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Acupuncture Coverage Under Medicare: CAOMA and AOMNC Take the Lead

By Robert E. Marcus, JD

Historical Perspective

On Oct. 22, 1998, Steven Schlachter, of the HCFA (Health Care Financing Administration, now the Centers for Medicare & Medicaid Services) Policy Team in Atlanta, Ga., in a letter to Richard Freiberg, OMD, NMD, stated, "Until Congress decides to add acupuncturists into the Medicare statute as an authorized provider, no Medicare payment can be made for any services provided by acupuncturists."

One month later, on Nov.
28, 1998, Donna Shalala, Secretary of the Department of Health and Human Services, chartered the Medical Coverage Advisory Committee (MCAC) to advise HCFA on whether "acupuncture among other medical services are reasonable and necessary under Medicare law."

Interestingly, the charter created a catch-22 scenario for "qualified acupuncturist services," since HCFA was seeking to evaluate "acupuncture" as a Medicare benefit. However, "qualified acupuncturist services" were not, and are still not, recognized as Medicare providers.

The charter was consistent with HCFA's administrative authority, which was (and still is) limited to narrowly interpreting the scope of benefit services provided by Medicare, as defined by the Congress in Title 18 of the Social Security Act (see list of benefit services below).

On Jan. 19, 1999, a letter from HCFA to Dr. Freiberg stated, "Acupuncture physicians, acupuncturists and/or Oriental medicine practitioners ... are not included in the definition of physician as set forth in the Medicare law ... Section 1861(r) of the Social Security Act, which defines physicians for Medicare purposes, states that the term physician means a doctor of medicine or osteopathy, a doctor of dental

surgery, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. Legislative action would be necessary to change these provisions."

Between Jan. and May 2000, MCAC extensively reviewed literature and other sources of information on acupuncture, including the articles underlying the *NIH Consensus Development Statement on Acupuncture* published in 1998.

On June 6, 2000, MCAC stated that it is "focusing on those areas identified by the NIH statement as most promising." MCAC stated that it is "interested in receiving additional information on the efficacy of simple acupuncture for: 1) Adult post-operative and chemotherapy pain and nausea, and 2) Post-operative dental pain for dental conditions covered by Medicare."

MCAC stated that it would "review scientific evidence submitted about other uses for acupuncture," but it was "primarily interested in the above indications." MCAC also stated that it hoped to receive "peer-reviewed literature reports of adequately powered and controlled trials," but it "will study the best evidence available." MCAC stated that it needs "to find validity in the application of study group results to Medicare populations, best shown by clinical trials that include" Medicare "beneficiaries." (*HCFA Quality of Care Information, Coverage Policies, Medicare Coverage Process, Review Issues, Acupuncture* [#CAG-00062] Tracking Sheet at www.hcfa.gov/quality/8b3-cc1.htm, visited July 3, 2000.)

In a conversation on Aug. 3, 2000, Ms. Joyce Eng, lead analyst on MCAC's review of acupuncture, told me she was totally unfamiliar with acupuncture and Oriental medicine when she was assigned the task of investigating it. She stated, "Ninety percent of the literature reviewed" on acupuncture by MCAC, which she reviewed herself, "was anecdotal."

According to Medicare's *Coverage Issues Manual*, Medicare's reason for not covering acupuncture as a health care benefit is as follows:

"Although acupuncture has been used for thousands of years in China and for decades in parts of Europe, it is a new agent of unknown use and efficacy in the United States. Even in those areas of the world where it has been widely used, its mechanism is not known.

"The National Institutes of Health (NIH), National Institute of General Medical Sciences, the NIH National Institute of Neurological Diseases and Stroke, and the NIH Fogarty International Center, have been designated to assess and identify specific opportunities and needs for research attending the use of

acupuncture for surgical anesthesia and relief of chronic pain."

(*Note:* According to Jill Robinson, an attorney, in an e-mail sent to Dr. Freiberg in October 1998, she informed him that the NIH had told her none of the above-cited units were specifically designed to assess and identify the opportunities and needs for acupuncture research.)

"Until the pending scientific assessment of the technique has been completed and its efficacy has been established, Medicare reimbursement for acupuncture, as an anesthetic or as an analgesic or for other therapeutic purposes, may not be made.

"Accordingly, acupuncture is not considered reasonable and necessary within the meaning of § 1862 (a)(1) of the Act." (*Coverage Issues Manual 35-8* [*Medical Procedures*] at www.hcfa.gov/pubforms/06_cim/ci35.htm#_1_9, visited on Sept. 14, 2000.)

On Nov. 22, 2000, Dr. Freiberg received a letter from Ms. Eng stating that as of November 1, 2000, "We have closed the acupuncture item for the time being because we did not receive any evidence in response to our request. However, we are open to reopening the item if additional information is submitted."

On May 14, 2001, John Whyte, MD, stated, before the White House Commission on CAM Policy, that an HCFA exploration of acupuncture has been dropped because distinctly licensed acupuncture providers are not approved practitioners by HCFA. Dr. Whyte stated that it would require an act of Congress for distinctly licensed acupuncture providers to be listed as Medicare providers. (*The Integrator for the Business of Alternative Medicine*, June 2001, Vol. 5, No. 9, pg. 11.)

