

Revised Regulatory Impact Statement for amendments to Sections 300.1, 300.33 and 300.34 and the addition of Sections 300.37 and 300.38 of Title 12 NYCRR.

1. Statutory authority:

The Workers' Compensation Board (hereinafter referred to as Board) is authorized to amend Sections 300.1, 300.33 and 300.34 and add Sections 300.37 and 300.38 to 12 NYCRR. Workers' Compensation Law (WCL) § 117(1) authorizes the Chair to make reasonable regulations consistent with the provisions of the WCL and the Labor Law. Section 117(1) also authorizes the Board to adopt reasonable rules consistent with and supplemental to the provisions of the WCL and Labor Law. WCL § 141 requires the Chair to enforce all the provisions of the WCL and authorizes him to make administrative regulations and orders providing for the receipt, indexing and examining of all notices, claims and reports, for the giving of notice of hearings and of decisions, for certifying of records, for the fixing of the times and places for the hearing of claims, and for providing for the conduct of hearings and establishing of calendar practice to the extent not inconsistent with the rules of the Board. Section 142 of the WCL sets forth the powers of the Board, which include the power to hear and determine all claims for compensation, to approve and fix attorney's fees, to take testimony by deposition, and to have and exercise all other powers and duties, other than purely administrative functions, conferred upon the Board.

WCL § 25 sets forth the procedures for the resolution of controverted workers' compensation claims and issues. Subdivision 2 of §25 requires an insurance carrier to file a notice of controversy either within 18 days of disability or within 10 days of knowledge of the accident, whichever is greater, or, if the Board sends a notice of indexing to the insurance carrier, within 25 days after the Board mails the notice. The notice of controversy must be on a form prescribed by the Chair. If the insurance carrier controverts a claim, subdivision 2-a mandates a pre-hearing conference be held "as soon as practicable but not to exceed 45 days after receipt of notice of controversy and a medical report referencing an injury." Therefore, while the latest date the pre-

hearing conference can be held is 45 days after receipt of both documents, if it can be held in less than 45 days it should be so scheduled. This subdivision also sets forth the purposes of the pre-hearing conference and the requirement that a pre-hearing conference statement be filed 10 days before the pre-hearing conference.

Paragraph d of subdivision 2-a provides that discovery closes at the of the pre-hearing conference and limits the use of evidence not disclosed or obtained after the pre-hearing conference. Paragraph (e) of subdivision (2-a) requires proceedings in the pre-hearing process to be conducted in accordance with rules promulgated by the Chair or Board.

The Chair is authorized to refer for a hearing any case in which the continued right to compensation is controverted, or where payments have been stopped or modified, to properly protect the rights of the parties. [WCL §25(3)(a)] Paragraph (d) of subdivision (3) establishes the expedited hearing process. The Chair may refer to the expedited hearing process claims in which issues have not been resolved after one year, multiple claims arising from the same incident, or claims where the parties agree or a notice of controversy has been filed. Claims in the expedited hearing process are to be scheduled so that, if appropriate, all open issues may be addressed at one hearing. An adjourned case in the expedited process shall be scheduled for hearing as soon as possible, but no later than 30 days following the adjournment. If an adjournment is requested of an expedited hearing that is not an emergency and is found to be frivolous, a penalty of \$1,000 will be assessed against the insurance carrier. If the insurance carrier is represented by a non-employee legal representative, the legal representative will be responsible for paying the penalty. If a non-emergency and frivolous adjournment is requested by a represented claimant, the legal representative shall be penalized \$500. Penalties may not be imposed on claimants who are not represented.

WCL §24 requires claims by legal representatives of claimants for fees must be approved by the Board in order to be enforceable. Further, the fee awarded to claimant's legal representative is a lien on upon the lost wage benefits awarded to the claimant.

