NEW YORK STATE | Workers' Compensation Board

ATTENDING DOCTOR'S REQUEST FOR AUTHORIZATION AND CARRIER'S RESPONSE

State of New York - Workers' Compensation Board
Answer all questions fully on this report

C-4 AUTH

WCB Case Number:	Carrier Case Number:	Date of Injury:

A. Patient's Name: ..... (First MI Last) ..... Social Security No.: .....

Address: ..... (Number and Street City State Zip Code)

Employer's Name: .....

Address: ..... (Number and Street City State Zip Code)

Insurance Carrier's Name: .....

Address: ..... (Number and Street City State Zip Code)

B. Attending Doctor's Name: .....

Address: ..... (Number and Street City State Zip Code)

Individual Provider's WCB Authorization No.: ..... Telephone No.: ..... Fax No.: .....

C. **AUTHORIZATION REQUEST**

*The undersigned requests written authorization for the following **special service(s) costing over $1,000** or requiring pre-authorization pursuant to the Medical Treatment Guidelines. Do NOT use this form for injuries/illnesses involving the Mid and Low Back, Neck, Knee, Shoulder and Non-Acute Pain, except for the treatment/procedures listed below under Medical Treatment Guideline Procedures Requiring Pre-Authorization. Please use the appropriate Medical Treatment Guideline form if any other procedure/test is being requested.*

Authorization Requested:	**Carrier Response: if any service is denied, explain on reverse.**
Diagnostic Tests:	
☐ Radiology Services (X-Rays, CT Scans, MRI) indicate body part: _____	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ Other _____	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
Therapy (including Post Operative):	
☐ Physical Therapy: _____ ___times per week for ___weeks	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ OccupationalTherapy: _____ ___times per week for ___weeks	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ Other _____	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
Surgery:	
☐ Type of Surgery (Describe, include use of hardware/surgical implants) _____	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
_____	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
Treatment:	
☐ Other _____	☐ Granted ☐ Granted w/o Prejudice ☐ Denied

Medical Treatment Guidelines Procedures Requiring Pre-Authorization *(Complete Guideline Reference for each item checked, if necessary. In first box, indicate injury and/or condition: K = **K**nee, S = **S**houlder, B = Mid and Low **B**ack, N = **N**eck, P = Non-Acute **P**ain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)*

☐ 1. Lumbar Fusions	B-E4a	1.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 2. Artificial Disk Replacement	-E	2.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 3. Vertebroplasty	B-E7ai	3.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 4. Kyphoplasty	B-E7ai	4.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 5. Electrical Bone Growth Stimulators	-Ea	5.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 6. Osteochondral Autograft	K-D1f	6.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 7. Autologous Chondrocyte Implantation	K-D1f	7.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 8. Meniscal Allograft Transplantation	K-D	8.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 9. Knee Arthroplasty (total or partial knee joint replacement)	K-F2	9.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 10. Spinal Cord Stimulators	P-G1	10.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 11. Intrathecal Drug Delivery (pain pumps)	P-G2	11.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 12. Second or Subsequent Procedure	-	12.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied

STATEMENT OF MEDICAL NECESSITY

Pursuant to 12 NYCRR 325-1.4(a)(1), it is the attending physician's burden to set forth the medical necessity of the special services required. Failure to do so may delay the authorization process.

_____

_____

_____

_____

Date of service of supporting medical in WCB Case File: _____ **(Attach if not already submitted.)**

*I certify that I am making the above request for authorization. This request was made to the insurance carrier/self-insurer: (Complete A **or** B)*

A. *By fax on (date)* _____ *to (person contacted)* _____

B. *By telephone on (date)* _____ *to (person contacted)* _____

***and** e-mailed/faxed/mailed on (date)* _____

A copy of this form was sent to the Board on the date below.

Provider's Signature: _____ Date: _____

D. **SELF-INSURED EMPLOYER / CARRIER RESPONSE TO AUTHORIZATION REQUEST**

Response Time and Notification Required:

The self-insured employer/carrier must respond to the authorization request orally and in writing via e-mail, fax or regular mail with confirmation of delivery within 30 days. The 30 day time period for response begins to run from the completion date of this form if e-mailed or faxed, or the completion date plus five days if sent via regular mail. The written response shall be on a copy of this form completed by the physician seeking authorization and shall clearly state whether the authorization has been granted, granted without prejudice, or denied. *Authorization can only be granted without prejudice when the compensation case is controverted or the body part has not yet been established. Authorization without prejudice shall not be construed as an admission that the condition for which these services are required is compensable or the employer/carrier is liable. The employer/carrier shall not be responsible for the payment of such services until the question of compensability and liability is resolved.* Written response must be sent to the health care provider, claimant, claimant's legal counsel, if any, the Workers' Compensation Board and any other parties of interest.

