***Instructions for Form WC 188***
***Authorized Treating Provider's Request for Prior Authorization***

Prior authorization for payment shall be requested by the authorized treating provider (ATP) when:

(1) A prescribed service exceeds the recommended limitations set forth in the Medical Treatment Guidelines;
(2) The Medical Treatment Guidelines otherwise require prior authorization for that specific service;
(3) A prescribed service is identified within the Medical Fee Schedule as requiring prior authorization for payment; or
(4) A prescribed service is not identified in the Medical Fee Schedule such as any unlisted procedure/service with a BR value or an RNE value listed in the RVP©

**When the indicators of the Treatment Guidelines are met, no prior authorization is required.**

To complete a prior authorization request, the provider shall concurrently explain the reasonableness and the medical necessity of the services requested, and shall provide relevant supporting medical documentation. Supporting medical documentation is defined as documents used in the provider's decision-making process to substantiate the need for the requested service or procedure.

When completing Form WC 188, the ATP shall provide the patient's information including the patient's name, date of injury, date of birth (DOB), carrier claim # (if known), and the date the request is being submitted to the carrier.

| ***Date of Injury:*** | ***Patient's DOB:*** | ***Carrier Claim #:*** | ***Date Sent:*** |
|---|---|---|---|
| ***Patient's Name****:* Last | First | | MI |

Insurance Carriers/Agents providing this Form may complete the information in the relevant boxes as part of their standard template (see example below). For the purpose of this form, an Agent is an entity or person who has responsibility and authority to discuss and approve the request.

| ***Insurance Carrier's/Agent's Name:*** | | | |
|---|---|---|---|
| ***Address****:* Number and Street | City | State | Zip Code |
| *Telephone Number:* | *Fax Number:* | | |

**Example:**

| ABC Healthcare | | | |
|---|---|---|---|
| 100 Standard Blvd. | Denver | CO | 80203 |
| *Telephone Number:* 303-123-4567 | *Fax Number:* 303-123-5678 | | |

The following boxes must be completed identifying the ATP requesting the prior authorization request:

| ***Provider's Name****:* | *Telephone Number:* | *Fax Number:* | *NPI/FEIN:* |
|---|---|---|---|
| ***Address****:* Number and Street | | City | State | Zip Code |

For all requests, please specify the services being requested, all known appropriate billing codes and the final diagnoses.

If Medical Treatment Guidelines have been met and no prior authorization is required, but the provider still chooses to submit a request, please include:

- An adequate definition or description of the nature, extent, and need for the procedure;
- Identify the appropriate Medical Treatment Guideline application to the requested service; and
- Document that the indicators in the guidelines have been met.

For all other requests, when prior authorization is indicated, please include:

- Compliance with the general principles of the Medical Treatment Guidelines including functional goals of treatment; and
- Any studies or articles that justify the medical necessity and use of the requested service or procedure.

If the requestor is attaching supporting documentation, please check the relevant box.

| Specify service(s) and billing code(s): | Dx/ICD-9 Codes: |
|---|---|
| Medical Justification for the requested procedure(s) or for treatment beyond guideline recommendation (Rule 17):<br><br>Supporting documentation attached: ☐ | |

If the requested procedure is not identified in the Medical Fee Schedule or does not have an established value, please include the following documentation:

- Identify and recommend a Medical Fee Schedule code that has an established value and is reasonably similar to the requested service or procedure;
- Why the recommended similar code value and any dollar value above or below this procedure is reasonable as requested;
- Any temporary CPT code for the service, if applicable;
- The number of times the service has been performed by the requesting provider;
- Whether the procedure will be performed independent from other services provided or at the same surgical site or through the same surgical opening; and
- Time, effort and equipment necessary to provide the service.

If the requestor is attaching supporting documentation, please check the relevant box.

| If establishing reimbursement for By Report (BR) or Relativity Not Established (RNE), please describe required procedure; give recommended payment based on requested code(s) with justification for payment:<br><br>Supporting documentation attached: ☐ |
|---|

The ATP or representative must print his/her name and sign the request, attesting to submission of this form to the appropriate carrier/agent.

