# *OUTPATIENT PHYSICAL THERAPY SERVICES*

WCH Service Bureau®

*We Can Help*

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# AGENDA

- Medical Necessity
- Supervision Levels
- Records requirements
- Bundled procedures
- Therapy Cap
- Medicare Proposed rule of 2019
- Medicaid Covered services
- FidelisCare Authorization requirements

# Covered Services

## Services must be individualized, medically necessary and require the unique skills of a therapist!

A service is not considered a skilled therapy service merely because it is furnished by a therapist.

If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnishes the service.

**Services that do not require the professional skills of a therapist are not medically necessary and therefore not covered!!!**

# Covered Services

While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled.

- The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury, or whether the service(s) can be carried out by non-skilled personnel
- If at any point in the treatment it is determined that the treatment becomes repetitive and does not require the unique skills of a therapist, the services are non-covered.
- The use of therapy equipment such as therapeutic pools or gym machines alone does not necessarily make the treatment skilled.

If a patient's therapy can proceed safely and effectively through a home exercise program, self management program, restorative nursing program or caregiver assisted program, payment cannot be made for therapy services.

# Covered Services

Services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation, do not constitute (covered) therapy services for Medicare purposes.

# Medical Necessity: Rehabilitative therapy

In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time. Improvement is evidenced by successive objective measurements whenever possible.

- If an individual's expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary.

- Therapy is not required to effect improvement or restoration of function where a patient suffers a transient and easily reversible loss or reduction in function which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities

# Medical Necessity: Rehabilitative therapy

Rehabilitative therapy occurs when the skills of a therapist are necessary to safely and effectively furnish a recognized therapy service, whose goal is improvement of an impairment or functional limitation.

The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can only be safely and effectively performed by a qualified clinician, or therapists supervising assistants.

**The documentation must establish that the patient needs the unique skills of a therapist to improve functioning.**

This is accomplished through a description of the patient's condition, and any complexities that impact that condition.

# Medical Necessity: Maintenance therapy

Skilled therapy services that do not meet the criteria for rehabilitative therapy may be covered in certain circumstances as maintenance therapy under a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent or slow further deterioration in function.

In the case of maintenance therapy, treatment by the therapist is necessary to maintain, prevent or slow further deterioration of the patient's functional status and the services cannot be safely carried out by the beneficiary him or herself, a family member, another caregiver or unskilled personnel.

# CPT 97110 - Therapeutic Exercises

Many therapeutic exercises may require the unique skills of a therapist to evaluate the patient's abilities, design the program, and instruct the patient or caregiver in safe completion of the special technique. However, after the teaching has been successfully completed, repetition of the exercise, and monitoring for the completion of the task, in the absence of additional skilled care, is non-covered.

# Supervision Levels

## Direct supervision by a physical therapist (for PTAs) is required when assistants provide therapy services in the private practice setting!

**Direct supervision**

"In the office setting means the **physician must be present** in the office suite and immediately available to furnish the assistance and direction throughout the performance of the procedure. The physician does not need to be present in the room when the procedure is performed."

# Supervision Levels

- A physical therapist assistant (PTA) is authorized under Education Law to provide patient/client-related activities, as directed by a licensed and currently registered physical therapist (PT).
- A PTA is prohibited by section 6738(a) of Education Law from performing evaluation, testing, interpretation, planning or modification of patient/client programs.
- A PT conducts the initial evaluation and develops the plan of care, and the treatment may be provided by the PTA.
- Generally, supervision of a PTA by a licensed PT must be on-site supervision, but not necessarily direct personal supervision. On-site supervision of a PTA means that the supervising PT is physically present in the same facility and is readily available to the PTA, unless otherwise provided in Education Law.

**A licensed PT must not supervise more than four PTAs.**

http://www.op.nysed.gov/prof/pt/ptalert4.htm

# The medical record information should:

- Include relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures;
- Paint a picture of the patient's impairments and functional limitations requiring skilled intervention;
- Describe the prior functional level to assist in establishing the patient's potential and prognosis;
- Describe the skilled nature of the therapy treatment provided;
- Justify that the type, frequency and duration of therapy is medically necessary for the individual patient's condition;
- Clearly document both Timed Code Treatment Minutes and Total Treatment Time in order to justify the units billed;
- Identify each specific skilled intervention/modality provided to justify coding.

