Managed Care Survival Guide

Respectfully submitted by BJ Palmer
(real name withheld to protect myself from the bullets and arrows)

Rarely a week goes by without at least one phone call from a DC complaining about managed care and companies like ACN/Optum and ASHN. The main complaint normally pertains to reduced treatment recommendations, followed by low fees, excessive paperwork, failure to pay for established patient E/M codes, restricted use of x-ray, restricted allowance for 98941 CMT, and grossly limited authorizations for rehabilitation or therapeutic exercises. I've been a network DC with ACN/Optum for example for years, and have experienced the same levels of frustration. However, I believe one can survive the rigors of managed care management and still thrive in practice. Allow me to humbly offer a few suggestions. Consider this your Managed Care Survival Guide.

- **What if I'm a subluxation-based DC?** Answer: Charge cash and don't play in the insurance game. Don't confuse philosophy with treatment and reimbursement. We live in a condition-based, evidence-based world. Accept that insurance will only serve to get your patient "mostly" out of pain, but will not pay for everything he/she needs. They don't pay for philosophy, only conditions.

- **Why do managed care companies frown upon high level E/M codes?** If you study the codes, you'll find that rarely are these codes necessary or appropriate in a chiropractic setting. If you use 99205 or 99215 expect to be micromanaged. These codes are rarely necessary for the management of a musculoskeletal condition. Use the codes which best describe the actual encounter. Do not use E/M codes every visit.

- **What about x-ray?** I understand the argument between red flag guidelines and biomechanical analysis which requires more x-ray. And I certainly understand the difference between an allopath who simply provides a script versus a DC who will enter force into a joint, therefore the logical application of x-ray prior to CMT being performed. However the payor community favors red-flag guidelines. So you have a choice to make:

    1. Provide and bill all the x-rays you feel the patient requires and risk falling into a category requiring micro-management including excessive paperwork, or worse yet, being kicked out of the network.
    2. Implement a more conservative approach to x-ray, and take less of them.
    3. Take all the x-rays you need but don't bill the carrier or the patient.
    4. Take all the x-rays you need, but only bill the carrier for limited series, or only for x-rays more consistent with red-flag guidelines. This could be a risky move however, and some would even consider it fraud. Theoretically, it is just as fraudulent to under-bill than it is to over-bill.

Bottom line: like it or not, if you x-ray every patient who enters your clinic, you will likely be considered an outlier with all the associated risks and hassles related to micromanagement. Full spine x-ray invites scrutiny. Many patients do well with a thorough consultation and examination. If the history/examination indicates x-ray (ex. recent trauma, radicular arm or leg pain, or numbness), by all means take them. Follow your gut, and document the rational basis for taking x-rays.

□ **Can I use a long-term treatment recommendation from the beginning of care like I used to use in the past?** Do not use long-term treatment plans from the initial visit. None of us know how fast our patient will respond, so schedule the patient based on ***current*** need and re-evaluate and adjust your initial treatment plan every 2-4 weeks. Base treatment on the uniqueness of your patient versus philosophy (condition-based, not philosophical based). Example: Why would you see a patient for 3x/wk for 4 week, then 2x/wk for 4 weeks, then 1x/wk for 4 weeks, if they were reduced down to a 1/10 on a VAS after the first 4 weeks? In other words base your treatment recommendations on actual need versus philosophy.

□ **But the carrier's treatment/authorization philosophy does not permit me to treat the patient enough to "correct" the problem, only enough to provide pain relief?** Answer: Welcome to the real world of insurance. The sooner you come to realize that insurance only pays for pain relief, the sooner your stress will reduce. After the relief phase, have the patient pay cash. However, during the relief phase, in addition to spinal manipulation, the literature clearly supports providing (1) assurance and advice to stay active regarding activities of daily living, (2) patient education, (3) NSAIDs, and (4) exercise.

□ **What is a typical treatment plan?** Typical plan examples include: 3x/week for 4 weeks for severe conditions (herniated discs, acute whiplash, 8-10/10 on VAS, etc.), 2x/week for 2-4 week for more moderate pain, and 1x/wk for 4 weeks for mild to moderate conditions, followed by re-evaluation. Reduce treatment from those levels as the patient improves.

□ **Can I use modalities long term?** Transition away from passive therapy within the first 4 weeks to a more active care approach.

□ **What about exercise?** Exercise in combination with spinal manipulation provides the most evidence-based and effective treatment combination for most musculoskeletal conditions. Naturally the insurance industry would prefer you provided exercise instruction only a few times and transition the patient to home exercise. In reality, many patients can do just that, while other patients need more extensive and closely monitored instruction. Like x-ray, just document the need for exercise and the rational basis of your treatment plan, and document the response to exercise as best you can using standard outcome assessment tools. When the time is right, provide the patient customized home-directed exercise.

- **How do I get my average number of visits as low (many networks prefer the "number" to be around 6-8 visits per patient) as a network prefers while still providing adequate care to my patients?** Remember that most patients who visit your office are "established patients" who need only 2-6 visits to recover from that episode, assuming the episode is mild to moderate in severity. Acute disc cases may need 20 or 30 visits to reach maximal therapeutic benefit, but that high number is easily offset by much more frequent established patients who only require 2-6 visits, thus the lower case visit average often quoted by ACN/Optum and others.

- **The network says the percentage of using 98941 versus 98940 is too high. Why can't I practice/treat full spine without fear of being labeled an outlier?** Remember, we exist in a condition-based insurance environment. While the main area may be low back, often the neck is also involved, therefore it is appropriate to treat full spine and bill for a 98941. However, not all areas will heal at the same rate, therefore as the secondary area of complaint resolves, reduce billing to 98940 while focusing on the main complaint. Your percentage of usage of 98941 vs. 98940 will drop and you'll move closer to their acceptable range.