Table of Contents

Chiropractor

This section covers all Medicaid services provided by health care providers of chiropractic services as deemed appropriate by the Department of Health and Welfare (DHW).

Sections of the Idaho Medicaid Provider Handbook applicable in specific situations are listed throughout the handbook for provider convenience. Additional handbooks which always apply to this provider type include the following:

- *General Billing Instructions*;
- General Information and Requirements for Providers; and
- *Glossary*.

Handbooks can only be used properly in context. Providers must be familiar with the handbooks that affect them and their services. The numbering in handbooks is also important to make note of as subsections rely on the content of the sections above them.

Example

Section 1.2.3.a The Answer requires the reader to have also read Section 1, Section 1.2 and Section 1.2.3 to be able to properly apply Section 1.2.3.a.

1. Provider Qualifications

Chiropractors in any state are eligible to participate in the Idaho Medicaid Program. They must be licensed in the state where the services are performed, and enroll as an Idaho Medicaid provider prior to submitting claims for services. Providers must follow the Idaho Medicaid Provider Handbook and all applicable state, and federal, rules and regulations.

Chiropractors do not qualify as ordering or referring providers.

See General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

1.1. References: Provider Qualifications

"Chiropractic Services: Provider Qualifications." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 534. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims." *MLN Matters SE1305, May 2019,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf.

2. Eligible Participants

Participants with Medicaid Basic and Enhanced Plans are eligible to receive chiropractic services. When billing for participants enrolled in other benefit plans, refer to General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for coverage. Providers must check participant eligibility prior to delivery of the service by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the trading partner account on Gainwell Technologies Idaho Medicaid website.

2.1. Referrals

Medicaid participants enrolled in Healthy Connections (HC), Idaho's Medicaid primary care case management (PCCM) model of managed care, may obtain chiropractic services without a referral when those services or procedures are performed in the chiropractor's office. Chiropractors do not qualify as referring providers.

2.2. EPSDT Services for Participants Under 21

Services identified as a result of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) which correct or ameliorate a defect will not be subject to the existing amount, scope, and duration limitations, but require prior authorization. The prior authorization process for EPSDT is separate from traditional chiropractic services. The medical necessity for the additional service must be documented. It must be proven safe, effective and accepted as a medical practice or treatment for the condition being addressed. Additional information for EPSDT may be found in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

3. Covered Services and Limitations

Idaho Medicaid pays for chiropractic services only when active care is medically necessary to treat a subluxation condition of the spine. Active care is treatment which has a direct, therapeutic relationship to the participant's condition and a reasonable expectation of functional improvement. Only acute and chronic spinal manipulation services are considered active care and reimbursable. Acute services are used for treatment of new injuries identified by x-ray or physical examination, when treatment is expected to improve or arrest the progression of the acute condition. Chronic services treat conditions that are not expected to significantly improve or resolve without intervention and continued treatment can be expected to provide functional improvement. A total of six (6) visits during any calendar year for remedial chiropractic care are covered without a prior authorization.

Maintenance therapy is not considered medically reasonable and necessary and is not covered by Idaho Medicaid. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

Medicaid does not reimburse for any other chiropractic services including x-rays or diagnostic tests for demonstrating the existence of a subluxation of the spine.

3.1. Establishing Medical Necessity

Establishing medical necessity is the responsibility of the provider. In addition to the standard requirements found in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, chiropractors have additional requirements to demonstrate medical necessity. The chief complaint causing the participant to seek treatment must be directly attributable to a subluxation of the spine as supported by clinical peer-reviewed publications.

A subluxation of the spine must be diagnosed by an x-ray, CT scan, MRI or a physical examination within twelve (12) months prior of initiating treatment. A CT scan or MRI cannot be ordered for the purpose of demonstrating a spinal subluxation, but may be used if previously obtained. X-rays, CT scans and MRIs are not reimbursable if performed, rendered, referred or ordered by a chiropractor. An x-ray, CT scan, or MRI would have to be ordered by a physician (Doctor of Medicine or Osteopathy) or non-physician practitioner and performed by a radiologist to be eligible for reimbursement. A chiropractor may take their own x-ray as documentation of a subluxation, but will not be reimbursed for it.

The diagnosis must include the level of subluxation in the documentation either directly stated or by descriptive terms. The precise level must be specified by the chiropractor for reimbursement.

