



Aetna Physical Medicine Tip Sheet

Patient Name: _____

Evaluation Date: _____

Surgery Date: _____

1. Cause for therapy: (Choose One)

- A. Traumatic
- B. Repetitive
- C. Work Related
- D. Motor Vehicle
- E. Unspecified

ICD10: a) _____

b) _____

c) _____

2. Is the cause of therapy related to a MVA? Yes | No | Unk/NA

3. Is this a workman's comp injury? Yes | No | Unk/NA

4. Select the type of service being rendered.

- A. Physical Therapy (PT)
- B. Occupational Therapy (OT)
- C. Physician/Medical Doctor (MD)
- D. Physician/Doctor of Osteopathic Medicine (DO)
- E. Chiropractor (DC)
- F. Other

5. Type of therapy being rendered: Rehabilitative | Habilitative | Neuro Rehabilitative

6. Is the evaluation > 60 days ago? Yes | No

7. Is the date of injury > 90 days ago? Yes | No

8. Which interventions do you feel this patient needs in therapy:* (Can Choose Multiple)

- A. Manipulation (CPTs: 98940, 98941, 98942, 98943, 98925, 98926, 98927, 98928, 98929)
- B. Active Procedures (CPTs: 97110, 97112, 97113, 97116, 97150, 97530)
- C. Self-Care, Cognitive, Sensory Skills (CPTs: 97127, G0515, 97533, 97535, 97542)
- D. Manual Interventions (CPTs: 97124, 97140)
- E. Modalities (CPTs: 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, G0289, S8948)
- F. Orthotics or Prosthetics (CPTs: 97760, 97761, 97763)
- G. Physical Performance Test (CPTs: 97750)

9. How many times do you plan to see the patient? 1, 2 or 3 more times

10. How many body parts are you treating? 1, 2, 3 or 3+

11. What is the body region/type? And Side?

Head/neck, Upper Extremity, Spine/Chest, Lower Extremity/Hip, Wound/Burn Care, Vestibular Rehab

12. What Functional Tool was used to assess this patient?

What was the score expressed as a percent of function? (25% disability = 75% functional)

13. When this patient resumes normal activities will they return to:

- A. Low functional demand activity
- B. Moderate to high functional demand activity

* Only choose the interventions that will be utilized. Units will be awarded to each category chosen.

Questions will vary depending on body part and condition within the Prior Authorization questionnaire. As you proceed to these areas, here are some general guidelines.

Body part portion of questionnaire:

- Identify the level of functional deficit the patient exhibits?
 - Severe
 - Moderate
 - Mild

- Identify how the patient exhibits their level of deficit, including but not limited to:
 - ROM Restrictions
 - Compensation patterns
 - Pain Limitations
 - Gait Patterns

- What is the expected Functional Demand that this patient will be expected to return to?
 - Functional Demand Categories describe the extent to which patients achieve or progress adequately toward the goals they hope to reach regarding their day to day activities at home, work, and/or recreation.
 - *High Functional Demand*
 - Higher resistance or higher frequency of repetitions, or a combination thereof.
 - *Moderate Functional Demand*
 - Moderate Resistance or Moderate frequency of repetitions, or combination thereof.
 - *Lower Functional Demand*
 - Low Resistance or Low Frequency of Repetitions, or combination thereof.

- Neurological Cases
 - Is there a fall risk?
 - Are there equipment needs?
 - Has there been a decline in status?
 - What level of assistance is required?

- Habilitative Care
 - Standardized testing scores (percentiles, and/or standard deviations below the norm)
 - Has there been a functional decline?
 - Has there been medical intervention such as Botox injections, surgeries, etc.
 - Are there equipment needs?
 - Does that patient have other gross or fine motor deficits affecting ADL's?