CHIROPRACTIC UTILIZATION GUIDELINES IN CONSULTATION WITH THE CHIROPRACTIC ADVISORY PANEL

EFFECTIVE 9/1/2022

Mission Statement

To ensure professional appropriate chiropractic care within the scope of practice while adhering to the Wyoming Workers' Compensation statutes, rules and regulations. It is the intent of the Chiropractic Advisory Panel to ensure a professional care management process that serves the injured worker, the Doctor of Chiropractic, and Employers in the State of Wyoming.

History

(a) The Chiropractic Advisory Panel was formed to assist the Workers' Compensation Division in meeting its statutory obligations. The formation of guidelines and protocols is intended to help clarify and govern the review and payment of Chiropractic claims.

(b) A Chiropractic Review panel consisting of three (3) members shall be appointed by the Administrator after an interview process and may be recommended by the Wyoming Chiropractic Association. Whenever it may become necessary to appoint a completely new review panel of three (3) members, the terms of those members will be on a staggered basis with one member serving a one (1) year term, one member serving a two (2) year term and one member serving a three (3) year term. After establishment of a new panel, any appointment or re-appointment of a panel member will be for a term of three (3) years. If a panel vacancy arises for an unexpired term, a new member will be re-appointed for the remainder of the unexpired term. No panel member may serve more than two (2) consecutive terms. Panel members must reside and practice chiropractic fulltime within the State of Wyoming. Panel members must be in good standing with the Wyoming Unemployment and Workers' Compensation Divisions. The Chiropractic Review Panel will provide guidance to the Wyoming Workers' Compensation Division on utilization matters and standard of care, and will function as peer review for the Division on chiropractic matters when requested. Panel members must accept Wyoming Workers' Compensation patients for treatment and Division fee schedules for payment of such treatment. Panel members must be cognizant of potential conflict of interest issues and recuse themselves from acting in any matter in which a conflict exists. Panel Members will be reimbursed for mileage and per diem according to the State of Wyoming established rates, for service performed on behalf of the Workers' Compensation Division. Panel members will be paid an hourly fee for their service on behalf of the Division as established by the Administrator. The Panel will meet when requested by the Division.

Authority

Doctors of Chiropractic may elect to provide care for injured Wyoming workers. Those providers who elect to serve patients within the Wyoming Workers' Compensation system must practice in a manner consistent with these guidelines. The authority for these

guidelines are derived from the Wyoming Workers' Compensation Rules, Regulations and Fee Schedules; Chapter 8, Section 1 and Chapter 10, Section 21.Goal of Chiropractic Treatment

The goal of treating the injured worker is to return him/her to pre-injury function or Maximum Medical Improvement (M.M.I.). Maximum Medical Improvement is defined as a medical condition or state that is well stabilized and unlikely to change substantially in the next year, with or without medical treatment. Over time, there may be some change; however, further recovery or deterioration is not anticipated. This term may be used interchangeable with the term "ascertainable loss", defined in W.S. § 27-14-102(a)(ii). As part of the assessment, the Doctor of Chiropractic's focus will be on identifying functional deficits that are causing impairment, recording them and documenting treatment and progress.

Fee Schedule
All bills and fees submitted for payment will be reviewed and audited for relatedness, appropriateness, and reasonableness in accordance with the adopted Wyoming Workers' Compensation Rules and Regulations and Fee Schedules.

Billing Guidelines

For assistance with coding or billing issues you may contact Provider Services at 307-777-5658 or email dws-providerrelations@wyo.gov

Medical Records
Health care is dependent on quality data. Good decisions are the result of accurate and complete facts being retrievable from a patient's record. Payment for medical services and professional fees is dependent on complying with the standard for content of medical records. See Rules and Regulations Chapter 10; Section 20 for more details @ https://rules.wyo.gov/Search.aspx?mode=1 The Chiropractic Advisory Panel strongly encourages typed notes.

Section 1

(a) Written Reports

To receive payment for chiropractic treatment of injured workers, Chapter 10, Section 20 of the Workers Compensation Rules and Regulations must be complied with and shall include:

(i) Examinations:
(A) Initial: For the first report, use Health Care Providers Initial Medical Report found at https://dws.wyo.gov/dws-division/workers-compensation/resources-information/forms-documents/

(I) Computerized office notes may be substituted if ALL of the required information is included. Notes must be titled "Initial

Exam"

(B) Re-exam: Use the Exam/Re-Exam form found at https://dws.wyo.gov/dws-division/workers-compensation/resources-information/forms-documents/

(I) Re-examination of the patient is to be done about every 4 weeks
(II) Re-examination notes are required for all treatments, including acupuncture
(III) Computerized office notes may be substituted if ALL of the required information is included. Notes must be titled "Re-exam Notes".

