

PHYSICAL MEDICINE PRECERTIFICATION—FORM 1 INSTRUCTION SHEET

This form is to be used for Chiropractic, Osteopathic Manipulation, Physical Therapy, Occupational Therapy (functional activities), Hand Therapy

Date: Date you are completing the form
Patient: Name of patient
DOI: Date of work injury
Claim #: Insurance claim number
Insurance: Name of insurer covering this claim

Attending physician: Physician ordering services
Evaluation Date: Evaluation date / start of service
Treatments Your Office to Date: Total number of visits *since evaluation*
Treatments Last Certification: Visits during last *certification period* only
Missed Appointments Last Cert: No shows, cancellations without reschedule during last certification period

Diagnosis: Condition for which patient referred to you (condition must be claimed by patient / worker through insurer)
ICD-9 Code: Code for above condition

Treatment Dates For This Pre-Certification: To cover 30 day period or less*
*request dates to encompass the duration of treatment *ordered*:
example: if duration *ordered* is 3 weeks, request 11-10-06 to 12-01-06, instead of 11-10-06 to 12-08-06 (4 weeks)

Subjective Reports: Give sample statement of patient's comments / complaints*
*for example, "c/o soreness after increasing intensity of HEP"; "reports decrease in pain symptoms with walking program"

Pain Scale: 0-10 pain rating. List level reported by patient as x / 10, either a range of severity or the average, or not applicable

Disability rating: Listed as %
Please check the box next to the scale that you are using when providing a percentage number:

Modified Oswestry Disability Questionnaire
TAOS/Care Connections
Optimal Instrument (APTA)
DASH (Disabilities of the arm, shoulder, hand)

Current Work Status: Level of work patient *currently performing*
Regular = full time, regular work for that patient for the patient's job at injury
Modified = different than usual duty at employer at injury; different type of job with new employer that accommodates limitations; working fewer than normal days / hours
Not working = unable to work due to injury; lost job or on leave; quit job

Recommendations for RTW: Therapist / provider assessment of patient's ability to return to work, based on current physical status
Regular duty = based on patient's job at injury, the total number of hours worked per day, and days worked per week prior to injury
Modified = number of daily hours, and days per week, altered to fit patient's current capacities
Hours per day = give number of hours per day that patient could reasonably tolerate in the occupational setting
Days per week = give number of days per week that patient could reasonably tolerate in the occupational setting

Strength Capacities: Maximum capacity for each activity listed
Muscle Strength: Use x / 5 manual muscle test levels
ROM Measurements: Degrees of ROM at joint(s) being treated; please indicate *active versus passive* measurements
Previous: measurement obtained during the prior certification period
Current: measurement obtained in the most recent certification period

Job Requirements / Functions: List major components of job at injury
Functional Limitations: List primary limitations that prevent worker from performing full duties as prior to injury
Measurable / Functional Goals: Goals being addressed during treatment period

Treatment Plan: primary therapy modalities that will be provided
CPT Codes: list corresponding code for each therapy modality

Proposed Treatment Plan: Enter days per week and number of weeks the patient will be scheduled for therapy. *This must coincide with the physician script or signature on the proposed treatment plan**

*for example, don't request 3x/week for 4 weeks if your progress note is cosigned by the physician for 3x/week for 3 weeks;
avoid using a range of visits or weeks; be specific

Comments / Justification For Further Care: Clinical statement as to why further treatment would benefit the patient, what is planned for the new certification period, if discontinuation of services anticipated*

*for example, “progressing with ROM, but continues to need directed strengthening program to achieve maximum potential”; “pain continues to be primary barrier to progress; will implement new exercises following mobilization”; “plan to finalize HEP and perform FCE this month; anticipate discharge in 4 weeks.”

Treating Therapist / Provider Must Fill Out Request Form and Fax Back

Please complete ALL sections of the form so that your request can be processed more efficiently. Include ALL treatment notes, evaluation reports, and /or progress notes, for the certification period leading up to the period for which you are requesting authorization. This *must* include a current physician’s order or signature on the active treatment plan that *indicates frequency and duration of services*.

Therapist Signature / Licensure Type: Signature of primary care provider. This person *must* be the paneled provider, and *must* provide the majority of services directly. If the primary provider of services is in the process of applying for the CMC panel, another paneled practitioner must co-sign the request.

Printed Name: Name and credentials of primary care provider printed legibly.

Facility: Clinic name where treatment occurring
Phone: Main clinic telephone number with area code
Fax: Office fax number with area code

NOTES:

In order to insure a timely response to the pre-certification request without a break in continuity of care for the worker, submit the paperwork one week prior to the start date of the time frame you will be requesting*

*for example, the time frame being requested begins on 01-24, send the pre-certification request to CareMark Comp on 01-17.

Also remember the 12 / 30 rule. When the worker has not been previously treated for the condition, or has had a surgical procedure without prior physical medicine treatment, pre-certification is not required for the first 12 visits, or 30 day period, which ever occurs first. This applies only for the first physical medicine treatment provided for the claim.