

WORKERS' COMPENSATION ALLIANCE (WCA)

Board of Governors

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August 25, 2008

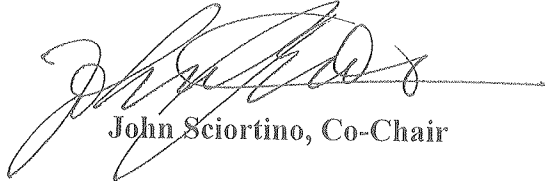
Hon. David A. Paterson
State Capitol
Albany, New York 12224

Re: Workers' Compensation Board Streamlined Docket Regulations

Dear Governor Paterson:

On behalf of the New York State Workers' Compensation Alliance (WCA), enclosed please find objections to the Streamlined Docket Regulations proposed by the Workers' Compensation Board on July 15, 2008.

Respectfully submitted,



John Sciortino, Co-Chair

JS:kw

Enclosures

cc: Administrative Regulations Review Commission
Governor's Office of Regulatory Reform
Hon. Zachary A. Weiss
Assemblywoman Susan John
Senator Joseph E. Robach
Cheryl M. Wood, Esq.

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THE “ROCKET DOCKET” PROPOSALS ARE UNWORKABLE, UNNECESSARY AND MUST NOT BE ADOPTED

(Dated 08/25/08)

Introduction

In his letter to the then-Chair of the Workers' Compensation Board dated June 1, 2007, Superintendent of Insurance Dinallo acknowledged that the Workers' Compensation system was, as a matter of necessity, intended to expedite the provision of wage replacement and medical care to injured workers. It was recognized that delays in receiving indemnity payments cause economic hardship, and delays in providing medical benefits affect the injured workers' long-term medical prospects and the ability to return to work. Because the Workers' Compensation Board was failing to accomplish this mission, the “Rocket Docket” Task Force was formed to propose regulatory change designed to reduce C-7 litigation inefficiencies and delays, thereby speeding the resolution of claim establishment defenses (benefitting claimants), while reducing claim defense costs (benefitting employers).

On July 15, 2008, the Workers' Compensation Board voted to propose modified streamlined docket regulations (colloquially referred to as the “Rocket Docket”) for publication in the New York State Register for public comment. The Workers' Compensation Alliance, a coalition of injured workers and other stakeholders committed to protecting the rights of New York's injured workers, opposes adoption of these regulations.

Rather than reducing friction opportunity and thereby shortening the process of resolving claim establishment controversies, the proposed regulatory scheme, in fact, encourages needless and baseless practices which will not only slow the resolution process but will trample the rights and interests of injured workers. This is accomplished by proposed regulations which are: (1) illegal in that they conflict with the unambiguous requirements of standing statutes; (2) ill-conceived and will likely encourage/increase litigation; and/or (3) unfair and/or overly burdensome in their application. It has also been shown that the Rocket Docket represents a co-option of the Legislature's prerogative to enact laws governing the subject matter of this excessively intrusive regulatory scheme (see statement of the President of the Injured Workers' Bar Association, July 20, 2008, copy attached).

Certain of the more glaring deficiencies existing in the proposed regulations as currently constituted are identified hereinbelow.

I.

Proposed Rule 300.37(b)

The first step in the processing of a claim by the Workers' Compensation Board is the establishment of a case file, a process known as "indexing" the claim. Under current Board practice, a claim is "indexed" upon receipt by the Board of any one of a number of documents indicating the claim involves an injury of more than a very minor nature justifying potential Board action. For example, the Board will currently always index a claim upon receipt of a C-7 notice that a claim for compensation is controverted. Prompt notice of indexing is critical to the expeditious advancement of the claim because it triggers the carrier's responsibility to, among other things, serve notice whether it is accepting or controverting the case [WCL §25(2)(a) and (b)].

Proposed Rule 300.37(b) allows for the indexing of a claim only upon the convergence of the following filings: (1) a "completed" enhanced C-2 or enhanced C-3 form; (2) a "completed" enhanced C-4 form; and, (3) a "completed" duly-executed "limited" authorization enabling the carrier to obtain "relevant" medical records.

FIRST, this proposed rule is ill-conceived because:

1. It elongates rather than shortens the Board's claim indexing--and, in turn, resolution--process, by requiring that a number of documents be properly completed and filed before the indexing of a claim can occur;
2. It complicates the claim indexing process by mandating usage of a number of prescribed forms, whereas the Board, supported by caselaw, has historically recognized that any document from which it might be reasonably inferred that a claim for compensation was being made was sufficient to constitute the filing of a claim. See, for example, *Stengel vs. Great Atlantic and Pacific Tea Company*, 14 A.D.2d 949 (3rd Dept. 1961). As the Third Department explained in *McCutcheon vs. Public Service Department*, 290 A.D.2d 679, 680 (3rd Dept. 2002), the "Workers' Compensation Law was particularly framed to avoid legal terminology and the technicalities of law pleading";
3. It fails to exclude death or other unwitnessed or unexplained accident cases, where current caselaw--relying on the §21 presumption--excuses the need for the filing of *prima facie* medical evidence [see, for example, *Barrington vs. Hudson Valley Fruit Juice*, 297 A.D.2d 886 (3rd Dept. 2002)];
4. It fails to require indexing upon the filing of C-669 notice that the claim is not disputed;
5. It discourages the prompt filing of a C-669 while the carrier waits to see whether claimant succeeds in completing the new, excessively technical filing requirements;
6. It suggests that either an enhanced C-2 or C-3 form will be required, when in practice every claim to be indexed will require the filing of a C-3--not just a C-2--because the required medical record authorization has been made a part of new C-3 form;

7. It fails to define what “relevant” medical records constitute, thereby inviting a new line of claim-delaying practices while the parties argue the matter; and,
8. It does not provide that the limited medical authorization is the exclusive authorization obtainable by a carrier, thereby inviting carriers to directly request from claimants blanket, unlimited and abusive medical record authorizations.

