AMI GROUP, L.P.

Value-Based Modeling: Secrets from a Medical Director? Are you ready?

Presented by
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CHIRO CONSULTING
Unlock your Growth Potential

Value-Based Healthcare
Are you prepared?

Medical Director Insights on How to Reduce Friction and Stress Related to Insurance!

A glimpse behind the curtain of the insurance industry! What are they looking for in billing?

- **The tale of two DCs!**
  (One lost….one thriving.)
- **Lessons from a referring PCP.**

Farabaugh Chiropractic Office

Quality Chiropractic Services Since 1982

About Dr. Farabaugh

- Past President-**Central Ohio Chiropractic Association**
- Past President-**Ohio State Chiropractic Association** (OSCA) 1996-1997
- Past President: **Ohio State Chiropractic Board** 2012-2013
- Appointed by **Governor's Voinovich and Strickland** for various committees and positions.
- Founder: **ChiroLtd and Chiropractic Bootcamp** seminars
- Past Chairman-The **Clinical Compass** (formerly the Council on Chiropractic Guidelines and Practice Parameters (CCGPP)
- **Published** ~ 15 papers (Clinical Practice Guidelines-CPGs) and a book chapter, etc.
- 2024 Appointed to The **Scientific Commission**/The Clinical Compass.
- **ODG Advisory Board**
- 2023 to Present: Chairman of **ACA Research Committee**
- Testimony/Expert opinion in over **100 malpractice cases**
- Fellow in **International College of Chiropractors**
- Elected: **CCE Councilor**-Cat. 2-Clinicians
- **AMI-National Physical Medicine Director**

Recommended Care Management Values to Reduce Stress and Friction

1. “If I can help you, I will tell you. If I cannot help you, I will tell you that as well and make a referral!”

2. “Give the patient what they need, and only what they need, nothing more, nothing less, always!”

TIP:
Just because you believe care is medically necessary, does not mean that it is within plan design and billable. Read the policy!!

What exactly IS Value-Based Modeling?

Definition:

Healthcare reimbursement model that rewards clinically effective and financially efficient patient care.

Question:

What are the rewards?

What will happen to “fee-for-service”?

The Problem:
Traditional (allopathic) Costs Low Back Pain

- What are the associated costs of a typical case per ODG?
- Source: http://www.odg-twc.com/

L/S Sprain: S33.5

- Typical case

Reserve Calculator Projections (Claim Typical)

Reserve Bucket	Estimated Exposure	Amount Paid to Date	Existing Reserves	Reserve Increase Requirement
Indemnity (-)	$1,493.89			$1,493.89
Medical (-)	$3,451.15			**$3,451.15**
Expense & Administrative (-)	$461.66			$461.66
Total	$5,406.70	$0.00	$0.00	**$5,406.70**

L/S Sprain: S33.5

- Typical case
  - With confounding factors of:
    - Pain > 30 days, obesity, opioids, depression

Reserve Calculator Projections (Claim Typical)

Reserve Bucket	Estimated Exposure	Amount Paid to Date	Existing Reserves	Reserve Increase Requirement
Indemnity (-)	$4,821.20			$4,821.20
Medical (-)	$10,917.59			**$10,917.59**
Expense & Administrative (-)	$1,183.31			$1,183.31
Total	$16,922.10	$0.00	$0.00	**$16,922.10**

Intervertebral disc displacement, lumbosacral region: M51.27

- Typical Case

Best Practice* (+)	Claim Typical (+)	Claim Max (+)	
Indemnity (-)	$3,531.02	$4,685.40	$6,111.39
Medical (-)	$19,630.73	$25,405.33	**$36,501.91**
Expense & Administrative (-)	$2,430.02	$2,004.13	$2,659.38
Total Cost	$25,591.77	$32,094.86	**$45,272.68**

Intervertebral disc displacement, lumbosacral region: M51.27

- With confounding factors of:
  - Pain > 30 days, obesity, opioids, depression

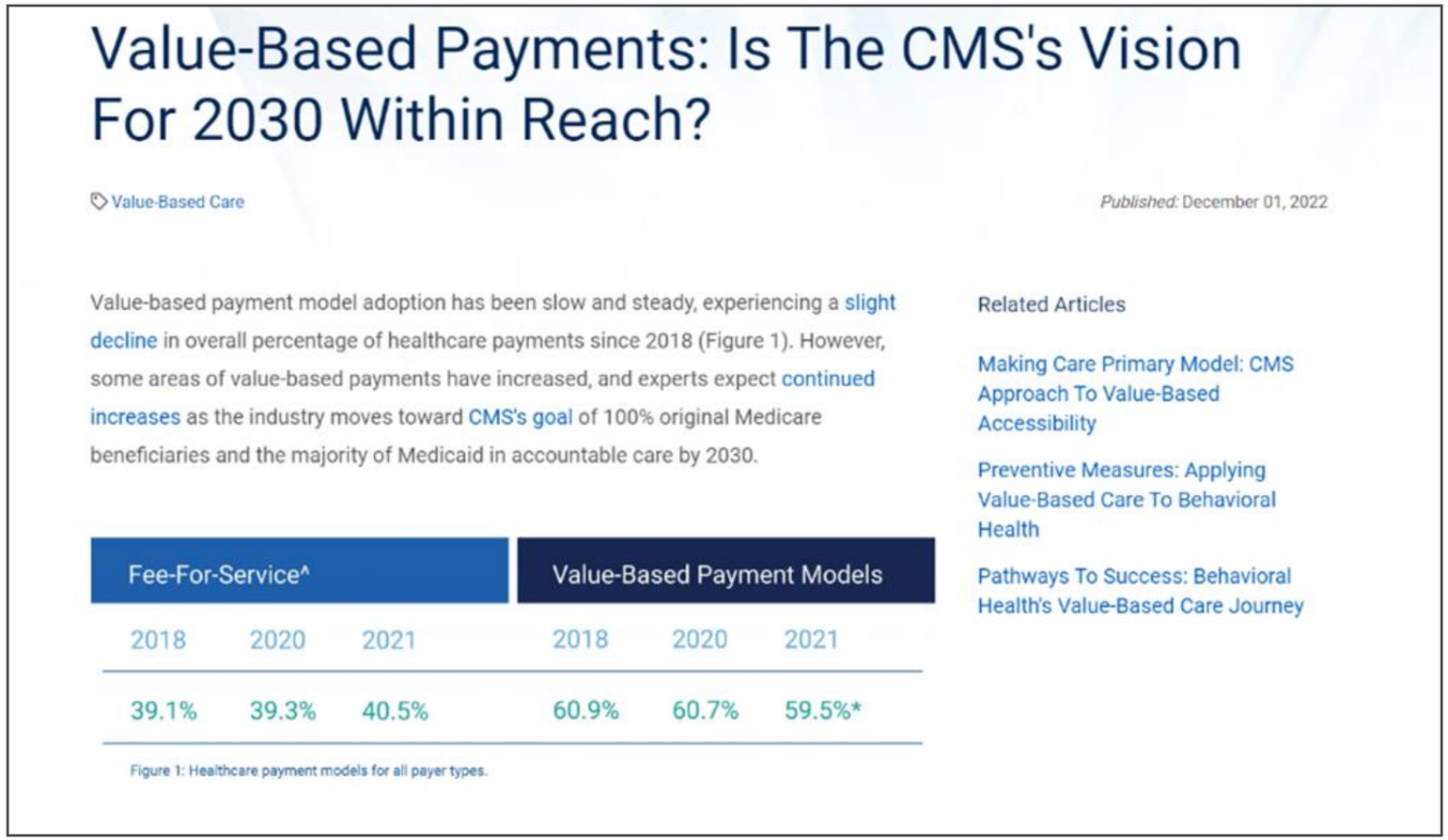
	Best Practice* (+)	**Claim Typical (+)**	**Claim Max (+)**
Indemnity (-)	$3,531.02	$16,840.26	$28,519.80
Medical (-)	$19,630.73	$80,368.78	**$196,548.73**
Expense & Administrative (-)	$2,430.02	$5,199.55	$10,289.45
Total Cost	$25,591.77	$102,408.59	**$235,357.98**

Post Laminectomy Syndrome: M96.1

- With confounding factors of:
  - Pain > 30 days, obesity, opioids, depression

Best Practice* (+)	Claim Typical (+)	Claim Max (+)	
Indemnity (-)	$1,493.89	$8,488.04	$20,575.00
Medical (-)	$34,505.05	$158,298.36	**$366,595.39**
Expense & Administrative (-)	$3,477.88	$8,064.49	$15,992.81
Total Cost	$39,476.82	$174,850.89	**$403,163.20**

Value-Based Payments are Coming soon! Are you ready!



Value-Based Payments: Is The CMS's Vision For 2030 Within Reach?

Value-Based Care

Published: December 01, 2022

Value-based payment model adoption has been slow and steady, experiencing a slight decline in overall percentage of healthcare payments since 2018 (Figure 1). However, some areas of value-based payments have increased, and experts expect continued increases as the industry moves toward CMS's goal of 100% original Medicare beneficiaries and the majority of Medicaid in accountable care by 2030.

Related Articles

Making Care Primary Model: CMS Approach To Value-Based Accessibility

Preventive Measures: Applying Value-Based Care To Behavioral Health

Pathways To Success: Behavioral Health's Value-Based Care Journey

Fee-For-Service^			Value-Based Payment Models		
2018	2020	2021	2018	2020	2021
39.1%	39.3%	40.5%	60.9%	60.7%	59.5%*

Figure 1: Healthcare payment models for all payer types.

https://www.cms.gov/priorities/innovation/about/strategic-direction

Where We Are Now: Adoption of Value-Based Payment

The wide variety of current payment models may be categorized along a continuum, from legacy fee-for- service to global capitated payment. The Health Care Payment Learning & Action Network (HCP-LAN) defines four broad categories of payment (adapted in Table 1).[2] Efforts to promote value-based payment focus on moving as many providers and as much revenue as possible to the third and fourth categories.

Penn LDI
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Health Care Access & Coverage | Brief

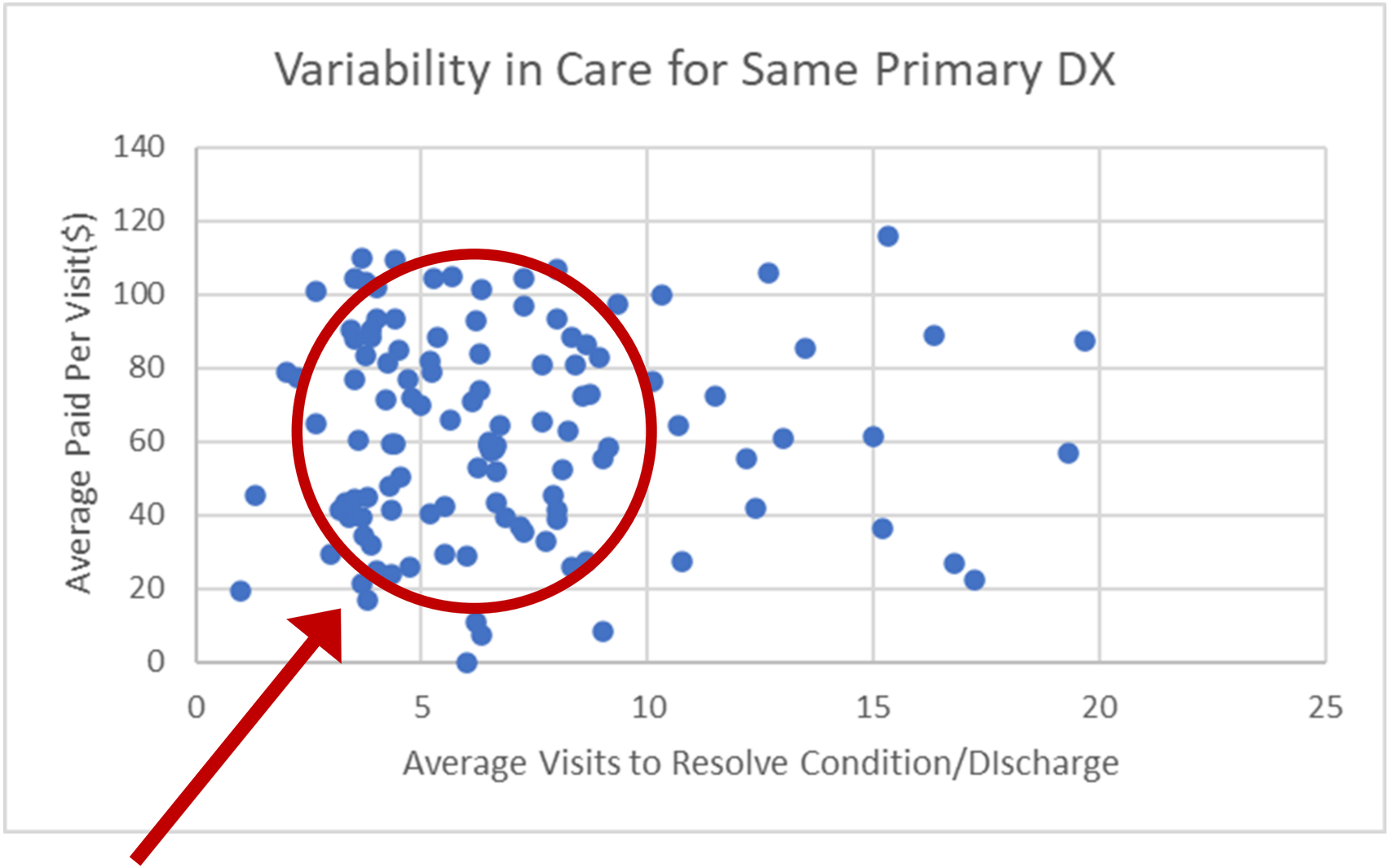
The Future of Value-Based Payment: A Road Map to 2030