(ii) Daily Progress Notes: SOAP Note Format (Strongly encourage typed notes)

(A) Subjective complaints**:** The patient's complaints must be recorded at each visit (in the patient's own words when possible) indicating improvement, worsening, or no change in a numerical pain scale 0-10.

(B) Objective Findings: Clinical signs of a condition must be noted at each visit in the doctor's own words and supported by objective data.

(C) Assessment or Diagnosis: It is not necessary to update this category at each visit

(D) Plan/Procedure: A plan of management must be made and maintained with the goal of returning the patient to work. Contemporaneous recording of procedures performed must include descriptions of manipulations performed, soft tissue techniques, modalities used with documentation to include area of treatment (body part), duration and who performed modality, exercises prescribed or prescribed diet and activity instructions and patient compliance or non-compliance.

(iii) Discharge

(A) Injured workers who have undergone a course of care and are considered to be at either pre-injury status or MMI should be discharged from active care
(B) Noncompliance with and/or non-attendance of established treatment protocols and Doctor of Chiropractic recommendations must be documented and immediately reported to the Division.

Section 2

(a) Treatment Parameters

(i) The Doctor of Chiropractic shall prepare a diagnosis based treatment plan, which includes specific treatment goals with an estimated time frame for completing, taking into consideration that the rate of healing varies from individual to individual and any complicating factors that could change the expectation of healing rate.

(A) Repair and Remodeling Phase – Usage of more than one care session per day may constitute accepted clinical practice for selected conditions with supporting documentation. Treatment needs usually decrease with patient progress. Use of modalities or procedures in addition to manipulation with the initiation of rehabilitation may be used when beneficial to the patient. If therapy does not produce the desired effect within thirty (30) days, continued use would not be clinically indicated.

(B) Rehabilitation/Stabilization – Treatment needs usually continue to decrease with patient progress, therefore modality use decreases or is eliminated.

(I) Rehabilitative procedures are encouraged during this phase of care.

(II) The patient should reach pre-injury status during this phase of care and should be discharged from active chiropractic care.

(III) The Doctor of Chiropractic should provide a closing exam to determine the patient's level of recovery and determine if the patient has reached pre-injury status or MMI.

(IV) If an impairment is identified, an impairment rating should be requested by the treating doctor once the patient has reached MMI and a form is to be filled out and sent in to the Workers' Compensation claims analyst for review and scheduling of the appointment.

(C) Exacerbation- In the event of an exacerbation or re-injury, the attending Doctor of Chiropractic must document said incident according to date, etiology, updated subjective and objective findings, updated diagnosis, prognosis, and treatment plan.

(D) Supportive Care – The need for supportive care after the patient has reached pre-injury status or MMI must be established through appropriate documentation and will be determined on a case-by- case basis. Supportive Care will only be considered for those workers who have sustained an ascertainable loss and received an impairment rating of at least 5% WPI*.

(I) Supportive care shall require a formal written treatment plan on an annual basis detailing the medical necessity and the number of sessions requested.

(II) Supportive Care shall consist of 2-4 visits per month.

(III) The monthly re-exam documentation is not required for approved supportive care.

Section 3

(a) General Guidelines

(i) The Division will pay for an initial examination, reexaminations, and discharge examinations. It is expected that the Doctor of Chiropractic will perform periodic reexaminations (approximately 3-4 weeks) to show progressive benefit of care. A reexamination should be performed in the event of an exacerbation.

(ii) Chart notes and supportive documentation must be attached to each billing form. All ICD10 diagnosis codes and CPT procedure codes must be validated in the patient chart and coordinated as to the diagnosis and treatment code descriptors. Please refer to Chapter 10, Section 20 for additional information regarding guidelines for documentation. Uniform chiropractic language should be used for describing care and treatment. All abbreviations and indexes should be defined and submitted along with the medical records every time medical records are sent in.

(iii) Complete, appropriate, orderly, and timely billing is required to receive a timely and correct payment. Currently all billing must be received within one year's time. All medical records must be received within 60 days of office visit.

