

Title	Description
Policy Name:	<b>Prior Authorization Requirements for Medical Treatment or Vocational Services</b>
Policy Number:	BRM-2017-10
Code/Rule Reference:	<a href="#">OAC 4123-6-16</a> , <a href="#">OAC 4123-6-16.1</a> , <a href="#">OAC 4123-6-16.2</a> , <a href="#">OAC 4123-6-16.3</a>
Effective Date:	10/1/2017
Supersedes:	All medical policies, directives, and memos regarding prior authorization requirements that predate the effective date of this policy.
History:	Revised 10/1/2017, Republished 4/1/2024
Review date:	10/1/2027

**I. POLICY PURPOSE: GENERAL OVERVIEW**

The purpose of this policy is to provide general information on prior authorization for services, requirements when submitting prior authorization requests, as well as services that require prior authorization. This policy will also clarify reimbursement impacts if prior authorization is required, but was not obtained in advance of treatment, as well as exceptions to the reimbursement impacts.

BWC requires prior authorization for non-emergency treatment and services through the submission of a C-9, or its equivalent, to the MCO. There are specific instances, however, when services are provided within the first 60 days from the date of injury, that physicians have presumed approval to provide treatment and services for specific work-related injuries - soft tissue and musculoskeletal injuries - the most common BWC injuries, if specific criteria are met.

Presumptive approval guidelines are meant to further BWC's goal of expediting early treatment management for **allowed conditions** in **allowed claims**. By eliminating wait time for authorizations, you may immediately schedule diagnostic testing and other procedures covered under the presumptive approval criteria at the time of the office visit. Quicker treatment means faster recovery, lower disability costs, and injured workers returning to gainful employment.

**II. APPLICABILITY**

This policy applies to all actions relevant to the request, authorization, and reimbursement of services within the Ohio Workers' Compensation System.

**III. DEFINITIONS**

**Emergency services:** See OAC 4123-6-01

**IV. POLICY**

**A. Submission of Prior Authorization –**

1. Requests for medical services that require prior authorization must be submitted by the physician of record or treating physician to the appropriate MCO prior to initiating any non-emergency treatment.
2. The preferred method of submission is the BWC physician's [C-9](#); however, any other physician-generated document may be used if the substitute document contains, at a minimum, the data elements on the [C-9](#).
3. The physician of record should identify additional conditions to be allowed in the claims on the [C-9](#) and should spell out additional conditions with supporting documentation.

**B. Assisting MCO In Medically Managing Injured Worker's Claim** - In order to assist the MCO in effectively medically managing the injured worker's claim, it is important for the physician of record/treating physician to comply with the request for medical services guidelines, including "*Presumptive Approval*", "*MCO Standardized Prior Authorization Table*", and "*Therapy Visit Limits*" included within the appendices (A, B, and C) of this policy.

**C. MCO Authorization Consideration & Expedite Payment** - The following guidelines were implemented to help the MCO consider authorization and expedite the payment of medical bills:

1. The MCO must respond to the physician within three (3) business days with a decision regarding the proposed treatment request.
2. For services provided under the Presumptive Authorization Guidelines, the MCO is required to notify the provider within three (3) business days acknowledging receipt of the [C-9](#) and that a review was completed to ensure that services being rendered are medically necessary for the claim allowance.
3. The MCO shall return fax of the authorized, denied or pended medical services request back to the physician within the required three (3) business days.
  - a. If faxing is not feasible, the MCO is required to call the physician in order to communicate the decision and follow-up in writing via mail.