SECOND, proposed Rule 300.37(b) is in contradiction of statutory mandates, rendering the rule unenforceable and subject to CPLR Article 78 attack.

More specifically, **newly amended WCL §25(2-a)(a)** (applicable only to claims occurring on or after 03/13/07) provides “(i)n any controverted case” upon receipt of the carrier’s C-7, a pre-hearing conference shall be scheduled as soon as practicable, but not to exceed 45 days after the receipt by the Board of the C-7 and “a medical report referencing an injury” (emphasis added).

Simultaneously, **WCL §25(2)(a)** provides, in a claim where the employer decides to controvert claimant’s right to compensation, the employer shall: on or before the 18th day after disability; or, within 10 days after it has knowledge of the alleged accident, whichever is greater, file a C-7 notice of controversy providing, among other things, “the reason why compensation is not being paid”.

The combined effect of newly amended Sections 25(2-a)(a) and 25(2)(a) is to guarantee to the injured worker a pre-hearing conference within 45-days after the statutorily mandated filing of a C-7 and a “medical report referencing an injury”. At no instance do these statutes require filing of a C-3 or medical release form in order for the pre-hearing conference to be scheduled. As such, because the scheduling of a pre-hearing conference necessitates that the claim first be indexed, any delay on the part of the Board to index while it awaits the filing of the new C-3 and/or medical record release forms as is required by the new Board rule will infringe on the injured workers’ statutorily mandated right to a speedy pre-hearing conference.

It is beyond cavil that the Workers’ Compensation Board has no authority to adopt a rule which is out of harmony with a statute. Zalenski vs. Crucible Steel 91 A.D.2d 807 (3rd Dept. 1982); Mit vs. T.S. & M. Catering Corp., 285 A.D. 506 (3rd Dept. 1955).

For example, the Workers’ Compensation Board was recently rebuked by the New York State Supreme Court for pursuing a policy that deemed appeals from a finding of *prima facie* medical evidence to be interlocutory in contravention of the statutory mandate of Workers’ Compensation Law §23 guaranteeing the right to appeal. See, New York State Insurance Fund vs. New York State Workers’ Compensation Board, Sup. Ct., Broome County, index number 2004-0131 (03/12/04) (copy attached).

II.

Proposed Rule 300.37(b)(1)(iii)

While Superintendent Dinallo’s letter of June 1, 2007 makes clear that “early enhanced disclosure” is fundamental to the accomplishment of the accelerated resolution of claims, it is equally fundamental that the early disclosure must be of relevant information only. Certainly, to clutter the early information exchange with unnecessary and irrelevant filings will only pave the way for the proliferation

of litigation and the elongation of the claims resolution process. This concern is particularly applicable to the early exchange of medical information regarding pre-existing but non-disabling conditions.

For decades, the Appellate Division, Third Department and the Workers' Compensation Board have rightfully guarded the principle that compensation will be found even where a particular claimant suffered from some pre-existing disease or condition, as long as it is shown that the employment acted upon that disease or condition in such a manner as to cause a disability which did not previously exist. See, for example, *Perez vs. Pearl-Wick Corporation*, 56 A.D.2d 239 (3d Dept. 1977). As such, the focus for determining the compensability of a claim is justifiably on the precipitation of a disability from work, not on the initiation or precipitation of the condition itself. And, as the Third Department recently reminded, the issue of apportionment does not apply to a claimant's claim for temporary disability benefits, but may apply--depending upon the particular facts of the case--at the time permanency is determined. *Bremner vs. New Venture Gear*, 31 A.D.3d 848 (2006).

Therefore, the requirement of proposed Rule 300.37(b)(1)(iii) that pre-existing medical information be exchanged at the outset and as a condition of the indexing of a claim represents a misguided derogation of the principles enunciated by the Third Department and consistently applied by the Board the past several years.

Furthermore, rather than reducing the number of controverted claims, the heightened focus on prior medical history at the commencement of a claim will only encourage carriers to controvert claims, on the heretofore irrelevant notion that a claimant's medical condition--not disability--was initiated prior to the alleged date of injury. Again, such theory represents a fundamental shift from the long-standing rule of *Perez*, where the focus for determining the compensability of a claim is rightfully centered on the initiation of the injured worker's disability from work.

Moreover, the new-found emphasis on pre-existing medical conditions will likely beget requests for additional or otherwise irrelevant prior medical records which will further delay the resolution of the claim while: (1) the claimant defends against the provision of such unnecessary information; and/or, (2) the carrier undergoes the typically time-consuming process involved in searching for and acquiring such additional records. It is feared that these delays will be particularly profound in the absence of appropriate regulatory provisions specifying the manner in which such disputes shall be heard and resolved. Proposed Rule 300.38(f)(2)(x) is woefully inadequate in this regard. Certainly, in view of the law of *Perez*, it should be incumbent on a carrier desirous of obtaining pre-existing medical records at the outset of the claim to apply to the Board specifying the reason such records are required through specific medical opinion evidence--not simply a generalized affidavit by the carrier's representative--establishing the particular manner in which such pre-existing medical records are relevant to the particular case.

