



## Physical Therapy UM Category C Treatment Authorization Guide

### Introduction: Physical Therapy Utilization Management Program

The Physical Therapy Utilization Management (UM) program has two primary objectives. First is to bring transparency and accountability to the practice patterns of network practitioners by comparing utilization patterns to regional and national norms. Second is to reward practitioners that demonstrate superior practice patterns with clinical autonomy. Active management is limited to practitioners whose utilization patterns deviate significantly from their regional peer group. To achieve these objectives the physical therapy network has been stratified into three tiers identified as Categories A, B and C.

The information below represents a summary of UM requirements associated with each UM Category:

#### UM Category A

- A Treatment Plan is not required.
- Patient self-reported Outcomes Assessment surveys are voluntary.

#### UM Category B

- The Waiver Program allows you to treat patients up to six (6) visits per calendar year without the submission of a Treatment Plan.
- A Treatment Plan is required for treatment that exceeds the Waiver Program.
- Patient self-reported Outcomes Assessment surveys are voluntary.

#### UM Category C

- A Treatment Plan is required after the first visit.
- A patient self-reported Outcomes Assessment survey is required with each Treatment Plan.

### Outcomes Assessments (Required)

Patient-driven outcomes assessment measures are vital components of quality clinical management. These patient self-reporting tools provide a valid, reliable and quantifiable measurement of a patient's clinical improvement over time, the effectiveness of treatment, and necessity of continued care.

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### Submitting the PSFS Outcomes Assessment

The Patient Specific Functional Scale (PSFS) outcomes assessment is *required* for your UM Category. The initial PSFS should be completed prior to the start of care. Record the patient's limited functional activities (minimum of three) and scores exactly as stated by the patient. This first assessment will serve to document the patient's baseline symptoms and/or functional limitations. Sign and date the form and send the completed initial PSFS to Landmark.

Each time you request authorization for ongoing treatment, send an updated PSFS with your Treatment Plan. Submit up-to-date scores to the same functional activities listed on the initial PSFS. For more information on the use of the PSFS, please refer to the PSFS Submission Guide on Landmark Connect.

#### Note

If you submit Treatment Plans electronically, you may include the PSFS by completing the "Outcomes Assessment" section of the Treatment Plan e-Form. All assessments are to be completed and signed by the clinician. If you submit the PSFS electronically, keep the signed hardcopy in the patient's file.

If you fax your Treatment Plans, include the PSFS with your fax.

Failure to submit required Outcome Assessments represents a lack of compliance with the UM Program. Repeated non-compliance with the UM Program is considered a breach of the Network Provider Agreement and results in disciplinary action and/or disaffiliation.

### Submitting the Initial Treatment Plan Form

The referring physician must obtain an initial authorization for physical therapy services with Blue Care Network. Approved referrals authorize the initial evaluation and one (1) treatment visit. You are required to submit Landmark's Treatment Plan form to request authorization for covered services beyond the initial evaluation and first treatment. To request authorization, report your clinical findings from the evaluation in the appropriate sections of the Treatment Plan form. **Begin your requested treatment plan with the date of the initial visit.**

You are also required to submit the Patient-Specific Functional Scale (PSFS) with every Treatment Plan. The first PSFS outcomes assessment survey should be completed prior to commencing treatment. See the Outcomes Assessment section for more information. We strongly encourage you to submit the Treatment Plan and PSFS within two (2) business days of the first visit. Prompt submission will assist in the timely evaluation of your request and notification of the review determination.

We accept Treatment Plan and PSFS forms submitted on-line, by fax, or by mail. If your forms are received before 5:00 PM in your time zone, they are considered received on the same day as you transmitted them to us. If your forms are received after 5:00 PM in your time zone, they are considered received on the next business day. Mailed forms could result in a delayed determination due to postal delivery times.

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These same procedures apply when physicians refer patients back to you for a new condition. For each episode of care, submit a new Treatment Plan form with updated clinical findings within two (2) business days.

