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11/29/22

ONBOARD: LIMITED RELEASE
PRIOR AUTHORIZATION REQUESTS

Dear Client,

The New York Workers' Compensation Board has now completed its initial rollout of its "OnBoard" project, which is designed to transition payers and health care providers from paper-based processes to online processes. This white paper will discuss the Board's prior authorization request ("PAR") process. PARs generally apply to requests for medical treatment that fall outside of the Board's Medical Treatment Guidelines.

Adoption and Implementation

The Board adopted amendments of Sections 324.1, 324.2, 324.3, 324.4, 325-1.4, 441.5, 441.6, 442.4, and 442.5 of 12 NYCRR, to generally become effective June 7, 2021. The regulations provided for the implementation of an internet portal-based submission and review process, available through the Medical Portal, called OnBoard. OnBoard has been implemented as part of the Board's Business Process Re-Engineering Program. It is the Board's goal to move most processes for health care providers and payers from paper to an electronic/web-based system. OnBoard includes processes for handling all prior authorization requests (PARs) and Requests for Decision on Unpaid Medical Bill(s) (Form HP-1.0).

The Board implemented the use of OnBoard, in a process they entitled OnBoard: Limited Release, in three phases. Phase One, effective March 7, 2022, applied to Medication PARs and Form HP-1.0. Phase 2, effective April 4, 2022, applied to Durable Medical Equipment (DME) PARs. Finally, Phase 3, effective May 5, 2022, applied to Treatment/Testing PARs.

Also, effective May 2, 2022 are updated Medical Treatment Guidelines (MTGs) for the knee, mid and low back, neck, shoulder, and non-acute pain. New MTGs for the following are also effective May 2, 2022: ankle and foot; elbow; hand, wrist, and forearm (including carpal tunnel syndrome); hip and groin; occupational interstitial lung disease; occupational/work-related asthma; post-traumatic stress disorder and acute stress disorder; work-related depression and depressive disorders; eye disorders; traumatic brain injury; and; complex regional pain syndrome.

Overview of the PAR Process

A PAR is a request by a claimant's health care provider to obtain prior approval from the payer to cover the costs related to a specific treatment. The provider will answer a series of questions to determine which type of PAR is applicable. There are seven different PAR types, each with different deadlines for response, as outlined in the following table.

PAR Type	Applicability	PAR ID Prefix	Deadline for Response
MTG Confirmation	For confirmation that the proposed treatment/tests are based upon a correct application of the Medical	MG1	8 business days

	Treatment Guidelines. Replaces Form MG-1.		
MTG Variance	For requests for treatment/tests that vary from the Medical Treatment Guidelines. Replaces Form MG-2.	MG-2	15/30 calendar days Must respond within 15 calendar days of receipt of request. If obtaining an IME or records review, notification must be sent within 5 business days through OnBoard, and then the time frame for response is extended to 30 calendar days from the receipt of the request.
MTG Special Services	Requests for special services as required per the Medical Treatment Guidelines. Replaces Form C-4AUTH.	SS	15/30 calendar days Must respond within 15 calendar days of receipt of request. If obtaining an IME or records review, notification must be sent within 5 business days through OnBoard, and then the time frame for response is extended to 30 calendar days from the receipt of the request.
Non-MTG over $1,000.00	Requests for treatment/tests costing more than $1,000.00 with no applicable Medical Treatment Guidelines. Replaces Form C-4AUTH..	O1K	30 calendar days
Non-MTG under $1,000.00	Requests for treatment/tests costing $1,000.00 or less with no applicable Medical Treatment Guidelines.	U1K	8 business days
Medication	For requests for non-formulary medications, including medical marijuana. Replaces prior Drug Formulary Process.	RX	4 calendar days

DME	Requests for DME not on the New York Durable Medical Equipment Fee Schedule or for an item on the fee schedule that requires prior authorization.	DME	4 calendar days

The PAR process provides for a three-level process of review, although 12 NYCRR 441.5, which addresses medications, is the only regulation that clearly outlines a three-level review process.

Level 1

A Level 1 request can be reviewed by anyone designated by the carrier, self-insured employer ("SIE"), or third-party administrator. The Level 1 reviewer can grant, grant in part, or deny the request. If the request is approved, the provider will be notified. A Level 1 reviewer may deny for administrative reason (disallowance, controversy, closure, cancellation, Section 32 agreement).

Any Level 1 request that is denied on an administrative basis will not automatically escalate to Level 2. If a Level 1 request for specialist consultations, surgical operations, physical or occupational therapy, x-rays, or special diagnostic laboratory tests costing more than $1,000.00, is denied administratively for the claim being controverted, and is not filed with an IME, it would result in the waiver of any IME should the case later be established.

Except for Medication PARs, any request that is granted in part or denied on a medical basis, including burden of proof, will automatically escalate for a Level 2 review. Please note that the escalation to Level 2 does not increase or reset the deadline for response.

