



Florida Medicaid

CHIROPRACTIC SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration



CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

<DATE>

Dear Medicaid Chiropractic Services Provider:

The Chiropractic Services Coverage and Limitations Handbook, January 2010, Section 59G- 4.040 is amended to implement changes to the handbook that include:

- Changes in fiscal agent references.
- Additional definitions.
- Language that is intended to improve the quality and integrity of services, specifically services provided to infants and young children.
- Clarification regarding place of service to mirror that of optometric services.
- Policy clarification.
- Clarification regarding mobile units.

Please contact your local Medicaid area office if you have any questions. The Medicaid area offices' phone numbers and addresses are listed on our Web site at www.ahca.myflorida.com. All of the Medicaid handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Provider Support**, and then **Provider Handbooks**.

We appreciate the services you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder, Chief
Bureau of Medicaid Services



Handbook UPDATE LOG

CHIROPRACTIC SERVICES COVERAGE

AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as either replacement pages in an existing handbook or a completely revised handbook.

It is very important that the provider read the updated material and if he maintains a paper copy, file it in the handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 800-289-7799.

UPDATE	EFFECTIVE DATE
Revised Handbook	August 2000
Update Pages	April 2001
Revised Handbook	October 2003
Update Pages	July 2004
Erratum	July 2004
Revised Handbook	January 2010

CHIROPRACTIC SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Table of Contents

<i>Chapter/Topic</i>	<i>Page</i>
<i>Introduction</i>	
Handbook Use and Format	ii
Characteristics of the Handbook	iii
Handbook Updates	iii
<i>Chapter 1 – Provider Qualifications and Enrollment</i>	
Purpose and Definitions	1-1
Provider Qualifications	1-2
Provider Enrollment.....	1-2
Provider Requirements	1-4
Mobile Chiropractic Units	1-6
<i>Chapter 2 – Covered Services, Limitations and Exclusions</i>	
General Service Requirements, Limitations and Exclusions	2-1
Patient Visits	2-4
Radiology Services	2-6
<i>Chapter 3 – Procedure Codes and Fees</i>	
Reimbursement Information.....	3-1
How to Read the Chiropractor Procedure Codes and Fee Schedule	3-2
Modifiers and Their Descriptions	3-3

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

Provider General Handbook describes the Florida Medicaid Program.
Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.
Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exception: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

Title XIX of the Social Security Act.
 Title 42 of the Code of Federal Regulations.
 Chapter 409, Florida Statutes.
 Chapter 59G, Florida Administrative Code.

In This Chapter

This chapter contains:

TOPIC	PAGE
Handbook Use and Format	ii
Characteristics of the Handbook	iii
Handbook Updates	iii

Handbook Use and Format

Purpose

The purpose of the Medicaid handbooks is to provide the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.

The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.

Provider

The term "provider" is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.

Recipient

The term "recipient" is used to describe an individual who is eligible for Medicaid.

General Handbook

General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.

Coverage and Limitations Handbook

Each coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of service will have more than one coverage and limitations handbook.

Reimbursement Handbook

Each reimbursement handbook is named for the claim form that it describes.

Chapter Numbers

The chapter number appears as the first digit before the page number at the bottom of each page.

Page Numbers

Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.

White Space

The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format

The format styles used in the handbooks represent a short and regular way of displaying difficult, technical material.

Information Block

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.

Note

Note is used most frequently to refer the user to important material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

Topic Roster

Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an "Update" and the "Effective Date."

How Changes Are Updated

The Medicaid handbooks will be updated as needed. Changes may be:

1. Replacement handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy.
 2. Revised handbook – Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook..
-

Handbook Updates, continued

Effective Date of New Material

The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

Identifying New Information

New material will be identified by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label and New Information Block

A new label and a new information block will be identified with yellow highlight to the entire section.

New Material in an Existing Information Block or Paragraph

New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence and/or paragraph affected by the change.

CHAPTER 1

CHIROPRACTIC SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Overview

Introduction

This chapter describes the Medicaid Chiropractic Program, explains the limitations and exclusions, and defines who is an eligible doctor of chiropractic medicine.

