



# Musculoskeletal Program: Massage Therapy Clinical Worksheet

These worksheets are used to collect the information needed for treatment request determinations. The determinations are made in accordance with the eviCore Massage Therapy Services Clinical Guidelines found at [evicore.com](http://evicore.com)

Please use this fax form for NON-URGENT requests only. Failure to provide all relevant information may delay the determination. Phone and fax numbers may be found on [evicore.com](http://evicore.com) under the Guidelines and Forms section. You may also log into the provider portal located on the site to submit an authorization request.

**URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE**

<b>Previous Reference/Auth Number (If Continued Care):</b>	<b>Date of Submission:</b>
<b>Place of Service:</b>	

<b>PATIENT</b>	First Name:	MI:	Last Name:
	Member ID:	DOB (mm/dd/yyyy):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Street Address:	Apt #:	
	City:	State:	Zip:
	Home Phone:	Cell Phone:	Primary: <input type="checkbox"/> Home <input type="checkbox"/> Cell
	Member Health Plan/Insurer:		

<b>PROVIDER</b>	First Name:	Last Name:	
	Primary Specialty:	TIN:	NPI:
	Physician Phone:	Physician Fax:	
	Address:	Suite #:	
	City:	State:	Zip:
	Office Contact:	Ext:	Email:

<b>Diagnoses:</b>			
Code	Description	Code	Description

<b>Start Date for this Request:</b>	
Has the patient been evaluated by their medical doctor for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please provide the most recent date of the medical doctor's evaluation: _____
Medical Doctor's Diagnosis: _____	

<b>ADMINISTRATIVE</b>	<b>Primary Treatment Area/Condition: Choose only one.</b>			
	<i>Musculoskeletal:</i>	<input type="checkbox"/> Headache / Migraine	<input type="checkbox"/> Cervical / Upper Thoracic	<input type="checkbox"/> Lower Thoracic / Lumbosacral
		<input type="checkbox"/> Shoulder / Arm	<input type="checkbox"/> Elbow / Forearm	<input type="checkbox"/> Hand / Wrist
		<input type="checkbox"/> Hip / Thigh	<input type="checkbox"/> Knee	<input type="checkbox"/> Ankle / Foot / Leg
	<i>Non-Musculoskeletal:</i>	<input type="checkbox"/> Cancer Pain	<input type="checkbox"/> Fibromyalgia	
		<input type="checkbox"/> Other		

<b>ADMINISTRATIVE</b>	<b>Secondary Treatment Area/Condition: Choose only one.</b>			<input type="checkbox"/> No second area being treated
	<i>Musculoskeletal:</i>	<input type="checkbox"/> Headache / Migraine	<input type="checkbox"/> Cervical / Upper Thoracic	<input type="checkbox"/> Lower Thoracic / Lumbosacral
		<input type="checkbox"/> Shoulder / Arm	<input type="checkbox"/> Elbow / Forearm	<input type="checkbox"/> Hand / Wrist
		<input type="checkbox"/> Hip / Thigh	<input type="checkbox"/> Knee	<input type="checkbox"/> Ankle / Foot / Leg
	<i>Non-Musculoskeletal:</i>	<input type="checkbox"/> Cancer Pain	<input type="checkbox"/> Fibromyalgia	
		<input type="checkbox"/> Other		

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Member Name:	Member ID:	Provider Name:
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Date of initial evaluation:	Date of current findings:
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Please **ONLY** complete the following section(s) based upon the Treatment Area/Conditions(s) selected above. Information specific to the Primary Treatment Area **MUST** be completed.

OUTCOME ASSESSMENT: MUSCULOSKELETAL		
Complete the following section for initial or follow-up care as appropriate		
Indicate which patient reported outcome score was used from the selection below. If not done, select "None Used": <input type="checkbox"/>		
None Used		
	Initial	Follow-Up
<input type="checkbox"/> Headache Disability Index (HDI)	_____ (0-100 score)	Current: _____ Initial: _____
<input type="checkbox"/> Neck Disability Index (NDI)	_____ % (0-100 score)	Current: _____ % Initial: _____ %
<input type="checkbox"/> Oswestry Disability Index (ODI)	_____ % (0-100 score)	Current: _____ % Initial: _____ %
<input type="checkbox"/> Roland Morris Disability Questionnaire (RMDQ)	_____ (0-24 score)	Current: _____ Initial: _____
<input type="checkbox"/> Disabilities of Arm, Shoulder, and Hand (DASH/QuickDASH) More than 3 blank answers?	_____ (0-100 score) <input type="checkbox"/> Yes <input type="checkbox"/> No	Current: _____ Initial: _____
<input type="checkbox"/> Shoulder Pain and Disability Index (SPADI)	_____ (0-100 score)	Current: _____ Initial: _____
<input type="checkbox"/> Lower Extremity Functional Scale (LEFS)	_____ (0-80 score)	Current: _____ Initial: _____
<input type="checkbox"/> Hip Disability and Osteoarthritis Outcome Score (HOOS Jr)	_____ (0-100 score)	Current: _____ Initial: _____
<input type="checkbox"/> Knee Disability and Osteoarthritis Outcome Score (KOOS Jr)	_____ (0-100 score)	Current: _____ Initial: _____
<input type="checkbox"/> Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC)	_____ (0-96 score)	Current: _____ Initial: _____
<input type="checkbox"/> Numeric Rating Scale (NRS)	_____ (0-10 score)	Current: _____ Initial: _____

OUTCOME ASSESSMENT: NON-MUSCULOSKELETAL		
Complete the following section for initial or follow-up care as appropriate		
Indicate which patient reported outcome score was used from the selection below. If not done, select "None Used": <input type="checkbox"/>		
None Used		
	Initial	Follow-Up
<input type="checkbox"/> Fibromyalgia Impact Questionnaire (FIQ)	_____ (0-100 score)	Current: _____ Initial: _____
<input type="checkbox"/> Numeric Rating Scale (NRS)	_____ (0-10 score)	Current: _____ Initial: _____
<input type="checkbox"/> Quality of Life Questionnaire Core 30 (QLQ-C30)	_____ (30-126 score)	Current: _____ Initial: _____
<input type="checkbox"/> Quality of Life Scale (QOLS)	_____ (16-112 score)	Current: _____ Initial: _____

RESPONSE TO CARE		
	Initial	Follow-Up
This care is expected to result in progressive improvement as described in the eviCore Massage Therapy Clinical Guidelines. Please mark if progress has been affected by the following:	N/A – Leave Blank for Initial Request	<input type="checkbox"/> N/A – Progress is not affected by any of the below listed options <input type="checkbox"/> "Overdid it" causing increase in symptoms <input type="checkbox"/> Symptoms progressed despite treatment <input type="checkbox"/> Suffered a new injury resulting in significant change <input type="checkbox"/> Unable to complete clinical visits <input type="checkbox"/> Current care is maintenance, preventive, or palliative in nature