

Chapter 19

Chiropractic Services Clinical Resource Group, Inc. (CRG)

CRG is a specialty service network providing chiropractic services for SCHA members. CRG is a delegated entity for credentialing, quality management, and utilization management. CRG works closely with chiropractors and the SCHA in establishing community standards of chiropractic care.

Eligible Providers

Providers eligible for SCHA reimbursement for chiropractic services must be credentialed and contracted with Clinical Resource Group. Only emergency care is eligible for reimbursement if provided by a non participating provider.

Covered Services

- Manual manipulation of the spine for treatment of subluxation (incomplete or partial dislocation) that is directly associated with a presenting complaint that is determined to be medically necessary by the CRG clinical treatment guidelines. Chiropractors performing manual manipulation of the spine may be reimbursed for such services when performed with handheld devices such as the “Activator”, but no additional payment shall be made when such a device is used.
- X-rays that meet network treatment guidelines for medical necessity.
- Patient exam, limited to one exam per patient each calendar year.

Service Authorization

Care beyond 6 visits in a 30 day period or 12 visits in a calendar year must be authorized by CRG. A request for care beyond the benefit guidelines must be submitted to CRG on a service authorization request form. This form can be obtained from the CRG web site, www.clinicalgroup.net, or by calling CRG at 866-281-1997. The completed form, along with a copy of the patient’s exam findings, daily notes and treatment plan must be faxed to CRG at 651-207-0209 to obtain authorization for continued care.

Chiropractic utilization management requests and referrals will be reviewed for medical appropriateness based on evidenced based standards of care, medical necessity criteria and the member’s benefit coverage. The attending or requesting chiropractor may contact CRG to discuss any utilization management denial, reduction or termination or services with CRG’s utilization management reviewer.

Community Care Connectors(CCC)/Case Management (CM) Referrals

Requests for care beyond 24 visits in a calendar year will initiate a referral to the SCHA CCC/CM to coordinate a multidisciplinary review of the member’s care to assure that all appropriate and available resources are being applied to the greatest benefit of the

member. CRG will concurrently review the request for continued care and provide its input to the CCC/CM review process.

Non-covered Services

The following list of non-covered services is not all-inclusive. Other services may be provided but are not covered.

- Office visits that do not include manual spinal manipulation
- Nutritional supplements, vitamins, or nutritional counseling
- Acupuncture or acupressure
- Treatment of a neurogenic or congenital condition that is not related to a diagnosis of subluxation
- Lab services
- X-Rays, other than those determined to be necessary to rule out other pathology or when trauma has occurred
- Durable medical equipment or supplies that are either supplied or prescribed by the chiropractor
- Physiotherapy modalities including, but not limited to the following:
 - Ultrasound
 - Diathermy
 - Electrical muscle stimulation
 - Interferential current
 - Application of hot packs and cold packs
 - Massage
 - Manual muscle stimulation
 - Activator

Member Enrollment Verification

SCHA members have a member identification card and should present that card at the time of service. CRG strongly recommends that providers verify current member eligibility prior to providing services as the member's eligibility may have expired after the card was issued. Eligibility status can change from month to month, so patients whose treatment spans from one month to another will require verification at the beginning of each month. *CRG will not pay for services that are provided to an ineligible member.*

Providers should use DHS' Eligibility Verification System (EVS) to verify eligibility prior to the time of service. EVS is the most current source of eligibility information. You can access EVS using the Internet at www.mn-its.dhs.state.mn.us or by accessing the CRG web site, www.clinicalgroup.net, and then selecting MN ITS Eligibility Verification. You will need to have your PAS code and authorization code that you received when you became a Minnesota Health Care Programs provider. If you do not know your codes, you can contact CRG provider services for assistance.

Billing Procedure

Chiropractic claims should be submitted electronically to CRG in 837P formatting through our clearing house partner, "Office Ally". A detailed Implementation Guide for CRG claim submission is available on the CRG website, www.clinicalgroup.net.

