

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**INAPPROPRIATE MEDICARE
PAYMENTS FOR
CHIROPRACTIC SERVICES**



Daniel R. Levinson
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E X E C U T I V E S U M M A R Y

OBJECTIVE

To determine the extent to which:

- (1) chiropractic claims allowed in 2006 for beneficiaries receiving more than 12 services from the same chiropractor were appropriate,
- (2) controls ensured that chiropractic claims were not for maintenance therapy,
- (3) claims data can be used to identify maintenance therapy, and
- (4) chiropractic claims were documented as required.

BACKGROUND

As required by the Social Security Act, Medicare pays only for medically necessary chiropractic services, which are limited to active/corrective manual manipulations of the spine to correct subluxations.

Chiropractors must use the acute treatment (AT) modifier to identify services that are active/corrective treatment and must document services in accordance with the Centers for Medicare & Medicaid Services' (CMS) "Medicare Benefit Policy Manual" (the Manual) when submitting claims. When further improvement cannot reasonably be expected from continuing care, the services are considered maintenance therapy, which is not medically necessary and therefore not payable under Medicare.

We identified allowed claims with the AT modifier for beneficiaries with more than 12 claims from the same chiropractor in 2006. We then contracted with a medical review contractor to review medical records from a simple random sample of 188 claims. For each treatment episode, the medical records were reviewed to identify the initial visit and subsequent visits (if relevant) to determine whether each sampled claim was active/corrective treatment or maintenance therapy, the extent to which chiropractors supported their use of the AT modifier with proper documentation indicating active/corrective treatment, whether claims were coded properly, and whether documentation met the Manual requirements.

FINDINGS

Medicare inappropriately paid \$178 million for chiropractic claims in 2006, representing 47 percent of claims meeting our study criteria.

E X E C U T I V E S U M M A R Y

In 2006, Medicare inappropriately paid \$178 million (out of \$466 million) for chiropractic claims for services that medical reviewers determined to be maintenance therapy (\$157 million), miscoded (\$11 million), or undocumented (\$46 million). These claims represent 47 percent of all allowed chiropractic claims that met the study criteria. Claims representing \$36 million had multiple errors.

Efforts to stop payments for maintenance therapy have been largely ineffective. CMS, carriers, and program safeguard contractors (PSC) use a number of strategies to deter inappropriate payments for maintenance therapy, including use of the AT modifier to indicate active/corrective treatment, provider education, frequency-based control edits (caps), and focused medical review. Despite these efforts, carriers and PSCs continue to report high errors for chiropractic claims. Carrier staff, PSC staff, and medical reviewers for this study agreed that the AT modifier did not prevent inappropriate payments for maintenance therapy because chiropractors continued to submit claims for maintenance therapy with the AT modifier.

Claims data lack initial visit dates for treatment episodes, hindering the identification of maintenance therapy. To identify active/corrective treatment and thereby distinguish it from maintenance therapy, it is useful to identify the start of a new treatment episode. However, claims data do not indicate when an episode begins. Thus, we asked sampled chiropractors and the medical reviewers to identify when an episode began and ended. Overall, only 50 percent of all treatment episodes remained active/corrective throughout the treatment episode. In addition, 78 percent of those treatment episodes that became maintenance therapy did so by the 20th visit. The Comprehensive Error Rate Testing (CERT) paid claims error rate used by CMS is based on a review of a single claim, which limits its ability to detect maintenance therapy and may underestimate errors in claims for chiropractic services.

Chiropractors often do not comply with the Manual documentation requirements. Separate from the undocumented claims counted as errors above, 83 percent of chiropractic claims failed to meet one or more of the documentation requirements. Consequently, the appropriate use of the AT modifier could not be definitively determined through medical review for 9 percent of sampled claims, representing \$39 million.

The medical reviewers indicated that treatment plans are an important element in determining whether the chiropractic treatment was active/corrective in achieving specified goals. Of the 76 percent of records that reviewers indicated contained some form of treatment plan, 43 percent lacked treatment goals, 17 percent lacked objective measures, and 15 percent lacked the recommended level of care.

RECOMMENDATIONS

Medicare continues to pay inappropriately for maintenance therapy despite acknowledging this vulnerability in response to previous Office of Inspector General work and subsequent efforts aimed at prevention. Because of high error rates and poor documentation, we recommend that CMS:

Implement and enforce policies to prevent future payments for maintenance therapy. CMS can achieve this by implementing a new modifier for chiropractic claims to indicate the start of a new treatment episode and/or implementing a cap on allowed chiropractic claims.