The Workers' Compensation Board has acknowledged that an employer's insistence on the production of irrelevant medical records can result in a protracted delay of the adjudication of claimant's rights. See, for example, *Eastman Kodak Company*, WCB Case No. 7041 1438 (3-Member Panel, 06/12/06) (copy attached). Irrelevant or unnecessary medical record searches also chill a claimant's willingness to pursue a claim, fearful that sensitive or embarrassing entries in medical records may be accessed by employers. And, it is impractical to expect that unrepresented claimants (claimants are typically unrepresented in the early stages of the claim) will have the ability to knowingly supply appropriate and informed medical releases, thereby raising the prospect of a proliferation of WCL Section 114-a fraud claims.

Lastly, any discussion involving the requirement of medical record authorizations must be measured in accordance with the recognized purpose of the Workers' Compensation Law, as was enunciated by the Court of Appeals in *Johannesen vs. New York City Department of Housing Preservation and Development*, 84 N.Y.2d 129 (1994), viz: "(t)he Workers' Compensation Law was enacted for socioeconomic remediation purposes as a means of protecting workers and their dependents from want in case of injury on the job".

III.

Proposed Rule 300.37(d)(1)(i)

Proposed Rule 300.37(d)(1)(i) requires that claimant's counsel certify in writing that claimant's claim has, or will likely have, evidentiary support. Beyond accepting the injured worker at his/her word, claimant's counsel has little practical ability to certify that the injured worker's claim has, or will likely have, evidentiary support. The certification requirement, therefore, is so onerous in view of the nature of standard Workers' Compensation practices and procedures that practitioners will likely be discouraged from accepting representation on controverted claims.

Furthermore, while counsel may, in the performance of the obligation to zealously represent his/her client (Disciplinary Rule 7-102), legitimately believe a claim to be justified by a reversal or modification of existing law, this provision will certainly chill counsel's willingness to appear on such innovative claims.

Unlike the carefully crafted certification provisions applicable in the Unified Court System (see 22 NYCRR130-1.1), the certification provisions of this proposed rule fail to define what is meant by "evidentiary support, fail to outline the process for determining whether a certification was wrongful, and fail to particularize the sanctions applicable in the event that a certification is determined to be defective.

IV.

Proposed Rule 300.38(g)(8)

Proposed Rule 300.38(g)(8) provides that the carrier's failure to serve and file an IME report within the requisite time frame shall constitute a waiver of the carrier's right to examine claimant; however, the proposed rule fails to provide that the failure to produce the required IME report constitutes a waiver of the carrier's right to cross-examine claimant's treating physician. There can be no justification for enabling a carrier, that has failed to produce a timely IME on the question of causal relationship, to belabor the claim by calling for the testimony of claimant's treating physician. Certainly, a carrier that has offered no contrary medical raising a triable issue cannot justify the time and expense involved in the taking of the claimant's physician's testimony.

It is widely recognized that no prejudice accrues as the result of the denial of the opportunity to cross-examine a medical expert where all experts are in agreement about the subject issue. *Torres vs. Tad Technical Services*, 193 A.D.2d 975 (3rd Dept. 1993); *Bryan vs. Borg-Warner Automotive*, 293 A.D.2d 856 (3rd Dept. 2002). Similarly, and by logical extension, no prejudice can be claimed where cross-examination is denied in the absence of direct evidence placing the issue into controversy.

The Third Department's decision in *Bryan* is particularly instructive. In *Bryan*, claimant's treating physician gave a positive opinion on causal relationship. The carrier's consultant, however, opined that causal relationship was difficult to prove or disprove. The Third Department ruled that "(i)n light of the unwillingness and/or inability of the carrier's expert to express a definitive opinion on the causal relationship issue, the unequivocal opinion of claimant's expert on that issue **was not controverted** and, therefore, no prejudice accrued as a result of the refusal to permit the carrier to cross-examine that expert on the causal relationship issue" (emphasis added) 293 A.D.2d at 857.

The Third Department has also found that no prejudice results from the Board's declination to allow a carrier to produce lay testimony. In *Potter vs. Springbrook Apartments*, 297 A.D.2d 884 (2002), the Third Department affirmed the Board's refusal to permit the employer to present testimony of a lay witness.

In *McDonald vs. John W. Danforth*, 286 A.D.2d 845 (2001), the Third Department held that a carrier does not have an absolute right to cross-examine a claimant's treating physician until the carrier has made a sufficient showing of a triable issue to overcome the presumption found at Worker's Compensation Law §21(5) [§21(5) creates a presumption that, in the absence of substantial evidence to the contrary, a claimant's medical report constitutes *prima facie* evidence of their contents].

Where a carrier has failed to raise a triable medical issue by the production of a contrary medical opinion, that carrier cannot claim any deprivation of a right to a trial by the refusal to allow that carrier to take the cross-examination of claimant's physician, since--as is true with standard summary judgment practice in the civil courts--the carrier has failed to make a showing there is anything to try.

V.

The Forms Developed to Implement the Rocket Docket are Deficient

The proponents of the Rocket Docket argue carriers must be better positioned to make an informed decision whether to accept or deny claims if delays caused by defense inefficiencies are to be reduced. It is theorized that enhanced forms providing increased disclosure about the specifics of the claim will assist in reducing the number of claims that are disputed. So important to the Rocket Docket scheme is this theory of enhanced disclosure that a claim will not even be indexed until such time as the enhanced disclosure documentation has been provided.

C-2.

