Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CHIROPRACTIC CARE
Medicaid Coverage

JUNE GIBBS BROWN
Inspector General

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OEI-06-97-00480

OFFICE OF INSPECTOR GENERAL

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OEI's Dallas Regional Office prepared this report under the direction of Chester B. Slaughter, Regional Inspector General. Principal OEI staff included:

REGION

Clark Thomas
Nancy Watts
Lisa White

HEADQUARTERS

Alan Levine
Barbara Tedesco

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E X E C U T I V E S U M M A R Y

PURPOSE

To determine and describe the current and anticipated chiropractic care benefits provided under each State Medicaid program.

BACKGROUND

Recent changes to Medicare chiropractic coverage policy under the Balanced Budget Act of 1997 require that the Health Care Financing Administration (HCFA) establish, by January 1, 2000, new utilization guidelines for Medicare chiropractic care in cases where spinal subluxation has not been demonstrated by x-ray. The Balanced Budget Act also eliminates the Medicare requirement for supporting x-rays by the year 2000. Additionally, recent changes in New York State law require private insurers to include chiropractic coverage in their benefit packages.

To better understand the impact of these changes on the Medicare and Medicaid programs and to learn more about other forms of utilization control, we undertook this inspection resulting in two reports. This report, "Chiropractic Care; Medicaid Coverage, (OEI-06-97-00480)" describes current and expected chiropractic care benefits under State Medicaid programs. A companion report, "Chiropractic Care; Controls Used by Medicare, Medicaid, and Other Payers, (OEI-04-97-00490)" examines Medicare, Medicaid, and private insurers' mechanisms for controlling expenditures and protecting the chiropractic benefit from potential waste and abuse.

A particular concern in the Medicaid program was whether there were any indications of potential explosive growth in the program overall.

FINDINGS

Thirty States Report Offering Some Form of Medicaid Chiropractic Benefit Under a Fee-For-Service Arrangement.

Twenty six States cover all categorically needy Medicaid eligible beneficiaries and twenty of these extend coverage to those considered to be medically needy but who do not qualify for financial assistance. All 30 States provide coverage for children under Early Periodic Screening, Diagnosis and Treatment (EPSDT) plans.

Conditions and Chiropractic Services Which Qualify for Reimbursement Vary by State.

Twenty States reported they only reimburse manual manipulation of the spine for treatment of spinal subluxation. Five States offer additional coverage for the treatment of back pain associated with nerve root damage. Eight States report they cover any treatment considered medically necessary.

States Impose a Variety of Limits on the Number and Duration of Chiropractic Treatments a Beneficiary May Receive.

The number of chiropractic treatments a beneficiary may receive is limited in twenty six States. These limits range from one treatment per day to one treatment per year. Some States also limit the length of the period within which beneficiaries can receive treatment.

Twelve States Have Changed the Level of Their Chiropractic Benefit Since 1990. No Tendency of General Expansion of Benefits is Evident, However.

Only two States adopted program changes that only limited their programs over the period. The remainder made changes that resulted in both expansions and limits. In some cases, such as Louisiana, later changes directly offset earlier ones, while other States expanded to include additional beneficiaries while limiting their numbers or duration of treatments. No State reported pending plans to expand their fee for service chiropractic benefit. Of the States reporting no current coverage, none indicated immediate plans to add a chiropractic benefit, although South Carolina reported the issue is under study.

Chiropractic Care Comprises a Small Proportion of Total State Medicaid Expenditures. No Consistent Trends in Expenditures Appear. Some States Experienced Decreasing Costs over Time, While Others Saw Only Minor Fluctuations in Expenditure Levels.

California, Iowa, Maine, Montana, and North Dakota appear to have experienced a slight downward trend in chiropractic payments relative to total expenditures between 1994 and 1996, while Vermont's expenditures decreased sharply. Louisiana and Indiana saw relatively large increases in 1995 which diminished in 1996. With the exception of Louisiana, where limiting eligibility to EPSDT beneficiaries likely drove expenditures down sharply between 1995 and 1996, we are unable to correlate States' expenditure patterns with their reported benefit coverages and limits.

