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CHIROPRACTIC FUTURE STRATEGIC PLAN

May 23, 2025

Formal Comments to the U.S. Department of Justice
Re: Regulatory Barriers to Chiropractic Physician Participation in Federal Programs
Submitted by Chiropractic Future

I. Introduction

Chiropractic Future, a not-for-profit advocacy group advancing healthcare through collaboration, improved patient access, and equitable policy, respectfully submits these comments in response to the request of the U.S. Department of Justice's Anticompetitive Regulations Task Force for comments on the DOJ study of regulatory structures that may restrict competition, harm consumers, or elevate healthcare costs. We commend the Department's initiative in addressing this important issue.

Chiropractic Future respectfully submits these formal comments to the U.S. Department of Justice's Anticompetitive Regulations Task Force. Building on our prior submission regarding the underenforcement of 42 U.S.C. § 300gg–5, this letter addresses additional regulatory structures—specifically those embedded in Medicare rules—that exclude chiropractic physicians from equitable participation in national health delivery systems. These exclusions suppress provider competition, elevate public healthcare costs, and restrict patient access to safe, evidence-based conservative care.

Chiropractors are recognized as "physicians" under 42 U.S.C. § 1395x(r) and are licensed in all 50 states to provide a broad scope of nonpharmacologic and nonsurgical care. However, current Centers for Medicare & Medicaid Services (CMS) policies arbitrarily limit reimbursement for chiropractic services to spinal manipulation only, deny DCs eligibility for telehealth reimbursement under 42 U.S.C. § 1834(m), and permit Medicare Advantage (MA) plans to exclude DCs from network adequacy standards under 42 C.F.R. § 422.116.

These exclusions violate principles of regulatory neutrality and fair competition, distort federal healthcare markets, and lead to avoidable public expenditures. Addressing them would restore lawful competition, improve patient access, and strengthen the healthcare workforce—especially critical amid projected shortages in primary care.

II. Legal and Regulatory Barriers

Chiropractic physicians face categorical exclusions from Medicare and Medicare Advantage despite their federal recognition as physicians. These exclusions have no defensible clinical basis and are instead rooted in outdated statutory interpretations.

Under 42 U.S.C. § 1395x(r), chiropractors are included in Medicare's definition of "physician," but only for manual manipulation of the spine to correct subluxations. This 1970s-era limitation imposes an unnecessarily narrow and clinically outdated constraint on chiropractic care. While the statute confers physician status, its implementation has resulted in a constrained reimbursement structure that excludes evaluation, diagnostic, and rehabilitative services, despite these services being well within the chiropractic scope of licensure. Notably, these same services are routinely covered when furnished by other Medicare-recognized providers. This interpretation has led to an anticompetitive policy outcome that restricts patient access to comprehensive, non-pharmacologic care.

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CMS's interpretation of 42 U.S.C. § 1834(m) excludes chiropractors from telehealth reimbursement altogether. Though chiropractors are federally defined as "physicians," they are not permitted to furnish reimbursable telehealth services under Medicare, even for non-manual services such as consultations, functional assessments, or patient education. This exclusion suppresses innovation and denies patients, especially those in rural areas, access to evidence-based conservative care.

Furthermore, 42 C.F.R. §§ 410.21 and 410.26 reinforce outdated exclusions. The former prohibits Medicare reimbursement for any chiropractic service other than spinal manipulation. The latter prevents chiropractors from billing for "incident to" services delivered by clinical staff or referring patients for diagnostics and therapies, privileges extended to other physician types. These restrictions carve chiropractic physicians out of modern team-based and value-based care models.

Although 42 C.F.R. § 422.116 includes chiropractors in Medicare Advantage network adequacy metrics, it does not require MA plans to count chiropractors toward adequacy thresholds. This regulatory gap permits health plans to exclude chiropractic physicians or limit their network presence, steering patients toward higher-cost care and reducing choice.

III. Economic and Clinical Impact

Chiropractic care is supported by strong clinical and economic evidence. Studies consistently demonstrate that chiropractic treatment improves outcomes and reduces downstream costs for musculoskeletal conditions, one of the leading drivers of disability and medical spending in the U.S.

- A 2024 systematic review found that patients initiating care with chiropractors experienced fewer surgeries, emergency department visits, and imaging referrals (Farabaugh et al., 2024).
- A 2022 study in Chiropractic & Manual Therapies reported that Medicare enrollees with spinal pain who saw both a chiropractor and a primary care physician had less than half the risk of filling an opioid prescription, as compared to those who received primary medical care alone (Whedon et al., 2022).
- A 2010 analysis of private claims data revealed that low back pain episodes starting with a chiropractor were nearly 40% less costly than those initiated by a medical doctor (Liliedahl et al., 2010).

Chiropractors deliver safe, effective, and patient-centered care aligned with federal goals to reduce opioid reliance and promote nonpharmacologic treatment. Excluding these providers from reimbursement and network participation runs contrary to both clinical evidence and cost-containment objectives.

IV. Provider Nondiscrimination Under 42 U.S.C. § 300gg–5

Section 2706(a) of the Public Health Service Act, codified at 42 U.S.C. § 300gg–5, prohibits health insurers from discriminating against any provider acting within their licensed scope of practice. Chiropractors meet this definition and are legally recognized in all states.

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Nevertheless, health plans routinely reimburse chiropractic physicians at lower rates than comparable providers for identical services, impose utilization restrictions not applied to other clinicians, and exclude chiropractors from network tiers—all without quality or performance justification.

These practices violate both the letter and spirit of the federal provider nondiscrimination law. Unfortunately, enforcement has been inconsistent, and insurers continue to engage in conduct that suppresses provider competition and reduces patient access. The DOJ is in a unique position to promote compliance and remedy these disparities through the Anticompetitive Regulations Task Force.

V. Recommendations

Chiropractic Future urges the Department of Justice to:

1. Investigate CMS's implementation of 42 U.S.C. § 1834(m) and 42 C.F.R. §§ 410.21 & 410.26 for their suppressive effects on provider competition.
2. Recommend that CMS update the Medicare Benefit Policy Manual to reflect the full statutory scope of physician recognition, including equitable reimbursement for services within state-authorized scope of practice.
3. Promote enforcement of 42 U.S.C. § 300gg–5 to prevent discriminatory insurer practices that exclude chiropractic physicians from participation or equal reimbursement.
4. Encourage HHS and CMS to develop value-based models inclusive of chiropractic physicians, particularly for chronic musculoskeletal conditions.
5. Collaborate with CMS to revise Medicare Advantage rules to require chiropractic physician inclusion in network adequacy determinations.

VI. Conclusion

Chiropractic physicians are educated, licensed, and federally recognized providers of conservative, non-opioid care. Current CMS policies that limit their participation in federal health programs are rooted in obsolete regulatory structures and violate statutory principles of equity and competition.

We respectfully request that the DOJ act to restore provider parity, improve patient access, and lower public healthcare costs by addressing these anticompetitive regulatory frameworks.

Respectfully submitted,
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