

August 20, 2013

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1600–P
P.O. Box 8016
Baltimore, MD 21244–8016

RE: CMS–1600–P Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014

The American Chiropractic Association (ACA) is a professional society composed of doctors of chiropractic (DCs) whose goal is to promote the highest standards of ethics and essential patient care, contributing to the health and wellbeing of millions of patients. The ACA is the largest association in America representing the chiropractic profession. Below are ACA's comments in response to the Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, and other revisions to Part B for calendar year 2014 Proposed Rule.

Chiropractors Billing for Evaluation & Management Services

The ACA appreciates CMS' consideration to authorize doctors of chiropractic to furnish and bill Medicare for Evaluation and Management (E/M) services when appropriate. The practice of chiropractic is a conservative, patient-centered branch of the healing arts recognized for its effective management of spinal and other musculoskeletal complaints. Doctors of chiropractic (also known as, chiropractic physicians, chiropractors, DCs) are licensed in all 50 States, U.S. Territories, and have specific or general licensure in over 80 foreign countries.

The practice of chiropractic is focused on wellness, prevention, and natural healthcare approaches. As first contact, portal-of-entry providers, doctors of chiropractic provide evaluation and management services to screen and diagnose patients' conditions/injuries prior to the initiation of treatment. Evaluation and management services are also provided to carefully evaluate patient progress, acute exacerbation of complaints, and any new complaints/conditions or injuries in order to set appropriate treatment plans, or to dismiss the patient from care with appropriate follow-up and home care recommendations. The treatments or interventions provided by a doctor of chiropractic may include, but are not limited to: spinal manipulation (adjustment), joint mobilization, soft tissue manipulation (both manual and instrument assisted), massage, physical medicine modalities and procedures, rehabilitation, exercise, ergonomics, dietary/nutritional and activities of daily life/lifestyle counseling.

Since the inception of the chiropractic profession, doctors of chiropractic have been trained to consider the whole patient and typically practice according to the evolving biopsychosocial philosophy of health. With an education that is equivalent in the basic and clinical sciences, including examination and diagnosis, to that of other physicians, the DC is well equipped to function in today's evolving integrated healthcare settings, as demonstrated by effective participation in out-patient spine centers, interdisciplinary practices and hospitals, as well as in military and veteran's centers. As with any competent primary care professional, DCs must examine

and diagnose their patient, develop a treatment plan, and/or consider referral or co-management with providers of another specialty.

Given the prevalence of acute and chronic musculoskeletal conditions in today's society, and the growing research support for conservative chiropractic care, it is axiomatic that chiropractic care be a covered and integrated condition-based service, rather than a limited intervention (i.e., "manual manipulation of the spine to correct a subluxation") in a modern, value-based health care system. All other practitioners have provisions for reimbursement for Evaluation and Management services under the Medicare Payment system. Chiropractic should no longer be the exception.

As requested, provided below please find our responses to the specific questions to which CMS is seeking comment.

Are there situations where a chiropractor would furnish E/M services that are with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) that are not included within the definition of the CMT codes? Specifically, we are seeking information on the situations, the services that would be provided, and the E/M codes that would be billed.

Yes, there are situations where a Doctor of Chiropractic (DC) would furnish Evaluation and Management (E/M) services that are with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) that would not be included within the definition of the Chiropractic Manipulative Treatment (CMT) codes. DCs perform E/M services (history, exam, clinical decision making) as a standard of care within the profession in order to determine the appropriateness of CMT. The physical examination is an element of the evaluation in which information regarding the clinical status is elicited by selecting and applying appropriate examination procedures.¹

As stated by the Centers for Medicare and Medicaid Services' (CMS) in the Medicare Benefits Policy Manual,² documentation requirements for the initial chiropractic visit shall include six elements: Patient History; Description of the present illness; Evaluation of musculoskeletal/nervous system through physical examination; Diagnosis; Treatment Plan; and Date of the Initial Treatment. Per the AMA/CMS E/M Documentation Guidelines, these elements are consistent with a significant, separately identifiable E/M service. The first three documentation requirements listed are equivalent to the first two key components of an E/M service. The remaining requisite documentation elements align with the third key component of the E/M Documentation Guidelines, which is the Medical Decision Making portion of the E/M service.

