Preauthorization

Generally, health care providers do not have to request preauthorization for any treatment or diagnostics, except for elective surgery, palliative care, ergonomic consultations, and more than three mechanical muscle tests. A provider may request preauthorization for diagnostic imaging studies. If a patient is enrolled in a certified managed care organization (MCO), the MCO may require preauthorization of certain services. Please check with each MCO.

Diagnostic imaging studies

For diagnostic imaging studies, other than plain film X-rays, you may contact an insurer in writing for preauthorization. The request must be separate from chart notes and clearly state that it is a request for preauthorization of diagnostic imaging studies. The insurer must respond to your request in writing whether or not the service is preauthorized, within 14 days of receipt of the request. Preauthorization is not a guarantee of payment.

Elective surgery

If you recommend elective surgery, you must notify the insurer using Form 5425 at least seven days before the date of the surgery. The insurer must respond within seven days of receiving your notification that the proposed surgery either is approved or is not approved and a consultation is requested. Emergency surgery to preserve life, function, or health is excluded from notification requirements.

Palliative care

After a patient becomes medically stationary, the attending physician needs to request approval from the insurer for palliative care (e.g., physical therapy).

Palliative care may begin **after** the attending physician submits the request to the insurer. If the request is ultimately not approved, the insurer is not liable for payment of the palliative care services. If the insurer approves the request, palliative care services are payable from the date service begins.

Before palliative care can begin, the attending physician must submit a written palliative care request to the insurer for approval. The request must do all of the following:

- Describe any objective findings
- Identify the medical condition for which palliative care is requested by the appropriate ICD diagnosis
- Detail a treatment plan that includes the name of the provider who will provide the care, specific treatment modalities, and frequency and duration of the care, not to exceed 180 days
- Explain how the requested care is related to the compensable condition
- Describe how the requested care will enable the worker to continue current employment, or a current vocational training program, and the possible adverse effect if the care is not approved

Within 30 days of receiving the request, the insurer must send written notice to the attending physician approving or disapproving the request.

Ergonomic consultation

An ergonomic consultation consists of a work station evaluation to identify the ergonomic characteristics relative to the worker, including recommendations for modifications. The insurer must preauthorize any ergonomic consultation.

Mechanical muscle tests

Mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient. The insurer must preauthorize more than three mechanical muscle-testing sessions per treatment program in writing.

Contact the Workers' Compensation Division Medical Team

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