- b. The MCO shall assign a tracking number to each treatment reimbursement decision made by the MCO and publish that tracking number on all copies of the decision distributed by the MCO.
  4. If the MCO is unable to make a decision within three (3) business days due to the need for additional information, the MCO shall send a request for [C-9-A](#) to the provider.
    - a. The provider must return the form C-9-A and any additional supporting documentation to the MCO within ten (10) business days.
    - b. The MCO has five (5) business days from the date additional information is received to make a subsequent decision.
    - c. The MCO must render a decision to allow or deny the medical services request if the physician does not provide the MCO with any requested documentation within ten (10) business days for all active claims.
    - d. The physician must be notified by fax or phone of the subsequent decision.
    - e. Note: In inactive claims - the MCO may dismiss the C-9 (with no Alternative Dispute Resolution appeal rights after the ten (10) days) if the C-9-A is not returned.
  5. If the MCO is unable to make a decision within three (3) business days due to the need for a medical review and the physician is notified, the medical review must take place and a decision granted within the five (5) business day period. The MCO shall notify the physician by fax or phone of the subsequent decision.
- D. **Medical Service Request Approval & Provider Treatment Initiation** - A medical services request shall be considered approved, and the provider may initiate treatments when all of these criteria are met:
  1. The MCO fails to communicate a decision to the physician within three (3) business days of receipt of an original medical services request or five (5) business days if the request was pending;
  2. The physician has documented the medical services request completely and correctly on a [C-9](#) or other acceptable documents;
  3. The physician has proof of submission to the appropriate MCO;
  4. Medical services are for the allowed conditions; and
  5. The claim is in a payable status.
- E. **No Response To [C-9](#) In Three (3) Business Days** - In instances where there is no response to a [C-9](#) within three (3) business days and the provider initiates treatment, the MCO shall provide concurrent and retrospective review of that treatment.
- F. **Discontinue Payment of Treatment** –
  1. If it is found before, after or during delivery, that any treatment, approved or not approved within three (3) business days, is not medically indicated or

necessary, not producing the desired outcomes, or injured worker is not responding, the MCO shall notify the parties of decision to discontinue payment of said treatment.

2. Only charges for treatments already rendered shall be paid.
3. If the provider, injured worker, or employer wishes to dispute the decision, they may do so via the Alternative Dispute Resolution process.

**G. MCO Authorization Decision Process On C-9 Request –**

1. The MCO shall authorize, deny, or pend a provider's proposed retroactive treatment request (submitted on a C-9 or other appropriate form) within thirty (30) calendar days from the MCO's Request for Medical Services request "receipt date."
2. When processing a C-9, or other acceptable document, that includes retroactive and future treatment request(s) the MCO must follow the normal three (3) business day timeframe requirements for each treatment request, including the ability to pend for additional medical documentation/review if necessary.

**H. Information Supporting Request & Authorization -** Information used to support requests and authorization for mental health services can also be submitted on the C-9.

**I. Request For Progress Notes -** Ohio law protects the confidentiality of the mental health provider's progress notes; therefore, the MCO cannot request copies of this document.

1. A request for copies of the progress notes with the deletion of any non-claim related information is also prohibited.
2. However, a detailed summary of the progress notes can be requested via a Mental Health Notes Summary (MEDCO-16) form, which can be used to support the C-9.

**J. Authorization Granted for Specific Number Of Sessions Or Period Of Time**

1. Authorization shall be granted for either a specific number of sessions or period of time.
2. **The MCO is prohibited from authorizing "continuous" or "indefinite" mental health treatment.**
3. Once the authorized limits have been reached, a new [C-9](#) and a detailed summary must be resubmitted to the MCO for re-evaluation of the treatment.
4. Medical Prior Authorization Requirements must be met - "*Presumptive Approval*" and "*MCO Standardized Prior Authorization Table*" and therapy limits- See Appendix A, B, and C, respectively.
5. Request for Medical Services Disclaimer

- a. A disclaimer may only be used on a [C-9](#) or any other physician generated request for treatment when the claim or the condition for which the treatment is being requested is not yet in an allowed status.
- b. A disclaimer shall not be used when authorizing treatment for allowed claims and conditions that are within the statute of limitations.
- c. The MCO may use the following disclaimer language, **only** when responding to a [C-9](#) or any other physician-generated request for treatment: *"This medical payment authorization is based upon a claim or additional condition that is currently being adjudicated by BWC and the IC as of the date of the MCO's signature. If the claim or additional condition is ultimately disallowed, the services/supplies to which this medical payment authorization applies may not be covered by BWC and may be the responsibility of the injured worker."*

