

Sections 325-5 and 325-6 of Title 12 NYCRR are repealed and new Sections 325-5 and 325-6 of Title 12 NYCRR are added to read as follows:

Subpart 325-5 Computer match between health insurers and workers' compensation carriers

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§ 325-5.1 Statement of purpose

The purpose of subdivisions (d) and (h) of section 13 of the Workers' Compensation Law and this Subpart is to assist health insurers in the identification of claims that they have paid which may be the responsibility of the employer, workers' compensation insurance carrier, or special fund, and to obtain reimbursement thereof. This Subpart also intends to regulate the behavior of HIMP agents as defined in section 325-5.2(h) of this Subpart.

§ 325-5.2 Definitions

As used in this Subpart:

(a) Accident shall include both an accident arising out of and in the course of employment and an occupational disease.

In the case of occupational disease, date of accident, where used in this Subpart, shall mean date of disablement.

(b) 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.

(c) ANCR shall mean accidental injury or occupational disease, notice and causal relationship.

(d) Board shall mean the Workers' Compensation Board, 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.

(e) Carrier shall mean a self-insured or uninsured employer, or workers' compensation insurance carrier as defined in section 300.1(a)(7) of this Title, or special fund created by the Workers' Compensation Law for payment of workers' compensation claims, but shall not include the uninsured employers' fund.

(f) Chair shall mean the Chairperson of the Workers' Compensation Board of the state of New York.

(g) Health insurer shall mean a health insurer, health benefits plan or other payor of health benefits as defined in section 13(d) of the Workers' Compensation Law, when acting directly or through a HIMP agent.

(h) HIMP means the Health Insurance Matching Program authorized by paragraphs (d) and (h) of section 13 of the Workers Compensation Law and refers to processes established by the Board to assist a health insurer in reimbursement from a carrier for payments made for medical and/or hospital services for or on behalf of an injured employee, and for arbitration of disputed claims for reimbursement.

(i) HIMP agent shall mean a person or entity that is designated and authorized by a health insurer to submit information for matching under this Subpart and to seek reimbursement from a carrier under Subpart 325-6 on behalf of the health insurer. A HIMP agent must execute a written agreement, prescribed by the Chair, between the HIMP agent, the health insurer and the Board and file such agreement with the Board. In addition a HIMP agent must comply with all laws, regulations and policies applicable to health insurers as set forth in Workers' Compensation Law section 13(d) and (h), and Subparts 325-5 and 325-6 of this Part. Failure to comply with all terms of such written agreement or such other agreements with the Board or with all applicable laws, regulations, and policies is grounds for termination of an individual or entity's status as HIMP agent and to preclude its participation in and rights under Workers' Compensation Law section 13(d) and (h), and Subparts 325-5 and 325-6 of this Part.

§ 325-5.3 Overview of the HIMP process

The Workers' Compensation Board shall conduct computer searches at least quarterly upon the request of health insurers upon their full compliance with these regulations. Health insurers desiring such searches shall submit to the Board the required information including all data elements in a technological format prescribed by the Chair. Such information shall be compared with the computer records of the Board, in order to identify claimants whose social security number, name, date of accident, date of birth, or other qualifiers match dates of treatment submitted by the health insurer.

§ 325-5.4 Eligibility to participate in the HIMP process

Only a health insurer shall be eligible to participate in this program. A health insurer may contract with a HIMP agent, as defined in sections 325-5.2 (h) and 325-6.1(i) of this Part, to act on its behalf. The HIMP agent must satisfy all requirements set forth in section 325-5.2(h) and 325-6.1(i) of this Part to maintain its eligibility to participate in this program.

§ 325-5.5 General procedure for data-matching

(a) Format of requests for computer searches. Health insurers participating in the match program shall submit requests for computer searches in a technological format prescribed by the Chair. Such requests for computer searches shall include the claimant's social security number, if known, last name, initial of first name or first name, sex, date of birth, date of treatment, or date of accident, if known, and such other qualifiers permitted or required by the Chair that would establish the identity of the claimant as the person whose payments were covered by the health insurer.

(b) Time limitations. The date of treatment or accident submitted by the health insurer will be matched against the date of accident contained in the Board's file. If the date of treatment submitted by the health insurer is within 360 days of the date of accident contained in the Board file, the health insurer will receive a match on this time limitation criterion. A match on the time limitation criterion is required for all full matches.

(c) Full Matches. The Board will compare all information supplied by the health insurer against individually identifiable information contained in Board case files. When there is an identity of information between the information supplied by the health insurer and the individually identifying information contained in a claimant's case file of a quality and quantity to create a reasonable basis for the Board to determine that they are the same person, based on criteria set by the Chair that would establish the identity of the claimant as the person whose payments were covered by the health insurer, the Board shall notify the health insurer that there is a full match with respect to the claimant. A match on the time limitation criterion is required for all full matches.

(d) Partial matches. The Board will compare all information supplied by the health insurer against individually identifiable information contained in Board case files. When there is some identity of information between the information supplied by the health insurer and the individually identifying information contained in the claimant's case file, but such identity of information is not of a quality or quantity to create a sufficient reasonable basis for the Board to

determine that they are the same person, based upon criteria set by the Chair that would establish the identity of the claimant as the person whose payments were covered by the health insurer, the Board shall notify the health insurer that there is a partial match with respect to the claimant.

(e) Match situations.

(1) Full match. When there is a "full match," the Board will provide the health insurer with the following information:

(i) the workers' compensation case number;

(ii) a description of the injury or illness (if and as available in the Board's computer database);

(iii) the workers' compensation carrier's identification number (carrier code);

(iv) the workers' compensation carrier's case number (if and as available in the Board's computer database);

(v) a designation as to whether the carrier accepted the case by filing a C-669 (if and as available in the Board's computer database);

(vi) a designation as to whether ANCR has been established (if and as available in the Board's computer database);

and

(vii) a designation as to whether the case is open or closed (if and as available in the Board's computer database).