Denial of the Request for Authorization of a Special Service: A denial of authorization of a special service **must** be based upon and accompanied by a **conflicting second opinion** rendered by a physician authorized to conduct IMEs, or record review, or qualified medical professional, or a physician authorized to treat workers' compensation claimants. (If authorization is denied in a controverted case, the conflicting second opinion must address medical necessity only.) When denying authorization for a special service, the employer/carrier must also file with the Board within 5 days of such denial Form C-8.1 Part A (Notice of Treatment Issue(s)/Disputed Bill Issue(s)). Failure to file timely the conflicting second opinion and Form C-8.1 Part A will render the denial defective. If denial of an authorization is based upon claimant's failure to attend an IME examination scheduled within the 30 day authorization period, contemporaneous supporting evidence of claimant's failure must be attached.

Failure to Timely Respond to Form C-4 AUTH: The special service(s) for which authorization has been requested will be ***deemed authorized*** by Order of the Chair if the self-insured employer/carrier fails to respond within the time specified above. An Order of the Chair is not subject to an appeal under Section 23 of the Workers' Compensation Law.

REASON FOR DENIAL(S), IF ANY. (ATTACH OR REFERENCE CONFLICTING SECOND MEDICAL OPINION AS EXPLAINED ABOVE.)

_____

_____

_____

_____

_____

Date of service of supporting medical in WCB case file: _____

*I certify that the self-insured employer/carrier **telephoned** the office of the health care provider listed above within the response time-frame indicated above and advised that the self-insured employer/carrier had either granted or denied approval for the special services for which authorization was sought, as indicated above, on the date below:*

and

I certify that copies of this form were e-mailed, faxed, or mailed to the health care provider, the claimant, the claimant's legal counsel, if any, the Workers' Compensation Board and all parties of interest on the date below:

By: (print name) _____ Title: _____

Signature: _____ Date: _____

REQUEST FOR WRITTEN AUTHORIZATION **IMPORTANT TO ATTENDING DOCTOR**

AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY

1. This form is used for a workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit case as follows: To confirm a telephone request for written authorization for special service(s) costing over $1,000 in a non-emergency situation or requiring pre-authorization pursuant to the Medical Treatment Guidelines.

2. SPECIAL SERVICES - Services for which authorization must be requested are as follows:

   Physicians - To engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or physiotherapeutic or other procedures, or to provide for special diagnostic laboratory tests costing more than $1,000.
   Podiatrists - In treating the foot, to provide physiotherapeutic procedures, X-ray examinations, or special diagnostic laboratory tests costing more than $1,000.
   Chiropractors - In treating a condition as provided in Section 6551 of the Education Law, to engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or physiotherapeutic or other procedures, or to provide for special diagnostic laboratory tests costing more than $1,000.
   Occupational/Physical Therapists - In treating a condition as provided in Article 136 or 156 of the Education Law, in the Workers' Compensation Law, and the Rules of the Chair relative to Occupational/Physical Therapy Practice to provide occupational/physical therapy procedures costing more than $1,000.
   Psychologists - Prior authorization for procedures enumerated in section 13-a(5) of the Workers' Compensation Law costing more than $1,000 must be requested from the self-insured employer or insurance carrier. In addition, authorization must be requested for any biofeedback treatments, regardless of the cost, or and special diagnostic laboratory tests which may be performed by psychologists. Where a claimant has been referred by an authorized physician to a psychologist for evaluation purposes only and not for treatment, prior authorization must be requested if the cost of consultation exceeds $1,000.
   Medical Treatment Guidelines - Lumbar Fusions, Artificial Disk Replacement, Vertebroplasty, Kyphoplasty, Electrical Bone Growth Stimulators, Spinal Cord Stimulators, Osteochondral Autograft, Autologus Chondrocyte Implantation, Meniscal Allograft Transplantation, Knee Arthroplasty (total or partial knee joint replacement), Intrathecal Drug Delivery (pain pumps).

3. When requesting authorization over the telephone, be sure to obtain the name of the person contacted since you must indicate this information along with the date of contact and certify its validity on the form.

4. It is the attending physician's burden to set forth the medical necessity of the special services required. Be sure to provide this information in the Statement of Medical Necessity section of this form.

5. This form must be signed by the attending doctor and must contain her/his authorization certificate number and code letters. If the patient is hospitalized, it may be signed by a licensed doctor to whom the treatment of the case has been assigned as a member of the attending staff of the hospital.

6. Please ask your patient for his/her WCB case number and the carrier's case number and show these numbers on this form. In addition, ask your patient if he/she has retained a representative. If represented, ask for the name and address of the representative.

   This request must be sent to the Workers' Compensation Board, the workers' compensation insurance carrier or self-insured employer, and, if the patient is represented by an attorney or licensed representative, such legal representative. If your patient is not represented, a copy must be sent to your patient.

7. If authorization or denial is not forthcoming within 30 calendar days, notify the nearest office of the Workers' Compensation Board.

8. HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Reports should be filed by sending directly to the Workers' Compensation Board at the address below with a copy sent to the insurance carrier:

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Number: 877-632-4996
Statewide Fax Line: 877-533-0337