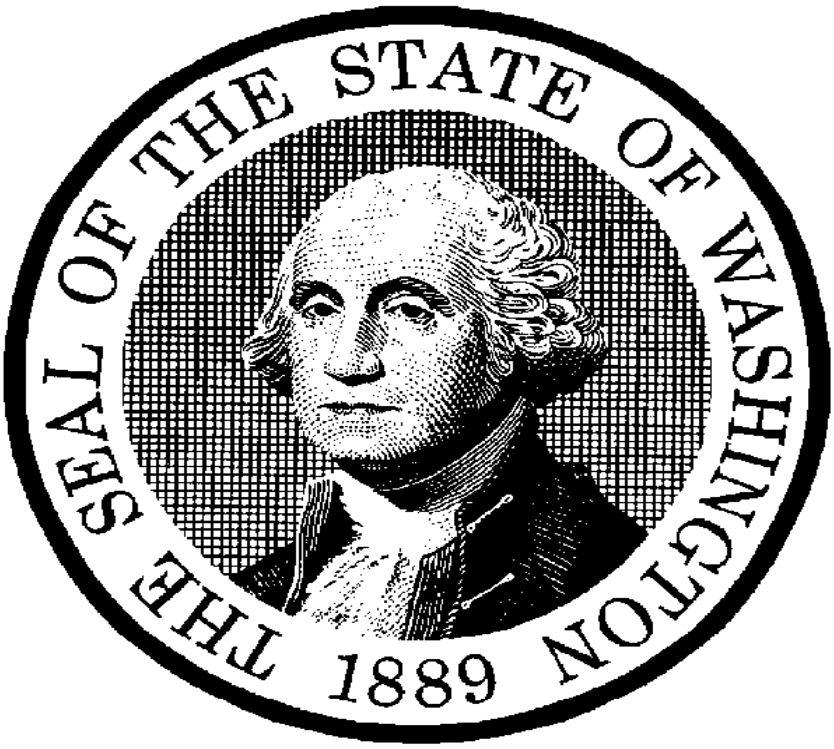
Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Health and Recovery Services Administration



Chiropractic Services for Children

Billing Instructions

Current Procedure Terminology CPT

About this publication

This publication supersedes all previous Chiropractic Billing Instructions and Numbered Memorandum 99-15 MAA.

Published by the Health and Recovery Services Administration
Washington State Department of Social and Health Services

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

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Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its program. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs.

Applying for a provider

Call:
Provider Enrollment
800.562-3022 and
Select Option #1

or call one of the following numbers:

360.725.1033
360.725.1026
360.725.1032

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9249
Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

Or write/call:
Provider Relations
PO Box 45562
Olympia WA 98504-5562
800.562.3022

Who do I contact if I have questions regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Call:
Provider Relations
800.562.6188

Private insurance or third party liability, other than Healthy Options?

Write/call:
Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
800.562.6136

Electronic Billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
360.725.1267

Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions.

Children's Health Insurance Program (CHIP) - The Children's Health program is the state-funded program for children under age 18 who are not eligible for Medicaid. (*Not to be confused with the Children's Health Insurance Program – CHIP.)*

Chiropractic Care – Manipulation of the spine to facilitate the recuperative powers of the body and the relationship between the musculoskeletal structures and functions of the body to restore health.

Community Services Office(s) (CSO) - An office of the department [that] administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement - A basic contract that the Health and Recovery Services Administration (HRSA) holds with providers serving HRSA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Department - The state Department of Social and Health Services. (WAC 388-500-0005)

Early and Periodic Screening, Diagnosis, And Treatment (EPSDT) – Also known as the "healthy kids" program, a program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the children's health program. (WAC 388-500-0005)

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medical Benefits (EOMB) – A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Facility setting maximum allowable fees – Fees paid when the provider performs the services in a facility setting and the cost of the resources are the responsibility of the facility (i.e. outpatient hospital).

