



2026 WORKERS' COMPENSATION CONFERENCE

COMMEMORATING THE 25TH ANNIVERSARY OF 9/11

OCTOBER 16 — ALBANY, NY



Workers'
Compensation
Board



Workers'
Compensation
Board

BEST PRACTICES & SUPPORT FROM THE MEDICAL DIRECTOR'S OFFICE



AUDREY CUNNINGHAM, DEPUTY DIRECTOR, MEDICAL DIRECTOR'S OFFICE

ACCREDITATION STATEMENT



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AGENDA

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Overview of the Medical Director's Office (MDO)





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

The MDO provides medical expertise to the NYS Workers' Compensation Board's (Board) stakeholders.

- **KEY FOCUS:** Ensure timely, high-quality care and successful outcomes for injured workers



- **HOW WE DO IT:**

- Develop and maintain current evidenced-based medical treatment guidelines
- Oversee recruitment, authorization, and retention of health care providers
- Maintain relationships with professional associations of health care 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
- Address stakeholder inquiries
- Serve as impartial reviewers of case files



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



MDO: WHO WE ARE



Clinical Standards Unit

**Fee Schedules and
Medical Billing Unit**

**Provider Administration
and Continuous Quality
Improvement Unit**



CLINICAL STANDARDS UNIT



WHAT WE OVERSEE

- Board's *New York Medical Treatment Guidelines (MTGs)*
- *NYS Workers' Compensation Drug Formulary (Drug Formulary)* and *Durable Medical Equipment (DME)*
- Special Services and *NYS Impairment Guidelines*

WHAT WE DO:

- Develop and maintain up-to-date guidelines and educational materials
- 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 to help injured workers obtain needed medications:
 - Regular calls with pharmacies about the release of necessary medications





FEE SCHEDULES AND MEDICAL BILLING UNIT



WHAT WE OVERSEE

- Disputed medical bills
- *Official New York Workers' Compensation Fee Schedules (Fee Schedules) and fee arbitrations*
- *CMS-1500 forms*

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* forms
- Implement new and/or updated fee schedules; review coding changes
- Oversee dispute resolution process for arbitration requests by health care providers



FEE SCHEDULES AND MEDICAL BILLING UNIT

WHAT WE DO (cont'd):

- Conduct arbitration hearings
- Oversee the dispute resolution process for unpaid or partially-paid medical bills
- Process administrative award requests from providers: *Request for Decision on Unpaid Medical Bill(s) (Form HP-1.0)*
- Act upon insurers/self-insured employers who do not respond to bills with a valid written objection within 45 days: *Notice to Health Care Provider/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)*
- Process insurer/self-insured employer objections to administrative awards
- Process consent to file judgements: *Provider's Request for Judgment of Award (Form HP-J1)*





PROVIDER ADMINISTRATION AND CONTINUOUS QUALITY IMPROVEMENT UNIT



WHAT WE OVERSEE

- **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

WHAT WE DO:

- Assist providers with Board-authorized credentialing
- Assist organization with delegated credentialing