Legal Authority

The state of Florida bases Medicaid chiropractic services on the federal Social Security Act, section 1902(a) (43) for adults and section 1905(r) for children. Chapter 409.906, Florida Statutes (F.S.), and Chapter 59G-4.040, Florida Administrative Code (F.A.C.), establish state authority for chiropractic services.

In This Chapter

This chapter contains:

TOPIC	PAGE
Purpose and Definitions	1-1
Provider Qualifications	1-2
Provider Enrollment	1-2
Provider Requirements	1-4
Mobile Chiropractic Units	1-6

Purpose and Definition

Purpose of this Handbook

This handbook is intended for use by doctors of chiropractic medicine who provide services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider General handbook, which contains information about the Medicaid Program in general, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment.

Note: All Medicaid handbooks are available on the Medicaid Web Portal at <http://www.mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Program Purpose

The purpose of the Chiropractic Services Program is to provide medically necessary and covered services to Medicaid-eligible recipients, within the scope of practice, and as permitted by law for chiropractic medicine.

Purpose and Definition, continued

Chiropractic Definition

A doctor of chiropractics (D.C.) is an individual who is licensed to engage in the practice of chiropractic medicine, as defined in Chapter 460, F.S.

Provider Qualifications

Licensing

To enroll as a Medicaid provider, a doctor of chiropractic medicine must be currently licensed, as defined in Chapter 460, F.S.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for information regarding out-of-state providers and services.

Fully Operational at Time of Enrollment

Doctors of chiropractic medicine must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers.

Fully operational is defined as a building that is open and operates as a medical office, providing chiropractic services performed by a doctor of chiropractic medicine, currently under licensure of the state of Florida. The practice must provide all facilities, staff, equipment and medical services a doctor of chiropractic medicine requires to perform the medical services required under his scope of practice.

Provider Enrollment

General Enrollment Requirements

Doctors of chiropractic medicine must meet the general Medicaid provider enrollment requirements contained in Chapter 2 of the Florida Medicaid Provider General Handbook.

In addition, doctors of chiropractic medicine must follow the specific enrollment requirements listed in this section.

Site Visit Requirement

A site visit is required for the initial enrollment of a chiropractic business, when the business is 50% or more owned by non-physicians.

Group Providers

When two or more providers using the same tax identification number render services to Medicaid recipients they must enroll as a group provider. Each member of the group that renders services to Medicaid recipients must also enroll as an individual Medicaid provider. The providers are not required to practice at the same location to enroll as a group. However, group providers must obtain a location code provider number for each location where they have a physical office.

The group provider number is used for billing and tax identification purposes only.

Provider Enrollment, continued

Multiple Locations

Individual or group providers who render services at more than one physical office location under a single license or certification are required to submit an Application for New Location Code and to identify each separate physical office address where services are to be provided. This is required for each type of service for which the provider is enrolled to provide.

Adding a Location Code to an Existing Group Practice

Group practices that are 50% or more non-physician owned must have an approved site visit before an additional location code is added to their provider enrollment file.

Note: See Multiple Locations in this section for the definition of location code and the proper application process.

Note: See Notifying Medicaid of Practice Location Change in this section for required notification procedures when an enrolled chiropractic practice changes address or relocates.

Notifying Medicaid Regarding Change of Address or Practice Location

The provider must notify the Medicaid fiscal agent of additional physical office practice locations. Notification must be made in writing on an Application for a New Location code and must include an effective date for the new location.

The provider must be assigned a separate Medicaid provider identification number for each physical location by the Medicaid fiscal agent. The provider must cross-reference its National Provider Identifier to its locations' Medicaid provider numbers using taxonomy or zip code plus four as identifiers.

