
NEW YORK STATE
Workers' Compensation Board
BETTER FOR WORKERS
BETTER FOR BUSINESS
BETTER FOR PAYERS
PAY TO THE ORDER OF

What Payers Need to Know

Agenda

1. Form updates
2. New travel reimbursement rate
3. OnBoard
4. Telehealth regulations
5. CMS-1500 form: streamlining the billing process
6. COVID-19
7. Tips for efficiency
8. Resources
9. Questions

Form updates

Form changes

- Legislation signed that removes the notarization requirement and allows affirmations to have the same force and effect as affidavits.
- To reflect this, the Board has updated several forms that previously required notarized affidavits, including:
  - *Application for Board Review (Form RB-89)*
  - *Rebuttal of Application for Board Review (Form RB-89.1)*
  - *Application for Reconsideration/Full Board Review (Form RB-89.2)*
  - *Rebuttal of Application for Reconsideration/Full Board Review (Form RB-89.3)*
  - *Section 32 Settlement Agreement: Claimant Release (Form C-32.1)*
  - *Carrier's/Self-Insured Employer's Affirmation (Form C-32AF)*
- A full listing can be found on the Forms section at **wcb.ny.gov**.

Disability benefits form updates

- The Board has posted the updated *Notice and Proof of Claim for Disability Benefits (Form DB-450)* to the Forms section at **wcb.ny.gov**
- The new *Notice of Denial of Claim for Disability Benefits (Form DB-DEN)* will be available upon request
- The Board has also revised the *New York State Disability Benefits Statement of Rights (Form DB-271S)*
- For more information, email **regulations@wcb.ny.gov**

Updated travel reimbursement rate

Updated travel reimbursement rate

Effective January 20, 2024

- The mileage rate for reimbursement to injured workers for travel by automobile is 67 cents per mile.

OnBoard

OnBoard updates

- To date, nearly 49,000 payers and reviewers have signed up for access.
- **Nearly 1.5 million prior authorization requests (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 two weeks.
- 95% of PARs were 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 three PAR reviews from over 8,000 down to zero!
- Multifactor authentication now in effect

Providers can assign delegates

New!

- Provider delegates can now draft and submit PARs.
- They can now also draft and escalate Medication PARs to Level 2 review.

Provider delegates also have ability to:

- Draft and submit PAR escalations to Level 3 for Medical Director's Office review.
- Respond to insurer requests for information.
- Draft and submit *Request for Decision on Unpaid Medical Bill(s) (Form HP-1.0).*

PAR response time frames

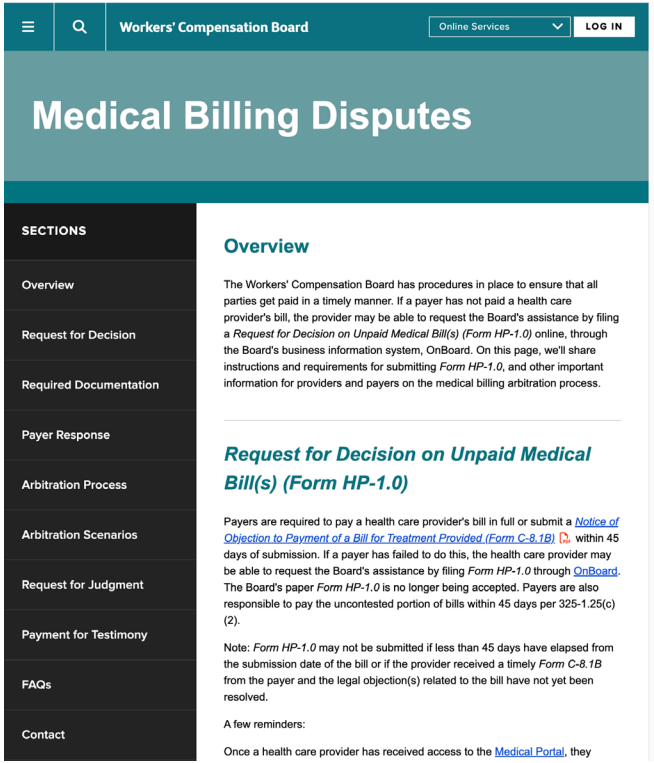
MTG Confirmation	Eight business days
MTG Variance	15 calendar days (extends to 30 with IME request)
MTG Special Services	15 calendar days (extends to 30 with IME request)
Non-MTG Over $1,000	30 calendar days
Non-MTG Under or = to $1,000	Eight business days
Medication	Four calendar days
Durable Medical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

