

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**Utilization Parameters for Chiropractic  
Treatments**



**JUNE GIBBS BROWN**  
**Inspector General**

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**OEI-04-97-00496**

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OEI's Atlanta Regional Office prepared this report under the direction of Jesse J. Flowers, Regional Inspector General and Christopher Koehler, Deputy Regional Inspector General. Principal OEI staff included:

#### **ATLANTA REGION**

Graham D. Rawsthorn, *Team Leader*  
Greg Jones, *Program Analyst*

#### **HEADQUARTERS**

Tricia Davis, *Program Specialist*  
Brian Ritchie, *Program Analyst*

#### **SAN FRANCISCO REGION**

Robert Gibbons, *Program Analyst*

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June Gibbs Brown  
Inspector General

OIG Final Report: "Utilization Parameters for Chiropractic Treatments," OEI-04-97-00496

Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

This report identifies potential impacts of implementing a chiropractic utilization review parameter of either 18 or 12 chiropractic treatments (manual manipulations of the spine) per year.

Dr. Grant Bagley, Director, Coverage and Analysis Group, Office of Clinical Standards and Quality, Health Care Financing Administration; and Dr. Grant Steffin, Chair, Chiropractic Medical Directors, Chiropractic Work Group requested this analysis following our presentation on chiropractic controls at a meeting of the Chiropractic Work Group.

The Health Care Financing Administration (HCFA) convened the Chiropractic Work Group to assist in developing new chiropractic policies required by the 1997 Balanced Budget Act. The Chiropractic Work Group considered two options, a utilization review parameter of 18 treatments per year and one of 12 treatments per year.

Dr. Bagley asked us to assist the Chiropractic Work Group by compiling 1997 chiropractic utilization data. Additionally, he asked that we quantify the potential impacts of implementing the two options -- utilization review parameters of 18 or 12 treatments per year.

Implementing either option would ensure that Medicare pays for all chiropractic services that Medicare beneficiaries are entitled to and would help prevent payments for services not authorized under the program. By requiring carriers with high chiropractic utilization review parameters to implement lower review parameters, Medicare outlays would be reduced. One carrier has demonstrated the effect of reducing chiropractic utilization parameters. That carrier cut its chiropractic parameter in half and saved almost \$3 million with virtually no change in program administrative costs. By establishing utilization review parameters at 18 or 12 beginning in 2000, we estimate annual Medicare outlays would be reduced by about \$19.4 or \$30.2 million respectively. We, however, recommend a parameter of 12. This is the most commonly used parameter (29 of 55 carriers), and it would require the least administrative change for carriers overall.

The 18 or 12 treatments per year would be a maximum review parameter that carriers would be allowed to use. Therefore, carriers with lower existing review parameters could remain unchanged. However, some carriers may choose to increase their existing parameters up to the new maximum review parameter. To the extent that this happens, our savings estimates would be reduced. The HCFA commented that they are using the information in this report in their effort to establish chiropractic utilization guidelines. The full text of their comments is attached.

## BACKGROUND

A utilization review parameter is not a “hard” cap but rather a “soft” cap. That is, it does not establish a threshold above which Medicare payments will not be made. Instead, a utilization review parameter establishes a point at which a carrier will review each additional claim for medical necessity. The carriers, however, can review any and all claims if they so choose. The HCFA allows each carrier to establish its own utilization review parameter for chiropractic treatments. In 1997, carrier utilization review parameters ranged from 11 to 52 treatments per year.<sup>1</sup> Three carriers did not have chiropractic utilization review parameters. Table 1 shows the various utilization review parameters and the number of carriers with each parameter.

TABLE 1														
MEDICARE CHIROPRACTIC UTILIZATION REVIEW PARAMETERS - 1997														
Parameters	11	12	18	22	24	28	29	30	40	46	48	51	52	0
# of Carriers	1	29	3	1	4	3	1	1	2	1	2	1	3	3

## SCOPE AND METHODOLOGY

This report is based on calendar year 1997 data collected as part of our chiropractic controls study,<sup>2</sup> and data extracted from a 1 percent sample of HCFA’s 1997 National Claims History file.

Our analysis covers Medicare Part B carriers for all 50 States and the District of Columbia. California and Missouri were serviced by two carriers and New York was serviced by three carriers. Therefore, we have information from 55 carriers. Our analysis covers about 1.4 million Medicare beneficiaries receiving almost 12.2 million chiropractic treatments at a cost of over \$310 million.