Insurance Carriers/Agents providing this form may complete the information in the relevant boxes as part of their standard template (see example):

| | |
|---|---|
| I certify that this request was sent to:<br>[Insert carrier/agent/self-insured here]<br>Ordering Provider or Representative:<br>[Print Name]<br>Signature: Date: | Submitted by:<br>☐ Mail<br>☐ Fax: ( )<br>☐ Email: |

**Example:**

| | |
|---|---|
| I certify that this request was sent to:<br>ABC Healthcare<br>Ordering Provider or Representative:<br>[Print Name]<br>Signature: Date: | Submitted by:<br>☐ Mail<br>☐ Fax: (303) 123-5678<br>☐ Email: parmailbox@abc.com |

The payer shall respond to all providers requesting prior authorization within seven (7) business days from receipt* of the provider's completed request. The duty to respond to a provider's written request applies without regard for who transmitted the request. Failure of the payer to timely comply** shall be deemed authorization for payment.

* Date of receipt of the bill may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the bill was mailed to the payer's correct address.

** See full requirements in Rule 16-10(A), (B), and (E)

The payer may respond to the prior authorization request by completing the bottom grayed portion of WC 188 or through their own system-generated letter as long as all required information is provided.

| | |
|---|---|
| A denial of authorization must be completed in accordance with the procedures as outlined in Rule 16-10(A) *Contest of Prior Authorization for Non-Medical Reasons* or 16-10(B) *Contest of Prior Authorization for Medical Reasons* and the payer must clearly identify whether granting or denying prior authorization for the services requested on this form. | Payer Response to Medical Service/Procedure request:<br><br>Granted (please provide authorization code): |

The payer may comply with this rule by either citing or attaching the applicable Medical Treatment Guideline(s). A denial for medical reasons shall include an explanation of the specific medical reasons for the contest, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion. A certificate of mailing of the written contest must be sent to the provider and parties.

| |
|---|
| Medical reasons for denial(s) of any request for prior authorization require a medical opinion/review in accordance with Rule 16-10(B) and Rule 17, applicable Treatment Guidelines to be attached to this response form. |
| I certify that copies of the approval/denial were completed and sent to the health care provider, the injured worker, and the injured worker's legal counsel on the date below: |

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

# AUTHORIZED TREATING PROVIDER'S REQUEST FOR PRIOR AUTHORIZATION

**Please fill out all required information, as missing information may delay your request.**

| ***Date of Injury:*** | ***Patient's DOB:*** | ***Carrier Claim #:*** | ***Date Sent:*** |
|---|---|---|---|

| ***Patient's Name****:* Last | First | MI |
|---|---|---|

***Insurance Carrier's/Agent's Name:***

| ***Address****:* Number and Street | City | State | Zip Code |
|---|---|---|---|

| *Telephone Number:* | *Fax Number:* |
|---|---|

## AUTHORIZED TREATING PROVIDER REQUESTING PRIOR AUTHORIZATION

| ***Provider's Name****:* | *Telephone Number:* | *Fax Number:* | *NPI/FEIN:* |
|---|---|---|---|

| ***Address****:* Number and Street | City | State | Zip Code |
|---|---|---|---|

## AUTHORIZATION REQUESTED/STATEMENT OF MEDICAL NECESSITY

| Specify service(s) and billing code(s): | Dx/ICD-9 Codes: |
|---|---|

Medical Justification for the requested procedure(s) or for treatment beyond guideline recommendation (Rule 17):

Supporting documentation attached: ☐

If establishing reimbursement for By Report (BR) or Relativity Not Established (RNE), please describe required procedure; give recommended payment based on requested code(s) with justification for payment:

Supporting documentation attached: ☐

| I certify that this request was sent to:<br><br>Ordering Provider or Representative:<br><br>Signature: Date: | Submitted by:<br>☐ Mail<br>☐ Fax: ( )<br>☐ Email: |
|---|---|

| **The self-insured employer or employee's insurance carrier shall respond with their required information (noted in the grey shaded areas) within seven (7) business days from receipt of the provider's completed request. Per Rule 16-9(C), requests delayed beyond seven (7) days will be deemed automatically approved.** | **Date Received:** |
|---|---|

| A denial of authorization must be completed in accordance with the procedures as outlined in Rule 16-10(A) *Contest of Prior Authorization for Non-Medical Reasons* or 16-10(B) *Contest of Prior Authorization for Medical Reasons* and the payer must clearly identify whether granting or denying prior authorization for the services requested on this form. | Payer Response to Medical Service/Procedure request:<br><br>Granted (please provide authorization code): |
|---|---|

Medical reasons for denial(s) of any request for prior authorization require a medical opinion/review in accordance with Rule 16-10(B) and Rule 17, applicable Treatment Guidelines to be attached to this response form.

I certify that copies of the approval/denial were completed and sent to the health care provider, the injured worker, and the injured worker's legal counsel on the date below:

| **By:** ***(Print Name)***<br><br>**Signature:** | Title:<br><br>Date: |
|---|---|