veterans

winning the new patient war

H.J. ROSS COMPANY

SAM
COLLINS

5.2024

About Us

H.J. Ross Company, one of the most highly trusted billing, coding, and compliance companies, has streamlined insurance operations for thousands of chiropractors nationwide for over 40 years. Clients can depend on the H.J. Ross Company to provide the most up to date protocols and procedures, and to be your coach, making it easy for you and your staff to adapt to the changing climate within the insurance industry including codes, laws, and regulations related to the practice of chiropractic.

As director, Dr. Sam Collins believes that you should get paid. His history is firmly rooted in chiropractic, both as a chiropractor from a chiropractic family and now, as he is proudly regarded as The Billing Expert in the chiropractic profession.

Due to our unique ability to stay ahead of the curve on the latest trends and changes in billing and coding by utilizing our direct channel of communication with the insurance companies and organizations that set the guidelines, you can trust you are in good hands!

There is a reason Chiropractors who trusted us with their business 40 years ago still trust us today.

Platinum Membership

- **Expert** support for billing & coding logistics, with state-specific compliance
- **Unlimited** phone and email access
- Keep **Updated** to stay fully compliant
- **Review** denied claims and revise for ensuring proper reimbursement
- **CPT & ICD-10 Coding**, general health insurance, workers' compensation, personal injury, Medicare, and VA
- 1 complimentary **Seminar** for the Practitioner *or* Staff Member
- Annual **Fee Schedule** adjustments
- Online **Document Library**: digital coding reference bank, insurance verification, informed consent, HIPPA, personal injury, fight-back letters, customizable office forms, and more!
- **ROI** : On average, our clients generate >3x the amount of income through proper filing of claims
- Monthly **Strategy** Meetings

H.J. ROSS COMPANY

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Impact of Chiropractic Care on Use of Prescription Opioids in Patients with Spinal Pain

Patients with spinal pain who saw a chiropractor had half the risk of filling an opioid prescription. Among those who saw a chiropractor within 30 days of diagnosis, the reduction in risk was greater as compared with those with their first visit after the acute phase.

- James M Whedon, DC, MS, Andrew W J Toler, MS, Louis A Kazal, MD, Serena Bezdjian, PhD, Justin M Goehl, DC, MS, Jay Greenstein, DC
- *Pain Medicine*, pnaa014, doi.org/10.1093/pm/pnaa014

About 5,000 Medicare Part D beneficiaries per month suffered an opioid overdose during the first 8 months of 2020.

National Governor's Association, 37 State Attorney Generals, State and National treatment guidelines recommend non-pharmaceutical chiropractic/acupuncture treatment for both acute and chronic pain and dysfunction.

- "Average per-episode costs for care that begins with a **DC** / PT / acupuncturist is **only $619,** compared **with $728 for primary care and $1,728 for specialist care.** If you make the initial investment in chiropractic / PT acupuncture, significant total-episode savings occur."

- "However, first contact with a DC / PT/acupuncturist only occurs in 30 percent of cases, compared to 70 percent for primary (30 percent) or specialist (40 percent) care.“

- “The actuaries have done the work, it's presented at the actuarial conference, the net of the increased conservative care will take out about 230 million in annual medical expenditures and reduce opiate prescribing for back pain by 25-26 percent."

- **American College of Physicians Back Treatment Guidelines** - The ACP updated prior guidelines, recommending non-drug treatment first for back pain, including chiropractic manipulative therapy (CMT), osteopathic manipulative therapy (OMT), exercise therapy, acupuncture, massage and yoga.

- **FDA Education Blueprint for Health Providers Involved in Pain Management** - The Blueprint recommends "The [health care provider] should be knowledgeable about which therapies can be used to manage pain and how these should be implemented." Chiropractic and acupuncture are specifically noted as non-pharmacologic therapies that can play an important role in managing pain.

The Rate Of Use Of Veterans Affairs Chiropractic Care:

A 5-year Analysis

Background

The US Department of Veterans Affairs (VA) has initiated various approaches to provide chiropractic care to Veterans. Prior work has shown substantial increase in use of VA chiropractic care between fiscal years (FY) 2005-2016. However, the extent of the availability of these services to the Veteran population remains unclear. The purpose of this study was to analyze the rate of Veteran use of VA chiropractic services, both from on-site care at VA facilities and VA purchased care from community care providers. This study analyzed facility characteristics associated with chiropractic use by both care delivery mechanisms (on-site and in the community).

Methods

Cross-sectional analyses of administrative data were conducted for FY 2014-2019. Data were obtained from VA's Corporate Data Warehouse. The variables extracted included number of unique Veterans receiving VA chiropractic care on-site and in the community, total Veteran population of the VA facilities, size of the VA chiropractic workforce (measured as Full-Time Equivalent, FTE), and facility characteristics (geographic region and the facility complexity). Descriptive statistics, mixed model, and multivariant models were used to analyze data.

Results

- Use of VA chiropractic care increased over the six-year period for both on-site and community care. National average for on-site use of the population was 1.27% in FY14 and 1.48% in FY19. Community care use was 0.29% and 1.76% for the same years.

- Use at individual facilities varied widely in each FY. Factors such as chiropractor FTE, geographic locations, and the complexity of the VA facility are associated with use of chiropractic services.

Conclusion

The VA has expanded the non-pharmacologic treatments available to Veterans by providing chiropractic services, yet chiropractic use remains low compared to other US populations. As Veterans have a high prevalence of pain and musculoskeletal conditions, continued work to assess and achieve the optimal levels of chiropractic use in this population is warranted.

Ryan Burdick , Kelsey L Corcoran , Xiwen Zhao , Anthony Lisi [5]

Affiliations:

•PMID: 35062971
•PMCID: PMC8781440
•DOI: 10.1186/s12998-022-00413-9

https://pubmed.ncbi.nlm.nih.gov/35062971/

2022 Jan 21;30(1):4. doi: 10.1186/s12998-022-00413-9.

Who Is Eligible?

Veterans only with community care benefits

Does not include spouses or children

VA Community Care Chiropractic

Chiropractic services are part of the standard Medical Benefits Package available to all eligible Veterans. Like other specialties, access to VA chiropractic services is by referral from a VA primary care or specialty provider. VA provides these services on-site at one or more VA facilities in each Veterans Integrated Service Network (VISN). VA facilities that do not have on-site chiropractic clinics provide these services via the VA Community Care Program or other community care mechanisms.

Community Care

- Veterans may be eligible for care through a provider in their local community depending on their health care needs or circumstances, and if they meet specific eligibility criteria. Even if a Veteran is eligible for community care, they generally still have the option to receive care from a VA medical facility.
- In most cases, **Veterans must receive approval from VA** before receiving care from a community provider to avoid being billed for the care. VA staff members generally make all eligibility determinations for community care.
- Care must be preauthorized, and the provider will receive a specific written authorization for care.

Veteran Eligibility

Veteran's eligibility for community care depends on his/her individual health care needs or circumstances. ***Please note the following about eligibility for community care:***

- Veterans must receive approval from VA prior to obtaining care from a community provider, in most circumstances.
- Veterans must either be enrolled in VA health care or be eligible for VA care without needing to enroll to be eligible for community care.
- Eligibility for community care will continue to be dependent upon a Veteran's individual health care needs or circumstances.
- VA staff members generally make all eligibility determinations.

VA Community Care Contact Center:

- 877-881-7618
- Option 1
- (8 a.m. – 9 p.m. Eastern Standard Time)
- https://www.va.gov/COMMUNITYCARE/

There are six criteria that can qualify a Veteran to receive community care

1. The Veteran needs a service not available at a VA Medical Facility
    - In this situation, a Veteran needs a specific type of care or service that VA does not provide in-house at any of its VA medical facilities.
        - For example: The patient needs dialysis, but there is no dialysis at any of our facilities. The Veteran may get dialysis from an in-network community provider.

2. Veteran lives in a US State or territory without a full-service VA Medical Facility
    - Veteran lives in Alaska, Hawaii, New Hampshire, Guam, American Samoa, the Northern Mariana Islands, or the U.S. Virgin Islands. These regions don’t have a full-service VA health facility in the state or territory. Veteran eligible to get care from an in-network community provider.

Distance and Appointment Eligibility

For this element, there are a few different ways that a Veteran could be eligible for community care.

3. Veteran needs a primary care or mental health appointment. One can't schedule an appointment at a VA health facility that's within a 30-minute average drive from their home, or an appointment cannot be scheduled within the next 20 days. In these cases, veteran is eligible to get primary or mental health care from an in-network community provider.
4. Specialty care such as cardio has a 60-minute average drive time and 28 days.

Referring Provider Authorization

5. Veteran may be referred to a community provider when the Veteran and the referring clinician agree that it is in the best medical interest to see a community provider.
   - Veteran has certain health condition that the VA provider doesn't have experience treating. But they live near an in-network community provider who specializes in this condition. If VA provider and Veteran agree it's in the best medical interest.

6. VA has identified a medical service line is not meeting VA's standards for quality based on specific conditions, Veterans can elect to receive care from a community provider under certain limitations.

Approved Referrals and Authorizations

The Veteran must have an approved referral/authorization from VA **BEFORE** an appointment can be scheduled. The approved referral/authorization is the process starting point. Providers must have an approved referral/authorization on file before rendering care, unless the Veteran needs urgent or emergent care. Providers may check the status of an approved referral/authorization using **HSRM**. (Health Services Referral Manager)

There are Three Ways to Generate an Approved Referral/Authorization

1. **The provider determines a Veteran patient needs additional care beyond what was originally authorized.**
    - Request additional or extended care by submitting an RFS form directly to VA, preferably through **HSRM** or via an EDI 278 compliant interface.

2. **The Veteran contacts his or her local VAMC to confirm CCN eligibility.**
    - If the Veteran is eligible, VA may refer the Veteran to a community provider, and either appoints the Veteran to a CCN provider, delegates appointing to TriWest, or allows the Veteran to self-schedule.

3. **VA assesses the Veteran's need and makes the determination to refer the Veteran for care in the community, therefore generating an approved referral/authorization.**
    - VA will then send the authorization information to TriWest/Optum for administrative purposes

Veterans Affairs Medical Center

1. **VAMC Direct Appointing**
    - Veteran's VAMC approves care.
    - Veteran's VAMC contacts the provider's office, schedules an appointment on behalf of the Veteran, and sends the authorization letter to the provider

2. TriWest/Optum Appointing

- Veteran's VAMC approves care and delegates the appointment process to carrier.
- Carrier contacts the CCN provider on behalf of the Veteran to schedule the appointment and then sends VA's authorization letter to the provider.

3. Veteran Self-Appointing

- Both the VAMC and TriWest/Optum offer self-appointing options for Veterans. A Veteran can self-appoint when he/she has an approved referral/authorization.
- Veterans MUST have an approved referral/authorization in order to self-appoint; otherwise, the provider risks not being reimbursed.
- If the Veteran does not self-appoint within 90 days after the approved referral/authorization was generated, the approved referral/authorization will be returned to VA.
- Either TriWest or VA sends the provider an authorization letter after receiving appointment information.
- If the provider hasn't received an approved referral/authorization letter within a week of a Veteran self-scheduling an appointment, the provider should contact the VAMC or TriWest to ensure the appointment information is available.
- A Veteran may also self-appoint through the Veteran self-service website or phone app.

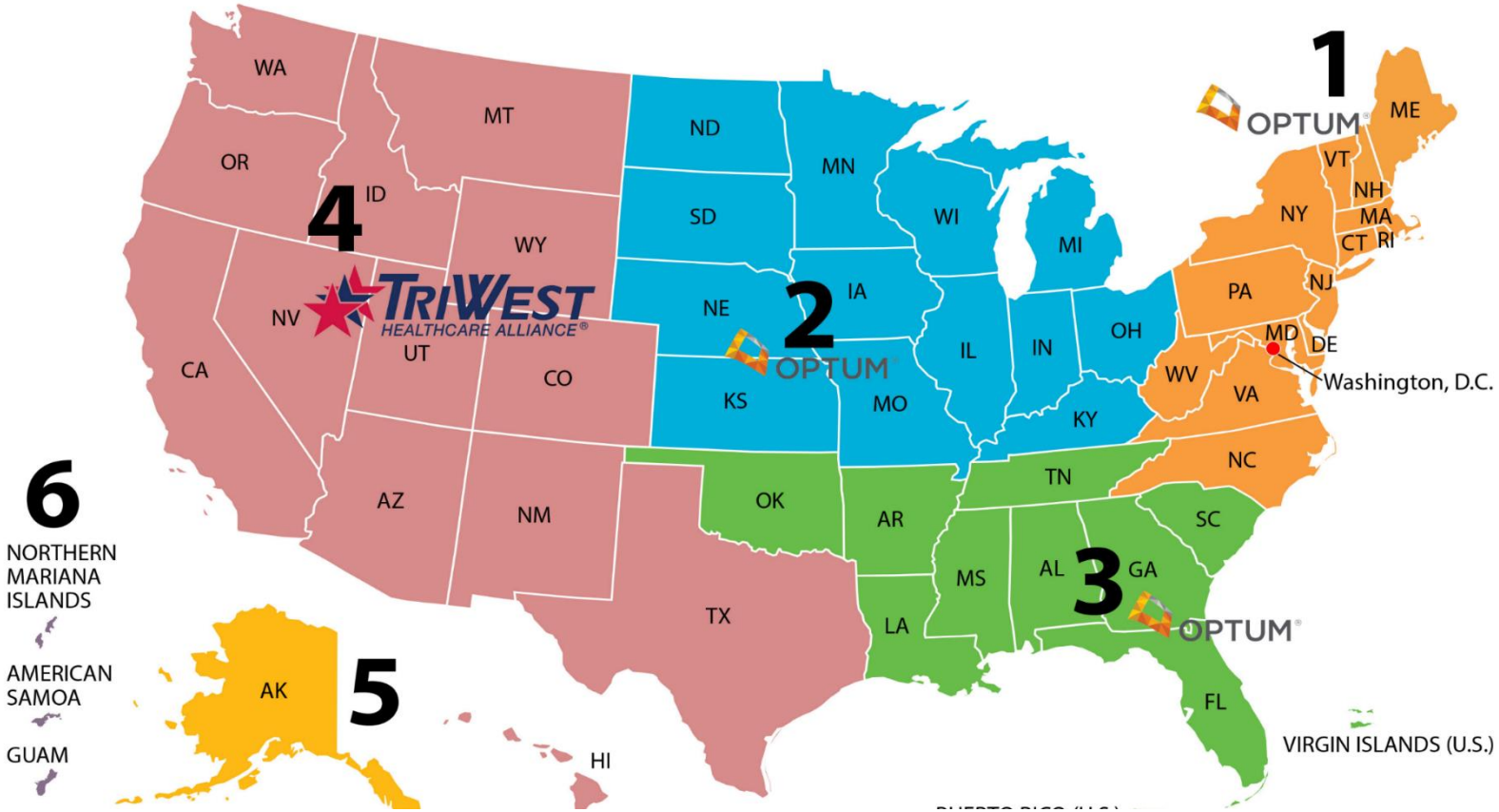
Veteran Must Advocate For Care

- Veterans should make a demand for chiropractic care specifically
- Indicate they do not wish to use any further medication or other medical services (including physical therapist care)
- When possible, request specifically with their provider of choice
- Veteran patients may use **https://www.myhealth.va.gov/mhv-portal-web/user-login** to make requests or get help in accessing care

