OnBoard: Limited Release Training for Health Care Providers
Agenda

1. Recap
2. Timeline
3. Registration and Administration
4. Delegates
5. Accessing OnBoard
6. Submitting a Request for Decision on Unpaid Medical Bill(s) (Form HP-1.0)
7. Submitting a Medication Prior Authorization Request (PAR)
8. Dashboard Walkthrough
9. Insurer Response
10. Escalating Medication PARs
11. OnBoard Training Resources
Digitize and streamline the PAR process for the following requests:

<table>
<thead>
<tr>
<th>New PAR Name</th>
<th>Current Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTG Confirmation*</td>
<td>Attending Doctor’s Request for Optional Prior Approval and Carrier’s/Employer’s Response (Form MG-1)</td>
</tr>
<tr>
<td>MTG Variance</td>
<td>Attending Doctor’s Request for Approval of Variance and Carrier’s Response (Form MG-2)</td>
</tr>
<tr>
<td>MTG Special Services</td>
<td>Includes 13 procedures and second or subsequent procedures related to the New York Medical Treatment Guidelines (MTGs) on the Attending Doctor’s Request for Authorization and Carrier’s Response (Form C-4 AUTH)</td>
</tr>
<tr>
<td>Non-MTG Over $1,000</td>
<td>Includes any treatments/tests for a body part not covered by applicable MTGs costing more than $1,000 on Form C-4 AUTH</td>
</tr>
</tbody>
</table>

*Claim Administrators can no longer “opt out” of the process.
A response to the PAR is now mandatory.
New PARs in OnBoard

- Medication PARs (replacing the current Drug Formulary Prior Authorization Request Process)
- Durable Medical Equipment PARs
- Non-MTG under or $1,000

Disputed Medical Bills Submission

- Digitize and streamline the submission of Requests for Decision on Unpaid Medical Bill(s) (Form HP-1.0)
OBLR Timeline

1. **Phase One**
   Medication PARs & *Form HP-1.0*
   *includes medical marijuana requests via Medication PAR*
   March 7, 2022

2. **Phase Two**
   Durable Medical Equipment PARs
   April 4, 2022

3. **Phase Three**
   Treatment/Testing PARs
   May 2, 2022
Registration

- All providers who currently have access to the Medical Portal will automatically be registered for OnBoard: Limited Release
- Visit the Medical Portal web pages for health care provider registration and OnBoard administration information
OnBoard Administration

- Health Care Providers can register delegates to:
  - Draft PARs, which must be reviewed and submitted by the health care provider
  - Draft escalations to Level 2 Medication PARs, which must be reviewed and submitted by the health care provider
  - Draft PAR escalations to Level 3 for Medical Director's Office review
  - Respond to insurer requests for information (must be designated by the health care provider from within OnBoard)
  - Draft and submit Request for Decision on Unpaid Medical Bills (Form HP-1.0)

- View administration instructions on the Medical Portal web page to assign delegates
Delegate vs Provider

Provider Delegates can create prior authorization requests (PARs) to be reviewed and submitted by the health care provider. Provider delegates can also draft and submit Form HP-1.0s. To learn more about the role of the provider delegate, visit the Medical Portal Access and Administration: Health Care Providers page.

Billing Delegates can draft and submit Request for Decisions on Unpaid Medical Bill(s) (Form HP-1.0).

Health Care Providers are required to submit the PAR, whether drafted by themselves or drafted by their delegates. Any PAR drafted by a delegate will appear under the Health Care Provider's Draft eForms tab for final submission.
Multiple Delegates

- Providers can designate multiple delegates to draft PARs on their behalf.
- If a provider has multiple delegates, the delegates will see all PARs drafted and submitted by other delegates and the provider.
- Users can be a delegate for multiple providers.
Accessing OnBoard: Limited Release
How to Access OBLR

Locate Online Services drop-down list on Board website

Select Medical Portal
How to Access OBLR - Providers

Enter NY.GOV ID Username and Password

Health Care Providers will select Prior Authorization Request (PAR) or Request for Decision on Unpaid Medical Bill (Form HP-1.0)
Entering Your OnBoard Dashboard
# OBLR Dashboard

![Dashboard Image]

## My Dashboard

### Prior Auth
- Draft eForms
- Submitted eForms

### Active
- Resolved

<table>
<thead>
<tr>
<th>PAR ID</th>
<th>Type</th>
<th>Due Date</th>
<th>Patient</th>
<th>DOB</th>
<th>Current Activity</th>
<th>Injury Date</th>
<th>WCB Case #</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA-00-0002-209</td>
<td>MTG Variance</td>
<td></td>
<td></td>
<td></td>
<td>Pending L3 Review</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**New York State Workers’ Compensation Board**
# My Downloads

## Downloads

Files downloaded in the last 24 hours:

<table>
<thead>
<tr>
<th>File Name</th>
<th>Related ID</th>
<th>Related Object Type</th>
<th>Date Downloaded</th>
</tr>
</thead>
</table>

No files downloaded in the last 24 hours.

Page 1 of 0  🎁  🎁  🎁  🎁  Showing 0-0 of 0  🌐  Items per page
# My Organizations

![Diagram of My Profile with options: My Account, My Organizations, Log Out.]

