Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CHIROPRACTIC CARE

Comparison of Medicare Managed Care and Fee-For-Service

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Inspector General

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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To compare chiropractic utilization in Medicare managed care risk plans to that in fee-for-service.

BACKGROUND

We previously completed a report describing policies and practices for providing chiropractic services to Medicare beneficiaries in seven managed care organizations — report number OEI-04-97-00494. Following issuance of that report, Health Care Financing Administration staff requested that we do a national analysis of chiropractic utilization in managed care as compared to that in fee-for-service.

Most Medicare beneficiaries can choose between the Medicare managed care program and the fee-for-service program. Medicare fee-for-service coverage of chiropractic services is limited to manual manipulation of the spine to correct a subluxation. Managed care plans offer that service, and can offer other chiropractic services. However, in this study, "chiropractic services" refers solely to the allowed Medicare benefit of manual manipulation of the spine to correct a subluxation.

We e-mailed a standardized survey to all 310 Medicare managed care risk plans to obtain utilization and other data. We obtained fee-for-service chiropractic utilization data from the Health Care Financing Administration — Part B Extract and Summary System, annual Data Compendiums, and the National Claims History file. We did a comparative analysis of the managed care and fee-for-service chiropractic utilization data from 1996 through 1998.

FINDINGS

Chiropractic utilization in managed care risk plans was lower than in fee-for-service. In 1998, 1.43 percent of beneficiaries in managed care risk plans used chiropractic services compared to more than 4 percent of beneficiaries in fee-for-service. In the same year, managed care beneficiaries received about seven chiropractic treatments per beneficiary compared to approximately nine treatments per beneficiary in fee-for-service.

Chiropractic utilization was higher in managed care risk plans when direct access was allowed versus primary care physician referral, but it was still lower than in fee-for-service. In 1998, 2.14 percent of beneficiaries in managed care risk plans that allowed direct access used chiropractic services compared to 1.08 percent of beneficiaries in plans that required a physician referral. Whereas, 4.42 percent of beneficiaries in fee-for-service used chiropractic services. During the same year, beneficiaries in managed

care risk plans that required a physician referral received about six treatments per beneficiary. In contrast, beneficiaries in managed care risk plans that allowed direct access and beneficiaries in fee-for-service received about nine treatments per beneficiary.

Chiropractors provided most of the chiropractic treatments to beneficiaries in managed care risk plans. In 1998, chiropractors performed 91 percent of the chiropractic treatments in managed care risk plans and 99 percent of the treatments in fee-for-service.

Managed care risk plans did not use co-payments to limit beneficiary access to chiropractic services. Of the 244 respondents, 220 plans required a co-payment to access chiropractic services. The co-payments ranged from $3-$27 with the most common co-payment being $5. The chiropractic co-payments were the same as co-payments for other similar services.

COMMENTS

The HCFA concurred with our findings and offered several technical comments. We made appropriate revisions. The full text of their comments is in Appendix C.

INTRODUCTION

PURPOSE

To compare chiropractic utilization in Medicare managed care risk plans to that in fee-for-service.

BACKGROUND

We recently completed a report describing policies and practices for providing chiropractic services to Medicare enrollees in seven managed care organizations.[1] That report compared chiropractic utilization in the managed care organizations to that in fee-for-service. As our report represented a limited sample, the results were not projectable.

However, following issuance of that report, Health Care Financing Administration staff requested that we do a national analysis of chiropractic utilization in managed care as compared to that in fee-for-service. Such a national study would enhance their understanding of chiropractic policies and practices in managed care organizations.

Chiropractic Services in Managed Care and Fee-For-Service

Most Medicare beneficiaries can choose between Medicare managed care plans, or the fee-for-service program.[2] Managed care risk plans require beneficiaries to use approved plan providers.[3] About 5.3 million Medicare beneficiaries were enrolled in managed care risk plans in 1998.

