Chiropractic
Treatment Plan Form Instructions

Date of this Request:

Enter the date on which the Treatment Plan form is completed using the MM/DD/YYYY format.

This date will be used to reference the submitted Treatment Plan when communicating the Utilization Review decision to you.

Enter the type of care by checking the appropriate box for:

- ❑ Initial care (patient has been treatment free for the past 60 days), or
- ❑ Continuing care (patient has presented with a new condition or there is continuing care for the same condition).

Insured Information:

Patient Last Name: Enter the last name of the patient.

Patient First Name: Enter the first name of the patient.

Patient M.I.: Enter the middle initial of the patient.

Gender: Check the box for "M" or "F" to indicate the gender of the patient.

Age:

Enter the patient's current age. (*Note: The patient's age must be entered. The age is used to verify the date of birth and is easily referenced by the Case Managers).*

Date of Birth:

Enter the patient's date of birth in the MM/DD/YYYY format. (*Note: The patient's date of birth must be entered. The date of birth is used to identify and/or confirm the identity of the patient in eligibility system.)*

Insured I.D. or SSN:

The insured or subscriber I.D. (identification) number or SSN (social security number) including the 2-digit billing code (i.e., 01, 02, etc.) should be obtained directly from the patient's insurance card. Remember that the insured's identification number will not be the same as the patient's SSN if the patient is not the insured.

Insured Last Name: Enter the last name of the insured.

M.I.: Enter the middle initial of the insured.

First Name: Enter the first name of the insured.

Patient Phone: Enter the area code and phone number of the patient.

Patient Address: Enter the street address of the patient.

City: Enter the name of the city in which the patient resides.

State: Enter the state in which the patient resides.

Zip Code: Enter the zip code of the patient's residence.

Payor Information

Employer Name:

Enter the name of the insured's employer. This is best obtained from the insurance card, as the patient is not always familiar with the enrolled group name.

Insurance Company:

Enter the name of the insured's insurance company. This can be found on the patient's insurance card.

Group #, Plan # or Union Local:

Enter the group number, plan number or union local number as obtained directly from the patient's insurance card

Injury or Illness is Related to:*

Check the appropriate box to describe where or how the patient was injured or became ill.

** This information relates to the coordination of benefits. The questions above help you determine the correct carrier to request care for the patient's condition. These questions will help save time in the long run as these issues can delay claims payment.*

Doctor Information

Doctor Last Name:

Enter the last name of the practitioner who is requesting the services for the patient.

Doctor First Name:

Enter the first name of the practitioner requesting the services for the patient.

Doctor M.I.:

Enter the middle initial of the practitioner requesting the services for the patient.

Area Code + Phone:

Enter the area code and phone number where the treating practitioner may be reached.

Area Code + Fax #:

Enter the area code and fax number where the treating practitioner may be reached.

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Doctor Address: Enter the address where services are being provided to the patient.

City: Enter the city where services are being provided to the patient.

State: Enter the state where services are being provided to the patient.

Doctor License #: Enter the practitioner's license number as reflected on the State Board of Chiropractic Examiners license. Please do not use Medicare, Medicaid or other types of practitioner numbers here.

Patient's Current Medical History

Please be aware that the use of standard medical abbreviations is encouraged to save time and space in completing the clinical portion of this form. All relevant clinical information should be included. Omitting key information may delay the authorization decision.

Subjective Complaints (required field):

A description of the subjective complaints for which the patient is presenting, or that the practitioner believes are relevant to the present complaints, should be described here. Describe the subjective complaints so that the Case Managers are able to create a picture of the member's condition.

Describe the severity of symptoms in terms of the following definitions of minimal, slight, moderate, or severe.

Minimal:

A pain that would be considered annoying, but would cause no limitation in the performance of a particular activity.

Slight:

A pain that could be tolerated, but would cause some limitation in the performance of an activity possibly preventing the activity from taking place.

Moderate:

A pain that could be tolerated, but would cause marked limitation in the performance of an activity.

Severe:

A pain that would preclude an activity from taking place. The frequency of the complaints should be described with the following definitions of occasional, intermittent, frequent or constant.

Occasional: Symptoms that occur approximately 25 percent of the time.

Intermittent: Symptoms that occur approximately 50 percent of the time.

Frequent: Symptoms that occur approximately 75 percent of the time.

Constant: Symptoms that occur approximately 90-100 percent of the time.

