

Section 325-1.1 of Title 12 NYCRR is amended to read as follows:

When a physician, in association or in copartnership with another physician or physicians, or through another physician or physicians as employees or agents, maintains and operates one or more offices principally for the treatment of injured claimants under the Workers' Compensation Law, he or she shall apply for a compensation medical bureau license.

Section 325-1.2 of Title 12 NYCRR is amended to read as follows:

All specialists, consultants, etc., shall submit a report of their findings in triplicate, one copy to the [c]Chair[man], one to the attending physician and one to the employer or insurance carrier. If the specialist acts as attending physician, he or she shall file the reports prescribed for attending physicians under section 325-1.3 of this Subpart.

Section 325-1.3 of Title 12 NYCRR is amended to read as follows:

In order to expedite the processing of claims and to avoid, so far as possible, the appearance of physicians in contested bill proceedings, the rules with respect to filing of medical reports by attending physicians are here stated:

(a) All medical reports filed by attending physicians and specialists must be on forms prescribed by the [c]Chair[man, Workers' Compensation Board,] and must contain the provider's authorization certificate number and code letters.

(b) Every physician shall file the following reports directly with the [c]Chair[man], and also with the employer or the employer's carrier, if known:

- (1) within 48 hours following first treatment, a 48-hour preliminary report;
- (2) within 15 days after filing the 48-hour preliminary report, and in no event later than 17 days after first

treatment, a 15-day report giving a complete report of injury and treatment;

(3) thereafter and during continuing treatment and without further request, a progress report at intervals of [22]45 days or less;

(4) immediately upon termination of treatment, a final report regardless of the date the last previous report was filed, except that where treatment is terminated within 48 hours following first treatment, the 48-hour preliminary report shall constitute the final report if so noted thereon. In case of a herniotomy, a final report by the operating surgeon must be filed immediately following final examination of the injured person made not less than eight weeks after operation in case of a single hernia and not less than 12 weeks in case of a double hernia;

(5) additional or more frequent reports when requested by the [c]Chair[man] and within three workdays after such request is made.

(c) Whenever a report is filed with the [c]Chair[man] by an attending physician after the time period for filing, as provided herein and in subdivision (4) of section 13-a of the Workers' Compensation Law, has elapsed, the physician shall attach thereto a signed and verified statement giving the true reason for which he requests excuse for late filing.

(d) The following forms are prescribed for the use of physicians in filing the required reports:

(1) [form C-48 for attending physician's 48-hour preliminary reports;

(2)] form C-4 for attending physician's 48-hour preliminary reports, 15-day reports, progress reports and final reports;

[(3) form C-5 for eye surgeon's reports;

(4) form C-24 for final report of operating surgeon in case of a herniotomy;

(5)] (2) form C-27 for medical report in support of application for reopening a closed case;

[(6)] (3) form C-64 for final report in a death case.

Section 325-1.4 of Title 12 NYCRR is amended to read as follows:

(a)(1) When it is necessary for the attending physician to engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or occupational therapy or physical therapy or special diagnostic laboratory ~~[texts]~~tests costing more than ~~[\$500]~~\$1,000, he or she must request and secure authorization from the employer or insurance carrier or the ~~[c]~~Chair, by setting forth the medical necessity of the special services required. For example, when the total fees for occupational or physical therapy treatment approach the sum of ~~[\$500]~~\$1,000, the physician ~~[shall]~~ must file an additional C-4~~[/C-48]~~ report and request authorization as prescribed in subdivision (5) of section 13-a of the Workers' Compensation Law.

(2) This section also applies to hospitals, specialists, consultants and surgeons, who are actually engaged to perform such services.

(3) Such ~~request~~s for authorization should be by telephone to the employer or carrier and ~~[later]~~ confirmed by letter.

(4) In order to process such requests expeditiously and within the time limits specified hereunder, the insurance carrier shall designate a qualified employee in its office, and the self-insured employer shall designate a qualified employee in its office or an authorized employee of its licensed representative, to receive and act upon such requests. To assure compliance within the time limits prescribed, qualified persons shall be specially designated, within each office of the ~~[Workers' Compensation]~~ Board, to deal with complaints relative to such ~~[authorizations]~~ requests.

(5) In response to requests for authorization, the self-insured employer or insurance carrier may have the patient examined within four business days if the patient is hospitalized or 30 days if the patient is not hospitalized, by an appropriate medical board-certified specialist who is also authorized in such specialty, by the ~~[c]~~Chair, to treat workers' compensation claimants. If such specialist is not available, consultation may be

rendered by an authorized physician who is acceptable to both the self-insured employer or insurance carrier and the physician requesting authorization, or in the event the parties cannot agree, a physician may be selected by the [c]Chair.

(6) The self-insured employer or insurance carrier shall grant or deny the requested authorization within four working days if the claimant is hospitalized, or within 30 days if the claimant is not hospitalized, by orally notifying the physician or hospital of its action. It shall confirm such action in writing by sending a notice to the physician, claimant's attorney or licensed representative and/or hospital within five days after the examination of the claimant when the four-day provision applies. When the 30-day provision applies, the written confirmation shall be mailed within such period. Written notice of denial must be based on a conflicting second opinion rendered by a physician authorized to treat workers' compensation claimants. Nothing herein shall relieve the carrier from complying with the provisions of section 300.23 of this Title.

(7) If such authorization or denial is not forthcoming within four working days if the patient is hospitalized, the [c]Chair may issue an order, after investigation, authorizing the special services, on the ground that such authorization has been unreasonably withheld and the employer or carrier shall be liable for the payment for such special services and investigation. If such authorization or denial is not forthcoming within 30 calendar days if the patient is not hospitalized, such request shall be deemed authorized and the employer or carrier shall be liable for payment for such special services. The [c]Chair may issue an order stating that such request is deemed authorized or requiring the employer or carrier to provide written authorization, if such documentation is required by the claimant to secure necessary medical treatment.

(8) Such authorization is not required in an emergency under the provisions of subdivision (5) of section 13-a of the Workers' Compensation Law.

(b) Authorization for medical care when the right to compensation is controverted.

(1) Whenever medical care or special services are required in cases when the right to compensation is

controverted or the time to controvert has not expired, the attending physician or the hospitals, specialists, consultants and surgeons engaged to perform such services shall request authorization from the employer or insurance carrier who would become responsible in the event the claim is adjudicated compensable; and all provisions of subdivision (a) of this section are applicable to such requests.

(2) The authorization herein referred to, if granted by the self-insured employer or insurance carrier, is limited to the question only of medical necessity of the services requested, and such authorization shall not be construed as an admission that the condition for which these services are required is compensable.

(3) When the [c]Chair issues an order, pursuant to paragraph (a)(7) of this section in a controverted case, the carrier shall not be responsible for the payment of such services until the question of compensability is resolved.

Section 325-1.5 of Title 12 NYCRR is amended to read as follows:

The authority of an employer [for] or carrier to authorize the services of a specialist in excess of a [\$500 fee] fee of \$1,000 applies only to the necessity for such services, but the choice of such specialist is entirely [within] the [jurisdiction] choice of the injured worker except to the extent an injured worker is required by Workers' Compensation Law Section 13-a(7) to obtain diagnostic tests or examinations from a provider network or networks with which the employer or carrier contracts.

Section 325-1.7 of Title 12 NYCRR is amended to read as follows:

A physician authorized to treat workers' compensation cases, when requested to supersede another physician, must, before beginning treatment of such patient, make reasonable effort to communicate with the attending physician to ascertain the patient's condition. The superseding physician must also advise the attending physician of the name of the person who has requested him or her to assume care of the case and state the reason therefore. If the [second] superseding physician can not contact the attending physician, and the

claimant's condition requires immediate treatment, the [said] superseding physician should advise the [doctor]physician previously in attendance within 48 hours that he or she now has the patient in his or her care. The preceding physician shall supply the [succeeding] superseding physician with a complete history of the case.

