Chiropractic Frequently Asked Questions (FAQs):

Is it better for a provider to be in network or out of network? *BCBSKS members would prefer to see an in-network provider. But ultimately, the decision is up to the provider. Providers can refer to the BCBSKS 2016 CAP letter; pages 2, 3 & 4 for a list of benefits to being an in-network provider. This information can be found on the bcbsks.com website.*

Are monthly visits covered? *More than likely, this would be maintenance care. Claims would probably pay, but could be problematic on an audit.*

Can Chiropractic Assistants initiate therapy? *No.*

When verifying chiropractic benefits, you will be told children are not covered. *No, children have benefits for chiropractic coverage. As with all treatments provided, medical necessity must be documented.*

Re-exams should be performed every 30 days, but not covered if billed with an adjustment. *Per Appendix B, Chiropractic Guidelines, E & M codes should not be billed in conjunction with any manipulations. With respect to re-exams every 30 days, the medical necessity for a re-exam depends on the patient's condition and response to treatment.*

When you see a patient for the first time, can you bill an adjustment and exam on the same visit? *Yes, new patient E & M visits and CMT can be billed on the same day.*

How often should you re-assess a patient and why? *The patient's progress and response to treatment should be documented within the record at each visit.*

Are goals necessary in each patient's record? Yes, *each patient should have measurable, functional goals. Goals should be patient specific and reviewed at every visit. Documentation should support progress towards these goals by providing measurable physical findings. 'Return patient to pre injury status' and 'decrease pain' are not measurable functional goals.*

What are the expectations for diagnosis? *The diagnosis should be consistent with the patient's chief complaint and the findings on the examination.*

What do we need to know about extremities? *Do not use 98943 with 98941 at every visit. If the Chief Complaint is an extremity problem, then 98943 would be reasonable.*

What's required to get reimbursed for an X-ray? What components are required to be in the medical record?

Interpretations of diagnostic imaging procedures reported separately for payment must include the following minimum information, either as a separate document or within the main body of the patient's record:

- *Patient's name and other appropriate identifier (date of birth, Social Security number, record number, etc.).*
- *Referring physician name.*
- *Name or type of imaging procedure performed.*
- *Date and time imaging procedure was performed.*
- *Name of interpreting physician.*
- *Date and time interpretation was performed.*
- *Body of the report including:*
    - *Procedures and materials.*
    - *Findings.*
    - *Limitations.*
    - *Complications.*
    - *Clinical issues.*
    - *Comparisons, when indicated and available.*
    - *Clinical impression and diagnosis, including differential diagnosis when appropriate.*
- *Legible signature (holographic or electronic).*

Can Chiropractic Assistants perform X-rays? *Yes, as long as they're properly trained.*

Modifiers-which ones do we need to use and when? *The appropriate modifier depends on the procedures being performed.*

Hypothetically, I release a patient. He comes back weeks later because his symptoms are starting to return. Covered service? If yes, how do you document for coverage. How do you determine maintenance care in this situation?
Document an acute exacerbation or recurrent problem in the Progress Note (SOAP note). If the documentation is appropriate, the service should be covered.

How do we properly discuss and document wellness/maintenance care with a patient and document properly?
CMS defines maintenance therapy 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 for prevent deterioration of a chronic condition.