Any closure, or intended closure, of a practice location must also be reported immediately to the Medicaid fiscal agent, in writing and on office letterhead stationery, along with the effective, or intended, date of closure. Additional information is provided in Chapter 2 of the Provider General Handbook,

Note: The Application for New Location Code may be obtained from the Medicaid fiscal agent by calling Provider Enrollment at 800-289-7799, and selecting Option 4, This application is available online at the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Enrollment. The Application for New Location Code is an attachment to the Florida Medicaid Provider Enrollment Application, AHCA Form 2200-0003,

Note: See Chapter 2 in the Provider General Handbook for additional information regarding group providers, multiple locations, and reporting changes to a provider's enrollment information. All Medicaid handbooks are available on the Medicaid Web Portal at <http://www.mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Random Site Visits

Providers are subject to random on-site inspections, in accordance with section 409.907(7), F.S.

Provider Enrollment, continued

Individual Providers Responsibilities Within a Group Practice

An individual treating provider must be enrolled as a member of group practices for which he performs services. It is the responsibility of the individual treating provider to notify the Medicaid fiscal agent of all group practice affiliations.

Any individual treating provider who is terminating his or her relationship with a group practice must update his provider file by notifying the Medicaid fiscal agent of this termination, in writing.

Provider Requirements

General Requirements

In addition to the general provider requirements and responsibilities contained in Chapter 2 of the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, a chiropractor is also responsible for complying with the provisions contained in this section.

Provider Responsibility

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). Medicaid providers, including their staff, contracted staff and volunteers, must meet the definition of a covered entity according to HIPAA and must comply with HIPAA privacy requirements effective April 14, 2003, and HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbook, CMS-1500 contains the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook. All Medicaid handbooks are available on the Medicaid Web Portal at <http://www.mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 866-586-0961 or 800-289-7799, select Option 3.

Provider Requirements, continued

<p>Direct Supervision</p>	<p>Delivery of all chiropractic services must be performed by or under the direct supervision of the chiropractor.</p> <p>Direct supervision means the licensed chiropractor:</p> <ul style="list-style-type: none"> • Is on the premises when the services are rendered; and • Reviews, signs and dates the medical record.
<p>Teaching Chiropractic Physicians</p>	<p>Teaching chiropractic physicians who seek reimbursement for oversight of the patient by a chiropractic student during their postgraduate education must directly supervise all services performed by the chiropractic student.</p> <p>Direct supervision means the chiropractor:</p> <ul style="list-style-type: none"> • Is on the premises when the services are performed; and • Reviews, signs and dates the medical record.
<p>Chiropractic Students</p>	<p>If a chiropractic student in a postgraduate program of study receives a salary that is considered in any facility's cost report, the chiropractic student may not bill Medicaid on a fee-for-service basis.</p>
<p>Students in Clinical Teaching Institutions</p>	<p>Students in Florida medical institutions may document in the medical record and participate in key components of a billable service. The medical record entry must be reviewed, dated and co-signed by the billing chiropractor.</p>
<p>Chiropractors Employed by Facilities</p>	<p>A chiropractor who is salaried by a facility that is reimbursed by Medicaid on a cost-related basis may not bill Medicaid on a fee-for-service basis, if the cost for the chiropractor's salary is included in the facility's cost report.</p>
<p>Rural Health Clinic, County Health Department or Federally Qualified Health Center</p>	<p>Chiropractor providers enrolled under the group number of a Rural Health Clinic (RHC), a County Health Department (CHD), or a Federally Qualified Health Center (FQHC), and who are providing services in the RHC, CHD, or FQHC, must bill all the services they provide in accordance with policies outlined in the RHC, CHD or FQHC Coverage and Limitations Handbooks, and may not bill Medicaid on a fee-for service basis.</p> <p>Note: All Medicaid handbooks are available on the Medicaid Web Portal at http://www.mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.</p>
<p>Requirement for Medical Records</p>	<p>See Chapter 2 of the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for record keeping requirements..</p> <p>Note: All Medicaid handbooks are available on the Medicaid Web Portal at http://www.mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.</p>

Mobile Chiropractic Units

Description

A mobile chiropractic unit is a fully operational chiropractic vehicle, unit, or trailer that travels to different locations for the provision of chiropractic services and is not a stationary chiropractic unit.

