Legal Issues

MAC Legal True or False

Misconceptions on Recent Blue Cross Issues, Explained

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MAC leadership and the central office have been fielding questions from member doctors across the state about recent actions by Blue Cross, including the 2017 fee schedule, MESSA's new policy on orthotics, new requirements for massage, and payment for extremity adjustments on the same day as a spinal manipulation. Many of these questions are based on starkly inaccurate information. We hope that this "True or False" document will answer some of these questions, set the record straight, and outline the MAC legal team's strategies moving forward on these critical issues.

True or False: The MAC negotiated the recent fee reductions with Blue Cross.

Answer: False. This is perhaps the biggest misconception out there – how Blue Cross sets their rates and what the MAC as an organization can do about it. The MAC does not – and legally CANNOT – "set" these or any other fees with Blue Cross. They have the right to set all their fees and their process for doing so is *completely* internal. Outside organizations such as the MAC have a very limited (if any) say in the Blue Cross fee-setting process.

True or False: The MAC refuses to take any action to ensure that the Blue Cross is using the appropriate methods to set their fee schedules.

Answer: False. While the Blue Cross process for setting their fees is completely internal, the MAC can ensure that they are following our 1999 Settlement Agreement, wherein they agreed to generate their fee schedules using the Resource-Based Relative Value Scale (RBRVS) relative values for CMT codes and the same conversion factors that they use for MDs and DOs.

The Centers for Medicare and Medicaid Services (CMS) uses the RBRVS to determine physician payment rates. When creating each CPT® code, the AMA assigns a "relative value" based on the resource costs expended by the provider in performing the service. These include the amount of "physician work" needed to perform the service (duration, physical exertion, know-how needed, stress from patient risk, etc. – approximately 51% of the relative value of the service), practice expense (approximately 45%), and malpractice expense (approximately 4%).

Once the relative value is assigned and adjusted by geographic region, it is then multiplied by a fixed "conversion factor" (determined by Blue Cross) to determine the amount of payment.

The MAC legal team is closely examining the fee schedule and vigorously investigating whether Blue Cross developed the rates properly and using the correct RVU and conversion factors.

True or False: As of July 1, 2017, fees for some services payable to chiropractors actually increased or stayed about the same.

Answer: True. While between 2016 and 2017, both CMT and OMT fees went down between 10-11%, and massage therapy fees went down approximately 25%, other physical medicine procedure fees were unchanged or slightly increased. Some E&M fees increased up to 3%, while a few others are statistically unchanged. Most radiology codes used by chiropractors also slightly increased or remained statistically unchanged. For the MAC's list of commonly used codes for 2017 and 2016, contact the MAC at info@chiromi.com or (517) 367-2225.

True or False: The MAC continues to work to resolve remaining Blue Cross/BCN Settlement implementation issues.

Answer: True. The 2015 Settlement Agreements were the result of many years of hard work from our leadership and were quite historic for the profession, as they are the most successful Blue Cross Agreements ever reached by a chiropractic state association.

Since the Agreements went into effect, there have been some critical concerns over payment policies, particularly surrounding physical medicine procedures and the extraspinal manipulation code, 98943. We have been negotiating with the Blues in an effort to change these policies. However, it is slow going, and we understand your frustration with the lack of a resolution to these issues.

In the meantime, we continue to push hard to assure our legal "test" (whether we are being treated the same as all other physician-level providers) is being met. If we do determine that the Blues are violating our Agreements, we will take appropriate action.

True or False: Prior to the Settlement Agreements, chiropractors were limited to billing one established patient Evaluation and Management (E&M) service code per year. This cap remained intact in the terms of the Agreements.

Answer: False. Coverage for evaluation and management services are now the same as they are for other physician-level providers. Chiropractors may now bill for any clinically necessary E&M code for established patients (codes 99211 through 99214). Be sure that your documentation supports the level of E&M service reported.

True or False: The MAC Settlement Agreements with Blue Cross require the Blues to reimburse chiropractors for services not required to be paid by Michigan law.

Answer: True. In the late 1970s, the Michigan Legislature re-wrote the state's Public Health Code and saddled Michigan chiropractors with the most restrictive chiropractic scope in the nation. For more than three decades afterward, we fought to change the state's archaic scope. Those efforts came to fruition in 2009 when Governor Granholm signed into law an updated scope that reflects the way chiropractors are educated and trained and allows chiropractors to perform additional physiotherapy services and adjustments of the extremities, which were

prohibited prior to the passage of the bill. Not only could chiropractors not be paid for performing these services, they legally could not perform them.

During the fight to pass our scope legislation, the insurance industry lobbied for and the Michigan Legislature approved a number of "trailer bills" to the scope language that essentially gave insurers like the Blues the option of whether or not they will pay for the new services allowed under scope.

This was something the MAC actively fought, but we did not have the political power to stop it.

In the 2015 Settlement Agreements, we were able to correct this non-payment problem with regard to Blue Cross and BCN. They are now required to pay for medically necessary physical medicine procedures that are part of a Blue Cross policy and within Michigan's updated chiropractic scope of practice.

True or False: The Blue Cross policy prohibiting chiropractors from delegating massage therapy services does not apply to other physician-level providers.