PROVIDER ADMINISTRATION AND CONTINUOUS QUALITY IMPROVEMENT UNIT

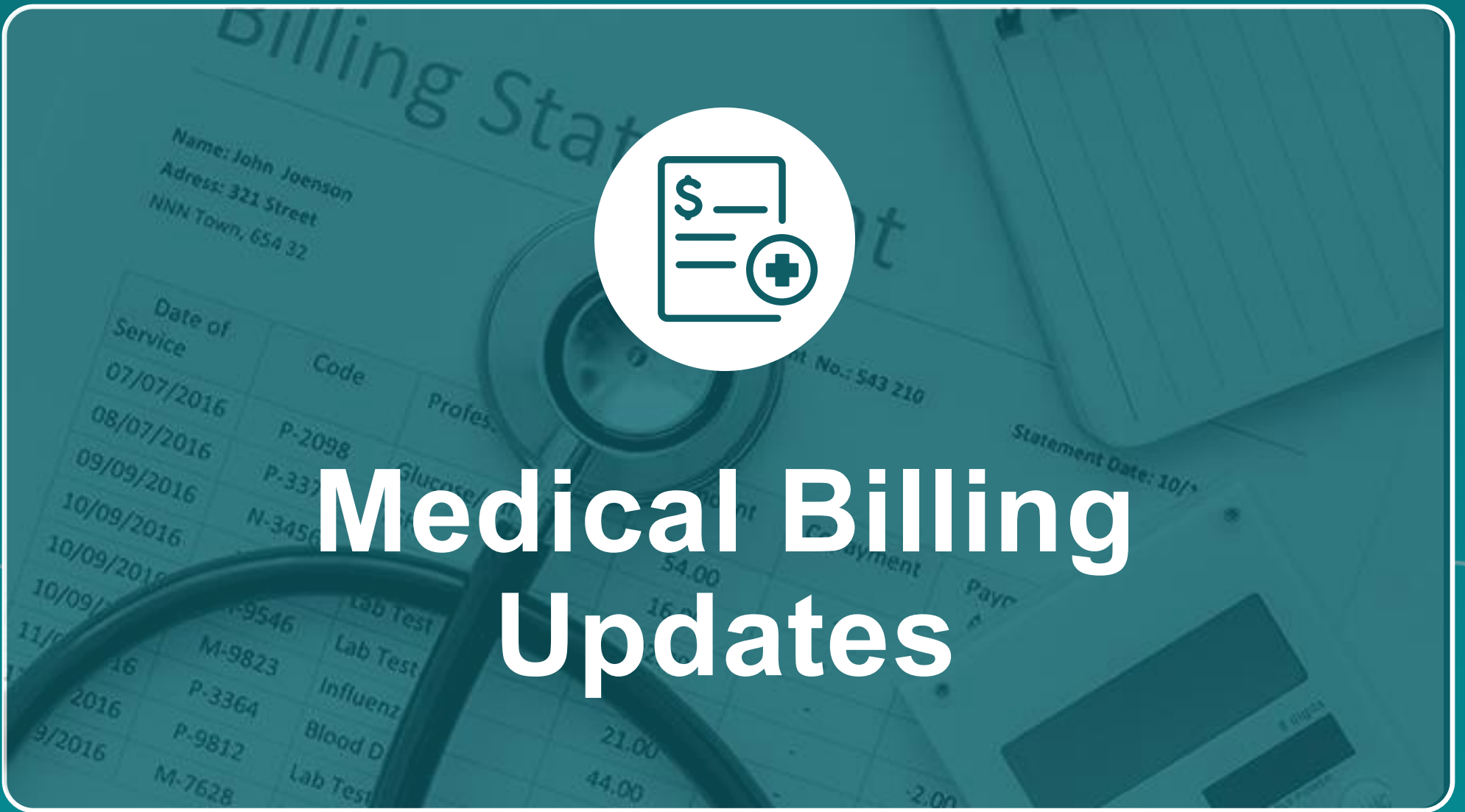


WHAT WE DO (cont'd):

- Help injured workers find health care providers in various specialties and geographies
- 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



Medical Billing Updates



Name: John Joenson
Address: 321 Street
NNN Town, 654 32

Date of Service	Code	Profes.	Amount
07/07/2016	P-2098	Glucose	54.00
08/07/2016	P-337	Glucose	16.00
09/09/2016	N-3456	Glucose	16.00
10/09/2016	N-3456	Glucose	16.00
10/09/2016	N-9546	Lab Test	16.00
10/09/2016	M-9823	Lab Test	16.00
11/09/2016	P-3364	Influenz	21.00
12/09/2016	P-9812	Blood D	44.00
1/9/2016	M-7628	Lab Test	2.00



CMS-1500
Mandatory Electronic
Submission

MEDICAL BILLING



CMS-1500: ELECTRONIC SUBMISSION NOW MANDATORY

- **As of August 1, 2025**, providers must submit *CMS-1500* forms and medical narratives through a Board-approved electronic submission partner.
- If providers submit a paper *CMS-1500* form, the payer will send an Explanation of Benefits/Explanation of Reviews (EOBs/EORs) that references **CARC 16/RARC N34** codes, which indicates the bill was not submitted electronically.
- Health care providers have **120 days** from the date service was rendered to resubmit the bill through an electronic submission partner.



The Board's electronic submission mandate applies to each health care provider in a practice who treats workers' compensation patients.



