to conciliation processing

Within 30 days of carrier's response to notice of indexing, all cases where the expected duration of benefits is 52 weeks or less shall be referred for conciliation processing, except if a case is suitable for motion calendar or administrative determination processing. If a case is initially controverted [(C-7 filed)], the case will be processed for a pre-hearing conference under subdivision 2-a of [section 25 of the Workers' Compensation Law](#).

Subdivision (h) of section 312.5 of Title 12 of the NYCRR is amended as follows:

(h) The carrier is to [file form C-8/8.6] submit the report of payments as required by section 300.22 showing payments have been made. [Form C-8/8.6 in conciliation cases is to be filed within the time frame enumerated in section 25 of the Workers' Compensation Law.]

Section 327.3 of Title 12 of the NYCRR is amended as follows:

§ 327.3 Notice of carrier's objections to bills and hospital's request for arbitration [of bills for services rendered on or after October 1, 1994]

(a)(1) A carrier objecting to any bill for hospital care or for services performed by a hospital shall notify the hospital in writing that the bill is not being paid and explain the reasons for non-payment within 45 days after the bill has been submitted in accordance with section 325-1.24 or 325- 1.25 of this Title. The notification shall contain the name, telephone number, [and] facsimile transmission number and email address, if available, of a contact person to whom the hospital may address any inquiry regarding the carrier's objection to the bill. The carrier shall set forth the specific basis for its non-payment of the bill and explain in detail the reasons supporting its objections. Any objection which sets forth the specific basis for non-payment but does not explain in detail the reasons supporting the objection shall not be considered sufficient notification in writing for purposes of this section.

(2) Notwithstanding the provisions of paragraph (1) of this subdivision, in any case the [filing of a completed form C-7] submission of a notice of controversy and [C-8.1] notice of treatment issue or bill dispute in the format prescribed by [with] the chair and service of the [completed form] notice upon the hospital within such 45 day period shall be deemed to be a notification in writing explaining the reasons for non-payment with respect to any legal objections raised therein. In lieu of providing [form C-7 or C-8.1] such notices to the hospital, the carrier may send the hospital a sufficiently detailed written explanation raising legal objections to the bill. If the carrier has timely [filed form C-7 and C-8.1] submitted such notices with the chair and served a copy of the [completed form] notice upon the hospital or sent the hospital a sufficiently detailed written explanation raising legal objections to the bill, the carrier shall notify the hospital in writing that the bill is not being paid and explain the reasons for non-payment, in the same manner as set forth in paragraph (1) of this subdivision, within 30 days after all questions duly and timely raised with respect to the carrier's liability for such bill have been finally determined adversely to the carrier; provided, however, that the explanation for non-payment shall not be on the basis of any issues previously adjudicated by the Workers' Compensation Law Judge or the Board which have been finally determined adversely to the carrier. If the carrier files an application for review of a decision by a Workers' Compensation Law Judge, the carrier shall serve a copy of the application for review, together with the prescribed cover sheet (form RB-89) on the hospital simultaneously with its service on all other parties required to be served. The carrier may notify the hospital in writing that it has filed an application for review, in lieu of serving a copy of the application and cover sheet on the hospital.

(3) If the carrier fails to object to a bill in accordance with the provisions of section 325-1.24 or 325-1.25 of this Title and this subdivision, the hospital may request an administrative award in accordance with section 325-1.24 or 325-1.25 of this Title.

(b) Upon receipt of a timely written notification of the carrier's explanation for non-payment in accordance with subdivision (a) of this section, the hospital may request arbitration by notifying the chair in accordance with the following:

(1) if the carrier has not raised legal objections to the bill, the request for arbitration shall be submitted a minimum of 45 days after the date of the hospital's submission of the bill to the carrier, but no later than 120 days after receipt of notification of non-payment, or

(2) if the carrier has raised legal issues, the request for arbitration shall be submitted subsequent to the hospital's receipt of the carrier's written explanation for non-payment but in any event no earlier than 30 days after the date of notice of a final decision by the Workers' Compensation Law judge or the board in favor of the hospital with respect to issues requiring adjudication, and no later than the later of 120 days after either the date of filing of such decision or the date of receipt of the carrier's explanation for non-payment. If the hospital wishes to arbitrate, it shall complete and sign the request form for arbitration [(HP-1)] and forward it to the address specified on such form. The hospital's failure to make a timely request for arbitration shall be deemed a waiver of the right to arbitration; provided, however, that upon application of the hospital, the chair may for good cause excuse the hospital for the delay in filing the request for arbitration and schedule the disputed bill for arbitration.

(c) The hospital's failure to submit a bill to the carrier within 120 days from the last day of the month in which services were rendered shall be deemed a waiver of the right to arbitrate the bill; provided, however, that upon application of the hospital, the chair may for good cause shown excuse the hospital for delay in submitting such bill to the carrier, and schedule the bill for arbitration.

Section 403.1 of Title 12 of the NYCRR is amended as follows:

§ 403.1 Priority processing of controverted claims for benefits by volunteer firefighters for death or disability due to disease or malfunction of the heart or of one or more coronary arteries

The following procedures shall apply to all controverted claims for benefits for the death or disability of a volunteer firefighter due to disease or malfunction of the heart or of one or more coronary arteries:

(a) All claims for benefits shall be filed with the chair on a form prescribed by the chair, completed with such information as may be required therein. After receipt of the prescribed form, a notice of indexing shall be mailed on an expedited basis.

(b) (1) Upon receipt of a notice of controversy, the board shall expedite the processing of the claim by scheduling any pre-hearing conference as may be required by the Workers'

Compensation Law on a priority basis. Any proceedings required before a Workers' Compensation Law judge subsequent to any pre-hearing conference shall also be scheduled on a priority basis. If the carrier has not timely [filed form C-6, C-7 or C-9] submitted a notice of initial action to the Board pursuant to section 25 of the Workers' Compensation Law and section 300.22 of this Title, a priority hearing shall be set. (2) When a hearing is set for testimony on any controverted issues, all witnesses shall be scheduled for testimony on that date.

(c) All controverted claims shall be entitled to priority processing as required by section 61 of the Volunteer Firefighters' Benefit Law and shall be processed in accordance with this section, provided, however, that the 90-day period for expedited determination of a claim pursuant to subdivision 2 of section 61 of the Volunteer Firefighters' Benefit Law shall commence from and be conditioned upon the board's receipt of a completed claim. For purposes of this section, a completed claim in a controverted case shall include a completed claim form as set forth in subdivision (a) of this section, prima facie medical evidence and a notice of controversy [(form C-7) filed with] submitted to the chair.

(d) Notwithstanding any other provisions of this Title to the contrary, an employer or carrier initially controverting a claim on the issue of whether the claimant has a causally related disability due to disease or malfunction of the heart or of one or more coronary arteries, and desiring to have the claimant examined by its consultant, shall have the claimant examined either prior to the first scheduled pre-hearing conference or within 30 days after receipt of a prima facie medical report stating that claimant has a causally related disability due to disease or malfunction of the heart or of one or more coronary arteries, whichever is later. In the event the carrier or employer fails to have the claimant timely examined in accordance with the foregoing, the carrier or employer shall not be granted an adjournment by the Workers' Compensation Law judge for the purpose of obtaining a consultant's report with respect to the issue of causally related disability as set forth in such prima facie medical report, unless it is determined that the failure of the carrier to have the claimant examined was due to circumstances which were solely within the control of the claimant.