Evaluation findings are critical to the clinical decision making process. They allow the chiropractic physician to properly identify: if a significant health problem, in the form of a neuromusculoskeletal condition necessitating treatment, is in existence; if there are any contraindications to spinal manipulation³; and/or the need for co-management with other providers. These are issues that must be considered not only for clinical effectiveness but the safety of the beneficiary. If the findings from the E/M service support the identification of a health problem necessitating chiropractic treatment, then and only then will the DC initiate the pre-manipulation assessment inherent in CMT; however, if the clinical evaluation findings do not support that CMT is a reasonable and necessary form of treatment, the DC will consider an alternate plan of care, including referral to another provider and/or collaborative care as necessary in the management of a patient.

Occasions in which it would be appropriate to furnish and bill an E/M service in conjunction with CMT were negotiated by the ACA and Health Care Financing Administration (HCFA) when the work relative values for the CMT codes were initially developed and accepted in 1997. In an interview with Dr. Grant Bagley, MD, JD, former Director of the Coverage and Analysis Group in the HCFA's Office of Clinical Standards and Quality, during that

year, he was specifically asked when it would be appropriate to bill for a separately identifiable E/M service in conjunction with CMT. In response he stated:

-You are going to get situations when you say "I'm spending more time doing evaluation and management here, but is it really part of an ongoing course of treatment with the manipulation I'm doing?" I think the answer is, if it's basically "I have a continuing course of treatment, I'm evaluating the results of it, I'm modifying the results of it, and I'm continuing with that" that E/M component, which is going to vary from visit to visit, is the E/M that is included in the manipulation code, and that's what it is. When it goes beyond that, then it becomes a separate service. And when it goes beyond, it's because you might have an additional problem that has come up. You might now suddenly have to say, "We have a worsening of symptoms. Is it because I now have a superimposed respiratory problem or is it simply because the problem is worse? I have to decide." That's a separately identifiable service because you're identifying the relationship to a new problem.

If the entire course of treatment is not going as you expect, then you say, "I need to drop back to square one and reevaluate this patient completely." That's a reevaluation of the patient that becomes a different level of service.

So I think when you have a new problem superimposed, when it requires a reassessment and reevaluation of the patient for purposes of deciding whether to continue to modify the treatment you're going through – all of those things represent a new problem, a new level of service, and then it is appropriately billed with an E/M code.⁴

This position was further substantiated in an April 13, 1998 letter from the American Medical Association's (AMA) Barry S. Eisenberg, MS, former Director of the Division of Payment Programs, to the New Jersey Department of Banking and Insurance, Enforcement/Consumer and Protection office. As stated in the letter:

While it is true that the chiropractic manipulative treatment (CMT) codes include a pre-manipulation patient assessment, it is incorrect to assume that all E/M services are included when reporting CMT. If the E/M services provided during the initial evaluation are, in the **practitioner's clinical judgment**, above and beyond the usual pre- or post-service work associated with performing CMT, then an E/M level of service may be reported in addition to the appropriate code(s) for the CMT performed. This circumstance may be reported by appending modifier -25 to the level of E/M service code. Further, the -25 modifier is available to report appropriate E/M services regardless of whether the visits are initial or subsequent.

While it is true that the CMT codes include a pre-manipulation patient assessment, it is incorrect to... [conclude]... that all E/M services are included when reporting CMT. Again, the principle applies in both initial and subsequent encounters.

