CHIROPRACTOR MAXIMUM ALLOWABLE FEE SCHEDULE

THIS IS YOUR WISCONSIN MEDICAID MAXIMUM ALLOWABLE FEE SCHEDULE, WHICH IS IN EFFECT AS OF THE DATE OF THIS REPORT. WISCONSIN MEDICAID CERTIFIED PROVIDERS WILL BE REIMBURSED FOR SERVICES PROVIDED TO PROGRAM RECIPIENTS AT THE LOWER OF THEIR USUAL AND CUSTOMARY CHARGE, OR THE MAXIMUM ALLOWABLE FEE.

SERVICES REIMBURSED BASED ON PROVIDER SPECIFIC (CONTRACTED RATES) AND REGIONAL OR SPECIALTY BASED RATES ARE NOT INCLUDED IN THIS FEE SCHEDULE.

NOTE: BADGERCARE PLUS BENCHMARK PLAN MEMBERS WILL BE RESPONSIBLE FOR A $15.00 COPAYMENT PER VISIT. A SINGLE COPAYMENT OF $15.00 IS ASSESSED PER VISIT, REGARDLESS OF THE NUMBER OF SERVICES PROVIDED DURING THAT VISIT.

ALTHOUGH THE FEE SCHEDULE DOES NOT ADDRESS THE VARIOUS COVERAGE LIMITATIONS ROUTINELY APPLIED BY WISCONSIN MEDICAID BEFORE FINAL PAYMENT IS DETERMINED (E.G., RECIPIENT AND PROVIDER ELIGIBILITY, BILLING INSTRUCTIONS, FREQUENCY OF SERVICES, THIRD PARTY LIABILITY, COPAYMENT, AGE RESTRICTIONS, PRIOR AUTHORIZATION, ETC.), IT DOES CONTAIN THE FOLLOWING INFORMATION:

PROC/M1/M2/TM

PROC - THE PROCEDURE CODE RECOGNIZED BY WISCONSIN MEDICAID TO IDENTIFY THE SERVICE PROVIDED.

M1/M2 - ONE OR TWO APPLICABLE MODIFIER(S) AFFECTING REIMBURSEMENT AMOUNT.
NOTE: CURRENTLY THERE ARE NO MODIFIERS AFFECTING REIMBURSEMENT ASSOCIATED WITH CHIROPRACTIC PROCEDURES.

TM - DESCRIPTIVE MODIFIER USED TO CONVEY INFORMATION FORMERLY CONVEYED BY TOS.
NOTE: IN CERTAIN INSTANCES THE MODIFIER LISTED IS BEING USED BOTH TO CONVEY INFORMATION FORMERLY CONVEYED BY TOS AND TO AFFECT THE REIMBURSEMENT AMOUNT. IN THESE INSTANCES THE MODIFIER WILL BE DISPLAYED TWICE, ONCE IN THE M1 OR M2 COLUMN AND ONCE IN THE TM COLUMN, EVEN THOUGH IT WILL ONLY BE BILLED ONCE ON THE CLAIM DETAIL.

DESCRIPTION - AN ABBREVIATED DESCRIPTION OF THE PROCEDURE CODE

PROVIDER TYPE - ALL APPLICABLE PERFORMING PROVIDER TYPES FOR THE PROCEDURE CODE. SEE TABLE I FOR A LISTING OF PROVIDER TYPES APPLICABLE TO THIS SCHEDULE.

PAC - THE PRICING ACTION CODE IDENTIFIES NON-COVERED SERVICES OR THE SOURCE AND METHOD OF PRICING THE PROCEDURE (REFER TO TABLE II).

EFFECT DATE - THE EFFECTIVE DATE OF SERVICE ON OR AFTER WHICH THE MAXIMUM ALLOWABLE FEE APPLIES.

MAX FEE - MAXIMUM ALLOWABLE FEES FOR THE PROCEDURE CODES LISTED. IF A MAX FEE IS NOT INDICATED, USE THE PAC AND TABLE II TO DETERMINE THE REASON (E.G., PAC 220 INDICATES SERVICE NOT COVERED; PAC 21J INDICATES INDIVIDUAL CONSIDERATION, ETC.).

THIS INFORMATION IS INTENDED TO HELP YOU UNDERSTAND THE WISCONSIN MEDICAID MAXIMUM ALLOWABLE FEE SCHEDULE. IF YOU HAVE QUESTIONS, PLEASE CONTACT WISCONSIN MEDICAID PROVIDER SERVICES AT: (608) 221-9883 OR (800) 947-9627*

*WHEN REQUESTING INFORMATION, PLEASE BE SPECIFIC AS TO WHICH PROVIDER TYPE YOU ARE REFERRING (I.E., CHIROPRACTORS ARE PROVIDER TYPE 30).

TABLE I
PROVIDER TYPES

| 30 | CHIROPRACTOR |

TABLE II
PRICING ACTION CODES (PAC)

<table>
<thead>
<tr>
<th>PAC</th>
<th>DESCRIPTION</th>
</tr>
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<tbody>
<tr>
<td>113, 21J</td>
<td>INDIVIDUAL CONSIDERATION, MEDICAL CONSULTANT</td>
</tr>
<tr>
<td>120, 220</td>
<td>NON-COVERED SERVICE, NOT A WISCONSIN MEDICAID BENEFIT</td>
</tr>
<tr>
<td>170, 270</td>
<td>PAID AT THE LOWER OF THE BILLED AMOUNT OR MAXIMUM ALLOWABLE FEE ACCORDING TO PROVIDER TYPE</td>
</tr>
<tr>
<td>279</td>
<td>REVIEW OF SERVICE, REPORT DETERMINES COVERAGE AND/OR REIMBURSEMENT</td>
</tr>
</tbody>
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TABLE III
MODIFIERS

