Background

Section 651 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108-173) provided for a two-year demonstration to evaluate the feasibility and advisability of covering expanded chiropractic services under Medicare. These services extended beyond the current coverage for manipulation to correct neuromusculoskeletal conditions typical among eligible beneficiaries, and diagnostic and other services that a chiropractor was legally authorized to perform by the State or jurisdiction in which the treatment was provided. Physician approval was not required for these services. The Demonstration was required to be budget neutral and was conducted in four sites, two rural and two urban and one site of each area type had to have been a health professional shortage area (HPSA).

Demonstration Geographic Areas

The Demonstration was conducted in four geographic areas- two rural and two urban. One rural and one urban area were located in a designated Health Professional Shortage Area (HPSA). These areas included the entire state of Maine (rural); the entire state of New Mexico (rural HPSA); 26 counties in Illinois and Scott County Iowa (urban); and 17 counties in Virginia (urban HPSA).

Federal Register Notice

The Federal Register Notice which was published on January 28, 2005, described the Demonstration covered services, budget neutrality methodology, and site selection process for the Demonstration. (See Downloads area for: Federal Register Notice.)

Press Release

A press release which was published on April 6 described the implementation of the Medicare Chiropractic Demonstration. (See Downloads area below for Press Release.)

Chiropractor Power Point Presentation

A PowerPoint presentation provided a general summary of the Demonstration for chiropractors. (See Downloads area for Chiropractor Power Point Presentation.)

Provision of Physical Therapy Services Incident to a Chiropractor

On Monday, July 25, 2005, CMS issued instructions requiring implementation of the provisions of CR3648 related to qualifications required for staff providing services billed as physical therapy and occupational therapy services incident to the services of a physician or non-physician practitioner. Due to pending litigation, CMS had previously delayed implementation of the regulation and manual provisions governing qualifications for auxiliary personnel furnishing services billed as physical therapy and occupational therapy services incident to the services of a physician or non-physician practitioner. On July 22, the US District Court dismissed the suit filed by the National Athletic Trainer Association. Chiropractors under the Demonstration were also subject to these requirements as of July 25, 2005. This meant that when a physical therapy service was provided "incident to" the service of a chiropractor, the person who furnished the service had to be a physical therapy qualified practitioner other than licensure (meeting the physical therapy definition at 42 CFR 484.4 other than licensure). Unless chiropractic

students, chiropractic assistants, or sports trainers had graduated from a physical therapy curriculum approved by: 1) the American Physical Therapy Association, or 2) the Committee on Allied Health Education and Accreditation of the American Medical Association, or 3) the Council on Medical Education of the American Medical Association and the American Physical Therapy Association they could not provide therapy services incident to a chiropractor. The only exception was that certain persons trained prior to January 1, 1966 could be grandfathered (42 CFR 484.4).

In cases where chiropractors were chosen to participate in the Demonstration, but could not comply with Medicare requirements for the qualification of their staff, chiropractors could bill the beneficiary for the cost of services that were not covered by Medicare. CMS recommended that chiropractors use a Notice of Exclusion of Medicare Benefits (NEMB) form and inform the beneficiary that the service would be covered by Medicare if it was performed by a qualified Medicare provider of therapy services (i.e., physician or qualified therapist.) (See Related Links Inside CMS for FFS NEMB form)

If a CA was providing physical therapy service(s), the claim was submitted without “demo 45” in Box 19 on CMS-1500 forms and, alternately, without “45” in 2300/REF02(P4) on electronic claims and had a GY modifier appended (e.g. 97035 GY.) In this manner, the chiropractor received a denial and was able to bill the beneficiary for the services.

Evaluation & Report to Congress

The legislation also required an evaluation of the Demonstration to assess cost effectiveness, cost benefit, beneficiary satisfaction, and other issues as the Secretary determines to be appropriate. A letter Report to Congress was released in October, 2008. (See Downloads area for Report to Congress.) It describes the experience and findings over the initial 18 months of the Demonstration, through September 2006. CMS plans to submit a full Report to Congress in fall 2009, covering findings over the entire 24 months of Demonstration experience, as well as the assessment of budget neutrality for the expansion of Medicare coverage of the chiropractic benefit.

Current Status

The Demonstration began on April 1, 2005, and ended on March 31, 2007.

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