CONCLUSION

While thirty States offer some form of coverage for chiropractic care under their Medicaid fee-for-service plans, State reported utilization data show no discernable trends suggesting explosive growth in Medicaid expenditures. Also, no State reported legislative or regulatory plans to expand their Medicaid chiropractic benefit beyond current coverage.

COMMENTS

The Assistant Secretary for Management and Budget (ASMB) provided comments on this report. ASMB asked us to further explain the growth in Medicaid chiropractic expenditures in the State of Utah. We provided this information on page eight of this report. The full text of these comments appears in Appendix A.

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INTRODUCTION

PURPOSE

To determine and describe the current and anticipated chiropractic care benefits provided under each State Medicaid program.

BACKGROUND

Chiropractic Care

Traditional chiropractic philosophy holds that the principal cause of disease is a bone out of place along the spine. Because nerves branch off the spine between the vertebrae to every part of the body, chiropractors theorized that a slight misalignment of the vertebrae could pinch a nerve extending to another part of the body causing pain and disease. Relieving that pressure through spinal manipulation should, therefore, eliminate or ameliorate the disease. Currently, chiropractors are prohibited from prescribing drugs or performing surgery. While some are willing to treat problems beyond back pain, many rely on x-rays to locate a kink in the spine that may cause the back pain and limit their treatment to that ailment.

Chiropractors commonly treat patients by manual manipulation of the spine, using either their hands or hand held devices to adjust spinal alignment. The Agency for Health Care Policy and Research (AHCPR) has found that this method of treatment is effective for patients suffering from acute low back problems, especially when used within the first month of symptoms.

Section 273 of the 1972 Social Security Act Amendments expanded the Medicare definition of "physician" to include chiropractors. Expansion of this definition allowed chiropractors to participate in the Medicare and Medicaid programs.

Current Medicaid Coverage

Coverage of chiropractic care is an optional benefit available to Medicaid beneficiaries in some States. Medicaid coverage of chiropractic care is limited to services that are provided by a chiropractor licensed by the State and consist of treatment by means of manual manipulation of the spine. States may also allow chiropractors to provide and bill for x-ray services, although there is no Federal Medicaid requirement that x-rays must be provided before services may be reimbursed. The mechanisms used to control expenditures on chiropractic treatments vary among the States providing benefits. Several have no restrictions and some simply require that the treatment be deemed medically necessary. Others restrict the number of visits or length of treatment period. Among these States, the limits range widely as well.

Medicare Coverage

Medicare chiropractic coverage is limited to manual manipulation of the spine to correct a subluxation, defined as a functional or structural abnormality involving one or more of the vertebrae. Medicare does not pay for spinal manipulations that provide preventative or maintenance care. Medicare currently requires an x-ray to determine or demonstrate that a subluxation exists. An x-ray for this purpose is covered by Medicare if ordered, taken, and interpreted by a physician who is a doctor of medicine or of osteopathy, but not when ordered by a chiropractor. In 1996 Medicare allowed charges for chiropractic care totaled more than $294 million and averaged about $24 per claim.

Recent changes to Medicare chiropractic coverage policy under the Balanced Budget Act of 1997 eliminate the requirement for supporting x-rays effective January 1, 2000. The Balanced Budget Act also requires that, by the year 2000, the Health Care Financing Administration (HCFA) establish new utilization guidelines for Medicare chiropractic care in cases where spinal subluxation has not been demonstrated by x-ray. Additionally, recent changes in New York State law require private insurers to include chiropractic coverage in their benefit packages.