Form HP-1.0 updates

- As of March 1, 2024, any *Form HP-1.0* submitted to the Board without proper documentation will be rejected.
- When submitting *Form HP-1.0*, providers must also attach:
  - Basis for provider belief that the clinical intervention was medically necessary,
  - Payer denial communications (if received), and
  - Scenario-specific documentation.

New! Medical billing disputes webpage

- Instructions, requirements, and details on the arbitration process.
- **wcb.ny.gov/content/main/hcpp/request-assistance-unpaid-medical-bills.jsp**
  - Visit wcb.ny.gov and search “medical billing disputes”



Form RFA-2 updates

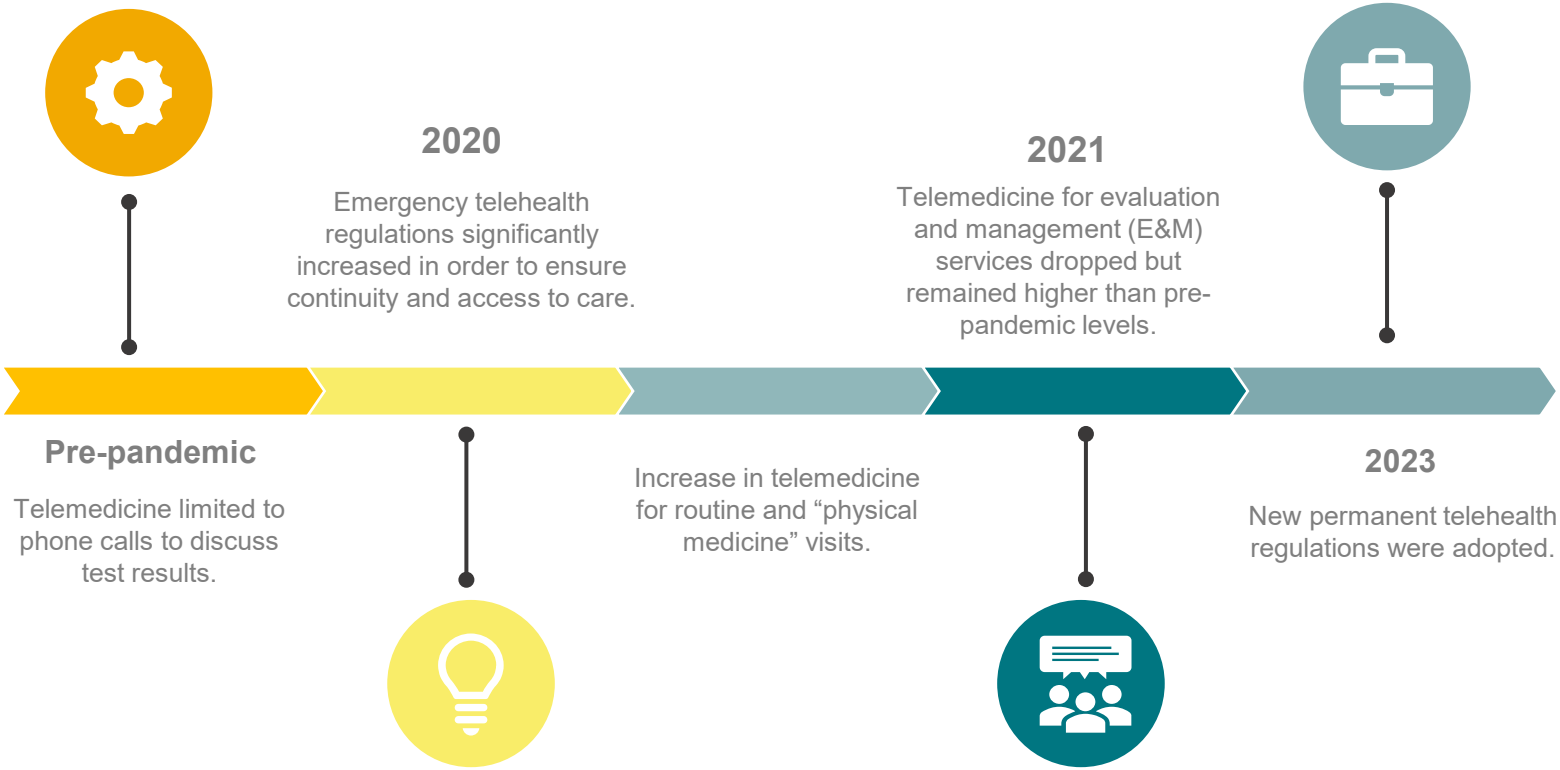
- The *Request for Further Action by Insurer/Employer (Form RFA-2)* has been modified.
- Updated version was available as of December 4, 2023.