Following is an example of using standard medical abbreviation and a subjective complaint description that covers all areas described above:

"occ., slt., dull lt. l/s pn in the afternoon/evening; non-radiating; increased by prolonged standing or walking, relieved by sitting or lying down."

The same example without abbreviations:

"Occasional, slight, dull, left lumbosacral pain in the afternoon and evening; non-radiating; increased by prolonged standing or walking, relieved by sitting or lying down."

Lost Days from Work:

Enter the total number of days the patient has not worked to date due to present injury or illness.

Days of Work Restriction:

Enter the total number of days to date that the patient has been restricted from work due to the present injury or illness.

Mechanism of Onset for Primary Diagnosis:

Date of Onset: Enter in MM/DD/YYYY format the date that the condition began. If the condition was of a gradual onset, enter the approximate date when the condition began, as specifically as possible.

Check the appropriate box to identify the mechanism of onset for the primary diagnosis.

- ❑ Acute trauma
- ❑ Worsening of prior illness/injury
- ❑ Repetitive motion
- ❑ Gradual onset
- ❑ Chronic
- ❑ Other

Description: Describe the details of onset as specifically as possible (i.e., lifting 10-pound box from ground without bending knees. For a condition of gradual onset, the description might read as follows: "Over past two months without identifiable causation."

Date of First Treatment at this office for this condition: Enter in MM/DD/YYYY format the date of first treatment in your office for the current condition being treated.

Please note that if treatment is related to a flare-up of a condition, the date of the first treatment should reflect the date of the original occurrence for the condition and not the flare-up date, as the condition is still the same one.

Objective Findings (required):

Date obtained: Provide the date of examination on which the objective findings described were obtained.

HT: Enter the patient's height

WT: Enter the patient's weight

BP: Enter the patient's as obtained during examination. If blood pressure not taken, indicate "not performed"

Temp: Enter the patient's temperature

Inspection: Enter any applicable inspection findings (i.e., antalgia, 20 degrees trunk flexion, limping gait favoring left knee, right shoulder elevated three inches). Quantifying terms, such as minimal, slight, moderate, degrees of antalgia, etc., are helpful, when applicable, to most clearly describe for the Case Managers the patient's clinical picture. Enter "none" if no significant inspection findings were noted upon examination.

Palpation: Provide any significant palpation findings noted upon examination (i.e., slight right trapezius muscle spasm, hypomobility C5/6, moderate tenderness left levator scapula). Quantifying terms, such as minimal, slight, moderate, etc., are helpful, when applicable, to most clearly describe for the Case Managers the patient's clinical picture. Enter "none" if no significant palpation findings were noted.

Cervical and Lumbar Range of Motion (ROM):

Left side of box = Cervical ROM

Right side of box = Lumbar ROM

Enter "WNL" for cervical and/or lumbar range of motion, as applicable, if all ranges of motion are found to be within normal limits.

If not "WNL" for all ranges, please enter the ranges observed in degrees (i.e., flexion 55^{o}, etc.). Percentages of range of motion are not allowed.

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Summary of Examination Findings:

Please provide a summary of your examination findings. This information should validate the diagnosis code. If Landmark cannot validate the diagnosis based on the submitted information, we cannot verify that treatment was for a correctly diagnosed condition.

1. ☐ **Localized pain reproduced on palpation or orthopedic testing (list area):** This checkbox can be used to summarize the dozens of tests used to identify localized joint pain associated with sprain/strain injuries. For instance, pain on resisted cervical range of motion confirms a cervical sprain diagnosis. Speed's test confirms bicipital tendonitis. Sacroiliac Compression test is part of the diagnostic criteria for a sacroiliac lesion, etc.
2. ☐ **Radiating pain below knee or elbow reproduced on nerve compression or stretch test (list nerve root distribution):** This checkbox summarizes any positive finding associated with a space occupying lesion or inflammation of the nerve or nerve root. For instance, if cervical compression produces pain below the elbow, you would check this box. Or if Laségue's and Braggard's (dural stretch) tests reproduce or exacerbate pain below the elbow or knee, you would check this box. If Valsalva's test (compression) produces pain below the knee, you could check this box. Checking this box validates nerve inflammation or compression-type syndromes.
3. ☐ **Pain referred from muscles or trigger points (list):** This checkbox summarizes soft tissue palpatory findings that are not well described by any orthopedic tests but are well described by various trigger point manuals (e.g., Travell). All myopathies from torticollis to myofascitis could be validated by this finding.
4. ☐ **Diffuse ache on passive motion (list joint/s):** Pain on passive motion of a joint distinguishes pain in the joint capsule, bursa, facet or other interarticular structure from pain due to muscle spasm or inflammation of connective tissue (as would be demonstrated by pain on active or resisted motion). Bursitis, capsulitis, arthritis or facet syndromes would be validated by this finding.
5. ☐ **Testing revealed pain, swelling or instability of joint or extremity (list joint/s):** Includes tests such as anterior drawer sign of the knee (Drawer's test) which identifies excessive motion of the anterior cruciate ligament.
6. ☐ **Neurological tests within normal limits:** A neurological examination should always be performed when appropriate and include testing of pertinent sensory and functions as well as deep tendon and superficial reflexes. If all test results are within normal limits, you do not need to record all tests performed on the treatment plan form – simply check the "WNL" (within normal limits) box.