If there is a full match, the health insurer will be placed on notice for future hearings and decisions. A health insurer will only be placed on notice for future hearings and decisions in cases where there is a full match.

(2) Partial match. When there is a "partial match," the Workers' Compensation Board will provide the health insurer with the following information:

(i) the workers' compensation carrier's identification number (carrier code);

(ii) the workers' compensation carrier's case number (if and as available in the Board's computer database); and

(iii) identification of the fields that failed the "full match" process.

In such a situation, the health insurer shall not receive copies of hearing and decision notices and shall not be provided with the claimant's workers' compensation case number, a description of the injury or other individually identifiable information.

(3) No match. A "no match" occurs when sufficient matching data is not available for either a full match or a partial match. Where there is a "no match," no information is provided to the health insurer on that record or request.

(f) Return of requests for computer searches. The Board shall process a health insurer's initial request for computer searches and notify the health insurer of the information on "full" and "partial" matches. The Board will make every effort, barring unforeseen circumstances, to respond to and return the search request of the health insurer within 30 days of receipt of the search request.

(g) Availability of information in Board files.

(1) When a health insurer has been notified of a "full match" pursuant to subdivision (e)(1) of this section and the workers' compensation claim has been established by a Board finding of ANCR or, if technologically feasible, by acceptance of a claim, the health insurer shall be eligible to access the Board's electronic case file for such claim. A health insurer or its HIMP agent must execute an agreement prescribed by the Board to be eligible to access the Board's electronic case files. Failure of a health insurer or its HIMP agent to comply with the terms of such agreement or with Board rules, regulations, or policies governing the Board's electronic case files shall be grounds, following a hearing, for the Chair to prohibit access to the Board's electronic files. In addition, if the files are not available electronically, such health insurer may make a request in writing to the Board for any information in the Board files as may be relevant to any bill that has been paid by such insurer or health benefits plan. Such requests shall be submitted to the Workers' Compensation Board at an address designated by the Chair.

(2) Upon receipt of a written request by a health insurer pursuant to paragraph (1) of this subdivision, the Board files shall be reviewed by Board personnel to determine which, if any, documents, reports, records and/or other materials contained therein are relevant and/or necessary to the request for reimbursement made by the health insurer. The cost for review of Board files by Board personnel shall be borne by the health insurer in accordance with section 325-5.6 of this Subpart. Copies of all such documents, reports, records and/or other materials contained therein determined to be relevant and/or necessary by Board personnel shall be made available to the health insurer requesting such information, provided, however, that no copies of such information shall be made available to a health insurer with respect to any compensation claim which has been closed without findings of accident, notice and causal relationship. In such cases where the case has been closed without findings of accident, notice and causal relationship, the Board shall so advise the health insurer in writing. The costs of photocopying documents, reports, records and/or other materials from Board files shall be borne by the health insurer in accordance with section 325-5.6 of this Subpart.

(h) Age of claims to be submitted. Requests for computer searches must be submitted to the Board within three years of the date of payment for services rendered by the health care provider.

§ 325-5.6 Payment for searches; process for submission of search requests

(a) Fees for computer match process.

(1) The Board will charge a health insurer \$0.045 for each search request submitted through the computer match process. Where multiple searches of the same record are required, there shall be a charge for each search. Payment shall be made in a form acceptable to the Chair and must be received prior to the Board performing the computer search.

(2) Submission of data; payment. A health insurer shall identify the number of claims submitted and the total cost as per the rates cited in subdivision (a)(1) of this section in a manner and at a time prescribed by the Chair as periodically provided to the health insurer by written or electronic notice or such method as shall be provided in such notice.

(b) Fees for manual searches by Board personnel

(1) Manual search of archived cases. The charge for a manual search by Board personnel of Workers' Compensation Board records in archived cases that are not available electronically will be \$2.50 per workers' compensation case number search. Payment must accompany the request for a manual search and is to be made in a form acceptable to the Chair.

(2) Manual review of an electronic file. The charge for a manual search by Board personnel of Workers' Compensation Board records in electronic case files will be \$2.50 per workers' compensation case number search. Payment must accompany the request for a manual search and is to be in a form acceptable to the Chair.

(3) Copying costs. The charge for copying documents pursuant to a request for a manual search of an archived case or for manual review of an electronic file shall be as specified in Public Officers' Law, section 87(1) (b) (iii). Copying costs shall be in addition to the fees charged for manual searches as specified in subdivisions (1) and (2) herein.

§ 325-5.7 Annual reporting

No later than March 31st of each year, each health insurer and HIMP agent participating in this program shall send a report to the Chair indicating the total amount of reimbursement requested and recovered, the total number of HIMP-1 forms submitted for reimbursement, the total number of requests for arbitration submitted in the prior calendar year as a result of this program, identifying the number of requests for a desk arbitration and the number of requests for an oral hearing, and including the number of arbitrations resolved in favor of the health insurer. Each health insurer and HIMP

agent shall report the name of each medical provider for which it has discovered duplicate payment made by the health insurer and the carrier and the number of such duplicate payments made in the prior calendar year.

§ 325-5.8 Confidentiality of information

Misuse of confidential information; penalties. A health insurer and HIMP agent receiving information pursuant to subdivisions (d) and (h) of section 13 of the Workers' Compensation Law and this Subpart shall use such information solely for the purpose of seeking reimbursement from the employer, workers' compensation insurance carrier or special fund. Every agreement between a health insurer and a HIMP agent shall specify that the HIMP agent may be terminated by the Board for misuse of confidential information. Upon notification to the Chair that either a health insurer or a HIMP agent has used such information for purposes other than those stated above, an administrative hearing shall be held before an employee of the Board, designated by the Chair to conduct such hearings. The Chair, upon a finding that such information has been used by a health insurer or a HIMP agent for purposes other than that stated above, may, after such hearing, impose a penalty of not more than \$10,000, and may prohibit such health insurer and HIMP agent from receiving information under subdivisions (d) and (h) of section 13 of the Workers' Compensation Law and this Subpart, for a period of up to three years. Additionally, a health insurer and HIMP agent receiving information pursuant to subdivision (h) of section 13 of the Workers' Compensation Law and this Subpart, shall comply with all applicable federal and state laws and regulations regarding the confidentiality of such information, including but not limited to section 110-a of the Workers' Compensation Law. In addition to any other available penalty or remedy at law, the Chair, upon a finding that such information has been used by a HIMP agent for purposes other than as stated above, may immediately terminate such individual or entity's status as a HIMP agent.

