CMS-1500 Crosswalk - PT/OT

☐ OCCUPATIONAL THERAPIST'S REPORT
☐ PHYSICAL THERAPIST'S REPORT

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

SERVICES PROVIDED UNDER WCB PREFERRED PROVIDER ORGANIZATION (PPO) PROGRAM? YES ☐ NO ☐

☐ 48 HR. INITIAL ☐ 15 DAY INITIAL ☐ 90 DAY PROGRESS *SEE ITEM 1 ON REVERSE FOR FILING INSTRUCTIONS*

PLEASE TYPE ALL INFORMATION - COMPLETE ALL ITEMS

WCB CASE NO.	CARRIER CASE NO. (IF KNOWN)	DATE OF INJURY	& TIME	ADDRESS WHERE INJURY OCCURRED (CITY, TOWN OR VILLAGE)	INJURED PERSON'S SOCIAL SECURITY NUMBER
Field 9a	Field 11b	Field 14			Field 1a

	(First Name) (Middle Initial) (Last Name)	ADDRESS (Include Apt. No.)	TELEPHONE NO.
INJURED PERSON	Field 2	Field 5	Field 5
EMPLOYER*	Field 4	Field 7	PATIENT'S DATE OF BIRTH: Field 3
INSURANCE CARRIER	Field 0	Field 0	
REFERRING PHYSICIAN/ PODIATRIST	Field 17		TELEPHONE NO.

*If treatment was under the VFBL or VAWBL show as "Employer" the liable political subdivision and check one: ☐ VFBL ☐ VAWBL

If you have filed a previous report, setting forth a history of the injury, enter its date and complete Items 3 to 16. If not, complete ALL items.

HISTORY

1. Diagnosis of referring physician/podiatrist.

PT/OT Narrative Report

2. If patient has given any history of pre-existing injury, disease or physical impairment, describe specifically.

EVALUATION/TREATMENT

3. Referral was for: ☐ Evaluation Only (Complete item a) ☐ Treatment Only (Complete item b-1,2,3) ☐ Evaluation and Treatment (Complete items a and b-1,2,3)

a. Your evaluation:

PT/OT Narrative Report

b. (1) Patient's condition and progress:

PT/OT Narrative Report

b. (2) Treatment and planned future treatment. If an authorization request is required (see items 4 & 5 on reverse), check box ☐ and explain below. If additional space is necessary, please attach request.

PT/OT Narrative Report

b. (3) Was such treatment plan upon prescription or referral of claimant's attending physician or, in the case of physical therapy, authorized physician or podiatrist?
☐ Yes ☐ No If yes, frequency of treatment ordered: PT/OT Narrative Report Period of treatment ordered: PT/OT Narrative Report

4. Date(s) of visits on which this report is based: Field 24A
Date of First Visit: Field 15
Will patient be seen again? ☐ Yes ☐ No If yes, when: PT/OT Narrative Report
If no, was patient referred back to attending doctor: ☐ Yes ☐ No

5. Is patient working? ☐ Yes ☐ No If yes, date(s) patient: resumed limited work of any kind resumed regular work

BILLING FORM

6. Diagnosis or nature of disease or injury (Relate Items 1,2,3 or 4 to Item 7E by line.) Enter ICD10 code and describe nature of injury.
1. Field 21A PT/OT Narrative Report
2. Field 21B PT/OT Narrative Report
3. Field 21C PT/OT Narrative Report
4. Field 21D PT/OT Narrative Report

7. A Dates of Service From MM DD YY To MM DD YY	B Place of Service	C Leave Blank	D (USE WCB CODES) Procedures, Services or Supplies (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E Diagnosis Code	F $ Charges	G Days or Units	H COB	I Zip Code Where Service was Rendered
Field 24A	24B		24D	24D	24E	24F	24G		Field 32

SIGNATURE

8. Federal Tax I.D. Number SSN EIN	9. NYS License Number	10. Patient's Account Number	11. Total Charges	12. Amt. Paid (carrier use only)	13. Bal. Due (carrier use only)
Field 25	Field 24J	Field 26	Field 28	Field 29	

Affirmed Under Penalty of Perjury	15. Therapist's Name, Address & Phone No.	16. Therapist's Billing Name, Address & Phone No.	
Field 31	Field 32	Field 33	**THE INJURED WORKER SHOULD NOT PAY THIS BILL**
14. Signature of Treating Therapist Date			

IMPORTANT
TO THE OCCUPATIONAL/PHYSICAL THERAPIST

1. This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases as follows:
   48 HOUR INITIAL REPORT - File this form, complete in all details, within 48 hours after you first render treatment.
   15 DAY INITIAL REPORT - File this form within 15 days after you first render treatment.
   90 DAY PROGRESS REPORT - Following the filing of the 15 Day Initial Report, file this form at intervals of 90 days during continuing treatment, unless change of condition necessitates additional reporting.
   All reports are to be filed with the Workers' Compensation Board, the workers' compensation insurance carrier (or self-insured employer), and if the patient is represented by an attorney or licensed representative, with such representative. If the claimant is not represented, a copy must be sent to the claimant. A copy must also be filed with the prescribing or referring physician or podiatrist.