Relative to this issue, it is also important to consider how the CMT code work values were established through the AMA's RUC process. CMT has been reimbursed by Medicare since 1972. Prior to 1997, this service was reported using the HCPCS Level II code, A2000 [Manipulation of spine by physician]. During the first five-year review process in 1995, a comment was submitted stating that the physician work in CMT is equivalent to the existing Osteopathic Manipulative Treatment (CPT® Codes 98925-98927) relative values. Consequently, the ACA conducted a RUC survey of the chiropractic profession and presented the data to the AMA's RUC HCPAC Review Board in April 1996. Recommendations were submitted to HCFA "based on survey responses of 106 chiropractors and a previous study performed by Lewin-VHI. The Review Board agreed that the work relative values for the CMT should be equivalent to the established relative values for Osteopathic Manipulative Treatment (OMT) codes."⁵

HCFA's support of a DC's ability to furnish and bill an E/M code in conjunction with CMT was evident in their acceptance of the RUC HCPAC Review Board's 1996 recommendations for relative value units for CMT. As stated by HCFA in the Medicare Physician Fee Schedule Final Rule for Calendar Year 1997, "The chiropractic manipulative treatment codes include a pre-manipulation patient assessment, as do the osteopathic manipulative treatment codes. Additional evaluation and management must be reported separately using the modifier -25, only if the patient's condition requires a significant separately identifiable evaluation and management service." HCFA agreed with the recommendation of the RUC HCPAC Review Board and accepted values that "essentially parallel that of the osteopathic manipulation codes."⁶

Subsequently, in 2011, the AMA RUC determined that when the OMT codes were initially valued, the services "were based on flawed methodology when established by Harvard" and recommended updated values for the family of OMT services. During the American Osteopathic Association's (AOA) 2011 presentation, "the RUC had a robust discussion regarding Evaluation and Management codes being reported separately on the same day," and both parties agreed that the "Evaluation and Management and the OMT procedure performed are separately identifiable procedures."⁷ Subsequently CMS stated in the 2012 Physician Fee Schedule Final Rule that based on "recent PFS data... [OMT services are] typically furnished on the same day as an E/M visit."⁸

Following CMS' acceptance of the RUC's 2011 recommendations for the OMT codes, the ACA resurveyed and presented updated data on Chiropractic Manipulative Treatment CPT® codes 98940-98943 to the RUC HCPAC during the October 2012 RUC Meeting. We are awaiting publication of the 2014 Physician Fee Schedule Final Rule to determine if CMS accepted the RUC HCPAC's updated CMT recommendations. RUC HCPAC deliberations are not public until the Final Rule is published. However, we would like to reiterate that CMS previously accepted the current **work relative values** for the CMT codes and determined them to be equivalent to the established relative values for Osteopathic Manipulative Treatment (OMT) codes.

It is clear that when the Chiropractic Manipulative Treatment CPT® codes were initially developed in 1996, ACA, HFCA, and the AMA agreed there are instances when it would be appropriate to bill CMT with an appropriate level E/M service and the chiropractic profession has universally adopted this payment policy. These instances include: the initial exam, interim re-exams, in the case of an exacerbation, re-injury or recurrence of the current problem, with new complaint, new condition or new injury, and at the time the patient is released from active care.

Would such a policy expand access to chiropractic services for Medicare beneficiaries? Are there other benefits that would accrue?

Evaluation and management (E/M) services are essential in order to properly evaluate and diagnose a patient's condition(s), order any additional testing needed, set an appropriate treatment plan, perform a Chiropractic Manipulative Treatment (CMT) service, and counsel the patient on risk avoidance and health promotion

