**VERMONT MEDICAID CHIROPRACTIC SERVICE REQUEST FORM**

**Per Health Care Administrative Rule (HCAR) 4.220, chiropractic services require prior authorization from the Department of Vermont Health Access for the following:**

* Members under the age of 12, or
* Members age 12 and older who have exceeded **12** treatments for correction of subluxation in the calendar year.
* Children age five and under require prior authorization and require documentation from the primary care providers demonstrating medical necessity of chiropractic treatment.
* Medicaid does not cover an x-ray ordered solely for the purpose of demonstrating a subluxation of the spine. Any charges incurred for the chiropractic x-ray must be borne by the beneficiary.
* Covered chiropractic services are limited to the treatment to correct a subluxation of the spine
* HCAR 4.220 can be found at: [**https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/4.220-chiropractic-services-adopted-rule.pdf**](https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/4.220-chiropractic-services-adopted-rule.pdf)
* Covered chiropractic service CPT codes: **98940, 98941 and 98942**
* To determine the status of a prior authorization and for any billing issues, please call fiscal agent Gainwell Provider Services at 1-800-925-1706.

**\*\*Please include clinical documentation that supports medical necessity for this request**

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| --- | --- | --- | --- |
| **Member Information** | | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: | | Medicaid ID #: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | ICD-10 Diagnosis Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **Supplying Provider Information** | | |
| Chiropractor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Medicaid Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Provider NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Provider Taxonomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| *\*Provide* ***both*** *NPI and taxonomy if Medicaid Provider # is unknown.* | | |
| Office Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Office Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**CPT Code(s) Requested:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Condition to be treated** (choose one):

Cervicogenic Headache

Cervical radiculopathy (acute or subacute) or spinal stenosis

Lumbar radiculopathy (acute or subacute) or spinal stenosis

Neck or low back strain

**Is the condition the result of a motor vehicle accident?  yes  no**

**Is this condition the result of a work-related injury?  yes  no**

**If yes, document why Worker’s Compensation is not the correct coverage source** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of onset:** Enter a date here. **Date treatment started:** Enter a date here. **Number of chiropractic visits this calendar year:** Enter text here. **Number of additional visits requested:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms (check all that apply):**

Decreased extremity strength

Neck, scapular, or extremity pain

Unilateral paresthesia

Decreased neck ROM

Other symptoms (please explain):

**Progress made in meeting treatment goals** (check all that apply):

Improved physical and functional status compared to prior measurements or assessments (using the same

assessment or measures)

Objective measures demonstrate continued impairment compared to normal

**Describe Functional limitations** (choose one):

Minimal limitations

* Intermittent symptoms, variable intensity
* Symptoms may worsen with or after activity
* Range of motion (ROM) may be limited
* Minimal functional deficits (e.g., activities of daily living (ADLs) or instrumental activities of daily living (IADLs), sitting or standing endurance, ambulation, or stair climbing)

Moderate limitations

* Consistent symptoms, variable intensity
* Symptoms may be present at rest, exacerbated by activity
* ROM and strength may be decreased
* Functional deficits (e.g., ADLs or IADLs, sitting, standing or lifting capacity, ambulation, stair climbing, or moving sit-to-stand)

Severe limitations

* Symptoms of consistent intensity, present at all times
* Loss of ROM, strength, or reflexes, may have muscle atrophy
* Unable to complete or avoids functional activities (e.g., ADLs or IADLs, driving, prolonged sitting, standing, or ambulation, lifting, carrying, or bending)
* Adaptive equipment and/devices and activity or task modification necessary

Other (please describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Plan of Care Goal Documentation:**

Patient is committed to program participation (including home treatment program):  **yes  no**

If not, please include documentation below that addresses plan to maximize adherence to home program.

List measurable short- and long-term/discharge treatment goals related to physical and functional deficits:

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Frequency of treatment visits and treatment activities to address deficit areas:

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