# Records requirements

- Evaluation and Plan of Care
- Certification and recertification
- Progress Reports
- Treatment notes for each treatment day

# CPT 97161-97163 – Physical therapy evaluation

- The initial evaluation should document the necessity of a course of therapy through objective findings and subjective patient/caregiver self-reporting
- Initial evaluations must be completed by the therapist or physician/NPP that will be providing the therapy services.

The evaluation should clearly describe the presenting complaint or problem for which the patient is seeking services, list the conditions and any complexities that make treatment more lengthy or difficult. Where it is not obvious, describe the impact of the conditions and complexities so that it is clear to the medical reviewer that the services planned are appropriate for the individual.

Only one initial evaluation code should be used, reflecting the level of complexity of the evaluation, and all presenting complaints and problems evaluated.

If over the course of an episode of treatment, a new, unrelated diagnosis occurs, another initial evaluation may be covered.

Initial evaluations may be covered when the documentation justifies the need for a skilled therapy evaluation, even if it is determined that the patient does not require a skilled level of treatment.

# CPT 97161-97163 – Physical therapy evaluation

- *The referral/order of a physician/NPP is the certification that the evaluation is needed and the patient is under the care of a physician.*

*Therefore, when evaluation is the only service, a referral/order and evaluation are the only required documentation.*

- Screening may be more appropriate than evaluation in some circumstances. Screenings are not billable services.
- Initial evaluations from other therapy disciplines performed on the same beneficiary may also be covered, provided the evaluation and plan of care are not duplicative.

# CPT 97161-97163 – Physical therapy evaluation

- Initial evaluations need to provide objective, measurable documentation of the patient's impairments and how any noted deficits affect ADLs/IADLs and result in functional limitations.
- Functional limitations refer to the inability to perform actions, tasks and activities that constitute the "usual activities" for the patient.
- Functional limitations must be meaningful to the patient and caregiver, and must have potential for improvement. In addition, the remediation of such limitations must be recognized as medically necessary.

# Summary: Evaluation

- Presenting condition or complaint...."What brings the patient to therapy at this time?”
- Diagnosis and description of specific problem(s) to be evaluated
- Subjective complaints and date of onset
- Relevant medical history
- Prior diagnostic imaging/testing results
- Prior therapy history for the same diagnosis, illness or injury (If recent therapy was provided, documentation must clearly establish that additional therapy is reasonable and necessary)
- Social support/environment
- What level of support is available, and what level of independence is required for the patient to be safe in the home environment?
- Prior level of function
- Functional testing
- Objective impairment testing
- Assessment
- Prognosis for return to prior functional status, or the maximum expected condition
- Plan of care
- Signature and credentials of the therapist or physician/NPP completing the initial evaluation and plan of care.

# Plan of care

- Diagnosis
- Long Term Goals (LTGs) –

-pertain to the functional impairment findings documented in the evaluation;

-reflect the final level the patient is expected to achieve as a result of therapy in the current setting;

-be realistic, and should have a positive effect on the quality of the patient's everyday functions;

-be function-based and written in objective, measurable terms with a predicted date for achieving the goals.

- Type of Treatment -types of treatment modalities, procedures or interventions to be provided
- Amount of Treatment -n*umber of times in a day the type of treatment will be provided. Where not specified, one treatment session a day is assumed.*
- Frequency of Treatment -*number of times in a week*
- Duration of Treatment -*number of weeks.*

# CPT 97164 – Physical therapy reevaluation

- The reevaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment, or terminating services.
- Reevaluation provides additional objective information not included in other documentation, such as treatment or progress notes.
- Reevaluations are distinct from therapy assessments. Assessments are considered a routine aspect of intervention and are not billed separately from the intervention.

# CPT 97164 – Physical therapy reevaluation

Indications for a reevaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care.

Reevaluations may be appropriate at a planned discharge when documentation supports the medical necessity for the reevaluation service.

✓Therapy reevaluations should contain all the applicable components of an initial evaluation and must be completed by a clinician.

A reevaluation is not a routine, recurring service. Do not bill for routine reevaluations, including those done for the purpose of completing an updated plan of care, a recertification report, a progress report, or a physician progress report.

✓Resolved problems do not need to be re-evaluated; new or ongoing problems may need to be re-evaluated, especially if there is an anticipated change to the long term goals.

# Progress Reports

- Progress reports provide justification for the medical necessity of treatment.
- Progress reports shall be written by a clinician at least once every 10 treatment days.
- A progress report is not a separately billable service.
- During each progress report period, the clinician must personally furnish in its entirety at least one billable service on at least one day of treatment.

