Frequently Asked Questions About Workers Compensation

Do the 15 visits and 30 days begin from the time of injury or from the date of referral from the treating physician?

- From date of injury
- Any care beyond the first 30 days post-injury, or after 30 days and/or 15 physical medicine visits, must be pre-certed.

Can the employer insist the work see their company doctor?

- Yes, but this does not mean the patient has made this physician their "choice" and they are entitled to seek their own medical and/or chiropractic care.
- The patient should be asked directly if they chose this doctor, or signed any document indicating they chose a particular doctor and it should be noted in the chart.

Can a patient receive physical therapy and chiropractic concurrently?

- If the patient is receiving both physical therapy and chiropractic concurrently, a single 15 visits and 30 days apply. If the patient has 7 visits to a physical therapist, that will leave only 8 visits for chiropractic treatments. In this scenario, it would be best to pre-cert both services.

Is chiropractic or physical medicine treatment required to be pre-certed BEFORE the first 15 visits or 30 days?

- No. The guidelines specifically state that physical medicine treatment (which includes chiropractic) do NOT have to be pre-certed unless it goes beyond 30 days or 15 visits.

Can an insurance claims adjuster or case manager only approve 4, 6, or some other limit of visits PRIOR to the 15 visits or 30-day time-frame?

- No. The guidelines allow 30 days and/or 15 visits, whichever comes first.
- After 15 visits/30 days, they may limit the number of visits pre-certed.
- If the treating doctor disagrees, they may request an expedited appeal, and ultimately a peer to peer review by a doctor of the same specialty.

Can a nurse review and deny approval of chiropractic treatment?

- A nurse can not deny any treatment as not being medically necessary. The nurse applies the adopted criteria to the case and if the claim meets the criteria, the nurse can approve. However, if the claim does not meet the criteria, the claim must be forwarded to a physician for review. Only a physician can deny treatment.

Can claims review, medical necessity reviews be performed by providers outside of the state of Mississippi?

- Only entities that are certified by the MS State Department of Health as Private Review Agents can perform the review for medical necessity.
- However, if the review results in the denial of treatment or payment, the provider reviewing must hold a MS license in the same or similar specialty.
- If they do not hold a MS license, they are in violation of the State Board of Chiropractic Examiners Rules and Regulations and the UR Regulations issued by the MS State Department of Health.

Who can approve treatment?

- The employer, insurance adjuster, and case manager.
- It is important to note the date, time, how they were contacted, and who approved care in the event claims are later denied. Since it becomes part of the medical record, the approval should be received in writing (either by fax or email), printed, and placed in the record.

Are you required to submit an initial report from the first visit to gain approval to treat within the first 15 visits or 30 days?

- No. The guidelines allow 15 visits or 30 days and then you must request approval for continued care.

How many procedures and/or modalities can be billed per encounter?

- A total of 4 procedures and/or modalities can be billed.

If a patient has a low back injury, can the chiropractor bill for full spine films and adjust and be paid for full spine treatment?

- No. The guidelines require treatment to be medically necessary and directly related to the injury.