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

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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: PTGP 420-424 OT GO 430-434  ST GN 440-444  Events Complicating Therapy: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Commitment/adherence to home program: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  If there are adherence concerns, what is 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 | **Initial Certification first 8 days of treatment**  **OR fourth certification period :**  Date of initial therapy for this condition in the current calendar year, at any non-inpatient facility, any pay source, regardless of previous discharges: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Projected date of 8th  visit: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Requested frequency or # of visits: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Avg. minutes/treatment: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  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: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Your direct collaboration with school personnel (for example: school therapist, physical education teacher, coach, athletic trainer) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Treatment Plan:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Procedure codes (codes must match treatment plan): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  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 (Circle One): PT OT  SLP-CCC  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| Row 2 | **First full certification period  (date after 8th visit)**  **OR fifth certification period:**  Date after the 8th visit: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested end date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested frequency or # visits: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Avg. minutes/treatment: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  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: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  School: Your direct collaboration with school personnel (for example: school therapist, physical education teacher, coach, athletic trainer):  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Treatment Plan:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Procedure codes (codes must match treatment plan): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  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 (Circle One): PT OT  SLP-CCC  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| Row 3 | **Second certification period**  **OR sixth certification period :**  Requested start date:  \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested end date:  \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested frequency or # of visits: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Avg. minutes/treatment: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  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: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  School: Your direct collaboration with school personnel (for example: school therapist, physical education teacher, coach, athletic trainer): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Treatment Plan:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Procedure codes (codes must match treatment plan): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  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 me:  Data from the start of the certification period: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Current data: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Therapist’s professional signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Credentials (Circle One): PT  OT  SLP-CCC  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| Row 4 | **Third certification period**  **OR seventh certification period :**  Requested start date:  \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested end date:  \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested frequency or # of visits: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Avg. minutes/treatment: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  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: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  School: Your direct collaboration with school personnel (for example: school therapist, physical education teacher, coach, athletic trainer): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Treatment Plan:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Procedure codes (codes must match treatment plan): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  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 (Circle One): PT OT  SLP-CCC  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |

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| **REQUESTS FOR EXTENSION OF REHABILITATION THERAPY SERVICES** | **INSTRUCTIONS FOR USE OF THE DVHA MEDICAID EXTENSION FORM** |
| **Outpatient providers/facilities:** Physical and occupational therapy, and speech language pathology, services for children are routinely covered for 8 visits per calendar year on initial Physician/ Advanced Practice Provider referral for the documented condition at any non-inpatient facility, 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 8 visits and any subsequent certification periods must be submitted to the DVHA. It is recommended that the submission be prior to the expiration of the current period to avoid interruption of payment.  **Note that all Medicaid rules and guidelines apply to the first 8 therapy treatment sessions despite the lack of DVHA oversight during this period of time. For any clinical questions during this period, please contact the clinical consultant at (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 their VT Medicaid provider number. If a specialist has initiated the treatment, it is recommended that 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, for the current calendar year. 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 hospitalization, trauma, and illness. * Collaboration with other team members, including other disciplines, and school-based therapist of the same discipline. * Documentation regarding commitment to/adherence to the home program. * Primary billing diagnosis, and other relevant diagnoses, ICD-10 diagnosis codes and dates of onset. 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 codes 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 and average minutes per treatment 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 certification period for which therapy is being requested. * Treatment frequency and average minutes per treatment during upcoming certification period. * Objective, measurable goals for the upcoming certification period. * Research based treatments/procedures to be provided during the upcoming certification period. * Date & Therapist’s signature with professional designation. * Date & signature of Physician/Advanced Practice Provider demonstrating endorsement of the care plan. * Procedure codes and modifiers.   This information can be provided by use of the attached therapy extension form or by another document that contains all of 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 INITIAL 8-VISIT PERIOD IS OVER:   * Top area of form with basic information. * Box 1, column 1 with information from the first 8 visits. * Box 1, column 2 with goals and plan from the first 8 visits. * Box 1, column 3 for current goal status. * Box 2, column 1 with information for the remainder of the first certification period. * Box 2, column 2 with goals and plan for the remainder of the first certification period.   SUBSEQUENT SUBMISSIONS OF THIS FORM:  FILL OUT **COMPLETELY** PRIOR TO THE EXPIRATION OF THE SECOND CERTIFICATION PERIOD:   * Box 2, column 3 for current status and results of treatment. * Box 3, column 1 with information for the upcoming certification period. * Box 3, column 2 with goals and plan for the upcoming certification period.   FILL OUT **COMPLETELY** PRIOR TO THE EXPIRATION OF THE THIRD CERTIFICATION PERIOD:   * Box 3, column 3 for current status and results of treatment. * Box 4, column 1 with information for the upcoming certification period. * Box 4, column 2 with goals and plan for the upcoming certification period.   **THERAPY COVERAGE BEYOND ONE YEAR**  If using this therapy extension form, begin a new form. 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-out, 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, goals related to toys, play, sports and leisure 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. 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) 241-9324 for clinical questions regarding therapy, including in- servicing, documentation, and coverage. For Prior Authorization status and billing issues please call DVHA’s fiscal agent Provider Services at 1-800-925-1706 or (802) 878-7871. |