Limitations and Exceptions

Medicaid will only reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinic (RHCs) for mobile unit chiropractic services.

Mobile unit providers must contract with FQHCs. RHC mobile units must be certified by Medicare as mobile FQHC and RHCs, in accordance with the Code of Federal Regulations, Title 42.

Mobile unit services must be provided and billed in compliance with this handbook and the applicable Florida Medicaid Federally Qualified Health Center or Rural Health Clinic Coverage and Limitations Handbook.

All chiropractic services performed in a mobile unit must be billed using the group identification number of the RHC or FQHC. Mobile chiropractic services that do not meet the contract and certification requirements specified above are not eligible for reimbursement.

Note: All Medicaid provider handbooks are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

CHAPTER 2

CHIROPRACTIC SERVICES

COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered and the limitations and exclusions under the Florida Medicaid Chiropractic Services Program.

In This Chapter

This chapter contains:

TOPIC	PAGE
General Service Requirements, Limitations and Exclusions	2-1
Patient Visits	2-7
Radiology Services	2-9

General Service Requirements, Limitations and Exclusions

Chiropractic Services

Chiropractic services include evaluation and medically necessary treatment performed on one or more areas of the body. Treatment consists of manual manipulation or adjustment with application of controlled force to re-establish normal articular function. Manual manipulation is used to restore optimum mobility and range of motion to the spine.

Covered Services

Only those services designated in this chapter and listed in the Chiropractic Procedure Codes and Fee Schedule can be reimbursed by Medicaid to a chiropractor.

Note: All Medicaid Fee Schedules are available on the Medicaid Web Portal at <http://www.mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

General Service Requirements, Limitations and Exclusions, continued

Medically Necessary

Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary or a covered service.

Duplicate Services

Medicaid will not reimburse a chiropractor and the following provider types for the same procedure, same recipient, and same date of service:

- Advanced registered nurse practitioner
 - County health department
 - Federally qualified health center
 - Physician
 - Physician assistant
 - Rural health clinics
-

General Service Requirements, Limitations and Exclusions, continued

Service Limitations

Medicaid will reimburse for a maximum of one visit per day, per recipient up to a maximum of twenty-four (24) visits per recipient within a calendar year. All recipients under 21 years of age must be referred for chiropractic services by their primary care physician, pediatrician, or orthopedic specialist prior to receiving the service.

Experimental and investigational chiropractic interventions are not covered by Medicaid. Manual manipulation performed on patients for non-musculoskeletal conditions, and on patients who are asymptomatic is considered experimental and investigational.

Preventive or maintenance chiropractic interventions or manual manipulation are not considered medically necessary. Chiropractic care provided to a patient whose condition is neither regressing nor improving is not considered medically necessary.

Non-manual or automated mechanical manipulation of the spine is not a covered service.

Note: See the Chiropractic Services Fee Schedule for maximum unit and fee limits. All Medicaid Fee Schedules are available on the Medicaid Web Portal at <http://www.mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

**MediPass
Authorization**

Recipients under 21 years of age who are enrolled in MediPass must be referred for chiropractic services by their MediPass primary care provider, prior to receiving the service.

Recipients 21 years of age and older and enrolled in MediPass may have 10 visits in each calendar year without a referral from their MediPass primary care providers. Visits 11 through 24 require authorization by the adult recipient's MediPass primary care provider. The MediPass authorization number must be entered in item 17A of the service provider's CMS-1500 claim form.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for instructions on entering the referring physician's name and Medicaid ID number on the claim. All Medicaid Provider Handbooks are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

General Service Requirements, Limitations and Exclusions, continued

Place of Service

Chiropractic services may be provided in the following locations:

- Ambulatory surgical center,
 - Chiropractor's office,
 - County health department,
 - Emergency room,
 - Federally qualified health center (FQHC),
 - Hospital,
 - or
 - Rural health clinic (RHC)
-