Authorization

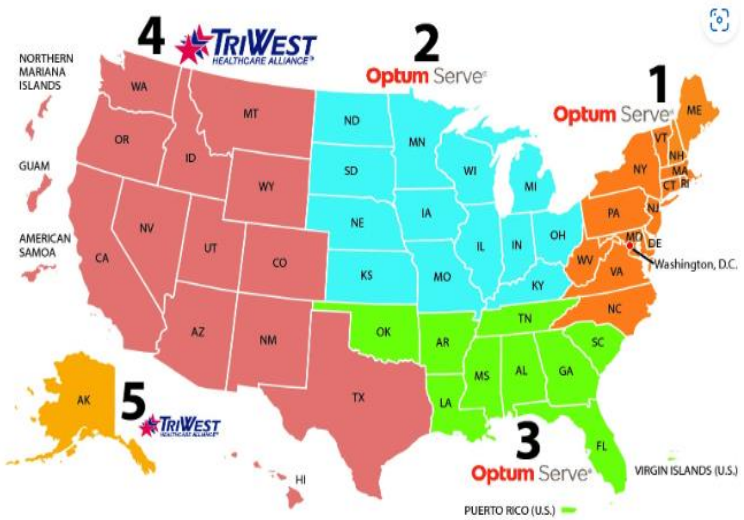
Veteran patient may use: **https://www.myhealth.va.gov/mhv-portal-web/user-login** to make requests or get help in accessing care

Provider Enrollment



Regional Networks

CCN is comprised of five regional networks that serve as the contract vehicle for VA to purchase care for Veterans from community providers.



Region 1	Region 1 map	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia
Region 2	Region 2 map	Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin
Region 3	Region 3 map	Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, Puerto Rico, South Carolina, Tennessee, Virgin Islands (U.S.)
Region 4	Region 4 map	American Samoa, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, New Mexico, Nevada, Northern Mariana, Islands, Oregon, Texas, Utah, Washington, Wyoming
Region 5	Region 5 map	Alaska

Community Care Network Regions

NOTE: Optum Public Sector Solutions, Inc. (Optum), part of UnitedHealth Group, Inc., serves as the third party administrator (TPA) for CCN regions 1, 2, and 3. TriWest Health Care Alliance (TriWest) serves as the TPA for regions 4 and 5.

Optum Health

Contact Information:

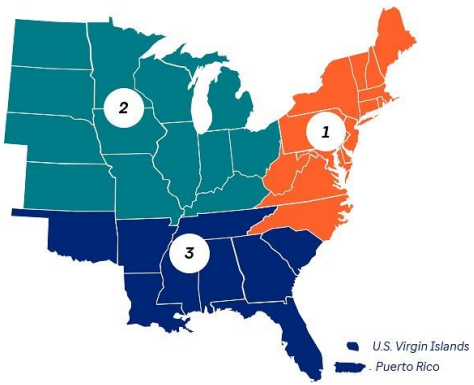
- Region 1: 888-901-7407
- Region 2: 844-839-6108
- Region 3: 888-901-6613

- https://vacommunitycare.com/provider
- https://www.myvaccn.com/site/vaccn/main/public/login#/home (registration page)

What is VA CCN?

VA recognizes that while the health care landscape is constantly changing, VA's unique population and broad geographic demands will continue to require community-based care for Veterans. VA is committed to providing eligible Veterans with the care they need when and where they need it. A significant component of having one method for Veterans to receive care from community providers is the ability for VA to purchase community services through the CCN contracts awarded to Third-Party Administrators (TPAs). Optum was awarded Region 1, Region 2 and Region 3.

Region 1	Region 2	Region 3
• Connecticut	• Illinois	• Alabama
• Delaware	• Indiana	• Arkansas
• District of Columbia	• Iowa	• Florida
• Maine	• Kansas	• Georgia
• Maryland	• Kentucky	• Louisiana
• Massachusetts	• Michigan	• Mississippi
• New Hampshire	• Minnesota	• Oklahoma
• New Jersey	• Missouri	• Puerto Rico
• New York	• Nebraska	• South Carolina
• North Carolina	• North Dakota	• Tennessee
• Pennsylvania	• Ohio	• U.S. Virgin Islands
• Rhode Island	• South Dakota	
• Vermont	• Wisconsin	
• Virginia		
• West Virginia		



Regions are based on provider locations. The provider may receive referrals for Veterans residing in a different state than the provider's location. To determine the appropriate phone number for the provider's region, click here.

VA CCN gives Veterans the opportunity to receive care from a network of community health care professionals, facilities, pharmacies, and suppliers.

Veterans have sacrificed to serve our country, and this is an opportunity to provide them with the timely, accessible and high-quality care they deserve. Providers can help Veterans access a network of community health care through their contract with Optum or another Network Partner. VA CCN only covers Veterans, not their families or dependents. VA determines a Veteran's eligibility to get care from community providers.

Network Resources

Optum's complete and comprehensive health care provider network includes, but not limited to:

UnitedHealthcare

UnitedHealthcare provides the network for traditional medical services for VA CCN. The UnitedHealthcare network includes:

- **Primary care providers**
- **Specialty and sub-specialty providers**
- **Acute care hospitals**
- **Laboratories**
- **Specialty pharmacies**
- **Ambulatory surgery centers**
- **Long-term acute care facilities**

- Federally Qualified Health Centers
- Rural Health Clinics
- Urgent care facilities
- Ancillary services, including home health, DME, hospice care, dialysis and diagnostic radiology

United Behavioral Health

United Behavioral Health (UBH) provides a network of behavioral health and substance use disorder facilities and providers who perform Complementary and Integrative Healthcare Services (CIHS) for VA CCN.

The UBH network includes:

- Psychiatric hospitals
- Inpatient and outpatient mental health and substance use disorder programs
- Psychiatrists
- Psychologists
- Social workers
- Marriage and family therapists
- Counselors

VA CCN CIHS includes biofeedback, hypnotherapy, relaxation techniques and Native American healing.

UBH serves all areas, except Puerto Rico and the U.S. Virgin Islands. Those areas are covered by a leased network.

OptumHealth Care Solutions, LLC

OptumHealth Care Solutions, LLC, (OHCS) provides a network of freestanding physical health providers and services for VA CCN, which includes:

- Physical therapy
- Occupational therapy
- Speech therapy
- Chiropractic services

The OHCS network also includes providers who provide some CIHS, including:

- Massage therapy
- Acupuncture
- Tai chi

Note: Chiropractic, Massage Therapy, and Acupuncture specialties are contracted on an individual NPI level only.

OHCS provides tai chi in all areas. All other specialties listed above are provided by OHCS in all areas, except Puerto Rico and the U.S. Virgin Islands. Those areas are covered by a leased network.

Optum Serve

Optum Serve (formally known as Logistics Health Inc. (LHI) provides a network of general and specialized dental providers covering all geographic areas. This network provides outpatient dental care to all eligible Veterans.

CVS Caremark Pharmacy

CVS Caremark Pharmacy serves as a Pharmacy Benefits Manager (PBM) and a retail pharmacy network covering all geographic areas for the VA CCN. The retail pharmacies provide prescription fulfillment services for urgent or emergent prescriptions from VA CCN and VA providers with an approved referral or Urgent Care Eligibility Record Number (UCERN).

VA Directive 1137 — Provision of Complementary and Integrative Health (recertified December 2022) establishes national VHA policy regarding the provision of CIH approaches.

VA facilities may provide the required CIH approaches internally, on-site, via telehealth, or in the community through volunteers, community partners or the Community Care Network. The CIH approaches included in the Veterans medical benefits package if deemed appropriate by their care team include:

Approaches for Treatment:

Acupuncture

Biofeedback

Clinical hypnosis

Massage therapy

Approaches for Well-Being:

Meditation

Guided imagery

Tai Chi / Qigong

Yoga

IHCC has reviewed these approaches and found evidence of benefits to Veteran care.

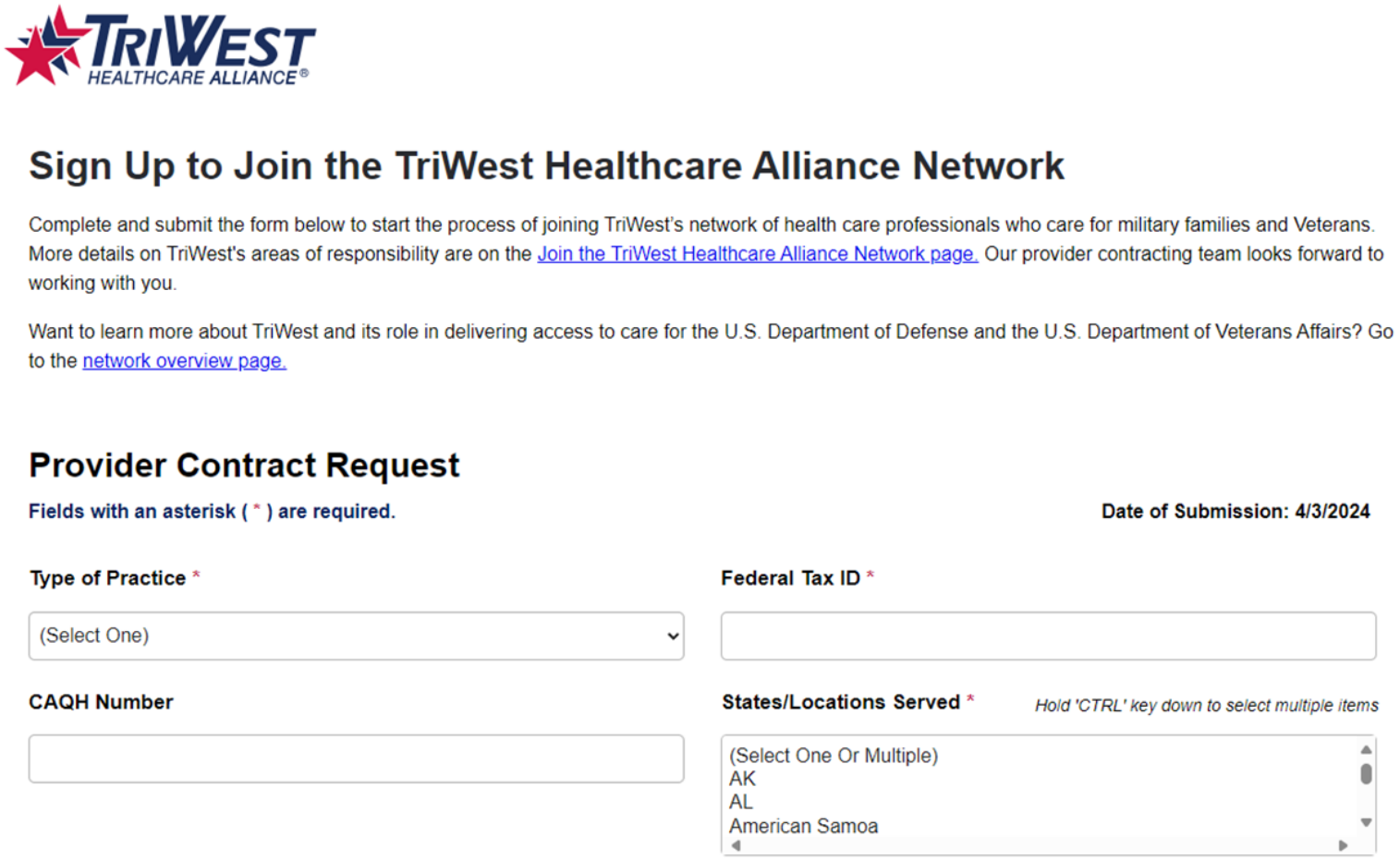
To download the 2024 Optum Community Care Provider Manual:

- https://vacommunitycare.com/doc/ccnProvManual/ccnPrManual

TriWest Customer Service: 877-266-8749

Enrollment

https://joinournetwork.triwest.com/



EMPOWER CHIRO
A Family Health America Company

- EmpowerChiro must be utilized to be part of the **TriWest** VA Choice provider network
- www.empowerchiro.com
- **(800) 819-9571**
- Enrollment https://empowerchiro.com/announcement/
- You may opt out their affiliated plans that are for PI and WC

EmpowerChiro
A Family Health America Company

Network Form – NATIONAL

You are automatically included in ALL HEALTH plans through your agreement. Please check below if you DO NOT wish to be included in any of the following:

_____Workers' Compensation
_____Auto/Personal Injury (PI)
_____Medicare
_____Medicaid

Please select your networks by checking either "Yes" or "No", initial each page and sign the last page. ***IF THIS FORM IS NOT RETURNED TO EMPOWERCHIRO, YOU WILL AUTOMATICALLY BE INCLUDED IN ALL PLANS.***

The allowed amount may not be what insurance pays and may include the patient's liability [copay, coinsurance and/or deductible, etc.) and may include codes that are not allowed and/or not paid under self-funded or other types of plans.

If you are billing with a group tax id number, if only one provider in the group has been credentialed by EmpowerChiro, all claims for all providers in the group may be processed as in-network.

Note – Family Health America, LC, dba EmpowerChiro, (FHA) selects the plan or plans in which it chooses to participate. Even if you opt into a specific Health Plan, or general type of plan, you will not be included in plans FHA as a company has opted out of now or may in the future (this includes individual accounts FHA may opt out of which are within an overall Health Plan). For any or no reason, FHA has the right to remove you from any plan or plans.

THIS FORM IS A PART OF YOUR PROVIDER AGREEMENT.

