Kentucky Medicaid Therapy Prior Authorization Request Form Instructions For Traditional or State Plan KY Medicaid Only

Provider Information Section:

Complete the **Provider Name**, **Kentucky Medicaid Provider Number** (not the NPI number), **Phone**, and **Contact Person.** The contact person noted should be the best person to answer any questions about the request, please enter the phone number for that person. The **Provider Address** is optional.

Member Information Section:

Enter the **Member Name**, **Medicaid Number**, **DOB**, and **Age**. The **Member Address** is optional. Add the applicable **Diagnosis Code Description** and **ICD 10 Code**. Use the diagnosis that the therapist listed on their treatment plan. If it is a referral for an evaluation, then enter the root cause medical diagnosis that caused the impairment that generated the referral. Once the evaluation is complete, add the treatment diagnosis and the root cause medical diagnosis. These are the diagnoses that the therapist is treating. For example: CP G80.0 and Lack of Coordination R27.8

Discipline Requested:

Add the therapy discipline requested (**OT**, **PT**, **ST**); more than one discipline may be listed. One form may be submitted if the member is being treated for all three disciplines. Ensure the treatment plan contains the correct dates and number of visits for each discipline.

The **number of visits** is limited to no more than 90 calendar days. This should match what the therapist recommended in their treatment plan. If it is for an evaluation, then enter how many visits and weeks to complete the evaluation. Example 1: Start date is day 1, End date is day 90. Example 2: OT 24 visits 08/01/2020-10/29/2020.

Only the discipline is needed for the review, not CPT codes. The authorization is based on a range of codes.

Form Instructions:

A brief overview of how to complete the form and the documents needed for the review. Refer to 907 KAR 8:040 for documentation requirements or reach out to us at: therapypa_request@gainwelltechnologies.com for guidance.

Request Checklist

When obtaining a prior authorization for services requested, it is for you as the provider to review the required information per 907 KAR 8:040 prior to the form submission.

Therapy Information:

The **Frequency and Duration** should match what the therapist recommended in the treatment plan. For example, 2 times per week for 13 weeks.

Notes/Additional Comments:

Tell us anything that might help with the review. This is **not** part of a medical record and not the place for any clinical information.

Outpatient Therapy Providers should make a note on the PA form stating the services being requested are not duplicative.

The desired mode of submission is to email the request and scan the supportive documents for review to: therapypa_request@gainwelltechnologies.como or fax to: 502-214-3560.
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