KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS

P. O. Box 1360
Frankfort, Kentucky 40602
Phone (502) 892-4250
Fax (502) 564-4818
http://kbce.ky.gov

REQUIREMENTS FOR SUBMISSION OF REQUESTS FOR PEER REVIEW

The following requirements are set forth for the submission of all claims to the Kentucky Board of Chiropractic Examiners to perform a fair and impartial review. **All items listed below must be submitted and all documents must be completely legible.**

INFORMATION REQUIRED

The following procedures are for **CARRIERS** (third party payors) submitting cases for peer review:

(1) The "Carrier's Records Certification" form must be completed and returned with all cases submitted.

(2) Two (2) copies of the records to be reviewed must be submitted. One (1) of these copies **MUST BE SANITIZED**. All names, addresses, or any other identifying information, including the name and address of the submitting party, must be sanitized. The initials of D.C., titles, and dates, including patient's date of birth, should not be sanitized. These copies of records must be submitted in the following manner:

(a) Reports must be submitted in ascending chronological order.

(b) Treatment billings must be submitted in ascending chronological order.

(c) Back up chiropractor's documentation.

(d) All pages must be numbered in the lower right hand corner of each page in ascending chronological date order.

The records must include the following information:

_____Date and history of onset of each complaint.

_____Examination test results and findings, including the chiropractic and neurological examination results and/or a narrative report.

_____X-ray findings.

_____Lab reports or special diagnostic procedures (CAT scans, MRIs, second opinions, consultations, etc.).

_____Diagnosis.

_____Description of manipulative and/or other therapy used and description of any particular problems involved in the manipulative or therapy utilization.

_____Prognosis or date treatment termination. Dates of exacerbations, if any.

_____Copies of daily clinical notes.

_____Progress notes.

_____If ICE performed, indicate by whom and attach copy.

_____If more than one doctor was involved, please separate documents and explain role by specialty.

_____Condition: Chronic or Acute.

_____Total number of chiropractic office visits.

_____Initial treatment date.

_____Last known treatment date.

_____Cost per visit.

_____Chiropractor's total cost.

_____Total cost of case.

AREA OF CONCERN:

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FEE REQUIRED

For each peer review request, a service fee of **$50.00** is required, with an additional $50.00 per hour to be paid prior to delivery of committee findings to all parties. A typical review requires a minimum of 5-6 hours. The initial $50.00 service fee must be paid via a check or money order written out to "Kentucky State Treasurer" and must accompany each case for processing. Please submit all requests for peer review to:

Kentucky Board of Chiropractic Examiners
PO Box 1360
Frankfort, KY 40602

PEER REVIEW RESULTS

Once the claim has been submitted and the initial $50.00 fee has been paid, the claim will be reviewed by staff for completeness. The doctor will be notified of the receipt of the claim. The complete case file with all supporting documents will be submitted to the Peer Review Committee. The lead reviewer will review the case and submit an evaluation to the committee. The final evaluation will then be mailed to all parties if no additional fees are required.

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IMPORTANT NOTICE TO ALL USERS OF THE KBCE PEER REVIEW COMMITTEE

All cases submitted for review by the Committee MUST meet the following criteria:

1. When sanitizing records for submission to the Peer Review Committee, please follow these instructions carefully: Black out or white out ALL names and addresses as well as any other identifying information. DO NOT cover up dates or doctor degree designations such as DC, DO, MD, etc. The sanitizing process applies to all doctors' names and addresses as well as those of the patient and the third party payors. It is imperative that the doctor degree not be sanitized. All cases which are not properly sanitized will be returned to the submitter. If you have any questions, please contact the Board.
2. All copies must have all pages numbered. The documentation should be placed in ascending, chronological date order (starting with the earliest date of treatment first) and numbered consecutively. Please number the pages in the lower right hand corner of the page, making sure it is not cut off during copying.
3. Page two (2) of the instructions must be completed and returned with each case submitted, along with the Petition for Review and the Certification of Records.

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PETITION FOR REVIEW

The undersigned hereby requests review of the following case file:

Patient Name:____

Address:____

City:__________________________State:________Zip:_____________

Doctor Name:____

Address:____

City:__________________________State:________Zip:_____________

Phone:________________________

Third Party Payor (Insurance Co.):___________________________

Address:____

City:__________________________State:________Zip:_____________

Phone:________________________

Senior Claims Representative Ordering Review:____________________

____

Person Requesting Review:____________________________________

Address:____

City:__________________________State:________Zip:_____________

Phone:______________________ Representing:____________________

REASON FOR REVIEW:

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(If more space is needed, attach separate sheet. Do not exceed one page.)

Please enclose a copy of the patient's signature authorizing release of information, or (patient) sign below to release information.

Please attach two (2) copies [one (1) sanitized copy, see attached instructions] of any written documentation that will assist the reviewer in evaluating the case (doctor reports, correspondence, etc.).

What steps have been taken to resolve this case prior to petitioning for this review? Please explain: ____________

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Has a qualified independent chiropractic examination been requested? (Circle one) Y / N
If yes, please attach a copy of the examiner's name, address, and a copy of the examiner's findings. Kentucky Board approved/certified only.

Signature:_______________________________________

Print Name:______________________________________

Date:______________________

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CHIROPRACTIC PEER REVIEW

CARRIER'S RECORDS CERTIFICATION

Pursuant to the requirements for the submission of claims for peer review, I HEREBY CERTIFY that I have submitted, to the best of my knowledge and belief, all records pertaining to the file of (patient's name) ____, having been submitted to the KBCE Peer Review Committee for review and consideration.

____ (Printed Name of Submitting Party)	____ (Title)
____ (Signature of Submitting Party)	____ (Date Signed)
____ (Address of Submitting Party)	
____ (City)	____ (State) (Zip Code)