

## Assessment of Public Comment

In June 2007 the Superintendent of Insurance submitted recommended streamlined adjudication regulations for controverted claims to the Board. The recommended regulations were developed based upon the work of an advisory committee comprised of representatives of the American Federation of Labor – Congress of Industrial Organizations (AFL-CIO), the Business Council of New York State, the New York State Assembly and Senate, the Department of Labor, the Board and the Insurance Department. The Board received a number of comments about the recommended regulations, which were carefully reviewed. In addition, the Board met with different groups who provided input on the recommended regulations. Finally, the Board received comments about them from its own staff, including workers' compensation law judges (WCLJs). Based upon all of the comments and input, the Board reviewed the recommended regulations and modified them to address some of the comments without changing the underlying essence of the recommended regulations of resolution of controverted claims within 90 days and increased information in the beginning to enable speedier resolution.

The Workers' Compensation Board (Board) received thirty-three comments from individuals, entities, associations and organizations. A number of the comments endorsed or supported comments submitted by others. Twelve of the individuals submitting comments were attorneys, five were individuals, one was an employee of a third party administrator and one was an employee of the Board. Comments were received from the Injured Workers' Bar Association, the Workers' Compensation Alliance, the Workers' Injury Law & Advocacy Group, Erie County Bar Association, New York Self Insurers Association, American Insurance Association, New York State Insurance Fund, Kennedy Valve, Business Council of New York State, New York State Trial Lawyers Association and the Medical Society of the State of New York. Three practice groups of medical providers provided comments on revisions to the Board's Attending Doctor's Report and Carrier/Employer Billing Form (C-4 form).

Some of the comments submitted pertained to modifications to forms C-2, C-3, and C-4. These form changes are not part of the proposed regulation but underwent a separate process which involved extended outreach. As the modifications to these forms are not part of this rule making, comments pertaining to them will not be discussed.

The Board received a number of comments that only expressed a general objection to the proposed regulations without any discussion. As these comments did not contain a discussion of why these individuals objected to the regulations, the Board is not able to analyze their comments. Most of the remaining comments focused on the same issues and made the same or contradictory arguments.

One attorney submitted comments that seem to be based upon the original version of the regulations and not the version actually proposed. This attorney commented that the proposed rules must be rejected as they will delay the indexing and adjudication of controverted claims. This comment is based on the following: 1) a case must be indexed before a pre-hearing conference can be scheduled; 2) there is no statutory requirement that an employee's claim form (C-3 form) or medical release be filed as a condition precedent to indexing a claim or scheduling a pre-hearing conference; and 3) the new indexing rules require an employer's report ( C-2 form) or C-3 form, attending doctor's report and carrier billing form (C-4 form) and a limited release, which as it will be attached to the C-3 form will be needed in every case. This attorney feels it will be difficult for claimants to comply with these requirements. Also, as it will be difficult to obtain an actual C-4 form in every case so the Board should continue the current practice of accepting any medical report to index a claim so there is no delay in the pre-hearing conference nor are carriers encouraged to delay filing a notice of acceptance of the claim.

These comments have been reviewed. First, a case does not need to be indexed before a pre-hearing conference can be held. The Workers' Compensation Law (WCL) does not include this requirement. The proposed regulations specifically provide at §300.37(c) that if the carrier files a notice of controversy before it is

indexed, it is not required to index the claim and may take appropriate action to address any issues or disputes. Therefore, if a notice of controversy is received for a case that is not indexed and a medical report referencing an injury is in the file, the pursuant to WCL§25(2-a) a pre-hearing conference will be scheduled. There is no statutory requirement that a C-3 form or medical release be filed in order for a case to be indexed. In fact the WCL does not define the terms indexed or index or indexing or any requirements for it to occur. Rather, WCL §141 empowers the chair of the Board to make administrative regulations and orders providing for the indexing of claims. Therefore, the statute empowers the chair to set the indexing rules. The proposed regulations do not require a C-3 form and limited release to index every case. The limited release, while part of the C-3 form, will also be a separate form so it can be filed without the C-3 form. Further, the regulations only require a limited release when the claimant has filed a C-3 form and indicated on the form that he or she has a prior injury to the same body part or similar illness to the one(s) listed on the form. The regulations require the Board when it creates a case but does not index it to send a claimant information packet to any unrepresented claimant. The claimant information packet contains a C-3 form as well as information on the need for a medical report and the limited release. To assist claimants with completing the C-3 form, injured workers can call a toll free number and complete the C-3 form over the phone. In addition, claimants may complete the C-3 form online.

Another comment from this attorney is that the increased focus on prior medical history will result in more controversy and delay by allowing the carrier to focus on “conditions” rather than “disability.” Requiring prior medical records be disclosed as a prerequisite to the indexing of a claim is contrary to the law, will encourage litigation and delay the resolution of controverted claims. The Board disagrees as the regulation does not increase the focus on prior medical history or allow the carrier to change its focus. Carriers routinely send general medical releases to claimants, which are signed. When claimants do not sign such releases, the issue is brought to a WCLJ who will direct the claimant sign the release. The Board has actually decreased the focus by

limiting the release to prior injuries to the same body part or similar illness to the one listed on the C-3. In a controverted claim, the carrier must request approval for a broader release from the Board and show relevance.

This attorney also commented on proposed revisions to the C-2 and C-4 forms. The C-2 and C-4 forms are not part of the proposed regulation. The revisions to the C-2, C-3 and C-4 forms underwent a separate process which involved outreach to representatives of labor, business, carriers, attorneys and medical providers, public hiring of a forms expert and readability expert, public comment period, and focus groups. As the revisions to the forms are not part of this rule making the specific comments will not be discussed except to state that the comments received are similar to those received during the process described above.

Finally, this attorney believes the Board should continue to enforce its existing rules to resolve controverted claims as it has to achieve the 88% resolution of controverted claims in 90 days.

A claimant's attorney commented that the time limits in the proposed regulation are unrealistic and are opposed by claimant and defense attorneys so they should not be adopted. The Board disagrees with the assessment that the time limits are unrealistic. For about a year now the Board has been expediting all controverted claims as authorized by WCL §25(3) (d) and working to resolve them within 90 days. To resolve controverted claims within 90 days the Board has basically been using the time frames in the proposal based upon existing statutory and regulatory authority. The process works as shown by the fact that 88% of controverted claims are being resolved in 90 days. This attorney comments that in his view the proposed regulation would sacrifice due process in order to attain some additional measure of efficiency. The comments do not state exactly how due process is sacrificed. Due process is not sacrificed and the regulations draw on the provisions in the statute relating to expedited hearings and pre-hearing conferences. Another comment is that the expanded C-3 form and the indexing requirements will delay the establishment of cases and create a defense not found in statute or present case law. It is not clear how this will occur as the C-3 form is not required to

index a claim and a claim does have to be indexed for the Board to take action if the carrier files a notice of controversy. Further, the regulations do not create any new defenses rather they provide a specific process.

Two attorneys wrote to request the Board not to adopt the proposed regulations as they will not work, have flaws and will delay claims. Specifics as to the flaws and how the proposed regulations will delay claims are not provided. The Board disagrees with these comments because, as stated above, it has already begun speeding up the resolution of controverted claims based upon its statutory authority.

Another attorney wrote to urge the Board to withhold adoption of the proposed regulations because they take the advancement of the claims handling process too far and will be detrimental to injured workers as it will make it less likely he or she will be able to succeed in bringing a claim. The commenter does not refer to any specific provisions in the proposed regulations so it is unclear how it makes less likely an injured worker will succeed in bringing a claim. The Board disagrees and believes it will be no harder for a claimant to bring a claim. As noted elsewhere in this document, the Board will be sending a claimant information packet with a copy of the C-3 form to the claimant upon receiving any document and creating a case file. This packet will also contain information about the need for a medical report and the Board will assist the claimant in obtaining such report. A medical report is necessary for any workers' compensation claim but is imperative for a controverted claim as a pre-hearing conference may not be scheduled until one is received. The process in §300.38 is only for controverted claims so claims that are accepted will proceed as they have in the past. The proposed regulations differ from the recommended regulations in that a limited medical release is now only necessary to index if the injured worker files a C-3 form and indicates prior injury to the same body part injured in the work related accident. The requirement of a limited medical release is to speed the exchange of information so that parties can make better informed decisions and quicker resolution. This requirement does not create any new defenses and does not violate the statute.

Another attorney commented that the proposed regulations are not needed since the Board has been expediting all controverted claims. The Board believes these regulations are necessary to clearly set forth the expedited process for controverted claims and the consequences of failing to follow the rules. This attorney also provided comments on specific provisions. First, he commented that it is difficult to get providers to complete the existing one page C-4 form, so it will be even more difficult to fill out the revised C-4 form which is longer. Currently, providers simply file their office notes so the requirement in 300.37 that a provider must use the Chair prescribed form before the claim is indexed will only delay the indexing of legitimate claims, which will not expedite but prolong the claim. Section 300.37(d) (4) requires providers, except in certain circumstances, to complete the C-4 form or lose payment for that treatment. Providers who are authorized to treat injured workers are required to submit medical reports on forms prescribed by the chair pursuant to WCL §13-a (4) (a) and 12 NYCRR §325-1.3(a). The forms prescribed by the chair for providers to submit are set forth in §325-1.3(d). Similar provisions exist for psychologists, podiatrists and chiropractors. A completed C-4 is necessary to ensure all information required is received without delay. Completing the C-4 will also assist with the payment of medical bills and with the resolution of disputed bills. While the Board has not enforced these provisions in the past, in order to speed claims processing, ensure receipt of necessary medical information and to eliminate disputes it must require the C-4 to be completed.