General Assistance Unemployable (GA-U) – A state-funded program providing medical care to unemployable persons not eligible for or not receiving federal aid.

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Healthy Kids (EPSDT) – See Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

Limited Casualty-Medically Needy Program (LCP-MNP) – A federally-funded program with a limited scope of medical coverage intended for persons whose income or resources exceed Medicaid's Categorically Needy Program (CNP) eligibility limits. The client's Medical ID Card will show LCP-MNP in the program and scope of care area.

Managed Care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount a provider may be reimbursed by HRSA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320 and 388-500-0005.

Medical Identification (ID) card – The document that identifies a client's eligibility for a medical program. This card was formerly known as the medical assistance identification (MAID) card or medical coupon.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Non-Facility Setting Maximum Allowable Fee – Fee paid for services when the provider performing the service typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed (i.e. office or clinic).

Patient Identification Code (PIC) - An alphanumeric code assigned to each Medical Assistance client consisting of:

a) First and middle initials (a dash (-) must be used if the middle initial is not indicated).
b) Six-digit birth date, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha character (tie breaker).

Program Support, Division of (DPS) - The division within the Health and Recovery Services Administration responsible for providing administrative services for the following: Claims Processing, Family Services, Managed Care Contracts, Provider Relations, Field Services, and Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Remittance and Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. (42 CFR 433.136)

Title XIX - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

Title XXI - The portion of the federal Social Security Act that authorizes grants to states for the Children's Health Insurance Program (CHIP).

Usual & Customary Fee – The rate that may be billed to the department for a certain service or equipment. This rate *may not exceed*:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

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About the Program

What is the purpose of the Chiropractic Services for Children Program?

The purpose of the Health and Recovery Services Administration's (HRSA's) Chiropractic Services for Children Program is to provide medically necessary chiropractic services to eligible HRSA clients **under 21 years of age.**

Who is eligible to be reimbursed for chiropractic services?

HRSA will pay only for chiropractic services that are:

- Provided by a chiropractor licensed in the state where services are provided and enrolled as an HRSA provider;
- Within the scope of the chiropractor's license;
- Listed in this document (see *Coverage* section); and
- Medically necessary.

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Client Eligibility

Who is eligible?

To be eligible for chiropractic services, clients must:

- Be under 21 years of age;
- Referred by a screening provider under the Healthy Kids/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; and
- Present their Medical ID Card with one of the following identifiers:

Medical ID Card Identifier	Medical Program
CNP	Categorically Needy Program
CNP - CHIP	Categorically Needy Program – Children's Health Insurance Program
CNP - Children's Health	Categorically Needy Program – Children's Health ***(This program is discontinued as of 10/01/02. Clients with this identifier will not be eligible for this, or any other Medical Assistance program.)***
GA-U - No Out of State Care	General Assistance-Unemployable - No Out of State Care
General Assistance - No Out of State Care	ADATSA
LCP - MNP	Limited Casualty Program – Medically Needy Program

Note: Include the referring provider number in field 17a on the HCFA 1500 claim form. If no HRSA provider number is available, enter the name in field 17. Keep referral information in the client's file.

Are children enrolled in managed care eligible for chiropractic services?

Clients with an identifier in the HMO column on their Medical ID Cards are enrolled in one of HRSA's Healthy Options managed care plans. All chiropractic services must be requested and provided directly through the client's Primary Care Provider (PCP). Clients can contact their PCP by calling the telephone number listed on their Medical ID Card.

Please check the client's Medical ID Card **prior** to scheduling services and at the **time of service** to make sure proper authorization or referral is obtained from the PCP and/or plan. You must bill the Healthy Options Plan directly for reimbursement for the chiropractic services.

Chiropractic Services for Children Coverage Table

HRSA covers only the following chiropractic services for children.