### Required Fields on the Treatment Plan Request

Clear and complete Treatment Plans will speed the processing of your authorization requests. Please be sure the following information is complete on your Treatment Plan before you submit it:

- Patient name
- Patient date of birth (must be included in addition to patient's age)
- Patient health plan ID number
- Name of health plan/insurance carrier
- Provider name and Tax Identification Number
- Dates, including:
  - Date of submission
  - Date of first treatment/visit
  - Date objective findings were obtained
  - Date of onset of the patient's condition
  - Diagnosis codes (specific ICD-9 codes and diagnosis descriptions)
  - Proposed Treatment Plan schedule - including "From" and "To" dates
- Number of visits anticipated

### Key Elements for Clinical Review of Treatment Plans

When a Treatment Plan is received, we will validate the presence of an initial authorization for the therapy services with Blue Care Network and review the case for medical necessity and/or clinical appropriateness. Clinical review decisions are based on key data provided with the Treatment Plan. It should be noted that uncomplicated cases requiring fewer visits do not require as detailed clinical information as complicated cases requiring more visits. Critical data impacting the review determination made by the clinical peer reviewers include:

- Age
- Mechanism of onset
- Date of onset
- Subjective complaints

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- Pain intensity levels
- Symptom frequency levels
- Objective findings (such as, orthopedic, neurologic, range of motion information)
- Co-morbidity issues (medical complications)
- Complicating factors
- Functional limitations
- Clinical diagnosis(es)
- Proposed plan of treatment
- Treatment goals

The clinical peer reviewers use the submitted clinical information in conjunction with our proprietary Clinical Practice Guidelines to decide the number of visits to authorize for each request. These Clinical Practice Guidelines are available to you through our secure provider portal at [www.LandmarkHealthcare.com](http://www.LandmarkHealthcare.com).

Treatment Plans that present a clear clinical picture (e.g., subjective complaints are validated by the objective findings), and that are accompanied by a consistent diagnosis better support the necessity for the requested treatment frequency.

Treatment is typically authorized in thirty (30) day increments, not to exceed the patient's benefit limit for the episode. Authorization in these timeframes allows the clinical peer reviewers to assess the patient's response to treatment. If additional care is required beyond the initial thirty (30) day Treatment Plan authorization, you must submit a new Treatment Plan for ongoing or concurrent care.

### **Concurrent (Ongoing) Treatment Requests**

When additional care is required after the expiration of an authorized Treatment Plan, a new Treatment Plan and PSFS reflecting the patient's current status and treatment goals are required. Please note that in order to establish the need for ongoing care, the patient record must document significant lasting benefit from previous treatment.

If you know that a patient will require ongoing treatment, we suggest that you submit the new request a few days to one week prior to the expiration date of the existing authorization.

To assist with the review, you may include a copy of all progress notes for treatment rendered since your last submission. This documentation allows the clinical peer reviewer to assess your patient's clinical improvement and can provide additional support for ongoing services. If you sent progress notes with a previous request, you only need to send the new progress notes.

## Retrospective Treatment Request

Retrospective authorization requests are those where all requested visits for a member have already occurred. Please note the following policies pertinent to retrospective authorization requests.

- You are required to include a copy of all applicable documents (i.e. Treatment Plan, examination findings, progress notes, Outcomes Assessments) for the services you provided.
- Landmark will provide a review determination within the timeframe required by applicable regulations.
- Landmark will not process retrospective authorization requests as expedited or urgent requests.

## Requests for Additional Information

If we cannot make a decision regarding a request for treatment due to the lack of information on the form, we will send you a "Request for Information" letter. The letter will describe the information required, and the length of time you have to submit it. If we do not receive the requested information within the designated time period, your authorization request may be denied. If you receive a denial, you will be provided with instructions on how to appeal the decision.

When you submit information, **attach a copy of the "Request for Information" letter** you received. If a copy of the letter is not attached, be sure that you note the following on your documentation to avoid processing delays:

- Case Reference Number
- Patient name
- Patient date of birth
- Patient ID number
- Practitioner name and Tax Identification Number
- Corrected Treatment Plan form, if applicable

### Note

If you resubmit a corrected Treatment Plan authorization request for any reason, be sure to write the word "CORRECTED" or "RESUBMITTED" across the top. And, if applicable, write the case Reference Number on the form.

