

## Assessment of Public Comment

The 45 day public comment period with respect to Proposed Rule I.D. No. WCB-14-15-00009-P, commenced on April 8, 2015 and expired on May 23, 2015. The Chair and the Workers' Compensation Board accepted formal written public comments on the proposed rule through May 23, 2015.

The Chair and the Board received four written comments. These comments were assessed and are discussed below. The comments are separated into comments about proposed regulatory changes and comments about language that existed in the prior regulation and has not been changed.

### *Comments on New Proposed Regulatory Language*

One vendor objected to the annual reporting requirements because the new regulations require tracking the total number of HIMP-1 forms submitted, and there currently is no such tracking technology available. The Board believes tracking the use of the HIMP system is a valuable and integral tool and as such, no change will be made.

One group representing health insurers commented that the definition contained in § 325-5.2(b) was too vague. The Board does not believe this definition is vague as it identifies the forms as those prescribed by the Chair, presently consisting of the FROI/SROI. Accordingly, no change will be made.

The same group requested that health insurers be allowed to access the Board's eCase system in cases where there was an acceptance of the claim by the compensation carrier, and there was a full match, but no ANCR. The Board recognizes the issue, and the Board will make access to eCase available in such cases when and if technologically feasible.

The same group questioned whether the "must be served" as stated in 325-6.2(b) was intended to be "must be filed" because requiring service within three years would cause timeliness issues and contradict § 325-6.3(b)(2). The Board acknowledges this language may cause confusion and will change "must be served" to "must be filed."

The group suggested modification of the proposed language contained in § 325-6.3 to recognize that workers' compensation carriers already have 90 days to seek medical records, and the group suggested requiring carriers to provide proof that any request for medical records was initiated within 14 days of the date of the filing of the HIMP request by the health insurer. The Board met extensively with stakeholders and carefully considered these issues before drafting the proposed regulations. As such, no changes will be made.

The majority of the comments concerned changes to HIMP in relation to the Medical Treatment Guidelines (MTG). In general, commenters argued a cost shift from workers' compensation carriers to health insurance carriers would result if the proposed changes are enacted. Further, the commenters contended that the narrowing of the guidelines and the stricter timeframes of the

matching program would make it more difficult for health insurers to recover costs for medical claims that were workplace injuries.

More specifically, commenters argued that the new objection contained in 12 NYCRR § 325-6.4(b)(11), “the treatment was not consistent with the applicable medical treatment guidelines adopted by the Board in Part 324.2(a)” makes the MTG applicable to health insurers or transmitting agents, which is contrary to the existing workers’ compensation law.

The commenters argued that health insurers’ standards are separate and distinct from the MTG standards. Health insurers pay for claims using the standard whether the claims demonstrate medically necessary care and care that is not excessive. The new regulations would impose a different standard on the health insurers, and the health insurers would not know the standard was applicable at the time of payment. The commenters further argued the workers’ compensation medical fee schedule protects against excessive payments.

After considering the extensive comments about the proposed objection contained in 12 NYCRR § 325-6.4(b)(11), “the treatment was not consistent with the applicable medical treatment guidelines adopted by the Board in Part 324.2(a),” the Board will change the objection to read: “the treatment provided by a Board authorized provider was not consistent with the applicable medical treatment guidelines adopted by the Board in Part 324.2(a)” to make the provision only applicable to medical providers who are authorized and regulated by the Board and who must adhere to the MTG.

#### *Comments about Regulatory Provisions where there is no Change in Proposal*

The Board reviews the following comments about regulatory language that was not changed in the repeal and proposal emphasizing that these regulations were originally enacted in 1993 and last amended in 2008. The Board stresses that the parties have worked with the regulations contained herein and health insurers have been able to recover significant reimbursements from carriers pursuant to these provisions.

Commenters requested modification to the proposed language contained in § 325-6.4(a) to ensure that carriers do not attempt to circumvent the HIMP process by filing a C-8.1 objection to the treatments outlined in the HIMP request. Furthermore, the Board has worked with its administrative law judges to ensure that improperly filed C-8.1s are denied. In every instance that a health insurer or vendor has identified an improperly filed C-8.1, the Board has intervened to ensure that such C-8.1 is denied.

The group expressed concern about the existing and proposed regulations because pursuant to 325-6.4(b)(8), health insurers are prohibited from directly seeking payments from health care providers who have also been paid by carriers. The Board notes that pursuant to WCL § 13(h), health insurers or other payors may use the information gained from the HIMP process to seek reimbursement only from carriers or employers, but may not use the information to seek reimbursement directly from health care providers. Therefore, the changes requested by the group are outside the scope and jurisdiction of the regulations. The Board also reiterates its clear

directive to all HIMP participants to notify the Board upon finding that a medical provider is consistently billing the health insurer instead of the compensation carrier.