Physicians, physical and occupational therapists, podiatrists, chiropractors and psychologists must submit reports on forms prescribed by the Chair in order to receive payment for treatment pursuant to WCL §§ 13-a(4)(a), 13-b(1)(d), 13-k(3)(a), 13-l(3)(a) and 13-m(4)(a). To treat and/ or conduct independent medical examinations of injured workers, physicians, podiatrists, chiropractors and psychologists must be authorized by the Chair. WCL §§ 13-d(2)(c), 13-k(10)(c), 13-l(10)(c) and 13-m(11)(c) require the Chair to remove authorized providers who fail to transmit copies of medical reports. Employers are required to file with the Board, on a form prescribed by the Chair, a report of any accident resulting in injury causing loss of time beyond the working day on which the accident occurred or requiring medical treatment beyond ordinary first aid.

Lastly, Section 80 of Chapter 6 of the Laws of 2007 authorizes the Chair of the Board, in consultation with the Superintendent of Insurance, to promulgate regulations relating to the procedural requirements needed to implement the provisions of Chapter 6 of the Laws of 2007.

2. Legislative objectives:

On March 13, 2007, Governor Spitzer signed into law sweeping reforms of the workers' compensation system. The reform legislation, Chapter 6 of the Laws of 2007, amended the law to increase benefits to claimants while decreasing costs to employers. The statute also expedited the resolution of controverted claims so claimants could receive benefits more quickly. Specifically, section 40 of Chapter 6 amended WCL Section 25(2-a) to reduce the period in which a pre-hearing conference is held from 60 days to 45 days and to require receipt by the Board of a medical report before scheduling a pre-hearing conference. These regulations build upon these legislative changes so that controverted claims can be resolved as quickly as possible.

3. Needs and benefits:

The WCL authorizes insurance carriers to controvert workers' compensation claims. When a claim is controverted, a claimant does not receive any lost wage benefits and medical providers are not paid for medical treatment they provide. While medical providers who are authorized by the Chair to treat claimants are required

to do so even when a claim is controverted, medical providers who are not authorized by the Chair to treat are not required to treat when a claim is controverted. Claimants who are unable to work because they are injured and who are not receiving lost wage payments because their claims are controverted face financial hardship. In addition, they may have trouble receiving all the medical care they need to recover so they can return to work. It is important that controverted claims are resolved as quickly as possible so claimants can afford to meet their needs and receive the medical care they need to recover.

In a letter dated March 13, 2007, Governor Spitzer directed the Superintendent of Insurance, with the assistance of the Chair of the Board and the Commissioner of Labor, to complete a number of tasks including the development of recommended regulations to adjudicate a controverted claim within ninety days. To assist the Superintendent, the Governor directed the formation of an Advisory Committee comprised of representatives of the AFL-CIO, Business Council of New York State, New York State Senate and New York State Assembly. On June 1, 2007, the Superintendent issued his report and recommended regulations. In his report the Superintendent noted that at that time it took over 200 days to resolve a claim from the point of dispute.

The Board received comments regarding the recommended regulations from attorneys, associations representing attorneys, one union, an occupational health and safety committee and the New York State Insurance Fund. In addition, the Chair and other representatives of the Board met with interested parties to discuss their concerns regarding the recommended regulations. Based upon the comments and concerns expressed, as well as logistical challenges identified by the Board, the recommended regulations have been revised to retain the goal of resolving controverted claims within 90 days and the core philosophy of the recommended regulations that more information is required as early as possible in the claim to enable the insurance carrier or self-insured employer to make informed decisions over whether to controvert a claim or not, and if the decision is to controvert, raising only the appropriate defenses.

Among the major changes from the recommended regulations are the elimination of the requirement that a determination of prima facie medical evidence be made within five days of receipt of the notice of controversy, the elimination of the required mediation conference and the removal of the requirement that the first expedited hearing occur immediately after the pre-hearing conference. The proposed regulations are based on a 30-60-90 timeframe. The pre-hearing conference will be held within 30 days of the filing of the notice of controversy and a medical report referencing an injury. The initial expedited hearing, at which all lay testimony will be taken, will be held 30 days after the pre-hearing conference or 60 days after the receipt of the requirement documents. If a second expedited hearing is necessary for medical testimony it will be held no more than 60 days after the pre-hearing conference. The 30-60-90 timeframe fits easily within the statutory requirements.