Second, proposed §300.37 requires a claimant to execute a limited medical release which will lead to further litigation about what constitutes “relevant medical records” regarding the claimant’s prior medical history and is contrary to existing law that an employer takes a claimant as he is. In other words, compensation is payable if the job injury is the cause of the disability regardless of a pre-existing condition. This attorney comments that this will delay resolution rather than expediting it as carriers will litigate about obtaining prior records even though apportionment is not applicable if the claimant is not disabled in a compensation sense at the time of the work related injury. Only claimants with prior injuries to the same body part as injured in the work related

accident or similar illness to the one claimed are required to complete a limited release. The relevant records are those relating to the same body part or similar illness. The requirement of the limited release does not change the statute or case law regarding pre-existing conditions. Carriers who attempt to litigate on these issues to delay may be subject to a penalty pursuant to WCL §114-a (3) for continuing without reasonable grounds. This requirement is to facilitate and speed the exchange of information and investigation by the carrier. Further, apportionment does apply if the claimant has a prior work related injury. The commenter is concerned that while litigation is occurring on these two issues the claimant is not receiving benefits. The Board is committed to resolving all controverted claims as quickly as possible, which the proposed regulations will accomplish. Further, if the claim is not indexed and the carrier has not filed a Notice of Controversy (Form C-7), the claimant will not be eligible to receive statutory disability benefits as the disability benefits carrier will not pay until it receives C-7 form. If the claimant is not able to receive disability benefits and the compensation claim is delayed, he or she will have to go to Social Services. As state elsewhere in this document, the regulations require actions on the part of the Board to obtain all necessary information to index a claim. However, carriers are required by WCL §25(2) (a) to file a notice of controversy within set time frames not related to the indexing of a claim.

A third issue is that proposed 300.38(g) (11) (iii) prohibits the direct testimony of a medical witness at a deposition unless authorized by the workers' compensation law judge (WCLJ), which will not be helpful. According to the commenter, often the medical provider at a deposition is using the direct examination to review the chart. Starting with cross-examination will confuse matters and may prolong the deposition and the attorney notes that in his experience there is no area of law where a witness is first cross-examined before direct examination occurs. He believes that WCLJs would prefer to review a transcript that begins with the doctor explaining his opinion of causal relationship rather than cross-examination. The medical reports of the treating provider and the independent medical examination (IME) report are the direct testimony of the medical

witnesses. Currently, medical witnesses are only called if the opposing side wants to cross-examine him or her. There is no reason in most cases to take the direct testimony, however the proposed rules provide that the WCLJs may grant requests to take the direct testimony. He is concerned that doctors may refuse to treat workers' compensation claimants because the C-4 is longer and they will be cross-examined without the opportunity for direct examination. The Board does not agree but will be monitoring the situation.

In the commenter's opinion, what delays payment to claimants is the automatic stay provision in WCL §23, which he states causes carriers to appeal the WCLJ decision. He feels that due to the number of appeals there is a backlog in the issuance of appeals by the Board. As the commenter notes, the automatic stay provision is in statute so the Board cannot adopt a regulation that changes it. However, the Board is working hard to reduce the time to decide an appeal and recently reorganized that part of the organization. The goal is to resolve appeals on average in four months from the date of the WCLJ decision.

Another attorney commented that he does not think that controverted cases are taking too long to resolve and believes that the statistics cited to support the need for the proposed regulations are suspect. Though he notes he does not have statistics of his own he believes that most controverted cases are being resolved now within 90 days. The Board agrees with the statistics cited by the Insurance Department as they are based upon the Board's data. Further, as noted by the chair in June of this year, since the Board began speeding the adjudication of controverted claims in June 2007, 88% of claims have been resolved in 90 days. The regulation codifies the changes the Board implemented in June 2007, and provides additional tools to speed this process. He believes that the proposed regulations will not reduce the time to resolve controverted claims, will create additional burdens for all parties, and will increase costs.

This commenter states that indexing rules should be as simple as possible and the rules in the proposed regulations are not as they call for case creation and then indexing. A case is created but not indexed if all of

the required forms have not been received. Contrary to the comments submitted a claim does not require a C-3 and limited release form in every case to be indexed. A claim may be indexed upon receipt of a C-2 and a C-4. WCL §110(2) mandates that employers file with the Board and its carrier if insured a report of any accident causing injury which results in two or more medical treatments or lost time beyond the day of the accident within ten days of the accident. WCL §13-b (4) (a) requires physicians to file a medical report on a form prescribed by the chair within 48 hours of the initial treatment. If the Board receives these two forms at the same time or a C-3 and C-4 it will index the case if a limited release is not necessary. A workers' compensation claim cannot proceed without a medical report. Further, a number of claims are controverted just because the medical report is not filed with the Board or sent to the carrier. The proposed regulation prevents this from happening.

He states the proposed indexing rules in §300.37 will delay indexing of a claim which will slow down the process. As stated elsewhere the regulations require actions on the part of the Board to inform the injured worker of what needs to be filed and assistance with obtaining the documents. This attorney also commented that a delay in filing the notice of controversy form will delay receipt of disability benefits because a disability benefits carrier will not make payments until such form is filed. Part of the purpose of the regulations is to provide more information up front so carriers will not controvert. If the carrier never controverts then disability benefits are not necessary. Further, WCL §25(2) (a) requires carriers to file a notice of controversy within certain time periods based on date of disability or knowledge of the accident. In 2006 almost 50% of claims were indexed from forms filed by a carrier, such as a notice of carrier's action on a claim, notice of controversy, notice that payment of compensation has stopped or been modified or notice of disputed medical bill. Finally, the commenter believes that the Board is creating a statistical improvement with no benefit to the claimant as the count down for claim resolution begins with notice of indexing. The Board disagrees as until an issue is raised or the claim is controverted there is nothing for the Board to resolve. The majority of claims are accepted

by carriers and most of them begin payment without any action by the Board. This is supported by the fact that in 2006 33% of claims were indexed when the carrier filed a notice of action on the claim, namely accepting it.

This attorney comments that the proposed regulations will create additional burdens for all parties. He again references the indexing rules but as noted above the C-2 and C-4 forms are statutorily required forms and the C-3 form is the vehicle for a claimant to make a claim. As stated elsewhere, the Board has implemented programs to make it easier for claimants to file a C-3 form. Another comment he submits is the same as the comment discussed above that requiring the limited medical release empowers carriers to raise a defense that contradicts case law. Requiring the limited release does not empower the carrier to raise a defense, but enables the carrier to conduct its investigation as to whether the claim is covered by the workers' compensation law, such as whether the injury really happened at work or happened at home. He also object to requiring the medical providers to use C-4 form and states that currently it is not mandated that a doctor submit a C-4 form. As stated above, both the law and rules require medical providers authorized by the chair to use the C-4 form. As part of his comments on this subject he states his belief that requiring medical providers to use the C-4 form is contrary to the presumption in WCL §21(5) that "the contents of medical and surgical reports introduced into evidence by claimants for compensation shall constitute prima facie evidence of facts as to the matter contained therein." This provision relates to how the reports are treated by the Board, not whether or not the chair or Board can require the use of a prescribed form. As noted above the statute is clear that the chair has this authority.

Another comment of this attorney is that it should be the employer not the carrier's representative who is required to sign the certification on the notice of controversy. He states that the rationale for this provision, encouraging additional discovery in controverted cases, is contrary to the fact that the trial before the WCLJ is the method of discovery. Having the carrier provide an "upon information and belief" certification merely creates an extra step without moving the case forward. No real discovery is done, just the claims adjuster

calling the employer regarding what happened and then the Board bringing the parties in to testify. The resolution of controverted claims is delayed because the parties take little if no action until they are required to appear before the Board. This provision is to require the parties to investigate and prepare themselves before appearing for a pre-hearing conference or hearing. Further, in many cases it is the carrier who wishes to controvert not the employer and pursuant to the insurance policy the carrier is ultimately responsible for how the case is handled. Finally, WCL §25(2-a) (d) provides that discovery is complete at the end of the pre-hearing conference.

This commenter believes that the provisions regarding the pre-hearing conference (PHC) statement indicate that the Board is seeking to turn workers' compensation hearing process into forms driven motion practice but Board is not Supreme Court. He believes that the PHC statement will end up being boiler plate bills of particulars that no one will read. Further, the regulation is inconsistent with WCL §28 which provides that if a carrier fails to raise a defense it is waived so as any good attorney would do, the carrier raises all defenses as it does not know what the claim is until claimant testifies. This is especially true in controverted claims. WCL §25(2-a) requires the filing of a PHC statement by represented parties at least 10 days before PHC. Further the law requires that PHC statement include the information listed in §25(2-a) (b) which are listed in this provision. Contrary to his argument, WCL §28 only provides for the waiver of failing to file timely, within 2 years, if it is not raised at the first hearing at which all parties are present. If carrier receives notice of indexing or notice of case assembly within 6 months or a year of the date of accident, it makes little sense to raise this defense. WCL §25(2) (b) provides that if the carrier fails to file the C-7 within 25 days of the notice of indexing then it is barred from pleading that the claimant was not an employee, or the employee did not sustain an accidental injury or that the injury did not arise in and out of the course of employment but the Board in the interest of justice and upon showing of good cause may permit filing of amended C-7 raising defenses not previously raised. As stated above, the parties must investigate the claim and the carrier needs to put forth only credible

defenses. This is especially true in light of WCL §114-a (3) which imposes penalties upon parties and legal representatives for instituting or continuing proceedings without reasonable grounds.