White Paper

February 17, 2021

By: Rachel M. Werner, MD, PhD , Ezekiel J. Emanuel, MD, PhD , Hoangmai H. Pham, MD, MPH , and Amol S. Navathe, MD, PhD

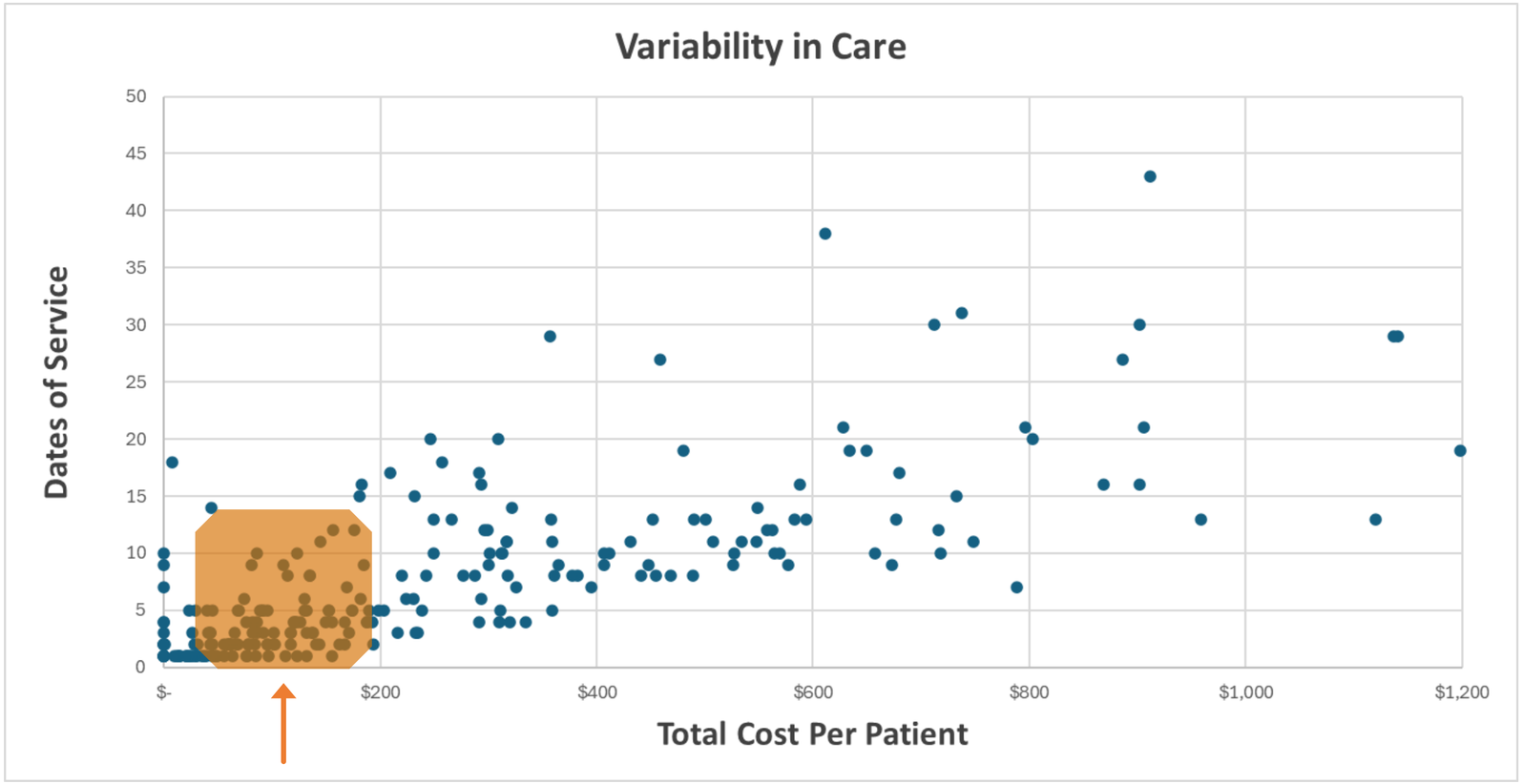
Why do payors struggle with chiropractors?



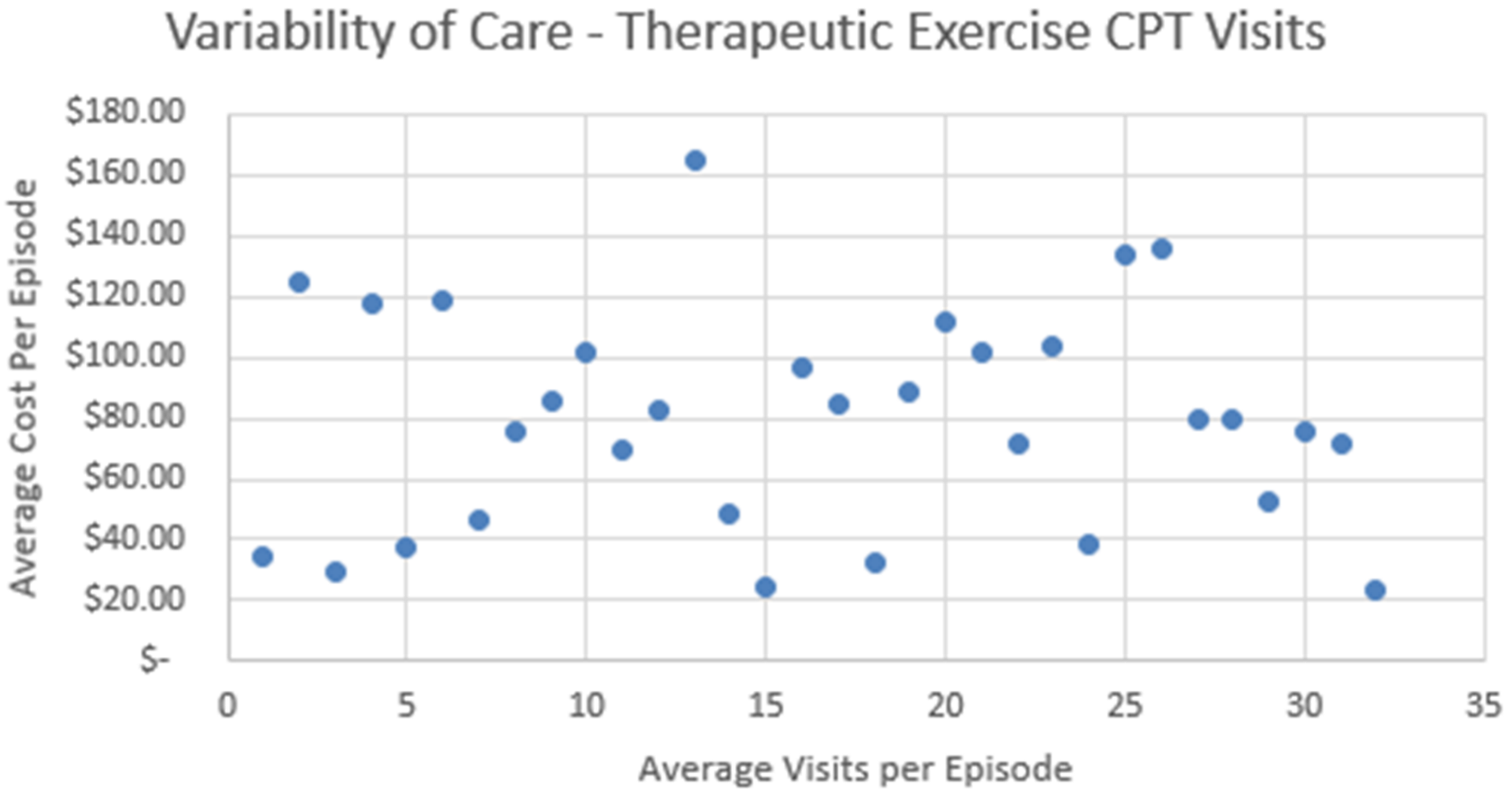
Care outside the expected ranges for a given DX are often targeted for review and evaluated for medical necessity.

Why are payors looking for solutions?

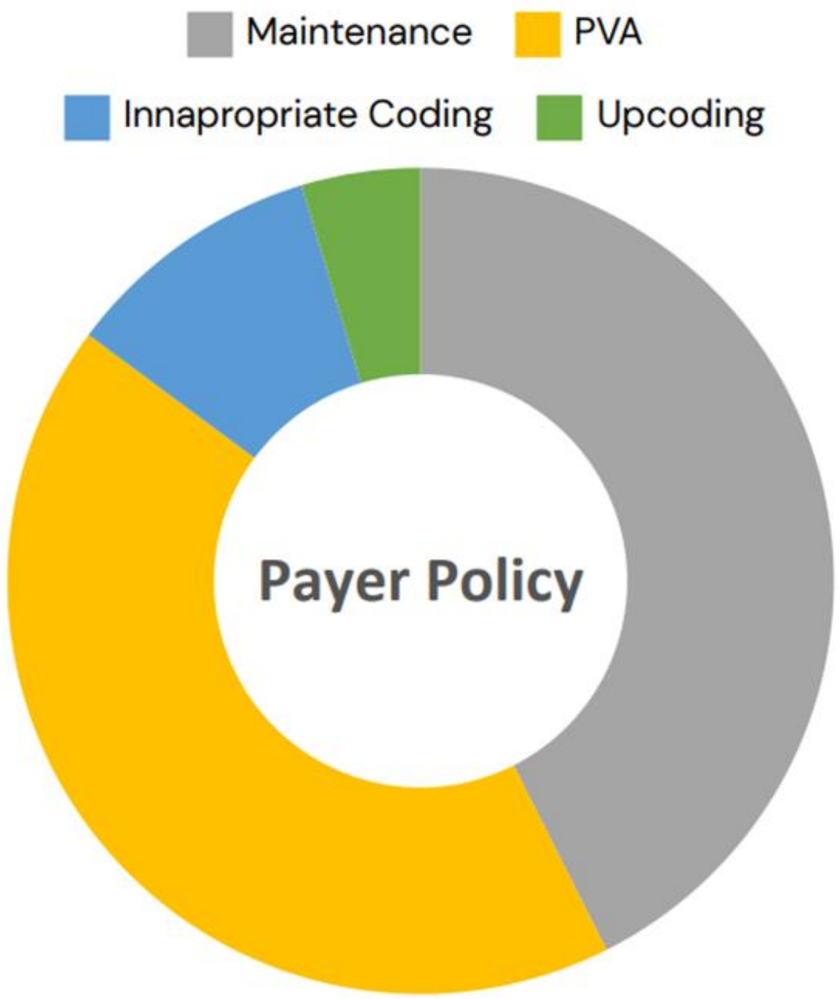
Treatment variability



Expected Variability of Care


Variability of Care - Therapeutic Exercise CPT Visits
Average Cost Per Episode
$180.00
$160.00
$140.00
$120.00
$100.00
$80.00
$60.00
$40.00
$20.00
$-
0
5
10
15
20
25
30
35
Average Visits per Episode

Typical Chiropractic Network Spend



Solution:

DC Self-audit: Are you aware of the policy, and are you treating within the policy?

The job of Medical Directors....