To estimate the potential Calendar Year 2000 savings, we used HCFA’s Part B Extract and Summary System data and calculated the growth in Medicare chiropractic payments from 1994 through 1997. During this time period, the chiropractic benefit grew at an average of 6.87 percent per year. We applied this growth rate to our calculated 1997 savings to estimate potential Calendar Year 2000 savings.

We did not collect parameter information for the Railroad Retirement Board nor Puerto Rico. Therefore, we excluded them from our analysis. Additionally, we excluded six carriers whose contracts were terminated part way through 1997, prior to our data collection efforts. We included parameter and utilization data for the carriers that took over for the six terminated carriers.

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<sup>1</sup> Seven Medicare utilization parameters are based on time periods other than one year. For such carriers, we annualized their parameters accordingly. For example, one carrier reported a parameter of 76 treatments in 540 days. Annualized, the parameter is 51.

<sup>2</sup> CHIROPRACTIC CARE: Controls Used by Medicare, Medicaid, and Other Payers (OEI-04-97-00490)

Additionally, we analyzed utilization data for Florida Blue Cross, spanning October 1, 1991 to September 30, 1993. We used 1 percent samples of HCFA’s 1991 - 1993 National Claims History files for this analysis.

**REDUCING PARAMETERS WILL PROBABLY RESULT IN REDUCED UTILIZATION**

Reducing chiropractic review parameters is likely to result in a reduction in actual utilization and the corresponding cost to Medicare. To test this premise, we analyzed the results achieved by Florida Blue Cross.

**Reduced Utilization Review Parameters Equates to Program Savings**

Beginning in Fiscal Year 1993, Florida Blue Cross cut its chiropractic utilization review parameter in half.<sup>3</sup> To test our assumption, we analyzed chiropractic utilization data, one year before and after Florida Blue Cross reduced its parameter. Table 2 displays the number of beneficiaries and treatments processed through Florida Blue Cross.

TABLE 2		
FLORIDA BLUE CROSS BENEFICIARIES AND TREATMENTS		
Fiscal Year	Beneficiaries	Treatments
FY 92	1,245	10,516
FY 93	1,253	9,215

Source: 1 percent sample of HCFA’s National Claims History File.

The number of beneficiaries receiving chiropractic treatments grew by less than 1 percent (0.64) from FY 92 to FY 93. Had Florida Blue Cross not reduced its utilization review parameter, we estimate that they would have paid for 10,584 chiropractic treatments in FY 93 - a 0.64% increase over FY 92.

As a result of the parameter reduction, Florida Blue Cross actually paid for 9,215 chiropractic treatments. Multiplying the 1,369 saved treatments (10,584-9,215) by the FY 93 treatment rate (\$21.50) results in estimated savings of \$29,434. As our data is from a 1 percent sample, projected to the population, Florida Blue Cross saved the Medicare Trust Fund over \$2.9 million by reducing its chiropractic utilization review parameter.

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<sup>3</sup> HCFA considers utilization parameters to be confidential information. Therefore, we do not enumerate the Florida BCBS parameters.

### **Reduced Utilization Review Parameters Does Not Significantly Increase Administrative Costs**

All claims that exceed a utilization review parameter should be reviewed for medical necessity. Therefore, reducing the chiropractic utilization review parameter would result in an increase in the number of requests for services that would require medical review and an associated increase in carrier medical review administrative costs.

However, based on the experience of Florida Blue Cross, the increased medical review workload will be short lived. To illustrate, during the 6 months prior to the utilization review parameter reduction, the claims denials, as a percent of total claims submitted, averaged 23 percent per month. During the 6 months immediately following the utilization review parameter reduction, the claims denials, as a percent of total claims submitted, increased to an average of 27 percent per month. Over the next 6 months, the percent of claims denied decreased to essentially what it was before the Florida carrier reduced its utilization parameter - 24 percent per month. In the last month of this period, the percent of claims denied had dropped to slightly below 23 percent.

### **POTENTIAL IMPLICATIONS OF ESTABLISHING A MAXIMUM UTILIZATION REVIEW PARAMETER OF 18 CHIROPRACTIC TREATMENTS PER YEAR**

If HCFA implemented a maximum utilization review parameter of 18 chiropractic treatments per year beginning in 2000, it could save the Medicare Trust Fund over \$19.4 million.

Implementing a parameter of 18 treatments per year would directly impact 22 of the 55 carriers. The remaining 33 carriers would not be directly impacted by a maximum review parameter of 18 as they already have parameters of 18 or less. Table 3 displays chiropractic utilization grouped by carrier utilization review parameters.

