Dynamic Chiropractic

An Enemy in Our Camp

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Chiropractors frequently ask me about reimbursement in the hospital setting. When money is their first question, I quote Jon Buriak, DC, chairman of the American Chiropractic Association's Hospital Relations Committee: "If your first concern is money, perhaps hospital practice is not for you." It is, however, reasonable to inquire as to the likelihood of reimbursement for the investment of time and money required to obtain hospital privileges.

In the pursuit of hospital privileges, chiropractors may have to sacrifice time from their personal lives to make hospital contacts, take a hospital protocol's course, and work toward obtaining an application for privileges. They may spend money to attend social gatherings, hospital-sponsored golf outings, or other events that will allow them to meet the people who can get them on staff at a hospital. It is unreasonable to expect a chiropractor to begin the journey toward hospital privileges without hope of success.

The short answer on reimbursement is yes, chiropractors do get reimbursed for working in hospitals. Very few chiropractors would give up hospital privileges voluntarily. There are rewards, and they are not limited to money. You cannot put a price on self-satisfaction, vicarious respect from being a part of a respected hospital staff, the development of new friends, and acceptance by the prestigious fraternity of the medical community.

It is my personal experience that most insurance companies reimburse for chiropractic care provided for inpatient, outpatient, and emergency department (ED) patients. As an example, Medicare reimburses for chiropractic services, but as for other providers, the fee is slightly lower than for similar services provided in the office setting. Apparently, the lower rate is due to consideration of the lesser overhead faced by the practitioner in the hospital. The *ChiroCode Desk Reference* lists the appropriate coding and documentation required for the billing of hospital-related Medicare services.

Occasionally, an individual insurance reviewer will deny a hospital claim improperly, as they will an office claim. The denial may be founded on personal prejudice, a lack of understanding of the role of chiropractic in the hospital, or human error. I was gratified recently when an arbitrator found an insurance company nurse did not have the expertise to deny a chiropractic claim originating from a hospital emergency department. This set a precedent against a prejudicial insurance company employee denying hospital chiropractic claims without basis. While prejudicial and human or computer-error denials are not appreciated, these types or rejections are not as upsetting as those that come from within the chiropractic profession.

Unfortunately, the only consistent lack of support for chiropractic care in the hospital comes from "chiropractor-administered" patient management and review services. These chiropractors are accustomed to managing a course of treatment over time in the office setting. By denying hospital-related claims, they demonstrate that they are not familiar with care as delivered in the hospital and ED settings.

Emergency treatment is not and should not be micromanaged by an outside agency. ED patients

typically are quite severe and acute. The purpose of treating this subcategory of chiropractic patients is much different than the course of rehabilitation therapy offered in the office setting. One company rejected a claim for chiropractic care in the ED because a pre-certification call was not made prior to treatment. On my next encounter with a similarly insured and injured patient, I intended to make a pre-certification call. Due to the pressure to treat the patient and make the room available for other patients with urgent needs, I was unable to make the call.

The chiropractor's actions in the ED are guided by the urgency of the needs of both the patient and the other people waiting to be seen by either the chiropractor or other members of the ED staff. The chiropractor's actions cannot be dictated by the insurance company's desire to limit care in an effort to lower reimbursement expenses.

In the ED, it is the attending physician's responsibility to determine the best course of treatment for each patient. Recently a middle-aged man presented to our ED. He was examined, radiographed, and administered Toradol, a strong nonsteroidal anti-inflammatory injection. While recumbent and supine, his pain was improved, but unfortunately, he continued to suffer severe, sharp, and incapacitating pain with any attempt to turn onto his side to raise himself out of bed.

According to EMTALA [Emergency Medical Treatment and Active Labor Act] regulations, an unstable patient cannot be transferred home, i.e., discharged. Patients with severe pain are considered medically unstable. And according to ERISA statutes, only the attending ED physician can determine which patients are unstable.

