NEW YORK STATE | Workers' Compensation Board

CONFERENCE 2024

OCTOBER 18

Navigating Patient/Provider Needs and Provider Best Practices

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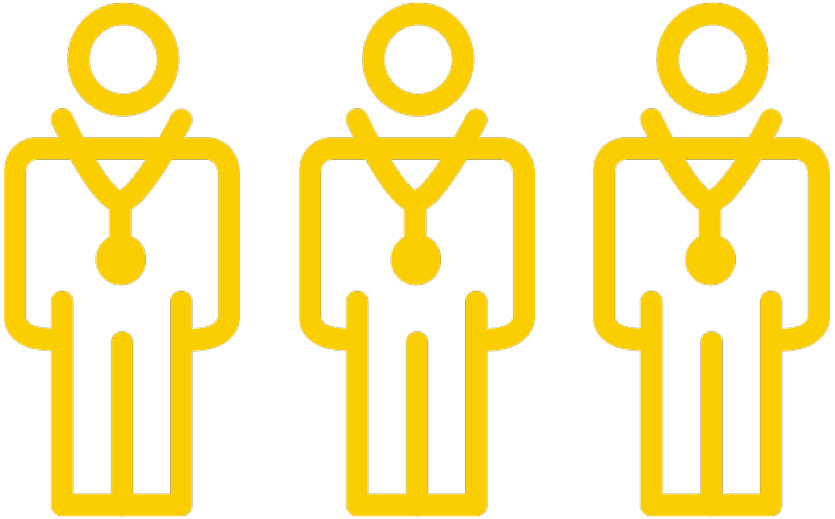
AGENDA

1. Who Can Do What
2. Official New York Workers' Compensation Fee Schedule
3. Telehealth
4. OnBoard Updates
5. CMS-1500
6. Health Care Efficiencies

AUTHORIZED PROVIDERS: WHO CAN DO WHAT



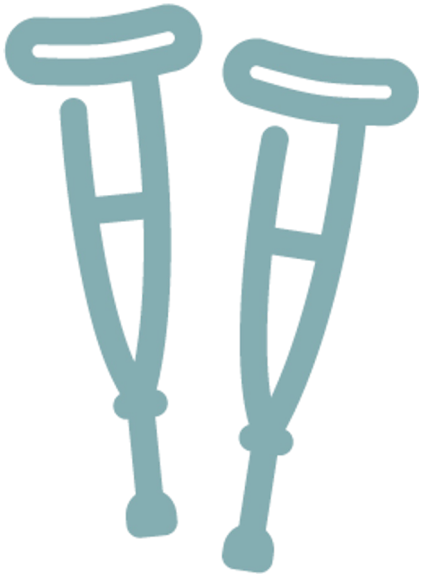
Provider Type	Treat	Treat via Telehealth*	Initial C/R and Diagnosis	Initial Disability	Ongoing Disability	Permanency	Depositions	IMEs	Prior Authorization Requests (PARs)
Acupuncturists	YES with referral	NO	NO	NO	NO	NO	NO	NO	U1K, O1K
Chiropractors	YES	NO	YES	YES	YES	YES	YES	YES	C, V, U1K, O1K, DME
Licensed Clinical Social Workers	YES	YES	YES	YES	YES	YES	YES	NO	C, V, U1K, O1K
Nurse Practitioners	YES	YES	YES	YES	YES	YES	YES	NO	All PARs
Occupational Therapists	YES with referral	NO	NO	NO	NO	NO	NO	NO	U1K, O1K
Physical Therapists	YES with referral	NO	NO	NO	NO	NO	NO	NO	U1K, O1K
Physicians	YES	YES	YES	YES	YES	YES	YES	YES	All PARs
Physician Assistants**	YES	YES	YES**	YES**	YES	YES**	Upon Board direction	NO	M, C, V, U1K, O1K, DME
Podiatrists	YES	YES	YES	YES	YES	YES	YES	YES	All PARs
Psychologists	YES	YES	YES	YES	YES	YES	YES	YES	C, V, U1K, O1k

Please see the Telehealth page on Board's website for information on appropriate uses.
***PA services may only be supplied under the direct supervision of a physician.*

Key for PARs			
	M = Medication PAR	**U1K** = Non-MTG Under or = to $1,000	**SS** = MTG Special Services
	C = Confirmation PAR	**O1K** = Non-MTG Over $1,000	**DME** = Durable Medical Equipment
	V = Variance PAR		

Official New York Workers' Compensation Fee Schedule (Fee Schedule)

FEE SCHEDULE UPDATES



- *Official New York Workers' Compensation Durable Medical Equipment Fee Schedule (DME Fee Schedule)* was updated and became effective June 28, 2024, and can be found in the June 26, 2024, edition of the State Register.

