Arkansas Department of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480 **TDD: 501-682-6789** **Internet Website: www.medicaid.state.ar.us**

TO: **Arkansas Medicaid Health Care Providers – Chiropractic**

DATE: **November 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #68**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000 – 202.110	10-13-03	201.000 – 202.100	11-1-06
—	—	203.000	11-1-06
211.000 – 212.000	10-13-03	211.000 – 212.000	11-1-06
214.000 – 215.000	10-13-03	214.000 – 214.215	11-1-06
232.000	10-13-03	232.000	11-1-06
241.000 – 242.100	10-13-03	242.000 – 242.100	11-1-06
242.300 – 242.310	10-13-03	242.300 – 242.310	11-1-06

Explanation of Updates

Section 201.000 has been revised to include current requirements for provider participation in the Medicaid Program. Information about limited services and routine services providers has been relocated to new sections.

Section 201.100 is a new section created to format for clarification.

Section 201.200 is a new section created to format for clarification. This section includes new policy for participation of providers in states not bordering Arkansas.

Section 202.000 has been revised for formatting purposes.

Section 202.100 has been revised for grammatical changes.

Section 203.000 is a new section added to include requirements for record keeping and retention of records.

Section 211.000 has been revised to clarify the purpose of and the required referral by the primary care physician for chiropractic services. The words recipient and recipients have been replaced with beneficiary and beneficiaries.

Section 212.000 has been revised by deleting the word recipient and replacing it with beneficiary. Reference to procedure codes has been deleted in this section since the information is located in section 242.100. Obsolete information has been deleted.

Section 214.000 has been revised with a new title.

Sections 214.100 through 214.210 are new sections added to include the request for extension of benefits process.

Section 215.000 has been deleted. Information previously included in this section has been relocated to section 203.000.

Section 232.000 has been revised to change the name of the Department of Human Services to Department of Health and Human Services.

Sections 241.000 and 242.000 have been revised to delete "formerly HCFA-1500" from references to the CMS-1500 claim form.

Section 242.100 has been revised to delete obsolete information.

Section 242.300 has been revised to delete "formerly HCFA-1500" from references to the CMS-1500 claim form.

Section 242.310 title has been revised to delete "formerly HCFA-1500" from reference to the CMS-1500 claim form. Instructions have been revised with minor wording changes for clarification.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 (TDD only).

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

NOTE: TOC required due to title changes, additions, and deletions.

200.000 CHIROPRACTIC GENERAL INFORMATION 10-13-03

201.000 Arkansas Medicaid Participation Requirements for Individual Chiropractic Providers 11-1-06

To participate in the Arkansas Medicaid Program, providers must adhere to all applicable professional standards of care and conduct. Individual providers of chiropractic services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

A. The provider must complete and submit to Provider Enrollment a provider application (form DMS-652), Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9) with the Arkansas Medicaid Program. **View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9)**.

B. 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.

1. Subsequent renewals of license must be forwarded to Provider Enrollment within 30 days of issuance.

2. If the renewal document(s) have not been received within this time period, the provider will have an additional, and final, 30 days to comply.

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

D. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider Agreement.

E. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

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 11-1-06

A. Providers in states not bordering Arkansas may enroll as closed-end providers after they have furnished services to an Arkansas Medicaid beneficiary and have a claim to file with Arkansas Medicaid. **View or print Provider Enrollment Unit contact information.**

A non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, **www.medicaid.state.ar.us/InternetSolution/Provider/Provider.aspx**, and then submit the application and claim to the Medicaid Provider Enrollment Unit.

B. Closed-end providers remain enrolled for one year.

1. If a closed-end provider treats another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the newer claim's last date of service, if the provider keeps the enrollment file current.

2. During the enrollment period the provider may file any subsequent claims directly to the Medicaid fiscal agent.

3. Closed-end providers are strongly encouraged to submit 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.

A. In situations where a chiropractor is a member of a group of chiropractors, the group and each chiropractor intending to participate in Medicaid must enroll in accordance with the following requirements.

1. Individual chiropractors enroll following the criteria established in section 201.000.

2. The group must complete and submit a provider application and Medicaid contract as an Arkansas Medicaid provider of chiropractic services.

B. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider Agreement.

C. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

D. All group providers are "pay to" providers only. Services must be performed and billed by a licensed and enrolled chiropractor who is linked to the group in the Medicaid provider enrollment files.

202.100 Group Providers of Chiropractic Services in States Not Bordering Arkansas 11-1-06

Group chiropractic providers in non-bordering states may be enrolled only as **closed-end providers**.

203.000 Records Providers of Chiropractic Services Are Required to Keep 11-1-06

A. Providers must contemporaneously establish and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with its delivery of medical assistance to any Medicaid beneficiary.

B. Providers furnishing any Medicaid-covered good or service for which a prescription, admission order, physician's order, care plan or other order for service initiation, authorization or continuation is required by law, by Medicaid rule, or both, must obtain a copy of the prescription, care plan or order within five (5) business days of the date it is written. Providers also must maintain a copy of each prescription, care plan or order in the beneficiary's medical record and follow all prescriptions, care plans, and orders as required by law, by Medicaid rule, or both.

C. The provider must make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary. When records are stored off-premise or are in active use, the provider may certify in writing that the records in question are in active use or in off-premise storage and set a date and hour within three (3) working days, at which time the records will be made

available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.

D. All records must be kept for a period of five (5) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish medical records upon request will result in sanctions being imposed. (See Section I of this manual.)

211.000 Introduction 11-1-06

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). As with most Medicaid services, chiropractic services 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 11-1-06

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. Benefits are not limited for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

Medicaid covered chiropractic services are available to Medicaid beneficiaries aged 21 years and older with a benefit limit of 12 visits per state fiscal year (July 1 through June 30).

Two chiropractic X-rays per state fiscal year (July through June) are covered by Medicaid. However, an X-ray is not required for treatment. Chiropractic X-rays count against the $500 per state fiscal year laboratory and X-ray benefit limit. The laboratory and X-ray benefit may be extended when medically necessary (see section 214.000). X-rays and documentation must be kept in the beneficiary's medical record for a period of five years for audit purposes. Chiropractic services may be provided in the provider's office, the patient's home, a nursing home or other appropriate place.

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.

214.000 Procedures for Obtaining Extension of Benefits 11-1-06

214.100 Extension of Benefits for X-Ray Services 11-1-06

A. Requests for extension of benefits for x-ray services must be mailed to Arkansas Foundation for Medical Care, Inc. (AFMC), Attention EOB Review. **View or print the Arkansas Foundation for Medical Care, Inc. contact information.**

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 by AFMC within 90 calendar days of the date of benefits-exhausted denial.

214.110 Completion of Request Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services" 11-1-06

A. Requests for extension of benefits for x-ray services must be submitted to AFMC for consideration. Consideration of requests for extension of benefits requires correct completion of all fields on the Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray (form DMS-671). **View or print form DMS-671.**

B. If the provider of service is a member of a provider group, the performing provider's number and the group provider number must be entered in the Medicaid provider ID number fields.

C. The provider's signature (with his or her credentials) and the date of the request are required on the form. Stamped or electronic signatures are accepted.

D. Claims for reimbursement must be filed in chronological order. Dates of service must be listed in chronological order on form DMS-671. When requesting benefit extension for more than four procedures, use a separate form for each set of four procedures.

E. Enter a valid type of service code using the applicable type of service code for paper claim(s).

F. Enter a valid diagnosis code and brief narrative description of the diagnosis.

G. Enter a valid procedure code and, if applicable, modifier(s) along with a brief narrative description of the procedure.

H. Enter the number of units requested under the extension.

214.120 Documentation Requirements for Benefit Extension Requests 11-1-06

A. To request extension of benefits for any benefit limited service, all applicable records that support the medical necessity of extended benefits are required.

B. 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 records for dates of service in chronological order
   d. Include a current medication list for the date of service
2. Laboratory and radiology reports *must* include:
   a. Clinical indication for laboratory and x-ray services ordered
   b. Signed orders for laboratory and radiology services
   c. Results signed by the performing provider

214.200 Administrative Reconsideration of Extensions of Benefits Denial 11-1-06

A. A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and **additional** supporting documentation.

B. The deadline for receipt of the reconsideration request will be enforced pursuant to sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar

days will be considered on an individual basis. Reconsideration requests must be mailed and will not be accepted via facsimile or email.

