

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

CHIROPRACTIC CARE

**Controls Used by Medicare, Medicaid, and
Other Payers**



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EXECUTIVE SUMMARY

PURPOSE

To describe how Medicare, Medicaid, and private insurers control chiropractic benefits.

BACKGROUND

The Balanced Budget Act of 1997 required the Health Care Financing Administration (HCFA) establish new utilization guidelines for Medicare chiropractic care by January 1, 2000. It also eliminated the X-ray requirement. In addition, New York recently enacted legislation requiring private insurers to include chiropractic coverage in their benefits packages.

We initiated two inspections to better understand the impact of these changes on the Medicare and Medicaid programs and to learn more about utilization controls. This report, "CHIROPRACTIC CARE: Controls Used by Medicare, Medicaid, and Other Payers, (OEI-04-97-00490)" describes Medicare, Medicaid, and private insurers' mechanisms for controlling expenditures and protecting the chiropractic benefit from potential waste and abuse. A companion report, "CHIROPRACTIC CARE: Medicaid Coverage, (OEI-06-97-00480)" describes current and expected chiropractic care benefits under State Medicaid programs.

Medicare, Medicaid, and private insurers do not consider control of chiropractic benefits a high priority or an area of major concern. All commented that more could be done to control utilization of the benefit but that resources are better spent controlling other more costly benefits.

FINDINGS

We found that Medicare, Medicaid, and private insurers rely on utilization caps, X-rays, physician referrals, co-payments, and post and prepayment reviews, in varying degrees, to control utilization of chiropractic benefits. Utilization caps are the most widely used, but these and other controls did not detect or prevent unauthorized Medicare maintenance treatments.

Utilization Caps Are the Most Widely Used Control Mechanisms

Ninety-five percent of Medicare and 46 percent of Medicaid programs use soft caps that can be exceeded with appropriate justification. Hard caps, which cannot be exceeded, are used by 50 percent of Medicaid programs and 94 percent of private insurers. Federal costs for Medicaid chiropractic benefits can exceed those for Medicare because Medicaid utilization caps are typically higher than those for Medicare.

X-rays Provide Little Control of Chiropractic Benefits

Few private insurers or Medicaid agencies require X-rays to document treatment necessity. Medicare currently requires X-rays; however, elimination of the X-ray requirement should have little impact on chiropractic controls since most contractors do not use X-rays as a control mechanism.

Physician Referral Is Commonly Used as a Control Mechanism for Managed Care, but Not for Fee-For-Service Plans

Sixty-eight percent of Medicaid and 66 percent of private managed care organizations used physician referrals to help control chiropractic utilization. However, only 8 percent of Medicaid and 9 percent of private fee-for-service plans required physician referrals. None of the Medicare fee-for-service plans required physician referrals.

Co-payments, Coinsurance, and Deductibles are Used to Help Control Chiropractic Benefits by Medicare and Private Insurers, but Not by Medicaid

Private insurers' co-payments ranged from \$5 to \$15 while Medicare coinsurance equaled 20 percent of approved charges. Both private insurers and Medicare used annual deductibles. Private insurers' deductibles ranged from \$200 to \$500 and Medicare's deductible equaled \$100.

Prepayment Reviews Do Not Control Chiropractic Benefits

Medicare and Medicaid contractors typically do prepayment reviews, however, it is basically a forms verification process. For those claims that exceed the soft caps, Medicare and Medicaid medical necessity prepayment reviews are mostly paper audits.

Post Payment Reviews are Used by Medicaid, but Not by Medicare, to Help Control Chiropractic Benefits

Sixty-five percent of Medicaid contractors use post payment reviews to help control chiropractic utilization. Medicare contractors, however, rarely conduct post payment reviews of chiropractic claims.

Unauthorized Chiropractic Maintenance Treatments are Not Detected and Prevented

HCFA policies preclude Medicare reimbursements for chiropractic maintenance treatments. However, only 40 percent of Medicare respondents claimed to do utilization reviews to identify and prevent such treatments. Our analysis identified over \$68 million in probable chiropractic maintenance treatments in 1996. If left unchecked, this could result in as much as \$447 million in improper Medicare payments from 1998 through 2002.

RECOMMENDATIONS

This report describes controls used by Medicare, Medicaid, and other payers for chiropractic benefits. Utilization caps were the most widely used control mechanism. Needless to say, their intent is to limit the quantity of services. However, neither the utilization caps, nor any of the other controls, detected and prevented reimbursements for unauthorized Medicare chiropractic maintenance treatments.

Accordingly, we recommend that HCFA develop system edits to detect and prevent unauthorized payments for chiropractic maintenance treatments. HCFA may do so by:

- ! requiring chiropractic physicians to use modifiers to distinguish the categories of the spinal joint problems (i.e. acute, exacerbation, recurrence, and chronic), and
- ! requiring all Medicare contractors to implement system utilization frequency edits to identify beneficiaries receiving consecutive months of minimal therapy.

COMMENTS

The HCFA Administrator, the Assistant Secretary for Planning and Evaluation (ASPE), and the Assistant Secretary for Management and Budget (ASMB) commented on our report. The full text of their comments are in appendix C.

The HCFA concurred with our recommendations. The Balanced Budget Act of 1997 required HCFA to develop utilization guidelines for chiropractic care. In developing such guidelines, HCFA will develop modifiers to distinguish categories of spinal joint problems, and utilization frequency edits as we recommended.

ASPE agreed that edits to identify inappropriate billings seemed desirable. However, ASPE commented that our use of “averages,” on pages four through six, to summarize the range of utilization caps was inappropriate because they did not reflect “real practice.” Our report provides the reader both the average utilization caps and the actual utilization caps for all Medicare and Medicaid respondents.

Further, ASPE suggested that more information is needed to substantiate two State Medicaid Administrators’ claims that physician referrals are effective controls for chiropractic services. Specifically, ASPE wanted to know how these States measured effectiveness. Additionally, ASPE noted that it would be helpful to know how the use of chiropractic services is distributed between managed care and fee-for-service providers. These questions were not part of the scope of this study. However, we plan to continue our analysis of chiropractic services and utilization in the future. These and other questions are likely topics for inclusion in future analysis.