This attorney also believes the requirements for the claimant's PHC statement are burdensome as much of the information requested is found on the forms. While some of the information could be found on the forms, not all of it can and most of the contents of the form are required by statute. He also states that the regulation ignores the fact that there need only be substantial evidence in the record to support a claim. The regulation does not change the fact and the PHC statement is required by law. Further, he feels that providing a list of medical witnesses is contrary to 12 NYCRR §300.10(c) which only allows a party to cross-examine another party's witness and serves to move towards medical testimony when it may not be necessary. The rule does not change any evidentiary rules, merely requires the party to list the names of the medical witnesses it intends to cross-examine and it does not require that a party cross-examine anyone. In addition, at the first hearing, after the carrier has served its IME report, the claimant's legal representative will be asked if he or she still wants to cross-examine the carrier's examiner. He also comments that requiring all documents be attached to the PHC statement assumes too much organization by claimant especially as claimants often do not obtain counsel until after notice of the PHC and it takes two weeks to scan a retainer and place the representative on notice so it is impossible to comply. The regulations contain provisions that address situations where the claimant is retained late or the documents are not in the possession of the claimant or his representative or could not reasonably be obtained. Further, the claimant's attorney could review the claim file at the Board's offices through existing procedures.

Finally, he comments on why he believes the proposed regulations will increase costs for all parties. He cites increased costs to the Board from receiving a longer C-4 form. However, currently, the average number of pages of each medical report is approximately three to four pages, so there should be little additional cost. Further, the C-4 could be submitted online at no cost to the Board and reduced cost to the provider as it would

not need to mail a copy to the Board. He also cites to the increase cost to the Board from scanning the PHC statement. This statement is required by statute and existing regulations. Further, the Board will be making this form available to be filed online. The documents required to be submitted are those that would be submitted at the PHC or the initial expedited hearing. Documents submitted at such time are currently scanned into the electronic case folder. Therefore, there should be only a change of when the documents are scanned not the scanning of additional documents. He also mentions the submission of affidavits, but this will only occur when the party is seeking an exception to the controverted claim process in the regulation. The need for affidavits should be small. Further, the Board currently requires the submission of affidavits if an extension of time to complete a deposition is required. The Board understands there are costs involved but is concerned that claimants whose claims are controverted currently are receiving no benefits or wages for months. To ensure claimants receive their benefits quickly, necessary information must be submitted as quickly as possible. While a claimant whose workers' compensation claim is controverted can receive disability benefits during that time, currently such benefits are only 50% of the average weekly wage up to a maximum of \$170.00 per week. To alleviate costs, the Board continues to work to develop the ability for more electronic filing of forms.

Another attorney who submitted comments endorsed the comments of the two attorneys discussed immediately above. In addition he commented that the delay in resolving controverted claims would not be a problem if WCLJs would properly perform their role under present regulations. The proposed regulations are intended to assist WCLJs in enforcing the process currently in place, which is reducing the time to resolve controverted claims and existing statutory provisions. In addition the regulations are intended to require the parties to know the case and be prepared for all proceedings before the Board. He also commented that delays in indexing of cases extends the time before a claim comes before a WCLJ so the regulations will prolong the resolution of a claim. The Board disagrees for all of the reasons set forth above. Like other comments discussed above, he believes requiring the C-4 form will prevent claims from coming before WCLJs. The

Board disagrees for the reason set forth above. He made two additional points: 1) the adverse financial incentives for doctors; and 2) adverse financial interest for claimant attorneys. With respect to the doctors he gives two examples of lower reimbursement rates for treating an injured worker as compared to group health insurance. The Board has no knowledge of the exact reimbursement rate for the group health insurer cited. We do acknowledge that the Workers' Compensation Medical Fee Schedule has not increased in over ten years. This is something under review at the present time and is the subject of separate regulations. He also notes that a major part of what he does is lobby providers to consider and answer basic questions relevant to the compensability of a claim. This makes clear that the office notes provided in lieu of the C-4 form are not sufficient. If a provider completes the C-4 form he will not have to do this. To enforce the requirements in the law and existing regulations, the proposed regulations include consequences for failing to use the C-4 form. With respect to claimant attorneys, he notes that their income is based on how much money flows to the claimant set off against the time the attorney spends on the case to establish the claim. This is correct. It is also correct that the longer it takes to establish the case there is more money moving to the claimant at the time it is established. The only additional steps that the proposed regulations impose are compliance with the requirement in law and current regulations to file a PHC statement, certification by the claimant attorney of the C-3 form, submission of documents intend to be used at the hearing as required by WCL §25(2-a) (b) and (d), and affidavits only if the party needs to deviate from the proposed process. Actually, the proposed regulations eliminate a requirement by prohibiting memorandums of law or summations or briefs unless authorized by the WCLJ in certain circumstances. He suggest that the Board merely enforce current regulations, which as discussed above would still require the submission of the C-4 and the pre-hearing conference statement, without the consequences for failing to comply as provided in the regulations.

The Injured Workers' Bar Association (IWBA), a statewide association of attorneys whose practices focus on representing injured workers, submitted comments as it is concerned with "the policy and legislative

implications” from adopting the proposed regulations. Attached to the letter from the President of the IWBA were comments addressing policy issues. In addition, the IWBA supports and adopts the comments of the WCA referenced below, which were attached to the IWBA’s comments.

The IWBA believes the proposed regulations are seriously flawed and violate the separation of powers between the executive and legislative branches. First the IWBA believes they are flawed because they ignore that workers’ compensation is administrative law rather than a court of law, as supported by WCL §118 which provides that the Board is not bound by common law or statutory rules of evidence or formal or technical rules of procedure. It also notes that the Board is not subject to the State Administrative Procedure Act. In its view the proposed regulations are very technical rules of evidence and procedure which violate the purpose and intent of WCL §118 and the purpose of the proposed regulations, to speed the resolution of claims. The Board disagrees as WCL §118 does not prohibit the Board from adopting its own procedures, rather it does not bind the Board to those used in courts of law. Further, the WCL requires the major components of the proposal as follows: 1) WCL §25(2-a) requires that a notice of controversy and a medical report referencing an injury be filed in order to schedule a PHC; 2) WCL §13-a(4) and 12 NYCRR §325-1.3 require a provider submit medical reports on prescribed forms (C-4 form); 3) WCL §110 requires employers or their designees to file a report of accident on prescribed form (C-2); 4) WCL §25(2-a)(d) require PHC statement be filed at least 10 days before the PHC, the contents of the PHC statement must contain the information listed in WCL §25(2-a)(b), discovery is complete at the end of the PHC, and evidence not disclosed at the PHC or obtained later is not admissible unless party can demonstrate it was not available or not discoverable with due diligence prior to the PHC; and 5) WCL §25(3)(d) provides that controverted cases may be referred to the expedited hearing process upon order of the chair, proceedings in the expedited process are to be conducted in an expedited manner, any adjourned case in the expedited process must be rescheduled for a date no more than 30 days after the first hearing; and

requests for adjournment that are not emergencies and are deemed frivolous are penalized. Further WCL §141 authorizes the chair to establish rules for indexing a claim.

The IWBA argues that the proposed regulations violate Executive Order #20 and should not be authorized by the Governor's Office of Regulatory Reform (GORR). The Board is not subject to Executive Order #20 as it is not an agency pursuant to SAPA §102(1), but it did receive approval from GORR to publish the rules.

Like others who submitted comments, the IWBA argues that the proposed regulations create a specific defense to the presumptions of WCL §21 by permitting, upon a mere allegation, that the accident/injury/disease is due to some pre-existing injury or medical condition. The Board disagrees. WCL §21 provides that it is presumed that claim arose out of and in the course of employment. The proposed regulation makes no reference to this presumption but provides the process when the carrier controverts the claim raising the defense that it did not arise out of and in the course of employment. To rebut this presumption the carrier must present substantial evidence to the contrary. In support of its position the IWBA points to the revised C-3 which requires the injured worker to list whether he/she has prior injuries or conditions. As stated above in response to other comments, the proposed rule does not create a new defense. While the carrier cannot raise a pre-existing injury to defend an injury that occurred while working, it can raise that the alleged injury did not occur in the course of employment but at home or elsewhere. An example is when the claimant alleges he or she broke his or her arm at work, but really broke it at home the day before and nothing occurred at work to aggravate the injury. In addition, some prior injuries or conditions are work related and the carrier can raise the defense that the injury is merely an aggravation of an old work injury or apportionment should apply. The proposed regulations in now way change any statutory provisions or violate the separation of powers.

The Workers' Injury Law & Advocacy Group submitted a letter objecting to the proposed regulations and supporting the comments of the IWBA.

The Workers' Compensation Alliance (WCA) submitted comments objecting to the proposed regulations. The WCA believes that the proposed regulations will encourage needless and baseless practices which will slow the resolution of claims and trample the rights and interests of injured workers. Specifically, the WCA states the proposed regulations are: "(1) illegal in that they conflict with the unambiguous requirements of standing statutes; (2) ill-conceived and will likely encourage/increase litigation; and/or (3) unfair and/or overly burdensome in their application." Further, the WCA believes it has already been shown that the proposed regulations "represent a co-option of the Legislature's prerogative to enact laws governing the subject matter of this extensively intrusive regulatory scheme (see statement of the President of the Injured Workers' Bar Association, July 20, 2008, copy attached.)" The comments of the Injured Workers' Bar Association (IWBA) will be addressed separately.