1. Inform,
2. Monitor, and
3. Educate!

Top Six concerns:

- Maintenance care
- Upcoding of spine CMT codes (98940-98942)
- Use of extremity codes (98943)
- Manual Therapy (97140)
- Patterns of practice vs. medical necessity: The ongoing use of passive and active therapy codes.
- Diagnosis Accuracy

Issues of Concern by Third Party Payors

Maintenance Care

TIP:
Few if any payors provide a billable benefit related to manual therapy beyond the acute phase of recovery.

#1 Question: Can we treat beyond the pain relief phase of care?

“Chiropractic” vs Insurance

Historically many DCs treat following a practice management or technique protocol which includes everything from pain relief to biomechanical “correction” and postural restoration.

Without judging the merits of the philosophical or technique arguments, the real question is:

“Which stage(s) of care are within the plan design of the payor?”

Why is the transition necessary?

Medicare Guidelines, Section 2251.3:

"A treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition is deemed **not medically necessary**"...

Demystifying Reimbursement models

"Car Insurance": What does it pay for?

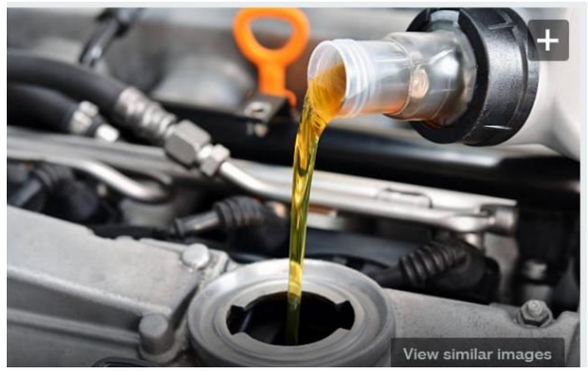
Accident repair

YES

Restoration

NO

Maintenance



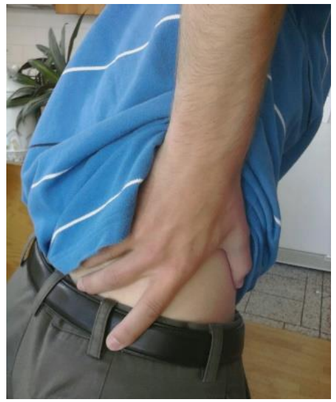
NO

Demystifying Reimbursement models

"Health Insurance"

Acute Pain

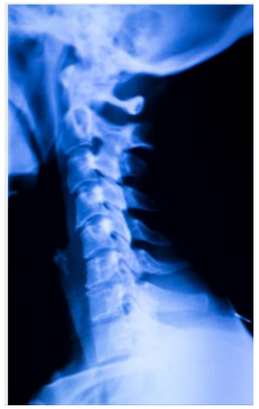
Condition-based



YES

Remodeling

- **Loss of curve**
- **No pain**
- **Routine x-rays**



NO!

Wellness/Chronic

<u>Weekly-Monthly care:</u>

- **Wellness**
- **Ongoing chronic pain management.**

NO!

Bottom line….

- Insurance only pays for the **acute** condition, with a beginning and an end-point.
- They do not pay for **spinal remodeling** of an otherwise asymptomatic spine, and
- They do not pay for ongoing chronic pain management or maintenance care/wellness care.

NO DIFFERENT THAN CAR INSURANCE!

Conflicting information vs. Conflicting understanding?

“But the Customer Service Rep (CSR) said xxxxxxxx!”

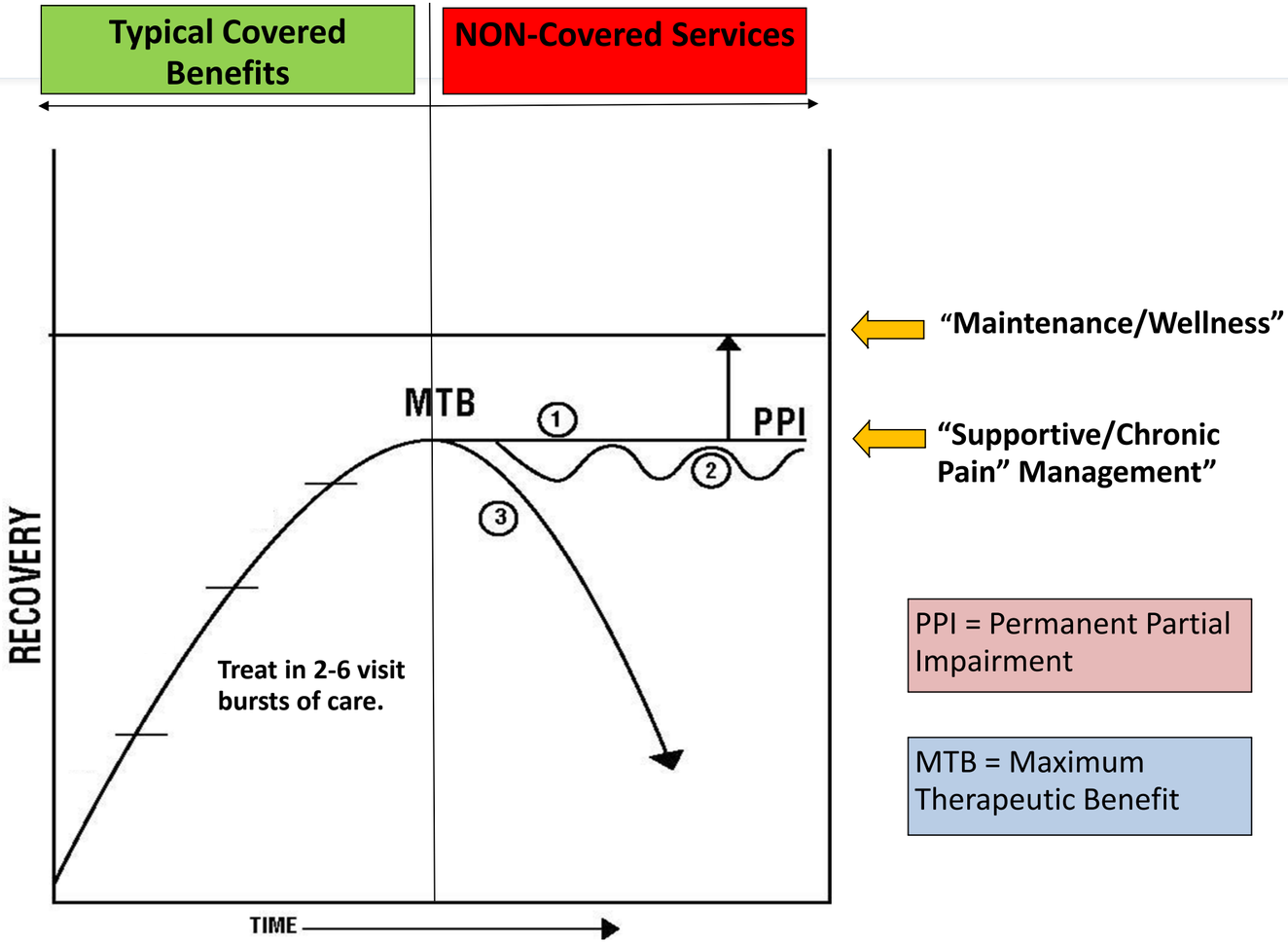
- It is helpful to remind the patient that to bill a service it must meet two criteria:

1. **Medically necessary**
2. **Within plan design**

- There are many services DCs provide that may be medically necessary and beneficial to the patient, but not within plan design.

TIP: It is important to remind yourself, and your patient, that guidelines are just that, guidelines. Additionally, the number of visits stated in a policy are not entitlements to care, but potential number of visits if care meets the two criteria stated above.

Understanding typical chiropractic care management, and how it differs from care which is either not medically necessary, or outside plan design.



"Maintenance/Wellness"

"Supportive/Chronic Pain" Management"

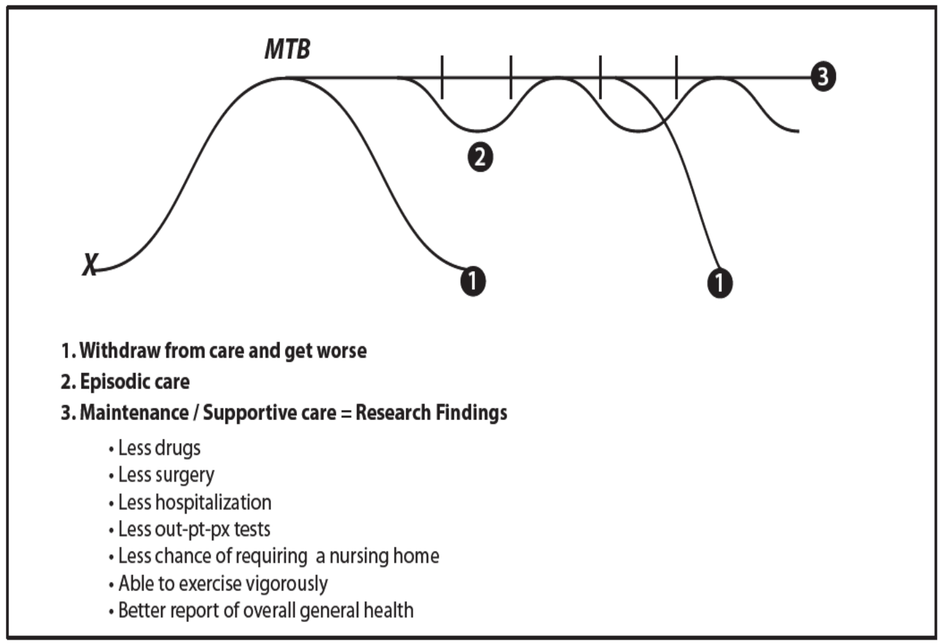
PPI = Permanent Partial Impairment

MTB = Maximum Therapeutic Benefit

Who explains to the patient what happens at the plateau in recovery? The DC or CA?

❑ ***Concept 5:***_____

At a certain point you're either 100% well, or as good as it's going to get. Then what?



1. Withdraw from care and get worse

2. Episodic care

3. Maintenance / Supportive care = Research Findings

- Less drugs
- Less surgery
- Less hospitalization
- Less out-pt-px tests
- Less chance of requiring a nursing home
- Able to exercise vigorously
- Better report of overall general health

If patients simply understood:

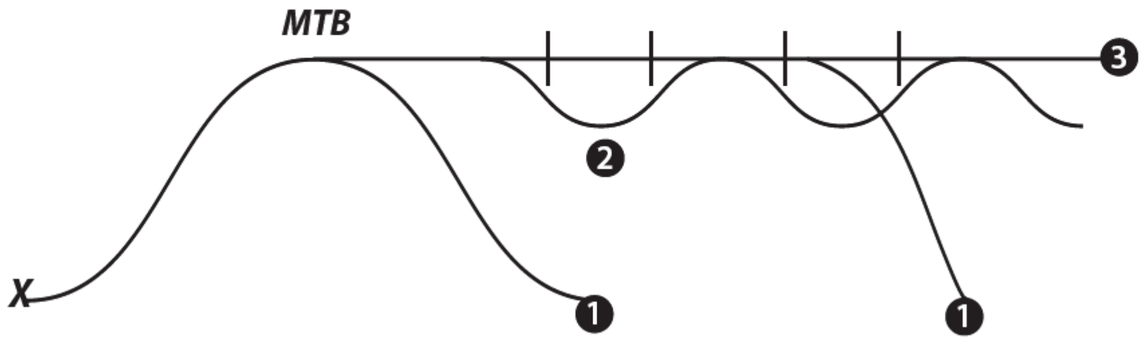
1. The benefits of joint mobility
2. The negative effects of joint tightness
3. The research, and
4. The cost issues.

Many would enthusiastically opt for "Wellness" [formerly maintenance] or "Chronic/recurrent and/or episodic" care [formerly supportive]. But be realistic and consider your own practice stats…most prefer pain relief!

Who explains to the patient what happens at the plateau in recovery? The DC or CA?

❑ ***Concept 5:*** _____

At a certain point you're either 100% well, or as good as it's going to get. Then what?



1. **Withdraw from care and get worse**
2. **Episodic care**
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   - Less drugs
   - Less surgery
   - Less hospitalization
   - Less out-pt-px tests
   - Less chance of requiring a nursing home
   - Able to exercise vigorously
   - Better report of overall general health

Practice Principles

1. **Give patients what they need, and only what they need, nothing more, nothing less, ALWAYS!**

2. ***“If I can help, I’ll tell you. And if I cannot help you, I’ll tell you that as well and make the proper referral!”***

Issues of Concern by Third Party Payors

CMT Coding/upcoding

The Problem:

The use of subluxation and/or segmental dysfunction codes in an attempt to justify upcoding to 98941 or 98942.

