NYSCA SUFFOLK COUNTY

District 7

OCTOBER 2020 NEWSLETTER

PRESIDENT'S MESSAGE

As many of you are aware, we are no longer sending out a paper newsletter, only a digital version. For the next three months our District will instead be sending oversized post cards to all Chiropractors in the county. The post cards will be sent as a reminder to our members of upcoming meetings as well as a reminder to look for the digital newsletter. January the digital newsletter will only be sent to NYSCA D7 members and those area DC's who have contacted us specifically to receive a copy.

I am happy to inform our members that effective 10/1/2020 the new No-Fault fee schedule went into effect. We are unable to send you the specific fees due to the fee schedule proprietary protections. The NF fees are now the same as the WC fees. The biggest fee change was in the conversion factor for all Physical Medicine codes, which is now 9.55. This increase was the result of years of persistent hard work and communication from our leadership on the state level.

I have received several calls from doctors receiving letters from Empire BC/BS Medicare regarding the use or misuse of some modifiers. These letters are informative only not punitive, my suggestion is to contact them and discuss with them their concerns. Also if you are a member and are having problems with any carriers please contact your board members to keep us informed. We are tracking consistent and persisting patterns of carriers not paying and need your information to make things change.

Thank you to everyone that attended the virtual NYSCA Convention this weekend. Let's hope in January we are able to resume face to face meetings. Until that time we all hope to see your faces at our upcoming District Zoom meeting at 8 pm on Wednesday, 10/21/20. Stay safe, stay well. Thank you.

Your President,
George Rulli, DC

3RD WEDNESDAY OF THE MONTH AT 8:00 PM

ZOOM MEETING

Members: Look for invite from NYSCA

October 21st - 8:00 PM
CONVENTION HIGHLIGHTS

November 18th - 8:00 PM

December 16th - 8:00 PM

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FROM THE EDITOR

Everything seems to change so quickly; however, your board members have discussed for years about going to a digital format. We fought for the paper tiger but alas it has been tamed. While we could pretend that we did it for the sole reason of going green that just is not true; it is about costs.

Our newsletter's mission to keep our district members informed of timely state issues and awareness of the topics of the upcoming meetings has not changed. As always, we still seek to find new members for NYSCA membership. Postcards will be mailed, for the next three months, to every DC in Suffolk to help make them aware of the changes. If non-members would like to receive our newsletter, they can request to receive a copy by contacting Dr. Rulli directly.

New features will include original practice perspectives from our board members and we will publish letters to the editor. Equiptment for sale, practice for sale or help wanted ads are still being accepted. We also would like to publish your articles as well; just contact me directly. Letters to the editor and ads must be received by the first day of the month for inclusion in the next edition.

District 7 will continue with our "coffee with a colleague" program. Call me or a Board member that you have not met with before and get together for a cup of coffee - on us. We want to find out about how you would like to see NYSCA better help Chiropractic in both our community and our practices. Perhaps we will feature your perspectives in a future edition of the newsletter.

As the president always reminds us in his message, the Board would like to see you more involved in our district. The invitation is extended to you to attend our monthly meetings, seminars and events. Have you ever thought about serving as an officer in the NYSCA? What topics would you like to see us cover at our district meetings and what seminars would you like to see as a part of our CE's and Coffee series?

Stay connected with the NYSCA, your district and remember to share our newsletter.

