PEHP Health & Benefits

PRIOR AUTHORIZATION for MECHANICAL STRETCHING DEVICES for CONTRACTURE and JOINT STIFFNESS

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

Date Requested:		Service Provider Name:
Service Provider NPI #:	Service Provider Tax ID #:	Service Provider Address:

Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth ☐ Urgent	**Requested Date of Service:**
Date of Injury and/or Surgery:	**Description of Injury and/or Surgery:**
Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**

Service/Durable Medical Equipment (DME) Requested:

Service/DME Description: _____ CPT/HCPCS code: _____ Joint: _____ ☐ Left ☐ Right ☐ Bilateral

Service/DME Description: _____ CPT/HCPCS code: _____ Joint: _____ ☐ Left ☐ Right ☐ Bilateral

Service/DME Description: _____ CPT/HCPCS code: _____ Joint: _____ ☐ Left ☐ Right ☐ Bilateral

(Please check device being requested.) **QUESTION**	YES	NO	COMMENTS/NOTES
A. ☐ **Dynamic Splinting Devices:**			
1. Is the dynamic splinting device to be used on the elbow, finger, knee, toe, or wrist joint?	☐	☐	
2. Is the dynamic splinting device to be used adjunctively with physical therapy *and* does the patient have documented signs and symptoms of significant motion stiffness/loss in the sub-acute injury or post-operative period (i.e. at least 3 weeks after injury or surgery)?	☐	☐	
3. Does the patient have a prior documented history of motion stiffness/loss in a joint, have had a surgery or procedure done to improve motion to that joint, *and* are in the acute post-operative period following a second or subsequent surgery or procedure?	☐	☐	
4. Is the patient having surgery for a "chronic" condition (no significant change in motion for a 4-month period)?	☐	☐	
5. Is the dynamic splinting device being used prophylactically in the management of a chronic contracture and joint stiffness due to joint trauma, fractures, burns, head & spinal cord injuries, rheumatoid arthritis, multiple sclerosis, muscular dystrophy, or cerebral palsy?	☐	☐	
6. Is the dynamic splinting device being used for any of the following conditions? *Please check.* a. ☐ Carpal Tunnel Syndrome b. ☐ Cerebral Palsy c. ☐ Head and spinal cord injury d. ☐ Injury of the ankle or shoulder e. ☐ Multiple Sclerosis f. ☐ Muscular Dystrophy g. ☐ Rheumatoid Arthritis h. ☐ Plantar Fasciitis i. ☐ Stroke j. ☐ Trismus k. ☐ Neuromuscular Disease related foot drop l. ☐ Improvement of outcomes following Botox injection for treatment of limb spasticity	☐	☐	
7. Is one of the following dynamic splinting systems being requested? *Please check.* a. ☐ Advance® Dynamic ROM b. ☐ Dynasplint® c. ☐ EMPI/JAS Advance d. ☐ LMB Pro-Glide™ e. ☐ Pro-Glide Dynamic ROM™ f. ☐ SaeboFlex® g. ☐ SaeboReach™ h. ☐ SaeboMAS i. ☐ Ultraflex	☐	☐	
B. ☐ **PASS and SPS Devices:**			
1. Is request for a PASS (Patient-Actuated Serial Stretch) device, such as, Elite Seat, ERMI Elbow, MPJ, or Knee Extensionator®, ERMI Knee/Ankle, or Shoulder Flexionater®, or JAS EZ?	☐	☐	
2. Is request for a SPS (Static Progressive Stretch) device?	☐	☐	

Additional Comments:

Please fax completed form and medical records to 801-366-7449.