Review treatment episodes rather than individual chiropractic claims to strengthen the ability of the CERT to detect errors in chiropractic claims. CMS should consider expanding the CERT review from a single sampled claim to a treatment episode that includes all claims from the initial visit to the sampled claim for a sample of (1) all chiropractic claims or (2) chiropractic claims for beneficiaries receiving 12 or more services per year because of their increased vulnerability. Under this review, CMS would continue to sample claims in the current CERT process but would also request associated claims prior to the sampled claims to augment the medical review.

Ensure that chiropractic claims are not paid unless documentation requirements are met. CMS can achieve this by requiring carriers, whose responsibilities will transition to Medicare Administrative Contractors (MAC) by 2011, to withhold payment on reviewed claims when required documentation is absent or requiring carriers/MACs to perform prepayment review of claims from chiropractors who repeatedly fail to meet documentation requirements.

Take appropriate action regarding the undocumented, medically unnecessary, and miscoded claims identified in our sample.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the report, CMS agreed with the second recommendation and described actions it would take to address the fourth recommendation. CMS did not indicate agreement or disagreement with the first and third recommendations.

In response to the second recommendation, CMS indicated that it is now reviewing 6 months of claims prior to sampled claims in response to a recommendation from a prior OIG report. As a result, the CERT error rate increased from 8.9 percent to 15.3 percent from 2005 to 2006. CMS indicated it would have to conduct a cost-benefit analysis to determine the utility of expanding this review to include claims beginning with the first claim of the treatment episode. We encourage CMS to conduct this analysis because the intent of CERT is to determine error rates, identify programs at risk, and prevent future overpayments. OIG has repeatedly found overpayments for maintenance therapy.

In response to the fourth recommendation, CMS stated that it would instruct the contractors to take any necessary corrective actions with respect to the sampled claims that this study identified as being in error.

In response to the first recommendation, CMS indicated that the objective data required to impose a national cap on the number of chiropractic services does not currently exist. In response to the third recommendation, CMS described the current process contractors use to review provider claims with a greater likelihood of payment error, but CMS indicated no change in future practice to prevent claims without required documentation from being paid in error. We ask that in its final management decision, CMS more clearly indicate whether it concurs with our first and third recommendations and what steps, if any, it will take to implement them.

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OBJECTIVE

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- (3) claims data can be used to identify maintenance therapy, and
- (4) chiropractic claims were documented as required.

BACKGROUND

As required by the Social Security Act (the Act), Medicare pays only for reasonable and necessary chiropractic services, which are limited to active/corrective manual manipulations of the spine to correct subluxations.¹ A chiropractic service “must have a direct therapeutic relationship to the patient’s condition and provide reasonable expectation of recovery or improvement of function.”² The Centers for Medicare & Medicaid Services (CMS) “Medicare Benefit Policy Manual” (the Manual) allows chiropractors an opportunity to produce functional improvement or arrest or retard deterioration for subluxations within a reasonable and generally predictable period of time.³ When further improvement cannot reasonably be expected from continuing care and the services become supportive rather than corrective, the services are

¹ Sections 1861(r) and 1862(a)(1)(A) of the Act, 42 U.S.C. § 1395x(r), 42 U.S.C. § 1395y(a)(1)(A)); 42 CFR § 410.21(b); CMS, “Medicare Benefit Policy Manual [Internet Only Manual],” Pub. 100-02, chapter 15, § 240.1.2, defines subluxation as “a motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact.” Available online at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Accessed on July 30, 2008.

² CMS, “Medicare Benefit Policy Manual [Internet Only Manual],” Pub. 100-02, chapter 15, § 240.1.3. Available online at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Accessed on July 30, 2008.

³ CMS, “Medicare Benefit Policy Manual [Internet Only Manual],” Pub.100-02, chapter 15, §240.1.5. Available online at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Accessed on September 29, 2008.

considered maintenance therapy.⁴ The Manual provides that maintenance therapy is not considered a medically necessary chiropractic service and is therefore not payable under Medicare.⁵

Medicare Requirements for Chiropractic Claims

Chiropractic claims have specific billing requirements. Chiropractors are limited to billing three Current Procedural Terminology (CPT) codes under Medicare: 98940 (chiropractic manipulative treatment; spinal, one to two regions), 98941 (three to four regions), and 98942 (five regions).⁶ When submitting manipulation claims, chiropractors must use an acute treatment (AT) modifier to identify services that are active/corrective treatment of an acute or chronic subluxation. Although the title of the modifier indicates that it should be used only for acute treatment, the Manual states that the modifier should be used for acute or chronic treatment as long as it is considered active/corrective. By using the AT modifier, chiropractors indicate that the treatment provided is indeed active/corrective in nature. Medicare should deny claims without the AT modifier as those services are considered maintenance therapy.⁷

The Manual outlines seven general documentation requirements for initial visits and three general documentation requirements for subsequent visits, as listed below.⁸

Initial visit.