# Progress note elements include:

- ✓Date of the beginning and end of the reporting period that this report refers to;
- ✓Date that the report was written by the clinician, or if dictated, the date on which it was dictated;
- ✓Objective reports of the patient's subjective statements, if they are relevant;
- ✓Objective measurements (impairment/function testing) to quantify progress and support justification for continued treatment;
- ✓Description of changes in status relative to each goal currently being addressed in treatment. Descriptions shall make identifiable reference to the goals in the current plan of care;
- ✓Assessment of improvement, extent of progress (or lack thereof) toward each goal;
- ✓Plans for continuing treatment, including documentation of treatment plan revisions as appropriate;
- ✓Changes to long or short term goals, discharge or an updated plan of care that is sent to the physician/NPP for certification of the next interval of treatment;
- ✓Signature with credentials of the clinician who wrote the report.

# Treatment Notes

Medical record documentation is required for every treatment day, and every therapy service to justify the use of codes and units on the claim.

# Treatment Notes

The treatment note must include the following required information:

- date of treatment;
- identification of each specific treatment, intervention or activity provided in language that can be compared with the CPT codes to verify correct coding;
- record of the total time spent in services represented by timed codes under timed code treatment minutes;
- record of the total treatment time in minutes, which is a sum of the timed and untimed services;
- signature and credentials of each individual(s) that provided skilled interventions.

# Treatment Notes

In addition, the treatment note may include any information that is relevant in supporting the medical necessity and skilled nature of the treatment, such as:

- patient comments regarding pain, function, completion of self management/home exercise program (HEP), etc.;
- significant improvement or adverse reaction to treatment;
- significant, unusual or unexpected changes in clinical status;
- parameters of modalities provided and/or specifics regarding exercises such as sets, repetitions, weight;
- description of the skilled components of the specific exercises, training, or activities;
- instructions given for HEP, restorative or self/caregiver managed program, including updates and revisions;
- communication/consultation with other providers (e.g., supervising clinician, attending physician, nurse, another therapist);
- communication with patient, family, caregiver;
- equipment provided
- any additional relevant information to support that the patient continues to require skilled therapy and that the unique skills of a therapist were provided.

# Treatment Notes

- Listing of exercise names (e.g., pulleys, UBE, TKE, SLR) does not alone imply that skilled treatment has been provided, especially if the exercises have been performed over multiple sessions. Be sure to occasionally document the skilled components of the exercises so they do not appear repetitive and therefore, unskilled.
- Documenting functional activities performed (e.g., “ambulated 35 feet with min assist”, “upper body dressing with set up and supervision”) also does not alone imply that skilled treatment was provided. The skilled components/techniques of the qualified professional/auxiliary personnel used to improve the functional activity should be occasionally documented to support medical necessity.

# Treatment time

When documenting treatment time, consistently use the CMS language of total “Timed Code Treatment Minutes” and “Total Treatment Time”.

Do not record treatment time as “Time in / Time out” for the entire session as this does not accurately reflect the actual treatment time. Do not “round” all treatments to 15-minute increments, but rather record the actual treatment time. Also do not record as “units” of treatment, instead of minutes.

Only “intra-service care” of skilled therapy services should be reflected in the time documentation.

Do not include unbillable time, such as time for:

- changing;
- waiting for treatment to begin;
- waiting for equipment;
- resting;
- toileting; or
- performing unskilled or independent exercises or activities.

# Timed CPT Codes

*1 unit ≥ 8 minutes through 22 minutes*
*2 units ≥ 23 minutes through 37 minutes*
*3 units ≥ 38 minutes through 52 minutes*
*4 units ≥ 53 minutes through 67 minutes*
*5 units ≥ 68 minutes through 82 minutes*
*6 units ≥ 83 minutes through 97 minutes*
*7 units ≥ 98 minutes through 112 minutes*
*8 units ≥ 113 minutes through 127 minutes*

**When the total Timed Code Treatment minutes for the day is less than 8 minutes, the service(s) should not be billed.**

# Example of units assigned for timed codes

24 minutes of neuromuscular reeducation (CPT 97112)
23 minutes of therapeutic exercise (CPT 97110)

_____

47 total Timed Code Treatment minutes

Utilizing the chart above, 47 minutes falls within the range for 3 units. To allocate those 3 units determine the 15-minute blocks first

24 minutes 97112 = one 15-minute block + 9 remaining minutes
23 minutes 97110 = one 15-minute block + 8 remaining minutes

Each code contains one 15-minute block; therefore, each code shall be billed for at least 1 unit.