The first and primary manner in which the carrier receives notice of a claim is by way of the employer's C-2 report of injury/illness [WCL §110(2)]. As such, relevant modifications to the C-2 form currently in use would significantly contribute to the goal of enhancing early disclosure. However, the C-2 revisions currently proposed fail to accomplish this goal.

Indeed, the newly proposed C-2 form:

1. Does not require the employer to provide a copy of claimant's written notice of injury;
2. Does not require the employer to provide a copy of the supervisor's written incident report;

3. Does not require the employer to provide a copy of any medical notes provided by the employee concerning the injury, the need for medical treatment, or the need for lost time;
4. Does not require the employer to comment whether the claimant was working without restriction at the time of the subject injury; and,
5. Does not mandate that the employer provide a copy of any existing written job description.

While the Workers' Compensation Board is rightfully concerned that any revisions to the current C-2 form be user friendly, all of the above-described information will be readily available to the appropriately motivated C-2 preparer, so that the inclusion of this high relevant information will not in any way prejudice the form filer's ability to swiftly complete the document. Furthermore, given that all of this information directly addresses most of the defenses raised at the outset of a claim, the absence of this information from the newly proposed C-2 form represents an inexcusable loss of opportunity and calls into question the true motivation of the Rocket Docket initiatives.

C-4.

Much has been said about the impractical length and cumbersome nature of the proposed C-4 forms. And, it is entirely premature to adopt new C-4 forms before the Medical Guidelines Task Force has completed its work. However, there is one particularly objectionable flaw existing in the newly proposed C-4 forms.

In their zeal to accomplish some measure of uniformity, the new C-4 forms ignore the fundamental premise that, to be credible, a medical opinion must be supported by a rational basis. See, *VanPatten vs. Quandt's Wholesale Distributors*, 198 A.D.2d 539 (3d Dept. 1993). This premise is particularly important to determining the comparative credibility of medical opinions on such issues as causal relationship and permanency. The Third Department, for instance, has made absolutely clear that a medical expert's conclusory opinion regarding causal relationship, offered without any medical hypothesis or rationale to substantiate said conclusion, should be rejected as speculative and without rational basis. *Ayala vs. Dre Maintenance Corp.*, 238 A.D.2d 674 (1997). And, time and again the Workers' Compensation Board has found that a medical opinion on permanency which neglects to offer a rationale which directly refers to the Workers' Compensation Board Medical Guidelines lacks credibility. See, for example, *Eastman Kodak Co.*, 2007 WL 4111626 (3-Member Panel, 11/07/07).

The proposed C-4 and C-4.2 forms fail to inform and guide the examining physician to provide the specific basis for his/her opinion in connection with such issues as causal relationship and permanency, thereby exposing the opinions offered by such forms to be ruled lacking in credibility.

VI.

The Rocket Docket Provisions are Unnecessary

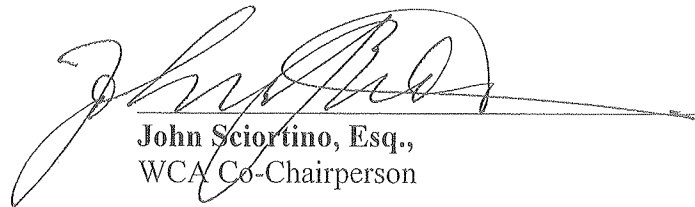
One must justifiably question the efficacy of enacting such controversial regulations as the Rocket Docket when the Workers' Compensation Board has itself recently admitted that a striking 88% of controverted claims have been resolved within the 90-day target window since January, 2008, simply by

virtue of a more stringent enforcement of existing laws and regulations (Press Release of Chair Zachary Weiss dated June 5, 2008, copy attached).

Conclusion

While certain of the Rocket Docket rules are admittedly beneficial to claimants, those rules that are offensive are so inextricably interwoven that the WCA believes the entire Rocket Docket proposal must be rejected, as to enable the Board to continue to pursue the strikingly successful initiatives it is currently undertaking to accomplish a speedy resolution of C-7 disputes through a more stringent enforcement of existing laws and regulations.

Respectfully submitted,



John Sciortino, Esq.,
WCA Co-Chairperson

JS:kw

THE ROCKET DOCKET: AN END TO LEGISLATIVE DUE PROCESS

Statement of the President of the Injured Workers' Bar Association
July 20, 2008

The proposed regulations [Subsection (a) of Section 300.1, 300.33, 300.37, and 300.38 of Title 12 NYCRR; hereinafter Rocket Docket] approved by the NYS Workers' Compensation Board (WCB) on July 15, 2008 are seriously flawed because they fail to be informed by existing statutory provisions, established case law, and legislative intent. Even more serious is the fact that the Rocket Docket is a violation of the separation of powers between the executive and legislative functions.

In its present form, the Rocket Docket suffers from conceptual and intellectual deficits, notably that its contents and processes ignore the fact that workers' compensation is administrative law and is not Civil, Criminal, nor a practice analogous in any court of general jurisdiction. The NYS Workers' Compensation Law [WCL] clearly acknowledges this reality as it is not subject to technical rules of evidence or procedure (WCL Sec. 118). Nor is the WCL subject to the State Administrative Procedure Act [SAPA] although the WCB is following SAPA for purposes of implementing the Rocket Docket as is prescribed in the WCL.