ASMB expressed serious concerns about the methodology we used to estimate payments for probable inappropriate chiropractic maintenance treatments. Specifically, ASMB was concerned about our use of a 10 percent estimate to represent the Medicare population who received

chiropractic care for chronic conditions. The 10 percent estimate, furnished by the American Chiropractic Association, is a universal percentage estimate of the population at large. Demographic data and specific analysis is not available to differentiate between the Medicare population and the population at large. However, we contacted several Medicare Carrier Medical Directors who stated, based on their reviews of Medicare chiropractic claims, that the 10 percent appeared to be a reasonable estimate for the Medicare population.

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INTRODUCTION

PURPOSE

To describe how Medicare, Medicaid, and private insurers control chiropractic benefits.

BACKGROUND

Chiropractic Treatment

Chiropractic treatment is becoming more commonplace with consumers, and gaining wider acceptance in the medical profession. Chiropractors treat neuromusculoskeletal disorders and related functional clinical conditions including, but not limited to, back pain, neck pain and headaches. Chiropractic care is most commonly sought for treatment of back pain. Back pain is one of the most common and costly problems affecting adults. An estimated 50 percent of adults experience back pain each year and almost 20 percent have frequent back pain.

A common chiropractic treatment for low back pain is spinal manipulation. Chiropractors use either their hands or hand held devices to perform manual spinal manipulations. Manual manipulations are most commonly performed to correct a subluxation of the spine. According to chiropractic theory, a subluxation is an incomplete dislocation, off centering, misalignment, fixation or abnormal spacing of vertebrae or intervertebral units. The Department of Health and Human Services, Agency for Health Care Policy and Research, has documented spinal manipulation to be a recommendable method of symptom control for low back pain in adults.¹

Growth in Number of Chiropractors

The chiropractic profession is licensed in all States and the District of Columbia. All licensed chiropractors are entitled by law to use either the title doctor of chiropractic or chiropractic physician. Approximately 55,000 chiropractors actively practice today, while less than 14,000 existed in 1970, according to the U.S. Census. The number of chiropractors has outgrown the U.S. population by three-fold. In 1970, almost seven chiropractors practiced per 100,000 U.S. residents. By 1997, this had increased to over 20 chiropractors per 100,000 residents.

Medicare Chiropractic Eligibility

In 1965, title XVIII of the Social Security Act created Medicare to provide health insurance for people 65 and over, people who are disabled, and persons with permanent kidney failure. Medicare has two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). In 1972, Section 273 of the Social Security Amendment (P.L. 92-603) expanded the definition of physician under Part B of Medicare to include chiropractors. This made chiropractors eligible to participate

¹ Agency for Health Care Policy and Research, Pub No. 95-0642, December 1994, Acute Low Back Problems in Adults

in the Medicare program. However, the only Medicare reimbursable chiropractic treatment is manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

Medicaid Chiropractic Eligibility

In 1965, title XIX of the Social Security Act created Medicaid as a program to provide medical assistance for certain individuals and families with low incomes and resources. This program is jointly funded by the Federal and State governments. Within broad Federal guidelines each State (1) establishes its own eligibility standards, (2) sets the type, amount, duration, and scope of services, (3) establishes rate of payment for services, and (4) administers the program.

In 1972, when chiropractors were recognized as physicians and became eligible to participate in Medicare, chiropractors also became eligible to participate in Medicaid. Under Medicaid, however, chiropractic services are not a mandatory benefit, but rather an optional service. Therefore, it is within each State's discretion whether to include chiropractic services in their Medicaid program. If offered, each State also establishes its own levels of services. However, according to Federal policy for Medicaid, chiropractic services should be limited to manual manipulation of the spine and X-ray services. Currently, 30 State Medicaid fee-for-service programs offer chiropractic services.

Private Insurers Chiropractic Benefits

Many private insurers now offer chiropractic benefits. The scope of chiropractic services are consumer driven. We found insurance plans ranging from no chiropractic coverage to substantial chiropractic coverage. Several insurers stated that they view the chiropractic benefit as a service they must provide to remain competitive. Moreover, they expect users of chiropractic services to "max-out" the benefit each year.

Chiropractic Controls

The Balanced Budget Act of 1997 required the Health Care Financing Administration (HCFA) establish new utilization guidelines for Medicare chiropractic care by January 1, 2000. It also eliminated the X-ray requirement. In addition, New York recently enacted legislation requiring private insurers to include chiropractic coverage in their benefits packages.

We initiated two inspections to better understand the impact of these changes on the Medicare and Medicaid programs and to learn more about utilization controls. This report, "CHIROPRACTIC CARE: Controls Used by Medicare, Medicaid, and Other Payers, (OEI-04-97-00490)" describes Medicare, Medicaid, and private insurers' mechanisms for controlling expenditures and protecting the chiropractic benefit from potential waste and abuse. A companion report, "CHIROPRACTIC CARE: Medicaid Coverage, (OEI-06-97-00480)" describes current and expected chiropractic care benefits under State Medicaid programs.

Medicare, Medicaid, and private insurers all use a variety of mechanisms to help control their chiropractic benefit. However, most did not consider control of this benefit a high priority or an

area of major concern. In fact, over 50 percent of Medicare and 60 percent of Medicaid respondents considered the chiropractic benefit to be a small part of their overall programs. Both Medicare contractors and State Medicaid agencies commented that more could be done to control utilization of the chiropractic benefit, but that resources are currently better spent controlling other more costly benefits. Also, private insurers were not concerned with controlling utilization, but it was because of their strict utilization caps rather than the size of the benefit.