(iv) The nationally accepted CMS (formerly known as HCFA) billing 1500 form must be completed in detail. This means all required fields must be completed. Patient's name, social security number, address, date of birth, sex, county where injury occurred, case number, date of injury, employer's name, ICD10 code(s), itemized CPT code(s), total charges, Doctor of Chiropractic's name, address, and date claim was filed. Completed claims are submitted to: CorVelStateofWyoming@onlinecapturecenter.com or can be mailed to State of Wyoming P.O. Box 2087, Portland, OR 97208-2087

Section 4

(a) Bills for services to Workers' Compensation claimants must be submitted using the following codes:

(i) E&M services: 99202-99215, please append a 25 modifier when CMT or other therapy modalities are performed on the same date of service.

(A) CODE 99202 Office or other outpatient visits for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total

time spent on the date of the encounter.

(B) CODE 99203 Office or other outpatient visits for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level medical decision making. When using time for code selection, 30-44 minutes of total time spent on the date of the encounter.

(C) CODE 99204 Office or other outpatient visits for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level medical decision making. When using time for code selection, 45-59 minutes of total time spent on the date of the encounter.

(D) CODE 99211 Office or other outpatient visits for the evaluation and management of an established patient that may not require the presence of a physician or other qualified healthcare professional.

(E) CODE 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time spent on the date of the encounter.

(F) CODE 99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

(G) CODE 99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

(H) CODE 95851 Range of motion measurements and report, each extremity (excluding hand) or each truck section (spine)

(I) CODE 95852 Range of motion measurements and report for the hand, with or without comparison with the normal side.

(ii) Diagnostic Radiology

(A) All injured areas are compensable.

(B) If the radiology services are only read by the clinic, please append a 26 modifier. If the radiology services are only taken by the

clinic, please append a TC modifier. If they are both taken and read by the clinic, no modifier is needed.

Section 5

(a) Supervised Reconditioning/Exercise Code Cap**.** The Division may pay up to four units (1 unit = 15 minutes) per day of any (one code or combination) of supervised exercise code as listed.
   (i) 97110 Therapeutic exercise
   (ii) 97112 Neuromuscular re-education
   (iii) 97116 Gait training
   (iv) 97530 Therapeutic activity
   (v) The application of these codes requires supervision by the Doctors of Chiropractic.

(b) Coding/Billing Procedures Each CPT code billed should represent a separate and distinct clinical procedure. Each CPT code utilized and its associated rehabilitative procedure should be clearly identified and well documented. Procedures such as brief cardiovascular warm up / cool down stretching exercising, etc. are considered components of other predominant procedures and should not be billed separately. CPT codes should be viewed as descriptors of service only, not billable items in their own right. Generally, CPT codes related to supervised reconditioning / therapeutic exercise are time based, billed in 15 minute increments. Total time must be documented in the chart notes.

   (i) Code 20560-20561 Dry Needling is a physical intervention to stimulate trigger points. It's used as a diagnostic tool and to treat neuromuscular pain and functional movement deficits. The approach is based on Western anatomical and neurophysiological principles. Dry needling is not the same as acupuncture, which is a Chinese medicine technique. Medical doctors, physiotherapists, chiropractors and acupuncturists are using dry needling in their practices for treatment of myofascial pain and dysfunction. Dry needling is considered to be within the scope of practice for chiropractors in the state of Wyoming, according to the Wyoming State Chiropractic Board. Chiropractors must show a minimum of 25 hours of face to face dry needling course study prior to using the dry needling technique.

   (ii) Code 98940 Chiropractic manipulative treatment; spinal, one to two regions

   (iii) Code 98941 Chiropractic manipulative treatment; spinal, three or four regions

   (iv) Code 98942 Chiropractic manipulative treatment; spinal, five regions

   (v) Code 98943 Chiropractic manipulative treatment; extra spinal, one or more regions. This code can be used by itself or in conjunction with a spinal CMT code.

(vi) Code 98943 Chiropractic manipulative treatment; extra spinal, one or more regions. This code can be used by itself or in conjunction with a spinal CMT code.

(vii) Code 97140 Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, and manual traction), one or more regions, each 15 minutes. This code is a duplicate service when performed to the same compensable region as CMT (98940, 98941, 98942, 98943). The 97140 code encompasses a range of manual techniques, including, but not limited to, joint mobilization / manipulation, manual lymphatic drainage, manual traction, and manual soft tissue mobilization.