In this regard, proponents of the Rocket Docket have also failed to appreciate the current deposition practice under its jurisdiction and cure the present defects employed in deposition practice. New 300.8 (g)(11) promotes depositions at the threshold of a claim. While the WCL (Secs. 121 and 142) requires only that depositions are to "be taken in the manner prescribed by law for like depositions in the supreme court", carriers routinely continue to engage court reporters in their offices (sometimes, even from the reporter's home) as officers to administer the oath. This occurs despite appellate court decisions on the subject as well as an opinion from the Board's General Counsel [see New York Workers' Compensation Handbook, Sec. 11.02(6), 2008]. Thus, while the Rocket Docket encourages medical litigation at the threshold of a claim, the WCB routinely ignores record objections to the absence of the affirming officer's presence with the medical witnesses. Consequently, the Rocket Docket, while encouraging litigation at the threshold of a claim, fails to address its own procedural requirements with respect to depositions [letter of April 26, 2002, Office of General Counsel; see Pitts, Sec. 11.02(6)].

The present Rocket Docket crafts [and proposes to graft upon the WCL] very technical rules of evidence and procedure onto or into an administrative proceeding conceived by the Legislature to reflect the "bargain" between the injured employee and the employer. This aspect of the Rocket Docket violates both the purpose and intent of WCL Sec. 118 by introducing substantial, technical rules of evidence and procedure.

This conceptual and intellectual dissonance not only frustrates the very purpose of the Rocket Docket, *viz.* to speed the resolution of claims, but, more importantly, portends to so burden the claimant and counsel as to defeat the legislative intent of the statutory scheme.

The criteria for adoption of regulations pursuant to the Governor's Office of Regulatory Reform [GORR] are that they be balanced, well drafted, and soundly based. Those criteria are also expressed as well-conceived, not overly burdensome, and understandable. Facially, the proposed Rocket Docket fails these tests and presents a complex set of legal labyrinths that defeat its stated purpose. The proposed Rocket Docket will transform administrative and adjudicatory processes designed to benefit injured workers into a system in which only the sophisticated may partake; and, then, only with substantial legal knowledge.

GORR functions under Executive Law 20 (Signed by Governor Pataki November 30, 1995) [www.gorr.state.ny.us] which provides [Section IV], in part, that proposed regulations must generally be consistent with legislative intent.

In contrast, the Rocket Docket creates a new, specific defense to the presumptions of WCL Sec 21 by permitting – upon a mere allegation – that the accident/injury/disease is due to some pre-existing injury or medical condition. To complement this new defense, the WCB has prepared new claims forms that require the claimant and his treating physician to identify this medical information. Thus, instead of the presumptions of Sec 21 – as a matter of statute – initiating a claim for benefits, the Rocket Docket, as a mere regulation puts into play a new defense. The courts have issued hundreds of decisions on this issue and crafted a jurisprudence that, in essence, holds such pre-existing condition or injury to be irrelevant except: 1) where the employer can rebut by substantial evidence that the claim was due to other medical factors; or, 2) the claimant was under active treatment for the pre-existing condition; or 3) meets the enumerated defenses in WCL Sec 21. Otherwise, both the statute and case law hold that “the employer takes the employee as he finds him.”

This phenomenon of the state's executive primacy in workers' compensation has upended both the Legislature's historical participation and the executive-legislative relationship.

The Rocket Docket is a gubernatorial plank in the platform of workers' compensation reform. As such, it has no legislative predicate as required under Executive Law 20. Adoption of the Rocket Docket will mean that a regulation trumps the statutory provisions as well as case law. Worse, it is legislation neither reflected as the intent of the Legislature nor consistent with existing statute and case law. In fact, the Rocket Docket's origin is reflected in a letter from the Superintendent of Insurance [April 27, 2008] noting that the Department is considering “procedures to minimize the number of hearings on cases involving undisputed factual issues and identify those cases that can be decided expeditiously without the taking of live testimony.”

To the contrary, the Rocket Docket encourages factual disputes, including the taking of testimony, as it provides for a novel defense to claims under WCL Sec 21.

On June 2008, the Chair of the WCB issued a press release indicating that the agency had achieved a rate of 88% of resolution of controverted claims -- without the Rocket Docket. The agency employed existing regulations and rules in this effort. In its 2006 Annual Report, the WCB stated that it achieved a 60% rate of resolution. This raises the question as to [according to GORR's criteria] how "well-conceived" the Rocket Docket regulations are. Also, if a higher rate of resolution can be achieved without them, then, they are "overly burdensome."

Nor has there been offered by the agency any rationale, or demand, to create a novel, statutory defense. If one exists, then such must be presented to the Legislature for consideration to amend WCL Sec. 21.

When compared to the criteria of Executive Order 20, the proposed regulations are not only inconsistent with legislative intent, they substitute for legislative purpose and function. Approval of the proposed regulations for publication in the State Register places the Governor in the position of substituting gubernatorial decision making for that of the Legislature or contravening the very purpose of Executive Order 20.

Specifically, the Rocket Docket on its face is not consistent with the criteria of Executive Order 20 Sec. III, Criteria for Rules, subsections 1. (a), (b), (c), (d), (e), and (j). Sec. IV of Executive Order 20, subsections 1 o 3, provide the basis for GORR and the Governor's Office to assure that proposed regulations are consistent with legislative purpose and intent as well as insure separation of functions and powers. Absent any legislative predicate, the Rocket Docket stands to endanger state constitutional principles and is not properly a set of regulations for gubernatorial approval.

As noted with an 88% resolution rate for controverted cases without the Rocket Docket, the proposed regulations must be re-submitted to the agency with a direction to demonstrate the necessity of new regulations in light of its success in their absence. In addition, the agency must be required to demonstrate that such new regulations do not intrude upon legislative purpose or function or statutory precedent.