Section 325-1.10 of Title 12 NYCRR is hereby amended to read as follows:

Bills for X-ray and consultation rendered by a specialist and bills for X-ray examination, diagnosis or treatment rendered by an X-ray laboratory or bureau of a voluntary hospital licensed by the [c]Chair[man] shall be submitted for payment directly to the employer or carrier. These services must be authorized in writing by the physician in attendance.

Subdivisions (b) and (c) of Section 325-1.11 of Title 12 NYCRR are hereby amended to read as follows:

(b) Employers, carriers, claimant's representatives or special funds upon written request to any hospital operating in New York State together with the claimant's written consent, may obtain for use in [b]Board proceedings, the hospital records of a claimant pertaining to his or her compensation claim.

(c) Written notice of such request together with proof of mailing shall be provided to the [b]Board.

Subdivisions (e) and (f) of Section 325-1.11 of Title 12 NYCRR are hereby amended to read as follows:

(e) Failure to provide the records or a reason why the records have not been provided in 20 days from written request by a party shall subject the hospital to a fine of \$200 imposed by the [c]Chair payable into the [b]Board's administrative funds.

(f) Failure by the hospital to provide the records in 30 days after notification to the requesting party of the reason for not initially providing such record and the date on which such records would be produced shall

subject the hospital to a fine of \$200 imposed by the [c]Chair payable into the [b]Board's administrative funds.

Section 325-1.17 of Title 12 NYCRR is amended to read as follows:

No insurance company or self-insurer may reduce the size of notice to employees (form C-105) which is to be posted in all places of employment covered by the [act]Workers' Compensation Law, unless such permission is granted on application to the [c]Chair[man].

Section 325-1.19 of Title 12 NYCRR is amended to read as follows:

Hospitals may render bills for board and room accommodations, medical and surgical supplies and nursing facilities. Voluntary hospitals may bill for X-ray services when rendered by an X-ray laboratory or bureau of such hospital duly licensed by the [c]Chair[man]. Hospitals may bill for physiotherapeutic, anesthesia and pathologic services when rendered by or under the supervision of salaried physicians on the staff. The names and qualifications of all physicians and persons rendering services for which charges are made by hospitals must be included in all bills, and all medical and X-ray reports shall be promptly filed with the [Workers' Compensation] Board and with the employer or its insurance carrier.

Section 325-1.21 of Title 12 NYCRR is amended to read as follows:

A physician, podiatrist, chiropractor, psychologist, operator of a medical bureau or laboratory authorized by the [c]Chair to render treatment and care to injured employees under the Workers' Compensation Law:

- (a) shall accept and treat such injured employees in a manner corresponding to that accorded other patients in his or her practice, without discriminating against such injured employees because they are or may be covered by the provisions of the Workers' Compensation Law; and
- (b) shall not refuse to provide treatment and care to such injured employees on the basis of a fee request

greater than that set forth in the applicable prescribed fee schedule, but shall submit to arbitration such fee dispute in accordance with the provisions of the Workers' Compensation Law, nor shall such treatment and care be denied to such injured employees because the source or manner of payment for such treatment and care is pursuant to the provisions of the Workers' Compensation Law.

Nothing contained in this section shall prevent a voluntary payment by the employer or carrier of an amount higher than the fees and charges found in the fee schedule where agreed to by the employer or carrier. An authorized physician, podiatrist, chiropractor, psychologist, operator of a medical bureau or laboratory whose actions violate or are inconsistent with the provisions of this section shall be charged with misconduct, and his or her authorization to treat workers' compensation cases shall be subject to suspension or revocation by the [c]Chair in accordance with the procedures set forth in the Workers' Compensation Law.

Subdivisions (a) and (b) of section 325-1.24 of Title 12 NYCRR are amended to read as follows:

(a) In the case of a bill rendered to a self-insured employer or carrier by a physician, self-employed occupational or physical therapist, podiatrist, chiropractor or psychologist, any such bill which has remained unpaid shall not be eligible for an administrative award or for arbitration pursuant to the provisions of subdivision 1 of section 13-g, subdivision 6 of section 13-k, subdivision 6 of section 13-1 or subdivision 7 of section 13-m of the Workers' Compensation Law unless the bill was initially submitted to the employer or carrier on a form prescribed by the [c]Chair (C-4) or standard claim form HCFA 1500 (national version) and completed with such information as may be required. In the case of a bill submitted by a hospital, the format for outpatient hospital bills shall be the New York State Universal Data Set specifications as described in section 400.18 and Appendices C-2 and C-3 of Title 10 NYCRR and such additional specifications as are approved by the Commissioner of Health. Bills for outpatient hospital services not submitted in this format shall not be eligible for an award.

(b) All bills, other than hospital bills, shall be submitted to a self-insured employer or carrier within 90 days from the last day of the month in which the services were rendered, or 90 days from the last day of the month in which the claimant received the final treatment in a continuous course of treatment, at the option of the health provider, in order to be eligible for an administrative award or for arbitration. Hospital bills shall be submitted within 120 days from the last day of the month as described herein. Notwithstanding the foregoing, upon application of the health provider or hospital, the [c]Chair may for good cause shown excuse a delay in submission of the bill to the self-insured employer or carrier.

Paragraph (2) of subdivision (c), and subdivisions (d), (e) and (f) of section 325-1.24 of Title 12 NYCRR is amended to read as follows:

(c)(2) If the self-insured employer or carrier has provided a copy of form C-7 or form C-8.1 to the health provider or hospital, or sent the health provider or hospital a detailed written explanation raising legal objections, in accordance with subparagraph (1) (iii) of this subdivision and a final decision establishing the self-insured employer's or carrier's liability for payment of the bill has been issued, the self-insured employer or carrier shall, within 30 days of the date of such final decision, either pay the bill or notify the health provider or hospital in writing that the bill is not being paid and explain in detail the reasons for non-payment, if explanation for nonpayment has not previously been provided. The reasons for non-payment shall not be on the basis of any issues relating to the self-insured employer's or carrier's liability for payment of the bill which have been finally determined adversely to the self-insured employer or carrier by the Workers' Compensation Law Judge, the [b]Board or a court. For purposes of this section, the date of final decision shall mean:

(i) the date of filing of a decision by a Workers' Compensation Law Judge establishing the self-insured employer's or carrier's liability for the payment of a medical bill in whole or in part, if such decision is not

reviewed by a Board [p]Panel; or

(ii) the date of filing of a decision by the Board which either affirms a decision described in subparagraph (i) above or establishes the self-insured employer's or carrier's liability for the payment of a medical bill, if the decision by the Workers' Compensation Law Judge did not establish the self-insured employer's or carrier's liability for the payment of such bill; or

(iii) the date of a decision by an appellate court establishing the self-insured employer's or carrier's liability for the payment of a medical bill, if the decisions by the Workers' Compensation [law]Law Judge and the Board did not establish the self-insured employer's or carrier's liability for the payment of such bill.

If the self-insured employer or carrier has filed an application for review of a Workers' Compensation Law Judge's decision, the self-insured employer or carrier shall serve a copy of the application for review (RB-89) on the health provider or hospital simultaneously with service of the application on all other parties required to be served.

The self-insured employer or carrier may notify the health provider or hospital in writing that it has filed an application for review, in lieu of serving a copy of the application for review on the health provider or hospital.