Since the total minutes allows for 3 units, the third unit shall be applied to the service with the most "remaining minutes" (97112 has 9 remaining minutes, whereas, 97110 has 8 remaining minutes). The correct coding is

**2 units 97112 + 1 unit 97110**

# Example of units assigned for timed codes

20 minutes of neuromuscular reeducation (CPT 97112)
20 minutes therapeutic exercise (CPT 97110)

_____

40 total Timed Code Treatment minutes

Utilizing the chart above, 40 minutes falls within the range for 3 units. To allocate those 3 units determine the 15-minute blocks first
20 minutes 97112 = one 15-minute block + 5 remaining minutes
20 minutes 97110 = one 15-minute block + 5 remaining minutes

Each code contains one 15-minute block, therefore, each code shall be billed for at least 1 one unit.

As 3 units is allowed, a review of the "remaining minutes" is required to determine which code should be billed the additional unit. Since the "remaining minutes" for each service are the same in this example, either of the codes may be billed for the additional unit. The correct coding is either one of the following

**2 units 97112 + 1 unit 97110**

***OR***

**1 unit 97112 + 2 units 97110**

# Example of units assigned for timed codes

18 minutes of therapeutic exercise (CPT 97110)
13 minutes of manual therapy (CPT 97140)
10 minutes of gait training (CPT 97116)
8 minutes of ultrasound (CPT 97035)

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49 total Timed Code Treatment minutes

Appropriate billing for a total of 49 minutes is 3 units. To allocate those 3 units, determine the 15-minute blocks first

18 minutes 97110 = one 15-minute block + 3 remaining minutes
13 minutes 97140 = zero 15-minute blocks + 13 remaining minutes
10 minutes 97116 = zero 15-minute blocks + 10 remaining minutes
8 minutes 97035 = zero 15-minute blocks + 8 remaining minutes

Code 97110 shall be billed for at least one unit as it contains one 15-minute block. The additional 2 units billable (for a total of 3 units for the day), must be applied to the services with the greatest remaining minutes. The correct coding is

**1 unit 97110 + 1 unit 97140 + 1 unit 97116**

There are not enough total minutes for the day to allow billing for the ultrasound. However, the ultrasound will still be documented in the treatment notes.

# Example of units assigned for timed codes

7 minutes of neuromuscular reeducation (CPT 97112)
7 minutes of therapeutic exercise (97110)
7 minutes of manual therapy (97140)

_____

21 total Timed Code Treatment minutes

The clinician shall select which CPT code to bill since each service was performed for the same amount of time and only one unit is allowed. The correct coding is

**1 unit 97112**
***OR***
**1 unit 97110**
***OR***
**1 unit 97140**

# Example of units assigned for timed codes

35 minutes OT evaluation (CPT 97165)
25 minutes therapeutic exercise (CPT 97110)
8 minutes therapeutic activities (CPT 97530)

_____

Total Timed Code Treatment minutes = 33 minutes
Total Treatment Time = 68 minutes

The evaluation, being an untimed code, is billable as “1” unit. Do not include the evaluation minutes in the total timed code treatment minutes when determining the appropriate number of units to bill for the timed codes. 33 total minutes of timed codes is billable as 2 units. To allocate the 2 timed code units, break out the 15-minute blocks first

25 minutes 97110 = one 15-minute block + 10 remaining minutes
8 minutes 97530 = zero 15-minute blocks + 8 remaining minutes

Since code 97110 has one 15-minute block, at least 1 unit of 97110 shall be billed. To determine which code shall be billed with the second unit,
compare the remaining minutes. Since code 97110 has more remaining minutes, the second timed code unit shall be applied to this code. Correct coding for this session is

**1 unit 97165 + 2 units 97110**

The medical record documentation will note that the therapeutic activities were performed.

Therapists, or therapy assistants, working together as a “team” to treat a patient cannot each bill separately for the same or different service provided at the same time to the same patient.

For example, if an OT and PT are co-treating a patient with sitting balance and ADL deficits for 30 minutes, then only 2 units total can be billed to the patient: either 2 units of OT only; 2 units of PT only; or 1 unit of OT and 1 unit of PT.

# Certifications and Recertifications

- Certification, which is a coverage condition for therapy payment, requires a dated physician/NPP signature on the therapy plan of care or some other document that indicates approval of the plan of care. A certification often differs from an order or referral in that it must contain all required elements of a plan of care.

