NEW YORK STATE | Workers' Compensation Board

CONFERENCE 2024

OCTOBER 18

NEW YORK STATE | Workers' Compensation Board

Medical Director's Office Services and Support

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AGENDA

1. Introduction to the Medical Director's Office (MDO)
2. Fee Schedules and Medical Billing Unit
3. Provider Authorization and Continuous Quality Improvement Unit
4. Clinical Standards Unit
5. Case Examples
6. Helpful Tips

MEDICAL DIRECTOR'S OFFICE (MDO): WHAT WE DO

The MDO provides medical expertise to the NYS Workers' Compensation Board's internal and external stakeholders.

KEY FOCUS: Ensures timely, high-quality care and successful outcomes for injured workers.

HOW WE DO IT:

- Develop & maintain up to date evidenced-based medical treatment guidelines.
- Oversee recruitment, authorization, and retention of providers.
- Maintain relationships with professional associations of physicians and providers, government agencies, labor, business, and commercial entities.

MDO: WHAT WE DO

HOW WE DO IT (cont'd):

- Implement strategies and programs to ensure proper instructions.
- Regularly field stakeholder questions.
- Routinely serve as impartial reviewers of case files.

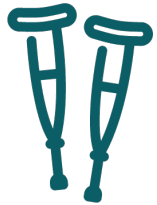
The MDO is overseen by a Medical Director and Deputy Director.

MDO: WHO WE ARE

1. Clinical Standards Unit
2. Fee Schedules and Medical Billing Unit
3. Provider Administration and Continuous Quality Improvement Unit

MDO: RECENT ACTIVITIES

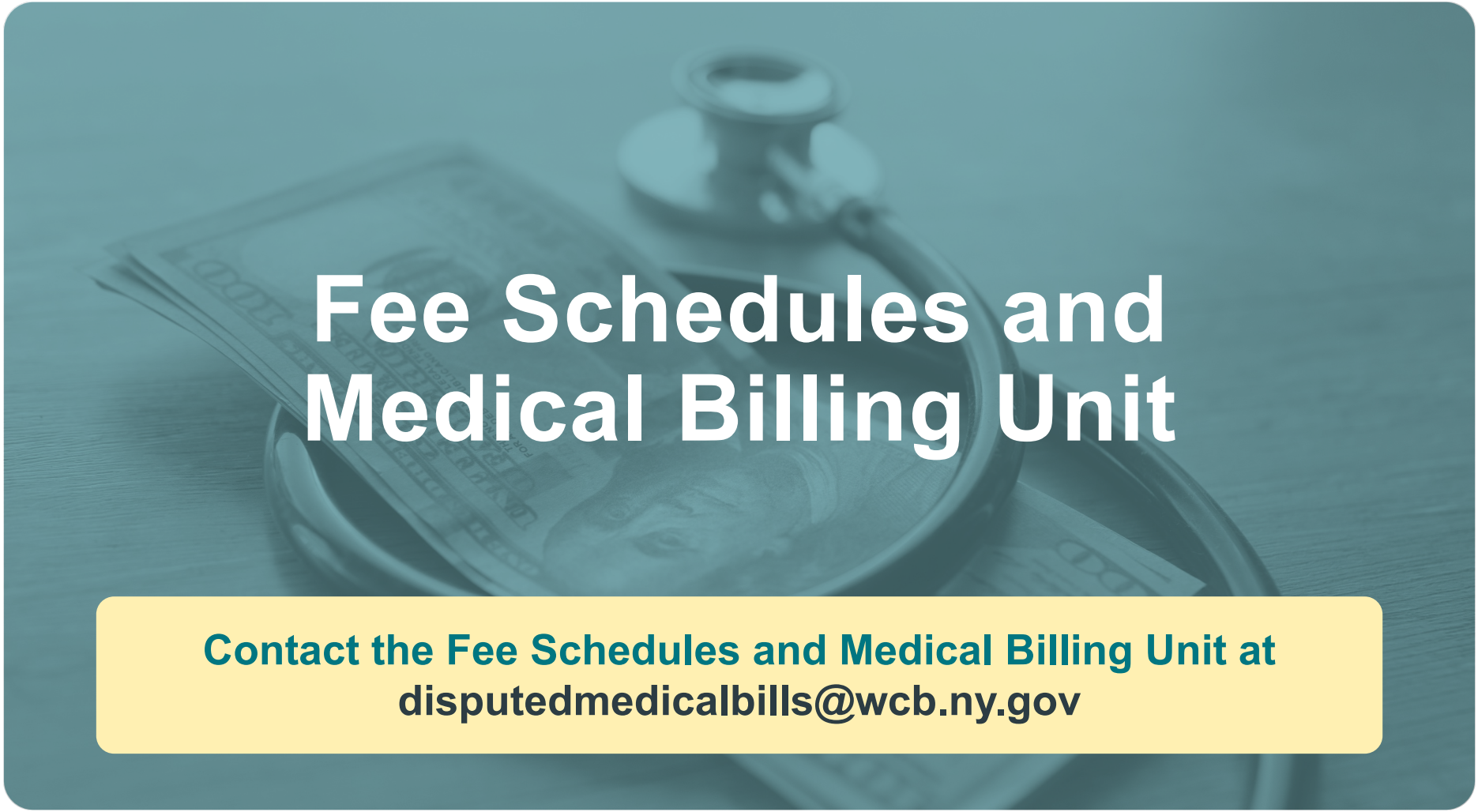
- OnBoard: Limited Release implementation (May 2022) — *Request for Decision on Unpaid Medical Bill(s) (Form HP-1.0)* and prior authorization requests (PARs)
- 16 new or updated *New York Medical Treatment Guidelines*
- *Durable Medical Equipment (DME) Fee Schedule* released 2022; updated yearly
- Disputed Medical Bills joined MDO in January 2022
- *CMS-1500* launched; mandatory electronic submission effective August 1, 2025
- New hires