## My Organizations

<table>
<thead>
<tr>
<th>Type</th>
<th>Name</th>
<th>Roles</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Provider</td>
<td><strong>John Smith</strong></td>
<td>Physician</td>
<td>01/01/2020</td>
</tr>
</tbody>
</table>

**Page 1 of 1**

**Showing 1 results**

**15 items per page**
Organization Details
Log Out
Submitting a Request for Decision on Unpaid Medical Bill(s) (Form HP-1.0)
Submit a Request
Claim Search

If the workers’ compensation insurance carrier hasn’t paid your bill within 45 days of submission and there are no outstanding legal issues regarding your bill’s compensability, the Board may be able to assist you. Use the wizard below to request help.

Claim Search

1. Enter either WCB Case # or Claim Administrator Claim #. The search uses exact values to locate a claim.

WCB Case #

Claim Admin Claim #

Must be 8 characters in length. The first character may be any number or letter EXCEPT [B,C,E,J,O]; the second character may be any number or letter EXCEPT [L,O], and the remaining 6 must be numbers.

[Search for Claim]  [Clear Search]
Claim Search

If the workers’ compensation insurance carrier hasn’t paid your bill within 45 days of submission and there are no outstanding legal issues regarding your bill’s compensability, the Board may be able to assist you. Use the wizard below to request help.

Claim Search

1. Enter either WCB Case # or Claim Administrator Claim #. The search uses exact values to locate a claim.

   WCB Case #
   
   Claim Admin Claim #

   Must be 8 characters in length. The first character may be any number or letter EXCEPT [B,C,E,I,O], the second character may be any number or letter EXCEPT [I,O], and the remaining 6 must be numbers.

2. Enter only two of the below fields to search for this claim.

   Date of Injury
   
   Date of Birth
   
   Lost Four of SSN
   
   Patient Last Name

   (MM/DD/YYYY) If exact date of injury/illness is not known, use other search criteria.

   (MM/DD/YYYY)

   Search for Claim   Clear Search
## Search Results

Matching Claim found. Please review the information populated here before proceeding with the Request.

### Patient

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient DOB</th>
<th>Patient SSN</th>
<th>Patient Gender</th>
<th>Patient Address</th>
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</thead>
</table>

### Case Information

<table>
<thead>
<tr>
<th>WCB Case #</th>
<th>Claim Admin Claim #</th>
<th>Date of Injury</th>
<th>Case Controverted</th>
<th>Case Established</th>
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<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Established For</th>
<th>Filed Date</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

### Employer

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Employer Address</th>
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<tr>
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</table>

### Insurer

<table>
<thead>
<tr>
<th>Insurer Name</th>
<th>Insurer ID</th>
<th>Claim Administrator</th>
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<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Admin Name</th>
<th>Claim Admin ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
User Information - Health Care Provider

User Information

On Behalf Of

License

WCB Authorization #

Is Treat Authorized?

'Yes'

Associated Specialties
Provider Information - Health Care Provider
Form C-8.4 Information

Notice of Refusal to Pay All (or a Portion of) a Bill Due to Valuation Objection(s) (Form C-8.4)

Information

Please Note: This information will be subject to independent verification by the WCB upon submission.

Medical Bill Submission Date*

01/01/2021

Within 45 days of receipt, an insurance carrier has the right to object to your bill with Form C-8.4 questioning the fairness of the total amount that you charged.

Have you received a valuation objection (Form C-8.4) from the claim administrator?*

- Yes
- No

When was the valuation objection issued by the claim administrator?*

01/08/2021

(yyyy/mm/dd)
Form C-8.1 Information

Notice of Treatment Issue/Disputed Bill (Form C-8.1) Information

Please Note: This information will be subject to independent verification by the WCB upon submission.

Within 45 days of receipt, an insurance carrier has the right to object to your bill with Form C-81 raising legal issues. These issues must be resolved in your favor through the adjudication process before you can proceed with your HRI request.

Have you received a legal objection (Form C-8.1) from the claim administrator?*

- Yes
- No

When was the legal objection issued by the claim administrator?*

01/08/2021

Once the legal objection (Form C-81) has been resolved, an official notice (Form EC-23 or PD-NSL) is issued with the ruling.

Have you received a notice of decision (Form EC-23 or PD-NSL) resolving the legal objection that was not appealed or objected to by any party?*

- Yes
- No

Was the legal objection resolved in your favor?*

- Yes
- No

What is the filing date of the notice of decision? You can find this date by looking at the lower-right hand corner of the decision.*

11/05/2021

*
Medical Bill Information

- **Total Charge**: $100.00
- **Amount Paid**: $50.00
- **Start Date of Service**: 12/01/2020
- **End Date of Service**: 12/07/2020
- **Number of Bills Attached**: 1
Documents

Recommended document format is PDF (.pdf). Other acceptable formats are: text (.doc, .docx, .rtf, .txt), spreadsheet (.csv, .xlsx, .xls), and image (.tiff, .jpeg, .jpg, .png). Non-PDF files will be converted to PDF. The maximum combined total for all uploaded documents is 30 MB.

Upload Required Documents
Copies of the medical bill(s) along with the written explanation of partial or non-payment (including Form C-8.4) must be attached.

### File Name Type Description Actions

<table>
<thead>
<tr>
<th>Medical Bill</th>
<th>Attached Medical Bill</th>
<th><img src="#" alt="Upload" /></th>
</tr>
</thead>
<tbody>
<tr>
<td>C-8.4 Notice of Refusal to Pay Due to Valuation Objection(s)</td>
<td>Attached C-8.4 Notice of Refusal to Pay Due to Valuation Objection(s)</td>
<td><img src="#" alt="Upload" /></td>
</tr>
</tbody>
</table>

Upload Additional Documents
Additional documents such as multiple bills and C-8.4 forms, detailed medical narrative, grouper calculation report, pro-rata agreement between co-surgeons, or invoice for medical supplies may also be attached for consideration by the Arbitrator.

