

PHYSICAL MEDICINE PRECERTIFICATION—FORM 2 INSTRUCTION SHEET

This form is to be used for Acupuncture, Massage, Speech-Language Pathology, Occupational Therapy (cognitive), Vision Therapy, Pain Program.

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 services
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 (for workers' compensation, condition must be claimed by worker through claims adjuster)
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, "reports decrease in double vision since last treatment and with continued exercise"; "c/o tight, stiff neck and upper back, especially on right"; "spouse indicating increased ability to sustain conversation without distraction"

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.

Current Functional Limitations: Give sample of activities worker cannot perform due to injury / surgical condition*
*for example: "unable to lift 30 pound child into car seat without increasing symptoms"; "difficulty turning head to left which impairs driving safety"; "unable to focus on writing tasks for more than 10 minutes at a time"

Progress During Last Certification Period: Give sample statement of gains made with treatment*
*for example: "can now lift 30 pound child into car seat without symptoms, using proper body mechanics"; "able to turn head to left fully as compared to right with muscle"

tightness, no pain”; “ability to focus on work simulation writing tasks increased to 20 minutes”

Measurable / Functional Goals This Certification Period: Goals being addressed during treatment period. These should be measurable and addressed with each certification request*

*for example: “will be able to lift 30 pound child into and out of car seat 6 times a day without back pain”; “to turn head fully to left throughout day without pain or muscle tightness”; “able to focus without distraction on simulated work activities for 30 minutes at a time”

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 2x/week for 3 weeks

Comments / Justification For Further Treatment: 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, “additional acupuncture visits indicated to abolish pain with lifting, prolonged postures”; “continue massage to release muscle tension in left upper trapezius to allow motion without restriction”; “continue out-patient SLP to maximize compensatory strategies for executive function, self-redirection to task”

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 30 day 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.

Signature Treating Therapist / Provider: 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 may co-sign the request.

Print Name / Credentials: 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

Tax ID: Clinic tax identification number

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.