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### **Notification of Review Determinations**

We will provide you with written notifications of clinical review determinations via a faxed letter. We will notify members by a separate mailed letter.

When we approve your request for authorization in its entirety, we will send you a notification letter identifying the number of visits and treatment period approved. The letter will also include information on how to submit a new Treatment Plan should additional care be necessary.

When the number of visits and/or services requested on a Treatment Plan is modified or denied, written notification will include the following:

- Number of visits approved and the treatment period during which such visits may be used.
- Clinical reasons for the decision.
- Instructions for requesting a copy of the Clinical Practice Guideline used in a decision.
- Instructions for contacting the clinical peer reviewer to discuss a modification or denial.
- Instructions for appealing a determination, including your right to submit additional information.
- Time limits for submitting an appeal request.

If the number of visits you requested is modified, and you agree with the clinical rationale, provide treatment up to the number of visits authorized. If you determine that the patient will require additional care beyond the treatment period authorized, submit a new Treatment Plan about one week prior to the expiration date. Refer to the Concurrent (Ongoing) Treatment Requests section for more information.

### **Authorization Request Follow-Up Process**

We will process authorization requests as dictated by applicable state and federal regulatory requirements. To check the status of your requests, login to Landmark Connect at [www.LandmarkHealthcare.com](http://www.LandmarkHealthcare.com) or call our Customer Service Department.

### **Duplicate Treatment Plan Authorization Request Forms**

Please do not resubmit your Treatment Plan unless you have verified that we did not receive your original submission. Submission of duplicate forms will create delays in processing.

### **Date Extensions of Existing Authorizations**

To extend the expiration date of an existing authorization, submit a request for a date extension. An extension may be necessary due to unforeseen delays, such as your patient's inability to attend all scheduled visits. If approved, date extensions will not exceed the benefit period for the patient's episode.

### To Submit a Date Extension Request

- Submit a Date Extension Request form on-line by logging on to Landmark Connect.
- Or, fax a Date Extension Request form. Remember to include the original start date and the new end date with your submission, along with your reason for the request.

### Complete Medical Records

Patient documentation serves as a permanent record that supports the treatment provided to your patients and allows for the reimbursement of that treatment. Good record keeping becomes especially important when establishing the medical necessity of the services you provide. Complete medical records include the following important elements:

- Must be legible with standard abbreviations, or a key to the unique abbreviations used.
- Patient name and/or identification number must be present on each page of the file.
- Demographic information, such as date of birth, sex, height, and weight must be present at least once.
- Complete medical history.
- Detailed description of subjective complaints.
- Detailed description of your objective examination findings.
- Description of any diagnostic testing, and the resultant findings.
- Working diagnosis or set of diagnoses.
- Treatment plan, including goals of treatment, frequency/number of visits, types of services planned, and expected time frame for improvement and discharge from care.
- If necessary, your referral of the patient to another practitioner and the clinical rationale for this decision.

### Clinical Practice Guidelines

The Clinical Practice Guidelines provide clinical decision support tools necessary for clinical peer reviewers to render medical necessity review determinations. The Clinical Practice Guidelines have been developed systematically, and are based on current peer-reviewed scientific evidence, consensus peer evaluation, and generally recognized professional standards. Development involves input and direction from applicably licensed practitioners with current knowledge and experience in the clinical principles and standards of care under review. This includes clinical peer reviewers, clinical/medical directors, practitioner advisory committee members, and/or outside content experts.

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The Clinical Practice Guidelines used for making authorization and review determinations are reviewed annually by a peer-review committee of participating practitioners. The review criteria are subject to further review by multi-disciplinary Utilization Management and Quality Improvement Steering Committees.