![Upload](#)
Documents

Recommended document format is PDF (.pdf). Other acceptable formats are: text (doc, .docx, .rtf, .txt), spreadsheet (.csv, .xls, .xlsx, .ods), and image (.tiff, .jpeg, .jpg, .png). Non-PDF files will be converted to PDF. The maximum combined total for all uploaded documents is 30 MB.

Upload Required Documents
A copy of the medical bill(s) must be attached.

<table>
<thead>
<tr>
<th>File Name</th>
<th>Type</th>
<th>Description</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical Bill</td>
<td>Attached Medical Bill</td>
<td>[Upload]</td>
</tr>
</tbody>
</table>

Upload Additional Documents
Additional documents such as multiple bills or nonpayment explanations (including Form C-8.4), detailed medical narrative, grouper calculation report, pro-rata agreement between co-surgeons, or invoice for the medical supplies can also be submitted along with the request for consideration by the Arbitrator.

[Upload]
Upload Documents

**Upload Document**

*Form Name:* Medical Bill

*Description*:

Attached Medical Bill

[Browser button]

No File Selected

[Upload button] [Cancel button]
Confirm Uploaded Documents

### Documents

Recommended document format is PDF (pdf). Other acceptable formats are text (.txt), docx, doc, rtf, rtf, spreadsheet (.csv, .xls, .xlsx), and image (.gif, .jpeg, .jpg, .png). Non-PDF files will be converted to PDF. The maximum combined total for all uploaded documents is 30 MB.

#### Upload Required Documents

Copies of the medical bill along with the written explanation of partial or non-payment (including Form C-84) must be attached.

<table>
<thead>
<tr>
<th>File Name</th>
<th>Type</th>
<th>Description</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Bill.pdf</td>
<td>Medical Bill</td>
<td>Attached Medical Bill</td>
<td>Update Description</td>
</tr>
<tr>
<td>Medication Documentation.ppt</td>
<td>C-84 Notice of Refusal to Pay Due to Valuation Objection(s)</td>
<td>Attached C-84 Notice of Refusal to Pay Due to Valuation Objection(s)</td>
<td>Update Description</td>
</tr>
</tbody>
</table>

#### Upload Additional Documents

Additional documents such as multiple bills and C-84 forms, detailed medical narrative, group calculation report, pro-rata agreement between co-surgeons, or invoice for medical supplies may also be attached for consideration by the Administrator.

- [Upload](#)

I affirm, under penalty of perjury, that:

1. The attached medical bill was submitted to the responsible insurer/self-insured employer for payment, AND
2. Proper payment in accordance with the applicable Fee Schedule has not been received, AND
3. I will abide by the NYS Workers’ Compensation Board’s decision.
I affirm, under penalty of perjury, that:

1. The attached medical bill(s) was submitted to the responsible insurer/self-insured employer for payment, AND
2. Proper payment in accordance with the applicable Fee Schedule has not been received, AND
3. I will abide by the NYS Workers’ Compensation Board’s decision.
Preview Form HP-1.0
## Submitting Form HP-1.0

- **eForm Document**: My Dashboard
- **eForm Name**: Submitted eForms
- **Patient Name**:
- **Patient DOB**:
- **WCB Case #**: UH-00-0001-015
- **eForm Details**: 06/28/2021
- **Provider**: Completed
- **Submitted Date**: 06/28/2021
- **Status**: Completed
- **Actions**:

### My Dashboard

- **eForm Document**: 245376
- **eForm Name**: Request for Decision on Unpaid Med
- **WCB Case #**: UH-00-0001-015
- **Provider**: 06/28/2021
- **Status**: Completed
- **Actions**:

- **eForm Document**: 245373
- **eForm Name**: PAR: Durable Medical Equipment Lev
- **WCB Case #**: PA-00-0001-630
- **Provider**: 06/25/2021
- **Status**: Completed
- **Actions**:

- **eForm Document**: 245370
- **eForm Name**: PAR: Non-MTG Over $1000 Level 1
- **WCB Case #**: PA-00-0001-629
- **Provider**: 06/22/2021
- **Status**: Completed
- **Actions**:

**New York State Workers’ Compensation Board**

38 **Better for Workers**

**Better for Business**
Submitting a Medication Prior Authorization Request
Create PAR

<table>
<thead>
<tr>
<th>PAR ID</th>
<th>Type</th>
<th>Due Date</th>
<th>Patient</th>
<th>DOB</th>
<th>Current Activity</th>
<th>Injury Date</th>
<th>WCB Case #</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA-00-0003-156</td>
<td>Medication</td>
<td>01/10/2022</td>
<td></td>
<td></td>
<td>Review Insurer Level 1 Deniel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PA-00-0001-643</td>
<td>MTG Confirmation</td>
<td>07/14/2022</td>
<td></td>
<td></td>
<td>Provider Response Request</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Select Prior Authorization Request

Prior Authorization Request

My Profile ➔ Submit a Request ➔

Prior Authorization (PAR)

Decision on Unpaid Medical Bill (HP-1.0)
Requester Information

Provider:

Please select License for this request:

B12408 Physician

WCB Authorization Number:

Claim Search ➜
Claim Search

If the workers’ compensation insurance carrier hasn’t paid your bill within 45 days of submission and there are no outstanding legal issues regarding your bill’s compensability, the Board may be able to assist you. Use the wizard below to request help.