General Service Requirements, Limitations and Exclusions, continued

Exceptions to Place of Service

Only when all of the following criteria are met, will chiropractic care be reimbursed when performed in: 1) the recipient's home, 2) a nursing home, 3) intermediate care facility for the developmentally disabled (ICF/DD), or 4) custodial care facility:

- The recipient is given the right to choose his chiropractic service provider;
- The chiropractic services provided in the facility or recipient's home are qualitatively comparable to chiropractic services provided in the provider's office;
- Transportation to the provider's office would require an ambulance or stretcher van or moving the recipient out of his home or residential facility room would pose an unacceptable health risk, due to the recipient's current and documented medical condition;
- The recipient's primary care physician or facility physician specifically orders medically necessary chiropractic services to be performed in the recipient's home, nursing home, ICF/DD, or custodial care facility;
- The physician's order (documentation of medical necessity) is valid up to 90 days after the order is signed and dated by the referring physician.
- If additional chiropractic services are required, the medical necessity for the service must be re-determined by the recipient's primary care physician.
- Pursuant to Chapter 59A-4. 107, F.A.C.; verbal treatment orders shall be countersigned by the primary care physician on the next visit to the residential facility and must be filed in the recipient's medical record at both the facility and the chiropractic provider's office.
- When services are provided in the recipient's home, documentation of medical necessity, as described above, and services received must be maintained in the recipient's medical record in the provider's office.
- When services are provided in the recipient's residential facility the documentation of medical necessity and documentation of services received must be maintained in both the facility and the provider's office.

The place of service must be entered on the provider's claim form. Chiropractic services performed in a recipient's home, nursing home, ICF/DD, or custodial care facility must not be billed with a place of service code designated for an office, inpatient, outpatient setting.

Note: Refer to Chapter 3 of the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for a list of all place of service codes and code descriptions. All Medicaid Provider Handbooks are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Note: Transportation services are included in the per diem rate of an ICF/DD.

General Service Requirements, Limitations and Exclusions, continued

Maximum Fee

The maximum fee is intended to pay the chiropractor for performing the complete procedure including both the technical and professional components.

The maximum fee can be billed only when the same provider performs both the technical and professional components during the same visit.

Professional Component Fee

The provider may bill for the professional component only when professional service has been rendered.

Technical Component

A technical component service includes the use of the provider's equipment, personnel, and supplies in the performance of a radiological exam.

Medicaid reimburses the radiological technical component for chiropractors in the office setting only.

To be reimbursed, the chiropractor billing the technical component must either perform or directly supervise the performance of the radiology study; or if a group practice, a member of the group must perform or directly supervise the radiological study.

The technical component is not reimbursed separately when a chiropractor or members of a group practice perform both the professional component and technical component of a radiological procedure.

Nursing Facility or ICF/DD

Recipients who reside in a nursing facility or an intermediate care facility for the developmentally disabled (ICF/DD) are eligible for Medicaid-reimbursed chiropractic services only when all criteria described in the Exceptions to Place of Service section of this Chapter are met.

The referring physician's name and Medicaid ID number, or National Provider Identifier (NPI), must be entered in items 17 and 17a of the service provider's claim form.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for instructions regarding entering the referring physician's name and Medicaid ID number, or NPI, on the claim.

Note: All Medicaid Provider Handbooks are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Provider Visits

New Patient Visit

A new patient is one who has not received any professional services from the chiropractic physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

The evaluation and management of a new patient or new patient visit is reimbursable only once per provider or provider group, per recipient.

The new patient visit includes manual manipulation of the spine. Spinal manipulation codes cannot be billed in addition to a new patient visit.

Radiology procedures are reimbursable in addition to a new patient visit.

Note: For assistance in billing a new patient or an initial patient visit for dually-eligible recipients, who qualify for both Medicare and Medicaid, see Chapter 4 in the Florida Medicaid Provider General Handbook. All Medicaid Provider Handbooks are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Initial Patient Office Visit

Procedure codes 99201-99203 are used when billing for a recipient's initial office visit.

Manual manipulation of the spine is included in the reimbursement of a new patient's initial office visit.