7. ☐ **Neurological deficits (describe):** If you check "Neurological deficits," describe your findings. Indicate whether the deficit is: (1) amenable to chiropractic care such as paresthesia of the upper extremity associated with a cervical-brachial syndrome, (2) indicative of a condition which will not respond to care such as loss of reflexes in a post-polio patient or (3) indicative of a condition which requires medical consult such as positive cranial nerve findings.

Possible Contraindications/Concurrent Care Section:

Completion of this section assists in the identification of patients who may need continuing care from their PCP or medical specialist.

The initial question assumes that you have asked the patient to complete a "Patient Information" form, to gather a complete medical history. The following listing includes common conditions that could contraindicate care. For any checked items, please attach an explaination.

Please check all that apply:

- ❑ Articular derangements (arthritides, autoimmune diseases, joint instability or hypermobility, etc.)
- ❑ History of infection (recent fever > 100, constant low grade fever, bone or joint infection, etc.)
- ❑ Circulatory or cardiovascular disorders (e.g., stroke)
- ❑ Bone weakening or destructive disorders (e.g. tumors)
- ❑ Neurological disorders (myelopathy, acute cauda equina syndrome, multiple sclerosis, etc.)
- ❑ Atrophy in the extremities
- ❑ Abnormal deep tendon reflexes or motor weakness
- ❑ Scoliosis >20 degrees adult or >10 degrees child
- ❑ Congenital connective tissue disorders
- ❑ Abnormal bowel or bladder function
- ❑ Signs or symptoms of vertebro basilar insufficiency
- ❑ Fever or localized redness and swelling or ankylosing spondylitis
- ❑ Signs or symptoms of cancer or chemotherapy tx
- ❑ Signs or symptoms of organic disease

- ❑ Patient is currently under PCP or medical specialist care; or referred on ___/___/___

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Diagnoses

ICD-9 Code:

Enter the appropriate ICD-9 Code(s) in order from the most important diagnosis, in terms of causation of the patient's condition, to the least important.

- External cause codes or "E" codes are not accepted as a primary diagnosis.
- Refrain from using non-specific diagnosis codes or diagnosis codes related to Unspecified Sites.
- Incorrect codes require subsequent review to determine the proper code and may cause delays in obtaining authorization.

Description:

List the patient's diagnoses that corresponds with the ICD-9 Codes in order from the most important diagnosis, in terms of causation of the patient's condition, to the least important.

It is important that the diagnosis given be supported by the mechanism of onset, subjective complaints and objective findings given. It is also important that the diagnosis given provide the most accurate reflection possible of the practitioner's clinical opinion as to the causation of the patient's condition.

For example, a diagnosis of cervicalgia (723.1) and hypokinesia (780.9) would not be sufficiently descriptive of the causation of the patient's condition. The diagnoses that describe subjective complaints or objective findings typically do not explain the most important function of a diagnosis, which is to reflect the practitioner's clinical opinion as to *why* the patient is having the types of subjective complaints and objective findings noted on presentation.

With the above example, it may be that the patient has suffered an acute cervical strain, which is *why* he or she has neck pain (cervicalgia) and decreased motion (hypokinesia), and/or the patient may have a subluxation at C5/6 causing cervical pain and decreased segmental motion. The primary causation of the patient's presenting condition would be listed first and then any diagnoses of lesser importance would follow in order of causation. In the previous example, instead of cervicalgia and hypokinesia, the diagnoses would be appropriately listed as cervical strain (847.0) followed by cervical subluxation (739.1).