Question:

Is it proper to submit asymptomatic subluxations codes to justify treating AND billing for additional regions of the spine?

NO!

TIP:
You cannot use just subluxation codes to justify billing another region of the spine.

Five Regions of the Spine

1. Cervical region (includes atlanto-occipital joint)
2. Thoracic region (includes costovertebral and costotransverse joints)
3. Lumbar region
4. Sacral region
5. Pelvic region (includes the sacro-iliac joint)

5 Extraspinal Regions

1. Head (including TMJ, excluding atlanto-occipital)
2. Lower Extremities
3. Upper Extremities
4. Rib cage (excluding costotransverse and costovertebral joints)
5. Abdomen

- **Medicare Documentation Job and Aid For Doctors of Chiropractic**
  - *Topic: Chiropractic Manipulative Therapy (CMT).*
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/JobAidChiropracticServices-FactSheet-MLN1232664.pdf

Medicare Documentation Job and Aid For Doctors of Chiropractic

Subluxation

☐ Subluxation demonstrated by X-ray, date of X-ray: _____

- A CT scan and/or MRI is acceptable evidence if subluxation of spine is demonstrated
- Documentation of chiropractor's review of the X-ray/MRI/CT, noting level of subluxation
- The X-ray must have been taken reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), an older X-ray may be accepted if the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.

or

☐ Subluxation demonstrated by physical examination (Pain, Asymmetry/misalignment, Range of motion abnormality, Tissue tone changes [P.A.R.T.]; at least 2 elements, 1 of which must be A. or R.)

- ☐ Include dated documentation of initial evaluation
- ☐ Primary diagnosis of subluxation (including level of subluxation)

☐ Documentation of presence or absence of subluxation must be included for every visit

☐ Any documentation supporting medical necessity

Medicare Documentation Job and Aid For Doctors of Chiropractic

Initial Evaluation

- ☐ History
  - ☐ Date of initial treatment
  - ☐ Description of present illness
  - ☐ Symptoms bearing a direct relationship to level of subluxation causing patient to seek treatment
  - ☐ Family history (if relevant) (recommended)
  - ☐ Past health history (recommended)
  - ☐ Mechanism of trauma (recommended)

Make it easy on yourself and report symptoms in the DX, otherwise records will need to be obtained to verify DX vs. CMT.

Typical Policy

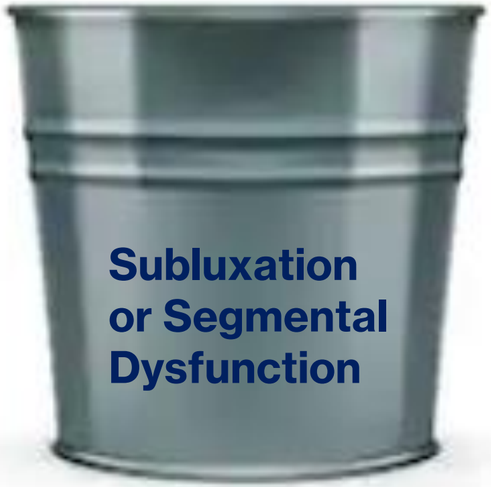
Indications for chiropractic services include all of the following:

1. Services are directed at neuro-musculoskeletal symptoms involving the spine, para-spinal soft tissues, and extremities.
2. Services provided are of the complexity and nature to require performance by a licensed chiropractor or provided under their direct supervision according to state licensure laws.
3. Subluxations of the spine must be evidenced with corresponding musculoskeletal symptoms.
4. Services are scheduled, modified, and discontinued appropriately based on the patient's response to treatment and are provided in accordance with an ongoing, written treatment plan and are appropriate for the diagnosis reported including documentation outlining quantifiable, attainable treatment goals.
5. Manipulation or Chiropractic Manipulation Therapy (CMT) is appropriate to reduce symptoms and/or to restore function that has been compromised by illness or injury.
6. Each region treated must be correlated with the patient's complaints and health assessment, as well as the member history, a clinical examination, and diagnosis.

4. **Not Medically Necessary and Not Covered:**
   Additional visits in the following circumstances are considered not medically necessary and not covered:
   - When there is no meaningful improvement within 30 calendar days of treatment despite treatment modification,
   - If therapeutic benefit has reached a plateau,
   - If the patient's condition becomes worse or regresses,
   - If the therapeutic goals have been reached,
   - If the patient has become asymptomatic,
   - If the patient or parent/caregiver can independently practice or self-administer the activities or services safely and effectively
   - If the services or activities are for the general good or welfare of the patient, such as exercise to promote overall fitness, flexibility, endurance, aerobic conditioning, maintenance of range of motion or strength, and weight reduction.

Three Buckets of Diagnoses

M99.01 Cervical Seg Dys
M99.23 Subluxation



M50.320 Cervical DDD
Q72.811 Congenital Shortening of right lower limb
M41.86 Scoliosis-Lumbar
M40.12 Kyphosis-Cervical

M54.5 Low Back Pain
M53.1 Cervicobrachial Syndrome

1. Pain-related
2. Injury. Ex. Strain, Sprain
3. Radicular: Ex. Radiculopathy, Cervical radiculitis, Sciatica, etc.

Which level of CMT can you bill given the following diagnoses?

NO	M99.01 Seg Dysfunction-Cervical
YES	M54.2 Cervicalgia
YES	G44.211 Episodic Headache
NO	M99.02 Seg Dysfunction-Thoracic
NO	M99.03 Seg Dysfunction-Lumbar
NO	M99.04 Seg Dysfunction-Sacral
NO	M99.06 Seg Dysfunction of hip
YES	M54.6 Pain in Thoracic spine

How many regions of the spine does this diagnostic grouping represent?

What level of CMT is appropriate given this set of diagnosis?

Answer: 98940

Which diagnostic codes reflect the pain reported by the patient?

YES	S33.6xxA SI sprain
NO	M99.02 Seg Dysfunction-Thoracic
NO	M99.03 Seg Dysfunction-Lumbar
NO	M99.04 Seg Dysfunction-Sacral
YES	M54.6 Pain in Thoracic spine

1. **How many regions of the spine does this diagnostic grouping represent?**

2. **What level of CMT is appropriate given this set of diagnosis?**

Answer: 98940

TIP: Remember that the "pelvic region" of the spine includes the SI joint. Therefore, an SI sprain or strain is still designated as ONE region of the spine, not two.

Extremity manipulation: 98943

Which style of case management is billable?

Condition/injury-based

- Patient complaint, pain, injury-related dysfunction, examination, diagnosis, treatment plan.

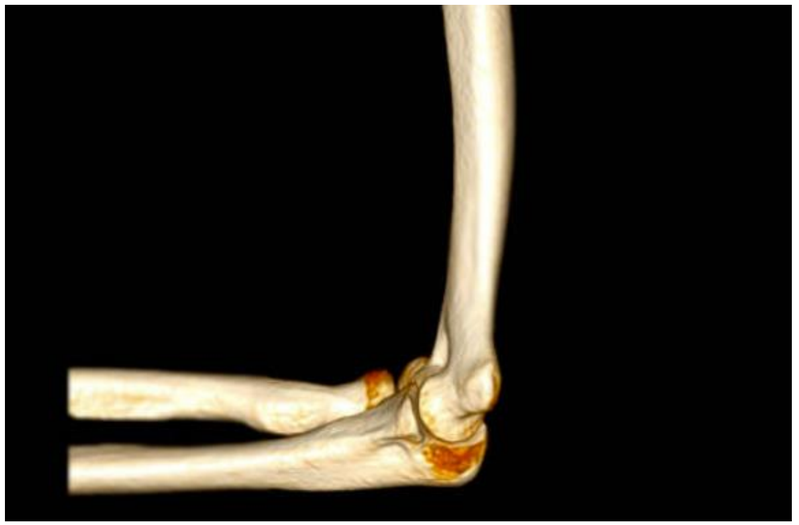
Philosophical or movement based.

- Creating neurological joint noise.
- May be beneficial to the patient, but just not billable.

98943-Extraspinal Manipulation

Expected care management items to justify billing 98943:

1. **Mechanism of injury**
2. **Patient complaint/injury/symptoms**
3. **Examination findings**
4. **Diagnosis**
5. **Treatment plan**
6. **Goals**
7. **Measureable outcomes**
8. **Discharge**



TIP:

- It is not appropriate to bill 98943 (or any other CPT code) on every patient at every visit.
    - Once MMI is reached, the treatment is no longer within plan design.

Issues of Concern by Third Party Payors

97140-Manual Therapy

TIP:
Avoid the “pattern of practice”, first visit to last of 97140, and active and passive therapies.

What is Manual Therapy (97140)?

97140

"Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes."

Why? "Performed in order to increase **functional performance**, increase **ROM**, decrease **inflammation**, and reduce **muscle spasm**."

Source: American Medical Association CPT 2021 Professional Addition

97140

- Remember: one cannot bill manual therapy on the same day, to the same anatomical region, as CMT.
- -59 signifies a separate anatomic region compared to CMT.

Review of Manipulation vs Manual Therapy

- Remember that manipulation codes (9894X) and the manual therapy code (97140) cannot be billed to the same region on the same date of service. Remember, the 97140 code –includes- manipulation.

Clinical Vignette:

- Patient presents with a lumbar strain and is treated with a lumbar manipulation.
- Patient is also treated with 10 minutes of trigger point therapy to the lumbar paraspinal musculature.

- ***In this case, either 98940 –or- 97140 can be utilized as they were performed on the same region. Not both!***

Manual Therapy (97140): Proper documentation and establishing medical necessity.

- **What should be documented to support the use of this code?**
  - **Four key elements** to document:
    1. What?
    2. Where?
    3. **Why?**
    4. How long?

Why? "Performed in order to increase **functional performance**, increase **ROM**, decrease **inflammation**, and reduce **muscle spasm**."

Question: Given the "Why" what needs documented to justify 97140?

TIP: Generic statements are not sufficient!

97124 vs 97140

- **97140: manual therapy to a specific muscle group**
- **97124: massage therapy**

These codes are NOT interchangeable.

TIP: must be done by a “qualified healthcare provider”.

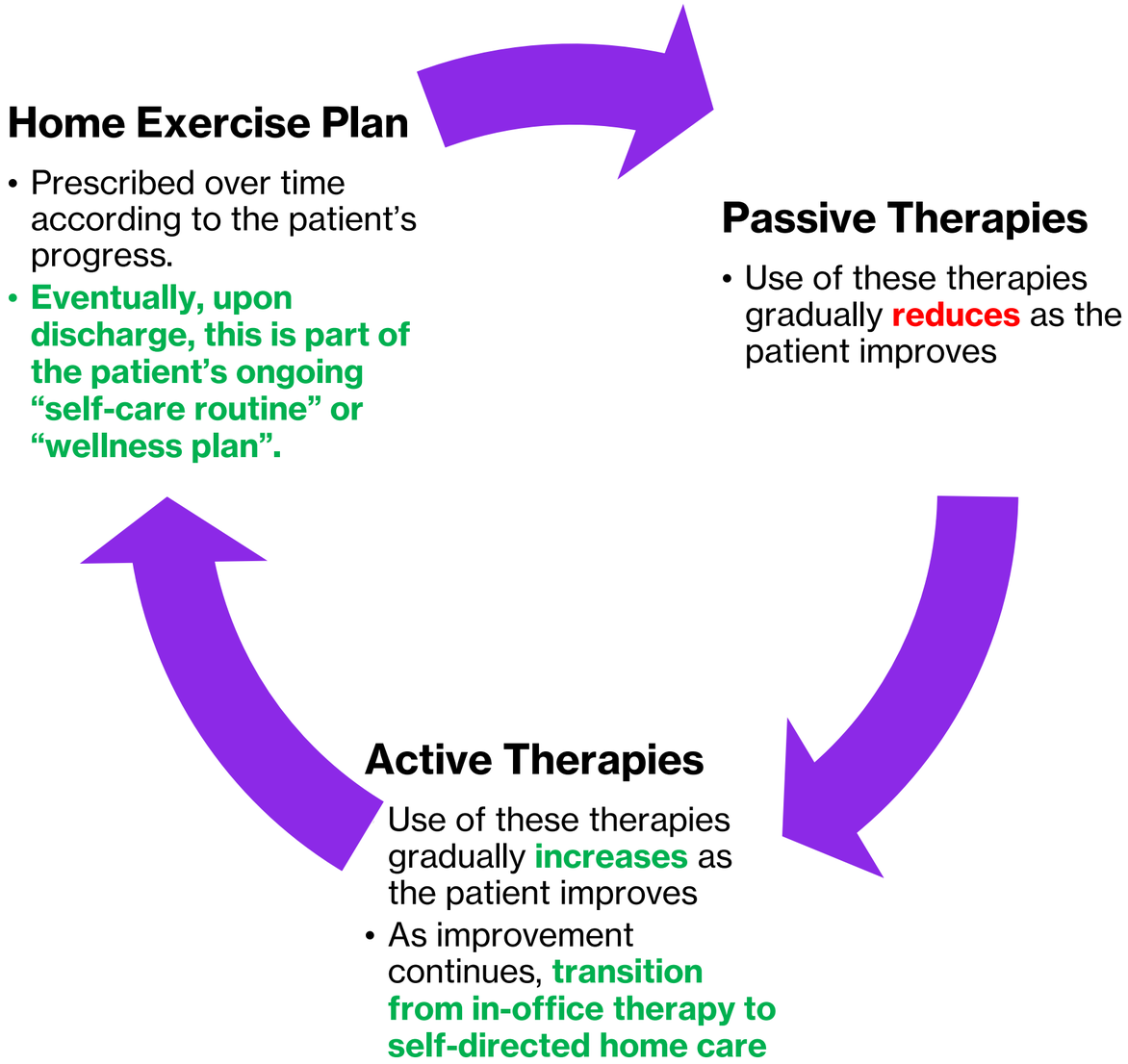
Issues of Concern by Third Party Payors

Pattern of practice vs. medical necessity:

The ongoing use of passive and active therapy codes.