Chapter 6 of the Laws of 2007 amended WCL § 25(2-a) to reduce the maximum time period in which a pre-hearing conference (PHC) must be held in a controverted case from 60 to 45 days and added the requirement that “a medical report referencing an injury” must also be received by the Board before the 45 day time limit begins to run. These changes clearly indicate the need for faster resolutions of controverted claims and that the evidence necessary to proceed to a PHC is a medical report referencing an injury. The purposes of the PHC are to: 1) ensure that all forms, including medical reports, have been filed and verify the information on the forms is accurate; 2) add necessary parties, if appropriate; 3) simplify and limit the factual and legal issues; 4) present a list of proposed witnesses; and 5) schedule the case for a hearing. [WCL §25(2-a)(b)] Discovery must close at the end of the PHC. [WCL §25(2-a)(d)]

The reduction in time from receipt of a notice of controversy to the convening of a PHC has obvious benefits for an injured worker who is not receiving workers’ compensation benefits. Additionally, in the past, many PHCs have been held only to find that there are no medical reports in the Board’s file for the Workers’ Compensation Law Judge (WCLJ) to review for the purpose of determining whether “prima-facie medical evidence” (PFME) exists. These types of “no medical evidence” hearings were of limited value. The statutory

amendment and the proposed regulations ensure that “no medical evidence” PHCs will no longer be held. In addition, the amendment makes clear that all that is needed in order to proceed to a pre-hearing conference at which discovery will close and a hearing will be scheduled is a medical report referencing an injury. Therefore, prima facie medical evidence is now a medical report referencing an injury and the proposed regulation sets forth this definition.

Additionally, the new case file creation, claim indexing, notice of indexing and notice of controversy regulations are designed to generate more claim information earlier in the process so that an employer/carrier can make an informed decision whether to accept or controvert a claim. If the decision is to controvert, the proposed regulations require the employer/carrier to specifically state the basis (es) of the controversy.

The proposed regulations require the filing of a PHC statement at least 10 days prior to the PHC. This statement must contain certain required information. It is intended to narrow the issues in dispute, provide witness names, and otherwise facilitate the prompt and efficient resolution of disputed issues relating to the basic, initial compensability of the claim.

The new regulations are designed to expedite the adjudication of controverted claims by requiring carriers to file Independent Medical Exam (IME) reports, if the carrier wishes to produce such a report in support of its controversy, on or before the initial expedited hearing date. The Notice of PHC includes this information to provide carriers with early notice and a set time within which to produce IME reports. An IME report is only necessary if the carrier is controverting the claim on the basis that there is a lack of a causal relationship between the employment and the injury.

The proposed regulations modified the recommended regulations to schedule the initial expedited hearing 30 days after the pre-hearing conference to ensure the most efficient use of resources. Under the recommended regulations, if a controversy was resolved at the PHC then the time blocked for the initial expedited hearing would not be used. To resolve all claims as quickly as possible, the Board must maximize the use of hearing

time. In addition, under the recommended regulations, parties would be required to prepare witnesses and prepare to examine witnesses before a WCLJ had ruled whether the witness could testify at the PHC. The proposed regulations require the taking of all medical testimony at a hearing to be held within 30 days after the initial expedited hearing or no more than 55 days after the PHC. These testimony time requirements are intended to expedite a decision in a controverted workers' compensation case.

Like the recommended regulations, the proposed regulations regulate and limit the circumstances under which adjournments in controverted cases can be granted. Adjournments usually prolong the time it takes to reach a decision in a controverted case. Additionally, the proposed regulations limit appeals of decisions that contain orders and directions that do not establish or disallow the claim. This provision is in accordance with existing regulations at 12 NYCRR §300.34.

Unlike the recommended regulations, the proposed regulations revise 12 NYCRR §300.33 and §300.34. These sections currently govern PHCs and the expedited hearing process. Changes were made to conform to the fact controverted claims are now governed by section 300.38 when a claimant is represented.

