Industrial Commission of Arizona
Medical Resource Office

MRO-1

PREAUTHORIZATION REQUEST AND PAYER DECISION

(Limited to chronic pain and/or opioids)

☐ Initial Request ☐ Request for Reconsideration ☐ Urgent & Life Threatening

EMPLOYEE INFORMATION			
Last Name*:	First Name*:		MI:
Address*:	City*:	State*:	Zip Code*:
Phone*:		E-mail Address:	
Date of Injury (MM/DD/YYYY)*:		Date of Birth (MM/DD/YYYY)*:	
Payer Claim Number:		Social Security No:	
ICA Case Number**:		Employer:	
Employee Attorney:		Attorney Phone:	
Attorney Address:		E-mail:	

PROVIDER INFORMATON			
Name*:		Contact Name*:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
Specialty:		NPI Number*:	
E-mail:			

PAYER INFORMATION			
Payer Name*:		Contact Name*:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
E-mail:			

REQUESTED TREATMENT: List each specific requested medical treatment or service below. Attach medical documentation supporting the medical necessity and appropriateness of request, such as office notes and diagnostic reports.

Diagnosis/ICD-Code	Treatment/Services Requested*	CPT Code/NDC Code*

Provider Signature: Date Submitted

PAYER INITIAL DECISION

Date Pre-authorization Request Received:

Payer Initial Decision: ☐ Approved ☐ Partial Denial ☐ Denied ☐ Payer Decision Supported by IME

Statement of what has been authorized, or if not authorized, the medical reasons supporting the Payer's Decision:

Payer Signature: Date Submitted:

REQUEST FOR RECONSIDERATION (State the specific reason(s)/justification to support your request for reconsideration. Provide supporting medical documentation if not previously provided).

Provider Signature: Date Submitted:

PAYER RECONSIDERATION DECISION
Date Request for Reconsideration Received:
Payer Reconsideration Decision: ☐ Approved ☐ Partial Denial ☐ Denied ☐ Payer Decision Supported by IME
Statement of what has been authorized, or if not authorized, the medical reason supporting the Payer's Decision:
Payer Signature: _____ Date Submitted:

Required Field** * ICA Claim Number or Social Security Number Required**

If, within 10 business days, a Payer fails to: 1) Notify you that your Pre-Authorization Request is incomplete, 2) Notify you that an IME has been requested, or 3) Send you a Decision on your Pre-Authorization Request, then you may submit a request for Administrative Review to *The Industrial Commission of Arizona, Attn: Medical Resource Office, 800 W. Washington St, Suite 305, Phoenix, AZ 85007*. MRO Phone: (602) 542-4308 MRO Fax: (602) 542-4797. Log onto MRO Portal at https://mro.azica.gov . You may use ICA MRO-2 form for this request.

To Request Review of a Payer Decision

- To **Request Reconsideration of a Payer's Initial Decision:** If you wish to request reconsideration of the decision regarding your request for authorization to provide treatment or services, please complete MRO-1 form Request for Reconsideration and submit to Payer:
- *Name of Payer*
  Attn: (name)
  Payer address
  Payer phone, fax, and email.

  You must include in your request for reconsideration the specific reason(s)/justification to support your request. Please include additional supporting medical documentation if not previously provided.

- To **Request Review of a Payer's Reconsideration Decision** or **Payer's Initial Decision Denying a Pre-Authorization Request that is Supported by the Guidelines:** If you disagree with the decision and wish to request review by the Industrial Commission of Arizona, then you may submit a request for administrative review by logging onto the MRO Portal at https://www.mro.azica.gov, or submit written request (MRO-2 form) to:

  Industrial Commission of Arizona
  Attn: Medical Resource Office, Suite 305
  800 W. Washington St, Suite 305
  Phoenix, AZ 85007.
  Phone: (602) 542-4308 Fax: (602) 542-4797 MRO Portal https://mro.azica.gov

  You must include the following information in your request for review to the ICA Medical Resource Office: Patient information (e.g. name, address, carrier claim number, and ICA claim number, date of injury, etc.); Diagnosis/ICD code Employer/Insurance Carrier/TPA information; Provider information; Information pertaining to request for treatment (e.g. request(s) and/or justification for treatment, applicable treatment guideline(s)), and denial of treatment by payer; Copies of relevant medical information or records; Copies of relevant documentation related to payer reconsideration decision, and; Whether the request for medical treatment or services involves a request for urgent care or a life-threatening condition."

- If you wish to **Request Review of <u>any Payer Decision that is Supported by an IME</u>,** then the injured employee is required to file a request for investigation under A.R.S. § 23-1061(J). For information about how to file an A.R.S. §23-1061(J) contact the Industrial Commission Ombudsman at (602) 542-3397.

Original to Provider Copy Sent to: ☐Employee ☐Employee's Attorney ☐ IME Report Attached