CRG Electronic Payer ID: CRGMN
 CRG's mailing address is:

Clinical Resource Group, Inc.
1700 W Hwy 36, Ste 520
Roseville, MN 55113

You can contact CRG by phone at 1-866-281-1997 or access their web site at www.clinicalgroup.net.

Providers refer to your contract with CRG for additional information on covered services, documentation, fee schedule and clinical guidelines

MANIPULATIONS CPT Code	PMAP (MA) Minnesota Care and Medicare Advantage Programs	
	Description	
98940	Spinal, one to two regions	
98941	Spinal, three to four regions	
98942	Spinal, five regions	
EXAMINATIONS* CPT Code	Description	
99201 – 99203	New Patient Exams	
99211 – 99213	Existing Patient Exams	
RADIOLOGY CPT Code	Description	
72020	Spine, single view	
72040	Spine, cervical, AP and lateral (includes APOM)	
72070	Spine, thoracic, AP and lateral	
72080	Spine, thoracic, thoracolumbar, AP and lateral	
72100	Spine, lumbosacral, AP and lateral	
	MEDICARE SERVICES* SeniorCare Complete and AbilityCare	
CPT Code	Description	
98940	Spinal, one to two regions	
98941	Spinal, three to four regions	
98942	Spinal, five regions	

MEMBER	Adults ages 65 and over	CRG Treatment Guidelines Apply - Additionally Medicare guidelines require Active Treatment: AT modifier, for reimbursement of covered services
BENEFIT	Adults ages 18 - 64	6 visits in the initial 30 days of treatment
GUIDELINES	Children ages 5 -17	5 visits in a 30 day period
	Children Birth - age 4	4 visits in a 30 day period
	All Members	All care must be medically necessary supported by medical records documenting progressive clinical or functional improvement. One Exam per calendar year and at least 4 months since the previous year's exam is covered.
	Services not Covered	Examinations other than the annually covered exam , Therapies, DME & Supplies, Laboratory and all Maintenance care

Overview of CRG Guidelines for Chiropractic Treatment

Chiropractic is an important component of the SCHA care model, but has very specific guidelines associated with it. These guidelines allow for chiropractic services to be provided without the need for routine prior authorization. When the guidelines are not observed and care is provided outside of these parameters, the services are subject to utilization review which can reduce or exclude services from reimbursement. Some key areas to become familiar with from your CRG Clinical Treatment Guidelines are included here.

Health Record Documentation Standards – A health care provider must maintain a record of all examinations treatment provided to a patient. If the records are handwritten they must be legible to others, not just the writer. They must express coherent ideas and describe the services provided to a unique patient. Documentation methods that require a key to interpret are discouraged. The complete standards for the CRG network are described in detail in the CRG provider manual available online at www.clinicalgroup.net.

30 day treatment plan – CRG treatment frequency standards are based on a 30 day treatment period that begins at the initial visit. Note that this time period is not a calendar month, but a distinct 30 day period that begins with the initial visit. A typical treatment plan for an adult allows for **up to 6 visits in a 30 day period**. If a patient

presents on the 15th of the June for example, that 30 day period runs through the 14th of July.

Ongoing Care past the initial treatment period – Care that continues beyond the initial 30 day treatment period must be supported by daily patient notes and clinical exam findings that demonstrate progressive improvement. When improvement plateaus, or if the condition worsens, continued care beyond the initial 30 day treatment period is either considered to be maintenance care or contraindicated to medical necessity. In either case the care is not covered.

Decreased Intensity and Frequency of Care – Treatment guidelines describe effective care reflected by decreasing intensity of care in the level of adjustment as well as the frequency of care over the course of treatment. This results in an overall ratio of 1:1 for 98940 to 98941 adjustments network wide. A treatment course that remains high in frequency and intensity will be subject to review as it does not mirror improvement in the patient's condition.