The WCA identified the "glaring deficiencies" in their comments. First, the WCA believes the indexing rules in new section 300.37(b) are ill conceived because:

- They lengthen rather than shorten the Board's claim indexing and resolution process since a number of documents must be properly completed and filed before a claim is indexed;
- They complicate the indexing process by requiring a number of prescribed forms rather than as previously recognizing that any document may be used to infer a claim was being made to constitute the filing of a claim.
- They do not exclude death or other unwitnessed or unexplained accident cases from the filing of prima facie medical evidence;
- They fail to require indexing upon receipt of a C-669 which indicates a carrier has accepted the claim;

- They discourage the prompt filing of the C-669 as the carrier waits to see whether claimant succeeds in completing the new technical filing requirements;
- Every claim will require a C-3 because the medical release is part of the new C-3 form.
- They do not define what are relevant medical records which will increase litigation;
- They do not state that the limited release is the only release carriers can use.

The Board disagrees with these comments for the reasons stated in response to similar comments above. In addition, it must be noted that the indexing of a claim and the filing of a claim are two different things. WCL §28 requires that a claim be filed within two years of the date of accident or two years from the date of disability and when the claimant knew or should have known that the disease was due to the nature of employment. The filing of a claim could be the submission of a letter from the claimant, a C-3 form or some other document and is not changed by the proposed regulation. If the Board received a C-3 and no other form for three years, the claim would still have been timely filed. The indexing of a claim is the Board taking charge of the claim and putting the carrier on notice that action is needed, in some cases action it should have taken on its own.

The regulations now define prima facie medical evidence (PFME) as a medical report referencing an injury, which includes traumas and illnesses. Even if an accident is unwitnessed or unexplained, the claimant still needs to submit a medical report indicating that he or she suffered an injury because in order to receive benefits claimants must have an injury. With respect to death claims, evidence of the worker's death must be submitted but it does not have to be on a C-4 form.

The regulations do not require the indexing of a claim upon receipt of a C-669 as §300.37(c) provides that the Board may take appropriate action without indexing the claim to address any issues. If the carrier files a C-

669 it has accepted the claim and there is no purpose to indexing the claim. Based upon the C-669 the Board can issue an administrative decision confirming the acceptance of the claim and take any action on any issues that arise, such as whether a request for authorization should be approved. The Board disagrees that the regulations discourage the carrier from filing a C-669. First, currently the Board only creates a case file when it indexes a claim, which requires the receipt of a C-3 or other documents, such as the C-2 or C-4, which indicate lost time greater than seven days or serious injury. Under the proposed regulations, the Board will be creating more case files and sending notice to the carrier and claimant of this action. In addition, the Board, as discussed above, will be providing information and assistance to claimants to help them file or obtain needed documents. In addition, WCL §25(1) requires a carrier to begin indemnity payments without an award from the Board within set time frames if it will accept the case and file notice with the Board.

As stated previously, a C-3 form is not required in every case because while the limited release is part of the C-3 form, it is also a separate form, and a limited release is only necessary if the claimant files a C-3 form and indicates on the form that he or she has a prior injury to the same body part or similar illness to that injured in the work related accident. Therefore a C-3 form is not needed to index every case. While the regulations do not state that the limited release is the only release that the carriers can use, the regulations provide that if the carriers need a broader release they must make such request on the PHC statement and the WCLJ will rule on the request at the PHC.

In addition the WCA believes §300.37(b) contradicts the statute so the rule is unenforceable. This comment is based on the belief that before a pre-hearing conference can be scheduled, a claim must be indexed. The WCA also points out that the statute does not require the filing of a C-3 in order to index a claim. The WCA believes §300.37(b) is not in harmony with the WCL and therefore the Board has no authority to adopt it. In support it cites to the 2004 Supreme Court decision in New York State Insurance Fund v. New York State Workers' Compensation Board.

Section 300.37(b) does not contradict the statute. There is no requirement that a claim must be indexed before a PHC is scheduled. This is the case currently, but that is due to the fact that a case file is not created until a claim is indexed. Under the proposed rules, upon receipt of any document a case file will be created. Upon receipt of a notice of controversy and a C-4, whether the claim is indexed or not, the Board will schedule a PHC. The WCA is correct that the statute does not require the filing of a C-3 in order to index a claim and neither do the regulations. Rather the regulations require the filing of either a C-2 or C-3. Further, as discussed above, WCL §141 empowers the chair to set the indexing rules for the Board.

The WCA is concerned about the requirement in §300.37(b) (1) (iii) that the claimant sign a limited medical release. The comments indicate that the WCA believes that a limited release must be signed in every case. As discussed previously this is not true. The WCA is concerned that it will clutter the beginnings of a claim with unnecessary and irrelevant filings of medical records that will only increase litigation and delay the resolution of claims. This is especially true regarding pre-existing but non-disabling conditions. The WCA references decisions finding that compensation awarded when a claimant suffered from pre-existing condition as long as the employment acted to cause the disability which did not previously exist. Further apportionment does not apply to a claim for temporary disability benefits but may apply at the time of permanency. Therefore, the WCA believes requiring the exchange of pre-existing medical information at the beginning of a claim and to index it is misguided and will increase the number of controverted claims. Carriers will now controvert on the basis that the claimant's medical condition, not disability, was initiated prior to the alleged day of injury. The WCA believes the search and acquisition of the prior medical records will delay the claim. As discussed in response to a number of comments above, the Board disagrees. The purpose of the limited release is to speed the carriers' investigations of the claims and does not create a new defense. Further, carriers currently send general, broader releases to claimants, under the rule the release will be the one prescribed by the Board.

The WCA objects to the requirement in §300.37(d) (1) (i) that claimant's counsel certify in writing that claimant's counsel has or will likely have evidentiary support. Claimant's counsel has little ability to make this certification beyond accepting the claimant at his/her word. This requirement is so onerous attorneys will be discouraged from accepting representation on controverted claims. In addition, this will chill attorneys' willingness to appear on a claim that requires the reversal or modification of existing law. The certification provisions fail to define what is meant by "evidentiary support," fail to outline the process for determining whether a certification was wrongful and fail to particularize the sanctions applicable when a certification is defective. The Board disagrees with these objections as the certification is upon information and belief and attorneys are required by the disciplinary rules to represent a client with the bounds of the law (22 NYCRR §1200.33) which includes not advancing a claim that is unwarranted under the law and not knowingly make a false statement of law or fact. Additionally, as noted above, WCL §114-a (3) prohibits a legal representative from instituting or continuing a claim without reasonable grounds. If the attorney is in compliance with this provision there must be reasonable grounds to support the claim and therefore he or she can certify the C-3 form. If the attorney believes that the existing law as it applies to a case should be modified or reversed then this must be based upon some aspect of the case, such as a fact or piece of evidence, because §1200.33(a)(2) requires the attorney to have a good faith argument for such action.

The WCA has concerns with §300.38(g)(8) because it does not provide that the failure to produce the independent medical examination (IME) report constitutes a waiver of the carrier's right to cross-examine claimant's treating physician. Without the IME report there is no contrary medical evidence so there is no evidence placing the issue of causal relationship into controversy. This issue relates to §300.10(c) of the Board's regulations, which is under separate review. The Board is currently reviewing this section and exploring possible amendments. This comment/suggestion relates to claims other than just those that are

controverted. At this time the Board is still researching its ability to take such action. Therefore, the Board did not include this provision in this regulation.

Finally, the WCA believes the proposed regulations are not necessary as the Board has already resolved 88% of controverted claims within 90 days by enforcing existing rules and laws. Similar comments to this one have been discussed above. The WCA admits that some provisions in the proposed rules are beneficial to claimants, but because some provisions are so offensive the entire rule should not be adopted. The beneficial provisions were not identified by the WCA.

A claimant attorney wrote to support the comments of the WCA and to ask that the regulations be rejected. He also commented that what is needed is better education of the WCLJs and Board staff and enforcement of the existing law and rules. As noted in response to similar comments, these rules are based on existing statutory requirements, some of which are ignored. The regulations clarify the applicability of these requirements and impose consequences for failing to comply with them. He notes that he experiences delays regarding the authorization of appropriate testing or treatment or the payment of proper benefits because hearings are not scheduled and these regulations fail to address such issues. The delays he experiences do not relate to the establishment of a controverted claim so they are outside the scope of this rule. However, the Board is working on improving the process for authorization of testing and treatment pursuant to WCL §13-a (5), which will be addressed through a different rule making.

The Erie County Bar Association (ECBA), upon the recommendation of the Workers' Compensation Committee, wrote to express its opposition to the proposed regulation. As stated in the comments of others discussed in this document, the ECBA states that the proposal puts burdensome and unnecessary requirements on claimants, attorneys, carriers and physicians, which will discourage attorneys from representing claimants in controverted claims and be especially hard on solo practitioners and small claimant firms. The proposed

regulations regarding the controverted claims process do include new filing requirements, however only two apply to claimant's attorneys in the regular course of adjudicating the claim. One is the certification requirement when the attorney is retained by the injured worker and he or she completes the C-3 form. Accompanying the certification must be a list of documents in the injured worker's custody which will be used to support the claim. The second is the pre-hearing conference statement. However, the requirement to file this document is set by statute. Further, as noted previously, the Board has already implemented the expedited scheduling of controverted claims so the PHC is 30 days after receipt of the notice of controversy and medical report, the first hearing is 30 days after the PHC and if a second hearing is necessary or depositions are ordered they are due within 30 days after the first hearing. The affidavits referenced in §300.38 are only necessary if the claimant attorney fails to timely file something, a witness fails to appear or an adjournment is necessary.