At a Term of the Supreme Court of
the State of New York held In and for the
Sixth Judicial District at the Broome County
Courthouse on March 12, 2004

PRESENT: HON JOSEPH P. HESTER, JR.
JUSTICE PRESIDING

STATE OF NEW YORK
SUPREME COURT :: COUNTY OF BROOME

In the Matter of the Application for a Judgment
pursuant to Article 78 of the Civil Practice Law
and Rules,

NEW YORK STATE INSURANCE FUND

Petitioner

vs.

NEW YORK STATE WORKERS' COMPENSATION
BOARD, JEFFREY R. SWEET, as Acting Chairman,
JOHN WEIGAND, DAVID MITCHELL and CAROL
BAILEY

Respondents

DECISION
INDEX NO. 2004-0131
RJI NO. 2004-0066

APPEARANCES: LEVENE, GOULDIN & THOMPSON, LLP
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HESTER JR., J.

In three separate cases, the individual respondents (hereinafter claimants) had claims pending before a workers' compensation law judge (hereinafter WCLJ). The WCLJ found in each case that the respective claimant had presented prima facie medical evidence to support their claims. In each case, petitioner filed an Application for Board Review with respondent NYS Workers' Compensation Board (hereinafter the Board) pursuant to Workers' Compensation Law § 23. The Board's Appeals Office advised petitioner that the applications were deemed interlocutory appeals and that the cases were being remanded to the district office to continue the claims before the WCLJ. On or about December 22, 2003 and shortly after the "determinations" in the three cases, respondent Jeffrey Sweet (the Board's Acting Chair) issued an announcement (subject number 04B-125) setting forth a policy that deemed appeals from a finding of prima facie medical evidence to be interlocutory. The policy prevents the Insurance carrier or employer from appealing that issue, which would not finally resolve the case, prior to a finding of liability. However, a finding that prima facie medical evidence did not exist would be a fatal determination as to the claimant and, as such, the claimant would be allowed to appeal.

Petitioner commenced this CPLR article 78 proceeding to compel the Board to accept and review appeals, by the carrier or employer, of findings of prima facie medical evidence, to issue written decisions thereon and to permanently enjoin the Board from applying the policy and procedure set forth in the announcement. The

Board answers and raises objections in point of law.¹

Petitioner argues that the Board is mandated by Workers' Compensation Law § 23 to issue a written decision which includes a statement of the facts that form the basis of its action and the failure to do so precludes an appeal to the Appellate Division, Third Department. Petitioner asserts that the Board's new policy is directly contrary to the previous procedure and is invalid because it was not properly promulgated as a new rule. Petitioner claims the determination to only review adverse findings to the claimant on the issue of prima facie medical proof is arbitrary and capricious.

The Board asserts that there is no decision on a threshold issue of liability so the determination is not final and not subject to CPLR article 78 review. The Board asserts that because the issue of prima facie medical evidence is not substantive, the Board is not bound to its prior policy of allowing interlocutory appeals. The Board claims that the issue has been preserved for administrative and court review and, therefore, petitioner has not exhausted its administrative remedies. Finally, the Board contends that the injunctive relief sought is extremely broad based and is not a proper subject of a CPLR article 78 proceeding.

Initially, the Board's argument that this proceeding is premature because the determination is not final is without merit. Although CPLR 7801 provides that a proceeding shall not be used to challenge a determination that is not final, finality is not necessary when the petitioner seeks mandamus to compel (*Matter of Hamptons Hosp. & Med Ctr. v Moore*, 52 NY2d 88, 96). This court does not have the jurisdiction to

¹ Respondent John Weigand appeared, but takes no position in this matter.

review the substance of any board determination; however, it can address broader issues in the nature of mandamus to compel (*Brooklyn Children's Aid Soc. v Industrial Bd. of the Dept. of Labor of State of N.Y.*, 136 Misc 379, *affd* 231 App Div 845, *affd* 256 NY 651). "Mandamus lies to compel the performance of a nondiscretionary, ministerial duty where there has been a showing of a clear legal right to the relief sought" (*Matter of Mitchell v Essex County Sheriff's Dept.*, 302 AD2d 732, 734).

Workers' Compensation Law § 23 provides that "[a]ny party may within thirty days after notice of the filing of an award or decision of a referee, file with the board an application in writing for a modification or rescission or review of such award or decision [and] [t]he board shall render its decision upon such application in writing and shall include in such decision a statement of the facts which formed the basis of its action on the issues raised before it on such application". Petitioner's applications were filed and, by unsigned letters in each of the respective cases, the Board's Office of Appeals determined that the issues were interlocutory and not currently appealable.² The Appellate Division, Third Department, which has exclusive jurisdiction to decide an appeal from the Board (*see*, Workers' Compensation Law § 23), also decides whether an issue is appealable in the first instance (*see*, *Matter of Montanaro v C.H. Quay & Sons*, 293 AD2d 919; *Matter of Byrne v Fall Flitting*, 266 AD2d 684; *Matter of Hutcheson v Trinity Tool & Die*, 201 AD2d 826).³ Nonetheless, the letters were not captioned as

² In each case, the letters remanded the claims to the district office for further proceedings.

³ The Board's argument that the issue of prima facie medical evidence is not a threshold legal issue and any appeal to the Appellate Division would be interlocutory is irrelevant.

"decisions" or reflect that the issue was considered by three panel members and, as such, indicate that the letters did not constitute written decisions as required by the statute (*see, Matter of Demel v Northern Telecom*, 5 AD3d 830; *Matter of Drummond v The Desmond*, 205 AD2d 711).