<b>TABLE 3</b>		
<b>CHIROPRACTIC UTILIZATION IN EXCESS OF 18 TREATMENTS</b>		
	Parameter <= 18	Parameter >18
# Carriers	33	22
Total Beneficiaries	7,923	6,209
# Beneficiaries Who Exceed 18 Treatments	337	867
% Beneficiaries Who Exceed 18 Treatments	4.25%	13.96%
Total Treatments	60,301	61,518
# Treatments in Excess of 18	3,147	9,448
% Treatments in Excess of 18	5.22%	15.36%

To quantify the impact, we compared utilization in carriers with parameters equal to or less than 18 treatments and those with parameters greater than 18 treatments per year. We included the three carriers with no set parameters in the group that had parameters greater than 18.

We used the 33 carriers with existing parameters of 18 or less treatments as our baseline population. Based on our assumption, if the 22 high-end carriers reduced their parameters to 18 treatments per year, their actual utilization should fall in line with the baseline population. Therefore, the high-end carriers, as shown in Table 3, would see their treatments, in excess of 18, fall from over 15 percent to about 5 percent.

This reduction within the 22 high-end carriers would equal 6,237 fewer treatments in excess of 18. The average 1997 reimbursement rate was \$25.49 per treatment.<sup>4</sup> Therefore, had the 22 high-end carriers imposed utilization review parameters of 18 treatments in 1997, they would have saved the Medicare Trust Fund \$159,011. Our analysis is based on a 1 percent sample. If we project to the population, the 1997 Medicare Trust Fund savings would have exceeded \$15.9 million.

Further, assuming a continued growth rate of 6.87 percent per year, we estimate that implementing a maximum utilization review parameter of 12 treatments per year beginning Calendar Year 2000 could result in Medicare Trust Fund savings of over \$19.4 million.

#### **POTENTIAL IMPLICATIONS OF ESTABLISHING A MAXIMUM UTILIZATION REVIEW PARAMETER OF 12 CHIROPRACTIC TREATMENTS PER YEAR**

If HCFA implemented a maximum utilization review parameter of 12 chiropractic treatments per year beginning in 2000, it could save the Medicare Trust Fund almost \$30.2 million.

Implementing a parameter of 12 treatments per year would directly impact 25 of the 55 carriers. The remaining 30 carriers would not be directly impacted by a maximum review parameter of 12 as they already have parameters of 12 or less. Table 4 displays chiropractic utilization grouped by carrier utilization review parameters.

<b>TABLE 4</b>		
<b>CHIROPRACTIC UTILIZATION IN EXCESS OF 12 TREATMENTS</b>		
	Parameter <= 12	Parameter >12
# Carriers	30	25
Total Beneficiaries	7,592	6,540
# Beneficiaries Who Exceed 12 Treatments	335	869
% Beneficiaries Who Exceed 12 Treatments	4.41%	13.29%
Total Treatments	58,455	63,364
# Treatments in Excess of 12	6,921	17,225
% Treatments in Excess of 12	11.84%	27.18%

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<sup>4</sup> We calculated the average reimbursement rate from our 1997 data, based on the total allowed charges and the total number of treatments for the 55 carriers.

To quantify the impact, we compared utilization in carriers with parameters equal to or less than 12 treatments and those with parameters greater than 12 treatments per year. We included the three carriers with no set parameters in the group that had parameters greater than 12.

We used the 30 carriers with existing parameters of 12 or less treatments as our baseline population. Based on our assumption, if the 25 high-end carriers reduced their parameters to 12 treatments per year, their actual utilization should fall in line with the baseline population. Therefore, as shown in Table 4, the high-end carriers would see their treatments, in excess of 12, fall from over 27 percent to about 12 percent.

This reduction within the 25 high-end carriers would equal 9,723 fewer treatments in excess of 12. The average 1997 reimbursement rate was \$25.49 per treatment. Therefore, had the 25 high-end carriers imposed utilization review parameters of 12 treatments in 1997, they would have saved the Medicare Trust Fund \$247,862. Our analysis is based on a 1 percent sample. If we project to the population, the 1997 Medicare Trust Fund savings would have exceeded \$24.7 million.

Further, assuming a continued growth rate of 6.87 percent per year, we estimate that implementing a maximum utilization review parameter of 12 treatments per year beginning Calendar Year 2000 could result in Medicare Trust Fund savings of over \$30.2 million.

## **RECOMMENDATIONS**

In requesting this analysis, Dr. Bagley and Dr. Steffin did not ask us to make recommendations. However, in light of our current and our previous analysis, we believe that it would be appropriate for us to do so.