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
72020	26	X-ray exam of spine		X-rays of the spine limited to: • A single view when the treatment area can be isolated; and • The cervical, thoracic, and lumbo-sacral (anterior-posterior and lateral) areas of the spine when treatment cannot be isolated.
72020	TC	X-ray exam of spine		
72020		X-ray exam of spine		
72040	26	X-ray exam of neck spine		
72040	TC	X-ray exam of neck spine		
72040		X-ray exam of neck spine		
72070	26	X-ray exam of thoracic spine		
72070	TC	X-ray exam of thoracic spine		
72070		X-ray exam of thoracic spine		
72100	26	X-ray exam of lower spine		
72100	TC	X-ray exam of lower spine		
72100		X-ray exam of lower spine		
98940		Chiropractic manipulation		Unlimited chiropractic manipulative treatments of the spine.
98941		Chiropractic manipulation		
98942		Chiropractic manipulation		

Note: HRSA does not pay for the following items under the Chiropractic Services for Children program:

- Therapy modalities such as light, heat, hydro, and physical;
- Any food supplements, medications, or drugs; and
- Any braces, cervical collars, or supplies.

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Billing

- HRSA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. HRSA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in HRSA's billing instructions.

- HRSA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders HRSA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to HRSA's satisfaction that there are other extenuating circumstances.

Note: If HRSA has recouped a plan's premium, causing the provider to bill HRSA, the time limit is 365 days from the date of recoupment by the plan.

- HRSA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to HRSA's billing limits.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the Medical ID Card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill HRSA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to HRSA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill HRSA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill HRSA.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

Note: HRSA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time period does not apply to overpayments that the provider must refund to DSHS. After the allotted time period, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ HRSA does not pay the claim.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee**.**

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical ID Card. An insurance carrier's time limit for claim submissions may be different from HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA *Remittance and Status Report* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA;

- Attach the insurance carrier's statement or EOB;

- If rebilling, also attach a copy of the HRSA *Remittance and Status Report* showing the previous denial; or

- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on HRSA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 800.562.6136.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain their service via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. **Please refer to the client's Medical ID Card to identify the client's PCCM.**

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager (PCCM) name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill HRSA, the claim will be denied.

  Newborns of Healthy Options clients that are connected with a PCCM are fee-for-service until they have chosen a PCCM. All services should be billed to HRSA.

Note: If you treat a Healthy Options client that has chosen to obtain care with a PCCM and you are not the PCP, or the client was not referred to you by the PCCM/PCP, **you may not receive payment.** You will need to contact the PCP to get a referral.

What records must be kept?

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, **for at least six years from the date of service** or more if required by federal or state law or regulation.

Fee Schedule

You may view HRSA's **Adult Day Health Fee Schedule** on-line at

http://maa.dshs.wa.gov/RBRVS/Index.html

Completing the 1500 Claim Form

Attention! HRSA now accepts the new 1500 Claim Form.

- **On November 1, 2006,** HRSA began accepting the new 1500 Claim Form (version 08/05).
- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 Claim Form.

Note: HRSA encourages providers to make use of electronic billing options.
For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 claim form. You may download this booklet from HRSA's website at: http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html or request a paper copy from the Department of Printing (see Important Contacts section).

The following 1500 claim form instructions relate to **Chiropractic Services for Children Billing Instructions**. Click the link above to view general 1500 claim form instructions.

For questions regarding claims information, call HRSA toll-free:

800.562.3022

1500 Claim Form Field Descriptions

Field No.	Name	Field Required	Entry
17.	**Name of Referring Physician or Other Source**		Enter the EPSDT/Healthy Kids referring physician. This field *must* be completed.
17a.	**I.D. Number of Referring Physician**		Enter the seven-digit, HRSA-assigned identification number of the EPSDT/Healthy Kids provider who *referred* the service.
24B.	**Place of Service**	Yes	These are the only appropriate code(s) for HRSA's Chiropractic Services for Children program: Code — To Be Used For 3 — Office
24C.	**Type of Service**	Yes	Enter a **9** for all services billed.

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