4. Costs:

Some of the provisions in the regulations already exist. IME reports have always been and continue to be optional. PHC statements are presently required in controverted cases when the claimant is represented. [WCL § 25(2-a) (d); 12 NYCRR § 300.33(e).] The proposed regulations eliminates the requirement in the recommended regulations that a mediation conference occur before the PHC. Carriers, self-insured employers and attorneys would have incurred costs in attending these conferences. There should be fewer controverted claims because carriers and self-insured employers will be able to make an informed decision due to the increased information they will receive and the requirement that the Board receive a medical report before indexing a claim. Currently, parties rarely file the PHC statement. The regulations reinforce the requirement to file a PHC statement and attach real consequences for the failure to comply. The regulations require parties to

use required forms. For example, medical providers do not always use the prescribed form for medical reports, the C-4 form. Pursuant to the proposed regulations, a C-4 form must be received to index a claim, requiring providers to only use this form and no longer file the HCFA 1500 or solely office notes. Employers, carriers, attorneys and medical providers may experience some increase in costs from fully complying with the WCL and regulations. Further, they may experience costs from the imposition of sanctions for failing to comply with requirements. The regulations will also reduce legal costs by expediting the resolution of claims.

There are some minimal costs that will be incurred regardless of whether the claim is controverted. Employers will incur minimal costs from complying with the requirement to distribute a Claimant Information Packet (Packet) to employees injured or who become ill on the job. The costs will be minimal because the employers can obtain the Packet from the Board or print out the required forms from the Board's website. Legal Representatives of claimants will incur small costs in complying with the requirement to submit a written certification and a list of documents if the representative is retained at the time the Form C-3, Employee's Claim for Compensation, is filed with the Board.

5. Local government mandates:

All local governments, especially the approximately 2,511 political subdivisions who currently participate in self-insured programs for workers' compensation coverage in New York State, will have to comply with these regulations. Local governments will be affected by the proposed rule in the same manner as all other employers. This means local governments that have purchased coverage will still be required to complete the Form C-2, Employer's Report of Work-Related Accident, but they will now have to certify that the Claimant's Information Packet was provided to an injured worker. Local governments that are self-insured will be required to comply with the requirements regarding the Form C-7, Notice that Right to Compensation is Controverted, obtaining Independent Medical Reports, submitting a Form PH-16.2, Statement on Specific Issues in Dispute, filing medical reports obtained through the use of the limited release with the Board, and timely completing all

requirements pursuant to the regulations in order to avoid the consequences set forth in the proposal. Since the purpose behind the regulations is to speed the resolution of controverted claims so claimants receive the benefits they are entitled to as quickly as possible, there is no justification or reason why an employee of a local government has any less right to a swift resolution when a local government decides to controvert a claim.

6. Paperwork:

The proposed rule imposes some paperwork requirements. First, the rule requires that all forms be completed fully. Historically, the Board has accepted forms such as the Form C-3, Employee's Claim for Compensation, Form C-2, Employer's Report of Work-Related Accident/Occupational Disease, and C-4, Attending Doctor's Report, no matter how much information was provided. The proposed rule changes this and creates consequences for failing to fully complete these forms. Specifically, new section 300.37(d) (4) provides that if a Form C-4 is not fully completed the medical provider shall not be paid. Further, parties have not historically filed the Form PH-16.2, Statement on Specific Issues in Dispute, with the Board as required by statute and regulation. The proposed regulations require represented parties to file the Form PH-16.2 and if a carrier fails to file a fully completed form, it waives defenses or production of the witnesses and/or documents unless good cause can be shown. If a claimant's legal representative fails to file the form his/her legal fee will be reduced unless good cause can be shown. Finally, in addition to the Form C-4, the Board has historically accepted medical narratives and HCFA 1500 forms. The proposed rule requires a Form C-4 in order to index a claim.

