Documenting the Medical Necessity of Chiropractic Services

1: Policies developed by the Centers for Medicare and Medicaid Services (CMS) indicate that coverage of chiropractic services is specifically limited to manual manipulation of the spine to correct a subluxation.

- True
- False

2: According to Medicare, medical necessity involves the "diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

- True
- False

3: Utilization management and/or review consists of pre-certifications only.

- True
- False

4: When denying a claim for reimbursement due to a lack of medical necessity, health plans are required to state the exact reason for the denial and provide an opportunity for the physician to discuss the denial with the reviewer.

- True
- False

5: Health plans are not required to inform their members of services that are excluded.

- True
- False

6: Whether a denial is based on medical necessity or benefit limitations, patients or their authorized representatives (such as their treating physicians) can appeal to health plans to reverse adverse decisions.

- True
- False

7: In some situations, physicians do have an obligation to file an appeal on the patient's behalf.

- True
- False

8: Introduced in the late 1970s, the ICD-9 code set was replaced by the more detailed ICD-10 code set on October 1, 2015.

- True
- False

9: ICD-10 codes are required to be used by anyone covered by the Health Insurance Portability Accountability Act (HIPAA).

- True
- False

10: For chiropractors using ICD-10 codes, the primary diagnosis must be subluxation, and must indicate the level of the subluxation.

- True
- False

11: The secondary diagnosis must reflect the neuromusculoskeletal condition necessitating the treatment.

- True
- False

12: CPT CODE 97010 is application of a modality to one or more areas; electric stimulation.

- True
- False

13: Constant Attendance Modalities are time-based and require direct one-on-one individual contact with the health care provider.

- True
- False

14: Modalities are any physical agent applied to produce a therapeutic change to biological tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electrical energy.

- True
- False

15: Medicare pays for spinal manipulation, physiotherapy and x-rays.

- True
- False

16: Chiropractic manipulation codes must be appended with the modifier AT to indicate the care is corrective or active. Omission of the modifier will result in an automatic denial of services.

- True
- False

17: Illegible notes can trigger a Medicare denial?

- True
- False

18: Not specifying the level of subluxation in daily treatment notes can trigger a Medicare denial.

- True
- False

19: Under Medicare only an x-ray may be used to document subluxation.

- True
- False

20: Acute subluxation--A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical examination.

- True
- False

21: The Gold Standard for daily office notations is the S. O. A. P. note.

- True
- False

22: The S. O. A. P. note records what the physician does to manage the patient's condition on a daily basis and is a standardized form of communication. Third party payers make decisions about reimbursement based on the quality, legibility, and completeness of daily office notations.

- True
- False

23: It is permissible for a DC to erase, skip lines, leave spaces, "squeeze in" notes, use correction fluid, or back date or alter a S.O.A.P. note.

- True
- False

24: Chiropractic claims require proper documentation and appropriate billing of codes to receive accurate reimbursement.

- True
- False

25: As a general rule of thumb, maintain patient records forever. Also, be knowledgeable of the statute of limitations for your particular state. Most states have statutes of limitation of 3 - 7 years.

- True
- False