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)

Provider's 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, and Shoulder; 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 body part: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck. 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. Spinal Cord Stimulators	B-E10ai	6.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 7. Anterior Acromioplasty of the Shoulder	S-D6	7.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 8. Chondroplasty	K-D1f	8.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 9. Osteochondral Autograft	K-D1f	9.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 10. Autologus Chondrocyte Implantation	K-D1	10.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 11. Meniscal Allograft Transplantation	K-D	11.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 12. Knee Arthroplasty (total or partial knee joint replacement)	K-F2	12.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 13. Second or Subsequent Procedure	-	13.	☐ 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: _____ **(If not already in file, supporting medical must be attached.)**

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 Board Form C-8.1 Part A (Notice of Treatment Issue(s)/Disputed Bill Issue(s)). Failure to file timely the conflicting second opinion and Board 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 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: _____