Dynamic Chiropractic

MUSCULOSKELETAL PAIN

We Get Letters & E-Mail

Time to Recognize DCs as Disaster Team Members

Dear Editor:

I read with interest the interview with Dr. Robert Lizana. [See "Chiropractic in the Eye of the Storm" in the Feb. 13 and Feb. 27 issues.] I am a member of a FEMA Disaster Medical Assistance Team (DMAT) here in Missouri. I spent 17 days working down there right after Katrina hit, working in a field hospital in a high school gym in Covington, Louisiana.

My primary job is logistics, as there is no formal designation for chiropractors in the federal disaster system. Nonetheless, I spent much of my time adjusting. Because Dr. Lizana and the other DCs were out of business, I treated other team members, locals and volunteers whose chiropractors were MIA. I returned about a month later and worked two weeks with the morgue operation in St. Gabriel, La. As you can imagine, recovering bodies and moving body bags played havoc on people's backs.

Some massage therapist volunteers were there along with us. Together, we worked some very long hours taking care of all those folks. My hope is that we can get formal recognition as chiropractors at the federal level of disaster management, so as to enhance our position as doctors on disaster teams. If anyone has any suggestions or contacts to help accomplish this, let me know.

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Editor's note: This letter to the editor addresses Samuel Collins' "Ask the Billing Expert" column, which appears in each issue of *Dynamic Chiropractic*. A response from Mr. Collins follows.

"Medicare Misinformation"

Dear Editor:

I am writing concerning the Medicare misinformation contained in the "Ask the Billing Expert" column in the Jan. 15, 2006 issue ("Medicare Regulations and Limits on Care," www.chiroweb.com/archives/24/02/05.html).

This is a very critical time in our profession, fighting to get out from under the negative findings in last year's OIG report. The ACC, ACA, COCSA, and the FCLB are taking strong steps to head off congression-al action that could result in "hard caps" and other unpleasant consequences for chiropractors.

Mr. Collins is described as an expert when, in fact, his writing makes it clear that he is not even close to being accurate and up to date. While his first paragraph is accurate, the second is absolutely wrong (in California). Medicare does not publish a list of secondary diagnoses categorizing short-, moderate- and long-term care. Some carriers in some states have done so, but

not here by our carrier, NHIC. NHIC does provide this information in their chiropractic LCD in the New England states that they service. Those guidelines even give a specific number of treatments for each code that may be acceptable.

I recently spoke with our chiropractic ombudsperson at NHIC and she verified that Medicare does not publish secondary diagnosis information.

Also of great importance here in California is the change to a "rolling year." Doctors used to feel confident that they could treat patients without concern 12 times at the end of the year and then another 12 starting in January. The calendar year is no longer valid. NHIC looks at a "rolling year" to determine whether treatment may be medically necessary. The number of visits or billing pattern that may trigger an audit is not available to providers.

A glance at your Jan. 29, 2006 issue indicates again that Mr. Collins is not accurate. In his first paragraph he states that the *ICD-9-CM* manual contains all the diagnoses currently billable under all insurance claims.

This is simply wrong again here in California. While most of the codes are the same, workers' compensation claims do utilize codes not found in the *ICD-9*, some of which were but are now obsolete, yet are still used here.

R. Dean Harman, DC
San Mateo, Calif.

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Dear Dr. Harman:

First and foremost, the articles that I author are written generically to suit the needs of all states, as *Dynamic Chiropractic* is a national publication. Specifically, my Jan. 15, 2006 article on Medicare limits and diagnosis references includes a list of secondary diagnoses that I offered to send, via e-mail, to those who requested it. This list is published by most state Medicare carriers.

You take issue that this list is not published by the specific California Medicare carrier NHIC. In that context, you are correct, because in NHIC, California has not published this list, but that does not render the information invalid for California providers. NHIC does publish such a list for their New England providers, but one that is much broader than the one I referenced. Note that NHIC oversees both California and New England Medicare.

Local Coverage Determination (LCD) of Medicare is done by each state's individual Medicare provider under the direction of CMS regulations. Individual state carriers will use and may publish this information to their providers, and it is not uncommon for a variance in published data to providers. Therefore, I specifically referenced the most common list used and purposely did not reference the New England list, as it is very broad in scope and lists treatment numbers allowed per diagnosis. Use of this list without proper guidance of documentation would be dangerous, as many may be tempted to use the codes that allow 30-58 visits without understanding all the facets needed to qualify those codes.

CMS does indeed direct policy coverage on the necessity of chiropractic care and diagnoses that are utilized. The decision by a state carrier to publish a list to its providers does not mean they will not use the CMS protocol for review of medical necessity.

The sole purpose of the Jan. 15, 2006 article was to make sure chiropractors are aware that

Medicare does not look only at subluxation for diagnosis, but that the secondary diagnosis is a major factor to determine care allowance. I have found, in my seven years as director of H.J. Ross Insurance Information Network, that many chiropractic providers mistakenly have the idea that they can only use pain or symptom diagnosis as secondary. I want to be sure chiropractic providers understand that they may use a wide variety of neuromusculoskeletal diagnoses, which can provide a clearer more accurate description of the patient's condition. This may and should lead to greater allowances of needed care without going through a denial and re-determination process that may likely occur when only low-level, symptom-related diagnosis is used.

For future reference, I will be sure to put a disclaimer on articles in which there could be some state-to-state discrepancy. By example, in Florida, you need not use a primary diagnosis of subluxation on the Medicare billing form, and can use the secondary neuromusculoskeletal diagnosis as the primary. Even considering this marked difference, the review process of the neuromusculoskeletal diagnosis code is essentially the same; therefore, the information in such an article would be pertinent to Florida doctors to understand how Medicare will view their Medicare claim.

Dr. Harman, your reference to the "rolling year" for Medicare in California is an important topic, but was not part of the question of my article or its tenor. Important, too, are the references to chiropractors and the OIG findings for chiropractic care. The latter of course is based on a lack of proper documentation to demonstrate care as medically necessary under Medicare guidelines. Both are important topics that I may address in future columns.

Finally, your last statement, about my Jan. 29, 2006 article on ICD-9 diagnosis, was an oversight on your part. You are mistakenly referencing CPT coding and the California Workers' Compensation Official Medical Fee Schedule coding, which use many similar procedure codes, but not all the same. The article of course was not about procedure coding, but diagnosis.

Regarding Medicare diagnosis coding, the secondary diagnosis does indeed help determine the level of care and though this list is not published by NHIC California, it has information that is useful to California chiropractors.

Considering that *DC* is a national publication, I strive for topics and information that are general enough for all to utilize. For this reason, I do not address topics such as workers' compensation as those are very state-specific issues.

Samuel A. Collins

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