TIP:
If you use any therapy first visit to last as a pattern of practice, on every patient, the odds of audit escalate dramatically.

General Expectations



Review of Specific Active and Passive Codes

97112 vs 97110 vs 97530

- What are the indications for each of these codes?
- What was provided for each code, and why?

97110-Therapeutic exercises

To develop strength, endurance, ROM, and flexibility

TIP:
Can you document how the services associated with this code are different than those associated with 97110?

97112-Neuromuscular Re-education

Movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.

TIP:
Can you document how the services associated with this code are different than those associated with 97110?

97530 – Kinetic Activity

CPT code 97530 is Therapeutic Activity, the use of a skilled activity in therapy to improve a patient's overall health or functional capacity. These are **whole-body rehabilitative procedures** that utilize performance skills such as reaching, standing, dynamic postures, bending, lifting, or carrying.

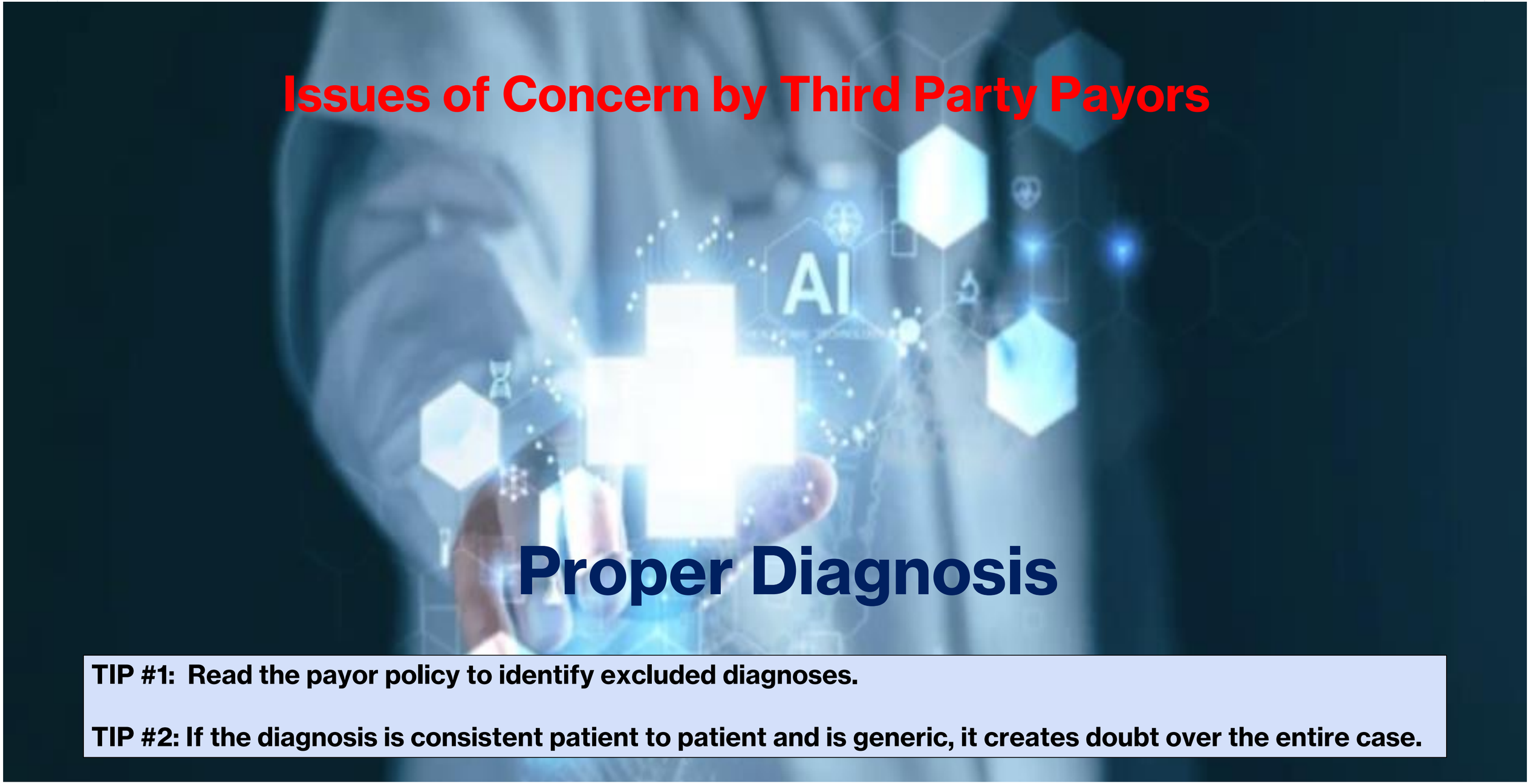
97014 vs 97032

- 97014: Supervised Electric stimulation
- 97032: Constant Attendance Electric stim

Question: When is it medically necessary to provide "Constant Attendance EMS"?

Tip: Just sitting in the room does not qualify for 97032

Issues of Concern by Third Party Payors



Proper Diagnosis

TIP #1: Read the payor policy to identify excluded diagnoses.

TIP #2: If the diagnosis is consistent patient to patient and is generic, it creates doubt over the entire case.

Subluxation codes: M vs S codes

M-Codes correspond to chiropractic or osteopathic biomechanical lesions.

- **M – Segmental Dysfunction (99.00-Head to 99.09-Abdomen)**
- **M – Subluxation Codes (99.10-Head to 99.19 Abdomen)**

S-Codes represent neurosurgical emergencies, trauma, spinal cord injury.

These codes are not synonymous or interchangeable.

LOW BACK PAIN

Question: **Is a diagnosis of simply “Low back pain” appropriate?**

As DCs, we need to get better at asking, “LBP....caused by what?”

If we do not know the cause, how can we determine the cure?

TIP:
Is the source of the pain:

1. **soft tissue,**
2. **joint,**
3. **disc or**
4. **nerve/radicular**?

Keep the diagnosis consistent with your examination findings.

M54.5-deleted

As of 10/1/2021 the code **M54.5 LUMBAGO/LOW BACK PAIN** is no longer a BILLABLE CODE and has been replaced with the following THREE CODE OPTIONS:

M54.50 Low back pain, unspecified
M54.51 Vertebrogenic low back pain
M54.59 Other low back pain

- Is **LBP** by itself ever a valid diagnosis? Or is it merely the symptom reported by the patient?
- What does "LBP, unspecified", or "Other LBP" mean, and when is it appropriate?
- **While "Other LBP" is certainly an option, why wouldn't a DC want to aspire to a more specific diagnosis. Ex. SI joint strain?**

Question during the consultation:
"Can you stand up and point to exactly where you have your pain?"

Vertebrogenic LBP

Normally associated with CLBP!

Pain Medicine, 23(S2), 2022, S63–S71
https://doi.org/10.1093/pm/pnac081
Editorial

OXFORD

Vertebrogenic Pain: A Paradigm Shift in Diagnosis and Treatment of Axial Low Back Pain

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Funding sources: None.

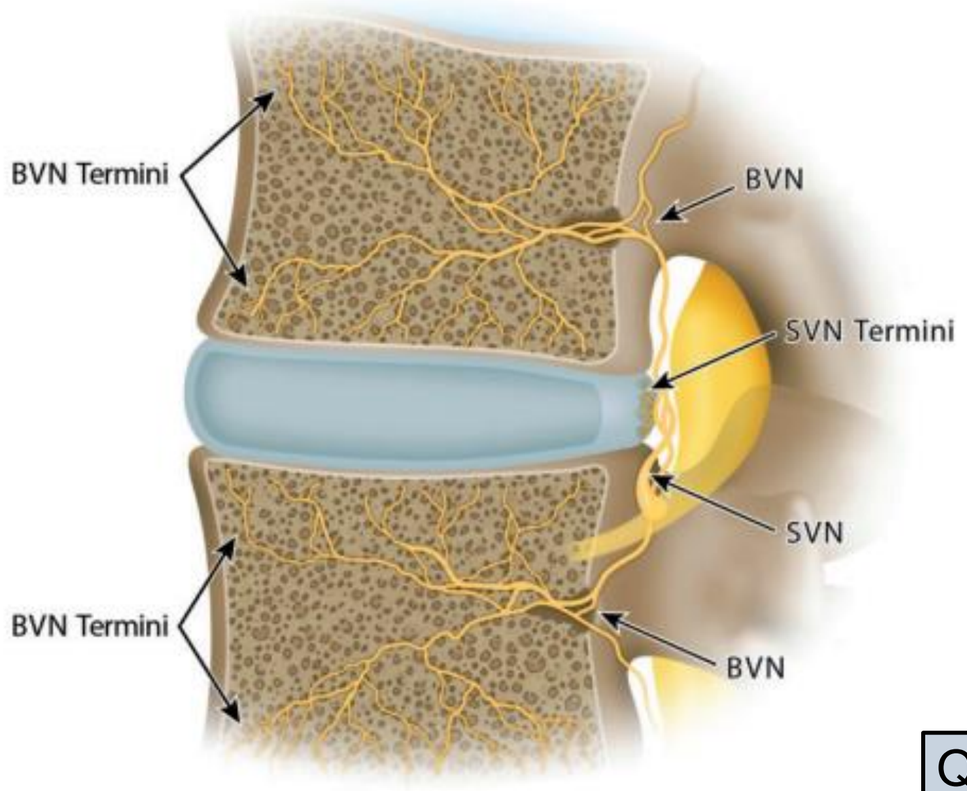
Disclosure and conflicts of interest: Dr. McCormick has received research funding from Relievant Medsystems Inc., paid directly to the University of Utah; Dr. Conger has received research funding from Relievant Medsystems Inc., paid directly to the University of Utah; Dr. Smuck has received research funding from Relievant Medsystems Inc., paid directly to Stanford University; Dr. Lotz has received research funding from Relievant Medsystems, Inc., paid directly to the University of California at San Francisco, has stock ownership in Relievant Medsystems and is a consultant to Relievant Medsystems Inc.; Dr. Truumees has received research funding from Relievant Medsystems Inc., paid directly to The University of Texas Dell Medical School; Dr. DePalma has received research funding from Relievant Medsystems Inc.

Supplement sponsorship: This article appears as part of the supplement entitled "Vertebrogenic Pain and Basivertebral Nerve Radiofrequency Ablation" sponsored by Relievant Medsystems Inc.