**Claim Search**

1. Enter either WCB Case # or Claim Administrator Claim #. The search uses exact values to locate a claim.

- **WCB Case #**
  - Must be 8 characters in length. The first character may be any number or letter EXCEPT [B,C,E,I,O], the second character may be any number or letter EXCEPT [L], and the remaining 6 must be numbers

2. Enter only two of the below fields to search for this claim.

- **Date of Injury**
- **Date of Birth**
- **Last Four of SSN**
- **Patient Last Name**

[Search for Claim] [Clear Search]
Unmatched Claim
Request Items

Request Items

Provide the information below to add one or more items that you will be requesting prior authorization for on this claim.

Request #1
Select category of PAR for this item:

- Treatment/Testing
- Medication
- Durable Medical Equipment
- Non-Medical

Save
First Request Added
Save as Draft

Dashboard: Request for Prior Authorization

Complete Request(s)

Request Details
PAR: Medication RX-L1

Save as Draft

PAR QUESTIONNAIRE

CLAIM DETAILS

New York State Workers’ Compensation Board
Request Details

- PAR QUESTIONNAIRE
  - COMPLETE REQUEST(S)
  - PAR: MEDICATION
    - Request Details
      - Medical Necessity / Supporting Medical
      - Review and Submit

- Medication (Name/Strength) *
  - Oxycodeine 5mg/ml

- Quantity Requested *
  - 60

- Days Supply *
  - 30

- Type of Drug *
  - Brand Name
  - Generic

- Units Requested *
  - 0

- Type of Prescription *
  - New (Including Change in Dosage)
  - Refill/Renewal (Taken Within the Last Six Months)

- Route of Administration *
  - Oral/SL/Buccal

- Medical Necessity / Supporting Medical
Statement of Medical Necessity

Provide/attach all relevant clinical information to support this prior authorization request. Include narrative, progress notes, and other supporting documentation (e.g., symptoms, justification for initial or ongoing treatment, diagnostic testing, equipment, etc.), any contraindications or adverse effects experienced, and, if applicable, evaluation of efficacy of previous treatment or medication.

Statement of Medical Necessity

AND/OR

Supporting Medical Documentation

Recommended document format is PDF (pdf). Other acceptable formats are: Text (.doc, .docx, .rtf, .txt), Spreadsheet (.csv, .xls .xlsx, .ods), and Image (.tif, .jpeg, .jpg, .png). Non-PDF files will be converted to PDF. The maximum combined total for all uploaded documents is 30 MB.

- File Name: [Upload Relevant Clinical Information]
- Description: Attached Statement of Medical Necessity / Statement of Medical Necessity / Supporting Medical Documentation
Upload a Document

Form Name: Attached Statement of Medical Necessity

Please complete the required fields and click "Upload" to attach the document.

Description:

Medical file supporting narcotic request

Cancel  Upload
Upload a Document

<table>
<thead>
<tr>
<th>File Name</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting Medical Narcotic.pdf</td>
<td>Attached Statement of Medical Necessity</td>
<td>Medical file supporting narcotic request</td>
</tr>
</tbody>
</table>

- [Update Description]
- [Remove]
- [Upload Additional Documents]

Your document has been uploaded successfully.
Review and Submit
Delegated User

Confirmation

PAR: Medication was successfully saved as Ready to Submit.

This PAR has been added to the Draft tab of the My Dashboard, as well as for the responsible provider. It is the responsibility of the requesting provider to share this information with the patient.
Health Care Provider Submission

[Image of a webpage interface with buttons for 'Medical Necessity / Supporting Medical', 'Attest and Submit', and 'Preview']
Health Care Provider Attestation

Attestation and Submission

By submission of this request for prior authorization I certify that: (1) my statements are true and correct, (2) I do not have a substantially similar request pending, (3) the patient understands and agrees to undergo/use the proposed treatment/test/medication/DME, and (4) I accept that the use of my password to submit a Prior Authorization Request to the Workers' Compensation Board is equivalent to placing my signature on the request, affirming the information contained herein.

Submit  Cancel
Submission Confirmation

Submission Confirmation

PAR: Medication was successfully submitted. Allow 4 calendar days for the insurer to respond.

Your submission has been added to your Submitted eForms. From your Dashboard you can check the status of your submission and view, print, or download the completed eForm. It is the responsibility of the requesting provider to share this information with the patient.
# Updated Dashboard

## Prior Auth > Active Tab

### My Dashboard

<table>
<thead>
<tr>
<th>Prior Auth</th>
<th>Draft eForms</th>
<th>Submitted eForms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active</strong></td>
<td><strong>Resolved</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAR ID</th>
<th>Type</th>
<th>Due Date</th>
<th>Patient</th>
<th>DOB</th>
<th>Current Activity</th>
<th>Injury Date</th>
<th>WCB Case #</th>
<th>Assigned Organizatio</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA-00-0050-924</td>
<td>Medication</td>
<td>01/01/2023</td>
<td>Jones, Doe</td>
<td>01/01/2020</td>
<td>Insurer Level 1 Review</td>
<td>01/01/2023</td>
<td>0123456789</td>
<td>1234567890</td>
</tr>
</tbody>
</table>

