How to Complete the X-ray Authorization Request Form

The instructions below will walk you through the X-ray Authorization Request Form. Sections of the form are indicated by CAPITAL LETTERS, specific fields are indicated by bold type with relevant instructions or tips following each field.

INSURED INFORMATION

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

Example: May 1, 2007 would be entered as 05/01/2007. This date will be used by eviCore to reference the X-Ray Authorization you requested when we communicate 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, First Name & M.I.: Enter the last name, first name & 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.

Date of Birth: Enter the patient’s date of birth in the MM/DD/YYYY format.

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, M.I. and First Name: Enter the last name, middle initial and 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, State & Zip: Enter the name of the city, state and zip code in which the patient resides.

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 X-ray Authorization 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.
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DOCTOR INFORMATION

Doctor Last Name, First Name & M.I.: Enter the last name, first name and middle initial of the practitioner who is 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, State, Zip: Enter the name of the city, state and zip code where services are being provided.

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

Use standard medical abbreviations to save time and space when 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 presenting complaints) should be described here. Describe the subjective complaints so that the Case Managers are able to create a picture in their mind of the member’s condition.

Describe the severity of the patient’s subjective complaints (symptoms) in terms of the following definitions of minimal, slight, moderate, or severe, as described below:

- **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, as described below:

- **Occasional:** Symptoms that occur up to 25 percent of the time.
- **Intermittent:** Symptoms that occur up to 50 percent of the time.
- **Frequent:** Symptoms that occur up to 75 percent of the time.
- **Constant:** Symptoms that occur up to 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
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The following example uses 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.”

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
- 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.

Doctor’s Objective Examination Findings: If the patient's complaints and objective findings relate to a body area other than cervical and/or lumbar, please attach a separate sheet or submit a copy of your actual history and examination form along with the X-ray Authorization Request form. If the patient is 21 years of age or under and scoliosis is suspected, please also fill out and submit a Scoliosis Evaluation Form.

Cervical and Lumbar Ranges of Motion (ROM):

Left side of box = Cervical ROM
Right side of box = Lumbar ROM

Check “WNL” for cervical and/or lumbar ranges 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.). Do not use “percentages” of ranges of motion.

Will radiographs be exposed in your office?

Check ☐ “Yes” if you are going to take the x-rays yourself.
Check ☐ “No” if you are referring the patient to another facility. If you checked “No,” list the Facility Name, Address, Telephone Number, Fax Number, and Tax I.D. Number (if known).

Previous Medical Imaging

Check ☐ “Yes” if the patient has had prior medical imaging of any kind (e.g., X-rays, MRI, CT Scan, Ultrasound, etc.).
Check ☐ “No” if the patient has not had prior medical imaging.
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If you checked “Yes,” list the date(s) that the imaging was performed, the views, and/or procedures (e.g., MRI, CT Scan, X-rays, etc.).

Include a brief summary of the findings and/or a radiology report if available. List any other relevant information under “Additional Comments.”

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 many tests used to identify localized joint pain associated with the reported complaint. For instance, pain reproduced on active and resisted cervical range of motion confirms a cervical strain diagnosis. A positive Speed’s test confirms bicipital tendonitis. Reproduction of pain on Sacroiliac Compression 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 knee, you would check this box. If Valsalva’s test (compression) produces pain below the elbow, you would check this box. Checking this box validates nerve inflammation or compression-type syndromes.

3. Neurological tests within normal limits: A neurological examination should always be performed when appropriate and include testing of pertinent sensory and motor 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. NOTE: If all the nerves tested are WNL, it would NOT be possible to have a nerve-related diagnosis.

4. 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 that would not be expected to respond to chiropractic care such as loss of reflexes in a post-polio patient, or (3) indicative of a condition which requires medical consultation such as positive cranial nerve findings.

DIAGNOSIS

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.
- Do not use 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: Again, list the patient’s diagnosis descriptors that correspond 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 provides 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
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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

<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>
Primary diagnosis (1) | | | | | | | | | | |
Secondary diagnosis (2) | | | | | | | | | | |
Additional diagnosis (3) | | | | | | | | | | |
Additional diagnosis (4) | | | | | | | | | | |

Symptom frequency according patient: Symptom frequency according patient: Five boxes (in 5% increments) are listed under each percentile range to provide a more accurate measurement of the patient’s symptom frequency.

<table>
<thead>
<tr>
<th>0-25%</th>
<th>26-50%</th>
<th>51-75%</th>
<th>76-100%</th>
</tr>
</thead>
</table>
Primary diagnosis (1) | | | | |
Secondary diagnosis (2) | | | | |
Additional diagnosis (3) | | | | |
Additional diagnosis (4) | | | | |

X-RAY INFORMATION

X-rays Requested: Checkboxes have been provided for your convenience. Check “Yes” if the x-rays have already been taken (retrospective request). Check “No” if the x-rays have not been taken yet and you are awaiting authorization.

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

List Applicable eviCore Radiographic Criteria:

Number: List the number or numbers (1-19) of the Radiographic Exam Criteria and Key Considerations listed on pages 8 and 9 of the Radiology Handbook located in the Practitioner Manual. If you do not have a Practitioner Manual or Radiology Handbook, contact eviCore’s Customer Service Department at (800) 638-04557 to request a copy.

Example:
Number: 1, 2, and 7

Description: Rule out fracture from slip-and-fall 3 days ago, patient age, & significant history of osteoporosis and chronic alcohol abuse.

SIGNATURE SECTION

Your signature affirms that everything you have submitted on the “X-Ray Authorization Request Form” is true and correct to the best of your knowledge. Sign, date, and submit the form.