Second, existing forms must be modified. The proposed regulations require revised Forms C-2, C-3, C-4, and PH-16.2. In addition, the Form C-7, Notice that Right to Compensation is Controverted, must be modified to conform to the proposed rules by providing for a written certification signed by the insurance carrier or its legal representative that the allegations and other factual matters asserted in controverting the claim or the defenses asserted have evidentiary support or will likely have such support after investigation. Along with the

Form C-7, the carrier must submit a list of witnesses and documents supporting the controversion or its defenses.

Third, new forms and documents are required. Claimants must complete a limited medical release in order for a claim to be indexed under the proposed rules. Further, if a claimant has retained a legal representative at the time the Form C-3 is filed, the legal representative must file a written certification that the allegations and facts in the form have evidentiary support or will have such support after an opportunity for investigation. Along with the certification, the legal representative must file a list of all documents that may be used to support the claim. The employer, upon receiving notice of a work place injury, must provide the employee with a Claimant Information Packet which includes the Form C-3, instructions for completing the form and how to receive assistance in completing the form, an explanation of the necessity of submitting a form C-4, a limited release and notice that an employee has the right to a legal representative in proceedings before the Board. The Board is required to send this packet to an individual who has not retained a legal representative and has a case number but whose claim has not been indexed. The limited release required by the regulations is only for relevant medical records for the same condition or injury site as that at issue in the workers' compensation claim. If an insurance carrier seeks a broader release, it must make an application to the Board supported by an affidavit showing relevance. Requests for adjournments under the proposed rule must be made by affidavit rather than merely submitting a letter or telephoning the Board.

The proposed rules will limit some paperwork because a finding that the medical report submitted is prima facie medical evidence is interlocutory and therefore cannot be appealed. Also, decisions containing orders and directions from the pre-hearing conference and expedited hearing process are not reviewable until a decision is issued either establishing or disallowing the claim. This will reduce the filing of appeals and rebuttals of those appeals. The proposed rule will also limit the number of summations, memoranda of law and/or briefs that are submitted. The proposal specifically prohibits such filings unless the Workers' Compensation Law Judge finds

that the claim presents extensive and complicated factual determinations or novel and important questions of law.

The proposed rule requires the parties to file all medical reports obtained by them through the use of medical releases with the Board.

7. Duplication:

These amendments will not duplicate any existing Federal or State requirements.

8. Alternatives:

One alternative would be to take no action. However, given the statutory amendment of WCL § 25(2-a) and gubernatorial directive to design a streamlined docket system to process workers' compensation claims, this is not a viable alternative.

Another alternative would be to propose and adopt the recommended regulations as submitted to the Chair and Board. However, the recommended regulations contain provisions which are inconsistent with statute, do not account for all types of claims that are filed with the Board, and contain provisions which are logistically difficult for the Board and the parties. The recommended regulations required the PHC statement to be filed 14 days before the PHC. The statute requires it to be filed 10 days before the PHC. Pursuant to the recommended regulations only an employer could file an employer's report of injury or C-2 form, however WCL §110(2) specifically authorizes employers to designate a third-party to file the form. The recommended regulations required medical providers to file medical reports electronically and legal representatives to file PHC statements electronically. However, State Technology Law §305(1) prohibits the Board from refusing to accept paper forms and requiring electronic filing without statutory authority. The recommended regulations only referenced the C-3 and C-2 forms, however if a worker has died due to a work related injury the claim form filed is a C-62. The Board is responsible for claims by volunteer firefighters and volunteer ambulance workers who file forms specifically designed for them. In addition, the recommended regulations required all medical providers to

complete the form prescribed by the Chair, the C-4 form, and did not accept office notes or a narrative. However, not all claimants are treated by medical providers authorized by the Chair who are required to complete the C-4 form. For example, claimants may be treated in an emergency room. Physicians who work in emergency rooms are not required to be authorized by the Board. Workers who are killed due to a work related injury may not be treated at all. Rather, a death certificate or autopsy report may provide the only medical evidence. As stated above, holding the first expedited hearing, to take all lay testimony, immediately after the PHC could easily result in wasted calendar time and make it difficult for the parties to prepare for the hearing. The proposed regulations address all of these issues.