214.210 Appealing an Adverse Action 11-1-06

Please see section 190.000 *et al* for information regarding administrative appeals.

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.

241.000 Introduction to Billing 11-1-06

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 beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claims submission.

242.000 CMS-1500 Billing Procedures 11-1-06

242.100 Procedure Codes 11-1-06

The procedure codes for billing chiropractic services are below.

98940	98941	98942	76499*

*Procedure code **76499** is to be used when filing claims for chiropractic x-ray. This benefit is limited to two (2) per state fiscal year. This service counts against the $500 per state fiscal year laboratory and X-ray benefit limit.

242.300 Billing Instructions - Paper Claims Only 11-1-06

EDS offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those that require attachments or manual pricing.

To bill for chiropractic services, use the CMS-1500 form. **View a CMS-1500 sample form.** Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to the EDS Claims Department. **View or print EDS Claims contact information.**

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

242.310 Completion of CMS-1500 Claim Form 11-1-06

Field Name and Number		Instructions for Completion
1.	Type of Coverage	This field is not required for Medicaid.
1a.	Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number.
2.	Patient's Name	Enter the patient's last name and first name.
3.	Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
	Sex	Check "M" for male or "F" for female.
4.	Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5.	Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name, (post office box or RFD), city name, state name and zip code.
6.	Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7.	Insured's Address	Required if insured's address is different from the patient's address.
8.	Patient Status	This field is not required for Medicaid.
9.	Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
	a. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
	b. Other Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	c. Employer's Name or School Name	Enter the employer's name or school name.
	d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10.	Is Patient's Condition Related to:	
	a. Employment	Check "YES" if the patient's condition was employment related (current or previous). If the condition was not employment related, check "NO."

Field Name and Number	Instructions for Completion
b. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two letter State postal abbreviation) where the accident took place. Check "NO" if not auto accident related.
c. Other Accident	Check "YES" if the patient's condition was other accident related. Check "NO" if not other accident related.
10d. Reserved for Local Use	This field is not required for Medicaid.
11. Insured's Policy Group or FECA Number	Enter the insured's policy group or FECA number.
a. Insured's Date of Birth	This field is not required for Medicaid.
Sex	This field is not required for Medicaid.
b. Employer's Name or School Name	Enter the insured's employer's name or school name.
c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12. Patient's or Authorized Person's Signature	This field is not required for Medicaid.
13. Insured's or Authorized Person's Signature	This field is not required for Medicaid.
14. Date of Current: Illness Injury Pregnancy	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15. If Patient Has Had Same or Similar Illness, Give First Date	This field is not required for Medicaid.
16. Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17. Name of Referring Physician or Other Source	Primary Care Physician (PCP) referral is required for Chiropractic services. Enter the referring physician's name and title.
17a. I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.
18. Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format.
19. Reserved for Local Use	Not applicable to Chiropractic services.
20. Outside Lab?	This field is not required for Medicaid.
21. Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with HCFA diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.
22. Medicaid Resubmission Code	Reserved for future use.

Field Name and Number	Instructions for Completion
Original Ref No.	Reserved for future use.
23. Prior Authorization Number	Enter the prior authorization number or benefit extension control number, if applicable.
24. A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.
B. Place of Service	Enter the appropriate place of service code. See Section 242.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See Section 242.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT procedure code.
Modifier	Enter when applicable.
E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only <u>one</u> diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD-9-CM.
F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H. EPSDT/Family Plan	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral.
I. EMG	Emergency - This field is not required for Medicaid.
J. COB	Coordination of Benefit - This field is not required for Medicaid.

Field Name and Number	Instructions for Completion
K. Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#." When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter the number in Field 33 after "GRP#."
25. Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. Patient's Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27. Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.
28. Total Charge	Enter the total of Column 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)
29. Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. Do not enter any amount previously paid by Medicaid. Do not enter any payment by the beneficiary. (See NOTE below Field 30.)
30. Balance Due	Enter the total amount due. **NOTE: For Fields 28, 29 and 30, up to 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
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 valid.
32. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If the place of service is other than home or office, enter the name and address, specifying the street, city, state and zip code of the facility where services were performed.
33. Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.

Field Name and Number	Instructions for Completion
PIN #	This field is not required for Medicaid.
GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after “GRP#” and the individual practitioner’s number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after “GRP#.”