Proving Necessity for Medicare

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Disclaimer: As a fellow chiropractor you probably rankle at the term "medical necessity" as much as I do. Please understand, I am not a shell for the AMA. I do use this type of language because this is the language that Medicare and most other third-party payers use. Most of you know the golden rule. Not that one, the other one that goes "Them what has the gold makes the rules." That was never truer than in the world of third party payers. When we can speak their language, we communicate better with them. When we communicate better with them they listen better and will work with us better. That's the reason I use terms such as "medical necessity" and "maximum medical improvement".

Let us start this discussion with a simple idea; not all care provided in your office will be considered medically necessary by Medicare. That does not mean that it is not clinically appropriate. You are the doctor and it is up to you to use your training, your knowledge, and your experience to determine what care is clinically appropriate for your patient. The fact that Medicare may not consider it to be medically necessary only means that they do not consider it appropriate to pay for that particular date of service. This article will help you greatly to determine which care Medicare would consider medically necessary and which care they would not.

Medicare considers chiropractic care to be episodic in nature. They expect to see a beginning and an end with periodic examinations along the way. It is difficult, if not impossible to prove that a single date of service is medically necessary by itself. Before we can prove that our care is medically necessary we need to determine what constitutes medical necessity for Medicare.

The Social Security Act, Section 1862(a)(1)(A) states; "(a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—(1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." So by law, Medicare cannot pay

for care that does not treat an illness or injury or improve the functioning on a malformed body part.

The Medicare Benefits Policy Manual, Chapter 15, Section 240.1.3 states; "The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam…" This indicates that there are four specific points to be considered to prove medical necessity to Medicare's satisfaction.

1. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment
2. The manipulative services rendered must have a direct therapeutic relationship to the patient's condition
3. The manipulative services rendered must provide reasonable expectation of recovery or improvement of function
4. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam

Let's take these points one at a time and determine exactly what we need to do to prove medical necessity for Medicare.

1. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment. When the patient presents in your office with a complaint for the first time you should perform an evaluation and management service (E/M service) on the patient. This would consist of a history, a consultation, an examination, and x-rays if indicated. From this information you should develop an assessment that will state how the problem is significant, why treatment is necessary for this condition, and what the diagnoses are (each spinal region treated should have a subluxation diagnosis and a neuromusculoskeletal diagnosis[1]). All of this information would combine to inform a written treatment plan.

2. The manipulative services rendered must have a direct therapeutic relationship to the patient's condition. You must indicate how the adjustments that you will render will positively affect the patient's condition. This would involve linking the condition in the patient's chief complaint with the vertebral segments that you will adjust. You would note this in the assessment portion of your notes for the initial visit.

3. The manipulative services rendered must provide reasonable expectation of recovery or improvement of function. Before you can prove that you have improved the function of your patient you need to establish a baseline for their functional impairment before they are adjusted. You accomplish this by using outcome assessment questionnaires as part of the initial visit examination. The most commonly used outcomes assessments in chiropractic are the Revised Oswestry Low Back Pain Disability Questionnaire and the Neck Disability Index. These two

[1] The Medicare Benefits Policy Manual, Chapter 15, Section 240.1.2(2)(A) states; Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Most Medicare Administrative Contractor's (MAC's) Local Coverage Determination (LCD) indicates; "the neuromusculoskeletal condition necessitating the treatment must be listed as the secondary diagnosis."

tools are, as the names might imply, used on the low back and neck respectively and they are scored using the same method. The score(s) should be noted in the assessment portion of your notes.

These outcome assessments can be used to determine whether the patient has a significant problem or not. The interpretation of the Revised Oswestry Low Back Pain Disability Questionnaire indicates that a score of 0% to 20% constitutes Minimal Disability. However a study was conducted that found that a score below 11% would be acceptable as a threshold for return to work.[2] That information could be extrapolated to indicate that a score of 11% or more would indicate a significant problem. The interpretation of the Neck disability Index indicates that a score of 0% to 8% is no disability and a score of 10% to 28% is mild disability. Therefore a score of 10% or more would indicate a significant problem.

The next question is how often do you administer the outcome assessment questionnaire. For the answer to that we need to consult the PQRS 2016 release notes for Measure #182: Functional Outcome Assessment released 11/17/2015. Under the definitions we find following; "Current (Functional Outcome Assessment) – A patient having a documented functional outcome assessment utilizing a standardized tool and a care plan if indicated within the previous 30 days." In Medicare's mind a functional outcome assessment is current if it is 30 or fewer days old. The care plan referenced here is a treatment plan. From this we can determine that the proper protocol for the use of outcome assessments in our offices is to administer one to the patient during the initial exam and at re-exams 30 days apart. A new treatment plan should be developed after each re-exam. You should also administer an outcome assessment at the time you discharge a patient from active care to determine their residual impairment, if any. This will prove helpful at the beginning of the next episode of care should one occur.

Now the question running through your mind must be how do we prove that there is functional improvement. First let us determine what Medicare expects. They define the following in the Medicare Benefits Policy Manual, Chapter 15, Section 240.1.3:

"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 exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition."

"Chronic subluxation-A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered."

From these definitions we can determine a few things. For an acute subluxation which would be considered a new condition that has caused the patient pain for less than 8 days. Pain for more than 8 days would indicate that there were complications that would increase the expected duration of treatment. The treatments are expected to result in an improvement of the patient's condition. For a chronic subluxation which would be a long term subluxation overlaid by a

[2] The Clinical Application of Outcomes Assessments, Steven G. Yeomans, Page 72

chronic condition such as Degenerative Disc Disease it is expected that the care would result in some functional improvement. We can develop some thresholds from this information. For an acute case you would expect to see more improvement between two outcome assessments 30 days apart than you would in a chronic case.

For an acute case you would want to see about 30% improvement over the previous outcome assessment. When you don't see 30% improvement or have another functional indicator of significant improvement you can determine that the patient has reached maximum medical improvement and release the patient to maintenance care. You can also chart the scores from one outcome assessment to the next and determine maximum medical improvement when the graph plateaus.

For a chronic case you want to see more than 4 points of improvement from one outcome assessment to another 30 days apart. A difference of 4 points or less is the standard deviation between two assessments 30 days apart. When you do not get that much improvement in a chronic case you can determine that the patient has reached maximum medical improvement. You can also chart these cases but you do not expect as much improvement between outcome assessments.

Once the patient reaches maximum medical improvement you would release them from active care to maintenance care and give them an ABN. They would basically remain on maintenance until they have another problem that would initiate an episode of care or a recurrence of the problem that you just treated. Either way, you would start with an initial exam again and set a new initial date of treatment for this patient.

4. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam. At the initial examination the presence of subluxation can be determined by physical examination using the P.A.R.T. system or by x-ray. It is up to the doctor to determine which method to use. It is also a good idea to note the presence of subluxation on each subsequent visit. You can do this easily using the P.A.R.T. system because all elements of P.A.R.T. can be determined through palpation.

Medicare is not telling you when to and when not to adjust with a determination of medical necessity. They are saying that care that is not medically necessary is care that they, by law, cannot pay for and that the patient is responsible for payment of that care. Using the methods and tools outlined in this article you can prove which care is medically necessary and which is not.