§ 325-5.9 Waiver of timely submission of bills

Sections 325-1.25(b), 327.3(c), 328.3(c), 342.2(c), 347.3(b) and 349-2.3(b) of this Title shall not apply where there is a "full match" under section 325-5.5 of this Subpart.

Subpart 325-6 Reimbursement for workers' compensation claims paid by health insurers; arbitration of disputed requests for reimbursement

<u>Section 325-6.1</u>	<u>Definitions</u>
<u>Section 325-6.2</u>	<u>Serving requests for reimbursement</u>
<u>Section 325-6.3</u>	<u>HIMP-1 service, procedures and reimbursement</u>
<u>Section 325-6.4</u>	<u>Objections to requests for reimbursement</u>
<u>Section 325-6.5</u>	<u>Eligibility for arbitration</u>
<u>Section 325-6.6</u>	<u>Time to request arbitration</u>
<u>Section 325-6.7</u>	<u>Initiation of arbitration</u>
<u>Section 325-6.8</u>	<u>Withdrawal of arbitration requests</u>
<u>Section 325-6.9</u>	<u>Time and place of arbitration; notification</u>
<u>Section 325-6.10</u>	<u>Fee structure</u>
<u>Section 325-6.11</u>	<u>Hearing of cases</u>
<u>Section 325-6.12</u>	<u>Decisions of the arbitrator; awards; interest</u>
<u>Section 325-6.13</u>	<u>Enforcement and appeals of decisions</u>
<u>Section 325-6.14</u>	<u>Dispute forum rules</u>
<u>Section 325-6.15</u>	<u>Means of service</u>
<u>Section 325-6.16</u>	<u>Party modification of HIMP process</u>
<u>Section 325-6.17</u>	<u>Qualifications of arbitrators</u>
<u>Section 325-6.18</u>	<u>Appointment of arbitrators</u>
<u>Section 325-6.19</u>	<u>Oaths</u>

§ 325-6.1 Definitions

As used in this Subpart:

(a) 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.

(b) Accident shall include both an accident arising out of and in the course of employment and an occupational disease. In the case of occupational disease, date of accident, where used in this Subpart, shall mean date of disablement.

(c) ANCR shall mean accidental injury or occupational disease, notice and causal relationship.

(d) Board shall mean the Workers' Compensation Board, 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.

(e) Carrier shall mean a self-insured or uninsured employer, or workers' compensation insurance carrier as defined in section 300.1(a)(7) of this Title, or special fund created by the Workers' Compensation Law for payment of workers' compensation claims, but shall not include the uninsured employers' fund.

(f) Chair shall mean the Chairperson of the Workers' Compensation Board of the state of New York.

(g) Dispute forum shall mean the American Arbitration Association or such other private arbitration association or forum for alternative dispute resolution designated by the Chair and posted on the Board's website to arbitrate disputed requests for reimbursement.

(h) Health insurer shall mean a health insurer, health benefits plan or other payor of health benefits as defined in section 13(d) of the Workers' Compensation Law, when acting directly or through a HIMP agent.

(i) HIMP means the Health Insurance Matching Program authorized by paragraphs (d) and (h) of section 13 of the Workers Compensation Law and refers to processes established by the Board to assist a health insurer in reimbursement from a carrier for payments made for medical and/or hospital services for or on behalf of an injured employee, and for arbitration of disputed claims for reimbursement.

(j) HIMP agent shall mean a person or entity that is designated and authorized by a health insurer to submit information for matching under this Subpart and to seek reimbursement from a carrier under Subpart 325-6 on behalf of the health insurer. A HIMP agent must execute a written agreement, prescribed by the Chair, between the HIMP agent, the health insurer and the Board and file such agreement with the Board. In addition a HIMP agent must comply with all laws, regulations and policies applicable to health insurers as set forth in Workers' Compensation Law section 13(d) and (h), and Subparts 325-5 and 325-6 of this Part. Failure to comply with all terms of such written agreement or such other agreements with the Board or with all applicable laws, regulations, and policies is grounds for termination of an individual or entity's status as HIMP agent and to preclude its participation in and rights under Workers' Compensation Law section 13(d) and (h), and Subparts 325-5 and 325-6 of this Part.

(k) Provider shall mean a physician, hospital, physical or occupational therapist, podiatrist, chiropractor, psychologist or other health provider to whom payment has been made by the health insurer.

§ 325-6.2 Filing requests for reimbursement

(a) The health insurer shall be responsible for initiating claims for reimbursement of amounts paid by them which may be the responsibility of the carrier, as provided in Workers' Compensation Law section 13(d). The health insurer shall develop with the carrier its own mechanisms and standard operating procedures for payment of undisputed claims for reimbursement.

(b) Claims for reimbursement must be filed within three years of the date of payment by the health insurer for services rendered by a provider as provided in Workers' Compensation Law section 13(d). Claims for reimbursement are deemed filed with the Board by submission of a request for a record search to the Board in the format prescribed by the Chair, pursuant to Subpart 325-5 of this Part, to identify claims which may be the responsibility of the carrier. If a health insurer receives a full match to a workers' compensation claim, the health insurer shall not be required to submit further records of treatments that are causally related to the same accident. The date of submission of the treatment that resulted in a full match shall be applicable to all subsequent treatments causally related to the same accident for purposes of the three year service requirement. HIMP-1 forms shall neither be served on nor accepted by the Board. No request for reimbursement may become eligible for arbitration unless it has been timely filed and served in accordance with the provisions of this section.