To better understand the impact of these changes on the Medicare and Medicaid programs and learn more about other forms of utilization control, we undertook this inspection resulting in two reports. This report, "Chiropractic Care; Medicaid Coverage, (OEI-06-97-00480)" describes current and expected chiropractic care benefits under State Medicaid programs. The companion report, "Chiropractic Care; Controls Used by Medicare, Medicaid, and Other Payers, (OEI-04-97-00490)" examines Medicare, Medicaid, and private insurers' mechanisms for controlling expenditures and protecting the chiropractic benefit from potential waste and abuse.

A particular concern in the Medicaid program was whether there were any indications of potential explosive growth in the program overall.

SCOPE AND METHODOLOGY

We distributed a mailed questionnaire to the Medicaid Administrators in the 50 States and the District of Columbia. We asked each State Administrator to forward this instrument to the individual most qualified to provide information about the chiropractic benefit. All 51 questionnaires were returned. We followed with telephone interviews where we required clarification or additional information. Published State Medicaid plans supplemented this information.

Although some States offer chiropractic coverage under managed care plans, because variation between plans both within and across States is great and because encounter data about chiropractic visits is limited, the discussion below focuses on the extent of benefits under fee for service plans.

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

F I N D I N G S

Thirty States Report Offering Some Form of Medicaid Chiropractic Benefit Under a Fee For Service Arrangement.

Twenty six States cover all categorically needy Medicaid eligible beneficiaries and twenty of these extend coverage to those considered to be medically needy but who do not qualify for financial assistance. All thirty States provide coverage for children under Early Periodic Screening, Diagnosis and Treatment (EPSDT) plans. Seventeen of these States also offer coverage to some beneficiaries under a managed care arrangement, including Oregon, which covers 85 percent of Medicaid beneficiaries under managed care. The remaining States and the District of Columbia reported that they offer no fee for service Medicaid coverage of chiropractic care.

TABLE 1. CHIROPRACTIC COVERAGE by STATE

STATE	MEDICALLY NEEDY	CATEGORICALLY NEEDY	EPSDT	STATE	MEDICALLY NEEDY	CATEGORICALLY NEEDY	EPSDT
ARKANSAS	✓	✓	✓	NEBRASKA	✓	✓	✓
CALIFORNIA		✓	✓	NEW HAMPSHIRE	✓	✓	✓
CONNECTICUT	✓	✓	✓	NEW JERSEY		✓	✓
FLORIDA	✓	✓	✓	NEW YORK			✓
IDAHO		✓	✓	N. CAROLINA	✓	✓	✓
ILLINOIS			✓	NORTH DAKOTA	✓	✓	✓
INDIANA		✓	✓	OHIO	✓	✓	✓
IOWA	✓	✓	✓	OREGON		✓	✓
KANSAS			✓	PENNSYLVANIA	✓	✓	✓
LOUISIANA	✓	✓	✓	SOUTH DAKOTA	✓	✓	✓
MAINE	✓	✓	✓	TEXAS		✓	✓
MASSACHUSETTS	✓	✓	✓	UTAH	✓	✓	✓
MICHIGAN	✓	✓	✓	VERMONT	✓	✓	✓
MINNESOTA	✓	✓	✓	WEST VIRGINIA	✓	✓	✓
MONTANA			✓	WISCONSIN	✓	✓	✓

Conditions and Chiropractic Services Which Qualify for Reimbursement Vary by State.

Twenty States reported that they limit reimbursement to coverage of manual manipulation of the spine for treatment of spinal subluxation. Five States also allow coverage for treatment of back pain associated with nerve root damage. Eight States reported that they allow coverage of additional treatments considered medically necessary or acceptable under State chiropractic regulations. One State, Kansas, covers only an annual chiropractic history and physical.

