# Acupuncture Treatment Plan Form Instructions

## Field Instructions

### Insured Information

**Date of this Request:** Enter the date on which the Treatment Plan form is completed using the MM/DD/YYYY format.

*Example: January 6, 1999 would be entered as 01/06/1999. This date will be used by eviCore to reference the submitted "Treatment Plan" form 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).

**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 eviCore’s computer system.*

**Insured I.D. or SSN:** The insured or subscriber I.D. (identification) number or SSN (social security number) 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

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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 or Plan # or Union Local: Enter the group number, plan number or union local number as obtained directly from the patient’s insurance card. Be certain to submit a copy of the patient’s insurance card with the Treatment Plan form to avoid any delays in determining benefit eligibility.

Injury or Illness is Related to*: Check the appropriate box to describe where or how the patient was injured or became ill.

Other Insurance*: Check the appropriate box to indicate whether the insured may have other insurance that might cover the injury or illness presented.

Other Carrier Name*: If the insured has other insurance that might cover the injury or illness presented, enter the other insurance carrier’s name here.

* This information relates to coordination of benefits. The three questions above help eviCore (and you) determine if eviCore is the correct carrier to bill for the patient’s condition. These questions will help save time in the long run as these issues can delay claims payment.

Acupuncturist Information

Acupuncturist Last Name: Enter last name of the practitioner rendering services to the patient.

Acupuncturist First Name: Enter first name of the practitioner rendering services to the patient.

M.I.: Enter middle initial of the practitioner rendering services to 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.

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

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

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

Zip Code: Enter the zip code where services are being provided to the patient.

Acupuncturist License #: Enter the practitioner’s license number. Please do not use Medicare, Medicaid or other types of practitioner numbers here.

Patient’s Current Medical History

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 visualize a clinical 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 occur approximately 25 percent of the time.

**Interruption:** Symptoms occur approximately 50 percent of the time.

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

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

The subjective complaints should also be discussed in terms of “**PQRST**.” Note that the “O” of **OPQRST** need not be addressed here as it is asked under the “Mechanism of Onset” and “Date of Onset” sections.

**P:** Significant palliative/provocative factors (i.e., worse with prolonged standing, relieved by walking or squatting)

**Q:** Quality of symptoms (i.e., burning, sharp, dull, etc.)

**R:** Radiation or referral of symptoms (i.e., refers to left lateral thigh or no radiation referral)

**S:** Site of symptoms (i.e., left lumbosacral junction)

**T:** Timing of symptoms

Following is an example of using a standard medical abbreviation and 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 (required):**

**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
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approximate date when the condition began, as specifically as possible (i.e., 1963, or March 1990).

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

**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 as this office for this condition:** Enter the date of first treatment in your office for the current condition being treated. Please note that if submitting the Treatment Plan due to a flare-up of a condition, the date of first treatment on the Treatment Plan form refers to the original occurrence of the condition and not the flare-up date, as the condition is still the same one.

**Objective Findings (required):** Provide the date of examination on which the objective findings described were obtained.

**Date obtained:**

**HT:** Enter the patient’s height.

**WT:** Enter the patient’s weight.

**BP:** Enter the patient’s blood pressure as obtained during examination.

**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, joint fixation 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.

**Tongue:** Note any significant findings related to the appearance of the tongue body and tongue coat such as: thin with fissure, red, no coat.

**Pulse Quality:** Note pulse qualities such as: deep, thin and wiry.

**Traditional Diagnosis** Note traditional diagnosis such as: Yin xu with heat.

**Cervical and Lumbar Range of Motion (ROM):**

Left side of box = Cervical ROM

Right side of box = Lumbar ROM

Check “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°, etc.). Percentages of range of motion are not
### Summary of Examination Findings:

1. **Box** 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 bicpital tendinitis. Sacroiliac Compression test is part of the diagnostic criteria for a sacroiliac lesion, etc.

2. **Box** 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 (disc lesion). For instance, if cervical compression produces pain below the elbow, you would check this box. Or if a 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 a nerve inflammation or compression-type syndrome (disc diagnosis).