The attending physician's choices in this example were to administer stronger narcotic analgesia, admit the patient for intravenous narcotic analgesia, obtain a surgical consultation, or obtain a chiropractic consultation. The patient had driven himself to the hospital, making it improper to administer narcotic analgesia. If he were unable to obtain a ride, he would be unable to return home. Narcotics only mask pain. Once the pain medication wore off, he would likely be in the same pain that brought him to the ED. He would then be motivated to return to the ED, fearing that the source of his pain had not been discovered. It is the attending physician's goal to prevent hospitalization whenever possible.

It is important to avoid potentially addictive narcotics. The patient's physical examination findings did not warrant a surgical evaluation. The attending physician's best choice was to call for a chiropractic consultation. As it turned out, after being treated by a chiropractor with electrical muscle stimulation, spinal manipulation, and Pettibon Wobble Chair stretching/exercises, the patient was able to walk out of the ED with no sharp pains upon active or passive movements.

Another example of an ED patient best treated by a chiropractor involved a young adult woman with an 11-year history of migraines. She presented to the ED after suffering for approximately one week of worsening headache. She advised us that by the time her husband brought her to the hospital, she was experiencing the worst headache of her life. She had self-medicated unsuccessfully with two triptan medications that had helped in the past. In the ED, she was evaluated to rule out serious neurological disorders. She was administered an injection of Toradol and then an injection of the strong narcotic analgesic Demerol. The patient continued to be incapacitated by her pain. Upon physical examination, the attending noted the tension and tenderness of the cervical paraspinal muscles. Believing that the patient was suffering from both migraine and simultaneous cervical tension cephalgia, the attending called for a chiropractic consultation. Approximately 30 minutes after the completion of chiropractic treatment, the patient had improved enough to be discharged from the hospital without additional medication or requiring hospitalization.

The nature of the ED environment is one of both thoroughness and efficiency. There are patients waiting to be seen and the expectation that critical patients will be arriving unexpectedly. It is improper for managed care companies to get involved in the control of care provided in the ED. The attending must be the one responsible for making the best decisions for the patient, making them quickly, and moving on to the next patient. When a chiropractor is called to the ED, it is expected that consultation and treatment will be provided expertly and efficiently, so the treatment room can be made available to the next patient. Keeping an efficient patient flow can be life-saving. It is unrealistic and possibly dangerous to consider involving managed care in the ED setting. Patients insured by managed care companies should not have their claims reviewed in the same manner they would if they presented to the chiropractor's office. The chiropractor working in the hospital also should not have to be on the panel of the patient's insurance carrier. Patients in severe pain who present to an ED do not know if they will be seen by a chiropractor. It would be ridiculous to expect them to search for a hospital with on-staff chiropractors who have contracted with their insurance plan.

Chiropractors on staff at hospitals need to use every means available to fight unfair decisions by "chiropractor managed" plans and the occasional bad decisions made by "medical managed" plans. Chiropractors can use ERISA and EMTALA statutes. Both internal and external reviews should be requested. When appropriate, use arbitration. If we allow unfair decisions to be tolerated, we are in danger of allowing the insurance industry to establish faulty precedents. Chiropractors who work for managed care companies need to search their souls. Chiropractic inclusion in the hospital setting may be the best advance for chiropractic since the onset of licensing. Chiropractic reviewers and plan administrators who discourage chiropractors from getting involved in hospital care and work against the tremendous strides we've made are acting against the good of our profession and should be considered as acting unethically. They should be censored by their peers and the national and state chiropractic organizations.

The good news is that while working on this article, I was contacted by a representative from one of the chiropractor-administered review organizations. She wanted to alert me that after numerous phone calls, letters, and meetings, her organization, in concert with a major insurance carrier, agreed that they would no longer blanket-deny chiropractic services provided in the hospital setting. The companies agreed to evaluate the merits of each individual claim. If you receive a denial for hospital-related chiropractic claim, contact the American Academy of Hospital Chiropractors at www.HospitalDC.com for assistance. While the majority of insurance carriers and plans reimburse for hospital-related chiropractic services, we should not relax our fight against the few - especially when they come from within our own profession.

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