Subdivision (l) of section 324.1 of Title 12 NYCRR is hereby amended to read as follows:

(l) Treating medical provider means [any physician, podiatrist, chiropractor, or psychologist] a duly licensed acupuncturist, chiropractor, nurse practitioner, occupational therapist, physical therapist, physician, physician assistant, podiatrist, psychologist, or social worker authorized by the chair, as such terms are defined in section 13-b of the workers' compensation law, that is providing treatment and care to an injured worker pursuant to the Workers' Compensation Law.

Subdivision (a)(1) of section 324.3 of Title 12 NYCRR is hereby amended as follows:

(a) Treating medical providers.

(1)(i) When a [Treading Medical Provider] treating medical provider determines that medical care that varies from the Medical Treatment Guidelines, such as when a treatment, procedure, or test is not recommended by the Medical Treatment Guidelines, appropriate for the claimant and medically necessary, he or she shall request a variance from the insurance carrier, third party administrator, or Special Fund by submitting the request in the format prescribed by the chair for such purpose. This section shall not apply to prior authorization requests from the formulary, as set forth in Part 441 of this chapter, or the durable medical equipment fee schedule, as set forth in Part 442 of this chapter.

(ii) A variance must be requested and granted by the carrier, Special Fund, the Board or order of the Chair before medical care that varies from the Medical Treatment Guidelines is provided to the claimant and a request for a variance will not be considered if the medical care has already been provided.

(iii) For the purposes of this section, a treating medical provider shall not include a physician assistant, acupuncturist, physical therapist, or occupational therapist, as defined in section 13-b

Subdivision (b)(2) and (3) of section 324.3 of Title 12 of NYCRR is amended as follows:

(2) Review by insurance carrier, third party administrator, or Special Fund.

(i) Without IME or review of records.

(a) The insurance carrier, third party administrator, or Special Fund shall review the variance request and respond to the variance request in the format prescribed by the chair within 15 days of receipt, except as provided in subparagraph (ii) of this paragraph. Receipt is deemed to be the date submitted [, if submitted by one of the prescribed methods of same day transmission, or, if sent by regular mail, five business days after the date the Treating Medical Provider requesting the variance certified that the form was sent to the insurance carrier or Special Fund].

(b) If the request for a variance was submitted after the medical care was rendered, a medical opinion by the insurance carrier, third party administrator, or Special Fund's medical professional, a review of records, or independent medical examination is not required and the insurance carrier, third party administrator, or Special Fund may deny the variance request on the basis that it was not requested before the medical care was provided.

(c) The insurance carrier, third party administrator or special fund may deny a request for a variance on the basis that the [Treating Medical Provider] treating medical provider did not meet the burden of proof that a variance is appropriate for the claimant and medically necessary as set forth in subdivision (a) of this section without review by the insurance carrier, third party administrator, or Special Fund's medical professional, a review of records, or an independent medical examination. If the insurance carrier, third party administrator, or Special Fund also wishes to obtain a medical opinion, a review of records, or independent medical examination, it must also comply with the timeframes set forth in subparagraph (ii) of this paragraph.

(d) When an insurance carrier, third party administrator or Special Fund denies a variance request on the basis that the [Treating Medical Provider] treating medical provider did not meet the burden of proof, the insurance carrier, third party administrator or Special Fund must also assert any other basis for denial or such basis for denial will be deemed waived.

(e) The insurance carrier, third party adaministrator, or Special Fund may deny a request for a variance on the basis that:

(1) the [Treating Medical Provider] treating medical provider seeks a variance for a treatment, procedure or test that is substantially similar to a prior variance request from the [Treating Medical Provider] treating medical provider that has not yet been denied by the carrier or Special Fund; or

(2) that a prior substantially similar variance request has been denied, and the subsequent variance request does not contain any additional documentation or justification to the previous variance request. The carrier or Special Fund may deny the variance request by specifying the basis for the denial. The carrier or Special Fund may submit the denial without a medical opinion by its medical professional, a review of records, or independent medical examination.

(f) A denial of the request for a variance for reasons other than those set forth in clauses (b), (c) and (e) of this subparagraph must be reviewed by the insurance carrier, third party administrator, or Special Fund's medical professional, if an independent medical examination or review of records is not conducted as set forth in subparagraph (ii) of this paragraph.