CMS-1500: BENEFITS OF ELECTRONIC SUBMISSION

- **Faster bill payments:** Health care providers typically paid quicker.
- **Reduced administrative burden:** The electronic submission partner submits the *CMS-1500* form to the insurer and the Board.
- Health care providers get **confirmation within seven days** that their bill was received by the insurer.
- With acknowledgement of receipt from the insurer, the health care provider is aware that they **do not need to resubmit** the bill.
- **In most instances, technical errors are identified quickly** so they may be corrected and resubmitted, instead of waiting for the insurer to deny the bill.
- **No or low cost!** A designated CPT code can be used to reimburse health care providers for up to \$1 per transaction.





CMS-1500: ELECTRONIC SUBMISSION OFFSET

- Health care providers can offset the cost of electronic submission by using **CPT code 99080** on the *CMS-1500* form.
 - No supporting documentation is required to use code 99080.
- Payers **MUST** pay the offset to health care providers for any bill submitted electronically containing code 99080 (unless the entire bill is denied). Payers who do not pay the offset may be subject to penalties.
- As of March 31, 2026, if a bill for services is paid (in full or in part) but the offset is not, health care providers may file a *Form HP-1.0*.



Medical Billing Dispute Updates

MEDICAL BILLING

FORM HP-1.0: UPDATES

- Turnaround times for billing disputes have been reduced from **two years** to **two months**.
- Health care providers should check the status of a billing dispute and refrain from submitting a duplicate *Form HP-1.0*.
 - A new pop-up alert now appears.
- Attestation required for *Form HP-1.0* submission has been updated.
- HP-1.0 process can now be used for disputes regarding the electronic submission offset.





FORM C-8.1B: IMPORTANT CHANGES

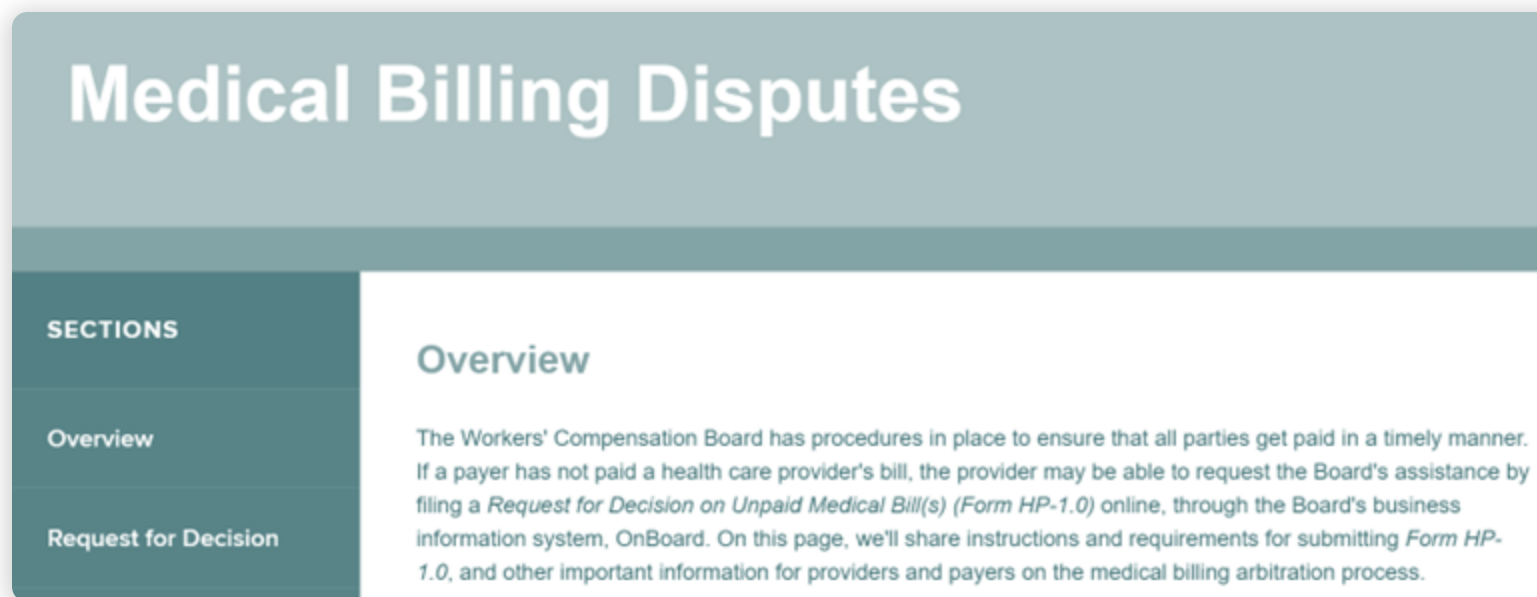
- Insurers now required to provide detailed explanation of objections on *Notice of Objection to a Payment of a Bill for Treatment Provided (C-8.1B)* forms.
 - Within Section C of *Form C-8.1B*, “Objection Reasons — Legal and Medical Treatment Guidelines”:
 - If a payer selects any objection reason listed in boxes 1-11, they must provide a detailed explanation in **box 12**.
 - If a payer selects any objection reason listed in boxes 13-19, they must provide a detailed explanation and MTG Reference Code in **box 20**.
- The information entered must provide clear and detailed narrative explanations of the payer’s objections. **Failure to provide a detailed explanation in boxes 12 and/or 20 may result in the C-8.1B form being deemed incomplete and denied.**