All services provided by practitioners must be delivered in accordance with the professionally recognized standards of care and practice, as reflected in the Clinical Practice Guidelines. Clinical criteria are used to establish medical necessity and to determine services covered and reimbursable under a member's benefit plan. We recognize that some practitioners provide services that are within their scope of practice, but do not meet the care parameters defined in the clinical criteria, or a member's benefit plan. We acknowledge that our Clinical Practice Guidelines are a subset of the professional practices provided within the practitioner community.

### **Access to Clinical Peer Reviewers**

Landmark uses licensed physical therapists and medical physicians to render review determinations. You may request a peer-to-peer discussion about Treatment Plan denial or modification determinations. Within one (1) business day of the request, a clinical peer reviewer will be available to you. To request such a peer-to-peer discussion, please call Customer Service. A representative will help connect you with a clinical peer reviewer.

### **Appropriate Utilization**

Through case management, the clinical department oversees and monitors patient care, ensuring that each patient receives effective, quality care resulting in a positive outcome. Accordingly, the clinical department affirms that:

- Clinical peer reviewers render authorization decisions based on the appropriateness of care and services.
- Clinical peer reviewers are not compensated in any way for denying, limiting, or modifying care.
- No incentive is provided to the clinical peer reviewers or consulting committee members to encourage modification or denial of requested care.

Review decisions and determinations are not arbitrary. All information submitted on a Treatment Plan authorization request, or other means of clinical documentation, is reviewed. Decisions are based on established Clinical Practice Guidelines, scientific evidence, and research literature.



## **Physical Therapy Provider FAQs**

### **Which BCN groups does Landmark manage?**

Landmark's utilization management services apply to:

- Commercial plans
- BCNA
- Premier Care
- Grad Care

Follow existing procedures for other BCN groups.

### **What is a "Patient Episode?"**

A Patient Episode of care refers to treatment rendered to a member, for a given condition, within a reporting period. Members that receive treatment for distinctly different conditions (i.e., shoulder and lumbar) within a reporting period are considered to have experienced two Patient Episodes of care. Patient Episodes are used to measure a practitioner's patient volume. The Mean Risk-Adjusted Visits per Episode of care is the primary metric used to assign UM Categories.

### **What is the "Peer Average?"**

The Peer Average is calculated based on data gathered from Blue Care Network's entire practitioner panel. The Peer Average allows providers to compare their practice patterns to the network peer standard.

### **How many other UM Categories are there and how do they differ?**

There are three UM Categories (A, B, and C). Each category has different Treatment Plan submission requirements. UM Category A does not have any Treatment Plan submission requirements. UM Category B providers have access to a six visit waiver. These practitioners may treat patients up to six times in a calendar year before they must submit Landmark's Treatment Plan form to request authorization for continued care. Providers in UM Category C have more stringent authorization requirements. UM Category C providers are required to submit Landmark's Treatment Plan form to request authorization for covered services beyond the initial evaluation and first treatment.

### **How do clinical peer reviewers decide on the number of visits they authorize?**

Clinical peer reviewers use the clinical information submitted for review and proprietary Clinical Practice Guidelines to decide the number of visits authorized for each request. Clinical peer reviewers take into account the complexity and severity of a member's condition when rendering a clinical review. As such, severe, complicated cases requesting high numbers of visits require more detailed clinical information to establish medical necessity than mild, uncomplicated conditions requesting few visits. Please see the

## **Physical Therapy Provider FAQs**

Authorization Guide for a detailed description of the authorization process.

### **Will these procedural changes affect my patients' coverage?**

No. Changes in your authorization procedures do not affect patient coverage.

### **When am I required to submit a Treatment Plan authorization request form?**

Services are subject to the Treatment Plan requirements for your UM Category assignment.

For patients you are actively treating during this transition, request authorization beginning with the first visit after any approval granted by BCN expires. For any new patients who present on or after the Landmark UM program effective date:

- Category B providers, submit the Treatment Plan to request authorization beginning with the seventh (7th) visit.
- Category C providers, submit the Treatment Plan to request authorization after the first treatment.