The Board received suggested changes to the recommended regulations from participants in the system and from within the Board.

The alternatives suggested include:

(a) Permitting the indexing of a claim upon receipt of any medical report that provides a history, a diagnosis and statement on causal relationship rather than restricting indexing to receipt of completed, prescribed medical report. The Board amended the recommended regulations to allow for the indexing of a claim without receiving the prescribed medical report when the claimant is treated out of state, treated in an emergency room and when the claimant has died due to his or her work related injury. Also the Board revised the definition of prima facie medical evidence in accordance with the amendment to WCL §25(2-a).

(b) Amending the recommended regulation §300.37 to make Claimant Information Packets that will be available to employers on the Board's website, available to anyone.

(c) Adding a provision to proposed regulation § 300.38 which imposes a waiver penalty for defenses raised without sufficient specificity.

(d) Elimination of the current carrier mandatory right to an adjournment for cross examination language of 12 NYCRR § 300.10(c) and instead permitting carrier cross examination of an attending provider only when the carrier has produced a conflicting medical report.

(e) Deleting the phrase “by an attending medical provider” from the recommended definition for PFME to allow the acceptance of PFME from a medical professional other than an “attending medical provider” in some cases, such as those where the attending provider is no longer available due to death or uncooperativeness. The definition of PFME has been completely changed and no longer contains a reference to attending provider.

(f) Deleting the requirement that a prescribed form (Form C-4) must be used for a medical report to qualify as PFME. The Board amended the recommended regulations to allow a medical report other than on the prescribed form when the claimant is treated out of state, treated in an emergency room and when the claimant has died due to his or her work related injury. Also the Board revised the definition of prima facie medical evidence in accordance with the amendment to WCL §25(2-a).

(g) Deleting sections relating to Limited Releases. Currently, claimants are directed to sign releases for prior medical records. The proposed regulations have been modified from the recommended regulations to only require receipt of a limited release to index a claim when a claimant notes on the C-3 form that he or she suffered a prior injury or similar illness to the work related injury or illness.

(h) Deleting the recommended regulation section relating to the written certification of the claimant’s legal representative as to evidentiary support for a claim.

(i) Elimination of the PFME requirement in unexplained or accident cases where there are no witnesses, i.e., death claim cases.

(j) Coordination of the PHC statement filing requirements which require submission of the statement 14 days prior to the conference and a listing of witnesses for cross examination, and the IME report filing requirements which allow the report to be submitted at the PHC as these regulations do not allow the claimant’s

legal representative the opportunity to evaluate the IME report to determine if the author should be listed as a witness for cross examination on the PHC statement. The proposed regulation requires the PHC statement to be filed 10 days before the PHC and the IME report to be filed before the initial expedited hearing.

(k) Deleting the recommended regulation section regarding mediation meetings as unnecessary and unworkable. The proposed regulation eliminates this provision.

(l) Modifying recommended regulation section 300.38(d) to indicate that photocopies or electronic copies of a Limited Release are the equivalent of an original signed release and must be accepted as such by medical professionals and hospitals. This suggestion is incorporated into the draft form prepared by the Board.

(m) Modifying recommended regulation section 300.38(h) (3) to exempt the disclosure of claimant fraud evidence from the carrier's PHC statement until after the claimant testifies.

9. Federal standards:

There are no federal standards applicable to this proposed rule.

10. Compliance schedule:

It is expected that the affected parties will be able to comply with the new definitions in §300.1 and the indexing requirements in §300.37 immediately and be able to comply with the changes to §300.33 and §300.34 and new controverted claims process in §300.38 by November 3, 2008. However, the statutory amendment to WCL § 25(2-a) requiring the PHC to be held within 45 days from the filing of the notice of controversy and a medical report referencing an injury became effective for claims filed on and after March 13, 2007, and has been implemented. Therefore, parties are already complying with these requirements.