MEDICAL BILLING DISPUTES WEB PAGE

- The updated page provides clear guidance for common scenarios.
- Visit **wcb.ny.gov** and access the Disputes page under the Billing tab of the Providers page.





STANDARDIZING INTEREST PERCENTAGES

Coming soon! The MDO is working on calculating interest owed on all awards issued in favor of providers on disputed medical bills.





BEST PRACTICES FOR BILLING

In addition to the Medical Fee Schedule, there are separate and distinct fee schedules for use by:

- Podiatrists
- Chiropractors
- Psychologists
- Dentists
- Licensed Clinical Social Workers (Behavioral Health Fee Schedule)

These provider types may only bill CPT codes contained in their respective fee schedules.





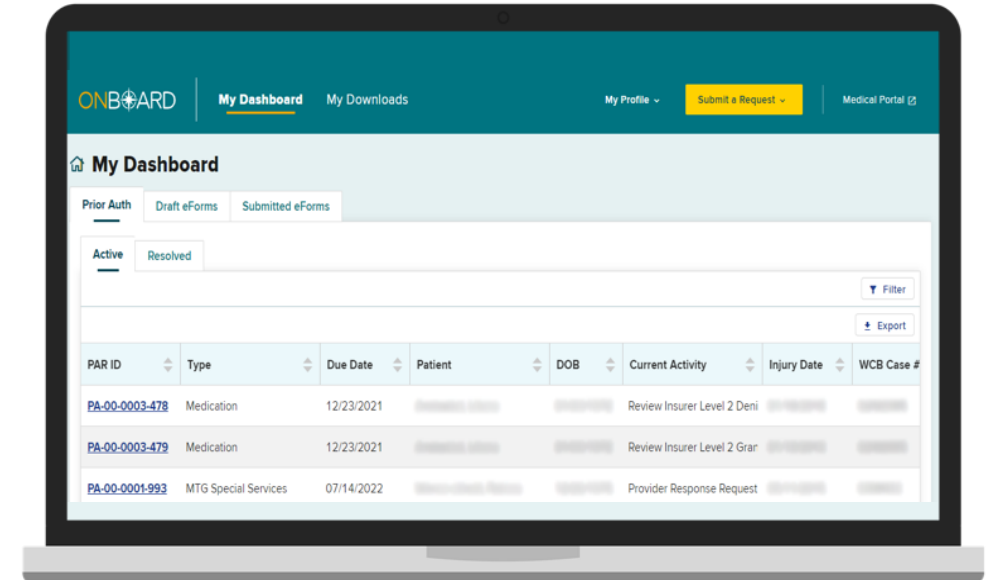
ONBOARD PAR

Updates & Best Practices



ONBOARD: PRIOR AUTHORIZATION REQUESTS (PARs)

- Online submission for **all** medical PARs
- **Over 75 PAR** process enhancements since May 2022 rollout
- To date: **3,500,000+ PARs** handled
 - **90%** without escalation to MDO
 - Fewer than **1%** needed a hearing
 - **95%** of medication, DME, Special Services, and mental health PARs resolved within one day, with the remaining 5% resolved within two days
- Authorization significantly **expedited** in comparison to prior paper requests





