



Workers'
Compensation
Board

BETTER FOR WORKERS

BETTER FOR BUSINESS

PAY TO THE
ORDER OF

BETTER FOR PAYERS



**What Payers
Need to Know**

Agenda

1 OnBoard

2 Telehealth regulations

3 Benefits updates

4 *CMS-1500* form: Reducing paperwork for providers

5 COVID-19

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A person is shown from the side, working at a desk. They are holding a document in their left hand and typing on a laptop with their right hand. The laptop screen displays a dashboard with a table of data. A large teal circle is overlaid on the right side of the image, containing the text 'OnBoard' in white. The entire image has a light teal tint.

OnBoard

New updates!

- Grant without prejudice at Level 1 review.
- Level 2 reviewer updates.
- Weeks added to duration fields.
- Unsupported browser alert.
- Updated training and resources.

PAR report card: launched May 2, 2022

- Initial release of OnBoard was implemented in phases from March 7, 2022, through May 2, 2022.
 - Nearly 49,000 payers and reviewers have signed up for access.
- **More than one million PARs have flowed through the system!**
- 100% of medication, behavioral health, and Durable Medical Equipment PARs are resolved within three days.
- Most other PARs are resolved within approximately 30 days.
- 95% of PARs were processed without escalation to Level 3 review.
- More than 45 enhancements were made in direct response to user feedback.

Access

- Payers must use the Medical Portal to access OnBoard.
- Claim administrator access is granted using organizational profiles based on eClaims Trading Partner information.
- Payers are responsible for the review of PARs.
- Payers may designate a Medical Review Organization (MRO) to review PARs.
- Visit the Payer section at wcb.ny.gov/onboard for more information.

ONBOARD
Registration, access and administration for payers, pharmacy benefit managers and medical review organizations through the Medical Portal

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I. Overview
Users need access to the Medical Portal to use OnBoard: Limited Release to submit and respond to prior authorization request (PAR) or Request for Decision on Unpaid Medical Bill(s) (Form HP-1.0). Some users may already have access and will not need to request access again. The information in this guide details who needs access, how to request (or register) for access, and how to designate and manage user roles in the system.

II. Medical Portal access: who has it, and who needs it?

User Type	Details
Payers (insurers, third-party administrators, self-insured employers)	Payers who already have access to the Medical Portal for Drug Formulary prior authorizations are automatically registered for OnBoard. A second registration is not required.
Pharmacy benefit managers (PBMs)	PBMs who already have access to the Medical Portal are automatically registered for OnBoard. PBMs not registered for the Medical Portal must complete the online PBM Medical Portal Registration process.
Medical review organizations (MROs)	MROs must complete the online Medical Review Organization Medical Portal Registration process.

PAR response time frames

MTG Confirmation	Eight business days
MTG Variance	15 calendar days (extends to 30 with IME request)
MTG Special Services	15 calendar days (extends to 30 with IME request)
Non-MTG Over \$1,000	30 calendar days
Non-MTG Under or = to \$1,000	Eight business days
Medication	Four calendar days
Durable Medical Equipment	Four calendar days

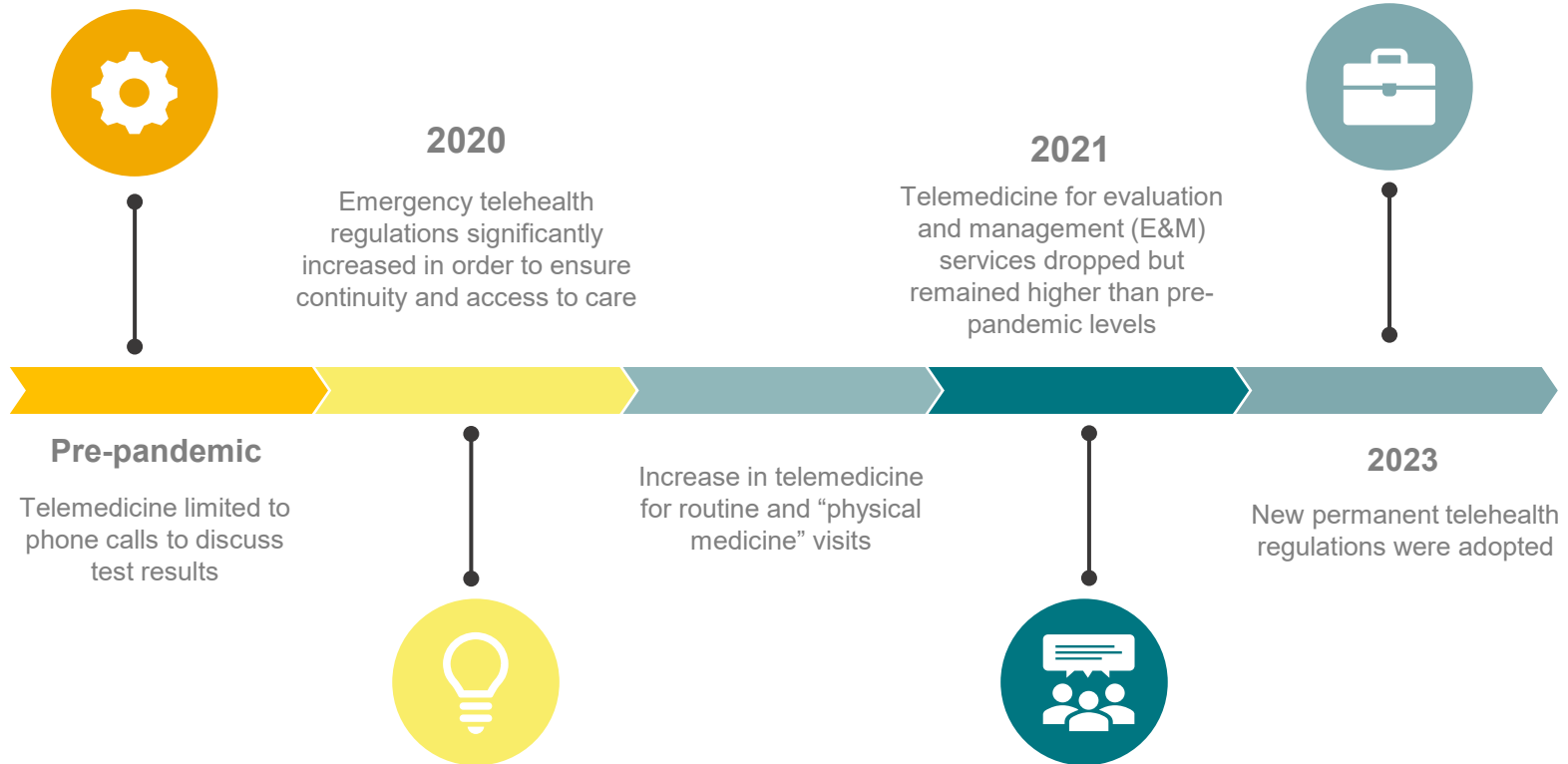
What's next?

