



STATE OF NEW YORK
INSURANCE DEPARTMENT
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Eliot Spitzer
Governor

Eric R. Dinallo
Superintendent

June 1, 2007

Honorable Donna Ferrara
Chair
Workers' Compensation Board
20 Park Street
Albany, New York 12207

Dear Ms. Ferrara,

In his March 13, 2007 letter, Governor Spitzer directed the New York State Department of Insurance to examine the resolution of disputed cases at the Workers' Compensation Board (the "Board") and to design methods for resolving them within ninety days from dispute.

After numerous meetings with our advisors, an examination of disputed case data, discussions with stakeholders who utilize the system, and observations of the current hearing process, we have developed a series of administrative and regulatory recommendations that will accelerate the resolution of these disputed cases. This letter contains a summary of our recommendations. For those recommendations that require a change in existing regulations, we have enclosed a draft of proposed regulations for your review.

Existing Delays in the Workers' Compensation System

Statistics from the Board paint a picture of a system where there are significant delays in adjudicating disputed cases, and the unproductive use of hearing time. It takes over 200 days to resolve a claim from the point of dispute. During this period, the injured worker may be receiving no indemnity or medical benefits from any source, and medical providers may not be paid for the worker's medical care. Delays in receiving indemnity payments cause economic hardship. Delays in medical benefits can affect the workers' long-term medical prognosis and the ability to return to work. Thus, it is of critical importance to resolve these cases as quickly as possible.

Under the current system, the information necessary to evaluate claims and defenses is often unavailable until the parties attend a pre-hearing conference – an average of 75 days after the Board indexes or docket the claim. Indeed this can be the first time that the parties meet face-to-face, and the first opportunity for the parties to discuss settlement and determine what discovery is needed. In 2004 and 2005, about 48 percent of the disputed claims were resolved at the pre-hearing conference, and about an additional 20 percent were resolved without taking testimony after the first and second hearings following the pre-hearing conference. It takes almost three hearings for a claimant to establish a disputed claim. In the 20 percent of cases that take more than three hearings, the average number of hearings is five. It can take up to 90 days to schedule each additional hearing.

Summary of Proposed Reforms

Our recommended regulatory reforms will significantly accelerate resolution of disputed cases and should on average result in resolving them within 90 days or less of the dispute. This will cut the time by more than half for the resolution of disputed claims.¹

These proposed reforms are as follows:

- For the insurer to make an informed decision about whether to dispute or accept a claim, the claimant, treating physician, and employer will be required to use enhanced forms to provide increased disclosure about the specifics of the claim, the medical treatment received and any relevant prior injuries. The Board will not docket or index a claim for expedited resolution until this information is received.
- The carrier will be required to provide a fact specific basis for defenses when it disputes a claim. Ample disclosure will obviate the need for “protective defenses” that have questionable merit.
- Throughout the process, attorneys for both the claimant and the carrier will be required to certify their filings to promote full and accurate disclosure.

¹ A timeline reflecting these benchmarks is attached to this letter.

- A pivotal threshold issue--the determination of prima facie medical evidence--will be made within days after a carrier disputes a claim.
- With the benefit of fuller disclosure, early mediation for purposes of settlement will be required and should be significantly more effective.
- The requirement that every represented party submit a pre-hearing statement will now be enforced, and failure to file will have real consequences. The statement will be designed to assure that the parties are in a position to prepare for trial and the judge is in a position to schedule and hold the trial.
- At the time of the pre-hearing conference, all discovery will be complete, medical reports filed, and unsupported defenses waived. Thus, the case will be trial ready.
- With all the parties present and the case trial ready, the first hearing for the claim will begin minutes after the end of the pre-hearing conference. Testimony from the claimant and all lay witnesses will occur at this hearing.
- The final hearing, if necessary, will occur no later than 40 days after the first hearing for the purpose of cross-examination of medical witnesses whose testimony is not taken by deposition. This will allow sufficient time to notify and schedule medical professionals and increase the likelihood that they will be able to appear at the final hearing.
- A decision will ordinarily be issued from the bench at the conclusion of a final hearing, or within ten business days from the close of evidence.
- Adjournments will be strictly regulated, and limited to extraordinary circumstances supported by affidavit.

The Streamlined Adjudication Process

The following sections provide a detailed discussion of these proposed changes, and a description of how each change is precisely designed to create meaningful time savings during the workers' compensation adjudication process.

