American
Chiropractic
Association

August 30, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8018
Baltimore, Maryland 21244–8018

Re: CMS 1385-P: Proposed Rule for Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2008 and Other Changes to Payment Under Part B

The American Chiropractic Association (ACA) is a professional society composed of doctors of chiropractic whose goal is to promote the highest standards of ethics and patient care, contributing to the health and well-being of millions of patients. The ACA currently has over 15,000 members, making it the primary representative of the chiropractic community.

Below are ACA's comments regarding CMS Proposed Rule 1385-P. Specifically, ACA is commenting on three facets of the rule: Diagnostic X-ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions (§ 410.32(a)(1)); Discussion of Chiropractic Services Demonstration; and the development and expansion of the Physician Quality Reporting Initiative (PQRI), a program created under the Tax Relief and Health Care Act of 2006 (Pub. L. 109-432).

- *Diagnostic X-ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests*

CMS Proposed Rule 1385-P, Technical Corrections

The Agency is proposing elimination of patient reimbursement for X-rays taken by a "non-treating physician," such as a radiologist, and used by a doctor of chiropractic to determine a subluxation. This reverses a policy adopted 12 years ago at the behest of ACA designed to protect the patient in terms of reimbursement for needed X-ray services. ACA strongly opposes this proposal.

The proposed rule change has to do with referring patients to a "non-treating" physician, such as a radiologist. As it stands now, a Doctor of Chiropractic can refer the patient to the radiologist and the radiologist could order the x-ray. That was covered by Medicare, and the patient was reimbursed. The proposed rule would eliminate this practice. There is already a Medicare standing rule that precludes coverage for services ordered by non-treating physicians—doctors of chiropractic had an exception to that rule. Now the Agency is proposing that the exemption granted chiropractic patients for x-ray is no longer necessary because x-rays are no longer required.

In a memorandum to all Associate Regional Administrators from the Director, Department of Health and Human Services (HHS) Office of Physician and Ambulatory Care Policy, dated April 11, 1996, the message states that *"This memo is follow-up to our memorandum of Nov 3, 1995 in which we [HHS] stated that if the test was ordered by a physician, but referred by a chiropractor, we should not deny payment for the x-ray. Our memorandum was intended to assure that services for a patient referred by a chiropractor to a physician who ordered tests and x-rays, would not be denied on the basis of referral by a chiropractor. (Emphasis ours) Nothing prohibits a chiropractor from referring a patient for services."*

The memo goes on to state: *"We can not, nor was it our intention to, apply a different set of standards for a radiologist ordering an x-ray, than for a physician ordering similar tests. (Emphasis ours) To sum up, the radiologist may order an x-ray for a patient referred by a chiropractor…"*

Thus, it is ACA's view that this proposal will adversely affect patient coverage. X-rays, when needed, are integral to the overall chiropractic treatment plan of Medicare patients, and unfortunately in the end, it is the beneficiary who will be negatively affected by this proposed change in coverage. The current X-ray Medicare protocol has served patients well, and there is no clinical reason for this proposed change. Additionally, if doctors of chiropractic are unable to refer patients directly to a radiologist, patients may be required to make additional and unnecessary visits to their primary care providers, significantly driving up the costs of patient care. Therefore, it is ACA's position that this proposal should be withdrawn immediately.

- *Discussion of Chiropractic Services Demonstration*

CMS Proposed Rule 1385-P, Chiropractic Services Demonstration

Here, the Agency is proposing to offset the cost of the Medicare chiropractic demonstration project with reductions to doctors of chiropractic alone and not reductions to all items and services included under Part B, as was congressional intent when the demonstration project was enacted in 2003.

The Medicare Chiropractic Demonstration Project began on April 1, 2005, and had far-reaching implications for both the chiropractic profession and the millions of beneficiaries as, currently; the only reimbursable service available to Medicare patients is manual manipulation of the spine to correct a subluxation.

Occurring in all of Maine and New Mexico, and parts of Illinois, Iowa, and Virginia, the chiropractic demonstration project allowed doctors of chiropractic to provide Medicare-approved services including exams, x-rays, and therapies. The project ended on March 31, 2007 and is currently under evaluation by the Agency and the entity assigned to analyze the demonstration program, Brandeis University.

ACA believes the Congressional intent in this area is clear: In funding the demonstration, the law directs the Secretary to *"provide for the transfer from the Federal Supplementary Insurance (Part B) Trust Fund … of such funds as are necessary for the costs of carrying out the demonstration projects under this section."* (See §651(f)(A))

While the Agency relies on the language in subsection (B) that directs the Secretary to "ensure" budget neutrality, the language itself doesn't tell the Secretary how to do it – that directive resides in subsection (A) immediately above. The ACA is not opposed to budget neutrality; it only objects to the means by which the Agency plans to implement it.