(ii) Review with IME or review of records.

(a) If the insurance carrier, third party administrator, or Special Fund wants an independent medical examination conducted of the claimant or a review of records in order to respond to the variance request, it shall notify the chair and the [Treating Medical Provider] treating medical provider of this decision in the format prescribed by the Chair within five business days of receipt of the variance request by one of the prescribed methods of same day transmission[, except if the Treating Medical Provider has certified he or she is not equipped to send and receive by one of such methods, then by regular mail to the requesting Treating Medical Provider]. A final response to the variance request shall be submitted in the format prescribed by the Chair in the same manner as the notice in the preceding sentence within 30 days of receipt of the request. Receipt is deemed to be the date sent[, if sent by one of the prescribed methods of same day transmission, or, if sent by regular mail, five business days after the date the Treating

Medical Provider requesting the variance certified that the form was sent to the insurance carrier or Special Fund].

(b) If the claimant fails to appear without reasonable cause for an independent medical examination scheduled by the insurance carrier, third party administrator, or Special Fund in order to respond to a request for a variance, the request for a variance shall be denied. The insurance carrier, third party administrator, or Special Fund shall submit the response to the variance request within 30 days of receipt of the request. Receipt is determined as provided in clause (a) of this subparagraph. If the claimant requests review of the denial of the variance request based on his or her failure to appear, such request for review shall be reviewed by the Board in the manner prescribed by the Chair. Such request for review of the denial of the variance shall be submitted in the manner prescribed by the Chair within 21 business days of receipt of the insurance carrier, third party administrator, or Special Fund's denial by the claimant. If the claimant requests review of the denial of the variance request and it is determined that the failure to appear was for reasonable grounds, the insurance carrier, third party administrator, or Special Fund will have 30 days from the date of the filing of the decision to obtain an independent medical examination and provide a further response to the request for a variance.

(3) Insurance carrier, third party administrator, or Special Fund response to variance request.

(i) The variance response shall be in the format prescribed by the Chair and shall clearly state whether the variance has been granted, denied, or partially granted. If a variance request has been partially granted, the variance response shall specify the medical treatment, procedure or test that has been granted.

(ii) The variance response shall be submitted by one of the prescribed methods of same day transmission to the [Treating Medical Provider] treating medical provider who requested the variance, the Board, claimant, claimant's legal representative, if any, or any other parties. [However, if the Treating Medical Provider certified he or she is not equipped to send and receive by one of the prescribed methods of same day transmission, and/or if the claimant, claimant's legal representative, if any, or any other party is not capable of receiving the response by one of the prescribed methods of same day transmission or has not provided the insurance carrier or Special Fund with the necessary contact information, the insurance carrier or Special Fund shall send the response to such individual or individuals by regular mail with a certification of the date and to whom the response was sent.]

(iii) If the insurance carrier, third party administrator, or Special Fund denies a variance request, it shall state the basis for the denial in detail and, if for reasons other than those set forth in clause (2)(i)(b) or (c) or (2)(ii)(b) of this subdivision, submit with its response the written report of the insurance carrier, third party administrator, or Special Fund's medical professional that reviewed the variance request or the review of records, if it has not already been submitted to the board and to all other parties. The denial shall identify the independent medical examination report or review of records report, if already submitted to the Board, by the document identification number in the electronic case folder and date received by the Board. The insurance

carrier, third party administrator, or Special Fund may submit citations or copies of relevant literature published in recognized, peer-reviewed medical journals in support of a denial of a variance request.

Subdivision (c) of section 324.3 is amended as follows:

(c) Request for review of denial of variance.