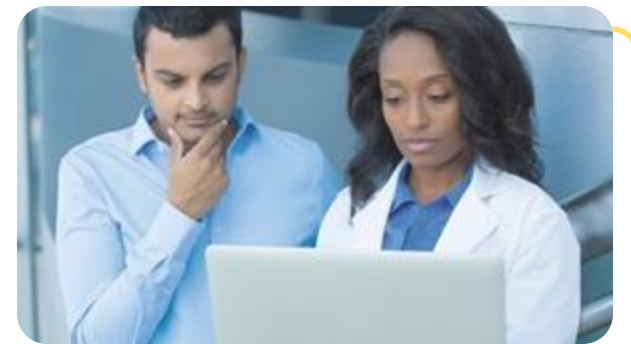
ONBOARD: ASSIGNED DELEGATES

Delegates **can** assist you by:

- Drafting and submitting *Form HP-1.0* and PARs
- Monitoring provider OnBoard dashboards for payer responses to PARs
- Responding to payer requests for information
- Drafting/escalating medication PARs to Level 2 carrier physician review
- Drafting and submitting PAR escalations to Level 3 for MDO review

Delegates **cannot**:

- Register with the Medical Portal
- Apply for authorization/renewal on behalf of a provider



ONBOARD: TIPS TO EXPEDITE PAR PROCESS

To help ensure PARs move through the system promptly:

- Submit correct PAR type
- Submit supporting documentation
- Use MTG Lookup Tool in the Medical Portal, or search and cut/paste the MTG reference in the published Workers' Compensation Board's *New York Medical Treatment Guidelines*
- Check (or have delegate check) the OnBoard dashboard regularly for insurer responses, and request Level 2 and Level 3 reviews in a timely manner



ONBOARD: TIPS TO EXPEDITE PAR PROCESS (cont'd)



- Include a clear clinical rationale for the request in the medical narrative section
- When escalating a PAR to Level 3 MDO review, include a rebuttal that addresses the payer's Level 2 denial rationale in the "Escalation Reason" field
- Use appropriate *MTG* reference codes
- Include frequency and duration, if applicable (now available as dropdown options)

Escalated PARS: Case Studies

ONBOARD

CASE STUDY 1: MTG VARIANCE PAR

MTG Variance PAR submitted for Discography

- Provider submitted peer-reviewed article as supporting documentation
- Carrier denial for discography
 - Not recommended in the *MTGs*
- MDO denied at Level 3
 - Not recommended in the *Lumbar MTGs*
 - Peer-reviewed article not relevant to injured worker's clinical picture



CASE STUDY 1: MTG VARIANCE PAR

MDO Rationale — Provider failed to support the following:

- Why the procedures recommended in the *MTGs* would be inappropriate for this injured worker
- Why something that is specifically not recommended in the *MTGs* would be appropriate





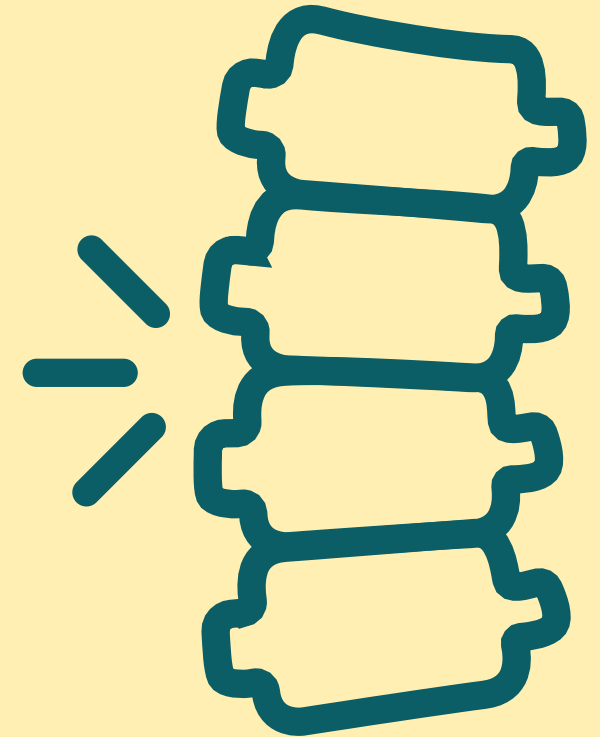
CASE STUDY 1: MTG VARIANCE PAR

	Request Details	MDO Review
1.	Body Part Bilateral Lower Back Area MTG Reference Code & Description Mid and Low Back - C.2.d: Other Studies - Lumbar Discography Insurer Response Deny Denial Reason Medical Necessity - documentation absent	MDO Decision Deny MDO Decision Rationale Although the provider has supplied peer reviewed articles and citations for the requested procedure, the attached clinical documentation does not support why other treatments found in the guidelines would be inappropriate for this injured worker.

