**Department of Vermont Health Access (DVHA)**

**Request for Re/habilitation Therapy Services Cover sheet:**

**This form is for use by Re/hab therapy practices choosing NOT to use the** [DVHA Therapy Request Form.](https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms)

**As of 1/1/23, prior authorization for Physical Therapy, Occupational Therapy, and Speech Language Pathology** **(PT, OT, and ST) treatment is required for all outpatient non-home health services, regardless of Accountable Care Organization attribution, beyond 30 combined** **PT, OT, and ST visits. Each discipline must complete a separate form. Home health PT, OT, and ST services require prior authorization after 4 months of service only for members who are not attributed to the ACO.**

Please fill out this form completely. Do not leave any blank spaces. Attachments **must** include the following:

Initial evaluation or re-evaluation note

Most recent progress documentation, endorsed by the Physician/Advanced Practice Provider. This progress documentation must include 1) home/community based functional goals, 2) objective, measurable progress to date toward each goal and 3) Care plan including specific therapeutic techniques.

Note: If a scale for measuring progress has been referenced in a goal, submit the scale documents including scale parameters.

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| **Member Information** | | |
| Legal name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: | Unique ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Supplying Provider Information** | |
| Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicaid Provider Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Referring Provider Information** | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicaid Provider Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Requested Services Information** | | |
| Select Service:  PT (GP) 420-424  OT (GO) 430-434  ST (GN) 440-444 | | |
| **NOTE: The billing diagnosis must be the diagnosis underlying the condition driving the need for therapy services. Do not use a pain diagnosis unless the underlying condition is a pain syndrome. Include surgical aftercare information and coding if there has been a pertinent surgery.** | | |
| Primary Billing Diagnosis (underlying condition): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Primary ICD-10 Diagnosis Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Onset for Primary Diagnosis: \_\_\_/\_\_\_/\_\_\_\_\_ |
| Other Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ICD-10 Diagnosis Codes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Onset for Other Diagnosis: \_\_\_/\_\_\_/\_\_\_\_\_ |

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| **Clinical Information** | |
| Initial date of therapy for the requested non-inpatient re/hab therapy discipline, any pay source, regardless of previous discharges: \_\_\_/\_\_\_/\_\_\_\_\_ | |
| Requested procedure codes:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Average time per visit (not for home health):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Requested frequency of services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Adherence to home program/voiced commitment to home program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Pediatrics**: care coordination with other medical disciplines, community supports, paid personal care attendants: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Pediatrics**: care coordination with school personnel, for example: PE teacher, coach, athletic trainer, school therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Pediatrics:** If there is no school involvement, legal guardian has been educated regarding school model services and that medical model services cannot take the place of school model services  Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Pediatrics:** If there are school services, legal guardian has agreed to care coordination with school  Yes  No and document that medical model goals are not duplicative of school model goals  Yes | |
| **Adults:** care coordination with other medical disciplines and community supports. Include Vocational Rehabilitation (HireAbility) and the VT Center for Independent Living for members with long term conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Etiology of injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Document if this is a work-related injury.  Yes  No  If yes, document why Worker’s Comp is not the primary pay source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**For clinical questions, please contact the DVHA Physical Therapist at 802 879 5903.**