TABLE 2. CONDITIONS COVERED, by STATE

STATE	SPINAL SUBLUXATION	NERVE DAMAGE	OTHER or ADDITIONAL COVERAGE
ARKANSAS	✓		
CALIFORNIA	✓		Strain, Sprain or dislocation of spine or neck
CONNECTICUT	✓		
FLORIDA	✓		Other Medically Necessary Treatment
IDAHO	✓		
ILLINOIS	✓		
INDIANA	✓		Medically Necessary Treatment
IOWA	✓		
KANSAS			Chiropractic Screening Only
LOUISIANA	✓	✓	Medically Necessary Treatment
MAINE	✓		
MASSACHUSETTS	✓	✓	Medically Necessary Treatment
MICHIGAN	✓		
MINNESOTA	✓		
MONTANA	✓		No Restriction By Medical Condition
NEBRASKA	✓		
NEW HAMPSHIRE	✓		
NEW JERSEY	✓	✓	Cover Any Conditions Within Scope of Chiropractic Care Under State Law
NEW YORK	✓		
NORTH CAROLINA	✓	✓	
NORTH DAKOTA	✓	✓	Strains/sprains
OHIO	✓		
OREGON	✓		
PENNSYLVANIA	✓		
SOUTH DAKOTA	✓		
TEXAS	✓		
UTAH	✓		
VERMONT	✓		
WEST VIRGINIA	✓		
WISCONSIN	✓		

States Impose a Variety of Limits on the Number and Duration of Chiropractic Treatments a Beneficiary May Receive.

The number of chiropractic treatments a beneficiary may receive is limited in 26 States. These limits range from one treatment per day to one treatment per year, with Kansas reporting coverage of a single examination with an allowed reimbursement of one dollar. Some States also limit the length of the period within which beneficiaries can receive treatment. Four States impose no limits, as their coverage only includes EPSDT eligible beneficiaries. Tables 3 and 4 describe these limits and allowed exceptions, by State, as they affect Medicaid coverage of chiropractic care. The companion report, "Chiropractic Care; Controls Used by Medicare,

Medicaid, and Other Payers, (OEI-04-97-00490)", considers these limits in greater detail as they are used to control utilization.

TABLE 3. LIMITS TO COVERAGE, by STATE

STATE	LIMITS to COVERAGE
ARKANSAS	12 Treatments per State Fiscal Year for Adults.
CALIFORNIA	2 Treatments per Month. (24 per year)
CONNECTICUT	No More Than 1 Visit in 24 hours. Maximum of 4 Exams or Treatments in Single Visit to Home or Nursing Facility. (60 visits per year)
FLORIDA	24 visits per calendar year.
IDAHO	2 Office Visits per Month. (24 per year)
INDIANA	5 Office Visits per Year, 50 Therapeutic Treatments per Year
IOWA	Acute Condition 40 Treatments in 6 months (80 per year) Chronic Condition 2 Treatments per month
KANSAS	1 Chiropractic History per Year 1 Physical
LOUISIANA	8 Treatments per Year Without Pre-authorization for EPSDT 12 Treatments per Year Without Pre-authorization for Adults, Maximum of 18
MAINE	Acute Condition 2 Treatments per Week for 1 month Chronic Condition 1 Treatment per Week
MASSACHUSETTS	20 Treatments per Year. State Does Not Cover Treatment and Initial Examination on the Same Day
MICHIGAN	18 Visits per 12 Month Period
MINNESOTA	6 Manipulations per Month 24 Manipulations per Year
NEBRASKA	18 Visits in First 5 Months of Treatment 1 Visit per Month Thereafter if Needed (25 per year)
NEW HAMPSHIRE	6 Treatments per State Fiscal Year
NEW JERSEY	1 Treatment per Calendar Day (365 per year)
NORTH CAROLINA	24 Visits per State Fiscal Year for Combination of All Physician Services
OHIO	4 Treatments per Month (48 per year)
OREGON	1 Treatment per Day (365 per year)
PENNSYLVANIA	1 Treatment per Day (365 per year)
SOUTH DAKOTA	1 Treatment per Day 30 Treatments per 12 Month Period
TEXAS	12 Treatments per Benefit Period Benefit Period is 12 months Beginning With First Treatment
UTAH	Limited to Number Appropriate for Diagnosis 1 Evaluation, All Additional Services are Preauthorized
VERMONT	10 Treatments per Year
WEST VIRGINIA	12 Treatments per 12 Month Period
WISCONSIN	20 Treatments per Spell of Illness (New spell of illness required to exceed 20 per year)

Twelve States Allow Exceptions to Their Chiropractic Coverage Limits.