CASE STUDY 1: MTG VARIANCE PAR

Part 1: Peer-reviewed article does not correlate to injured worker's clinical picture

- Article was related to discography in asymptomatic patients
- Analyzed false positives
- Did not address the issue of whether the discography would be appropriate
- Injured worker at issue was not asymptomatic





CASE STUDY 1: MTG VARIANCE PAR

Part 2: Same PAR, separate line item

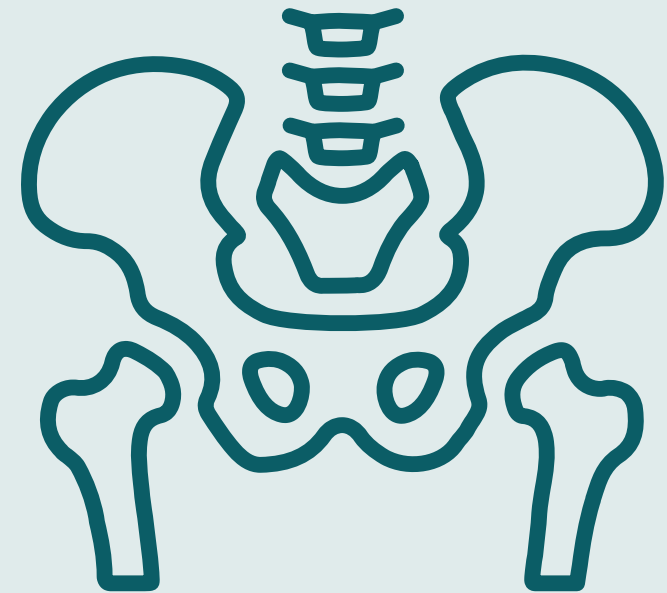
- Variance PAR requesting a three-level lumbar decompression with a percutaneous intradiscal electrothermal annuloplasty (IDET)
 - MTG reference code used makes it look like a standard discectomy
 - IDET is not recommended in the *MTGs*
- Provider submitted a peer-reviewed article that does not correlate to injured worker's clinical picture
 - Article related to the “Disc-Fx” system procedure
 - Disc-Fx is distinct from an IDET procedure
 - Not from a reputable medical journal



CASE STUDY 2: SPECIAL SERVICES PAR

Example of clear clinical rationale

- **Provider request:** Right hip arthroscopy with labral repair
- **Carrier Level 2 denial:** Clinical course unclear, no evidence conservative care was exhausted; clinical does not support



CASE STUDY 2: SPECIAL SERVICES PAR

Example of clear clinical rationale (cont'd)

- **Level 3 escalation explained by provider:**
Description of clinical course since surgery, recent physical exam findings with a date of exam provided, and details regarding conservative care
- Escalation includes medications attempted and notes PT 2x/week since previous surgery in January 2026
 - Provider also gives a summary of why the surgery is medically necessary



CASE STUDY 3: VARIANCE PAR

Level 3 Variance PAR

- **Provider request:** Therapeutic interventions that focus on cognitive function
- **Carrier Level 2 denial:** Payer indicating that the patient has already completed 15 cognitive rehabilitation sessions with documented improvement in memory, processing speed, and other targeted cognitive domains
- MDO approved up to 12 visits



CASE STUDY 3: VARIANCE PAR

Level 3 Variance PAR

- Rebuttal clearly documented the need for cognitive therapy
- Provider underscored how repeat testing is medically necessary to provide an objective comparison with the patient's initial assessment following a course of cognitive rehabilitation.



CASE STUDY 3: VARIANCE PAR

Level 3 Variance PAR

- Per rebuttal, the requested repeat evaluation will identify areas of persistent cognitive weakness, as well as provide and document additional objective gains made during treatment



CASE STUDY 3: VARIANCE PAR

Level 3 Variance PAR

- This information is directly relevant to ongoing management
- Identification of domains that remain impaired will guide the selection and prioritization of cognitive rehabilitation targets



CASE STUDY 4: DENIAL AS MOOT

Denial as moot

- Denied as moot due to an outstanding *Request for Further Action (RFA)*
- Only mechanism to resolve PAR in OnBoard
- Not a denial based upon medical necessity





CASE STUDY 4: DENIAL AS MOOT

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 5: NO CARRIER RESPONSE

MTG Confirmation PAR: knee meniscal surgery

- Insurer failed to respond within the required eight business days
- MDO approved “administratively” due to insurer’s failure to respond



CASE STUDY 5: NO CARRIER RESPONSE

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 [REDACTED]

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 - Meniscectomy/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 5: NO CARRIER RESPONSE

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 5: NO CARRIER RESPONSE

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 New York State Workers' Compensation Law and must be paid by the payer.

