



Paul R. LePage, Governor

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Request for Prior Authorization of Physical/Occupational Therapy Services for Treatment of Chronic Pain Participation in Therapy to alleviate chronic pain

MaineCare Benefits Manual, Chapter 2, Section 85/Section 68, Physical/Occupational Therapy Services, covers up to six (6) Physical/Occupational therapy visits(one (1) evaluation visit and five (5) treatment visits) for management of long-term non-acute pain.

Member's Name: _____ Birth Date: _____ MaineCare ID#: _____

Diagnosis _____ ICD Diagnosis Code _____

1. Is this referral part of a treatment plan for newly diagnosed Long-term non-acute pain? (Non-acute pain is any pain that has lasted, or is expected to last, more than 60 days and impacts/is expected to impact a member's level of function for more than 60 days.) (Must check one)
 - Yes
 - No

2. Is this referral part of a Long-term non-acute Pain Management Care Plan? (Must check one)
 - Yes
 - No

3. This member has the following conditions: (Must check one)
 - Pain present greater than 60 days and has:
 - Medical visits >2 for the same pain diagnosis within a 60 day period
 - Loss of work for greater than 2 weeks related to this condition

4. Risk Assessment
 - At risk for Narcotic/Opioid Use
 - Is this patient program intended to prevent the use of opioids?
 - Yes
 - No
 - Receiving Narcotics/Opioids
 - Is this patient program intended to reduce or eliminate the current use of opioids?
 - Yes
 - No

5. Is this referral for a Chronic Pain Management Program in accordance with Section 80.07, Pharmacy Services?
 - Yes
 - No

Request for Prior Authorization of Physical/Occupational Therapy Services (continued)

This request is for _____(up to 5) Physical/Occupational therapy visits.

Member has 12 months to complete the Physical/Occupational Therapy treatment.

Date of most recent face-to-face visit with patient:_____

Signature of the practitioner prescribing the opioid medication. This patient's medical records are available to the Department upon request.

Physician Signature:_____ Date:_____

Printed Physician Name_____Office Telephone Number:_____

[Physical/Occupational Therapy provider—complete this section at the end of treatment]

Member has participated in Physical/Occupational therapy for chronic pain related to the diagnosis above mentioned and has **met/not met** goals.

Therapist's Signature:_____ Date:_____

Printed Therapist Name: _____ Office Telephone Number:_____