# How to complete a Treatment Plan Form

<table>
<thead>
<tr>
<th>Field</th>
<th>Instructions</th>
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<tbody>
<tr>
<td><strong>Insured Information</strong></td>
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<tr>
<td>Date of this Request:</td>
<td>Enter the date on which the Treatment Plan form is completed using the MM/DD/YYYY format.</td>
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<td>Example: January 6, 1999 would be entered as 01/06/1999. This date will be used by eviCore to reference the submitted Treatment Plan when communicating the Utilization Review decision to you.</td>
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<td>Enter the type of care by checking the appropriate box for:</td>
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<tr>
<td>• Initial care (patient has been treatment free for the past 60 days), or</td>
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<td>• Continuing care (patient has presented with a new condition or there is continuing care for the same condition.</td>
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<tr>
<td>Patient Last Name:</td>
<td>Enter the last name of the patient.</td>
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<tr>
<td>Patient First Name:</td>
<td>Enter the first name of the patient.</td>
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<tr>
<td>Patient M.I.:</td>
<td>Enter the middle initial of the patient.</td>
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<tr>
<td>Gender:</td>
<td>Check the box for “M” or “F” to indicate the gender of the patient.</td>
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<tr>
<td>Age:</td>
<td>Enter the patient’s current age.</td>
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<td>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.</td>
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<tr>
<td>Date of Birth:</td>
<td>Enter the patient’s date of birth in the MM/DD/YYYY format.</td>
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<tr>
<td>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.</td>
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<tr>
<td>Insured I.D. or SSN:</td>
<td>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.</td>
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<tr>
<td>Insured Last Name:</td>
<td>Enter the last name of the insured.</td>
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<tr>
<td>M.I.:</td>
<td>Enter the middle initial of the insured.</td>
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<tr>
<td>First Name:</td>
<td>Enter the first name of the insured.</td>
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<tr>
<td>Patient Phone:</td>
<td>Enter the area code and phone number of the patient.</td>
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<tr>
<td>Patient Address:</td>
<td>Enter the street address of the patient.</td>
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<tr>
<td>City:</td>
<td>Enter the name of the city in which the patient resides.</td>
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<tr>
<td>State:</td>
<td>Enter the state in which the patient resides.</td>
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</tbody>
</table>
**Chiropractic Treatment Plan Form Instructions**

**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. Be certain to submit a copy of the patient’s insurance card with the PTR 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:** If the insured has other insurance that might cover the injury or illness presented, enter the other insurance carrier’s name here.

* This new information relates to the 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.

### Doctor Information

**Doctor Last Name:** Enter the last name of the practitioner who is rendering the services to the patient.

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

**Doctor M.I.:** Enter the middle initial of the practitioner rendering the 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.

**Doctor 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.

**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.

**Subjective Complaints**  
*(required field)*

A description of the subjective complaints for which the patient is presenting, or that the doctor 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.

The subjective complaints should also be discussed in terms of “**PQRST.**” Note that the “O” of **PQRST** 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 standard medical abbreviation and a subjective complaint description that covers all areas described above:

“occ., slt., dull lt. 1/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 (i.e., 1963, or March 1990).

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
- Old trauma

**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 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)**

**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 blood pressure as obtained (when applicable) during examination. If blood pressure is not taken, indicate by entering “not performed.”

Situations in which taking the blood pressure is recommended include the following:

- History of hypertension
- History of cardiovascular accident (CVA)
- History of dizziness or headaches
- History of cardiovascular disease or other vascular diseases
- History of smoking
- History of oral birth control pills
- Family history of hypertension, CVA, or cardiovascular disease
- Age 65 or over
• African-American descent
• Obese patients
• Patients in whom high velocity cervical manipulation is proposed

**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.

**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 allowed.

Next to the ranges of motion circle “A” or “P,” as applicable indicating that symptomatology occurred (“P” = present) with the particular range of motion performed or that symptomatology was not present (“A” = absent) with the particular range of motion performed.

**Summary of Examination Findings:**

Please provide a summary of your examination findings. This information should validate the diagnosis code. If eviCore 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 Lasègue’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 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 that you have asked the patient to
complete the eviCore healthcare “Patient Information” form, or you
have used a similar form to gather a complete medical history. We
recommend that you use the eviCore form because the questions on
that form identify the most common signs and symptoms of cancer,
heart disease, neurological or immune dysfunction. The following
listing includes common conditions that could contraindicate care.
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

Continuing Care:
The selection of the continuing care 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 in place.

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

Diagnoses

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.

- 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 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).

**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.

**Pain intensity according to patient:**

0 = None, 10=Severe

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<td>Diagnosis 1.</td>
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<td>Diagnosis 2.</td>
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<td>Diagnosis 3.</td>
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<td>Diagnosis 4.</td>
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**Symptom frequency according patient:**

0-25%  26-50%  51-75%  76-100%

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**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 diseases, etc.
Chiropractic Treatment Plan Form Instructions

**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:*

**Blank area:**

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.

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**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 chiropractic care).

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

eviCore 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, 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 becomes dependent on the
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 eviCore 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.

**Please feel free to submit any and all additional information not included on the Treatment Plan form that you feel is necessary to support the services you are requesting.**

eviCore has added this statement to the bottom of the Treatment Plan Form to remind practitioners to send in all pertinent information with their request. At times, there may not be enough room on the Treatment Plan Form to list all pertinent information required to support the number of treatments, types of services, or the time period being requested. If you have additional information you feel would help to substantiate the services you are requesting, you should submit it with your Treatment Plan Form. This information may include, but not limited to, patient intake forms, patient history and/or examination forms, interim history and/or exam forms, laboratory results, diagnostic tests (x-rays, MRI, CT scans, etc.), physician reports, narratives, progress notes/reports, etc.