All bases for denial need to be asserted at Level 1 or Level 2, or they will be deemed waived.

A reviewer may request additional information from the provider at Level 1 or Level 2, by selecting Request for Further Information in OnBoard under Actions and identifying what information is needed. The timeframe for response is not extended when a request for further information is made, even when there is no response.

Level 2

A Level 2 review must be performed by the carrier's physician. Both the review and the response must be submitted by the carrier's physician. The Level 2 physician reviewer will be able to view the supporting documents uploaded by the Level 1 reviewer. Level 2 reviewers will be able to review prior treatment request determinations that have been submitted via OnBoard over the life of a claim. If any supporting documents should be part of the Level 2 response, they will need to be downloaded and then uploaded as a supporting attachment as part of their PAR response.

The health care provider can either treat the injured worker per the decision from the Level 2 review or request a Level 3 review by the Board within 10 calendar days. A denial of a Non-MTG over $1,000.00 PAR will be addressed at a priority hearing scheduled by the Board. With the exception of Medication PARs, administrative denials are not eligible for Level 3 review. If the claimant disagrees with an administrative denial on all PAR types with the exception of Medication,

they can file an RFA-1. If the claimant disagrees with a medical denial on an MTG Special Services or MTG Variance PAR, they can file an RFA-1.

Level 3

Level 3 reviews are performed by the Medical Director's Office (MDO) and will be a determination on the issue of medical necessity of MTG related procedures, DME, or medications. The determination on medical necessity is final and a carrier, SIE or administrator may not dispute payment based upon medical necessity, however, the determination does not resolve any outstanding legal issues.

If the claimant does not agree with the MDO's determination on a Medication, DME, MTG Variance, or MTG Special Services, they can request additional review via adjudication by filing an RFA-1. If a carrier/employer wishes to request review of the Medical Director's Office's determination on an MTG Special Services or MTG Variance PAR, they may do so by filing an RFA-2.

All medical providers are required to notify the claimant when they submit or escalate a PAR. Any response to a PAR must be copied to the claimant, except for Medication PARs. If the claimant is represented, their attorney or representative will be notified of any action that has been taken if the attorney is identified as claimant's attorney/representative on the claim in eCase and has an email address associated with the R number at the time of submission of the PAR. When the Board acts on a PAR, it will send a copy of the Order of the Chair or Notice of Resolution by the Medical Director's office to the claimant.

Any denial or partial approval at Level 1 or Level 2 for all PAR types except Medication, can be changed to a grant, if it is due to administrative, jurisdictional, or IME-related reasons. A denial made on a medical basis cannot be changed. A Level 1 response can be changed until there is a response by the Level 2 reviewer. A Level 2 reviewer can change a response to grant until there is a Notice of Resolution issued by the MDO. Any documentation in support of the change can be uploaded when the response is changed.

In the event a provider submits multiple requests of the same PAR type (except Medication), they will all be processed in a group under one PAR ID. The Level 1 and Level 2 review will follow the same process in terms of response, however, there will not be a final determination until all of the requests under the PAR ID have a final determination. If multiple requests of the same PAR type are received and some are granted and one is denied for medical reason, all items will proceed to a Level 2 review. At the Level 2 review, the physician must issue a decision on all of the items. If one is denied, the PAR will show that the Level 2 request is denied. If the requesting medical provider seeks a Level 3 review, they can proceed with the items that were granted, but the PAR will not be moved to the "Resolved" tab until there is a decision by the Medical Director's Office.

As with the prior C-4AUTH and MG-2.0 forms, PARs can be granted without prejudice. This may only be done when a FROI-04 or SROI-04 denying the claim has been filed and the controversy is still pending, or the body part of condition has not been accepted on a FROI or SROI or been established by the Board (must be done by a Level 2 reviewer).

In the event a carrier, SIE, or administrator wishes to obtain an IME prior to responding to a MTG Variance or MTG Special Services PAR, the claimant, claimant's attorney (if applicable), and the requesting health care provider, must be notified within 5 business days of the submission of the PAR. The notification is made through OnBoard. Once the notification is made, the timeframe for response is automatically extended from 15 days to 30 days. In the event the claimant fails to appear for an IME, or reschedules outside of the timeline for response, the PAR should be denied on that basis. If the claimant wishes to request review for the denial of a Special Services PAR or Variance PAR based upon his or her failure to appear, an RFA-1 must be filed requesting review within 21 days. If, upon receipt of the RFA-1 requesting review of the denial, the Board determines that the failure to appear was for reasonable grounds, the carrier, SIE, or administrator will have 30 days from the filing date of the decision to obtain

an IME. However, the carrier, SIE, or administrator must respond within 15 days to the PAR if not obtaining an IME or records review.