2. Please ask your patient for his/her WCB Case Number and the Insurance Carrier's Case Number, if they are known to him/her, and show these numbers on your reports. In addition, ask your patient if he/she has retained a representative. If so, ask for the name and address of the representative. You are required to send copies of all reports to the patient's representative, if any.

3. This form must be signed by the occupational/physical therapist and must contain his/her authorization number, address and telephone number.

4. **AUTHORIZATION FOR SPECIAL SERVICES** - Prior authorization for occupational/physical therapy procedures costing more than $1,000 or procedures requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder must be requested from the self-insured employer or insurance carrier.

5. **AUTHORIZATION MUST BE REQUESTED AS FOLLOWS:**
   a. Telephone the self-insured employer or insurance carrier, explain the need for the special services, and request the necessary authorization.
   b. Confirm the request in writing, setting forth the medical necessity for the special services in item 3 b(2) of this form. Attach copy of request, if necessary.
   c. The self-insured employer or insurance carrier may have the patient examined within 4 working days of the request for authorization, if the patient is hospitalized, or within 30 calendar days if the patient is not hospitalized.
   d. If authorization or denial is not forthcoming within 30 calendar days, notify the nearest office of the Workers' Compensation Board.

6. **LIMITATION OF OCCUPATIONAL/PHYSICAL THERAPY TREATMENT** - Treatment by a licensed occupational/physical therapist is limited as defined in Article 136 or 156 of the Education Law, in the Workers' Compensation Law, and the Rules of the Chair relative to Occupational/Physical Therapy Practice.

7. **HIPAA NOTICE** - In order to adjudicate a workers' compensation claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

IMPORTANT TO THE PATIENT

YOUR DOCTORS' BILLS (AND BILLS FOR HOSPITALS AND OTHER SERVICES OF A MEDICAL NATURE) WILL BE PAID BY YOUR EMPLOYER, THE LIABLE POLITICAL SUBDIVISION OR ITS INSURANCE COMPANY OR THE UNAFFILIATED VOLUNTEER AMBULANCE SERVICE IF YOUR CLAIM IS ALLOWED. DO NOT PAY THESE BILLS YOURSELF, UNLESS YOUR CASE IS DISALLOWED OR CLOSED FOR FAILURE TO PROSECUTE.

IF YOU HAVE ANY QUESTIONS CONCERNING THIS NOTICE OR YOUR CASE, OR WITH RESPECT TO YOUR RIGHTS UNDER THE WORKERS' COMPENSATION LAW, OR THE VOLUNTEER FIREFIGHTERS' OR VOLUNTEER AMBULANCE WORKERS' LAWS, YOU SHOULD CONSULT THE NEAREST OFFICE OF THE BOARD FOR ADVICE. ALWAYS USE THE CASE NUMBERS SHOWN ON THE OTHER SIDE OF THIS NOTICE, OR ON OTHER PAPERS RECEIVED BY YOU, IF YOU FIND IT NECESSARY TO COMMUNICATE WITH THE BOARD OR THE CARRIER. ALSO, MENTION YOUR SOCIAL SECURITY NUMBER IF YOU WRITE OR CALL THE BOARD.

IMPORTANTE PARA EL PACIENTE

LAS FACTURAS POR SERVICIOS MEDICOS INCLUYENDO HOSPITALES Y TODO SERVICIO DE NATURALEZA MEDICA SERA PAGADO POR EL PATRONO O POR LA ENTIDAD RESPONSABLE O SU COMPANIA DE SEGUROS SEGUN SEA EL CASO; SI SU RECLAMACION ES APROBADA, NO PAGUE ESTAS FACTURAS A MENOS QUE SU CASO SEA DESESTIMADO EN SU FONDO O ARCHIVADO POR NO REALIZAR LOS TRAMITES CORRESPONDIENTES.

SI USTED TIENE ALGUNA PREGUNTA, EN RELACION A ESTA NOTIFICACION O A SU CASO O EN RELACION A SUS DERECHOS BAJO LA LEY DE COMPENSACION OBRERA O LA LEY DE BOMBEROS VOLUNTARIOS O LA LEY DE SERVICIOS DE AMBULANCIAS VOLUNTARIOS DEBE COMUNICARSE CON LA OFICINA MAS CERCANA DE LA JUNTA PARA ORIENTACION. SIEMPRE USE EL NUMERO DEL CASO QUE APARECE EN LA PARTE DEL FRENTE DE ESTA NOTIFICACION, O EN OTROS DOCUMENTOS RECIBIDOS POR USTED. SI LE ES NECESARIO COMUNICARSE CON LA JUNTA O CON EL "CARRIER." TAMBIEN MENCIONE EN SU COMUNICACION ORAL O ESCRITA SU NUMERO DE SEGURO SOCIAL.

New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
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Customer Service Toll-Free Line: 877-632-4996

Statewide Fax Line: 877-533-0337