Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

Why It Makes Sense to Become a DME Provider for Medicare

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As a chiropractor, there are two simple goals I have in practice. Of course, there are many expansions to be made to make these goals achievable. The first and foremost of these two goals is: how can I help this patient, who is in front of me right now, get well and stay well? The second goal, every bit as important as the first, is: how I can make a profit so I can continue to help patients get well and stay well. To me, the first reason is the very heart and soul of being a chiropractor. This is the real reason why so many good chiropractors work deeply into an advanced age. One of my mentors was still practicing at age 96 (4 hours per week). It is in our blood. Chiropractic had become a major mission and purpose in our life. In so many ways, it is who we are.

Becoming a DME (Durable Medical Equipment) provider/supplier for Medicare solidly enhances both goals. Supplying durable medical equipment such as lumbar braces, helps patients burdened, for example, with lumbar instability syndromes achieve stability. The net profits, as predetermined by DME Medicare (the reimbursement rates are set by Medicare), are very good at this time. A typical brace commonly used in the lumbar spine can easily have a net profit anywhere from $300 to $1,000 per brace.

I talk with chiropractors and medical physicians every day concerning becoming a certified DME provider for Medicare and how to enhance the implementation of DME supplies for a practice. In fact, a chiropractor and a medical physician are under the same credentialing criteria. Both are entitled to the same rights and privileges with one exception. Both, as recognized physicians within the Medicare system, are able to deliver these supplies to patients. This is the same credentialing process that neurosurgeons, orthopedic surgeons and general practitioners must use in order to deliver a back brace to Medicare patients and to be paid for this service by Medicare. Chiropractors can do the same. (*Ed. Note*: For more information on credentialling, contact the author directly. Info is in his bio.)

Interestingly, chiropractors use very few lumbar braces. In my early years, I did not understand how helpful lumbar braces are in stabilizing difficult spinal conditions and, honestly, because I was paid very poorly for using them. Once I understood how wonderfully lumbar braces enhanced my clinical ability to help people with spine issues, and I found out how well Medicare paid a chiropractor who was properly certified, there was no stopping me from doing this.

Why Offering DME Works

I understand that some chiropractors do not see the need for using DME items, such as lumbar spinal braces, often called LSOs or lumbosacral orthotics. After all, we chiropractors have been caring for these patients with our own ways for a long time now. Medical physicians, however, seem to accept and understand much better the need and usefulness for lumbar braces in patients. Many Medical experts I have heard speak on this subject estimate that more than 99% of all orthopedic physicians

use back braces. I guess that we chiropractors make up the "less than 1%."

While there are many peer reviewed papers and opinions supporting lumbar brace use (this is one reason Medicare pays so well for them), I want to share with you one opinion given by Khan AM., Salih M. and Lnach B. from the Department of Orthopedics and Trauma at King George Hospital and Nothwick Hospital in Essex. They report that "there is good compliance and control of back pain ... with a visual analogue mean pain scale reduction from 8.30 to 4.90."[1] This is, in my opinion, a very significant point clinically. The conditions studied in this article consisted of various diagnoses such as spondylolitheses, osteoarthritis and "unspecified back pain."

In another study by the University of South Florida, College of Public Health, OSHA Training Institute Education Center on 1,100 workers, using a very small lumbar belt (covering the L5-S1 junction), found strong effectiveness in reduction of both pain and exacerbations of back conditions in subjects that used the lumbar support.[2] Both are components that are highly desirable as patient care outcomes.

How a physician, such as a chiropractor would decide when a lumbar brace (LSO) would be appropriate is worth exploring. Let us look at the most common DME supply, a lumbar brace, a chiropractor would use in practice and how it works. Lumbar support orthotics (LSO) offer core or thoracic/lumbar/sacral stability to a person. The LSO will hinder the person from normal or excess movement in flexion, extension, rotation, lateral flexion or combinations of these movements. The LSO will also add core trunk compression, similar to, but not quite the same as, strong abdominal muscles. Braces thereby offer a safe, non-invasive way to help one heal from current conditions of prevent future problems.[3]

Spinal braces are commonly used for low back pain, trauma, infections, muscular weakness and osteoporosis.[4] Spinal instability is a common indication in conditions such as chronic facet syndrome, herniated disc syndrome, sciatica, spondylolitheses and lumbar stenosis. Braces are also used for a variety of reasons such as controlling pain, lessening the chance of further injury, allowing healing to take place, to compensate for muscular weakness and to prevent or correct deformity.[5]

[pb]Successful use of braces such as LSOs may lead to decreased pain, increased strength, improved function, increased proprioception, improved posture, correction of spinal deformity, protection against spinal instability, minimize spinal problem complications and improve the healing of ligaments and bones. The two types of bracing commonly used in an outpatient office are the soft brace which limits some movement and is used for lifting occasions such a employment requiring the lifting of heavy loads. The other is a rigid brace which could be a form fitting plastic type mold that restricts motion by as much as 50% and is used for low back pain and instability when non-rigid (soft) bracing is not enough. Hard braces offer both immobilization and support.[6]

Common Examples

Here are a few examples of patient presentations I commonly see in my practice.

Example 1: The patient has a history of reoccurring low back pain that seems to be worsening over time. She does not want back surgery. Conservative care helps for a while but it seems to take longer to get better now and never seems quite "right." X-rays show a pars defect with slippage of L5.

Diagnosis is Spondylolithesis Grade 1, with instability. Application of semi-rigid LSO for acute stage and for home use under exacerbation stages. Also recommended to use when in dangerous activities that could trigger back syndrome exacerbation.

Example 2: The patient presents with a history of chronic low back pain, has been to many doctors, has had no real help yet and is worsening. Range of motion of the lumbar spine exhibits both pain and limitations, x-ray show slippage of l4 on L5, grade 2 without pars defect. Diagnosis is degenerative spondylolitheses with lumbar instability. As part of a treatment plan, application of rigid LSO for core stability is delivered.

Example 3: Patient presents with a history of low back pain for no reason. Exam shows antalgia with moderate to severe muscle spasm. Diagnosis is probable disc syndrome. Application of a rigid LSO to facilitate protection and stability is given.

When using LSOs, the treating physician must provide clinical necessity in his notes. Clinical necessity should include some type of instability syndrome or pain syndrome that is to be helped by providing core stability. The LSO would function to provide core stability in both the short and/or long term. While positive clinical results do not always occur, one should document an anticipated prognosis of a positive effect on the patient and the treatment plan. Then, later on in the notes, the documentation should reflect what the actual clinical result is.

Remember, if this LSO is in the best interests concerning the patients back problem, the documentation should be relatively easy and concise. For the patient, they desire less pain and less episodes of difficulty. This, in turn, clearly leads to a better quality of life for the patient. For the physician, this means functional improvement and success in the goals of care and the physician is well paid for his efforts. Concerning the fiscal impact to the patient, the insurance payers, and society at large, this means less money is "burned up" taking care of patients with these problems. Everybody wins!

I love the fact that, as a chiropractor who is a certified Medicare provider/supplier for DME, I am able to help patients with a "gold standard" method of care, am able to do so with a minimum of effort in time and documentation requirements and am paid handsomely for it.

References:

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