§ 325-6.3 HIMP-1 service procedures and documentation

(a) A health insurer requesting reimbursement must serve the HIMP-1 form, or other form or format for request prescribed by the Chair, on the carrier before such request may become eligible for arbitration. The HIMP-1 form may only be served on the carrier after the health insurer is notified of a "full match" pursuant to Subpart 325-5 of this Part.

(b) The following time limitations shall govern requests for reimbursement by a health insurer:

(1) The health insurer must submit the data concerning medical treatment to the Board for a match or have received a full match in connection with the same workers' compensation claim within three years of the date of payment for services rendered by the health care provider to be eligible for arbitration.

(2) A health insurer must serve a HIMP-1 form on the carrier, in accordance with subdivision (a) of section 325-6.15 of this Subpart, within one year of the latest date of the following:

(i) the acceptance of the claim or the establishment of ANCR to the particular body part or disease in question;

(ii) the date the Board notifies the health insurer of the full match pursuant to Subpart 325-5 of this Part;

(iii) the date of payment for services; or

(iv) the effective date of this regulation.

(c) The health insurer must complete all information required on the HIMP-1 form and must serve the completed form on the carrier, together with copies of all provider bills and/or other documents which form the basis for the request for reimbursement. The provider bills and/or other documents shall include the name of the person for whom treatment was rendered, a diagnosis with applicable ICD code(s), the date(s) of treatment or hospitalization, an itemization of the services rendered and the corresponding charges with standardized billing codes, and in the case of hospital bills, the nature of the treatment for which the claimant was hospitalized. The bills or supplemental documentation must also identify the diagnosis and/or treatment codes, including CPT codes or DRG codes where applicable, utilized by the health insurer to determine the amount of payment to the provider. All requests for reimbursement served on the carrier after establishment of ANCR must contain a form C-23, C-18, C-67 or any other notice of decision issued by the Board establishing ANCR to the part of the body or for the condition for which the health insurer made payment to the provider, if such form was available to the health insurer at the time form HIMP-1 is served. The name of the claimant (or, in the case of death, the decedent) on the notice of decision must be the same as that of the person on whose behalf the health insurer made the payments for which reimbursement is being sought. 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.

(d) A health insurer may submit more than one treatment for reimbursement on a single HIMP-1 form so long as the health insurer provides separately the date(s) of treatment or hospitalization, an itemization of the services rendered and the corresponding charges, and in the case of hospital bills, the nature of the treatment for which the claimant was hospitalized for each treatment or hospitalization.

(e) Reimbursement to a health insurer by a compensation carrier under Workers' Compensation Law section 13(d), shall, except as otherwise provided in section 13(d), be for an amount that is equal to the amounts actually expended by the health insurer for the medical and hospital services, provided that such amount is within the limits of the fee schedules established pursuant to Workers' Compensation Law, sections 13(a), 13- k(2), 13-l(2), and 13-m(3) or, in the case of inpatient hospital bills, the rate of payment for inpatient hospital services established pursuant to the provisions of the Public Health Law. If the amount of reimbursement claimed by the health insurer differs from the amounts expended by the health insurer and/or the amount actually paid to a provider differs from the amount set forth in the provider's bill, the health insurer must explain the basis for the difference, and what the difference represents.

(f) Medical records. (1) A carrier, through its attorney, may request from the treating health care provider such medical records associated with the treatment paid by the health insurer and submitted for reimbursement under this Subpart that are necessary for the carrier to manage the related workers' compensation claim. The treating health care provider shall provide such records to the carrier, within fourteen days of the request. Failure to comply with such request may be grounds for action pursuant to section 13(d) of the Workers' Compensation Law.

(2) A carrier may issue a subpoena duces tecum to the treating health care provider in accordance with Workers' Compensation Law section 119 to compel production of medical records set forth in section 325-6.3(f)(1) of this Subpart.

(3) The health insurer and carrier shall not unreasonably refuse to modify filing deadlines to allow time for a carrier to receive medical records, where necessary for resolution of a reimbursement request, as provided in section 325-6.16 of this Subpart. Requests for medical records shall not be used by a carrier solely to delay reimbursement or arbitration of a request for reimbursement.

§ 325-6.4 Objections to requests for reimbursement

(a) Notice of objection by a carrier to any request for reimbursement by a health insurer shall be served on the health insurer in accordance with section 325-6.15(a) of this Subpart, within 90 days after the date the HIMP-1 form was served on the carrier. Notwithstanding the foregoing, the parties may mutually agree in writing to extend the period in which the carrier must serve a notice of objection. The basis for objection shall be specified on the HIMP-1 form or copy thereof which was sent by the health insurer to the carrier.

(b) The following issues may be interposed by a carrier as objections to requests for reimbursement, in whole or in

part, by a health insurer:

(1) The compensability of the claim has not been established or the workers' compensation case has been closed without acceptance of the claim or findings of accident or occupational disease, notice and causal relationship, or the compensability of the claim is the subject of a pending application for review to the Board or a pending appeal to the courts, and is not subject to arbitration and therefore the claim is not subject to reimbursement.

(2) The request for reimbursement has not been timely served in accordance with section 325-6.2 or section 325-6.3(b) of this Subpart.

(3) The treatment, services or hospitalization for which the health insurer made payments was on behalf of a person other than the workers' compensation claimant, or was for a condition or injury unrelated to the workers' compensation claim, or for treatment of a part of the body for which causal relationship has not been established.

