

## Assessment of Public Comment

The 45-day public comment period with respect to Proposed Rule I.D. No. WCB471100009 commenced on November 23, 2011, and expired on January 7, 2012. The Chair and the Workers' Compensation Board (Board) received and accepted formal written public comments on the proposed rule through January 7, 2012.

The Chair and Board received two formal written comments. The Board received a written comment from the Medical Society of the State of New York (MSSNY) dated January 3, 2012. The Board also received a written comment from Weingarten, Reid and McNally on behalf of One Call Medical dated December 31, 2011. These comments were reviewed and assessed. This assessment will summarize and respond to the comments by author.

### MSSNY'S COMMENTS:

The Definition of "Reasonable Distance": The distance that an injured worker may be required to travel from home or work to undergo a diagnostic study remains too far of a distance to be fair or practical to the injured worker as it will require injured workers to travel up to an hour when the best diagnostic provider or facility is not within the network. The best providers or facilities will not be in-network as they are unwilling to accept the steep discounts required by the network. Thus the networks will result in reduced quality of care.

Response: Workers' Compensation Law §13-a (7)(a) required the Board to define what constitutes a reasonable distance from the claimant's residence or place of employment by regulation. The regulation defines "reasonable distance" as 25 miles from the injured workers' home or residence, except within five miles in the City of New York, ten miles in the cities of Albany, Buffalo, Niagara Falls, Rochester, Schenectady, Syracuse, Troy and Yonkers and 15 miles within the counties of Nassau, Rockland, Suffolk and Westchester. The injured worker may have to travel up to one hour when there are no facilities within a reasonable distance from his or

her home. It appears that the majority of the diagnostic testing networks have ample facilities within the parameters defined in the regulation.

Ultrasound should not be subject to the network requirement: Ultrasounds are routinely used for treatment and care of patients as both a diagnostic tool and for guided procedures. Failure to exempt ultrasound from the network requirements will further drive quality medical providers from the workers' compensation system.

Response: The regulation only requires ultrasounds used for diagnosis to be obtained in-network. An ultrasound that is used during a medical procedure is not a diagnostic test or examination covered by the regulation. For example an ultrasound used for guiding injections instead of fluoroscopy is not diagnostic.

Treating medical providers should receive notice for each claim: The carrier should be required to provide the medical provider with notice for each claimant/patient required to use a diagnostic testing network rather than supplying notice via a general mailing to medical providers who treat workers' compensation claimants when the carrier or employer contracts with the diagnostic testing network. The regulation should require that a claimant who fails to provide the treating medical provider with the notice regarding the required use of a diagnostic testing network be directly responsible for the cost of the examination either personally or through his or her private insurer. If the carrier has not supplied the claimant with written notice the carrier should be liable for the cost of the diagnostic examination or test at the fee schedule rate. The regulations should require the Board to create a flow chart explaining when use of a network is required and should also maintain on its website regarding use of diagnostic networks.

Response: The regulation amplifies the notice requirements set forth in WCL §13-a(7) inasmuch as it requires the treating medical provider to receive notice that the carrier requires claimants to use diagnostic testing networks. Carriers are permitted to give treating medical providers notice with each claim, but they are also permitted to notify the medical provider when it engages the diagnostic testing network. This type of general notice mirrors the notices that are mailed by private health insurers to medical providers advising them

of the required use of particular lab facilities for testing or other types of network use. In addition, this type of mailing ensures that the cost savings generated by use of diagnostic testing networks are passed on to New York State employers through reduced insurance premiums rather than absorbed as an increased administrative cost by a diagnostic testing network. WCL §13-f prohibits medical providers from recovering from claimants for medical care. While the regulation does not require the Board to maintain information concerning diagnostic testing networks on its website, the Board intends to share as much information as possible by publication on its website, so that information concerning the use of diagnostic testing networks is readily available to claimants and medical providers.

The Chair should not be given broad authority to inspect the offices of affiliated network providers: This is an unnecessary expansion of powers and the Board already has ample power to address quality of care issues and fraud issues.

Response: The Chair's ability to inspect the premises of an affiliated network provider conducting diagnostic examinations and tests of claimants is not an unreasonable expansion of powers. It is assumed that this right will only be exercised where there is an allegation that a facility is inappropriate for the conduct of the tests or examinations being performed. This authority is intended to inspire confidence in use of diagnostic testing networks by claimants and their treating medical providers.

ONE CALL MEDICAL'S COMMENT:

Recommends that the regulation be amended to indicate that hospitals are exempt from MIPPA accreditation. Hospitals are exempt from Medicare Improvements for Patients and Providers Act (MIPPA) accreditation pursuant to Section 1834(e) of the Social Security Act and thus the Board's regulations should be revised to note this exemption.

Response: The exemption provided for in the federal legislation preempts the Board's regulation and thus no change to the regulation is necessary.

CHANGES TO THE REGULATION:

The Regulation that is being adopted contains the following insubstantial changes from the proposed rule published in the November 23, 2011 State Register:

- In section 325-7.5(b)(2)(ii), the reference to section 325-7.1(**l**) has been changed to 325-7.1(**k**)
- In section 325-7.5(b)(2)(iv), the reference to section 325-7.3(**h**) has been changed to 325-7.3(**i**)
- In section 325-7.5(c), the reference to section 325-7.3(**h**) has been changed to 325-7.3(**i**)