

Physician Name and Tax ID Number _____

Office Number (____) _____ Fax Number (____) _____

1. New Patient Established Patient

2a. Begin Date of Service for this request: ____/____/____ (Including initial visit)

2b. Onset / Date Of Injury ____/____/____

3. Patient Last Name: _____ First: _____ MI: ____ M F

4. Member ID No. found on Member's ID card: _____ DOB: ____/____/____

5. **Present Chief Complaints:** C T L S Pelvic Non Spinal

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

7. **Numeric Pain Rating Scale (NPRS):**

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

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

(no limitations) 0 1 2 3 4 5 6 7 8 9 10 (totally disabled)

9. **Duration of symptoms:** 0 - <3 weeks >3 - 6 weeks >6 weeks

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

11. **Physical Work Capacity 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)

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

13. **Diagnoses**

ICD-9 No.: _____ Describe: _____
ICD-9 No.: _____ Describe: _____
ICD-9 No.: _____ Describe: _____
ICD-9 No.: _____ Describe: _____
ICD-9 No.: _____ Describe: _____

14. **Exam Codes:**

- 99201 - 99202 - 99203

- 99211 - 99212 - 99213

- Other* (numeric) _____ *copy of exam narrative is required.

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Patient Name: _____ **Member ID#:** _____

15a. Treatment: CMT

- Activator Diversified Distraction Gonstead Thompson
 Pierce SOT Toggle Other: _____

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 code: _____

15c. Treatment: Therapeutic Procedures

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

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

- 0 1 2 3 Other (numeric): _____

17. 1-2 Regions – 98940 3-4 Regions – 98941 5 Regions – 98942

- Extra Spinal more than one region – 98943 N/A

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

19. I have attached additional objective clinical information to describe concurrent conditions, co-morbidities, contraindications, clinical alerts and or relevant clinical issues.

Comments: _____

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