Subdivisions (d), (e) and (f) of section 325-1.24 of Title 12 NYCRR are amended to read as follows:

(d) A health provider or hospital requesting an administrative award for payment or arbitration of a bill which has not been paid in full or in part shall submit its request for an award or arbitration to the [c]Chair on a form (HP-1) prescribed by the [c]Chair no earlier than 45 days from the date of submission of the bill or 30 days from the date of a final decision establishing the self-insured employer's or carrier's liability for the bill, and no later than 120 days from:

- (1) the date of receipt of notification of nonpayment; or
- (2) the expiration of the time within which the employer or carrier is required to notify the health care

provider or hospital of nonpayment in accordance with subdivision (c) of this section; or

(3) the date of expiration of any continuous course of treatment of the claimant.

If the self-insured employer or carrier has provided a timely explanation in writing in accordance with subdivision (c) of this section, and the parties cannot agree as to the value of the services rendered by the health care provider or hospital, the bill shall be submitted for arbitration if requested by the provider in accordance with the provisions of [p]Parts 327, 328, 332, 342, 347 or 349-2 of this Title, as applicable. Notwithstanding the foregoing, upon application of the health provider or hospital, the [c]Chair may for good cause shown excuse a delay in the submission of the request for an administrative award or arbitration.

(e) A health provider or hospital requesting an administrative award for payment of a bill which has not been paid in full or in part, and for which the self-insured employer or carrier has not notified the health provider or hospital in writing of the reasons for nonpayment in accordance with subdivision (c) of this section, shall submit its request for an administrative award on a form (HP-1) prescribed by the [c]Chair and completed with such information as may be required therein. A request for an administrative award shall not be submitted, and an administrative award may not be made, until all issues duly and timely raised by the self-insured employer or carrier with respect to the self-insured employer's or carrier's liability have been finally determined adversely to it. No request for an administrative award shall be accepted unless the health care provider or hospital completes the form with such information and in such form as may be required, including but not limited to the following, which shall be affirmed under penalty of perjury:

(1) the bill was timely submitted to the self-insured employer or carrier and the bill was not returned by postal authorities; and

(2) the self-insured employer or carrier did not submit payment within 45 days after the bill was submitted or within 30 days after all other questions duly and timely raised related to the self-insured employer's or carrier's liability therefor was finally determined adversely to the self-insured employer or carrier; and

(3) (i) the self-insured employer or carrier did not provide a copy of form C-7 or form C-8.1 or detailed written explanation for nonpayment of the bill within 45 days after the bill was submitted; or

(ii) the self-insured employer or carrier provided a copy of form C-7 or C-8.1, or a written detailed explanation raising legal objections, but did not provide a detailed written explanation of nonpayment of the bill raising valuation (arbitration) issues within 30 days after all questions duly and timely raised relating to the self-insured employer's or carrier's liability for the bill were finally determined adversely to the employer or at any time prior; and

(4) the bill conforms to the fee schedule, if any, promulgated by the [c]Chair for the treatment rendered; and

(5) the bill was submitted on the form prescribed by the [c]Chair (form C-4) or form HCFA 1500, or the form prescribed for outpatient hospital bills by the Commissioner of Health.

(f) Upon receipt of a completed request for an administrative award by a health care provider or hospital, the request shall be examined to determine if it is in compliance with the requirements of this section. If the request is not in full compliance with the requirements, the request shall be returned to the health provider or hospital with an explanation of why the request has been returned. In the event the request is in full compliance with the requirements of this section, a notice of decision signed by the [c]Chair or the [c]Chair's designee (HP-2) an administrative award making an award to the health provider or hospital, not in excess of the fee schedule, if any, shall be sent to parties in interest notifying them of the proposed administrative award and the proposed filing date. The proposed filing date shall be at least 30 days after the date of the proposed administrative award. Any party in interest may submit a written objection on a form prescribed by the [c]Chair (HP-2) to the proposed award on or before the proposed filing date. All documents or other evidence supporting the objection shall be submitted together with the written objection. If there is no written objection received prior to the proposed filing date, the proposed award will become final on the proposed filing date. If an objection is received from any party before the proposed filing date, the objections shall be reviewed by the [c]Chair or the

[c]Chair's designee, who shall make a decision on the request for an award based upon all documents and other evidence submitted. Upon review, a determination on reconsideration (HP-3) shall be sent to all parties in interest.

Section 325-2.1 of Title 12 NYCRR is amended to read as follows:

To establish procedures and protections governing the ability of an employer or carrier to recommend a designated network or provider to an injured employee in accordance with sections 13-a(1), 13-i and 13-j(1) of the Workers' Compensation Law. This Subpart does not apply to the binding direction of care which is authorized by [a]Article 10-A and section[s 126 and] 25(2-c) of the Workers' Compensation Law.

Notwithstanding any other provision to the contrary, this Subpart does not apply when a carrier or employer has contracted with a network or networks to perform diagnostic tests, x-ray examinations, magnetic resonance imaging, or other radiological examinations or tests of claimants and requires claimants to undergo all such diagnostic tests from such network or networks pursuant to section 13-a (7) of the Workers' Compensation Law and any applicable regulations.

Subdivision (b) of section 325-2.2 of Title 12 NYCRR is amended to read as follows:

(b) Only those parties who are either (1) [participating in the managed care pilot program under section 126 of the Workers' Compensation Law, (2)] participating in a certified preferred provider organization (PPO) arrangement under [a]Article 10-A of the Workers' Compensation Law, or ([3]2) participating in the alternative dispute resolution pilot program under section 25(2-c) of the Workers' Compensation Law may direct the care of injured employees to a designated network or health care provider. Only those parties who are complying with the provisions of sections 13-a(1) and 13-i of the Workers' Compensation Law may recommend a designated network or health care provider to an injured employee.

Subdivision (a) of section 325-2.3 of Title 12 NYCRR is amended to read as follows:

(a) For purposes of this Subpart, an employer or carrier is deemed to have recommended the care of an injured employee to a designated network or health care provider if (1) it has a contractual relationship with a network or provider with respect to the treatment of employees' work-related injuries or illnesses other than a contract pursuant to [section 126,] section 25(2-c)[,] or [a]Article 10-A of the Workers' Compensation Law or (2) it endorses or promotes the utilization of a specified network or provider in employee handouts, postings or other written materials.

Section 325-2.4 of Title 12 NYCRR is amended to read as follows:

(a) Any injured employee who elects to utilize a designated network or health care provider based upon the recommendation of his[/] or her employer or its carrier must sign a prescribed consent form [(form C-3.1)] indicating that he or she voluntarily elects to receive treatment from the employer or carrier recommended network or provider. Such consent forms may not be executed prior to the occurrence of a work-related injury or illness.

(b) Any employer whose employees have signed the above consent form must both maintain a record of the signed, original form and provide a copy of the signed form to each employee signing such consent. Employers' copies of individual employee consent forms may be inspected by the [Workers' Compensation] Board at any time.

(c) Under no circumstances shall the requirement related to the completion of [form C-3.1]the required consent form pursuant to subdivision (a) of this section in any way hinder the ability of an injured employee to secure timely, appropriate treatment for a work-related injury or illness.

Section 325-2.5 of Title 12 NYCRR is amended to read as follows:

No waiver agreements with respect to an injured employee's medical benefits or treatment beyond the properly executed prescribed consent form [C-3.1] shall be valid and enforceable unless reviewed and approved by the [b]Board in accordance with section 32 of the Workers' Compensation Law and section 300.36 of this Title.

Section 325-2.6 of Title 12 NYCRR is amended to read as follows:

Any party may secure a list of all authorized physicians in their vicinity by applying to the [c]Chair.

