TREATMENT PLAN TEMPLATE | CHRONIC PAIN MANAGEMENT

Patient Name:	Start Date:

Dx/Presenting Problem:	
Code:	*Description:*
Code:	*Description:*
Dx Symptom Qualifiers	

Goals and Objectives: *The goal of this treatment plan is to improve pain management, enhance function, and reduce reliance on medications where possible.*	
Long Term Goal 1:	
Objective 1:	*Intervention(s)*
	Duration/Frequency:

<table>
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<tr><td rowspan="2">Objective 2:</td><td>Intervention(s)</td></tr>
<tr><td>Duration/Frequency:</td></tr>
<tr><td rowspan="2">Objective 3:</td><td>Intervention(s)</td></tr>
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Goals and Objectives: *The goal of this treatment plan is to improve pain management, enhance function, and reduce reliance on medications where possible.*	
Objective 3:	*Intervention(s):*
	Duration/Frequency

Medical Necessity Checklist

1. Diagnosis & Symptoms

❒ *Documented history of chronic pain lasting >3 months*

❒ *Functional impairment due to pain*

❒ *Multimodal treatment approach documented (e.g., PT, non-opioid meds, CBT)*

❒ *Opioid use (if applicable) follows best practices*

❒ *Treatment is expected to improve pain management and quality of life*

2. Clinical Justification

❒ *Treatment/procedure aligns with **evidence-based guidelines***

❒ *Condition **would likely worsen** without this intervention*

Medical Necessity Checklist
❒ *Non-invasive or lower-cost alternatives* ***were attempted or ruled out*** ❒ *Treatment is not primarily for patient preference, convenience, or cosmetic purposes* ***3. Previous Treatments & Alternatives Considered*** ❒ ***Conservative treatments attempted:*** ❒ *OTC medications* ❒ *Prescription medications* ❒ *Lifestyle modifications* ❒ *Physical therapy* ❒ *Other (specify): _____* ❒ *Documented reason for* ***why alternatives were ineffective or inappropriate*** ***4. Provider's Clinical Judgment & Supporting Evidence*** ❒ *Medical notes document* ***necessity of intervention*** ❒ *Diagnostic imaging/lab results support clinical need* ❒ *Risk-benefit assessment performed and documented* ❒ *Expected clinical outcome with treatment: _____* ***5. Insurance/Payer Criteria Compliance*** ❒ *Meets payer-specific* ***medical necessity guidelines*** ❒ *Required* ***pre-authorization obtained*** *(if applicable)* ❒ *Documentation includes:* • ❒ *Physician's rationale* • ❒ *Supporting test results* • ❒ *Prior authorization reference number (if applicable)*

Provider Attestation		
I attest that the above treatment plan is medically necessary and aligns with clinical guidelines.		
Provider Name:	**Signature:**	**Date:**

Progress Plan: *Milestone dates for assessment, with a transition plan or alternative actions if needed.*	
*Progress will be reassessed every **[ ]** weeks, with modifications as needed.*	
Functional Improvement Milestones: *Patient should achieve increased mobility, pain reduction, or activity tolerance.*	
If goals not met: *Consider pain specialist referral, medication adjustments, or alternative therapies.*	*Additional Notes:*