We have set specific time benchmarks for each stage of the proceedings, accelerated the time when evidence must be submitted and testimony taken, and required professional representatives and medical providers to meet their responsibilities in a timely fashion, with consequences for not doing so.

Another theme that runs through many of our recommended regulations is reducing the number of cases that are disputed and ultimately must be decided. Early enhanced disclosure is one route to that end. Another route to early resolution is settlement. A

number of recommendations encourage it. Early settlement not only preserves resources and reduces the adjudication system costs, but importantly, it delivers earlier to the claimant the payment of indemnity and medical benefits.

Preliminary Matters and

Timeline: *Enhanced Form Disclosure*

There are three forms that are filed with the Board, which can supply a great deal of information about a claim: an Employer's Report of Work-Related Accident/Occupation Disease ("C-2"), an Employee's Claim for Compensation ("C-3"), and an Attending Doctor's Report and Carrier/Employer Billing Form ("C-4").

An employer must file a C-2 after learning of an accident. A treating medical provider must file a C-4 after first rendering treatment and at subsequent intervals. Claimants will file a C-3 in order to initiate a claim.

Currently, these forms do not provide insurers with sufficient information about the claim.² From the perspective of a form filer, these forms are intimidating. Questions on them are often unclear, disjointed, and offer little space for complete answers. If these forms requested more information in a user friendly manner, there would be greater disclosure, which would mean that claims could be investigated more quickly and the number of disputed cases reduced.

Consequently, we recommend that the Board redesign these forms. This redesign process should include careful consideration of any information that should be requested from the form filer in order to provide clear, comprehensive and relevant disclosure.³ The Board should retain experts to assist in designing the forms, hold focus groups with stakeholders, and conduct field tests to make sure that the forms enhance disclosure without compromising claimants' access to the workers' compensation system.

Releases for medical records and previous claims filed with the Board are often not provided until the pre-hearing conference. As do many other states, we would recommend claimants be required to provide a limited release for relevant medical records and prior claims filed with the Board. This release should provide access to any past history of complaints or treatment of a condition similar to that presented in the claim or other conditions that may be related to the injured body part.

Requiring releases at the onset of a claim will eliminate the significant delay that often exists before insurers can fully evaluate the merits of a claim and schedule a medical examination of the claimant.

² The term "insurer" in this letter refers to private insurers, the State Insurance Fund and self-insured employers.

³ For the C-2 to fulfill this objective, it should be expanded to include information that would also be on the C-3. In examining forms from other jurisdictions, we were particularly impressed with the clarity, ease of use, and comprehensiveness of the employer, injured worker, and medical reports promulgated by the Ontario Workplace Safety and Insurance Board. We recommend that the Board use them as a point of reference in any form redesign project it undertakes.

A Revised Indexing System

The Board will currently docket or “index” a case based upon the filing of a C-2, a C-3, a C-4, or a form entitled Notice that Compensation is Controverted (“C-7”). Once a case is indexed, the insurer has twenty-five days to dispute or controvert⁴ the claim. By Board regulation, this must be accomplished through filing a C-7. Failure to controvert bars the insurer from asserting certain defenses to the claim, including that the injury did not arise out of and in the course of employment.

Under the current system, the insurer may have no factual or medical information about the claim that will permit it to make an informed judgment about whether to controvert it. Insurers often file what are called “protective” C-7s in order to preserve legal defenses. These C-7s often contain a summary laundry-list of defenses. Once a C-7 is filed along with a medical report referencing an injury, the case is then scheduled for a pre-hearing conference.⁵

It is generally not until the pre-hearing conference that the parties may learn for the first time the facts supporting the claim and any defenses to it. In practice, this means that pre-hearing conference time is wasted on cases that could have been easily settled beforehand or on needless adjournments for the parties to continue to gather information and prepare the case for a hearing.

Our recommended regulation provides that the Board only index a case for a pre-hearing conference where there is a signed limited release, a fully completed C-2 or C-3, and a C-4. A case should be only considered a controverted case where a C-7 is filed after these documents have been received.

These procedural changes coupled with enhanced C-2, C-3, and C-4 disclosure should enable insurers to promptly investigate cases, stop non-specific defenses due to inadequate disclosure, and eliminate unnecessary hearings. This approach has the added benefit of implementing in a principled manner the legal requirement that a “claim for compensation” must be filed with the Board.