*New York State Workers’ Compensation Board*
### Updated Dashboard

**Submitted eForms**

<table>
<thead>
<tr>
<th>eForm Document</th>
<th>eForm Name</th>
<th>Patient Name</th>
<th>Patient DOB</th>
<th>WCB Case #</th>
<th>eForm Details</th>
<th>Provider</th>
<th>Submitted Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>345378</td>
<td>PAR: Medication Level 1 Request</td>
<td></td>
<td>01/09/1972</td>
<td>PA-00-0001-631</td>
<td></td>
<td></td>
<td>07/01/2021</td>
<td>Completed</td>
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<tr>
<td>345376</td>
<td>Request for Decision on Unpaid Medical Bill(s)</td>
<td></td>
<td>01/09/1972</td>
<td>UB-00-0001-015</td>
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<tr>
<td>345373</td>
<td>PAR: Durable Medical Equipment Level 1 Request</td>
<td></td>
<td>01/09/1972</td>
<td>PA-00-0001-630</td>
<td></td>
<td></td>
<td>06/25/2021</td>
<td>Completed</td>
</tr>
<tr>
<td>345370</td>
<td>PAR: Non-MTG Over $1000 Level 1 Request</td>
<td></td>
<td>12/26/1975</td>
<td>PA-00-0001-629</td>
<td></td>
<td></td>
<td>06/22/2021</td>
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</table>
Insurer Response to Medication PAR
**Insurer Response**

**Medication Request**

<table>
<thead>
<tr>
<th>Related Entities</th>
<th>Request Details</th>
<th>Medical Necessity</th>
<th>Documents</th>
<th>Related PARs</th>
<th>Correspondence History</th>
<th>Related Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deny</td>
<td>Overall L2 Insurer Response</td>
<td>L2 Reviewer Name - Title</td>
<td></td>
<td>L2 Response Date &amp; Time</td>
<td>3/10/2021 11:16 PM</td>
<td></td>
</tr>
</tbody>
</table>

**Request Items**

<table>
<thead>
<tr>
<th>Request #1</th>
<th>Medication Requested</th>
<th>Quantity Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-Anxiety Agent</td>
<td>Test</td>
<td>2</td>
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</table>

**Additional Request Details**

<table>
<thead>
<tr>
<th>Level 1 Insurer Response Details</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Level 2 Insurer Response Details</th>
</tr>
</thead>
</table>
Escalating the Medication PAR to Level 2 or Level 3 Review
### Escalating to Level 2 Review

<table>
<thead>
<tr>
<th>PAR ID</th>
<th>Type</th>
<th>Due Date</th>
<th>Patient</th>
<th>DOB</th>
<th>Current Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA-00-0003-139</td>
<td>Medication</td>
<td>12/16/2021</td>
<td></td>
<td></td>
<td>Review Insurer Level 1 Grant in Part</td>
</tr>
</tbody>
</table>
Request L2 or L3 Review
Rationale for Level 2 Escalation

**Level 2 Request**
Providers are required to provide relevant clinical information in the space below or attach additional relevant documentation to support the Level 2 request for review and specifically address the issues raised in the Level 1 denial or partial approval.

**L2 Request Details**

**Rationale for L2 Request**
Additional relevant document is attached describing why an increase to Qty #60 is indicated.

**Provider Details**

Provider Name: [Name]
Date of Request: 07/01/2021

**Supporting Documentation**
Please attach additional relevant documentation to support your request.

Recommended document format is PDF (.pdf). Other acceptable formats are: Text (.doc, .docx, .rtf, .txt), Spreadsheet (.csv, .xls, .xlsx, .ods), and Image (.tiff, .jpeg, .jpg, .png). Non-PDF files will be converted to PDF. The maximum combined total for all uploaded documents is 30 MB.

<table>
<thead>
<tr>
<th>File Name</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upload Relevant Clinical Information</td>
<td>Supporting Documentation</td>
<td>Supporting Documentation for L2 Review Request</td>
</tr>
</tbody>
</table>

[Upload Additional Documents]
Escalation Reason for Level 3 Review

Request for MDO Prior Auth Review: RX-L3

Please select which item(s) you would like to escalate.

Therapeutic Category
- Narcotic

Insurer Response
- Deny

Rationale
The documentation of efficacy from previous use of this medication does not provide enough rationale for the increase in quantity.

Escalation Reason

Medication (Name/Strength)
- Oxycodone 5/325mg

Denial Reason
- Continuation of Medication - no documentation of efficacy

Without Prejudice

Submit  Cancel
Escalation Submitted

PAR: Medication Level 2 Request - RX-L2 Successfully Submitted

Your submission has been added to your Submitted eForms.
Thank you for your submission, your request has been submitted.

eForm Confirmation Number
345394

Submitted On
07/09/2021 10:39 AM

PAR Details
PA-00-0001-635

Associated Document(s)
- DO-00-0001-887: PAR.ATT:SMN - Attached Statement of Medical Necessity

[Links: Print Completed eForm, Download Completed eForm, View Completed eForm]
### Escalation in Submitted eForms

<table>
<thead>
<tr>
<th>eForm Document</th>
<th>eForm Name</th>
<th>Patient Name</th>
<th>Patient DOB</th>
<th>WCB Case #</th>
<th>eForm Details</th>
<th>Provider</th>
<th>Submitted Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>345394</td>
<td>PAR: Medication Level 2 Request</td>
<td></td>
<td></td>
<td>P0-00-0001-635</td>
<td></td>
<td></td>
<td>07/01/2021</td>
<td>Completed</td>
</tr>
</tbody>
</table>