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.**
- Need an OnBoard refresher? Visit **wcb.ny.gov/onboard/payers-overview.jsp**

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):

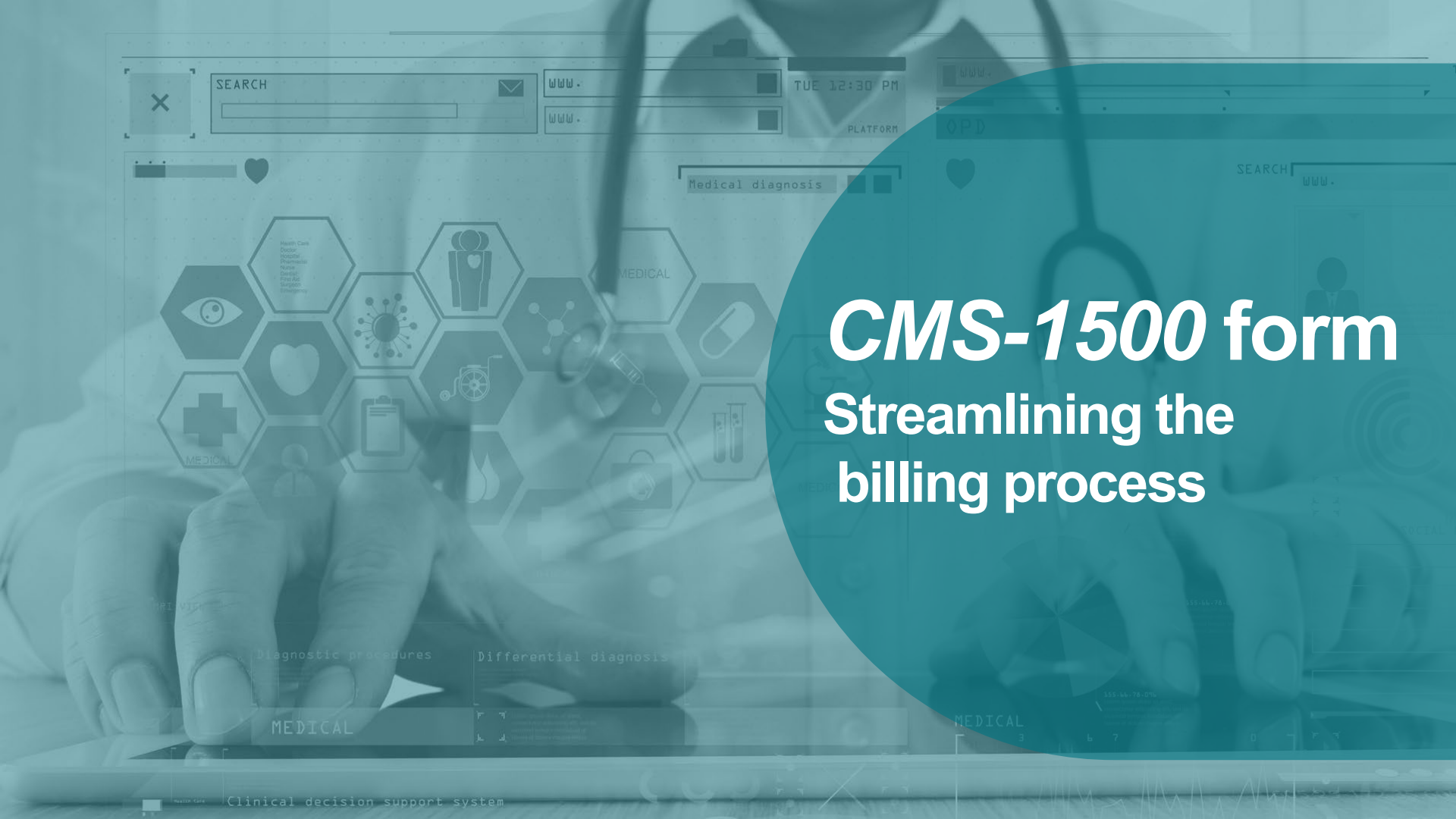
- **Psychologists** and **licensed clinical social workers (LCSWs)**:
  - Telehealth should be permitted for first and subsequent visits.
- Remote behavioral health visits should be limited to situations when there is no additional benefit compared to in-person services, or where in-person visit poses 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*).