activities. Thus, these services are already being performed by the Doctor of Chiropractic (DC) to Medicare beneficiaries and are considered standard of care. Patients currently are responsible for covering the cost of E/M services rendered by a DC. Thus, allowing DCs to furnish and bill Medicare for these services when provided to Medicare beneficiaries could potentially remove a barrier to care, resulting in expanded access. In fact, there were signs that demand for chiropractic services did rise slightly during the second year of the demonstration project.⁹ However, at the same time, use of other services for back pain decreased, causing the authors of the *Evaluation of the Demonstration of Expanded Coverage of Chiropractic Services under Medicare Final Report* to comment that a substitution effect may have occurred.¹⁰ Other studies have shown that the use of chiropractic services does not appear to raise costs. The most definitive study on this topic to date showed that use of chiropractic services “did not add to overall medical spending in a nationally representative sample with neck and back problems”.² In summary, such a policy has the potential to reduce barriers to care access for Medicare beneficiaries. However, that increase in care is likely to be modest and may result in reduced Medicare expenditures for other services.

The chiropractic profession believes other benefits would accrue from the proposed policy change to cover E/M services. Most significantly would be the profession’s ability to fully participate and perform under current quality driven programs. This expanded participation would provide concrete information to CMS about the quality and cost-effectiveness of care provided by DCs to their patients. Currently DCs are only able to report on two quality measures under the Physician Quality Reporting System (PQRS). . These include: Measure #131 - Pain Assessment and Follow-Up and Measure #182 - Functional Outcome Assessment. In fact it is a stretch to link these two measures with CMT services. This is illustrated by the fact that the measures both include other CPT® codes in the denominator, all of which are assessment rather than procedure codes.

Based on the current scope of practice for doctors of chiropractic, by expanding coverage for E/M services, DCs would be able to report on at least seven additional quality measures. Examples include:

- #128 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- #130 - Documentation of Current Medications in the Medical Record
- #154 - Falls: Risk Assessment
- #155 - Falls: Plan of Care
- #173 - Preventive Care and Screening: Unhealthy Alcohol Use – Screening
- #226 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- #317 - Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Another example is the Medicare Electronic Health Record (EHR) Incentive Program. When it was launched in 2011, members of the chiropractic profession were, and remain, committed to the Program. A change in E/M reimbursement policy would allow the chiropractic profession to more fully demonstrate more of the clinical quality measures within meaningful use of certified electronic health record technology.

Significant progress has been made on Capitol Hill to transform the nation’s healthcare system to a more quality-based system. Legislation currently being considered would require providers to report quality measures, and participation and performance of reporting could significantly affect an individual provider’s future reimbursement for services provided to Medicare beneficiaries. A doctor of chiropractic’s inability to furnish and be reimbursed for E/M services unfairly restricts the profession’s ability to fully perform under current quality driven programs. Those restrictions will only continue to affect the chiropractic Medicare patients on a broader scale unless the proposed policy change is made.

If payment were to be allowed for E/M services, which codes would be appropriate to report chiropractic E/M services? For services provided in an office, would it be appropriate to allow billing of all five office E/M codes for new or existing patient as appropriate? Should one or a set of codes be created specifically for chiropractic

E/M services similar to those for therapy evaluations or ophthalmic evaluations? With what frequency should chiropractors be allowed to bill E/M services?

The ACA House of Delegates adopted the following statement regarding CPT® Audit Requirements for E/M during the 1997 annual meeting:

RESOLVED that ACA adopt as ACA policy the audit requirements used by physicians for the CPT evaluation and management codes. These audit requirements are to be reviewed for updates as appropriate by the insurance committee.

Doctors of Chiropractic (DCs) are well trained in the appropriate use and billing, as well as the audit requirements developed jointly by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS), associated with Evaluation and Management (E/M) services. “The approach used in chiropractic training and practice for clinical diagnosis is similar to that of all health care disciplines: a history, physical examination, and specialty-specific assessments. The Council on Chiropractic Education specifies that these basic clinical competencies must be taught in all accredited institutions, and chiropractors are expected to differentiate mechanical musculoskeletal problems from visceral abnormalities that may present with a similar clinical picture. Chiropractic practice guidelines developed by the profession rate history taking, physical examination, and periodic reassessments of progress as ‘necessary’ attributes of good practice.”¹¹

DCs currently utilize the full range of new patient and established patient E/M codes in the private sector. Therefore, if payment were to be allowed for E/M services provided to in-office Medicare beneficiaries, yes, it would be appropriate to allow billing of all five office E/M codes for new (CPT® codes 99201-99205) or existing (CPT® codes 99211-99215) patients, as appropriate.

