

Issue	PROCESS	APPLICABLE RULE/DOWC COMMENT
	PRIOR AUTHORIZATION OF SERVICES	
Prior authorization	When requesting prior authorization, providers must explain the medical necessity of the service and submit supporting documentation. The request must be as specific as possible.	Rule 16-9(E)
Lack of authorization from adjuster	All authorization given to a provider should be specific, in writing, and internally routed to the bill reviewer and all other parties for proper handling of bill.	Rule 16-9(G) -Authorization confirmed in writing; Rule 16-9(B)-Response time to a request for prior authorization
Denial of authorization	All denials of prior authorization must be in complete compliance with Rule 16-10	Rule 16-10(E) - allows for automatic authorization if denial is not done timely; Rule 16-10(F)-Unreasonable denial may lead to penalties.
	PRIOR TO SUBMITTING BILLS	
Incomplete or inaccurate bills	Before sending the bill, the provider should verify the billed information on the CMS 1500 (08-05) (formerly CMS 1500) to insure the fields are properly filled out and the information is correct.	Rule 16-7(B) & (D)
Provider tax info not available or wrong	Providers should verify the tax ID number	
Provider specialty not identified on bill	Bill for only one provider per CMS 1500 (08-05) (formerly CMS 1500). Field 31 of the CMS 1500 may be used to identify the supervising provider, and Field 19 used to identify the provider rendering the treatment, if different than the supervising provider.	
Provider's submission of notes and supporting documentation	The Division recommends submitting all billing documentation at the time of submitting the bill unless a private agreement exists between parties.	Rule 16-7(E)-Accompanying Documentation, Rule 16-7(E)- A Division form titled "Physician's Supplemental Report" (WC-164) with the initial and closing visit billing
Hospitals are charging for copies of records	The payers request for records from the hospital needs to be specific. Ex.: A physician's billed ER visit only requires the physician's ER note.	Rule 16-7(E)(5)

Hospitals are not releasing records	The entire hospital records may not be necessary for bill review. The hospital audit procedure may be appropriate if questioning the extent of services provided.	Rule 16-12(C); Rule 16-7(E)(5)-requires hospitals to make records available upon request.
Provider PPO discounts taken w/o a signed contract or the contract agreement has expired.	Payers need to verify payment reductions are in compliance with PPO contracts.	Rule 16-11(B)(3)(f)
		Relatedness: If an ATP asserts the injury is work related, a denial of relatedness by the payer requires a medical review Rule 16-11(B)(2).
	REVIEW AND PROCESSING OF BILLS	
No acknowledgment of receipt of bill	Within thirty days of receipt of a bill, payer should notify the billing provider, either by EOB or letter, of all bills received, even if the claim has not been established, the bill has been submitted to the wrong insurer, or the services billed are nonwork related.	Rule 16-11(B)- Non-Medical Contest; Rule 16-11(C)- Medical Contest
Unestablished Claims - "First Report of Injury" has not been filed in a timely manner or the medical services billed are non-work related.	In cases of unestablished claims (no "First Report of Injury"), the provider should inform the patient of the need to file a claim with DOWC.	
	Payer internal documentation routing should not necessitate a second request for documentation and/or a bill going unpaid	Rule 18-6(G)(1) - Any second request for medical records by the payer should generate a copying fee billed by the provider and paid by the payer. Requests for second copies of documentation will be reimbursed at the rate established in Rule 18-6(C).
	The payer verifies all billed codes/modifiers, policy number, etc. and issues a reimbursement check and an explanation of benefits (EOB) within 30 days from receipt of bill.	Rule 16-11(A)(2) and Rule 16-11(B)(3) require a response to the provider within 30 days of receipt of the bill.
	Payers must pay for the services as billed or deny the codes/modifiers not supported by the presented ocmumentation and/or Relative Values for Physicians/DOWC rules. Payers are required to	Rule 16-11(B) - Contested payment for billed services based on non-medical issues. Rule 16-11(C) -contested payment for billed services based on medical issues. Rule 16-11(B)(4) - changing codes.

	be very clear and specific on why they are denying the billed codes. Payers cannot change billed codes except as outlined. A physician's review must be completed for all contested payment based on medical issue. The provider has 60 days to resubmit the denied codes and modifiers with additional information.	Rule 16-11(D) – disputes.
	PAYMENT OR DENIAL OF PAYMENT RECEIVED	
	The provider should contact the payer if no check or EOB is received within 30 days to verify receipt of bills and to crossverify accuracy of the bill.	
Re-review of claims	The provider has 60 days to contest reasons for nonpayment and present their argument	Rule 16-11(D)(1)
	Payer has thirty days from receipt of resubmission to pay or explain continued denial.	Rule 16-11(D)(1)
	DISPUTE RESOLUTION	
Disputes	In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts In addition, issues may be brought to the Division's Medical Policy Unit to identify the issues, mediate a resolution or for RVP or Rule Assistance.	Rule 16-11(D)(3)