(4) The treatment, services or hospitalization for which the health insurer made payments were not furnished on an emergency basis, and were obtained by the injured employee after authorization for such treatment, services or hospitalization was requested by the injured employee and such authorization was denied by a Workers' Compensation Law judge or other duly designated Board employee or such authorization was denied by the carrier and the claimant or health care provider did not seek a Board or Workers' Compensation Law judge determination on the denial.

(5) The fee was in excess of the workers' compensation fee schedule or, in the case of inpatient hospital bills, in excess of the rate of payment for inpatient hospital services established pursuant to the provisions of the Public Health Law, or the proper fee schedule amount or rate of payment for inpatient hospital services cannot be determined. In any case in which this objection is interposed, the carrier must explain why the fee was in excess of the fee schedule or rate of payment or why the proper amount cannot be determined. If this is the sole objection to the request for reimbursement, the carrier must state the amount which it believes to be the proper amount and must pay the undisputed amount to the health insurer.

(6) The bill should have been pro-rated with another physician or health provider.

(7) The carrier cannot determine from the documentation served whether it is responsible for payment.

(8) The carrier has previously reimbursed the health insurer or paid the health provider with respect to the claim. Proof of payment must be submitted.

(9) The treatment was provided on or after the date that the Board approved a waiver on the part of the claimant to the right to medical treatment in connection with an agreement made pursuant to Workers' Compensation Law section 32.

(10) The carrier would not be obligated to pay for the treatment pursuant to Workers' Compensation Law section 29 because the claimant recovered proceeds from a third party and the corresponding carrier lien or offset has not been extinguished.

(11) 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).

(c) In addition to the objections which may be interposed pursuant to subdivision (b) of this section, a carrier may interpose any objection to a request for reimbursement which demonstrates that the request for reimbursement should not be made, unless such objection is specifically prohibited by subdivision (d) of this section.

(d) The following issues may not be interposed as objections by a carrier to requests for reimbursement by a health insurer:

(1) The failure of a provider to seek prior authorization for treatment pursuant to section 13-a (5) of the Workers' Compensation Law and the rules and regulations promulgated there under.

(2) The failure of a provider to file notices and/or reports required by section 13-a(4), 13-k(3), 13-l(3) or 13-m(4) of the Workers' Compensation Law and the rules and regulations promulgated there under.

(3) The treatment was excessive or too frequent, except as set forth in the applicable medical treatment guidelines adopted by the Board in Part 324.2(a).

(4) The period of hospitalization was excessive and/or unnecessary, except as set forth in the applicable medical treatment guidelines adopted by the Board in Part 324.2(a).

(e) Where an objection to a request for reimbursement has been made on any of the bases set forth in subdivisions (b)(4)-(10) and (c) of this section, the issues interposed as objections shall be subject to mandatory arbitration. Where the basis for the objection is the failure to establish ANCR, no such request for reimbursement is eligible for or subject to arbitration until the compensability of the claim is established.

(f) All objections to requests for reimbursement pursuant to subdivisions (b) and (c) of this section must explain in detail the basis for the objection and must be accompanied by documentation supporting the objection. Except as provided

in sections 325-6.6(c), 325-6.7(c) and 325-6.11(c) of this Subpart, no objections or supporting documents will be considered unless they have been timely served on the health insurer in accordance with the provisions of this Subpart.

§ 325-6.5 Eligibility for arbitration

(a) Except as provided in subdivision (b) of this section, all claims for reimbursement by a health insurer which have been timely served in accordance with the provisions of section 325-6.2 of this Subpart are eligible for and subject to mandatory arbitration to be conducted under this Subpart provided the carrier:

(1) fails to make full payment or serve an objection within 90 days after the date of service of the HIMP-1 form by the health insurer on the carrier; or

(2) serves an objection to reimbursement to the health insurer within 90 days after the date of service of the HIMP-1 form by the health insurer.

(b) Claims for reimbursement that has not been established, either by acceptance of the claim or by Board finding of ANCR, are ineligible for arbitration.

§ 325-6.6 Time to request arbitration

(a) A health insurer requesting arbitration must send such request for arbitration to the dispute forum on the HIMP-1 form, in accordance with sections 325-6.7 and 325-6.15 of this Subpart:

(1) within 90 days after the date on which the carrier served its notice of objection on the HIMP-1 form to the health insurer; or

(2) if the carrier has not made payment or served an objection to the health insurer:

(i) within 90 days from the expiration of the period within which an objection or payment was required to be made;

and

(ii) in no event earlier than 95 days from the date on which the HIMP-1 form requesting reimbursement was initially sent by the health insurer to the carrier.

Notwithstanding the foregoing, the parties may mutually agree in writing to extend the period in which the carrier must reply to a request for reimbursement.

(b) Where the health insurer has served a timely request for reimbursement, as defined in this Subpart, and has served or supplemented its claim for reimbursement by sending a HIMP-1 form to the carrier, and the carrier has objected or

failed to object in accordance with section 325-6.4 of this Subpart, the health insurer shall be deemed to have waived its right to arbitration if such request for arbitration is not timely served on the dispute forum in accordance with the provisions of subdivision (a) of this section.

(c) In any case in which a request for arbitration has been served based on the failure of a carrier to make payment or send notice of objection to the request within 90 days after the request for reimbursement has been made, the carrier shall be deemed to have waived any objections it may have been entitled to interpose pursuant to section 325-6.4(b) and (c) of this Subpart, except as provided in section 325-6.11(c) of this Subpart.

§ 325-6.7 Initiation of arbitration

(a) (1) The health insurer shall initiate the request for arbitration by serving the completed HIMP-1 form requesting arbitration and supporting documents on the carrier.

(2) The health insurer shall serve two copies of the completed HIMP-1 form requesting arbitration and supporting documents, proof of service of the request for arbitration upon the carrier, and the prescribed filing fee on the dispute forum.

