Chiropractic Guide

Claim Processing and Benefit Overview

Updated: May 2022

Disclaimer:

- This information is provided as a courtesy from *i*Care to assist you with claims submission and billing. This does not replace ForwardHealth and CMS Guidelines. *i*Care relies upon ForwardHealth and CMS for payment rules and regulations for claim submission.

Prior Authorization Info

- Refer to our procedure specific Prior Authorization list to determine if any services require prior authorization
- https://www.icarehealthplan.org/Provider.htm
  - For Providers>Prior Authorizations

Medicare Benefits-**Standard**

- Benefits are available under *i*Care Medicare
- Additional services are not allowed
- Deductible and Co-Insurance does apply

- Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, i.e., by use of hands. Additionally, manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine

Medicare Modifiers

- AT Modifier – Required for **Standard** Benefits
- Do NOT use the CE modifier (Enhanced Benefits Ended)

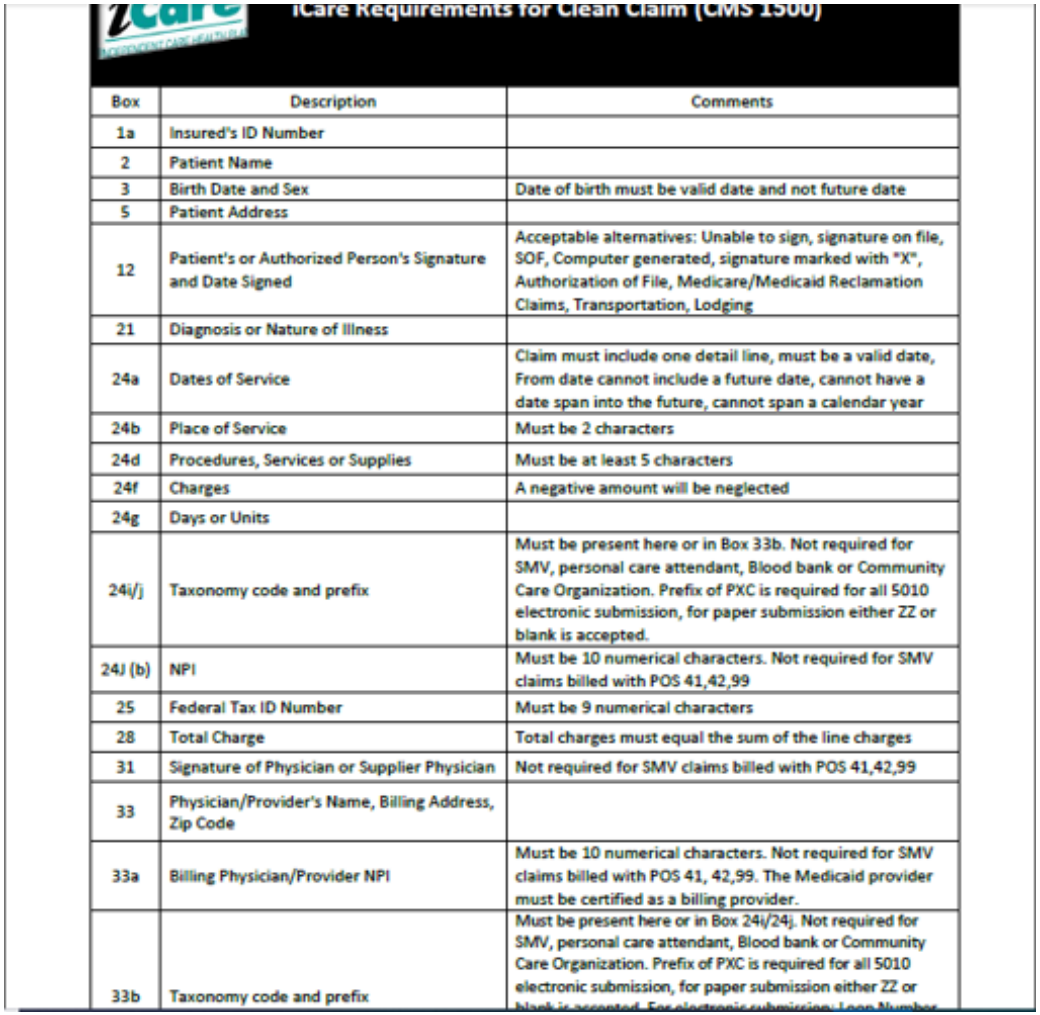
Medicaid Benefits

- Manual manipulations of the spine are reimbursed only when the member's diagnosis is subluxation. Manipulations for strains and sprains are not covered
- The initial visit and 20 manipulations do not require PA
- One Spinal adjustment per Date of Service per Member is reimbursable

