Neurodevelopmental Program: OT Therapy Intake Form

Required for all Neurodevelopmental Conditions

Please use this fax form for NON-URGENT requests only. Failure to provide all relevant information may delay the determination. Phone and fax numbers may be found on eviCore.com under the Guidelines and Forms section. You may also log into the provider portal located on the site to submit an authorization request.

URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE

Previous Reference/Auth Number (If Continued Care):		**Date of Submission:**	

Please note: The following demographic sections contain information necessary to initiate a fax request. When submitting by fax, all of the information below is **required**. When submitting online, you will only be prompted to provide the information necessary to query and select the appropriate patient and provider for this request.

PATIENT

First Name:		MI:		**Last Name:**	
Member ID:		DOB (mm/dd/yyyy):		Gender: ☐ Male ☐ Female	
Street Address:				Apt #:	
City:		State:		Zip:	
Home Phone:		Cell Phone:		Primary: ☐ Home ☐ Cell	
Member Health Plan/Insurer:					

PROVIDER

First Name:		Last Name:			
Primary Specialty:		TIN:		NPI:	
Physician Phone:		Physician Fax:			
Address:				Suite #:	
City:		State:		Zip:	
Office Contact:		Ext:		Email:	

ADMINISTRATIVE

Diagnoses:

Code	*Description*	*Code*	*Description*

Start Date for this Request:

This is a request to treat (please select the most appropriate response):

☐ New condition not previously treated ☐ Same/previous condition

Date of most recent evaluation:		Date of onset of CONDITION:	
Date of Current Findings:			

Is this request for fabricating a splint/orthotic or developing a home exercise program only? ☐ Yes ☐ No

Please answer the following for patients residing in Florida only

☐ Receive PDN (private duty nursing) service in the home ☐ Reside in a SNF (skilled nursing facility)

☐ Receive services in a PPEC (prescribed pediatric extended care center

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Member Name:		Member ID:		Provider Name:	

CLINICAL INFORMATION

Indicate General Clinical Condition:

- ☐ Autism Spectrum Disorder
- ☐ Torticollis
- ☐ ADHD/Sensory Processing Disorder
- ☐ Cerebral Palsy
- ☐ Other neurologic/neuromuscular disorder (Spina Bifida, Genetic, Post-Surgical)
- ☐ Developmental Disorder or Delay (e.g. coordination, delayed milestones, etc.)
- ☐ Other condition

OT Clinical Problems to be addressed in this authorization request:

- ☐ Muscle Tone
- ☐ ROM
- ☐ Strength
- ☐ Fine Motor/Coordination
- ☐ Posture
- ☐ Visual Motor/Perceptual Skills
- ☐ Sensory Processing
- ☐ Oral Motor/Feeding
- ☐ Self-Care Skills
- ☐ Play/Social Skills
- ☐ Attention/Behavior/Cognition
- ☐ Other clinical problem
- ☐ None of the Above

Has your patient had surgery in the past 2 months OR is expected to have surgery in the next 2 months? ☐ Yes ☐ No

TREATMENT REQUEST

Required for all requests. Enter "0" if unknown. If request is for one visit every 2 weeks, please enter .5 in Visits Requested.

Please indicate number of:

Visits Requested PER WEEK: Number of Units Requested per Visit: Number of Weeks:

Previous Treatment – Enter '0' if no prior visits this year. Number of visits to date this calendar year:

STANDARDIZED TEST RESULTS. If Treatment is for Torticollis, please skip to Torticollis section.

Standardized Testing is required every 6-12 months. Standardized scores must be reported with each request. (Age equivalent testing or screening tools do not meet the requirement for standardized testing.) Please enter **only** the relevant or lowest sub-scale or composite scores. *Please select from list in appendix 1.*

If no standard test was performed, please enter reason below:

☐ Patient not sufficiently regulated ☐ Unable to tolerate testing ☐ Other reason

Test Name (1):	Standardized Score	Test Name (2):	Standardized Score
Subtest:	SS	Subtest:	SS
Subtest:	SS	Subtest:	SS
Subtest:	SS	Subtest:	SS
Subtest:	SS	Subtest:	SS
Subtest:	SS	Subtest:	SS
Subtest:	SS	Subtest:	SS

Please enter date test was performed. _____ (NOTE: test should be within the past year to be considered valid)

Please enter patient adjusted age (in months): _____ If not applicable, leave blank.

FOR PATIENTS WITH CEREBRAL PALSY. Manual Ability Classification (MACS). Please select description that best fits.

See appendix 2 for explanation of levels, if needed

- ☐ Level 1. Handles objects easily and successfully.
- ☐ Level 2. Handles most objects but with somewhat reduced quality and/or speed of achievement.
- ☐ Level 3. Handles objects with difficulty: needs help to prepare and/or modify activities.
- ☐ Level 4. Handles a limited selection of easily managed objects in adapted situations.