In the late 1990s, a team of researchers led by Dr. Heggeness reported that vertebral bodies were richly vascularized by vertebral capillaries and innervated by nociceptors that traced back to a single source, the ***basivertebral nerve.***

Subsequently, it was demonstrated that the BVN is a ***branch of the sinuvertebral nerve (SVN)*** *that enters the vertebral body through the foramen in its posterior wall, then it arborizes caudal and cephalad to densely innervate the vertebral endplates.*

Vertebrogenic LBP

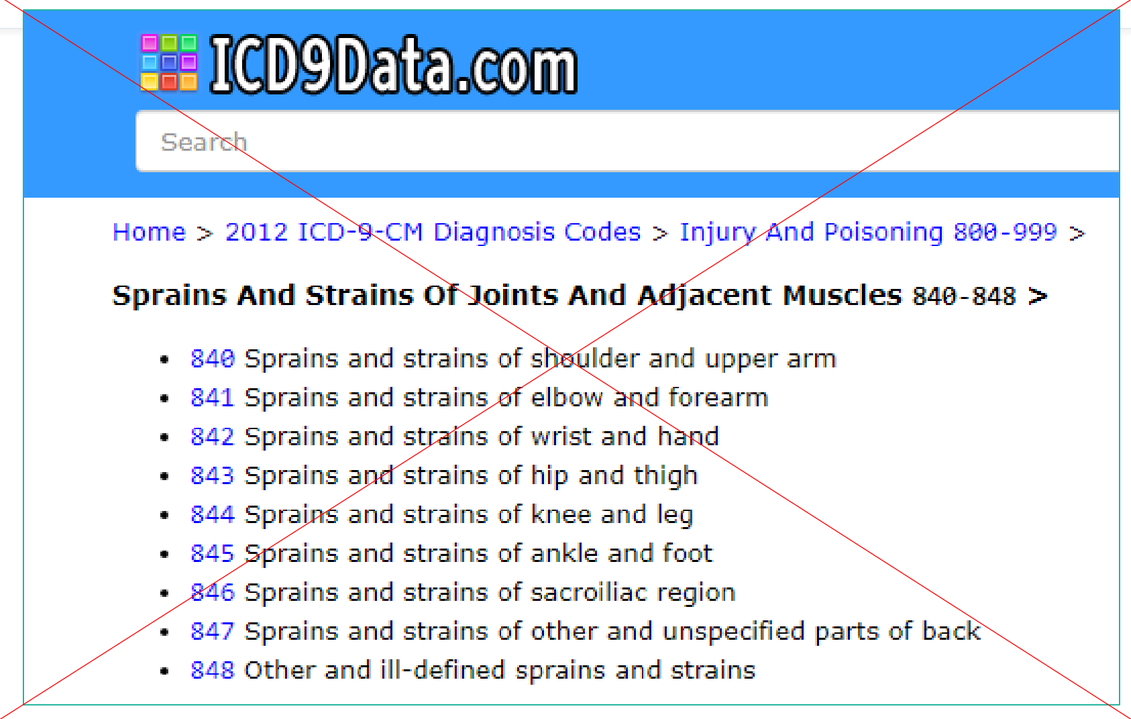


Imaging Characteristics of Vertebrogenic Pain: Endplate Defects and Modic Changes

A correlation between vertebral endplate pathology on MRI and LBP was first suggested in 1988 by ***Modic*** *et al. who found intraosseous* ***MRI changes adjacent to vertebral endplates defects*** *in individuals with chronic LBP. Inflammation and bone marrow changes surrounding endplate defects are visible as Modic changes (MC) on MRI.*

Question: Absent MRI, can you diagnose Vertebrogenic LBP?

Strain vs. Sprain



- These codes were originally combined into one heading.
- Many EHR systems did not properly convert these with the transition to ICD-10.
- There is a difference in prognosis and treatment for these two different injuries.

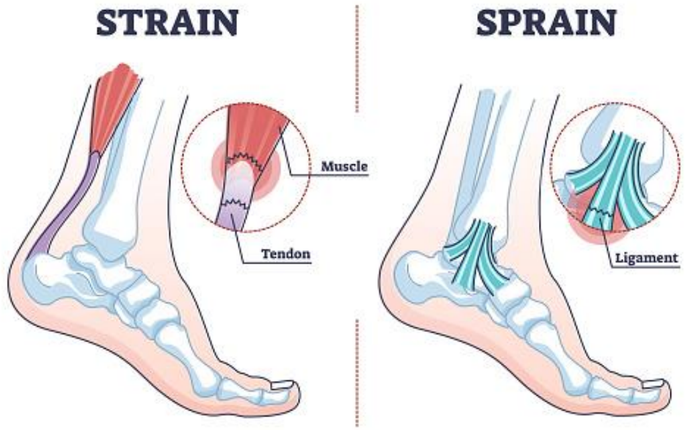
Strain

- “A muscle strain is an injury to a muscle or a tendon- the fibrous tissue that **connects muscles to bones**.”

Mayo Clinic

Sprain

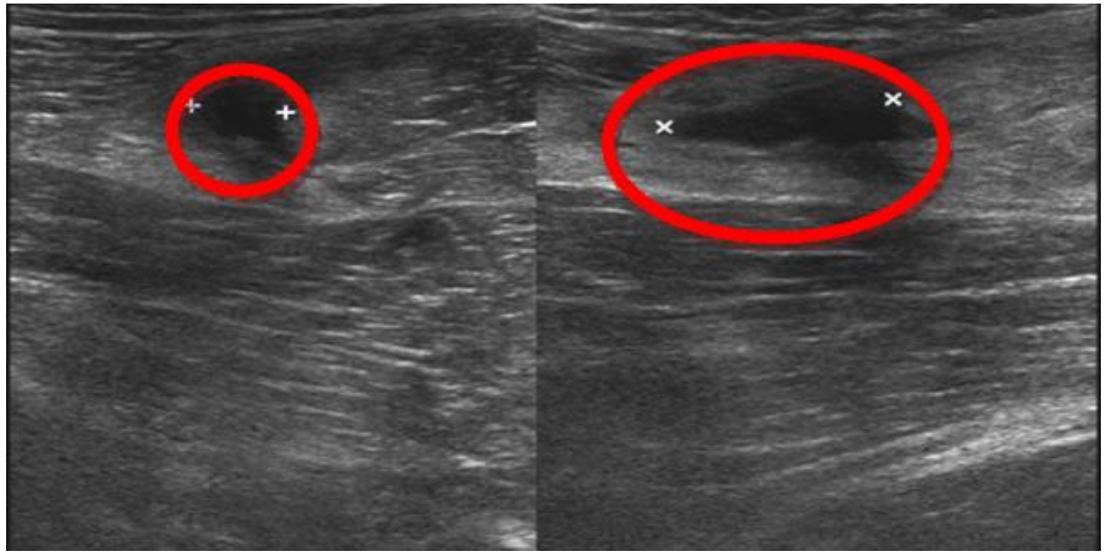
- “A sprain is a stretching or tearing of ligaments- the tough bands of fibrous tissue that **connect two bones together** in s.”



Diagnosing Strains and Sprains

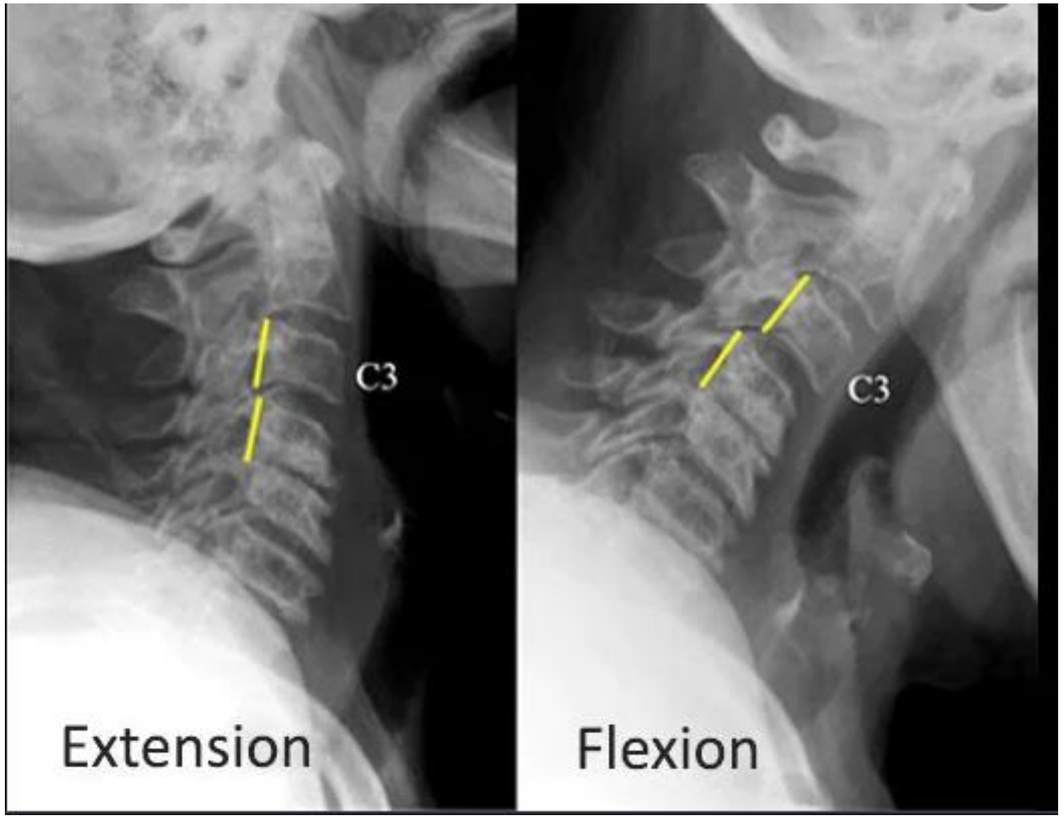
Strain

- History of Trauma
  - Pain is felt within the muscle and/or tendon.
- Motor strength
  - Motor strength may be reduced.
- Orthopedic tests
  - **Stability is maintained.**
- Visual Signs
  - Bruising/swelling/redness within the muscle belly/tendon.
- Imaging
  - May be seen via MRI or diagnostic ultrasound.



intechopen.com

Diagnosing Strains and Sprains

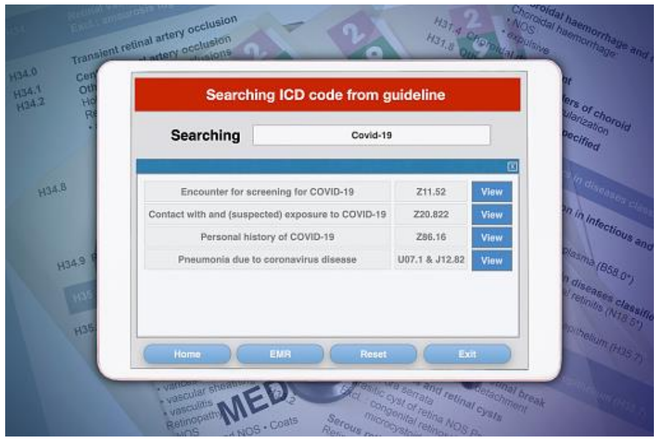


reference.medscape.com

Sprain

- History of Trauma
  - Pain is felt at the joint.
- Motor strength
  - Motor strength is preserved (unless there is also an active strain).
- Orthopedic tests
  - **Instability may be recognized via end-range joint play tests.**
- Visual Signs
  - Bruising/swelling/redness in and around the joint space.
- Imaging
  - May be seen with MRI, diagnostic ultrasound, or flexion/extension x-ray.

Typical Diagnostic Codes used by DCs



Strain

- Cervical Strain
  S16.1XXA
- Thoracic Strain
  S29.012A
- Lumbar Strain
  S39.012A
- Right Shoulder Strain
  S46.011A

Sprain

- Cervical Sprain
  S13.4XXA
- Thoracic Sprain
  S23.3XXA
- Lumbar Sprain
  S33.5XXA
- Right Shoulder Sprain
  S43.401A

Panniculitis

Panniculitis (**inflammation of the subcutaneous fat**) is a relatively uncommon condition that usually presents with inflammatory nodules or plaques. A wide variety of subtypes of panniculitis exist, including panniculitides related to infection, external insults, malignancy, and inflammatory diseases (table 1).Mar 7, 2022

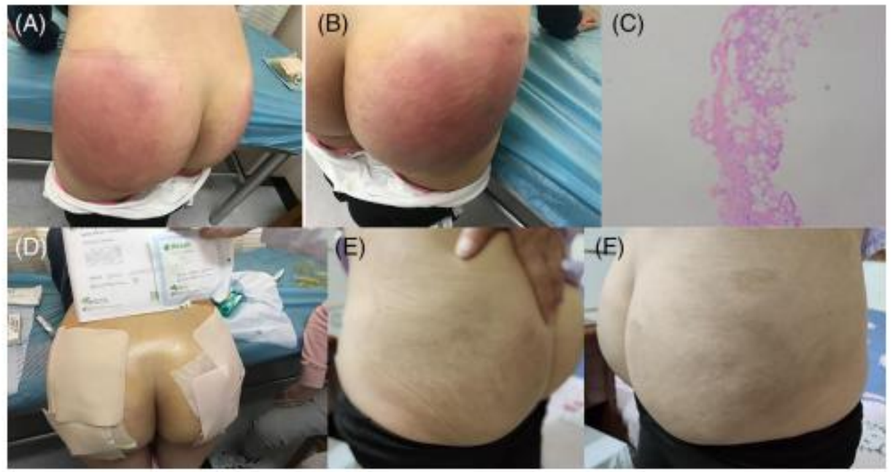


FIGURE 1 A, Pain and swelling of the left hip occurred after progesterone injection. B, The same symptoms appear in the right buttock. C, The occurrence of panniculitis was confirmed by pathology. D, The patient received physical therapy. E, The left hip recovered well. F, The right hip recovered well

Again, **facet syndrome is NOT synonymous** with Panniculitis!