MDO: RECENT ACCOMPLISHEMNTS

Provider disputes resolved faster than ever

- Administrative HP-1 Awards
  - Current turnaround time is less than two months
  - Down from 36,000 to 1,900
- Arbitration HP-1 Awards
  - Current turnaround time is two to three months
  - Down from 8,400 to 120



Fee Schedules and Medical Billing Unit

Contact the Fee Schedules and Medical Billing Unit at
disputedmedicalbills@wcb.ny.gov

FEE SCHEDULES AND MEDICAL BILLING UNIT

WHO WE ARE:

- Disputed Medical Bills
- Fee Schedules and Fee Arbitrations
- *CMS-1500*

WHAT WE DO:

- Provide clinical and billing expertise and stakeholder administrative support.
- Facilitate fee schedule updates, clarifications, and arbitrations.
- Address stakeholder questions and concerns regarding *CMS-1500.*

FEE SCHEDULES AND MEDICAL BILLING UNIT

WHAT WE DO (cont'd):

- Implement new and/or updated fee schedules; review coding changes.

  Updated *DME Fee Schedule* 2024

- Oversee the dispute resolution process for arbitration requests by health care providers.

- Conduct arbitration hearings.

FEE SCHEDULES AND MEDICAL BILLING UNIT

WHAT WE DO (cont'd):

- Oversee the dispute resolution process for unpaid or partially-paid medical bills.
- Process administrative award requests (*HP-1.0*) from providers: insurers/self-insured employers do not respond to bills with valid written objection [*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) (C-8.4)*] within 45 days.
- Process insurer/self-insured employer objections to administrative award .
- Process consent to file judgement.

MEDICAL BILLING DISPUTES

Enhanced Medical Billing Disputes section of the website includes arbitration scenarios and recommended actions.

Payee (health care provider) scenarios	Action and/or documentation required
Withdrawal	If your disputed bill has been paid according to the *Fee Schedule* since you submitted your arbitration request, please submit a *Notice to Chair: Health Provider's and Insurer's Withdrawal of Request for Arbitration (Form HP-4)* to withdraw your arbitration request.
Prior Authorization / MTGs	If the services required prior authorization, please submit documentation indicating that the services were approved by the payer through OnBoard or via the appropriate administrative or judicial communication from the Board. In 250 words or fewer, with specificity, please explain the medical necessity for the services, and include the appropriate *MTGs* reference. If the services do not require prior authorization, please submit an *MTGs* Verification Summary from the MTG Lookup Tool demonstrating so. Documentation from the MTG Lookup Tool does not constitute a prior authorization nor does it constitute a guarantee of payment.
Evaluation and Management Codes	If the payer has reduced payment, please provide, in 250 words or fewer, with specificity, a rationale for the CPT code that you billed.

