**VERMONT MEDICAID CHIROPRACTIC SERVICE REQUEST FORM**

Patient Name: Medicaid ID Number: Date of birth:

Chiropractor Name: Medicaid Provider #:

Office Contact Person: Phone: Fax:

**Chiropractic services require prior authorization from the Department of Vermont Health Access for the following: (1) Beneficiaries under the age of 12, or (2) Beneficiaries age 12 and older who have exceeded 10 treatments for correction of subluxation in the calendar year. Chiropractic services for children age five and under require prior authorization and require documentation from the primary care providers demonstrating medical necessity of chiropractic treatment. HCAR 4.220**

[**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 services are limited to the treatment to correct a subluxation of the spine

Covered chiropractic CPT codes: 98940, 98941 and 98942

Categories are limited to a maximum of 10 visits

**Please include all documents that support medical necessity for this request**

**Code requested:**

Check appropriate box (choose one):

Cervicogenic Headache

Spinal Disorders, Cervical

Spinal Disorders, Lumbar

Strain, Low Back

Strain, Neck

**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**

**Diagnoses/Subluxations**:

**Date of onset:** **Date treatment started:** **Number of chiropractic visits this calendar year:**

**Number of additional visits requested:**

**Objective, measurable treatment goals:**

**Criteria Spinal Disorders (check all that apply):**

Acute < 6 weeks

Subacute > 6 weeks

Unilateral weakness by physical exam

Unilateral pain

Unilateral paresthesias

Spinal cord compression, cauda equina or myelopathy excluded by history and physical exam

Neck or scapular pain

Ipsilateral pain localized to neck and head region

Pain precipitated by neck movements

Limited neck or trunk ROM

Low back stiffness

Normal neurological examination

Xray:

Nondiagnostic for etiology of symptoms

Not indicated

**Pain Level:** InitialChoose an item. Current Choose an item.

Radicular or Non-Radicular:

**Location**:

Describe Functional limitations **(check all that apply)**:

ADL’s or IADL’s

Symptoms

Intensity

ROM

Strength

Frequency

**Documented prognosis for clinical or functional improvement**

Progressive Treatment Program

Patient committed to program participation **(must include all)**:

Spinal manipulation or manual therapy

Therapeutic exercise for strength, ROM, or endurance

Documented adherence to home exercise program

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

Reduction in intensity and frequency of symptoms or findings

Improvement in function and reduction in limitations:

Improved neck ROM

Improved muscle strength, reflexes, or atrophy

Improved functional performance

Decreased pain

Endurance

Muscle tenderness

Spasm

Other

To determine the status of a prior authorization, and for any billing issues, please call Provider Services at 1-800-925-1706 or (802) 878-7871.