### **If a patient has existing authorizations in the BCN system, do I have to send a new request for services that BCN already authorized beyond the Landmark UM program effective date?**

No. BCN is honoring treatment plans that have already been processed and approved by BCN. For example: You requested authorization on 7/15/08 for 20 visits from 7/17/08 through 9/17/2008, and BCN approved 20 visits from 7/17/08 through 9/17/08.. Continue to utilize the existing approved treatment plan from BCN until that authorization is exhausted.

Follow Landmark's authorization requirements for any unauthorized services falling on or after the Landmark UM program effective date.

### **Where can I obtain Treatment Plan forms?**

Treatment Plan forms are available on Landmark's secure provider portal at [www.LandmarkHealthcare.com](http://www.LandmarkHealthcare.com). You may also submit electronic Treatment Plan "eForms" through Landmark's secure provider portal.

### **Can I call in an authorization?**

Requests for authorization must be either completed on-line via Landmark's secure provider portal or faxed utilizing Landmark's Treatment Plan form to (888) 565-4225.

In cases of an emergency, requests are considered urgent if the standard review process could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or in the opinion of a practitioner with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Contact Landmark for such services at (877) 531-9139.

**How do I submit authorization requests to Landmark for therapy services?**

Submit the Treatment Plan form to Landmark:

- Web      Login to the secure provider portal at  
            www.LandmarkHealthcare.com  
            Click the eForms tab for electronic Treatment Plans
- Fax      (888) 565-4225

**Who do I direct questions to about my authorization request?**

Check the status on-line through Landmark’s secure portal or call Landmark for inquiries about your authorization request at (877) 531-9139. Your approved or denied authorization can also be found in BCN’s on-line system through WebDenis.

**Who do I call to verify Member Benefits?**

Member benefits for therapy can be verified by following the normal BCN process for eligibility of benefits. The BCN options available include:

- Web-DENIS (Dial-in Eligibility Network Information System)
- CAREN (automated telephone system)
- BCN’s Provider Inquiry

**Where do I submit claims?**

There is no change in the claims process. Continue to submit claims directly to BCN.

**Can I include DME supplies on an authorization request to Landmark?**

You may document that a patient requires specialized DME equipment; however, DME supplies will not be authorized by Landmark. **Follow the normal BCN process for all DME.**

**How do I appeal services not approved as medically necessary?**

The review determination letters provided by Landmark include appeal information. Follow the information provided to you in this letter.



## Contact Us

### Landmark Connect

[www.LandmarkHealthcare.com](http://www.LandmarkHealthcare.com)

### E-mail

[info@LMhealthcare.com](mailto:info@LMhealthcare.com)

### Phone

(877) 531-9139

### Fax

(888) 565-4225

### Mail

Landmark Healthcare, Inc.  
1750 Howe Avenue, Suite 300  
Sacramento, CA 95825

### Office Hours

8:30 am to 8:00 pm (Eastern)



## Patient Specific Functional Scale Submission Guide

### Patient Specific Functional Scale (PSFS) Requirements

Patient-driven Outcome Assessments are vital components of quality clinical management. The revised PSFS outcomes tool provides a valid, reliable and quantifiable measurement of a patient's clinical improvement over time, the effectiveness of treatment and the necessity of continued care.

The submission of the PSFS is an optional element for UM Category B providers and a required element for UM Category C practitioners. Failure to submit the PSFS for Category C providers represents a lack of compliance with the Utilization Management (UM) Program. Specific aspects of this requirement are outlined below:

1. The submission of an updated PSFS is required with each submission of a Treatment Plan.
2. All assessments are to be completed and signed by the clinician. When completing the PSFS, you must record the activities and scores exactly as stated by the patient.
3. You must use the version of the PSFS included in this packet (also available on Landmark Connect).
4. A baseline PSFS(s) must be completed prior to the start of treatment. The baseline outcome assessment must be submitted with the first Treatment Plan.
5. A follow-up Outcome Assessment(s) must be completed and submitted with each subsequent Treatment Plan.

### Completing the Initial PSFS

The initial PSFS will serve to document the patient's baseline functional limitations and should be completed on the patient's first visit, after the history and before the examination.