Member Name:		Member ID:		Provider Name:	

☐ Level 5. Does not handle objects and has severely limited ability to perform even simple actions.
☐ None of the above/Unknown

General Assessment

SENSORY Assessment. Complete if Sensory Processing is a clinical problem Test Date: _____ ☐ Not Performed

☐ *Sensory Processing Measure (SPM)*

Planning/ideas:	☐ Typical	☐ Problems	☐ Difference	***Vision:***	☐ Typical	☐ Problems	☐ Difference
Social Participation:	☐ Typical	☐ Problems	☐ Difference	***Hearing:***	☐ Typical	☐ Problems	☐ Difference
Balance / Motion:	☐ Typical	☐ Problems	☐ Difference	***Touch:***	☐ Typical	☐ Problems	☐ Difference
Body Awareness:	☐ Typical	☐ Problems	☐ Difference	***Total Sensory:***	☐ Typical	☐ Problems	☐ Difference

☐ *Sensory Profile-2 (SP2)*

Auditory processing	☐ Much less	☐ Less	☐ Just like others	☐ More	☐ Much more
Visual processing	☐ Much less	☐ Less	☐ Just like others	☐ More	☐ Much more
Touch processing	☐ Much less	☐ Less	☐ Just like others	☐ More	☐ Much more
Movement processing	☐ Much less	☐ Less	☐ Just like others	☐ More	☐ Much more
Body Position processing	☐ Much less	☐ Less	☐ Just like others	☐ More	☐ Much more
Oral Sensory processing	☐ Much less	☐ Less	☐ Just like others	☐ More	☐ Much more
Conduct	☐ Much less	☐ Less	☐ Just like others	☐ More	☐ Much more
Social Emotional responses	☐ Much less	☐ Less	☐ Just like others	☐ More	☐ Much more
Attentional responses	☐ Much less	☐ Less	☐ Just like others	☐ More	☐ Much more

☐ *Sensory Profile*

Sensory Processing:	☐ Typical Performance	☐ Probable Difference	☐ Definite Difference
Modulation and Behavior:	☐ Typical Performance	☐ Probable Difference	☐ Definite Difference
Emotional Responses:	☐ Typical Performance	☐ Probable Difference	☐ Definite Difference

Additional Information

Please indicate if any of the following are present:

☐ N/A ☐ Language Barrier ☐ Impulsive/Aggressive Behavior that interferes with regulation

☐ Severe attention deficit disorder or intellectual disability ☐ Lack or consistent caregiver at home

TREATMENT GOALS (3 goals) - NOTE: Complete applicable section – initial goals or follow-up
For follow up requests, enter goals for *previous treatment period* and the % success towards the goals.

Initial or New Short Term Goals (designed to be met in this authorization period)
1.
2.
3.

Progress Towards Previous Goals (goals from prior authorization period)	**Change** (Since Start of Care)
1.	% ☐ N/A
2.	% ☐ N/A
3.	% ☐ N/A

Follow-up Requests: Is the patient/family compliant with the home program? ☐ Yes ☐ No ☐ N/A

Appendix 1. List of Commonly Used Standardized Tests

1. Alberta Infant Motor Scale (AIMS)
2. Bayley Scales
3. Batelle Developmental Inventory
4. Beery VMI
5. BOT-2 (Bruininks Oseretsky Test
6. Developmental Assessment of Young Children
7. Developmental Profile – 3
8. Developmental Test of Visual Perception
9. Gross Motor Functional Measure
10. Miller Function and Participation
11. Movement Assessment Battery for Children
12. Peabody Developmental Motor Scales
13. PEDI – CAT
14. REAL (Roll Evaluation of Activities of Life)
15. Test of Visual Motor Skills
16. Test of Visual Perceptual Skills
17. Wide Range Assessment of Visual Motor Ability

Appendix 2. Manual Ability Classification System.

Explanation of levels. (Adapted from Eliasson AC, Rosblad B, Beckung E, et al. The Manual Ability Classification System (MACS) for children with cerebral palsy: scale development and evidence of validity and reliability. Dev Med Child Neurol 48:549-54, 2006.)

- Level 1. At most, limitations in the ease of performing manual tasks requiring speed and accuracy. However, any limitations in manual abilities do not restrict independence in daily activities.
- Level 2. Certain activities may be avoided or achieved with some difficulty. Alternate means of performance might be used, but manual abilities do not usually restrict independence in daily activities.
- Level 3. Performance is slow and achieved with limited success with respect to quality and quantity. Activities are performed independently if they have been set up or adapted.
- Level 4. Performs part of activities with effort and limited success. Continuous support, assistance, and/or adapted equipment is required.
- Level 5. Total assistance required.