X-Rays – While x-rays remain an valuable tool for diagnosing patient conditions, today's improved clinical exam techniques and practitioner diagnostic skills in this area allow most chiropractic patients to be safely treated without exposing them to the risk and expense of x-rays. X-rays are indicated in cases where **trauma** has occurred or the chiropractor has reason to suspect some **other pathology** is present, such as a tumor, fracture, infection, congenital anomaly or the patient has not responded as expected to an initial course of chiropractic care. (See Chiropractic Treatment Guidelines, Part D, Medical Imaging)

Treatment of Children/Infants – CRG and SCHA have adopted conservative treatment guidelines for this group of patients. Chiropractic care within the initial 30 day treatment period should be limited to 4 visits for infants and toddlers (Birth -4) and 5 visits for children 5 through 18. The SCHA benefit covers spinal related conditions only. Treatment of childhood conditions such as colic, bed wetting, and ear infection must have clear subluxation levels documented. The treatment outcome expectation for these patients is for them to respond within the initial treatment period. If they do not, continued care is not indicated as SCHA prefers these conditions closely monitored by the member's primary care physician. Upon subsequent examination by the primary care physician, if continued chiropractic treatment is indicated a referral from the PCP will be necessary.

Daily notes required with claims – Daily treatment notes must be submitted in the following cases:

1. Treatment of a patient age birth through age 4
2. When a treatment code 98942 is used
3. When Multiple view X-Rays have been taken

Case Management and Referral – Each SCHA member has a clinical case manager assigned to them. They can be a valuable resource to you when you have a need to

bring other health care disciplines together to develop a multi disciplinary plan of care or you need help with the referral of a challenging patient. If you need assistance with a referral we ask that you contact CRG and we will arrange for a case manager to work with you.

Quality Monitoring Standards – The CRG network’s Quality Improvement Council has established the following provider performance measures that your own clinic’s performance will be measured against. These are based on actual network utilization data and community standards of care. Of particular emphasis to all new providers is that up-coding of the manual manipulation code is prohibited. Adjusting 3 to 4 areas of the spine is not compensable at the 3 to 4 area level, 98941, unless the patient presents with symptoms documented to be in those same areas.

We have found that some providers have become accustomed to billing 3-4 or 5 level adjustments for all of their government program patients. While fee for service MA and Medicare may not monitor chiropractic cases closely, CRG is accountable to CMS and SCHA for assuring the appropriate treatment and accurate billing of services provided to patients and we monitor this very closely. Billing for a higher level of treatment than the patient’s condition or complaint warrants, or up-coding, is fraudulent and CRG is responsible to identify, and report it when encountered.

CRG’s chiropractic treatment database on this population of patients extends over 8 years and includes more than 65,000 doctor/patient encounters. This broad base of treatment information allows us to predict typical patient population mix of intensity and frequency of care. Our Quality Improvement Council has established a standard of 50% 98940 and 50% 98941 as a Quality measure for the expected ratio of patient adjustments in a network practice.

The following Quality Monitoring Standards are the backbone of our Quality Improvement Program. You will need to become familiar with them as your clinic’s own performance will be measured against these as you begin to provide services to CRG patients.



CRG Quality Monitoring Standards 2011
*QM Standards are shown in **bold***

Description of Standard	Standard Adults age 65>	Standard Adults age 18 thru 65	Standard Children age 5 to 17	Standard Children Birth thru 4yrs
Patient Visit Average: The total number of visits for all patients treated by a provider divided by the total number of patients over a twelve month period.	<10	<6	<5	<4
% 98940: The percentage of patients who receive a one / two level adjustment	>50	>50	>50	>50
% 98941: The percentage of patients who receive a three / four level adjustment	<50	<50	<50	<50
% 6+ visits/30 days: The percentage of patients who are seen at least 6 times within the first 30 days of care	<50	<20	<20	NA.
% 4 visits/30 days: The percentage of very young patients who are seen at least 4 times within the first 30 days of care.	NA	NA	NA	<50
% of Patients x-rayed: The percentage of patients who receive at least one radiographic exam over the course of the year	<25	<25	<10	<10