Chiropractor Directory Search

____Yes No - Patients from all across America visit this search page every day to find a chiropractor. The EmpowerChiro Chiropractor Directory Search Page is a sponsored listing which enables patients in each city to locate a chiropractor. As a preferred provider, unless you notify us otherwise, you automatically receive a FREE listing of your practice information (name, address, phone and fax) on the "Find-A-Chiro" page of our website, www.empowerchiro.com. To add "About Us" and "Driving Directions" or photos, please email the information to help@empowerchiro.com.

NeedaChiro
Helping Patients Find a Quality Chiropractor

____Yes No - A directory website to assist patients in locating our most esteemed member chiropractors. As part of your EmpowerChiro membership, you receive a "mini website" at www.NeedAChiro.com which includes photos and information about your practice.

TRIWEST HEALTHCARE ALLIANCE®

TriWest Healthcare Alliance (TriWest) was founded in 1996 to provide Service Members and Veterans with access to high quality health care and customer service. Through the Veterans **Community Care Network (CCN)** in the following TriWest CCN states (Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Texas, Utah, Washington, and Wyoming) can treat Veterans referred from the VA through TriWest referral. TriWest will process the referral from the VA, schedule appointments, track medical documentation and pay claims.

Reimbursement is based on the TriWest Addendum included with this packet.

AMERICAN PPO
The Organization Preferred

American PPO Inc (APPO) is a large national PPO. **APPO will discount provider's billed charges 15%.**

Atlantic Integrated Health, Inc. (AIH), a subsidiary of The Beacon Company, is a large medical PPO located in **North Carolina**. The AIH fee schedule is as follows:

CPT	ALLOWED FEE	CPT	ALLOWED FEE
99201	$ 48.45	97026	$ 11.03
99202	$ 75.71	97035	$ 17.00
99203	$111.50	97530	$ 36.75
99204	$162.50	72010	$151.26
99205	$205.50	72020	$ 57.43
99211	$ 26.00	72040	$ 82.28
99212	$ 45.00	72050	$121.63
99213	$ 62.00	72052	$147.32
99214	$ 97.00	72070	$ 86.51
99215	$144.00	72100	$ 89.79
97010	$ 10.18	72110	$123.34
97012	$ 18.90	98940	$ 24.50
97014	$ 18.23	98941	$ 33.91
97016	$ 22.05	98942	$ 44.37
97024	$ 11.03	98943	$ 22.71

Note: For any CPT4 or HCPCS code not listed on the fee schedule, reimbursement will be 80% of provider's billed charges.

stratose®

Since 1995, Stratose (formerly known as Coalition America) has served payors of all kinds, including insurance carriers, third-party administrators (TPAs), health maintenance organizations, stop-loss carriers, Labor/Taft-Hartley funds and health plans. We currently serve the medical, dental and workers' compensation payor markets.

Health Insurance Plans reimbursement will be 105% of the Medicare fee schedule for each applicable region.

____Yes No - Workers' Compensation Plans – Unless otherwise required by law, the contract rate for workers' compensation plans shall be equal to ninety (90) percent of the fees listed under the state or federal workers' compensation fee schedule less any copayments, deductibles and coinsurance, if applicable.

CommuniCare ADVANTAGE

CommuniCare Advantage is a Medicare Advantage plan serving residents in Indiana, Ohio, and Maryland. Reimbursement is 115% of the applicable Medicare fee schedule. If submitted code is not covered by the then current Medicare fee schedule, payment will be 80% of submitted billed charges.

evolutions HEALTHCARE SYSTEMS

Evolutions Healthcare Systems, Inc. (EHS) is a large national PPO. **The allowed amount will be 120% of RBRVS or provider's charges will be discounted 22%, whichever is less.**

Fortified Provider Network ("FPN") is a national direct-contracted preferred provider network. FPN's select provider network is utilized by self-funded employer groups, insurance carriers and regional and local provider networks that process end-user patient claims. FPN works hard to insure its valued healthcare providers benefit from attractive reimbursement levels, fast reimbursement terms and superior customer service. Our goal is for end-user patients to receive excellent care in the location of their choice from high-quality providers at a reasonable cost.

***Note: I understand if I see patients through any of the Fortified Provider Network (FPN) networks or products, EmpowerChiro will bill me monthly 10% of the allowed amount via auto debit of checking account or credit card on file.**

*** YOU WILL AUTOMATICALLY BE INCLUDED IN FPN HEALTH**
FPN's Payors will reimburse at a rate of two hundred percent (200%) of current allowable Medicare (CMS) rates. For those codes not on the current Medicare (CMS) allowable fee schedule, FPN's Payors will reimburse at sixty percent (60%) of total billed charges (amounting to a 40% discount for FPN's Payors).

____Yes _No- Workers' Compensation - In states where state-mandated fee schedules are in effect, FPN's Payors will reimburse at the lessor of eighty-five percent (85%) of the state-mandated fee schedule (amounting to a 15% discount for FPN's Payors) or thirty percent (30%) off of total billed charges (amounting to a 30% discount for FPN's Payors). In states where there is no state-mandated fee schedule in effect, FPN's Payors will reimburse at a rate of seventy percent (70%) of usual, customary and reasonable fees as determined by FPN's vendor Fair Health (amounting to a 30% discount off UC&R for FPN's Payors).

____Yes _No- Auto (Personal Injury) - In states where state- mandated fee schedules are in effect (including the states of FL, HI, NY, NJ, OR, PA and UT), FPN's Payors will reimburse at a rate of eighty- five percent (85%) of the state-mandated fee schedule (amounting to a 15% discount for FPN's Payors). In states where there is no state- mandated fee schedule in effect, FPN's Payors will reimburse at a rate of seventy percent (70%) of total billed charges (amounting to a 30% discount for FPN's Payors).

Health - Galaxy Health Network (GHN) is a large national PPO. GHN will reimburse 85% of billed charges for patient services in all states except WA, OR, CA, FL, HI, NY and NJ.

GHN will reimburse 82% of billed charges in WA, OR, CA, FL, HI, NY and NJ.

Galaxy Medical Savings Network

Galaxy Health Network has found a way to integrate Interactive Voice Response (IVR) technology into a system that addresses consumers' need for a benefit discount by applying it to the "repricing" of claims by a provider.

Program Details: The patient will call directly to schedule their appointment. The patient will present their membership card upon arrival to their appointment. The patient must pay you the reduced amount in full at the time of service to be eligible for the reduced rates. MedNet will reprice your charges and fax a completed EOB form to you while the patient is still in your office by calling (800) 813-6877.

HealthCare's Finest Network (HFN) is a large medical network that accesses our network in the following states: **Illinois, Indiana, Iowa, Wisconsin and St. Louis, Missouri.** HFN's services include health insurance, work comp and PI. **The allowed amount will be the lesser of 140% of the Medicare rates for Region #16 of the Chicago area or 90% of provider's billed charges.**

Interplan Health Group (IHG), formerly Accountable and DirectCare America (DCA) is a large national PPO**. IHG will discount provider's charges (or usual and customary rates for your region) by 25%.**

NovaNet Inc (NovaNet) is a national network that may include third party administrators, national payors and insurance companies with PPO products only. Through NovaNet, our providers will be eligible to receive referrals from members in **Alabama, Florida and a small portion of South Carolina.**

For health services rendered to a participant, the fee schedule is 140% of the allowable charges based on the Georgia current year's RBRVS. If the provider's billed charges are less than 140% of the Georgia Medicare rate, the provider's charges will be discounted 15%.

Prime Health Services Inc. (PHS) is a large national PPO.

Health: The allowed amount for chiropractors participating in PHS Group Health product will be 130% of the current Medicare fee schedule. If submitted code is not covered by the current Medicare fee schedule, payment will be 80% of submitted billed charges.

____Yes No - ***Medicare and Medicare Advantage Program(s):*** For chiropractors participating in PHS Medicare programs, the allowed amount will be 100% of the current Medicare fee schedule.

____ Yes No - ***Workers' Compensation Plans:*** The allowed amount for chiropractors participating in PHS Worker's Compensation product will be 75% of any maximum allowable rate as specified by State Law.

____Yes No – ***First Party Auto Medical:*** The allowed amount for chiropractors participating in PHS Auto Medical PPO product will be 75% of the maximum allowable rate as specified by State or Federal Law.

USA Managed Care Organization (USA) is the nation's largest privately held medical provider network and may also be known as USA H&W Network, USA Workers' Injury Network, USA Transnet, USA Genesis, USA WIN SPAA and USA Professional Negotiations. **(We are not currently participating in worker's compensation or auto medical w/ this group.)**

Health: USA/MCO will discount provider's charges (or usual and customary rates for your region) according to the Relative Values for Physicians fee schedule. Any fees not established will be reimbursed at 80% of billed charges. (You may contact USA/MCO regarding reimbursement for specific CPT codes.)

MultiPlan Beech Street

PHCS PHCS SAVILITY

HealthEOS HealthEOS Plus+ HealthEOS Select HealthEOS Select+

ValuePoint By MultiPlan (Non-insured Arrangement)

***Note: I understand if I see patients through any of the Multiplan networks or products, EmpowerChiro will bill me monthly 10% of the allowed amount via auto debit of checking account or credit card on file.**

*** YOU WILL AUTOMATICALLY BE INCLUDED IN MULTIPLAN HEALTH** which includes MultiPlan, Beech Street, PHCS, PHCS Savility, HealthEOS and ValuePoint (Discount Card) Program - Any MultiPlan, Inc. contract, insurance policy, health benefit plan or other health plan or program under which Participants are eligible for benefits. The contract rate for the above MultiPlan networks and programs shall be equal to one hundred and five (105%) percent of the CMS RBRVS fee schedule less any Co-payments, Deductibles, and Co-insurance, if any, as specified in the Participant's Benefit Program and will replace any existing fee schedules for the above plans.

___Yes____No - *Workers' Compensation
Unless otherwise required by law, the Contract Rate for workers' compensation Programs shall be equal to the lesser of (i) eighty-five (85%) of the fee under the state or federal workers' compensation fee schedule less any Co-payments, Deductibles, and Co-insurance, if any, as specified in the workers' compensation Program.

___Yes____No - *Auto Medical
Unless otherwise required by law, the Contract Rate for auto medical Programs shall be equal to the lesser of (i) ninety (90%) of the fee under the state auto medical fee schedule less any Co-payments, Deductibles, and Co-insurance, if any, as specified in the Participant's auto medical Program. If there is a CMS RBRVS fee schedule, the contract rate shall be equal to 105% of the CMS RVRBS fee schedule.

If there is not a CMS RBRVS fee schedule, the contract rate shall be equal to sixty (60%) percent of the Participating Provider's Billed charges, less any Co-payments, Deductibles, and Co-insurance, if any, as specified in the Participant's Benefit Program.

MediNcrease Health Plans™ 5 YEARS

***Note: I understand if I see patients through any of the MediNcrease networks or products, EmpowerChiro will bill me monthly 10% of the allowed amount via auto debit of checking account or credit card on file.**

*** YOU WILL AUTOMATICALLY BE INCLUDED IN MEDINCREASE HEALTH** For Provider Services furnished to each Commercial Covered Person, the settlement will be: 70% of Provider's Charge for Services Rendered.

___Yes____No Worker's Compensation (WC)- Allowed amount will be 75% of the state or federal mandated fee schedule, or 75% of the usual and customary amount (when no state or federal mandated fee schedule exists), or 70% of Provider's Charges (if no state or federal mandated fee schedule exists and a usual and customary amount is not applied by the Client or Payer).

____Yes____No Auto Compensation- Allowed amount will be 75% of the state or federal mandated fee schedule, or 75% of the usual and customary amount (when no state or federal mandated fee schedule exists), or 70% of Provider's Charges (if no state or federal mandated fee schedule exists and a usual and customary amount is not applied by the Client or Payer).

WPPA, INC. ProviDRs Care™

WPPA's ProviDRs Care Network (WPPA) is a preferred provider organization covering approximately 50,000 members across Kansas and parts of Missouri. Please call 316-687-34444 for the fee schedule. **EmpowerChiro bills providers 6% of the allowable each month.**

Provider Signature **Date**

Printed Name

Tax ID Number

COMPLETED FORM MAY BE FAXED TO 316-687-2113 OR EMAILED TO HELP@EMPOWERCHIRO.COM

Disclaimer: This Network Selection Form is a part of your provider agreement and governed exclusively by the rules and regulations of the State of Kansas, USA. You are responsible for knowing and following the rules of your state.

March 2021

Credentialing Requirements

1. Provider must meet the requirements of state and local laws and if applicable must have a full, current, non-probationary and unrestricted license in the state where services are delivered.
2. Provider must remain in compliance with the seven (7) elements of the OIG's Compliance Program Guidance.
    1. Implementing written policies, procedures and standards of conduct.
    2. Designating a compliance officer and compliance committee.
    3. Conducting effective training and education.
    4. Developing effective lines of communication.
    5. Conducting internal monitoring and auditing.
    6. Enforcing standards through well-publicized disciplinary guidelines.
    7. Responding promptly to detected offenses and undertaking corrective action.
3. If applicable, provider cannot have had any state license termed for cause or have relinquished any state license after being notified in writing by that state of potential termination for cause.
4. If applicable, providers shall meet all Medicare Conditions of Participation (CoP) and Conditions for Coverage (CfC), where such conditions exist, subject to CMS modifications, as required by the U.S. Department of Health and Human Services (HHS). Chiropractors however are exempt and need not be enrolled in Medicare.

- Nursing home care including state Veterans' Home per diem, which implies that when the Veteran is in a domicile/residence, the services would be excluded. When a person is at an unskilled site for a skilled need, it can be included.
- Home deliveries and deliveries by direct entry midwives, also known as lay midwives or certified professional midwives.
- Ambulance services. All ambulance services must always be referred directly to VA for payment consideration.

Specific Credentialing Requirements for Professional Providers

Most providers will have to fulfill the following two credentialing requirements along with other sets of unique requirements, mentioned in the tables below:

- State license, full, current, and unrestricted license in the state where services are delivered.
- If a provider is or has been licensed in more than one state, TriWest must always confirm that the provider certifies that none of those states has terminated such license for cause, and that the provider has not involuntarily relinquished such license in any of those states after being notified in writing by that state of potential termination for cause.

