Handbook for Providers of Chiropractic Services

Illinois Department of Healthcare and Family Services
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Revision History

Date	Reason for Revisions
Policies and procedures as of August 2, 2023. Published: August 2, 2023	New document

Chiropractic Services
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Foreword

The Department of Healthcare and Family Services (HFS) or "Department" is the agency that administers Illinois' Medical Assistance (Medicaid) Program, as well as other public healthcare programs. This handbook, along with recent provider notices and Chapter 100, the Handbook for Providers of Medical Services, General Policy and Procedures, will act as an effective guide to participation in the Department's Medical Programs. It is important that both the provider of services and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions and supplements to the handbook are released as necessary based on operational need and State or federal laws requiring policy and procedural changes and are posted on the Provider Handbooks webpage.

Providers are held responsible for compliance with all policy and procedures contained herein. Providers should register to receive e-mail notification when additional information has been posted by the Department.

Charges for services provided to customers enrolled in a HealthChoice Illinois managed care organization (MCO) must be billed to the MCO. Providers should always verify eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the customer's coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The Recipient Eligibility Verification (REV) System, the Automated Voice Response System (AVRS) at 800-842-1461, and the Medical Electronic Data Interchange (MEDI) systems are available.

Providers submitting X12 electronic transactions must refer to Chapter 300, the Handbook for Electronic Processing. This handbook identifies information specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Department. Inquiries regarding coverage of a service or billing issues may be directed to the Bureau of Professional and Ancillary Services at 877-782-5565.

Acronyms and Definitions

Customer – A term used to identify an individual receiving coverage under one of the Department's medical programs. It is interchangeable with the term "recipient".

Department of Healthcare and Family Services (HFS) or (Department) - The Department of Healthcare and Family Services (HFS) or (Department) is the agency that administers Illinois' Medical Assistance (Medicaid) Program, as well as other public healthcare programs.

Document Control Number (DCN) – As identified on the HFS 194-M-2 paper Remittance advice, a twelve-digit number assigned by the Department to identify each claim that is submitted by a provider. The format is CCYYDDDLLSSSSSS or YDDDLLSSSSSS.

CCY Century and decade in which claim was received

Y Last digit of year claim was received
DDD Julian date claim was received
LL Document Control Line Number
SSSSSS Sequential Number

Fee-for-Service – A payment methodology in which reimbursement is considered for each service provided.

HCPCS – Healthcare Common Procedure Coding System.

HFS 2432 – The Split Billing Transmittal for MANG Spenddown Program Form issued by the Department of Human Services.

Identification Card or Notice - The card issued by the Department to each person or family who is eligible under the Department's Medical Programs, including Qualified Medicare Beneficiaries (QMB) who are not eligible for Medical Assistance, but are eligible for Department consideration of Medicare coinsurance and deductibles.

National Provider Identifier (NPI) - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for healthcare providers and health plans. For healthcare providers, this identifier is referred to as the National Provider Identifier (NPI).

Procedure Code – The appropriate codes from the American Medical Association Current Procedural Terminology (CPT) or appropriate HCPCS Codes.

Provider Enrollment Services (PES) – The section of the Department of Healthcare and Family Services that is responsible for maintaining provider enrollment records.

Recipient Identification Number (RIN) – The nine-digit identification number unique to the individual receiving coverage under one of the Department's Medical Programs. It is vital that this number be correctly entered on billings for services rendered.

Remittance Advice – A document issued by the Department which reports the status of claims (invoices) and adjustments processed. May also be referred to as a voucher.

201 Provider Participation

201.1 Chiropractor Enrollment

A provider who holds a valid Illinois (or state of practice) license to practice chiropractic medicine is eligible to be considered for enrollment to participate in the Department's Medical Programs.

To comply with the Federal Regulations at 42 CFR Part 455 Subpart E - Provider Screening and Enrollment, Illinois has implemented a new electronic provider enrollment

system. The web-based system is known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT).