1. Subluxation(s) demonstrated by x-ray or physical examination (physical examinations must demonstrate at least two of the four following criteria: pain/tenderness, asymmetry/misalignment,

⁴ CMS, “Medicare Benefit Policy Manual [Internet Only Manual],” Pub 100-02, chapter 15, § 30.5.B, defines maintenance therapy as “a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.” Available online at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Accessed on July 30, 2008.

⁵ Ibid. CMS, “Addressing Misinformation Regarding Chiropractic Services and Medicare.” Available online at http://www.cms.hhs.gov/MLNProducts/downloads/Chiropractors_fact_sheet.pdf. Accessed on July 30, 2008.

⁶ American Medical Association, “Current Procedural Terminology,” 2006.

⁷ CMS, “Medicare Benefit Policy Manual [Internet Only Manual],” Pub. 100-02, chapter 15, § 240.1.5. Available online at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Accessed on July 30, 2008.

⁸ CMS, “Medicare Benefit Policy Manual [Internet Only Manual],” Pub. 100-02, chapter 15, § 240.1.2. Available online at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Accessed on July 30, 2008.

abnormal range of motion, and tissue/tone changes, one of which must be either asymmetry/misalignment or abnormal range of motion),⁹

2. Diagnosis of subluxation(s),
3. Patient history (lists such items as symptoms and past health history),
4. Description of present illness,
5. Treatment plan (includes a recommended level of care, specific treatment goals, and objective measures to evaluate treatment effectiveness),
6. Physical examination, and
7. Date of initial treatment.¹⁰

Subsequent visit.

1. Patient history (lists such items as changes since last visit),
2. Physical examination, and
3. Documentation of treatment provided at each visit.

CMS Oversight

The Federal Managers Financial Integrity Act requires each executive agency to establish and maintain internal controls for oversight, including appropriate payment of claims.¹¹ CMS monitors the rates of inappropriate payments for Medicare fee-for-service claims through the Comprehensive Error Rate Testing (CERT) program.¹² At the time of our review, CMS contracted with Medicare Part B carriers and program safeguard contractors (PSC) to perform oversight, including program integrity and data analysis activities.¹³ CMS required that carriers and

⁹ Ibid.

¹⁰ Although seven requirements are listed here for the initial visit, only five are listed in Appendix A. The medical reviewers analyzed the initial visit requirements 6 and 7 (physical exam and date of initial treatment) in conjunction with the initial visit requirement 1 (subluxation demonstrated by x-ray or physical examination).

¹¹ 31 U.S.C. §§ 3512(b) and (c).

¹² CMS also uses the Hospital Payment Monitoring Program to measure error rates for fee-for-service claims. This program does not include chiropractic services.

¹³ Under Medicare Contracting Reform, responsibilities of carriers are transitioning to Medicare Administrative Contractors (MAC). At the time of our review, none of the carriers had completed the transition.

PSCs provide assurances that controls were in place to identify and correct any areas of weakness in program operations.¹⁴

CERT. CMS has established the CERT program to randomly sample and review different types of service claims submitted to Medicare. The 2006 and 2007 CERT reports listed overall error rates for chiropractic services of 16 percent and 11 percent, respectively.¹⁵

To calculate error rates, CERT staff randomly select claims for services each month from each contractor. CERT staff then request only the medical record associated with the sampled claim from the provider that submitted the claim. CERT staff do not request medical records related to complete treatment episodes for sampled chiropractic claims.