Type/Specialty	VA Specialty-Specific Requirements
Chiropractor, Clinical Psychologist (PHD, EdD, PsyD, EdS), Physicians, Physical Therapist, Podiatrists	No additional requirement other than the two requirements mentioned above.
Acupuncture, Licensed Acupuncturist/Doctor of Oriental Medicine	•Physician Acupuncturists (MD/DO) must hold a valid unrestricted license to practice medicine including acupuncture, and either be a member of the American Academy of Medical Acupuncture (AAMA) or be certified by the American Board of Medical Acupuncture. •State license, full, current, unrestricted license is required in the state where services are delivered or National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) certification

Professional Liability Coverage

Providers must maintain, during the term of their Provider Agreement, professional liability insurance issued by a responsible insurance carrier of not less than (per specialty per occurrence):

- $1,000,000 per occurrence
- $3,000,000 aggregate

Optum | United Healthcare

Provider Credentialing

Veterans Affairs Community Care Network (VA CCN)

Optum, United Healthcare or its designee must credential Providers and facilities, according to requirements of nationally recognized accrediting organizations. Credentialing is generally not required for health care professionals who are permitted to furnish services only under the direct supervision of another licensed independent practitioner or for hospital-based or facility-based health care professionals who provide service to covered persons incidental to hospital or facility services. Providers who are currently credentialed and participating with Optum or United Healthcare, as applicable, are not required to complete a separate credentialing application for VA CCN.

The credentialing process involves obtaining primary-source verification of the Provider's education, board certification, license, professional background, malpractice history and other pertinent data.

New VA CCN Providers who are not currently credentialed and participating with one of our network partners will have to complete a standardized, applicable, nationally accredited credentialing process.

All services, facilities, and Providers must adhere to all applicable federal and state regulatory requirements. Optum will monitor the U.S. Department of Health and Human Services Office of Inspector General (OIG) exclusionary list. If the provider is on the exclusionary list the provider won't be eligible to participate in the network. See oig.hhs.gov/exclusions for more information about the exclusionary list. If Provider doesn't maintain active credentialing status, the contract could be terminated.

If a VA CCN Provider is licensed, registered or certified in more than 1 state, the Provider must confirm that:

- None of the Provider's licenses, registrations or certifications in those states have been terminated for cause
- Provider has not involuntarily relinquished the provider's license, registration or certification in any of those states after being notified in writing by that state of a potential termination for cause

The Provider must notify the appropriate network partner within 5 business days of the occurrence of an action, lapse or limit impacting the Provider license, registration or certification. If any state in which a Provider is licensed, registered or certified terminates such license, registration or certification, the Provider will be removed from VA CCN.

If a VA CCN Provider's specialty is not subject to an accredited credentialing process, the Provider must operate within the scope of the Provider's professional license. The VA CCN Provider must maintain and provide to the appropriate network partner, upon request, the following documentation:

- Proof of identity with a government-issued photo and I-9 documentation
- An active, unrestricted license from the state where the service is provided, if applicable (Unskilled home health excluded)
- Criminal background disclosure
- Current national provider identifier (NPI) number. (Unskilled home health excluded)
- Drug Enforcement Agency (DEA) number if controlled substances are prescribed
- Education and training, if applicable (unskilled home health excluded)
- Professional references

- Proof of professional liability insurance in an amount in accordance with the laws of the state in which the care is provided
- Tax identification number (TIN)
- Work history

Contact Information

For more information about the credentialing process or to become a participating Provider with VA CCN, please contact the appropriate network based on your Provider type:

Table 1: Participating Provider Networks

Network	Provider Type	Website or email address
United Healthcare	Medical professionals, facilities, and ancillary providers	UHCprovider.com/Join
United Healthcare	National laboratory and national ancillary providers	naspi@uhc.com
United Healthcare Home and Community Based Services	Adult day care Homemaker/Personal Care Private duty nursing (non-Medical Certified Home Health)	hcbsprovidernetwork@uhc.com
United Healthcare Vision	Routine vision services	spectera.com > Join Our Network
United Behavioral Health	Mental health and substance abuse	providerexpress.com > Our Network
Optum Serve	Dental providers	providers.optumserve.com > Join Our Network
Optum Complex Care Management	Skilled nursing facilities	UHCprovider.com/Join
Optum Health Care Solutions	Acupuncture, chiropractic, massage therapy, occupational therapy, physical therapy, speech pathology, tai chi	myoptumhealthphysicalhealth.com > Interested in becoming a Provider?

Patient Nomination

If you have difficulty in credentialing based upon the “network is full”

The patient or veteran may nominate and request for your office to be part of the program and this may be the spark to allow your office to be credentialed.

- They request chiropractic and specifically indicate you (The DC) with their reasons why – Past experience, reputation, access, location, etc

VA PTP

Triwest or Optum

Ombudsmen (myhealthevet.com)

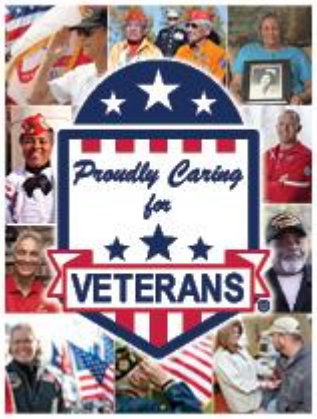
How Will Anyone Know or Find You?

Your now enrolled but how do you get a patient?

Tell Your Community You Proudly Care for Veterans

Thank you for joining our mission and proudly caring for Veterans!

If you want to let your community know that you're treating Veterans at your clinic, office, or organization, please feel free to use the tools below.



https://www.triwest.com/en/provider/training-and-help/proudly-caring-for-veterans/

Print Ready Signs and Embed

Find VA locations

Find a VA location or in-network community care provider. For same-day care for minor illnesses or injuries, select Urgent care for facility type.

Coronavirus update: Please call first to confirm services or ask about getting help by phone or video. We follow CDC guidelines for wearing masks at our facilities.

City, state or postal code (*Required) Use my location

Facility type (*Required)

Choose a facility type

Service type

Search

Please enter a location (street, city, state, or postal code) and facility type, then click search above to find facilities.

https://www.va.gov/find-locations

All Care Must Be Authorized

VA Office of Community Care

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Community Care

UNDERSTANDING THE VA COMMUNITY CARE PROCESS

Consult Creation and Review

A consult is a request from a VA provider that refers a Veteran for specialty medical and/or behavioral care.

The VA medical center referral coordination team reviews the request and determines if the care can be delivered locally, face to face or virtually and assesses the Veteran's community care eligibility.

VA then contacts the Veteran. If the Veteran is deemed to be community care eligible and opts-in to receive community care, the referral is prepared for scheduling with an in-network community provider.

Scheduling

After the referral has been reviewed and the modality confirmed, the Veteran may proceed to self-schedule their appointment. If the Veteran prefers, VA can schedule the appointment for them.

If the Veteran decides to self-schedule, they are either given the contact information of the applicable providers near them in the community network or can use https://www.va.gov/find-locations/ to find acceptable providers.

The Veteran is asked to inform VA of the details of the appointment within 14 days to add to the Veteran's chart. This allows VA staff to help coordinate care when needed or requested by the Veteran.

Authorization

After the appointment is scheduled, an authorization is created.

Authorizations are approvals from VA for Veterans to receive care from a community provider.

Veterans receive a letter with:

- An authorization number
- The approved in-network community provider info
- A description of the authorized care
- The time period the Veteran is authorized to receive care.

Community Care Visit

At the scheduled day and time, Veterans attend their community care appointment.

VA will have already sent relevant medical records to the community provider.

However, if instructed by the community provider, the Veteran may be asked to bring copies of diagnostic imaging (CT or MRI) with them.

The wait time is calculated from the date of the referral to the date the appointment is completed

1 → 2 → 3 → 4

Day 1	Up to 14 Days	Dependent upon community provider availability and Veteran's scheduling preference

Receiving a Referral

			
Eligibility	**VA contacts CCN provider**	**Schedule appointment**	**Reviews consult order**
VA confirms a Veteran's eligibility to receive Community Care	VA requests CCN provider accept referral and confirms provider's preferred method to receive referral	Veteran, VA staff member or Optum schedules an appointment with a CCN Provider	Provider reviews consult order included with the approved referral for services being requested by VA

Upon a CCN provider accepting a referral from VA, an approved referral packet will be sent, using the provider's preferred method to receive it. Options for preferred methods are:

- HealthShare Referral Manager (HSRM)
- Secure fax
- Secure email (VA only)
- Direct messaging (VA only)

CCN providers can find more information about the methods directly from VA at va.gov/COMMUNITYCARE/providers/index.asp.

Standard Episode of Care

What is an SEOC?

- An SEOC is a set of clinically related healthcare services for a specific unique illness or medical condition (diagnosis and/or procedure) provided by an authorized provider during a defined, authorized period of time not to exceed one year.
- This will be sent to you and specifically define the diagnoses and services for that patient

Chiropractic Care

- Standard Episode of Care (SEOC)
- Chiropractic Initial
- Chiropractic Continuation
- Chiropractic Pain Management

SEOC ID: PMR_CHIROPRACTIC INITIAL_1.0.12
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order.
Duration: 90 days

Procedural Overview:
1. Initial outpatient evaluation and outpatient re-evaluation as clinically indicated for the referred condition indicated on the consult order.
2. Plain film x-ray of the region of complaint specified on the consult order if not yet performed at the VA and is clinically indicated.
a. Plain film x-ray imaging only when medically necessary based on widely accepted indications such as clinical suspicion of fracture, dislocation, or other significant pathology. X-ray is not authorized solely for biomechanical/postural assessment, and/or determining manipulative technique approach.
3. Authorized up to twelve (12) chiropractic visits for this episode of care.
Note: A Chiropractic plan of care typically includes chiropractic manipulative treatment for the relevant condition. Plan of care can also include manual therapy, massage therapy, therapeutic exercise, neuromuscular re-education, and acupuncture which must be performed by a chiropractor subject to the provider's given state licensure and scope. Any services outside of the licensure and scope of the chiropractor, including manual therapy, massage therapy, therapeutic exercise, neuromuscular re-education, and acupuncture, must have an RFS and supporting medical documentation submitted to the VA for clinical review prior to the care being rendered by another provider. If acupuncture is integrated into the chiropractor's plan of care, additional units of acupuncture must be medically necessary and require documentation of face to face provider time and evidence of reinsertion by the chiropractor.
Note: Requests for additional chiropractic care beyond this trial must provide documentation of: Objective measures demonstrating the extent of meaningful clinical improvement to date; AND Rationale for the additional treatment requested (e.g. to reach further durable improvement, or for ongoing pain management); AND Any further information supporting the need for additional care
* Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following:
* Pharmacy prescribing requirements
* Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements
* Preservtification (PRCT) process requirements
* Request for Services (RFS) requirements

Chiropractic Initial

- **20560, 20561** (Dry Needling)
- **72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72081, 72082, 72083, 72084, 72100, 72110, 72114, 72120, 72170, 72190, 72200, 72220, 73020, 73030, 73501, 73502, 73503, 73521, 73522, 73523, 73560**
- **97012, 97018, 97022, 97026, 97033, 97035, 97110, 97112, 97113, 97116, 97124, 97140, 97535, 97750, 97810, 97811, 97813, 97814**
- **98940, 98941, 98942, 98943**
- **99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215**
- **0552T** (Laser)
- **G0283**
- **G0463** (Hospital outpatient clinic visit for assessment and management of a patient
- **G0466, G0467** (FQC new & established patient visit)

97140 - MANUAL THERAPY 1/> REGIONS 99214 - OFFICE/OUTPATIENT VISIT EST ICD Codes: R52 - Pain, unspecified M54.50 - Low back pain M53.86 - Other specified dorsopathies, lumbar region M46.07 - Spinal enthesopathy, lumbosacral region M54.09 - Panniculitis affecting regions, neck and back, multiple sites in spine M99.03 - Segmental and somatic dysfunction of lumbar region M99.04 - Segmental and somatic dysfunction of sacral region M99.02 - Segmental and somatic dysfunction of thoracic region ********** ***** ------Chiropractic Treatment Order------ Continuation of chiropractic treatment trial Attending Physician:

Provisional Diagnosis: M5450 Low back pain, unspecified

Services Authorized

The VA Order Reason for Request is the official clinical order. This scope of services associated with the medical care for this authorization is found below. Necessary services that are not included must be requested using the Request for Services procedures. Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements.

Service Requested: Chiropractic Continuation of Initial_PRCT SEOC 1.1.14

Category of Care: CHIROPRACTIC

Procedural Overview - Standardized Episode of Care (SEOC)

Chiropractic Continuation of Initial_PRCT SEOC 1.1.14 Duration: 30 Days

No.	Service/Procedure	Number Of Visits Authorized
1	Outpatient re-evaluation (limit of one (1)) as clinically indicated for the referred condition indicated on the consult order	1
2	Plain film x-ray of the region of complaint specified on the consult order if not yet performed at the VA and is clinically indicated a. Plain film x-ray imaging only when medically necessary based on widely accepted indications such as clinical suspicion of fracture, dislocation, or other significant pathology. X-ray is not authorized solely for biomechanical/postural assessment, and/or determining manipulative technique approach.	999
3	Authorized up to six (6) chiropractic visits for this episode of care Note: A Chiropractic plan of care typically includes chiropractic manipulative treatment for the relevant condition. Plan of care can also include manual therapy, massage therapy, therapeutic exercise, neuromuscular re-education, and acupuncture which must be performed by a chiropractor subject to the provider's given state licensure and scope. Any services outside of the licensure and scope of the chiropractor must have an RFS and supporting medical documentation submitted to the VA for clinical review prior to the care being rendered by another provider. If acupuncture is integrated into the chiropractor's plan of care, additional units of acupuncture must be medically necessary and require documentation of face-to-face provider time and evidence of reinsertion by the chiropractor. Note: Requests for additional chiropractic care beyond this trial must provide documentation of: Objective measures demonstrating the extent of meaningful clinical improvement to date; AND rationale for the additional treatment requested (e.g., to reach further durable improvement, or for ongoing pain management); AND any further information supporting the need for additional care	6

SEOC Disclaimer

Chiropractic Continuation of Initial

- 20560, 20561
- 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72081, 72082, 72083, 72084, 72100, 72110, 72114, 72120, 72170, 72190, 72200, 72220, 73020, 73030, 73501, 73502, 73503, 73521, 73522, 73523, 73560
- 97012, 97018, 97022, 97026, 97033, 97035, 97110, 97112, 97113, 97116, 97124, 97140, 97535, 97750, 97810, 97811, 97813, 97814
- 98940, 98941, 98942, 98943
- 99211, 99212, 99213, 99214, 99215,
- 0552T
- G0283
- G0463
- G0466, G0467

Provisional Diagnosis: [redacted]

Services Authorized

The VA Order Reason for Request is the official clinical order. This scope of services associated with the medical care for this authorization is found below. Necessary services that are not included must be requested using the Request for Services procedures. Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements.

Service Requested: Chiropractic Pain Management_PRCT SEOC 1.2.14

Category of Care: CHIROPRACTIC

Procedural Overview - Standardized Episode of Care (SEOC)

Chiropractic Pain Management_PRCT SEOC 1.2.14 Duration: 180 Days

No.	Service/Procedure	Number Of Visits Authorized
1	Outpatient re-evaluation (limit of two (2)) as clinically indicated for the referred condition indicated on the consult order	2
2	Authorized up to eight (8) chiropractic visits Note: A Chiropractic plan of care typically includes chiropractic manipulative treatment for the relevant condition. Plan of care can also include manual therapy, massage therapy, therapeutic exercise, neuromuscular re-education, and acupuncture which must be performed by a chiropractor subject to the provider's given state licensure and scope. Any services outside of the licensure and scope of the chiropractor must have an RFS and supporting medical documentation submitted to the VA for clinical review prior to the care being rendered by another provider. If acupuncture is integrated into the chiropractor's plan of care, additional units of acupuncture must be medically necessary and require documentation of face-to-face provider time and evidence of reinsertion by the chiropractor. Note: Expectations of service for chiropractic chronic pain management include: a. Assessment of patient function after a withdrawal of chiropractic care; AND b. Consideration of other indicated medical, psychological, behavioral, and/or social interventions; AND c. Inclusion of appropriate, individualized active care strategies such as home exercise and self-management approaches to empower patient self-efficacy	8

SEOC Disclaimer

* Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following: * Pharmacy prescribing requirements * Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements * Precertification (PRCT) process requirements * Request for Services (RFS) requirements

REFER ALL QUESTIONS RELATED TO THIS APPROVAL TO THE ISSUING VA OFFICE

Referring VA Facility: Greater Los Angeles VA Medical Center
Station Number:
Telephone Number: —

Chiropractic Pain Management

- 20560, 20561
- 97012, 97018, 97022, 97026, 97033, 97035, 97110, 97112, 97113, 97116, 97124, 97140, 97535, 97750, 97810, 97811, 97813, 97814
- 98940, 98941, 98942, 98943
- 99211, 99212, 99213, 99214, 99215,
- 0552T
- G0283
- G0463
- G0466 G0467

Fee Schedule

VA payment will be at Medicare rates

If there is no Medicare rate for the service, it will default to UCR

2024 Medicare Fee Schedule California

2024 Deductible $240

Limiting charge applies to unassigned claims by non-participating providers.

Procedure Code	Par Fee	Nonpar Fee	Limiting Charge
Southern California – Area 17 (Ventura County)			
98940	$29.22	$27.76	$31.92
98941	$41.88	$39.79	$45.76
98942	$53.77	$51.08	$58.74
Southern California – Area 18 (Los Angeles County) & 26 (Orange County)			
98940	$29.60	$28.12	$32.34
98941	$42.44	$40.32	$46.37
98942	$54.48	$51.76	$59.52
Southern California – Area 71 (Imperial County)			
98940	$27.99	$26.59	$30.58
98941	$40.22	$38.21	$43.94
98942	$51.75	$49.16	$56.53
Southern California – Area 72 (San Diego County)			
98940	$29.32	$27.85	$32.03
98941	$42.03	$39.93	$45.92
98942	$53.95	$51.25	$58.94
Southern California – Area 73 (San Luis Obispo County)			
98940	$28.43	$27.01	$31.06
98941	$40.81	$38.77	$44.59
98942	$52.44	$49.82	$57.29
Southern California – Area 74 (Santa Barbara County)			
98940	$29.04	$27.59	$31.73
98941	$41.64	$39.56	$45.49
98942	$53.47	$50.80	$58.42
Northern California – Area 62 (Riverside & San Bernadino Counties)			
98940	$28.09	$26.69	$30.69
98941	$40.33	$38.31	$44.06
98942	$51.85	$49.26	$56.65

Southern California – Area 17 (Ventura County)

97810	$ 40.77
97811	$ 29.83
97813	$ 48.64
97814	$ 39.09
99202	$ 77.88
99203	$ 118.75
99204	$ 176.71
99205	$ 232.69
99211	$ 26.02
99212	$ 61.21
99213	$ 97.33
99214	$ 136.83
99215	$ 191.72
97012	$14.81
97016	$12.46
97018	$6.10
97022	$18.71
97024	$8.04
97026	$7.26
97028	$9.10
97032	$15.20
97033	$20.96
97034	$15.02
97035	$15.02
97036	$39.06
97110	$31.60
97112	$36.38
97113	$39.97
97116	$31.60
97124	$33.28
97140	$28.99
97150	$19.25
97530	$40.17

Southern California – Area 18 (LA/OC)

97810	$ 41.31
97811	$ 30.25
97813	$ 49.28
97814	$ 49.27
99202	$ 78.89
99203	$ 120.37
99204	$ 179.36
99205	$ 235.95
99211	$ 26.31
99212	$ 61.99
99213	$ 98.61
99214	$ 138.66
99215	$ 196.82
97012	$15.01
97016	$12.62
97018	$6.18
97022	$18.93
97024	$8.14
97026	$7.36
97028	$9.21
97032	$15.40
97033	$21.22
97034	$15.21
97035	$15.21
97036	$39.49
97110	$32.00
97112	$36.83
97113	$40.45
97116	$32.00
97124	$33.67
97140	$29.36
97150	$19.50
97530	$40.65

Laser 0552T $6.00-9.00

VA Fee Schedule

This is the link to the fees for services that do not have a Medicare rate

https://www.va.gov/COMMUNITYCARE/revenue_ops/Fee_Schedule.asp

Diagnosis Will be indicated on the authorization and ensure the primary diagnosis is on your claim

VHA Directive 1232. "Consult Processes and Procedures" designate this clinic as low risk. Pursuant to the directive, CONSULTS WILL BE DISCONTINUED AFTER 1 NO SHOW. Please inform your patient about this policy.

Inter-facility Information
This is not an inter-facility consult request.

PROBLEM LIST

Sensitive Diagnoses

No sensitive diagnoses were provided.

Other Diagnoses

Problem	Code
Cervicalgia	M54.2
Chronic rhinitis	J31.0
Essential (primary) hypertension	I10.
Fatty (change of) liver, not elsewhere classified	K76.0
Gastroesophageal reflux disease with hiatal hernia	R69.
Hereditary and idiopathic neuropathy, unspecified	G60.9
Hyperlipidemia, unspecified	E78.5
Long QT syndrome	I45.81
Low back pain, unspecified	M54.50
Male infertility, unspecified	N46.9
Morbid (severe) obesity due to excess calories	E66.01
Obstructive sleep apnea (adult) (pediatric)	G47.33
Personal history of nicotine dependence	Z87.891
Proteinuria, unspecified	R80.9
Radiculopathy, cervical region	M54.12
Sarcoidosis, unspecified	D86.9
Type 2 diabetes mellitus without complications	E11.9
Vitamin D deficiency, unspecified	E55.9

MEDICATIONS

100 most recent outpatient medications released by VA to Veteran in the last 6 months

Medication Name and Dose	Quantity	Refill Number	Issue and Fill Date	Status
ACCU-CHEK GUIDE (GLUCOSE) TEST STRIP	Qty:50	Fill: 1 of 3	Orig: 2022-03-23	ACTIVE
USE ONE (1) STRIP FOR TESTING BLOOD GLUCOSE TWO (2) TIMES PER WEEK			Last: 2022-03-28	
ATORVASTATIN CALCIUM 40MG TAB	Qty:90	Fill: 1 of 2	Orig: 2022-02-09	ACTIVE

2024 CHIROPRACTIC MANIPULATION (98940-98943)
PHYSICAL MEDICINE & REHABILITATION
(97010 - 97799)

CHIROPRACTIC MANIPULATION

98940 Chiropractic manipulative treatment, spinal one or two regions
98941 Chiropractic manipulative treatment, spinal three or four regions
98942 Chiropractic manipulative treatment, spinal five regions
98943 Chiropractic manipulative treatment, extraspinal one or more regions

MODALITIES
Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.

SUPERVISED
The application of a modality that *does not* require direct (one one-on-one) patient contact by the provider.

Application of a modality to one or more areas;

97010 Hot or cold packs
97012 Traction, mechanical
97014 Electrical stimulation, (unattended)
G0283 Electrical stimulation, (**VA,MC, UHC**)
97016 Vasopneumatic devices
97018 Paraffin bath
97022 Whirlpool
97024 Diathermy (Includes Microwave)
97026 Infrared
97028 Ultraviolet

CONSTANT ATTENDANCE
The application of a modality that requires direct (one on one) patient contact by the provider.

Application of a modality to one or more areas;

97032 Electrical Stimulation (manual), 15 min.
97033 Iontophoresis, each 15 minutes
97034 Contrast baths, each 15 minutes
97035 Ultrasound, each 15 minutes
97036 Hubbard tank, each 15 minutes
97039 Unlisted modality (specify type and time if constant attendance)

LASER
S8948 Application of a modality with constant attendance to one or more areas; Low-level laser; each 15-minute
0552T Low-level laser therapy dynamic photonic and dynamic thermokinetic energies, provided by physician or other qualified health professional

THERAPEUTIC PROCEDURES
A manner of effecting change through the application of clinical skills and or services that attempt to improve function.

Physician or therapist required to have direct (one one-on-one) patient contact.

Therapeutic procedure, one or more areas, 15 min.

97110 Therapeutic exercises to develop strength and endurance, range of motion, and flexibility.
97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception.
97113 Aquatic therapy with therapeutic exercises
97116 Gait training (includes stair climbing)
97124 Massage, including effleurage, petrissage, tapotement (stroking, compression, percussion)
97139 Unlisted therapeutic procedure (specify)
97140 Manual therapy techniques, one or more regions.(for example, mobilization, manipulation, manual traction, manual lymphatic drainage)

Additional Procedures

97150 Therapeutic procedure(s), group (2 or more)
97530 Therapeutic activities, direct (one one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 min.

2024 CHIROPRACTIC MANIPULATION (98940-98943)
PHYSICAL MEDICINE & REHABILITATION
(97010 - 97799)

97535 Self-care/home management training (e.g. activities of daily living (ADL) and compensatory training, safety procedures, and instructions in use of adaptive equipment) direct one one-on-one contact by provider, each 15 minutes.
97537 Community/work reintegration training (eg. avocational activities and/or work environment/modification analysis, work task analysis), direct one one-on-one contact by provider, each 15 minutes.
97542 Wheelchair management/propulsion training, each 15 min.
97545 Work hardening/conditioning; initial 2 hours.
97546 *each additional hour*
97799 Unlisted physical medicine/rehabilitation service.

ORTHOTIC FITTING AND TRAINING

97760 Orthotics management and training (including assessment and fitting when not otherwise reported) upper and lower extremities or trunk each 15 min.
97763 Orthotic(s)/Prosthetic(s) management and or training upper and lower extremity(ties) and or trunk, subsequent encounter each 15 minutes

TESTS & MEASUREMENTS

97750 Physical performance test / measurement(e.g., musculoskeletal functional capacity) with written report, each 15 minutes

MAINTENANCE CARE

S8990 Physical or manipulative therapy performed for maintenance rather than restoration.

ACUPUNCTURE

97810 Acupuncture, one or more needles: without electrical stimulation, initial 15 minutes of personal one-on-one contact with patient
97811 Each additional 15 minutes of personal one-on-one with patient, with re-insertion of needles
97813 Acupuncture, one or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with patient
97814 Each additional 15 minutes of personal one-on-one with patient, with re-insertion of needles

DRY NEEDLING

20560 Needle insertion without injection 1-2 muscle(s)
20561 3 or more muscles

CMT

- 98940 1-2 regions
- 98941 3-4 regions
- 98942 5 regions
- 98943 Extraspinal regions (one or more)

- Code is determined by diagnosis and regions manipulated not the technique or style of manipulation alone
- Note the diagnoses on the authorization

Documentation of Services

Ensure all services coded are properly documented

Evaluation & Management

- The exam must be documented above and beyond the day-to-day evaluation associated with treatment
- The level billed must be reflected
  - Medical decision making (severity)
  - Time

NEW PATIENT

A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

99202 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99203 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99204 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

ESTABLISHED PATIENT

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

99211 **Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.

99212 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

99213 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99215 **Office or other outpatient visi**t for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

Time

99202 Meet or exceed15 min
99203 30 minutes
99204 45 minutes
99205 60 minutes

Medical Decision Making

99202 1 self limited or minor problem
99203 2 or more / acute injury
99204 Acute complicated injury
99205 Threat to life or bodily function

Therapies

- What
- Where
- Time if a timed service
- Purpose

Modalities and Procedures

- 97012
- 97018
- 97022
- 97026
- 97033
- 97035
- 0552T

- 97110
- 97112
- 97113
- 97116
- 97124
- 97140
- 97535
- 97750

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S8948 Application of a modality with constant attendance to one or more areas; Low-level laser; each 15-minute
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THERAPEUTIC PROCEDURES
A manner of effecting change through the application of clinical skills and or services that attempt to improve function.

Physician or therapist required to have direct (one one-on-one) patient contact.

Therapeutic procedure, one or more areas, 15 min.

97110 Therapeutic exercises to develop strength and endurance, range of motion, and flexibility.
97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception.
97113 Aquatic therapy with therapeutic exercises
97116 Gait training (includes stair climbing)
97124 Massage, including effleurage, petrissage, tapotement (stroking, compression, percussion)
97139 Unlisted therapeutic procedure (specify)
97140 Manual therapy techniques, one or more regions.(for example, mobilization, manipulation, manual traction, manual lymphatic drainage)

Additional Procedures

97150 Therapeutic procedure(s), group (2 or more)
97530 Therapeutic activities, direct (one one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 min.

ACUPUNCTURE CODES

CPT Codes	
97810	Acupuncture, one or more needles: without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.
97811	Without electrical stimulation, each additional 15 minutes of personal one- on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
97813	Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	With electrical stimulation, each additional 15 minutes of personal one-on- one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

How is the 15-minute session defined?

The 15-minute increment of time is defined as personal one-on-one contact with the patient. This means that the physician acupuncturist is in the room with the patient, and is actively performing a medically necessary activity that is a component of acupuncture or electroacupuncture (this would include a review of history, day-to-day evaluation, hand washing, choosing, and cleaning points, inserting and manipulating needles, removal, disposal as well as completion of the chart notes while the patient is present). The time that the needles are retained is specifically excluded to determine the time and consequently reimbursement.

