Ohio | Bureau of Workers' Compensation

Completing the Physician's Treatment Request ECP-TX

Instructions

- Please print or type this report.
- You cannot use this form for claims of self-insuring employers.
- If the injured worker is employed by a state-fund employer, complete this form, and mail or fax it to the appropriate managed care organization (MCO).
- To determine the appropriate MCO, ask the injured worker or employer to visit BWC's Website at www.bwc.ohio.gov, or call BWC at 1-800-644-6292, and listen to the options.
- Use this form if this is a request for services even if services are being provided under the 60-day presumptive authorization,
  if recommending additional condition(s) or if diagnosis has changed.
- Complete all applicable sections of the form to avoid possible delays in processing this request.
- You can obtain additional copies of this form at www.bwc.ohio.gov or by calling BWC at 1-800-644-6292 and listening to the options.

General claims/Demographic information

- Enter the injured worker's name, BWC claim number, the date the injured worker was injured or contracted an occupational disease, physician's name and address, employer name and injured worker's position of employment at time of injury.

Section I – Treatment plan

Please provide below or attach a comprehensive treatment plan that includes all of the following:

- Treating diagnosis for this request (include body part/levels);
- Dates of service (begin and end);
- Requested services with Current Procedural Terminology/Healthcare Common Procedure Coding System codes;
- Frequency of treatment;
- Duration of treatment;
- The two-digit facility site of service code as used by the Centers for Medicare and Medicaid Services, if applicable;
- Rendering provider's name;
- Rendering provider's address.

Please note: You must indicate whether your treatment plan is an initial care plan or subsequent care plan.

Section II – Additional conditions

- If you are recommending additional conditions to the claim, you must provide supporting medical documentation.
- Provide diagnosis (narrative description only), and location and site for additional requested conditions.
- Please indicate your opinion, based on history from the injured worker, your clinical evaluation and expertise, whether the diagnosis or condition is casually related, either directly or proximately, to the industrial accident or exposure.
  - o Casually related refers to the establishment of a relationship between the injury or occupational disease and the industrial accident or exposure.
  - o An explanation must accompany your response.

Section III - POR physician signature - mandatory

- Physician/provider signature, individual BWC provider number and date of this report

Section IV - Treating physician if different from the POR - mandatory

- Treating physician/provider name and address, and date of service (i.e. surgeon)

Section V - MCO authorization of medical services

(BWC will address any recommendations for additional condition(s))

- The MCO must complete this section.
- BWC will notify all parties and the MCO of the decision on additional allowance recommendations.

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Physician's Treatment Request
ECP-TX

Injured worker name	Claim number	Date of injury	Date of exam

Employer name	Physician name and address (REQUIRED)

Treatment plan (Please see instructions for clarification for completing this section.)

1 Please provide below or attach a comprehensive treatment plan that includes all of the items requested on page one of the instructions.

This is my (check one): ☐ Initial care plan ☐ Subsequent care plan

Additional conditions (Please see instructions for clarification for completing this section.)

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POR physician signature - mandatory

3	Physician/authorized signature (required)	Individual BWC provider number (required)	Date (required)

Treating physician if different from the POR - mandatory

4	Treating physician's name (required)	Treating physician's address (required)	Service date

MCO authorization of medical services (BWC will address any recommendation for additional condition(s).)

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☐ **Approved with disclaimer:** This medical payment authorization is for a claim that BWC/The Industrial Commission of Ohio is considering for initial allowance as of the date of the managed care organization's (MCO's) signature. If the claim is ultimately disallowed, BWC may not cover the services/supplies to which this medical payment authorization applies. The injured worker may be responsible for these services/supplies.

☐ Approved in its entirety.

☐ Approved in part, denied in part; please explain in detail:

☐ Denied in its entirety, please explain in detail:

☐ Pending: You must submit the documentation requested to the MCO case manager within 10 business days to allow for a treatment decision. Failure to respond may result in denial.

***For specialists and ancillary service providers:** For an initial care plan in an allowed claim, BWC shall pay for services provided in accordance with Official Disability Guidelines (ODG) prior to MCO authorization. The MCO must provide prior authorization for treatment that falls outside of ODG guidelines.

MCO company name	This authorization is being signed and completed by (please sign or stamp name):		
	MCO number	Telephone number	Date