Section 325-2.10 of Title 12 NYCRR is amended to read as follows:

(a) The [c]Chair or the [c]Chair's designee shall investigate any complaints regarding direction of care outside of the [managed care pilot program under section 126 of the Workers' Compensation Law, the] PPO program under [a]Article 10-A of the Workers' Compensation Law or the alternative dispute resolution pilot program under section 25(2-c) of the Workers' Compensation Law as well as complaints regarding employer or carrier recommendation of a designated network or provider which is not in compliance with the provisions of this Subpart.

(b) At the [c]Chair's discretion, the [c]Chair or the [c]Chair's designee may collect and examine (1) the list of health care providers offering treatment in accordance with the employer/carrier-recommended arrangement, (2) any contracts between these providers and employers or carriers with respect to workers' compensation related treatment, (3) any informational materials distributed to employees regarding their workers' compensation related treatment, (4) any forms or documentation required of injured employees or providers during the course of treatment, and (5) such other information as may be requested for the purpose of ensuring the accessibility and adequacy of the network as well as the injured employees' voluntary participation in the treatment

arrangement.

(c) An attempt to improperly interfere with the injured employee's selection of a provider in violation of section 13-a(6) may constitute a misdemeanor. Such non-compliance may also reflect an attempt to make a false statement or representation for the purpose of affecting benefits in violation of section 114 and thus, may constitute a felony. As such, following an investigation by the [b]Board, alleged violators of these provisions may be referred to prosecutorial authorities.

In addition to the above criminal penalties, parties who allegedly violate these provisions will be referred to the following agencies for consideration of administrative penalties. Workers' compensation insurance carriers who allegedly violate these provisions will be referred to the Insurance Department. Networks who allegedly violate these provisions will be referred to the Department of Health. Self-insured employers and individual authorized providers who allegedly violate these provisions will be referred to the [b]Board's compliance bureau.

Section 325-3.8 of Title 12 NYCRR is amended to read as follows:

[Form C-105, a]A notice of the rights of an injured employee and the responsibilities of the employer, shall be posted in each compensation medical bureau and first-aid station.

Section 325-3.10 of Title 12 NYCRR is amended to read as follows:

A medical center jointly operated by labor and management representatives, approved by and under the supervision of the New York State Department of Health, and which complies with the provisions of subdivision 3 of section 13-c of the Workers' Compensation Law, may be authorized by the [chair, Workers' Compensation Board,]Chair to provide medical treatment and care under the Workers' Compensation Law. Application for such authorization shall be made on a form to be furnished by the [chair]Chair. All rules and

procedures of the [chair]Chair under the Workers' Compensation Law pertaining to:

(a) medical and surgical care and treatment, podiatry care and treatment, and chiropractic care and treatment of injured employees;

(b) the schedules of fees to be charged therefor; and

(c) the arbitration of disputed bills for such treatment and care, shall be equally applicable to any authorized medical center to the extent that they are not inconsistent with the provisions of subdivision 3 of section 13-c.

Section 325-4.1 of Title 12 NYCRR is amended to read as follows:

A hospital as defined in article 28 of the Public Health Law or a health maintenance organization holding a valid certificate of authority issued pursuant to article 44 of the Public Health Law or operating under the provisions of article 43 of the Insurance Law, which complies with the provisions of subdivision 4 of section 13-c of the Workers' Compensation Law, may be authorized by the [chairman]Chair of the Workers' Compensation Board to provide out-patient medical treatment and care under the Workers' Compensation Law. Application for such authorization shall be made on a form to be furnished by the [chairman]Chair. All rules and procedures of the [chairman]Chair under the Workers' Compensation Law pertaining to medical care and surgical treatment, podiatry care and treatment, and chiropractor care and treatment of injured employees, shall be equally applicable to any authorized hospital or health maintenance organization to the extent that such rules and procedures are not inconsistent with the provisions of subdivision 4 of section 13-c of the Workers' Compensation Law or the rules contained in this Subpart.

Subdivisions (b) and (e) of section 325-4.2 are amended to read as follows:

A hospital or health maintenance organization authorized by the [chairman]Chair to provide out-patient medical treatment and care shall:

(b) require that full and truthful medical reports be prepared and signed by a doctor who is authorized by the [chairman of the Workers' Compensation Board]Chair to treat workers' compensation claimants and who is actually rendering the treatment, and to submit such reports directly to the [chairman]Chair and the carrier, pursuant to subdivision 4 of section 13-a of the Workers' Compensation Law, and to section 325-1.3 of this Part;

(e) render only those services specified in the hospital's or health maintenance organization's operating certificate or certificate of authority issued by the New York State Department of Health; and notify the [chairman]Chair immediately of any change in, or renewal of, the operating certificate or certificate of authority and submit a copy of the new certificate; and notify the [chairman]Chair at once in the event the operating certificate or certificate of authority is suspended or revoked;

The opening paragraph of Section 325-4.3 of Title 12 NYCRR is amended to read as follows:

A hospital or health maintenance organization authorized by the [chairman]Chair to provide out-patient medical treatment and care:

The opening paragraph of Section 325-4.5 of Title 12 NYCRR is amended to read as follows:

The [chairman]Chair may suspend or revoke the authorization of a hospital or health maintenance organization after a hearing, upon a finding that:

Subdivisions (f) and (g) of section 325-4.6 of Title 12 NYCRR are amended to read as follows:

(f) A copy of the record of the proceeding shall be submitted to the [chairman of the Workers' Compensation Board,]Chair together with the report, findings and recommendation of the Medical Appeals Unit.

(g) Until final action is taken by the [chairman]Chair on the findings and recommendation of the Medical

Appeals Unit, the accused hospital or health maintenance organization may continue to provide out-patient medical treatment and care under the Workers' Compensation Law, unless otherwise specifically ordered by the [chairman]Chair.

Section 325-5.3 of Title 12 NYCRR is hereby amended to read as follows:

The [Workers' Compensation]Board shall conduct computer searches at least quarterly upon the request of health insurers or health benefits plans, upon their full compliance with these regulations. Health Insurers and health benefits plans desiring such searches shall submit to the [b]Board [a magnetic computer tape] the required information including all data elements [as required by the board] in a technological format acceptable to the Board. Such [tape] information shall be compared with the computer records of the [b]Board, in order to identify employees whose social security numbers, name, date of accident, ZIP codes or other qualifiers match.

Subdivision (b) of Section 325-5.5 of Title 12 NYCRR is hereby amended to read as follows:

(b) *Pooling of [tapes] requests for computer searches permitted.* Each health insurer or health benefits plan wishing to have searches conducted pursuant to subdivision (h) of section 13 of the Workers' Compensation Law and this Subpart shall submit [a tape] the request in a technological format acceptable by the Board which shall include claims from such health insurer or health benefits plan. Pooling of [tapes] requests for computer searches, by groups of health insurers or health benefits plans, shall be permitted, but must specifically indicate the individual health insurer or health benefits plan to be placed on notice in accordance with section 325-5.6(b)(1) of this Subpart. The [b]Board shall respond to such [tape submissions] requests for computer searches in accordance with section 325-5.6(c) of this Subpart.

Subdivision (a) of Section 325-5.6 of 12 NYCRR is hereby amended as follows:

(a) *Format of [magnetic tape to be submitted] requests for computer searches.*

Health insurers and health benefits plans that are interested in participating in the match program shall submit [a magnetic tape using the record format as defined by the workers' compensation board] requests for computer searches in a technological format acceptable to the Board. Such [tape] requests for computer searches shall include the claimant's social security number, last name, initial of first name, sex, ZIP code, and date of treatment or date of accident, if known. If the [tape] request made does not include a social security number, a search will be attempted using the claimant's last name, initial of first name, sex, ZIP code, and date of treatment or accident. When a match request is made by using the claimant's social security number, the claimant's first initial of the first name will not be part of the matching criteria. In regard to the date of treatment or accident submitted by the health insurer or health benefits plan, this date will be matched against the date of accident contained in the [b]Board's file, and will result in a match on this criterion if the date of treatment or accident submitted by the health insurer or health benefits plan is within 30 days of the date of accident contained in the [b]Board file.