1 unit (set) must include a minimum of 8 minutes face to face time with insertion (8-22 minutes = 1 unit)
2 units (sets) must be at least 23 minutes of face-to-face time (23-37 2 units)
3 units (sets)must be at least 38 minutes of face-to-face time (38-52 = 3 units) 4 units (sets) must be at least 53 minutes face-to-face (53-67 = 4 units)

Do I need to reinsert needle(s) to bill the add-on codes 97811 or 97814?

Yes. According to the CPT Assistant, June 2005/Volume 15, Issue 6, “re-insertion of the needle(s) is required for the use of add-on codes 97811 and 97814.

May I mix and match electrical and non-electrical stimulation procedures in the same session?

Yes. However, only one initial insertion of the needles is permitted per session per day. Therefore, per CPT, you should never code 97810 and 97813 on the same claim. If the first set is manual then code 97810 and if the subsequent set is electrical then 97814. You may code 97810 with 97811 or 97814. The same applies to 97813 it too can be coded with 97811 or 97814.

A simple rule of thumb is to never combine 97810 and 97813 on a single claim for acupuncture services because these two codes both describe an **initial** 15-minute treatment with the insertion of one or more needles.

Dry Needling

20560 Needle insertion without injection in 1 or 2 muscles.

20561 needle insertion without injection but focuses on 3 or more muscles

GP Always Therapy Modifier

All physical medicine services

97010-97799 require modifier GP

This is in addition to any need for other modifiers

97140 59 GP

Order does not matter but that they both must appear

Billing

Missed Appointments

Regardless of the appointing pathway, providers may NEVER charge a Veteran for not keeping a scheduled appointment under CCN.

Timely Filing

- Providers must submit claims within 30 days after rendering services. There is a 180-day timely filing limit
- Appeal of a claim also requires it be submitted within 180 days of the denial

- corrected claim
VS rebill ?

TRIWEST HEALTHCARE ALLIANCE®
Claims
PO Box 42270
Phoenix, AZ 85080-2270

March 13, 2023

[redacted]

Veteran: [redacted]
Date(s) of Service: 07/13/2020
Total Charge: $190.00

[redacted]

Dear Patient Accounts Manager:

TriWest has received your request for timely filing reconsideration on the above referenced claim. Unfortunately our denial stands. The documentation submitted does not meet the guidelines set forth by the VA. The VA EOB denial must have been submitted to TriWest within 180 days of the date of the denial.

Also please be advised that TriWest can no longer override timely filing for claims that were originally submitted to non-VA payers, such as TRICARE, Medicare, or other health insurers.

Mail to the following address:
TriWest Claims
ATTN: Reconsideration
P.O. Box 42270
Phoenix, AZ 85080-2049

If you have any questions, please contact TriWest Claims Customer Service at 1-877-226-8749.

Sincerely,

TriWest Healthcare Alliance

Exceptions to Timely Filing

If you have a claim that was denied for timely filing, and it meets ALL the requirements below, you may submit a corrected claim

1. TriWest denied your claim(s) because it exceeded the 180-day timely filing deadline.
2. Your original claim submission was filed TIMELY with VA, Optum, or TriWest.
3. You have documentary evidence to validate your original claim(s) was TIMELY filed with the wrong VA payer entity.

Billing for Services Rendered to Veterans

- All care requires an approved referral/authorization except for urgent care. A claim submitted without a VA referral/authorization number will be denied/rejected.
- Providers should not collect copays, cost-shares or deductibles. CCN reimburses up to 100% of the allowed amount, including any patient obligation.
- Payments made by TriWest/Optum or VA shall be considered payment in full under CCN. Providers may not impose additional charges to TriWest or the Veteran for covered services.
- Providers are required to share the VA referral/authorization number with the ancillary providers included in a Veteran's episode of care. The ancillary provider is also required to use this same VA referral/authorization number when submitting their claim for the specific episode of care.
- For CCN, TriWest/Optum follows Medicare billing guidelines, fee schedules and payment methodology when applicable.
- Remember, providers are not allowed to balance bill Veterans or TriWest/Optum for services provided under the CCN contract, including any remaining balances or after a timely filing denial.

Claims Submission Options

- TriWest/Optum has designated PGBA as the claim's payer for all authorized claims. Providers will submit all claims to PGBA either through the electronic claim's submission process, or via a paper claim form.

- All CCN claims process electronically, regardless of the method of submission. This is a requirement and, therefore, filing claims electronically is preferred and encouraged. If you choose to submit paper claims, they must scan to an electronic format. Claims that cannot be scanned cleanly may reject.

Electronic Claim Submission

- Claims submitted electronically are less likely to be rejected compared to paper claims. Improve your claim submission accuracy and get your payments faster by signing up for electronic claim submission and funds transfer.
- Providers can submit electronic claims without a clearinghouse account through Availity's Basic Clearinghouse option. The Basic Clearinghouse option is FREE to CCN providers.

Optum

- E Payer ID: VACCN
- Mailing Address:
  VA CCN Optum P.O. Box 202117
  Florence, SC 29502
- Secure Fax: 833-376-3047
- Correspondence
  VA CCN Correspondence
  PO Box 202118
  Florence, SC 29501

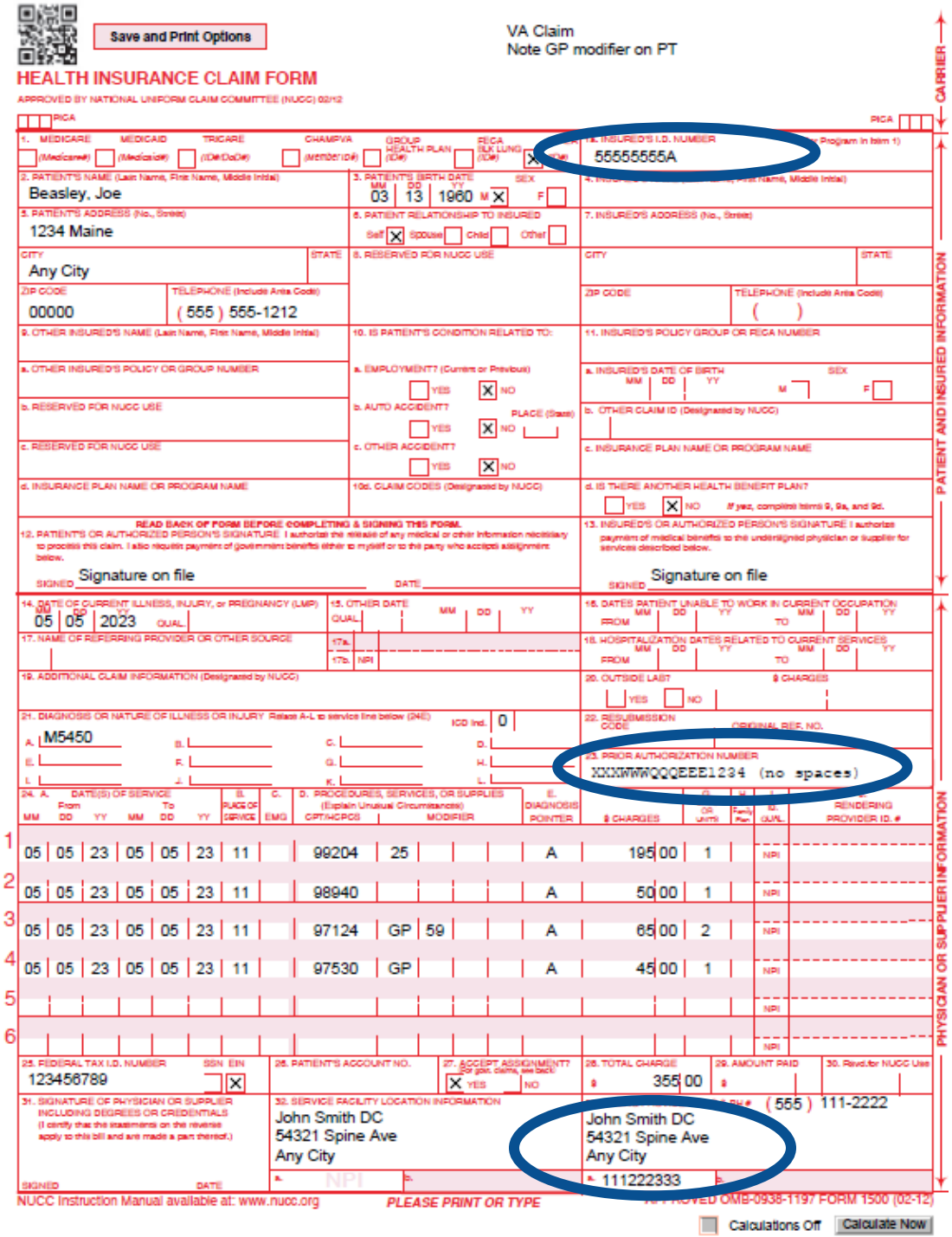
Triwest

- PGBA Claims Submission Details
- **Payer ID**
  TWVACCN
- Address to Submit Paper Claims to PGBA
  TriWest VA CCN Claims
  PO Box 108851
  Florence, SC 29502-8851

Clean Claim Requirements

- Once the provider receives an authorization letter from either TriWest/Optum or VA, the referral/authorization number is the unique identifier assigned for each approved referral/authorization's episode of care.
- Billing requires that the provider include this number on the claim or the claim will be denied/rejected.

- VA referral number (Proper format example: VA1234567890) AND one of the following:
  - 17-digit Master Veteran Index (MVI) ICN
  - Social Security number (SSN)
  - 10-digit Electronic Data Interchange Personal Identifier (EDIPI)
  - Last 4 digits for SSN with preceding 5 zeros (e.g., 00000XXXX)
- It is extremely important that you do not use any extra characters, spaces, or words with the referral/authorization number, or the claim will deny. For example, if the correct referral/authorization number is VA0001234567, referral numbers included in the following format would be denied/rejected:
  - Auth VA0001234567
  - Auth # VA0001234567
  - Ref VA0001234567
  - Ref # VA0001234567
  - VA 0001234567



Save and Print Options

VA Claim
Note GP modifier on PT

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) X OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 55555555A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Beasley, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 03 13 1960 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 Maine

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: Any City STATE:

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 00000 TELEPHONE (Include Area Code): (555) 555-1212

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES X NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES X NO PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on file DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature on file

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 05 2023 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M5450 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: XXXWWWQQQEEE1234 (no spaces)

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	$ CHARGES	F. DAYS OR UNITS	G. EPSDT Family Plan	H. ID. QUAL.	I. RENDERING PROVIDER ID. #
1	05	05	23	05	05	23	11		99204	25	A	195 00	1		NPI	
2	05	05	23	05	05	23	11		98940		A	50 00	1		NPI	
3	05	05	23	05	05	23	11		97124	GP 59	A	65 00	2		NPI	
4	05	05	23	05	05	23	11		97530	GP	A	45 00	1		NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 123456789 X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) X YES NO

28. TOTAL CHARGE $ 355 00

29. AMOUNT PAID $

30. Rsvd.for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION: John Smith DC 54321 Spine Ave Any City

a. NPI b.

33. PH # (555) 111-2222

John Smith DC
54321 Spine Ave
Any City

a. 111222333 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Calculations Off Calculate Now

Claim Status Check

- Providers can check the status of claims through Availity.
- Login to Availity and then click on the Claims & Payments option located on the top-left
- Under Claims & Payments, select the Claim Status option
- Providers can also search claims by:
  - Member ID
  - Tax ID Service date
  - Claim number

Claims Processing Time

- CCN strives to pay all clean claims within 30 days
- Notification of denial 45 days
- Claims are exempt for penalties and interest

- VA CCN providers should maintain medical records in a manner that is current, detailed, and organized. Medical documentation must be presented in a legible format.
- As part of the required VA CCN medical documentation, providers must have a release of medical records with the Veteran's signature on file. *(block 12 of the CMS1500)*
- When a Veteran has signed a release of information statement, providers should indicate "Signature on File" on the claim submission. A new signature is required every year.

- Medical records and documentation are required for all provided services. Providers are required to submit medical documentation directly to the authorizing VAMC, preferably via upload to the **HSRM**.
- VA requires providers submit medical documentation to the authorizing VAMC within the following timeframes:
  - Initial medical documentation for outpatient care – **30 days** of the initial appointment
  - Final outpatient medical documentation – **30 days** of the completion of the SEOC

Rehabilitative Services

Chiropractic Care SEOC 1.0.1

Description: This authorization covers services associated with all medical care listed below as clinically indicated.

Duration: - 365 days
Frequency: 12 visits per year

Procedural Overview

1. Initial outpatient evaluation and manual manipulation therapy for the patient complaint per authorization.

2. Standard imaging relevant to the patient complaint/condition should be completed at VA to extent possible.

3. Office visits for this episode of care are limited to 12 visits per year. Chiropractic care justification must include a detailed plan with a specific timeline linked to objective measureable improvement.

4. Expectations of service for chiropractic treatment include:
    a. Significant durable pain intensity decrease
    b. Functional improvement demonstrated by: clinically meaningful improvement on validated disease-specific outcomes instruments; return to work; and/or documented improvement in activities of daily living

5. Documented decreased utilization of pain-related medications

** All requests for additional therapeutic modalities, including heat/cold modalities and massage therapy require VA review.
** All requests for supplements will be routed through the VA.
** Additional consultations needed relevant to the patient complaint/condition require VA review and approval.
** DME, prosthetics and orthotics will be reviewed by the VA for provision.
** All routine medications will be provided by the VA.

Urgent/emergent prescriptions can be provided for a 14 day supply only.
The Veteran will be required to pay out of pocket for any urgent/emergent medications and can submit a reimbursement request to their local VA facility.

Data Driven Care

Tracking changes in restrictions of activities of daily living

Quality based care model

PROMIS

Patient Reported Outcome Measurement Instruments

General Pain Index	Patient Specific Functional Scale	PROMIS Short Form – Pain Interference
Pain and Functional Rating Scale (VA & DOD)	Oswestry (LBP index)	Neck Disability Index

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE_____ [60] BENCHMARK = 5 _____

The Patien-tSpecific Functional Scale

This useful questionnaire can be used to quantify activity limitation and measure functional outcome for patients with any orthopaedic condition.

Clinician to read and fill in below: Complete at the end of the history and prior to physical examination.

Initial Assessment:

I am going to ask you to identify up to three important activities that you are unable to do or are having difficulty with as a result of your__problem. Today, are there any activities that you are unable to do or having difficulty with because of your_____ _____problem? (Clinician: show scale to patient and have the patient rate each activity).

Follow-up Assessments:

When I assessed you on (state previous assessment date), you told me that you had difficulty with (read all activities from list at a time). Today, do you still have difficulty with: (read and have patient score each item in the list)?