Fee-for-service allows beneficiaries to use any doctor, hospital, or other health care provider who accepts Medicare. About 32.5 million Medicare beneficiaries were enrolled in fee-for-service in 1998.

Medicare fee-for-service and managed care plans are required to provide the chiropractic service of manual manipulation of the spine to correct a subluxation.[4] In addition, managed care plans can offer other chiropractic services. Beneficiary utilization, however, can differ among fee-for-service and managed care plans. In this study, "chiropractic services" refers solely to the Medicare benefit of manual manipulation of

[1] Chiropractic Services Covered by Medicare Managed Care Organizations (OEI-04-97-00494)

[2] Beneficiaries with end-stage renal disease are not eligible to participate in the managed care program.

[3] The managed care risk plans discussed in this report are now known as Medicare+Choice risk plans. The name change is due to the Balanced Budget Act of 1997 which established the Medicare+Choice program beginning 1999.

[4] According to the Medicare Carrier Manual, a subluxation is defined as the incomplete dislocation, off centering, misalignment, fixation, or abnormal spacing of vertebrae or intervertebral units.

the spine to correct a subluxation. Such chiropractic services can be provided by any provider meeting the definition of "physician". The term "physician" as defined by section 1861 of the Social Security Act, includes doctors of medicine, osteopathy, and chiropractic.

Prior Chiropractic Studies

As part of our continuing study of Medicare and Medicaid issues, we published several reports on chiropractic care over the past two years. For example, in addition to the previously mentioned study of seven managed care organizations, we issued reports on controls used by Medicare, Medicaid, and other payers, Medicaid coverage of chiropractic care, and utilization parameters for chiropractic treatments. Our website, http://www.dhhs.gov/progorg/oei, lists our current reports on chiropractic issues.

METHODOLOGY

The Health Care Financing Administration maintains centralized data systems that capture utilization data on services provided to Medicare beneficiaries enrolled in fee-for-service. However, no such centralized data system exists to capture utilization data for beneficiaries enrolled in managed care plans. Therefore, we developed our own database on chiropractic utilization in managed care risk plans.

To do so, we surveyed all 310 managed care risk plans in April 1999. We e-mailed a standardized data collection instrument to each plan. As needed, we followed-up on incomplete and non-responses. Ultimately, 244 plans provided self-reported information — a 79 percent response rate. In instances where managed care plans did not respond to a particular question, we based our analysis on the number who responded. Where applicable, we noted the differences throughout the report.

Although HCFA did not require managed care plans to capture utilization data for chiropractic services, 190 of the 244 respondents claimed to capture such data. However, not all 190 plans provided complete utilization data for each year of our inspection period — 1996 through 1998. We defined complete utilization data to include the number of beneficiaries enrolled, the number of beneficiaries receiving chiropractic services, and the number of treatments received. For example, 125 plans provided complete 1998 utilization data. The 125 plans represented 53 percent of the Medicare enrollees in the 244 plans that responded.

The 54 plans (244-190) provided several reasons why they did not capture utilization data. The two most common reasons were they 1) paid physicians a set amount to provide chiropractic services to their enrolled beneficiaries, i.e. a capitated payment, and 2) had few Medicare beneficiaries enrolled.

We obtained fee-for-service chiropractic utilization data from the Health Care Financing Administration. First, we used Data Compendiums to identify the number of Medicare beneficiaries. Next, we used a 1 percent sample of the National Claims History file to estimate the number of beneficiaries using chiropractic services. The 1 percent sample

provided a large number of claims, and a high degree of precision. Finally, we used the Part B Extract and Summary System to determine the number of treatments received by beneficiaries and the allowed charges for the treatments. The specific codes associated with the chiropractic service were A2000, 98940, 98941, and 98942.

We did a comparative analysis of the managed care and fee-for-service chiropractic utilization data for 1996 through 1998 as shown in Tables 1 through 6. In addition, we summarized the tables in Appendix B.