Title 18 of the Social Security Act

Given that CMS has stated that "qualified acupuncturist services" cannot be reimbursed under Medicare without an act of Congress, and that CMS has not interpreted the Social Security Act in a way that would include "acupuncture" as a covered benefit under Medicare, let's look at the section of Title 18 of the Social Security Act, which HR 1477 - the Federal Acupuncture Coverage Act of 2003 - seeks to amend.

HR 1477 would amend 42 United States Code Section 1395x(s)(2), which defines medical and other services under Title 18 of the Social Security Act. The following is Medicare's scope of benefit services under this statute:

1. services and supplies furnished as incident to a physician's services;
2. hospital services incident to a physician's services;
3. diagnostic services furnished to an outpatient by a hospital;
4. outpatient physical and occupational therapy;
5. rural health clinic services;
6. home dialysis supplies and equipment, including erythropoietin;
7. antigens prepared by a physician;
8. physician assistant or nurse practitioner services;
9. clinical and qualified psychologist or clinical social worker services;
10. blood clotting factors for hemophilia patients;
11. prescription drugs used in immunosuppressive therapy for individuals receiving organ transplants;
12. clinical nurse specialist services;
13. certified nurse-midwife services;
14. prostate cancer screening tests;
15. oral drugs, including those prescribed as an anti-emetic, prescribed as an anticancer chemotherapeutic agent;
16. colorectal cancer screening tests;
17. diabetes outpatient self-management training services;
18. screening for glaucoma;
19. medical nutrition therapy for beneficiaries with diabetes or renal disease;
20. diagnostic X-ray tests;
21. X-ray, radium and radioactive isotope therapy;
22. surgical dressings, splints and casts and other devices to reduce fractures and dislocations;
23. durable medical equipment;
24. ambulance services;
25. prosthetic devices, which replace all or part of an internal organ, including colostomy bags;
26. eyeglasses furnished subsequent to cataract surgery;
27. contact lens furnished subsequent to cataract surgery with insertion of an intraocular lens;
28. leg, arm, back and neck braces;
29. artificial legs, arms and eyes;

30. pneumococcal vaccine;
31. hepatitis B vaccine;
32. services of a certified registered nurse anesthetist;
33. extra depth shoes with inserts or custom-molded shoes with inserts for an individual with diabetes;
34. screening mammography;
35. screening pap smear; and
36. bone mass measurement.

Therefore, the only interpretation by CMS of the above statute would be for CMS to provide reimbursement for "acupuncture" for all of the aforementioned providers and services, none of which are "qualified acupuncturist services" as defined by HR 1477. In other words, DHHS can administratively make "acupuncture" a covered benefit under Medicare for everybody **except** licensed acupuncturists.

Title 5 of the United States Code

Likewise, there is no statutorily mandated coverage of "qualified acupuncturist services" under the Federal Employee Health Benefits Program. HR 1477 would remedy this by amending Title 5 of the United States Code, Section 8902(k)(1), which currently lists the following professional health care services as reimbursable for federal employees:

1. clinical psychologist;
2. optometrist;
3. nurse midwife;
4. nursing school administered clinic;
5. nurse practitioner/clinical specialist; and
6. clinical social worker

by adding "acupuncturist."

Current Statements by the U. S. Department of Health and Human Services Regarding the current position of the FEHB program vis-à-vis the reimbursement of qualified acupuncturist services, César A. Aristeiguieta, MD, White House Fellow, Immediate Office of the Secretary, U.S. Department of Health and Human Services, Washington, D.C., stated to me, by e-mail, on June 12, 2003:

"Coverage for acupuncture services under the Federal Employees Health Benefit Program is an individual plan decision at this time. The program administrator cannot approve the coverage by administrative action, but would have to have such coverage mandated by statute (i.e., Congress would have to require the coverage)."

Regarding the current position of CMS vis-à-vis reimbursement of qualified acupuncturist services under Medicare, Dr. Aristeiguieta stated to me on June 25, 2003 (also by e-mail):

"As a follow-up to my previous e-mail, I would like to give you an update regarding HR 1477, the Federal Acupuncture Act of 2003. Per your request I have checked with CMS, and our Legislative Affairs division, regarding HHS support for the bill."

"HHS has not adopted a position on the bill at this time. If the bill begins to move through Congress, HHS may or may not develop a position on it (HHS does not adopt a position on all health care related bills)."

Conclusion

Dr. Aristeiguieta's e-mails confirm the above statements dating back to 1998: that only Congress can mandate the coverage of qualified acupuncturist services under the FEHB program, and likewise, DHHS is looking to Congress to decide whether Medicare will cover qualified acupuncturist services.

Therefore, the only way qualified acupuncturist services will be reimbursed by Medicare and the FEHB program is by the passage of HR 1477, thus creating a new statutory category of qualified acupuncturist services.

By working for passage of the Federal Acupuncture Coverage Act of 2003, The Council of Acupuncture and Oriental Medicine Associations (CAOMA) and the Acupuncture and Oriental Medicine National Coalition (AOMNC) are moving the profession of acupuncture and Oriental medicine forward by supporting national and federal recognition of the medicine in the public arena. Up-to-date information on the HR 1477 lobbying campaign can be found at www.aomnc.com and at www.acucouncil.org.

I welcome practitioners and patients to represent acupuncture and Oriental medicine as additional point persons in congressional districts across the country to lobby their representatives to co-sponsor HR 1477.

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