The group objected to omitting language presently contained in § 325-6.4(b)(4), which is an objection stating, “The treatment, services or hospitalization for which the health insurer made payments were not furnished on an emergency basis...” The group argues that health insurers must be able to argue the services, treatment or hospitalization was incidental. The group objects to language contained in § 325-6.4(b)(3) for the same reason that consequential treatment may be related in the workers’ compensation injury, and the health insurers must be able to show that the treatment was related to the workers’ compensation injury. The Board met extensively with stakeholders and carefully considered these issues before drafting the proposed regulations. As such, no changes will be made.

The group proposed additional language for the objection contained in § 325-6.4(b)(7), “the carrier cannot determine from the documentation served whether it is responsible for payment.” The group requests adding a provision to require carriers to provide a detailed explanation why it cannot determine from the documentation whether it is responsible for the payment. The Board met extensively with stakeholders and carefully considered these issues before drafting the proposed regulations. As such, no changes will be made.

The group argued that changes should be made to § 325-6.12 to allow health insurers to be awarded attorneys’ fees in order to curb dilatory tactics by carriers. The Board met extensively with stakeholders and carefully considered these issues before drafting the proposed regulations. As such, no changes will be made.

The group suggested imposing penalties in the event carriers fail to pay within 30 days after an arbitration decision, because currently, the health insurers’ only recourse is a costly and time consuming action in Supreme Court under Article 75. The Board met extensively with stakeholders and carefully considered these issues before drafting the proposed regulations. As such, no changes will be made. The Board notes that the American Arbitration Association Rules for NY Workers' Compensation Health Insurers' Match Program (HIMP) govern the process required in the event of non-payment, and according to Rule 25, the party seeking enforcement may enter a judgment pursuant to the Workers’ Compensation Law § 26.

Commenters requested clarification for the provision contained in § 325-6.4(d)(1) as it lists issues that may not be identified as objections to requests for reimbursement and the first item states, “the failure of the provider to seek prior authorization for treatment pursuant to section 13-a(5) of the WCL...” The commenters contend that bills paid by health insurers that are found to be the responsibility of the carrier through the HIMP process would not have been presented for prior authorization. The Board met extensively with stakeholders and carefully considered these issues before drafting the proposed regulations. As such, no changes will be made.

#### CHANGES TO THE REGULATION:

The Regulation that is being adopted contains the following insubstantial changes from the proposed rule published in the April 8, 2015 State Register:

- In § 325-5.2(b), “form” is changed to “format prescribed by the Chair.” The sentence reads “Acceptance of the claim shall mean the filing of notice in the format prescribed by the Chair of the carrier’s acceptance of a claim of benefits.”
- In § 325-5.2(d), “conciliator” is added to the list of decisions. The sentence is changed to “... and in the case of Board determinations shall include those made by a member or panel of the Board, by a Workers’ Compensation Law Judge, conciliator or by the Full Board.”
- In § 325-5.2(e), “or” is added. The sentence now reads, “Carrier shall mean a self-insured or uninsured employer, or workers’ compensation insurance carrier ...”
- In § 325-5.5(g)(1) the clause, “if technologically feasible” is added. The sentence is changed to “... and the workers’ compensation claim has been established by a Board finding of ANCR or, if technologically feasible, by acceptance of a claim...”
- In § 325-5.8, an “a” is added to the last line. The last line now reads “such individual or entity’s status as a HIMP agent.”
- In § 325-6.1(a), “form” is changed to “format prescribed by the Chair.” The sentence, is changed to, “Acceptance of claim shall mean the filing of notice in the format prescribed by the Chair of the carrier’s acceptance of a claim of benefits.”
- § 325-6.1(d) is changed to add “conciliator” to the list of decisions. The sentence is changed to read “... and in the case of Board determinations shall include those made by a member or panel of the Board, by a Workers’ Compensation Law Judge, conciliator or by the Full Board.”
- In § 325-6.1(e), a grammatical error is corrected by adding an “or.” The sentence is changed to “Carrier shall mean a self-insured or uninsured employer, or workers’ compensation insurance carrier...”
- The heading and first line of § 325-6.2(b) is changed to change “Serving” and “served” to “Filing” and “filed.” The heading is now “Filing Requests for Reimbursement” and the first line is “Claims for reimbursement must be filed within three years...”
- In § 325-6.3(c), the word “form” is replaced the last two sentences with “document” and “documentation.” The sentences now read “All requests for reimbursement served on the carrier before establishment of ANCR must contain documentation indicating acceptance of the claim. The name of the claimant (or, in the case of death, the decedent) on such document must be the same as that of the person on whose behalf the health insurer made the payments for which reimbursement is being sought.”
- In § 325-6.4(b)(11), the sentence “the treatment was not consistent with the applicable medical treatment guidelines adopted by the Board in Part 324.2(a),” is changed to “the

treatment provided by a Board authorized provider was not consistent with the applicable medical treatment guidelines adopted by the Board in Part 324.2(a)” in order to make the provision only applicable to medical providers who are authorized by the Board to provide treatment to injured workers and who are subject to the MTG.

- The effective date of the regulation is established to be June 1, 2016.