Under the IMPACT system, category of service(s) (COS) is replaced with Specialties and Subspecialties. When enrolling in IMPACT, a Provider Type Specialty must be selected.

Refer to IMPACT Provider Types, Specialties and Subspecialties for additional information.

201.2 Participation Approval

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing certain data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see the Handbook Supplement. **Please note**: The enrollment begin date will not be backdated further than the IMPACT enrollment submission date.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic 201.4.

Enrollment of a provider is subject to a provisional period and shall be conditional for one year unless otherwise specified by the Department. During the period of conditional enrollment, the Department may terminate or disenroll the provider from the Medical Assistance Program without cause.

201.3 Participation Denial

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten (10) calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten (10) calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination.

Department rules concerning the basis for denial of participation are in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are in 89 Ill. Adm. Code 104 Subpart C.

201.4 Provider File Maintenance

The information carried in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

The provider should ensure that all information in the IMPACT system is accurate and up to date at all times. Provider Enrollment Services (PES) is the section within the Department of Healthcare and Family Services that is responsible for reviewing and approving any modifications to provider enrollment records.

201.5 Provider Responsibility

Information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found must be corrected by submitting a modification in Illinois Medicaid Program Advanced Cloud Technology (IMPACT).

Provider change information must be updated via the on-line application available on the IMPACT Provider Enrollment web page. The on-line change function is available to notify the Department of updates or changes to enrollment information for the following categories:

- National Provider Identifier (NPI)
- Provider name
- Provider demographic (address, phone, email)
- Payee demographic (address, phone, email)
- Add a Pay To (payee)
- Close a Pay To (payee)
- Close enrollment
- License
- Clinical Laboratory Improvements Amendments (CLIA)

Failure of a provider to properly update the IMPACT with corrections or changes may cause an interruption in participation and payments. Please note: Any changes/corrections to a provider's IMPACT enrollment will not be backdated further than the modification submission date.

201.6 Department Responsibility

When a provider submits a modification in IMPACT, the Department will review the request and either reject or approve the modification. The Department will generate an updated Provider Information Sheet reflecting the modification and the effective date of the modification, if appropriate. The updated sheet will be sent to the provider's office address and to all billing providers associated to the provider in IMPACT.

202 Chiropractic 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 payer or other persons applicable to the provision of services must be reflected as a credit on any claim submitted to the Department for those services or items.

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 or item. Providers may only bill the Department after the service has been provided.

To be eligible for reimbursement, all claims, including claims that are corrected and resubmitted, must be received within 180 days of the date of service. The Department must receive a claim after disposition by Medicare or its fiscal intermediary no later than twenty-four (24) months from the date of service, unless one of the exceptions to the timely filing rule applies. Refer to the Timely Filing Override Submittal Instructions for a list of exceptions to the 180-day rule and billing instructions for each.

Please note, it is the provider's responsibility to verify the claim(s) were received by the Department.

A chiropractor may charge only for services personally provided. A chiropractor may not charge for services provided by another chiropractor even though one may be in the employ of the other.

Covered services must be billed to the Department using the Current Procedural Technology (CPT) codes or alphanumeric HCPCS codes.

202.2 Electronic Claim Submittal

Refer to Chapter 100 for general policy and procedures regarding claim submittal.

All services must be billed electronically. For claims requiring attachments providers must use the Attachment Upload Portal. Further information concerning electronic claims submittal can be found in Chapter 300, 5010 Companion Guide.

Providers 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 for further details.

If a problem occurs with electronic billing, providers should contact the Department. 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.

202.3 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 for payment procedures utilized by the Department and explanations of Remittance Advice detail provided to providers.

For customers eligible for Medicare Part B benefits, payment will be considered on the deductible and co-insurance amounts and/or for the Department's Medical Programs covered services that are not covered by Medicare. If the Department's rate is lower than Medicare's rate, it may result in no payment being due. Refer to Chapter 100.