The provider should obtain certification as soon as possible after the plan of care is established, unless the requirements of delayed certification are met. “As soon as possible” means that the physician/NPP shall certify the initial plan as soon as it is obtained, or **within 30 days of the initial therapy treatment**.

Timely certification of the initial plan is met when physician/NPP certification of the plan is documented, by signature or verbal order, and dated in the 30 days following the first day of treatment (including evaluation). If the order to certify is verbal, it must be followed within 14 days by a signature to be timely. A dated notation of the order to certify the plan should be made in the patient’s medical record.

Certifications which include all the required plan of care elements will be considered valid for the longest duration in the plan (such as 3x/wk for 6 weeks which will be considered as a total **of 18 treatments**). If treatment continues past the longest duration specified, a recertification will be required.

# Certifications and Recertifications

Certifications/recertifications should include the following elements:

- The date from which the plan of care being sent for certification becomes effective (for initial certifications, the initial evaluation date will be assumed to be the start date of the certified plan of care);
  - Diagnoses;
  - Long term treatment goals;
  - Type, amount, duration and frequency of therapy services;
  - Signature, date and professional identity of the therapist who established the plan; and
  - Dated physician/NPP signature indicating that the therapy service is or was in progress and the physician/NPP makes no record of disagreement with the plan.

# Changes to the Therapy Plan

- While the physician/NPP may change a plan of treatment established by the therapist providing such services, the therapist may not significantly alter a plan of treatment established or certified by a physician/NPP without their documented written or verbal approval (see §220.1.3(C)).
- A change in long-term goals, (for example if a new condition was to be treated) would be a significant change.
- Physician/NPP certification of the significantly modified plan of care shall be obtained within 30 days of the initial therapy treatment under the revised plan.

# Discharge Notes

- A discharge note is required for each episode of treatment and must be written by the clinician.
- The discharge note is a progress report covering the time from the last progress report up to the date of discharge, and includes all required components of a progress report.

**The discharge note may be considered the last opportunity to justify the medical necessity of the entire treatment episode!!!**

In the case of an unanticipated discharge, the clinician may base any judgments required to write the report on the treatment notes and verbal reports of the assistant or qualified auxiliary personnel.

In the case of a discharge anticipated within 3 treatment days of the progress report, the clinician may provide objective goals which, when met, will authorize the assistant to discharge the patient. In that case, the clinician should verify that the services provided prior to discharge continued to require the skills of a therapist. There must be indication that the clinician has reviewed the treatment notes and agrees to the discharge.

# Bundled services

Some services are bundled

Example **CPT 97530 - Therapeutic Activities is inclusive to CPT 97140 - Manual Therapy Techniques**

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day

Modifier 59 may be reported if the two procedures are performed in distinctly different 15 minute time blocks.

For example, one service may be performed during the initial 15 minutes of therapy and the other service performed during the second 15 minutes of therapy. Alternatively, the therapy time blocks may be split. For example, manual therapy might be performed for 10 minutes, followed by 15 minutes of therapeutic activities, followed by another 5 minutes of manual therapy. CPT code 97530 should not be reported and modifier 59 should not be used if the two procedures are performed during the same time block

# Therapy Cap

Therapy cap amounts are thresholds above which claims must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record.

Along with this KX modifier threshold, the targeted medical review (MR) process is placed at a lower threshold amount of $3,000.

The targeted MR process means that not all claims exceeding the MR threshold amount are subject to review.

For **CY** 2018 this KX modifier threshold amount is:

$2,010 for PT and SLP services combined, and

$2,010 for OT services.

# Proposed rule 2019

Proposing to discontinue the functional status reporting requirements for services furnished on or after January 1, 2019.

# NY Medicaid Covered services

- Medicaid covers full deductible as a secondary as well as MLTC plans
- Medicaid does not cover Coinsurance as of 2015 as well as some MLTC plans

For straight primary Medicaid of NY only below procedures are covered

97530 Therapeutic activities $17.87

97542 Wheelchair management $16.39

# Medicaid

Physical therapy, occupational therapy, and speech therapy visits in private practitioners' offices, are limited to 20 each per twelve-month benefit year.

Medicaid will pay for up to 20 physical therapy visits, 20 occupational therapy visits, and 20 speech therapy visits per enrollee in a twelve-month benefit year.

For Medicaid fee-for-service (FFS) enrollees, the twelve-month benefit year is a state fiscal year beginning April 1 of each year and running through March 31 of the following year.