### K. Provider Compliance for Prior Authorization

1. The provider submitting a C-9 after treatment has been provided may be subject to payment reduction.
2. Per OAC 4123-6-16.3 "Reimbursement of Retroactive Medical Treatment Reimbursement Requests," BWC is authorized to reduce reimbursement for retroactive treatment requests not meeting excused reasons noted in "just cause" section "K.6" on this page.
3. Reimbursement shall be at seventy-five percent (75%) of the applicable fee schedule for non-emergency treatment delivered, rendered, or directly supervised by the physician of record or eligible treating provider.
4. Only individuals eligible to submit a C-9 are subject to this payment reduction.
5. Retroactive medical treatment reimbursement requests submitted within seven (7) calendar days of treatment initiation or prior to the date of the next encounter with the injured worker, whichever is earlier, are not subject to this payment reduction.
6. The "just cause" or excused reasons to submit a retroactive C-9 noted in OAC 4123-6-16.3 include:
  - a. The treatment requested was emergency treatment;
  - b. The provider was not aware that services were for a workers' compensation claim;
  - c. The provider was non-BWC certified and had no established relationship with the injured worker;
  - d. The provider was initially BWC certified within six (6) months prior to the treatment request;
  - e. The treatment requested was for a pending claim allowance or additional allowance with BWC or IC;

- f. The treatment provided was within BWC's presumptive authorization guidelines, or does not require prior authorization per the "Provider Billing and Reimbursement Manual";
- g. The treatment request was submitted retroactively due to BWC or MCO error; and/or
- h. Other documented justification as deemed sufficient by BWC.
- i. A provider who does not agree with the discounted reimbursement may utilize the grievance hearing procedure for disputed bill payments.

### L. **C-9 Approved Service Timeframes**

- 1. Approved C-9s set forth timeframes for the delivery of services and is noted on the C-9.
- 2. Timelines for approvals of routine diagnostics (x-rays, CAT scans, MRI scans, and EMG/NCV) are generally no longer than two (2) weeks.
- 3. Timelines for approvals of other medical treatments or services with no specified timeframe on the request are generally no longer than thirty (30) days.
- 4. If services cannot be completed within the approved timeframe, the MCO must be notified.
- 5. The MCO shall update any approved authorization timeline changes and place a note in the claim.
- 6. Services that run continuously over a longer timeframe (such as facility placement) are generally not being approved for more than six (6) months at a time.
- 7. Approval of C-9s submitted by a Physical Therapist or Occupational Therapist shall be valid for no longer than thirty (30) days unless the approval specifies a longer period and such longer period is supported by the prescription accompanying the C-9.

### Appendix A: Presumptive approval criteria

1. **(All criteria must be met.)** Treatment is for a soft tissue or musculoskeletal injury for allowed conditions in allowed claims and includes only the following treatment(s):
  - a. A maximum of 12 physical medicine visits per injured worker claim which may include any combination of osteopathic manipulative treatment, chiropractic manipulative treatment, and physical medicine and rehabilitation services performed by a provider whose scope of practice includes these procedures, including, but not limited to, doctor of chiropractic (DC), doctor of osteopathic medicine (DO), doctor of allopathic medicine (MD), physical therapist, occupational therapist, athletic trainer, or massage therapist;
  - b. Diagnostic studies, including X-rays, CAT scans, MRI scans, and EMG/NCV.
    - i. Note: Medical necessity for the allowed conditions is always the driver for services.
    - ii. Surgical diagnostics, such as arthroscopic procedures, are not included unless it is an emergency.
    - iii. MCO case managers may advise providers when they identify procedures that do not appear to be medically necessary but as long as a provider follows commonly accepted treatment guidelines when treating allowed conditions in a claim, the bill will be paid;
  - c. Fracture care recasting/splinting procedures - as medically necessary;
  - d. Up to three soft tissue or joint injections involving the joints of the extremities (shoulder including acromioclavicular, elbow, wrist, finger, hip, knee, ankle, and foot including toes) and up to three trigger point injections. Note: Injections of the paraspinal region, including epidural injections, facet injections, and sacroiliac injections are not included in the presumptive approval guidelines; and
  - e. Consultation services.
2. All of the following are completed prior to initiating treatment noted above:
  - a. The First Report of Injury (FROI) is filed with the MCO;
  - b. The Physician's Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9) is filed with the MCO.
    - i. The MCO will notify the provider within three business days acknowledging receipt of the C-9 and that a review was completed to ensure that services being rendered are medically necessary for the claim allowance.

