ATTACHMENT 3
Therapy Prior Authorization Review Checklist

(A copy of the Prior Authorization Review Checklist is located on the following pages.
Providers are *not* required to complete this checklist
and should *not* submit it with a PA request.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11009 (01/02)

THERAPY PRIOR AUTHORIZATION REVIEW CHECKLIST

OT / PT / ST

- FOR WISCONSIN MEDICAID CONSULTANT USE ONLY -

Recipient	Provider	First Reviewer Name	Second Reviewer Name
Medicaid No.	Prov. No.	Date	Date
PA No.	PT only — MS NM CP I	ICN No. ☐ Yes ☐ No ☐ N/A	ICN No. ☐ Yes ☐ No ☐ N/A
Consultant has reviewed previous treatment in PA file –			

INDICATE WHETHER THE FOLLOWING ARE INCLUDED IN SUFFICIENT DETAIL TO SUPPORT MEDICAL NECESSITY.

Return Codes		Yes	No	Comments	Yes	No	Comments
	Section B. Pertinent Diagnoses / Problems to be Treated						
A19-1	Diagnoses with dates of onset.						
A19-2	Problems to be treated.						
	Section C. Brief Pertinent Medical / Social Information						
A19-3	Brief pertinent history includes referral information, living situation, functional status, and other pertinent information.						
	Section D. Pertinent Therapy Information						
C-87	Previous treatment is identified by provider.						
A19-4	Supportive documentation is attached (IEP, IFSP, IPP).						
A55-8	Co-treatment is not proposed.						
A19-5	Ongoing coordination of POC with other providers is documented.						
A19-6	Place of service is identified and supports treatment outcome.						
	Section E. Evaluation						
A33-1	A comprehensive evaluation is included.						
A19-7	A baseline is established for limitations.						
A19-8	Functional limitations are related to an identified condition.						
A33-2	A pertinent reevaluation is included.						
	Section F. Progress						
C59-1	Specific, measurable, objective progress is documented.						
C72	Progress is correlated/related/linked to previous goals and identified limitations.						
C59-2	Significant functional progress has been demonstrated within the past six months.						
C59-3	Carryover to other settings of skills gained in therapy is demonstrated within six months.						
	Section G. Plan of Care (POC)						
A55-1	Therapist's skilled intervention required to meet the goals.						
A55-2	Therapist's skilled intervention required to implement procedures.						
A55-3	A home program, equipment or environmental adaptations alone cannot meet the recipient's needs.						
A55-4	Requested treatment is within professional scope of practice.						
A55-5	Requested treatment is within professional standards of practice.						
A55-6	Requested treatment is not experimental or unproven.						
C78	Goals are specific, measurable, and objective.						
A26	Goals are related to a functional outcome.						
C89	Goals are related to an identified deficit.						
A55-7	Goals and procedures are not duplicative of other services.						
A49	POC is consistent with current physician's order.						
A19-9	POC supports the requested CPT codes.						
A19-10	Req. frequency is consistent with goals and rehab potential.						
A19-11	Requested duration is consistent with goals and rehab potential.						
A19-12	Requested min/session is consistent with goals and rehab potential.						
	Section H. Rehabilitation Potential						
A19-13	Potential for progress as stated is supported by the document.						

OTHER APPLICABLE RETURN CODES A39 A75 B00 B23 B29 B49 B59 B74 C24 C44 C62 C73

For Wisconsin Medicaid Consultant use only.

REVIEW ACTION	1st REVIEW ACTION	2nd REVIEW ACTION
Service is requested ____X/week for ____weeks for ____min/session Service is approved ____X/week for ____weeks **FINAL DISPOSITION** ☐ Approve ☐ Modify ☐ Deny **Comments**	☐ Approve ☐ Return ☐ Recom. Mod. ☐ Recom. Denial ☐ Forward to DHCF **Comments**	☐ Approve ☐ Return ☐ Recom. Mod. ☐ Recom. Denial ☐ Forward to DHCF **Comments**