Day 1: *An Enhanced Notice of Controversy*

In completing a Notice that Compensation is Controverted or a C-7, an insurer is currently required to clearly state defenses raised with an explanation of the reasons for the controversy, but no penalties are imposed for non-compliance. In its current form, the C-7 form contains little space to do anything more than name the defense the insurer is raising. The predictable result is C-7 filings that recite a litany of defenses unanchored to any specific factual allegations.

⁴ Under the Workers’ Compensation Law, a controverted claim is one where the insurer argues the claimant has no right to compensation whatsoever.

⁵ This phenomenon is evidenced by the fact that in 2006, there were over 14,000 controverted claims where the C-7 was filed before receipt of a C-4 or other medical report.

The recommended enhanced forms respecting the claim are well-calculated to provide the insurer with sufficient information to investigate the case and develop defenses before determining whether to accept or controvert the claim. We propose a regulation that eliminates the use of non-specific defenses in a C-7 and recommend a revised C-7 form that provides ample space to specify the basis for defenses. Additionally, there must be a certification that there is evidentiary support or likely to be so, for the controversion and any asserted defenses. The C-7 will be accompanied by an identification of relevant documents in the employer's possession. These improvements should provide claimants with information that is at present typically not provided until later in the adjudication process and should serve to accelerate settlements and refine disputed issues so that hearing time can be used efficiently.

An Enhanced Attorney Retention Statement

Any attorney or licensed representative who represents a claimant before the Board must file a notice of retainer with the Board. In controverted cases, a large proportion of attorneys and licensed representatives enter the case within 20 days after it is indexed. Because they have had an opportunity to thoroughly familiarize themselves with the claimant's case, these legal representatives are in the best position to make sure that a C-3 has been filed and to know whether or not the C-3 already on file has been completely filled out.

Specifically, we propose that the claimant's attorney or licensed representative file along with a notice of retainer (1) a C-3 if none has been previously filed or (2) an amended C-3 if any information on the original C-3 is inaccurate, incomplete or in need of supplementation, and (3) an identification of relevant documents in the possession of claimant or claimant's representative. For any C-3 that is filed, the attorney or licensed representative must file a certification, like that on the C-7 filed by the insurer, that any allegations asserted in the C-3 have evidentiary support or are likely to have evidentiary support.

Day 6: *Early Review of Prima Facie Medical Evidence*

Prima facie medical evidence ("PFME") is a medical report by an attending medical provider that gives a history of the accident or occupational disease and a statement that the claimant's injury is causally related to the accident or occupational disease. Unless a claimant submits PFME, the claim for compensation cannot go forward. Discussions with Board judges and other practitioners indicate that determining PFME is an extremely common source of adjournments and other delays.

The new workers' compensation law requires a "medical report referencing an injury" before a pre-hearing conference can be scheduled. The intent of this requirement is to avoid the frequent delays that presently occur where a pre-hearing conference needs to be rescheduled because the claimant has yet to produce PFME.

This new legislative provision should be implemented by having the Board determine PFME before the pre-hearing conference is scheduled. By deciding this threshold issue early in the case, only cases that are ready to be tried will be placed on the pre-hearing conference calendar. Consequently, we have submitted a proposed regulation that requires a judge to review all medical reports that are filed in controverted cases and to issue a decision on PFME within five days of a C-7 filing.

Day 20: *Early Mediation of Controverted Cases*

Our proposed changes will provide more information to the parties as early as possible in the life of a claim. This means that cases that are currently settled at the pre-hearing conference or in subsequent hearings should now be able to be settled before the pre-hearing conference even occurs. Consequently, we propose a regulation that requires parties to consider settlement early in the process. After an interlocutory finding of PFME and at least 25 days before the pre-hearing conference, the parties will be required to engage in settlement discussions under the direction of a Board mediator.

Day 31: *Enhanced Pre-Hearing Conference Statements*

By Board regulation, represented parties are required to file pre-hearing conference statements noting all of the specific issues in dispute and attach a limited number of documents to them.⁶ Since there is no penalty for failing to file a conference statement, this regulation is honored more in the breach than the observance, and parties very rarely file these statements.