Workers' Compensation Law § 23 mandates that the Board issue a written decision upon a proper application by the aggrieved party (*cf., Remington Rand Inc. v Greenbush*, 277 App Div 919). Notwithstanding the general authority of the Chair to make administrative rules, regulations and orders under Workers' Compensation Law §§ 141, 152, the Board's policy as delineated in subject number 046-125 was not duly promulgated and is in contravention of the statutory mandate (*see, Matter of Hart v Pageprint/DeKalb*, 6 AD3d 947, *Matter of Mealing v Hills*, 132 AD2d 759, *re denied* 70 NY2d 612). The issuance of a written decision, without regard to its substance, is a ministerial, nondiscretionary act.

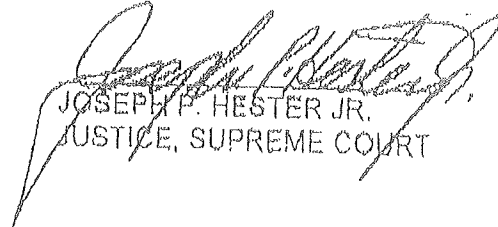
Given the above, petitioner has demonstrated a clear legal right to the relief sought. The petition is granted to the extent that the Board is mandated to issue written decisions in compliance with Workers' Compensation Law § 23 on each of the three individual claims in this proceeding. There is no basis to infer that the Board will not comply with the statutory mandate on future claims and, as such, petitioner's request for broad injunctive relief is denied.

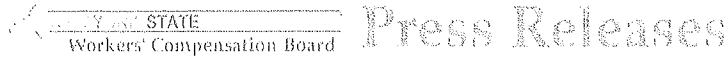
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FAX NO.

This constitutes the decision of the court. Counsel for petitioner to submit a judgment, on notice

Dated: *August*
~~July~~ 2nd, 2004
Binghamton, New York


JOSEPH P. HESTER JR.
JUSTICE, SUPREME COURT



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FOR IMMEDIATE RELEASE
June 5, 2008

Chair Zachary Weiss Statement on the Board's Efforts to Speed Claims Operations

On June 1, 2007, the New York State Workers' Compensation Board began the task of reducing the amount of time in which controverted claims are resolved from an average of about 200 days to 90 days or less. Currently, new regulations are under review to help us accomplish just that. Even though our work is not complete, the Board has made significant progress towards meeting this goal. In fact, since January of this year, 88 percent of controverted claims have been resolved within this 90-day target. As we move forward, the Board will continue to focus on improving our procedures to make sure injured workers receive fair compensation in a timely manner.

CONTACT: publicinfo@wcb.state.ny.us



LEGAL APPEALS UNIT
 WORKERS' COMPENSATION BOARD
 20 PARK ST
 ALBANY, NY 12207
 www.wcb.state.ny.us

State of New York - Workers' Compensation Board

In regard to

WCB Case #7041 1348

MEMORANDUM OF BOARD PANEL DECISION

keep for your records

Opinion By: Donna Ferrara
 Ellen O. Paprocki
 Robert M. Zinck

By Notice of Decision filed on February 14, 2006, the Workers' Compensation Law Judge (hereinafter "WCLJ") made awards for a temporary total disability for the period from November 16, 2004 until August 19, 2005 and for a temporary partial disability for the period from August 19, 2005 until November 14, 2005, directed employer reimbursement, awarded an attorney's fee to the claimant's attorney, found that surgery is authorized for a right total knee replacement as requested by the claimant's treating orthopedic surgeon, Dr. David B. Spector, M.D., directed the self insured employer to produce plant medical records and any medical records obtained by subpoena, and stated that no further action is planned by the Board at this time.

The self insured employer's attorney, in an application for review dated February 24, 2006, requests review of the said decision. The employer's attorney contends that the authorization for surgery should be rescinded, because the employer has not received all of the claimant's prior medical treatment records as requested by the self insured employer's letter of October 28, 2005. While the employer's attorney acknowledges that the claimant has provided some authorizations for the requested medical records, the attorney argues that the claimant's treating physicians have not adequately responded to their request for records. The claimant's attorney further argues that the employer's plant medical records show that the claimant had a pre-existing degenerative arthritis of her right knee, and therefore the employer should be permitted to fully develop the record on the issue of whether the claimant's proposed right knee replacement surgery is causally related to her work related accident.

In a rebuttal dated March 22, 2006, the claimant's attorney contends that the decision should be affirmed. The claimant's attorney notes that the employer failed to obtain a contrary second medical opinion to support its denial of authorization for surgery within 30 days of receiving the request for authorization, as required by WCL §13-a(5) and 12 NYCRR §325-1.4(a), and therefore the requested surgery is deemed authorized. The claimant's attorney argues that the employer failed to file an IME as directed by the WCLJ at the hearing held on August 24, 2005 and by the Notice of Decision filed thereafter on August 30, 2005. The claimant's attorney further argues that the

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|-----------------------|------------|-----------------------------------|-----------------------|
| Claimant - | | Employer - | Eastman Kodak Co |
| Social Security No. - | | Carrier - | Eastman Kodak Company |
| WCB Case No. - | 7041 1348 | Carrier ID No. - | W395008 |
| Date of Accident - | 11/15/2004 | Carrier Case No. - | 001488-101396 |
| District Office - | Rochester | Date of Filing of this Decision - | 06/12/2006 |

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

WCLJ's denial of a further adjournment to produce an IME is not subject to review, in accordance with 12 NYCRR §300.10(b).