SCOPE AND METHODOLOGY

We surveyed Medicare contractors, Medicaid agencies, and private insurers. More specifically, we surveyed:

- ! all Medicare fee-for-service Part B contractors,
- ! the 10 largest, by number of enrollees, Medicare managed care organizations from 10 different States,
- ! all 50 State Medicaid agencies, and the District of Columbia (each were sent a two-part survey - one for their fee-for-service contractors and one for their largest, by number of enrollees, managed care organizations), and
- ! twenty private insurers (10 judgmentally selected Federal employee health benefit plans, and benefit managers for the 10 largest, by number of employees, private sector companies).

In instances where respondents did not answer every survey question, our percentages are based on the number who responded.

In addition to the surveys, we did on-site evaluations of one Medicare fee-for-service contractor, one Medicare managed care organization, two Medicaid fee-for-service contractors, and three Medicaid managed care organizations. Moreover, we interviewed officials with the Indiana Chiropractic Association, the American Chiropractic Association, and the Carrier Medical Director Chiropractic Clinical Workgroup.

Finally, we used a 1 percent sample of HCFA's 1996 National Claims History data to determine if Medicare contractors paid claims in accordance with HCFA policies, and to quantify the extent of chiropractic utilization. Appendix A further details our scope and methodology.

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We conducted our inspection between October 1997 and December 1997. We conducted this inspection in accordance with *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

We found that Medicare, Medicaid, and private insurers use a variety of techniques to control utilization of chiropractic benefits. Allowable chiropractic benefits vary in both quantity and type of treatments. Along with varying benefits come varying controls. Typical controls include utilization caps, X-rays, physician referrals, co-payments, and post and prepayment reviews. Utilization caps are the most widely used, but these and other controls did not detect or prevent unauthorized Medicare maintenance treatments.

UTILIZATION CAPS ARE THE MOST WIDELY USED CONTROL MECHANISMS

Limiting the number of visits by establishing utilization caps was the most widely used control mechanism reported by all groups surveyed. A companion report on chiropractic benefits for Medicaid beneficiaries discusses benefits, treatment limits, and exceptions in detail (Chiropractic Care: Medicaid Coverage, OEI-06-97-00480).

Utilization caps are most commonly broken down into two separate types - soft caps and hard caps.

Soft caps are established service limits that can be exceeded with appropriate justification. For example, one such justification would be documentation that a beneficiary has aggravated an existing condition.

Hard caps, as the name implies, are concrete service limits or dollar amounts that cannot be exceeded for any reason within a specified time frame.

Table 1 shows the average soft and hard utilization caps for respondents included in our survey.

TABLE 1			
AVERAGE SOFT AND HARD UTILIZATION CAPS			
	MEDICARE	MEDICAID	PRIVATE
SOFT CAPS	21	28	N/A
HARD CAPS	N/A	104	27

Ninety-five Percent of Medicare and 46 Percent of Medicaid Programs Use Soft Caps

Ninety-five percent (52 of 55) of all Medicare survey respondents said they use soft caps. The soft caps ranged from 11 to 52 treatments per year, with 12 treatments being the most common. On average, the Medicare respondents used a soft cap of 21 treatments. Table 2 shows chiropractic soft caps used by the Medicare respondents included in our survey.

# Treatments	11	12	18	22	24	28	29	30	40	46	48	51	52
Respondents	1	29	3	1	4	3	1	1	2	1	2	1	3

HCFA requires all Medicare contractors to establish soft caps. Each contractor, however, determines the level of the cap (i.e. the number of treatments). HCFA further requires all Medicare contractors to evaluate the effectiveness of their caps on a quarterly basis. Based on these evaluations, HCFA granted 5 percent (3 of 55) of its contractors permission to deactivate their chiropractic caps. The three contractors documented that their soft caps were not cost effective. Instead, they now focus on post payment reviews to identify aberrant providers.

Forty-six percent (12 of 26) of States that provide chiropractic benefits reported using soft caps. The soft caps ranged from 1 to 80 treatments per year, with the average being 28 treatments. Table 3 shows chiropractic soft cap limits used by State Medicaid Agencies.

# Treatments	1	6	10	12	18	20	24	30	48	60	80
Respondents	1	1	1	1	1	1	2	1	1	1	1

Fifty Percent of Medicaid Programs and 94 Percent of Private Insurers Use Hard Caps

Half (13 of 26) of the States that provide chiropractic benefits reported using hard caps to control their Medicaid chiropractic benefits. The hard caps ranged from 12 to 365 treatments per year. The average hard cap is 104 treatments, however, this includes three States that allow one treatment per day. Excluding these three States, the average Medicaid hard cap is 29 treatments. Table 4 shows the chiropractic hard caps used by State Medicaid agencies.

# Treatments	12	18	20	24	25	50	56	365
Respondents	2	1	1	3	1	1	1	3

Ninety-four percent (16 of 17) of private insurers relied on hard caps to control benefit utilization. The 16 private insurers used 11 utilization caps and 5 financial caps. The utilization caps ranged from 12 to 60 treatments per year, with the average being 27 treatments. Table 5 shows the chiropractic utilization hard caps used by private insurers.

# Treatments	12	20	24	25	26	30	40	60
Respondents	2	2	1	1	1	2	1	1

The financial caps, used by private insurers, ranged from \$225 to \$2,000 per year, with the average being \$1,035. Table 6 shows the chiropractic financial hard caps used by private insurers.

TABLE 6				
PRIVATE CHIROPRACTIC FINANCIAL HARD CAPS TREATMENTS PER YEAR				
\$ Cap	\$225	\$250	\$700	\$2000
Respondents	1	1	1	2

Federal Costs for Medicaid Chiropractic Benefits Can Exceed That for Medicare

Twenty-six States offer Medicaid chiropractic benefits. However, we limited our comparative analysis of Medicaid and Medicare Federal costs for chiropractic benefits to 24 States. We did so because one State did not have a Medicaid utilization cap and the Medicare contractor in another State did not have a utilization cap.

The Federal reimbursement rates and cost per treatment rates for Medicaid chiropractic treatments are typically lower than they are for Medicare. Medicaid Federal matching reimbursement rates for the 24 States ranges from 50 percent to over 73 percent with 60 percent being the average. This is lower than Medicare, where Federal costs are 80 percent of allowed charges. Likewise, the average Federal cost for Medicaid manual manipulations of the spine is only \$8.92, but for Medicare the average Federal cost is \$18.92.

