**VERMONT MEDICAID CHIROPRACTIC SERVICE REQUEST FORM**

Per [Health Care Administrative Rule (HCAR) 4.220](https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/4.220-chiropractic-services-adopted-rule.pdf),

* Chiropractic services require prior authorization (PA) for 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 PA 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 member.
* Covered chiropractic services are limited to the treatment to correct subluxation of the spine. Covered CPT codes: **98940, 98941 and 98942**
* To determine the status of a PA and for any billing issues, please call fiscal agent Gainwell Provider Services at 1-800-925-1706.
* HCAR 4.220: <https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/4.220-chiropractic-services-adopted-rule.pdf>

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

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

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

**Code Requested:** Enter text here.

Check appropriate box (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** Click or tap here to enter text.

**Date treatment started:** Enter a date here.

**Number of chiropractic visits this calendar year:** Enter text here.

**Number of additional visits requested:** Enter text here.

**Etiology of underlying condition (origin and onset):**

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

 [ ]  Decreased extremity strength

 [ ]  Neck, scapular, or extremity pain

 [ ]  Unilateral paresthesias

 [ ]  Decreased neck ROM

 [ ]  Other symptoms (please explain):

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**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):

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**Plan of Care Goal Documentation:**

Patient is committed to 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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