When medically necessary, treatment may continue beyond the standard limits in several States. Most require documentation or prior authorization before allowing exceptions, however.

TABLE 4. EXCEPTIONS TO COVERAGE LIMITS, by STATE

STATE	EXCEPTIONS TO COVERAGE LIMITS
CONNECTICUT	Authorized Treatment Must be Initiated Within 6 Months of Date of Authorization
IOWA	Medically Necessary Treatment May be Authorized Upon Review by Chiropractic Consultant
MICHIGAN	Documented Medically Necessary Treatments Can Exceed Limits
MINNESOTA	Prior Authorization and Documented Medical Necessity . Can Exceed Limit
NEW HAMPSHIRE	Overridden by Medical Director with Substantial Evidence of Medical Necessity
NORTH CAROLINA	Medically Necessary Treatment May be Authorized by Medical Director
OHIO	Medically Necessary Treatment Can be Authorized by the Department on a Case by Case Basis
SOUTH DAKOTA	Medically Necessary Treatment May be Authorized Upon Review by Chiropractic Consultant
UTAH	Additional Services May be Approved Through Preauthorization
VERMONT	Prior Authorization Based on Documentation of Medical Necessity
WEST VIRGINIA	Medical Necessity Documented and Reviewed by State Chiropractic Consultant. No More Than 40 Total Treatments
WISCONSIN	Medical Necessity Reviewed by Chiropractic Consultant

Twelve States Have Changed the Level of Their Chiropractic Benefit Since 1990. No Tendency of General Expansion of Benefits is Evident, However.

Only two States adopted program changes that only limited their programs over the period. The remainder made changes that resulted in both expansions and limits. In some cases, such as Louisiana, later changes directly offset earlier ones. Other States expanded to include additional beneficiaries while also limiting the numbers or duration of treatments. No State reported pending plans to expand their fee for service chiropractic benefit. Of the States reporting no current coverage, none indicated immediate plans to add a chiropractic benefit, although South Carolina reported the issue is under study.

TABLE 5. CHANGES IN COVERAGE SINCE 1990, by STATE

STATE	YEAR	EXPAND	LIMIT	CHANGE
	1991	✓		Expanded to include adults(7/91)
	1991			Limited coverage to under 21 only(12/1/91)
	1994	✓	✓	One x-ray per State fiscal year covered (7/94)
ARKANSAS	1996	✓		Expand to all ages (7/96)
FLORIDA	1992	✓		Treatment limit expanded from 12 to 24 per year
ILLINOIS	1995		✓	Limited to EPSDT and Qualified Medicare Beneficiaries
INDIANA	1992		✓	Treatment and diagnosis limits added
	1983		✓	Limited or eliminated many services
KANSAS	1991		✓	Limited to history and physical for EPSDT
	1995		✓	Limit to EPSDT only
LOUISIANA	1997	✓		Expanded to include all Medicaid beneficiaries
	1991		✓	Eliminated adults
	1993	✓		Reinstated adults with 12 visits per year
MICHIGAN	1996	✓		Increased 12 visits to 18
NEBRASKA	1993		✓	Limited number of treatments
NEW HAMPSHIRE	1995	✓		Allow coverage of x-rays
NEW JERSEY	1997	✓		Added initial diagnostic visit to coverage
NORTH CAROLINA	1991			Budget neutral. Allows chiropractor to perform x-ray, no longer requires physicians.
WEST VIRGINIA	1992	✓		Began x-ray reimbursement and raised limits from 6 treatments to 40 per year (more than 12 require prior approval)

Chiropractic Care Comprises a Small Proportion of Total State Medicaid Expenditures. No Consistent Trends in Expenditures Appear. Some States Experienced Decreasing Costs over Time, While Others Saw Only Minor Fluctuations in Expenditure Levels.