Another comment of the ECBA is that the onerous time constraints will force carriers into defensive and litigious positions. However, in the year since the Board implemented the expedited process allowed under the law there has not been such an increase. As stated above in response to other comments, the Board does not agree that the proposed regulations are contrary to existing statutory and case law or that the indexing provisions will delay the resolution of claims.

The New York State Trial Lawyers Association (NYSTLA) submitted comments objecting to the proposed regulations as they will not achieve the stated goal of expediting the resolution of claims and will hamper the rights of injured workers to obtain benefits for their injuries. The specific concerns of the NYSTLA are the same or similar to those expressed by others who commented and discussed above, and they will not be discussed further. Specifically the NYSTLA is concerned that the proposed regulations: 1) create additional delays due to the indexing requirements in §300.37(b); 2) increase litigation because §300.37(b)(1)(iii) requires claimants to submit evidence of prior injuries and a medical authorization for relevant prior injuries which is not defined; 3) create additional barriers for claimants as §300.37(d)(1)(i) requires claimants' attorneys to certify in

writing that the claim has or will likely have evidentiary support; and 4) are unconstitutional as they impose technical rules of evidence on administrative proceedings.

A comment was received from a WCLJ employed by the Board. In general he finds the proposed regulations much improved from the recommended regulations and believes the timeframe in §300.38 will work for most claims, and a “way out” has been provided for cases that do not fit that timeframe. He finds the new provisions to be a reasonable approach. He submitted some questions about provisions in the proposed regulation. Specifically, he asks whether PFME is different from a medical report referencing an injury. Pursuant to the proposed regulation, a prima facie medical report ("a medical report referencing an injury, which includes traumas and illnesses") is all that is needed to schedule the pre-hearing conference. However, claimant still must meet the burden of proving by competent evidence that the injury or trauma or illnesses he/she sustained and for which he/she seeks compensation arose in and out of the course of employment. Such competent evidence can include medical reports, documents, and testimony. When a claimant introduces a medical report, the presumptions of WCL § 21 provide "that the contents of medical and surgical reports introduced in evidence by claimants for compensation shall constitute prima facie evidence of fact as to the matter contained therein." Competent medical evidence, whether it is the first medical report submitted or one that is submitted later, must establish a recognizable link (causal relationship) between claimant's condition and his/her occupation.

He also noted that the word “statement” was left out of §300.33(d), which is a non-substantial change to the adopted text. With respect to §300.33(f) (12) he asked whether it should require the hearing to be scheduled within 30 days rather than the 60 provided in the regulation. The paragraph correctly requires the hearing within 60 days as it applies to the resolution of controverted claims when the claimant is unrepresented and therefore not subject to the process in §300.38(h). This language is intended to give the WCLJ flexibility as to the proper scheduling for the particular case at hand. He also stated that five business days for the WCLJ to

issue a written decision is not enough. Many times the WCLJ will be able to issue a bench decision at the final hearing in the controverted case. For those cases wherein a reserved decision is appropriate, then five business days, while a short time, should be sufficient to enable the WCLJ to render the written decision. Clearly the target is five business days; however, if there are exceptional circumstances then a day or two longer may be necessary. Finally, he questioned whether additional time would be provided if additional parties are added to the case at the PHC. On occasion additional parties may be added. When that occurs the case may fall into the “complex” case category wherein the timeline is extended.

The Medical Society of the State of New York (MSSNY) commented that the current system is costly and burdensome to all and takes too long, which results in physicians waiting months, even years, to receive payment for treatment. MSSNY stated it appreciates the efforts by the Board to establish new a new process so injured workers can receive assurance in a timelier manner that necessary health care will be covered. Members of MSSNY are concerned about the provision in §300.37(d) (4) that medical providers will not be paid if it does not completely answer all questions on the prescribed form. The concern is that the provision could be construed that all questions on the form must be answered regardless of relevancy. This is not the intent of this provision. Rather it requires medical providers to submit their reports of treatment on the prescribed forms and to respond to questions that are relevant to the particular injured worker and his or her injury. In addition some members of MSSNY concerned that the combination of this requirement and the new prescribed forms will result in instances where physicians are unfairly uncompensated because of he or she inadvertently did not respond to every question. A provider who inadvertently does not respond to a relevant question or two on the form should not be denied payment. Further, providers will not be required to use the new forms immediately but will be afforded a few months to implement and become use to the new forms before their use is mandatory.

MSSNY noted in its comments that it appreciated the Board’s outreach on the new prescribed medical report form, many members are concerned that it will be time consuming to complete the form and asks for

information that the Board, carrier or employer should already have or asks for information that may be appropriate to include such as social security number. As previously stated the content of the medical report forms are not part of the proposed regulation. However, in revising the form the Board strived to only ask relevant, necessary information to identify the correct claimant and case file, speed the resolution of the claim and eliminate areas of dispute. Correct identification of the claimant and claim and speedier resolution of the claim benefits providers as it speeds reimbursement and authorization for special services. Eliminating areas of dispute also benefits providers as it will reduce the need for their testimony, freeing their time to treat patients. MSSNY commented that there has not been an increase in the workers' compensation medical fee schedule in fourteen years. The Board acknowledges this fact and is studying this issue to determine a course of action.

MSSNY proposed two amendments to §300.37(d) (4) of the proposed regulations. The first would this section to require the medical report to include essential information but not total completion if circumstances do not require it. As stated above, the regulation requires the use of the prescribed medical report forms and the completion of relevant questions on the form. This change is not necessary because the regulation does not require, nor does the Board want, a provider to answer a question that does not pertain to the injury or claimant. In addition, the use of the phrase "essential information" would be problematic as it is not clear what that means and from whose perspective. The second would amend the same provision to provide that non-payment is among the remedies the Board may impose if the form is not completed sufficiently but not the sole remedy. MSSNY does not state what other remedy the Board should impose. The Board did not make this change as the only other remedies are to suspend or revoke the authorization of the provider to treat workers' compensation claimants. Such action is harsher than non-payment, takes considerable time and may require the provider to incur the cost of retaining legal counsel. The Board determined that the best alternative was to impose non-payment when the provider does not use the prescribed forms or does not substantially complete the relevant portions.

MSSNY also commented that §300.37(d) (2) (ii) (f) (3) should be amended. This provision requires the claimant information packet to contain information that the insurance carrier may have contracted with a diagnostic network to perform certain diagnostic tests, the employee may be required to obtain such diagnostic tests from a provider who is part of the network, and the insurance carrier must send notice to the employee about the network. MSSNY suggested that the provision be amended to clarify that the requirement to use the network is limited to the extent that patient is required pursuant to WCL §13-a (7). Regulations cannot supercede statute, therefore regardless of what is put into any regulation, the limitations of law provide. Further, this is just a statement of what is to be in the information packet, not the actual language to be used. Therefore, the Board does not feel that this change is necessary.

An officer of a third party administrator licensed by the Board to handle workers' compensation claims submitted a comment on the proposed regulations. This commenter wrote to express concern that because a C-3 form is not required to index a claim in all cases, carriers and self-insured employers will have less information than under the current rules and procedures. Therefore, the commenter suggested that 300.37 be changed to provide that a claim may only be indexed if a C-2 and C-3 and a limited release and a medical report are received. The lack of a C-3 form to index does not provide less information to carriers than under current rules and procedures. Currently the indexing rules are not in regulation and the Board will index a claim upon receipt of a C-2 or C-4 if the forms contain information that there is more than 7 days of lost time or a serious injury. In addition the Board indexes a claim upon receipt of a notice of acceptance or controversy filed by the carrier. Requiring a C-3 form to index a claim was discussed in depth by the committee that advised the Superintendent. The recommended regulations do not require a C-3 form to index a claim. The Board considered this suggestion when it reviewed the comments on the recommended regulation. It was decided that requiring the C-3 form to index would be too restrictive and possibly negatively impact claimants. However, recognizing that the filing of a C-3 form would be helpful, the proposed regulations require the Board to send a

claimant information packet to claimants when it creates a case, the Board has not received a C-3 form and the claimant is unrepresented. As stated above the claimant information packet contains a C-3 form and instructions on how to complete it. Further, the Board now offers a toll free number for claimants to call and complete a C-3 form over the telephone and the ability to complete the C-3 form online.

The New York State Insurance Fund submitted comments commending the Board for its efforts to streamline the process and speed the disposition of controverted claims and appreciated the Board's consideration of its comments on the recommended regulations.

A large law firm that represents carriers submitted comments, a few of which noted technical errors. The firm is correct that the cite in §300.37(a) should be to WCL §25(2) (b), which has been corrected in the final text. The word "statement" was added after "pre-hearing conference" in §300.33(d) as noted. The firm suggests that §300.38(g)(6) and (7) be amended to delete the phrases about the claimant being represented in each paragraph as the entire subdivision only applies to represented claimants. The Board elected to retain the language so the provisions are as clear as possible that they do not apply to unrepresented claimants. With respect to §300.34(c), the firm is unclear why a PHC statement would be filed before an order directing a transfer to the expedited process. In cases where the claimant is unrepresented, the insurance carrier will have filed a PHC statement prior to the PHC. If the claimant is still unrepresented at the PHC, the case may still be expedited but in accordance with §300.34, not §300.38. When that occurs, the PHC statement will have been filed before the transfer. The firm also noted that the cite in §300.34(c) refers to §300.33(c), which discusses the PHC notice not the statement, when it should be §300.33(d). This is correct and the change has been made to the adopted text.

