Preauthorization Request for Physical/Occupational Therapy

If you do not have web access for entering a treatment authorization request, please complete this form along with the Pre-Authorization Request Form and fax to: 888-492-1025.

Treatment Authorization: Please complete the Pre-Authorization Request Template (attached) by responding to all questions and fax **with this page as the cover sheet**. Instructions on how to complete the form are included.

Patient Name:_____ **Provider Name:** _____

Patient ID:_____ **Fax #:** _____

Patient DOB (MM/DD/YYYY):_____/_____/_____ **Billing ID**_____

Date Submitted (MM/DD/YYYY):_____/_____/_____

Rendering Provider Type:

DC _____ **PT**_____ **OT**_____ **PT & OT** _____ **DO**_____ **MD**_____ **DPM** _____ **OD**_____ **LAC**_____**Other**_____

What Type of Services are anticipated for patient's plan of care? (check all that apply)

Manipulative Therapy _____ **Physical Medicine** _____ **Occupational Therapy** _____ **Acupuncture**_____

Ordering Provider Information: If you have a referral from a healthcare provider for treating this patient, please enter their information here:

Ordering Provider:	
Address:	
City, State, Zip Code	
Phone #:	
Fax #:	
Referring Diagnosis or Condition:	
Referral Date:	

Signature: _____

TIPS:

- When submitting a Manual Authorization request via fax, please ensure that the Manual Auth Submission Form is complete and **SIGNED** and the appropriate template is filled out in its entirety
- Please provide your provider **NPI#** on the "Billing ID" line of this submission form and the **full address** of the practice on the "Location" line of the attached template
- When complete, fax **BOTH** forms to WholeHealth Living, Inc. Utilization Management Department at 888-492-1025.

Note please send ONE submission form/template combo per patient per fax

WholeHealth Living

Preauthorization Request for Physical/Occupational Therapy

Patient Name: _____ **Provider/Facility:** _____

Submitted by: _____ **Date Submitted (MM/DD/YYYY):** ____/____/ _____

1.	Do you have a referral from a healthcare provider for treating this patient?	[X] yes [X] no
2.	What is the requested Start Date for this authorization?	[M][M] / [D][D] / [Y][Y][Y][Y]
3.	Is this authorization request for a new episode or continuation of care?	[X] new [X] continuation
4.	Is this condition new, recurring or chronic?	[X] new [X] recurring [X] chronic
5.	What type of injury or condition is this request related to? [check all that apply]	[X] work [X] auto [X] other injury [X] post surgery [X] none
6.	How long has the patient had this condition?	[X] < 1mo [X] 1-3 mo [X] > 3 mo
7.	What is the Initial Date you began treating this patient for this episode of care?	[M][M] / [D][D] / [Y][Y][Y][Y]
8.	Have you or anyone in your facility, provided treatment to this patient within the past 6 months for any condition?	[X] yes [X] no [X] Unknown
9.	How many visits are being requested (including evaluation)?	[#][#] visits
10.	How many weeks will it take to complete the requested visits?	[#][#] weeks
11.	What is the primary Diagnosis Code for this episode?	
12.	Enter the secondary Diagnosis Code, if applicable.	
13.	Indicate the body region(s) involved (you may check more than one).	[#] UE [#] LE [#] L/S Spine [#] C/T Spine [#] Hand/Wrist [#] Other
14.	Patient's most recent score for Patient Specific Functional Scale?	[#][#] . [#] on a scale of 00 to 10
15.	What is the patient's average rating of pain over the past 2 weeks?	[#][#] on a scale of 0 to 10 (10 = severe)
16.	Does the patient have a history of pain for > 3 months?	[X] yes [X] no
17.	Does the patient currently use and/or abuse the following?	[X] tobacco [X] alcohol
18.	Is the patient currently taking any opioids?	[X] yes [X] no
19.	Is the patient overweight or obese (BMI ≥25)?	[X] yes [X] no
20.	Does the patient perform moderately intense exercise 3 times per week?	[X] yes [X] no
21.	Do you feel the patient is confident in their ability to overcome their problem?	[X] yes [X] no
22.	Does the patient currently have significant issues with depression or anxiety?	[X] yes [X] no
23.	Are there any factors that limit effective communication with the patient?	[X] yes [X] no
24.	Does the patient currently have Diabetes?	[X] yes [X] no
25.	Does the patient currently have a Neurological Condition of the CNS?	[X] yes [X] no
26.	Does the patient currently have a Cardiovascular Condition?	[X] yes [X] no
27.	Does the patient currently have Cancer?	[X] yes [X] no
28.	Does the patient currently have Chronic Lung Disease?	[X] yes [X] no

Verify the information is correct, submit the authorization request, and file with the patient's records. When your request is authorized, the approved visits must be delivered within the pre-authorized time limits. Please record the information below.