Subluxation of the Spine Crosswalk				
Area of Spine	**Names of Vertebrae**	**Number of Vertebrae**	**Short Form**	**Subluxation ICD-10-CM**
Neck	Occiput Cervical Atlas Axis	7	Occ, CO C1-C7 C1 C2	M99.00 M99.01
Back	Dorsal	12	D1-D12	M99.02

	Thoracic Costovertebral Costotransverse		T1-T12 R1-R12 R1-R12	
Low Back	Lumbar	5	L1-L5	M99.03
Pelvis	Ilii, R and L (I, Si)	N/A	I, Si	M99.05
Sacral	Sacrum, Coccyx	N/A	S, SC	M99.04

Descriptive terms should refer to the condition of the spinal joint involved in the subluxation or the direction of the bone's position. Common terms include:

- Off-centered;
- Misalignment;
- Malpositioned;
- Spacing (i.e. abnormal, altered, decreased, increased)
- Incomplete dislocation;
- Rotation;
- Listhesis (i.e. antero, postero, retryo, lateral, spondylo); and
- Motion (i.e. limited, lost, restricted, flexion, extension, hypermobility, hypomotility, aberrant).

3.1.1. Physical Examinations

Physical examinations to establish medical necessity must document either an asymmetry/misalignment or a range of motion abnormality, and either pain/tenderness or tissue tone, texture and temperature abnormality. See the subsection below for individual requirements on these indicators.

a) Asymmetry/Misalignment

An asymmetry/misalignment is identified on a sectional or segmental level through observation (posture and heat analysis), static palpation for misalignment of vertebral segments, and/or diagnostic imaging.

b) Range of Motion Abnormality

A range of motion abnormality is a change of active, passive or accessory joint movements resulting in an increase or decrease of sectional or segmental mobility. Abnormalities may be identified through motion palpation, observation, stress diagnostic imaging, range of motion and/or other measurements.

c) Pain/Tenderness

An evaluation determining pain or tenderness must document the location, quality, and intensity of the feeling and the method used to determine each. Pain or tenderness may be identified through observation, percussion, palpation or provocation. Intensity can be assessed using visual analog scales, algometers and questionnaires. The documentation must also note which vertebrae has the capacity to manifest pain or tenderness in that location.

d) Tissue Tone, Texture, and Temperature Abnormality

Abnormalities in this category are defined as a change in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle and ligaments. These are identified through observation, palpation or use of instrumentation, test of length or strength of the affected tissue.

3.2. References: Covered Services and Limitations

3.2.1. CMS Guidance

"Chapter 15 – Covered Medical and Other Health Services." *Medicare Benefit Policy Manual*, Centers for Medicare & Medicaid Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

"Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits." *MLN Matters SE1601, May 2019,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2016-Transmittals-Items/SE1601.html.

"Referral of Patients for X-rays by Chiropractors." *MLN Matters SE0416, May 2019,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0416.pdf.

3.2.2. Idaho Medicaid Publications

"Attention: Chiropractic Providers." *MedicAide Newsletter,* October 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202017%20MedicAide.pdf.

House Bill 260 Budget Reductions – Chiropractic Services, Information Release MA11-10 (5/24/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho, http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA11-10.pdf.

3.2.3. Regulations

"Chiropractic Services: Definitions." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 530. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Chiropractic Services: Coverage and Limitations." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 532. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

4. Documentation Requirements

Documentation requirements applicable in specific situations are listed throughout the handbook for provider convenience. General documentation requirements are also required and found in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

4.1. Initial Visit

The initial visit should have documentation of symptoms sufficient to demonstrate a subluxation of the spine as specified in the Establishing Medical Necessity subsection. It must also include development of a Plan of Care.

The participant's history must include:

- The chief complaint causing the participant to seek treatment, including symptoms;
- Family history, if relevant; and
- Past medical history including general health, prior illness, injuries, hospitalizations, medications and surgeries.

A description of the participant's present illness including:

- Source of trauma;
- Quality and character of symptoms/problem;
- Onset, duration, intensity, frequency, location and radiation of symptoms;
- Factors that aggravate or relieve the symptoms;
- Previously applied interventions, treatments, medications and secondary complaints; and
- Symptoms causing the participant to seek treatment.

4.2. Subsequent Visits

Documentation for subsequent visits must include the treatment provided and progress notes with an updated history and physical examination.

An updated history for the participant includes:

- A review of the chief complaint;
- Changes since the last visit; and
- A systems review, if relevant.

A physical examination should be conducted to direct treatment including:

- Examination of the spinal area involved in the diagnosis;
- Assessment of changes in the patient since the last visit; and
- Evaluation of the treatment's effectiveness.

