Form 221a **Restorative Services Authorization/Denial – SPINE** Rev 7/2024

Patient's Last Name:	First:	Middle:	Referring Physician:	Date of Injury:
Patient's Address:			Patient's Phone:	
Social Security Number:		Date of Birth:	Height:	Weight:
Employer:			Employer Address:	
Phone:	FAX:			
Insurance Carrier:			Provider: Address: City: State: Zip:	
Address: City: State: Zip:			Provider Discipline ☐ MD ☐ DO ☐ DC ☐ PT ☐ OT	
Adjuster Name: Email:			Tax ID Number:	
Phone:	FAX:		Phone FAX:	
Diagnosis Specific to Industrial Claim:			Other Conditions or Complicating Factors that May Affect Recovery:	

List from the patient's essential job functions, measurable objective requirements needed to return to work without restrictions (i.e.: lifting, carrying, grip, reaching overhead, standing or sitting duration, bending, etc.)	Capabilities Recorded on First Visit **Date:** _____	Capabilities on 8th Visit **Date:** _____	Capabilities on 14th Visit **Date:** _____	Capabilities on 20th Visit **Date:** _____
Floor-Waist Max Lb. _____ Freq. _____	Max. Lb. _____	Max. Lb. _____	Max. Lb. _____	Max. Lb. _____
Waist-Shoulder Max Lb. _____ Freq. _____	Max. Lb. _____	Max. Lb. _____	Max. Lb. _____	Max. Lb. _____
Overhead Max Lb. _____ Freq. _____	Max. Lb. _____	Max. Lb. _____	Max. Lb. _____	Max. Lb. _____
Carrying Max Lb. _____ Freq _____	Max. Lb. ___ Ft ___	Max. Lb. ___ Ft ___	Max. Lb. ___ Ft ___	Max. Lb. ___ Ft ___
Push/Pull Horizontal force Lb.				
Functional ROM O=overhead, S=shoulder, H=horizontal, K=knee, F=floor	O☐ S☐ H☐ K☐ F☐	O☐ S☐ H☐ K☐ F☐	O☐ S☐ H☐ K☐ F☐	O☐ S☐ H☐ K☐ F☐
Sitting tolerance Min. _____	_____ Min.	_____ Min.	_____ Min.	_____ Min.
Standing tolerance Min.	_____ Min.	_____ Min.	_____ Min.	_____ Min.
Squat/stoop/bend Min.	Min.	Min.	Min.	Min.
Modified Oswestry Disability Questionnaire Neck Disability Index				
Hours required to work per shift / Day	Hrs working / Day	Hrs working / Day	Hrs working / Day	Hrs working / Day
Patient's Reported Average Pain Intensity (0 to 10 Scale)	/10	/10	/10	/10
Patient's Reported Average Pain Frequency (% of the Day: 0-10-20-30-40-50-60-70-80-90-100%)	%	%	%	%

Treatment Plan: (Visits 1-8, include frequency) ☐ Manual Therapy ☐ Manipulation ☐Therapy Exercise ☐ Ultrasound ☐ Electrical Stim ☐ FCE Testing ☐ ADL Instruction ☐ Neuromuscular Re-education ☐ Others (List):	(Visits 9-14) ☐	(Visits 15-20) ☐	Visits (21-26) ☐
Expected number of visits to reach stated functional goals:			
Attended/Prescribed Visits (Prescribed visits are those that should have been scheduled as per the plan of care)			
Provider Comments:			
Provider Signature: Date:			
Payor: Approval for Future Visits ☐ Yes ☐ No	(Visits 9-14) ☐	(Visits 15-20) ☐	Visits (21-26) ☐
Payor Signature: Date:			
Payor Comments:			

UTAH LABOR COMMISSION
Industrial Accidents Division

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 www.laborcommission.utah.gov