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- ii. When the claim or condition for which treatment is being requested is not yet in an allowed status, the MCO may use disclaimer language notifying the provider that service will not be paid if the claim is not allowed; and
- c. The MCO is notified within 24 hours of treatment if the injured worker will be off work for more than two calendar days.

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### Appendix B: Standard Prior Authorization Table

Service	Prior Authorization Required	No Prior Authorization Required
Physical medicine services, including chiropractic/osteopathic manipulative treatment and acupuncture	Yes	
Psychological services	Yes	
Dental	Yes	
Evaluation and management services	Yes, for psychological consults or chronic pain program consults	All other evaluation and management services
Diagnostic testing	Yes. For drug test, please refer to the <a href="#">"Drug Testing (PDF)"</a> policy.	Basic X-rays
Durable Medical Equipment (DME)	Yes, if purchase price is equal or greater than \$250  Yes, for DME rentals anticipated to or having the probability to exceed 80 percent of the purchase price of the DME  For DME, please refer to the <a href="#">"Durable Medical Equipment (PDF)"</a> policy.	DME purchase price is less than \$250
Home/Vehicle modifications	Yes. For home/vehicle modifications, please refer to the <a href="#">Home and Vehicle Modifications</a> policy.	
Home health agency services	Yes	
All inpatient and outpatient hospital services treatment and ambulatory surgery center services	Yes, unless for emergency services. Emergency inpatient hospitalization may be through the emergency department or by direct admission	
In-home physician services	Yes, after first visit. For in-home physician services, please refer to the <a href="#">"Reimbursement For In-Home Physician Visits and Physician Mobile Office Visits (PDF)"</a> policy.	First visit

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<b>Service</b>	<b>Prior Authorization Required</b>	<b>No Prior Authorization Required</b>
Injections	Yes	
Non-emergency ambulance (medical transportation) services	Yes	
Orthotic	Yes, if greater than \$250	
Prosthetic or artificial appliance and/or repair	Yes, if greater than \$250.	
Skilled nursing facility (SNF)/Extended care facility (ECF)/TBI facility/Adult day care, etc.	Yes	
TENS and NMES units	Yes, for both rental and purchase. For TENS and NMES units, please refer to the " <a href="#">Transcutaneous Electrical Nerve Stimulators (TENS) &amp; Neuro-Muscular Electrical Nerve Stimulators (NMES) (PDF)</a> " policy.	
TENS and NMES monthly supplies	Yes, with a maximum of six months per authorization. Please refer to the " <a href="#">Transcutaneous Electrical Nerve Stimulators (TENS) &amp; Neuro-Muscular Electrical Nerve Stimulators (NMES) (PDF)</a> " policy.	
Vision and hearing services	Yes, if greater than \$100	Vision and hearing services less than or equal to \$100
Vocational rehabilitation – all vocational rehabilitation services, in or out of plan	Yes, unless meets the "No PA Required" criteria.	Transitional work on-site therapy services provided by an occupational therapist that fall under the presumptive authorization criteria. Note: Occupational rehabilitation/Comprehensive (work hardening) requires CARF

**Appendix C: Therapy Visit Limits**

- A. Therapy Visits –
  - 1. The maximum time allowable per visit for therapy services with timed procedure codes (i.e., physical medicine, rehabilitation modalities, and therapeutic procedures) should be no longer than one (1) hour without prior authorization.
  - 2. If therapy services with timed codes are billed over one (1) hour per day, further medical review and approval shall occur if services were not authorized prior to the payment being made.
- B. Maximum Approval Period –
  - 1. Timelines for delivery of medical treatments or services with no specified timeframe on the request shall be no longer than thirty (30) days.
  - 2. Services not rendered in this time must have an update in the injured worker's claim notes as to the rationale for the delayed service delivery.
  - 3. Services that run continuously over a longer timeframe (e.g., facility placement) shall not receive approval for more than six (6) months.