Chiropractic Treatment Paradigm 2021

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Paradigm

- Paradigm is defined as "a typical example or pattern of something; a model."
- This is a typical example of how a chiropractic patient receives care.
- We will cover the assessment/evaluation visit vs. treatment visit paradigm and the episode of care paradigm.

Medicare

- The Medicare Benefits policy manual, Chapter 15, Section 240.1.5 states - Treatment Parameters
- The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (e.g., strains or sprains) problems may require as many as three months of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.
- Chronic spinal joint condition implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

The initial Visit

- This is where you become familiar with the patient and the patient becomes familiar with you.
- You collect a history.
- You have a one-on-one consultation with the patient.
- You perform an examination.
- You combine all of this information to assess the patient's condition.
- You develop a plan of care for the patient that is unique to that patient.

The Treatment Visits

- This is where you carry out the plan of care that you developed during the initial visit.
- You continue to collect subjective information regarding the patient's condition.
- You continue to examine the area of the problem by palpating the patient's spine.
- You assess the patient's progress mainly by determining if the patient is progressing as expected or faster or slower than expected.

The Re-Exam

- After 30 calendar days the patient should be examined again to determine progress or lack thereof.
- The history should cover information regarding the patient's condition.
- The examination should cover all previous positive tests and significant negative tests.

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- The assessment should determine if the patient has significant improvement.
- If the patient has significant improvement then a new plan of care is developed.
- This process continues until the patient reaches maximum medical improvement.

Block of Care

- A block of care consists of an exam (either an initial exam or a re-exam), a series of treatment visits, and a re-exam.
- A block of care is covered by a single treatment plan and is 30 days long.
- At the end of each block of care the patient is evaluated to determine if they have had significant improvement or have reached maximum medical improvement.
- Care continues until the patient reaches MMI.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2 *Initial evaluation visit*	3	4 First treatment visit	5	6 Second treatment visit	7
8	8 Third treatment visit	10	11 Fourth treatment visit	12	13 Fifth treatment visit	14
15	16 Sixth treatment visit	17	18 Seventh treatment visit	19	20 Eighth treatment visit	21
22	23 Ninth treatment visit	24	25 Tenth treatment visit	26	27 Eleventh treatment visit	28
29	30 Twelfth treatment visit	31	1 *First re-evaluation visit*	2	3	4

Episode of Care

- An episode of care consists of however many blocks of care that it takes for the patient to reach maximum medical improvement.
- Medicare regulations state that an episode of care for an acute condition can take up to 3 months and for a chronic condition can take longer.
- There are reasons that can justify an episode of care being extended.
- These must all be covered in the assessment portion of your documentation.

Complicating Factors

- The follow complicating factors can increase the time required for recovery:
    - Symptoms present for more than 8 days can increase recovery time by a factor of 1.5
    - Injury superimposed on the following conditions can increase recovery time by a factor of 2
        - Pre-existing Condition

        - Underlying Pathologies
        - Congenital anomalies
    - 4 to 7 previous episodes can increase recovery time by a factor of 2
    - Presence of skeletal anomaly can increase recovery time by a factor of 2
    - Presence of structural pathology can increase recovery time by a factor of 2
    - Presence of severe pain can increase recovery time by a factor of 2

Indicators of Chronicity

- The following are indicators of chronicity:
    - Severity of symptoms and objective findings
    - Patient compliance and/or non-compliance
    - Factors related to age
    - Severity of initial mechanism of injury
    - Number of previous injuries (N=3 episodes)
    - Number and/or severity of exacerbations
    - Psycho-social factors (pre-existing or arising during care)
    - Pre-existing pathology or surgical alteration
    - Waiting >7 days before seeking some form of treatment
    - Ongoing symptoms despite prior treatment
    - Nature of employment / work activities or ergonomics
    - History of lost time
    - History of prior treatment
    - Lifestyle habits
    - Congenital anomalies
    - Treatment withdrawal fails to sustain Maximum Medical Improvement

Duration and Frequency

- The duration and frequency of the care is listed in the plan of care.
- The duration is 30 days because the patient should be examined every 30 days while under care.
- The frequency of care will vary depending upon the patient's progress.
- Three times per week would be appropriate at the beginning of care for the first block.
- The frequency would decrease in subsequent blocks as the patient improves.

Reviews

- For a reviewer to make an accurate determination of medical necessity they must review the entire block of care.
- A reviewer needs to know what the patient's condition was before the treatments were rendered, what treatments were rendered, and what the patient's condition is after the care is rendered.
- With this information a determination can be made regarding medical necessity.

- This determination cannot be made with the information from a single treatment visit.
- Reviewers will request a single date of service, usually a treatment visit.
- A single treatment visit will not provide enough information for the reviewer to make a determination of medical necessity for the care rendered.
- That is why you send documentation for the entire block of care whenever there is a records request.
- This forces the reviewer to use Clinical Review Judgment.
- The Clinical Review Judgement involves two steps:
    - (1) The synthesis of all submitted medical record information (e.g., progress notes, diagnostic findings, medications, nursing notes) to create a longitudinal clinical picture of the patient, and
    - (2) The application of this clinical picture to the review criteria to make a reviewer determination on whether the clinical requirements in the relevant policy have been met.
- If your documentation is solid and proves medical necessity, and you send the documentation for the entire block of care, and you have the care denied then you should appeal.
- You appeal letter should summarize the patient's condition prior to care, the care rendered, and the patient's condition after care.
- You should also state that the reviewer did not use Clinical Review Judgment as required by Medicare Regulations.
- By taking these actions Medicare reviewers will be forced to review our claims as the unique chiropractic claims a that they are and not as medical claims.
- The fact that Medicare reviewers do not understand these concepts is one of the reasons that we have the high error rates that we do with Medicare.

Summary

- Chiropractic has a unique treatment paradigm.
- We do not just evaluate patients and then refer them to technicians for treatment or prescribe drugs that the patient self-administers.
- We also supply the treatment to the patient during treatment visits.
- While these treatment visits are documented, they do not provide enough information by themselves to make a determination of medical necessity