4.3. Plan of Care

The Plan of Care must be signed and dated by the chiropractor, physician or non-physician practitioner and specify:

- Diagnosis;
- Anticipated short and long-term goals that are outcome-based with measurable objectives;
- Frequency of treatment;
- Expected duration of treatment;
- Discharge plan;
- Reports of current status;

- Communication and coordination with other providers. Documentation may include dates of communication, person contacted, summary of services provided by other providers, and the unique and specific contribution of each provider;
- Copies of the daily entries completed within the last 30 days; and
- Current progress notes.

4.4. References: Documentation Requirements

"Attention: Chiropractic Providers." *MedicAide Newsletter,* October 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202017%20MedicAide.pdf.

"Educational Resources to Assist Chiropractors with Medicare Billing." *MLN Matters SE1603, May 2019,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1603.pdf.

"Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits." *MLN Matters SE1601, May 2019,* Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1601.pdf.

5. Prior Authorization (PA)

The Medical Care Unit reviews requests for chiropractic services that exceed limitations. Providers must submit a PA request for additional chiropractic services after the initial six (6) visits. An additional twelve (12) visits may be approved through the prior authorization process if medical necessity to correct a subluxation is clearly demonstrated. Professionally-recognized standards of care have not established medical necessity for over 18 visits per year. Requests for more than 18 visits will be denied as other interventions may be more appropriate. PAs are valid for the dates indicated on the authorization. Providers cannot bill Medicaid participants for covered services.

The following documentation is required to determine the need for additional visits:

- Completed Chiropractic Request Form;
- Chiropractic evaluation completed within the past year; and
- Current Plan of Care (POC) signed and dated by the chiropractor, physician or non-physician practitioner.

Please fax all complete and valid PA requests to 1 (877) 314-8779. Failure to provide all required documentation at time of submission will result in denial of the prior authorization request.

The status of a prior authorization request for may be checked by providers online at the Gainwell Technologies portal under "View Authorizations", using your NPI, or by contacting Gainwell Technologies at 1 (866) 686-4272.

5.1. References: Prior Authorization (PA)

"Attention: Chiropractic Providers." *MedicAide Newsletter,* October 2017, https://www.idmedicaid.com/MedicAide%20Newsletters/October%202017%20MedicAide.pdf.

6. Reimbursement

Chiropractors are paid on a fee-for-service basis except for services provided in Rural Health Clinics (RHC), Federally Qualified Health Clinic (FQHC), or Indian Health Services (IHS). Usual and customary fees are paid up to the Medicaid maximum allowance. Some participants may be responsible for a co-pay for chiropractic services. See the *Ambulatory Health Care Facility*, Idaho Medicaid Provider Handbook for information on encounter fees for services provided in an RHC, FQHC or IHS.

The following CPT® codes are reimbursable for chiropractic services. Only one code and one unit is available per day. The use of manual devices, and services provided by assistants or aides, are included in the payment.

Covered Chiropractic Services	
CPT® Code	**Description**
98940	Chiropractic manipulative treatment; spinal, 1 - 2 regions.
98941	Chiropractic manipulative treatment; spinal, 3 - 4 regions.
98942	Chiropractic manipulative treatment; spinal, 5 regions.

Only services provided for treatment of the diagnoses identified in Appendix A. Diagnosis Codes Covered for Chiropractic Services are eligible for payment. Claims for services provided outside of a Rural Health Clinic, Federally Qualified Health Clinic or Indian Health Services encounter are only eligible for payment when one of those diagnoses appears as primary.

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding policy on billing, prior authorization, and requirements for billing all other third party resources before submitting claims to Medicaid.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-pays.

6.1. CMS-1500 Claim Form: Supplemental

Except for places of service (POS) Rural Health Clinics (RHC), Federally Qualified Health Clinic (FQHC) or Indian Health Services (IHS), only code 11 (office) is reimbursable for chiropractic services.

Any claim with an injury-related diagnosis code must include the cause of the injury, and when and where the injury occurred. Enter this information in field 19 of the paper CMS-1500 claim form or attach injury-related documentation when billing electronically.

6.2. References: Reimbursement

"Attention: Optometrists, Podiatrists, and Chiropractors." MedicAide Newsletter, October 2011, *https://www.idmedicaid.com/MedicAide%20Newsletters/October%202011%20MedicAide.pdf.*

7. References: General Chiropractor

7.1. CMS Billing Guidance

Billing and Coding Guidelines: CHIRO-001-Chiropractic Services. Centers for Medicare & Medicaid Services, https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/34585_19/L34585_CHIRO001_BCG.pdf.