However, overall Medicaid Federal costs for chiropractic services can exceed the cost for such services paid for by Medicare. This is because Medicaid’s utilization caps are significantly higher than Medicare’s. Sixty-seven percent (16 of 24) of States offering chiropractic care through their Medicaid fee-for-service programs have higher utilization caps than Medicare. In one State, for example, the Medicare utilization cap is 12 treatments per year while the Medicaid utilization cap is 50 treatments.

Medicaid's average utilization cap for the 24 States is 71 treatments per year, whereas Medicare's average utilization cap is only 19 treatments per year. Federal costs, at the maximum utilization cap for Medicaid chiropractic benefits, average \$554 per person, whereas in Medicare it is only \$365 per person.

X-RAYS PROVIDE LITTLE CONTROL OF CHIROPRACTIC BENEFITS

Few Medicaid Agencies and Private Insurers Require X-rays to Document Treatment Necessity

Thirty-one percent (8 of 26) of Medicaid programs require X-rays. However, 58 percent (15 of 26) of Medicaid programs will reimburse chiropractors for X-rays.

Only 12 percent (2 of 17) of private insurers require X-rays to ensure appropriateness of chiropractic claims.

Elimination of the X-ray Requirement Should Have Little Impact on Chiropractic Controls since Most Medicare Contractors Do Not Use X-rays as a Control Mechanism

Seventy-eight percent (43 of 55) of Medicare respondents claimed X-rays were not essential for ensuring the appropriateness of chiropractic claims. They said chiropractic benefit control would not be affected by the Balanced Budget Act of 1997, which eliminates the X-ray requirement by the year 2000. Several respondents commented that they do not use X-rays, but rather they compare diagnosis with treatment plans to determine appropriateness of treatments.

The remaining 22 percent (12 of 55) said elimination of the X-ray requirement would impact their ability to verify spinal subluxations.

PHYSICIAN REFERRAL IS COMMONLY USED AS A CONTROL MECHANISM FOR MANAGED CARE, BUT NOT FOR FEE-FOR-SERVICE PLANS

Physician Referral Is Common for Managed Care Plans

In 68 percent (15 of 22) of Medicaid managed care organizations and 66 percent (4 of 6) of private managed care organizations, physician referrals are required to obtain chiropractic care. According to the American Chiropractic Association, this common managed care gatekeeper practice restricts access to chiropractic care.

Private insurers typically use physician referrals in conjunction with hard caps to control chiropractic utilization. Only one private insurer used physician referrals as its only control mechanism.

Few Fee-For-Service Programs Require Physician Referral

Overwhelmingly, Medicare, Medicaid, and private insurers allow direct access to chiropractors without a physician referral. No Medicare fee-for-service program required physician referral for access to chiropractors.

Only 8 percent (2 of 26) of Medicaid fee-for-service programs require physician referrals to access chiropractic services. The two Medicaid programs that do require physician referrals, however, said physician referral is a very effective control mechanism. It allows primary care physicians to monitor and coordinate clients' health care needs.

About 9 percent (1 of 11) of private fee-for-service insurers require physician referrals to access chiropractic services.

CO-PAYMENTS, COINSURANCE, AND DEDUCTIBLES ARE USED TO HELP CONTROL CHIROPRACTIC BENEFITS BY MEDICARE AND PRIVATE INSURERS, BUT NOT BY MEDICAID

Medicare and private insurers require co-payments, coinsurance, or deductibles. Medicaid programs, however, typically do not require co-payments, coinsurance, or deductibles.

A co-payment is a set amount beneficiaries must pay when they visit a physician. The private insurers in our survey had co-payments ranging from \$5.00 to \$15.00 per chiropractic treatment. These co-payments are common in both managed care and fee-for-service plans.

Coinsurance is the percentage of medical expenses for which a patient is responsible. For Medicare Part B services, coinsurance equals 20 percent of approved charges.

A deductible is the amount a beneficiary must pay before a health plan begins payment for covered services. Medicare has a \$100 annual deductible for Part B services, including chiropractic treatments. Private insurers' yearly deductibles ranged from \$200 to \$500 per year. These deductibles applied to all physician services, including chiropractic care.

Medicaid fee-for-service programs required co-payments in only three States. These co-payments ranged from 50 cents to \$2.00 per chiropractic visit. Likewise, only one Medicaid managed care organization responded that a co-payment was required -- \$1.00 per visit.

Such patient cost sharing may be important when considering how best to control chiropractic utilization. A study by the Agency for Health Care Policy and Research suggests that the actual out-of-pocket expense a patient incurs greatly affects their use of chiropractic services.² To illustrate, the study shows that when patients have to share 25 percent or more of the cost, they decrease their chiropractic usage by half.

PREPAYMENT REVIEWS DO NOT CONTROL CHIROPRACTIC BENEFITS

² Agency for Health Care Policy and Research, Pub No. HS06920, 1996, The Affect of Cost Sharing on the Use of Chiropractic Services

Medicare and Medicaid Contractors Typically Do Prepayment Reviews, However, it Is Basically a Forms Verification Process

All Medicare and Medicaid contractors conduct prepayment reviews. However, the reviews are merely computerized edits or manual reviews to ensure that claim forms are properly completed. The level of prepayment review for Medicare and Medicaid is similar and usually includes the following edits:

- ! appropriate procedure codes,
- ! appropriate diagnosis codes,
- ! date of X-ray,
- ! date of first treatment falling within a specified time period of the X-ray date,
- ! appropriate physician identification number, and
- ! no more than one treatment per day.

Medicare and Medicaid Prepayment Reviews for Medical Necessity Are Paper Audits

Medicare and Medicaid policies require that all services be medically necessary. However, Medicare and Medicaid contractors generally do not verify the medical necessity of chiropractic treatments.