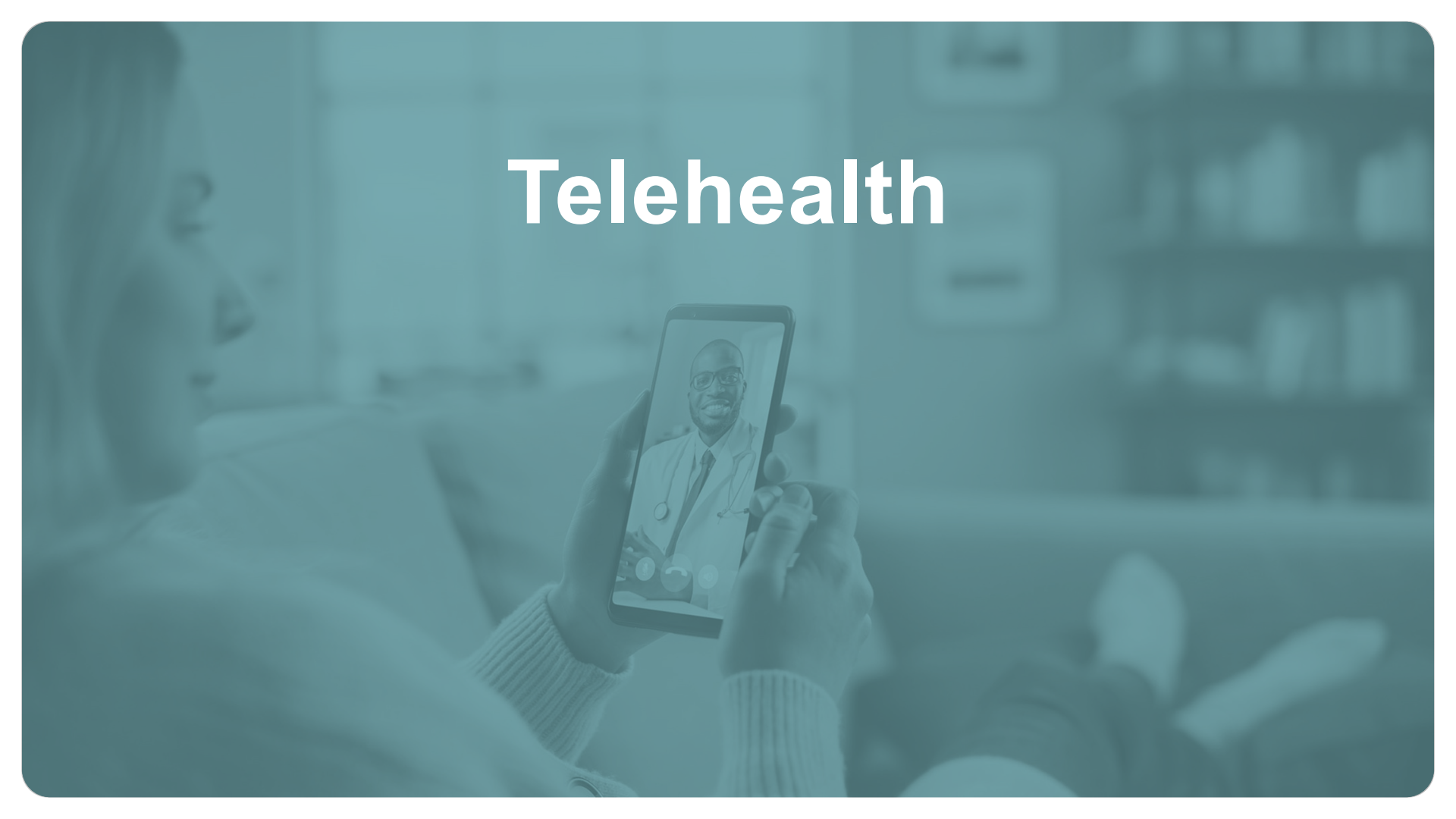
- Current *DME Fee Schedule* and proposed updates can be found under the 'Provider' section at **wcb.ny.gov.**

FEE SCHEDULE UPDATES: COMING SOON!