In certain instances, a PAR can be denied for administrative reasons, and without the review of a physician. A PAR can be denied without the review of a physician when:

- The PAR (Variance or Special Services) was submitted after the treatment was rendered.
- A substantially similar request has been denied and the new request does not contain any additional information, documentation, or justification (Variance, DME, Special Services)
- The case is closed;
- The case is disallowed;
- The case has been cancelled;
- The medical treatment has been resolved with a Section 32 agreement;
- The medical treatment is subject to an offset pursuant to an approved third-party settlement (Variance, Special Services);
- The claim is controverted (Variance, Special Services, DME, Confirmation), or;
- When the claimant fails to appear for a scheduled IME.

When a PAR is denied without review by a physician, there will be no review by the MDO. A claimant can file a RFA-1 that demonstrates the basis for the denial is factually inaccurate. The Board can respond with a letter or refer for adjudication. The regulations provide for this for Variance PARs, Special Services PARs, Confirmation PARs, and Non-MTG over $1K PARs.

Specifics of Each PAR Type

Medication PARs (RX)

Health care providers are required to submit a PAR for:

1) a drug not listed on the Drug Formulary, including medical marijuana;
2) a formulary brand name drug, when a generic is available;
3) Combination products, unless already on the Drug Formulary;
4) a brand name drug when a generic version containing the same active ingredients is commercially available in a different strength/dosage;
5) a compound drug;
6) Formulary drugs prescribed in a manner inconsistent with the MTGs.

If there is established apportionment, the provider must seek prior authorization from all carriers and SIEs. Any carrier, SIE, or administrator may approve or partially approval the PAR and a subsequent denial or partial approval by any carrier, SIE, or administrator shall not affect the validity of the PAR approval.

A response at Level 1 and Level 2 must be submitted within four calendar days. A Level 1 response does not need to be performed by a physician. Claimants are not required to be notified of responses. A partial approval (limiting length of time, quantity prescribed, number of refills) or a denial must provide a specific reason for the denial or partial approval with reference to the specific PAR request made by the provider. A Level 1 partial approval or denial must provide information regarding how to request review of the denial by the carrier's physician. The provider will be notified of the Level 1 reviewer's decision. The provider can agree with the Level 1 reviewer's decision, or manually submit a request for Level 2 Review.

A Level 2 review must be completed by the carrier's physician, again within 4 calendar days. If Level 2 review is requested, the provider will be notified of the Level 2 reviewer's decision. The provider can then agree with the payer's decision, or request Level 3 review from the Medical Director's office. The provider must request

review of a Level 2 denial or partial approval by the Medical Director's Office within 10 calendar days. The provider must submit all documentation submitted in support of its Level 1 and Level 2 review, and the denial or partial approval following the Level 1 and Level 2 review. In the event a PAR is denied on the merits, the provider may not submit a new PAR for the same medication unless evidence is submitted that there has been a change in the claimant's medical condition.

A claimant may request review of a Medical Director's Office decision by filing an RFA that demonstrates that the requested medication is medically necessary and the denial or partial approval adversely impacts the claimant's interests. The Board will respond to the requests for review by letter or referral for adjudication. Such decisions are not appealable.

Regarding Medication PARs for medical marijuana, Level 1 review must be conducted in accordance with New York State law regarding medical marijuana. A Medication PAR for medical marijuana must include the following:

- A serious life-threatening condition, and associated condition, as defined by Public Health Law;
- A compensable work-related condition;
- Indication that the claimant has been certified by the NYS Department of Health to receive medical marijuana;
- Description of other treatments that have been trialed without success; and,
- Expected functional improvement from medical marijuana.

Durable Medical Equipment PARs – DME

A DME PAR must be submitted for requests for DME not on the New York Durable Medical Equipment Fee Schedule or for an item on the fee schedule that requires prior authorization. A DME PAR should also be filed if the item is not addressed, not recommended, or does not meet the criteria outlined in the MTGs. In this instance, the provider must list the MTG reference codes and an explanation as to why the item is being requested. If there is established apportionment, the provider must seek authorization from the primary carrier or SIE, as identified by the Board. Approval by the primary carrier or SIE will be deemed approval by all responsible carriers or SIEs.

If a DME PAR is submitted prior to the creation of a case, the Board will promptly review the PAR to identify the proper carrier, SIE, or administrator. Upon identification, the PAR will be sent to the proper carrier, SIE, or administrator who will have 4 calendar days to respond. If a PAR is submitted after the creation of a case, but prior to the filing of the mandatory FROI identifying the administrator responsible for handling the claim, the Board may direct the request to an administrator that has been designated by the carrier or SIE as handling all or a portion of its claims. In this instance, the administrator still has 4 calendar days to respond. If a PAR is submitted after the mandatory FROI filing is due, and no FROI is filed, the Board may issue an Order of the Chair or Notice of Resolution approving the requested treatment.