Provider Administration and Continuous Quality Improvement Unit

Contact the Provider Authorization and Continuous Quality Improvement Unit at provider@wcb.ny.gov

PROVIDER ADMINISTRATION AND CONTINUOUS QUALITY IMPROVEMENT UNIT

WHO WE ARE:

- Clinical Support & Quality Assurance
  - Provides specialized, provider-level support
  - Reviews internal/external processes
- Provider Administration & Compliance
  - Oversees authorization process of new providers and re-registration
  - Reviews complaints regarding providers and related entities

PROVIDER ADMINISTRATION AND CONTINUOUS QUALITY IMPROVEMENT UNIT

WHAT WE DO:

- Assist providers with Board-authorized credentialing.
- Assist organization representatives with delegated credentialing.
- Provide injured workers with assistance in finding health care providers in various specialties and geographies.

PROVIDER ADMINISTRATION AND CONTINUOUS QUALITY IMPROVEMENT UNIT

WHAT WE DO (cont'd):

- Conduct outreach to providers' offices regarding workers' compensation.
- Keep provider medical specialties up-to-date.
- Collaborate with social work team to assist injured workers in crisis
- Work with other units to ensure compliance.
  - Billing practices
  - Provider conduct

Clinical Standards Unit

Contact the Clinical Standards Unit at
MDO@wcb.ny.gov

CLINICAL STANDARDS UNIT

WHO WE ARE:

- Medical Treatment Guidelines
- Drug Formulary and DME
- Special Services and Impairment Guidelines

WHAT WE DO:

- Develop and maintain up-to-date guidelines and educational materials.
- Routinely answer stakeholder inquiries.
- Resolve disputes over prior authorization requests (PARs).

CLINICAL STANDARDS UNIT

WHAT WE DO (cont'd):

- Provide one-on-one assistance with OnBoard and PAR process
  - OnBoard registration issues
  - Submission of PARs
- Provide one-on-one assistance with obtaining needed medications
  - Regular calls with pharmacies about the release of necessary medications


ONBOARD

ONBOARD: LIMITED RELEASE

- Since May 2022, **OnBoard: Limited Release** has been providing stakeholders with increased accuracy, paperless transactions, and a user-friendly interface for interacting with the Board.
- Today, health care providers and insurers are using OnBoard to request and review PARs for Medication, DME, and treatment/testing.
- Hundreds of PARs are successfully flowing through the system each day.

ONBOARD UPDATES

Recent enhancements

- Enable delegate submission of PARs
- Prevent duplicate submissions of *Form HP-1.0*
- Grant without prejudice at Level 1 review
- Level 2 review process updates
- Multi-factor authentication for improved security
- Other system processing efficiencies