Expect benchmarked and reasonable increases to the new *Official New York Workers' Compensation Medical Fee Schedule*

***Dental Fee Schedule* – plan to propose an update soon**

Telehealth



TELEHEALTH: OVERVIEW OF THE NYS REGULATION

Telehealth:

- Physicians, podiatrists, psychologists, nurse practitioners, physician assistants, licensed clinical social workers
- Audio/visual or audio-only communication
- In-person within a reasonable travel time, if necessary

TELEHEALTH: OVERVIEW OF THE NYS REGULATION

In-person requirements for MD, DO, DPM, NP, PA:

- Initial visit
- Every third visit (acute/subacute)
- Every three months (if chronic, but not at MMI – maximum medical improvement)
- Annually (if chronic and at MMI)

TELEHEALTH: OVERVIEW OF THE NYS REGULATION

In-person requirements (cont'd):

- **Psychologists** and **licensed clinical social workers (LCSWs)**:
  - Telehealth should be permitted for first and subsequent visits
  - Remote behavioral health visits should be limited to situations when there is no additional benefit compared to in-person services, or where in-person visit poses undue risk or hardship
  - In-person within a reasonable travel time, if necessary
  - Reason for use of telehealth should be documented with any such visit
- Treatment may not be rendered via telehealth for chiropractors, acupuncturists, physical therapists, or occupational therapists

TELEHEALTH: IN-PERSON CONSIDERATIONS

- Factors indicating in-person exam **may not be necessary**:
  - Routine follow-up after comprehensive initial in-person exam
  - Discuss test results or counsel on clinical options
- Factors indicating in-person exam **is necessary**:
  - Procedures, emergencies, eye conditions, nuanced or complex issues
  - Affects assessment, treatment, or recommendations
- Factors **requiring** in-person visit:
  - Urine drug testing, permanency, disability, initiation of chronic medication
  - Patient lacks technology, capacity, or desire for telehealth
- Independent medical exams:
  - Permissible if parties agree, and not for permanency

TELEHEALTH GUIDANCE FOR PAYERS

- **Believing telehealth treatment has been provided improperly should not be the sole bases for a legal objection to a bill for such treatment, if the provider is otherwise permitted to treat via telehealth.**
- Payer may request that future services be conducted in person by filing a *Request for Further Action by Insurer/Employer (Form RFA-2).*
- If a Board order to conduct service in-person instead of via telehealth is ignored, the provider may be subject to administrative action.
- When a payer believes that treatment has been provided improperly by a provider not permitted to treat via telehealth, the payer may file a *Notice of Objection to a Payment of a Bill for Treatment Provided* (*Form C-8.1B*).


ONBOARD
Updates

ONBOARD UPDATES

- To date, more than 59,000 providers have registered for OnBoard and more than 51,000 delegates have been added.
- **More than 2 million prior authorization requests (PARs) have flowed through the system.**
- 100% of medication, behavioral health, and durable medical equipment PARs are resolved within 1-2 days.
- Most other PARs are resolved within approximately 30 days or less.
- 93% of PARs are processed without escalation to Level 3 review.
- More than 75 enhancements were made in direct response to user feedback.
- The Board has reduced the backlog of Level 3 PAR reviews

PAR TYPE BREAKDOWN

Request Type	Request Count
Durable Medical Equipment	63,959
MTG Confirmation	531,519
MTG Special Services	77,396
MTG Variance	558,149
Medication	628,078
Non-MTG Over $1,000	3,363
Non-MTG Under or = to $1,000	17,499
Total	**1,879,963**

BENEFITS OF ONBOARD

OnBoard has a number of benefits for providers, including:

- Increased accuracy, paperless transactions, and a user-friendly interface for interacting with insurers and the Board.
- Ability of health care providers to request Board action on unpaid medical bills through submission of *Request for Decision on Unpaid Medical Bills* (*Form HP-1.0)* to ensure accuracy and timely receipt.
- Electronic submission of PARs for treatment, medication, DME, and complicated and/or invasive medical procedures (Special Services).
- No confusion on which forms to use.
- Automatic routing with time/date stamp.