Upon receipt of the denial of the variance request, the claimant or claimant's legal representative, if any, shall consult with the [Treating Medical Provider] treating medical provider who requested the variance to determine if such variance is still appropriate and medically necessary. If the [Treating Medical Provider] treating medical provider still believes it is appropriate and medically necessary, the claimant or claimant's legal representative, if any, may request review of the denial of the variance. A request for review of the denial of the variance shall be submitted within 21 business days of receipt of the insurance carrier, third party administrator, or special fund's denial by the claimant. Receipt is deemed to be the date sent, if sent by one of the prescribed methods of same day transmission, or, if sent by regular mail, five business days after the date the insurance carrier, third party administrator, or Special Fund certified that the variance response was sent to the claimant or the claimant's legal representative, if any. The request shall be made in the format prescribed by the Chair and provide all information requested, unless the claimant is unrepresented. When a denial is not based on a claimant's failure to appear for an independent medical examination pursuant to subparagraph (b)(2)(ii) of this section and the claimant seeks review of such denial, a represented claimant or such claimant's legal representative shall notify the chair if he or she requests resolution by adjudication, including an expedited hearing if necessary, and in accordance with paragraph (d)(3) of this section simultaneous with requesting review of the insurance carrier, third party administrator, or Special Fund's denial of the request for a variance. If a represented claimant or such claimant's legal representative does not notify the Chair of his or her request for resolution by adjudication, including an expedited hearing, the request for review of the denial of the variance request will be resolved through the medical arbitration process set forth in paragraph (d)(2) of this section. If the request is not received by the Board within 21 business days of receipt of the denial, the denial of the request for the variance will be deemed final. If the claimant or claimant's legal representative, if any, is informed or knows that the [Treating Medical Provider] treating medical provider is trying to informally resolve the denial of the variance request in accordance with subdivision (d) of this section, the claimant or claimant's legal representative shall not request review of the denial until advised that attempts at informal resolution have been unsuccessful or the informal resolution period has expired. If the claimant or claimant's legal representative submits a timely request for review of the denial of the variance, such request will be resolved in accordance with paragraph (d)(2) or (3) of this section.

(d) Process for requesting review of denial of variance except denials based on the claimant's failure to appear for an IME.

(1) Informal resolution.

(i) If the insurance carrier, third party administrator, or Special Fund denies the variance request in accordance with subdivision (b) of this section, the [Treating Medical Provider] treating medical provider who requested the variance may elect to try to resolve the dispute by discussing the variance request directly with the insurance carrier, third party administrator, or Special Fund's medical professional prior to the resolution of the dispute through the medical arbitrator process set forth in paragraph (2) of this subdivision or the expedited hearing process set forth in paragraph (3) of this subdivision.

(ii) If the dispute is resolved, the insurance carrier, third party administrator, or Special Fund confirms the resolution by submitting notice of resolution in the format prescribed by the Chair for this purpose reflecting the resolution to the treating medical provider, Board, claimant, claimant's legal representative, if any, and to any other parties, by one of the prescribed methods of same day transmission or, if one of the recipients is not equipped to receive the notice of resolution through one of the prescribed methods, by regular mail to such recipient.

(iii) The parties shall make every effort to resolve the dispute, however, if the discussion fails to resolve the dispute the [Treating Medical Provider] treating medical provider shall notify the claimant and the claimant's legal representative, if any, that the dispute was not resolved so that the claimant or claimant's legal representative, if any, may request review of the denial of the request for a variance and have the dispute resolved through the medical arbitrator process set forth in paragraph (2) of this subdivision or expedited hearing process set forth in paragraph (3) of this subdivision.

(2) Medical arbitrator process.

(i) If the claimant or claimant's legal representative requests review of the denial of a variance, the Chair shall order the claim into the medical arbitrator process, when:

(a) the [Treating Medical Provider] treating medical provider and insurance carrier, third party administrator, or Special Fund have attempted and failed to resolve the denial of the variance informally; and

(b) the claimant or insurance carrier, third party administrator or Special Fund has not requested that the issue be decided by expedited hearing as provided in paragraph (3) of this subdivision.

(ii) The request for review, variance request, and denial will be reviewed by the medical arbitrator. Such review will not commence if the treating medical provider and insurance carrier, third party administrator, or Special Fund resolve the denial of the variance informally and the insurance carrier, third party administrator, or Special Fund confirms the resolution by submitting the notice of resolution in the format prescribed by the Chair for this purpose as provided in subparagraph (1)(ii) of this subdivision. The medical arbitrator shall rule on the request for review of the denial of the variance and issue a notice of resolution setting forth the ruling and the basis for such ruling. If the basis for the insurance carrier, third party administrator, or Special Fund's denial of the variance request was that the [Treating Medical Provider] treating medical provider failed to meet the burden of proof that the variance was appropriate for the claimant and medically necessary, and the medical arbitrator rules that the

[Treating Medical Provider] treating medical provider did meet his or her burden of proof, the medical arbitrator shall then immediately rule on whether the variance request is approved or denied. The notice of resolution issued by the medical arbitrator is binding and not appealable under Workers' Compensation Law section 23.

