Healthways WholeHealth Networks
Rapid Response System (RRS)

HEALTHWAYS

Preauthorization Request Instructions

Chiropractic or Manipulative Therapy Services

Question	Explantation
1. What is the requested Start Date for this authorization?	Enter the start date for this request using a MM/DD/YYYY format. **Please Note: if the requested start date is more than 10 days in the past, your preauthorization request will not be considered timely and will be pended for a retrospective review; you will also need to submit clinical records.**
2. Is this authorization request for a new episode or continuation of care?	Select **New** if this is a new episode for the patient or select **Continuation** if this is a continuation of care for the patient within the current episode of care
3. Is this condition new, recurring or chronic?	Select New, Recurring or Chronic condition. New means this is a new condition for the patient or the first time the patient was ever treated for this condition in your office.
4. What type of injury or condition is this request related to? [check all that apply]	Select if injury or condition is related to work, auto accident, post-surgery, other type of accident or injury, or none of the above.
5. How long has the patient had this condition?	Indicate the approximate timeframe the patient has experienced symptoms for the present condition [less than 1 month, between 1 and 3 months or greater than 3 months]
6. What is the Initial Date you began treating this patient for this episode of care?	Enter date you began treating the patient for the current primary diagnosis in MM/DD/YYYY format.
7. How many treatments (visits) have you, or anyone in your facility, provided to this patient over the past 6 months for <u>any</u> diagnosis?	Enter number of visits that have been provided by you or anyone in your office for this patient, for <u>any</u> condition in the past six months.
8. Is this patient's MD/DO currently co-treating the condition?	State if the patient is being co-treated by a medical physician for the primary condition.
9. How many visits are being requested for the current phase of care (including evaluation)?	Enter the number of visits being requested for authorization for the current phase of care including any evaluation or re-evaluation visit.
10. How many weeks will it take to complete the requested visits?	Including any evaluation, enter estimated number of weeks required to complete the visits requested.
11. What is the first (primary) Diagnosis Code?	Enter the primary Diagnosis Code as will be submitted on your claim form**. IMPORTANT: If the requested start date for this authorization request is 10/01/2015 or later, please use ICD-10 Codes. If the requested start date is before 10/1/2015, please use ICD-9 Codes.**
12. What is the second Diagnosis Code?	If indicated, enter the secondary diagnosis. If none, skip to next question.
13. What is the third Diagnosis Code?	If indicated, enter the tertiary diagnosis. If none, skip to next question.
14. What is the patient's average rating of pain over the past 2 weeks?	Using a scale of 0 to 10, rate the severity of the pain with 10 being the most severe
15. Does the patient have a history of pain for > 3 months?	Select Yes or No
16. Patient's most recent score for Patient Specific Functional Scale?	Using the instructions for the Patient Specific Functional Scale (PSFS) outcomes tool, indicate the patient's current score.

17. Does the patient routinely exercise with moderate intensity ≥ 3 times per week?	Select Yes or No The CDC defines moderate-intensity activity level as 50-70% of maximum heart rate or a 12-14 level ('somewhat hard') on the Borg Rating of Perceived Exertion scale. In the case of injury, respond based on the patient's pre-injury activity level.
18. Does the patient smoke or use tobacco products?	Select Yes or No
19. Does the patient have a history of Diabetes?	Select Yes or No
20. Does the patient have a history of Stroke?	Select Yes or No
21. Does the patient have a history of Cancer?	Select Yes or No
22. Is the patient overweight or obese (BMI ≥ 25)?	Select Yes or No This is observational and does not require submission of a BMI score.
23. Does the patient currently have significant problems with depression or anxiety?	Select Yes or No
24. Are there any factors that limit effective communication with the patient?	Select Yes or No e.g., language barrier, literacy level, cognitive dysfunction, etc.