"Chapter 15 – Covered Medical and Other Health Services." *Medicare Benefit Policy Manual*, Centers for Medicare & Medicaid Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Fact Sheet L37254: Chiropractic Services. CGS Administrators, LLC, https://www.cgsmedicare.com/partb/mr/pdf/chiropractic.pdf.

7.2. Idaho Medicaid Publications

Basic Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/BasicBenchmark.pdf.

House Bill 260 Budget Reductions – Chiropractic Services, Information Release MA11-10 (5/24/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho, http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA11-10.pdf.

7.3. Regulations

"Chiropractic Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 530 – 534. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Definitions." Social Security Act, Sec. 1905(g) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

Definitions – Medical or Other Remedial Care Provided by Licensed Practitioners, 42 C.F.R. Sec. 440.60(b) (2012). Government Printing Office, https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=5f3c1217461d97825091955cda925f93&mc=true&r=SECTION&n=se42.4.440_160.

"Definitions of Services, Institutions, Etc." Social Security Act, Sec. 1861(r) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1861.htm.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2006). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/.

Appendix A. Diagnosis Codes Covered for Chiropractic Services

Only the following ICD-10-CM diagnosis codes for dates of service on or after October 1, 2015 have been identified to align with Idaho Medicaid coverage requirements. Chiropractic treatment for any other diagnosis is non-covered. Claims for services provided outside of a Rural Health Clinic, Federally Qualified Health Clinic or Indian Health Services encounter are only eligible for payment when one of these diagnoses appears as primary.

Diagnosis Codes Covered for Chiropractic Services	
ICD-10 CM - Diagnosis Codes	**ICD-10 CM - Diagnosis Description**
M99.00 – M99.05	Segmental and somatic dysfunction
M99.10 – M99.15	Subluxation complex (vertebral)
S13.110A – S13.110S	Subluxation of C0/C1 cervical vertebrae
S13.120A – S13.120S	Subluxation of C1/C2 cervical vertebrae
S13.130A – S13.130S	Subluxation of C2/C3 cervical vertebrae
S13.140A – S13.140S	Subluxation of C3/C4 cervical vertebrae
S13.150A – S13.150S	Subluxation of C4/C5 cervical vertebrae
S13.160A – S13.160S	Subluxation of C5/C6 cervical vertebrae
S13.170A – S13.170S	Subluxation of C6/C7 cervical vertebrae
S13.180A – S13.180S	Subluxation of C7/T1 cervical vertebrae
S23.110A – S23.110S	Subluxation of T1/T2 thoracic vertebra
S23.120A – S23.120S	Subluxation of T2/T3 thoracic vertebra
S23.122A – S23.122S	Subluxation of T3/T4 thoracic vertebra
S23.130A – S23.130S	Subluxation of T4/T5 thoracic vertebra
S23.132A – S23.132S	Subluxation of T5/T6 thoracic vertebra
S23.140A – S23.140S	Subluxation of T6/T7 thoracic vertebra
S23.142A – S23.142S	Subluxation of T7/T8 thoracic vertebra
S23.150A – S23.150S	Subluxation of T8/T9 thoracic vertebra
S23.152A – S23.152S	Subluxation of T9/T10 thoracic vertebra
S23.160A – S23.160S	Subluxation of T10/T11 thoracic vertebra
S23.162A – S23.162S	Subluxation of T11/T12 thoracic vertebra
S23.170A – S23.170S	Subluxation of T12/L1 thoracic vertebra
S33.110A – S33.110S	Subluxation of L1/L2 lumbar vertebra
S33.120A – S33.120S	Subluxation of L2/L3 lumbar vertebra
S33.130A – S33.130S	Subluxation of L3/L4 lumbar vertebra
S33.140A – S33.140S	Subluxation of L4/L5 lumbar vertebra

Appendix B. Chiropractor, Provider Handbook Modifications

This table lists the last three years of changes to this handbook as of the publication date.

