September 29, 2020

RE: Injured Worker:

KEMI Claim #:

Date of Injury:

Dr.      :

Kentucky Employers’ Mutual Insurance (KEMI) has received your request to refer       for treatment with a pain management physician.

In order to review your request, please provide a written treatment plan, in accordance with 803 KAR 25:096, Section 5. For your convenience, we have included a blank treatment plan. As the Regulations require submission of a treatment plan seven (7) days in advance of the referral, please provide the completed treatment plan within seven (7) days of the date of this request. Failure to provide a complete, comprehensive treatment plan may result in denial of the referral.

You may return the completed treatment plan by fax to 859-425-7822.

If you have any questions or concerns, please contact me at: 1-800-868-4553, ext.      . Thank you in advance for your time.

Sincerely,

Claims Examiner

Enclosure(s):

cc:

PAIN MANAGEMENT REFERRAL TREATMENT PLAN

Date:       Physician:

Injured Worker:       Date of Birth:

Claim Number:       DOI: ­­

Please complete the following treatment plan to better document our file regarding the rationale for the requested referral to pain management. A treatment plan is a written plan that:

      (a) May consist of copies of charts, consultation reports or other written documents maintained by the employee's designated physician discussing symptoms, clinical findings, results of diagnostic studies, diagnosis, prognosis, and the objectives, modalities, frequency, and duration of treatment;

      (b) Shall include, as appropriate, details of the course of ongoing and recommended treatment and the projected results.

1. Current Work-Related Diagnosis(es): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Current Medications being prescribed for the **WORK INJURY ONLY**: (use the back of this page for additional space if necessary) \*\*\*Please state the diagnosis for each medication.\*\*\*

|  |  |  |
| --- | --- | --- |
| Medication | Diagnosis | Dosage  |
|  |  |  |
|  |  |  |
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1. Please explain the need for this prescription regimen.

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1. Please outline the treatment received to date and any derived benefit from this treatment.

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1. Please provide your medical rationale for the requested referral to pain management.

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1. Are other physicians or medical professionals involved in the patient’s care? If yes, please identify the physician or professional and the services provided.

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1. What is your prognosis for this patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \*\*\*\*\*\*\*\*\*Please fax completed treatment plan to: 859-425-7822\*\**\*\*\*\*\*\*\**