- eForm/API expansion:
 - *Request for Further Action (Form RFA-1LC)* and *Request for Assistance by Injured Worker (Form RFA-1W)* are transitioning to an eForm.
 - Attorneys will have the option to submit *Form RFA-1LC* through an Application Programming Interface (API).
- OnBoard full program requirements and planning.

A photograph of a male doctor in a white lab coat with a stethoscope around his neck, sitting at a desk and looking at a computer monitor. The image is overlaid with a teal circular graphic on the right side containing the text.

Telehealth regulations

Telehealth in workers' compensation



Telehealth: overview of 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.

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).
- Annually (if chronic and at MMI).

Telehealth: overview of NYS regulation

Telehealth 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 visit should be documented with each use of a telehealth visit.
- Treatment may not be rendered via telehealth for chiropractors, acupuncturists, physical therapists, or occupational therapists.
- Telehealth appointments scheduled prior to July 11, 2023, need not be changed to in-person visits.
- Any appointments scheduled after July 11, 2023, must conform with the new regulation.

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 / 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 futures 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)***.



Benefits updates



Disability regulations updates

- **April 25, 2023:** Chair adopted amendments to sections 355.4, 363.1, 363.13, and additions to sections 363.15 and 363.16 of Title 12 NYCRR.
- Updated and clarified the disability benefits regulations and disability benefits claims process.
- Conformed the regulations to the statute.
- Aligned several sections with Paid Family Leave.
- Published in the May 10, 2023, edition of the State Register.
- Changes will take effect January 1, 2024.



CMS-1500 form Reducing paperwork for providers

SEARCH

TUE 12:30 PM

Medical diagnosis

SEARCH



Diagnostic procedures

Differential diagnosis

MEDICAL

MEDICAL

Clinical decision support system

One year of the *CMS-1500* form!

- Since July 1, 2022, the Board received more than six million *CMS-1500* forms!
- 1.4 million electronic submissions.
- More than 10,000 providers have submitted *CMS-1500* forms electronically through an XML submission partner.

CMS-1500 form

- Consolidate/eliminate certain medical forms in exchange for *CMS-1500* form
- Electronic submission through an XML submission partner is **strongly** encouraged.
- Payers are required to use the new *Form C-8.1B and Notice to Health Care Provider and Claimant of an Insurer's Refusal to Pay All (or a Portion of) a Medical Bill Due to Valuation Objection(s) (Form C-8.4)* with applicable Claims Adjustment Reason Codes, or CARCs, to object to medical bills.

CMS-1500 medical narrative report template and requirements

- Providers should use the medical narrative report template with their submissions.
- Template includes the three elements for most narratives:
 - Patient's work status,
 - Causal relationship of the injury or illness to the patient's work activities,
 - Temporary impairment percentage.
- A medical narrative report may be found legally defective if these elements are missing, though payers should not routinely file *Form C-8.1B* to deny payment.

