Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

We Get Letters & E-Mail

A Chiropractor's Look at the Managed Care Industry

Dear Editor:

"An Insider's Look at the Managed Care Industry" ["An Insider's Look at Managed Care," Jan. 15, 2012 issue, We Get Letters & E-Mail] by R. Lloyd Friesen, DC, vice president of public affairs for American Specialty Health, attempts to educate the readers to the functions of an MCO. In his article, he reviews topics such as documentation, financial incentive, reimbursement, the appeals process and finally, provider participation. I think we would all agree that some type of managed care is needed. If we are going to participate, policies and procedures need to be followed. I believe in general most of the criteria ASH has set up are reasonable.

However, on the topic of provider participation, Dr. Friesen stated, "Managed care participation is an individual business decision or choice that cannot be discussed with a peer or an association," and goes on to mention anti-trust activity. Provider participation is the topic I think most chiropractors have an issue with. It becomes increasingly difficult to run a business when we (chiropractors) are not on a level playing field.

In July 2011, ASH took over managing claims for a large insurance carrier. This insurance carrier paid for services performed by a chiropractor at a similar rate to other providers providing same or similar services in the treatment of musculoskeletal conditions such as disc injury, plantar fasciitis, or a shoulder injury. It should be noted that this same insurance company uses a separate managed care organization for physical therapists. If we compare the treatment of a typical patient a physical therapist or a chiropractor would treat, the most common codes used by these providers would be spinal manipulation (98940), mobilization/manipulation (97140) and therapeutic exercise (97110).

Prior to July 2011, this particular insurance carrier gave a relative value to these procedures, which was similar among provider types. So, if a patient with a musculoskeletal condition was treated by a chiropractor, the typical reimbursement would be approximately $65 a visit and the physical therapist doing same or similar treatment was reimbursed $73.

In early 2011, contracted Ohio chiropractors received a letter from this insurance company that it was going to terminate their contract. The only way they would be able to be considered in-network was if they contracted through ASH. The insurance company stated any reduction in payment had nothing to do with them, but was controlled by ASH.

Since ASH has taken over the claims, the $65 reimbursement has dropped to a per-diem reimbursement of approximately $35 for doing the same work. Physical therapists are still receiving approximately $73. Adding insult to injury is that a $30 co-pay is very common. This means we collect $30 from the patient and spend the time and resources to file the claims to eventually receive $5 from ASH.

I don't think most chiropractors have a problem with proper documentation or providing evidence-based care that all other providers are required to follow. The problem is when our provider type is

singled out and has reimbursement greatly reduced compared to other providers who render the same service.

Let's compare a treatment for an acute disc rendered by a chiropractor and a physical therapist. Both will utilize manipulation/mobilization as well as postural exercises, with common goals of centralizing the pain. If both providers spend the same time with the patient, this time would be reflected in units billed. If a patient with a $30 copay requires 40 units from start of care to eventually being released from care, the breakdown would look like this: A physical therapist is being reimbursed for four units per visit, which allow this condition to be resolved in 10 visits at a $300 cost to the patient. A chiropractor spending an equal amount of time with the patient requires 20 visits, as they are only being reimbursed two units per visit. This would be a $600 cost to the patient, since they selected this provider type for the same treatment. This greatly restricts the trade of the provider as well as restricting provider choice for the patient.

I agree with Dr. Friesen that there is an anti-trust issue. I believe if this issue were challenged, the provider and patients would win. So yes, joining an MCO is a business decision, but again, it should be based on a level playing field.

Lou Rossi, DC
Medina, Ohio

When It Comes to Insurance, You Have a Choice – But What Is It?

Dear Editor:

Every year, doctors of chiropractic receive letters from their affiliated preferred provider organizations, PPO, stating that they will relegate the administration of their chiropractic claims to a claim-management vendor. Additionally, in order to continue seeing their patients as an in-network PPO provider, they will now have to join this claim-management vendor's sub-network, abide by this vendor's rules, receive lower reimbursement rates, and subrogate the doctor's clinical judgment to the claim vendor's utilization reviewer. The other types of medical providers in this PPO will continue enjoying greater reimbursement for the same health services and do not have to subrogate their clinical judgment.

The answer to this proposal would be an easy *no* if the PPO insurance company did not have control over a large percentage of the patient population. Is accepting or rejecting such conditions the only choice? What are all the choices available?
In a parallel dilemma, the public purchasing an insurance product is choosing the higher-premium PPO policy to have more freedom of choice in their health care decisions. They pay a higher premium to stay away from the managed care HMO's restrictions on care. They want their doctor making their health care decisions, not a stranger or a committee. How do the treatment restrictions and reimbursement cuts these claim-management vendors impose affect the patient's rights to choose chiropractic treatment?

As a chiropractor, my experience regarding chiropractic claim-management vendors is that they have not truly followed a comprehensive best-practices model, but have instead hampered patient care by delaying care, rationing treatment, and slashing reimbursement below usual and customary levels. In my opinion, the treatment rationale and reimbursement rates promoted by these entities have been unfair, self-serving and counterproductive.

At the same time, as an attorney I have seen some shameful displays of excessive billing and

incoherent treatment plans by doctors of chiropractic, as well as the other health care providers in medicine. Therefore, what can an insurance medical executive do to render the best care to its members at the best possible price?

Adopting an internal proven best-practices management plan that focuses on the patient's condition and manages the whole health care services scheme will probably have a positive effect in patient care and decrease the insurance company's total reimbursement cost. A coherent and logical best practices model for musculoskeletal conditions, like low back pain, will guide treatment by focusing on the patient's condition, not on the type of provider. This model would be best performed as an internal insurance function, not by an outside chiropractic claim vendor, because it would have to consider the proper utilization of all available treatments by all providers to ensure the best patient outcome. Also, this effort would be better managed internally since it would require innovative provider bonding and education to train all types of providers to treat patients as a team, per best-practices guidelines.

"Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline From the American College of Physicians and the American Pain Society" represents a comprehensive scheme in which spinal manipulative therapy has an important role in resolving acute and chronic low back pain before the patient is escalated to more invasive and expensive treatments, procedures and diagnostic tests. This guideline has been recommended by the DoD and VA in their health services.

Medical insurance executives have to be educated in relevant insurance research supporting the finding that increased utilization of chiropractic services reduces total costs for musculoskeletal pain conditions, decreases hospitalizations, decreases diagnostic tests, and decreases surgeries and other expensive medical procedures. Insurance plans that restrict access to chiropractic services may also be inadvertently increasing their reimbursement costs. (See "Doctors of Chiropractic: A Low-Cost Solution to High-Cost Health Care": www.acatoday.org/pdf/Cost_Summit_2012.pdf.)

In the meantime, until the age of enlightenment comes, how can doctors of chiropractic deal with their forced participation in sub-networks that will slash their reimbursement, arbitrarily limit their care and subvert their clinical judgment while the other medical providers are paid higher fees for the same services and enjoy an unencumbered relation with the insurance company PPO? Many states have insurance reimbursement equality laws and anti-discrimination laws that protect providers and patients from unfair insurance practices. Doctors of chiropractic and their associations should make an effort to understand the protective application of these laws. I am in the process of researching these laws in Illinois.

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