Chiropractor, Provider Handbook Modifications				
Version	**Section**	**Update**	**Publish Date**	**SME**
18.0	All	Published version	12/31/2020	TQD
17.1	All	Removed DXC references, rebranded to Gainwell Technologies	12/31/2020	TQD
17.0	All	Published version	04/01/20	TQD
16.3	4.3 Plan of Care	Clarified that a Plan of Care must be signed and dated by the chiropractor, physician or non-physician practitioner.	03/27/20	W Deseron E Garibovic
16.2	3.1 Establishing Medical Necessity	Reiterated that a CR scan or MRI require a physician or non-physician practitioner's order.	03/25/20	W Deseron E Garibovic
16.1	Chiropractor	Clarified how to read a provider handbook.	03/25/20	W Deseron E Garibovic
16.0	All	Published version	01/01/20	TQD
15.18	Appendix A. Diagnosis Codes Covered for Chiropractic Services	Added clarifying language about covered diagnoses.	11/26/19	W Deseron E Garibovic
15.17	1.7 References	Renamed section to Referenced: General Chiropractor	11/26/19	W Deseron E Garibovic
15.16	1.6.2 References: Reimbursement	New subsection	11/26/19	W Deseron E Garibovic
15.15	1.6.1 CMS-1500 Claim Form: Supplemental	Added clarification of place of service for FQHC, IHS and RHC.	11/26/19	W Deseron E Garibovic
15.14	1.6 Reimbursement	Added reminder about co-pays and reference to covered diagnoses.	11/26/19	W Deseron E Garibovic
15.13	1.5.1 References: Prior Authorization (PA)	New subsection	11/26/19	W Deseron E Garibovic
15.12	1.5 Prior Authorization (PA)	Moved documentation criteria to Documentation section. Added checking PA status	11/26/19	W Deseron E Garibovic
15.11	1.4 Documentation Requirements	New section to align with Medicare	11/26/19	W Deseron E Garibovic
15.10	1.3.2 References: Covered Services and Limitations	New subsection.	11/26/19	W Deseron E Garibovic

Chiropractor, Provider Handbook Modifications				
Version	**Section**	**Update**	**Publish Date**	**SME**
15.9	1.3.1.1 Physical Examinations	New subsection	11/26/19	W Deseron E Garibovic
15.8	1.3.1 Establishing Medical Necessity	Added requirement of chief complaint related to subluxation of spine. Clarified medical necessity information. Added requirement for diagnosis and documentation.	11/26/19	W Deseron E Garibovic
15.7	1.3 Covered Services and Limitations	Removed EPSDT information and added to section 1.2.2	11/26/19	W Deseron E Garibovic
15.6	1.2.2 EPSDT Services for Participants Under 21	New subsection	11/26/19	W Deseron E Garibovic
15.5	1.2.1 Healthy Connections (HC)	Renamed section to Referrals. Added Chiropractors cannot refer for services	11/26/19	W Deseron E Garibovic
15.4	1.1.1 References: Provider Qualifications	New subsection	11/26/19	W Deseron E Garibovic
15.3	1.1 Provider Qualifications	Added Chiropractors cannot order/refer	11/26/19	W Deseron E Garibovic
15.2	1.0 Chiropractor	Added Glossary to list of applicable Handbooks	11/26/19	W Deseron E Garibovic
15.1	1. Section Modifications	Moved to Appendix B. Removed changes over three years old.	11/26/19	W Deseron E Garibovic
15.0	All	Published version	01/10/19	TQD
14.1	2.3 Covered Services and Limitations	Defined active care, acute and chronic services. Added EPSDT coverage information.	01/10/19	W Deseron E Garibovic
14.0	All	Published version	08/27/18	TQD
13.5	2.5. References	Formatting of references	08/27/18	E Garibovic D Baker
13.4	2.4. Reimbursement	Information about encounter rates	08/27/18	E Garibovic D Baker
13.3	2.2. Eligible Participants	Information about checking eligibility and language clean-up	08/27/18	E Garibovic D Baker
13.2	2.1. Provider Qualifications	Removed redundant language	08/27/18	E Garibovic D Baker
13.1	2. Chiropractor	Direction to required handbooks	08/27/18	E Garibovic D Baker
13.0	All	Published version	05/18/18	TQD
12.2	Appendix A: Diagnosis Codes Covered for Chiropractic Services	Added additional diagnosis references	05/18/18	W Deseron E Garibovic C Loveless

Chiropractor, Provider Handbook Modifications				
Version	**Section**	**Update**	**Publish Date**	**SME**
12.1	2.4 Reimbursement	Added additional billing references	05/18/18	W Deseron E Garibovic C Loveless
12.0	All	Published version	05/09/18	TQD
11.1	2.3.2 Prior Authorization (PA)	Clarification on IDAPA requirements and PA requirements.	05/09/18	K Eidemiller W Deseron E Garibovic D Baker
11.0	All	Published version	04/26/18	TQD
10.1	All	Document restructured and updated throughout	04/26/18	W Deseron D Baker E Garibovic C Loveless