**Step 1** Complete the patient and provider demographic information.

**Step 2** Enter the ICD-9 code corresponding to the patient's primary diagnosis in this diagnosis column. Activities listed in the activity column must all relate to the primary diagnosis.

**Step 3** Enter the date of the initial assessment in the first date field.

## Patient Specific Functional Scale Submission Guide

- Step 4** Ask the patient to state in their own words, at least three (3) activities that he or she is unable to perform or is having the most difficulty performing because of the chief complaint. Enter these three activities in rows one, two and three of the activity column.
- Step 5** Ask the patient to score each activity limitation on a numerical rating scale of 0-10 ("0"= Able to perform the activity at the same level as before injury or problem, "10"= Unable to perform activity). Enter the patient-reported score for each documented activity limitation in the appropriate field.

### Note

Multiple PSFS forms can be used if a patient has a complaint in more than one body region. A new PSFS is required for each body region and the steps detailed above should be followed to complete each form.

## Completing the Follow-up/Discharge PSFS

The same PSFS form used during the initial assessment should be used to capture comparative data over time. The PSFS should be updated at least every 30 days or more frequently as deemed necessary.

- Step 1** The same PSFS for should be used for each follow-up and/or discharge assessment.
- Step 2** Enter the date of the follow-up/discharge assessment in the appropriate date field.
- Step 3** The activity column will contain activity limitations that the patient had previously identified related to their primary condition (and secondary condition(s) if applicable). During the follow-up/discharge assessment ask the patient to score each of the activities previously listed on the PSFS, using the numerical rating scale 0-10 ("0"= Able to perform the activity at the same level as before injury or problem, "10"= Unable to perform activity).
- Step 4** Each activity MUST be scored during every assessment period. If an activity is longer limited and the patient can perform the activity at the same level as before the injury or problem, then the activity should be given a score of "0". If the patient relates a new functional limitation, you may add the activity to the form and it should be assessed for the duration of the treatment episode.

## PSFS Example

A 35 Year old female patient with diagnoses of Sprain/Strain of the Lumbar Spine is evaluated for Physical Therapy treatment. During the initial assessment on 12/01/07, after the history was completed, the patient reported three functional limitations to the clinician and each activity was rated using the numerical rating scale 0-10. The patient was re-assessed on 12/15/07. During this follow-up assessment the patient rated each of the previously reported activities using the same 0-10 numerical rating scale. A discharge assessment was performed on 1/4/08; again the patient rated each of the previously reported activities using the same 0-10 numerical rating scale.

Activity	Diagnosis (ICD-9)	DATE: <b>12/01/07</b>	DATE: <b>12/15/07</b>	DATE: <b>01/04/08</b>	DATE:
1. Difficulty standing for long periods to do the dishes	847.2	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
		<b>5</b>	<b>2</b>	<b>0</b>	
2. Difficulty picking up 10 month old baby		Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
		<b>7</b>	<b>4</b>	<b>0</b>	
3. Difficulty walking from car to grocery store		Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
		<b>8</b>	<b>5</b>	<b>0</b>	
<b>Average Score</b>		<b>6.7</b>	<b>3.7</b>	<b>0.0</b>	

## Submitting the PSFS

You can submit the PSFS on-line using Treatment Plan eForm or via fax. The Treatment Plan eForm is available on Landmark Connect. Whatever method of submission you choose (eForm or fax), please continue using the same method throughout the entire treatment episode.

## **Patient Specific Functional Scale Submission Guide**

### **When to Complete a New PSFS**

The same PSFS form is to be used to track functional progress throughout an episode of care. However, the following instances will require the completion of a new or additional PSFS:

1. The patient's previous condition is resolved and the patient presents for treatment of a new condition. Use of the previous PSFS should be discontinued and a new PSFS should be completed for the new condition.
2. The patient presents for treatment of a new condition and the previous condition continues to require ongoing care. A new PSFS must be completed for the new condition, while the previous PSFS will continue to be used for the original condition. You will need to submit two PSFS forms, one for each condition.

