

**Provider Instructions for the Initial Care Plan**  
**Do Not Submit this Form for Pre-certification**  
**This is for informational purposes only.**

*The following information is provided to you and your staff to aid in the process of filling out an Initial Care Plan to permit pre-certification for treatment. The Initial 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 twenty-four (24) hours 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 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**

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**1.  New Patient       Established Patient**

A patient is classified as a New Patient when they first present to your office for evaluation or if they have not had services for three years. An Established Patient has been evaluated and/or treated at your office within the past three years for any condition.

**2a. Begin date of service for this request: \_\_\_\_/\_\_\_\_/\_\_\_\_ (including 1<sup>st</sup> visit)**

This field must indicate the very first date for the period that you are requesting prior approval. Even if the first date on which you saw your patient did not require pre-approval, you must use this date to ensure that the initial approved treatment period includes that date of service.

**2b. The Onset/Date of injury \_\_\_\_/\_\_\_\_/\_\_\_\_:**

This is the date on which the first symptoms of or the injury responsible for your patient's current condition occurred.

**3 Patient's last name:    Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_**  
 **M    F**

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

**4. Member's ID No. found on Member's ID card: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_**

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

**The information requested in fields 5 through 18 MUST be answered or this form will be returned to you with a request for the missing information. Prior approval of services will not be processed without all required information.**

**5.  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 head, 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. Duration of symptoms:**

0 – <3 weeks  >3 – 6 weeks  >6 weeks

Use this question to indicate the length of time that your patient has suffered from their current symptoms or complaints. If their current symptoms are related to a chronic or recurrent condition, please indicate the duration from the original onset of this condition.

**10. History of prior spinal surgery?**

- Yes  No
  - Asymptomatic >1 year
  - Multiple recurrences of symptoms < or = 2 per year
  - Frequent recurrences of symptoms per year >2

Check the appropriate box to indicate if the patient has ever had spinal surgery, yes or no. If no, then proceed to question 11. If yes, then indicate the patient's symptoms since surgery. Has the patient been asymptomatic for greater than one year, had recurrences lasting more than 24 hours one or two times per year, or frequent recurrences more than twice per year?

**11. Physical Work Capacity as it relates to the patients current condition:**

- No work limitations  Capable of restricted work duty  Unable to work
- N/A (Children, F/T students, Retirees, Permanent total disability)

In question #11 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 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 in question #11.

**12. Number of Previous Episodes:**  0-3     4-5     >5

Please indicate the number of times your patient has experienced an episode of this condition in the past.

**13. Diagnosis:**

ICD-9#: \_\_\_\_\_ Describe: \_\_\_\_\_  
ICD-9#: \_\_\_\_\_ Describe: \_\_\_\_\_  
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ICD-9#: \_\_\_\_\_ Describe: \_\_\_\_\_  
ICD-9#: \_\_\_\_\_ Describe: \_\_\_\_\_  
ICD-9#: \_\_\_\_\_ Describe: \_\_\_\_\_

Please indicate the current ICD-9 diagnosis code with the description.

**14. Exam Codes:**

99201         99202         99203  
 99211         99212         99213  
 Other\* (numeric): \_\_\_\_\_

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

\* When selecting “Other” please submit supporting narrative documentation.

**15a. 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 analysis unrelated to the pre-approval process.

**15b. Treatment: Physical Modalities**

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

**15c. 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 code for that service on the line marked “Other”.

**16. How many combined physical modalities and/or therapeutic procedures will be used per visit?**

- 0     1     2     3     Other: \_\_\_\_\_

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

17.  1-2 Regions - 98940     3-4 Regions - 98941     5 Regions 0 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.

**18. Requested Treatment Plan: Total number of visits requested \_\_\_\_\_ (including initial visit)**

- 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.

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

Comments:

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Please include any other information that you would like to have taken into consideration regarding the 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.**