A response to a DME PAR must be submitted within 4 calendar days. A partial approval or a denial of a DME PAR must be issued by the carrier's physician, unless the PAR is for DME that is the subject of a prior PAR that has been denied or not yet acted upon, or if the case has been closed, disallowed, cancelled, or settled with a Section 32. A denial or partial approval must provide a specific reason with reference to the specific PAR made by the provider. Any denial or partial approval must provide information regarding how to request review of the denial from the Medical Director's Office.

If a partial approval reduces the price of the DME requested by the provider, the partial approval must:

- Identify two sources of the adjusted price (including the address and phone number, and reason for the adjustment).
- The DME must be available at a supplier located within 15 miles of the claimant's residence or place of employment if the claimant resides in a rural area, as defined in Section 440.2, or

within 5 miles of the claimant's residence or place of employment if the claimant resides in a municipality, or the DME must be delivered to the claimant's residence.

- The DME must be delivered or supplied completely assembled and useable without further fittings within 48 hours

Unless a PAR has been properly denied, or granted as medically necessary but without liability, the carrier may not object to payment for the DME at the fee schedule rate. Any such objections will be rejected, and penalties imposed.

Carriers, SIEs, or administrators cannot direct a claimant to use a specific supplier for DME, except as part of a Preferred Provider Organization (PPO), under 12 NYCRR 325-8. If a carrier has a dedicated DME network with which it contracts, that can be referenced as part of the review process as a recommendation, but the claimant cannot be required to use such supplier.

MTG Confirmation PARs (MG1)

The MTG Confirmation PAR may be submitted by a health care provider to seek confirmation that the proposed treatment/tests are based upon a correct application of the Medical Treatment Guidelines. Health care providers are not required to submit a PAR if they believe the treatment is consistent with the MTGs, but if they do submit a PAR a response is required. A carrier, SIE, or third-party administrator may not object to or deny payment of a bill solely because the treating provider did not submit a MTG Confirmation PAR. Such objection or denial could result in penalties.

If a PAR is submitted prior to the creation of a case, the Board will promptly review the PAR to identify the proper carrier, SIE, or administrator. Upon identification, the PAR will be sent to the proper carrier, SIE, or administrator who will have 15 calendar days, or 30 calendar days if an IME is being obtained to respond. This is the language contained in the regulation but appears to be inconsistent with the eight-business day deadline for a created case, as outlined below.

If a PAR is submitted after the creation of a case, but prior to the filing of the mandatory FROI identifying the administrator responsible for handling the claim, the Board may direct the request to an administrator that has been designated by the carrier or SIE as handling all or a portion of its claims. In this instance, the administrator still has eight business days to respond. If a PAR is submitted after the mandatory FROI filing is due, and no FROI is filed, the Board may issue an Order of the Chair or Notice of Resolution approving the requested treatment.

A response to MTG Confirmation PAR must be submitted within eight business days. Failure to timely respond may result in approval of the requested treatment by an Order of the Chair. Failure to timely respond can result in penalties. OnBoard will not automatically confirm if treatment is consistent with the MTGs or not. The Level 1 reviewer will need to review the request and respond based upon the specifics of the individual claimant's case. If the carrier, SIE, or third-party administrator agrees that the requested treatment is consistent with the Guidelines or is medically necessary it can respond. Any denial or partial approval must be reviewed by a carrier's physician, unless the case is closed, disallowed, cancelled, controverted, or where ongoing medical treatment has been resolved by a Section 32. When a PAR is denied or partially approved, any other basis for denial must be asserted or deemed waived. An approval that concedes medical necessity but does not affirm the approved medical treatment will be paid at the fee schedule rate, must be reviewed by the carrier's physician. Any denial issued by anyone other than the carrier's physician will not be valid and the requested treatment may be approved. An invalid denial can be subject to penalties.

If medical necessity is conceded, a PAR may only be granted without liability only if the case has been controverted, or if the medical care is for a body part or condition that has not been accepted or established. If the claim is controverted or if the time to controvert the claim has not run out and the carrier, SIE, or administrator agrees the treatment is consistent with the Guidelines or is medically necessary, that response shall not be construed

as an admission that the body part or condition is compensable or that the carrier, SIE or third-party administrator is liable for payment.

When a PAR is denied without review by the carrier's physician there will be no review by the Medical Director's Office. A claimant can request review by filing an RFA that demonstrates the basis for the denial is not factually accurate. The Board will respond by letter or referral for adjudication.

If the requested treatment is denied as not being consistent with the MTGs, the treating provider may elect to submit a Variance PAR, or submit a request for review by the Medical Director's Office. The request for review by the MDO must be done within 10 calendar days of the date of the denial. The Medical Director's Office will then rule on whether the requested treatment is consistent with the MTGs and issue a Notice of Resolution, setting forth the ruling and the basis for the ruling.

A carrier, SIE, or third-party administrator may not dispute a bill on the basis the treatment was not consistent with the MTGs if they granted the PAR, the Board issued a decision approving the treatment, or an Order is the Chair was issued approving the treatment.

