CMS-1500 Crosswalk - Psychology Report

ATTENDING PSYCHOLOGIST'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	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 18. If not, complete ALL items.

HISTORY

1. Describe incident or occupational history that precipitated onset of related symptoms:

Psychology Narrative Report

2. Has patient given any history of pre-existing psychological impairment? If so, describe specifically.

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EVALUATION/TREATMENT

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

a. Your evaluation:

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

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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.

Psychology 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: *Psychology 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 *Psychology Narrative Report*

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6. Was the occurrence described above (or in your previous report) the competent producing cause of the injury or disability (if any) sustained? ☐ Yes ☐ No *Psychology Narrative Report*

REMARKS

7. Enter here additional pertinent information

Psychology Narrative Report

BILLING FORM

8. Diagnosis or nature of disease or injury (Relate Items 1,2,3 or 4 to Item 9E by line.) Enter ICD10 code and describe nature of injury.

1. *Field 21A* *Psychology Narrative Report*
2. *Field 21B* *Psychology Narrative Report*
3. *Field 21C* *Psychology Narrative Report*
4. *Field 21D* *Psychology Narrative Report*

9. 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

10. Federal Tax I.D. Number SSN EIN	11. WCB Authorization Number	12. Patient's Account Number	13. Total Charges	14. Amt. Paid (carrier use only)	15. Bal. Due (carrier use only)
Field 25	Field 19	Field 26	Field 28	Field 29	

SIGNATURE

Affirmed Under Penalty of Perjury

Field 31

16. Signature of Treating Psychologist Date

17. Psychologist's Name, Address & Phone No.

Field 32

18. Billing Name, Address & Phone Number

Field 33

THE INJURED WORKER SHOULD NOT PAY THIS BILL.

IMPORTANT
TO THE PSYCHOLOGIST

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 and thereafter during continuing treatment without further request, when a follow-up visit is necessary, except the intervals between reports shall be no more than 90 days.
   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.

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 psychologist and must contain his/her authorization number, address and telephone number.

4. **AUTHORIZATION FOR SPECIAL SERVICES** - Prior authorization for procedures enumerated in Section 13-a (5) of the Workers' Compensation Law costing more than $1,000 or those procedures requiring pre-authorization pursuant to the Medical Treatment Guidelines, must be requested from the self-insured employer or insurance carrier. In addition, authorization must be requested for any biofeedback treatments, regardless of the cost, or any special diagnostic laboratory tests which may be performed by psychologists. Where a claimant has been referred by an authorized physician to a psychologist for evaluation purposes only and not for treatment, prior authorization must be requested if the cost of consultation exceeds $1,000. Prior authorization is not necessary if the procedure/treatment is consistent with the Medical Treatment Guidelines.

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 3b(2) on 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 PSYCHOLOGY TREATMENT** - Treatment by a psychologist is limited as defined in Article 153 of the Education Law, in the Workers' Compensation Law, and the Rules of the Chair relative to Psychology Practice.

7. HIPAA Notice - In order to adjudicate a workers' compensation claim, WCL13-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 OE BOMBEROS VOLUNTARIOS O LA LEY DE SERVICIOS OE AMBULANCIAS VOLUNTARIOS OEBE 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.

Reports should be sent directly to the Workers' Compensation Board address listed below:

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Line: 877-632-4996 **Statewide Fax Line: 877-533-0337**

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION