

B-202 Chiropractor Reimbursement

When billing for services, the claim submitted for payment must include a diagnosis and the coding must reflect the actual services provided. Any payment received from a third-party payor, a program participant or other person's incident to provision of chiropractic services must be reflected as a credit on any claim submitted to the department bearing charges for covered services. (Exception: department co-payments are not to be reflected on the claim. Refer to [Chapter 100](#), Topic 114 for more information on patient cost-sharing.)

B-202.1 Charges

Charges billed to the department must be the provider's usual and customary charge billed to the general public for the same service. Providers may only bill the department after the service has been provided. A provider may only charge for services he or she personally provides. Providers may not charge for services provided by another provider, even though one may be in the employ of the other.

Charges for services and items provided to participants enrolled in a Managed Care Organization (MCO) must be billed to the MCO according to the contractual agreement with the MCO.

B-202.2 Electronic Claims Submittal

Any services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in [Chapter 100](#), Topic 112.3.

Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three (3) years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims. Refer to [Chapter 100](#), Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if the department determines that the service rejections are being caused by the submission of incorrect or invalid data.

B-202.3 Claim Preparation and Submittal

Refer to [Chapter 100](#), Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services and

submittal of claims for participants eligible for Medicare Part B, refer to [Chapter 100](#), Topics 112.5 and 120.1. For specific instructions for preparing claims for Medicare covered services, refer to Appendix B-1a.

[Form HFS 1443 \(pdf\)](#), Provider Invoice, is to be used to submit charges for all chiropractic services provided other than Medicare covered services. Detailed instructions for completion are included in Appendices B-1.

The department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix B-1 for technical guidelines to assist in preparing paper claims for processing. The department offers a claim scannability/imaging evaluation. Please send sample claims with a request for evaluation to the following address.

Healthcare and Family Services
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

B-202.31 Claims Submittal

All routine paper claims are to be submitted in a pre-addressed mailing envelope provided by the department for this purpose, HFS 1444. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim submittal, use HFS 2248, Special Handling Envelope. A non-routine claim is:

Any claim to which Form HFS 1411, Temporary MediPlan Card, is attached.

Any claim to which any other document is attached.

For electronic claims submittal, refer to Topic B-202.2 above. Non-routine claims may not be electronically submitted.

=B-202.32 Required Coding- Procedures and Diagnosis Codes

Revised: Effective July 1, 2012

Procedure Codes

All services for which charges are made are to be coded on [Form HFS 1443 \(pdf\)](#), Provider Invoice, with specific codes as described on the department's [fee schedule](#) for chiropractors. Refer to Topic B-202.5. No other procedure codes are acceptable.

Diagnosis Codes

In addition to the coding required which describes the specific procedure performed, all invoices require a primary diagnosis code as listed in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). The primary diagnosis code must identify the nonallopathic lesion region of the spinal subluxation. Additionally, chiropractors must identify and code any secondary diagnosis.

B-202.4 Payment

Payment made by the department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the department. Refer to [Chapter 100](#), Topics 130 and 132, for payment procedures utilized by the department and General Appendix 8 for explanations of Remittance Advice detail provided to providers.

B-202.5 Fee Schedule

A listing of allowable procedure codes by provider type is on the department's Web site. The listing can be found at:

<http://www.hfs.illinois.gov/reimbursement/>

Paper copies of the listings can be obtained by sending a written request to:

Healthcare and Family Services
Bureau of Comprehensive Health Services
607 East Adams
Springfield, IL 62701

The Web site listings and the downloadable rate file are updated annually. Providers will be advised of major changes via a written notice. Provider notices will not be mailed for minor updates such as error corrections or the addition of newly created HCPCS or CPT codes.

=B-203 Covered Services

Revised: Effective July 1, 2012

A covered service is a service for which payment can be made by the department.

Chiropractic services are covered for participants under the age of 21.

Services are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

The services covered in the chiropractic program are limited to the treatment of the spine by manual manipulation to correct a subluxation of the spine. Only the following procedures may be submitted for reimbursement by the chiropractor:

- Chiropractic Manipulative Treatment (CMT): Spinal one or two regions
- Chiropractic Manipulative Treatment (CMT): Spinal three or four regions
- Chiropractic Manipulative Treatment (CMT): Spinal five regions

For each date of service no more than one procedure code may be billed.

=B-204 Non-Covered Services

Revised: Effective July 1, 2012

Services for which medical necessity is not clearly established are not covered by the department's Medical Programs. The objective of the department's Medical Programs is to enable eligible participants to obtain necessary medical care. "Necessary medical care" is that which is generally recognized as standard medical care required because of disease, disability, infirmity, or impairment. Refer to [Chapter 100](#), Topic 104, for a general list of non-covered services. Additionally, payment will not be made to chiropractors for these services:

- Services provided to participants 21 years of age and older.
- Services provided to participants eligible for Medicare benefits if the services are determined not medically necessary by Medicare.
- Services provided to participants in group care facilities by a provider who derives direct or indirect profit from total or partial ownership of such facility.
- Office visits- Diagnostic or screening
- Treatment when a definitive pathology is not present.
- Maintenance therapy.

The department will not make payments to a chiropractic provider for X-ray examinations or laboratory tests. A chiropractic provider may, within his professional prerogative defined by state licensure laws, order X-rays or laboratory tests necessary for diagnosis and treatment of a patient's condition from other qualified providers. Payment for such services will be made directly to those providers if they are participating in the Medical Assistance Program.

Completion	Item	Explanations and Instructions
Required	11.	Recipient Name – Enter the patient’s name exactly as it appears on the MediPlan Card, Temporary MediPlan Card, All Kids Card or Notice of Temporary All Kids Medical Benefits. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.
Required	12.	Recipient Number- Enter the nine-digit number assigned to the individual as shown on the MediPlan Card, Temporary MediPlan Card, All Kids Card or Notice of Temporary All Kids Medical Benefits. Use no punctuation or spaces. Do not use the Case Identification Number.
Optional	13.	Birth Date – Enter the month, day and year of birth of the patient as shown on the Medical Programs card. Use the MMDDYYYY format. If the birth date is entered, the department will, where possible, correct claims suspended due to recipient name or number errors. If the birth date is not entered, the department will not attempt corrections.
Not Required	14.	H Kids- Leave Blank.
Not Required	15.	Fam Plan- Leave Blank.
Not Required	16.	St/Ab- Leave Blank.
Required	17.	Primary Diagnosis Description- Enter the primary diagnosis that describes the condition primarily responsible to the patient’s treatment.
=Required <i>Revised May 2013</i>	18.	Primary Diag. Code- Enter the specific ICD-9-CM code, without the decimal, for the primary diagnosis described in Item 17. The primary diagnosis code must identify the nonallopathic lesion region of the spinal subluxation.
Required	19.	Taxonomy – Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to Chapter 300, Appendix 5.
Optional	20.	Provider Reference – Enter up to 10 numbers or letters used in the provider’s accounting system for identification. If this field is completed, the same data will appear on Form 194-M-1, Remittance Advice, returned to the provider.
Not Required	21.	Ref Prac No. - Leave Blank.
Optional	22.	Secondary Diag Code- A secondary diagnosis code may be entered when applicable.

Completion	Item	Explanations and Instructions
	23.	Service Sections- Complete one Service Section for each item or service provided to the patient.
Required		Procedure Description/Drug Name, Form, and Strength or Size- Enter the description of the service provided.
Required		Proc. Code/NDC- Enter the appropriate CPT, HCPCS or NDC.
Conditionally Required		Modifiers- Enter the appropriate two-byte modifier (s) for the service performed. The department can accept a maximum of 4 two-byte modifiers per Service Section.
Required		Date of Service- Enter the date the service was provided. Use MMDDYY format.
Required		Cat. Serv. – Enter the appropriate two-digit category of service code. 05- Chiropractic Services
Conditionally Required		Delete- When an error has been made that cannot be corrected, enter an “X” to delete the entire Service Section. Only the “X” will be recognized as a valid character; all others will be ignored.
Required		Place of Serv. – Enter the two-digit Place of Service code from the following list: 11- Office 12- Home 13- Assisted Living Facility 14- Group Home 31- Skilled Nursing Facility 32- Nursing Facility 33- Custodial Care Facility
Conditionally Required		Units/Quantity- Enter one unit.
Not Required		Modifying Units- Leave Blank.
Conditionally Required		TPL Code- If the patient’s Mediplan or All Kids Card contains a TPL code, the three digit code is to be entered in this field. If there is no TPL resource shown on the card, no entry is required. If more than one third party made a payment for a particular service, the additional payment(s) are to be shown in Section 25.