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Chiropractic Authorization Requests: Tip Sheet and Checklist

Updated April 2024

Information required at intake

- Questions will vary depending on the condition being treated. At intake, you'll need the patient's name, date of birth, evaluation date, surgery date (if applicable), and the diagnosis(es) code(s).

- Additional questions include:
  1. Cause for care: Traumatic, repetitive, work-related, motor vehicle, unspecified (choose one).
  2. Select the type of service:
     a. Physical therapy.
     b. Occupational therapy.
     c. Chiropractic services.
  3. Type of care: Rehabilitative, habilitative, neurorehabilitative. Choose "rehabilitative" for chiropractic care.
  4. Authorization start date (if different from evaluation date).
  5. Date of onset/injury.
  6. Planned number of sessions: One, two, or three or more visits.
  7. Body regions being treated, quantity: One, two, or three or more regions.
  8. Body regions being treated, location(s): Head/neck, upper extremity, spine, lower extremity, wound, vestibular, balance/falls.
  9. Identify the level of functional deficit the patient exhibits (mild, moderate, or severe).
  10. How many visits are you requesting?

Documentation recommendations

Initial authorization requests

- When a case pends for clinical information, submit the initial evaluation, daily treatment notes, re-evaluations, and standardized outcome measures.

Subsequent authorization requests

- If requesting additional visits on an existing authorization, include:
  - Most recent evaluation/re-evaluation (if not previously submitted).
  - Most recent progress note with updated plan of care.
  - Daily treatment notes.
  - Standardized outcome measures.

Documentation details checklist

Initial evaluation must include:

- Past medical history (mechanism of injury, date of onset and/or exacerbation of condition, prior level of function).
- Subjective information (current level of function as well as underlying impairments).
- Objective measures, standardized test scores, and/or functional outcome scores appropriate for condition.
- Individualized assessment (detailed clinical interpretation of findings and expected progress of care).
- Detailed plan of care
  - Treatment.
  - Frequency and duration commensurate with level of dysfunction.
  - Specific, measurable, and time-oriented goals targeting identified functional deficits.
  - Anticipated discharge recommendations.
- Progress notes
  - Updated objective measures and overall functional progress toward goals.
  - Summary of patient's response to treatment (or lack thereof and why).
- Evidence of skilled treatment interventions that a layperson cannot perform.

Common reasons medical necessity criteria are not met

- Evolent issues authorizations in accordance with their clinical guidelines. Guidelines for chiropractic services are based on evidence-based research, generally accepted industry standards, and best practice guidelines established by the corresponding national organizations.
- Visit RadMD.com. In the Resources drop-down menu, click Clinical Guidelines & Other Resources.

Lack of information*

Initial evaluation

- Required at the initial or subsequent request after RadMD approval. Document medical need for a course of treatment through objective findings and subjective reporting. Include current and prior functional status, objective measures, and standardized testing that shows an impaired functional status and detailed clinical observations.

Progress notes

- Must be completed at regular intervals. Documentation should include assessment of overall progress (or lack thereof) toward treatment goals, changes in objective outcome measures/standardized testing, clinical observations, and treatment plan revisions including frequency and duration of treatment.

Objective measures

- Objective measures and/or standardized testing showing impairment or a decline in function. These should be completed at the initial evaluation to assess progress.

Lack of skilled care*

- Records don't support skilled treatment in the interventions, goals, or plan of care. Services must be reasonable or necessary and require the specific training, skill, and knowledge of a licensed chiropractor.
- The following does NOT support medical necessity:
  - Diagnosis alone: Clinical documentation must show why skilled care from a chiropractor is required.
  - Services that can be self-administered or safely and effectively carried out by an unskilled person without a chiropractor's direct supervision.
  - Activities for general fitness and flexibility, sports-specific training enhancement, or general tutoring for improvement in educational performance.
  - Patients with mild complaints and minimal functional limitations who may be released to a home exercise program.

Lack of progress*

- Chiropractic records must demonstrate clear, specific, and measurable improvement in the patient's pain and function every two weeks or at regular intervals as appropriate for the documented condition.
- Discharge from an episode of care is expected once maximum therapeutic benefit has been reached. This can be determined when:
  - Patient has returned to their prior level of function.
  - Meaningful improvement has occurred; however, there's no basis for further meaningful improvement or continued treatment.
  - Patient no longer demonstrates meaningful clinical improvement or meaningful improvement hasn't been achieved.

Excessive request (partial denial)*

- The plan of care submitted is excessive for the documented condition and/or doesn't allow for demonstration of progress toward goals and improved function at regular time frames. After approved visits have taken place, the provider should submit current notes, which will be reviewed for medical necessity.

Excessive frequency*

- Intense frequencies (3x/week or more).
- Considered for severe functional deficits: May be appropriate during initial phase, but progressive decrease in frequency is typical. Will require additional documentation and testing.

Moderate frequency (2x/week)

- Should be consistent with moderate functional deficits as established by objective measures and/or general guidelines of formal assessments used in the evaluation.

Overlapping authorizations*

- Treatment shouldn't duplicate services provided in multiple settings. If the requested service is duplicative or overlaps another authorization, notes from the previous clinic or provider are required to show end of care and may include ONE of the following:
  - Discharge summary from previous provider.
  - Written and signed note from the patient with last date of treatment.
  - Call from the previous provider confirming the last date of treatment.

*HMSA/Evolent Clinical Guideline: Record Keeping and Documentation Standards: Chiropractic Care (HMSA_CG_606-02) • Evolent Clinical Guideline: Measurable Progressive Improvement (NIA_CG_605)
Non-therapy and non-chiropractic providers (M.D., D.O., D.P.M., etc.) are exempt from the HMSA/Evolent program. HMSA manages such authorization requests.