Subdivision (c) of Section 325-5.6 of 12 NYCRR is hereby amended as follows:

(c) *Return of [tape] requests for computer searches.* The health insurer's or health benefits plan's initial [magnetic tape] request for computer searches will be returned unchanged, along with [an updated file, on a separate magnetic tape] a separate file, notifying the insurer of the information on "full" and "partial" matches. The [workers' compensation]Board will make every effort, barring unforeseen circumstances, to respond to the health insurer's or health benefit plan's search request and return the health insurer's or health benefits plan's initial [magnetic tape] request for computer searches within 30 days of its receipt. Where a pooled submission is made by a group of health insurers and/or health benefits plans, the [b]Board will issue separate response [tapes] files to each health insurer and/or health benefits plan which will contain information relating only to its

individual search requests.

Paragraph (1) of subdivision (d) of Section 325-5.6 of 12 NYCRR is hereby amended as follows:

(d) *Availability of information in [b]Board files.* (1) When a health insurer or health benefits plan has been notified of a “full match” pursuant to paragraph (b)(1) of this section, such health insurer or health benefits plan may make a request in writing to the [b]Board for any information in the [b]Board files as may be relevant to any bill that has been paid by such insurer or health benefits plan. Such requests shall be submitted to the Workers’ Compensation Board, Attention: [Assistant Director of Operations, Room 601, 180 Livingston Street, Brooklyn, NY 11248] HIMP Coordinator, State Office Building, 44 Hawley Street, Binghamton, NY 13901.

Subdivision (a) of Section 325-5.7 of 12 NYCRR is hereby amended as follows:

(a) *Fees.* The [workers’ compensation][b]Board will charge a health insurer or health benefits plan for each search request submitted through the computer match process, and/or for any manual review of the case file. The cost of searches shall be computed based on actual costs to the [b]Board. Where multiple searches of the same record are required, there shall be a charge for each search.

(1) *Computer searches.* The cost of computer searches shall be computed based on the actual costs to the [b]Board. For the purposes of computing the costs for computer searches, the costs shall include the actual search by computer to determine whether there is a full match pursuant to section 325-5.6(b)(1) of this Subpart. In its submission to the [Workers’ Compensation] Board, the health insurer or health benefits plan must include, at the end of the [tape]file, the total number of records or requests on that [tape] file. Payment, at the initial rate of \$0.043 per search, must [accompany the tape] immediately follow the submission of the file. Payment is to be in the form of a standard or certified check made payable to: [The New York State Office of General Services.] The New York State Workers’ Compensation Board and sent to the Workers’ Compensation Board,

Attention: Finance Office, 20 Park Street, Albany, NY 12207. After the search or searches, the [b]Board will recompute the cost for the search or searches based on the actual cost of the search or searches and on the actual number of searches performed. Following such computation, the [b]Board will bill the health insurer or health benefits plan for the amount that the actual cost of performing such search or searches exceeds the amounts submitted by the health insurer or health benefits plan [with its search request], and/or if the number of searches conducted exceeds the record count on which the health insurer or health benefits plan computed payment. If there is an overpayment on the part of the health insurer or health benefits plan, the [b]Board will issue a refund for the overpaid amount or, if requested by the health insurer or health benefits plan, use the overpayment as a credit against future submissions.

(2) Review of file after a full match. The charge for manual review by the [b]Board of [b]Board files which may be necessary to provide the health insurer or health benefits plan with the information specified in section 325-5.6(d)(2) of this Subpart once a full match has been determined will be at the rate of \$1.795 per search. In its request for review of the files, the health insurer must include the total number of searches requested and payment at the rate of \$1.795 per search must accompany the request. Payment is to be in the form of a standard or certified check made payable to: [The New York State Office of General Services.] The New York State Workers' Compensation Board.

(3) Manual search. The charge for a manual search of [Workers' Compensation]Board records by the [b]Board will be \$25 per search. Payment must accompany the request for a manual search and is to be made in the form of a standard or certified check made payable to: [The New York State Office of General Services.] The New York State Workers' Compensation Board. The review of the [b]Board [ties]files pursuant to section 325-5.6(d)(2) of this Subpart shall not be deemed a manual search for the purpose of this paragraph.

Paragraph (1) of subdivision (b) of Section 325-6.2 of 12 NYCRR is hereby amended as follows:

(b) Claims for reimbursement must be filed within three years of the date of payment by the health insurer for services rendered by a provider or by October 15, 1992, whichever is later, as provided in section 13(d) of the Workers' Compensation Law. Requests for reimbursement are filed by:

(1) submission of a [magnetic tape] request for computer searches to the [b]Board [for a computer search], pursuant to Subpart 325-5 of this Part, to identify claims which may be the responsibility of the carrier; or

Paragraph (1) of subdivision (a) of Section 325-6.3 of 12 NYCRR is hereby amended as follows:

(1) after the health insurer is notified of a "full match" pursuant to Subpart 325-5 of this Part, if the original request for reimbursement was filed by submission of a [magnetic tape] request for computer searches to the [b]Board [for a computer search] to identify claims which may be the responsibility of the carrier or was filed in accordance with section 325-6.2(b)(3) of this Subpart; or

Subdivision (a) of Section 325-6.10 of 12 NYCRR is hereby amended as follows:

(a) The health insurer shall initiate the request for arbitration by forwarding the completed request for arbitration to the carrier and two copies of the completed HIMP-1 form together with two copies of all documents previously submitted to the carrier, proof of service of all documents upon the carrier and the prescribed filing fee to the dispute forum. In the event that the carrier has failed to mail a notice of objection to the request for reimbursement within 50 business days in accordance with section 325-6.4 of this Subpart, the health insurer shall state in the request for arbitration that no objections have been received and shall provide proof of the date of service of the request for reimbursement with the carrier. Where the request for reimbursement is initiated by [the submission of a magnetic tape] a request for computer matching to the [b]Board [for computer matching purposes] on or after the effective date of this Subpart as a final rule, the health insurer shall submit proof of service of both the [submission of the tape] request for computer matching

as well as proof of service of the HIMP-1 form.

Section 325-8.3 of Title 12 NYCRR is amended to read as follows:

Preferred provider organization providers must submit full and truthful reports of their findings to the employer and the [b]Board. Providers who improperly alter or edit their reports or otherwise misrepresent their findings to the employer or the [b]Board will have their authorization revoked by the chair in accordance with sections 13-d, 13-k, 13-1 and 13-m of the Workers' Compensation Law.

Section 325-8.4 of Title 12 NYCRR is amended to read as follows:

All insurance carriers and self-insured employers who have contracted with a preferred provider organization for the treatment of workers' compensation injuries and illnesses shall report to the [chair]Chair the names and addresses of insured employers who have elected to utilize the preferred provider organization. As required by the [chair]Chair, such carriers and self-insured employers shall also report to the [chair]Chair, in a prescribed format, specified data pertaining to utilization, quality of care, costs and outcomes.

Subdivision (c) of section 325-8.5 of Title 12 NYCRR is amended to read as follows:

(c) All functional activities which are subcontracted by a PPO through a management contract arrangement in accordance with section 732-2.5(b) of Title 10 NYCRR, including case management services, as defined by the parties to the management contract, shall conform to the provisions of section 13-a(6) and 13-j(1) of the Workers' Compensation Law. Copies of all management contracts shall be provided to the [chair]Chair as well as the Commissioner of Health for compliance purposes. Where necessary, the [chair]Chair or the Commissioner of Health shall seek additional information from insurers, carriers and self-insured employers who enter into such arrangements with PPOs to ensure compliance with this Part.