# Physical Therapy Treatment Plan

Landmark Healthcare, Inc., 1750 Howe Ave., Suite 300, Sacramento, CA 95825  
FAX (888) 565-4225

Date of Submission \_\_\_/\_\_\_/\_\_\_

Please check type of care:

Initial care  Continuing care

INSURED

Patient Last Name	Patient First Name	M.I.	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth (MM/DD/YYYY) ___/___/___
Insured I.D. or SSN	Insured Last Name	M.I.	First Name	Patient Phone (area code first)	
Patient Address		City	State	Zip Code	

PAYOR

Employer Name	Insurance Company	Group Plan # or Union Local (Submit Copy of Patient's Insurance I.D. Card)			
Injury or illness is related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other	Referring Physician/Practitioner	Doctor License #	Date of Referral ___/___/___		

PT/OT

Therapist Last Name	Therapist First Name	M.I.	Group Name	Provider/Group ID#
Provider/Group Address		City	State	Zip Code
			Phone # ( )	Fax # ( )

PATIENT'S CURRENT MEDICAL HISTORY

<b>Subjective Complaints:</b>	<b>Mechanism of Onset for Primary Diagnosis</b>
Lost days from work to date _____ Days of work restriction to date _____	Date of Onset ___/___/___ Date of Initial Evaluation ___/___/___ <input type="checkbox"/> Acute Trauma <input type="checkbox"/> Worsening of prior illness/injury <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Gradual Onset <input type="checkbox"/> Chronic <input type="checkbox"/> Other Description: _____

<b>Objective Findings</b> Date Obtained ___/___/___ Inspection/Palpation: _____	<b>Spinal Range of Motion</b> _____° Flexion _____° _____° Extension _____° _____° R.Lat.Flex _____° _____° L. Lat. Flex _____° _____° R. Rotation _____° _____° L. Rotation _____°		<b>Extremity Range of Motion</b> (Circle Painful Tests) Extremity: (specify) _____ Active (Degrees)      Passive (Degrees)      Manual Muscle Test Strength (0-5)		
	Cervical ROM	Lumbar ROM	Flex.	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		Ext.	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		Abduction	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		Adduction	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		Int rotat.	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		Ext rotat.	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		Supination	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		Pronation	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		L Deviation	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		R Deviation	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		Opposition	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		Plantar flex	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		Dorsi flex	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		Eversion	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___
		Inversion	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___	R ___/___/___ L ___/___/___

Summary of Clinical Findings (Orthopedic, Neurologic, Additional Info.)

Date of first tx at this office for this condition \_\_\_/\_\_\_/\_\_\_ Anticipated Release Date \_\_\_/\_\_\_/\_\_\_

DIAGNOSES

ICD-9 Code:	Description:	Pain Scale (0-10)	<b>Activities of Daily Living</b> Functional Limitations (check all that apply) <input type="checkbox"/> Locomotion/movement <input type="checkbox"/> Bed mobility <input type="checkbox"/> Transfers (such as moving from bed to chair, from bed to commode) <input type="checkbox"/> Walking _____ (Duration/Distance) <input type="checkbox"/> Stair climbing <input type="checkbox"/> Self-care (such as bathing, dressing, eating, toileting) <input type="checkbox"/> Home management (such as household chores, shopping, driving/transportation, care of dependents) <input type="checkbox"/> Community and work activities <input type="checkbox"/> Work/School <input type="checkbox"/> Recreation or play activity <input type="checkbox"/> Lifting/Carrying <input type="checkbox"/> Overhead _____ lbs. <input type="checkbox"/> From waist _____ lbs. <input type="checkbox"/> From floor _____ lbs. <input type="checkbox"/> Other _____
1. Primary _____	_____	_____/10	
2. Secondary _____	_____	_____/10	
3. Additional _____	_____	_____/10	
4. Additional _____	_____	_____/10	

