**Request for Extension of Rehabilitation Therapy Services: ADULT NON-HOME HEALTH**

**For use only with the diagnoses of acute stroke, traumatic brain injury, amputation, spinal cord injury, or severe burn**

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| Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Birthdate: \_\_\_/\_\_\_/\_\_\_\_\_  Unique ID#: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Supplying Provider Facility: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Supplying Provider Facility #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Physician/Advanced Practice Provider Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Physician/Advanced Practice Provider #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Modifiers and Revenue Codes:**  Check One: PT GO 420-424 OT GO 430-434  ST  GN 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:**  ICD-10 dx code: **\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_**  Definition: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date of onset: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Other Dx**:** ICD-10 dx codes: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Definition: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date of onset: \_\_\_/\_\_\_/\_\_\_\_\_  Note: the ICD-10 codes 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, patient-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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| Row 1 | **First 30 combined therapy visits**  Date of initial therapy for this condition, at any non- inpatient facility including home health, any pay source, regardless of previous discharges, for this calendar year: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Current number of visits to date for this calendar year **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Avg. minutes/treatment: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Procedure codes: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  I have reviewed the treatment plan and goals and am in agreement with the plan of care.  Physician/Advanced Practice Provider signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | Goal 1:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Goal 2:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Goal 3:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Treatment plan including procedures, modalities, family/caregiver training, and collaboration with other disciplines.  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Procedure codes (codes must match treatment plan): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Transition planning:  Vocational rehabilitation  VT Center for Independent Living  Other | 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: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Credential: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| Row 2 | **First request for treatment extension**  Date after 30 combined therapy visits: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested end date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Avg. minutes/treatment: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  # visits requested: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  I have reviewed the treatment plan and goals and am in agreement with the plan of care.  Physician/Advanced Practice Provider signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | Goal 1**:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Goal 2: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Goal 3: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Treatment plan including procedures, modalities, family/caregiver training, and collaboration with other disciplines.  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Procedure codes (codes must match treatment plan): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Transition Planning:  Vocational Rehabilitation  VT Center for Independent Living  Other | 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: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Credential: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| Row 3 | **Second request for treatment extension**  Requested start date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested end date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Avg. minutes/treatment: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  # visits requested: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  I have reviewed the treatment plan and goals and am in agreement with the plan of care.  Physician/Advanced Practice Provider signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | Goal 1: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Goal 2: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Goal 3: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Treatment Plan including procedures, modalities, family/caregiver training, and collaboration with other disciplines.  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Procedure codes (codes must match treatment plan): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Transition planning:  Vocational Rehabilitation  VT Center for Independent Living  Other | 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: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Credential: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |

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| **REQUESTS FOR EXTENSION OF REHABILITATION THERAPY SERVICES: ADULT OUTPATIENT** | **INSTRUCTIONS FOR USE OF THE DVHA MEDICAID EXTENSION FORM FOR ADULT OUTPATIENT THERAPY SERVICES** |
| Outpatient physical and occupational therapy, and speech language pathology services are covered for 30 combined visits per calendar year upon initial Physician/Advanced Practice Provider certification.  A written request by the practitioner to extend the period of treatment beyond the 30 combined visits for the diagnoses of acute stroke, traumatic brain injury, spinal cord injury, amputation, and severe burn only, must be submitted to the Department of VT Health Access prior to the end of current period to avoid interruption of payment. **The request must include:**   * Beneficiary 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 the payment. * Name of attending Physician/Advanced Practice Provider and their VT Medicaid provider number. If a specialist has initiated the treatment, it is recommended that, when appropriate, the subsequent endorsements be obtained from the primary care provider whose practice is the medical home for the beneficiary’s medical record. * Date of initial therapy for the condition by any non-inpatient 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) 241-9324. * Date and events complicating therapy that affect extension of Medicaid service, including hospitalizations, trauma and illness. * Collaboration with other team members, including other medical disciplines, and community resources including Vocational Rehabilitation and VT Center for Independent Living. * Documentation regarding adherence/commitment to the home program. * Primary and other relevant diagnoses, ICD-10 diagnosis codes, and dates of onset. Documented diagnoses must match billing diagnoses. Include surgical aftercare information and codes if there has been a pertinent surgery. * Final date of the 30 combined visit period. * Number of treatments and average minutes per treatment during the initial 30 combined visit period. * Training of caregivers including direct training of personal care attendants if applicable. * Objective, measurable goals for the initial 30 visit period. * Research based treatments/procedures provided during the initial 30 visit period. A discharge plan should 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. * Number of therapy visits being requested. * Average minutes per treatment during the upcoming authorization period. * Objective, measurable goals for the upcoming authorization period. * Research based treatments/ procedures to be provided during the upcoming authorization period. * Date & Therapist’s signature with professional designation. * Date & Signature of Physician/Advanced Practice Provider demonstrating endorsement of the care plan.   This information can be provided by use of the attached form or by other documentation that contains all the above information. Any additional attachments which further clarify the beneficiary’s medical status and treatment are welcome. | **FIRST SUBMISSION OF THIS FORM:**  FILL OUT **COMPLETELY** BEFORE THE INITIAL 30 COMBINED VISIT PERIOD IS OVER:   * Top area of form with basic information * Box 1, column 1 with information from the first 30 visits of treatment * Box 1, column 2 with goals and plan from the first 30 visits of treatment * Box 1, column 3 for current goal status * Box 2, column 1 with information for the upcoming authorization period * Box 2, column 2 with goals and plan for the upcoming authorization period   **SECOND SUBMISSION OF THIS FORM:**  FILL OUT **COMPLETELY** PRIOR TO THE EXPIRATION OF THE PREVIOUS CERTIFICATION PERIOD:   * Box 2, column 3 for current status and results of treatment * Box 3, column 1 with information for the upcoming authorization period * Box 3, column 2 with goals and plan for the upcoming authorization period   **ADDITIONAL SUBMISSIONS:**  Continue to fill out the form using the above format. Note that the response area expands as the form is completed electronically.  This form is part of the medico-legal record. Corrections should be a single strike with 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. Functional goals are particularly understandable to lay readers.  Please save a copy of this form for your records. The Medicaid copy can be sent to the DVHA: NOB 1 South 280 State Drive, Waterbury VT 05671-1010 or faxed to (802) 879 5963 For clinical questions regarding therapy, including in servicing, documentation, and coverage: (802) 241-9324. For prior authorization (PA) status and billing issues please call DVHA’s fiscal agent Provider Services at 1-800-925-1706 or (802) 878-7871. |