CLINICAL RESOURCE GROUP, INC.
BRINGING PRACTITIONERS AND HEALTH PLANS TOGETHER

NETWORK NEWS

Volume 7, May 2008

CRG Launches 2008 Documentation Quality Initiative

CRG presented its 2008 quality improvement initiative, "Patient Care Documentation Assessment and Improvement", to the South Country Health Alliance Quality Assurance Committee in Owatonna on April 10th.

Phase I will consist of an assessment of patient care documentation through conducting medical records reviews on a cross section of network providers. This work is already underway and will be completed by the end of June. Phase II will assess the level of adherence to network documentation standards. The results of the assessment will determine what action may be required to assure network documentation of patient care is meeting CRG and CMS standards.

Dr. Bob Daschner, Waseca, MN, Chair of CRG's Quality Improvement Council said "this initiative supports the efforts of the Board of Chiropractic Examiners who establish the minimum level of acceptable documentation in the state." The Quality Initiative also supports South Country Health Alliance's own goals for conducting ongoing inspection of patient care documentation by all health plan providers.

CRG has adopted PARTS as its key documentation for supporting medically necessary care. The Center for Medicare & Medicaid Services (CMS) expects CRG to review claims submitted to verify that services are medically necessary.

Currently, medical records reviews are conducted on all newly credentialed providers as part of the probationary status, on selected high volume practices as part of their periodic site survey process, and in cases where treatment exceeds the network treatment guidelines and records have been obtained for determination of medical necessity.

CRG's goal is to have conduct reviews on half of all network providers by the end of 2008, and all providers by the end of 2009.

The Initiative was enthusiastically approved by the SCHA Quality Assurance Committee and asked to be apprised periodically of progress.

In This Issue:

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Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis

A 2001 report by The Office of Inspector General (OIG) found that approximately 67 percent of chiropractic services allowed by Medicare in 2001 did not meet Medicare coverage criteria and/or were miscoded or undocumented, potentially costing the program and its beneficiaries approximately $285 million. Chiropractors who reviewed the patient records determined that more than 90 percent of this amount represented services that were not medically necessary. Most of the medically unnecessary services were maintenance or preventative treatments, which are not Medicare-covered benefits.

SCHA added its Medicare Dual eligible programs AbilityCare and SeniorCare Complete in 2007. CRG has examined a large volume of claims from these members. We have found that much of the care being provided to these members does not meet the standards for Medicare coverage even though it has been previously reimbursed. Providers need to be aware of the Medicare coverage requirements that CRG adheres to; the patient must be progressing clinically or functionally and the medical record must clearly document the same.

CRG is monitoring all patients who had 18 or more visits in 2007 for ongoing care. Such cases will be reviewed for medical necessity as claims are received. Providers are responsible for adhering to CRG network treatment guidelines and knowing when services are no longer meeting standards for medical necessary care. Such care will not be reimbursed and if it has previously been reimbursed, those payments will be recovered.

Doctor to Doctor: by Dr. Jeff Maness

Wellness, Preventive and Maintenance Care

We as chiropractors believe strongly in wellness and preventative care. However, this is an area that typically is not considered a covered service by health plans. Research has yet to convince most private and government payers that wellness/preventive care is a cost effective investment.

In the case of Medical Assistance (MA/GAMC) programs, covered services are even more specific, covering only the treatment of conditions resulting from subluxations of the spine. Funding for these programs is pressed to the limits, and is stretched even further when providers expand the range of treatments they expect to be reimbursed for.

Care that results in either objective improvement or functional improvement in the patient's condition, and is related to a spinal subluxation, is typically considered a covered service. When improvement plateaus however, continued care is considered to be "maintenance" and is not covered. Many of the Medicare patients fall into this category. Network providers are expected to identify maintenance care by the use of the appropriate Medicare modifiers and must not attempt to obtain reimbursement for it as acute treatment.

