NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Durable Medical Equipment (DME)

Fee Schedule and Arbitration

Agenda

1. *Official New York Workers' Compensation Durable Medical Equipment (DME) Fee Schedule*
2. Arbitration
3. FAQs
4. OnBoard
5. Additional Resources
6. Q&A

DME Fee Schedule

New *DME Fee Schedule*

Summer 2021

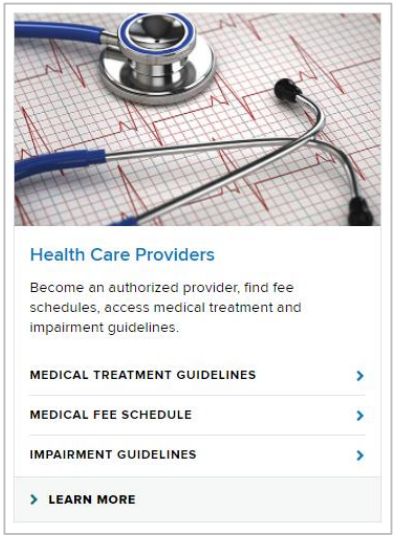
- 2020 *DME Fee Schedule* becomes effective.
- Amendments to replace the *DME Fee Schedule*, updated fees and the prior authorization process are scheduled to become effective.

New *DME Fee Schedule*

- **Coincides with the Board's new OnBoard system.**
- **Will allow a DME Prior Authorization to be requested through OnBoard in accordance with the fee schedule.**
- **A DME prior authorization request (PAR) will be required prior to prescribing DME items from the *DME Fee Schedule* that are labeled as PAR, or not included in the *DME Fee Schedule*.**

DME Fee Schedule

- The current *DME Fee Schedule* is available on the “Providers” section of the Board’s website at **wcb.ny.gov**.
- Note: the *DME Fee Schedule* will be effective with the implementation of OnBoard Limited Release this summer.



Effective Date To Be Announced

NY Official Workers' Compensation
Durable Medical Equipment Fee Schedule

CODE	SHORT DESCRIPTION	FULL DESCRIPTION	PURCHASE	RENTAL PER WEEK	PAR REQUIRED
A6540	Gc stocking waistlngth 30-40	Gradient compression stocking, waist length, 30-40 mmhg, each	$101.23		
A6541	Gc stocking waistlngth 40-50	Gradient compression stocking, waist length, 40-50 mmhg, each	$104.94		
A6544	Gc stocking garter belt	Gradient compression stocking, garter belt	$15.00		
A6545	Grad comp non-elastic bk	Gradient compression wrap, non-elastic, below knee, 30-50 mm hg, each	$77.97		
A6549	G compression stocking	Gradient compression stocking/sleeve, not otherwise specified			PAR
A7000	Disposable canister for pump	Canister, disposable, used with suction pump, each	$4.35		
A7001	Nondisposable pump canister	Canister, non-disposable, used with suction pump, each	$27.31	$0.64	
A7002	Tubing used w suction pump	Tubing, used with suction pump, each	$0.92		
A7003	Nebulizer administration set	Administration set, with small volume nonfiltered pneumatic nebulizer, disposable	$2.23		
A7004	Disposable nebulizer sml vol	Small volume nonfiltered pneumatic nebulizer, disposable	$1.29		
A7005	Nondisposable nebulizer set	Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable	$16.19		
A7006	Filtered nebulizer admin set	Administration set, with small volume filtered pneumatic nebulizer	$5.37		
A7007	Lg vol nebulizer disposable	Large volume nebulizer, disposable, unfilled, used with aerosol compressor	$2.89		
A7008	Disposable nebulizer prefill	Large volume nebulizer, disposable, prefilled, used with aerosol compressor	$10.06	$0.23	
A7009	Nebulizer reservoir bottle	Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer	$34.69	$0.81	
A7013	Disposable compressor filter	Filter, disposable, used with aerosol compressor or ultrasonic generator	$0.11		
A7014	Compressor nondispos filter	Filter, nondisposable, used with aerosol compressor or ultrasonic generator	$0.80		
A7015	Aerosol mask used w nebulize	Aerosol mask, used with dme nebulizer	$1.06		
A7016	Nebulizer dome & mouthpiece	Dome and mouthpiece, used with small volume ultrasonic nebulizer	$5.97	$0.14	
A7018	Water distilled w/nebulizer	Water, distilled, used with large volume nebulizer, 1000 ml	$0.25		
A7025	Replace chest compress vest	High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each	$275.00		
A7026	Replace chst cmprss sys hose	High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each	$28.75		
A7027	Combination oral/nasal mask	Combination oral/nasal mask, used with continuous positive airway pressure device, each	$179.35		
A7028	Repl oral cushion combo mask	Oral cushion for combination oral/nasal mask, replacement only, each	$49.54		
A7029	Repl nasal pillow comb mask	Nasal pillows for combination oral/nasal mask, replacement only, pair	$20.24		