CMS-1500 form

Streamlining the billing process

CMS-1500 form updates

- **Since July 1, 2022, the Board received nearly 10 million CMS-1500 forms!**
- Nearly **three million** electronic submissions.
- More than **11,000 providers** have submitted *CMS-1500* forms electronically through an electronic submission partner.

CMS-1500 form

- Consolidate/eliminate certain medical forms in exchange for *CMS-1500* form.
- The Board **strongly** encourages health care providers to submit through an electronic submission partner.
- 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.

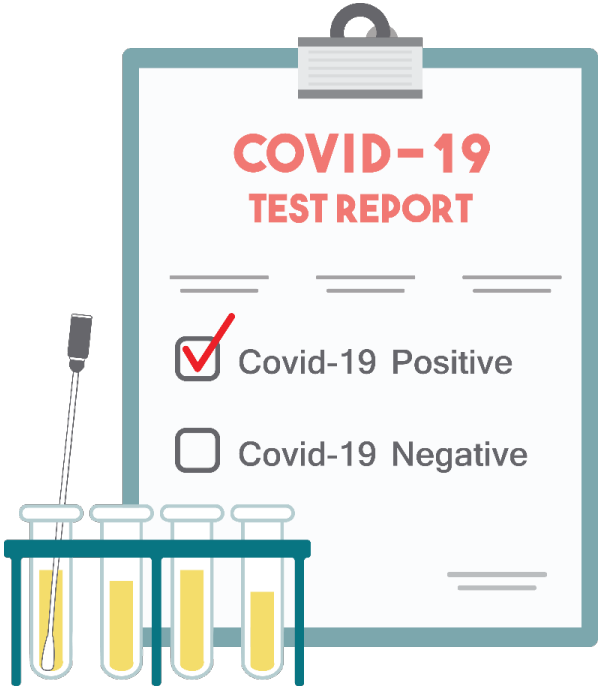
CMS-1500 medical narrative report template and requirements

- Payers are required to pay a health care provider's bill in full to submit a *Form C-8.1B* within 45 days of submission.
- If the payer fails to do this, the health care provider may be able to request the Board's assistance by filing *Form HP-1.0* through OnBoard.
- A complete medical bill must include:
  - CMS-1500, and
  - the supporting medical narrative.
- **Note:** there are some instances where the medical narrative report is not needed to properly adjudicate the medical bill.

Workers' compensation and COVID-19

Workers' compensation and COVID-19

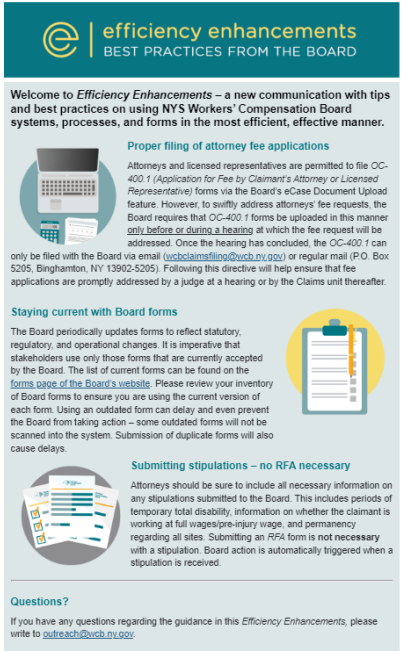
- Payers provide crucial benefits to both employees and employers.
- Payers should:
  - Be proactive in distributing information about COVID-19 claims.
  - Encourage employees to file claims, and employers to help.
  - Review claims carefully and timely.
- Employers may not discipline or discriminate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



