PROVIDER BULLETIN

TOPIC: Preauthorization …..Follow up QUICK FACTS

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The purpose of this Provider Bulletin is to notify Health Care Providers of the requirements for preauthorization, decisions for approval or denial of requests, division contacts, and treatment guideline updates.

What is preauthorization?

Preauthorization is a prospective review and approval of health care based solely on medical necessity and reasonableness. A provider obtains preauthorization *before* the health care is provided.

Which treatments and services require preauthorization?

A. Emergency health care does not require preauthorization.

B. Non-emergency health care *requiring* preauthorization includes the following:

1. **Spinal surgery;**
2. **Musculoskeletal surgeries or procedures;**
3. **Charite artificial disc;**
4. **Spinal cord stimulators;**
5. **Implantable medication pumps;**
6. **Pain clinic/therapy/substance abuse programs;**
7. **Inpatient hospital admissions including the principal scheduled procedure(s);**
8. **Outpatient or ambulatory surgical services;**
9. **Rehabilitation program admission; (head injury, work conditioning)**
10. **Nursing home, residential, and all home health care service;**
11. **Psychological evaluations as a recommendation from treating Health Care Providers;**
12. **Any investigational or experimental service or device.**

What are the requirements for the preauthorization request form?

The provider must submit a form (e-mail, fax, mail), which includes case specific information as well as the following:

- **►Injured worker information/name/case number/date of birth/date of injury;**
- **► ICD-9-CM Diagnosis Code/Diagnosis;**
- **►CPT Code/Procedure;**
- **► The facility name/date of service/length of stay (inpatient/outpatient ambulatory);**
- **►Indications for surgery/treatment/procedure;**
- **►The medical information to substantiate the need for the requested health care;**
- **►Requesting provider information/name/office phone and fax/contact/best time to contact the provider.**

►►►The provider MUST sign the form prior to submitting it to the Preauthorization nurse.

Contacts:

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How will the Division handle preauthorization requests?

(1) The Preauthorization nurse will compare the clinical information provided by the requesting Health Care Provider to the Division's Treatment Guidelines.

(2) If the clinical information meets the Treatment Guideline criteria and the service (s) are medically necessary and related to the accepted workers' compensation injury, the preauthorization nurse will grant approval.

(3) The case analyst will send an approval letter to the injured worker, Health Care Provider, and employer.

(4) If the clinical information does not meet the Treatment Guideline criteria, the preauthorization nurse may:

- **(a) contact the requesting Health Care Provider for additional information;**
- **(b) recommend the injured worker be scheduled for a second opinion, independent medical evaluation, further diagnostic test, or psychological examination;**
- **(c) refer the request to a Medical Advisor for review;**
- **(d) the Medical Advisor may contact the requesting Health Care Provider to discuss the case or request additional information;**
- **(e) the Medical Advisor may recommend the injured worker be evaluated by a specialty consultant;**
- **(f) the Medical Advisor will make a recommendation whether to authorize or deny the request.**

(5) If the preauthorization request is denied, the claims analyst will send a final determination letter to the injured worker, Health Care Provider, and employer outlining the reasons. The letter provides instructions to request a hearing.

Who determines what constitutes necessary medical information?

■ The Health Care Provider initially determines which medical information is necessary to substantiate the need for the proposed services (s) and should have this documentation accompany the preauthorization request form.
■The preauthorization nurse may request additional documentation if the division does not have the medical information in the current file.

What is the authorization response time from the Division?

Fifteen days (15). The Division must respond within (15) days to a request for preauthorization of nonemergency health care services.

Does preauthorization approval guarantee payment?

◆If the injury is determined compensable by the case analyst, the Division is responsible for all reasonable and necessary medical costs of health care to treat the compensable injury.

◆When preauthorization is granted by the nurse for a compensable injury, services rendered by the Health Care Provider will be reimbursed as per the current Wyoming fee schedules in effect.

◆The provider should attach a copy of the approved and signed preauthorization request form to their billing for expedited processing.

◆If the health care treatment is NOT related to the compensable injury, the Division is not responsible for reimbursement.

Treatment Guidelines

The Treatment Guidelines may be viewed and printed from the web site. (http://doe.wyo.gov/) You may also request a copy be faxed or mailed to you free of charge by contacting Patty Ware at 307-777-3630.

The next sets of DRAFT guidelines are:

1. **Chronic pain management.**
2. **Implantable devices for pain management.**
3. **Knee procedures.**
4. **Shoulder procedures.**

Please watch for draft guideline mailings as we strongly encourage you to submit your input.