3. **Box** 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. **Box** 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 or connective tissue (as would be demonstrated by pain on active or resisted motion). Bursitis, capsulitis, arthritis or facet syndrome would be validated by this finding.

5. **Box** Testing revealed pain, swelling or instability of joint or extremity (list joints): Includes tests such as anterior drawer sign of the knee (Drawer’s test) which identifies excessive motion of the anterior cruciate ligament. This question is used to identify sprains in the extremities. Check this box if the patient presents with pain, swelling and ligamentous instability on passive joint motion or joint stress tests such as Drawer’s test which identifies excessive motion of the anterior cruciate ligament.
6. □ Exam reveals wheezing, shortness of breath and diminished vital capacity, no wet or absent sounds: This checkbox identifies asthma and rules out pneumonia. Check this box if auscultation of the chest reveals wheezing but does not reveal wet or absent lung sounds. Measuring vital capacity with a spirometer is a good way to quantify improvement.

7. □ Exam reveals redness in nose and throat with clear nasal discharge, no thick yellow discharge: This checkbox identifies nasal allergy as opposed to sinus infection.

Patient Information

Completion of this section allows eviCore to demonstrate to the medical directors of the health plans with whom we do business that we are doing everything we can to identify patients who may need continuing care from their PCP or medical specialist.

The initial question assumes a practitioner has used a Patient Information Form with the patient to obtain specific diagnostic information that possibly may contraindicate care. We recommend you use the eviCore form because the questions on our form identify the most common signs and symptoms of cancer, heart disease, neurological or immune dysfunction. Use of a Patient Information Form could protect you legally by asking the patient to check any conditions, that could contraindicate care.

Does the Patient Information Form have any checked conditions?

□ Yes □ No (answer is required)

The remaining questions list common conditions which could contraindicate care, or require referral or, at a minimum, indicate the need for concurrent care with the patient’s primary care physician:

- History of infection (recent fever >100 degrees, constant low-grade fever, bone or joint infection, etc.
- Autoimmune diseases
- Circulatory or cardiovascular disorders (e.g., stroke)
- Bone weakening or destructive disorders (e.g., tumors)
- Atrophy in the extremities
- Abnormal deep tendon reflexes or motor weakness
- Pathological reflexes
- Abnormal bowel or bladder function
- Blood pressure greater than 145 systolic or 95 diastolic
- Signs or symptoms of cancer
- Signs or symptoms of organic disease
- For any of the checked items, please attach an explanation.

□ Patient is currently under □ PCP or medical specialist care: or □ referred on ____/____/____: The selection of this box enables eviCore to know that the patient is or will be under continuing care. The case manager will delay authorization if they have a concern that the patient needs to be receiving continuing care and you have not indicated that continuing care is already in place.

Diagnoses
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ICD Code

Enter the appropriate ICD Code(s) in order from the most important diagnosis, in terms of causation of the patient’s condition, to the least important. Refer to your payor pages for the correct diagnosis.

- External cause codes or “E” 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 Code(s) 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 be supported by the mechanism of onset, subjective complaints and objective findings. It is also important that the diagnosis provide the most accurate reflection possible of the practitioner’s clinical opinion as to the causation of the patient’s condition.

For example, a patient presents complaining of neck pain. If you did not perform an examination of the patient and only inserted needles in the areas of pain, you might submit a diagnosis of cervicalgia (723.1). This diagnosis code does not indicate why the patient has neck pain. As a result, the acupuncture case manager will assume that the pain is muscular in origin, and will resolve quickly. If the history reveals the patient has neck pain as a result of an auto accident that violently jerked the patient’s neck, resulting in splinting spasm, difficulty in holding the head upright and severely restricted range of motion, a more appropriate diagnosis would be cervical sprain/strain (847.0). History of onset suggests that muscle and connective tissue was stretched and torn (sprain) and the muscles are in a protective spasm (strain). Pain is understood to be present but it is not the diagnosis. With this history and diagnosis, the acupuncture case manager will assume that more extensive treatment is needed to allow the time required for healing connective tissue.