Finally, we conducted non-response analyses. First, we did an analysis to determine if significant differences existed between the 244 plans that responded and the 66 plans that did not respond. We found a significant difference based on the size of the plan, therefore, we conducted more detailed analyses. We based the analyses on whether plans required co-payments, and whether a plan allowed direct access or required a physician referral. We found no response/non-response bias.

The second analysis was conducted because all respondents did not provide complete utilization data. Among the 125 plans that provided complete utilization data for 1998, we found no bias in plans that conducted or did not conduct utilization reviews. Appendix A shows our non-response analysis in detail.

We conducted our inspection between January 1999 and November 1999. We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Chiropractic utilization in managed care risk plans was lower than in fee-for-service, but it has increased

Beneficiary use

Beneficiaries in managed care (MC) risk plans used chiropractic services to a lesser extent than did those in fee-for-service (FFS). Table 1, for example, shows that 1.43 percent of beneficiaries in managed care risk plans used chiropractic services in 1998. In contrast, more than 4 percent of fee-for-service beneficiaries used chiropractic services.

Table 1
Beneficiaries Using Chiropractic Services: Managed Care versus Fee-For-Service

	1996		1997		1998	
	57 MC risk plans	FFS	99 MC risk plans	FFS	125 MC risk plans	FFS
Number of Medicare Beneficiaries	1,532,256	33,509,382	2,224,235	32,933,535	2,767,418	32,545,955
Beneficiaries using chiropractic services	10,644	1,391,600	26,763	1,405,400	39,669	1,437,200
Percent using chiropractic services	0.69%	4.15%	1.20%	4.27%	1.43%	4.42%

Treatments per beneficiary

Beneficiaries enrolled in managed care risk plans, on average, received fewer chiropractic treatments per beneficiary than did those in fee-for-service. To illustrate, Table 2 shows that managed care beneficiaries received about 7 treatments per beneficiary in 1998. Medicare beneficiaries in fee-for-service averaged about 9 chiropractic treatments.

Table 2
Chiropractic Treatments Per Beneficiary: Managed Care versus Fee-For-Service

	1996		1997		1998	
	57 MC risk plans	FFS	99 MC risk plans	FFS	125 MC risk plans	FFS
Beneficiaries using chiropractic services	10,644	1,391,600	26,763	1,405,400	39,669	1,437,200
Number of treatments received	70,592	12,274,583	185,820	12,957,421	295,226	13,491,616
Treatments per beneficiary	6.63	8.82	6.94	9.22	7.44	9.39

Recent overall increases

From 1996 through 1998, chiropractic use increased in both managed care risk plans and fee-for-service. However, chiropractic use increased to a greater extent in the managed care risk plans. To illustrate, Table 1 shows that the percent of beneficiaries using chiropractic services increased from 0.69 to 1.43 percent in managed care plans. In fee-for-service, however, the increase was from 4.15 to 4.42 percent.

Also, from 1996 through 1998, the average number of treatments per beneficiary increased more in managed care than in fee-for-service. To illustrate, Table 2 shows that the number of treatments per beneficiary increased from 6.63 to 7.44 treatments in managed care risk plans — an increase of .81 treatments per beneficiary. In fee-for-service, the increase was from 8.82 to 9.39 — an increase of .57 treatments per beneficiary.

Chiropractic utilization was higher in managed care risk plans when direct access was allowed versus primary care physician referral

Beneficiary use

More beneficiaries used chiropractic services when managed care plans allowed direct access than when the plans required a primary care physician referral. For example, in 1998, 2.14 percent of beneficiaries enrolled in managed care risk plans that allowed direct access used chiropractic services. Conversely, 1.08 percent of beneficiaries enrolled in managed care risk plans that required a primary care physician (PCP) referral used chiropractic services.