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>CURRENTLY THERE ARE NO MODIFIERS AFFECTING REIMBURSEMENT ASSOCIATED WITH CHIROPRACTIC PROCEDURES.</td>
</tr>
<tr>
<td>PROC (M1 M2 TM)</td>
<td>PROVIDER TYPE</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>72010</td>
<td>RADIOLOGIC EXAMINATION/SPINE/ENTIRE SURVEY STUDY/ANTEROPOSTERIOR AND LATERAL</td>
</tr>
<tr>
<td>72020</td>
<td>RADIOLOGIC EXAMINATION/SPINE/SINGLE VIEW</td>
</tr>
<tr>
<td>72040</td>
<td>RADIOLOGIC EXAMINATION, SPINE, CERVICAL; TWO OR THREE VIEWS</td>
</tr>
<tr>
<td>72050</td>
<td>RADIOLOGIC EXAMINATION/SPINE/CERVICAL; MINIMUM OF FOUR VIEWS</td>
</tr>
<tr>
<td>72052</td>
<td>RADIOLOGIC EXAMINATION / SPINE / CERVICAL; COMPLETE</td>
</tr>
<tr>
<td>72070</td>
<td>RADIOLOGIC EXAMINATION, SPINE, CERVICAL; MINIMUM OF FOUR VIEWS</td>
</tr>
<tr>
<td>72080</td>
<td>RADIOLOGIC EXAMINATION/SPINE/CERVICAL; COMPLETE</td>
</tr>
<tr>
<td>72100</td>
<td>RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; TWO OR THREE VIEWS</td>
</tr>
<tr>
<td>72110</td>
<td>RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; MINIMUM OF FOUR VIEWS</td>
</tr>
<tr>
<td>72120</td>
<td>RADIOLOGIC EXAMINATION/SPINE/LUMBOSACRAL/BENDING VIEWS</td>
</tr>
<tr>
<td>72200</td>
<td>RADIOLOGIC EXAMINATION/ SACROILIAC JOINTS/LESS THAN THREE VIEWS</td>
</tr>
<tr>
<td>72202</td>
<td>RADIOLOGIC EXAMINATION/ SACROILIAC JOINTS; THREE OR MORE VIEWS</td>
</tr>
<tr>
<td>73000</td>
<td>RADIOLOGIC EXAMINATION/ CLAVICLE/ COMPLETE</td>
</tr>
<tr>
<td>73010</td>
<td>RADIOLOGIC EXAMINATION/ SCAPULA/ COMPLETE</td>
</tr>
<tr>
<td>73020</td>
<td>RADIOLOGIC EXAMINATION/ SHOULDER; ONE VIEW</td>
</tr>
<tr>
<td>73030</td>
<td>RADIOLOGIC EXAMINATION/ SHOULDER; COMPLETE; MINIMUM OF TWO VIEWS</td>
</tr>
<tr>
<td>73040</td>
<td>RADIOLOGIC EXAMINATION/ ACROMIOCLAVICULAR JOINTS/BILATERAL W/NO WEIGHTED DISTRACTION</td>
</tr>
<tr>
<td>73060</td>
<td>RADIOLOGIC EXAMINATION; Humerus/ Minimum of Two Views</td>
</tr>
<tr>
<td>73070</td>
<td>RADIOLOGIC EXAMINATION, ELBOW; TWO VIEWS</td>
</tr>
<tr>
<td>73080</td>
<td>RADIOLOGIC EXAMINATION/ ELBOW; COMPLETE/ MINIMUM OF THREE VIEWS</td>
</tr>
<tr>
<td>73100</td>
<td>RADIOLOGIC EXAMINATION/ HIP; UNILATERAL/ ONE VIEW</td>
</tr>
<tr>
<td>73150</td>
<td>RADIOLOGIC EXAMINATION/ HIP; COMPLETE/ MINIMUM OF TWO VIEWS</td>
</tr>
<tr>
<td>73160</td>
<td>RADIOLOGIC EXAMINATION/ HIPS/BILATERAL/ MINIMUM OF TWO VIEWS</td>
</tr>
<tr>
<td>73164</td>
<td>RADIOLOGIC EXAMINATION/ PELVIS AND HIPS/ INFANT OR CHILD/ MINIMUM OF TWO VIEWS</td>
</tr>
<tr>
<td>81000</td>
<td>UNRINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, KETONES</td>
</tr>
<tr>
<td>98940</td>
<td>CHIROPRACTIC MANIPULATIVE TREATMENT (CMT);SPINAL ONE TO TWO REGIONS</td>
</tr>
<tr>
<td>98941</td>
<td>CHIROPRACTIC MANIPULATIVE TREATMENT (CMT)SPINAL, THREE TO FOUR REGIONS</td>
</tr>
<tr>
<td>98942</td>
<td>CHIROPRACTIC MANIPULATIVE TREATMENT; (CMT)SPINAL, FIVE REGIONS</td>
</tr>
<tr>
<td>99201</td>
<td>OFFICE/OP VISIT-NEW PATIENT: PROB-FOCUSED HIST/EXAM &amp; STRAIGHT MED DECISION (10 MIN)</td>
</tr>
<tr>
<td>99202</td>
<td>CERVICAL, FLEXIBLE, NON-ADJUSTABLE (FOAM COLLAR)</td>
</tr>
<tr>
<td>99204</td>
<td>CERVICAL, SEMI-RIGID, ADJUSTABLE (PLASTIC COLLAR)</td>
</tr>
<tr>
<td>99205</td>
<td>THORACIC, RIB BELT</td>
</tr>
</tbody>
</table>

END OF REPORT