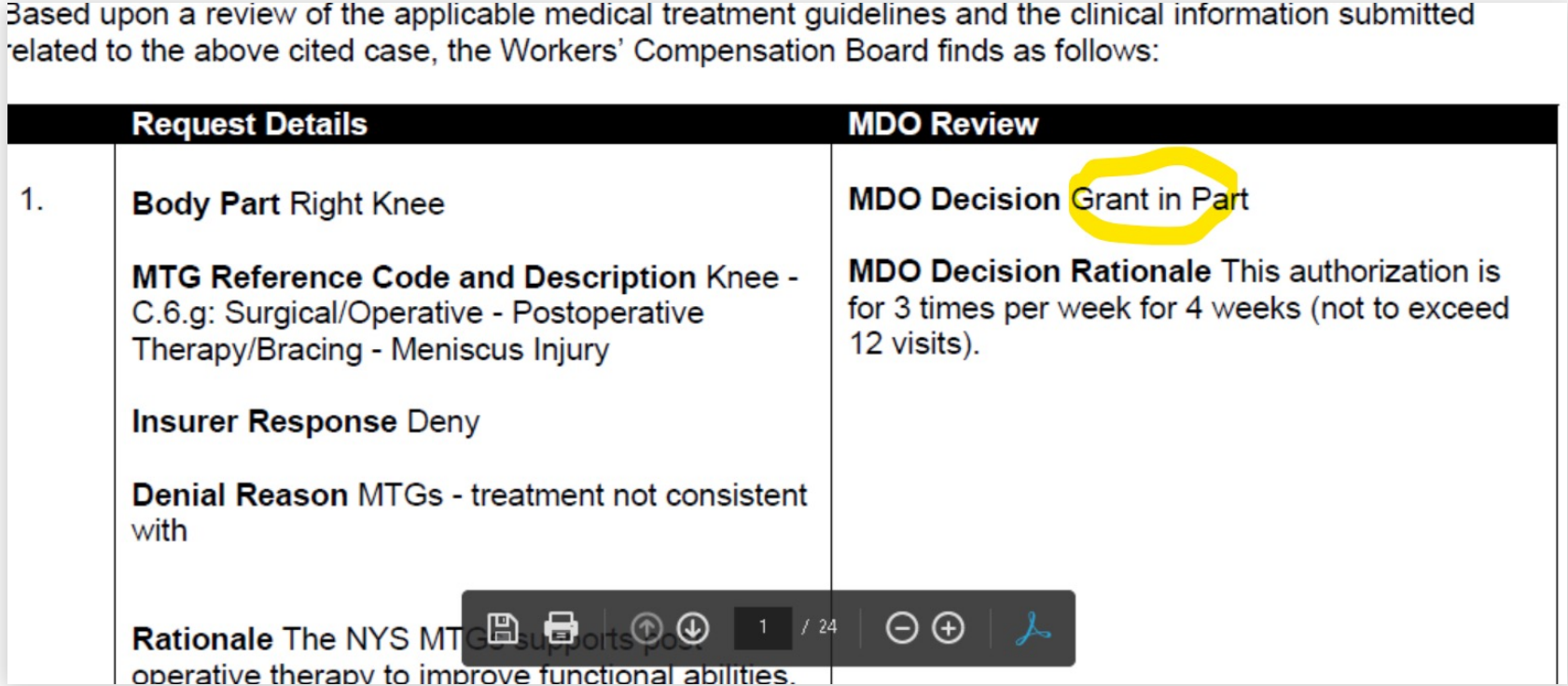

HELPFUL TIPS

HELPFUL TIP: MULTIPLE LINE ITEMS

- PARs may have multiple line items
- Review each line item

  Grant; Grant in Part; Deny within one PAR

HELPFUL TIP: MULTIPLE LINE ITEMS

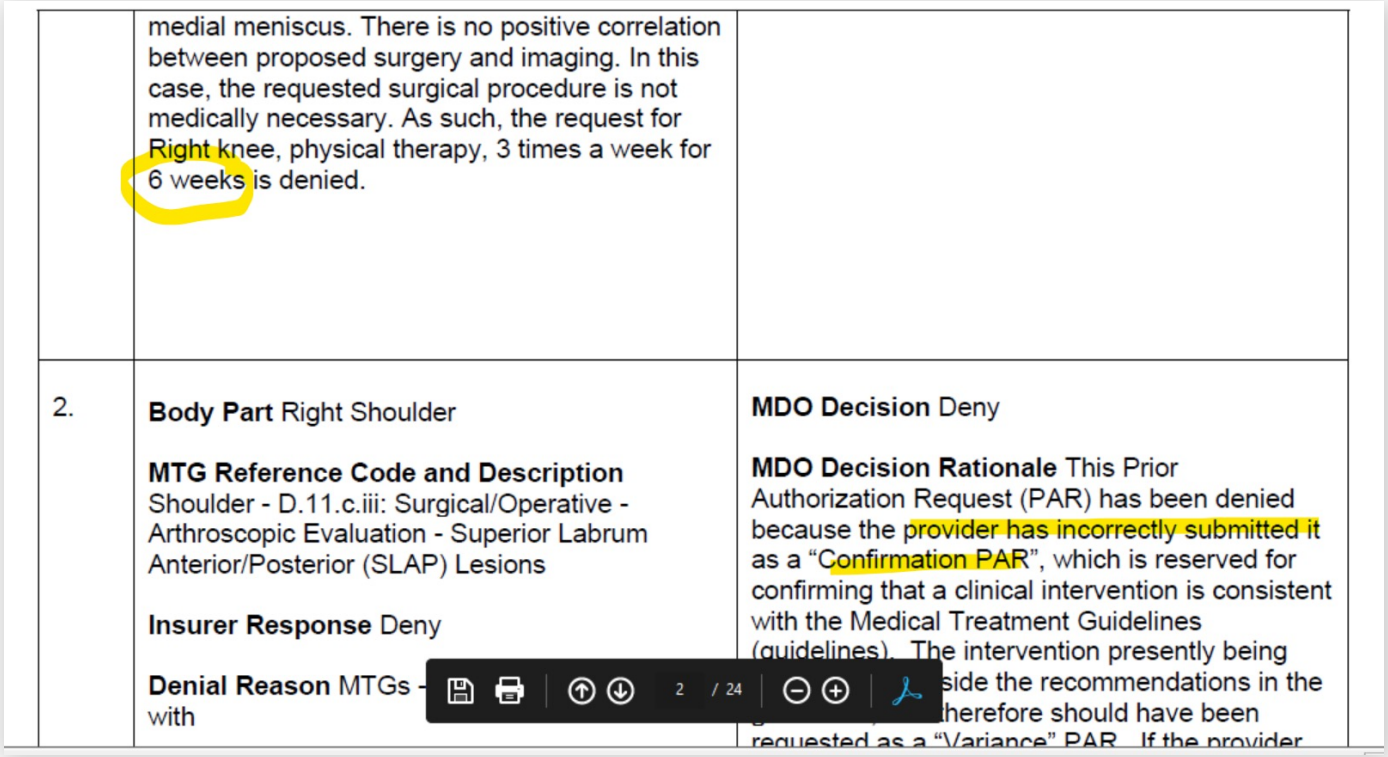


Based upon a review of the applicable medical treatment guidelines and the clinical information submitted related to the above cited case, the Workers' Compensation Board finds as follows:

	Request Details	MDO Review
1.	**Body Part** Right Knee **MTG Reference Code and Description** Knee - C.6.g: Surgical/Operative - Postoperative Therapy/Bracing - Meniscus Injury **Insurer Response** Deny **Denial Reason** MTGs - treatment not consistent with **Rationale** The NYS MTGs supports post operative therapy to improve functional abilities.	**MDO Decision** Grant in Part **MDO Decision Rationale** This authorization is for 3 times per week for 4 weeks (not to exceed 12 visits).

1 / 24

HELPFUL TIP: MULTIPLE LINE ITEMS



	medial meniscus. There is no positive correlation between proposed surgery and imaging. In this case, the requested surgical procedure is not medically necessary. As such, the request for Right knee, physical therapy, 3 times a week for 6 weeks is denied.	
2.	**Body Part** Right Shoulder **MTG Reference Code and Description** Shoulder - D.11.c.iii: Surgical/Operative - Arthroscopic Evaluation - Superior Labrum Anterior/Posterior (SLAP) Lesions **Insurer Response** Deny **Denial Reason** MTGs - with	**MDO Decision** Deny **MDO Decision Rationale** This Prior Authorization Request (PAR) has been denied because the provider has incorrectly submitted it as a "Confirmation PAR", which is reserved for confirming that a clinical intervention is consistent with the Medical Treatment Guidelines (guidelines). The intervention presently being side the recommendations in the herefore should have been requested as a "Variance" PAR. If the provider