Thereafter, the employer's attorney filed a reply to the rebuttal, dated April 19, 2006, responding to the claimant's argument under 12 NYCRR §300.10(b). The claimant's attorney filed a response to this reply, dated April 21, 2006, contending that the reply is unauthorized and reiterating his prior contentions.

The Board Panel has reviewed the entire record and has considered the proceedings and evidence therein. The findings of fact and the opinion of the WCLJ, as set forth on the record at the hearing held on February 8, 2006, are fully supported by the record. No errors of fact or law have been made. The Board Panel, therefore, adopts the findings of fact and the opinion of the WCLJ as the findings of fact and the opinion of the Board Panel. The Board Panel makes the following additional findings in support of its decision.

The Board Panel finds that surgery was properly authorized by the WCLJ in accordance with the requirements of the Workers' Compensation Law and the applicable Board rules. WCL §13-a(5) provides as follows:

(5) No claim for specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, x-ray examinations or special diagnostic laboratory tests costing more than five hundred dollars shall be valid and enforceable, as against such employer, unless such special services shall have been authorized by the employer or by the board, or unless such authorization has been unreasonably withheld, or withheld for a period of more than thirty calendar days from receipt of a request for authorization, or unless such special services are required in an emergency, provided, however, that the basis for a denial of such authorization by the employer must be based on a conflicting second opinion rendered by a physician authorized by the workers' compensation board.

The Court of Appeals has construed the procedural requirements of this section of the Workers' Compensation Law as being intended by the legislature to prevent unnecessary delay in authorizing surgery and other special services for the care and treatment of injured employees (see *Burlew v. American Mut. Ins. Co.*, 63 N.Y.2d 412, 482 N.Y.S.2d 720 [1984]). The Board has adopted rules to implement the statutory requirements of WCL §13-a(5), which rules are codified in 12 NYCRR §325-1.4.

The record in this case clearly shows that the carrier failed to comply with the procedural requirements of WCL §13-a(5) and 12 NYCRR §325-1.4(a). The statute and the Board's rules require that, in order to be effective, a denial of authorization for special services by a carrier must be issued within 30 days of its receipt of a request for authorization for special services, and must be based on a conflicting second opinion rendered by a physician authorized by the Workers' Compensation Board.

To date, the employer has not filed a contrary second medical opinion in response to Dr. Spector's June 7, 2005 request for authorization. The employer apparently believes that it is entitled to obtain any of the claimant's medical records that are arguably relevant to the request for authorization before it has any obligation to file a contrary second medical opinion, and in the interim can deny authorization without the need for a medical opinion supporting its denial. Neither WCL §13-a(5) nor the Board's rules support this contention. WCL §13-a(5) contains no provision staying the employer's obligation to provide a contrary medical opinion until after it obtains all of the claimant's prior medical records. To the contrary, it is clear that the legislature intentionally limited the carrier's

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opportunity to obtain and file a contrary second medical opinion to a 30 day period, without any allowance for protracted discovery of the claimant's prior medical records.

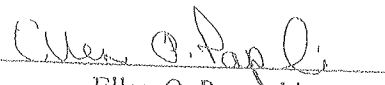
As the claimant's attorney notes, the employer has a plant medical department and had substantial medical records concerning the claimant's prior medical treatment in its possession before this work-related accident even occurred. The employer's contention that the claimant's total knee replacement surgery is causally related to her pre-existing osteoarthritis, rather than to this work-related accident, is largely based upon these plant medical records. The Board Panel concurs with the claimant's attorney that the employer has shown no compelling reason why an independent medical examination could not have been conducted within 30 days of Dr. Spector's request for authorization, with its independent medical examiner filing with the Board and supplying to the other parties any requests for information, including the employer's plant medical records and any other or other records provided to him for use in conducting such examination (*see WCL §137; 12 NYCRR §300.2*).

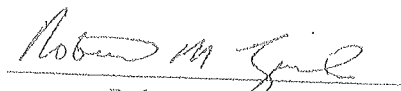
In the event the carrier's independent medical examiner found that additional medical records were necessary for him to determine whether the claimant knee replacement surgery is causally related to her work-related right knee fracture, then the independent medical examiner could have stated that opinion in a timely filed IME report. If the employer had followed such procedure, and actually filed a timely contrary second medical opinion, it may have been appropriate for the WCLJ to continue this case to direct the claimant to produce additional medical records or medical authorizations necessary to enable the carrier's independent medical examiner to render a definitive medical opinion. Any medical records identified as necessary by the carrier's independent medical examiner for a definitive medical opinion, utilizing such a procedure, would most likely be limited to relevant areas of inquiry. In the instant case, the employer's blunderbuss insistence on all of the claimant's medical records, including those of her cardiologist and other records that have no apparent relevancy to this claim, has simply resulted in a protracted delay of the claimant's surgery without producing any material evidence on the causal relationship of her knee replacement surgery to her work-related medial condyle fracture of her right femur. Under the circumstances, the claimant's right knee replacement surgery was properly authorized, since the employer's failed to support its denial of authorization with a timely contrary second medical opinion.

Accordingly, the WCLJ's decision filed on February 14, 2006 is affirmed. The claimant's total knee replacement surgery for her right knee requested by Dr. Spector is authorized. No further action is planned by the Board at this time.

All concur.


Donna Ferrara


Ellen O. Paprocki


Robert M. Zinck

Pursuant to the provisions of § 142(5) of the Workers' Compensation Law, Gallagher Bassett of NY, Inc. is assessed the sum of \$150.00.

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