COLORADO
Department of Health Care Policy & Financing

HCBS Complementary and Integrative Health Services Care Plan

Member Information	
Name of Provider:	Date:
Provider Email:	Provider Phone:
Member Full Name:	
Medicaid ID:	Member Phone:
Case Management Agency:	
Case Management Email:	
Care Plan Service Authorization Period*	
Start Date:	End Date:

*Request Certification dates from the member's Case Manager. (365 Day Max., Care Plan must be updated annually)

Please note that the member may be receiving additional complementary and integrative health services (CIHS) from other service providers thus may need to receive less than the recommended amount. There is an annual unit limit of 204 units for a single modality, or a combined annual unit limit of 408 units for all three modalities. There is a daily limit of 4 units per modality. **The final Prior Authorization Request (PAR) units will be determined by the member and their case manager.**

Is this a request for a PAR revision? ☐ Yes ☐ No

Provided Services *(Check all that apply)*		
☐ **Acupuncture** – if providing this service enter recommended amount, frequency and expected outcome		
Total number of 15 min. acupuncture units (97814) per authorization period	Recommended frequency of acupuncture treatments	Expected acupuncture outcomes
☐ **Chiropractic** – if providing this service enter recommended amount, frequency and expected outcome		
Total number of 15 min. chiropractic units (98942) per authorization period	Recommended Frequency of chiropractic treatments	Expected chiropractic outcomes

Provided Services *(Check all that apply)*		
☐ **Massage Therapy** – if providing this service enter recommended amount, frequency and expected outcome		
Total number of 15 min. massage therapy units (97124) per authorization period	Recommended Frequency of massage therapy treatments	Expected massage therapy outcomes

Please explain how acupuncture, chiropractic and/or massage therapy will be used for the treatment of conditions or symptoms related to the member's qualifying condition and inability to independently ambulate:

Signature of rendering provider:	Date:

This care plan is a recommendation of services and number of treatments required by 10 CCR 2505-10 8.517.11.D Complementary And Integrative Health Care Plan. It is not a guarantee of payment. Submit the completed Care Plan to the member's Case Manager so it can be used to develop the PAR. CIHS will be added to the PAR only if recommended in a Care Plan and agreed to by the member. Upon the PAR approval, the Case Manager will notify the service provider by sending them a copy of the approved PAR so services may be rendered and billed.

Please maintain a copy of this CIH Care Plan in the member's file.