Medicare and Medicaid contractors, for example, typically review claims for medical necessity only if they exceed their soft caps. One Medicare contractor’s policy states “services exceeding more than what Medicare allows, in a given time frame, are subject to review for medical necessity.” Another commented that “we review every claim for medical necessity that exceeds the cap.” A Medicaid agency said “medical necessity must be documented in order to receive additional treatments (beyond the utilization cap).”

Medical necessity reviews in excess of the caps, however, are paper audits. Contractors typically determine medical necessity by verifying that a claim form was completed properly. They verify that the diagnosis codes are from the approved list. In addition, they verify that comments, such as “aggravated existing condition,” are on the claim form. In effect, such reviews are “check the appropriate box” edits, and not verification that services are truly medically necessary. Patient records and other documentation of medical necessity are typically not reviewed.

POST PAYMENT REVIEWS ARE USED BY MEDICAID, BUT NOT BY MEDICARE, TO HELP CONTROL CHIROPRACTIC BENEFITS

Medicaid Contractors Use Post Payment Reviews to Help Control Chiropractic Utilization

Sixty-five percent (17 of 26) of State Medicaid fee-for-service agencies monitor and control chiropractic claims using post payment reviews. The reviews are typically limited to quarterly

Surveillance and Utilization Review Surveys. Such reviews identify aberrant providers. Three States said they do not do more extensive individual reviews due to the small nature of the chiropractic program and the limited number of problem claims found in the past.

Medicare Contractors Rarely Conduct Post Payment Reviews of Chiropractic Claims

HCFA policy requires Medicare contractors to conduct focused medical reviews and comprehensive medical reviews. A focused review is a treatment specific audit, whereas a comprehensive review is a provider specific audit. It is up to the contractors to determine which benefits to review. All Medicare respondents conduct these reviews, however, most had focused little to no activity on chiropractic benefits since 1994.

Eighteen percent (10 of 55) of Medicare respondents claimed to conduct focused reviews of chiropractic benefits. Since 1994, three of the 10 respondents claimed to have saved about \$759,000 as a result of focused reviews. However, of the respondents, one accounted for over 99 percent of those savings. The remaining seven respondents conducted, on average, less than two focused reviews per year.

Thirty-six percent (20 of 55) of Medicare respondents claimed to conduct comprehensive reviews of chiropractic benefits. Ten respondents claimed their comprehensive reviews resulted in financial savings totaling about \$330,500. However, one of the respondents accounted for about 71 percent of those savings. The remaining respondents conducted varying numbers of reviews resulting in such things as educational efforts and a couple of fraud referrals.

UNAUTHORIZED CHIROPRACTIC MAINTENANCE TREATMENTS ARE NOT DETECTED AND PREVENTED

According to HCFA policy,³ chiropractic maintenance treatments are not authorized for payment. However, our analysis of a 1 percent sample of HCFA’s National Claims History database showed that in 1996, Medicare likely paid for 28,889 chiropractic maintenance treatments. These inappropriate maintenance treatments cost Medicare \$688,821. This projects to over \$68 million for the Medicare program in 1996. Projected over five years, Medicare reimbursements for unauthorized chiropractic maintenance treatments is about \$447 million.

Chiropractic Coverage Policies

HCFA’s Medicare Carrier Manual identifies treatment of acute and chronic subluxations as Medicare reimbursable conditions. Maintenance treatments, however, are not a covered service.

HCFA and local carrier policies, and Agency for Health Care Policy and Research guidelines, show that chiropractic treatment for acute conditions should consist of intense treatments early on with additional treatments tapering off quickly. To illustrate, the HCFA approved Medicare Part

³ HCFA Medicare Carrier Manual, section 2251.1

B Model Local Medical Review Policy for Chiropractic Service calls for “vigorous therapy” the first month, “less vigorous therapy” the second month, and finally, “minimum therapy” of up to four treatments the third month.

However, HCFA and local carrier policies allow chiropractic treatment for chronic conditions. Such conditions require less frequent treatments than acute conditions. A patient’s condition is considered chronic if it has existed for an extended period of time. A chronic condition is not expected to be completely resolved, but continued chiropractic therapy is expected to result in some functional improvement. Hence, chiropractic treatments may need to extend over long periods.

On the surface, it seems difficult to distinguish between unauthorized chiropractic maintenance treatments and authorized treatments for chronic conditions. The treatment patterns are similar. Unauthorized chiropractic maintenance treatments are generally indicated by consecutive months of minimal therapy of four treatments or less. Likewise, authorized chiropractic treatments for chronic conditions are generally indicated by four or fewer treatments per month for an extended time period.

It is possible, however, to distinguish between the two. To illustrate, a utilization frequency analysis of chiropractic treatments will enable carrier staff to identify potential unauthorized maintenance treatments. However, some of these treatments could be for authorized chronic conditions. Therefore, carrier staff must also review individual claims documentation to identify treatments for chronic conditions. Beneficiary symptoms and chiropractor diagnosis are two pieces of claims information that allow carrier staff to distinguish between treatments for chronic conditions and maintenance.

Estimated Medicare Reimbursement for Maintenance Treatments

To estimate potential unauthorized Medicare reimbursements for chiropractic maintenance treatments, we conducted a utilization frequency analysis of chiropractic treatments in 1996. Thereafter, we adjusted our findings to exclude possible treatments for chronic conditions. In making the adjustment, we did not review individual claims, but rather we used an estimate on the extent of chronic conditions nationwide.

We based our utilization frequency analysis on a 1 percent sample of HCFA’s 1996 National Claims History file. We used the local model policy criteria of minimum therapy of four treatments or less in the third and final month of treatment. We then identified beneficiaries with treatment utilization of two or more consecutive months of minimum therapy. This analysis identified beneficiaries who received either maintenance or chronic chiropractic treatments (see appendix A for additional information on our methodology).

HCFA data files did not distinguish between treatments for acute or chronic conditions. Therefore, we adjusted our findings by deleting chiropractic treatments for possible chronic conditions. To do so, we used information provided by the American Chiropractic Association. That research showed that 10 percent of chiropractic conditions are chronic. After eliminating

beneficiaries with chronic conditions from our analysis, we concluded that 7,594 Medicare beneficiaries received 28,889 probable unauthorized maintenance treatments at a cost of \$688,821. Table 7 summarizes maintenance treatments in 1996.