ASSIGNED DELEGATES

Delegates can assist you by:

- Drafting **and submitting** *Form HP-1.0* and PARs.
- Monitoring provider OBLR dashboards for payer responses to PARs.
- Responding to payer requests for information.
- Drafting **and** escalating Medication PARs to Level 2 carrier physician review.
- Drafting and submitting PAR escalations to Level 3 for Medical Director's Office (MDO) review.

Visit **wcb.ny.gov/onboard** to view a registration guide under "Training & Resources."

ASSIGNED DELEGATES MAY NOT

Delegates cannot do the following:

- Accept the electronic submission partner agreement.
- Register with the Medical Portal.
- Report on a provider's authorization status/renewal.

FORM HP-1.0 UPDATES

- Turnaround times for billing disputes have been reduced from **two years** to **two months.**
- Providers should check the status of a billing dispute and refrain from submitting duplicate *HP-1.0s.*

  Attestation required for *HP-1.0* submission has been updated.

  A new pop-up alert now appears for users.

- Visit the Training: Health Care Providers page at **wcb.ny.gov/onboard** for more information.
- Access the new Medical Billing Disputes section of the Board's website from the Provider landing page.

TIPS TO EXPEDITE THE PAR PROCESS

To help ensure PARs move through the system promptly:

- Submit the correct PAR type.
- Submit supporting documentation.
- Use the MTG Lookup Tool in the Medical Portal, or search/cut/paste the MTG reference in the published *New York Medical Treatment Guidelines* (*MTGs).*
- Check (or have delegate check) the OBLR dashboard regularly for insurer responses, and request Level 2 and Level 3 reviews in a timely manner.
- Include a clear clinical rationale for the request in the medical narrative section.

TIPS TO EXPEDITE THE PAR PROCESS (cont'd)

- When escalating a PAR to Level 3 MDO review, include a rebuttal that addresses the payer's Level 2 denial rationale in the "Escalation Reason" field.
- Use appropriate MTG reference codes.
- Include frequency and duration, if applicable (Now available as dropdowns)
- Remember that the *New York Workers' Compensation Drug Formulary (Drug Formulary)* medications recommended by the *MTGs* do not require prior authorization.

KEEP YOUR INFORMATION UP TO DATE

If any information changes during an authorization period, please inform the Board:

- Log into the Medical Portal.
- Visit the “Medical Providers” section.
- Select one of the following:
  - New Provider Authorization Request
  - Authorization Renewal
  - Update Authorization Information
- Providers must renew authorization every two or three years.

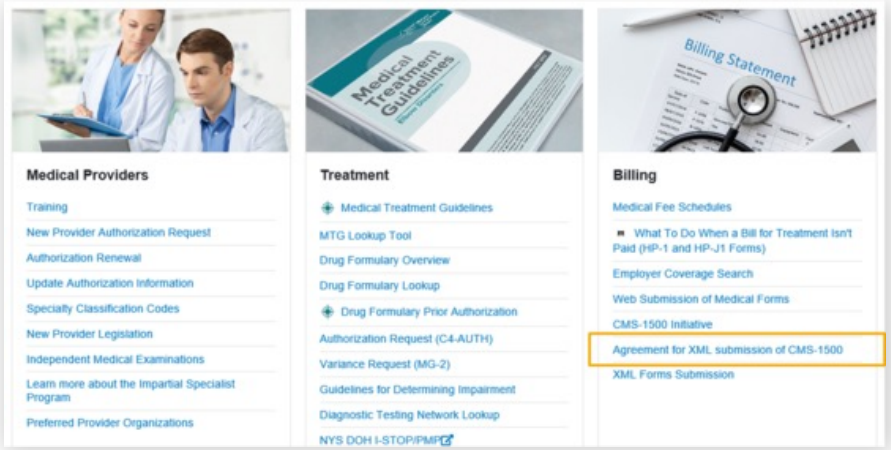

CMS-1500
Reducing Paperwork for Providers

CMS-1500: FORM

- **Since July 1, 2022, the Board has received nearly 4.1 million *CMS-1500* forms.**
- Nearly 13,000 providers have submitted *CMS-1500* forms electronically through the Board's eight authorized electronic submission partners.
- Consolidate/eliminate certain medical forms in exchange for *CMS-1500* form.
- Providers must prominently report the injured worker's temporary impairment percentage, work status, and the causal relationship of the injury at the top of the *CMS-1500* form medical narrative.