(3) Expedited hearing process.

(i) Upon request of a party, the case may be referred [for]to adjudication, and if necessary, set for an expedited hearing for review of the denial. A request for referral [for] to adjudication, and if necessary, set for an expedited hearing is applicable only to the specific variance denial under review. Subsequent requests for review of a variance denial shall be referred to the medical arbitrator process unless a party requests referral for an expedited hearing.

(ii) Claims referred to the expedited hearing process to resolve the request for review of the denial of a variance may be heard by a Workers' Compensation Law judge designated to hear such issues. Notice of the expedited hearing shall provide that the parties may take the testimony of the claimant's treating medical provider and the insurance carrier, third party administrator, or Special Fund's medical professional, independent medical examiner, or records reviewer who wrote the written report upon which the denial of the variance request was based at or prior to the hearing, unless the denial was solely based on the failure of the [Treating Medical Provider] treating medical provider to meet his or her burden of proof as provided in clause (b)(2)(i)(c) of this section. If the medical professionals are deposed, transcripts shall be provided to the board on or before the hearing and within 30 days of the request for the expedited hearing. If the claimant is unrepresented the testimony of claimant's attending physician and the independent medical examiner shall be taken at a hearing. For good cause shown, the Workers' Compensation Law Judge may grant an adjournment if one or both of the medical professionals cannot be deposed and transcripts filed with the board at or prior to the hearing, or if one or both of the medical professionals cannot appear to testify at the expedited hearing. The Workers' Compensation Law Judge shall issue his or her decision on the request for review of the denial of the variance at the expedited hearing, including the reasons and evidence supporting the decision, and a notice of decision will be sent after the close of the hearing, unless the Workers' Compensation Law Judge determines on the record that there are complex medical issues, in which case he or she will reserve his or her decision and the written decision shall be issued shortly after the expedited hearing. The case shall not be continued for further development of the record except where there are complex medical issues of diagnosis, treatment or causation present and then it shall be continued for no more than 30 days.

(4) The claimant and the [Treating Medical Provider] treating medical provider who requested the variance shall have the burden of proof that such variance is appropriate for the claimant and medically necessary.

(5) The Board shall consider relevant literature published in recognized, peer-reviewed medical journals cited by the [Treating Medical Provider] treating medical provider or the insurance carrier, third party administrator, or Special Fund or both, and may consider relevant literature

not previously cited, in determining whether a variance is medically necessary, including satisfaction of the relevant requirements in paragraph (a)(3) of this section.

(6) If the insurance carrier, third party administrator, or Special Fund fails to respond to the variance request, fails to timely deny the variance request in accordance with subdivision (b) of this section, or, except if the basis for the denial is one of the reasons set forth in clause (b)(2)(i)(b) or (c) or subdivision (e) of this section, fails to submit the written report, or identify the report in the electronic case folder, the variance [is] may be deemed approved on the ground that such approval was unreasonably withheld and the Chair will issue an order stating that the request is approved. Such order of the Chair is not appealable under Workers' Compensation Law section 23. When a substantially similar variance has been submitted in violation of paragraph (a)(7) of this section, the failure of the carrier or Special Fund to timely deny such request shall not result in the variance being deemed approved and the Chair is not required to issue an order stating that the request is approved.

(7) When the Chair issues an order as provided in paragraph (6) of this subdivision in a claim that is controverted or the time to controvert the claim has not expired, the insurance carrier, third party administrator, or Special Fund shall not be responsible for the payment of such medical care until the question of compensability is resolved and then only if that insurance carrier, third party administrator, or Special Fund is found liable for the claim.

Section 325-1.4(a) of Title 12 NYCRR is hereby amended to read as follows:

§ 325-1.4(a) Authorization for special services

(a) Authorization for medical care in accepted or established claims.

(1) When it is necessary for the attending [physician] provider 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 tests costing more than $1,000, [or when it is necessary for a self-employed physical or occupational therapist to continue physiotherapeutic or occupational therapy procedures prescribed by an attending physician costing more than $1,000,] he or she must request and secure authorization from the employer or insurance carrier or the Chair, by setting forth the medical necessity of the special services required in the electronic format prescribed by the Chair [on the Chair prescribed form for such purpose]. Such requests are not required in an emergency or for pre-authorized procedures as set forth in subdivision (d) of this section and section 324.2[(c)](d) of this Title.

