EviCore
By EVERNORTH

Neurodevelopmental Program: PT-OT Clinical Worksheet

Required for all Neurodevelopmental Conditions

Please use this fax form for NON-URGENT requests only. Failure to provide all relevant information may delay the determination. Phone and fax numbers may be found on eviCore.com under the Guidelines and Forms section. You may also log into the provider portal located on the site to submit an authorization request.

URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE

Previous Reference/Auth Number (If Continued Care):		**Date of Submission:**	
Place of Service:			

Please note: The following demographic sections contain information necessary to initiate a fax request. When submitting by fax, all of the information below is **required**. When submitting online, you will only be prompted to provide the information necessary to query and select the appropriate patient and provider for this request.

PATIENT

First Name:		MI:		**Last Name:**	
Member ID:		DOB (mm/dd/yyyy):		Gender: ☐ Male ☐ Female	
Street Address:				Apt #:	
City:		State:		Zip:	
Home Phone:		Cell Phone:		Primary: ☐ Home ☐ Cell	
Member Health Plan/Insurer:					

PA Health Plans ONLY : ORDERING PROVIDER

I agree that the Ordering Physician on this case is a registered MD, DO, PA, or NP ☐ Yes ☐No					
First Name:		Last Name:			
Primary Specialty:		TIN:		NPI:	
Physician Phone:		Physician Fax:			
Address:				Suite #:	
City:		State:		Zip:	
Office Contact:		Ext:		Email:	

PROVIDER

First Name:		Last Name:			
Primary Specialty:		TIN:		NPI:	
Phone:		Fax:			
Address:				Suite #:	
City:		State:		Zip:	
Office Contact:		Ext:		Email:	

ADMINISTRATIVE

Diagnoses:

Code	*Description*	*Code*	*Description*

Start Date for this Request:

Is this request for: ☐ Fabricating a splint/orthotic ☐ Developing a home exercise program ☐ Wheelchair evaluation / adjustment ☐ Other treatment that requires 2 visits or less?

Section 1 - GENERAL INFORMATION – required for all requests

Indicate Clinical Condition (Choose only one):

☐ Developmental disorder / delay ☐ Torticollis ☐ Autism Spectrum Disorder

☐ Neurologic/neuromuscular disorder (e.g. Cerebral Palsy, Spina Bifida, genetic, post-surgical, etc.) ☐ Other

Section 2 - TREATMENT PLAN – required for all requests.

Enter "0" if unknown. If request is for one visit every 2 weeks, please enter .5 in Visits

Visits Requested PER WEEK	Units Requested PER VISIT:	Weeks of care requested:

Member Name:		Member ID:		Provider Name:	

Section 3 - Initial Requests ONLY: (for continuing care, please use section 4 instead.)

CLINICAL OBSERVATION RESULTS - Torticollis

Amount of Cervical Rotation on affected side* _____ **Patient age (IN MONTHS) when treatment started** _____

*(*Example – if rotation is to 75 degrees, enter 75. This is considered a deficit of 15 degrees.)*

CLINICAL OBSERVATION RESULTS – All other conditions. *No additional information required FOR INITIAL REQUESTS.*

Section 4 - Continuing Care Requests (please complete 4 and 4a or 4b, as appropriate)

Has there been a recent change in status of this patient (e.g. neurological event, recent/illness/surgery requiring hospitalization?
☐ Yes ☐ No If yes: please enter the date of the occurrence: / /

Section 4a - CLINICAL OBSERVATION RESULTS – Torticollis Only

Amount of Cervical Rotation on affected side* _____ **Patient age (IN MONTHS) when treatment started** _____

*(*Example – if rotation is to 75 degrees, enter 75. This is considered a deficit of 15 degrees.)*

Section 4b - CLINICAL OBSERVATION RESULTS – All other conditions

Is treatment directed towards the acquisition of new skills? ☐ Yes ☐ No

Is treatment directed towards the practice/repetition of a newly acquired skill? ☐ Yes ☐ No

Indicate the functional activities being addressed with treatment: (Choose ALL that apply):

☐ Mobility / Gait / Balance ☐ Gross Motor Skills ☐ Self-Care (e.g. Dressing, Bathing, etc.) ☐ Feeding
☐ Fine Motor Skills ☐ Sensory Processing ☐ Other (e.g. visual-motor, play skills, etc.)

Please indicate patient status: (Select only ONE)

☐ Period of rapid change of skills ☐ Needs repetition/practice for skill development
☐ Requires monitoring to prevent regression ☐ Loss of previous skill / unable to acquire new skills

STANDARDIZED TEST RESULTS

Standardized Testing is required every 6-12 months. Standardized scores should be reported with each continuing care request. Please enter **only** the relevant or lowest sub-scale or composite scores. *Please select from list in below.* *(Note: Age equivalent testing or screening tools do not meet the requirement for standardized testing)*

Test Name: **Date Performed:**

☐ No test performed (explain): ☐ Patient not sufficiently regulated ☐ Unable to tolerate testing ☐ Other reason

Subtest:	**Standard Score:**	Subtest:	**Standard Score:**
Subtest:	**Standard Score:**	Subtest:	**Standard Score:**
Subtest:	**Standard Score:**	Subtest:	**Standard Score:**
Subtest:	**Standard Score:**	Subtest:	**Standard Score:**

List of Standardized Tests

1. Alberta Infant Motor Scale (AIMS)
2. Bayley Scales
3. Batelle Developmental Inventory
4. Beery VMI
5. BOT-2 (Bruininks Oseretsky Test
6. Developmental Assessment of Young Children
7. Developmental Profile – 3
8. Developmental Test of Visual Perception
9. Gross Motor Function Measure
10. Miller Function and Participation
11. Movement Assessment Battery for Children
12. Peabody Developmental Motor Scales
13. PEDI – Cat
14. Test of Visual Motor Skills
15. Test of Visual Perceptual Skills
16. Wide Range Assessment of Visual Motor Ability