(viii) Code 99050 Services requested after posted office hours in addition to basic service

(ix) Code 97012 Application of a modality to one or more areas; traction, mechanical. Traction performed by use of mechanical means to effect elongation of soft tissue to increase joint mobility

(A) Documentation must state "mechanical" traction. Flexion/distraction, intersegmental distraction, Cox, Leander are considered techniques that would be inclusive in the manipulative codes (98940, 98941, 98942). In office mechanical traction will be considered a duplication of service and will not be reimbursed when the patient is performing home traction to the same treatment area.
(B) 97012 also includes S9090. S9090 will not be paid unless billed under 97012

(x) Code 97014 Application of a modality to one or more areas; electrical stimulation (unattended) the use of electrical current for peripheral nerve injuries or pain reduction which does not require constant attendance. Once applied this modality requires on-site supervision.

(A) If electrical stimulation and ultrasound are provided through the same transducer, no additional charge shall be made for electrical stimulation. The simultaneous application of ultrasound and electrical stimulation through the same transducer, to the same region, during the same period of time, does not add value to the basic service performed.

(xi) Code 97024 Application of diathermy to one or more areas; diathermy involves use of equipment which exposes soft tissue to magnetic or electrical field.

(A) The use of diathermy and ultrasound on the same treatment on the same visit will be considered a duplication of service as they both provide heat. Consideration will be given to one but not both

therapies. Documentation must include the area of application

(xii) Code S8948 Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes

(A) Please use S8948 in place of 97026

(xiii) Code 97032 Application of electrical stimulation to one or more areas; electrical stimulation (manual), each 15 minutes. The use of electrical current for peripheral nerve injuries, muscle relaxation or pain reduction which requires continuous manual application and supervision or extensive teaching on the use of a device. Documentation must clearly state attendance at bedside for adjustments and safety.

(A) If electrical stimulation and ultrasound are provided through the same transducer, no additional charge shall be made for electrical stimulation. The simultaneous application of ultrasound and electrical stimulation through the same transducer, to the same region, during the same period of time, does not add value to the basic service performed.

(xiv) Code 97035 Ultrasound, each 15 minutes, Ultrasound with or without Electrical Stimulation: using sonic generators to deliver acoustic energy for therapeutic thermal and/or non-thermal soft tissue treatment.

(A) The use of ultrasound and diathermy on the same treatment area on the same visit will be considered a duplication of service as they both provide deep heat. Consideration will be given to one but not both therapies. If electrical stimulation and ultrasound are provided through the same transducer, no additional charge shall be paid for electrical stimulation. The simultaneous application of ultrasound and electrical stimulation through the same transducer, to the same region, during the same period of time, does not add value to the basic service performed.

(xv) Code 97124 Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion). This is a soft tissue procedure performed on one-to-one direct patient contact. Only a Doctor of Chiropractic, or massage therapist under the Doctor of Chiropractic's supervision and in conjunction with an active chiropractic treatment program, can be compensated for this. Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion) will be considered for reimbursement when performed to the same region as CMT with appropriate documentation (i.e. myofascial release, trigger point therapy, myelotherapy, soft tissue mobilization, massage). The documentation must be co-signed by the supervising Doctor of Chiropractic. Reimbursement for massage will only be made for massage applied to the area(s) of the original compensable injury.

(A) Please append a 59 modifier to this service when performed with other CMT and/or therapy modalities

(xvi) Code 97139 Unlisted procedure, modality or supply code (i.e. 97139, 97039, 99070) If no specific procedure code is available fitting the description of the procedure performed and an unlisted procedure code must be used, include the narrative description on item 19 of the HCFA 1500 form, if a coherent description can be provided within the confines of that box. If not, an

attachment must be submitted with the claim. The unlisted procedure must be supported by documentation in the patient's record.

(xvii) Code 97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility The instruction of a patient in a supervised exercise program which may include: strengthening, stability, flexibility, ROM, and/or cardiovascular conditioning. The intent of the program should be to improve the level of function progressing to an independent exercise program. The progress toward goals can be objectively measured.

(xviii) Code 97112 Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception Neuromuscular Reeducation: movement, balance, coordination, kinesthetic sense, posture and proprioception techniques to normalize muscle tone, patterns of specific movement, automatic neuromuscular response and motor control. These techniques require constant assessment and reassessment during treatment period.

(xix) Code 97116 Gait training: skilled training of a patient with significant gait abnormalities and/or complex adaptation of equipment to normalize weight-bearing and movement patterns.

(xx) Code 97760 Orthotics fitting and training, upper and / or lower extremities, each 15 min Orthotics will be considered on an individual case basis.