Non-MTG Under or Equal to $1,000.00 PAR (U1K)

A Non-MTG Under or Equal to $1,000.00 PAR may be submitted by a health care provider to seek authorization for treatment/tests costing $1,000.00 or less with no applicable Medical Treatment Guidelines. A Non-MTG Under or Equal to $1,000.00 PAR is optional for a health care provider, but if one is submitted a response is mandatory.

A Non-MTG Under or Equal to $1,000.00 PAR follows the same requirements and procedures as a MTG Confirmation PARs, including the eight-business day deadline for response.

If the carrier, SIE, or administrator denies that the requested treatment is causally related or medically necessary, the treating provider may submit a request for review. If a request for review is received, the PAR will be referred to conciliation for a determination as to whether the treatment is causally related or medically necessary. A Proposed Conciliation Decision will be issued setting forth the ruling and the basis for the ruling. The claimant, carrier, SIE, or administrator can object to the Proposed Conciliation Decision within 30 calendar days. The treating provider cannot object to the Proposed Conciliation Decision.

Non-MTG Over $1,000.00 PARs (O1K)

The Non-MTG over $1,000.00 PAR must be submitted for all request for treatment costing over $1,000.00 for non-MTG body/parts conditions. A Non-MTG Over $1,000.00 PAR falls under 12 NYCRR 325-1.4, which is entitled "Authorization for Special Services," however, this section of the regulations does not apply to Special Services PARs. Special Services PARs fall under 12 NYCRR 324.3 which discusses the variance process.

If the PAR is related to an established site or condition, an IME must be conducted within 4 days if the claimant is hospitalized, or 30 days if the claimant is not hospitalized. If a PAR is submitted prior to the creation of a case, the Board will promptly review the PAR to identify the proper carrier, SIE, or administrator. Upon identification, the PAR will be sent to the proper carrier, SIE, or administrator who will have 15 calendar days, or 30 calendar days if an IME is being obtained to respond. If a PAR is submitted after the creation of a case, but prior to the filing of the mandatory FROI identifying the administrator responsible for handling the claim, the Board may direct the request to a third-party administrator that has been designated by the carrier or SIE as handling all or a portion of its claims. In this instance, the administrator still has 30 calendar days to respond. If a PAR is submitted after the mandatory FROI filing is due, and no FROI is filed, the Board may issue an Order of the Chair or Notice of Resolution approving the requested treatment.

A response to a Non-MTG over $1,000.00 PAR must be submitted within 30 days. If a response is not submitted within 30 days, the request will be deemed authorized and the carrier, SIE, or administrator will be liable for the cost of the treatment/service. An Order of the Chair may be issued authorizing the request or requiring the carrier, SIE, or administrator to provide written authorization, if needed by the claimant to secure the treatment/service. The carrier, SIE, or third-party administrator must send the claimant notice of the approval, partial approval, or denial of the PAR. Failure to do so can result in penalties. If a request is denied, the carrier, SIE, or third-party administrator must submit the written response with the IME report or record review. If the IME report or record review is already in the Board file, the carrier, SIE, or third-party administrator should not submit the report but should identify the report by providing the name of the IME physician who gave the conflicting opinion, the date of the report, and the date it was received by the Board. Upon a timely denial with a report offering conflicting medical, the Board will order the claim into the Expedited Hearing Process, with an Expedited hearing to be scheduled within 30 days.

If a carrier, SIE, or administrator wishes to obtain an IME prior to responding to the PAR, and the claimant fails to attend an IME, the carrier, SIE or administrator may file the form prescribed by the Chair along with the supporting evidence showing the claimant failed to attend the IME. Upon receipt, Board will order the claim into the Expedited Hearing process, with a hearing to be scheduled within 30 days on the PAR and the claimant's failure to attend the IME.

A carrier, SIE, or administrator may deny a request without an IME when the case is closed, disallowed, canceled, or if ongoing medical treatment is resolved by a Section 32 agreement. If a request is denied without an IME, there will be no review by the Medical Director's Office. A claimant can file an RFA that demonstrates the basis for the denial is not factually accurate. The Board may respond by letter or by referral for adjudication.

If a treating provider provides treatment or a special service to more than one body part or condition, or more than one treatment or special service to the same body part, such treatment or special service will be considered separate and not require a PAR if they individually cost less than $1,000.00. If the treatment or special services are a series of related treatment or care, or part of a battery of related tests, the aggregate amount of such treatment, care or tests will be considered a single request and will require a PAR if the aggregate amount is more than $1,000.00.