The firm asks that the elimination of the 21 day notice requirement for PHC be restored to ensure sufficient notices so PHC statements are filed timely. In order to schedule PHCs thirty days after receipt of the notice of

controversy and a medical report referencing an injury, the Board has modified its calendaring system and changed when notices of hearings and PHCs are mailed. As of August 15, 2008, notices are now sent three weeks prior to the hearing or PHC. The Board did not restore this provision as it unnecessary as the Board routinely provides three weeks notice. The Board is keenly aware that the sufficient notice is important if the PHC statement is to be filed at least 10 days before the PHC. However, carriers should not be waiting until notice of the PHC to begin gathering the information to complete the PHC. It is the carrier that files the notice of controversy and the carrier has the ability to know if the Board has received any medical reports. The Board makes available a program known as eCase by which carriers, attorneys and third-party administrators can access the electronic case files of the claims for which they are responsible through the internet. Since the regulations make clear that a PHC conference will be schedule thirty days after receipt by the Board of the notice of controversy and a medical report referencing an injury, the carrier can easily determine approximately when the PHC will be scheduled and act accordingly. As many carriers receive their notices electronically there is no delay for mailing. Finally, carriers have the ability through eCase to have notices sent to their attorneys.

The law firm noted that other than the provision in §300.34(i) there the proposed regulations do not contain any effective dates. The effective dates are part of the Notice of Adoption that will be filed with the Department of State and will be published in the State Register. The firm asked that the effective date be January 1, 2009. The amendments to §300.1 and new §300.37 will be effective on the date the Notice of Adoption is published in the State Register and the amendments to §300.33 and §300.34 and new §300.38 will be effective November 3, 2008. As stated previously, many of the provisions of the proposed regulations have already been implemented and therefore the time provided should be sufficient.

The firm also sought clarification as to whether the “conference statements” in §300.34(f) (4) and (5) are the same form as the “pre-hearing conference statement” in §300.38(f). The term “conference statement” in §300.34 (f) is the same as “pre-hearing conference statement” and to clarify the regulation the term “pre-

hearing” as suggested has been added to the text of the regulation. The firm also notes that the duties of the WCLJ or conciliator at the PHC when the claimant is represented are different from the duties when the claimant is not, but feels they should be the same. However, while §300.38(g) applies only to PHCs in controverted claims when the injured worker is represented, §300.33 applies to non-controverted claims with outstanding issues which cannot be processed through conciliation or administrative determination and controverted claims involving unrepresented claimants. The differing provisions account for these differences and provide flexibility to the WCLJ or conciliator conducting the PHC. If a provision in §300.38(g) is appropriate, the §300.33(f) does not prevent the WCLJ or conciliator from applying it to the specific case.

The firm recommends that the definition of prima facie medical evidence (PFME) in §300.1(9) be revised as it does not require any history of the accident or conditions leading to the illness nor a specific diagnosis nor an opinion on causal relationship. The definition is taken from WCL §25(2-a) (a), which requires a medical report referencing an injury in order to schedule a controverted case for a PHC. This language makes clear that all that is necessary for a claim to advance to a PHC is such a medical report. Injured workers must still meet the burden of proving by competent evidence that the injury or trauma or illnesses he/she sustained and for which he/she seeks compensation arose in and out of the course of employment. Such competent evidence can include medical reports, documents, and testimony. When a claimant introduces a medical report, the presumptions of WCL § 21 provide "that the contents of medical and surgical reports introduced in evidence by claimants for compensation shall constitute prima facie evidence of fact as to the matter contained therein." Competent medical evidence, whether it is the first medical report submitted or one that is submitted later, must establish a recognizable link (causal relationship) between claimant's condition and his/her occupation. The definition in previous Board decisions were either before the change to WCL §25(2-a) (a) and in accordance with current §300.33(e) which defined prima facie medical evidence. However, this regulatory provision pre-dates the amendment of WCL §25(2-a). Further, the requirement that medical providers complete the prescribed medical

forms by providing information in response to the relevant questions will result in the receipt of a history, a diagnosis and an opinion on causal relationship.

Another recommendation is to require a C-3 form and limited release as a prerequisite for scheduling the PHC or as a prerequisite to indexing a claim. The Board cannot require a C-3 form and limited release before scheduling a PHC as WCL §25(2-a) requires the Board to schedule a PHC upon receipt of the notice of controversy and a medical report referencing an injury. As discussed elsewhere in this document, the Board fully considered whether to require a C-3 form and a limited release in order to indexing between the time it received the recommended regulations from the superintendent of insurance and the time it proposed these regulations. The recommended regulations actually required the receipt of a limited release in all cases. However, only a small number of claims are controverted, and a limited release is not necessary in all claims. Therefore, the Board decided to only require the limited release when it received a C-3 form indicating prior injuries. The recommended regulations from the superintendent did not require a C-3 form in every case, rather a C-2 or C-3 form. The Board has revised the C-2 form to closely mirror the questions on the C-2 so if the C-2 is fully completed, the carrier will receive most of the information an injured worker would provide on the C-3 form.

Like others who commented, the firm urges the Board to permit direct testimony in all cases. For the reasons stated in response to other comments this recommendation was not adopted. The regulations authorize the WCLJ to allow direct testimony upon a finding of exceptional circumstances. Further, due to the expedited resolution there will only be about 30 days between the filing of the IME report and testimony of the medical witnesses, so few additional medical reports should be filed by the treating provider after the IME report is filed.

Finally the firm requests that the regulations be amended to provide that if an injured worker is unrepresented at a PHC and requests legal representation, that the PHC be rescheduled and the injured worker's legal representative be required to submit a PHC statement before the rescheduled PHC. This requirement is already present in the regulations. If the injured worker has retained legal representation for the rescheduled PHC, it will be still be governed by §300.38. This section requires a legal representative of an injured worker to file a PHC statement even if he or she is retained within 10 days of the PHC. The firm also asks that if a claimant retains a legal representative within 10 days of the PHC, that the PHC be rescheduled for 15 days later and the legal representative be required to file a PHC statement. The injured worker's legal representative is required to file the PHC statement pursuant to the proposed regulations. The Board did not amend the regulations as requested because the regulations already provide for an adjournment if the information provided on the PHC statement is material and new or different. The carrier will have the PHC statement filed by the injured worker's legal representative no later than the PHC.

An attorney with a firm that represents carriers submitted comments regarding §300.38(h) (2) (iii) and (iv). He notes that there is a difference between the consequences of the IME examiner failing to appear for testimony and the when the treating provider does not appear. He asks if there is an intended difference between the phrases "fails to appear" and "does not appear." There is no intended difference, both mean that the witness was not present when his or her testimony was scheduled to be taken whether by deposition or at a hearing. He believes that the different treatment is a denial of the carrier's right to due process and equal protection, and is unfair to carriers and unnecessary. He asks why the two are not treated the same. The IME examiner is hired by the carrier to be its expert witness so the carrier determines what to pay the examiner for the IME report and testifying before the Board. It is common for an IME examiner to no longer have an active practice treating people. On the other hand, the treating medical provider is not chosen by the injured worker to be his/her expert witness but to treat the injury or illness. The treating medical provider is paid pursuant to a fee

schedule set by the chair for the treatment he provides and his testimony, which are less than the fees paid to the IME examiner. Treating medical providers have active practices and therefore are more likely to have emergencies or conflicts preventing their appearance. Further, it is not uncommon in the WCL for carriers to suffer harsher penalties than injured workers. For example in WCL §25(3)(d) the penalty imposed on a carrier that requests an adjournment of an expedited hearing when it is not an emergency and the WCLJ deems it to be frivolous is \$1,000, or if the carrier is represented by outside counsel the penalty is imposed on the counsel. The penalty on the legal representative of an injured worker is \$500 and there is no penalty on an unrepresented claimant. Another example is in WCL §25(3) (e) which imposes a \$50 penalty on an employer or carrier who fails to file a form or report timely but imposes no penalty on an injured worker.

Another law firm that represents carriers submitted comments on the proposed regulations. This firm also noted the deletion of the provision in §300.33 of the requirement to send PHC notices 21 days before the PHC. It believes the requirement for 8 days notice in §300.8 is not sufficient as it would not allow a party to file the PHC statement 10 days before the PHC. First, §300.8 only applies to hearings and not PHCs. Second, the Board sends notices of hearings, PHCs and meetings three weeks before the date of the hearing, PHC or meeting. The Board did not make any changes in response to this comment for the reasons set forth when discussing this issue previously in this document.

The firm comment that the reference to “discovery” in the proposed regulation is misplaced as there is no mandatory discovery process for workers’ compensation claims. The Board did not change the word discovery because WCL §25(2-a) (d) specifically provides that discovery “shall close at the end of the” PHC. This provision makes clear that it is expected that all discovery, whether or not there is a compulsory discovery process, is to occur up to and until the end of the PHC.

The same as others who have commented, the firm states that the PHC should not be schedule until the C-3 form is filed. The Board did not make this change for the reasons set forth previously.

