



PREAUTHORIZATION AND CONCURRENT REVIEW REQUIREMENTS

For certain services, your doctor must obtain prior approval. Below is a list of those services:

- Inpatient hospital admission including the principal scheduled procedure(s) and the length of stay
- Outpatient surgical or ambulatory surgical services
- Spinal surgery
- All Chiropractic services including office visits and manipulations greater than 8 visits
- Psychological testing and psychotherapy, repeat interviews, and biofeedback; except when any service is part of a preauthorized or exempt rehabilitation program
- External and implantable bone growth stimulators
- Chemonucleolysis
- Myelograms, discograms, or surface electromyograms
- Repeat individual diagnostic study, with a fee established in the current Medical Fee Guideline of greater than \$350
- Work hardening and work conditioning services provided in a facility that has not been approved for exemption by the Commissioner.
- Rehabilitation programs to include outpatient medical rehabilitation and chronic pain management/interdisciplinary pain rehabilitation
- Chronic pain management/interdisciplinary pain rehabilitation
- Durable medical equipment (DME) in excess of \$500 per item (either purchase or expected cumulative rental) and all transcutaneous electrical nerve stimulators (TENS) units
- Nursing home, convalescent, residential, and all home health care services and treatments
- Chemical dependency or weight loss programs
- Investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care
- Physical and occupational therapy which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
 - (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
 - (i) Modalities, both supervised and constant attendance;
 - (ii) Therapeutic procedures, excluding work hardening and work conditioning;
 - (iii) Orthotics/Prosthetics Management;
 - (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and
 - (B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;
 - (C) Except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following the date of injury or a preauthorized surgical intervention-
- Intrathecal drug delivery system

- Refills of an intrathecal drug delivery system with drugs excluded from the closed formulary, with annual preauthorization required thereafter.
- Refills of an intrathecal drug delivery system whenever (A) medications, dosage or range of dosages or the drug regime differs from the medications, dosage or range of dosages or the drug regime previously authorized for that prescribing doctor; or (B) there is a change in prescribing doctor.
- For injuries occurring on or after 09.01.11, drugs not included in the closed formulary.
- For injuries occurring on or after 09.01.11, drugs identified with a status of “N” in the current edition of the *ODG Treatment in Workers’ Comp* (ODG)/Appendix A, *ODG Workers’ Compensation Drug Formulary* and any updates
- For injuries occurring on or after 09.01.11, any compound that contains a drug identified with a status of “N” in the current edition of the *ODG Treatment in Workers’ Comp* (ODG)/Appendix A, *ODG Workers’ Compensation Drug Formulary* and any updates
- Treatments and services that exceed or are not addressed in the ODG treatment guidelines and are not contained in a preauthorized treatment plan

Some treatment will be reviewed as you receive it. Below is a list of those services:

- Inpatient length of stay
- Work hardening or work conditioning services
- Physical and Occupational Therapy services
- Investigational or experimental services or use of devices
- Chronic Pain Management/Interdisciplinary Pain Rehabilitation programs
- Required Treatment Plans

Emergency treatment and services and life-threatening or post stabilization treatment are exempt from preauthorization review.

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How to submit a preauthorization or concurrent review request

Utilization review requests may be submitted by telephone or facsimile by contacting the Utilization Review Department at the following numbers.

Telephone: 800-664-2276

Fax: 603-334-0329

You may use the following form, as desired, to facilitate the handling of your preauthorization or concurrent review request.



CONFIDENTIAL INFORMATION
WORKERS' COMPENSATION UTILIZATION REVIEW REQUEST

Liberty Mutual performs utilization review in the following jurisdictions. Please indicate the jurisdiction of the request and fax this form to the appropriate number to ensure the timely review of your request.

State	Fax Number	State	State	Fax Number
Alabama		Maine	California *	603-334-8141
Arkansas		Michigan	Illinois	603-334-8206
Colorado		Mississippi	Massachusetts	866-953-5165
Connecticut	603-334-0330	New Hampshire	Texas	603-334-0329
Florida		North Carolina		
Kentucky		Tennessee		
Louisiana *		West Virginia		

* California must use the DWC-RFA form
* Louisiana Out Patient must use the 1010 state required form

****THE JURISDICTIONS LISTED ABOVE REQUIRE UM REVIEW – ALL OTHER JURISDICTIONS, CONTACT CLAIMS****

FROM: _____ **PHONE #:** _____ **FAX#:** _____

Requesting Provider Date & Time of Availability to facilitate Peer-to-Peer contact: _____

Patient Information:

Name: _____ **Claim Number:** _____

Date of Birth: _____ **Date of Injury:** _____

Request Type (select one) _____

- ☐ Initial Request ☐ Retrospective
☐ Extension ☐ Appeal
☐ Peer to Peer Discussion (URAC)- If applicable

Treatment Setting (select one) _____

- ☐ Inpatient
☐ Outpatient

Treatment Type (select one) _____

- ☐ Diagnostic Test ☐ Surgical
☐ Physical Therapy ☐ Psychiatric
☐ Occupational Therapy ☐ DME Rental
☐ Chiropractic ☐ DME Purchase
☐ Other: _____

Diagnosis (ICD 9) code: _____ **Description:** _____

Procedure (CPT) code: _____ **Description:** _____

Expected Start Date: _____ **Expected Completion Date:** _____

COMPLETE THE FOLLOWING FOR TREATMENT WITH FREQUENCY & DURATION COMPONENTS

Units (# of visits/days): _____ Frequency: _____ Duration: _____
Example: Units 12 Frequency 3 x week Duration 4 weeks

Ordering Provider Name: _____

License Category: _____ **Specialty:** _____

Address: _____ **Phone:** _____ **Fax:** _____

FTIN: _____

Servicing Provider/Facility Name: _____

License Category: _____ **Specialty:** _____

Address: _____ **Phone:** _____ **Fax:** _____

FTIN: _____

****PLEASE PROVIDE ANY DIAGNOSTIC TESTS, PHYSICAL EXAM FINDINGS, MD/THERAPY EVALUATIONS/NOTES TO SUPPORT REQUEST.****

Is Supporting medical information attached (Select one): ☐ Yes ☐ No

Comments/Additional Information: _____