Table 3
Beneficiaries Using Chiropractic Services: Managed Care Direct Access versus Primary Care Physician Referral

	1996 — 57 plans		1997 — 99 plans		1998 — 125 plans	
	Direct Access (17 plans)	PCP Referral (40 plans)	Direct Access (35 plans)	PCP Referral (64 plans)	Direct Access (43 plans)	PCP Referral (82 plans)
Number of Medicare Beneficiaries	522,727	1,009,529	762,904	1,461,331	919,037	1,848,381
Beneficiaries using chiropractic services	4,444	6,200	12,739	14,024	19,622	20,047
Percent using chiropractic services	0.85%	0.61%	1.67%	0.96%	2.14%	1.08%

Treatments per beneficiary

Beneficiaries received more chiropractic treatments, per beneficiary, when managed care plans allowed direct access than when the plans required a primary care physician referral. To illustrate, in 1998, beneficiaries received, on average, 9 treatments when allowed direct access. However, beneficiaries enrolled in plans requiring a primary care physician referral, received about 6 treatments per beneficiary.

Table 4
Chiropractic Treatments Per Beneficiary: Managed Care Direct Access versus Primary Care Physician Referral

	1996— 57 plans		1997— 99 plans		1998— 125 plans	
	Direct Access (17 plans)	PCP Referral (40 plans)	Direct Access (35 plans)	PCP Referral (64 plans)	Direct Access (43 plans)	PCP Referral (82 plans)
Beneficiaries using chiropractic services	4,444	6,200	12,739	14,024	19,622	20,047
Number of treatments received	40,684	29,908	106,676	79,144	178,424	116,802
Treatments per beneficiary	9.15	4.82	8.37	5.64	9.09	5.83

Chiropractic utilization was lower in managed care risk plans that allowed direct access than in fee-for-service

Beneficiary use

Beneficiaries enrolled in managed care plans that allowed direct access used chiropractic services to a lesser extent than did beneficiaries enrolled in fee-for-service. For example, in 1998, 2.14 percent of beneficiaries enrolled in managed care risk plans that allowed direct access used chiropractic services. Conversely, 4.42 percent of beneficiaries enrolled in fee-for-service used chiropractic services.

Table 5 Beneficiaries Using Chiropractic Services: Managed Care Direct Access versus Fee-For-Service						
	1996		1997		1998	
	Direct Access (17 plans)	FFS	Direct Access (35 plans)	FFS	Direct Access (43 plans)	FFS
Number of Medicare Beneficiaries	522,727	33,509,382	762,904	32,933,535	919,037	32,545,955
Beneficiaries using chiropractic services	4,444	1,391,600	12,739	1,405,400	19,622	1,437,200
Percent using chiropractic services	0.85%	4.15%	1.67%	4.27%	2.14%	4.42%

Although beneficiary use was less in plans that allowed direct access, the process for beneficiaries to obtain chiropractic services was similar to that for beneficiaries in fee-for-service. The process allowed beneficiaries to go directly to chiropractors and other providers without requiring a physician referral.

Treatments per beneficiary

Beneficiaries enrolled in managed care risk plans that allowed direct access received 9.09 treatments per beneficiary in 1998. This is comparable to the 9.39 treatments per beneficiary in fee-for-service for the same year.

Table 6 Chiropractic Treatments Per Beneficiary: Managed Care Direct Access versus Fee-For-Service						
	1996		1997		1998	
	Direct Access (17 plans)	FFS	Direct Access (35 plans)	FFS	Direct Access (43 plans)	FFS
Beneficiaries using chiropractic services	4,444	1,391,600	12,739	1,405,400	19,622	1,437,200
Number of treatments received	40,684	12,274,583	106,676	12,957,421	178,424	13,491,616
Treatments per beneficiary	9.15	8.82	8.37	9.22	9.09	9.39

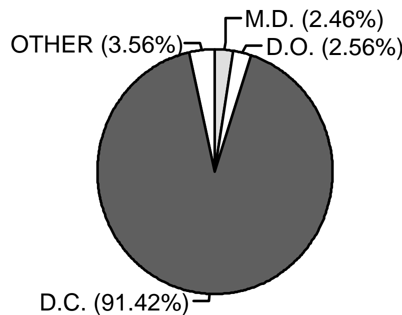
Chiropractors provided most of the chiropractic treatments to beneficiaries in managed care risk plans

