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

**Request for Prior Authorization for Re/habilitation Therapy Services:**

**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.

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

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

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

|  |
| --- |
| **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: \_\_\_/\_\_\_/\_\_\_\_\_ |

|  |
| --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Requested coverage date range: \_\_/\_\_\_/\_\_\_\_\_ through \_\_/\_\_\_/\_\_\_\_\_ |
| 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 Clinical Operations Unit at 802 879 5903.**