If a treating provider wishes to obtain a consultation with a specialist, surgery, physiotherapeutic or occupational therapy procedures, x-rays, or special diagnostic laboratory tests costing more than $1,000.00, or it is necessary to for a physical or occupational therapist to continue physiotherapeutic or occupational therapy procedures prescribed by the treating provider costing more than $1,000.00 AND the claim is controverted, the time to controvert the claim has not expired, or the body part or condition has not been established, the treating provider shall submit a PAR. Authorization of such a request is limited only to the question of medical necessity and should not be construed as an admission that the body part or condition is compensable. If an Order of the Chair due to failure to timely authorize or deny the requested treatment, the carrier, SIE, or third-party administrator will not be responsible for the payment of the requested treatment until the question of compensability is resolved, and then only if the claim is compensable.

MTG Variance PAR (MG2)

The MTG Variance PAR must be used for requests for treatment/tests that vary from the Medical Treatment Guidelines, such as when a treatment, procedure or test is not recommended by the MTGs but the health care provider determines it is appropriate for the claimant and medically necessary. The burden of proof is on the health care provider to show the requested treatment is appropriate and medically necessary. However, a variance PAR cannot be denied on burden of proof grounds without review by the carrier's physician. An MTG Variance PAR is also required for any second or subsequent performance of the same procedure because of failure or incomplete success of the same. A second or subsequent performance of the same procedure was previously required to be requested by a C-4H.AUTH.

The health care provider must submit all necessary medical documentation to support the PAR at the same time the PAR is submitted, which can include literature from peer-reviewed and recognized medical journals to support their request The provider must answer all questions on the PAR by completely and clearly providing information that includes:

- A medical opinion from the treating provider that includes the basis for the opinion that the requested treatment is appropriate for the claimant and medically necessary;
- A statement that the claimant has been informed the variance has been submitted and that the claimant agrees to the requested treatment;
- An explanation as to why alternatives under the MTGs are not appropriate or sufficient;
- If appropriate, a description of any signs or symptoms that have failed to improve with previous treatment that was in accordance with the MTGs;
- If appropriate, if the PAR involves frequency or duration of a particular treatment, a description of the functional outcomes, to date, that have shown to continue to demonstrate objective improvement from the requested treatment and are expected to continue to improve further if the requested treatment is approved.

A carrier, SIE, or administrator must respond to a Variance PAR within 15 calendar days of receipt of request. If obtaining an IME or records review, the provider and the Chair must be notified within 5 business days through OnBoard, and then the time frame for response is extended to 30 calendar days from the receipt of the request. The response is still due within 30 days. Claimants must be sent notice of any approval, partial approval, or denial. If there is no response to a PAR, if the response is untimely, or in the absence of one of the designated exceptions, the response fails to include a written report or identify it within the Board file, the variance may be deemed approved by an Order of the Chair. The Order of the Chair will not be appealable. If a substantially similar PAR is submitted, the failure to timely deny such a request will not result in the PAR being deemed approved and an Order of the Chair will not be issued.

If the claimant fails to attend an IME without reasonable cause, the PAR should be denied. If the claimant requests review of the denial of the PAR based upon their failure to appear, a request for review must be submitted within 21 days of receipt of the denial by the claimant. If it is determined that the claimant's failure to attend the IME is found to be for reasonable grounds following review, the carrier, SIE, or third-party administrator will have 15 calendar days from the filing date of the decision to respond or 30 calendar days if obtaining an IME.

A PAR response must state whether the PAR has been granted, denied, granted with respect to medical necessity but with liability for payment withheld, or partially granted. Any denial or partial approval issued by anyone other than the carrier's physician, except for the instances outlined on page 4 will not be considered valid and the request may be approved. Invalid denials may be subject to penalties. Denials or partial approvals on burden of proof grounds and those conceding medical necessity but not affirming the treatment will be paid for at the fee schedule rate need to be reviewed by a physician. A denial must state the basis for the denial in detail. If the PAR is partially granted, the response must specify the medical treatment, procedure or test that has been granted. When the denial is based upon an IME, the IME should be identified if already submitted to the Board by the document ID number.

If medical necessity is conceded, a PAR may only be granted without liability only if the case has been controverted, or if the medical care is for a body part or condition that has not been accepted or established. If a claim is controverted or the time to controvert has not expired, and PAR is granted or partially granted, such a grant is limited to the question of appropriateness and medical necessity, and shall not be construed as an admission that the body part or condition is compensable or that the carrier, SIE or third-party administrator is liable for payment. Unless a PAR has been properly denied or granted as to medical necessity with liability withheld, payment for the requested medical care at the fee schedule cannot be objected to. Any such objections will be rejected by the Board and penalties imposed.

If a PAR is denied without review by a carrier's physician, when applicable, there will be no review by the Medical Director's Office. A claimant may request review by filing an RFA that demonstrates the basis for the denial is factually inaccurate. The Board can respond by letter or a referral for adjudication.