---

**New York State Workers’ Compensation Board**
**Escalation in Submitted eForms**

![My Dashboard](image)

| PAR ID       | Type    | Due Date | Patient | DOB   | Current Activity   | Injury Date | WCB Case # | Assigned Org
er
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PA-00-0003-139</td>
<td>Medication</td>
<td>12/10/2021</td>
<td></td>
<td></td>
<td>Insurer Level 2 Review</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Level 3 Response

<table>
<thead>
<tr>
<th>PAR ID</th>
<th>Type</th>
<th>Patient</th>
<th>DOB</th>
<th>PAR Status</th>
<th>PAR Status Date</th>
<th>Injury Date</th>
<th>WCB Case #</th>
<th>Claim Admin Claim #</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA-00-0003-139</td>
<td>Medication</td>
<td></td>
<td></td>
<td>L3 Granted - Final</td>
<td>12/06/2021 13:19:24</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
View Notice of Resolution
Navigating Your Dashboard
Dashboard Features

Sorting Columns
Dashboard Features
Filtering Columns
**Prior Auth - Active Tab**

![My Dashboard](image)

### Table: My Dashboard

<table>
<thead>
<tr>
<th>PAR ID</th>
<th>Type</th>
<th>Due Date</th>
<th>Patient</th>
<th>DOB</th>
<th>Current Activity</th>
<th>Injury Date</th>
<th>WCB Case #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Assigned Organization</th>
<th>Assigned User</th>
<th>Claim Admin Claim #</th>
<th>Claim Admin</th>
<th>Insurer</th>
<th>Provider</th>
<th>PAR Status</th>
<th>PAR Status Date</th>
</tr>
</thead>
</table>
## Prior Auth – Resolved Tab

### My Dashboard

<table>
<thead>
<tr>
<th>Prior Auth</th>
<th>Draft eForms</th>
<th>Submitted eForms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resolved</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAR ID</th>
<th>Type</th>
<th>Patient</th>
<th>DOB</th>
<th>PAR Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PA-00-0001-568</strong></td>
<td>Durable Medical Equipment</td>
<td>[Redacted]</td>
<td>[Redacted]</td>
<td>Grant After Deny</td>
</tr>
<tr>
<td><strong>PA-00-0001-573</strong></td>
<td>Durable Medical Equipment</td>
<td>[Redacted]</td>
<td>[Redacted]</td>
<td>L1 Granted - Final</td>
</tr>
</tbody>
</table>
Draft eForms Tab

My Dashboard

Prior Auth  Draft eForms  Submitted eForms

If you want to resume an existing draft of an eForm, do so from the link below.

Draft eForm Name

PAR: MTG Variance Level 1 Review Draft

Patient Name

Page 1 of 1  1  >  >|  Showing 1-1 of 1

021

Actions

Discard Draft
Submitted eForms Tab

<table>
<thead>
<tr>
<th>eForm Document</th>
<th>eForm Name</th>
<th>Patient Name</th>
<th>Patient DOB</th>
<th>WCB Case #</th>
<th>eForm Details</th>
<th>For</th>
<th>Submitted Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>347375</td>
<td>PAR: Medication Level 1 Request</td>
<td></td>
<td>9/13/1988</td>
<td></td>
<td>PA-00-0002-797</td>
<td></td>
<td>8/10/2021</td>
<td>Completed</td>
</tr>
<tr>
<td>347373</td>
<td>PAR: Medication Level 1 Request</td>
<td></td>
<td>9/13/1988</td>
<td></td>
<td>PA-00-0002-796</td>
<td></td>
<td>8/10/2021</td>
<td>Completed</td>
</tr>
<tr>
<td>347371</td>
<td>PAR: Medication Level 1 Request</td>
<td></td>
<td>9/13/1988</td>
<td></td>
<td>PA-00-0002-795</td>
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<td>8/10/2021</td>
<td>Completed</td>
</tr>
<tr>
<td>347369</td>
<td>PAR: Medication Level 1 Request</td>
<td></td>
<td>9/13/1988</td>
<td></td>
<td>PA-00-0002-794</td>
<td></td>
<td>8/10/2021</td>
<td>Completed</td>
</tr>
</tbody>
</table>
Document: DO-00-0003-791

PRIOR AUTHORIZATION REQUEST: MEDICATION

Listed below are details of a Prior Authorization Request (PAR) that was submitted to request non-formulary medication(s). The claim administrator is required to respond by 08/14/2021; parties will be notified of the outcome.

<table>
<thead>
<tr>
<th>CLAIM INFORMATION</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>WCB Case #</td>
<td>Date of Injury</td>
<td>Claim Admin Claim #</td>
</tr>
</tbody>
</table>

Patient Name
Address
SSN
DOB
Gender

Employer Name
Address

Insurer Name
Address

Form ID
RX-L1

Form Name
PAR: Medication Level 1 Request

Description
Source
eForm

Viewable Date
8/10/2021

Received Date
8/10/2021

Related Information
Related ID
Related Object Name
## PAR Details

### Durable Medical Equipment Request

<table>
<thead>
<tr>
<th>Related Entities</th>
<th>Request Details</th>
<th>Medical Necessity</th>
<th>Documents</th>
<th>Related PARs</th>
<th>Correspondence History</th>
<th>Related Activity</th>
</tr>
</thead>
</table>

#### Patient Details

- **Patient Name:** [Redacted]
- **Last 4 of Patient SSN:** [Redacted]
- **Patient DOB:** [Redacted]

#### Claim Details

- **WCB Case #:** [Redacted]
- **Date of Injury:** 1/25/2018
- **Claim Admin Claim #:** [Redacted]

