**Department of Vermont Health Access**

**Request for Extension of Home Health Re/habilitation Therapy Services:**

**For non-ACO attributed members only. Each discipline must complete a separate form.**

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| Member Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Member Birthdate: **\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**  Member Unique ID#: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Supplying Provider Facility: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Supplying Provider Facility #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Referring Physician/Advanced Practice Provider Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Referring Physician/Advanced Practice Provider #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Modifiers and Revenue Codes:**  Check One: PT 420-424 OT 430-434  ST 440-444  Events complicating therapy: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Commitment/adherence to home program: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  If there are adherence concerns: document the plan for adherence improvement: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Is the condition a result of a motor vehicle accident? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Is the condition a result of a work-related accident? If so, document why Worker’s Compensation or Social Security Disability Insurance is not the proper coverage source: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Underlying condition driving the care plan (primary billing diagnosis):**  ICD-10 dx code: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Definition:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date of onset: **\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**  Other conditions:  ICD-10 dx codes: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Definitions: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date of onset: **\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**  Note: the ICD10 code for the above conditions must also appear on your claim forms. **Do not use pain codes as the underlying condition unless there is a diagnosed pain syndrome. Include surgical aftercare information and coding if there has been a pertinent surgery.** |

**Column 1 Column 2 Column 3**

|  | **Report Period** | **Objective, measurable, member-oriented goals and research-based treatment plan** | **Goals met/not met (check one). If not met, show progress toward each goal using initial and current objective parameters** |
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| **Introductory section** | **First 4 months of Treatment  OR**  **Treatment beyond one year :**  Date of initial therapy for this condition, at any non-inpatient facility, any pay source, regardless of previous discharges: \_\_\_\_/\_\_\_/\_\_\_  Requested Start Date: \_\_\_/\_\_\_/\_\_  Requested End Date: \_\_/\_\_\_/\_\_\_\_  Visit frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Annual review candidate? Y N  I have reviewed the treatment plan and goals and agree with the plan of care.  Physician/Advanced Practice Provider Signature/date:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_/\_\_\_/\_\_\_\_ | Goal 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Coordination of care with other medical model disciplines:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pediatric only: Your **direct** care coordination with school personnel (for example: school therapist, physical education teacher, coach, athletic trainer) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Adult only: Transition planning:  Vocational Rehabilitation  VT Center for Independent Living  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Treatment Plan: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Paid personal care attendant training: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Goal 1: met  not met  Data from the start of the certification period: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Current data: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Goal 2: met  not met  Data from the start of the certification period: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Current data: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Goal 3: met  not met  Data from the start of the certification period: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Current data: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Therapist’s professional signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Credentials (check one): PT OT  SLP-CCC  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| **First extension request section** | First request for treatment extension  OR  Treatment beyond one year:  Requested Start Date: \_\_\_/\_\_\_/\_\_\_  Requested End Date: \_\_/\_\_/\_\_\_  Treatment Frequency or # Visits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Annual review candidate? Y N  I have reviewed the treatment plan and goals and agree with the plan of care.  Physician/Advanced Practice Provider Signature/date:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_/\_\_\_/\_\_\_\_ | Goal 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Care coordination with other medical model disciplines: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pediatric only: Your **direct** care coordination with school personnel (for example: school therapist, physical education teacher, coach, athletic trainer):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Adult only: Transition planning:  Vocational Rehabilitation  VT Center for Independent Living  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Treatment Plan including procedures, modalities, and family/caregiver training: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Paid personal care attendant training: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Goal 1: metnot met:  Data from the start of the certification period: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Current data: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Goal 2: met  not met :  Data from the start of the certification period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 3: met  not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Therapist’s Professional Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Credentials (check one): PT  OT  SLP-CCC  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| **Second extension request section** | Second request for treatment extension  OR  Treatment beyond one year:  Requested Start Date: \_\_\_/\_\_\_/\_\_\_  Requested End Date: \_\_/\_\_/\_\_\_  Requesting Frequency or # Visits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Annual review candidate? Y N  I have reviewed the treatment plan and goals and agree with the plan of care.  Physician/Advanced Practice Provider Signature/date:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_/\_\_\_/\_\_\_\_ | Goal 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Care coordination with other medical model disciplines: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pediatric only: Your **direct** collaboration with school personnel (for example: school therapist, physical education teacher, coach, athletic trainer):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Adult only: Transition planning:  Vocational Rehabilitation  VT Center for Independent Living  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Paid personal care attendant training: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Treatment Plan including procedures, modalities, and family/caregiver training: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Goal 1: met  not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 2 metnot met:  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 3 metnot met:  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Therapist’s Professional Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Credentials (check one): PT  OT  SLP-CCC  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |

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| **REQUESTS FOR EXTENSION OF RE/HABILITATION THERAPY SERVICES** | **INSTRUCTIONS FOR USE OF THE DVHA MEDICAID EXTENSION FORM** |
| **Home Health Agencies:** Physical and occupational therapy, and speech language pathology services for children and adults are routinely covered for 4 months on initial Physician/Advanced Practice Provider referral for the current condition, regardless of pay source or history of discharges/readmissions. All certification dates are based on this initial date. The supplying provider is responsible for contacting the referring provider to determine the start of care date.  A written request by the therapy practitioner to extend the period of treatment beyond the first 4 months must be submitted to the Department of Vermont Health Access (DVHA). It is recommended that the submission be prior to the expiration of the current period to avoid interruption of payment.  **For any clinical questions, please contact DVHA Physical Therapist at (802) 879-5903.**  **The request must include:**   * Member name, date of birth and Medicaid unique ID. * Supplying provider facility name and VT Medicaid provider number. This is the provider/facility that will be receiving payment. * Name of referring Physician/Advanced Practice Provider and their VT Medicaid provider number. If a specialist has initiated the treatment, it is recommended that, when medically indicated, the subsequent endorsements be obtained from the primary care provider. * Date of initial therapy by any non-inpatient home/community based re/hab therapy practitioner/facility, regardless of pay source or history of discharges/readmissions, for the current condition. If you are not sure if a change indicates a new condition, contact DVHA at 802-879-5903. * Date and events complicating therapy that affect the extension of Medicaid service including hospitalization, trauma and illness. * Care coordination with other team members, including other medical disciplines, school-based therapist of the same discipline, and any other pertinent school based personnel such as athletic trainer, coach, or physical education teacher for children, and community resources including as Vocational Rehabilitation and VT Center for Independent Living for adults. * Documentation re: commitment/adherence to the home program. If adherence has been an issue, document the plan to maximize adherence. * Primary billing diagnosis, and other relevant diagnoses, ICD-10 diagnosis codes, and dates of onset. The billing diagnosis must be the primary medical condition which underlies the functional problems encountered by the member. Documented diagnoses must match billing diagnoses. Do not use pain codes as the underlying condition unless there is a diagnosed pain syndrome. Include surgical aftercare information and coding if there has been a pertinent surgery. * Final date of the introductory 4 month visit period. * Number of treatments during the introductory 4 month visit period. * Training of family/caregivers including the therapist’s direct training of the paid personal care attendant if applicable. * Treatment frequency or number of visits during the   introductory 4 month period.   * Objective, measurable goals for the introductory 4 month period. * Research based treatments/ procedures provided during the introductory 4 month period. A discharge plan must be put in place at the time of the initial evaluation. * Progress toward each unmet goal, using objective parameters. Provide both initial and current data to clearly show the progress to date. * If goals were not met, an explanation of why they were not met. * Initial and final dates of the upcoming 4 month period for which therapy is being requested. * Treatment frequency or number of visits during the upcoming 4 month period. * Objective, measurable goals for the upcoming 4 month period. * Research based treatments/ procedures to be provided during the upcoming 4 month period. * Date and therapist’s signature with professional designation. * Date and signature of Physician/Advanced Practice Provider demonstrating endorsement of the care plan.   This information can be provided by use of this therapy extension form or by other documentation which contains all of the above information. A Medicare 700/701 form or HCFA 485-7 may be utilized, provided that all of the required information listed above is included. Any additional attachments which further clarify the member’s medical status and treatment are welcome. | **FIRST SUBMISSION OF THIS FORM:**  FILL OUT **COMPLETELY** BEFORE INTRODUCTORY 4 MONTH PERIOD IS OVER:   * Page 1 of form with basic information * Introductory section, columns 1, 2, and 3. * First extension request, columns 1 and 2.   **SECOND SUBMISSION OF THIS FORM:**  FILL OUT **COMPLETELY** PRIOR TO THE EXPIRATION OF THE PREVIOUS CERTIFICATION PERIOD:   * First extension request, column 3 * Second extension request, columns 1 and 2.   **ADDTIONAL SUBMISSIONS IF THE FORM IS FULLY USED:**  FILL OUT **COMPLETELY** PRIOR TO THE EXPIRATION OF THE PREVIOUS CERTIFICATION PERIOD:   * Second extension request, column 3 * Begin a new form and complete introductory extension request columns 1 and 2. * Check the box to indicate treatment beyond one year.   Note that the response areas expand when the form is completed electronically.  This form is part of the medical-legal record. Corrections should be a single strike-out with the date and your initials. Do not erase, scribble, or use liquid paper (white-out). This document may be read by lay readers including federal and state auditors and legal personnel. All documentation must be written such that the lay reader can clearly see the medical necessity of the goals and plan. For example, vocational and avocational/sports/leisure goals are not clearly medical in nature. For children, toys and play are part of your plan, as strategies to help the child achieve the clearly medical goals. Functional goals are particularly clear to lay readers. Note also that goals related to school or work are not covered, because they are covered by other coverage sources.  Please save a copy of this form for your records. The Medicaid copy can be sent to the DVHA at NOB 1 South 280 State Drive, Waterbury VT 05671-1010 or faxed to (802) 879- 5963. Please call (802) 879-5903 for clinical questions regarding therapy, including in-servicing, documentation, and coverage. For prior authorization (PA) status and billing issues please call DHVA’s fiscal agent Gainwell Technologies Provider Services at (800) 925-1706. |
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