It is important to emphasize up front that we view the goal of establishing controls on Medicare payments for chiropractic benefits as twofold: to ensure that Medicare pays for all chiropractic services that Medicare beneficiaries are entitled to; and to prevent making payments for services not authorized under the program.

In our earlier report, "Chiropractic Care: Controls Used by Medicare, Medicaid, and Other Payers (OEI-04-97-00490), we showed that use of utilization review parameters alone was not enabling Medicare carriers to detect and prevent payments for maintenance treatments, which are not authorized under the Medicare program. Hence, we recommended that additional measures be taken, such as requiring chiropractic physicians to use modifiers to distinguish the categories of spinal joint problems and requiring all Medicare contractors to implement system utilization frequency edits to identify beneficiaries receiving consecutive months of minimal therapy.

We did not make any recommendations regarding utilization review parameters, also referred to as utilization caps. However, we do not wish that omission to be interpreted as a lack of support for utilization caps. Our intention was to offer additional measures that could be used, in conjunction with utilization caps, to safeguard against payments for unauthorized maintenance payments. Thus, we wish to take this opportunity to clarify that we do recommend that utilization caps be used.

With regard to the type of cap, we recommend that they be the "soft" caps, which are the subject of this report. These caps do not automatically disallow payments for services above the cap. Rather they trigger a more intensive review of claims to ensure that the billed services are necessary and covered. Such soft caps are consistent with the twofold goal described in the opening paragraphs of our recommendations.



With regard to the number of services specified by the cap, we recommend that the maximum be 12. Our analysis in this report clearly demonstrates that Medicare savings would be higher with a cap of 12 rather than 18 treatments per year. This is the number most commonly used by Medicare carriers; 29 of the 55 carriers already have chiropractic utilization parameters set at 12 treatments per year. Therefore, implementing a utilization parameter of 12 will result in the least administrative change for carriers overall.

It is important to restate that the goal of utilization parameters is to ensure that carriers pay for all valid claims, and only valid claims. Our recommendation of a cap of 12 rather than a cap of 18 in no way implies that chiropractic services should be limited to a specific number.

It does, however, imply a tradeoff in terms of resources and potential vulnerabilities. The lower cap of 12 potentially increases the number of claims that need to be reviewed for medical necessity, thereby increasing administrative costs. Adopting a higher cap of 18 could reduce the administrative costs, but increase the potential of invalid claims paid and thereby increase the costs associated with improper payments.

At present, we have no reliable data about the costs on both sides of this trade off--e.g., we do not know the cost of increased reviews associated with utilization caps at either 12 or 18 treatments per year. However, we believe that the approaches we recommended in our prior report, when used in connection with a standardized utilization cap, would increase the chances of avoiding improper payments while not increasing administrative costs. The Florida Blue Cross experience supports this expectation.

No matter which level of services is chosen for the utilization caps, we recommend that data about the cost of administering them, related edits and frequency screens, and medical reviews be collected and analyzed with a view to finding the best mix of these controls and re-calibrating them after 1 or 2 years of experience.

## **COMMENTS**

The HCFA commented that they are using the information in this report in their effort to establish chiropractic utilization guidelines. The full text of their comments is attached.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator  
Washington, D.C. 20201

OCT 26 1999

DATE:

TO: June Gibbs Brown  
Inspector General

FROM: Michael M. Hash  
Deputy Administrator

SUBJECT: Office of Inspector General Report: "1997 Utilization Data for Chiropractic Medical Directors, Chiropractic Work Group" (OEI-04-97-00496)

Thank you for the opportunity to review the above referenced report and we have the following comments. As you know, the Health Care Financing Administration convened the Chiropractic Work Group to assist in developing new chiropractic policies required by the Balanced Budget Act of 1997. We asked the OIG to assist the Chiropractic Work Group by compiling 1997 chiropractic utilization data. Specifically, we asked the OIG to examine: (1) a maximum utilization parameter of 18 chiropractic treatments per year, and (2) a maximum utilization parameter of 12 chiropractic treatments per year.

The information provided in the report will be very helpful as we assess our options in establishing chiropractic utilization guidelines. We are continuing our consideration as to the most appropriate utilization screen that will maintain program integrity, protect the Medicare beneficiary, represent a reasonable and viable threshold, and reflect the best interests of all involved parties.

We note, further, that the OIG recommended continuing data analysis and would like to take this opportunity to state that we look forward to working with you in this endeavor.

We appreciate the effort that went into this report, and thank you for the opportunity to comment on it. If you have any questions, please contact Dorothy Honemann, 410-786-5702.