Auth Reference #: _____ Visits Approved: _____ Approved Through: ____/____/_____

You will receive a fax confirmation of the prescreening results. The RRS pre-screening will either approve or pend your authorization request. If additional information is required, you will receive a fax request indicating the specific clinical information to submit for utilization review. Use the request form, which is bar-coded for this specific patient, as a cover sheet when faxing clinical records and any other relevant clinical information that will support the present diagnosis(es) and treatment plan to: **1-888-492-1025.**

Preauthorization Request Instructions

Physical /Occupational Therapy or Physical Medicine

Question	Explanation
1. Do you have a referral from a healthcare provider for treating this patient?	Select if a referral was presented. Some health benefit plans may require a PCP or specialist referral document.
2. What is the requested Start Date for this authorization?	Enter the start date for this request using a MM/DD/YYYY format. **Please Note: if the requested start date is more than 10 days in the past, your preauthorization request will not be considered timely and will be pended for a retrospective review; you will also need to submit clinical records.**
3. Is this authorization request for a new episode or continuation of care?	Select "New" if this is a new episode for the patient or select "Continuation" if this is a continuation of care for the patient within the same episode of care.
4. Is this condition new, recurring or chronic?	Select New, Recurring or Chronic condition. New means this is a new condition for the patient or the first time the patient was ever treated for this condition in your office.
5. What type of injury or condition is this request related to? [check all that apply]	Select if injury or condition is related to work, auto accident, post-surgery, other type of accident or injury, or none of the above.
6. How long has the patient had this condition?	Indicate the approximate timeframe the patient has experienced symptoms for the present condition [less than 1 month, between 1 and 3 months or greater than 3 months]
7. What is the Initial Date you began treating this patient for this episode of care?	Enter the patient's initial date of treatment for this episode of care in MM/DD/YYYY format.
8. Have you or anyone in your facility, provided treatment to this patient within the past 6 months for any condition?	Select yes or no if you or anyone in your office has provided treatment for this patient, for <u>any</u> condition in the past six months.
9. How many visits are being requested (including evaluation)?	Enter the number of visits currently being requested for authorization for the current phase of care including any evaluation or re-evaluation.
10. How many weeks will it take to complete the requested visits?	Including any evaluation, enter estimated number of weeks required to complete the visits requested.
11. What is the primary Diagnosis Code for this episode?	Enter the primary Diagnosis Code that will be submitted on your claim form.
12. Enter the secondary Diagnosis code, if applicable.	If indicated, enter the secondary diagnosis. If none, skip to next question.
13. Indicate the body region(s) involved (you may check more than one).	☐ UE ☐ LE ☐ L/S Spine ☐ C/T Spine ☐ Hand/Wrist ☐ Other Select from the options of the body region(s) involved in the treatment. Choose Upper Extremity, Lower Extremity, Lumbo-Sacral Spine, Cervical-Thoracic Spine, Hand/Wrist, or Other. More than one region may be checked.
14. Patient's most recent score for Patient Specific Functional Scale?	Using the instructions for the Patient Specific Functional Scale (PSFS) outcomes tool, indicate the patient's current score.
15. What is the patient's average rating of pain over the past 2 weeks?	Rate the patient's average level of pain over the past 2 weeks on a scale of 0 to 10 with 10 being the most severe.

16. Does the patient have a history of pain for > 3 months?	Select Yes or No
17. Does the patient currently use and/or abuse the following:	[X] tobacco [X] alcohol Select 'tobacco' if the patient currently smokes or uses tobacco products. Select 'alcohol' if the patient currently is an 'at-risk' or 'heavy drinker,' based on the National Institute on Alcohol Abuse and Alcoholism (NIAAA) definition: o Men: Five or more drinks on any single day, or more than 14 drinks per week o Women: Four or more drinks on any single day, or more than 7 drinks per week A standard drink is defined as 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of distilled spirits
18. Is the patient currently taking any opioids?	Select Yes or No Medications that fall within this class include codeine, fentanyl, hydrocodone (e.g., Vicodin), hydromorphone (e.g. Dilaudid), morphine, oxycodone (e.g., Oxycontin, Percocet), Pethidine (e.g. Demerol), Propoxyphene (e.g., Darvocet), Tramadol (e.g. Ultram), etc.
19. Is the patient overweight or obese (BMI ≥ 25)?	Select Yes or No This is observational and does not require submission of a BMI score
20. Does the patient perform moderately intense exercise 3 times per week?	Select Yes or No The CDC defines moderate-intensity activity level as 64-76% of maximum heart rate or a 12-14 level ('somewhat hard') on the Borg Rating of Perceived Exertion scale. In the case of injury, respond based on the patient's pre-injury activity level.
21. Do you feel the patient is confident in their ability to overcome their problem?	Select Yes or No
22. Does the patient currently have significant issues with depression or anxiety?	Select Yes or No
23. Are there any factors that limit effective communication with the patient?	Select Yes or No (e.g., language barrier, literacy level, cognitive dysfunction, etc.)
24. Does the patient currently have Diabetes?	Select Yes or No
25. Does the patient have a history of a Neurological Condition of the CNS?	Select Yes or No
26. Does the patient currently have a Cardiovascular Condition?	Select Yes or No
27. Does the patient currently have Cancer?	Select Yes or No
28. Does the patient currently have Chronic Lung Disease?	Select Yes or No