

Physical & Occupational Therapy Prior Authorization Clinical Checklist: Initial Request for Pediatric Care

Required Documents	Required Information for Developmental Care:	Required Information for Non-Developmental Care:	Additional Information for All requests:
Prior Authorization Form includes:	<ul style="list-style-type: none"> <input type="checkbox"/> Number of visits and frequency of visits requested for the episode of care 	<ul style="list-style-type: none"> <input type="checkbox"/> Number of visits, units and frequency of visits requested for episode of care 	<ul style="list-style-type: none"> <input type="checkbox"/> Dates of service for authorization period
Initial Evaluation includes:	<ul style="list-style-type: none"> <input type="checkbox"/> Subjective levels of current function <input type="checkbox"/> Patient/Caregiver's Goal(s) for therapy (such as Goal Attainment Scale [GAS]) <input type="checkbox"/> Patient/caregiver's stage of readiness for participation <p>Test and Measures (choose one):</p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>Standardized norm-referenced test with standard or scaled scores for each area to be targeted in treatment plan goals (age-equivalents are <u>not</u> acceptable). May include objective measurements if test scores do not demonstrate a deficit.</i> <input type="checkbox"/> If standardized norm-referenced testing is unable to be completed, include all: <ol style="list-style-type: none"> 1. reason for lack of standardized testing 2. Criterion-referenced test scores 3. objective measures of impairments and impact on current function 	<ul style="list-style-type: none"> <input type="checkbox"/> Subjective levels of current function <input type="checkbox"/> Patient/Caregiver's Goal(s) for therapy (such as Goal Attainment Scale [GAS]) <input type="checkbox"/> Level of functioning prior to the acute incident or exacerbation of existing condition and onset date <input type="checkbox"/> Objective measurements of impairments (such as ROM, strength, balance, coordination, etc.) and the impact on function <input type="checkbox"/> Special test(s) for the condition as applicable <input type="checkbox"/> Functional Outcome Measure (RMDQ, WOSI, WOMAC, IKDC, FAAM, LEFS, PSFS, etc.) <input type="checkbox"/> Patient/caregiver's stage of readiness for participation 	<ul style="list-style-type: none"> <input type="checkbox"/> Dated within the health plan requirements for this current request <input type="checkbox"/> Information must represent most current clinical findings <input type="checkbox"/> Information supports medical necessity for treatment <p>If applicable:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Barriers or complicating factors that may affect progress <input type="checkbox"/> Other therapies currently provided <input type="checkbox"/> Past treatment history
Treatment Plan or Plan of Care includes:	<ul style="list-style-type: none"> <input type="checkbox"/> Short- and long-term goals that lead to the patient's/caregiver's ultimate goal <input type="checkbox"/> Definitive, reasonable and predictable timeline for reaching therapy goals related to patient/caregiver's goal (GAS) <input type="checkbox"/> Expectation for progress and rehabilitation potential 	<ul style="list-style-type: none"> <input type="checkbox"/> Short- and long-term goals <input type="checkbox"/> Definitive, reasonable and predictable timeline for reaching therapy goals related to the patient/caregiver's goal (GAS) <input type="checkbox"/> Expectation for progress and rehabilitation potential 	<p>Each short-term goal includes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> S.M.A.R.T. goals (<u>S</u>pecific/<u>M</u>easurable/<u>A</u>ctionable/<u>R</u>ealistic/<u>T</u>ime bound) <input type="checkbox"/> Goals must target delayed or impaired skills identified through interpretation of test results (avoid writing goals specific to standardized test items)



Physical & Occupational Therapy Prior Authorization Clinical Checklist: Request for Continuation of Pediatric Care

Required Documents	Required Information for Developmental Care:	Required Information for Non-Developmental Care:	Additional Information for All requests:
<p>Prior Authorization Form includes:</p>	<ul style="list-style-type: none"> □ Number of visits and frequency of visits requested for the episode of care 	<ul style="list-style-type: none"> □ Number of visits, units and frequency of visits requested for the episode of care 	<ul style="list-style-type: none"> □ Dates of service for authorization period (start/stop dates)
<p>Progress Report and updated Plan of Care:</p>	<p>Analysis and interpretation of:</p> <ul style="list-style-type: none"> □ Progress/plateau/regression toward patient/caregiver’s goal(s) for therapy (GAS) □ Developmental milestones and/or accomplishments made towards both short and long term treatment goals (i.e. progress) □ Identification and rationale for unmet goals (i.e. lack of caregiver compliance, plateau, or regression due to illness, etc.) <p>Note: Standardized developmental testing need not be repeated more than once a year (or every 6 months in Texas), unless clinically indicated</p>	<p>Analysis and interpretation of:</p> <ul style="list-style-type: none"> □ Report of progress/plateau/regression toward patient/caregiver’s goal(s) for therapy (GAS) □ Current objective measures and functional information related to goals. □ Include progress made in meeting short- and long- term goals, plan of treatment, along with any updates to the goals or treatment plan □ Identification and rationale of unmet goals (i.e. lack of progress, plateau, or regression) 	<ul style="list-style-type: none"> □ Modifications to the POC and S.M.A.R.T. goals □ Information supports medical necessity for ongoing treatment □ Rationale for continued care requiring the unique skills of a therapist □ Description of patient/caregiver’s participation, attitudes or behaviors toward therapy □ Assessment of effectiveness of service provided □ Coordination of services (school, outpatient, specialty care) to prevent duplication of services □ Dated within the health plan requirements for current request