Billing is based on the Fee Schedule – no invoices required!!

DME fees for injured workers

- **If you accept an injured worker as a patient, you must bill no more than the fees indicated in the *DME Fee Schedule*.**

DME fees for injured workers

- **The Workers' Compensation Law does not permit DME suppliers to collect from, or bill, an injured worker for services rendered, with a few exceptions.**

Requesting prior authorization

- The new *DME Fee Schedule* outlines the PAR process for durable medical equipment.
- Prior Authorization is required for items not listed on the DME Fee Schedule, as well as items on the schedule categorized as PAR.
- Prior Authorization must be requested by the Board-authorized provider who ordered or prescribed the DME item.
- DME suppliers are not eligible to submit Prior Authorization Requests through OnBoard: Limited Release.

Requesting prior authorization

- **Not all DME codes are listed on the new *DME Fee Schedule*.**
- **When a health care provider recommends durable medical equipment that is not listed on the *DME Fee Schedule*, prior authorization, including a proposed purchase price or rental price for such equipment, must be obtained prior to prescribing or supplying such DME.**

Arbitration

Arbitration

- **The following groups are eligible to submit a *Request for Decision on Unpaid Medical Bill (Form HP-1)* for durable medical equipment:**
  - Board-authorized providers who prescribe DMEs.
  - Any DME supplier who is registered to use the Medical Portal.

Arbitration

- **Maximum permissible charge for the purchase or rental of DME is fee payable for such equipment per the *DME Fee Schedule*.**
- **If you are billing for a code which is not listed in the *DME Fee Schedule*, you should attach an invoice showing the acquisition cost of the item.**

Frequently asked questions

Question 1: I am a Board-authorized health care provider and I have a Medicaid DME supplier license. Can I bill for DME items dispensed in the office that are medically necessary according to the Workers' Compensation Board's *New York Medical Treatment Guidelines (MTGs)* using the *DME Fee Schedule*?

- Yes, you can bill for DME items or services using *Form CMS-1500* and the applicable HCPCS code (not CPT code 99070).
- Visit the "Requirements" section at **wcb.ny.gov/CMS-1500** to learn more.

Question 2: Do I have to request prior authorization for DME items that were previously approved or provided to the injured worker?

- Prior authorization is not required for the same item. It is at the discretion of the insurer of whether to repair or replace.

Question 3: Can I bill for a DME item that is not on the *DME Fee Schedule* and which is medically appropriate?

- When a health care provider recommends DME that is not listed in the *DME Fee Schedule*, prior authorization must be obtained prior to prescribing or supplying such DME.
- The PAR must be submitted by the appropriate health care provider.
- This will be effective with OnBoard: Limited Release. Currently, prior authorizations for DMEs are submitted on a *Doctor's Initial Report (Form C-4) or Attending Doctor's Request for Approval of Variance and Insurers Response (Form MG-2).*

Question 4: Is there a resource to research recommended DME items that may be prescribed for MTG body parts to be used in conjunction with the request for prior authorization?

- DME items should be prescribed subject to medical necessity and should be appropriate for the medical condition of the injured worker.
- Providers should review the MTGs for the appropriateness of DME items for relevant body parts.

Question 5: What do I do if the insurer does not respond to the PAR within four days?

- A request for prior authorization that is not responded to within four calendar days (by an approval, denial or grant in part) may be approved upon the Board's issuance of an *Order of the Chair (OOC)* and the insurer shall be subject to a penalty pursuant to section 25(3)(e) of the Workers' Compensation Law.

Question 6: What happens when I submit a DME PAR for an injured worker, but am unable to identify whether the injured worker has a WCB claim number?