(2) (i) This section also applies to hospitals, specialists, consultants and surgeons, who are actually engaged to perform such services.
(ii) For the services of a physician assistant, the supervising physician shall make the request for authorization for special services,

(3) The attending provider seeking authorization shall file the form prescribed by the Chair for this purpose with the Board and also on the same day serve a copy on the insurance carrier by one of the prescribed methods of same day transmission set forth in section 324.1[(h)](i) of this Title or by regular mail with confirmation of delivery. All questions on the form prescribed by the Chair for this purpose shall be answered completely,

clearly setting forth the medical necessity of the special services requested. The attending physician or self-employed physical or occupational therapist shall not request authorization for the same special service multiple times without any change of the claimant's medical condition.

(4) In order to process such requests expeditiously and within the time limits specified hereunder, the insurance carrier shall designate a qualified employee or employees in its office, and the self-insured employer shall designate a qualified employee or employees in its office or an authorized employee or employees of its licensed representative, to receive and act upon such requests.

(5) In response to requests for authorization for treatment related to an established body part or illness, the self-insured employer or insurance carrier may have the claimant examined within four business days if the claimant is hospitalized or 30 days if patient is not hospitalized, by an appropriate specialist who is authorized by the Chair, to conduct independent medical examinations of workers' compensation claimants. If such specialist is not available or where the claimant resides outside of state, consultation may be rendered by a qualified provider who may conduct the independent medical examination as provided in Workers' Compensation Law section 137 (3) (a) and section 300.2(b)(9) and (d)(7) of this Title.

(6) The self-insured employer or insurance carrier shall respond to the authorization request orally and in writing by one of the prescribed methods of same day transmission as defined in section 324.1 (h) of this Title or by regular mail with confirmation of delivery within 30 days. The 30 day time period begins to run from the date the completed form prescribed by the Chair for this purpose was sent if sent by one of the prescribed methods of same day transmission or five days after it was sent if sent by regular mail with confirmation of delivery. The written response shall be on a copy of the form prescribed by the Chair completed by the attending physician seeking authorization and shall clearly state whether the authorization request has been granted or denied. If the authorization has been denied, the insurance carrier shall submit with the written response a report offering a conflicting opinion from an independent medical examiner, a qualified medical professional as defined in section 300.2 (b)(9) [and (d)(7)] of this Title, or, if the report was made upon review of the records without a physical examination, a physician authorized to treat workers' compensation claimants. If the report offering a conflicting opinion is already contained in the Board file, the insurance carrier shall not submit the report but shall identify the report on the form prescribed by the Chair by providing the name of the independent medical examiner, qualified medical professional as defined in section 300.2(b)(9) of this Title, or physician authorized to treat workers' compensation claimants who gave the conflicting opinion, the date of the report, and the date it was received by the Board. Nothing herein shall relieve the carrier from complying with the provisions of section 300.23 of this Title.

(7) The oral response to the authorization request shall be to the attending [physician or self-employed physical or occupational therapist] provider who requested the authorization. The written response to the authorization request shall be to the attending [physician or self-employed physical or occupational therapist] provider with a copy to the Board, claimant, claimant's legal counsel, if any, and to any other parties of interest.

(8) If such authorization or denial has not been sent by one of the prescribed methods of transmission in section 324.1 (h) of this Title to the attending [physician or self-employed

physical or occupational therapist] provider with copies to the Board, the claimant's legal representative, if any, and to any other parties within 30 calendar days, such request shall be deemed authorized and the employer or insurance carrier shall be liable for payment for such special service. The 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. Such order of the Chair is not appealable under Workers' Compensation Law section 23.

