# Speech Therapy
# Treatment Plan Form Instructions

## Date of this Request:

Enter the date on which the Treatment Plan form is completed using the MM/DD/YYYY format.

*This date will be used to reference the submitted Treatment Plan when communicating the Utilization Review decision to you.*

Enter the type of care by checking the appropriate box for:

❑ Initial care (patient has been treatment free for the past 60 days), or

❑ Continuing care (patient has presented with a new condition or there is continuing care for the same condition).

## Insured Information:

**Patient Last Name:** Enter the last name of the patient.

**Patient First Name:** Enter the first name of the patient.

**Patient M.I.:** Enter the middle initial of the patient.

**Gender:** Check the box for "M" or "F" to indicate the gender of the patient.

**Age:**

Enter the patient's current age. (*Note: The patient's age must be entered. The age is used to verify the date of birth and is easily referenced by the Case Managers*).

**Date of Birth:**

Enter the patient's date of birth in the MM/DD/YYYY format. (*Note: The patient's date of birth must be entered. The date of birth is used to identify and/or confirm the identity of the patient in eligibility system.*)

**Insured I.D. or SSN:**

The insured or subscriber I.D. (identification) number or SSN (social security number) including the 2-digit billing code (i.e., 01, 02, etc.) should be obtained directly from the patient's insurance card. Remember that the insured's identification number will not be the same as the patient's SSN if the patient is not the insured.

**Insured Last Name:** Enter the last name of the insured.

**M.I.:** Enter the middle initial of the insured.

**First Name:** Enter the first name of the insured.

**Patient Phone:** Enter the area code and phone number of the patient.

**Patient Address:** Enter the street address of the patient.

**City:** Enter the name of the city in which the patient resides.

**State:** Enter the state in which the patient resides.

**Zip Code:** Enter the zip code of the patient's residence.

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## Payor Information

**Employer Name:**

Enter the name of the insured's employer. This is best obtained from the insurance card, as the patient is not always familiar with the enrolled group name.

**Insurance Company:**

Enter the name of the insured's insurance company. This can be found on the patient's insurance card.

**Group #, Plan # or Union Local:**

Enter the group number, plan number or union local number as obtained directly from the patient's insurance card

**Injury or Illness is Related to:***

Check the appropriate box to describe where or how the patient was injured or became ill.

*\* This information relates to the coordination of benefits. The questions above help you determine the correct carrier to request care for the patient's condition. These questions will help save time in the long run as these issues can delay claims payment.*

**Referring Physician/Practitioner:**

Enter the name of the physician/practitioner who requested physical/occupational therapy services.

**Doctor License #:** Enter the license number of the referring physician, if available.

**Date of Referral:**

Enter the date the referral was originally made. If this is a recurrent condition, enter the date of the most recent referral.

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## ST Information

**Therapist Last Name:**

Enter the last name of the practitioner who is requesting the services for the patient.

**Therapist First Name:**

Enter the first name of the practitioner requesting the services for the patient.

**Therapist M.I.:**

Enter the middle initial of the practitioner requesting the services for the patient.

**Group Name:**  Enter the name of the group, if any, to which the treating therapist belongs.

**Provider/Group ID#:**

Enter the provider/group number that identifies you with the plan.  If you are a non-participating provider please enter your Federal Tax Identification Number.

**Provider/Group Address:**

Enter the address where services are being provided to the patient.

**City:**  Enter the city where services are being provided to the patient.

**State:**  Enter the state where services are being provided to the patient.

**Area Code + Phone:**

Enter the area code and phone number where the treating practitioner may be reached.

**Area Code + Fax #:**

Enter the area code and fax number where the treating practitioner may be reached.

## Patient's Current Medical History

*Please be aware that the use of standard medical abbreviations is encouraged to save time and space in completing the clinical portion of this form. All relevant clinical information should be included.  Omitting key information may delay the authorization decision.*

**Therapy History (required field):**

Please place the date of the first visit this patient was seen for their speech therapy.

**Discharge Date (required field):**

Please place the date of the last visit this patient was seen for their speech therapy prior to this presentation.

**Number of Visits**

Please place the number of visits rendered on the previous therapy schedule(s) (if known)

**Subjective Complaints (required field):**

A description of the subjective complaints for which the patient is presenting, or that the practitioner believes are relevant to the present complaints, should be described here. Describe the subjective complaints so that the Case Managers are able to create a picture of the member's condition.

Describe the severity of symptoms in terms of the following definitions of minimal, slight, moderate, or severe.

**Mild:**

A finding or deficit that could be tolerated, but would cause some limitation in communication and/or activities of daily living.

**Moderate:**

A finding or deficit that could be tolerated, but would cause marked limitation in communication and/or activities of daily living.

