Instructions for Completing the HealthSystems of Mississippi Outpatient Physical/Occupational/Speech Therapy Precertification Request Form

Section I Beneficiary Information

1. ***Patient Name*** - Enter the patient's last and first name as it appears on the Mississippi Medicaid ID card. If the beneficiary is a K baby, list baby's name.
2. ***Medicaid #*** - Enter the beneficiary's number that appears on the Mississippi Medicaid ID card.
3. ***Date of Birth*** – Enter the month, date, and year of the patient's birth.
4. ***Age*** - Enter the age of the patient at the time service is to be rendered.
5. ***Sex*** - Indicate the sex of the patient.
6. ***K-Baby*** - Indicate if the patient is a K-baby.
7. ***Mother's Name*** - Enter the full name of the K baby's mother.
8. ***Mother's Date of Birth*** - Enter the month, date, and year of the mother's birth.
9. ***Therapy in other setting*** – Indicate either yes or no if the patient is receiving therapy in any other setting.
10. ***Place of Service Code*** – If the patient is receiving therapy in another setting, indicate the place of service code.
11. ***Last Physician, Nurse Practitioner, or Physician Assistant's Visit*** – Enter the date of the last visit with the practitioner's.
12. ***Next Scheduled Physician, Nurse Practitioner, or Physician Assistant's Appointment*** – Enter the date of the next scheduled practitioner's appointment.

Section II Provider Information

1. ***Request Date*** – Record the date of the request.
2. ***Medicaid #*** - Enter the provider's Mississippi Medicaid Provider Number.
3. ***Provider Name*** - Enter the name of the provider that will provide the care.
4. ***Contact /Requester*** - Enter the name of the individual who is primary contact for this case.
5. ***Telephone #*** - Enter the contact person's telephone number, including area code and extension.
6. ***Fax #*** - Enter the provider's contact fax number, including area code.
7. ***Intended Place of Service Code*** – Indicate the intended place of service code.
8. ***Ordering Physician, Nurse Practitioner, or Physician Assistant*** – Indicate the name of the ordering MD/NP/PA.
9. ***Telephone #*** - Indicate the telephone number of the ordering MD/NP/PA.
10. ***Services to be Provided By*** – Indicate the type of provider that will provide therapy services.

Section III Request Type

1. ***Precertification*** - If the request is for precertification, insert the following:
   - A. ***Date of Evaluation Visit*** - Enter the date of initial evaluation visit provided to patient.
   - B. ***Date of Next Planned Visit*** - Enter date of the next scheduled visit to provide therapy service to patient.
   - C. ***No Additional Visits Planned*** – Indicate if patient does not qualify for or need additional therapy visits.

   NOTE: Attach a Copy of the Physician, Nurse Practitioner or Physician Assistant's Order (verbal or written), Initial Evaluation Visit notes and Plan Of Care.
2. ***Urgent or Same Day Non-Urgent*** **-** Insert the following:
   - A. ***Date of evaluation Visit*** - Enter the date of initial evaluation visit provided to the patient.
   - B. ***Date of Next Planned Visit*** - Enter date of the next scheduled therapy visit.
   - C. ***No Additional Visits Planned*** – Indicate if patient does not qualify for or need additional therapy

visits.

D. ***Reason for Urgent Services*** - Indicate reason(s) the urgent services were required.

NOTE: This area should be completed for urgent services rendered at any point in the patient's care. Attach a copy of the order, initial evaluation assessment visit notes and plan of care.

3. ***Concurrent*** - If the request is for concurrent review (certification for continuing services), complete the following:
   A. ***Existing Certification #*** - Enter existing certification number.
   B. ***Date of Last Service Authorized*** - Enter the date of last service authorized.
   C. ***Date of Next Planned Visit*** - Enter the date of the next scheduled therapy visit.

   NOTE: Current Physician, Nurse Practitioner, or Physician Assistant's orders, current plan of care, notes from therapist's last visit, and documentation of patient's progress toward achieving goals.

4. ***Retrospective*** - Check box for retrospective review and complete the following, if applicable:
   A. ***TCN*** - Transaction Control Number

   NOTE: A copy of the patient's complete medical record must be attached to this request form.

Section IV. Diagnoses and ICD-9-CM Codes

1. ***Medical Diagnoses/ICD-9-CM Codes*** - Enter the patient's primary and secondary diagnoses for this admission (if applicable) and enter the ICD-9-CM codes that correspond to the diagnoses.

2. ***Therapy Diagnoses/ICD9-CM Codes*** – Enter the patient's therapy diagnoses for this admission (if applicable) and enter the ICD-9-CM codes that correspond to the diagnoses.

Section V. Requested Therapy

1. ***Therapy Type*** – Indicate if therapy type is physical (PT), occupational (OT) or speech therapy (ST).
2. ***Narrative Description of Procedure*** – Indicate a narrative description of the CPT® code procedure.
3. ***CPT® Code*** – Use a valid CPT® code.
4. ***Frequency*** – Indicate the number of times services are to be rendered per duration, such as 3 times per week for 4 weeks.
5. ***Units*** –
   a. Record the number of units requested per visit for each CPT® code.
   b. Record the total number of units requested for each CPT® code.
6. ***Dates of Service*** – Indicate date service will start and the date the service will end.
7. ***Signature of Provider*** – Indicates that the services listed in Section V of this form are those exact services ordered and certified as medically necessary by the ordering MD/NP/PA specified in Section II of this form for the beneficiary specified in Section I of this form.