Another comment from the firm is that it provides an “unreasonable timetable” for the filing of IME reports as employers are only given 27 days following the PHC to file the report. This section applies to PHCs in claims other than controverted claims and controverted claims when the injured worker is not represented and provides for the hearing to be schedule up to 60 days after the PHC. Further, the carrier should not be waiting until the PHC to begin scheduling the IME. If the carrier legitimately raises causal relationship and wants to obtain an IME, it should be scheduling it at the same time the notice of controversy is filed. Therefore the carrier will have at least 57 days in which to schedule the IME and have the report filed and served.

The firm comments that §300.33(f)(11) which provides that decisions containing orders or directions made by the WCLJ or conciliator at the PHC are interlocutory and are not reviewable until a decision has been issued on the controverted issues is a denial of due process. The only difference between the proposed provision and the current provision in §300.33 is the addition of the words “decisions containing,” so this is not new. Further, the definition of PFME has been modified in accordance with WCL §25(2-a) to be a medical report referencing an injury. This change should reduce the number controversies over PFME and therefore the need for the any action by the WCLJ on this issue at the PHC. WCL §23 relates to appeals of decisions and awards. The WCLJ will be making orders and directions at the PHC. The Board has fully researched and studied this issue and believes that the provision is supported by law.

The firm comments that the provision in §300.33(f) (12) requiring the hearing be scheduled within 60 days of the PHC to be impractical. This provision applies to claims which cannot be resolved through conciliation or administrative determinations and controverted claims where the claimant is unrepresented. An IME report and/or medical testimony will not be necessary in all of these cases. Further, if the claimant is unrepresented

depositions will not be ordered, but any testimony would be at a hearing. Giving a 60 day time frame is to provide the WCLJ who is scheduling the case the flexibility to account for the varied types of cases and the special considerations unrepresented claimants need.

With respect to §300.34, the firm noted that issues not resolved after one year should be handled expeditiously but WCLJs should always have the ability to consider the facts in the claim. The firm objects to all controverted cases being transferred to the expedited process. However, it should be noted that WCL §25(3) (d) authorizes the transfer of all controverted claims to expedited process and Order of the Chair #113, filed with the Secretary of the Board on October 2, 2007, directs all controverted claims into the expedited process. Therefore, for almost a year all controverted claims have been expedited. The Board did not change this provision as the direction to use the expedited process has enabled the Board to resolve 88% of its controverted claims within 90 days. The firm is concerned about the use of the term “emergency” with respect to adjournments as it a strong term, is not adequately defined, and the regulation implies it applies at the time the request for an adjournment is made. The term “emergency” is used in the statute regarding adjournments in expedited cases therefore the Board will not change it. A definition of emergency is found in §300.38(j), which the Board believes to be sufficient. Finally, the statute specifically provides that a request for an adjournment that is not an emergency and is deemed frivolous is subject to the penalty. The regulation conforms to the statute and was not changed. The firm also questioned why the penalty for requesting an adjournment that is not an emergency higher for the carrier than for the claimant. WCL §25(3) (d) specifies the penalty for requesting an adjournment that is not an emergency; the language in the regulation merely conforms to the statute. Finally, the law firm objects to the provision that states decisions solely containing determinations, directions or orders are interlocutory and not appealable pursuant to WCL §23 until resolution of all outstanding issues. This provision is not new but already exists in the regulations. As stated in response to the similar comment with respect to §300.33(f) (12), the Board believes this provision is supported by the law.

The firm comments that requirement for legal representatives to certify the notice of controversy is overbroad. Further, requiring both the carrier and its legal representative to certify the notice of controversy when the carrier completes the form is dual certification. It is not necessary to require dual certification and may prevent carriers from having representation at the PHC or expedited hearings if the representative is denied entry because he or she will not certify the notice of controversy. As stated above in response to the objections regarding the similar requirement for legal representatives of injured workers, the Board disagrees. The certification required is upon information and belief. Attorneys are required by the disciplinary rules to represent a client with the bounds of the law (22 NYCRR §1200.33). This disciplinary rule prohibits an attorney from advancing a claim that is unwarranted under the law and from knowingly making a false statement of law or fact. Additionally, as noted above, WCL §114-a (3) prohibits a legal representative from instituting or continuing a claim without reasonable grounds. If the attorney is in compliance with these provisions there must be reasonable grounds to support the filing of a notice of controversy and the defenses raised and therefore he or she can certify the C-3 form.

The firm objects to the provision requiring the notice of PHC to inform the carrier that an IME report is due three days before the initial expedited hearing and failure to timely file and serve the IME report shall be a waiver to have an IME of the injured worker as it permits no judicial discretion. This comment ignores the provision in §300.38(g)(8) that if the carrier makes a showing of good cause for the failure to file timely and that it acted in good faith and with due diligence, the carrier will be able to file an IME report. The firm objects to §300.38(h)(1) which requires the IME report to be filed and served three days prior to the initial expedited hearing. This comment is the same as the one with regards to §300.33(f) (7), and is fully addressed above. Like others who have commented, the firm believes that direct examination of medical witnesses should be allowed for the reasons already discussed above. Finally, the firm's comments regarding the consequences if a

medical witness fails to appear and adjournments have already been fully discussed above and were not adopted for the reasons set forth previously.

The Business Council of New York State (BCNYS) submitted comments regarding the proposed regulation. BCNYS believes that the state must fully implement the 2007 reform legislation and related administrative reforms in order to achieve long term cost savings. A reasonable, more efficient hearing process can reduce costs and provide more timely resolution of disputed claims, which will benefit injured workers, employers and insurers. The BCNYS generally supports the Board's efforts to improve the hearing process but has several concerns regarding the proposed regulations. For the same reasons also cited by other commentators, the BCNYS suggests that a claim be indexed only upon receipt of a C-3 form, C-2 form and C-4 form. In other words, a C-3 form would be required to index all claims. The Board did not adopt this suggestion for the reasons discussed at length above. The BCNYS submitted a related comment regarding §300.37(b) (1) (iii) which only requires a limited release when a filed C-3 form indicates prior injuries to the same body part as injured in the work related accident or similar illness. BCNYS support the provision in the recommended regulations that required a limited release in all cases. For the reasons set forth previously in this document, the Board determined this was unnecessary and too restrictive. The BCNYS suggests as an alternative that the regulation provide a mechanism for insurers to petition the Board to require the submission of a limited release, which could be addressed at the PHC. The proposed regulations already address this issue. If the injured worker has not already signed and submitted a limited release by the PHC, §300.38(g) (5) (i) requires the WCLJ at the PHC to obtain the names of all relevant medical providers and direct the injured worker, if necessary, to sign a limited release.

Another comment relates to the use of the term "medical report" in the regulations. The BCNYS believes there is some confusion over this term and definitions should be added. The Board does not agree. A medical report is the prescribed form for authorized providers to report on their treatment of injured workers, except

when the claimant is treated by a provider who is not authorized by the Board, such as a provider located outside the state, than the medical report is the document submitted by that provider. As the Board does not feel that the use of the term is confusing it did not make the suggested change. The BCNYS commented that the employer should receive a notice of indexing. This provision reflects current practice that employers do not receive the notice of indexing unless it is uninsured or self-insured. The reason for this practice is that by purchasing the insurance policy, the employer has transferred responsibility for handling the claim to the carrier. The Board determined it would not change its practice or this provision at this time.

The BCNYS suggests that the Board amend §300.37(b) (4) (ii) (B) regarding how it refers to §300.38(g) (8) so as to avoid confusion about the fact that this section provides for both the waiver and the exception to the waiver. The Board does not believe there is any confusion so the suggested additional language is not necessary. The BCNYS also comments that the provision in §300.37(d)(3)(i) is inconsistent with the proposed rule making added Part 440 regarding the pharmacy fee schedule to the Board's regulations and the provision in this regulation should be more generic. The proposed pharmacy fee schedule regulation is being revised. If substantial changes are made to the notification requirements in Part 440 that conflict with the provisions in this regulation, such provision will be revised. The Board does not find the provisions in the two regulations to be inconsistent.

The BCNYS also commented on the difference in penalties imposed on carriers as opposed to the injured worker for the failure to timely file a PHC statement. This issue was addressed in response to similar comments by others. Finally, the BCNYS suggests that the phrase "but not limited to" be included so that extraordinary circumstances are considered for an adjournment. Again, this issue was addressed in response to the same comments by others previously in this document.

Comments were submitted on behalf of Kennedy Valve, a self insured employer. According to the comments submitted, Kennedy Valve supports streamlining the hearing process and believes that some of the provisions of the proposed regulations will greatly enhance the Board's ability to expeditiously resolve cases. However, some of the provisions which are intended to expedite matters may result in parties not receiving a fair opportunity to investigate claims, fully present their evidence and outline their legal position with respect to the evidence. Kennedy Valve comments that the provisions in §300.37 are well thought out and will prove helpful to the extent they will increase the amount of information available to the carrier. The increased discovery required will help Kennedy Valve prepare for trial and assist its third-party administrator and attorneys in preparing the case for trial. Finally, in comparison to the current system, the proposed rules will create a more uniform system so employers/carriers can implement procedures consistently to promptly investigate a claim and quickly decide on whether to accept or controvert the claim. However, Kennedy Valve seems to believe that a claim will only be indexed if the Board receives a C-3 form and a limited authorization. As stated above this will not only be the case. However, as a C-2 form will be required to index a claim when a C-3 form is not received, and the revised C-2 form contains many of the questions on the C-3 form, employers and carriers will be receiving more information earlier in the claim.

