Dynamic Chiropractic

Medicare: Penny Wise and Pound Foolish

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By now, most of you have heard about the scathing 2009 report on chiropractic from the Office of the Inspector General (OIG).[1] This is the latest in a series critical of chiropractic claims. OIG reports from 1986, 1998, 1999 and 2005 also allege that inappropriate payments were made for maintenance therapy and miscoded, improperly documented claims. The response from the chiropractic profession has been a sort of collective *mea culpa*. Professional organizations have vowed to address documentation problems, while entrepreneurs have offered seminars, publications and software programs promising to make your practice "audit proof."

The timing of the report's release, given the debate on national health policy, would appear to play into the hands of those who would like to "contain and eliminate" the chiropractic profession. To put things in perspective, total Medicare expenditures for 2006, the year reviewed in the latest report, amounted to more than $382 billion.[2] The report notes that expenditures for chiropractic services in 2006 amounted to $466 million. This is 0.12 percent of the total Medicare expenditures. The amount of alleged overpayment was $178 million, or 0.047 percent of the total.

The methodological shortcomings of the report, including unsubstantiated claims, faulty logic and outright bias, are beyond the scope of this article. Interested readers are referred to a comprehensive analysis of the OIG report by Matthew McCoy, DC, MPH, which is available online at no cost.[3] An overriding concern is that the OIG report demonstrates a fundamental lack of understanding of vertebral subluxation. Furthermore, it reflects a perspective that should be at the heart of any health care reform debate.

The Centers for Medicare & Medicaid Services (CMS) limits care of vertebral subluxations not associated with a secondary condition by defining them as "maintenance therapy," which is not a covered condition. CMS defines maintenance therapy as follows: "A care plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition."[4] While this should be the goal of every doctor, regardless of specialty, Medicare explicitly excludes such services.

Medicare regulations not only look at subluxation for diagnosis, but also require a secondary diagnosis to establish necessity and determine care allowance.[5] This means that the beneficiary must have two diagnoses related in order to cover subluxation care: a diagnosis of subluxation and a diagnosis of a secondary condition. The secondary conditions are musculoskeletal disorders. For many, if not most of these covered secondary conditions, evidence of efficacy and effectiveness for spinal manipulation is lacking. Indeed, there are organic conditions for which stronger evidence exists.

The current policy represents the application of a political agenda to limit chiropractic care to people with musculoskeletal conditions, rather than the objective application of evidence. The result is flawed policy; a diagnosis of subluxation alone is insufficient to trigger coverage.

Exploding costs are directly related to the system's focus on urgent care, to the exclusion of strategies that address health problems before they become costly and difficult to treat. Coverage of early interventions, such as regular chiropractic care for vertebral subluxations, could result in significant cost savings. A study of 311 chiropractic patients, ages 65 years and older, who had received chiropractic maintenance care for five years or longer, demonstrated significantly lower health care costs. To control for overall health status, patients in the study completed a general health survey. Chiropractic patients, when compared with U.S. citizens of the same age and health status, spent only 31 percent of the national average for health care services. The chiropractic patients also experienced 50 percent fewer medical provider visits compared with U.S. citizens of the same age.[6]

Another study examined the utilization, cost and effects of chiropractic services on Medicare program costs compared to similar data for beneficiaries treated by other provider types.[7] There were 5.8 million beneficiaries in total. Of these, 1.5 million (26.8 percent) received chiropractic care. Despite averaging more claims per capita than nonchiropractic patients, beneficiaries who received chiropractic care had lower average Medicare payments per capita for all Medicare services ($4,426 vs. $8,103) and lower average payments per claim for Medicare services ($133 vs. $210). Aside from high levels of patient satisfaction and improved health behaviors, senior citizens receiving chiropractic care had reduced medical utilization, spent significantly less time in hospitals and spent much less on medical care than individuals not receiving chiropractic care.

Including Medicare coverage for care of vertebral subluxations without a requirement for a second diagnosis would result in significant cost savings. Using an average of 12 visits per year at $32.52 each, the resulting cost would be an average of $390.24. The Muse study[7] reported that beneficiaries who received chiropractic care had lower average Medicare payments per capita for all Medicare services ($4,426 vs. $8,103). Thus, for a cost of approximately $400 per person, potential savings of more than $3,000 could potentially be realized. Officials at CMS have exercised their discretion to limit coverage for early-intervention services, such as care for vertebral subluxation, without weighing the long-term financial and medical benefits of covering these services against their short-term costs.

It is proposed that the Medicare Act be amended to cover the assessment and care of vertebral subluxations without the requirement that a beneficiary has a concomitant musculoskeletal condition. The amendment should also provide for objective assessment of vertebral subluxation, prohibit the use of arbitrary "caps," and include coverage for examinations, imaging studies and the use of specialized instrumentation to evaluate vertebral subluxation and how it affects the beneficiary's general health. Finally, chiropractors should be added to the list of practitioners who may elect to "opt out" of Medicare and contract directly with patients for professional services.

These proposals merely seek parity with other providers. Yet the potential cost savings, as well as improvement in health-related quality of life, could be a step toward the desperately needed reformation of the health care system. We need true health care, not merely earlier detection and treatment of specific diseases. Citizens who have been paying into the system deserve nothing less.

Those seeking a more in-depth analysis of chiropractic services under Medicare may download my paper, "Defining Scope of Coverage for Care of Vertebral Subluxation Under Medicare."[8]

References

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