Patient-specific activity scoring scheme (Point to one number):

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity

Able to perform activity at the same level as before injury or problem

(Date and Score)

Activity	Initial					
1.						
2.						
3.						
4.						
5.						
Additional						
Additional						

Total score = sum of the activity scores/number of activities Minimum detectable change (90%CI) for average score = 2 points
Minimum detectable change (90%CI) for single activity score = 3 points

PSFS developed by: Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change on individual patients: a report of a patient specific measure. Physiotherapy Canada, 47, 258-263.

Pain Interference – Short Form 6a

Please respond to each question or statement by marking one box per row.

In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
1	How much did pain interfere with your day to day activities?	☐	☐	☐	☐	☐
2	How much did pain interfere with work around the home?.....	☐	☐	☐	☐	☐
3	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
4	How much did pain interfere with your household chores?.....	☐	☐	☐	☐	☐
5	How much did pain interfere with the things you usually do for fun?	☐	☐	☐	☐	☐
6	How much did pain interfere with your enjoyment of social activities?.....	☐	☐	☐	☐	☐

Pain Interference – Short Form 6b

Please respond to each item by marking one box per row.

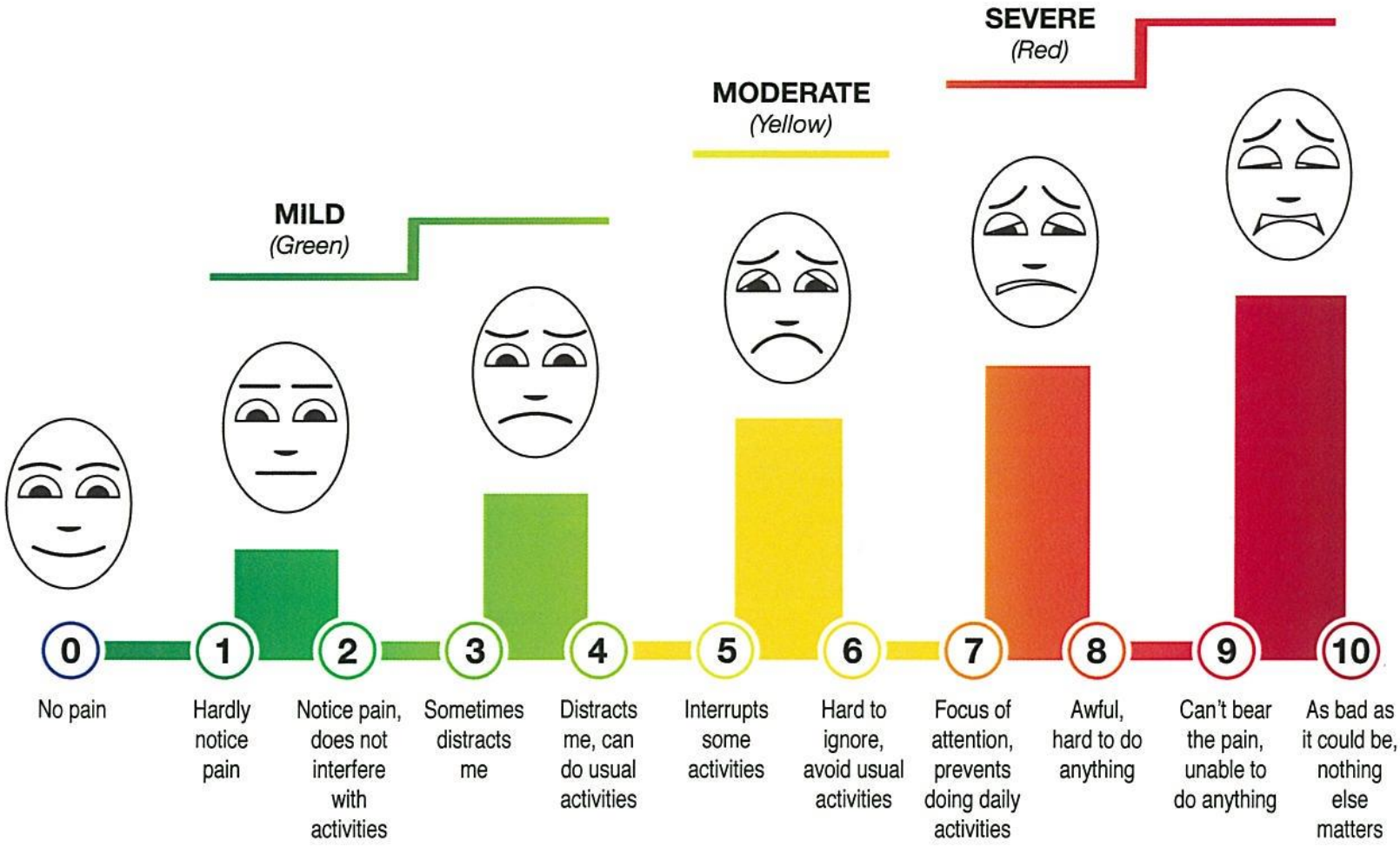
In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ3	How much did pain interfere with your enjoyment of life?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ8	How much did pain interfere with your ability to concentrate?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ9	How much did pain interfere with your day to day activities?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ10	How much did pain interfere with your enjoyment of recreational activities?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ14	How much did pain interfere with doing your tasks away from home (e.g., getting groceries, running errands)?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
PAININ26	How often did pain keep you from socializing with others?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Defense and Veterans Pain Rating Scale



v 2.0

DoD/VA Pain Supplemental Questions

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual <u>ACTIVITY</u>:

Does not interfere — Completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your <u>SLEEP</u>:

Does not interfere — Completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected your <u>MOOD</u>:

Does not affect — Completely affects

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your <u>STRESS</u>:

Does not contribute — Contributes a great deal

**Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994.*

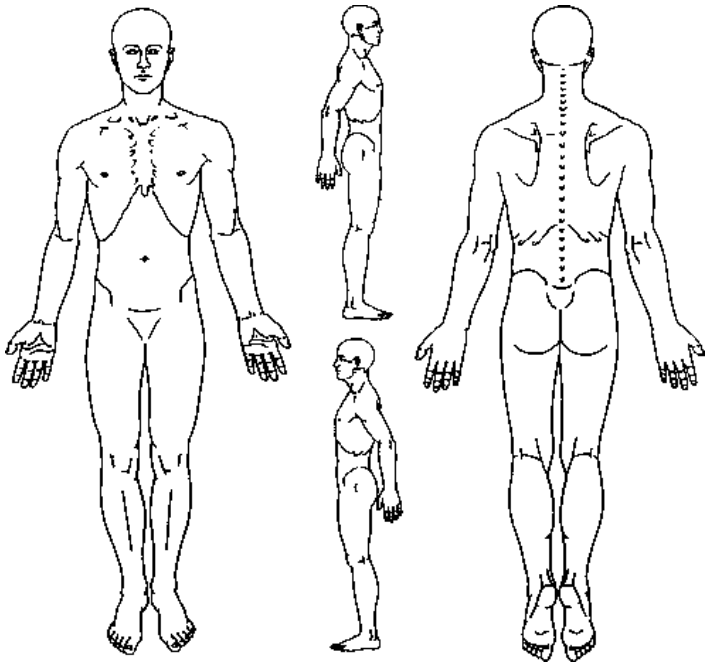
v 2.0

THE NECK DISABILITY INDEX QUESTIONNAIRE

NAME_____ DATE _____

How long have you had neck pain _____years _____months _____weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER

OVER PLEASE ⇒

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity
A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SIGNATURE:_____ **DATE:**_____

DISABILITY INDEX SCORE: _____ **%**

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

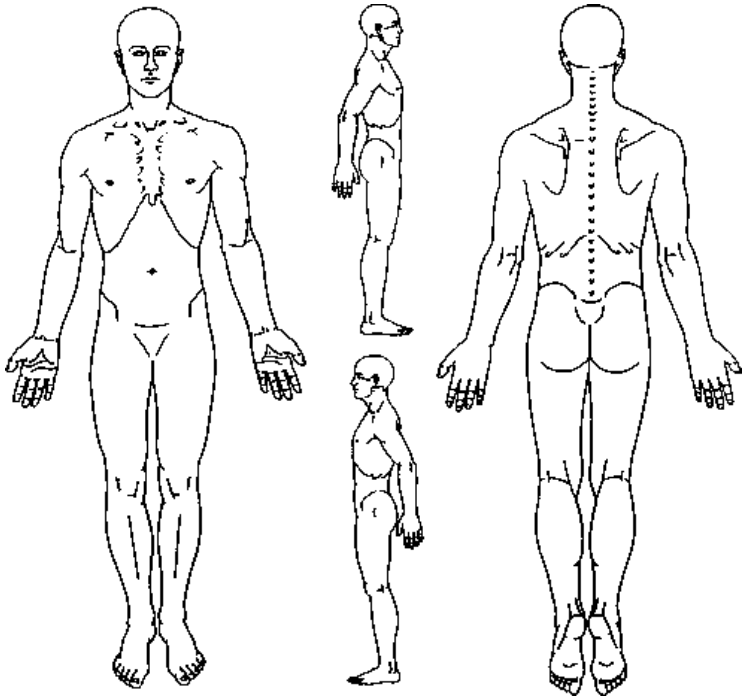
SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all all.

THE LOW BACK PAIN QUESTIONNAIRE

NAME _____ DATE _____

How long have you had back pain _____years _____months _____weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.



A = ACHE **B** = BURNING **N** = NUMBNESS
P = PINS & NEEDLES **S** = STABBING **O** = OTHER

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing and essentially remain in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights , but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 --Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than 1/4 mile.
D. Pain prevents me from walking more than 100 yards.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 -- Standing
A. I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7--Sleeping
A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain , my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8--Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have no social life due to pain.

SECTION 9--Traveling
A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain prevents all forms of travel except that done lying down.
F. Pain prevents all forms of travel.

SECTION 10--Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

DISABILITY INDEX SCORE: %_____

SEOC ID: PMR_CHIROPRACTIC INITIAL_1.0.12
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order.
Duration: 90 days

Procedural Overview:
1. Initial outpatient evaluation and outpatient re-evaluation as clinically indicated for the referred condition indicated on the consult order.
2. Plain film x-ray of the region of complaint specified on the consult order if not yet performed at the VA and is clinically indicated.
a. Plain film x-ray imaging only when medically necessary based on widely accepted indications such as clinical suspicion of fracture, dislocation, or other significant pathology. X-ray is not authorized solely for biomechanical/postural assessment, and/or determining manipulative technique approach.
3. Authorized up to twelve (12) chiropractic visits for this episode of care.
Note: A Chiropractic plan of care typically includes chiropractic manipulative treatment for the relevant condition. Plan of care can also include manual therapy, massage therapy, therapeutic exercise, neuromuscular re-education, and acupuncture which must be performed by a chiropractor subject to the provider's given state licensure and scope. Any services outside of the licensure and scope of the chiropractor, including manual therapy, massage therapy, therapeutic exercise, neuromuscular re-education, and acupuncture, must have an RFS and supporting medical documentation submitted to the VA for clinical review prior to the care being rendered by another provider. If acupuncture is integrated into the chiropractor's plan of care, additional units of acupuncture must be medically necessary and require documentation of face to face provider time and evidence of reinsertion by the chiropractor.

Note: Requests for additional chiropractic care beyond this trial must provide documentation of: Objective measures demonstrating the extent of meaningful clinical improvement to date; AND Rationale for the additional treatment requested (e.g. to reach further durable improvement, or for ongoing pain management); AND Any further information supporting the need for additional care

Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following.
* Pharmacy prescribing requirements
* Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements
* Preservtification (PRCT) process requirements
* Request for Services (RFS) requirements

VA Pacific Islands Healthcare

Chiropractic Supplemental Documentation

1JUN2022

Due to recent findings by the Office of Inspector General published 8 Dec 2021, which revealed nation-wide evidence of fraud, waste and abuse of specifically in Acupuncture and Chiropractic Services (https://www.va.gov/oig/pubs/VAOIG-20-01099-249.pdf), a change in process has been set in motion. The implementation of this form sets out to improve the review process for those reviewing Requests for Service by utilizing an at-a-glance method to authorize additional/ongoing care. This form will replace the PROMIS form, formerly introduced into the process. We thank you for your patience as we continually improve to make the process as seamless as possible in order to get the authorizations to you, the vendors in a timely manner.

For consideration of continued care, vendors are contractually obligated to submit a Request for Service with supporting documentation, this additional form will now be required: ***ALL*** the below must be present:

o An initial series of successful chiropractic treatment: Yes / No
o Assessment of patient function after a withdrawal of care: Yes / No
o Consideration for other medical, psych, behavioral, and/or social interventions: Yes / No
o Inclusion of appropriate, individualized active care strategies such as home exercise and self-management approaches: Yes / No

and ***MUST*** include ***one or more*** of the following:

o Continued durable improvement in condition being treated: Yes / No
o Continued functional improvement demonstrated by: **clinically meaningful improvement on validated disease-specific outcomes instruments; return to work; and/or documented improvement in activities of daily living**: Yes / No
o Continued documented decreased utilization of medications: Yes / No

Please do not submit any RFS prior to validity end date before:

30 days for an initial 90-day SEOC/Authorization
Or, 45 days for a 180-day Chiropractic Pain Management SEOC/Authorization
RFSs that are received prior to the end validity date timeframes will be discarded. Please be judicious in the use of the allotted visits noted on the SEOC.

Chiropractor Name: _____

Chiropractor Signature: _____

"By submitting this form, you are certifying that the above entries are true and correct to the best of your knowledge. Please be advised that intentionally including inaccurate, untrue, or misleading information in this form will warrant referral to the VA Office of Inspector General or other investigative agencies for investigation of potential fraud, waste, or abuse."

Physical Medicine and Rehabilitation

Chiropractic Pain Management SEOC 1.2.2

SEOC ID: PMR_CHIROPRATIC_PAINMGMT_1.2.2

Description: This authorization covers services associated with all medical care listed below for the referred condition on the consult. In this situation, additional lasting improvement beyond what was seen after the initial and/or continued trial is not expected. Patients have reported meaningful improvement of reasonable duration, but have plateaued and reached MMI from chiropractic care. Patients experience degradation in functional gains after some period when chiropractic care is withdrawn. All other indicated medical, psychological, behavioral and social interventions have been tried or considered. Appropriate active care and self-management strategies are part of the overall treatment plan and patients are compliant with recommendations.