(3) In the event that the carrier has failed to serve a notice of objection to the request for reimbursement within 90 days in accordance with section 325-6.4 of this Subpart, the health insurer shall state in the request for arbitration that no objections have been received and shall provide proof of service of the initial HIMP-1 form upon the carrier.

(b) Upon receipt of the completed request for arbitration, the dispute forum shall acknowledge receipt of the request for arbitration by notifying both parties. Any request for arbitration which is not accompanied by the completed form, proof of service and/or the required fee shall not be processed and shall be returned to the health insurer. Any objection for improper or untimely service of a HIMP request or request for arbitration shall be an issue to be determined by an arbitrator. The defense of improper or untimely service of a reimbursement or arbitration request must be raised within 14 days after the date of acknowledgment of the completed request for arbitration from the dispute forum.

(c) Within 14 days after the date of acknowledgment of the completed request for arbitration from the dispute forum, the carrier shall serve on the dispute forum two copies of all documents supporting its objections to the requests for reimbursement, together with proof of timely service of such documents upon the health insurer. Except as provided in section 325-6.11(c) of this Subpart, such documents will not be considered by the arbitrator, unless the carrier has

previously served a timely notice of objection and such supporting documents with the health insurer in accordance with section 325-6.4 of this Subpart. The carrier shall place the dispute forum's case identification number on each document.

(d) In the event that the carrier serves documents or other materials on the dispute forum that it did not previously serve upon the health insurer, the health insurer shall have ten days to respond to such documents or other materials.

§ 325-6.8 Withdrawal of arbitration requests

The parties may, by mutual agreement, withdraw the request for arbitration on a form prescribed by the dispute forum for that purpose. Such form must be signed by the parties and served on the dispute forum. If requested by the parties, their agreement to withdraw may be incorporated in an arbitration award. Additionally, the health insurer may unilaterally withdraw a request for arbitration by serving such request for withdrawal on the dispute forum and serving a copy to the other party. Where the request for arbitration has been withdrawn, fees paid to the dispute forum shall not be refundable, except as provided in section 325-6.10(b) of this Subpart. No request for arbitration may be unilaterally withdrawn unless the withdrawing party has reimbursed the other party for any non-refundable fee which such other party has paid to the dispute forum.

§ 325-6.9 Time and place of arbitration; notification

(a) Unless either party requests an oral hearing, all hearings shall be desk arbitrations based on documents alone.

(b) A health insurer requesting an oral hearing must make such request together with the service of its request for arbitration. A carrier may make a request for an oral hearing within 14 days after receipt of its copy of the request for arbitration. Such request must be made in writing to the dispute forum, and a copy of such request must be simultaneously served on the health insurer.

(c) The dispute forum shall set the location, date and time of oral hearing and shall notify the parties no less than fourteen days in advance of such oral hearing. The dispute resolution may utilize video conferencing or such other technology to enable the parties to participate in the oral hearing from disparate locations.

§ 325-6.10 Fee structure

(a) The health insurer shall, together with its request for arbitration, submit a nonrefundable filing fee in the amount of

\$175 per request to the dispute forum. For desk arbitrations, the arbitrator shall receive a fee of \$60 per arbitration, payable by the dispute forum from the filing fees received by it.

(b) In the event either party shall demand an oral hearing, a fee in the amount of \$475, of which \$250 shall be paid to the arbitrator, shall be paid to the dispute forum together with such demand. The party requesting the oral hearing shall pay an additional sum of \$250 as the arbitrator's fee for any additional day of oral hearing. In the event the request for oral hearing is withdrawn prior to the commencement of the oral hearing, the sum of \$250 representing the arbitrator's fee shall be refunded by the dispute forum to the party requesting such hearing.

(c) In the event of a request for reconsideration, pursuant to subdivision (d) of section 325-6.12 of this Subpart, the dispute forum shall pay the arbitrator \$75 of the additional filing fee.

(d) The fees payable pursuant to the provisions of this section shall apply to all requests for arbitration properly served on the dispute forum 90 days after the effective date of this Subpart as a final rule.

§ 325-6.11 Hearing of cases

(a) The arbitrator shall determine initially whether the claim is eligible for or subject to mandatory arbitration. If the arbitrator determines that the claim is not eligible pursuant to section 325-6.5(b) of this Subpart, the claim shall not be arbitrated and the arbitrator shall notify the parties in writing. Any party aggrieved by the arbitrator's determination may, within 30 days after notification by the arbitrator, serve on the dispute forum, upon notice to the other party, a request that the arbitrator issue a decision pursuant to section 325-6.12 of this Subpart denying the claim on the basis that the claim is not eligible for or subject to mandatory arbitration. Such decision may be appealed pursuant to section 325-6.13 of this Subpart.

(b) The arbitrator shall not be bound by common law or statutory rules of evidence or by technical or formal rules of procedure but may make such investigation or inquiry and conduct the hearing in such manner as he or she deems proper and necessary, and shall have the power to issue subpoenas, in accordance with section 7505 of the Civil Practice Law and Rules. In any oral hearing, the health insurer may present its case, call witnesses and present proofs, and submit to questions thereon. The defending carrier may present its defense, call its witnesses, present its proofs and submit to questions thereon. The arbitrator may, in the event of nonappearance, decide the issue on the basis of the evidence before

it. Either party may be represented by an attorney.