Section 325-8.6 of Title 12 NYCRR is amended to read as follows:

All rules and regulations of the [chair]Chair and the [Workers' Compensation]Board with respect to the rights, duties and obligations of employees, employers, insurance carriers, and authorized providers under the Workers' Compensation Law are expressly made applicable to preferred provider organization arrangements except to the extent that such rules and regulations are inconsistent with [a]Article 10-A of the Workers' Compensation Law or the rules and regulations promulgated pursuant to [a]Article 10-A of the Workers' Compensation Law.

Section 326-1.1 of Title 12 NYCRR is amended to read as follows:

Application of a duly licensed physician of the State of New York for authority to render medical care under the Workers' Compensation Law or for rerating thereunder, shall be made upon the application form prescribed for that purpose by the [chairman, Workers' Compensation Board,]Chair and shall be filed with the county medical society, or with the workers' compensation committee of the county medical society, of the county in which his office is located, except that in the case of a licensed physician with a degree of doctor of osteopathic medicine [who is licensed as an osteopath], such application may be filed with the appropriate county medical society or with the New York State Osteopathic Medical Society, Inc. The [chairman]Chair will notify the physician of approval or nonapproval of his or her application within 60 days after receipt by the [b]Board of the recommendation by the medical society, workers' compensation committee of the county medical society, or in the case of a licensed physician with a degree of doctor of osteopathic medicine [who is licensed as an osteopath], by the appropriate county medical society or the New York State Osteopathic Medical Society, Inc.

Section 326-1.2 of Title 12 NYCRR is amended to read as follows:

Applications for licenses to operate compensation medical bureaus or laboratories and for other laboratories and bureaus shall be made upon the application form prescribed for the purpose by the [chairman, Workers' Compensation Board,]Chair and shall be filed with the county medical society, or the workers' compensation committee of the county medical society, of the county in which such medical bureau or laboratory is located.

Subdivision (c) of section 326-1.5 of Title 12 NYCRR is amended to read as follows:

(c) A copy of the record of the proceeding shall be submitted to the [chairman of the Workers' Compensation Board]Chair, together with the report, findings and recommendation of the county medical society or of the workers' compensation committee of a county medical society, as the case may be.

Section 326-2.2 of Title 12 NYCRR is amended to read as follows:

Within 30 days after service of a copy of the report, findings and recommendation of the county medical society, or of the workers' compensation committee of the county medical society, the accused physician, medical bureau or laboratory may appeal therefrom to the Medical Appeals Unit by serving written notice of appeal, personally or by mail, upon the secretary of the Medical Appeals Unit, [180 Livingston Street, Brooklyn, NY 11248] 100 Broadway - Menands, Albany, NY 12241, and also upon the county medical society or the workers' compensation committee of the county medical society, whichever made the report, findings and recommendation from which appeal is taken.

Section 326-2.6 of Title 12 NYCRR is amended to read as follows:

Where oral argument or the taking of additional testimony is permitted, the Medical Appeals Unit shall fix a time and place for such argument or for the taking of testimony, and notice thereof shall be given by mail to the appellant, or [his] appellant's attorney if there is noted the appearance by an attorney, and to the county medical

society or the workers' compensation committee of a county medical society, as the case may be, from the findings and recommendation on which the appeal was taken.

Section 326-2.10 of Title 12 NYCRR is amended to read as follows:

Until final action is taken by the [c]Chair[man, Workers' Compensation Board,] on the findings and recommendations of the county medical society, or the workers' compensation committee of a county medical society, or the Medical Appeals Unit, the accused physician, medical bureau or laboratory may continue in the practice of his or her profession or the conduct of said bureau or laboratory under the Workers' Compensation Law, unless otherwise specifically ordered by the [chairman, Workers' Compensation Board]Chair.

Section 329.1 of Title 12 NYCRR is amended to read as follows:

[This medical fee schedule is applicable to medical, physical therapy and occupational therapy services rendered on or after October 1, 1997, regardless of the date of accident. Sections containing rates for medicine, physical medicine, anesthesia, surgery, radiology, pathology and laboratory, and evaluation and management services are included.] The fee schedule applicable to medical, physical therapy and occupational therapy services [rendered on a date prior to October 1, 1997] shall be the medical fee schedule in effect on the date on which the medical, physical therapy or occupational therapy services were rendered, regardless of the date of accident.

Section 329.3 of Title 12 NYCRR is amended to read as follows:

(a) The medical fee schedule for medical, physical therapy and occupational therapy services shall be the *Official New York Workers' Compensation Medical Fee Schedule*, [First Edition, August 1996, amended September 1997,] updated April 1, 2006, prepared by the [Workers' Compensation] Board and published by

[Medicode Publications] Ingenix, Inc., which is herein incorporated by reference.

(b) The *Official New York Workers' Compensation Medical Fee Schedule* incorporated by reference herein may be examined at the office of the Department of State, 41 State Street, Albany, NY 12231, the Legislative Library, the libraries of the New York State Supreme Court, and the district offices of the [Workers' Compensation] Board [in Albany, Binghamton, Brooklyn, Buffalo, Hempstead, Rochester and Syracuse]. Copies may be purchased from [Medicode] Ingenix, Inc., by writing to New York Workers' Compensation Medical Fee Schedule, c/o [Medicode, Inc., Dept. CH 10928, Palatine, IL 60055-0928, or by telephone at 1-800-765-6023] Ingenix, Inc., PO Box 27116, Salt Lake City, UT 84127-0116, or by telephone at 1-800-464-3649.

Section 329.4 of Title 12 NYCRR is amended to read as follows:

This schedule is applicable to ambulatory surgery services provided by licensed freestanding ambulatory surgical centers and hospital-based ambulatory surgery services rendered on or after [January 1, 1995] April 1, 2006, regardless of the date of accident.

Subdivision (b) of section 329.5 of Title 12 NYCRR is hereby amended to read as follows:

(b) the provision of section 86-4.40(d)(5) of [this] Title 10 NYCRR shall not be applicable to claims for payment for prosthetic and orthotic appliances provided during or integral to an ambulatory surgery procedure. Claims for payment for prosthetic and orthotic appliances provided during or integral to an ambulatory surgery procedure and which cost more than [five hundred]one thousand dollars shall be subject to the prior authorization request requirements [for pre-authorization] set forth in section 13-a(5) of the Workers' Compensation Law and section 325-1.4 of this Title.

Section 329.6 of Title 12 NYCRR is amended to read as follows:

[This schedule is applicable to hospital services consisting of minor surgery or emergency treatment rendered in a room other than an operating room on or after July 1, 1995, regardless of the date of accident.] The fee schedule applicable to outpatient hospital services, including minor surgery or emergency treatment rendered in a room other than an operating room, [rendered on a date prior to July 1, 1995,] shall be the outpatient fee schedule in effect on the date on which the outpatient hospital services were rendered, regardless of the date of accident.

Section 330.1 of Title 12 NYCRR is amended to read as follows:

Application by a duly licensed psychologist of the State of New York to practice under the Workers' Compensation Law shall be made upon a form furnished by the [c]Chair [of the Workers' Compensation Board, which form] and shall be filed with the Psychology Practice Committee, Workers' Compensation Board, [180 Livingston Street, Brooklyn, NY 11248] Health Provider Administration, 100 Broadway-Menands, Albany, NY 12241. Such application shall state, fully and truthfully, all the information required by law, and the applicant shall make and sign the statutory agreement. The [c]Chair shall notify the psychologist of approval of his or her application within 60 days after receipt by the [c]Chair of a recommendation for approval from the Psychology Practice Committee.

