



# Handbook for Providers of Chiropractic Services

## Chapter B-200 Policy and Procedures for Chiropractic Services

**Illinois Department of Healthcare and Family Services**

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# Chapter B-200

## Chiropractic Services

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## Foreword

### Purpose

This handbook, along with recent [provider notices](#), will act as an effective guide to participation in the [Department's Medical Programs](#). It contains information that applies to fee-for service Medicaid providers. It also provides information on the Department's requirements for enrollment and provider participation.

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. Updated handbooks are posted on the [Provider Handbooks](#) page of the website.

Providers are held responsible for compliance with all policy and procedures contained herein. Providers should register to receive [e-mail notification](#), when new provider information has been posted by the Department.

Providers should always verify a participant's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the participant'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 1-800-842-1461, and the [Medical Electronic Data Interchange \(MEDI\)](#) systems are available.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Professional and Ancillary Services at 1-877-782-5565.

## Acronyms and Definitions

**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 1443](#)** – The Department of Healthcare and Family Services Provider Invoice claim form.

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

**[HFS 3797](#)** – The Department of Healthcare and Family Services Medicare Crossover Invoice claim form.

**Identification Card or Notice** - The card issued by the Department to each person or family who is eligible under Medical Assistance, All Kids, FamilyCare, Veterans Care, Health Benefits for Workers with Disabilities (HBWD) and Qualified Medicare Beneficiaries (QMB) who are not eligible for Medical Assistance, but are eligible for Department consideration of Medicare coinsurance and deductibles.

**National Drug Code (NDC)** - A universal product identifier for human drugs that is required by the Food and Drug Administration (FDA) pursuant to requirements under the Drug Listing Act of 1972. The National Drug Code (NDC) is a three-segment number. The first segment identifies the product labeler. The second segment identifies the drug, strength, and dosage form. The third segment identifies the package size and type.

**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).

**Participant** – A term used to identify an individual receiving coverage under one of the Department’s medical programs. It is interchangeable with the term “recipient”.

**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.

## B-200 Basic Provisions

For consideration of payment by the Department for chiropractic services, such services must be provided by a provider enrolled for participation in the Department's Medical Programs via the web-based system known as Illinois Medicaid Program Advanced Cloud Technology ([IMPACT](#)). Services provided must be in full compliance with applicable federal and state laws, the general provisions contained in the [Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures](#) and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook apply to participants enrolled in traditional fee-for-service and **do not apply** to patients enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs). Providers submitting X12 electronic transactions must refer to [Chapter 300, Handbook for Electronic Processing](#). Chapter 300 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 Illinois [Department of Healthcare and Family Services](#).

## **B-201 Provider Participation**

### **B-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. A provider type subspecialty may or may not be required.

Refer to [IMPACT Provider Types, Specialties and Subspecialties](#) for additional information.

### **B-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 Appendix B-3.

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 B-201.4.

### **B-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](#).

#### **B-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.

##### **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 and the Department notified immediately via [IMPACT](#).

Failure of a provider to properly update the [IMPACT](#) with corrections or changes may cause an interruption in participation and payments.

##### **Department Responsibility**

When there is a change in a provider's enrollment status or the provider submits a change, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider's office address and to all payees listed if the payee address is different from the provider address.

## **B-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.

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

To be paid for services, 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. 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.

Charges for services and items provided to participants enrolled in a Managed Care Managed Care Organization (MCO) or Managed Care Community Network (MCCN) must be billed to that entity according to the contractual agreement with the MCO or MCCN. Information regarding MCOs and MCCNs can be found on the [HFS Care Coordination web page](#).

### **B-202.2 Electronic Claim Submittal**

Refer to [Chapter 100](#) for general policy and procedures regarding claim 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 300](#), 5010 Companion Guide.

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](#) 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 billing method 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 Paper Claim Preparation and Submittal**

The Department will not accept paper claim forms hand-delivered to HFS office buildings by providers or their billing entities. HFS will return hand-delivered claims to the provider identified on the claim form. All services for which charges are made must be coded on the appropriate claim form.

For general information on billing Medicare covered services provided and submittal of claims for participants eligible for Medicare Part B, refer to the [Chapter 100 Handbook](#).

Form [HFS 1443](#), 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 Appendix B-1.

Form [HFS 3797](#), Medicare Crossover Invoice, is to be used to submit charges for all Medicare covered chiropractic services. Detailed instructions for completion are included in Appendix B-2.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendices B-1 and B-2 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scanability/imaging evaluation. Turnaround on a claim scanability/imaging evaluation is approximately seven to ten working days and providers are notified of the evaluation results in writing.

Please send sample claims with a request for evaluation to the following address:

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

## **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](#) for payment procedures utilized by the Department and explanations of Remittance Advice detail provided to providers.

For participants 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](#).

## **B-202.5 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.

## B-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.

To comply with the requirements of [Public Act 097-0689\(pdf\)](#), the Department limits covered chiropractic services to children through age 20. **Chiropractic services are not covered for adults age 21 years and older.**

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.

While the various procedure codes listed in the [Chiropractic Fee Schedule](#) are to be used to designate services provided or procedures performed, 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 participant enrolled in [Coordinated Care](#), prior authorization and payment must be obtained from that entity.

## **B-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 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. Payment will not be made to chiropractors for the following 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.

## **B-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.

### **B-205.1 Office Record**

Chiropractors must maintain an office medical record for each participant. 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 participant'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.

### **B-205.2 Services Provided in an Institution**

Although the primary medical record indicating the participant'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.

## **B-210 General Limitations and Considerations on Covered Services**

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

### **B- 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 which 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.

### **B-210.2 Home and Long Term Care Facility Services**

A provider may render services to a participant in his or her place of residence (private home or a long term care facility) when the participant 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 B-205 for additional record requirements.