TABLE 7			
NUMBER OF MEDICARE BENEFICIARIES RECEIVING UP TO FOUR CHIROPRACTIC TREATMENTS DURING TWO OR MORE CONSECUTIVE MONTHS IN 1996			
# Beneficiaries	# Consecutive Months	Probable Maintenance Treatments	Allowed Amounts
3,298	2	5,259	\$125,058
1,486	3	4,370	\$104,321
855	4	3,545	\$84,788
563	5	3,090	\$74,388
348	6	2,256	\$53,751
247	7	1,881	\$45,103
187	8	1,585	\$37,462
128	9	1,204	\$28,298
138	10	1,504	\$36,012
88	11	962	\$23,356
256	12	3,233	\$76,284
7,594		28,889	\$688,821

Our findings in Table 7 are based on a 1 percent sample, therefore, we projected them to the Medicare population. We concluded that 759,400 Medicare beneficiaries received 2,888,900 probable chiropractic maintenance treatments at a cost to the Medicare program of \$68,882,100. Assuming chiropractic reimbursements continue to increase by 6.87 percent per year, Medicare reimbursements for unauthorized chiropractic maintenance treatments, over a five year window (1998-2002), would be about \$447 million.

At the request of HCFA officials, we included the above information, broken out by State, in appendix B.

RECOMMENDATIONS

This report describes controls used by Medicare, Medicaid, and other payers for chiropractic benefits. Utilization caps were the most widely used control mechanism. Needless to say, their intent is to limit the quantity of services. However, neither the utilization caps, nor any of the other controls, detected and prevented reimbursements for unauthorized Medicare chiropractic maintenance treatments.

Accordingly, we recommend that HCFA develop system edits to detect and prevent unauthorized payments for chiropractic maintenance treatments. HCFA can do so by:

- ! requiring chiropractic physicians to use modifiers to distinguish the categories of the spinal joint problems (i.e. acute, exacerbation, recurrence, and chronic), and
- ! requiring all Medicare contractors to implement system utilization frequency edits to identify beneficiaries receiving consecutive months of minimal therapy.

COMMENTS

The HCFA Administrator, the Assistant Secretary for Planning and Evaluation (ASPE), and the Assistant Secretary for Management and Budget (ASMB) commented on our report. The full text of their comments are in appendix C.

The HCFA concurred with our recommendations. The Balanced Budget Act of 1997 required HCFA to develop utilization guidelines for chiropractic care. In developing such guidelines, HCFA will develop modifiers to distinguish categories of spinal joint problems, and utilization frequency edits as we recommended.

ASPE agreed that edits to identify inappropriate billings seemed desirable. However, ASPE commented that our use of “averages,” on pages four through six, to summarize the range of utilization caps was inappropriate because they did not reflect “real practice.” Our report provides the reader both the average utilization caps and the actual utilization caps for all Medicare and Medicaid respondents.

Further, ASPE suggested that more information is needed to substantiate two State Medicaid Administrators’ claims that physician referrals are effective controls for chiropractic services. Specifically, ASPE wanted to know how these States measured effectiveness. Additionally, ASPE noted that it would be helpful to know how the use of chiropractic services are distributed between managed care and fee-for-service providers. These questions were not part of the scope of this study. However, we plan to continue our analysis of chiropractic services and utilization in the future. These and other questions are likely topics for inclusion in future analysis.

ASMB expressed serious concerns about the methodology we used to estimate payments for probable inappropriate chiropractic maintenance treatments. Specifically, ASMB was concerned about our use of a 10 percent estimate to represent the Medicare population who received chiropractic care for chronic conditions. The 10 percent estimate, furnished by the American Chiropractic Association, is a universal percentage estimate of the population at large. Demographic data and specific analysis is not available to differentiate between the Medicare population and the population at large. However, we contacted several Medicare Carrier Medical Directors who stated, based on their reviews of Medicare chiropractic claims, that the 10 percent appeared to be a reasonable estimate for the Medicare population. Additionally, HCFA’s implementation of our recommendations will produce demographic data needed to more precisely differentiate chiropractic chronic care use by Medicare beneficiaries.

APPENDIX A

SCOPE AND METHODOLOGY

Medicare

We had 55 responses to the Medicare fee-for-service survey. We received responses for all 50 States. The additional five responses are detailed in Table 1.

TABLE 1	
MEDICARE RESPONSES	
	# of responses
50 States	50
California - serviced by 2 contractors	1
Missouri - serviced by 2 contractors	1
New York - serviced by 3 contractors	2
District of Columbia	1
Total	55

Medicaid

Our sample population consisted of 26 State fee-for-service programs that offered a chiropractic benefit to the majority of their Medicaid population. Although 30 State fee-for-service programs reported offering some type of chiropractic service to Medicaid beneficiaries, four States only offered a very limited benefit to children as part of their Early and Periodic Screening, Diagnostic and Treatment program. Due to the limited scope of those four programs, we excluded them from our sample.

Although we surveyed both State Medicaid fee-for-service and managed care programs, for the purposes of this study we limited our primary Medicaid focus to those 26 State programs offering a chiropractic benefit through the traditional fee-for-service environment. Observations made regarding State Medicaid managed care programs will be noted by specifically referring to that group.

Utilization Caps

Seven Medicare utilization caps and nine State Medicaid utilization caps are based on time periods other than one year. For such States, we annualized their utilization caps accordingly. For example, one State reported a utilization cap of 76 treatments in 540 days. Annualized, the cap is 51 treatments.

Probable Maintenance Treatments

To identify probable maintenance treatments we took several steps. First, we used a 1 percent sample of HCFA’s 1996 National Claims History file and identified 13,974 Medicare beneficiaries who received 122,047 chiropractic treatments at a cost of \$2,937,668. Next we did a utilization frequency analysis of this data and identified 8,990 beneficiaries with two or more consecutive months of minimal therapy (1-4 treatments). These beneficiaries received 41,094 chiropractic treatments at a cost of \$982,588. We considered this subpopulation to be receiving unauthorized maintenance treatments or treatments for chronic conditions.

