Chiropractic and Medicare: Is the Criticism About Unnecessary Care Valid?
Respectfully submitted by Dr. Ronald J. Farabaugh

Like most other doctors of chiropractic, I read the headline suggesting that the majority of chiropractic care in 2013 was improper. The information was released by Medicare and reported in Medscape. The following article was written to provide historical context and put this issue in perspective. The article, “Most Medicare Claims From Chiropractors Improper, HHS Says” was authored by Robert Lowes. Robert Lowes is a journalist for Medscape Medical News and a former senior editor at Medical Economics magazine and contributor to numerous healthcare publications. I have no idea whether or not he has been fair in his treatment of the chiropractic profession, but Medscape and Medical Economics are popular resources for public information, thus their headlines make news. In this case, the headline is exceptionally misleading. Please bear with me for a few paragraphs and allow me to provide context.


The study included the confusing observation by HHS: “Concern about improper payments to chiropractic physicians prompted the US Department of Health and Human Services to describe chiropractic services as a “significant vulnerability” for Medicare.” Yet the conclusion of the study quoted Medicare’s actual expenditures: “Chiropractic claims account for less than 1/10th of 1% of overall Medicare expenditures.” [Source: https://www.ncbi.nlm.nih.gov/pubmed/23773429] How significant can the issue be when chiropractic represents only 1/10th of 1% of total expenditures? Furthermore, does it pass the smell test suggesting that 82% of all treatment was found to be unnecessary? Common sense should challenge that assertion.

History

In case you were unaware, chiropractic was included as a limited benefit in Medicare in approximately 1972. [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf]. However reimbursement was limited to only spinal manipulation for the correction of a “subluxation”. Medicare used to require x-ray to demonstrate subluxation, but would not pay for the x-ray. They eventually dropped the x-ray requirement. However, they still require an examination, but do not pay for the exam. They expect DCs to provide exercise instruction and improve function, but do not provide reimbursement for exercise/rehab. How are these completely irrational policies possible? No other profession has such limited and irrational coverage. Answer: Historical prejudice and power. Sadly, the politics in 1972 recognized the need to add chiropractic as a benefit, but the medical leaders in charge basically threw society a bone, and only allowed for treatment of subluxation with spinal manipulation, and for years only allowed 12 visits. Eventually the 12 visit limit was replaced with “medically necessary” allowances, related to only acute pain or acute exacerbations of chronic pain.
AMA Discrimination: Consider the history of the AMA and their successful efforts to contain and eliminate our profession. On November 2, 1963, the AMA Board of Regents created the "Committee on Quackery" with the goals of first containing, and then eliminating chiropractic. H. Doyle Taylor, the Director of the AMA Department of Investigation and Secretary of the Committee on Quackery, outlined the steps needed:

- to ensure that **Medicare should not cover chiropractic**
- to ensure that the U.S. Office of Education should not recognize or list a chiropractic accrediting agency
- to encourage continued separation of the two national associations
- to encourage state medical societies to take the initiative in their state legislatures in regard to legislation that might affect the practice of chiropractic.

The AMA worked to spread information designed to discredit chiropractic through public media and the scientific literature.

So, for patents seeking a conservative pathway to control acute and chronic pain, it’s been an uphill battle. Can you imagine if patients only had access to their medical physicians for only acute pain? Can you imagine patients 65 years and older not being permitted access to medication to control chronic pain? Yet that is exactly what we currently have in regards to conservative care of chronic pain and access to chiropractors. Consider the current definition of maintenance care:

**B. Maintenance Therapy**

"Under the Medicare program, Chiropractic maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. For information on how to indicate on a claim a treatment is or is not maintenance, see §240.1.3." [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf].

Just try to imagine if you replaced the word “chiropractic” with “drugs” in the above definition. The medical profession would never stand for it, and the pharmaceutical industry would spend billions to change the policy. Chiropractic is tiny in comparison to organized medicine and Big Pharma, thus the irrational policies related to chiropractic versus medicine. What possible logic exists in Medicare to allow drugs but not conservative care that could reduce reliance on drugs and keep people more functional? I would suggest that it is all about politics and power, certainly not science.

Lastly, consider this unfairness. For medical physicians, Part B (Medical Insurance) covers most medically necessary doctors’ services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, mental health care, and some home health and ambulance services. **For MDs, everything is covered. For DCs, only spinal manipulation for the correction of subluxation. Why?**
Terminology Confusion

“Medically unnecessary” or simply “not a payable benefit”. This entire issue is exemplary of several national guideline organizations and their current challenges related to terminology. There is a huge difference between a treatment being “medically unnecessary” versus not a “payable benefit”, yet Medicare uses the terms/concepts interchangeably resulting in distorted calculations related to “medically unnecessary care”. Decent research exists related to the benefits of ongoing care by chiropractic physicians. Please consider the schematic below to visually understand the differences between true wellness (formerly called maintenance care), and chronic care (formerly called supportive care). Chronic care related to chiropractic is not only medically necessary, but very beneficial to patients, and to society in general (considering the cost issues), but it may not be currently a payable benefit. Classifying care that may be necessary and beneficial but not payable as “unnecessary” is not fair or accurate.