Xiao et al. Panniculitis caused by progesterone injection can be treated by physical therapy. Dermatol Ther. 2021 Jan;34(1):e14501. doi: 10.1111/dth.14501. Epub 2020 Nov 12. PMID: 33141504 PMCID: PMC7900959 DOI: 10.1111/dth.14501

Enthesopathy

Enthesitis Diagnosis

Enthesitis is hard to diagnose. Patient presentation may include edema of affected joints, along with pain elicited on compression testing. Pt may report improved symptoms following exercise. **Diagnostic tools may include bloodwork for inflammatory markers as well as imaging of affected joints.**

Facet syndrome is NOT synonymous with enthesopathy!

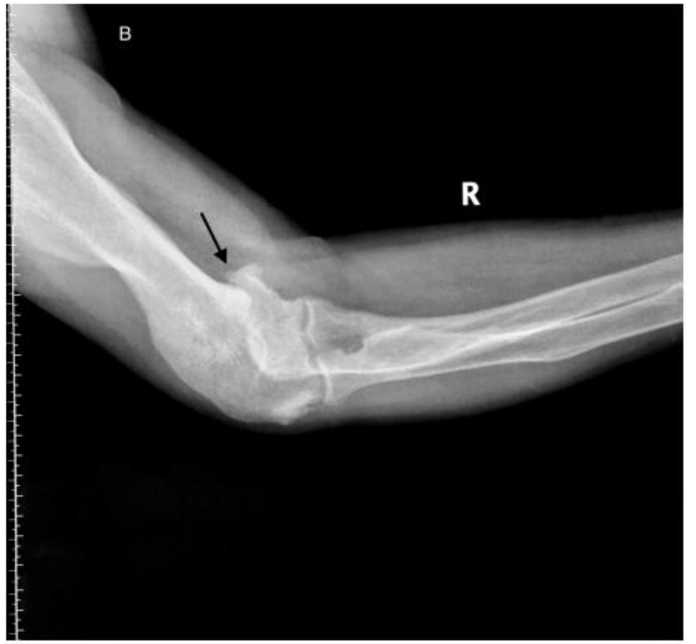


Figure 2 Lateral radiograph of right elbow showing calcification of the right biceps brachii tendon (marked in black arrow).

Rimesh Pal et al. X-linked hypophosphatemia with enthesopathy. 2017 BMJ
http://dx.doi.org/10.1136/bcr-2017-220920.

Other problematic diagnoses

- Cervicocranial Syndrome
- Cervicobrachial Syndrome
- Neuralgia
- Radiculopathy
- Enthesopathy

Cervicobrachial Syndrome/Neuralgia/Radiculopathy

Homework: As a challenging exercise please complete the following chart to remind yourself what one must do to differentiate between these diagnoses?

Condition:	Brief description of symptoms:	Can it be preliminarily diagnosed by physical exam alone, YES/NO?	Does is require additional diagnostic tests to confirm the diagnosis? If yes, which tests? (ex. MRI or NCV/EMG)
Cervicobrachial Syndrome			
Cervicobrachial Neuralgia			
Cervical Radiculopathy			
Brachial Radiculitis			

Odds and Ends

- Spondylosis *(facet syndrome?)*
- Scoliosis
- Degenerative disc/joint disease
- Abnormal postural
- Kyphosis

- Lumbar instabilities
- Muscle spasm
- Myalgia

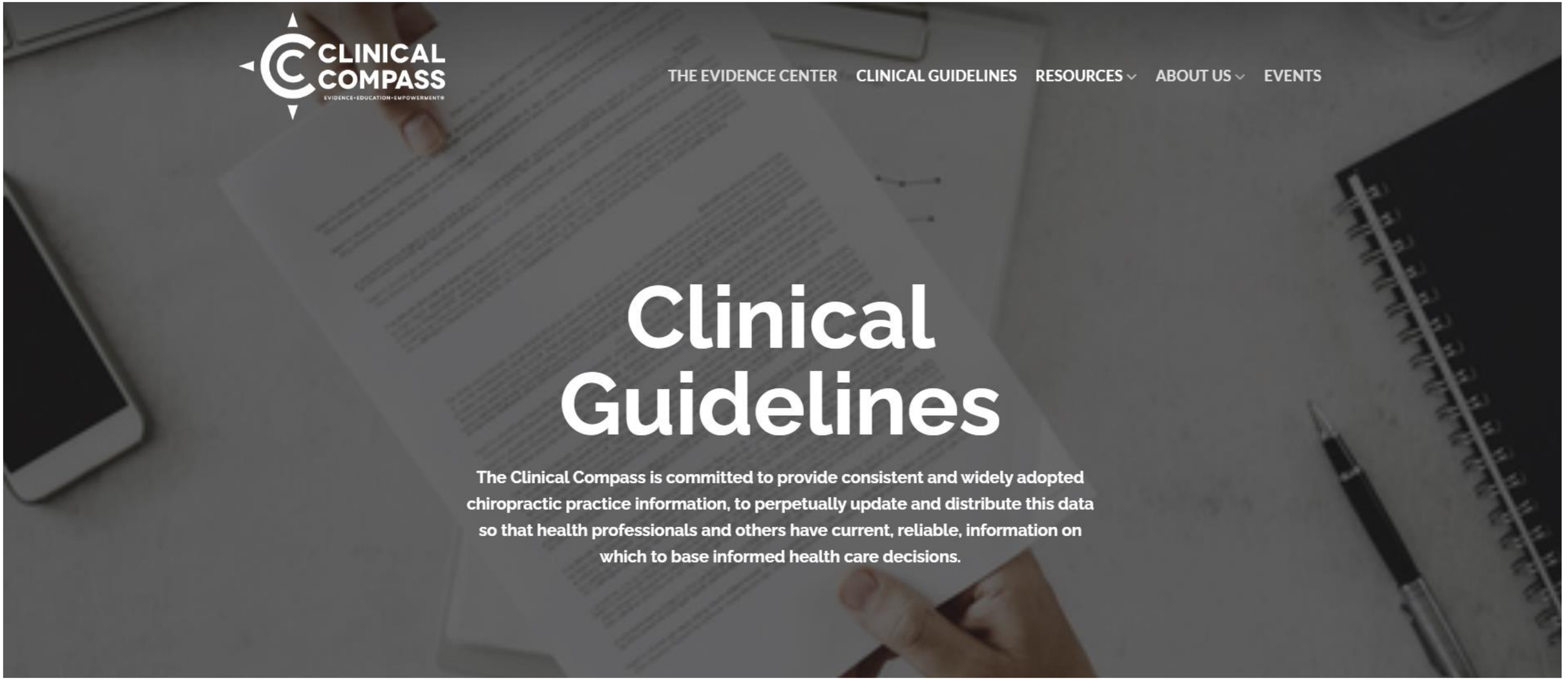
Question:
If CMS, or the payor contract, **requires symptoms** in the same region as the subluxation that caused the patient to visit the office, **but the condition you wish to report can be present without symptoms,** is it worth reporting as a diagnosis vs. a physical finding in your records?

TIP:
Put another way, even though ICD10 codes exist for these terms, should they really be used as stand-alone diagnoses, or are they more consistent with reportable physical findings that should be present in the clinical records?

Issues of Concern by Third Party Payors

Evaluation and Management Codes

TIP #:
Do your notes justify the level of E/M code billed? Was it necessary to conduct an E/M or could the normal pre and post manipulative assessment sufficed?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Clinical Guidelines
The Clinical Compass is committed to provide consistent and widely adopted chiropractic practice information, to perpetually update and distribute this data so that health professionals and others have current, reliable, information on which to base informed health care decisions.

THE JOURNAL OF ALTERNATIVE AND COMPLEMENTARY MEDICINE
Volume 26, Number 10, 2020, pp. 884–901
Mary Ann Liebert, Inc.
DOI: 10.1089/acm.2020.0181

ORIGINAL ARTICLES

Best Practices for Chiropractic Management of Patients with Chronic Musculoskeletal Pain: A Clinical Practice Guideline

Cheryl Hawk, DC, PhD,[1] Wayne Whalen, DC, BSN,[2] Ronald J. Farabaugh, DC,[3] Clinton J. Daniels, DC, MS,[4] Amy L. Minkalis, DC, MS,[5] David N. Taylor, DC,[6] Derek Anderson, PhD,[4] Kristian Anderson, DC, MS,[7] Louis S. Crivelli, DC, MS,[8] Morgan Cark, DC,[9] Elizabeth Barlow,[10] David Paris, DC,[11] Richard Sarnat, MD,[3] and John Weeks[12]

Abstract

Objective: To develop an evidence-based clinical practice guideline (CPG) through a broad-based consensus process on best practices for chiropractic management of patients with chronic musculoskeletal (MSK) pain.

Design: CPG based on evidence-based recommendations of a panel of experts in chronic MSK pain management.

Methods: Using systematic reviews identified in an initial literature search, a steering committee of experts in research and management of patients with chronic MSK pain drafted a set of recommendations. Additional supportive literature was identified to supplement gaps in the evidence base. A multidisciplinary panel of experienced practitioners and educators rated the recommendations through a formal Delphi consensus process using the RAND Corporation/University of California, Los Angeles, methodology.

Results: The Delphi process was conducted January–February 2020. The 62-member Delphi panel reached consensus on chiropractic management of five common chronic MSK pain conditions: low-back pain (LBP), neck pain, tension headache, osteoarthritis (knee and hip), and fibromyalgia. Recommendations were made for nonpharmacological treatments, including acupuncture, spinal manipulation/mobilization, and other manual therapy; modalities such as low-level laser and interferential current; exercise, including yoga; mind–body interventions, including mindfulness meditation and cognitive behavior therapy; and lifestyle modifications such as diet and tobacco cessation. Recommendations covered many aspects of the clinical encounter, from informed consent through diagnosis, assessment, treatment

[1]Texas Chiropractic College, Pasadena, TX, USA.
[2]Private Practice, Santee, CA, USA.
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[5]Palmer Center for Chiropractic Research, Davenport, IA, USA.

