PROCEDURE NUMBER: 11.00

Subject: Chiropractic Care

Reference: Policy HC-02, Chiropractic Care; Memorandum of Agreement of the Provision of Chiropractic Services

Approved: _____
for Management Committee

Effective: December 1, 2003

ITEM NO. **PAGE**

11.01 INTRODUCTION

The Commission recognizes chiropractic treatment as defined in Policy Statement HC-02 which states:

> Chiropractic treatment is a health care service covered by the Commission where the treatment is rendered by a chiropractor who is registered and in good standing with the Newfoundland and Labrador Chiropractic Board.

Under the section, Coverage for Chiropractic Care the policy states:

> Chiropractors are considered primary care providers and can be selected by injured workers as their only or principal provider of care for their injury. Chiropractic care can also be provided on a referral basis, from another licensed health care practitioner.

The Commission has entered into a Memorandum of Agreement with providers of chiropractic care services.

For the purpose of this procedure, the term "decision maker" refers to the appropriate Intake Adjudicator or Case Manager who is responsible for the claim at any given time.

11.02 COVERAGE FOR CHIROPRACTIC CARE – ACUTE CARE

Initial Assessment and Initial Purchase Order for Treatment on New Claims

11.02.1 New Claims

For the purpose of this procedure, a new claim is considered one where chiropractic care is obtained within 90 days of the date of injury.

Regardless of whether a new claim has been accepted or not, upon receipt of the first Chiropractor's Form 8/10 Report – Initial Assessment, and providing that the date of the initial chiropractor visit is less than 90 days from the date of injury, the system will:

i. automatically approve payment for the initial assessment visit and report fees (providing no initial assessment has previously been paid for on that claim); and

ii. automatically issue a purchase order for up to a maximum of fifteen (15) treatments (providing that no previous purchase orders have been issued on that claim).

A system generated message will be sent to notify the decision maker that an initial assessment visit and report fee have been paid and that an initial purchase order for treatment has been issued. The default end date for all initial purchase orders will be 90 days from the first date of service. In other words, once treatment has commenced, it must be completed within 90 days of the first treatment.

However, initial purchase order end dates can be extended for greater than 90 days if special circumstances exist. For example, an offshore worker who works shift rotations of 3 weeks on / 3 weeks off will have difficulty accessing regular treatment and the decision maker may decide to extend the initial purchase order to 120 days in these circumstances.

In order to extend an end date on an initial purchase order that has already been automatically been issued, the decision maker will have the ability to change the end date on the purchase order maintenance screen. The revised purchase order will automatically be re-printed the following business day and sent to the treating chiropractor.

If the decision maker subsequently denies a new claim in which chiropractic treatment has begun, all treatments provided up to and including the date of written notice of the denial will be approved for payment. The decision maker will inform the Chiropractor and injured worker first by telephone and thereafter in writing, within three (3) business days of the denial. As well, the decision maker is responsible for inactivating the purchase order effective the date of the written notice. The Commission will not be responsible for payment of chiropractic treatment on the claim after the date of the written notice.

11.02.2 Chiropractic Treatment Beyond 90 days on a New Injury and Chiropractic Treatment on All Recurrences

For new injuries greater than 90 days, providing that an initial assessment visit and report fee have not already been paid, upon receipt of the first Chiropractor's Form 8/10 Report – Initial Assessment, the system will automatically approve the first assessment (visit and report fees) only. A system generated message will notify the decision maker that an initial assessment visit and report fee have been paid.

For recurrences that have already been determined to be compensable, and providing that an initial assessment visit and report fee have not already been paid in the last 31 days, upon receipt of the first

Chiropractor's Form 8/10 Report – Initial Assessment, the system will automatically approve the first assessment (visit and report fees) only. A system generated message will notify the decision maker that an initial assessment visit and report fee have been paid.

In the case of an inactive claim where the Chiropractor Form 8/10 is the first indication of a possible recurrence, and providing that an initial assessment visit and report fee have not already been paid in the last 31 days, upon receipt of the first Chiropractor's Form 8/10 Report – Initial Assessment, the system will automatically approve the first assessment (visit and report fees) only. A system generated message will notify the decision maker that an initial assessment visit and report fee have been paid and that a form 6R and 7R are required for adjudication. In these instances, once all the necessary information has been received, the decision maker must determine if the recurrence is compensable in accordance with Policy EN-03 Recurrences, before proceeding further.