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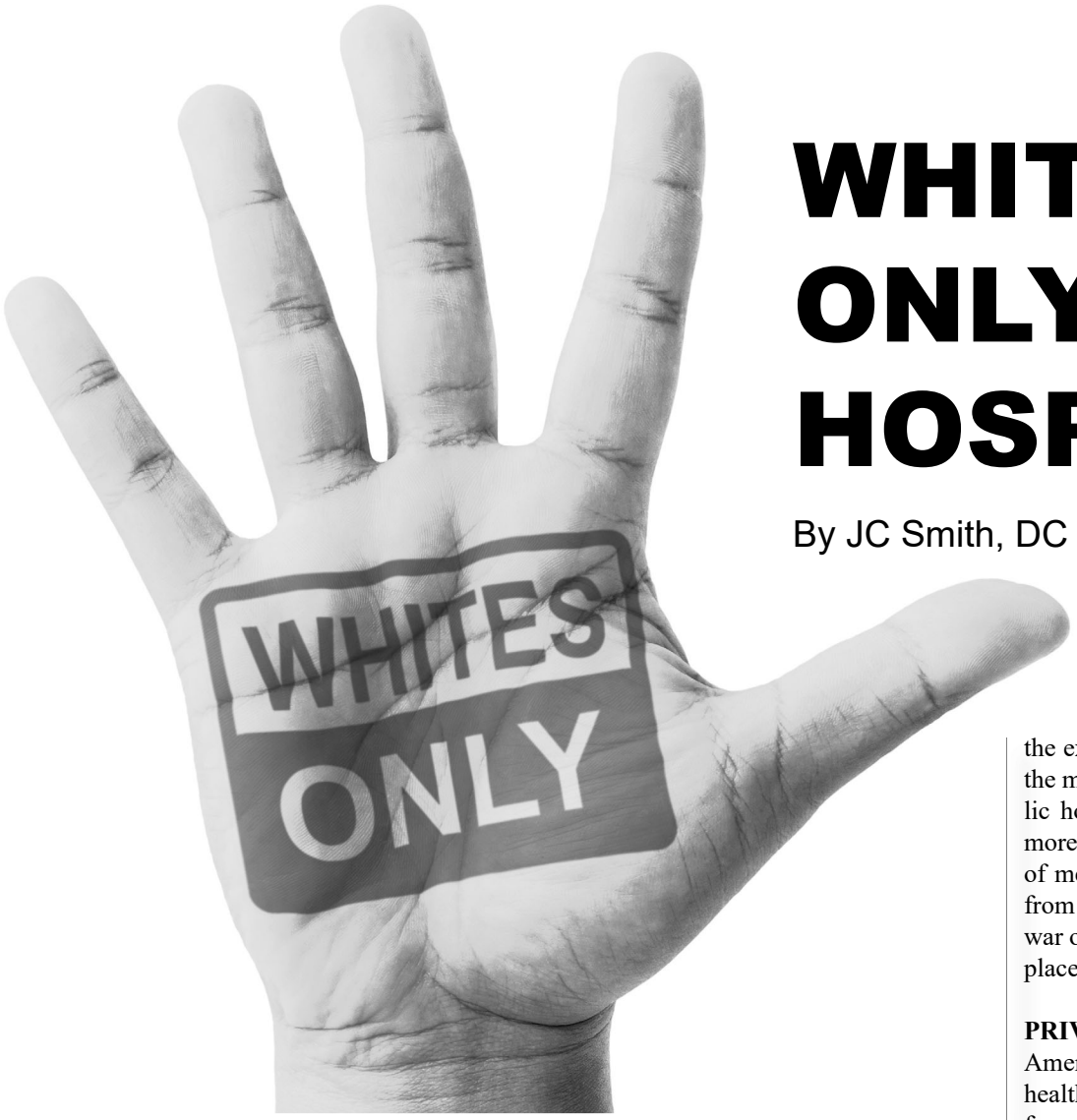

WHITES ONLY IN HOSPITALS

By JC Smith, DC

The foremost example of medical supremacy and taxation without representation is the continuing blockade of chiropractors from public hospitals despite a major lawsuit rendering illegal the medical boycott of chiropractors in public hospitals.

Imagine if there were a sign on any hospital stating, "Whites Only," the public would be outraged although this obvious discrimination was common during the era of Jim Crow, MD. A fascinating 2016 article in The Atlantic summarized this issue, America's Health Segregation Problem Has the country done enough to overcome its Jim Crow health care history?:

> Like other forms of segregation, health-care segregation was originally a function of explicitly racist black codes and Jim Crow laws. Many hospitals, clinics, and doctor's offices were totally segregated by race, and many more maintained separate wings or staff that could never intermingle under threat of law.
>
> The sweeping tide of Civil Rights papered over the fissures that were built into Jim Crow-era health-care, but progress was slow and proved much more difficult to assess than progress in education or housing. Generations of strict geographical segregation left hospitals that served black people deeply segregated, understaffed, and underresourced. The number of black physicians has never come close to matching their demographic share of the total population. Unlike the temporary integration gains in education, there is no real high-water mark for the state of health-care integration.

This obvious act of racial discrimination was a clear example of illegal segregation and the lack of free enterprise as well as an example of "taxation without representation." With the excuse of protecting "patient welfare," the medical profession has taken over public hospitals as if black MDs or DCs are more dangerous compared to their brand of medical care. Nothing could be further from the truth; in fact, it is simply a turf war over money by controlling the marketplace (hospital).

PRIVILEGE OR RIGHT?

America has yet to answer the question: Is healthcare a right or a privilege not only for patients of all colors and those who can afford it, but for doctors of all types?

Even the term "hospital privileges" suggests an exclusive private supremacy club for medical members only, most of whom are white male MDs.

Obviously, it is a privilege if you can afford it and if your insurance gatekeeper allows you to see the practitioner of your choice. Obviously, for many people the gate is still closed when chiropractic care is unavailable or restricted. Sadly, "profits over patients" is the guiding light in America's for-profit healthcare system and will remain as long as the medical-industrial industry is the largest lobby on Capitol Hill guarding its monopoly.

Continued on page 12

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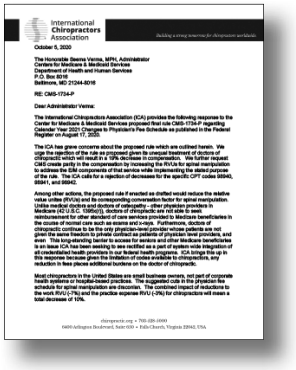


October 5, 2020

The Honorable Seema Verma, MPH, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-1734-P

Dear Administrator Verma:

The International Chiropractors Association (ICA) provides the following response to the Center for Medicare & Medicaid Services proposed final rule CMS-1734-P regarding Calendar Year 2021 Changes to Physician's Fee Schedule as published in the Federal Register on August 17, 2020.