Tips for efficiency

Efficiency campaign

- Regular updates on efficiency enhancements and best practices



efficiency enhancements
BEST PRACTICES FROM THE BOARD

Welcome to *Efficiency Enhancements* – a new communication with tips and best practices on using NYS Workers' Compensation Board systems, processes, and forms in the most efficient, effective manner.

Proper filing of attorney fee applications

Attorneys and licensed representatives are permitted to file *OC-400.1 (Application for Fee by Claimant's Attorney or Licensed Representative)* forms via the Board's eCase Document Upload feature. However, to swiftly address attorneys' fee requests, the Board requires that *OC-400.1* forms be uploaded in this manner only before or during a hearing at which the fee request will be addressed. Once the hearing has concluded, the *OC-400.1* can only be filed with the Board via email (wcbclaimsfiling@wcb.ny.gov) or regular mail (P.O. Box 5205, Binghamton, NY 13902-5205). Following this directive will help ensure that fee applications are promptly addressed by a judge at a hearing or by the Claims unit thereafter.

Staying current with Board forms

The Board periodically updates forms to reflect statutory, regulatory, and operational changes. It is imperative that stakeholders use only those forms that are currently accepted by the Board. The list of current forms can be found on the forms page of the Board's website. Please review your inventory of Board forms to ensure you are using the current version of each form. Using an outdated form can delay and even prevent the Board from taking action – some outdated forms will not be scanned into the system. Submission of duplicate forms will also cause delays.

Submitting stipulations – no RFA necessary

Attorneys should be sure to include all necessary information on any stipulations submitted to the Board. This includes periods of temporary total disability, information on whether the claimant is working at full wages/pre-injury wage, and permanency regarding all sites. Submitting an *RFA* form **is not necessary** with a stipulation. Board action is automatically triggered when a stipulation is received.

Questions?

If you have any questions regarding the guidance in this *Efficiency Enhancements*, please write to outreach@wcb.ny.gov.

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.

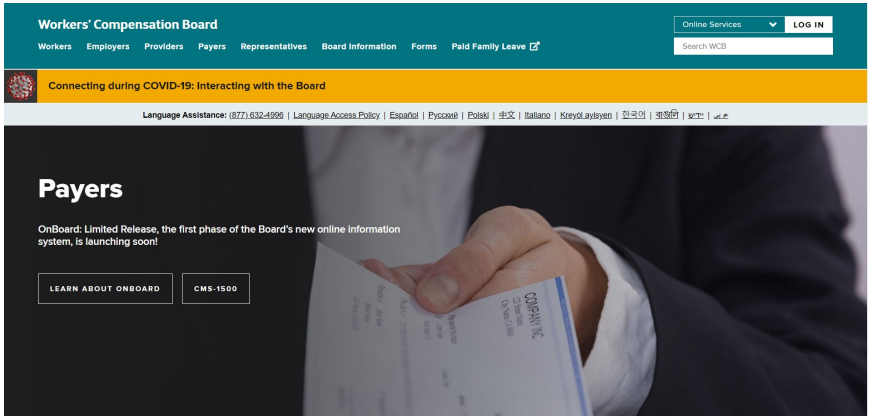
Prompt filing:

- 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.



NEW! What Payers Need to Know

Our toolkit for payers is now live on the Board's website (wcb.ny.gov). Easily access it from the Quick Links on the Payers page.

- Important resources and requirements.
- Instructions for accessing OnBoard and registering for the Medical Portal and eCase.
- Payer news and updates.
- And more!

PAYER TOOLKIT

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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Thank you

Questions?