REGISTER: MEDICAL PORTAL/ELECTRONIC SUBMISSION

- Take advantage of online services through the Medical Portal.
- Contact an approved electronic submission partner to discuss details.
- Register for electronic billing through an approved electronic submission partner:
  1. Log in to Medical Portal.
  2. Select “Agreement for XML submission of CMS-1500.”
  3. Accept agreement.



CMS-1500: SUBMISSION PROCESS

- Providers will submit the bill and narrative attachment to the electronic submission partner they have a relationship with in the agreed-upon format.
- Electronic submission partner will forward the bill and narrative attachment to the payer.
- Payer will accept the *CMS-1500* form from the electronic submission partner and return electronic acknowledgement of receipt.
- The electronic submission partner will forward the acknowledgement, including receipt date, to the provider and post the information to the case folder.
- When submitting electronically, providers should not mail, fax, or email a duplicate paper form to the Board.

CMS-1500: FORM

- Electronic submission through an electronic submission partner will become mandatory beginning **August 1, 2025**.
- Providers may still submit paper forms to the submission partners.
- Providers will have the ability to offset the cost of using an electronic submission partner by using billing code 99080.

CMS-1500: ELECTRONIC SUBMISSION BENEFITS

- Providers typically get paid faster.
- Providers will have confirmation within seven days that their bill was accepted or rejected by the payer.
- With acknowledgement of receipt from the payer, the provider is aware that they do not need to resubmit the bill.
- Technical errors are identified quickly so they may be corrected and resubmitted, instead of waiting for the payer to deny the bill.
- Makes billing process **easier**: no need to submit to the payer and the Board, and no more paper.

CMS-1500: ELECTRONIC SUBMISSION

Please keep the following in mind:

- Mandatory electronic submission is effective August 1, 2025.
- Providers will still be able to submit a paper *CMS-1500* form to the electronic submission partner (who will then submit it electronically to the Board on the provider's behalf).
- Providers decide which electronic submission partner they want to use. Costs and services may vary by company.
- Providers will have the ability to offset the cost of using an electronic submission partner.
- Payment may be denied when a bill is submitted improperly (i.e., not submitted electronically through an approved electronic submission partner).

CMS-1500: MEDICAL NARRATIVE REPORT TEMPLATE AND REQUIREMENTS

Providers must attach a narrative report with clinical visit history and examination findings, including:

- History of the injury/illness
- Any objective findings based on the clinical evaluation
- Diagnosis(es)/assessment of the patient
- Plan of care

CMS-1500: MEDICAL NARRATIVE REPORT TEMPLATE AND REQUIREMENTS

It is imperative (for providers who are expected to do so) to include these three elements with the narrative:

- Patient's work status
- Causal relationship of the injury or illness to the patient's work activities
- Temporary impairment percentage

Report template and attachments can be found in the 'Requirements' section of wcb.ny.gov/CMS-1500.

DOCTOR'S REPORT OF MMI/PERMANENT IMPAIRMENT (FORM C-4.3)

The CMS-1500 form may be used to electronically submit medical bills for permanency evaluations using an electronic submission partner as long as medical providers:

- Only use CPT codes 99243 or 99245.
- Only use **one** CPT code (99243 or 99245) on the medical bill.
- Attach a completed *Doctor's Report of MMI/Permanent Impairment (Form C-4.3)* to the *CMS-1500* form as the medical narrative.

Do not separately send *Form C-4.3* to the Board.


Healthcare
Efficiencies

HEALTHCARE EFFICIENCIES

Most medications that are recommended in the MTGs and listed in our *Drug Formulary* do not require prior authorization.

Most perioperative medications do not require prior authorization.

- Perioperative drug list
- Period is four days before through four days following a surgery

HEALTHCARE EFFICIENCIES (cont'd)

Detailed guidance for medical billing disputes:

Medical billing disputes section of website

- Guidance for submitting Form HP-1.0
- Information on the arbitration process

HEALTHCARE EFFICIENCIES (cont'd)

Enhanced reimbursement for primary care, behavioral health providers:

- **Ground Rule 17:** Designated Provider Enhanced Reimbursement
- **Ground Rule 18:** Behavioral Health Provider Enhanced Reimbursement

MEDICAL DIRECTOR'S OFFICE

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