**Department of Vermont Health Access**

**Request for Extension of Home Health Rehabilitation Therapy Services:**

|  |  |  |
| --- | --- | --- |
| Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Birthdate: **\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**  Unique ID#: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Supplying Provider Facility: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Supplying Provider Facility #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Physician/Advanced Practice Provider Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Physician/Advanced Practice Provider #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 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:  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, 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** |
| --- | --- | --- | --- |
| Row 1 | **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: \_\_/\_\_\_/\_\_\_\_  Treatment Frequency or # Visits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Annual review candidate? Y N  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: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Collaboration:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  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  Personal care attendant training: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Treatment Plan: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 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 (Circle One): PT OT  SLP-CCC  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| Row 2 | **Second 4 Months of Treatment  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 am in agreement with the plan of care.  Physician/Advanced Practice Provider Signature/date:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_/\_\_\_/\_\_\_\_** | Goal 1: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Goal 2: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Goal 3: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Collaboration: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  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  Personal care attendant training: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Treatment Plan: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 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 (Circle One): PT  OT  SLP-CCC  Date: **\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_** |
| Row 3 | **Third 4 Months of Treatment  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 am in agreement with the plan of care.  Physician/Advanced Practice Provider Signature/date:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_/\_\_\_/\_\_\_\_** | Goal 1: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Goal 2: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Goal 3: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Collaboration: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  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  Personal care attendant training: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Treatment Plan: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 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 (Circle One): PT  OT  SLP-CCC  Date: **\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_** |

|  |  |
| --- | --- |
| **REQUESTS FOR EXTENSION OF REHABILITATION 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 certification for the current condition, regardless of pay source or history of discharges/readmissions. All certification dates are based on this initial date. The requesting provider is responsible for contacting the primary care physician to determine the start of care date.  A written request by the 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 14 days prior to the expiration of the current period to avoid interruption of payment.   * **Note that all Medicaid rules and guidelines apply to the first 4 months of therapy treatment despite the lack of DVHA oversight during this period of time. For any clinical questions during this period, please contact the clinical consultant [802 241 9324]**   **The request must include:**   * Beneficiary name, date of birth and UID number * Supplying provider facility name and VT Medicaid provider number. This is the provider/facility that will be receiving payment. * Name of attending Physician/Advanced Practice Provider and 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 by any non-inpatient home/community based 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 the extension of Medicaid service including: hospitalization, trauma and illness. * Collaboration with other team members, including other disciplines, and school-based therapist of the same discipline for children, and community resources such as Vocational Rehabilitation and VT Center for Independent Living for adults. * Documentation re: commitment/adherence to the home program. * 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 beneficiary. 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. * Training of family/caregivers including the therapist’s direct training of the personal care attendant if applicable. * Initial and final dates of the previous certification period. * Treatment frequency or number of visits during the   previous certification period.   * Objective, measurable goals for the previous certification period. * Research based treatments/ procedures provided during the previous certification period. * 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 and time per treatment 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 & 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 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 beneficiary’s medical status and treatment are welcome. | **FIRST SUBMISSION OF THIS FORM:**  FILL OUT **COMPLETELY** BEFORE INITIAL CERTIFICATION PERIOD IS OVER:   * Top area of form with basic information. * Box 1, column 1 with information from the first 4 months of treatment. * Box 1, column 2 with goals and plan from the first 4 months of treatment. * Box 1, column 3 for current status. * Box 2, column 1 with information for the upcoming 4 months of treatment. * Box 2, column 2 with goals and plan for the upcoming 4 months of treatment.   **SUBSEQUENT SUBMISSIONS 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 4 months of treatment. * Box 3, column 2 with goals and plan for the upcoming 4 months.   **THERAPY COVERAGE BEYOND ONE YEAR**  Begin a new copy of this form. Check the box to indicate treatment beyond one year.  This form is part of the medical-legal record. Corrections should be a single strike with your initials; no erasures or use of 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, for children, goals related to toys or play are not clearly medical in nature; the toys and play are part of your plan, as strategies to help the child achieve the clearly medical goals. For adults, vocational and avocational/sports/leisure goals are not clearly medical in nature. Functional goals are particularly clear to lay readers.  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) 241- 9324 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 Provider Services at 1-800-925-1706 or (802) 878-7871. |
|  |  |