Established Patient Visits

An established patient is one who has received professional services from the chiropractic physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

An established patient visit consists of manual manipulations of the spine.

Established patient visits for manual manipulations of the spine are limited to a maximum of 24 visits per calendar year.

Maximum Visits Per Calendar Year

The 24 visits per calendar year, for manual manipulation of the spine, can be calculated as:

- Twenty-four (24) established patient visits; or
 - One (1) new patient visit and twenty-three (23) established patient visits.
-

Provider Visits, continued

Visits in Excess of Maximum Limitation

Medicaid does not reimburse for chiropractic visits in excess of 24 visits per year for recipients age 21 and older.

Authorization for reimbursement for visits exceeding the 24-visit limit may only be approved for recipients under age 21. The additional visits must be medically necessary, referred by the recipient's primary care physician, or MediPass primary care provider, and authorized by Medicaid, prior to the additional service being provided.

Note: See Chapter 2 of the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for procedures on requesting prior authorization for services. All Medicaid Provider Handbooks are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Chiropractic Manipulation Treatment (CMT)

Medicaid reimburses the following procedure codes for follow-up visits:

- 98940—Chiropractic manipulation treatment (CMT); spinal, one to two regions.
- 98941—Chiropractic manipulation treatment (CMT); spinal, three to four regions.
- 98942—Chiropractic manipulation treatment (CMT); spinal, five regions.

Note: For assistance in billing manipulation treatment codes for dually-eligible Medicare and Medicaid recipients, see Chapter 4 in the Florida Medicaid Provider General Handbook. All Medicaid Provider Handbooks are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Two Procedures on the Same Day

A provider may not bill for more than one chiropractic manual manipulation treatment procedure code for the same recipient on the same date of service.

Manual manipulation of the spine is included in the new patient office visit payment.

Codes and Fees

See the Chiropractic Services Fee Schedule for a list of covered procedure codes and associated fees.

Note: All Medicaid Fee Schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

Radiology Services

Description

Medicaid reimburses chiropractic providers for diagnostic radiology services, identified on the Chiropractic Services Fee Schedule.

Note: For assistance in billing radiology codes for those dually eligible recipients, who qualify for both Medicare and Medicaid, see Chapter 4 of the Florida Medicaid Provider General Handbook. All Medicaid Provider Handbooks and Fee Schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks, or Fee Schedules.

Supervision

Non-invasive radiological studies do not require direct chiropractor supervision to be reimbursed by Medicaid, but do require indirect supervision.

Indirect supervision is defined as:

- The supervising chiropractor (provider) must authorize the procedure and be on the premises while it is performed; and
- Shall require the supervising physician to be reasonably available in order to be physically present to provide consultation or direction in a timely fashion as required for appropriate care of the recipient.

Direct supervision means the supervising chiropractor (provider) must:

- Be physically present when the services are rendered; and
 - Review, sign and date the medical record.
-

Maximum Fee

To be reimbursed the maximum fee for a radiology service, the chiropractor must provide both the technical and professional components. The maximum fee includes the professional component and the technical component of the radiological service.

When a non-invasive radiological study is performed in an office setting, the chiropractor billing the maximum fee must directly or indirectly supervise the technical component of the study. The provider must directly perform the interpretation and results of the study.

If a group practice, members of the group must perform both components of the service.

The maximum fee is not reimbursed if the professional component and the technical component are billed separately on the claim form.

Radiology Services, continued

Professional Component

A professional component service is the chiropractor's interpretation and reporting of the radiological exam and is identified by adding a modifier 26 to the procedure code on the claim form.

Medicaid reimburses for the professional component service only when the service is provided in an office, clinic, inpatient hospital or outpatient hospital setting.

If the professional service component is provided for an emergency room recipient, use "outpatient hospital" for place of service on the claim.

The professional component is not reimbursed separately when a chiropractor or members of a group practice perform both the professional component and technical component.