Carrier responsibilities. Carriers' primary function was to pay for Medicare-covered services that are reasonable and necessary for eligible individuals. Carriers may have implemented frequency-based controls that generally fall into one of two categories: soft caps and hard caps. With either type of cap, the carrier determined a frequency or dollar threshold for the services that it would routinely allow during a specified time period, usually 1 year.¹⁶

- Soft caps—Medicare carriers generally used soft caps to suspend payment for any claims for service that were submitted exceeding a threshold. Carriers requested additional documentation from the chiropractors for claims exceeding the threshold. The claims were paid if the documentation demonstrated that continued treatment was medically necessary.
- Hard caps—For certain services, carriers tracked the number of services or expenditures per patient and did not pay for services beyond an established threshold even if they were medically necessary. Carriers did not use hard caps for chiropractic claims at the time of our review, although hard caps existed in other disciplines, such as physical therapy. Other health care payors use

¹⁴ CMS, "Medicare Financial Management Manual [Internet Only Manual]," Pub. 100-06, chapter 7, § 30.1. Available online at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Accessed on July 30, 2008.

¹⁵ CMS, "Improper Medicare Fee-For-Service Payments Report - November 2006 Long Report" and "Improper Medicare Fee-For-Service Payments Report - November 2007 Long Report." Available online at http://www.cms.hhs.gov/apps/er_report/index.asp. Accessed on September 25, 2008.

¹⁶ OIG interviews with carrier staff conducted in association with "Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis" (OEI-09-02-00530).

hard caps for chiropractic claims. For example, many Federal Employee Health Benefit plans impose frequency limits on chiropractic claims ranging from 12 to 20 per year.

PSC responsibilities. A PSC can perform one or more of the following payment safeguard functions: medical review, cost report audit, data analysis, provider education, and fraud detection and prevention.¹⁷ Medicare expects each PSC to:

- prevent fraud by identifying program vulnerabilities;
- proactively identify incidents of potential fraud that exist within its service area and take appropriate action on each case;
- investigate allegations of fraud made by beneficiaries, providers, CMS, the Office of Inspector General (OIG), and other sources;
- explore all available sources of fraud referrals in its jurisdiction;
- initiate appropriate administrative actions to deny or to suspend payments that should not be made to providers where there is reliable evidence of fraud;
- refer cases to OIG for consideration of civil and criminal prosecution and/or application of administrative sanctions; and
- refer any necessary provider and beneficiary outreach to the education staff at the carrier.¹⁸

Previous OIG Work

Previous OIG studies published in 1986, 1998, and 1999 found that significant vulnerabilities existed in connection with chiropractic claims, particularly concerning Medicare payments for maintenance

¹⁷ CMS, “Medicare Program Integrity Manual,” Pub 100-08, Change Request 1143. Available online at <http://www.cms.hhs.gov/Transmittals/Downloads/R12PIM.pdf>. Accessed on August 1, 2008. Under Medicare Contracting Reform, PSCs are responsible only for benefit integrity work (CMS, “Medicare Administrative Contractor Workload Implementation Handbook,” chapter 7, § 7.3.1. Available online at <http://www.cms.hhs.gov/MedicareContractingReform/downloads/MACImplementationHandbook.pdf>. Accessed on August 1, 2008.)

¹⁸ CMS, “Medicare Program Integrity Manual [Internet Only Manual],” Pub 100-08, chapter 4, § 4.2.2. Available online at <http://www.cms.hhs.gov/manuals/downloads/pim83c04.pdf>. Accessed on August 1, 2008.

therapy.¹⁹ Each of these studies recommended frequency edits or caps on the number of chiropractic claims allowed. In 2005, OIG conducted an additional study that found that 40 percent of allowed chiropractic claims in 2001 were for maintenance therapy and that when chiropractors provide more than 12 services per year to a beneficiary, the likelihood that some of those services were maintenance therapy increased greatly.²⁰ OIG recommended that CMS require carriers or PSCs to conduct routine service-specific reviews of chiropractic services to identify improper payments and implement frequency-based controls to target high-volume services for review. Additionally, OIG recommended that CMS require carriers to educate chiropractors on documentation requirements as outlined in the Manual.

In its written response to the OIG draft report, CMS concurred with those OIG recommendations and indicated that it had taken a number of steps to reduce chiropractic error rates, including targeted educational efforts and service-specific medical reviews. CMS issued three updates in 2004 to the Manual requiring providers to use the AT modifier for all chiropractic claims when such services were for active/corrective treatment.²¹ CMS also acknowledged in its written comments that because the CERT paid claims error rate is based on a review of a beneficiary's claim at a single point in time instead of claims over time, the ability to detect services meeting the definition of maintenance therapy is limited.²²

METHODOLOGY

We used multiple methods to achieve our objectives. The primary method used was medical review of records supporting chiropractic claims. We also interviewed CMS central office staff, carrier staff, and PSC staff; analyzed historical claims data; and reviewed recent chiropractic literature.