In order to rectify this problem and to enhance the value of the pre-hearing statement, we have drafted a proposed regulation that requires that the pre-hearing conference statement include more detailed information and an exchange of *all* relevant documents so that the parties can prepare for trial, and the judge at the pre-hearing conference can precisely identify the issues in dispute and schedule their prompt resolution. This regulation will also allow the judge to impose penalties for failing to properly complete this form, including precluding defenses and a mandatory reduction in the fee of claimant's representative, unless the affected party can demonstrate good cause for the omission.

Day 45: *A Streamlined Pre-Hearing Conference*

The pre-hearing conference is intended to make sure that the claim is ready to be adjudicated. However, because there is currently so little up front disclosure, the pre-hearing conference has degenerated into a forum where the parties first learn about the facts of the case and schedule further discovery. Our proposed regulation is designed to assure that the pre-hearing conference is used in the way in which it was intended—as a

⁶ The claimant's statement is required to be accompanied by a C-3 and a completed C-4 or prima facie medical report giving a history and diagnosis and opinion as to causal relationship. The insurer's statement is to be accompanied by a C-2 and any medical reports which the insurer has in its possession. No other documents are required to be exchanged.

grant a judge an additional 15 days to render such decisions where a judge makes these findings on the record.

Currently, many lawyers request postponement of the decision for as long as ninety days in order to file post-hearing written summations and briefs. Review of these filings and our discussions with judges have led us to conclude that it is the rare workers' compensation case where such filings are necessary or reduce the likelihood of judicial error. Thus, we propose a regulation that will only allow a short ten day period to submit these materials where a judge finds, on the record, that the case involves a novel issue of law or unusually complicated factual situation.

A Stringent Adjournment Standard

A hearing system designed to speed the resolution of controverted claims will not work if adjournment rules are porous. Unless the parties realize that a hearing date is final, they lack a compelling incentive to make sure that depositions are finished and that all witnesses are available to testify. Currently, Board regulations do not adequately control adjournment practice. In contrast, the proposed regulation requires a legal representative to file an affidavit setting forth the basis for the adjournment requested and limits all adjournments to "extraordinary circumstances" as specifically defined.

Conclusion

We are mindful that claimants must have ready access to resources that help them participate in the system. Our recommended regulations require the employer to obtain information about the claim from the employee so that it may be filed with the Board and to provide the employee with information packets describing how to file a claim. The Board will follow up by sending an additional copy of the information packet to the employee and will establish a telephone hotline exclusively dedicated to assisting employees in filing claims, including an interactive service by which the Board obtains the relevant claim information over the telephone, inputs it on a computer form and then sends the completed form to the employee for review and signature.

We recommend that the Board expand its web site to enable employees to file claims over the internet and explore the possibility of expanding its Office of the Injured Workers' Advocate so that it will be able to provide a walk-in capability at its various offices for assistance to all unrepresented claimants throughout the adjudication process.

Finally, we recommend that the Board's calendaring system provide expedited resolution of claims made by injured workers who are not receiving indemnity payments and are having difficulty obtaining medical benefits.

We believe that the proposed reforms will much better serve injured workers who will receive benefits in a timely manner and the employers who will have reduced frictional costs that should lead to reduced premiums.⁷

In the coming months, we look forward to developing additional proposals for improving both the quality and timeliness of adjudication in other areas within the workers' compensation system as well for overarching matters that may concern the professionals who practice before and at the Board. In that connection, we will recommend a regulation implementing the newly amended Section 114-a (3) of the Workers' Compensation Law, regarding proceedings that are initiated or continued without reasonable grounds.

We trust that the highly collegial and productive dialogue and process that we have with our advisors will continue to support us in meeting the challenges.

Sincerely,



Eric R. Dinallo
Superintendent
New York State Insurance Department

cc: Honorable Eliot L. Spitzer
Honorable Joseph L. Bruno
Honorable Sheldon Silver
Honorable Susan John
Labor Commissioner M. Patricia Smith
Edward M. Bartholomew, Jr., Esquire
Charlotte Hitchcock, Esquire
Denis M. Hughes
Cathleen M. McKeown, CWCP
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⁷ These recommendations only apply to cases where claimants are represented by either lawyers or licensed representatives. There was broad consensus among interested parties that a streamlined docket for parties with professional representatives might not work well for unrepresented claimants, and that additional study was warranted in this area. In addition, because of statutory and practical considerations, these recommendations do not apply to claims where there is an uninsured employer.

Streamlined Docket Timeline

