RIVER VIEW
PROVIDER GROUP

Pre-authorization of Medical Care

All pre-authorization review services are provided by Sedgwick. The following provides a list of treatments and services that require pre-authorization; however, any specialist contracted with the River View Provider Group may submit a treatment plan for pre-authorization. If the treatment plan contains any of the following services and said plan is pre-authorized, the specialist will not be required to submit separate requests for services as outlined below (completion dates are required for pre-authorization):

1. In-patient hospital admissions including the principal scheduled procedure(s) and the length of stay;
2. Outpatient surgical or ambulatory surgical services;
3. Spinal surgery, as provided by Texas Labor Code §408.026;
4. All psychological testing and psychotherapy, repeat interviews, and biofeedback; except when any service is part of a preauthorized or exempt rehabilitation program;
5. All external and implantable bone growth stimulators;
6. All chemonucleolysis;
7. All myelograms, discograms, or surface electromyograms;
8. Unless otherwise specified, repeat individual diagnostic study, with a fee established in the current Medical Fee Guideline of greater than $1500 or documentation of procedure (DOP); or without a reimbursement rate established in the current Medical Fee GuidelineWork hardening and work conditioning services provided in a facility that has not been approved for exemption by the Division;
9. Work hardening and work conditioning services provided in a facility that has been approved for exemption by the Division;
10. Rehabilitation programs to include (a) outpatient medical rehabilitation and (b) chronic pain management/interdisciplinary pain rehabilitation;
11. All durable medical equipment (DME) in excess of $500 per item (either purchase or expected cumulative rental) and all transcutaneous electrical nerve stimulator (TENS) units;
12. Nursing home, convalescent, residential, and all home health care services and treatments;
13. Chemical dependency or weight loss programs;
14. Any 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; and

15. Physical and occupational therapy services which are those listed in the Healthcare Common Procedure Coding System (HCPCS) Level 1 code range for Physical Medicine and Rehabilitation, but limited to: (a) modalities, both supervised and constant attendance; (b) therapeutic procedures, excluding work hardening and work conditioning; and (c) other procedures, limited to the unlisted physical medicine and rehabilitation procedure code. **NOTE:** Preauthorization is not required for the first 12 visits or 4 weeks, whichever occurs first, of physical or occupational therapy following the evaluation when such treatment is rendered within the first three weeks immediately following: (a) the date of injury, or (b) a surgical intervention previously approved by the payer
16. Treatments and services that exceed or are not addressed by the River View Provider Group adopted treatment guidelines or protocols and are not contained in a treatment plan previously preauthorized.
17. All Compound Drug Prescriptions (even for those prescriptions that do not contain any N Drug ingredient(s))

If you are submitting a request for pre-authorization for a treatment plan, the following must be included (in addition to the standard documents):

1. Current diagnosis code(s)
2. Reference to evidence-based treatment guidelines
3. A list of all recommended or anticipated diagnostics
4. A list of all recommended or anticipated physical or occupational therapy; including the number of sessions
5. A list of all treatment recommendations including office visits, prescriptions or other general medical care no otherwise outlined
6. Length of time of the treatment plan must not be more than 60 days

In the event the diagnosis changes and the treatment plan is no longer valid, the requesting provider can either submit a new treatment plan or individual pre-authorization request if applicable.