- **Case Controverted:** No
- **Body Part(s)/Condition(s):** CAREGIVER INJURED LEFT THUMB WHILE TRYING TO CALM AN INDIVIDUAL

#### Prior Authorization Request

- **Prior Authorization Request Type:** Durable Medical Equipment
- **Requested Date:** 8/9/2021

---

*Better for Workers*  
New York State Workers’ Compensation Board
## Durable Medical Equipment Request

**Patient Name:** [Redacted]  
**WCB Case #:** [Redacted]  
**Date of Injury:** 1/25/2018  
**Status:** L2 - Requested  
**System ID:** PA-00-0002-755

### Related Entities

<table>
<thead>
<tr>
<th>Related Entities</th>
<th>Request Details</th>
<th>Medical Necessity</th>
<th>Documents</th>
<th>Related PARs</th>
<th>Correspondence History</th>
<th>Related Activity</th>
</tr>
</thead>
</table>

### Related Entities and Users

- **Healthcare Provider:** SED324
- **WCB Authorization #:** [Redacted]
- **National Provider Identifier (NPI):** [Redacted]
- **Optometrist:**

- **Claimant:**

- **Claim Sender:** Insurance
- **WC Insurer ID:** [Redacted]
- **Entity Type:** Insurer

- **WCB Case #:** [Redacted]
- **Entity Type:** Claimant
- **Contact Address:** [Redacted]
- **Attorney Email Addresses:** [Redacted]
Durable Medical Equipment Request

Patient Name: [Redacted]  WCB Case #: [Redacted]  Status: L2 - Requested
Patient DOB: [Redacted]  Date of Injury: 1/25/2018  System ID: PA-00-0002-755

Related Entities  Request Details  Medical Necessity  Documents  Related PARs  Correspondence History  Related Activity

---

### Additional Request Details

<table>
<thead>
<tr>
<th>Item</th>
<th>Estimate Purchase Price</th>
<th>Estimated Rental Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMV Duration</td>
<td>$251511</td>
<td>$806</td>
</tr>
</tbody>
</table>

---

### Level 1 Insurer Response Details

- **L1 Insurer Response**: Deny
- **Purchase or Rental**: Deny
- **Dental Category**: Medical Reasons
- **Dental Reason**: Medical Necessity - documentation absent
- **Dental Rationale**: Insufficient medical documentation.

### Level 2 Insurer Response Details

- **L2 Insurer Response**: Deny
- **Purchase or Rental**: Deny
- **Dental Category**: Medical Reasons
- **Dental Reason**: Medical Necessity - documentation absent
- **Dental Rationale**: Insufficient documentation.

### Additional PAR Details

- **Is This Claim Apportioned?**: No
## Durable Medical Equipment Request

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>WCB Case #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Injury:</th>
<th>System ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>25/2018</td>
<td>PA-00-0002-755</td>
</tr>
</tbody>
</table>

### Statement of Medical Necessity

The injured worker requires bracing post-operatively to restrict movement.

Information related to medical necessity may also be viewed in the Documents section below if the provider uploaded supporting documentation.
# Durable Medical Equipment Request

**Patient Name:** [Redacted]

**WCB Case #:** [Redacted]

**Date of Injury:** 1/25/2018

**Status:** L2 - Requested

**System #:** PA-00-0002-755

## Documents

<table>
<thead>
<tr>
<th>Document ID</th>
<th>Form ID</th>
<th>Form Name</th>
<th>Received Date</th>
<th>Submitting User</th>
<th>On Behalf Of</th>
<th>Attachments</th>
</tr>
</thead>
<tbody>
<tr>
<td>DO-00-0095-027</td>
<td>EC-325-M62</td>
<td>PAR: MTG Variance Order of the Chair</td>
<td>12/10/2021 12:00 AM</td>
<td>[Redacted]</td>
<td>No</td>
<td>Actions</td>
</tr>
<tr>
<td>DO-00-0095-400</td>
<td>OTHER</td>
<td>Supporting Medical Documentation</td>
<td>11/24/2021 2:20 PM</td>
<td>[Redacted]</td>
<td>No</td>
<td>Actions</td>
</tr>
<tr>
<td>DO-00-0095-399</td>
<td>PAR.ATT.SM</td>
<td>Attached Statement of Medical Necessity</td>
<td>11/24/2021 2:20 PM</td>
<td>[Redacted]</td>
<td>No</td>
<td>Actions</td>
</tr>
<tr>
<td>DO-00-0095-398</td>
<td>M62-L1</td>
<td>PAR: MTG Variance Level 1 Request</td>
<td>11/24/2021 2:20 PM</td>
<td>[Redacted]</td>
<td>Yes</td>
<td>Actions</td>
</tr>
</tbody>
</table>
Durable Medical Equipment Request

Patient Name: [Redacted]
Patient DOB: [Redacted]
WCB Case #: [Redacted]
Date of Injury: 1/25/2018
System ID: PA-00-0002-755
Status: L2 - Requested

Related Entities  Request Details  Medical Necessity  Documents  Related PARs  Correspondence History  Related Activity

Related PARs

<table>
<thead>
<tr>
<th>PAR ID</th>
<th>Type</th>
<th>Provider</th>
<th>Request Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA-00-0002-807</td>
<td>Medication</td>
<td>[Redacted]</td>
<td>09/28/2021</td>
<td>L1 Denied</td>
</tr>
<tr>
<td>PA-00-0002-806</td>
<td>Medication</td>
<td>[Redacted]</td>
<td>08/27/2021</td>
<td>L1 Granted in Part - Final</td>
</tr>
</tbody>
</table>
# Durable Medical Equipment Request

