Third-Party Pay and the Mercy Guidelines

By Editorial Staff

An often asked question that puts fear into many chiropractors regarding the Mercy Guidelines is, "What type of impact will these guidelines have on my practice with insurance reimbursement?"

I have heard some chiropractors say that insurance companies are already using the Mercy Guidelines to cut their bills.

I even heard one state association official say that a large insurer was ready to sign an agreement when suddenly, due to the Mercy Guidelines, they cut chiropractic to 12 visits, quit paying for paraspinal EMGs, and massacred chiropractors in that state.

My experience is completely opposite. I have found the Mercy Guidelines very well received by insurers. In fact, Blue Cross/Blue Shield of Oklahoma uses it as the primary source for their decisions regarding chiropractic. The Oklahoma State Employee and Education Group Insurance Board has specifically adopted language directly out of chapter eight ("Treatment Frequency and Duration") in their plan document. Other insurers, based on input from the Mercy Guidelines, have dropped "caps" on chiropractic care and substituted the Mercy Guidelines.

What this means to a DC is that if you practice within the guidelines, you can get virtually unlimited care for a patient that "needs" it. However, if you do not practice within the guidelines, there is a strong basis for claims denial.

The Mercy Guidelines help focus chiropractors on doing services that are necessary for the benefit of the patient. They clearly do not promote services that are of little or no value.

Let’s take a case in point. The patient has plateaued in response to care and came back into the DC’s office saying, "Dr., I feel okay until about five o’clock in the afternoon, and then the pain returns."

The Mercy Guidelines, according to chapter eight states:

Failure to Meet Treatment/Care Milestones/Objectives (Uncomplicated Cases):
A. Acute Disorders: After a maximum of two therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered.

B. Unresponsive Acute, Subacute or Chronic Disorders: Repeated use of passive treatment/care normally designed to manage acute conditions should be avoided as they tend to promote physician dependence and chronicity.

C. Systematic interview of the patient and immediate family should be carried out in search of complicating or extenuating factors responsible for prolonged recovery.

D. Specific treatment care goals should be written to address each issue.

E. Continued failure should result in patient discharge as inappropriate for chiropractic care or having achieved maximum therapeutic benefit.

Complicated Cases:

Implementation of up to two independent treatment plans relying on repeated use of passive care is generally acceptable in the management of cases undergoing prolonged recovery. Signs of chronicity: All episodes of symptoms that remain unchanged for two to three weeks should be evaluated for risk factors of pending chronicity.

Patients at risk for becoming chronic should have treatment plans altered to de-emphasize passive care and refocus on active care approaches. ¹

What these guidelines mean is that the DC has the responsibility to find out why this patient’s condition returns at approximately 5:00 p.m.

It makes no sense to continue treating, with no results. The reason why the patient may not be responding may include factors such as the patient’s work position, stress from work or family activity, multilevel disk degeneration, etc. It could also be because the doctor has not identified the correct diagnosis and the patient has an underlying condition. The treating DC has the responsibility to identify what it is that is hampering the patient’s response, and address it through a written treatment plan. Let’s be honest. Isn’t that only fair to a patient?
If a DC in fact does exactly what these guidelines suggest, and an insurer attempts to reduce his bill, then the DC has some very powerful ammunition that will continue to get his claim paid. However, if he simply keeps treating and treating, without attempting to solve the patient’s underlying problem, then the insurer has powerful ammunition to deny payment of the insurance claim.

This also goes for diagnostic testing. There are many doctors that utilize a diagnostic test that has no real benefit to a patient. For example, paraspinal EMG. There is no question that paraspinal EMG measures muscle spasm. The question is how does this help enhance the patient’s outcome or help determine correct treatment. Some doctors charge $600 for this testing and do it once a month, yet the patient does not get any faster relief or better outcome. And frankly, there is absolutely no difference in treatment that the provider gave prior to paraspinal EMG testing. The only one who benefits from this is the doctor running the test.

The Mercy Guidelines says this about paraspinal EMG:

All of the electrodiagnostic methods are safe when carried out by specially trained personnel. Interpretation should be carried out only by physicians with extensive training in the technical and clinical considerations that can readily confound the findings.

Kinesiologic surface (scanning) EMG is a rapidly proliferating, safe procedure that has not been shown effective with the exception of limited use for flexion/relaxation and mean/median frequency shifting measures. Generally, its use remains investigational. Specific procedures of flexion/relaxation and mean/median frequency shift evaluation are considered promising based on Class II and Class III evidence.

Strength of recommendation -- scanning surface EMG: Type C. Consensus Level: 2

Strength of recommendation -- flexion/relaxation and mean/median frequency shift measures: Type B. Consensus Level: 1

Type B: Positive recommendation based on Class II evidence.

Type C: Positive recommendation based on strong consensus of class III evidence.

Is this wrong? In my opinion, no. However, more information must be gained regarding paraspinal surface scanning EMG that will help us understand what to do with the information they are giving us. When this is understood, then the rating can change to a more positive rating. All that the Mercy Guidelines has done is
focused on a weakness of the test. When this weakness is solved, then the rating will change. Until a practical use is determined for the equipment and testing, then most insurers will deny its use.

However, remember when an insurer accepts our guidelines, they also accept our treatment parameters. Consequently, I see the acceptance of the guidelines as a strong benefit to chiropractic and relationships with insurers. The most important benefit is to the patient.

The Guidelines for Chiropractic Quality Assurance and Practice Parameters, Proceedings of the Mercy Center Consensus Conference, held January 25-30, 1992, is a breath of fresh air, and one example of many guideline documents that are forthcoming for all health care professions. Our country cannot afford to keep paying for services that do not benefit a patient, resolve their conditions, or aid in better outcomes. The chiropractic profession is leading the way in this area.

Reference:


Editor’s Note: Dr. Hayes practices in Tulsa, Oklahoma, and has consulted for Blue Cross/Blue Shield of Oklahoma, Aetna, Prudential, USF&G, Shelter Insurance, Quality Inc., the Oklahoma State Employee and Education Group Insurance Fund, Provident, and Allstate, among others. He has published books, articles, and manuals covering insurance, malpractice, nutrition, HMO/PPO, workers’ compensation, personal injury, and other topics. Dr. Hayes teaches seminars for many state chiropractic associations and other chiropractic organizations, along with seminars for the insurance industry across the nation. In addition, he has served as a postgraduate education instructor for three chiropractic colleges.

In the national arena, Dr. Hayes served two terms as president of the Congress of Chiropractic State Associations; at the state level, two terms as the president of the Chiropractic Association of Oklahoma, and the Oklahoma Chiropractic Insurance Joint Advisory Committee. He has been named "Chiropractor of the Year" by the Chiropractic Association of Oklahoma twice, and by Practice Management Associates.

Dr. Hayes has made presentations to two National Anti-Fraud Conferences for the National Association of Blue Cross/Blue Shield, and presentations to the Southwest Insurance Association, in addition to numerous in-house training programs for individual insurers and third-party administrators.
Dr. Hayes works with PruCare HMO in Tulsa. He set up the chiropractic interface for Custom Care, a Prudential direct access HMO for the Southwestern Bell Telephone Company in a five-state region. Dr. Hayes has set up a chiropractic PPO for Blue Cross/Blue Shield of Oklahoma, and Bob Johnston Company, a large third-party administrator, as well as Prudential Plus.

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