All 244 managed care risk plans that responded to our survey provided the chiropractic benefit of manual manipulation of the spine to correct a subluxation. Of the 244 plans,

231 used both chiropractors and other providers to perform chiropractic services. Other providers included osteopaths, doctors of medicine, orthopedists, physical therapists, physiatrists, and rheumotologists. The remaining 13 plans did not use chiropractors, but relied solely on the other providers to perform chiropractic services.

As mentioned in our methodology, only 125 of the 244 plans provided complete utilization data for 1998. Of the 125 plans, 110 provided their chiropractic utilization data by the type of provider who performed the service. Figure 1 shows that chiropractors performed 91.42 percent of the chiropractic treatments in 1998 for the 110 managed care risk plans.

Figure 1



In contrast, 99.96 percent of chiropractic treatments were performed by chiropractors under the fee-for-service program in 1998.

Managed care risk plans did not use co-payments to limit beneficiary access to chiropractic services

Of the 244 managed care risk plans, 220 required a co-payment for chiropractic services and 24 did not. Of the 220 risk plans, 219 established pre-set co-payment amounts. The co-payments ranged from $3-$27 with the most common co-payment being $5. The remaining plan set the co-payment at 20 percent of the charged amount.

Chiropractic co-payments in 208 of the 219 plans were the same as co-payments for similar services -- primary care physician office visits, physical therapy, or podiatry services. In 10 plans, the co-payment for chiropractic services was $6 higher, on average, than such similar services. The remaining plan's chiropractic co-payment was $2 lower than such similar services.

In addition, the chiropractic co-payment in managed care plans was similar to that of fee-for-service. The fee-for-service co-payment is 20 percent of allowed charges. The average allowed charge in 1998 was $27.75. Hence, the average co-payment was $5.55.

AGENCY COMMENTS

The HCFA concurred with our findings and offered several technical comments. The full text of their comments is in Appendix C.

In response to HCFA comments, we added a summary table on chiropractic utilization from 1996 through 1998 in Appendix B. We further explained that chiropractors and other physicians can provide manual manipulation of the spine. Finally, we clarified that beneficiary utilization of chiropractic services can differ among fee-for-service and managed care plans.

We did not add a comparison of chiropractic utilization of fee-for-service and managed care organizations in rural versus urban areas as HCFA suggested. This was beyond the scope of our study. We also did not make any enrollment comparisons for the entire population of managed care plans as HCFA suggested. As explained in our methodology not all plans responded to our survey. Therefore, we only had enrollment data for the 244 plans that responded.

APPENDIX A

Analysis of Respondents versus Non-Respondents

A consideration in using surveys is whether the results may be biased by significant differences between respondents and non-respondents. To determine if significant differences occurred in this survey, we conducted two separate analyses. The first was an analysis of plans that responded to the survey versus plans that did not respond. The second analysis was conducted because all respondents did not provide complete utilization data.

Analysis of respondents vs. non-respondents

We surveyed all 310 Medicare managed care risk plans in April 1999. Out of the 310, 244 plans responded to our survey, while 66 plans did not respond. The number of enrollees as of April 1999 was the only information we had on both the responding and the non-responding plans. We ranked the 310 plans based on ascending enrollment size. We then, split the plans into three equal groups — small, medium, and large. We defined small plans as those with 0 to 3,901 enrollees, the medium with 3,902 to 14,985 enrollees, and the large with 14,986 or more enrollees. This analysis is shown in Table 1 below.