The ACA does not believe that one or a set of codes should be created specifically for chiropractic E/M services, similar to those for therapy evaluations or ophthalmic evaluations. In every other payment system, DCs have the ability to furnish and bill for E/M services and they utilize the current E/M codes to report that work. DCs are well trained in the audit requirements and understand the necessary components and documentation requirements associated with appropriate performance and billing for these services.^{3,12}

The frequency at which DCs should be allowed to bill E/M services should be “when clinically indicated,” as previously referenced in the letter from the AMA’s Barry S. Eisenberg, MS. Again, it would be appropriate to bill an E/M code in conjunction with a CMT code for the initial exam, interim re-exams, in the case of an exacerbation, re-injury or recurrence of the current problem, with new complaint, new condition or new injury, and at the time the patient is released from active care.

What would justify E/M services beyond those included in CMT codes? Should they be allowed on every treatment day or only at the onset of treatment?

If Evaluation and Management (E/M) services provided are, in the ***practitioner’s clinical judgment***, are based upon the individual patient’s condition and examination findings, and are above and beyond the usual pre-service or post-service work associated with performing Chiropractic Manipulative Treatment (CMT), then an E/M level of service should be reported in addition to the appropriate code(s) for the CMT performed. As agreed upon by the ACA and HCFA when the CMT codes were initially developed, it is appropriate to bill a separately identifiable E/M service when a patient has a new problem, or requires a reassessment and/or reevaluation for the purpose of deciding whether to continue or modify treatment.

Are these E/M services ones that are already being furnished by another physician or other practitioner? If these are not services currently covered by Medicare, what volume could be expected?

Evaluation and Management (E/M) services associated with the delivery of a CMT service are not already being furnished by another physician or other practitioner.

The best estimate of what volume could be expected with the proposed policy change comes from data collected under the *Demonstration of Expanded Coverage of Chiropractic Services under Medicare*. The average number of E/M services billed was 1.28 per patient over the two-year time period of the *Demonstration Project*. The frequency distribution for both new and established patients found during the *Demonstration Project* is listed in the table below.

E/M CPT® Code	Frequency (%)
<i>New Patient</i>	
99201	10
99202	30
99203	47
99204	11
99205	1
<i>Existing Patient</i>	
99211	16
99212	41
99213	34
99214	8
99215	2

The chiropractic profession has adopted standards of care dictating that the instances in which an E/M service should be furnished and billed would be at the practitioner’s clinical judgment. As stated previously, these instances would include: the initial exam, interim re-exams, in the case of an exacerbation, re-injury or recurrence of the current problem, with new complaint, new condition or new injury, and at the time the patient is released from active care.¹³

The ACA is committed to providing ongoing continuing information to the chiropractic profession about appropriate E/M service reporting, as well as to working closely with CMS on the proper implementation should this critical change in policy occur.

Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System

Proposed Changes to the Criterion for Satisfactory Reporting of Individual Quality Measures via Claims for Individual Eligible Professionals for the 2014 PQRS Incentive and the 2016 PQRS Payment Adjustment

The ACA fully supports CMS’ proposal to revise the criterion for reporting individual measures via claims and require that at least nine measures, covering at least three of the National Quality Strategy domains, be reported in order to avoid the 2016 payment adjustment. We understand and agree that there is a need to collect enough quality measures data to better capture the picture of the care being furnished to Medicare beneficiaries.