**Patient Name:** [Redacted]; **WCB Case #:** [Redacted]; **Status:** L2 - Requested

**Patient DOB:** [Redacted]; **Date of Injury:** 1/25/2018; **System ID:** PA-00-0002-755

## Correspondence History

### Activity History Table

<table>
<thead>
<tr>
<th>Activity</th>
<th>Activity Status</th>
<th>Comments</th>
<th>Supporting Attachment</th>
<th>Assignee</th>
<th>Response Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Response Requested</td>
<td>Ready</td>
<td>Please provide more medical documentation</td>
<td></td>
<td></td>
<td>09/28/2021</td>
</tr>
</tbody>
</table>

**Page 1 of 1** | **Showing 1-1 of 1** | **10** Items per page
Durable Medical Equipment Request

Patient Name: [Redacted]
Patient DOB: [Redacted]
WCB Case #: [Redacted]
Date of Injury: 1/25/2018
Status: L2 - Requested
System ID: PA-00-0002-755

Correspondence History

Response Date: 09/28/2021
Response to Insurer
### Correspondence History

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>WCB Case #:</th>
<th>Status:</th>
<th>System ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>L2 - Requested</td>
<td>PA-00-0002-755</td>
</tr>
</tbody>
</table>

| Date of Injury: | 1/25/2018 |

#### Related Entities

#### Request Details

#### Medical Necessity

#### Documents

#### Related PARs

#### Correspondence History

---

**Response to Insurer**

**Response Date:** 09/28/2021  
**Actions:**

**Response to Insurer**

- **Further Information for Insurer:**

**Upload Supporting Attachment(s):**

- Recommended document format is PDF. Other acceptable formats are: text, doc, .docx, .rtf, .txt, spreadsheet (csv, .xls, .xlsx, .ods), and image (tif, .jpeg, .jpg, .png). Non-PDF files will be converted to PDF. The maximum combined total for all uploaded documents is 30 MB.

[Form Fields: Upload, Submit, Cancel]
Durable Medical Equipment Request

Patient Name: [Redacted]  |  WCB Case #: [Redacted]
Patient DOB: [Redacted]  |  Date of Injury: 1/25/2018

Status: L2 - Requested  |  System ID: PA-00-0002-755

Correspondence History

Response to Insurer

Request for further information:
Please provide more medical documentation.

Additional information for insurer:

Supporting Attachment(s)
Supporting attachments will open in a new tab.
- DO-00-0005-541

Close
# Durable Medical Equipment Request

**Patient Name:** [Redacted]  
**WCB Case #:** [Redacted]  
**Date of Injury:** 1/25/2018  
**Status:** L2 - Requested  
**System ID:** PA-00-0002-755  

## Related Activity History

This subsection contains a view of all activity requests. Please navigate to your dashboard for further information regarding open requests that may be assigned to you.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Activity Status</th>
<th>Due Date</th>
<th>Source</th>
<th>Assignee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurer Level 1 Review</td>
<td>Ready</td>
<td>07/14/2022</td>
<td>System Generated</td>
<td>Cycle 8 Insurance</td>
</tr>
<tr>
<td>Provider Response Requested</td>
<td>Completed</td>
<td>07/14/2022</td>
<td></td>
<td>[Redacted]</td>
</tr>
<tr>
<td>Provider Response Submitted</td>
<td>Auto Closed</td>
<td>07/14/2022</td>
<td></td>
<td>[Redacted]</td>
</tr>
</tbody>
</table>

Page 1 of 1  
Showing 1-3 of 3  
10 items per page
OnBoard
Training Resources
Health Care Providers

Physicians, PAs, NPs and other types of Board-authorized providers as well as dentists, audiologists and optometrists.

OVERVIEW

TRAINING

RESOURCES
<table>
<thead>
<tr>
<th>Accessing OnBoard: Limited Release</th>
<th>Claim Search</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dashboard Overview</td>
<td>Request for Decision on Unpaid Medical Bills (Form HP-1.0)</td>
</tr>
<tr>
<td>Notifications for Updates to Dashboard</td>
<td>Medication PAR</td>
</tr>
<tr>
<td>Generated Documents</td>
<td></td>
</tr>
<tr>
<td>Independent Medical Exam Request Notification</td>
<td></td>
</tr>
</tbody>
</table>
Submitting a Medication PAR

Provider Delegates can create prior authorization requests (PARs) to be reviewed and submitted by the health care provider. To learn more about the role of the provider delegate, visit the Medical Portal Access and Administration: Health Care Providers page.

Health Care Providers are required to submit the PAR, whether drafted by themselves or drafted by their delegates. Any PAR drafted by a delegate will appear under the Health Care Provider's Draft eForms tab for final submission.

Create PAR

To create a Medication PAR, select the Submit a Request button on the top right of your dashboard.
What’s Next?

- **Phase Two** will add Durable Medical Equipment PARs to OnBoard: Limited Release on April 4, 2022.
- **Phase Three** will add Treatment/Testing PARs to OnBoard: Limited Release on May 2, 2022.
- DME and Treatment/Testing training webinars will be announced via WCB Notifications!
General Questions: OnBoard@wcb.ny.gov

Other Questions: (877) 632-4996

News and Updates: Subscribe to WCB Notifications

Instructions: wcb.ny.gov/onboard/