Table 1
Number of Respondents versus Non-Respondents

Size of Plan	Number of Respondents	Percent of Respondents	Number of Non-Respondents	Percent of Non-respondents
Small	75	31%	29	44%
Medium	79	32%	24	36%
Large	90	37%	13	20%
Totals	244		66	

Chi-Square =7.57- Significant at the 95 percent confidence level
df=2

Due to the significant chi-square statistic, additional analysis was necessary. To determine whether significant differences existed in this survey, we analyzed co-payment requirements, and whether direct access was allowed or a physician referral was required. For each of these analyses, we found no relationship based on plan size which suggests that no statistical bias was evident.

Analysis of utilization data and utilization reviews

Out of 244 respondents, 125 provided complete utilization data for 1998. In order to test for bias with respect to the utilization data not provided by the remaining 119 plans, we performed an analysis on a question where all 244 plans provided a response.

In the survey, we asked, "Do you conduct utilization reviews for manual manipulation of the spine?" The Table below shows that out of 244 respondents, 75 plans indicated "yes" they did conduct utilization reviews, and 169 plans indicated "no" they did not conduct the reviews. We then, broke out the "yes and no" answers according to whether or not the plan provided utilization data. Table 2 below shows this break down.

Table 2
Analysis of Conducting Utilization Reviews by Whether Utilization Data was Provided

	Did the plans conduct utilization reviews?		
	Yes	**No**	**Totals**
Responses from all 244 plans (% of Total)	75 (31%)	169 (69%)	244
Number of plans that provided utilization data (% of Total)	52 (42%)	73 (58%)	125
Number of plans that did not provide utilization data (% of Total)	23 (19%)	96 (81%)	119

Chi-square=14.21- Significant at the 99 percent confidence level
df=1

Since the chi-square test was significant, we performed an analysis on plans that provided utilization data based on whether or not plans conducted utilization reviews.

When 125 plans provided utilization data, the difference between conducting or not conducting utilization reviews varied by .55 percent. Approximately 1.72 percent of beneficiaries enrolled in plans that conducted utilization reviews, and provided utilization data used chiropractic services. Whereas, 1.17 percent of beneficiaries enrolled in plans that did not conduct utilization reviews, and provided utilization data used chiropractic services. This data is shown in Table 3 below.

Among the 125 plans that provided utilization data, beneficiaries enrolled in plans that conducted utilization reviews received about 2.03 treatments more per beneficiary than plans that did not conduct utilization reviews. Table 3 shows that the plans that conducted utilization reviews averaged 8.31 treatments per beneficiary. Whereas, the plans that did not conduct utilization reviews averaged 6.28 treatments per beneficiary.

Table 3 Chiropractic Utilization by Plans that Did and Did Not Conduct Utilization Reviews						
Conduct Utilization Reviews	**Number of 1998 Enrollees**	**Small Plans**	**Medium Plans**	**Large Plans**	**# of beneficiaries used service**	**# of treatments received**
Yes	1,324,889	13	18	21	22,723	188,782
		10.4%	14.4%	16.8%	1.72%	8.31
No	1,442,529	18	29	26	16,946	106,444
		14.4%	23.2%	20.8%	1.17%	6.28
Totals	2,767,418	31	47	47	39,669	295,226
		24.8%	37.6%	37.6%	1.43%	7.44

APPENDIX B

Summary of Chiropractic Utilization: Managed Care Plans versus Fee-For-Service from 1996 through 1998

	1996				1997				1998			
	MC risk plans			FFS	MC risk plans			FFS	MC risk plans			FFS
	PCP referral (40)	Direct Access (17)	Total (57)		PCP referral (64)	Direct Access (35)	Total (99)		PCP referral (82)	Direct Access (43)	Total (125)	
# of Medicare beneficiaries	1,009,529	522,727	1,532,256	33,509,382	1,461,331	762,904	2,224,235	32,933,535	1,848,381	919,037	2,767,418	32,545,955
Beneficiaries using chiropractic services	6,200	4,444	10,644	1,391,600	14,024	12,739	26,763	1,405,400	20,047	19,622	39,669	1,437,200
% using chiropractic services	0.61%	0.85%	0.69%	4.15%	0.96%	1.67%	1.20%	4.27%	1.08%	2.14%	1.43%	4.42%
# of treatments received	29,908	40,684	70,592	12,274,583	79,144	106,676	185,820	12,957,421	116,802	178,424	295,226	13,491,616
Treatments per beneficiary	4.82	9.15	6.63	8.82	5.64	8.37	6.94	9.22	5.83	9.09	7.44	9.39