As previously stated in our comments on Section J of the Proposed Rule, by allowing doctors of chiropractic (DCs) to furnish and bill Medicare for Evaluation and Management (E/M) services, the profession would also have the opportunity to expand participation in quality efforts such as the Physician Quality Reporting System (PQRS). Currently, DCs are only able to report on two quality measures which have the chiropractic manipulation codes in the denominator of the measure: Measure #131 - Pain Assessment and Follow-Up and Measure #182 - Functional Outcome Assessment. Allowing a DC the ability to furnish and be reimbursed for E/M services would greatly expand the profession's participation in quality efforts such as PQRS.

Based on the current scope of practice for doctors of chiropractic, by expanding coverage for E/M services, DCs would be able to report on a minimum of 9 quality measures. This is an important factor to consider, should CMS' proposal to revise the criterion for reporting individual measures via claims, and require that providers report on at least nine measures in order to avoid the 2016 payment adjustment, be accepted. Additionally, this expanded participation would provide concrete information to CMS about the quality and cost-effective care that DCs provide to their patients. It would allow CMS to obtain more accurate and reliable quality reporting data as well as see a more complete picture of our healthcare delivery system.

The ACA is greatly concerned with the proposal to eliminate the claims-based reporting mechanism beginning with the reporting period (calendar year 2017) for the 2019 PQRS payment adjustment. Based on findings in the 2011 PQRS and eRx Experience Report, the majority (approximately 72%) of eligible professionals participating in PQRS in 2011 reported quality measures through claims-based reporting. In addition, the elimination of the claims-based reporting method would obstruct a large portion of the chiropractic profession from participating in PQRS.

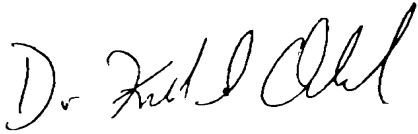
If claims-based reporting should be eliminated, the remaining reporting methods (currently approved) would include: Registry Reporting; Group Practice Reporting; and EHR Incentive Program Reporting. Each of these methods presents issues for the chiropractic profession's ability to participate in PQRS. Currently DCs do not have access to a registry that allows for reporting; therefore, they are unable to participate using this method. Under the Group Practice Reporting method, a group practice is defined as "a single Tax Identification Number (TIN) with 2 or more individual eligible professionals (as identified by Individual National Provider Identifier [NPI]) who have reassigned their billing rights to the TIN." The vast majority of practicing DCs are solo-practitioners and do not meet the requirements of this definition and are unable to participate in PQRS using this method. The EHR Incentive Program Reporting is a method that could be utilized, but by only a small portion of the profession. While ACA has strongly encouraged the profession to adopt, current figures show that only 10 percent of DCs have implemented EHR technology in their clinics.

A DC's inability to report quality measures through PQRS could also have a negative effect on a Medicare beneficiary's perception of the chiropractic profession. For example, Physician Compare was created to provide beneficiaries with information, such as provider participation in quality programs like PQRS, to help them make informed healthcare decisions. Eliminating the profession's ability to report under PQRS would also exclude DCs and the patients they treat, from the benefits this resource has to offer.

By eliminating the claim-based reporting mechanism beginning with the reporting period (calendar year 2017) for the 2019 PQRS payment adjustment, doctors of chiropractic would not be able to provide concrete information to CMS or Medicare beneficiaries about the quality and cost-effective care that DCs provide to their patients. By maintaining the claim-based reporting mechanism, CMS would be able to continue obtaining accurate and reliable quality reporting data about the chiropractic healthcare delivery system.

The ACA truly appreciates the opportunity to provide comments on the 2014 Medicare Physician Fee Schedule Proposed Rule. If you should have any questions, please feel free to contact Meghann Dugan-Haas, ACA Director of Federal and Regulatory Affairs, at (703) 812-0242. Thank you.

Sincerely,



Keith Overland, DC, CCSP, FICC
President, American Chiropractic Association

Cc: Ms. Roberta Epps
Ms. Pauline Lapin
Ms. Christine Estella

References:

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