The ICA has grave concerns about the proposed rule which are outlined herein. We urge the rejection of the rule as proposed given its unequal treatment of doctors of chiropractic which will result in a 19% decrease in compensation. We further request CMS create parity in the compensation by increasing the RVUs for spinal manipulation to address the E/M components of that service while implementing the stated purpose of the rule. The ICA calls for a rejection of decreases for the specific CPT codes 98940, 98941, and 98942.

Among other actions, the proposed rule if enacted as drafted would reduce the relative value unites (RVUs) and its corresponding conversation factor for spinal manipulation. Unlike medical doctors and doctors of osteopathy - other physician providers in Medicare (42 U.S.C. 1395x(r)), doctors of chiropractic are not able to seek reimbursement for other standard of care services provided to Medicare beneficiaries in the course of normal care such as exams and x-rays. Furthermore, doctors of chiropractic continue to be the only physician-level provider whose patients are not given the same freedom to private contract as patients of physician level providers, and even This long-standing barrier to access for seniors and other Medicare beneficiaries is an issue ICA has been seeking to see rectified as a part of system wide integration of all credentialled health providers in our federal health programs. ICA brings this up in this response because given the limitation of codes available to chiropractors, any reduction in fees places additional burdens on the doctor of chiropractic.

Most chiropractors in the United States are small business owners, not part of corporate health systems or hospital-based practices. The suggested cuts in the physician fee schedule for spinal manipulation are draconian. The combined impact of reductions to the work RVU (-7%) and the practice expense RVU (-3%) for chiropractors will mean a total decrease of 10%.

This is significant on its own, however, for chiropractors the reduced compensation is compounded because of the lack of payment through Medicare for E/M codes. The combined effect of reduced RVUs, reduced conversion factor and lack of payment for E/M codes results in an actual payment decrease of over 19%. Even without the economic challenges created by COVID-19, this is an extraordinary burden that most providers will be challenged to absorb. It also shows a lack of parity between compensation of the non-drug professions.
Overall, the proposed rule has far reaching and negative effect on the ability of all Essential Health Care Workers, chiropractors included, to recover from forced closures and limitations to practice during the global COVID-19 pandemic.

As you may know in some states there were forced closures and other limitations to operations of health care offices including chiropractors. This resulted in a total loss of income for many and a dramatic reduction in income for some of 70% or more for several months. The negative effects of this are still being felt and will take years for the health system to recovery. If implemented as proposed, these drastic reductions will negatively affect the ability of Medicare beneficiaries across the nation to access needed non-drug services.

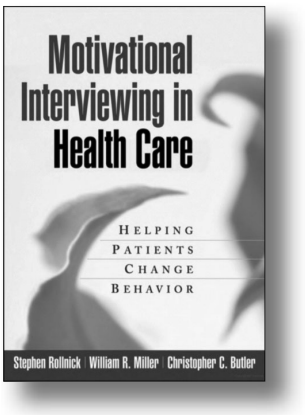
The ICA understands there is a statutory requirement for CMS to re-evaluate RVUs and seek to maintain budget neutrality. We call for a more reasoned and balanced approach from CMS to provide a level of parity in reimbursements while seeking budget neutrality. If implemented, the rule will increase the disparity between physician level providers compensation, not decrease it, given the restrictions on codes for doctors of chiropractic. We specifically request no decrease for CPT codes 98940, 98941, and 98942. While doctors of medicine and doctors of osteopathy are paid for E/M codes and will see increases in reimbursement due to increases in RVUS with these codes, doctors of chiropractic will not, but will be burdened with a reduction in compensation. Given that CMS is proposing to reduce the RVUs and the conversion factor for spinal manipulation codes, the only codes Medicare reimburses for chiropractors, impact to Medicare beneficiaries and their chiropractic providers creates a significant disparity in the treatment of the profession and those who seek its non-drug approach to care. ICA requests instead that CMS address the disparity and increase the RVUs for spinal manipulation to address the E/M components.

To read the full ICA response, click here.

Chiro's Read

By Dr. Philip A. Facquet III, Editor

Consider the task of conversion of a patient from a sick, problem focused, care plan to a well care program. It is not always easy. During Saturday's NYSCA Convention this idea was addressed by Dr. Thomas Ventimiglia. He talked about the concept of a 'Wellness Interview.' His discussion centered around ideas from a book he recommended, entitled Motivational Interviewing in Health Care, and his own practice experience.



Evidence based acute care does have an ending point for both active manipulation and therapy delivery. Good care with a start and a finish. Following that are we just to let a patient go or is there more help that a DC can offer to improve their health and overall care experience? What about the discovery, during our consultations and history, concerning the comorbidities and lifestyle choices that our patients are making? Can we help them change; can we help improve their health?

We are uniquely qualified as DC's to offer help for exercise, weight loss, diet and nutrition, stress, spiritual life and even improvement in home or work environments. According to Dr. Ventimiglia to do this we have to have our patients first agree to discuss it and then to buy in to the process of change. A tool he uses to start this process is a wellness questionnaire used at Princton.

The Princeton Wellness Self-Assessment Tool was suggested to be sent home with the patient following their first visit. https://umatter.princeton.edu/sites/umatter/files/media/princeton-umatter-wellness-self-assessment.pdf

During the subsequent visit the patient returns the assessment and during the 'wellness interview' he asks the patient a powerful question: "Do you mind if we talk about (weight, smoking, exercise, etc.) next time you come in?" It is yes or no. We want a buy in; if not we have to let it go at this time for the patient. Some are just not ready to talk about it. The patient is always in charge of their health care and we must respect that boundry.