Medicaid Covered Diagnosis

Diagnosis Code	Description
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region

Clean Claim Guidelines - HCFA



iCare Requirements for Clean Claim (CMS 1500)

Box	Description	Comments
1a	Insured's ID Number	
2	Patient Name	
3	Birth Date and Sex	Date of birth must be valid date and not future date
5	Patient Address	
12	Patient's or Authorized Person's Signature and Date Signed	Acceptable alternatives: Unable to sign, signature on file, SOF, Computer generated, signature marked with "X", Authorization of File, Medicare/Medicaid Reclamation Claims, Transportation, Lodging
21	Diagnosis or Nature of Illness	
24a	Dates of Service	Claim must include one detail line, must be a valid date, From date cannot include a future date, cannot have a date span into the future, cannot span a calendar year
24b	Place of Service	Must be 2 characters
24d	Procedures, Services or Supplies	Must be at least 5 characters
24f	Charges	A negative amount will be neglected
24g	Days or Units	
24i/j	Taxonomy code and prefix	Must be present here or in Box 33b. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted.
24J (b)	NPI	Must be 10 numerical characters. Not required for SMV claims billed with POS 41,42,99
25	Federal Tax ID Number	Must be 9 numerical characters
28	Total Charge	Total charges must equal the sum of the line charges
31	Signature of Physician or Supplier Physician	Not required for SMV claims billed with POS 41,42,99
33	Physician/Provider's Name, Billing Address, Zip Code	
33a	Billing Physician/Provider NPI	Must be 10 numerical characters. Not required for SMV claims billed with POS 41, 42,99. The Medicaid provider must be certified as a billing provider.
33b	Taxonomy code and prefix	Must be present here or in Box 24i/24j. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted. For electronic submission: Loop Number

Claims Filing Limits

- *i*Care's Timely Filing Limit is 120 days from the date of service (DOS) on a CMS 1500 claim form unless otherwise specified in the Provider's Contract.
- *i*Care's Timely Filing Limit is 120 days from the Thru date on a UB04 claim form unless otherwise specified in the Provider's Contract.
- New day paper claims submitted with a Primary carrier explanation of benefits (EOB) will be processed as timely as long as the EOB has been submitted within 90 days of the Primary carrier's EOB date.

iCare Provider Portal Access

- Your time is valuable. *i*Care's Provider Portal allows you to view prior authorizations, service requests, verify eligibility and view claim information for the *i*Care members you serve.

- **Getting Started**

- Registration can be completed with information already at your disposal using your TIN (Tax ID Number), NPI and most recent check number. Use the Facility/Group name as listed on your Explanation of Payment. *i*Care can also generate a one-time PIN, you can request a one-time PIN via the request button below. **If you have checks with more than 20 claims processed your will need to request a PIN to register.**
- If you do not receive your PIN, please contact *i*Care at ProviderRelationsSpecialist@*i*CareHealthPlan.org for additional assistance.
- If an organization chooses to assign roles for the employees, the Office Manager will need to create a user account for the users within your organization. Office Managers can set up additional users individually and invite them to register or you can create user accounts in bulk via spreadsheet upload.
- The ***i*Care Portal User Guide** provides step by step instructions for registration and outlines functionalities. If you have any questions, please contact ProviderOutreach@*i*CareHealthPlan.org or ProviderRelationsSpecialist@*i*CareHealthPlan.org
- Use care when entering your password in the Provider Portal. If the incorrect password is attempted 3 times, your account will be locked. If you are not able to reset your own password or retrieve your forgotten password, email ProviderOutreach@*i*CareHealthPlan.org or ProviderRelationsSpecialist@*i*CareHealthPlan.org. Include your Username and your password will be reset within 24 hours.

GENERAL CONTACT/INDIVIDUAL DEPARTMENT PHONE AND FAX NUMBERS

MAIN NUMBER
414-223-4847 or 800-777-4376

Claims/Appeals/Reconsiderations
Local: 414-231-1029
Fax: 414-231-1094
Out of Area: 877-333-6820
Email: department-providerservices@icarehealthplan.org

Eligibility and Provider Services
Local: 414-231-1029
Fax: 414-231-1094
Out of Area: 877-333-6820

Prior Authorization
Local: 414-299-5539
Out of Area: 855-839-1032
Fax: 414-231-1026

Provider Contracting
414-225-4741
Fax: 414-272-5618