After receipt of the initial chiropractor form 8/10 on new injuries or recurrences already accepted or after receipt of the initial chiropractor form 8/10 and it is subsequently determined that a recurrence is accepted, the decision maker must then determine the propriety of treatment which may be done in consultation with a Commission chiropractor consultant. If it is determined that chiropractic treatment should be covered, the decision maker will issue an initial purchase order for up to a maximum of 15 treatments. The default end date for the purchase order will be 90 days from the date of issue unless the decision maker determines that an end date greater than 90 days is appropriate. A purchase order can be issued retrospectively in cases where a decision maker determines that chiropractic treatment is appropriate and a chiropractor has already begun treatment. However, this is not the preferred approach recommended by the Commission.

If the decision maker determines that chiropractic treatment will not be covered, the decision maker will inform the Chiropractor and injured worker first by telephone and thereafter in writing, within three (3) business days of the denial. Where a chiropractor chooses to begin treatment without an active purchase order number, and the decision is subsequently made not to cover treatment, payment for treatment will be denied.

11.02.3 Extensions

The Decision maker may approve payment for extensions beyond the initial 15 treatments where evidence-based care has shown further objective functional improvement is achievable based on the worker's progress to date.

The following applies to extension requests for new claims, new injuries greater than 90 days, and all recurrences.

In accordance with the Memorandum of Agreement, a chiropractic extension request will be provided by the Chiropractor at least by the ninth (9^{th}) treatment of each fifteen (15) or by the beginning of the fourth (4^{th}) week in each extension period.

The following factors should be considered when determining whether to approve coverage for an extension request:

i. the worker's objective functional improvement to date;
ii. the reason for, and amount of, the extension requested;
iii. the functional goals expected as a result of extending the treatment coverage;
iv. the potential for an early and safe return to work or participation in a labour market re-entry program as a result of extending the treatment coverage;
v. other relevant issues that may impact the worker's progress.

In issuing an extension purchase order:

i. the decision maker may approve the first extension of treatment if there is clear evidence of objective functional improvement;
ii. the Commission's chiropractor consultant may be consulted at any time on extension requests for less than 30 treatments.
iii. All extension requests after 30 treatments must be reviewed by a chiropractor consultant.

The number of treatments covered will be based on the objective needs of the worker and will not necessarily be an automatic extension for 15 more treatments. The decision maker may approve extensions for up to a maximum of 15 treatments per extension. In the case where the decision maker has decided to cover an extension of 15 treatments, the issuance of the purchase order will serve as notification. If the decision maker is approving an extension for less than 15 treatments, the decision maker must communicate this verbally or in writing to the treating chiropractor prior to issuing the extension purchase order.

Default end dates for extension purchase orders will be 120 days from the date of issue. As with initial purchase orders for treatment, the end date can be extended by the decision maker, if necessary.

If the decision maker determines that an extension of chiropractic treatment will not be covered, the decision maker will inform the Chiropractor and injured worker first by telephone and thereafter in writing, within three (3) business days of the decision. Where a chiropractor chooses to extend treatment without an active purchase order number, and the decision is subsequently made not to cover an extension of treatment, payment for treatment will be denied. A purchase order can be issued

retrospectively in cases where a decision maker determines that an extension for chiropractic treatment is appropriate and a chiropractor has already begun treatment. However, this is not the preferred approach recommended by the Commission.

Extensions will not be covered where maximum medical improvement has been achieved and continued treatment is solely for symptomatic relief. If maximum medical improvement has been achieved, in order for the Commission to continue coverage for chiropractic care, the worker's condition would have to meet the policy criteria under Supportive Care.

11.03 COVERAGE FOR CHIROPRACTIC CARE – SUPPORTIVE CARE

From Policy HC-02:

> Supportive care is care that:
> 1. is therapeutically necessary,
> 2. is provided to injured workers who have reached maximum medical improvement and have returned to work or are participating in a labour market re-entry program, and
> 3. is required because the worker fails to sustain this level of recovery and demonstrates progressive, objective deterioration with periodic withdrawal of treatment on a trial basis.
>
> Supportive care follows appropriate application of passive and active care, including rehabilitation and lifestyle modifications. It is appropriate where alternate care options, including home-based self-care, have been considered or attempted.
>
> Supportive care may be inappropriate where it interferes with other appropriate primary care or where the risk of supportive care outweighs its benefits.
>
> Supportive care will only be covered in cases where the Commission's Chiropractic Consultant agrees that the worker has reached maximum medical improvement for the compensable injury and that there is objective evidence of progressive deterioration with periodic withdrawal of treatments.

In all cases where a request is made by the treating chiropractor to continue chiropractic treatments as supportive care, the decision maker must refer the claim to a Commission chiropractor consultant for review. The Commission's chiropractor consultant will determine:

i. if the worker has reached maximum medical improvement, and
ii. whether the treating chiropractor has periodically withdrawn treatment on a trial basis and, as a result, the worker has demonstrated progressive, objective deterioration.

