

11 Chiropractor

Chiropractors are enrolled only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

Policy provisions for chiropractors associated with EPSDT can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 11.

11.1 Enrollment

HPE enrolls chiropractors and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Refer to Chapter 2, *Becoming a Medicaid Provider*, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a Chiropractor is added to the Alabama Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for chiropractic-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

Chiropractors are assigned a provider type of 15. Valid specialties for chiropractors include the following:

- Chiropractor (150)
- QMB/EPSDT (600)

Enrollment Policy for Chiropractors

To participate in the Medicaid program, chiropractors must have a current certification and/or be licensed to practice and operate within the scope of practice established by the state's Board of Chiropractic Examiners.

11.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Chiropractic services are only covered for QMB recipients or for recipients referred directly as a result of an EPSDT screening.

For more information about the EPSDT program, refer to Appendix A, EPSDT.

11.3 Prior Authorization and Referral Requirements

Chiropractic services generally do not require prior authorization since services are limited to QMB recipients and EPSDT referrals. Some codes may require prior authorization before services are rendered. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines on determining if a prior authorization is needed and how to obtain the information.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39 to determine whether your services require a referral from the Primary Medical Provider (PMP). When an EPSDT referral is required for treatment of medically necessary services, the Alabama Medicaid Referral Form (Form 362) must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for the referral.

Signature Requirement for Referrals: Effective May 16, 2012:

For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee is required. **Stamped or copied signatures will not be accepted.** For electronic referrals, provider certification is made via standardized electronic signature protocol.

11.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

\$3.90 for procedure codes reimbursed \$50.01 and greater
\$2.60 for procedure codes reimbursed between \$25.01 and \$50.00
\$1.30 for procedure codes reimbursed between \$10.01 and \$25.00

* The following CPT codes are considered office visits and the copayment is based on Medicaid's allowed amount (fee schedule) for each procedure:

99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued

by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

11.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Chiropractors who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

11.5.1 Time Limit for Filing Claims

Medicaid requires all claims for chiropractors to be filed within one year of the date of service. Refer to Chapter 5 for more information regarding timely filing limits and exceptions.

11.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. . These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885 or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

11.5.3 Procedure Codes and Modifiers

Chiropractors use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most Medicaid required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, P. O. Box 930876, Atlanta, GA 31193-0873 or 1-800-621-8335.

11.5.4 Place of Service Codes

The following place of service codes apply when filing claims for chiropractic services:

<i>POS Code</i>	<i>Description</i>
11	Office

11.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims with Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Chapter 5 Required Attachments, for more information on attachments.

11.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care EPSDT	Chapter 7 Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N