Subdivision (c) of section 330.4 of Title 12 NYCRR is hereby amended to read as follows:

(c) A true copy of the record of each proceeding shall be submitted to the [c]Chair [of the Workers' Compensation Board,] along with the report, findings and recommendation of the Psychology Practice Committee.

Section 330.7 of Title 12 NYCRR is amended to read as follows:

The [c]Chair [of the Workers' Compensation Board] shall designate a member of the Psychology Practice Committee to serve as chair of the committee, and shall also appoint a secretary of such committee.

Section 331.2 of Title 12 NYCRR is amended to read as follows:

The attending psychologist shall [get]obtain from the claimant a complete history of the claimant's injury or condition and shall report this to the [c]Chair, together with a full report of the known injury or condition as determined by his or her examination and diagnosis, as well as of any other injury or condition. Known injury or condition includes any condition the existence of which is ascertainable through psychological diagnosis and evaluation. Reported injury or condition includes any condition the existence of which is ascertainable either visually or from an authoritative source, such as the claimant, employer, a physician, etc. The report of injury or condition so ascertained shall not be deemed to constitute a professional diagnosis or opinion.

Subdivision (b) and (c) of section 331.3 is amended to read as follows:

(b) Every psychologist shall file the following reports directly with the [c]Chair, and also with the employer or the employer's carrier, if known:

- (1) within 48 hours following first treatment, a 48-hour preliminary report;
- (2) within 15 days after filing the 48-hour preliminary report and in no event later than 17 days after first treatment, a 15-day report giving a complete report of injury and treatment;
- (3) thereafter and during continuing treatment and without further request, a progress report at intervals of [30] 45 days or less;
- (4) immediately upon termination of treatment, a final report regardless of the date the last previous report was filed, except that where treatment is terminated within 48 hours following first treatment, the 48-hour

preliminary report shall constitute the final report if so noted thereon; and

(5) additional or more frequent reports when requested by the [c]Chair and within three workdays after such request is made.

(c) Whenever a report is filed with the [c]Chair by an attending psychologist after the time within which it is to be filed, as provided herein and in subdivision (4) of section 13-m of the Workers' Compensation Law, has elapsed, the psychologist shall attach thereto a signed and verified statement giving the true reason or reasons why he or she requests to be excused for late filing.

Section 331.4 of Title 12 NYCRR is amended to read as follow:

(a) No claim for payment for biofeedback treatments[, as defined in Appendix C-7 of this Title,] shall be valid and enforceable as against the employer or its carrier or the special fund under section 25-a of the Workers' Compensation Law, unless such treatment is required in an emergency or shall have been authorized[, in accordance with the provision of Appendix C-7,] by the employer or its carrier or, in cases under section 25-a, the [c]Chair.

(b) Where a claimant has been referred by an authorized physician to a psychologist for evaluation purposes only and not for treatment, prior authorization shall be required if the cost of such consultation shall exceed \$[500]1,000.

(c) All rules and procedures of the [c]Chair, relating to authorization for special services as set forth in section 325-1.4 of this Title are made applicable to requests for authorization for, and performance of, the services set forth in subdivisions (a) and (b) of this section, and any special diagnostic laboratory tests which may be performed by psychologists, to the extent they are not inconsistent with the provisions of section 13-m of the Workers' Compensation Law and the other rules duly promulgated thereunder.

Section 331.5 of Title 12 NYCRR is amended to read as follow:

A psychologist authorized to treat workers' compensation cases, when requested to [succeed] supersede another psychologist or a physician, must, before beginning treatment, make reasonable effort to communicate, after obtaining the consent of the patient (or guardian), with the attending psychologist or the physician to ascertain the patient's condition and whether or not there is any injury or condition other than mental, nervous, emotional and behavioral disorders and illnesses. The [succeeding] superseding psychologist must also advise the attending psychologist or physician of the name of the person who has requested him or her to assume care of the case and state the reason therefor. If the [succeeding] superseding psychologist cannot contact the attending psychologist or physician, and the claimant's condition is such as to require immediate treatment, the [succeeding] superseding psychologist should advise the psychologist or physician previously in attendance, within 48 hours, that he or she now has the patient in his or her care and send a copy of such notice to the employer or carrier and to the [c]Chair. The preceding psychologist or physician shall supply the [new] superseding psychologist with a complete history of the case.

Section 331.6 of Title 12 NYCRR is amended to read as follow:

All rules and procedures of the [c]Chair relating to advertising by a physician as set forth in section 325-1.16 of this Title are made applicable to psychologists, to the extent that they are not inconsistent with the provisions of section 13-m of the Workers' Compensation Law and the other provisions duly promulgated thereunder.

Section 331.7 of Title 12 NYCRR is amended to read as follow:

Insurance carriers shall not supply names of authorized psychologists to their policyholders. Employers may secure a list of all authorized psychologists in the vicinity of their places of business by applying to the [c]Chair.

Section 331.9 of Title 12 NYCRR is amended to read as follow:

No psychologist who examines for an insurance carrier or an employer or is a psychology consultant for the carrier or employer in the case of an injured employee, shall subsequently participate in the psychological care of such injured employee. Nothing herein contained shall affect the right of transfer by written consent of the injured employee, [but] and the [succeeding] superceding psychologist shall comply with the provisions of [section 331.4 of] this Part.

Section 333.1 of Title 12 NYCRR is amended to read as follows:

[This psychology fee schedule is applicable to psychological services rendered on or after October 1, 1997, regardless of the date of accident.] The fee schedule applicable to psychological services [rendered on a date prior to October 1, 1997] shall be the psychology fee schedule in effect on the date on which the psychological services were rendered, regardless of the date of accident.

Section 333.2 of Title 12 NYCRR is amended to read as follows:

(a) The psychology fee schedule for psychology services shall be the *Official New York Workers' Compensation Psychology Fee Schedule*, [First Edition, August 1996, amended September 1997,] updated April 1, 2006, prepared by the [Workers' Compensation] Board and published by [Medicode Publications] Ingenix, Inc., which is [herein] hereby incorporated herein by reference.

(b) The *Official New York Workers' Compensation Psychology Fee Schedule* incorporated by reference herein may be examined at the office of the Department of State, 41 State St., Albany, New York 12231, the Legislative Library, the libraries of the New York State Supreme Court, and the district offices of the [Workers' Compensation] Board [in Albany, Binghamton, Brooklyn, Buffalo, Hempstead, Rochester and Syracuse]. Copies may be purchased from [Medicode] Ingenix, Inc., by writing to New York Workers' Compensation

Medical Fee Schedule, c/o [Medicode, Inc., Dept. CH 10928, Palatine, IL 60055-0928, or by telephone at 1-800-765-6023] Ingenix, Inc., PO Box 27116, Salt Lake City, UT 84127-0116, or by telephone at 1-800-464-3649.

Section 340.1 of Title 12 NYCRR is amended to read as follows:

Application by a duly licensed podiatrist of the State of New York to practice or for rerating under the Workers' Compensation Law shall be made upon a form furnished by the [c]Chair[man, Workers' Compensation Board,] which shall be filed with the Podiatry Practice Committee, [180 Livingston Street, Brooklyn, NY 11248] Health Provider Administration, 100 Broadway - Menands, Albany, NY 12241. Such application shall state, fully and truthfully, all the information required by law and the applicant shall make and sign the statutory agreement. The [c]Chair[man] will notify the podiatrist of approval of his or her application within 60 days after receipt by the [c]Chair[man] of a recommendation for approval from the Podiatry Practice Committee.

Section 340.7 of Title 12 NYCRR is amended to read as follows:

The [c]Chair[man, Workers' Compensation Board,] shall designate a member of the Podiatry Practice Committee as [chairman]chairperson and shall also appoint a secretary of such committee.