Upon receipt of a denial or partial approval of a PAR by the carrier's physician, the treating provider may request review of the denial by the Medical Director's Office within 10 calendar days of the of the denial. When a denial or partial approval is based upon an IME, the medical provider may request review by the Medical Director's Office, unless an RFA is filed by the claimant. If the request is not received by the Board within 10 calendar days, the denial of the PAR will be deemed final. The treating provider must submit the request for review with all documentation submitted in support of its initial request, and the denial or partial approval issued following the request.

If a denial is based upon the carrier's physician's review AND if the basis for the denial was that the PAR was submitted after the medical care was rendered, the request is substantially similar to a request that has not yet been denied, or the request is substantially similar to a request that has been denied and does not contain any additional documentation or justification, the request for review shall be submitted to the Medical Director's Office.

A claimant can request review of a Medical Director's Office Decision or denial by the carrier's physician by filing an RFA that demonstrates the treatment is medically necessary. The filing of an RFA following denial by the carrier's physician will render a request for review by the medical provider to the Medical Director's office moot and a decision on the denial will be made by adjudication. The Board will respond with a letter, or referral for adjudication, including use of the expedited hearing process.

MTG Special Services PAR (SS)

The MTG Special Services PAR falls under 12 NYCRR 324.3, which is which is entitled "Variances." While this section of the regulations is entitled "Variances," it specifically outlines when an MTG Special Services PAR is required. An MTG Special Services PAR must be submitted for all requests for special services as required per the Medical Treatment Guidelines. This includes the following: lumbar fusion; artificial disc replacement; vertebroplasty; kyphoplasty; electrical bone stimulation; osteochondral autograft; autologous chondrocyte implantation; meniscal allograft transplantation; knee arthroplasty (total or partial); spinal cord pain stimulators; intrathecal drug delivery (pain pumps); sacroiliac joint fusion; and, peripheral nerve stimulation. Previously, any request for a second or subsequent performance of the same procedure because of its failure or incomplete success was requested via C-4AUTH. However, unlike the other procedures listed above, an MTG Special Services PAR is not required. Instead the provider must request such a subsequent or second procedure with an MTG Variance PAR.

As the MTG Special Services PAR falls under the same regulation as the MTG Variance PAR, it follows the same procedural requirements.

Comments and Recommendations

There are some obvious inconsistences between the regulations and the Board's implementation of the PAR process through OnBoard. One notable example is the blanket use of a three-level review process for all PAR types, when a three-level review process is only specifically outlined in the regulations for medication PARs. The most problematic aspect of this blanket implementation is that for all PAR types, exception Medication PARs, a denial at Level 1 does not extend or restart the deadline for response. Accordingly, it is imperative that all PAR requests are reviewed promptly at Level 1 to determine if the request should be granted or sent for review by a physician. Therefore, in the event an assigned Level 1 Reviewer is out of the office, expected or unexpectedly, we strongly recommend having a process in place to ensure any PARs will be reviewed by another individual in that person's absence. With

the unreasonably short deadlines for response, or even for notification of an IME, having a PAR sit for a day or two could be problematic.

In terms of the deadlines, the most unreasonable is the 4-day deadline for Medication and DME PARs. In that regard, another inconsistency in the Board's online training materials is its indication that General Construction Law § 25-a, which extends any deadline falling on a Saturday, Sunday, or public holiday to the next business day, applies to DME PARs but the materials do not specify same for Medication PARs. However, it would be our position that General Construction Law § 25-a applies here. The regulations for both simply indicate four calendar days and absent some intent otherwise, there would be no reason why General Construction Law § 25-a would not apply.

A notable difference, albeit not necessarily inconsistent, is that while the deadline for Medication PARs resets upon the health care provider's submission of a request for a Level 2 review, the timeline does not reset for DME PARs. Therefore, both the initial Level 1 Review and the Level 2 review by physician must be completed within 4 calendar days.

The 8-day business day deadline for MTG Confirmation PARs and Non-MTG under $1,000.00 is also problematic. An inconsistency in the regulation is that there seems to be an extension of time to 15 days or 30 days if one intends to get an IME or record review but only when the PAR is submitted prior to the creation of a case. We suspect that that was simply an error in the drafting of the now adopted regulation and it would be best to simply respond within eight business days.

When reviewing any PAR it is crucial to raise any other (non-medical) defenses at the outset. This can include causal relationship, new accident/injury, etc. It may be a good idea to make specific files notes on each claim of any pertinent issues/facts to allow for quick review of PARs. This could include previously denied procedures, whether there has been a finding of MMI, apportionment, causal relationship concerns, weaning directions, etc. That said, while carriers, SIE and third-party administrators have in the past generally been able to raise these types of issues, some of the Board's guidance and regulations suggest these types of issues can only be raised if the case is not yet established in the time to controvert is not expired, or if the body site or condition is not established or accepted.