- If a PAR is submitted prior to the creation of a workers' compensation case by the Board, the prior authorization request will be held by the Board for a period of up to three business days.
- If this is the case, the prior authorization will be submitted by the Board and the insurer has four calendar days to approve, partially approve or deny the request.

Question 7: What is the variance process and how does it relate to DME?

- **A variance must be secured for DME related to a body part covered by the MTGs, if the provider feels that the injured worker does not meet the criteria in the guidelines. Possible reasons for not meeting guidelines include, but are not limited to:**
  - extended duration of a DME item when an injured worker is continuing to show objective functional improvement;
  - individual circumstances, such as other medical conditions, may delay an individual's response to treatment, or make certain treatment appropriate;
  - actual DME item is not addressed by the MTGs*;*
  - peer reviewed studies may provide evidence supporting new/alternative DME items.

Question 8: What is the approval process for DME items not covered by the MTGs?

- A variance request would be required if the DME item is related to a body part covered by the MTGs and is not addressed in the MTGs.
- Once the variance is approved, a PAR request for the DME may also be required as described in the *DME Fee Schedule*.

Question 9: As a Board-authorized provider and/or physician, how do I request prior authorization for a DME item?

- Once OnBoard: Limited Release is implemented in summer 2021, you will be able to submit a paperless request for prior authorization for a DME through OnBoard once you are registered.
- Providers will need to register at **wcb.ny.gov/medicalportal** in order to use OnBoard.
- Once registered, providers can log onto OnBoard to submit all PARs and view payers responses.

Question 10: I am a Board-authorized provider and dispensed DME items that were medically necessary according to the MTGs. Can the medical facility that I work for bill for DME items dispensed?

- Yes, the facility can bill for DME items or services using *Form CMS-1500*.
- The Board has provided specific examples of using *Form CMS-1500* for the billing DME items. To view these, visit wcb.ny.gov/cms-1500/requirements.
- Please provide the facility NPI in *Form CMS-1500* and the MMIS ID# in the attachment.

Question 11: As a Board-authorized provider, am I able to provide for DME items in an emergency setting?

- In the event of a medical emergency, requiring immediate use of DME following an accident or injury, exacerbation of an earlier accident or injury or unanticipated results following surgery, DME items may be dispensed without prior authorization.
- The provider shall submit the bill for the DME together with a description of the emergency and justification of the need, along with the submission of the appropriate medical bill/report.
- Inappropriate identification of a need for emergency DME by a provider may result in imposition of penalties by the Board.

Question 12: As a Board-authorized provider, am I able to bill separately for surgical supplies?

- **Supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies, and hot cold packs are included in the fee for the medical services in which such supplies are used and should not be billed separately.**

Question 13: Can I bill for DME items or services supplied while the injured worker was in the hospital, ambulatory surgery center, ER, rural clinic, or hospital-based mental clinic?

- All DME items used when an injured worker is in an inpatient status are included in the All Patients Refined Diagnosis Related Groups (APR-DRG) reimbursement.
- Medically necessary and appropriate DME items required for a safe discharge/transition to home following an inpatient stay are reimbursed in accordance with the *DME Fee Schedule*.
- All DME items used when an injured worker is at an ambulatory surgery center, emergency room, rural clinic or hospital-based mental health clinic are included in Enhanced Ambulatory Patient Groups (EAPG) methodology reimbursement.

Question 14: What is the PAR process?

- **The PAR process is the means by which Board-authorized providers obtain approval to prescribe treatment, medical supplies or services, or medications not included in applicable *MTGs*, Fee Schedules, or the *Drug Formulary*.**
- **When OnBoard: Limited Release is implemented, certain DME will be a PAR item.**
- **A DME PAR will be required prior to prescribing DME items from the *DME Fee Schedule* that are labeled as PAR, or not included in the *DME Fee Schedule*.**

Question 15: What do I need to submit when I make a request to review the grant in part/denial from the insurer?

- The provider shall submit the request to the Medical Director's Office through OnBoard: Limited Release within 10 calendar days of the denial date together with all documentation submitted in support of its PAR, and the denial or grant in part issued by the insurer's physician.
- The Medical Director's Office (or designated accredited entity) decision is final and binding for the health care provider and the insurer under Workers' Compensation Law (WCL) section 23.