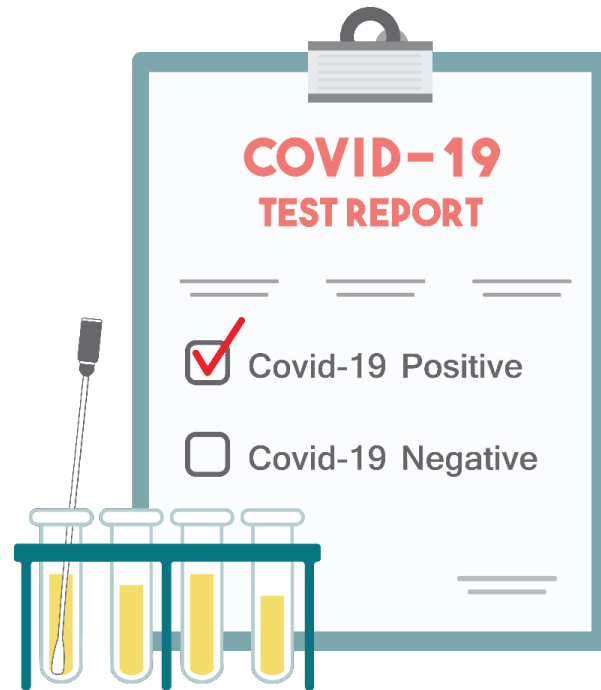
Report template and medical narrative requirements can be found at:
wcb.ny.gov/CMS-1500/requirements.jsp.

A person in a white lab coat is shown in profile, holding a smartphone. The phone screen displays a video call with a smiling male doctor wearing glasses and a white lab coat. The background is a blurred clinical setting. A large teal circle is overlaid on the right side of the image, containing the title text.

Workers' compensation and COVID-19

Workers' compensation and COVID-19

- Payers provide crucial benefits to both employees and employers.
- Payers should:
 - Be proactive in distributing information about COVID-19 claims.
 - Encourage employees to file claims, and employers to help.
 - Review claims carefully and timely.
- Employers may not discipline or discriminate against employees who file COVID-19 claims.
- More information at wcb.ny.gov/covid-19.



A close-up photograph of a person's hands typing on a white keyboard. The image is overlaid with a semi-transparent teal circle on the right side. The text "Tips for efficiency" is written in white, bold, sans-serif font within this circle. The background is a blurred office setting with a laptop and a mouse visible.

Tips for efficiency

Form C-8.1B and Form C-8.4

- Payers are required to use updated *Form C-8.1B* and *Form C-8.4* to notify the Board of legal and valuation objections.
- Scenarios when you should not file *Form C-8.1B* or *Form C-8.4*:
 - When the amount billed for a CPT code exceeds the amount designated by the applicable fee schedule, and the payer pays the bill at the medical fee schedule amount.
 - Payer reduces the amount of the bill to 12, 15 or 18 relative value units for evaluation services and modalities, as set forth in the applicable medical fee schedule.
 - Payer reduces the amount of the bill pursuant to a contractual agreement with the provider (e.g., network or PPO discount).
 - There is a duplicate bill.

Form RFA-1LC, Form RFA-1W, and Form RFA-2

- Use appropriate checkbox instead of “other” field.
- Provide documentation or document ID to support request for reduction or suspension.



PAR tips to enhance your experience

- Payers should only use the Level 1 administrative denial “disallowed” when the condition or body part has been formally disallowed by the Board.
- Payers should respond to PARs in a timely manner to avoid receiving an *Order of the Chair* or a *Notice of Resolution* from the Medical Director’s Office.



Timely FROI filings

Claim administrators should:

- Ensure timely filing of FROIs so the Board has the proper claim administrator on notice.

Prompt filing:

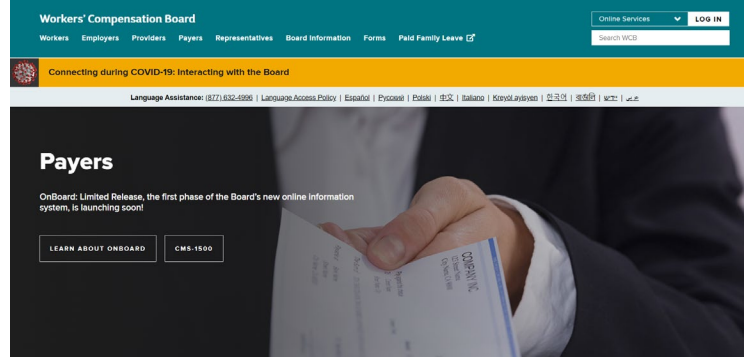
- Avoids untimely filing penalties assessed by the Board's Monitoring unit.
- Provides accurate information to OnBoard, ensuring PARs are given to the correct claim administrator.



Making the Board better for payers

As we continue to work on implementing improvements for payers, we're committed to:

- Increased communication.
- Regular engagement regarding OnBoard.



OnBoard resources

WEBSITE: wcb.ny.gov/onboard

- Walkthrough of registration process
- Video tutorials
- Recorded presentations

CMS-1500 resources

WEBSITE: wcb.ny.gov/CMS-1500

EMAIL: CMS1500@wcb.ny.gov

More information

HELPLINE: (877) 632-4996

WEBSITE: wcb.ny.gov
(select 'Payers' link on top of page)

CLAIM INQUIRIES: wcb.ny.gov/contactclaims/

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wcb.ny.gov (“Get WCB Notifications”)



**Workers'
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Thank you

Questions?