202.4 Fee Schedule

Fee schedules, including the Chiropractor Fee Schedule, are posted to the Department's website under the Provider Medicaid Reimbursement page. The listings identify the allowable procedure codes by provider type.

Providers will be advised of major changes via an electronic notice. Provider notices will not be released for minor updates such as error corrections or routine updates to the HCPCS or CPT code sets.

Providers should sign up to receive electronic notification of new information on the Department's website. Please mark "All Medical Assistance Providers" as well as each specific provider type for which notification is requested.

203 Covered Services

A covered service is a service for which payment can be made by the Department in accordance with 89 Ill. Adm. Code 140.3. Services and materials 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:

Procedure Codes:

- 98940- Chiropractic Manipulative Treatment (CMT): Spinal one or two regions
- 98941- Chiropractic Manipulative Treatment (CMT): Spinal three or four regions
- 98942-Chiropractic Manipulative Treatment (CMT): Spinal five regions

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

While the procedure codes listed in the Chiropractic Fee Schedule are to be used to designate services provided, such listing does not necessarily assure payment. Any questions a provider may have about coverage of a particular service should be directed to the Department prior to provision of the service. Providers may call the Bureau of Professional and Ancillary Services at 1-877-782-5565.

If services are to be provided to a customer enrolled in a managed care plan, prior authorization and payment must be obtained from that entity.

204 Non-Covered Services

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to 89 Ill. Adm. Code 140.6 for a general list of non-covered services.

The objective of the Department's Medical Programs is to enable eligible customers 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. Payment will not be made to chiropractors for the following services:

- Services provided to customers eligible for Medicare benefits if the services are determined not medically necessary.
- Services provided to customers 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.

205 Record Requirements

The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. In the absence of proper and complete medical records, no payment will be made, and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action. See Chapter 100 for record requirements applicable to all providers. The retention requirements are not intended to replace professional judgment, nor do they supersede record retention requirements under law or

regulations of other agencies. The chiropractor may choose to retain records beyond the Department's required period.

205.1 Office Services

Chiropractors must maintain an office medical record for each customer. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the specific provider rendering the services.

The record is to include the essential details of the customer's health condition and of each service provided. All entries must include the date, time, and signature of the chiropractor rendering the service, and must also be legible and in English. Records which are unsuitable because of illegibility or language may result in sanctions if an audit is conducted. Transcription may be required for purposes of peer, quality of care, or utilization reviews by the Department.

205.2 Services Provided in an Institution

Although the primary medical record indicating the customer's condition, treatment and services ordered and provided during a period of institutionalization may be maintained as a part of the facility chart, an abstract of the facility record, including diagnosis, treatment program, dates and times services were provided, is to be maintained by the provider as an office record to show continuity of care.

210 General Limitations and Considerations on Covered Services

Certain services are covered only when provided in accordance with the limitations and requirements described below.

210.1 Division of Specialized Care for Children (DSCC)

Federal regulations require that persons less than 21 years of age who have congenital or acquired crippling conditions leading to crippling must be referred to the Division of Specialized Care for Children (DSCC) for evaluation.

A crippling condition in this context is a tissue or functional defect of bone, muscle and joint origin that is chronic or, if unattended, may lead to chronicity with subsequent disability and handicap. Persons in this age group with congenital or acquired systemic disease, which may also involve the spine, or conditions which are associated with, or may lead to impairment of the musculo-skeletal system, and those who require specialized health providers for proper evaluation, treatment design and management are to be referred to DSCC.

Conditions that require referral to DSCC include severe or complex handicaps involving the spine which may be crippling or lead to crippling.

210.2 Home and Long Term Care Facility Services

A provider may render services to a customer in his or her place of residence (private home or a long term care facility) when the customer is physically unable to go to the chiropractor's office.

All services rendered by the provider to patients in long term care facilities are to be documented by the provider in the medical record, which is maintained by the facility, and all orders given by the provider, to be carried out by the facility staff, are to be signed by him or her. A rubber stamp of the chiropractor's signature is not considered adequate. Refer to Topic 205 for additional record requirements.