Answer: False. Per Blue Cross, medically necessary therapeutic massage (97124) may be delivered by Blue Cross participating providers when such massage is within their scope of practice. However, no provider (including MDs, DOs, PTs, or chiropractors) can supervise therapeutic massage or delegate therapeutic massage. It is important to know that this rule applies to all physician-level providers.

Note: Self-insured groups may elect a different benefit design that is not consistent with these rules. For example, MESSA does allow supervision and delegation of massage. Doctors will want to be sure and check all patient's benefits.

True or False: Since the 2015 Settlement Agreements went into effect, chiropractors are no longer reimbursed for mechanical traction (97012).

Answer: False. Chiropractors are currently reimbursed for medically necessary traction. This is unchanged by the Agreements. Additional medically necessary physical medicine procedures (other than traction) must be included in the treatment plan that is communicated to the patient's primary care physician so they are informed of their patient's care. For the services to be payable, the plan must then be signed by the primary care physician, dated, and filed in the patient's record. This must be done sometime during the patient's course of treatment.

True or False: Blue Cross' policy on not reimbursing for extraspinal manipulation when performed on the same day as a spinal manipulation only applies to chiropractors.

Answer: False. If medically necessary, CMT code 98943 (extra-spinal) and related radiological codes are payable. However, Blue Cross has a payment policy that 98943 will not be covered if performed on the same day as another spinal manipulation code (98940, 98941, or 98942). At this time, the policy is applied to all providers who perform manipulation services. We are continuing to work with the Blues to change this policy.

<u>True or False</u>: Chiropractors have not really gained all that much from the Settlement Agreements.

<u>Answer</u>: False. In addition to the areas already discussed, such as E&M, the Settlement Agreements allow for reimbursement for medically necessary physical medicine procedures that are part of a Blue Cross policy and in the chiropractic scope. Examples include (but are not limited to) electric stimulation (97014), ultrasound (97035), therapeutic exercises (97110), neuromuscular reeducation (97112), gait training (97116), and manual therapy (97140).

The MAC was successful in negotiating this additional coverage even though these services were not part of the original legal complaint, as at the time the original lawsuits were filed we had not yet passed our updated scope of practice.

To be a covered benefit, physical medicine services must be part of a physical medicine treatment plan. Chiropractors, like MDs and DOs, may delegate physical medicine services (except for massage, unless there is an exception like MESSA – see above), if provided "incident to." Per Blue Cross, to qualify as "incident to," services must be part of the patient's normal course of treatment, during which the chiropractor (or MD or DO), personally performed an initial service and remains actively involved in a course of treatment. Qualifying "incident to" services must be provided by someone whom the chiropractor, MD, or DO, directly supervises.

<u>True or False</u>: The MAC continues to educate Blue Cross and other insurers about the importance of fair reimbursement for chiropractic services to ensure that patients have access to conservative, cost-effective care.

<u>Answer</u>: True. With the issues facing health care in the 21st Century, including skyrocketing health care costs, the opioid epidemic, decreasing clinical outcomes for "traditional" medical care treatment of neuromusculoskeletal conditions (surgery, prescription drugs, etc.) it is more critical than ever before that insurance companies, health care policy makers, and purchasers of insurance coverage understand the healing and cost-savings potential of chiropractic care. The fact remains: When patients have access to our conservative, cost-effective care, costs go down and outcomes (and patient satisfaction) go up. The MAC is committed to continuing to educate these stakeholders on the innumerable benefits of chiropractic care.

<u>True or False</u>: The MAC is doing nothing about MESSA's new policy on chiropractors and orthotics.

<u>Answer</u>: False. As you no doubt have heard by now, effective June 1, 2017, MESSA no longer reimburses for orthotic services when provided by a chiropractor, unless that chiropractor is certified by the American Board for Certification in orthotic, prosthetic, and pedorthic services (commonly known as "ABC-Certification").

Our attorneys have been in close contact with MESSA's attorneys on this issue, and, in early August, MAC Executive Director Kristine Dowell met with the MESSA's executive director in

an effort to reverse this discriminatory policy and work toward a resolution that will be in the best interest of chiropractic patients and our members.

Please stay tuned to the usual channels of MAC communications – email and/or fax, the *Journal* and *eJournal*, www.chiromi.com, and our social media channels – for more information as it becomes available.

True or False: With all the changes to the healthcare system, both here in Michigan and nationally, it is absolutely critical going forward to support the organization that fights for chiropractors and their patients.

Answer: ABSOLUTELY TRUE! MAC leadership wants you to know that the fight continues and we are working daily for you. As stated above, these efforts include:

- Ascertaining whether Blue Cross set their fees properly, and if they were developed using the proper relative value and conversion factors
- Determining whether Blue Cross is attempting to circumvent the intent of the Settlement Agreements through fee changes and other payment policies
- Educating Blue Cross and other insurers about the importance of fair reimbursement for chiropractic services to ensure that patients have access to conservative, cost-effective care
- Continuing to fight through the resolution process outlined in the Agreements to resolve all other outstanding payment issues, including non-payment of 98943 on the same day as a spinal CMT, and MESSA's new orthotics policy requiring certification
- Sustaining our aggressive oversight of current national and state changes to the health care system
- Regularly keeping our membership abreast of all our critical efforts

We hope this has cleared up some of your questions. Watch for updates on all these outstanding issues in our *Action News*, *eJournal*, and *Journal*!