Question 16: Can physical and occupational therapists (PT/OT) request a variance for the duration in the use of a rental DME item?

- No – the request for extended duration can only be made by the treating health care provider (physician, nurse practitioner, or chiropractor).
- The treating health care provider will have to follow the variance process to request any extension to the duration of the rental DME item.

New business information system coming soon!

ONBOARD

- **What is OnBoard?**
  - Next chapter in the modernization of the New York State Workers' Compensation Board.
  - A new business information system replacing current paper-based processes.
  - A single, web-based platform.

ONBOARD

- **OnBoard Upgrades**
  - Improved and expanded access to real-time claim data.
  - New electronic self-service features for interacting with the Board.
  - Overall reduction in the number of paper forms.
  - Improved system responsiveness to stakeholder needs.

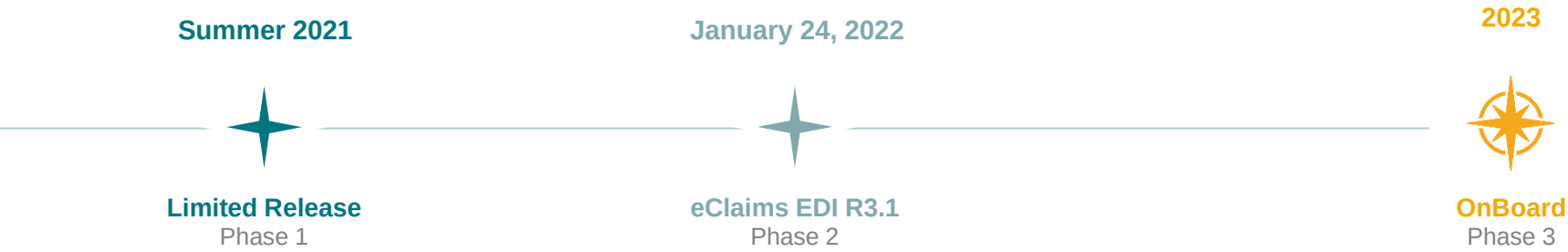
Increasing injured worker access to benefits and medical care.

Why OnBoard: Limited Release?

- **Expanded Provider Law (EPL) became effective on January 1, 2020.**
- **Expands types of medical providers authorized to treat in New York's workers' compensation system.**
- **The Board expects significant increases in:**
  - Number of provider registrations received by the Board.
  - Number of providers authorized to treat workers' compensation injured workers.
  - Volume of medical treatment forms received and processed through the Board
- **OnBoard: Limited Release focuses on the automation of Provider Authorization Requests (PARs) and the submission of Request for Decision on Unpaid Medical Bill(s) (Form HP-1).**
- **All improvements designed to make it easier/better for providers to participate in the workers' comp system, ensuring better care for injured workers.**

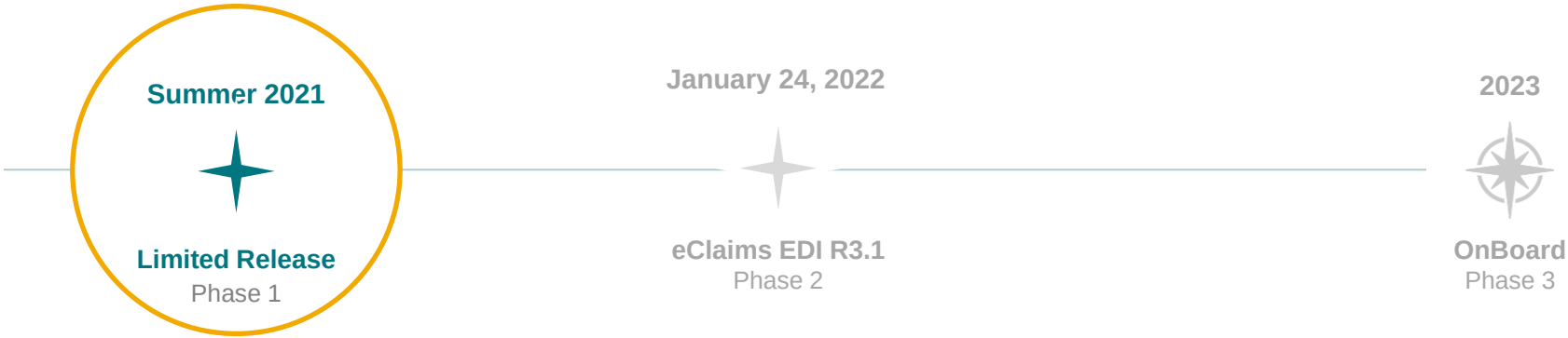
OnBoard Timeline

- **Began in summer 2019.**
- **Identified opportunities to release system functionality early, to better assist stakeholders.**
  - OnBoard: Limited Release
- **OnBoard will be released in three phases:**