Dr. V. reminds us that doctors helping patients change behavior is dependent on the skills docs develop in practice communication. Being able to use the patient's voice, their own phrasing, helps the doctor communicate that we understands their concerns. Our goal is to help our patients arrive at the realization that lifestyle changes will be helpful to them and that we have the expertise needed.

Developing a respectful form of doctor patient communication, which promotes the patient's innate ability to change, is the goal. The necessity of getting the patient to state that they understand lifestyle concerns is key for the discussion of setting goals and making positive lifestyle changes. He states that this care is based on a process of developing trust and the patient's actualization that they can change. This is not a one time effort. For a video of this discussion see the following link: https://www.physio-pedia.com/Physiotherapy_communication_approaches_in_management_of_obesity_and_overweight

Be SMART in setting goals:

Specific
Measurable
Achievable
Relevant
Time based

SPECIFIC
MEASURABLE
ACHIEVABLE
RELEVANT
TIME BASED

Is this idea an "Above Atlas Adjustment?" What if patient empowerment was as important as a chiropractic adjustment to helping the patient to obtain better health?

We can change the world one patient at a time and these ideas will help us do it better.

ICD-10 Changes for 2020-2021 - Effective October 1, 2020

By Rebecca Scott, CPC

As we prepare for the changing of the season, pulling out coats ahead of the cold weather, it's also the time to pull out current coding books. Because ICD-10 diagnosis codes are controlled by the government, they work on a government fiscal year, October 1-September 30. New codes go into effect prior to CPT code changes that happen every January. For that reason, we must be diligent in reviewing our diagnosis codes and habits to prepare for the updates. This year there are several new diagnosis codes commonly used in Chiropractic and some that have been discontinued. Here we outline some of the changes that are expected to affect doctors in this profession.

CHAPTER 13-DISEASES OF THE MUSCULOSKELETAL SYSTEM

Usually, the most dog-eared pages in a chiropractor's coding book are from this chapter of codes. For 2021, this chapter has 57 new codes and 3 deleted codes (M92.50, M92.51, and M92.52 Juvenile osteochondrosis). Many of these new codes simply add options for "other specified sites" providing another option for individual areas that didn't exist before. Most of these fixed the problem of your only option being a specific site (like a certain joint) or an unspecified site. Now, these changes open the possibility for "another specified site" if not listed with a code.

The codes for TMJ have been expanded to describe other specified sites of arthritis and osteoarthritis, as well as arthritis and arthropathy of the TMJ (e.g., M266.51, Arthropathy of right temporomandibular joint). In addition, there are added bilateral and bone-specific codes for juvenile osteochondrosis of the tibia and fibula such as M92.523 (Juvenile osteochondrosis of tibia tubercle, bilateral). Be sure to have your codebook in front of you.

AVOID "UNSPECIFIED" AND "NOT ELSEWHERE CLASSIFIED" IF POSSIBLE

Codes with "Unspecified" or "not elsewhere classified (NEC)" notated in the title are for use when the information in the medical record provides detail for a code that does not exist in ICD-10. The provider is then left with choosing a more generalized code, or in other words, it's "as good as it gets." Last year they chose to expand the code this way for diagnosing myalgia. If the location of the myalgia were not the head and neck but another specific region, you would most likely use code M79.18 - 'other site.' This means the medical record provides detail for which a specific code does not exist. Nobody wants to say the 'medical record is insufficient' so when possible, AVOID using "unspecified" diagnosis codes. For this, we are grateful that many of the code families have been updated to include this option.

These are a collection of some of the updated, "other specified" codes added for this year:

M24.19 Other articular cartilage disorders, other specified site
M24.29 Disorder of ligament, other specified site
M24.39 Pathological dislocation of other specified joint, not elsewhere classified
M24.49 Recurrent dislocation, other specified joint
M24.59 Contracture, other specified joint
M24.69 Ankylosis, other specified joint
M24.89 Other specific joint derangement of other specified joint, not elsewhere classified
M25.39 Other instability, other specified joint
M25.59 Pain in other specified joint
M25.69 Stiffness of other specified joint, not elsewhere classified

Here are the changes to the TMJ family of codes:

M26.641 Arthritis of right temporomandibular joint
M26.642 Arthritis of left temporomandibular joint
M26.643 Arthritis of bilateral temporomandibular joint
M26.649 Arthritis of unspecified temporomandibular joint
M26.651 Arthropathy of right temporomandibular joint
M26.652 Arthropathy of left temporomandibular joint
M26.653 Arthropathy of bilateral temporomandibular joint
M26.659 Arthropathy of unspecified temporomandibular joint

CHANGES TO THE DESCRIPTION OF HEADACHE

In ICD-10, headache related conditions reside in Chapter 6, Diseases of the Nervous System, and most begin with the letter G. An example is G44.201, described as Tension-type headache, unspecified, intractable. Don't worry…these haven't changed. But a review of this code in your coding resource indicates an "Excludes 1" remark for Headache code R51. A type 1 Excludes note is a pure excludes note. It means "NOT CODED HERE!" An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1. So, we are taught not to use R51 at the same time as a G level headache code.

