

Provider Instructions for completing the Extension of Care Plan

Do Not Submit this Instructional Form for Pre-certification.

The modified form below is for informational purposes only.

The following information is provided to you and your staff to aid in the process of filling out the Extension of Care Plan to permit pre-certification for treatment. The Extension of Care Plan is a two-page document that should be filled out and faxed to TRIAD the same day that the patient has been seen. If you do not receive a response from TRIAD within one (1) business day of your submission, please refax or call TRIAD at 800-409-9081. Please type or print legibly in black ink throughout the forms.

The top portion of both pages must be completed with the name of the primary treating physician providing care to this patient. Indicate your Tax ID Number, office and fax numbers with area code. This is important, since all certifications for treatment will be sent to you at this fax number. Each page must have the patient's name and Member ID number indicated. Please indicate the date on which the form is filled out.

Administrative Information

1. Begin date of service for this extension:

Please indicate the first date you are requesting pre-approval for this new coverage period. It is important that you do not submit an extension of care plan for additional visits until either all the visits on the previous care plan have been used or the coverage period has expired. The date that should appear in this area is the first date you plan to see your patient after the previous care plan has expired or you have exhausted all pre-approved visits.

2. Patient Name: _____ Member ID#: _____

Please be sure to include the name and insurance identification number of your patient in these fields. Do not include the name and insurance identification number of parents, guardians or other related individuals.

3. Date patient was last seen prior to the date entered in question #1: ___/___/___

Please indicate the date that your patient was last seen, in your office, prior to the first date for which you are requesting approval on this form.

4. Number of visits to date for this episode: _____

Please indicate the total number of visits that you have rendered to your patient for this episode. Please be sure to enter the number of visits that you have actually rendered not the number that had been pre-approved.

5. Present chief Complaint: C T L S Pelvic Non-spinal complaint

Please check all applicable regions above to indicate where your patient has described pain or related symptoms.

6. Spine Pain Radiation:

- Level I: Pain localized to spine
- Level II: Pain radiating to the elbow or knee
- Level III: Pain radiating below the elbow or knee
- N/A (for non spinal complaints only)

Check the appropriate box indicating your patient's distribution of pain. If your ONLY selection in question number 5 is Non-spinal, please select only N/A in this question.

7. Numeric Pain Rating Scale (NPRS):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Indicate the number that best describes your patient's present level of pain along a numeric-rating scale from 0 to 10; where zero equals no pain, and ten equals the most severe pain. If your patient has complaints in multiple spinal regions, please indicate their pain level only for that region in which pain is most severe.

8. Restrictions of Activities of Daily Living (Functional Index):

(No limitations) 0 1 2 3 4 5 6 7 8 9 10 (bed ridden)

Indicate the number that describes your assessment of your patient's current functional restrictions as they impact Activities of Daily Living. Zero represents no limitations and ten represents total disability.

9. Physical Work capabilities as it relates to the patients current condition:

- No work limitations
- Some work limitations
- Unable to work
- N/A (Children, F/T student, Retirees, Permanent total disability)

In this question we are trying to determine if your patient's current condition has impacted on their ability to work. Please indicate your assessment of your patient's current work capacity as it relates to THEIR normal baseline work capacity. For example, if your patient can do the same work that they could do prior to the onset of their current condition, they have no work limitations related to their current condition. Select "N/A" only if your patient is not normally engaged in any type of work activity. Students, retirees and disabled individuals who normally work should be evaluated for their work capacity and this information included above.

10. Overall Improvement since the initial visit for this episode

(None) 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% (totally disabled)

Please indicate the patients' reported overall improvement since the initial visit: 0% represents no improvement, 100% represents overall total improvement.

If there have been any CHANGES in the original diagnosis, please explain on next page:

Resolved Diagnosis since last care plan:

ICD-9#: _____ Describe: _____
ICD-9#: _____ Describe: _____

Additional Diagnosis identified since last care plan:

ICD-9#: _____ Describe: _____
ICD-9#: _____ Describe: _____

Has there been a resolution/addition in the patient's diagnosis since the submission of the prior care plan?

11. Exam Codes:

99211 99212 99213
 Other* (numeric): _____ *copy of exam narrative required

Please indicate what exam codes you used or will use during the requested treatment period.

*When selecting "Other," please submit supporting narrative documentation.

12a. Treatment: CMT

Activator Diversified Distraction Gonstead
 Thompson Pierce SOT Toggle
 Other: _____

Please select what type of CMT you will be administering to your patient.

NOTE: The descriptions under CMT will be used for the purposes of data collection and research and will not be used in the non-clinical review process.

12b. Treatment: Physical Modalities

US – 97035 EMS Unattended – 97014 Diathermy – 97024
 EMS Attended – 97032 Traction 97012 Other CPT
codes: _____

12c. Treatment: Therapeutic Procedures

Massage - 97124 Manual Therapy Technique - 97140
 Therapeutic exercise - 97110 Neuromuscular Re-education - 97112
 Other CPT code: _____

Please indicate physical modalities and therapeutic procedures that you anticipate utilizing during the course of the requested treatment plan. If you plan to use a physical modality or therapeutic procedure that is not listed, please include the appropriate CPT for that service on the line marked "Other."

13. How many modalities will be used per visit?

0 1 2 3

Other: _____

Please indicate the number of combined modalities/procedures, not including CMT, that you will be providing per office visit.

14. 1-2 Regions - 98940 3-4 Regions - 98941 5 Regions - 98942

Extra Spinal more than one region – 98943 N/A

Please indicate the number of regions that you will be treating with CMT. Please note, generally, the number of regions considered medically necessary to treat with CMT is related to both the number of regions of patient complaint and the number of regions of diagnosed condition.

15. Requested Treatment Plan: Total number of visits requested _____

Therapeutic/Rehabilitative Care – 30 days

OR

- Supportive Care - 30 days
 60 days
 90 days
 120 days
 150 days
 180 days

Please select what type of care you will be administering to your patient. Be sure to also select a timeframe when you select “Supportive Care.” It is not necessary to select a timeframe for “Therapeutic/Rehabilitative Care” because this type of care will be approved for thirty-day periods only. You may select only ONE type of care on any given care plan. Incorrectly selecting both “Therapeutic/Rehabilitative Care” and “Supportive Care” on the same care plan will result in the form being returned to you for correction of this information and delays in the approval of care. If the type of care that you are providing to your patient changes from “Therapeutic/Rehabilitative Care” to “Supportive Care” or visa versa, as their condition requires, a new care plan must be submitted indicating the current condition of the patient and the new type of care requested.

16. I have attached additional objective clinical information to concurrent conditions, comorbidities, contraindications, clinical alerts and or relevant clinical issues.

Comments:

Please include any other information that you would like to have taken into consideration regarding review of their care plan.

The Physician acknowledges that this Care Plan has been personally reviewed, contains information that is truthful and accurate and has been submitted by authorized staff on behalf of Physician.