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Do you want to re-define medical necessity?

by Dr. John Davila

Do you want to re-define medical necessity? I do!

Don't laugh! We have a greater chance of getting this done now more than ever. The problem is that it's going to require our profession to embrace certain things we may not want to. The neurological component of the subluxation is our greatest weapon to expanding the definition of medical necessity and the funny part is that this is where Medicare policy will help us more than you think.

According to Medicare's definition of medical necessity, "The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function."

The important word in all of this is "neuromusculoskeletal." If we were to take this word and deconstruct it, we could use it in three parts. First, we could show significant improvement of muscles regarding conditions such as spasms. Second, we could improve skeletal issues to show functional increases in ROM or posture.

But, we always seem to miss out on the "neurological" issues that have been a part of our philosophy and heritage for over 100 years. We talk about it but the subluxation and neurology has been such a nebulous issue we could never get our hands on. This is where our philosophy has carried us with our patients and their results. Unfortunately, the insurance carriers state these reports are not proven and have no value to them.

What is even worse is that insurance carriers do not fully understand what it is we are trying to get accomplished. The chiropractic profession has used the "square peg in a round hole" analogy for so long that we are neither square nor is the hole round!

We try to show what we do works and that we are better than everyone else who treats the same conditions. Because we have some proof in the skeletal or muscular issues we deal with, we get compared to those other professionals. When these types of issues are addressed by the carriers or CMS, we get reports like the 2005 OIG report on Chiropractic Services in the Medicare Program. The report stated that the OIG reviewed a statically significant number of patient charts and found out that the average

chiropractor's notes couldn't support more than 18-24 visits for any condition.

Why is this important? The biggest reason is that the report was based on doctors who have two major issues that would taint the results. The first problem was that the doctors' notes were poor and second problem was the lack of ability to prove medical necessity.

As a result of this report, major medical carriers and Medicare are looking long and hard at the number of visits allowed per case. In numerous places, carriers have set caps at 18-24 visits. In addition, most insurance companies have stated to use 18 as a threshold to set off computerized tracking of a doctor's claims and then audits later if the pattern continues.

Some chiropractors feel the amount of evidence against us is insurmountable. But we have a few issues we need to face before we take our first step.

*** We need to be able to document what we do to satisfy the requirements of those who indemnify the people we treat.

*** We need show a neurological connection to the subluxation so we have the proof we have talked about over the years and then tie that connection to functional improvement.

*** We MUST become compliant with all of the rules related to Medicare and CMS.

This is our road map to success! Think about these issues real hard. When the OIG produced the 2005 report, did they ever take into consideration any of these three points? The answer is, yes! That was their mission and the report laid us out as a profession.

On the other hand, do you think any of these points were ever thought about by the California chiropractors whose notes were reviewed? Not only was the answer "NO" at the time, it is still "NO" today -- three years later. And, because it is still not an issue in the profession we will continue to deal with the hole we have dug for ourselves.

So, my question to you is: What would the results of the 2005 OIG report on Chiropractic in the Medicare Program have been if all three of the above points were taken seriously by those same doctors? Do you think the results would be different?

Of course!

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