PHYSICAL MEDICINE PRECERTIFICATION—FORM 1
INSTRUCTION SHEET

Precertification is required after the initial 30 days duration of physical medicine or 12 visits, whichever comes first, and for every 4 weeks thereafter.

This form is to be used for Chiropractic, Osteopathic Manipulation, Physical Therapy, Occupational Therapy (functional activities) and 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 initial evaluation*
 # Treatments Last Certification: Visits during last *certification period* only
 # Missed Appointments Last Cert: No shows, cancellations without reschedule during the last certification period

Diagnosis: Condition(s) for which the patient was referred to you (for workers' compensation, condition(s) must be claimed by the worker through the claims adjuster).

Current ICD-CM Code: Code for above condition(s)

Treatment Dates For This Pre-Certification: To cover a 4 week period or less. The requested date range must encompass the duration of the treatment.

Subjective Reports: Give a sample statement of the 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 the level reported by the patient as x/10, either a range of severity or the average, or not applicable.

Current Work Status: Level of work the 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 the 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 = the number of daily hours, and days per week, altered to fit patient's current capacities.
- Hours per day = give the number of hours per day that the patient can reasonably tolerate in the occupational setting.
- Days per week = give the number of days per week that patient can reasonably tolerate in the occupational setting.

Strength Capacities: The 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 the major components of the job at injury.

Functional Limitation: List the primary limitations that prevent the worker from performing full duties prior to injury.

Goals for This Next Certification Period: Goals being addressed during this treatment period.

Treatment Plan: Primary therapy modalities that will be provided.

CPT Codes: List the corresponding code for each therapy modality.

Proposed Treatment Plan: Enter the number of 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 Care: A 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 the primary barrier to progress; will implement a 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 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.

Signature Treating Therapist/Provider: Signature of primary provider of treatment. This person *must* be the contracted provider, and *must* provide the majority of the services directly. If the primary provider of the services is in the process of applying for the CareMark Comp panel, another contracted practitioner may co-sign the request.

Print Name/Credentials: Name and credentials of primary provider of treatment 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

Note: In order to insure a timely response to the pre-certification request without a break in continuity of care for the worker, paperwork must be submitted one week prior to the start date of the time frame you are requesting. For example, the time frame being requested begins on January 24th, send the pre-certification request to CareMark Comp on January 17th.

Also, remember the 12/30 rule. When the worker has not received therapy for the condition, pre-certification is not required for the first 12 visits, or 30 day period, whichever occurs first. This applies only for the first physical medicine treatment provided for the claim.

Post-surgery physical medicine beyond 9 visits requires precertification by the therapist.