OnBoard: Limited Release

- The first rollout, known as **Limited Release**, is planned for summer 2021.
- Why did we choose to provide a limited release of the system?



Why OnBoard: Limited Release?

- **OnBoard: Limited Release focuses on the automation of PARs and the submission of *Request for Decision on Unpaid Medical Bill(s) (Form HP-1.0).***
- **All improvements designed to make it easier/better for providers to participate in the workers' comp system, ensuring better care for injured workers.**

What Will OnBoard: Limited Release Do?

- **Facilitate electronic communications for parties involved in the PAR process (e.g., Insurers, Claim Administrators, Pharmacy Benefit Managers, the Board's Medical Director's Office).**
- **Eliminate the following paper forms:**
  - *Attending Doctor's Request for Optional Prior Approval and Carrier's/Employer's Response (Form MG-1)*
  - *Attending Doctor's Request for Approval of Variance and Carrier's Response (Form MG-2)*
  - *Attending Doctor's Request for Authorization and Carrier's Response (Form C-4 AUTH)*

Prior Authorization Requests

PAR Type	Request Type	Mandatory Time Frame for Insurer Response
MTG Confirmation	Requests previously done using the Attending Doctor's Request for *Optional Prior Approval and Carrier's/Employer's Response (Form MG-1).*	Eight business days
MTG Variance	Requests previously done using the *Attending Doctor's Request for Approval of Variance and Carrier's Response (Form MG-2).*	15/30 calendar days in accordance with GCL* Insurers must respond within 15 calendar days of receipt of a request from a health care provider. If an insurer decides to request an independent medical examination (IME) or the review of records, it must notify the Chair within five business days of such decision and respond within 30 calendar days of receipt of the request.
MTG Special Services	MTG-related requests previously done using the *Attending Doctor's Request for Authorization and Carrier's Response (Form C-4 AUTH).*	15/30 calendar days in accordance with GCL* Insurers must respond within 15 calendar days of receipt of a request from a health care provider. If an insurer decides to request an IME or the review of records, it must notify the Chair within five business days of such decision and respond within 30 calendar days of receipt of the request.
Non-MTG Over $1,000	Requests for treatment costing over $1,000 for non-MTG body parts previously done using the *Attending Doctor's Request for Authorization and Carrier's Response (Form C-4 AUTH).*	30 calendar days in accordance with GCL*
Non-MTG Under or = $1,000 (new)	Requests for treatment costing $1,000 or less for non-MTG body parts.	Eight business days
Medication (new)	Medication requests, including medical marijuana (replacing the current New York Workers' Compensation Drug Formulary [Drug Formulary] prior authorization request process).	Four calendar days
Durable Medical Equipment (new)	Requests in accordance with the new Official New York Workers' Compensation Durable Medical Equipment (DME) Fee Schedule.	Four calendar days in accordance with GCL*

* General Construction Law (GCL) 25a states: "*When any period of time, computed from a certain day, within which or after which or before which an act is authorized or required to be done, ends on a Saturday, Sunday or a public holiday, such act may be done on the next succeeding business day…*"

Disputed Medical Bills Submission

- Digitize and streamline the intake of *Requests for Decision on Unpaid Medical Bill(s) (Form HP-1.0).*

Resources

Resources

- For *DME Fee Schedule* questions, email **arbitration@wcb.ny.gov**.
- For DME PAR and variance questions, email **MedicalTreatmentGuidelines@wcb.ny.gov**.
- For *Form CMS-1500* billing questions, email **CMS1500@wcb.ny.gov**.
- For OnBoard questions, email **OnBoard@wcb.ny.gov**.
- Health Care Provider Updates
  - Visit wcb.ny.gov
  - Select ‘Health Care Providers’ and ‘Provider Updates’

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Thank you