



Chiropractic Associates of Minnesota, LLC

January 1, 2006

Dear Doctor:

The five business goals of CAMN are:

1. Continue to negotiate fair fee schedules for our members.
2. Continue to increase access to chiropractic care.
3. Continue to provide a network of quality doctors for the health plans we contract with.
4. Increase our non-withhold income so we require less withhold from our members to operate our business.
5. Support the MCA.

In order to maximize the amount of care our member doctors are allowed and to keep the reimbursement at the highest level possible the utilization review department must ensure the care being provided is properly documented and justified and meets the published treatment standards and guidelines. One of the ways this is done is by evaluating the CPT codes used by our members and determining which codes will be accepted.

For care provided on or after January 1, 2006 CAMN is making some changes to the codes that are accepted. We feel these changes will benefit the majority of our members and will allow us to meet the goals we have set for our organization and our members.

The changes are as follows:

* **97010 “Hot or Cold Packs”** is not a covered service

* **97022 “Whirlpool”** is not a covered service

* **97036 “Hubbard Tank”** is not a covered service

* **97124 “Massage”** - only one (1) unit will be allowed per visit

* **97140 “Manual Therapy”** – only one (1) unit will be allowed per visit

The therapeutic value of massage therapy has come under scrutiny by current research and the insurance industry because it has not been proven to provide long-term therapeutic benefit. CAMN has been able to substantiate the allowance of one (1) unit of massage therapy - 97124 per visit if documentation justifies the necessity of the therapy performed. Because of the scrutiny massage therapy has come under, manual therapy - 97140 has also come under scrutiny. CAMN has substantiated allowing one (1) unit of manual therapy per visit if documentation justifies the necessity of the therapy performed.

* **Hydrotherapy / Hydrobeds:** The appropriate procedure code to use for this service is 97039.

* **Cardio Warm-up and Cool-down** – Do not require one-on-one supervision and are considered non-covered services

* **Med-X Testing Typically Billed as Physical Performance Testing or Measurement (e.g., Musculoskeletal, functional capacity) with written report each 15 Minutes:**

The following rules will apply:

2 units of 97750 will be allowed if documentation supports 1 region of the body is being evaluated and the time needed to perform the service is 30 minutes.

3 units of 97750 will be allowed if documentation supports 2 regions of the body are being evaluated and the time needed to perform the service is 45 minutes.

(A written report must be included in the documentation and it must support the necessity of testing. Further rehab must be based on the patient’s subjective complaints, effects on Activities of Daily Living (ADL’s) and Demands of Employment (DE’s), objective findings, the doctor’s interpretation of findings, updated diagnosis and future treatment plan and goals.)

- * **J-tech testing:** Will be considered part of the examination fee and is not a separately billable service.
- * **Report of Findings:** Will be considered part of the examination, even if the report of findings is done on a different day than the original examination, and is not a separately billable service.

In the past we have received questions from our member doctors regarding the following services:

What is Maintenance Care and Preventive/Wellness Care and is it a covered service?

According to the 2005 ACA Coding Solutions Manual Maintenance Care is defined as “elective care that is typically long-term, by definition not therapeutically necessary, but is provided at preferably regular intervals to prevent symptomatic deterioration. Preventive care is defined as “elective care that is, by definition, not therapeutically necessary, but is provided to prevent disease, prolong life, promote health, and enhance the quality of life. These are non-covered services.

Which Evaluation / Management Code do I Use? The components and documentation requirements for each level of examination are summarized and described in detail in the AMA’s Current Procedural Terminology (CPT) and ACA’s Chiropractic Coding Solutions Manual. For new patient examinations all of the key components (i.e., history, examination and medical decision making) must meet or exceed the stated requirements. For established patient examinations two of the three key components must meet or exceed the stated requirements.

How do I determine which level of Chiropractic Manipulative Treatment Code to use? The documentation submitted must contain each of the following: (1) Subjective documentation of the patient complaint(s) in all regions being manipulated, (2) Objective findings to support the necessity of manipulation in all regions and (3) Each region treated must have a documented diagnosis, and (4) Documentation that manipulation was performed in all regions.

What documentation is necessary if x-rays or other diagnostic studies are performed? The documentation must include the established medical necessity for ordering the study, the order for the study and a report of the findings of the study.

Are cryptic or repetitive daily notes accepted by CAMN? NO. Effective January 1, 2006 documentation that is cryptic or repetitive in nature will not be accepted by CAMN. Documentation must be encounter specific and must support the medical necessity of the services being provided. This is consistent with the Guidelines for Chiropractic Quality Assurance and Practice Parameters, Proceedings of the Mercy Center Consensus Conference and Procedural/Utilization Facts, Chiropractic/Physical Therapy Treatment Standards, Fifth Edition by Richard E. Olson.

According to the ACA Documentation Guidelines:

1. Accurate and consistent clinical documentation is an important part of everyday practice.
2. Consistent and accurate documentation is crucial for patient protection, case management, risk management and proper reimbursement.
3. It is the responsibility of the Doctor to meet the needs and expectations of patients and payers in regard to the documentation of patient care in today’s healthcare environment.
4. Doctors of Chiropractic MUST RISE TO A NEW LEVEL OF AWARENESS AND RESPONSIVENESS TO INTEGRATE ACCURATE AND CONSISTENT CLINICAL DOCUMENTATION AS A CORE BUSINESS PRACTICE.

If you would like the CAMN Review Department to review your documentation to make sure it meets the CAMN guidelines please contact the CAMN office. To view the CAMN Documentation Guidelines go to the CAMN website at www.camn.us and click on the Utilization Review tab.

If you have any questions regarding the information contained in this letter please feel free to contact me via e-mail at jsmith@casd.us or in writing at the address below.

Sincerely,

Jeffrey J. Smith
Executive Director

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