ACA believes the Agency's plan to offset the demonstration's costs with payment reductions to existing chiropractic services only, and not with reductions to the totality of services payable under the Part B Trust Fund as directed, is flawed. ACA believes strongly that the totality of funds under Part B, not a discrete minority of services within it, should finance the demonstration program.

- *Consensus Organizations and Consensus-Based Process for Developing Measures*

CMS Proposed Rule 1385-P, TRHCA-SECTION 101(b): PQRI

Given the importance of having a transparent quality measures development, endorsement and implementation system as the foundation of the PQRI, the ACA appreciates the Agency's clarification of the respective roles of the National Quality Forum (NQF) and AQA Alliance. However, we urge the Agency to provide more guidance on how measures that are adopted by the AQA Alliance before December 2006, but not endorsed by NQF until after December 2006, be recognized under the 2008 PQRI. ACA recommends that the Agency allow such measures to be included, as removing these types of measures from the program in mid-year would be disruptive for participating Medicare providers, and leave gaps in data collection. We encourage the Agency to be more direct in the Final Rule and state expressly how such measures will be recognized.

Doctors of chiropractic are in a unique position as Medicare recognizes few CPT codes for chiropractic care (codes 98940-98942). For this reason, none of the proposed 2008 PQRI measures are applicable for use by doctors of chiropractic. We understand that the *Quality Insights of Pennsylvania's* structural measures regarding health information technology (HIT) adoption and use may be applicable to doctors of chiropractic. The ACA is working with *Quality Insights of Pennsylvania* to see how the specifications of such a measure may be modified to recognize chiropractic services. However, it is important to point out that most chiropractic offices are too small to justify the costs associated with HIT adoption. Therefore, even if such a measure is restructured to recognize the adoption and use of HIT in the delivery of recognized Medicare chiropractic codes, it is likely that a low volume of reporting would occur.

CMS is encouraged to improve the utility of the PQRI by augmenting the scope of services provided by eligible professionals to whom PQRI measures apply. For doctors of chiropractic, the prioritization of a measurement set in the area of back pain is critical in expanding the utility of the PQRI.

ACA understands that *Quality Insights of Pennsylvania* is in the process of moving into Phase II of its measures development initiative to expand the number of quality measures available for recognized Medicare providers. We look forward to the Agency's support in facilitating the development of quality measures through *Quality Insights of Pennsylvania* that recognize chiropractic care.

We encourage the Agency to list the numerator and denominator specifications for each measure in the Final Rule. The applicability of the proposed measures to various Medicare providers is not transparent unless such specifications are listed. Small differences regarding the inclusion or exclusion of particular CPT codes in the denominator will largely determine which health care practices should increase their staff and financial resources necessary to successfully participate in the 2008 PQRI.

ACA supports the careful development of a mechanism for submitting data on quality measures through a data registry or electronic health record. However, the ability of most Medicare providers, like doctors of chiropractic, to participate in such reporting depends on several factors. These include, but are not limited to: Measures applicable to back pain must eventually be included in the PQRI, only then will doctors of chiropractic be afforded the opportunity to participate in a national quality reporting and data gathering initiative.

The adoption of HIT in the chiropractic office is not widespread as most are one-person offices with limited resources to expend on purchasing the hardware and software necessary to participate in a medical registry; and

Technology support must be provided by the Agency to allow Medicare providers to participate in data registry reporting. Specifically, the development of appropriate algothriums that accurately compute quality measures reporting. Moreover, the Agency must set the standard framework for a national data registry that allows Medicare providers who do not have specific data registries to participate, as well as those specialty societies that have data registries the opportunity to link-up with the Agency's data registry system.

The Agency's five options for utilizing data registries are commendable. It is from the perspective that not all Medicare providers are prepared for data registry adoption and use that ACA supports the exploration of blending elements from the proposed options. For example, Option 5 calls for a registry data dump for Medicare beneficiaries for all information in a provider's registry for the service period of interest. This option may be beneficial for a medical specialty that has a robust data registry, but not so practical for a specialty that does not have wide adoption of HIT. Therefore, blending elements of Option 5 with elements from Option 1 (having the registries provide the quality-data codes requested for the PQRI measures plus the beneficiary code) allows smaller Medicare providers the opportunity to participate in small scale registry reporting. Overall, the Agency must provide the infrastructure support necessary to support robust Medicare provider participation in data registry reporting.

In conclusion, we support a data registry reporting system that is transparent and open to all Medicare providers, both large and small. Ultimately, monitoring the frequency of Medicare provider use of data registries, as well as the accuracy of data collection, will determine what mechanisms employed by the Agency are successful in improving the quality of care delivered to Medicare beneficiaries.

Thank you in advance for your consideration of our comments. ACA stands ready to work with CMS in its efforts to improve the quality of care provided to our nation's Medicare beneficiaries. Please contact John Falardeau at 703-812-0214, or by email, jfalardeau@acatoday.org if you should need additional information or clarification regarding ACA's comments.

Sincerely,

Kevin P. Corcoran
Executive Vice President