Improving Performance Metrics

Proper Use of Clinical Guidelines

Guidelines

Tips to Improve the Guideline Metric

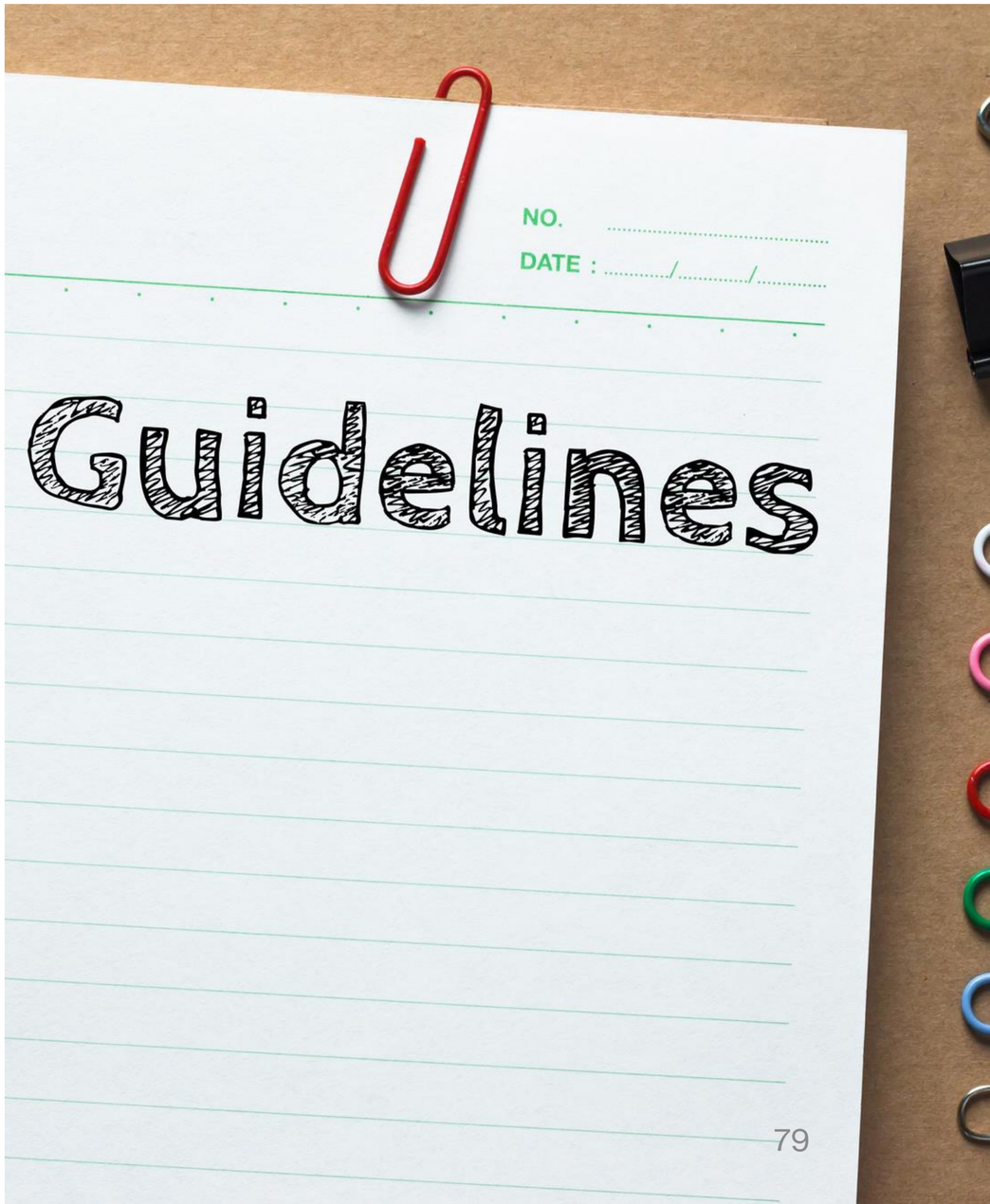
- Awareness of guidelines: The Clinical Compass. https://clinicalcompass.org/
- Read the latest Clinical Practice Guidelines: acute and chronic neck and LBP.
- Understand proper use of CPGs.
- **Guidelines should not be reduced to frequency and duration alone.**
- There is a myriad of important elements contained in a Clinical Practice Guideline (CPG).

TIP:
Clinical Guidelines do not represent limits to care, nor entitlements to care!

They should never be used as the sole reason for denial!!

IMPROVING PERFORMANCE METRIC GUIDLINES

- Guidelines are not meant to serve as treatment plans
- Always consider the progression of care and modify the treatment plan based upon patient response to treatment.
- Avoid old-fashioned treatment planning *(ex. Months of care from day 1)*
- **Treat in 2-6 visit bursts of care.**
- Remember, exacerbations typically require fewer visits!
- Not every patient will fit into a well-defined guideline box.



IMPROVING PERFORMANCE METRIC GUIDLINES

CONT'D

- **Document thoroughly,** noting complications, improvements, and other relevant issues in your assessment.

- As the **treatment plan evolves**, consider changes to frequency and modalities being utilized. The goal for every new case is to reach a point of MMI as quickly as possible for the good of the patient.

- Understand that "guidelines" are **much more than simple frequency and duration parameters.** Please consider guidelines in their totality versus just the number of visits for a condition.

IMPROVING PERFORMANCE METRIC GUIDLINES

CONT'D

Guidelines provide far more than frequency and duration parameters. They provide information and guidance related to:

- o Elements of a consultation
- o Elements of an examination/when E/Ms are necessary
- o Reassessments
- o Identifying red flags, yellow flags, etc.
- o Imaging
- o Informed consent
- o Complicating factors
- o Co-morbidities
- o Social Determinants of health
- o Developing a diagnosis
- o Establishing a plan of care
- o Home care advice
- o Co-management and referral
- o Discharge from active care
- o Treatment algorithms
- o Treatment modalities: passive and active therapy

AMI:
12-page resource available on how to avoid an audit!
(3-hour seminar or webinar)

- **TIP: Do not treat to a guideline. Treat based upon patient response to care and make adjustments accordingly based upon the success or failure of care.**

Clinical/Coding
Brain Teaser of the Day!

Can you bill insurance for
“technology/service”?

Presenter:

Dr. Ronald J. Farabaugh

With the emergence of new technology, it is important to consider whether billing is appropriate, or not?

Research the appropriateness of billing!

Understand the codes and what is required to use and bill certain codes to describe the technology or service.

What are your thoughts?

With the emergence of new technology, it is important to consider whether billing is appropriate, or not?

Research the appropriateness of billing!

Understand the codes and what is required to use and bill certain codes to describe the technology or service.

Can you bill 97012, Mechanical Traction when using a xxxxxxxx?

- To bill **97012, mechanical traction**, one has to be able to document the **angle of pull and the pounds of pull/traction.**

- Is that possible to document when using a **xxxxxxxx**? Answer: NO.

For those who want more detail, see below!

I hope this has been helpful!

Contact Information:

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This lecture was sponsored by SideCar (Nathan Unruh-CEO)

SIDECAR

What are your thoughts?

With the emergence of new technology, it is important to consider whether billing is appropriate, or not?

Research the appropriateness of billing!

Understand the codes and what is required to use and bill certain codes to describe the technology or service.

Can you bill 97110, therapeutic exercise, when using xxxxxx?

- **97110 is a time dependent code**: At a minimum the total number of minutes needs to be documented. Additionally, time in and out being could be recorded in the notes as an extra measure?
- **97110 is a supervised code**: Are you supervising the patient as they sit in a xxxxxxxx?
- **97110** must be supervised by a **license physician or qualified therapist**.
- **97110** is related to improvement in **ROM, flexibility or strength**. Where in the notes did the DC document a deficiency in ROM, flexibility or strength?

Can you bill 97110, therapeutic exercise?

97110 requires substantial documentation:

Expected care management items to justify billing 97110: What, Where, Why, How long?

1. Treatment plan
2. Goals
3. Measurable outcomes
4. Discharge

Is any of that documented as it relates to a xxxxxxxx?

Can you bill 97110, therapeutic exercise?

Does it pass the “smell test”?

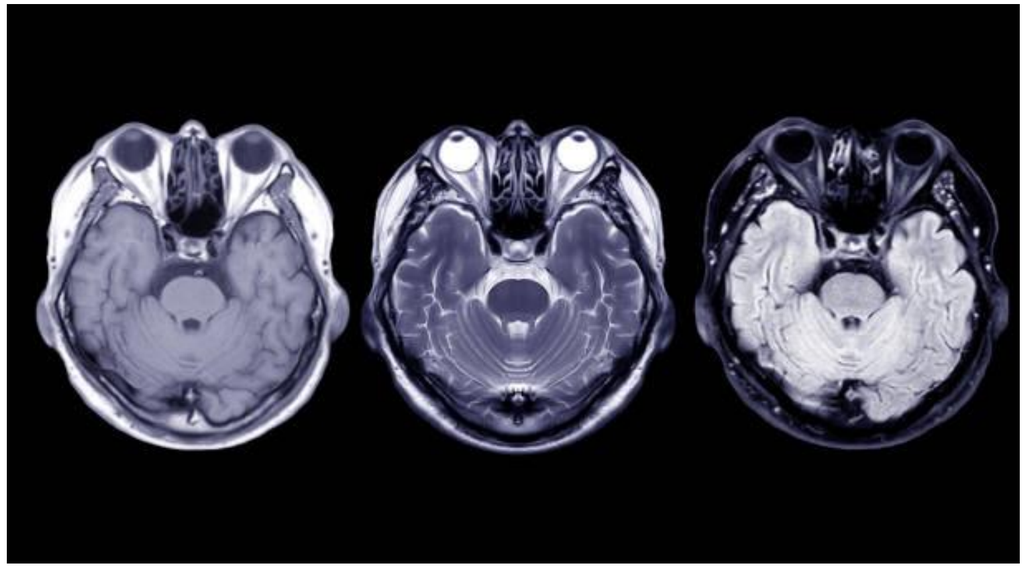
Can you realistically take a nap in a xxxxxxxx and consider that “therapeutic exercise”?

Can you bill 97112, neuromuscular re-education when using a xxxxxxxx?

- **97112** is related to improvement in **movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.**
- Where in the notes did the DC document a deficiency in any of the above-mentioned issues?
- How can a **xxxxxxxx** improve any of the neurological issues mentioned above?

Can you bill 97112, neuromuscular re-education when using a xxxxxxxx?

- 97112 must be performed by a physician or licensed therapist.
- **Is the xxxxxxxx the equivalent of a physician, or licensed therapist?**



Can you bill 97140, Manual Therapy when using a xxxxxxxx?

- 97140 must be performed by a physician or licensed therapist.

- **Is the xxxxxxxx the equivalent of a physician, or licensed therapist?**
  Answer: NO!

Can you bill 97140, Manual Therapy when using a xxxxxxxx?

- **Definition:** “Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes.”

- Is a xxxxxxxx the equivalent of “mobilization/manipulation, lymphatic drainage or manual traction?” **Answer: NO!**

- **Additionally, how could one bill 97140 knowing it cannot be billed the same day as a CMT to the same region?**

Can you bill 97140, Manual Therapy when using a xxxxxxxx?

- 97140 is a time dependent code. Does the provider routinely document the total number of minutes?

- Lastly, **is there any literature** supporting the theory that a xxxxxxxx provides “mobilization/manipulation, manual lymphatic drainage, manual traction”?

Can you bill 97124, massage therapy, when using a xxxxxxxx?

- **97124** is a therapeutic procedure that describes massage therapy, including **effleurage, petrissage, and/or tapotement**, for one or more body areas every 15 minutes.
- It's a **timed code** that **qualified healthcare providers, such as physical and occupational therapists**, use.

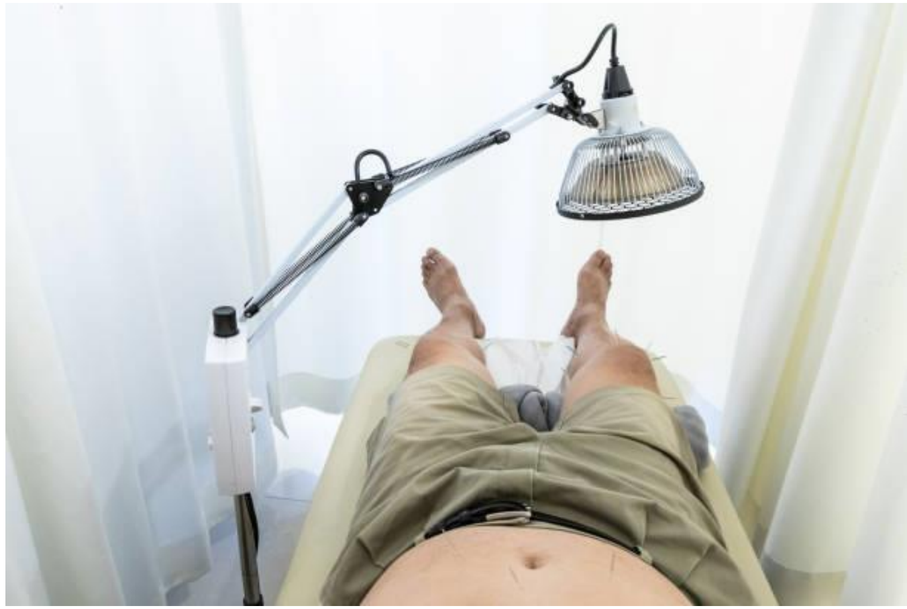
Can you bill 97010, application of hot or cold packs, when using a xxxxxxxx?

- **Answer: NO.** Most payors no longer pay for ice/heat since that can be apply at home.

Can you bill 97026 (infrared) or 97028 (ultraviolet) when using a xxxxxxxx?

Can you bill 97024, diathermy when using a xxxxxxxx?

- Answer: NO. A massage therapy chair is not equivalent to diathermy, infrared or ultraviolet technology, nor can it be supported as a medically necessary therapy when simply sitting in a xxxxxxxx that happens to light up.



With the emergence of new technology, it is important to consider whether billing is appropriate, or not?

Research the appropriateness of billing!

Understand the codes and what is required to use and bill certain codes to describe the technology or service.

Discussion

How will you use this information?

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