When an x-ray is taken in the emergency room, only one of the following types of service providers can be reimbursed for the professional component:

- Practitioner;
 - o MD or DO
 - o ARNP
 - o Physician's Assistant
- Emergency room physician;
- Chiropractor; or
- Radiologist.

Technical Component

A technical component service includes the use of the provider's equipment, personnel, and supplies in the performance of a radiological exam and is identified by adding a TC modifier to the procedure code on the claim form.

Medicaid reimburses the radiological technical component for chiropractors in only the office setting.

For non-invasive radiology studies, the physician billing the technical component must either perform or indirectly supervise the performance of the radiological study; or if a group practice, a member of the group must perform or indirectly supervise the radiological study.

The technical component is not reimbursed separately when a chiropractor or members of a group practice perform both the professional component and technical component of a radiological procedure.

Diagnostic Radiology

Diagnostic radiology includes the following:

- Limited exam, which includes anterior, posterior and lateral views and is only part of a complete exam; or
- Complete exam that includes all necessary views for optimal examination.

All procedures are considered complete unless otherwise indicated. The procedure is performed by the same chiropractor.

Radiology Services, continued

Radiology Frequency

Only one interpretation per radiology procedure, per recipient, is reimbursable.

More than one x-ray is reimbursable on the same day

Service Exclusions

Medicaid does not reimburse chiropractors for the following:

- Mobile radiology services;
- X-rays for soft tissue diagnosis;
- Ultrasound or electrical stimulation; or
- As a separate fee-for-service provider in rural health clinics, county health departments or federally qualified health centers.

When an x-ray is taken in the emergency room, Medicaid reimburses either the emergency room physician or a chiropractor for the interpretation, but not both.

Codes and Fees

See the Chiropractic Services Fee Schedule for a list of covered procedure codes and associated fees.

Note: All Medicaid Fee Schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

CHAPTER 3

CHIROPRACTIC SERVICES PROCEDURE CODES AND FEES

Overview

Introduction

This chapter provides and describes the procedure codes for the services reimbursable by Medicaid that must be used by chiropractors providing services to eligible recipients.

In This Chapter

This chapter contains:

TOPIC	PAGE
Reimbursement Information	3-1
How to Read the Chiropractor Fee Schedule	3-2
Modifiers and Their Descriptions	3-3

Reimbursement Information

Procedure Codes

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes, Level 1. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the current CPT book for complete descriptions of the standard codes. CPT codes and descriptions are copyrighted by the American Medical Association. All rights reserved.

HCPCS Level 1 codes (CPT) is a systematic listing and coding of procedures and services performed by providers. Each procedure or service is identified by a five digit numeric code.

Diagnosis Code

A diagnosis code is required on the CMS-1500 claim form for all chiropractic procedures. Use the most current and specific code available. Fourth and fifth digits are required when available.

Copayment

Medicaid recipients, unless they are exempt, are responsible to pay a copayment of \$1.00, per provider or group provider, per day, for chiropractic services.

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for categories of recipients and services that are exempt from the copayment. All Medicaid Provider General Handbooks are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

How to Read the Chiropractic Procedure Codes and Fee Schedule

Introduction

Specific CPT codes are reimbursed by Medicaid to chiropractors. Covered CPT codes are listed on the Chiropractic Services Fee Schedule.

Note: See the Chiropractic Services Fee Schedule for a list of covered procedure codes, code descriptions and associated fees. All Medicaid Fee Schedules are available on the Medicaid Web Portal at <http://www.mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

Description

The chiropractic fee schedule is a table of columns listing CPT procedure codes, their descriptors and other information pertinent to each code.

The following information explains the fee schedule columns, reading from left to right.

Code

The number in this column identifies the procedure being billed.

Code Description

The information in this column describes the service or procedure associated with the procedure code. Medicaid providers are instructed to refer to the current CPT book for a complete description, for billing purposes. The CPT book includes identifying numeric codes and descriptions for reporting chiropractic services and medical procedures.

Age 00-20 Max Fee

The fee in this column is the maximum allowable amount Medicaid will reimburse for that procedure code, for Medicaid recipients under the age of 21.