Rev 7/2024

Restorative Services Authorization/Denial – SPINE

Glossary of Terms

List the Essential Job Functions: Use specific, functional, and measurable terms (pounds, degrees of motion, length of reach or carry, minutes of tasks, etc.) to describe tasks the individual needs to perform in order to return to their full duty work position. Clinicians can also identify those essential job functions that currently limit the client's ability to perform his or her usual duties. Clinicians are encouraged to discuss the physical demands of the position with both the client and the employer. The job description should then be compared to the client's current physical demands in order to identify the essential job functions that will be used as goals to ascertain whether or not the client is making acceptable progress with the treatment being given in returning to work. The goals should be described in objective, measurable, and functional terms. Examples include: 1) "occasional lifts of 30 lbs. from floor to shoulder height, 2) able to perform light assembly work above eye level for up to 20 minutes at one time and 2 ½ hours a day, 3) able to be up on their feet for up to 2 hours at one time and 6 hours throughout the day, and 4) able to type for 45 minutes at one time without increased symptoms." Improvement in stated functional goals, hours worked, and subjective pain ratings will be used to determine whether or not further treatment will be authorized.

Patient's Essential Job Functions: Measurable objective requirements to return to work: listed as maximum weights able to be lifted from floor to waist, waist to shoulder, and to overhead levels; maximum weight able to be carried; and maximum horizontal force to push/pull.

Functional Range of Motion: This indicates the ability the individual has to functionally reach overhead, shoulder height, reach out horizontally, to knee height, and to the floor.

Sitting/Standing tolerance: Ability to sustain functional sitting or standing.

Squat/Stoop/Bend: Squat (knee bend with upright trunk posture), stoop (combination of flexed knees and forward flexed torso), and bend (forward lumbar flexion)

Modified Oswestry Disability Questionnaire: The Modified Oswestry Disability Questionnaire is a standardized perceived ability assessment for daily tasks, ability to assume various postures, pain intensity, work tasks and recreational activities. This questionnaire is primarily used for the lumbar spine. The following link is a copy of the Modified Oswestry Disability Questionnaire and how to score the form:

http://laborcommission.utah.gov/media/pdfs/industrialaccidents/forms/oswestry_disability_index.pdf

Neck Disability Index: The Neck Disability Index is a standardized perceived ability assessment for daily tasks, ability to assume various postures, pain intensity, work tasks and recreational activities. This questionnaire is primarily used for the cervical spine. The following link is a copy of the Neck Disability Questionnaire and how to score the form:

http://laborcommission.utah.gov/media/pdfs/industrialaccidents/forms/neck_disability_index.pdf

Quadruple Visual Analog Scale: The Quadruple Analog Scale is a standardized assessment for reported pain intensity. This questionnaire asks the intensity of pain at the best, at the worst, on average or most typical, and at the current time. The following link is a copy of the Quadruple Visual Analog Scale

http://laborcommission.utah.gov/media/pdfs/industrialaccidents/forms/quadruple_vas_2.pdf

Hours Required to Work Per Shift/Day: This should reflect the pre-injury average hours required per shift the patient was required to work for a full day's work. On the 8, 14 and 20th visits, list the average numbers of hours per day the individual is currently working.

Pain Intensity: The individual will rate their pain on a 10-centimeter visual analog scale with "0" being to pain and "10" being worst imaginable.

Pain Frequency: Individuals rate what percentage of the day their pain is present, i.e. 0-10-20-30-40-50-60-70-80-90-100% of the day.

Expected Number of Visits to Reach Stated Goals: The clinician is to estimate from their experience treating patients with a similar condition the number of visits required to meet the treatment goals.

Treatment Plan: General description of the indented plan of care for the patient. Changes to the program should be noted on the 8, 14 and 20th visits requests for authorization.

Attended/Intended Visits: The number of visits that the patient has attended is divided by the number of visits the patient should have attended according to the treatment plan. In other words, if the patient should be receiving treatment three times a week but has only attended four times in the past three weeks, the result would be 4 (visits attended) with 9 (visits intended).

Provider Comments: Space is provided for the clinician to provide additional information regarding the patient not covered by previous sections.