Bulletin

Michigan Department of Community Health

Distribution: Chiropractors 01-03

Issued: May 1, 2001

Subject: Uniform Billing Project
Elimination of Local Code
Conversion to Calendar Year Billing Cycle

Effective: August 1, 2001

Programs Affected: Medicaid, Children's Special Health Care Services

Effective for services rendered on or after August 1, 2001, the Department of Community Health (DCH) is implementing changes in coverage and reimbursement policies, and claim submission requirements for Chiropractors. These changes will help align DCH requirements with those of other major health insurers and are a step toward HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance.

This bulletin contains information about specific changes being implemented for Chiropractors. You should also refer to Medicaid Bulletin MSA 01-01 (revised Chapter IV) issued January 1, 2001, for additional information regarding claim completion requirements. Copies of all draft and final policy bulletins, the electronic claim transaction set, and other information related to changes being made are available on the DCH website at www.mdch.state.mi.us, click on Medical Services Administration, Information for Medicaid Providers.

The following changes will be implemented August 1, 2001:

- Effective August 1, 2001, chiropractors must bill utilizing the National Electronic Data Interchange Transaction Set Health Care Claim: Professional 837 (ASC X12N 837, version 3051) for electronic claims or the HCFA 1500 paper claim form.

- The local code X2010, Additional Spinal Manipulation by Chiropractor, used when manipulations exceeded 18 per year will be discontinued as of August 1, 2001. Only CPT procedure codes will be accepted for dates of service on and after August 1, 2001.

- If more than 18 visits are medically necessary, effective August 1, 2001, providers must submit a **PRIOR AUTHORIZATION (PA) REQUEST**. This will replace the current procedure of submitting documentation on the first claim that exceeds frequency. Providers **must** obtain prior authorization before performing additional manipulations.

- The PA request must be submitted by a letter to:

  Review and Evaluation Division
  Medical Services Administration
  PO Box 30170
  Lansing, Michigan 48909

  Or fax it to: 517-335-0075

- The letter requesting prior authorization must include:

  - Patient name and Medicaid ID number
  - Provider's name, address, and Medicaid Provider ID number
  - Contact person and phone number
  - The CPT procedure code of the procedure(s) that will be performed
  - The patient's pertinent information:
    - Height
    - Weight
    - Provide the date of onset of current complaint and the frequency of visits to date
    - Indicate level of subluxation and associated diagnosis, including complications of predisposing conditions, if present
    - Specify physical and objective findings
    - Specify radiographic findings, including significant findings in support of the diagnosis
    - Indicate the patient's response to current treatment (improvement to date, if any)
    - Provide your estimate of continued treatment necessary for current complaint
    - Provide expected and anticipated benefit of continued treatment
    - Include any additional details, comments, etc. that you feel may be of assistance in the evaluation

- The provider will receive a written response from Medicaid. If the PA request is approved, the provider will receive a 9-digit prior authorization number that they will be required to enter onto the HCFA 1500 Claim Form, Box 23, Prior Authorization Number. **There is no need to submit a copy of the approval letter with the claim.**

- Failure to receive prior authorization before providing more than 18 visits will result in rejected claims.

- Effective January 1, 2002, Medicaid will reimburse up to 18 chiropractic visits per calendar year, (i.e. Jan.-Dec.). Currently, visits are reimbursed up to 18 chiropractic visits per 12-month period (365 days) based on the first manipulation appointment of the beneficiary. If more than 18 visits are medically necessary during the calendar year, providers must use the Prior Authorization process as outlined above.

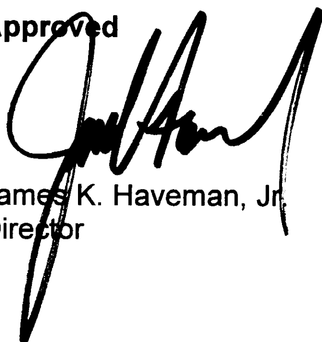
Manual Maintenance

Retain this bulletin for future reference.

Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, MI 48909-7979, or e-mail at ProgramSupport@state.mi.us. Providers may phone toll-free 1-800-292-2550.

Approved



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