Authorization Request for Therapy Services

Prior Authorization Department: Phone: 1-800-322-6027/ Fax: 1-866-946-2052
Requests and supporting documentation may be submitted via Web-Portal at www.MissouriCare.com

Effective August 1, 2010 therapy services for eligible members 21 years of age and older is no longer a covered benefit.

Completion of all required informational fields and submission of all required clinical documentation will allow the prior authorization staff to initiate medical necessity review. Submission of requests without the required information as outlined below will prompt a Prior Authorization "Unable to Process Request" notice being sent to the requesting provider.

Yes No Member is currently receiving therapy services and annual (12) visit maximum without prior authorization has been depleted.
If NO, indicate remaining number of visits before authorization is required: ____

Member Information

Last Name First Name MI		**Missouri Care Member ID Number**
Parent/Caregiver Responsible for member < 18 years of age		**Contact Information**
Other Insurance Carrier Information	**Policyholder's Name**	**Policy Number**

Therapy Provider Information: Participating Provider Yes No

Provider/Company Name	**Address**
Therapist Name:	**Telephone:**
	Fax:

*****ALL IN HOME THERAPY REQUIRES PRIOR AUHTORIZATION**

Comments

Indicate in the table below the CPT code(s) associated with the visit(s) or service(s) being requested, number requested number of visits, and the number of weeks requested up to a maximum of (12) weeks. Missouri Care does not generally authorize therapy services beyond a (12) week time frame due to date specific eligibility and to promote timely outcome reporting.

Therapy CPT Code(s) procedure codes	Visits Per Week	Number of Weeks Requested	Total Visits Requested

Required Information and Documentation

Yes No Member is under the age of 21 years at the time of this request.

Yes No Condition being treated is related to MVA or work injury

Yes No Member age falls between birth and (3) years AND has 50% or greater delay in development or a diagnosed medical condition know to cause developmental delay.

Yes No Member has an Individualized Family Service Plan (IFSP) or Individualized Educational Program (IEP).

Yes No Member has a medical condition related to injury, or services are being requested to support post-operative recovery.

Yes No Member has a medical condition for which therapy services are being requested instead of surgery or prior to further diagnostic testing (e.g. MRI of lumbar spine)

- Physician determined diagnosis: ICD-9 ______________________________

Required documentation:

- A copy of the Primary Care Provider's current order for initiating or continuing therapy (order date must be within 14 days of request date).
- Initial evaluation AND most recent Re-evaluation (if performed prior to this request)
- Current Treatment Plan which must include at a minimum the following to be considered a complete:
  - reason for request, i.e., identify deficits, delays, or injury and impact on ADLs
  - identify established goal(s) based on the ability of the member to: (1) achieve age appropriate growth and development; (2) minimize the progression of a disability; or (3) attain, maintain, or regain functional capacity
  - discuss treatment or activities to be performed
  - results or outcome based on goals established, using standardized, objective, quantifiable measures
  -
- Copy of current IEP/IFSP must be provided if above indicates "Yes".
- Copy of written parental consent for the school to release IEP records or for the regional office, or the BSHCN service coordinator to release IFSP records, if not previously submitted for the current school year.