Now enter the updated ICD-10 code set. R51 has been deleted as of October 1, 2020. There are two more specific codes to replace it.

R51.0 Headache with orthostatic component, not elsewhere classified
R51.9 Headache, unspecified

ICD-10 ADDITIONAL CHANGES

There are almost 600 changes that include 490 new codes and 47 revised codes in the update this year. We have only elaborated on the ones that are most likely to affect chiropractors. In total, there are now 72,606 codes for you to choose from. Please review all your codes on an annual basis and ensure they are up to date to avoid claim denials after October 1. Don't forget to update these in your practice management software for all billing October 1 or later.

Remember to read the Instructions. Each year the Coding Guidelines are updated. Be sure you understand the terms such as 'and', 'code also' and the recently updated term 'with' (see Page 12 of 120) of the ICD-10 CM Official Guidelines for Coding and Reporting.

Because making the right coding choices saves time and money, learn to get your chiropractic coding done right, the first time. Understand exactly what is necessary to protect your practice, and maximize your profitability – quickly, and easily.

Join the KMC University Library and get the do-it-yourself chiropractic CPT, and ICD-10 coding training you need. It includes monthly webinars (CEUs available!), timely news updates, and our email and live HelpDesk to answer your questions. Remember, you don't have to know everything when you know the people who do. Let us protect you!

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FACT

128 Americans die every day from an opioid-related overdose. To build greater awareness of non-pharmacological options such as chiropractic care, September has been designated as Drug-Free Pain Management Awareness Month.

#ThinkChiropractic

Through drug-free chiropractic care, individuals can improve mobility and stability and achieve a more comfortable night's rest. Optimal health starts with chiropractic care.

#ThinkChiropractic

WHITES ONLY IN HOSPITALS CONTINUED FROM PAGE 3

The illegal restraints of "hospital privileges" in public hospitals still prevail in our for-profit healthcare by limiting patient access to chiropractic care. The lack of 'privileges' is a good example of antitrust behavior—the boycott and prejudice against chiropractors (chirophobia)—evident by the absence of DCs in 96.4% of public hospitals.[1]

Put simply, antitrust law is about ensuring a level playing field for competition designed to keep markets fair. When it works correctly, antitrust law is supposed to prevent companies from abusing their dominance in the marketplace to gain an unfair competitive advantage.

We saw this recently when Congressmen confronted the chief executives of Amazon, Apple, Facebook, and Google with documents showing the companies had abused their market power and crushed competitors unfairly.

Obviously not allowing chiropractors in a public hospital is an unfair advantage to a huge market as the Wilk v. AMA antitrust trial demonstrated. Today only 3.6% of doctors of chiropractic (DCs) hold staff privileges at a hospital, more than 30 years after the Wilk decision.[2]

This medical dominance is fought for billions of good reasons.

The pandemic of back pain has become the leading medical expense in the US among the 154 conditions with an estimated $134.5 billion in spending in 2016.[3] The US chiropractic market size was valued at $12.26 billion in 2017. If the quasi-boycott continues, the chiropractic revenue is expected to grow only slowly, rising at an annualized rate of 1.2% over the five years to 2020 to $16.3 billion.

As the boycott continues, the chiropractic revenue is expected to grow only slowly, rising at an annualized rate of 1.2% over the five years to 2020 to $16.3 billion. If and when this boycott ends, considering 50-90% of all back surgeries are deemed unnecessary, our market share will skyrocket.

Keep in mind this slow growth occurs while back pain is the leading disability in society, workplace, military and globally. Also keep in mind this slow growth is due to the medical monopoly that has handcuffed chiropractors evident by only 3.6% have hospital privileges.

Keep in mind chiropractors are excluded from public hospitals despite the fact our public taxes pay for these public facilities. If any racial minority were excluded from a public hospital, civil right activists would come down on the hospital administration like a load of bricks. If female MDs were excluded or limited by glass ceilings, lawsuits would fly. But when chiropractors are systematically excluded despite being licensed by the state governments and a preferred front-line conservative care, nothing is said. The boycott of DCs in public hospitals was the major point of the Wilk v. AMA antitrust lawsuit. George McAndrews mentioned at trial the AMA's boycott of chiropractors was solely to monopolize the public facilities and to keep its leading competitors out.

According to Applying for Hospital Privileges: What Physicians Need to Know:

"In order for a physician to perform specific procedures at a specific hospital, they must apply for privileges. Appointment and reappointment for hospital privileges cost providers vast amounts of time and attention but are an essential component to high-quality healthcare and patient safety."

On the surface, this may seem reasonable to ensure "high-quality healthcare and patient safety," but underneath this definition hides the goal to keep out practitioners of different disciplines (CAM) and for many years to keep out people of different race, gender, religions, or creed.

Of course, this blatant medical discrimination has been allowed under the pretext of "hospital privileges" and "protecting patient welfare." Protection from what? Considering medical care is the most dangerous of all healthcare and ranks among the most ineffective in spine care, it is rather ironic the medical society casts aspersions at the CAM providers.