Duration: 180 days

Procedural Overview

1. Additional outpatient re-evaluation as clinically indicated on consult.
2. Eight (8) authorized chiropractic visits. Chiropractic services include: chiropractic manipulative treatment, manual therapy, therapeutic exercise, and/or neuromuscular re-education

Note: Expectations of service for chiropractic chronic pain management include:

a. Assessment of patient function after a withdrawal of chiropractic care; AND

b. Consideration of other indicated medical, psychological, behavioral, and/or social interventions; AND

c. Inclusion of appropriate, individualized active care strategies such as home exercise and self-management approaches to empower patient self-efficacy

*All requests for additional therapeutic modalities require VA review.

*All requests for supplements will be routed through the VA.

*Additional consultations needed relevant to the patient complaint/condition require VA review and approval.

*DME, prosthetics and orthotics orders must be submitted to the local VA facility prosthetics department for provision.

*All routine medications must be faxed/sent to the VA to be dispensed by the VA.

*Urgent/emergent prescriptions can be provided for a 14 day supply only.

*The Veteran will be required to pay out of pocket for any urgent/emergent medications and can submit a reimbursement request to their local VA facility.

Medical Necessity & Request For Services (RFS)

- Significant durable pain intensity decrease
- Functional improvement by clinically meaningful improvement on validated disease-specific outcomes instruments; return to work; and/or documented improvement in activities of daily living
- Documented decreased utilization of pain-related medications
- Objective measures demonstrating the extent of meaningful clinical improvement today and the rationale for additional treatment requested example to reach further durable improvement or for ongoing pain management and any further information supporting the need for additional care
- Include any barriers to recovery suck as complicating conditions or comorbidities but also how the patient has changed to date and how the care would continue the same trajectory

Plan of Care

A multi-modal treatment approach, ideally addressing each of the biggest contributors to their pain, with interventions that are:

- Most effective (compared to other interventions in their category)
- Simple (complexity reduces compliance)
- Easily understood(if patients can't understand why they're doing them, they may not do them at all)
- Low-friction (low-tech/no-tech, easily done at home, more likely to get done)
- Reproducible across providers and patients (no guru needed – easily scalable across the MSK world and patient world)

Request For Additional Visits

Do not make any request for added visits before the visits that are preauthorized are completed or the time of authorization has elapsed

Reasons to Submit an RFS to the VAMC

- More visits are needed than included in the Standardized Episode of Care (SEOC) approved referral/authorization
- A condition needs to be addressed that wasn't indicated for treatment
- Additional needed services are not included, or specifically excluded, on the initial approved referral/authorization and are not commonly rendered
- The Veteran needs to be referred to a specialty service not included on the original approved referral/authorization
- The valid date range included on the initial approved referral/authorization needs to be extended

Request For Additional Visits

- Requesting approval for additional services Providers must submit a Request for Service (RFS) form 10-10172 to VA
- RFS may be submitted online (preferred) via the HSRM
- VA will process all requests within three business days, and the provider will be notified of the decision or outcome through their preferred method of communication. The notification will also indicate if the care will be provided within VA or in the community. The provider is required to send the completed form to VA the same day the provider determines care is needed.
- Use this link to download the form
  - https://www.va.gov/find-forms/about-form-10-10172/

Department of Veterans Affairs

REQUEST FOR SERVICES (RFS) FORM

PREVIOUS AUTHORIZATION NUMBER:

TODAY'S DATE *(MM/DD/YYYY)*:

NOTE: The Request for Services (RFS) Form 10-10172 must be submitted via an approved method (HSRM, Electronic fax, Direct Messaging, traditional fax, or mail). Completion of this form is **REQUIRED** and **MUST BE SIGNED** by the requesting provider for further care to be rendered to a Veteran patient.

SECTION I: VETERAN INFORMATION

1. VETERAN'S LEGAL FULL NAME *(First, MI, Last)*:

2. DOB *(MM/DD/YYYY)*:

3. VA FACILITY:

4. VA LOCATION:

SECTION II: ORDERING PROVIDER INFORMATION

5. REQUESTING PROVIDER'S NAME:

6. NPI #:

7. SPECIALTY:

8. OFFICE NAME & ADDRESS:

9. SECURE EMAIL ADDRESS:

10. PHONE NUMBER:

11. FAX NUMBER:

☐ 12. INDIAN HEALTH SERVICES (IHS) PROVIDER?

SECTION III: TYPE OF CARE REQUEST

13. PLEASE INDICATE CLINICAL URGENCY *(Urgent care is only applicable for requests that require less than 3 days to process. If care is needed within 48 hours or if Veteran is at risk for Suicide/Homicide, please call the VA directly on the same day as completed RFS form submission. Do NOT mark urgent for administrative urgency)*:

☐ ROUTINE ☐ URGENT

14. DIAGNOSIS *(ICD-10 Code/Description)*:

15. DATE OF SERVICE *(MM/DD/YYYY)* &/OR ANTICIPATED LENGTH OF CARE:

16. CPT/HCPCS CODE &/OR DESCRIPTION OF REQUESTED SERVICES *(Include units/visits, add second list page, if needed)*:

17. HOW MANY VISITS HAVE OCCURRED SO FAR? *(If known)*

18. IS THIS A REFERRAL TO ANOTHER SPECIALTY?
☐ YES *(If "YES," please fill out the Servicing Provider/Specialty information below)* ☐ NO

19. SERVICING PROVIDER'S NAME:

20. NPI #:

21. SPECIALTY:

22. OFFICE NAME & ADDRESS:

23. SECURE EMAIL ADDRESS:

24. PHONE NUMBER:

25. FAX NUMBER:

SECTION IV: TYPE OF SERVICE REQUESTED

26. OUTPATIENT CARE: ☐ PT ☐ OT ☐ SPEECH THERAPY
FREQUENCY & DURATION:

27. SURGICAL PROCEDURE: ☐ INPATIENT ☐ OUTPATIENT
FACILITY NAME:

28. ☐ IN-OFFICE PROCEDURE

29. INPATIENT CARE: ☐ LTACH ☐ ACUTE REHAB ☐ BH

30. ☐ ADDITIONAL OFFICE VISITS *(List # needed)*:

31. ☐ EXTENSION OF VALIDITY DATES

32. ☐ EMERGENCY ROOM CARE

33. ☐ LABS *(If done outside of office, please provide facility above)*

34. ☐ RADIOLOGY/IMAGING *(If done outside of office, please provide facility above)*

35. ☐ PRE-OPS LABS ☐ CHEST XRAY ☐ EKG
☐ OTHER:

36. JUSTIFICATION FOR REQUEST *(To avoid delays in care, include appropriate documentation such as office notes, current treatment plans, clinical history, laboratory results, radiology results &/or medications to support the medical necessity of services requested)*.

VETERAN'S LEGAL FULL NAME *(First, MI, Last)*:

SECTION V: GERIATRICS AND EXTENDED CARE SERVICES *(If applicable)*

37. ☐ COMMUNITY ADULT DAY HEALTH CARE ☐ COMMUNITY NURSING HOME ☐ HOMEMAKER/HOME HEALTH AIDE
☐ HOME INFUSION ☐ HOSPICE/PALLIATIVE CARE ☐ RESPITE
☐ SKILLED HOME HEALTH CARE ☐ OTHER:

FREQUENCY & DURATION:

38. JUSTIFICATION FOR REQUEST *(To avoid delays in care, include appropriate documentation such as office notes, current treatment plans, clinical history, laboratory results, radiology results &/or medications to support the medical necessity of services requested).*

SECTION VI: HOME OXYGEN INFORMATION *(If applicable)*

39. PaO2 AT REST: | 40. O2 SAT AT REST: | 41. OXYGEN FLOW RATE:

42. EXTENT OF SUPPORT *(Continuous, Intermittent, Specific Activity)*:

43. OXYGEN EQUIPMENT *(Stationary/Portable)*:

44. DELIVERY SYSTEM *(Cannula, Mask, Other)*:

SECTION VII: DME & PROSTHETICS INFORMATION *(If applicable)*

45. HCPS FOR THE ITEM(S) BEING PRESCRIBED:

46. BRAND, MAKE, MODEL, PART NUMBERS:

47. MEASUREMENTS:

48. QUANTITY: | 49. ICD-10: | 50. PROVISIONAL DIAGNOSIS:

51. DELIVERY/PICKUP OPTIONS:
☐ DELIVER TO ORDERING PROVIDER'S ADDRESS ☐ VETERAN WILL PICKUP AT THE VA MEDICAL CENTER
☐ DELIVER TO COMMUNITY VENDOR FOR DELIVERY & SETUP FOR DME ☐ DELIVER TO VETERAN'S HOME

SECTION VIII: DURABLE MEDICAL EQUIPMENT *(DME)* EDUCATION & TRAINING *(If applicable)*

Please see DME Requirements/Pharmacy Requirements - Community Care (va.gov) for URGENT DME requests.

NOTE: Failure to thoroughly complete the RFS for DME will result in delayed patient care & prevent the VA from DME fulfillment.

52. BEFORE DME WILL BE ISSUED, EDUCATION, TRAINING, &/OR FITTING OF DME *(as applicable for the specific DME being ordered)* TO THE VETERAN MUST BE COMPLETE. PLEASE INDICATE WHETHER THE FOLLOWING HAS BEEN COMPLETED FOR THE VETERAN.

NOTE: If not completed, DME will be mailed to requesting provider's address to coordinate an alternative time for proper instruction on DME use.

A. EDUCATION:	☐ YES	☐ NO	
B. TRAINING:	☐ YES	☐ NO	☐ N/A
C. FITTING:	☐ YES	☐ NO	☐ N/A

53. JUSTIFICATION FOR REQUEST *(To avoid delays in care, include appropriate documentation such as office notes, current treatment plans, clinical history, laboratory results, radiology results &/or medications to support the medical necessity of services requested).*

VETERAN'S LEGAL FULL NAME *(First, MI, Last)*:

SECTION IX: THERAPEUTIC FOOTWEAR ASSESSMENT INFORMATION *(If applicable)*

54. FILL OUT THE INFORMATION BELOW *(If applicable)*:

☐ LEFT FOOT ☐ RIGHT FOOT ☐ BILATERAL

☐ PREFABRICATED THERAPEUTIC FOOTWEAR

☐ CUSTOM THERAPEUTIC FOOTWEAR

NOTE: For prescription of therapeutic footwear for severe or gross foot deformity which cannot be accommodated with conventional footwear.

DESCRIBE FOOT DEFORMITY AND ADDITIONAL DETAILS:

NOTE: For prescription of therapeutic footwear due to disease pathology resulting in neuropathy or peripheral artery disease.

55. CHECK APPROPRIATE DIABETIC/AMPUTATION RISK SCORE:

☐ **RISK SCORE 2:** PATIENT DEMONSTRATED SENSORY LOSS *(inability to perceive the Semmes-Weinstein 5.07 monofilament)*, DIMINISHED CIRCULATION AS EVIDENCED BY ABSENT OR WEAKLY PALPABLE PULSES, FOOT DEFORMITY, OR MINOR FOOT INFECTION, & A DIAGNOSIS OF DIABETES.

☐ **RISK SCORE 3:** PATIENT DEMONSTRATED PERIPHERAL NEUROPATHYWITH SENSORY LOSS *(i.e., inability to perceive the Semmes-Weinstein 5.07 monofilament)*, AND DIMINISHED CIRCULATION, AND FOOT DEFORMITY, OR MINOR FOOT INFECTION & A DIAGNOSIS OF DIABETES, OR ANY OF THE FOLLOWING BY ITSELF: (1) PRIOR ULCER, OSTEOMYELITIS OR HISTORY OF PRIOR AMPUTATION; (2) SEVERE PERIPHERAL VASCULAR DISEASE *(PVD) (intermittent claudication, dependent rubor with pallor on elevation, or critical limb ischemia manifested by rest pain, ulceration or gangrene)*; (3) CHARCOT'S JOINT DISEASE WITH FOOT DEFORMITY; & (4) END STAGE RENAL DISEASE.

NOTE: Only patients who are experiencing medical conditions noted in the risk scores can be prescribed therapeutic/diabetic footwear.

***ATTESTATION:** I do hereby attest that the forgoing information is true, accurate, & complete to the best of my knowledge & I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

I do hereby acknowledge that VA reserves the right to perform the requested service(s) if the following criteria are met: (1) The patient agrees to receive services from VA (2) Service(s) are available at VA facility & are able to be provided by the clinically indicated date (3) It is determined to be within the patients best interest. Upon completion of the requested service(s), VA will provide all resulting medical documentation to the ordering provider. If all criteria listed are not true & VA agrees the service(s) are clinically indicated, VA will provide a referral for services to be performed in the community.

I do hereby attest that upon receipt of order/consult results, I will assume responsibility for reviewing said results, addressing significant findings, & providing continued care.

56. REQUESTING PROVIDER SIGNATURE *(Required)*:

57. TODAY'S DATE *(MM/DD/YYYY)*:

To facilitate timely review of this request, the most recent office notes & plan of care must accompany this signed form.

For more information please visit: https://www.va.gov/COMMUNITYCARE/providers/Care_Coordination.asp.

VA Community Care Medical Policies describe standard VA health care benefit for services and procedures that community providers may recommend as necessary for a Veteran. Prior to providing care, providers should use the Community Care Medical Policies as a reference when determining if a Veteran meets VA clinical criteria. When additional services are requested, Community Care Medical Policies will be used to determine approval by a clinical reviewer. Community Care Medical Policies & supporting information can be found at: https://www.va.gov/COMMUNITYCARE/providers/Medical-Policy.asp

- VA prefers providers submit an RFS via **HSRM**.
- To access and submit an RFS online:
- Go to the **VA Storefront**
  - Click “Request and Coordinate Care” on the left-hand navigation bar under “For Providers”
  - Click “Request for Service (RFS) Requirements”
  - Navigate to the link to the RFS form at the bottom of the section
- Send the RFS directly to the authorizing VAMC via:
  - VA’s **HSRM portal** (preferable) or an EDI 278 transaction
  - Direct messaging
  - Secure email
  - Secure online file exchange
  - eHealth Exchange
- Once approved, providers will receive an authorization letter from either your VAMC or TriWest. Providers can also check the RFS status through VA’s **HSRM** (which is preferable), EDI 278 transaction, or by calling the VAMC.

Self-Service Resources & Educational Videos

https://vacommunitycare.com/training-and-guides

Functional Change

Questions?

- What if care is not authorized?
- Is their post-authorization?
- What provides the best chance to get care authorized?
- What happens if they have an unrelated accident or condition?
- What can I do if they indicate “network” is full?