“Maintenance” versus “Ongoing Chronic pain management”: As the chart identifies above, the two terms/levels of care are not the same, and should never be used synonymously. Both Medicare and various guideline organizations use the terms interchangeable, which should change ASAP. It is
understandable why elective “Wellness/maintenance care” often is classified as a non-payable benefit. Patients who desire this level of service should be self-pay. But ongoing chronic pain management is NOT wellness care. These are the same patients who often ingest large amounts of medication, including narcotics, to help control chronic pain. If ongoing conservative care is preferred by the patient, and can result in (1) control of pain, (2) maximize the attained level of function, (3) minimize the needs and reliance on drugs, (4) keep the patient either employed, or better able to engage in activities of daily living, why would it be considered “medically unnecessary”? Yet, that is exactly what both Medicare and several guideline organizations do currently. This is an unfair classification that needs to change immediately in my opinion. Research supports conservative chronic pain management. It is much less expensive, safer, and preferred by millions. More importantly, there are guidelines and algorithms in place that can prevent abuse related to chiropractic management of the chronic pain patient.

**Documentation:**

Please also consider the reality of what a DC has to do to comply with all aspects of Medicare documentation requirements. Virtually none of these requirements are forced upon medical doctors. Why? Answer: Politics and power!! But if we fail to miss a single element, Medicare can deem our care “medically unnecessary” and request a refund. Remember, that unlike medical doctors, doctors of chiropractic are limited in scope (only spinal manipulation is payable), and diagnosis (only subluxation is reimbursable). What other profession is limited to the treatment of a single condition? Again, ask yourself “Why?”

Additionally, we have to remain vigilant to excessive documentation/legal requirements:

1. **ABN (Advanced Beneficiary Notice):** An Advance Beneficiary Notice (ABN), also known as a waiver of liability, is a notice the patient receives when a provider or supplier offers a service or item they believe Medicare will not cover. Remember that we may have taken care of many of our patients on and off for decades. If we fail to have them sign this on a particular visit, Medicare can classify care as not medically necessary and we can be financially penalized.
2. **PQRS (Physician Quality Reporting System):** During billing and documentation, we have to identify on every visit the status of pain and function. If we miss, Medicare can classify care as not medically necessary and we can be financially penalized.
3. **PART (Pain, asymmetry, range of motion, tissue tone):** We DCs have to document at least two of four PART elements on each visit to help identify the existence of a subluxation (used to require x-ray). If we miss, Medicare can classify care as not medically necessary and we can be financially penalized.
4. **Coding: AT versus GA:** When the patient reaches a plateau in care we must switch to a GA modifier if the patient wants treatment (that they know will not be covered, thus self-pay), but wants us to still bill it to Medicare. If we mistakenly use an AT modifier Medicare can classify that care as medically unnecessary for which we can be financially penalized.
5. **Case management:** We are expected to manage Medicare patients correctly, including performing an initial history and examination, and pre-and post-manipulative assessment that
they will not reimburse. But they will compensate MDs and DOs for the exact same service(s). The same holds true of periodic update re-evaluations/examination, the use of therapy, exercise, etc. We have to take the time to do the job correctly despite being compensated for only spinal manipulation and only during the acute period of care. If the documentation audit finds any of the expected case management elements missing or lacking, Medicare can consider the care “medically unnecessary”, even if it is clear that the patient benefited from care.

6. **CMT Coding (Chiropractic manipulative therapy):** There are three levels of codes (98940, 98941, 98942) and if documentation or diagnosis does not adequately support the code submitted then Medicare can deem all care as medically unnecessary, even if the patient benefited from care.

As you can see, there is more to the original headline than meets the eye. Maybe now you can see how 82% of care could be considered “medically unnecessary”. It’s nearly impossible to maintain the level of vigilance required as a DC when it comes to documentation, coding and reporting. However, in recent years our profession has elevated documentation efforts significantly, in large part thanks to EHR. I would suggest that if MDs had the same level of scrutiny 82% of their care would also be considered medically unnecessary.

If the original headline read, “Documentation found to be lacking at least 82% of the time”, I would not have objected. But to equate documentation or case management issues with care being medically unnecessary is simply not fair, appropriate, or accurate. This article is politics at its finest. Do not be taken in by those who would misclassify care that may extend outside policy benefit design as automatically being “unnecessary”. I’d be very interested to discover how much care was truly unnecessary based upon case management standards, versus deemed unnecessary simply due to documentation requirement issues. As it stands, the existing numbers are useless.

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