As another example, suppose you perform an examination and find that the patient has pain and tingling radiating into the right arm when downward pressure is applied to the head. This indicates a cervical disc injury, a more serious condition that will not only be more complex to treat, but may also require MRI or referral to an orthopedist. In other words, the patient’s complaint, history of onset and examination findings should all paint a consistent picture. Your acupuncture case manager needs to see that picture through your Treatment Plan and reported diagnosis.

Pain Intensity Section

The section on pain intensity of symptoms is required for two reasons;

1. It enables eviCore case managers to quantify the improvement of the patient over time, and
2. It gives eviCore the data to demonstrate to health plans and employers that we are providing a valuable service to the insured.
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**Pain intensity according to patient:**
0 = None, 10 = Severe

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

Diagnosis 1. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Diagnosis 2. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Diagnosis 3. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Diagnosis 4. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

**Symptom frequency according patient:**
0-25%  26-50%  51-75%  76-100%

<table>
<thead>
<tr>
<th>0-25%</th>
<th>26-50%</th>
<th>51-75%</th>
<th>76-100%</th>
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Diagnosis 1. [ ] [ ] [ ] [ ]
Diagnosis 2. [ ] [ ] [ ] [ ]
Diagnosis 3. [ ] [ ] [ ] [ ]
Diagnosis 4. [ ] [ ] [ ] [ ]

**Herbal Therapy**

**Proposed Herbal Therapy**
Some plans do not cover herbal therapy; however, eviCore still requires basic information about herbal therapies if you are using these remedies.

The information requested on the herbal section of the Treatment Plan informs the case manager as to your proposed herbal treatment and gives information which can help identify possible contraindications for the use of certain herbs with certain conditions and also to identify possible drug-herb interactions.

**Product Code:**
If herbal therapy is not covered by the patient’s health plan, you do not need to provide a product code.

The “Product code” in the lower left corner is where you write in the manufacturer’s product number and the manufacturer’s prefix as listed below (manufacturer’s prefix is displayed in parenthesis):

- Brion Corporation (BR), Crane (CR), Golden Flower (GF), Health Concerns (HC), Institute of Traditional Medicines (IT), K’an (KA)
- KPC (KP), Lotus (LO), McZand (MZ), Min Tong (MT), May Way (MW), Planetary Formulas (PF), QualiHerb (QH)

**Current Medications:**
Enter the name of any current medication the patient is taking.

**Possible Herbal Therapy Contraindications:**
Please disclose if the patient has any possible contraindications to herbal therapy:

- [ ] Pregnant
- [ ] Nursing
- [ ] Hypertension
- [ ] Heart disease
- [ ] Diabetes
- [ ] Nerve/seizure disorder
- [ ] Kidney dialysis
- [ ] NONE
## Treatment Plan

### Treatment Schedule (Dates) (required):

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

- eviCore uses dates because the claims payment area in eviCore is designed to only pay claims, that fall within the authorized time period.
- Enter the requested beginning and end dates for the authorization period in an MM/DD/YYYY format.
- **Remember, eviCore does not pay for maintenance or preventative care.**

### 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 acupuncture care).

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

The case managers have expectations based on clinical guidelines and personal practice experience as to how long a condition should take to resolve. For example, 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, eviCore 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 can become 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 Treatment Modalities:

Case management uses this section to see what your treatment methodology and goals are. In the future, we may conduct research to see if one technique has better outcomes with certain conditions.

As to the treatment goals, committing to quantifiable goals and an anticipated date of completion allows the case manager to evaluate whether goals have been met or additional treatment is required.

**Proposed Treatment Modalities:**

- Acupuncture
- Electroacupuncture
- Moxa
- Cupping
- Other ______
Comments/Goal of Tx:  Reduce Pain  _____ %  
Improve ROM  _____ %  
Other  ______

Anticipated release date: _____________

Complicating Factors: (check and circle any that apply)

Poor tissue healing such as: anemia, peripheral neuropathy, diabetes, thyroid disease, long term steroid use, chemotherapy.

Other ______

Anatomical deficit such as: congenital or acquired joint anomaly, severe scoliosis, >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.