(c) Except as provided in sections 325-6.6(c) and 325-6.7(c) of this Subpart, the arbitrator will only consider those objections to requests for reimbursement which have been timely served on the health insurer in accordance with section 325-6.4 of this Subpart, and documents supporting objections to requests for reimbursement which have been timely served on the health insurer in accordance with section 325-6.4(a) and (f) of this Subpart or supporting the request for reimbursement, which have been timely served on the carrier in accordance with section 325-6.2 of this Subpart. Any party wishing to serve new or additional objections or documents based solely on newly discovered evidence after the expiration of the time for serving objections or documents must serve such objections or documents on the dispute forum within 14 days after the date of acknowledgment of the completed request for arbitration from the dispute forum, in the case of desk hearings, or no later than 14 days prior to the scheduled date of an oral hearing. The new or additional objections or documents must be accompanied by an affidavit substantiating why such objections or documentation could not have been made or discovered and served within the prescribed time period, together with proof of service of all additional objections or documents, including the supporting affidavit, on the other party. The arbitrator may, in his or her sole discretion, consent in writing to the service of new or additional objections or documentation and consider such new or additional objections or documents when making his or her decision if he or she determines that special circumstances exist whereby such evidence could not have been previously discovered and consideration of the new or additional objections or documentation in the interests of justice is warranted. Where payment is made by the carrier after the request for arbitration has been served, the carrier must submit proof of payment. If it is determined by the arbitrator that full payment has been made but such payment was not timely, the arbitrator must award the health insurer any filing fees paid by it, in accordance with this section.

(d) A record of such oral hearing shall not be required. Any party requesting a readable, viewable or audible record of an oral hearing shall inform the other party and the arbitrator of such intent, shall make the necessary arrangements and pay the cost thereof directly to the person or agency making such record. The arbitrator and any other party or parties to the arbitration shall be entitled to view or hear the record and shall be entitled to a copy of such record upon payment of the cost of a copy of such record.

(e) The arbitrator may postpone or adjourn any hearing upon request of a party or upon the arbitrator's own motion.

Each party may cause one adjournment without the payment of an adjournment fee if the adjournment request is received by the dispute forum at least two business days prior to the scheduled arbitration. There shall be an adjournment fee of \$50 payable to the dispute forum by the party requesting any subsequent adjournment if such request is received by the dispute forum at least two business days prior to the scheduled arbitration. An adjournment fee of \$100 shall be payable to the dispute forum by the party causing the adjournment within two business days or less prior to the scheduled hearing. Such fees shall be used to defray the cost of administration of the dispute forum.

§ 325-6.12 Decisions of the arbitrator; awards; interest

(a) The arbitrator shall make a decision in writing no later than 30 days after completion of a hearing. The decision shall contain a dollar amount of an award or a denial of the claim, and shall specify the basis of the decision on the form prescribed by the dispute forum for such purpose. The decision may include any stipulation made by the parties, including stipulations as to payment of fees. The decision shall be delivered to each party in accordance with section 325-6.15(b) of this Subpart.

(b) In the event the arbitrator's decision is in favor of the health insurer in the full amount requested, the amount of the award shall be increased by the amount of any filing fee, or any additional fee paid by the health insurer including any fee for manual searches as provided in section 325-5.6 (b) of this Part, except attorney's fees, for oral hearings. In the event the claim for reimbursement is denied in full, the arbitrator shall make an award in favor of the carrier for any filing fees or additional fees, except attorney's fees, paid by the carrier. In all other cases, the arbitrator shall, in his or her discretion, determine whether such fees shall be allocated and the manner of such allocation provided, however, that in all cases in which the arbitrator's decision is based in whole or in part upon objections or documents received and accepted by the arbitrator as newly-discovered evidence pursuant to section 325-6.11(c) of this Subpart, and is entirely or partly in favor of the party which served the objections or documents untimely, any filing fees shall be chargeable to such party in whole or in part. In any such case the arbitrator, when allocating such fee, shall consider the extent to which the other party may have been prejudiced by the prevailing party's failure to serve the objections or documentation in a timely manner. If payment is made to the health insurer after the time within which the carrier was required to object or making payments

has expired and the carrier submits proof of payment after the health insurer has served a request for arbitration, the arbitrator shall make an award to the health insurer for any filing fees paid by it.

(c) If the arbitrator determines that the carrier's objection to or non-payment of the reimbursement or the health insurer's request for arbitration was frivolous or was not made in good faith, he or she may impose in his or her discretion a penalty of no greater than \$1,000 against the party whose position was frivolous or not made in good faith. Such determinations shall be limited to instances where the objection to non-payment or request for arbitration had no basis in fact, or was not warranted by existing law or good faith argument for the extension, modification, or reversal of existing law. Any penalty shall be issued in the form of an arbitrator award payable to the opposing party by the party whose position was deemed frivolous or not made in good faith.

(d) Within fifteen (15) days of the date of the arbitrator's decision, either party may serve a request for reconsideration by serving a written request for reconsideration on the opposing party and by serving two copies of the written request with proof of service of the request for reconsideration and an additional filing fee of \$150 on the dispute forum. The party seeking reconsideration shall have the burden of establishing that the original decision is incorrect as a matter of law or fact. The party opposing reconsideration shall have fifteen days to serve its written response on the serving party and two copies on the dispute forum. Such reconsideration shall be conducted by the arbitrator who issued the underlying decision. The arbitrator shall issue a written decision on the request for reconsideration in accordance with subdivision (a) of this section. The arbitration decision, including payment of arbitrator's awards and reimbursement of filing fees, shall not become final for purposes of subdivision (e) of this section during the pendency of a request for reconsideration and shall be stayed during the pendency of such request for reconsideration. If the arbitrator determines that the request for reconsideration was frivolous, he or she may impose in his or her discretion a penalty of no greater than \$1,000 against the party seeking reconsideration. The proceeds of the penalty shall be paid in equal parts to the dispute forum and the other party. In no case shall the arbitrator impose the additional filing fee for a request for reconsideration on the party opposing reconsideration.

(e) Awards shall be paid to the prevailing party no later than 30 days after service of the decision upon the parties. Any awards remaining unpaid after said 30-day period shall draw simple interest from 30 days after the making of the award at the rate provided in section 5004 of the Civil Practice Law and Rules.