There is inconsistency between the regulations when it comes to handling of PARs for controverted claims and controverted body sites and conditions. The regulation for MTG Confirmation PARs indicates that if the claim is controverted or the time to controvert has not yet expired, agreeing that medical care is consistent with the Guidelines is not to be construed as an admission of compensability, and the carrier, SIE, or administrator is not liable for payment until the claim or condition is established. The MTG Confirmation regulation is silent on whether a carrier, SIE, or administrator will be liable of the cost of treatment in a controverted claim or for an established site or condition, if there is no response to a PAR and an Order of the Chair issued. It does state that a carrier, SIE, or administrator may not dispute a bill on the basis the treatment was not consistent with the Guidelines, or that it was not causally related or medically necessary if the PAR was approved, the Board issued a decision approving it, or an Order of the Chair was issued.

The regulation for Non-MTG Over $1,000.00 PARs provides that if a claim is controverted or the body part or condition is not established, authorization of a Non-MTG Over $1,000.00 PAR is limited to only a question of medical necessity and shall not be construed as an admission of compensability. The same subsection goes on to state that in the event an Order of the Chair is issued in a controverted case for failure to timely respond, the carrier, SIE, or administrator shall not be responsible for the payment until the question of compensability is resolved and then only if the claim is compensable. This does not explicitly state it is applicable in the event a claim is established but a body part or condition is controverted. It is unclear if the Board will treat responsibility for payment of services authorized by an Order of the Chair differently in a controverted claim as compared to an established claim with a controverted body site or condition.

The regulations for MTG Special Services PARs, DME PARs, and MTG Variance PARs indicate that if medical necessity is established, but the claim is controverted or the body part or condition has not been accepted or established by the Board, a PAR can be granted without prejudice. The grant without prejudice must still be completed by a physician. This requires reference to a FROI-04 or SROI-04 in a controverted claim. In the instance of an established claim with a body part or condition that has not been established by the Board or that has not been accepted without or without liability on a FROI or SROI, reference be made to the FROI or SROI.

Therefore, carriers, SIEs, and administrators should be mindful of the body sites that they are listing on FROIs and SROIs. They should only list body sites they are accepting and the claimant is treating for, not just claiming or complaining of.

In the instance of an Order of the Chair being issued for a failure to respond to a MTG Special Services PARs or a MTG Variance PAR, where the claim is controverted or the time to controvert has not expired, the regulation provides that a carrier, SIE, or administrator will not be responsible for the payment until the question compensability has been resolve. Here again, this provision of the regulation only references when the claim is controverted, not when a body part or condition is controverted.

The regulation pertaining to DME PARs is silent on responsibility for payment in a scenario where an Order of the Chair is issued and the claim is controverted or the body site or condition is controverted. It simply states that if an Order of the Chair is issued for failure to timely respond to a PAR, a carrier may not object to payment. In a separate subsection, the regulation states that unless a carrier, SIE, or administrator has properly denied or granted as to medical necessity but withheld liability for the claim, the carrier may not thereafter object to payment for such DME. It is unclear if this applies to payment for DME authorized by an Order of the Chair but for a controverted case or a condition not yet accepted or established.

The regulation for Medication PARs is makes no mention of the procedure for responding in the event the claim is controverted or the body site or condition is controverted. Nor is there any mention of responsibility for payment in the event the claim is controverted or the body site or condition is controverted.

It is entirely unclear if the Board will treat responsibility for treatment and payment for treatment differently if the case is established, the body site or condition is established, but there is a valid question of causal relationship such as in the case of evidence of a new accident.

It is our understanding that Level 2 reviewers, will only be able to see what is viewable in OnBoard. It does not appear that Level 2 reviewing physicians will have access to the entire electronic case file, as an IME physician would. Therefore, if there is any information that the Level 2 reviewing physician should be made aware of, such as a body part or condition not being established, a weaning direction or a new accident to name a few, that should be included in the Level 1 response. We do not see another mechanism that would allow for a Level 2 reviewing physician to be made aware of these issues.

All PAR types, except Medication PARs, require that claimants be notified of any response to a PAR, including IME Request Notifications. Neither the regulations, nor the Board's guidance provide any mechanism of how notification is supposed to be sent. Therefore, we assume the default is postal mail, unless a claimant has indicated that they will accept notification via email.

As OnBoard and the PAR process is new, there is still a lot to be seen with how the Board will be handle issues that arise, as well as the inconsistencies we have outlined. Taking a proactive approach to ensure all PARs are responded to within the prescribed timeline and as required is of the upmost importance. Timely and appropriate response is the best mechanism to ensure you are not found to be responsible for costs associated with medications, treatment, services, or DME that are not medically necessarily or appropriate, are not casually related, or are not for sites or conditions that are not established.

Please feel free to contact attorney Maila Hazen at mhazen@hwcomp.com or attorney Renee Heitger at rheitger@hwcomp.com with any questions or if you wish to discuss any aspect of these amended regulations and associated changes.

Very truly yours,

HAMBERGER & WEISS LLP