APPENDIX C

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

IG
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MAY 26 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Chiropractic Care: Comparison of Medicare Managed Care and Fee-For-Service," (OEI-04-97-00495)

Thank you for the opportunity to review the above-mentioned report. We would also like to thank the OIG for its efforts to provide the Health Care Financing Administration (HCFA) with additional information and insights on utilization differences in managed care and fee-for-service Medicare for the chiropractic service of manual manipulation of the spine to correct a subluxation.

HCFA is committed to ensuring that all Medicare beneficiaries receive the high-quality, medically-appropriate care they deserve. The report's findings were of great interest. For example, while beneficiaries in fee-for-service used more chiropractic services than beneficiaries in managed care, the utilization in managed care is increasing at a faster rate. It is also interesting that utilization differs by type of managed care plan. As the report notes, in 1998 the number of chiropractic treatments per beneficiary for direct access plans was 9.09 (similar to the fee-for-service figure of 9.39), compared to 5.83 in plans that required a referral from a primary care physician.

Another important finding was that most chiropractic services for managed care beneficiaries -- 91 percent -- were provided by chiropractors, rather than physicians. Further, the findings on copays charged for chiropractic services provide evidence that managed care plans are not using copayments to limit access to this type of service.

We also have some comments on the report. Page 3 of the report states, "The HCFA did not require fee-for-service and managed care plans to provide similar beneficiary utilization of chiropractic services." The law only requires coverage of the same

services, not the same utilization rates between managed care and fee-for-service. We suggest revising the above sentence to read, "The law does not require fee-for-service and M+C plans to provide the same beneficiary utilization for any type of covered service across the two programs."

We are also attaching our technical comments for OIG's consideration.

Attachment

Technical Comments on OIG's Chiropractic Care Draft Report

- We suggest that the OIG add a summary table to display all of the information in Tables 1-6. Such a table would present a consolidated view of the individual data findings that the OIG has highlighted in this report. Such a table could be organized as follows:

Chiropractic utilization: M+C PCP referral plans, M+C direct access plans, FFS plans

	1996				1997				1998			
	M+C			FFS	M+C			FFS	M+C			FFS
	PCP	DA	TOT		PCP	DA	TOT		PCP	DA	TOT	
Number of Medicare beneficiaries												
Beneficiaries using chiropractic services												
Percent using chiropractic services												
Number of treatments received												
Treatments per beneficiary												

- The findings (page 1) note differences in utilization for various groups. Was any other analysis done to explain the differences between fee-for-service and managed care? For example, perhaps some of the higher utilization of chiropractic care in fee-for-service was related to the availability of these services in areas (e.g., rural areas) where fee-for-service is predominant.

- Page 3 notes that both fee-for-service Medicare and managed care plans must provide for the chiropractic service of manual manipulation of the spine to correct a subluxation. It may be useful to also note that these services do not have to be provided by a chiropractor, but may be provided by a physician.

- HCFA had requested including the percentage of Medicare+Choice (M+C) enrollees represented by the 125 plans that provided utilization data. On page 4, a percentage has been added ("The 125 plans represented 53 percent of the Medicare enrollees in the 244 plans that responded.") We believe a slightly different statistic would be useful that would show the portion of the entire M+C enrolled population for which the OIG had data (e.g., The 125 plans represented xx percent of all M+C enrollees).

- On Page 9, the report states that all plans responding to the survey provided the benefit of manual manipulation of the spine to correct a subluxation. It's not clear why OIG notes this as a finding, as it's not optional for plans to provide this benefit.