While many people may think any licensed or any willing provider should have hospital privileges and access to a public facility, this medical game is rigged to exclude competition. In no way does the medical society or hospital association want black MDs and certainly not chiropractors cutting into their domain, especially into the lucrative $85.9 billion low back pain market. There is simply too much money at stake via spine surgeries to allow chiropractors on staff despite the research showing chiropractic care ranks highest among the "best practices" for nonspecific spine care (excluding red flag cases).

Judge Getzendanner at the antitrust lawsuit, Wilk v. American Medical Assn, {671 F. Supp. 1465, N.D. Ill. 1987}, noted the evidence showed chiropractic care was more scientific and chiropractors were better trained than medical doctors:

> "…chiropractic was more effective than the medical profession in treating certain kinds of…back injuries" and "chiropractors were better trained to deal with musculoskeletal problems than most medical physicians." 671 F. Supp. at 1481-83

Mr. McAndrews explained how the AMA's claims justifying the boycott of chiropractic as an "unscientific cult" and a "threat to patient welfare" backfired in the federal courtroom:

> "The AMA has been tripped up by the very scientific studies that it demanded and which now have been used in court to confirm the finding of guilt in the antitrust case. It is certainly hoped that medical and chiropractic physicians, recognizing the scientific proof of the efficacy of chiropractic care, will now cooperate for the benefit of patients everywhere."

For the rest of the story go to:

https://www.chiropractorsforfairjournalism.com/Whites_Only.html

July 1, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

AMERICAN CHIROPRACTIC ASSOCIATION

Dear Secretary Azar:

The undersigned organizations support the actions of the Centers for Medicare & Medicaid Services (CMS) in last year's Medicare physician payment final rule to utilize the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel coding framework and AMA Specialty Society Relative Value Scale Update Committee (RUC) recommended values for office and outpatient visits starting January 1, 2021. The framework was the result of significant collaboration by an AMAconvened workgroup that brought together more than 170 state medical and specialty societies. CMS' new office visit policy will lead to significant administrative burden reduction and better describe and recognize the resources involved in office visits as they are performed today.

Our organizations also appreciate the actions of the U.S. Department of Health and Human Services (HHS) and its agencies to provide flexibility, regulatory relief, and financial assistance to physicians and health care professionals to meet the needs of patients during the COVID-19 pandemic. We greatly appreciate HHS' frequent outreach to the physician community and its responsiveness to our recommendations, questions, and concerns. As a result of confronting the novel coronavirus in hard-hit communities and mitigating its spread throughout the country, many practices face a myriad of economic hardships. We are concerned that the financial instability created by this public health crisis will be exacerbated by budget neutrality adjustments required when CMS implements a widely supported Medicare office visit payment policy finalized for 2021. Therefore, we strongly urge HHS to utilize its authority under the public health emergency declaration to preserve patient access to care and mitigate financial distress due to the pandemic by implementing the office visit increases as planned while waiving budget neutrality requirements for the new Medicare office visit payment policy.

We are deeply concerned about the impact of the sizable budget neutrality cuts this update will impose on many physicians and health care professionals who do not report office visit codes, including radiologists, pathologists, and physical therapists, all of whom face estimated 2021 payment cuts of more than 8% solely due to budget neutrality. Specialties including general surgeons, critical care physicians, anesthesiologists, emergency physicians and hospitalists face estimated cuts ranging from 5% to 7.8%. The budget neutrality driven cuts also will reduce the positive impacts of the office visit changes for primary care physicians, oncologists, pediatricians, and other specialties for whom the office visits are a high proportion of their services.

Payment reductions of this magnitude would be a major problem at any time, but to impose cuts of this magnitude during or immediately after the COVID-19 pandemic, including steep cuts to many of the specialties that have been on the front lines in efforts to treat patients in places with widespread infection, is unconscionable. Recent survey and claims analysis suggest that physician practice revenue decreased at least 50% between March and May 2020,1 which translates to a $70.6 billion reduction in revenue based on AMA analysis of CMS' National Health Expenditure data for 2018. Some physician practices may be able to recoup a portion of that revenue, but not all physicians will be able to do so. The reopening is occurring in phases for physician practices, certain patients are unable or unwilling to leave home for an in-office service or procedure, and physicians will not be able to see nearly as many patients as they did before COVID-19 due to new safety precautions and personal protective equipment supply. In addition to having reduced capacity due to safety precautions, physicians also face increased expenses post-pandemic due to these same safety precautions. We believe it is a reasonable assumption that practice revenue would be reduced by a minimum of 25% from the norm over the June to August period. That would amount to another $35.3 billion reduction in revenue based on AMA analysis of CMS' National Expenditure data for 2018. While some of that revenue loss has been offset by the CARES Act Provider Relief Fund grants, the estimated $11 billion received thus far from the $50 billion of general distribution funding represents only 10% of the total estimated revenue loss.

