**Outpatient Rehabilitation (service type 0204) Service authorization checklist**

1. Provider Contact Name:
2. Provider Contact Number:
3. Is This a Retro Review: Yes / No
4. Which type of OP Rehab therapy is requested?
   1. Physical Therapy: Yes / No
   2. Occupational Therapy: Yes / No
   3. Speech Therapy: Yes / No
5. Please submit the patient’s diagnosis relevant to OP Rehab services and the date of onset of illness or injury.
6. List presenting clinical information or brief summary of signs & symptoms; please provide date of the patient’s first visit with you, i.e. start of care date.

Has the patient previously received therapy for this diagnosis?

1. For PT and OT requests, please list specific mobility and functional limitations including ROM and ADL’s: Describe specific limitation with respect to ambulation. Does the patient require assistance with ambulation? Does the patient use assistive device for ambulation?
2. For PT and OT requests; describe patient’s limitation/ability to perform ADL’s
3. For SLT, provide diagnosis that led to the specific speech language disorder and/or swallowing (dysphasia) disorder and the date the diagnosis was received.
4. For SLT, describe patient’s cognitive abilities- is patient able to comprehend written and/or verbal instructions and accurately follow them?
5. For SLT, describe the patient’s current mode of communication. If the patient uses communication device ,please indicate this and how long device has been used by patient
6. Please include short and long term goals and target dates for achievement
7. Is there an MD Ordered for Therapy: Yes/No( **this is required**)
8. If the request is for an extension of visits, please indicate if patient has met previously set long and short term goals. Please submit progress towards any/all unmet goals.
9. Please describe any other pertinent information related to this PA Request:

**\*\*\*Note\*\*\***

Hospitals use designated revenue codes.

OP Rehab Agencies/CORFS use designated CPT codes.

Reference the DMAS Medicaid Memo dated May 27, 2009.

**Outpatient Rehabilitation (service type 0204) Service authorization checklist**

**Out of State Providers**

1. **Please select one of the four questions which best meets the reason you are requesting Out of State Provider Services and specify how the request meets the selected reason:**

**Services provided out of state for circumstances other than these specified reasons shall not be covered.**

The medical services must be needed because of a medical emergency;

Medical services must be needed and the Member's health would be endangered if he were required to travel to his state of residence;

The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

It is the general practice for Members in a particular locality to use medical resources in another state.

Explain selected response:

1. Enrolled in Virginia Medicaid:  **Yes  No**

**Out of state providers may enroll with Virginia Medicaid by going to:**

<https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment>. At the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box.  **It may take up to 10 business days to become a Virginia participating provider.**