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Business Service Tips

Treatment Guidelines

Chiropractic is an important component of the SCHA care model, but has very specific guidelines associated with it. These guidelines allow chiropractic services to be provided without the need for prior authorization. When the guidelines are not observed and care is provided outside these parameters, the services are subject to utilization review which can reduce or exclude services from reimbursement. Some key areas to become familiar with from the CRG Clinical Treatment Guidelines are included here.

30 day treatment plan – CRG treatment frequency standards are based on a 30 day treatment period that begins at the initial visit.
On-going Care past the initial treatment period – Care that continues beyond the initial 30 day treatment period must be supported by daily patient notes and clinical exam findings that demonstrate progressive improvement.
Decreased Intensity and Frequency of Care – Treatment guidelines describe effective care reflected by decreasing intensity of care in the level of adjustment as well as the frequency of care over the course of treatment.
X-Rays –X-rays are indicated in cases where trauma has recently occurred or the chiropractor has reason to suspect some other pathology present, such as a tumor, fracture, infection, congenital anomaly or if the patient has not responded as expected to an initial course of chiropractic care. (See Chiropractic Treatment Guidelines, Part D, Medical Imaging).

Treatment of Children/Infants –Chiropractic care within the initial 30 day treatment period should be limited to 4 visits for infants and toddlers (Birth – 4) and 5 visits for children (5 – 17). The SCHA benefit covers spinal related conditions only. Treatment of childhood conditions such as colic, nocturnal enuresis, and otitis media must have clear subluxation levels documented. The treatment outcome expectation for these patients is for them to respond within the initial treatment period. If they do not, continued care is not indicated as SCHA prefers these conditions be closely monitored by the member's primary care physician. Upon subsequent examination by the primary care physician, if continued chiropractic treatment is indicated, a referral from the PCP must be obtained and must accompany future medical claims.

Daily notes required with claims – Initial evaluation and daily treatment notes must be submitted in the following cases:

- *Treatment of a patient birth through 6 years of age*
- *When a treatment code 98942 is used*
- *When Multiple view X-rays have been taken*
- *Care is provided beyond 30 days.*

"One of the challenges we face is how to fairly evaluate the costs and benefits of care being provided for health care complaints that are clinically linked to subluxations but are not typical musculoskeletal in nature. These are particularly prominent among very young patients and the elderly."

– Dr. Jeff Maness, Chiropractic Director

Submitting a "Clean Claim"

Currently, CRG requires claims be submitted in paper form via postage mail. Due to the high volume of claims processed every month, CRG is instituting submission format requirements in order to minimize processing errors and decrease the time necessary to process claims.

In the interest of assuring a properly completed claim on the first submission, the following guidelines for submitting claims to CRG for processing should be adopted immediately.

- Sorted
    1. First by last name
    2. Then by DOS
    3. In descending order
- No paperclips
- Staple notes/primary EOB
    1. Staples in center of page
- Folding
    1. No more than tri-fold format (two creases)
    2. Fold in Bulk. Don't fold individual claims.

Your adherence to these requirements will help assure the timely payment of your claims.

Management Notes: by Gene Helle, President

April Marks 5 Years of Service

CRG began providing chiropractic network services to South Country Health on April 1, 2003. At that time 39 original network chiropractors from 13 counties provided services to about 10,000 SCHA members. Today 115 providers in 31 counties serve more than 24,000 SCHA members. Over that time 4,690 South Country members received 32,400 chiropractic treatments at network offices.

One of the challenges we face as a network administrator is how to fairly evaluate the appropriateness of care being provided for health care complaints that are clinically linked to subluxations but are not typical musculoskeletal in nature. "These cases are particularly prominent among the very young and the older patient groups," according to CRG Chiropractic Director, Jeff Maness.

Documentation that supports the effectiveness of care will be the key to evaluating the benefit of chiropractic treatment and the driving force in reimbursement of services.

Clearly, chiropractic care is a very important and popular component of the care South Country members receive on a regular basis. CRG wants to acknowledge the support of each participating provider and express our appreciation for the commitment to patient care.