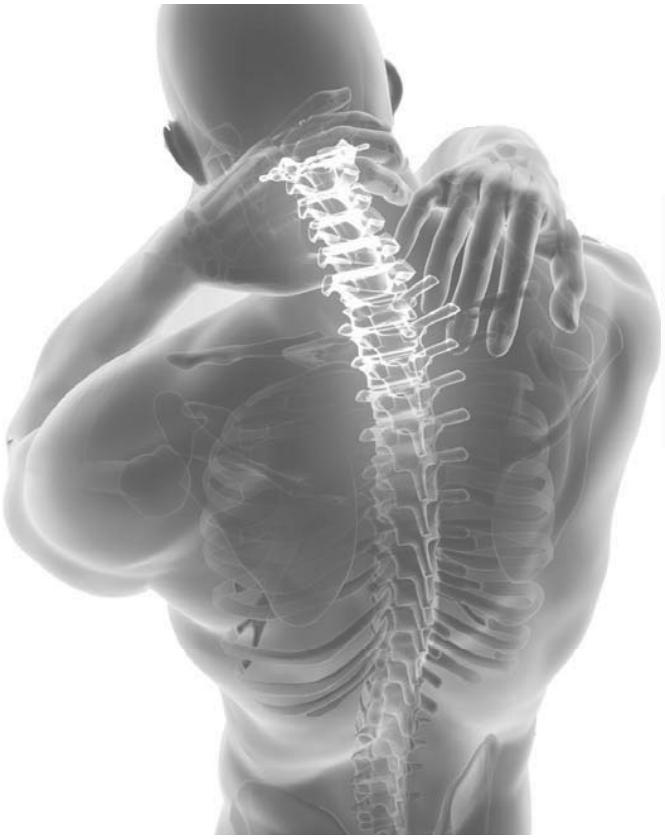
In addition, CMS loaned $40.4 billion as a lifeline to physicians, health care professionals, and other Part B suppliers during the initial phase of the pandemic through the Advanced Payment Program. Under current terms, these loans will be recouped by offsetting Medicare payments beginning in August. Our organizations are seeking regulatory and statutory improvements to these loan repayment terms, including a much lower interest rate, but even in the event of improved terms, many physician practices face the possibility that they will have either just finished repaying these loans or still be in the process of repaying them when the budget neutrality cuts take effect, compounding its negative impact.

These challenges highlight the urgent need for HHS to ensure practices facing severe economic strain and uncertainty are able to continue meeting the needs of patients during and after the pandemic. For these reasons, our organizations strongly urge HHS to use its authorities and flexibilities under the public health emergency to implement the office visit increases and waive the requirement for CMS to adjust Medicare physician payments for budget neutrality when it implements the office visit coding and payment changes that it has finalized for 2021.

Sincerely,

American Medical Association
Academy of Nutrition and Dietetics
AMDA-The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Audiology
American Academy of Child & Adolescent Psychiatry
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Ophthlamology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngic Allergy
American Academy of PAs
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Academy of Sleep Medicine
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Neuromuscular & Electrodiagnostic Medicine
American Association of Oral and Maxillofacial Surgeons
American Chiropractic Association

To read the full list, click here.



SpineCare LONG ISLAND

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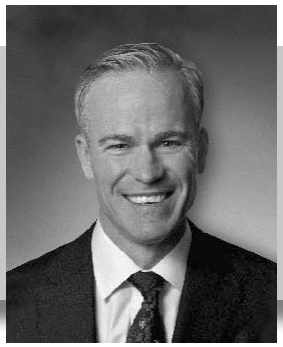
SpineCare Long Island was founded in 2017 by Dr. Kevin Mullins, Dr. Salvatore Zavarella and Dr. Amit Sharma who believed spine care could be improved with a spine center approach that combined the expertise of non-surgical MDs and spine surgeons who would collaborate for the benefit of the person with back or neck pain. The spine center has affiliate spine therapists that work closely with the physicians to provide customized home exercise programs that make the back and neck stronger, more flexible and resistant to future strain.



Kevin J. Mullins, MD, FAANS, FACS

Salvatore M. Zavarella, DO, FACOS

Amit Sharma, MD

For appointments patients are encouraged to call: 833-LI-SPINE (833-547-7463)

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WEST ISLIP, NY 11795

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ST. CATHERINE OF SIENA
MEDICAL OFFICE BLDG.
48 ROUTE 25A, SUITE 302
SMITHTOWN, NY 11787

PLAINVIEW
901 OLD COUNTRY RD
PLAINVIEW, NY 11803

SpineCareLongIsland.com

Help Avert Planned Cuts to Medicare Reimbursement

The Centers for Medicare and Medicaid Services plans on cutting reimbursement across a wide swath of providers, including chiropractors, starting Jan. 1, 2021.

TAKE ACTION
acatoday.org/hr8505

ACA

ACA has been part of two coalitions fighting these cuts and is supporting legislation designed to place a one-year moratorium on the planned cuts, to allow congress to develop a long-term solution. Contact your federal representative here and urge them to cosponsor this legislation, H.R. 8505.

THANK YOU

to all the healthcare workers and public service professionals across the nation who are on the frontline working to fight against this COVID-19 pandemic

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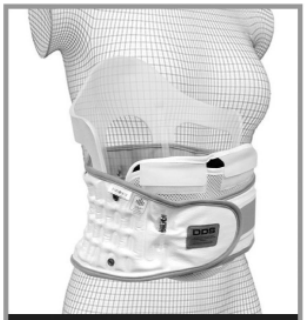

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This article was originally published in the **September 2020 edition of On The Agenda**, the official newsletter of the New York State Chiropractic Association.