TREATMENT PLAN

<b>Treatment Goals (Functional Improvement and Outcomes Expected)</b>	
<b>Treatment Plan</b> (MM/DD/YYYY) From ___/___/___ To ___/___/___ <b>Anticipated No. of Visits</b> _____ <b>Patient Home Care</b> <input type="checkbox"/> Stretching <input type="checkbox"/> Exercise <input type="checkbox"/> Hot/cold	<b>Complicating Factors</b> (Check any that apply and /or list) <input type="checkbox"/> Surgery: Date ___/___/___ Type _____ Precautions _____ <input type="checkbox"/> Poor tissue healing such as: pernicious anemia, diabetes, thyroid disease, pregnancy Other: _____

I declare that the above information is true and correct to the best of my knowledge. Further, it is my professional judgment that physical therapy is not contraindicated for this patient. If I am required under state law to obtain a prescription prior to rendering this treatment, I have obtained such a prescription in compliance with state law.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**REVISED PATIENT SPECIFIC FUNCTIONAL SCALE (PSFS)**

**FAX (888) 565-4225**

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) / /
Provider Last Name	Provider First Name	Provider Phone (Area code first)	

**Clinician Instructions:** Complete after the history and before the exam

**Initial Assessment**

Ask the patient to list and score at least 3 activities that they are unable to perform or have the most difficulty performing, because of their chief complaint.

**Follow-up or Discharge Assessment**

Ask the patient to score the same activities that they were previously unable to perform, or were having the most difficulty performing, because of their chief complaint.

**Patient Specific Activity Scoring scheme** (Score one number for each activity for each date):

0=Able to perform at the same level As before injury or problem.	0	1	2	3	4	5	6	7	8	9	10	10=Unable to perform activity
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ACTIVITY	DIAGNOSIS (ICD- 9 CODE)	DATE:	DATE:	DATE:	DATE:	DATE:
1.		Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
2.		Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
3.		Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
4.		Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
5.		Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
6.		Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
<b>Average Score</b>						

I understand that the information I have provided above is current and complete to the best of my knowledge.

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Register for your account today!

Landmark’s secure provider portal, **Landmark Connect**, is the quick, easy way to access important clinical tools, including:

- Clinical and Administrative Guidelines and Forms
- Interactive Clinical Tools
- Practitioner Performance Summary (PPS) – Landmark’s comprehensive practitioner profiling report.

## System Requirements

Simply verify that your system meets the requirements below, then follow the step by step registration instructions.

- A broadband connection or at least a 56k modem speed dial-up connection
- Internet Explorer 4.0 or higher with 128-bit encryption, or
- A browser that is set up to enable cookies. Cookies help us recognize you as a user and are required for log on and use of the site.

## General Account Registration

It’s easy to establish your Landmark Connect account:

1. Go to **www.LandmarkHealthcare.com**, click on the **Practitioners** menu and select “**Landmark Connect (Secure Area)**.”
2. Click the “**Register**” link under **New User Registration**.
3. Read and accept **Landmark’s Terms & Conditions of Use**.
4. Complete the registration form as shown in **Figure 1**. Please note, the License and Tax ID(s) entered must be those assigned to the named Practitioner.

You will receive an E-mail confirmation from Landmark to the E-mail address you provided during registration. Click on the link in this E-mail message to activate your account. Then,

5. Log on to Landmark Connect using the E-mail address (User ID) and password you selected during registration.

## Account Registration for OPT’s, Facilities, and Hospitals

Follow Steps 1 through 3 above to download the **Landmark Connect** user application.

## Need Help?

Call us at (877) 531-9139

Landmark’s Web Support team is available to assist you Monday – Friday from 8:30 AM to 5:00 PM EST.

Figure 1

E-mail (User ID)	<input type="text"/>
Confirm E-mail (User ID)	<input type="text"/>
Your first name	<input type="text"/>
Your last name	<input type="text"/>
Practitioner First Name	<input type="text"/>
Practitioner Last Name	<input type="text"/>
License Number	<input type="text"/>
State	Choose State <input type="button" value="v"/>
Number of Tax ID's	1 <input type="button" value="v"/>
Tax ID Number 1	<input type="text"/>
Password	<input type="text"/>
Confirm Password	<input type="text"/>
Question For Password Reset	****Please select a question**** <input type="button" value="v"/>
Answer	<input type="text"/>