Dynamic Chiropractic

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Denied Care: The Art of the Appeal (Pt. 1)

Ronald J. Farabaugh, DC

One of my patients was involved in an accident that left him permanently disabled. Although he finds welcome relief through an evidence-based, integrated approach to his injuries, the managed care organization (MCO) denied his care.

As practitioners, we need to know how to address these challenging situations to help our patients receive the care they need. This two-part article focuses on how to increase your odds of success when care is denied by taking an unemotional, fact-based approach to your rebuttal communications.

The Patient

Here is Bill's story: Twenty years ago, he was a strong, well-built 42-year-old man, sitting in the front passenger seat of his work truck as his co-worker pumped gas. As he sat there relaxed, right foot on the dash, left foot on the floor, listening to his favorite old-rock tunes on the radio, who would have thought his idyllic life was about to change in a big way – and never again return to normal.

At that time, an elderly woman traveling down the same street lost control of her car. She ran off the road and hit the hedgerow between the gas station and adjacent property. The relatively light weight and speed of her car, combined with the thickness of bushes, resulted in her car being launched into the air. The front end of her car came crashing down in the truck cab directly behind Bill, smashing him into the dashboard and windshield.

The good news: both of them lived. The bad news: Bill suffered irreparable damage that included a fractured right shoulder, broken teeth and jaw, severe neck injury (two herniated discs, severe sprain/strain, ligament instability), and severe low back injury (herniated discs, ligament damage).

Chiropractic Intervention

Initially, Bill was treated medically to address his acute injuries. As time passed, his neck and low back pain continued and he was forced to submit to countless pain-management injections in addition to ingesting massive amounts of narcotic medication. He eventually became addicted to the drugs. In an effort to reduce narcotic intake, he eventually found his way to our chiropractic office, where he has been treated ever since.

Bill controls his permanent pain with the combined use of spinal manipulation, massage therapy, acupuncture, electric stim, mechanical traction, and medication. He is one of only two patients in my 35-year-old practice who visits the office weekly. His case is extreme and he has clearly drifted beyond "basic guidelines" for an acute injury.

The Insurance Denial

In an apparent effort to stop excessive chiropractic-related care, the worker's compensation managed-care organization handling his case sent his file to an independent medical examiner

(IME), who recommended a denial of payment based upon his belief that "treatment exceeded guidelines." This scenario has become so common that most primary care physicians (PCPs) in Westerville, Ohio will not accept a work comp or personal-injury patient.

The Art of the Appeal

Since DCs still treat these patients, they need to become skilled at the art of the appeal. In response to this case, we successfully argued against the negative IME denial with the facts about both the case and the proper use of guidelines.

Consider including the following information into your appeals in an effort to remind the hearing officer or case manager as they relate to the use of guidelines:

- All guidelines serve merely as background information to assist doctors in the clinical decision-making process.
- A guideline serves as a "compass" for care, not a cookbook for care.
- Guidelines should never be used punitively or as prescriptions for care.
- Each patient is unique and treatment recommendations must be based on the specific factors pertaining to the individual case.
- Guidelines are only one piece of evidence to consider when considering the medical necessity of care. Other pieces of evidence include: research, clinical experience / decision-making, patient values, risk stratification, process of care, response to care, and documentation. Again, guidelines are not meant to be cookbooks with rigid dosages for treatment.
- Each case is unique and may present with many complications that should be reported and considered to help clarify why treatment may have extended beyond the natural healing time, or expected recovery time, compared to a non-complicated, mild, acute case.
- Any reviewer / consultant who recommends a denial based upon his/her belief that a guideline was exceeded should provide the rationale, and/or be challenged to produce the page, paragraph and sentence in the guideline being referenced, indicating where the provider of record exceeded the guideline.

The strength of your appeal begins with the basics: proper case management, adherence to guidelines, and documentation. Too often, DCs make it easy for IMEs to recommend denial of payment due to the poor quality of information supporting patient care.

Thus, in order to win your cases, I suggest you make it easier for a hearing officer to overturn the denial. If you are prepared in advance with a case that is properly documented and file an appeal that is strong, then allowance should be the only option. Here are a few basic rules to consider:

Case Management

1. Read the guidelines published by the Council on Chiropractic Guidelines and Practice Parameters (otherwise known as the Clinical Compass) to gain a better understanding of case management and documentation.[1]
2. Monitor progress using pain scales and/or outcome assessment scores (OATs) after the initial six visits. (*Note*: This is not to be construed as a six-visit limit in care!)
3. Examine and report every 12 visits, or in 30-day intervals.
4. Provide evidence-based care (e.g., spinal manipulation and patient-specific exercises).
5. When appropriate, there should be a shift away from passive care toward more active care, including a transition to home-based exercise. (*Note*: This should not be construed to mean there is no value to passive care as the case progresses.)
6. Once the patient reaches a plateau in recovery (i.e., maximum therapeutic benefit), implement a therapeutic withdrawal to determine the stability of the condition, and consider

a transition to self-pay unless the plan specifically identifies ongoing care as a payable benefit.

Documentation

1. Again, be sure to read the Clinical Compass guidelines in their entirety.
2. Consultation / history: be thorough in describing the mechanism of injury, including the causal link between the pain and the injury.
3. Conduct condition-specific examinations: initial, interim and final; and qualify and quantify abnormal orthopedic and neurological findings. (*Example*: "Foraminal compression was positive, producing dull to sharp pain, 6/10 on VAS, radiating into the left trap region and lateral upper arm.")
4. Describe prognostic factors for chronic pain. (e.g., see pages 11 and 12 of the 2016 CCGPP low back pain guideline).[2] Review previous Clinical Compass guidelines for charts (Table 2) identifying specific complicating factors.[3]
5. Describe both short and long-term goals for exercise / active rehabilitation.
6. Follow the guidelines you are using. Once there is a plateau in recovery, draft a simple discharge summary describing the future needs of your patient. (*Example*: patient released PRN, transitioned to home-based exercises, recovered with permanent residual soft-tissue damage, etc.).

Editor's Note: In part 2 of this article, Dr. Farabaugh presents a detailed appeal outline that can serve as a guide if filing your own appeal is ever necessary.

References

1. Globe G, Farabaugh RJ, Hawk C, et al. Clinical practice guideline: chiropractic care for low back pain. *JMPT,* 2016 Jan;39(1):1-22.
2. *Ibid*.
3. Farabaugh RJ, Dehen MD, Hawk C. Management of chronic spine-related conditions: consensus recommendations of a multidisciplinary panel. *JMPT*, 2010 Sep;33(7):484-492.

AUGUST 2017