(9)

(i) Upon the timely receipt by the Board of the form prescribed by the Chair denying authorization of the special medical service and a report offering a conflicting opinion from an independent medical examiner, a qualified medical professional as defined in section 300.2(b)(9) [and (d)(7)] of this Title, or, if the report was made upon review of the records without a physical examination, a physician authorized to treat workers' compensation claimants, the Board shall order the claim into the Expedited Hearing Process wherein an expedited hearing shall be scheduled within 30 days. Notice of the expedited hearing shall provide that the parties may depose the claimant's attending physician and the independent medical examiner, qualified medical professional, or physician authorized to treat workers' compensation claimants who submitted the conflicting medical report at or prior to the hearing. If the physicians are deposed, transcripts shall be provided to the Board on or before the hearing. If the claimant is unrepresented the testimony of claimant's attending physician and the independent medical examiner shall be taken at a hearing. For good cause shown, the Workers' Compensation Law Judge may grant an adjournment if one or both of the medical professionals cannot be deposed and transcripts prior to the Board at or prior to the hearing, or if one or both of the medical professionals cannot appear to testify at the expedited hearing. If authorization is denied for one of the procedures listed in section 324.2 (d)(2) of this Title, the Workers' Compensation Law Judge may require examination of the claimant or a review of the claimant's records and submission of a report of such examination or review by an impartial specialist pursuant to Workers' Compensation Law Section 13 (e) as additional evidence to consider in rendering a decision. The Workers' Compensation Law Judge shall rule on the authorization at the expedited hearing and file a subsequent decision, or shall issue a reserved decision on the issue within 15 days of the expedited hearing date. The case shall not be continued for further development of the record except where there are complex medical issues of diagnosis or causation present and then it shall be continued for no more than 30 days.
(ii) If the form prescribed by the Chair denying the authorization is untimely or does not reference or have attached a conflicting medical report from an independent medical examiner, a qualified medical professional as defined in section 300.2 (b) (9) of this Title, or, if the report was made upon review of the records without a physical examination, a physician authorized to treat workers' compensation claimants, the Chair will issue an order stating that such request is deemed authorized. Such order of the Chair is not appealable under Workers' Compensation Law section 23.

(10) Pursuant to Workers' Compensation Law section 13-a (4) (b), claimants shall cooperate in an examination by the insurance carrier's independent medical examiner. If a claimant fails to attend an examination scheduled in accordance with Workers' Compensation Law section 137 and section 300.2 of this Title at a medical facility convenient to the claimant

during the 30 day authorization time period, the insurance carrier may file the form prescribed by the Chair along with contemporaneous supporting evidence that claimant failed to attend a scheduled medical examination pursuant to the provisions of Workers' Compensation Law section 137. Upon receipt of the form prescribed by the Chair for this purpose and the contemporaneous supporting evidence of failure to attend the scheduled medical examination, the Board shall order the claim into the Expedited Hearing Process wherein an expedited hearing shall be scheduled within 30 days on the request for prior authorization and the claimant's failure to attend the independent medical examination.

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

Section 325-1.4(b) of Title 12 NYCRR is hereby amended to read as follows:

§ 325-1.4(b) Authorization for medical care when the right to compensation is controverted or the body part or condition has not been established.

(1) When it is necessary for the attending [physician] provider to secure specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, x-ray examinations or special diagnostic laboratory tests costing more than $1,000, or when it is necessary for a physical or occupational therapist to continue physiotherapeutic or occupational therapy procedures prescribed by an attending [physician] provider costing more than $1,000, and the claim is controverted or the time to controvert the claim has not expired or the body part or condition has not been established, [he or she] the attending provider shall request and obtain authorization from the employer or insurance carrier who would become responsible in the event the claim is adjudicated compensable by following the procedures in subdivision (a) of this section. All such procedures 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 Chair issues an order, pursuant to paragraph (a)(8) 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 and then only if the claim is established as compensable.

Section 325-1.4(c) of Title 12 NYCRR is hereby amended to read as follows:

(c) Multiple special services. If an attending [physician] provider provides medical treatment or special services to more than one body part or more than one medical treatment or special service to the same body part, such treatment or special services shall be considered separate and shall not require a request for prior authorization pursuant to Workers' Compensation Law section 13-a (5) or this section if the medical treatments or special services individually costs less than $1,000. Notwithstanding the previous sentence, if the medical treatment or special services are a series of related treatment or care, such as physical or occupational therapy, or part of a battery of related tests, such as electro-diagnostic tests, the aggregate amount of such treatment, care, or tests shall be considered as a single request and shall require a request for prior authorization

pursuant to Workers' Compensation Law section 13-a (5) or this section if the aggregate amount is more than $1,000.