If the Commission's chiropractor consultant determines that the worker meets the foregoing criteria, then the decision maker may issue a purchase order to cover supportive care treatments. The Commission will generally pay for a maximum of fifteen (15) treatments for a period of 12 months.

Additional supportive care treatments can be covered if, after re-evaluation, the worker continues to meet the above criteria.

11.04 COVERAGE FOR CHIROPRACTIC CARE PREVENTATIVE/ MAINTENANCE CARE

Preventative/maintenance care is elective care that is chosen by the patient to prevent disease, prolong life, promote health and enhance quality of life. This elective care will not be covered by the Commission.

If a decision maker has any difficulty in determining if continued coverage of chiropractic treatment would be considered supportive or preventative/maintenance care, the claim will be referred to a Commission chiropractor consultant to assist in making that determination.

11.05 REASSESSMENT

A "reassessment" (any full re-evaluation of an injured worker by the chiropractor, including a detailed physical examination, which occurs after an initial assessment) may be required in the course of acute

or supportive chiropractic care to assist in determining if the direction or continuation of further chiropractic care is appropriate.

The decision to cover a reassessment is usually determined by the decision maker in discussion with the treating chiropractor and/or may be done in consultation with, or at the recommendation of, the Commission's chiropractor consultant. Once this determination is made, the decision maker can issue a purchase order for this purpose. The default end date for reassessment purchase orders will be 14 days but can be extended by the decision maker in special circumstances.

11.06 CHANGING CHIROPRACTIC CLINICS

Changing chiropractors during the course of treatment is not encouraged or advisable, as it may interrupt the continuum of care and negatively impact recovery from the work injury. However, there may be circumstances where a change in chiropractors is necessary or unavoidable. In such cases, the worker or the new chiropractor must request the initial chiropractor to forward a progress report to the new chiropractor and to the Commission. This should include the number of treatments provided to date.

It is important to note that the Commission's purchase order numbers are not transferable from one health care provider to another; therefore, the chiropractor taking over the worker's care must request the Commission's approval for coverage.

When a worker changes chiropractic clinics, the decision maker may issue a purchase order for another initial assessment with the new chiropractor. In most cases, the decision maker will also issue a purchase order for the remaining number of chiropractic treatments which should take in to account the number of chiropractic treatments already given to the worker. The decision maker must also inactivate the purchase order for the previous chiropractor clinic to ensure no further payments are made for treatment to that clinic.

11.07 REPORTING

Treating chiropractors will submit reports in accordance with the Memorandum of Agreement, Schedule A Services – Reporting.

11.08 TELEPHONE CONSULTS

The decision maker may initiate a telephone consultation with a treating chiropractor regarding an injured worker's recovery. In these cases, the Commission will reimburse the chiropractor in accordance with the Fee Schedule outlined in the Memorandum of Agreement, Schedule C. The decision maker who is initiating the telephone consultation will complete a Chiropractor Telephone Consult form and submit to a health care benefits assistant for payment.

11.09 MISSED APPOINTMENTS

Where, in the opinion of the treating chiropractor, an injured worker has missed more than one appointment without a reasonable explanation (e.g. a reasonable cause may be extreme weather

conditions), or is otherwise non-compliant, the chiropractor must notify the decision maker within one (1) business day in accordance with the Memorandum of Agreement.

When the decision maker has been advised of missed appointments, a decision on further entitlement will be made in accordance with Policy EN-17, Interruptions and Delays in Work Injury Recovery**.**

11.10 HEALTH CARE ENTITLEMENT CONSIDERATIONS

Cost related to travel and board associated with chiropractic care under this Procedure will be considered in accordance with the Commission's Policy HC-13 Health Care Entitlement and Procedure #60 Health Care Fees and Expenses.

Automatic approval of 15 treatments of acute chiropractic care for claims awaiting adjudication does not imply approval of other health care items. Such items must be approved in accordance with standard medical aid practices already in place.

11.11 CHIROPRACTIC X-RAY BILLING

The Commission will reimburse chiropractors who provide x-ray services in their private clinics based on hospital weighted units at a Commission-approved unit rate.

EXAMPLE:
Hospital x-ray billing for various charges for taking routine views of the lumbosacral spine* are as follows:

CODE	DESCRIPTION	UNITS
2005	Reception and Initial Handling	6
2020	Quality Control	2
2025	Technical Supervision	1
	Technical Units Producing Films	15
2010	Filing	5
2015	Report Typing and Handling	4
TOTAL		33

* Any additional views – 5 units per film.