(xxi) Code 97530 Therapeutic activities, supervised patient contact (use of dynamic activities to improve functional performance), each 15 minutes Functional Activities: instructing, monitoring, and progressing a patient in adaptations of functional activities that result in the patient's ability to perform the activity independently and safely with or without adaptive devices. Functional activities could range from getting out of bed and self-care to positioning themselves at a machine and driving heavy equipment

(xxii) Code 97535 Self-care / home management training, each 15 minutes. Activities of daily living: performance of physical and psychological self-care skills and/or daily life management skills to a level of independence.

- (A) Patient Education: imparting information and developing skills to promote independence after discharge. Teaching patients and/or their care givers in the programs (e.g. exercises, TENS instruction) to meet long term goals.
- (B) The Division will pay up to four teaching/monitoring sessions for up to two units per session maximum per case. The documentation must demonstrate medical necessity and goals.

(xxiii) Codes 29200, 29240, 29260, 29280, 29530, 29540 Body and Extremity strapping, any age (Kinesio Tape)

(xxiv) Code 97750 Physical performance test or measurement (e.g., musculoskeletal, functional; capacity), with written report, each 15 minutes.

(xxv) Code 97810 Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient. Provider must provide documentation of advanced training for acupuncture.

- (A) Currently the Division requires all Acupuncturists to be licensed

through the State of Wyoming. Please see Chapter 10, Section 1.

(xxvi) Code 97811 Acupuncture without electrical stimulation, each additional 15 minutes of personal one- on- one contact with patient, with re-insertion of needle(s). (List separately in addition to code for primary procedure.)

(xxvii) Code 99070 Supplies and material (except spectacles), provided by the Doctor of Chiropractic over and above those usually included with the office visit or other services rendered (list braces (proper HCPCS code required), supplies, nutritionals, or materials provided). Supplies will be paid per Workers' Compensation Division guidelines and fee schedule, and may require itemization. Nutritionals will only be approved for impairments or disabilities requiring the use of a wheelchair, (Statute 27-14-102, Definitions.(a)(xii) Medical and Hospital Care)

(xxviii) Code 99071 Educational supplies, such as books, tapes, and pamphlets, provided by the Doctor of Chiropractic for the patient's education at cost to Doctor of Chiropractic. An invoice and supportive documentation must be supplied with the billing.

Section 6

(a) References

(i) Wyoming Laws – Wyoming Chiropractic Examiners Licensing Act

(ii) ICA Best Practices and Practice Guidelines, International Chiropractic Association Donald 3.Harrison, PhD, DC, MSE, Leonard Siskin, BS, DC

(iii) Relative Values for Doctors of Chiropractic, St. Anthony's Publishing, Inc. (current edition)

(iv) ACA's Official Chiropractic Coding Solutions (current edition), American Chiropractic Association, (current edition)

(v) Rehabilitation of the Spine, Williams and Wilkins, 1996, Craig Leibsen, D.C.

(vi) The Chiropractic Profession NCMIC Group Inc., (current edition)

(vii) ACA Clinical Documentation Manual, (current edition)

(viii) Chirocode Deskbook 2012, (current edition)

(ix) Council on Chiropractic Guidelines and Practice Parameters, subject specific, (current edition)

(x) Practicing Chiropractor's Committee on Radiology Protocols (PCCRP)

(xi) Quantitative Functional Capacity Evaluation by Steven G. Yeomans, DC, FACO

(xii) Exercise Manual for (QFCE deficits) Steven G. Yeomans, DC, FACO

(xiii) The Clinical Application of Outcome Assessments by Steven G. Yeomans, DC, FACO

(b) Revised

August 2015
January 2016
March 2018
September 2019
November 2019
August 2022

WYOMING WORKERS' COMPENSATION DIVISION HEALTH
HEALTH CARE PROVIDER INITIAL MEDICAL REPORT
Return to: 5221 Yellowstone Rd. Cheyenne, WY 82009
Workers Compensation is exempt from HIPAA regulations

PLEASE PRINT

An injury report must be on file before any benefits are paid to either the claimant or provider. WS § 27-14-502(c)

Claim Number: (If Known)

Patient

1. Employee's First Name Middle Initial: Last Name | 2. Social Security Number: | 3. DOB: | 4. Sex:

5. Street Address: City: State: Zip: | 6. Phone No.: | 7.HT: | 8.WT:

9. Name of Employer: | 10. Address: | 11. Phone No.:

History

12. Date Injured: | Hour: | am ☐ pm ☐ | 13. Last Date Worked: | 14a Has This Body Part Been Injured/Treated Before? ☐ Yes ☐ No

14b. If "Yes" State When and Describe:

15. Employee's Statement of Cause of Injury or Illness (in First Person):

16. Describe Complaints (In First Person):

Examination

17. Findings of Examination:

18. ICD-(Code(s) (Required) _____._____ _____._____ _____._____ _____._____.

19. Diagnosis (Written Description)

20. Is the Condition Requiring Treatment the Result of the Industrial Injury **or** Exposure Described on #15? ☐ Yes ☐ No ☐ Undetermined: | If "No" Explain:

Treatment

21. Date of First Treatment: Hour: am ☐ pm ☐ | 22. Type of Treatment:

23. If Hospitalized, What Hospital? ☐ Inpatient ☐ Outpatient | 24. If Claim Referred to Another Doctor of Chiropractic, Give Doctor of Chiropractic's Name and Address:

Disposition

25. Is Condition Medically Stationary? Yes☐ No☐ | 26. Is Any Further Treatment Required? ☐ Yes ☐ No If "Yes" Date of Next Visit. | 27. Will Injury Cause Permanent Impairment? Yes☐ No☐

28. Does Injury Prevent Return to Regular Employment? Yes☐ No☐ If "Yes" Estimate Time Loss: Modified Employment: Yes☐ No☐ If "Yes" Explain Restrictions: | 29. Date Released for Work:

30. Remarks or Outline of Proposed Treatment:

31. Are There Any Conditions That Would Retard or Prevent Recovery? Yes ☐ No ☐ If "Yes" What Are They?

32. Name and Type of Health Care Provider: (MD, DC, OD, etc) | 33. Address: | 34. Phone No.:

35: Federal Tax ID Number: | 36. Date | 37. Health Care Provider's Original Signature:

*This report satisfies the initial Health Care Provider report required by W. S. § 27-14-501(a)(b)

WYOMING WORKERS' COMPENSATION DIVISION

Chiropractic Patient Exam/Re-exam Form (Use if patient is under active care)

Return to: Workers' Compensation Division 5221 Yellowstone Rd Cheyenne, Wyoming 82009
https://dws.wyo.gov/dws-division/workers-compensation/

Patient:_____. _____Claim #:_____Date:_____

Has patient been discharged from care? Yes_____If yes, please list date of discharge, sign and return form via fax to 307-777-6552
No_____If no, please complete the form in its entirety_____Number of prior treatments

1) Current Subjective Complaints:

2) Activities of Daily Living Limitations or Duties Under Duress:

3) Exacerbations Since Last Exam:

4) Current Orthopedic / Neurologic Evaluation:

5) Measured Range of Motion: Cervical, Thoracic, Lumbar , Other_____(circle)

	Normal	Current	Pain	Notes
Flexion				
Extension				
Right Lat Flex				
Left Lat Flex				
Right Rotation				
Left Rotation				

6) Muscle Strength Test:

7) P.D.Q. Scores:

8) Assessment :

9) Plan :

10) Additional Info. / Complicating Factors:

Doctor of Chiropractic Name:_____Signature:_____

CHIRO
Chiro Exam/Re-Exam Form Revised 10/16
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WYOMING WORKERS' COMPENSATION DIVISION
HEALTH CARE PROVIDER REQUEST FOR IMPAIRMENT RATING

Return to: Workers' Compensation Division 5221 Yellowstone Rd. Cheyenne, Wyoming 82009

Workers' Compensation is exempt from HIPAA regulations

PLEASE PRINT

<table>
<tr><td colspan="3"></td><td colspan="3">Claim Number</td></tr>
<tr><td colspan="3">1. Employee's First Name Middle Initial Last Name</td><td colspan="2">2. Social Security Number:</td><td>3. DOB:</td><td>4. Sex:</td></tr>
<tr><td colspan="4">5. Street Address City State Zip</td><td colspan="3">6. Phone No</td></tr>
<tr><td colspan="3">7. Date Injured</td><td colspan="4">8. Area(s) Injured</td></tr>
<tr><td colspan="7">9. ICD Codes
_____. ____ _____. ____ _____. ____ _____. ____ _____. ____ _____. _</td></tr>
<tr><td colspan="7">10. Diagnosis (Written Description)</td></tr>
<tr><td colspan="3">11. Initial Treatment Date</td><td colspan="4">12. MMI Date</td></tr>
</table>

I,_____(Doctors Name) have done an examination of the _____(Patient Name) and determined that they have reached maximum medical improvement (MMI). At this time I would request an Independent Medical Exam be performed and an Impairment Rating be performed. Thanks

Doctor of Chiropractic Name:_____Signature: _____