Age 21+ Max Fee

The fee in this column is the maximum allowable amount Medicaid will reimburse for that procedure code, for Medicaid recipients age 21 and older.

Age 00-20 PC Fee

The fee in this column designates the maximum allowable amount reimbursable for **only** the professional component of that procedure code, for Medicaid recipients under the age of 21.

Age 21+ PC Fee

The fee in this column designates the maximum allowable amount reimbursable for **only** the professional component of that procedure code, for Medicaid recipients age 21 and older.

Age 00-20 TECH Fee

The fee in this column designates the maximum allowable amount Medicaid will reimburse for **only** the technical component of that procedure code, for Medicaid recipients under the age of 21.

How to Read the Chiropractic Procedure Codes and Fee Schedule, continued

Age 21+ TECH Fee

The fee in this column designates the maximum allowable amount Medicaid will reimburse for **only** the technical component of that procedure code, for Medicaid recipients age 21 and older.

Modifiers and Their Descriptions

Definition of Modifier

A modifier is a two-digit code that is used with a procedure code to more fully describe the procedure performed so that accurate payment may be determined.

Pricing Modifiers

Pricing modifiers are used with the procedures listed in the fee schedule to affect the procedure code's fee or cause a claim to pend for review. The provider is required to use pricing modifiers under certain circumstances described in Chapter 2 of this handbook or in the pricing modifiers' definitions in this section.

Entering Modifiers on the Claim Form

The modifier is entered in the field located immediately to the right of the procedure code field in item 24D, Modifier, on the CMS-1500 claim form.

If more pricing modifiers are applicable than the number of spaces available in item 24D, Modifier, on the CMS-1500 claim form, enter the multiple pricing modifier, 99 in the last modifier space. See Modifier 99 in this chapter for the full requirements.

22 Unusual Services

Use this modifier **only** when a provided service(s) exceeds the usual service as described in the CPT. Modifier 22 requires the claim to be reviewed by a Medicaid medical consultant for appropriate pricing. Documentation must be submitted that clearly indicates why modifier 22 is being used.

Additional documentation will need to be submitted along with routine documentation to indicate why additional reimbursement is being requested: examples include explanation of increased complexity of the service or unexpected complications during a service.

Failure to submit the requested documentation can result in denial of the service, request for more information, or no increase in reimbursement.

If a claim denial is received for units of service exceeded, use of modifier 22 would be appropriate. Inappropriate use of this modifier can result in claim denial or delayed reimbursement time.

Modifiers and Their Descriptions, continued

26 Professional Component

Certain procedures are a combination of a professional component and a technical component.

Use this modifier when the professional component is reported separately.

Acceptable procedure codes billable for professional component are identified in the "PC" column in the fee schedule.

TC Technical Component Radiology

Certain procedures are a combination of a professional component and a technical component.

Use this modifier when the radiological technical component is reported separately. Acceptable procedure codes billable for technical component are identified in the "TC" column in the fee schedule.

99 Multiple Modifiers

Modifier 99 is used when two or more modifiers are applicable to one procedure code line.

Modifier 99 is used when two or more modifiers are applicable to one procedure code line. Claims with 99 modifiers must be submitted with reports.

When modifier 99 is used, there must be an indication made on the documentation indicating the individual modifiers that 99 represents, (Example: 99=22 and 26). Absence of this indication can result in a claim denial.

Use of this modifier requires the claim to be reviewed by a Medicaid medical consultant for appropriate pricing. Pricing will be based on the use of valid modifiers applicable to the procedure code.

**Your search for
Health Care Information
may be over.**

Connecting Florida
with Health Care
Information

Compare hospitals,
surgery centers,
health plans,
nursing homes,
and pharmacies

Find information on
medical conditions,
symptoms, surgeries,
and treatments



www.FloridaHealthFinder.gov



Charlie Crist
Governor

Thomas W. Arnold
Secretary

2727 Mahan Drive
Tallahassee, FL 32308

<http://ahca.myflorida.com>