In order to account for the chronic conditions, we used information provided by the American Chiropractic Association that showed that 10 percent of chiropractic conditions are chronic. To be conservative, we assumed that the full 10 percent of chronic conditions were included in our sample. Therefore, we took 10 percent of the 1 percent figures and subtracted them from our subpopulation figures. For example, we took 10 percent of the \$2,937,668 and subtracted it from our subpopulation treatment costs of \$982,588. This resulted in probable unauthorized maintenance charges, adjusted for chronic conditions, of \$688,821.

We used the same process to reduce the number of beneficiaries to 7,594 and the number of chiropractic treatments to 28,889. Since these numbers are based on a 1 percent sample, we project them to the Medicare population to conclude that 759,400 Medicare beneficiaries received 2,888,900 probable chiropractic maintenance treatments at a cost to the Medicare program of \$68,882,100.

Using Part B Extract and Summary System data for 1994 through 1997, we calculated the growth in Medicare chiropractic payments. This growth averaged 6.87 percent per year. We then used this growth rate to predict reimbursements for maintenance treatments for 1998 through 2002. Accepting that the \$68.8 million in maintenance costs for 1996 would continue to go unchecked, and applying the 6.87 percent average growth, Medicare reimbursements for chiropractic maintenance treatments can cost in excess of \$447 million from 1998 through 2002.

Private Insurers

Of the 20 private insurers surveyed, 10 were judgmentally selected Federal employee health benefit plans, and the other 10 were benefit managers for the largest, by number of employees, private sector companies.

All 10 Federal employee plans responded, two of which had both a “high” and a “standard” option. Therefore, we have 12 Federal employee plan responses.

Seven of the 10 private sector companies responded, two of which offered both fee-for-service and managed care plans. Therefore, we have 9 private sector company responses.

Combined, we received 21 private insurer responses to our chiropractic survey. However, four private insurers did not offer chiropractic benefits. Therefore, we based our analysis on the 17 private insurers that offered chiropractic benefits.

We included private insurers in our inspection for comparison purposes. We do not attempt to generalize to the private insurance population.

APPENDIX B

STATE	TOTAL CHIROPRACTIC TREATMENTS	TOTAL ALLOWED CHARGES	MAINTENANCE TREATMENTS	ALLOWED MAINTENANCE CHARGES	
NH	413	\$9,902	147	\$3,577	36.1%
DC	59	\$1,586	20	\$540	34.0%
IA	5,802	\$130,193	1,975	\$44,109	33.9%
VT	333	\$7,889	111	\$2,583	32.7%
SD	784	\$17,343	231	\$5,085	29.3%
MI	6,994	\$175,359	2,019	\$50,296	28.7%
MO	2,671	\$58,477	756	\$16,440	28.1%
GA	2,654	\$63,211	745	\$17,662	27.9%
DE	312	\$7,863	85	\$2,129	27.1%
MA	2,059	\$53,678	545	\$14,147	26.4%
OH	4,685	\$111,027	1,232	\$28,650	25.8%
ND	858	\$19,600	221	\$5,037	25.7%
AZ	2,415	\$60,058	618	\$15,285	25.5%
PA	7,340	\$178,658	1,869	\$45,255	25.3%
IL	6,739	\$156,487	1,719	\$39,517	25.3%
ME	1,035	\$25,737	259	\$6,471	25.1%
NM	349	\$8,036	86	\$1,990	24.8%
UT	512	\$12,093	127	\$2,973	24.6%
VA	1,878	\$44,046	456	\$10,449	23.7%
KY	1,213	\$25,875	292	\$6,065	23.4%
OR	1,598	\$37,751	377	\$8,834	23.4%
IN	2,277	\$50,692	535	\$11,758	23.2%
WA	3,635	\$90,893	841	\$21,081	23.2%
CA	8,133	\$208,445	245	\$47,839	23.0%
CO	1,059	\$25,343	1,881	\$5,818	23.0%
CT	1,237	\$33,982	281	\$7,762	22.8%
WY	223	\$5,114	51	\$1,160	22.7%
NY	7,988	\$210,107	1,833	\$47,299	22.5%
MN	2,916	\$68,753	1,123	\$15,008	21.8%
NJ	5,092	\$137,541	645	\$30,038	21.8%
TN	2,623	\$59,188	1,045	\$12,702	21.5%
WI	4,719	\$107,771	567	\$23,200	21.5%
MT	507	\$11,360	107	\$2,409	21.2%
WV	464	\$10,443	100	\$2,189	21.0%
KS	2,911	\$67,623	608	\$13,849	20.5%
AK	188	\$5,179	37	\$1,046	20.2%
NC	2,253	\$50,867	457	\$10,119	19.9%
TX	7,445	\$172,613	1,481	\$34,071	19.7%
AL	1,157	\$25,410	231	\$4,985	19.6%
NE	1,988	\$44,682	390	\$8,720	19.5%
FL	6,701	\$166,095	1,294	\$31,948	19.2%
MD	860	\$20,989	162	\$3,947	18.8%
ID	704	\$15,722	127	\$2,786	17.7%
SC	800	\$17,540	145	\$3,102	17.7%
AR	1,701	\$38,920	287	\$6,594	16.9%
NV	650	\$16,521	106	\$2,695	16.3%
RI	192	\$4,972	30	\$773	15.5%
PR	79	\$1,632	12	\$252	15.4%
LA	1,069	\$23,820	163	\$3,572	15.0%
HI	155	\$4,169	22	\$604	14.5%
MS	546	\$11,758	67	\$1,471	12.5%
OK	1,058	\$24,267	130	\$2,924	12.0%
Unknown	14	\$388	0	\$0	0.0%

APPENDIX C

COMMENTS ON THE DRAFT REPORT

We present, in full, comments from the HCFA Administrator, the Assistant Secretary for Planning and Evaluation (ASPE), and the Assistant Secretary for Management and Budget (ASMB).