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Pain Intensity Section:

The section on pain intensity of symptoms is required as it enables Landmark case managers to quantify the improvement of the patient over time

Pain intensity according to patient:
0 = None, 10=Severe

	0	1	2	3	4	5	6	7	8	9	10
Diagnosis 1.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diagnosis 2.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diagnosis 3.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diagnosis 4.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Symptom frequency according patient:

	0-25%	26-50%	51-75%	76-100%
Diagnosis 1.	☐	☐	☐	☐
Diagnosis 2.	☐	☐	☐	☐
Diagnosis 3.	☐	☐	☐	☐
Diagnosis 4.	☐	☐	☐	☐

Significant X-Ray Findings

When x-rays are clinically indicated, complete the following information regarding the radiographic studies exposed.

X-rays Requested/Taken:

We have checkboxed the most commonly used CPT codes for your convenience.

X-Rays Requested/Taken:

- ☐ 3 view Cervical CPT 72040 (AP, APOM, LAT)
  2 view Thoracic CPT 72070 (AP, LAT)
  2 view Lumbar CPT 72100 (AP, LAT)
- ☐ Other
- ☐ CPT

Medical X-ray Findings:

The following section provides a space to write in any pathological findings such as fracture, tumor, congenital anomaly, degenerative joint disease, etc.

Medical X-Ray Findings:
Positive for:
Fracture/Dislocation
Gross Osseous Pathology
Pathology noted below:

Chiropractic X-ray Findings:

This section provides space to write non-pathological findings that are relevant to chiropractic care such as loss of cervical curve, lumbar scoliosis, etc. You need not provide subluxation listings, as they will not affect the case manager's decision regarding the number of allowed visits, etc.

Date taken ___/___/___ (enter date in MM/DD/YYYY) format

Describe:

Use the remaining blank area under "Chiropractic x-ray Findings" to list any significant x-ray findings (i.e., Grade II L5 spondylolisthesis or IVF encroachment at C5/6 on the left). Findings should be of the type that impact diagnosis and/or treatment plan.

Treatment Plan

Treatment Plan (Dates) (required):

This section asks you to write the dates you want covered in the treatment plan.

- Enter the requested beginning and end dates for the authorization period in an MM/DD/YYYY format.

Number of Visits Requested: (required):

In this space, please write the number of visits you anticipate will be required to correct the problem (to the extent that is possible with chiropractic care).

Treatment Plans are generally authorized for one to three-month periods depending on the patient's condition.

Landmark case managers have expectations based on clinical guidelines and personal practice experience as to how long a condition should take to resolve. Torticollis for

example, normally resolves without treatment within a week. 92% of lumbar pain cases (including discogenic pain) resolve without treatment in 60 days. If your treatment plan exceeds the normal and customary treatment for a diagnosis, Landmark will require additional documentation such as the patient's progress notes. If your treatment plan appears reasonable according to our guidelines, your authorization will be approved quickly and easily.

Patient Home Care:

The Patient Home Care section is important because we want to know what you have advised the patient to do to help themselves. We urge you to involve the patient in a stretching and exercise program. Without active involvement, the patient becomes dependent on the caregiver. The consensus of research literature is that passive modalities should only be employed in the first 30 days of care. After that, the best outcomes are achieved by the patient's own efforts.

Check the appropriate box for the home care instructions given to the patient:

Stretching
Exercise
Hot/Cold

Proposed Adjustive Techniques:

Case management uses this section to see what your treatment methodology and goals are.

Proposed Adjustive Techniques:
Manual Technique(s) ☐ Diversified
☐ Gonstead ☐ Activator ☐ Other_____

Comments/Goal of Tx:
Reduce pain _____%
Improve ROM_____%
Other:_____
Anticipated release date: _____/____/_____

Complicating Factors:

This space is to be used to convey any additional information of clinical significance in terms of the patient's condition that would impact the patient's management. Checking one of the following boxes will help Landmark case managers understand why a particular patient may be expected to take longer to respond to care.

Complicating Factors:

- ❑ Poor tissue healing such as : pernicious anemia, diabetes, thyroid disease

  Other:_____
- ❑ Anatomical deficit such as: asymmetrical facets, djd, spinal stenosis, spondylolisthesis, congenital or acquired joint anomaly, 3rd trimester pregnancy, >100 lbs. Overweight
- ❑ Other:_____

Signature Section

Your signature affirms that everything you have submitted on the "Treatment Plan" form is true and correct to the best of your knowledge.