HELPFUL TIP

Body Part Not Established vs. Body Part Disallowed

- Carrier **INAPPROPRIATELY** denies administratively on the basis that body part/condition is **not established**

  Carrier must deny for **medical reasons** OR

  Grant Without Prejudice

ESCALATED PARS: CASE STUDIES

CASE STUDY: DENIAL AS MOOT

Level 3 VARIANCE PAR

- Denied as moot due to an outstanding RFA
- Only mechanism to resolve PAR in **OnBoard**
- Not a denial based upon medical necessity

CASE STUDY: DENIAL AS MOOT (cont'd)

	Request Details	MDO Review
1.	**Body Part** Right Knee **MTG Reference Code and Description** Knee - D.3.d: Therapeutic Injection - Protein Rich Plasma (PRP) **Insurer Response** Deny **Denial Reason** Medical Necessity - documentation absent **Rationale** In this case, the patient reported complains of moderate right knee pain rated at visual analog scale (VAS) 10/10. The pain is constant and sharp, shooting. Pain is localized	**MDO Decision** Deny **MDO Decision Rationale** The request to review is moot. Review of the case file indicates that a RFA (Request for Further Action) has been filed requesting adjudication review of this PAR, therefore the MDO is unable to review this issue further at this time. PLEASE NOTE: The above-referenced "MDO review" was ONLY an ADMINISTRATIVE REVIEW, to determine the administrative status of this issue. It was NOT a CLINICAL REVIEW to determine medical necessity.

CASE STUDY: NO CARRIER RESPONSE

- MTG Confirmation PAR: **knee meniscal surgery**
- Insurer failed to respond within the required 8 business days.
- MDO approved “administratively” due to insurer’s failure to respond.

CASE STUDY: NO CARRIER RESPONSE (cont'd)

NOTICE OF RESOLUTION REGARDING TREATMENT
MTG Confirmation Prior Authorization Request
KEEP FOR YOUR RECORDS

This resolution is being issued in the above cited case in accordance with the Board's medical treatment guidelines for work-related injuries or illness.