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: AUG 10 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

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AUG 11 P 2:47
DEPARTMENT OF
GENERAL

SUBJECT: Office of Inspector General (OIG) Draft Reports on Chiropractic Care:
"Controls Used by Medicare, Medicaid, and Other Payers," (OEI-04-97-00490) and "Medicaid Coverage," (OEI-06-97-00480)

We reviewed the above-referenced reports that describe the current and anticipated chiropractic care benefits provided under each state Medicaid program and how Medicare, Medicaid, and private insurers control chiropractic benefits. The report recommends that The Health Care Financing Administration (HCFA) develop system edits which will detect and prevent unauthorized payments for chiropractic maintenance treatments.

We concur with the report recommendations. Our detailed comments follow.

OIG Recommendations

HCFA should: (1) require chiropractic physicians to use modifiers to distinguish categories of spinal joint problems (i.e., acute, exacerbation, recurrence, and chronic); and (2) require all Medicare contractors to implement system utilization frequency edits which will identify beneficiaries receiving consecutive months of minimal therapy.

HCFA Response

We concur. HCFA is developing utilization guidelines as specified in section 4513(c) of the Balanced Budget Act of 1997 (BBA). Section 4513(c) requires two actions: (1) the deletion of the x-ray requirement for chiropractic coverage; and (2) the development of utilization guidelines for chiropractic services in cases in which a subluxation has not been demonstrated by x-ray to exist. The implementation date for these provisions is January 1, 2000. We believe the OIG report recommendations will be addressed by the forthcoming action in response to the BBA. Once the utilization guidelines are developed, we will be able to develop modifiers and edits as necessary.

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DIG-MP
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GOC/IG
ExecSec
Date Sent 8/10/98



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JUL 20 1998

JUL 24 11:00

TO: June Gibbs Brown
Inspector General

FROM: Margaret A. Hamburg, M.D. *M.A.H.*
Assistant Secretary for Planning and Evaluation

SUBJECT: OIG Draft Reports on Chiropractic Care -- COMMENTS

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AIG-LC	_____
OGC/IG	_____
ExecSec	_____
Date Sent	7-24

We were pleased to have the opportunity to review these two draft reports concerning chiropractic care in the Medicaid program and controls on chiropractic benefits used by Medicare, Medicaid and private insurers.

We offer the following observations based on our review:

- While the development of edits or other mechanisms to identify inappropriate billings for chiropractic care certainly seems desirable, Medicare contractors must weigh the returns on investment in this activity against the returns likely on other investments of their resources for administration.
- The two State Medicaid programs that use physician referral in fee-for-service cite this requirement as a very effective means of control. More information is needed to substantiate this observation by State officials. How do these States measure the effect of physician referral? Is physician referral the only tool these States use to control spending on and/or use of chiropractic benefits? If they use other measures, how do they isolate the effect of physician referral? Finally, do these States factor in to their assessment of effectiveness the additional cost to the State of physician visits that may be necessary for the referral?
- To assess the relative importance of controls in Medicaid managed care compared to fee-for-service, it would be helpful to know how utilization of chiropractic services is distributed between these two sectors and the Medicaid populations they may roughly reflect (i.e., low-income families and SSI eligibles, respectively).
- The use of weighted averages (pp. 4-6) to summarize the range of utilization caps is inappropriate. The average values, which do not reflect real practice by any state or contractor, are actually meaningless and may mislead. For example, although 28 treatments/year is cited as the average among Medicaid plans that cover chiropractic services, not a single state actually has 28/year as its cap. Even more striking, the 104/year among plans with a hard cap doesn't even come close to any of the hard caps actually used by any of the 13 states that use them.

Page 2 - June Gibbs Brown

If you have any questions, please contact Julia Paradise of my staff at 690-6476 or jparadis@osaspe.dhhs.gov.



JUL 31 1998

MEMORANDUM TO:

June Gibbs Brown
Inspector General

FROM:

John J. Callahan
Assistant Secretary for Management and Budget

SUBJECT:

OIG Draft Reports on Chiropractic Care

- IG
- EAIG
- SAIG
- PDIG
- DIG-AS
- DIG-EC
- DIG-EI
- DIG-OI
- DIG-MIP
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Thank you for the opportunity to review the draft OIG reports entitled "Chiropractic Care - Medicaid Coverage (Ref. OEI-06-97-00480), and Chiropractic Care - Controls Used by Medicare, Medicaid and Other Payers (Ref. OEI-04-97-00490). For your consideration, we have comments on both reports as follows:

The manner of Data Collection for Both Reports

With respect to the manner of data collection, we believe that the collection of this information has Paperwork Reduction Act (PRA) implications. As we have recently discussed, we encourage you to establish a coherent OIG-wide approach to compliance with PRA requirements.

Chiropractic Care - Medicaid Coverage

While the report provides much useful information, more discussion of the methodology might be helpful. Also, we noted that there is one state - Utah - with a consistent upward trend in Chiropractic expenses. Are you aware of any reason for this growth?

Chiropractic Care - Controls

Methodology

We have serious reservations concerning the methodology used to estimate the incidence of chiropractic maintenance treatments billed to Medicare and the "probable" inappropriate payment estimates of \$68 million (\$447 million over five years). We do not believe the study's methodology supports these estimates. The application of a universal percentage estimate of chiropractic "conditions" to Medicare claims for chiropractic services does not seem to account for differences between all chiropractic services and those for which insurance claims are submitted, not to mention the differences in service usage, condition, etc. between the universe of chiropractic patients and Medicare chiropractic patients. Without: a) some extensive demographic analysis: b) a comparison of frequency of service utilization and insurance

Page 2.

coverage information for all chiropractic patients v. Medicare chiropractic patients, or c) a small subsample of claims which have actually been reviewed, there is nothing to validate your estimates. We recommend eliminating the estimates of inappropriate payment from the report.

We hope our comments have been useful. Questions can be addressed to Frank Burns on 690-6353.