§ 325-6.13 Enforcement and appeals of decisions

Any decisions of an arbitrator made pursuant to the provisions of this Subpart may be enforced, vacated or modified in accordance with the applicable provisions of sections 7509, 7510, 7511 and 7514 of the Civil Practice Law and Rules. No other provisions of article 75 of the Civil Practice Law and Rules, except as may be otherwise provided in this Subpart, shall be applicable to arbitration pursuant to this Subpart. The arbitrator, dispute forum and the Board shall not be made parties to a court proceeding relating to an arbitration award. The participation of a party in such an arbitration proceeding shall be a waiver of any claim against an arbitrator or the dispute forum for any act or omission in connection with any arbitration conducted under these rules.

§ 325-6.14 Dispute forum rules

All parties subject to the provisions of this Subpart shall be subject to any rules promulgated by the dispute forum with respect to its own internal procedures regarding the administration of disputed requests for reimbursement, to the extent that such rules are not inconsistent with this Subpart.

§ 325-6.15 Means of service

(a) Pre-arbitration. The health insurer and carrier shall serve the request for reimbursement and any payments or objections thereto using the HIMP-1 form. Service shall be effective if performed by: (1) personal delivery; (2) first class mail; (3) certified mail return receipt requested; (4) overnight delivery service; (5) facsimile transmission, provided that the receiving party has designated a facsimile number for this purpose to the other party or the Board; (6) electronic mail with confirmation of delivery, provided that the receiving party has designated an electronic mail address for this purpose to the other party or the Board; or (7) such other means of delivery (electronic or otherwise) as is agreed upon between the carrier and the insurer in a written agreement. Service by facsimile transmission shall be complete upon the receipt by the sender of a signal from the equipment of the carrier served indicating that the transmission was received. Service by electronic mail shall be complete upon the receipt of confirmation of electronic delivery.

(b) Arbitration. Any documents to be served on the dispute forum and opposing party in arbitration or to be served on the parties by the dispute forum, including the initial request for arbitration, the carrier's objections, and notices or decisions from the dispute forum, shall be delivered by one of the following means: (1) personal delivery; (2) first class

mail; (3) certified mail return receipt requested; (4) overnight delivery service; (5) facsimile transmission, provided that the receiving party has designated a facsimile number for this purpose to the other party or the Board; (6) electronic mail with confirmation of delivery, provided that the receiving party has designated an electronic mail address for this purpose to the other party or the Board; (7) submission on an electronic case filing platform maintained by the dispute forum; or (8) such other means of delivery provided for by the dispute forum in its written rules. Service by facsimile transmission shall be complete upon the receipt by the sender of a signal from the equipment of the carrier served indicating that the transmission was received. Service by electronic mail shall be complete upon the receipt of confirmation of electronic delivery. Service by submission on an electronic case filing platform shall be complete upon the receipt of confirmation of electronic delivery and shall be effective with respect to service on the dispute forum and the other party, provided that the case filing platform provides prompt delivery of documents or access thereto to the other party.

§ 325-6.16 Party modification of HIMP

A health insurer and a carrier may agree to modify certain aspects of the HIMP reimbursement process, including the deadlines for service, the means of service between the parties, the conditions required for reimbursement, or other aspects of HIMP reimbursements, by executing a written agreement setting forth any such modified conditions and specifying whether the modifications shall be enforceable through arbitration.

§ 325-6.17 Qualifications of arbitrators

(a) The Chair shall appoint an advisory committee composed of four members who will review the qualifications of applicants for the position of arbitrator of disputed requests for reimbursement and review their performance. The advisory committee shall make recommendations in a timely manner to the chair pertaining to the appointment and dismissal of arbitrators. The committee shall consist of one representative each of the AFL-CIO, the Business Council of New York, the State Insurance Fund, and the Board.

(b) An arbitrator shall have a basic knowledge of the Workers' Compensation Law which will qualify such arbitrator to resolve issues involved in reimbursement disputes. Documentation of such knowledge and related experience shall be submitted to the advisory committee.

(c) All arbitrators shall be appointed by, and serve at the pleasure of, the Chair and subject to the following:

(1) The arbitrator shall serve a term of three years. Such term shall run from the date of appointment by the Chair or the effective date of this regulation whichever date is later. The three year term shall expire on March 31st of the third year following the year of appointment. Renewal shall be at the discretion of the Chair. An arbitrator shall continue to serve, following March 31st of the third year, pending renewal by the Chair.

(2) An arbitrator candidate shall disclose to the Chair any circumstance which is likely to create an appearance of bias or which might disqualify such a person as an arbitrator, and the Chair shall determine whether the candidate should be disqualified. The Chair shall forward the names of all arbitrators to the dispute forum, and promptly inform the dispute forum of all additions to, and deletions from, the panel of arbitrators.

(d) Any arbitrator appointed by the Chair shall be subject to disqualification with respect to a particular case for the reasons specified in section 325-6.18 of this Subpart.

§ 325-6.18 Appointment of arbitrators

The dispute forum shall select from the panel of arbitrators, on a rotational basis, an arbitrator who will hear the case and shall submit the name of the arbitrator to each party to the arbitration. Any person appointed as an arbitrator shall disclose to the dispute forum any circumstance likely to affect impartiality, including any bias, financial and/or personal interest in arbitration. Upon receipt of such information from the arbitrator or another source, the dispute forum shall communicate the information to the parties, and if it deems appropriate to do so, to the arbitrator and other interested parties. If a party objects to the appointment of an arbitrator, the specific grounds for such objection shall be submitted in writing to the dispute forum, which shall determine within 15 days after receipt of the challenge whether the arbitrator shall be disqualified. The dispute forum shall determine whether the arbitrator shall be disqualified and shall notify the parties of its decision, which shall be final and binding. In the event an arbitrator shall resign, be disqualified or be otherwise unable to perform his or her duties, the dispute forum shall appoint another arbitrator.

§ 325-6.19 Oaths

All arbitrators shall be required to take an annual oath of office. Arbitrators shall require all witnesses to testify under oath or affirm that their statements are true under penalty of perjury.

Effective Date: June 1, 2016