A prior authorization is required for each visit to track the number of therapy visits authorized for each beneficiary. **Must be obtained prior to each visit via web.**

**Exemptions**

Certain Medicaid enrollees, settings, and circumstances are exempt from the 20-visit limitation and prior authorization process.

- Children from birth to age 21 (until their 21st birthday)
- Recipients with a developmental disability (R/E code 95)
- Recipients with a traumatic brain injury (TBI) (waiver recipients R/E code 81, or any claim with a primary diagnosis code (850-854) for traumatic brain injury)
- Recipients with both Medicare Part B and Medicaid coverage (dually eligible enrollees) when Medicare Part B payment is approved
- Rehabilitation services received as a hospital inpatient
- Recipients receiving rehabilitation services in a nursing home in which they reside
- Rehabilitation services provided by a certified home health agency (CHHA)

# Fidelis Care AUTHORIZATION REQUIREMENTS

The initial evaluation and the first 10 visits of each therapy type do not require prior authorization. Additional visits beyond the first 10 require authorization.

- The **Medicaid and MLTC** benefit is limited to 40 visits for Physical therapy beginning with the calendar year 2018.
- There is no visit limit for **CHP**.
- Members enrolled in **Fidelis Dual Advantage Flex** (Plan 017) have a separate $2,010 annual dollar limit for Physical and Speech Therapy combined and $2,010 annual dollar limit for Occupational Therapy.
- **Qualified Health Plans and essential plans -**The benefit is limited to 60 visits per condition per plan year. The visit limit applies to all therapies combined.

# Fidelis Care AUTHORIZATION

- Via web or faxed completed form
- If enrollment via NYNM – TAX ID of the practice must not be used – instead provider ID given by NYNM
- Requests for services beyond the initial 10 visits require submission of therapy progress notes from the first 10 visits.
- Maintain Authorization Number , period, number of visits
- Provide Billing Department with the information

FIDELIS CARE®

# ST, PT or OT Treatment Request Form

Required for: Metal-Level Products, Managed Medicaid, CHP, and Medicare Advantage

**Fax**: (800) 860-8720 **Questions**: (888) 343-3547

***PreAuthorization is not required for the first 10 visits in a calendar year.***

☐ **Speech Therapy** ☐ **Physical Therapy** ☐ **Occupational Therapy**

| **Member Information** | | |
|---|---|---|
| Fidelis Care Member Name: | Fidelis Care Member ID #: | Date of Birth: |

| **Speech Therapy (SP), Physical Therapy (PT), Occupational Therapy (OT) Services** | | |
|---|---|---|
| ICD-10 Diagnosis (Dx) Code(s): | CPT/Procedure Code(s): | Check if applicable:<br>☐ Medicare ☐ Worker' Comp<br>☐ No-Fault: Date of Injury: / / |
| Date of Evaluation:<br>Desired Date of 1st Visit:<br>Number of Visits Desired: _____<br>Number of Weeks Desired:_____ | Total # of visits member has used this calendar year:_____<br>Please check one: ☐ Initial Treatment ☐ Concurrent Treatment<br>If concurrent, from:____/____/____ to ____/____/____ Auth #:_____<br>Number of visits used on the existing auth with provider:_____<br>Check as applicable: ☐ Developmentally Disabled ☐ TBI (include waiver) | |

Progress since last request:

1. Ambulation:
2. Transfers:
3. Pain control:
4. Activities of daily living:
5. Is a home program in place?
6. Other:
7. Date of Surgery (if applicable):

| **Speech/Physical/Occupational Referring Provider and Therapist Information** | | |
|---|---|---|
| Name of Referring Provider: | Referring Provider Phone:<br>( ) - | Referring Provider Tax ID or NPI#: |
| Therapist Name: | Billing Provider ID # / Tax ID: | ST/PT/OT Phone: |
| ST/PT/OT Facility/Group Name: | ST/PT/OT Servicing Address: | ST/PT/OT Fax #: |
| IPA Affiliation (if applicable): | | |

- This form is to be completed in its entirety; please fax to 1-800-860-8720. You will be notified of the service determination within the appropriate regulatory timeframe.
- Authorization does not guarantee that benefits will be paid. Payment of claims is subject to member eligibility and adherence to correct coding standards.
- Requests after the first 90 day period must provide a new prescription as evidence that the referring provider has been informed of progress to date.
- Requests for services beyond the initial 10 visits require submission of therapy progress notes from the first 10 visits.

Rev. 1.1.2018

# Thank you !

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