Section 341.1 of Title 12 NYCRR is amended to read as follows:

A podiatrist who is authorized to treat workers' compensation claimants shall be limited, pursuant to law, to the treatment of injuries that affect only the foot and shall render such treatment only within the field of his or her professional competence as recognized by his or her authorized rating.

Section 341.2 of Title 12 NYCRR is amended to read as follows:

The attending podiatrist shall get from the claimant a complete history of the claimant's injury or disease and shall report this to the [c]Chair[man], together with a full report of the known injury or disease as determined by his or her examination and diagnosis, as well as of any injury or disease other than the foot. *Known* injury or disease includes any condition the existence of which is ascertainable through experienced podiatry examination and diagnosis. *Reported* injury or disease includes any condition the existence of which is ascertainable either visually or from an authoritative source, such as the claimant, employer, a physician, etc. The report of injury or disease so ascertained shall not be deemed to constitute a professional diagnosis or opinion.

Section 341.3 of Title 12 NYCRR is amended to read as follows:

In order to expedite the processing of claims of disabled workers and to avoid, so far as possible, the appearance of podiatrists in contested bill proceedings, the rules with respect to the filing of podiatry reports by an attending podiatrist are here stated:

(a) All podiatry reports filed by an attending podiatrist must contain his or her authorization certificate number and code letters.

(b) Every podiatrist shall file the following reports directly with the [c]Chair[man], and also with the employer or the employer's carrier, if known:

- (1) within 48 hours following first treatment, a 48-hour preliminary report;
- (2) within 15 days after filing the 48-hour preliminary report and in no event later than 17 days after first treatment, a 15-day report giving a complete report of injury and treatment;
- (3) thereafter and during continuing treatment and without further request, a progress report at intervals of [22]45 days or less;

(4) immediately upon termination of treatment, a final report regardless of the date the last previous report was filed, except that where treatment is terminated within 48 hours following first treatment, the 48-hour preliminary report shall constitute the final report if so noted thereon;

(5) additional or more frequent reports when requested by the [c]Chair[man] and within three workdays after such request is made.

(c) Whenever a report is filed with the [c]Chair[man] by an attending podiatrist after the time within which it is to be filed, as provided herein and in subdivision (3) of section 13-k of the Workers' Compensation Law has elapsed, the podiatrist shall attach thereto a signed and verified statement giving the true reason or reasons why he or she requests to be excused for late filing.

(d) The following forms are prescribed for the use of podiatrists in filing the required reports:

(1) form C-4[8] for attending podiatrist's 48-hour preliminary reports;

(2) form C-4 for attending podiatrist's 15-day reports, progress reports and final reports; and

(3) form C-27[P] for podiatry report in support of application for reopening of a closed case.

Section 341.4 of Title 12 NYCRR is hereby amended to read as follows:

All rules and regulations of the [c]Chair, relating to authorization for special services as set forth in section 325-1.4 of this Title, are made applicable to requests for authorization for special podiatry services to the extent that they are not inconsistent with the provisions of section 13-k of the Workers' Compensation Law, and the other provisions duly promulgated thereunder.

Section 341.6 of Title 12 NYCRR is amended to read as follows:

A podiatrist authorized to treat workers' compensation cases, when requested to supersede another podiatrist or a physician, must before beginning treatment, make reasonable effort to communicate with the attending

podiatrist or the physician to ascertain the patient's condition and whether or not there is any injury or disease affecting any part of the body other than the foot. The superseding podiatrist must also advise the attending podiatrist or physician of the name of the person who has requested him to assume care of the case and state the reason therefor. If the superseding podiatrist cannot contact the attending physician or podiatrist and the claimant's condition is such as to require immediate treatment of the foot, the superseding podiatrist should advise the podiatrist or physician previously in attendance, within 48 hours, that he or she now has the patient in his or her care, and send a copy of such notice to the carrier and to the [c]Chair[man]. The preceding podiatrist or physician shall supply the [succeeding] superseding podiatrist or physician with a complete history of the case.

Section 341.7 of Title 12 NYCRR is amended to read as follows:

(a) No podiatrist may be or continue to be authorized who is employed by or associated with a purveyor of appliances, including shoes; except that employment of a podiatrist by an employer solely for the purpose of rendering podiatry care to the employer's employees and their families shall not, of itself, prejudice the podiatrist in his or her application to be authorized or to continue to be authorized under the Workers' Compensation Law.

(b) All rules and procedures of the [c]Chair[man] relating to advertising by a physician as set forth in section 325-1.16 of this Title are made applicable to podiatrists, to the extent that they are not inconsistent with the provisions of section 13-k of the Workers' Compensation Law, and the other provisions duly promulgated thereunder.

Section 341.8 of Title 12 NYCRR is amended to read as follows:

Insurance carriers shall not supply names of authorized podiatrists to their policyholders. Employers may

secure a list of all authorized podiatrists in the vicinity of their places of business by applying to the [c]Chair[man].

Section 341.10 of Title 12 NYCRR is amended to read as follows:

No podiatrist who examines for an insurance carrier or an employer or is a podiatric consultant for the carrier or employer in the case of an injured employee, shall subsequently participate in the podiatric care of such injured employee. Nothing herein contained shall affect the right of transfer by written consent of the injured employee, but the [succeeding] superceding podiatrist shall comply with the provisions of [section 341.6 of] this Part.

Section 341.11 of Title 12 NYCRR is amended to read as follows:

When an examination is had under subdivision (3) of section 13-k of the Workers' Compensation Law it shall be by a qualified podiatrist at a place reasonably convenient to the claimant and in the presence of the claimant's podiatrist or physician, if in the latter's opinion his or her presence is necessary. A duplicate copy of all notices of request for such examinations shall be sent to the attending podiatrist or physician.

Section 341.12 of Title 12 NYCRR is amended to read as follows:

When the injury or condition is one without the limits prescribed by the Education Law for podiatry care and treatment, or the injuries or condition involved affect other parts of the body in addition to the foot, the podiatrist must so advise the injured employee and instruct him or her to consult an authorized physician, of [siad] said patient's choice, for appropriate care and treatment. In such event the physician shall have overall supervision of the patient's care.

Section 343.1 of Title 12 NYCRR is amended to read as follows:

[This podiatry fee schedule is applicable to podiatry services rendered on or after October 1, 1997, regardless of the date of accident.] The fee schedule applicable to podiatry services [rendered on a date prior to October 1, 1997] shall be the podiatry fee schedule in effect on the date on which the podiatry services were rendered, regardless of the date of accident.

Section 343.2 of Title 12 NYCRR is amended to read as follows:

(a) The podiatry fee schedule for podiatry services shall be the *Official New York Workers' Compensation Podiatry Fee Schedule*, [First Edition, August 1996, amended September, 1997,] updated April 1, 2006, prepared by the [Workers' Compensation] Board and published by [Medicode Publications] Ingenix, Inc., which is [herein]hereby incorporated herein by reference.

(b) The *Official New York Workers' Compensation Podiatry Fee Schedule* incorporated by reference herein may be examined at the office of the Department of State, 41 State Street, Albany, NY 12231, the Legislative Library, the libraries of the New York State Supreme Court, and the district offices of the [Workers' Compensation] Board [in Albany, Binghamton, Brooklyn, Buffalo, Hempstead, Rochester and Syracuse]. Copies may be purchased from [Medicode] Ingenix, Inc., by writing to New York Workers' Compensation Medical Fee Schedule, c/o [Medicode, Inc., Dept. CH 10928, Palatine, IL 60055-0928, or by telephone at 1-800-765-6023] Ingenix, Inc., PO Box 27116, Salt Lake City, UT 84127-0116, or by telephone at 1-800-464-3649.