Certified Network Procedure Summary

Subject: Preauthorization Procedure

Rules:

- Emergency care never requires preauthorization.

- Emergency Admission: Notification to the Network of the hospital admission, and any request for preauthorization for continuation of the inpatient stay, should occur as soon as the injured employee is stabilized. The preauthorization process will proceed with review of the length of stay.

- Frequency of concurrent review for a continued length of stay is dependent upon the approved length of stay. The Network would not anticipate a concurrent review every day.

- Initial evaluations for physical therapy or occupational therapy <u>does not</u> require preauthorization.

- Initial psychological evaluations <u>do not</u> require preauthorization.

- <u>*Official Disability Guidelines (ODG):*</u> Network providers are contractually obligated to follow the *Official Disability Guideline.* Any treatments, services, or durable medical equipment that falls outside, or is not recommended by the *ODG*, requires preauthorization prior to providing the treatment or service in order to receive reimbursement. The *ODG* should be consulted and used as medical evidence prior to requesting preauthorization.

- <u>Return to Work Programs:</u> When requesting a return-to-work program (such as work hardening), include the specific job to which the injured employee will return with the request and a treatment plan of care specific to that job description. <u>All</u> programs must be approved through the preauthorization process, including programs with Commission for Accreditation of Rehabilitation Facilities (CARF) accreditation.

STEPS IN PROCESS:

1. The provider should submit a request for preauthorization or concurrent review, using the IMO Preauthorization Form. A copy is provided in this manual and is also available for printing at the IMO website, www.injurymanagement.com. Once the form on the web is completed, fax to 214-217-5937.

2. If there has been an emergency admission to a facility, the request for a continued length of stay should be submitted within one (1) business day of the admission.

3. A Request for Preauthorization must include:
   i. The specific health care, with frequency and duration of treatments
   ii. Medical information to support the medical necessity
   iii. Phone, fax and e-mail contact information
   iv. Name of provider and facility
   v. Estimated date of care

4. An IMO nurse will review the request and submitted medical records. It is very important to submit information that will assist the nurse in reviewing, including any citations from the *ODG.*

   The nurse may approve the request but is not allowed by statute to disapprove a treatment or service. If the nurse is unable to approve, based on her knowledge and the submitted information, the preauthorization medical information is submitted to a physician or other appropriate provider for review and decision.

5. If the reviewing physician has tentatively decided to disapprove the services, the physician will give the requestor a chance to discuss clinical basis for denial.

DECISION:

I. Within <u>three calendar days</u> of a completed preauthorization request, the Network will contact the physician or physician's office to provide an approval or disapproval of services.

II. If a facility requests additional inpatient days for injured employee, the Network will contact the facility within one day of the request. This contact may be by phone.

III. If the approval or denial was provided verbally, within one business day, the Network will send a letter to the requestor of the preauthorization, the injured employee, and, if the injured employee has a representative, a letter will be also sent to the representative

6. Basis of Decision: The basis of approval or disapproval must be dependent upon the medical necessity of the treatment or service requested. The preauthorization decision is not based upon the following issues:
    vi. Unresolved compensability, (for example, did it happen at work?)
    vii. Extent of injury or relatedness issues (for example, is the shoulder pain related to the broken wrist?)
    viii. Carrier liability for injury (for example, did the employer have employees' compensation coverage at the time of this injury?)
    ix. Maximum medical improvement (for example, a previous physician has said that the injury is completely healed).

7. The Network does not make decisions regarding compensability of the injury, the extent of the injury, relatedness, and/or carrier liability. The carrier or third party administrator handling the workers' compensation claim will notify the Network of any disputes regarding these issues. Information regarding any disputes will be added to the preauthorization approval notification.

8. If the Network initially disapproves the request for preauthorization, the provider may request reconsideration of the preauthorization request. This reconsideration must be submitted within 30 days after the date of the Network issuance of a written initial disapproval of preauthorization.

9. The Network will respond to the reconsideration request within five (5) days of receipt of most reconsideration requests. The exception is if the request is for concurrent review or reconsideration request for length of stay in a facility. The Network will respond within three (3) days if it is a reconsideration request for concurrent review. The Network will respond within one (1) calendar day if it is a reconsideration request for continued length of stay in a facility.

10. If the Network disapproves the preauthorization reconsideration, the notification will include information about how to request for an Independent Review as described in this Provider Manual and more thoroughly in 28 TAC §133.308

11. The Network also has a quicker process when there is an urgent medical need for it. The Network will handle these cases in no longer than one day. Call the Network at (888) 466-6381 if there is a need for a quicker response.

PREAUTHORIZATION LIST:

Unless there is an emergency need, the following health care treatments and service must be preauthorized by the Network prior to being rendered:

  b. Hospital and Surgical Care
      i. Inpatient admissions including length of stay and, when necessary continued length of stay

ii. Inpatient length of stay, starting with the first business day after an emergency admission
iii. Inpatient and outpatient surgical procedures performed in a hospital or ambulatory surgical center (ASC) setting

c. Mental Health Care
   i. Psychiatric and repeat psychological evaluations
   ii. Psychological testing or psychotherapy
   iii. Biofeedback

d. Physical Medicine, regardless of place of service
   i. Osteopathic or chiropractic manipulations
   ii. Physical or occupational therapy

e. Diagnostic Testing
   i. CT myelograms and discogram CTs
   ii. Electromyelograms (EMGs) and nerve conduction velocity studies (NCVs)
   iii. Some initial diagnostics and all repeat diagnostic tests billed at $350 or greater

f. Injections: epidural steroid injections (ESIs), facet injections, medial branch blocks, and rhizotomies

g. Programs
   i. Work hardening, work conditioning, and outpatient rehabilitation regardless of accreditation
   ii. Pain management, chemical dependency, and weight loss

h. Durable Medical Equipment (DME) billed at $500 or greater per item, either cumulative rental or purchased. All electrical and/or neuromuscular stimulators including transcutaneous electrical stimulators (TENS) or interferential stimulators

i. Nursing home, convalescent, and residential care and all home health care services

j. Any investigational or experimental services or devices

k. Any treatments, medications, services, or DME that falls outside of or not recommended by the *ODG*.