CASE STUDY 6: 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.



CASE STUDY 6: DME PAR

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 7: MEDICATION PAR

PAR for Tramadol 50mg

- Insurer recently granted 180 days
- PAR submitted 30 days later

Denied by MDO

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



Helpful Tips

ONBOARD



TIP 1: MULTIPLE LINE ITEMS



PARs may have multiple line items

- Review each line item:
 - Grant
 - Grant in Part
 - Deny within one PAR



TIP 1: 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 support 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





TIP 1: 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 considered the recommendations in the therefore should have been requested as a "Variance" PAR. If the provider



TIP 2: PROPER CARRIER DENIAL REASONS

Body Part Not Established vs. Body Part Disallowed

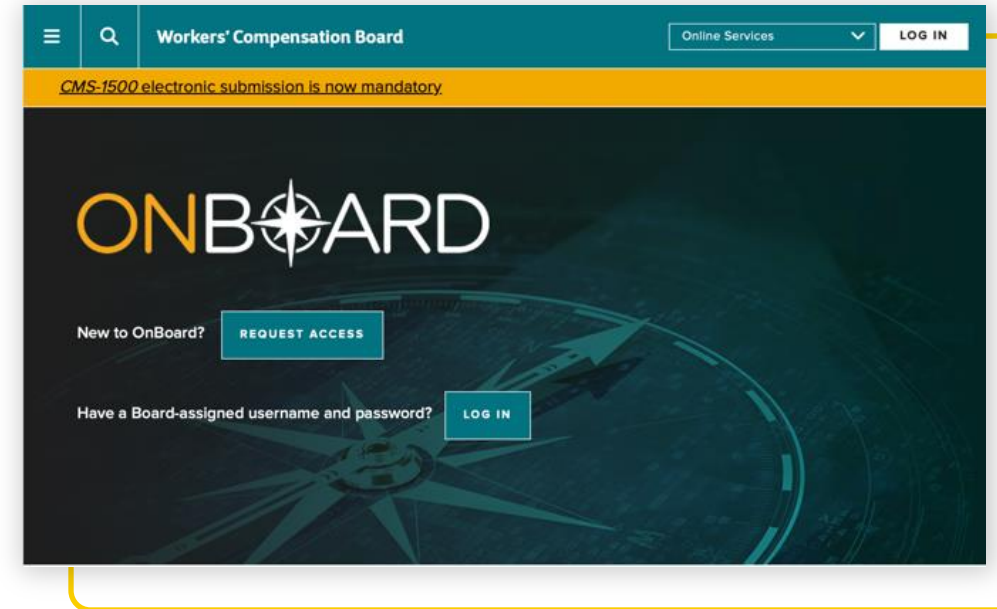
- Carrier **INAPPROPRIATELY** denies administratively on the basis that body part/condition is **not established**
 - Carrier must deny for medical reasons OR
 - **Grant Without Prejudice**



TIP 3: KEEP YOUR INFORMATION UP TO DATE

If any information changes during your authorization period, please inform the Board:

- Log into Medical Portal
- Visit “Medical Providers” section
- Select one of the following:
 - New Provider Authorization Request
 - Authorization Renewal
 - Update Authorization Information



Health care providers must renew authorization every two or three years

ASK FOR HELP – WE'RE HERE TO SUPPORT YOU!

- **MDO HELPLINE:** (800) 781-2362, mdo@wcb.ny.gov
- **PROVIDER AUTHORIZATION AND CONTINUOUS QUALITY IMPROVEMENT UNIT:** provider@wcb.ny.gov
- **ONBOARD TECHNICAL SUPPORT:** (844) 337-6305
- **GENERAL QUESTIONS, FEEDBACK, SUGGESTIONS:** hcpfeedback@wcb.ny.gov
- **WEBSITE:** wcb.ny.gov



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THANK YOU