No-Fault Changes Finally Take Effect

For many years, the NYSCA in conjunction with our lobbyist have been working tirelessly to gain Chiropractic parity in reimbursement with other health care providers.

Last year through the hard work of many in our association, we were able to secure a significant increase of the conversion factors for Physical Medicine when treating Workers compensation and motor vehicle injuries.

As many of you are aware **Work Comp adopted these changes last** year but the no-fault insurance carries petitioned the Department of Financial Services for a deferral until October 1st 2020 in order to make rate adjustments in response to a perceived increase in costs. This was granted by DFS although the move was opposed by the NYSCA.

The wait is over and effective Oct. 1st, 2020, the new conversion factor for Physical Medicine will be in effect for No-Fault as well.

To provide you with the most accurate information, the NYSCA in conjunction with NYCC will be presenting webinars on September 2nd and again in October.

These webinars will be an overview of conversion factors, RVU values (relative value unit) and the documentation required for each of the most commonly used codes in many of our offices.

Here is a brief example of what we will discuss.

Conversion factors for Region 1 and 2 will be 7.69; region 3, 8.79; and region 4, 9.55. Each procedure is given a value based on a number of "units" which is then multiplied by the RVU to determine it's allowable fee.

The New Patient max RVU allowed will be 18 units, re-exams 15 and office visits 12.

Here is an example of how to calculate the fee; spinal manipulation code of 98940 (1 to 2 spinal areas) has an RVU value of 4.57; in region 4 the conversion factor is 9.55.

Using the formula of your area's conversion factor (CF) and the procedures RVU (CFxRVU) you can determine your reimbursement which in this case is 4.57 x 9.55 = $43.64 for the spinal manipulation as a stand alone procedure.

We are not limited to just that fee on a visit as follow up visits are allowed up to 12 units per visit. The example above that gives us 7.43 RVU's still left to bill if you provide the services to justify that level of billing. A provider may add in things like Therapeutic Exercise or other appropriate services, and now, get reimbursed for services previously not possible.

We will do our best to keep our members up to date on what is covered and what is excluded from treatment. Since we are unable to provide all this information in this newsletter we anticipate the webinars will be full.

Please do your best to sign up as soon as you get the e-mail for registration.

New York State Chiropractic Association

PO Box 557, Chester NY 10918 | 518-785-6346 | 518-785-6352 FAX
info@nysca.com | www.nysca.com

APPLICATION FOR MEMBERSHIP

Contact Information

Last Name:	First Name:	MI:	☐ Male ☐ Female
Business Address:		County:	
City:	State:	Zip:	
Office Phone:	Office Fax:	Email:	
Referred to NYSCA by:		**All fields required unless otherwise specified.**	

Education Information

Degree(s):	
Chiropractic College:	Year Graduated:
NY Chiropractic License Number:	Date of Issuance: (MM/DD/YYYY):

Personal Information

Date of Birth:	Home Phone (opt):	Mobile Phone (opt):
Home Address:		County:
City:	State:	Zip:

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☐ 2nd Year Licentiate – up to 3 years from date of licensure	$240 or $20/month
☐ 3rd Year Licentiate – up to 4 years from date of licensure	$360 or $30/month
☐ 4th Year Licentiate – up to 5 years from date of licensure	$480 or $40/month
☐ 5th Year Licentiate – Greater than 5 years from date of licensure	$600 or $50/month
★ New Member Special ★ One-time offer applicable to Regular Membership only when year is PAID IN FULL. Eligibility subject to verification. Subsequent year's dues payable at usual rate. Cannot be combined with other discounts	25% off
☐ Part-time, practicing 20 hours or fewer per week Discount applicable to Regular Membership only. A certification of working hours, signed by a NYSCA district officer, must be submitted to the administrative office; Cannot be combined with other discounts	50% off
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☐ 2nd Year Licentiate – up to 3 years from date of licensure	$120 or $10/month
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☐ 4th Year Licentiate – up to 5 years from date of licensure	$240 or $20/month
☐ 5th Year Licentiate – Greater than 5 years from date of licensure	$300 or $25/month
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☐ a full-time staff member in residence at a chiropractic or other accredited university, college, school, or institution; or ☐ a full-time employee of any recognized governmental agency; or ☐ a member of the Armed Forces of the United States on active duty; or ☐ not in active chiropractic practice AND is employed full-time as supplier/vendor of chiropractic products and services, or other practice equipment, in service to members of the chiropractic professional field; or ☐ practicing exclusively in a state or jurisdiction other than New York State †out-of-state affiliate members may neither vote in NYSCA elections nor hold office	$60
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I fully understand and agree that upon acceptance of my application, I shall abide by the certificate of incorporation of the NYSCA, its Bylaws, Canon of Ethics, all rules and regulations adopted by the Board of Directors and House of Delegates, and the laws of the State of New York, the Board of Regents, and the State Education Department. I further understand that the NYSCA regularly communicates with its members by electronic means and therefore permit NYSCA to send me communications and advertisements (regarding upcoming events, etc.) via fax/email.

Signature:

For Office Use Only — Date Received:

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