The Workers' Compensation Board Medical Director's Office (MDO) has reviewed the carrier or self-insured employer ("carrier") denial/no response and the clinical information submitted with the prior authorization request for the MTG Confirmation by Muhammad Moral.

Based upon a review of the applicable medical treatment guidelines and the clinical information submitted related to the above cited case, the Workers' Compensation Board finds as follows:

	Request Details	MDO Review
1.	**Body Part** Other **MTG Reference Code and Description** Knee - C.6.f.ii: Surgical/Operative - Meniscetomy/Meniscus Repair - Meniscus Injury **Insurer Response** None	**MDO Decision** Grant **MDO Decision Rationale** The above-referenced "MDO review" was ONLY an ADMINISTRATIVE REVIEW, to determine the nature of the provider's Prior Authorization Request (PAR) and the payer's response. It was NOT a CLINICAL REVIEW to determine medical necessity. This PAR is being GRANTED by the NYS Workers' Compensation Board (the Board) SOLELY because the CARRIER FAILED TO PROVIDE A TIMELY RESPONSE TO THE PAR, as required by regulation, and it is the MDO's opinion that A SECOND OPINION regarding the medical necessity of the requested procedure IS ADVISABLE. To the PATIENT. A second opinion is advisable any time you are considering a surgical or

CASE STUDY: NO CARRIER RESPONSE (cont'd)

The prior-referenced "MDO review" was ONLY an ADMINISTRATIVE REVIEW, to determine the nature of the provider's PAR and the payer's response. It was NOT a CLINICAL REVIEW to determine medical necessity. This PAR is being GRANTED by the NYS Workers' Compensation Board (the Board) SOLELY because the CARRIER FAILED TO PROVIDE A TIMELY RESPONSE TO THE PAR, as required by regulation, and it is the MDO's opinion that A SECOND OPINION regarding the medical necessity of the requested procedure IS ADVISABLE.

To the PATIENT:

A second opinion is advisable any time you are considering a surgical or invasive procedure. It is recommended that you discuss with your treating physician whether you should obtain a second opinion from another physician regarding the risks and benefits of this medical service.

CASE STUDY: NO CARRIER RESPONSE (cont'd)

To the PROVIDER:

The Board has advised the patient to discuss with you whether to obtain a second opinion with respect to the requested medical services.
While a second opinion is not required, you are required to document in the medical record any discussions with the patient concerning a second opinion, and the results of the second opinion obtained.

To the PAYER:

A second opinion obtained by the patient for the requested medical service is considered medically necessary under the Workers' Compensation Law and must be paid by the payer.

CASE STUDY: DME PAR

PAR for a $110,000 myoelectric prosthetic

- 20-year-old injured worker suffered traumatic hand amputation.
- Body-powered prosthetic with hook is being utilized currently.
- Myoelectric testing done by provider, and injured worker found to be ready for myoelectric.

Two prior Level 3 PARs:

- Denied due to lack of tolerance to prosthetic.
- Denied due to documentation of non-healed stump.
- With this latest PAR, provider documentation of fully healed stump, lack of range of motion (ROM), and no fine motor skills with current body powered prosthetic.
- Injured worker has a new baby expected soon and is concerned regarding the hook and lack of mobility.

CASE STUDY: MTG CONFIRMATION PAR

22-year-old mechanic suffered lower-back injury in 2018 while lifting a tire. Provider requesting epidural steroid injection at L2-L3

- Receiving indemnity benefits; currently out of work.
- Underwent lumbar discectomy in 2019.
- MRI conducted in May 2022 demonstrates herniated discs L1-L5 and impingement of nerve roots at requested levels

CASE STUDY: MTG CONFIRMATION PAR (cont'd)

Rationale for Denial by MDO:

- Subsequent surgery — MTG Confirmation PAR should have been submitted as a Special Services PAR pursuant to 12 NYCRR 324.3.
- Review by MDO of the supporting documentation did not support a subsequent surgery — patient did not meet the criteria outlined in the *MTGs.*

CASE STUDY: MEDICATION PAR

PAR Request: Tramadol 50mg

- Insurer recently granted180 days
- PAR submitted 30 days later

MDO Denied:

- Supporting documentation must be submitted with PAR
- Statement of medical necessity did not include relevant information

MEDICAL DIRECTOR'S OFFICE (MDO)

HELPLINE: (800) 781-2362

EMAIL: MDO@wcb.ny.gov

WEBSITE: wcb.ny.gov

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THANK YOU