PHYSICAL MEDICINE PRECERTIFICATION—FORM 2
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 Acupuncture, Massage, Speech-Language Pathology, Occupational Therapy (cognitive), Vision Therapy, Pain Program, Work Hardening and Biofeedback.

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(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, "reports decrease in double vision since the last treatment 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 the level reported by the patient as x/10, either a range of severity or the average, or not applicable.

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

Progress During the Last Certification Period: Give a sample statement of gains made with treatment. For example, "can now lift a 30 pound child into car seat without symptoms, using proper body mechanics"; "able to turn head to the left fully as compared to the 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 a 30 pound child into and out of a car seat 6 times a day without back pain"; "to turn head fully to the 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 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 Treatment: 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, "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 outpatient 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 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.