SECTION II - CHIROPRACTIC

CONTENTS

200.000 CHIROPRACTIC GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Individual Chiropractic Providers — 11-1-09

Chiropractic Services providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. The provider must be licensed to practice in his or her state. A copy of the current license must accompany the provider application and Medicaid contract.

B. The provider must be enrolled in the Title XVIII (Medicare) Program.

201.001 Electronic Signatures — 10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

201.100 Providers in Arkansas and Bordering States 11-1-06

A. Providers in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled in the Medicaid Program as routine services providers if they meet all Arkansas Medicaid participation requirements outlined in Section 201.000.

B. Reimbursement may be available for covered services in the Medicaid Program. Claims must be filed according to billing procedures included in this manual.

201.200 Providers in States Not Bordering Arkansas 3-1-11

A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).** **View or print Provider Enrollment Unit contact information.**

B. Limited Services providers remain enrolled for one year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.
2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.
3. Limited Services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

202.000 Group Providers of Chiropractic Services in Arkansas and Bordering States 11-1-06

Group providers of chiropractic services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

If a chiropractor is a member of a group of chiropractors, each chiropractor and the group must both enroll according to the following criteria:

A. Each individual chiropractor within the group must enroll following the criteria established in Section 201.000.

B. All group providers are "pay to" providers only. Services must be performed and billed by a Medicaid-enrolled licensed chiropractor within the group.

202.100 Group Providers of Chiropractic Services in States Not Bordering Arkansas 3-1-11

Group chiropractic providers in non-bordering states may be enrolled only as limited services providers.

203.000 Reserved 11-1-09

210.000 PROGRAM COVERAGE

211.000 Introduction 5-1-18

Arkansas Medicaid assists Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual.

Chiropractic services are covered by Medicaid **only** to correct a subluxation of the spine (by manual manipulation). Chiropractic services do not require a referral from the Medicaid beneficiary's primary care physician (PCP). Chiropractic services are covered by Medicaid for beneficiaries of all ages.

212.000 Coverage of Chiropractic Services 7-1-22

A. Chiropractic services must be administered by a licensed chiropractor, meeting minimum standards promulgated by the Secretary of Health and Human Services under Title XVIII of the Social Security Act. Manipulation of the spine for the treatment of subluxation is the **only** chiropractic service covered by Medicaid.

B. Benefits.

1. Benefits are not limited for beneficiaries under twenty-one (21) years of age (in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program), except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.
2. Medicaid covers chiropractic services for beneficiaries twenty-one (21) years of age and older, with a benefit limit of twelve (12) visits per State Fiscal Year (SFY: July 1 through June 30).
3. Two (2) chiropractic X-rays per SFY are covered by Medicaid. However, an X-ray is not required for treatment.
4. Chiropractic X-rays count against the five-hundred-dollar per SFY radiology/other services benefit limit.

   Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
5. The radiology/other services benefit may be extended when medically necessary (see Section 214.000). All X-rays and documentation must be kept in the beneficiary's medical record for a period of five (5) years for audit purposes. Chiropractic services may be provided in the provider's office, the patient's home, a nursing home, or another appropriate place.

C. For beneficiaries who are eligible for Medicare and Medicaid, see Section I of this manual for additional coinsurance and deductible information. See **Section III** for instructions on filing joint Medicare/Medicaid claims.

213.000 Exclusions 10-13-03

Medicaid does not pay for any other diagnostic or therapeutic services furnished by a chiropractor.

214.000 Procedures for Obtaining Extension of Benefits

214.100 Extension of Benefits for X-Ray Services 8-1-21

A. Requests for extension of benefits for x-ray services must be submitted to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient days.**

1. Requests for extension of benefits for x-ray services are considered only after a claim is filed and is denied because the patient's benefits are exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

B. A request for extension of benefits for x-ray services must be received within ninety (90) calendar days of the date of benefits-exhausted denial.

214.110 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests for extension of benefits for clinical services (physician's visits), outpatient services (hospital outpatient visits), laboratory services (diagnostic laboratory tests), and radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services: form (Form DMS-671). **View or print form DMS-671.**

Complete instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in **Section V** of each Provider Manual.

214.120 Documentation Requirements for Benefit Extension Requests 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements include the following:

1. Clinical records *must:*

a. Be legible and include records supporting the specific request;

b. Be signed by the performing provider;

c. Include clinical, outpatient, and emergency room records for dates of service in chronological order

d. Include related diabetic and blood pressure flow sheets;

e. Include a current medication list for the date of service;

f. Include obstetrical record related to current pregnancy; and

g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for laboratory and radiology/other services signed by the physician.

2. Diagnostic laboratory and radiology/other reports *must* include:

a. Clinical indication for diagnostic laboratory and radiology/other services ordered;

b. Signed orders for diagnostic laboratory and radiology/other services;

c. Results signed by the performing provider; and

d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests.

214.200 Administrative Reconsideration and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

214.210 Reserved 6-1-25

220.000 PRIOR AUTHORIZATION 10-13-03

Prior authorization is not applicable to chiropractic services.

230.000 REIMBURSEMENT

231.000 Method of Reimbursement 10-13-03

The reimbursement methodology for chiropractor services is a “fee schedule” methodology. Under the fee schedule methodology, reimbursement is made at the lower of the billed charge for each procedure or the maximum allowable for each procedure. The maximum allowable fee for a procedure is the same for all chiropractors.

231.010 Fee Schedules 12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://medicaid.mmis.arkansas.gov/** under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

232.000 Rate Appeal Process 11-1-06

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services (DHHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

240.000 BILLING PROCEDURES

241.000 Introduction to Billing 7-1-20

Chiropractic providers use form CMS-1500 to bill the Arkansas Medicaid Program on paper for services provided to Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claims submission.

242.000 CMS-1500 Billing Procedures

242.100 Procedure Codes 7-1-22

The procedure codes for billing chiropractic services are in the link below.

View or print the procedure codes for Chiropractic services.

A. *Authorized procedure codes must be used when filing claims for chiropractic X-rays.

B. Chiropractic X-rays are limited to two (2) per State Fiscal Year (SFY: July 1 through June 30). This service counts against the five-hundred-dollar per SFY (per beneficiary) radiology/other services benefit limit.

C. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

242.200 Chiropractic National Place of Service (POS) Codes

242.210 National Place of Service (POS) Codes 7-1-07

Electronic and paper claims now require the same National Place of Service code.

Place of Service	POS Codes
Doctor's Office	11
Patient's Home	12
Nursing Facility	32
Skilled Nursing Facility	31
Other Locations	99

242.300 Billing Instructions – Paper Claims Only 11-1-17

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. **View or print the Claims Department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

242.310 Completion of the CMS-1500 Claim Form 2-1-22

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.

Field Name and Number	Instructions for Completion
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.

Field Name and Number	Instructions for Completion
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The “Claim Codes” identify additional information about the beneficiary’s condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED’S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED’S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE	Enter “Signature on File,” “SOF” or legal signature.
13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE	Enter “Signature on File,” “SOF” or legal signature.
14. DATE OF CURRENT: lLLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Not required
17a. (blank)	Not required.
17b. NPI	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 242.200 for codes.
C. EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail. **Refer to Section 242.100** for procedure codes.
MODIFIER	Modifier(s) if applicable.

Field Name and Number		Instructions for Completion
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30.	RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

242.400 Special Billing Procedures 10-13-03

Not applicable to this program.