Kennedy Valve objects to the definition of prima facie evidence in §300.1(a) (9) as there already exists a definition in Board case law and the Board has no legal authority to change the definition. Specifically, Kennedy Valve points to a lack of authorization in the 2007 reform legislation to redefine legal terms. The Board disagrees with these arguments in support of the objection. First, the definition of prima facie medical evidence is currently in §300.33(e). Pursuant to WCL §117(1) the Board clearly has the authority to amend its regulations. Second, as prima facie medical evidence has been defined by the Board in its decisions, the Board can change such definition if it explains its reasons. Further, prior decisions of the Board have found prima facie medical evidence exists based upon the medical report in the file plus other documents and, in some cases, the

testimony of the claimant. Finally, the 2007 reform legislation does authorize this definition. WCL §25(2-a) was amended by the reform legislation to require a PHC be scheduled after receipt of a medical report referencing an injury. Therefore, the legislation makes clear that all that is required in order for the Board to schedule a PHC is a medical report that references an injury.

In support of its objection, Kennedy Valve alleges that the Board is redefining prima facie medical evidence to avoid compliance with the decision of the Supreme Court regarding a subject number the Board issued in 2003. This is not correct. The purpose behind revising the definition is to comply with the statutory change to WCL §25(2-a). Further, the Board disagrees with Kennedy Valve's interpretation of the decision. It should be noted that §300.33 currently provides, and has for a number of years, that directions and orders made at the PHC are not appealable until a decision has been rendered on the controverted issues. This is in line with WCL §23 which pertains to awards and decisions. The WCLJ will be making directions and orders at the PHC with respect to such things as whether medical testimony will be taken at a hearing or by deposition

Kennedy Valve objects to the provision which prohibits conducting direct examination of medical witnesses as it interferes with the right to present evidence. In support of its objection, Kennedy Valve argues that direct examination allows for the full and fair development of the record, is essential to the rights of the parties, allows for additional issues to be addressed, provides an opportunity to clarify opinions, allows for the qualification of the expert and allows legal representatives to present the case in a persuasive manner. Kennedy Valve sees no good reason for eliminating direct examination. However, Kennedy Valve does agree that many times the direct examination is little more than the medical witness reading their written reports into the record and this is of little value. The proposed regulations do allow parties to request permission from the WCLJ to take direct testimony so it is not eliminated in all cases. Further, these objections do not account for the fact that a party cannot request the testimony of its own medical witnesses. Rather a party can only request the cross-examination of the other side's medical witness. Therefore, if a party does not request the cross-examination of

a medical witness, that witness does not testify at a hearing or by deposition but through his or her reports. Further, if a party wants his/her medical witness to comment on some new development he or she can make a request to the medical witness for a written report addressing said development.

Kennedy Valve also objects to the certification requirement by legal representatives as it will raise costs as attorneys will need to be involved in all aspects of the case and it creates ethical issues. These arguments have been addressed above. In response to this provision, Kennedy Valve suggests that the Board create a Notice of Retainer for carriers and its attorneys to sign that would put the attorneys on notice. The Board notes that this is not necessary as carriers and self-insured employers already have the ability to put their attorneys on notice to view the electronic case folder and to receive notices of hearing, decisions, etc. This requirement should in no way prevent a legal representative from being able to certify the notice of controversy based upon a review of the investigation conducted by the carrier. This is especially true in light of the fact that the certification is upon information and belief. With respect to the argument that the requirement that the carrier identify all documents that it intends to use to support any defense is overbroad and includes privileged documents, the Board disagrees. If a carrier intends to introduce a document at the hearing in support of a defense it is only right that it be identified.

Finally, Kennedy Valve argues that attorneys should be able allowed to submit memoranda of law. While Kennedy Valve acknowledges that oral summations are appropriate in routine cases, a more persuasive argument can be made in writing since it allows for legal research, especially on new legal issues that emerge through testimony. The Board disagrees as a review of the memoranda of law submitted today show them to be of limited value as they merely recite the facts with limited legal research beyond the rudimentary. A WCLJ must still review the case, including any transcripts, and conduct his or her own research in drafting an opinion. Further there is no evidence that memoranda of law prevent a WCLJ from making an incorrect legal determination.

The American Insurance Association (AIA) also presented comments on the proposed regulations. While AIA supports the Board's efforts to streamline the process to resolve controverted claims, it has concerns about several provisions. The concerns expressed by the AIA are that: 1) there are differing, harsher sanctions imposed on carriers for failing to adhere to deadlines than are imposed on claimants; 2) the strict deadlines for filing the pre-hearing conference statement and IME report and taking medical witness testimony may be impracticable; 3) the medical release is too limited; and 4) there is no appeal of the determination of prima facie medical evidence. The comments expressed by AIA with respect to the differing sanctions are the same or similar to those already discussed above and will not be examined again. With respect to the strict deadlines, it is noted that this issue has been discussed at length in response to other comments. One suggestion of the AIA is to allow 60 days for a full investigation. In other words, it seems the AIA is suggesting the PHC statement be filed 60 days after the notice of controversy. This is not possible based upon the statute which requires a PHC to be scheduled for no more than 45 days after the receipt of a notice of controversy and a medical report referencing an injury and requires a PHC conference statement to be filed at least 10 days before the PHC. Therefore, even if the Board were to schedule the PHC for the 45<sup>th</sup> day, the PHC statement would be due no later than the 35<sup>th</sup> day. However, as the regulations provide for the scheduling of a PHC on the 30<sup>th</sup> day, the PHC statement must be filed no later than the 20<sup>th</sup> day. With respect to the timing of the filing of the IME report and the taking of the medical witness testimony, the Board has been implementing a 30-60-90 time period for over a year now with great success. Further, during the past year the Board has required the IME report to be filed by the PHC, so the time period in the proposed regulation is longer.

In its comments, AIA makes technical recommendations for the PHC statement. First it recommends that the requirement of statutory and case citations when setting forth the theory of the case be removed as it will increase expenses as it will require the additional involvement of counsel. The Board did not accept this recommendation as the statutory and case citations will help the opposing parties and the WCLJ understand the

carrier's position and evaluate settlement possibilities. Second, it recommends that the requirement of an offer of proof for each defense raised be changed to an explanation for each defense. It is important that carrier identify what proof it intends to offer in support of each defense, so that all issues can be identified and limited to the greatest extent before proceeding with the resolution of the claim. Third, AIA recommends that the requirement that carrier provide the basis for the challenge of PFME be removed as it is the claimant's burden to produce sufficient PFME. While that may be true, the claimant and the WCLJ need to know how the carrier feels that the medical report submitted does not meet the definition of PFME. Finally, AIA recommends that the requirement that the estimated time needed for the testimony of lay witnesses be deleted as it will be uncertain when the PHC statement is filed. The requirement is for an estimate, the Board believes it is important for the parties to provide some estimate so the WCLJ can gage the amount of time needed for the hearing at which the lay testimony will be taken.

The New York Self-Insurers Association (NYSIA) also submitted comments regarding the proposed regulations. Like others who commented, NYSIA believe that some amendments should be made to the proposed regulations as some of the provisions will cause delays and appeals inconsistent with the purpose of the changes. The major concerns of NYSIA are the same as or similar to those of others whose comments are discussed above, and to the extent they are the same or similar they will not be discussed further. Specifically, NYSIA is concerned that the proposed regulations: 1) provide different sanctions for failing to serve and file the PHC statement, list or witness or include a document for carriers/employers than for claimants; 2) provide different sanctions for carriers as opposed to claimants when a medical witness fails to appear for cross examination; 3) require a WCLJ to render a written decision within 5 business days if the decision is not issued from the bench; 4) provides for an unduly restrictive limited release as it only relates to prior injuries or illnesses; and 5) require written affidavits and certifications. With respect to the limited release, NYSIA notes that the release does not include records of treatment of the claimant for the injury dispute. The Board did not

include this in the limited release as the carrier/employer is entitled to these records to determine payment issues, so it is not necessary. With respect to the comment that the certification and affidavit requirements unnecessarily restrict the ability of the WCLJs to manage their calendars, the Board disagrees. The certification requirements relate to the C-3 form and the notice of controversy (C-7) form. In all likelihood both forms will be submitted before a WCLJ is even assigned to the case. With respect to the affidavits, they are only submitted if a party misses a deadline due to good cause and the after exercising good faith and due diligence. The submission of affidavits is an exception, not the rule.

The three practice groups of physicians submitted comments regarding revisions to the Chair prescribed C-4 form. While the proposed regulations reference a medical report form, they do not include the actual content and format of the form. Therefore revisions to the C-4 form are not part of this rule making. However, the comments submitted that the form is too long and redundant as some providers submit office notes have been considered. The revised C-4 form is longer, which is due in part to increased spacing to improve the ease of reading and completing the form. Additional information is requested and check boxes of common answers are provided in place of blank space. The intent is to increase the likelihood of receiving all the necessary information. Further, the expanded form is intended to replace the need for narrative notes, which do not always contain all necessary information. Providers will be able to complete the form online through the Board's website or by submitting them in an XML format. To reduce the need for redundant information from visit to visit, the Board has created a new form the C-4.2 form which is two pages and is for follow-up visits. In developing the forms the Board held outreach sessions with providers, carriers, attorneys, business representatives and labor representatives, hired a forms expert and readability expert, posted the forms for public comment and conducted focus sessions.