We asked States to report data for the years 1994 through 1996, distinguishing between adult and EPSDT beneficiaries and between managed care and fee-for-service expenditures. Few reported data in that form, either because the data was unavailable or could not be extracted in the form requested. Several States indicated they did not maintain separate data for adult and EPSDT beneficiaries or did not disaggregate EPSDT expenditures. Also, most States did not have managed care data within which chiropractic expenditures were identifiable. However, 15 States did provide financial data reflecting total Medicaid expenditures and allowed payments for chiropractic care under their fee-for-service plans. Table 6. summarizes this information.

TABLE 6. STATE-REPORTED CHIROPRACTIC EXPENDITURES AND PERCENT OF TOTAL MEDICAID EXPENDITURES, by STATE

	1994		1995		1996	
STATE	Chiropractic Payment	% Total	Chiropractic Payment	% Total	Chiropractic Payment	% Total
ARKANSAS	36,912	0.0034	44,095	0.0035	36,407	N/A
CALIFORNIA	638,226	0.0064	607,915	0.0056	632,545	0.0553
IDAHO	42,117	0.0127	41,962	0.0117	52,622	0.0130
INDIANA	7,068,000	0.3020	2,822,000	0.1388	6,736,000	0.2766
IOWA	1,664,533	0.1665	1,676,029	0.1523	1,648,935	0.0384
LOUISIANA	9,177,891	0.3412	15,995,086	0.5777	4,282,654	0.1746
MAINE	408,795	0.0455	376,786	0.0384	359,034	0.0363
MINNESOTA	1,758,851	0.0811	2,246,935	0.0843	1,814,085	0.0617
MONTANA	Not Available	N/A	15,693	0.0049	10,488	0.0031
NEW JERSEY	439,919	0.0111	568,693	0.0135	503,829	0.0115
NORTH CAROLINA	459,733	0.0161	700,158	0.0208	770,540	0.0207
NORTH DAKOTA	255,085	0.0898	231,086	0.0779	224,490	0.0753
TEXAS	783,882	0.0101	777,752	0.0101	1,028,304	0.0134
UTAH	64,451	0.0125	235,237	0.0423	349,088	N/A
VERMONT	166,557	0.0409	116,211	0.0345	114,374	N/A

Beyond noting that chiropractic care is a very small percentage of total Medicaid expenditures, few overall trends are apparent. Within States, California, Iowa, Maine, Montana, and North Dakota appear to have experienced a slight downward trend in chiropractic payments relative to total expenditures, while Vermont's expenditures decreased sharply. In all but three of the remaining States, chiropractic expenditures and their relative proportion of State totals fluctuated only slightly over the three year period. Utah's expenditures increased, while Louisiana, and Indiana saw relatively large increases in 1995 which diminished in 1996. With the exception of Louisiana, where limiting eligibility to EPSDT beneficiaries likely drove expenditures down between 1995 and 1996, and Utah, where chiropractic coverage began in July of 1994 and expenditures rose over the next two years, we are unable to correlate States' expenditure patterns with their reported benefit coverages and limits.

CONCLUSION

While thirty States offer some form of coverage for chiropractic care under their Medicaid fee-for-service plans, State reported utilization data show no discernable trends suggesting explosive growth in Medicaid expenditures. Also, no State reported legislative or regulatory plans to expand their Medicaid chiropractic benefit beyond current coverage.

COMMENTS

The Assistant Secretary for Management and Budget (ASMB) provided comments on this report. ASMB asked us to further explain the growth in Medicaid chiropractic expenditures in the State of Utah. We provided this information on page eight of this report. The full text of these comments appears in Appendix A.

A P P E N D I X A

TEXT OF AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

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

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

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.