**Severe:**

A finding or deficit that would preclude communication and/or activities of daily living from taking place.

The frequency of the complaints should be described with the following definitions of occasional, intermittent, frequent or constant.

**Occasional:** Symptoms that occur approximately 25 percent of the time.

**Intermittent:** Symptoms that occur approximately 50 percent of the time.

**Frequent:** Symptoms that occur approximately 75 percent of the time.

**Constant:** Symptoms that occur approximately 90-100 percent of the time.

**Mechanism of Onset for Primary Diagnosis:**

**Date of Onset:** Enter in MM/DD/YYYY format the date that the condition began. If the condition was of a gradual onset, enter the approximate date when the condition began, as specifically as possible.

**Date of Initial Evaluation:** Enter in MM/DD/YYYY format the date that you first evaluated the patient for this condition

Check the appropriate box to identify the mechanism of onset for the primary diagnosis.

- ❑ Acute Onset
- ❑ Congenital
- ❑ Chronic
- ❑ Developmental
- ❑ Neuro/CV/Cerebral Event
- ❑ Other

**Description:** Describe the details of onset as specifically as possible (i.e., Patient had a closed head injury due to a MVA; Patient was born prematurely, etc.)

## Objective Findings (required):

**Date obtained:** Provide the date of examination on which the objective findings described were obtained.

Identify any and all Objective Findings, noting the severity of those findings. If additional space is needed, please provide those findings on a separate sheet.

## Current Condition:

**Date of onset:** Provide the date of onset on which the current condition began.

**Type of condition:** Identify whether this is a new condition, gradual onset, a behavioral change, etc., and your date of initial evaluation.

## Summary of Clinical Findings:

Please provide a summary of your examination findings. Please provide any other tests used to validate the submitted diagnosis code, if necessary and appropriate. If we cannot validate the diagnosis based on the submitted information, we cannot verify that treatment was for a correctly diagnosed condition.

## Date of first treatment at this office for this condition:

Enter in MM/DD/YYYY format the date the patient was seen at this office for the condition being treated. If the patient is being treated for multiple conditions, do not include other dates for different conditions.

## Anticipated Release Date:

Enter in MM/DD/YYYY format the date you anticipate releasing the patient from therapy. This estimate is useful anticipating recurrent authorization requests in the future.

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## Diagnoses

**ICD-9 Code:**

Enter the appropriate ICD-9 Code(s) in order from the most important diagnosis, in terms of causation of the patient's condition, to the least important.

- External cause codes or "E" codes are not accepted as a primary diagnosis.
- Refrain from using non-specific diagnosis codes or diagnosis codes related to Unspecified Sites.
- Incorrect codes require subsequent review to determine the proper code and may cause delays in obtaining authorization.

**Description:**

List the patient's diagnoses that corresponds with the ICD-9 Codes in order from the most important diagnosis, in terms of causation of the patient's condition, to the least important.

The diagnosis listed by the referring physician/practitioner is usually the one listed in this area. If you suspect a different diagnosis is warranted following your evaluation, you should request clarification from the referring physician/practitioner. The listed diagnosis should correspond with the treatment plan in order to reduce delays in the authorization decision.

## Additional Diagnostic Info

List any additional diagnostic information used in helping to diagnose this patient's condition. Also include a summary of any and all additional diagnostic testing.

## Prognostic Indicators

List any prognostic indicators that may alter the expected length of treatment. If additional space is needed, please submit a separate sheet to better explain the prognostic indicators.

## Treatment Plan

**Treatment Schedule (Dates) (required):**

This section asks you to write the dates you want covered in the treatment plan.

Enter the requested beginning and end dates for the authorization period in an MM/DD/YYYY format.

**Number of Visits Requested: (required):**

In this space, please write the number of visits you anticipate will be required to correct the problem (to the extent that is possible with speech therapy).

Treatment Plans are generally authorized for one to three-month periods depending on the patient's condition.

Case managers have expectations based on clinical guidelines and personal practice experience as to how long a condition should take to resolve. If your treatment plan appears reasonable according to our guidelines, your authorization will be approved quickly and easily.

**Treatment Goals (Functional Improvement and Outcomes Expected):**

Briefly describe the objective goals you set for the patient based on the clinical presentation described previously. Be specific about the amount of improvement expected and the probable timeframe. Describe the ultimate clinical and functional endpoints you expect to realistically obtain.

**Special Considerations:**

This space is to be used to convey any additional information of clinical significance in terms of the patient's condition that would impact the patient's management.

## Signature Section

Your signature affirms that everything you have submitted on the "*Treatment Plan*" form is true and correct to the best of your knowledge.

It also attests that if you are required under state law to obtain a prescription prior to rendering this treatment, you have obtained such a prescription in compliance with state law.