¹⁹ “Inspection of Chiropractic Services under Medicare” (OAI-05-86-00002); “Chiropractic Care: Controls Used by Medicare, Medicaid, and Other Payers” (OEI-04-97-00490); and “Utilization Parameters for Chiropractic Treatments” (OEI-04-97-00496).

²⁰ “Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis” (OEI-09-02-00530).

²¹ CMS, “Medicare Benefit Policy Manual,” Pub. 100-02, Change Request 3063, released in May 2004 was rescinded and replaced in September 2004 with Change Request 3449, which was reissued in October 2004.

²² “Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis” (OEI-09-02-00530). See “Agency Comments” section.

Population Identification

We obtained Medicare-allowed claims data for chiropractic claims submitted with procedure codes 98940, 98941, and 98942 and with an AT modifier from CMS's 2006 National Claims History Part B Carrier file. This population contained 22,964,790 claims with a total allowed amount of \$762,148,017. We limited the population to claims for beneficiaries who received more than 12 services from the same chiropractor in 2006.²³ This population contained 13,827,382 claims with a total allowed amount of \$465,959,195.

Sample Selection

We selected a simple random sample of 200 allowed claims from the population. Twelve claims were removed from the sample because of ongoing OIG investigation work, leaving a final sample of 188 allowed claims. We projected our results to the population from which we drew the sample. Point estimates with confidence intervals for selected statistics are contained in Appendix A.

Medical Review

We contracted with a medical review contractor to assist us in data collection, selecting medical reviewers, and reviewing medical records. The medical review contractor sent up to three medical record request letters (the last request via certified mail) to each provider for the sampled claims at predetermined time intervals. The letters requested all medical records from each chiropractor for the beneficiary from the first visit through the end of the treatment episode involving the sampled claim, not just records to support the sampled claim. The contractor conducted a minimum of three follow-up telephone contacts with providers who failed to respond to mailed requests. The contractor successfully contacted all chiropractors for all the sampled claims; however, chiropractors did not respond with requested documentation for seven sampled claims.²⁴

We worked with the medical review contractor to select chiropractors with previous experience in reviewing chiropractic services provided to Medicare beneficiaries to serve as medical reviewers for this study. These medical reviewers determined whether each sampled claim was

²³ As previously stated, recent OIG work determined that when chiropractors provide more than 12 services per year to a beneficiary, the likelihood that some of those services constituted maintenance therapy increased greatly.

²⁴ The chiropractors failing to comply with our request for information have been referred to CMS and OIG's Office of Investigations for appropriate action.

active/corrective treatment or maintenance therapy, the extent to which chiropractors supported their use of the AT modifier with proper documentation indicating active/corrective treatment, whether claims were coded properly, and whether documentation met the Manual requirements. For each treatment episode, the medical reviewers identified the initial visit if the practicing chiropractor failed to specify the initial visit in their submission of documentation. The medical reviewers then reviewed the initial visit and subsequent visits (if relevant) to determine whether documentation requirements were met and whether maintenance therapy was provided.

We did not automatically exclude records from our medical review when chiropractors failed to comply fully with documentation requirements. For example, even if not all visits included patient histories and descriptions of present illnesses, which are required by Medicare, the records were still reviewed. The services rendered on those days were not automatically deemed to be maintenance therapy by the medical reviewers because documentation was missing.

We defined inappropriate payments as those made for sampled claims that the medical reviewers identified as maintenance therapy, miscoded, or undocumented.²⁵ We then projected our results to the population of 13.8 million chiropractic claims representing those claims for beneficiaries receiving more than 12 services in a year. This may have caused us to underestimate error rates for both dollars and services because the weight of estimates was divided by 200 rather than 188 (because of 12 cases under review by OIG). Upcoding and downcoding were determined by the number of regions manipulated as supported by the documentation compared to the number of regions manipulated as indicated by the submitted claims. The net differences were reported (i.e., adding or subtracting the amount for the correct code from the amount allowed for these claims).

Interviews and Documentation Collection

We conducted structured interviews with and collected documentation from CMS central office staff, carrier staff, and PSC staff to determine how they ensured that claims with the AT modifier were not maintenance therapy. CMS interviews included questions about

²⁵ Claims were undocumented if the provider did not provide the requested documentation or if the records did not document that any service was rendered on the date claimed.

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documentation requirements, provider education and outreach, and Medicare policies. The carrier and PSC staff interviews included questions about local coverage determination policies, provider education and outreach, coordination of oversight, medical review strategies, and resources. When clarification was necessary, we obtained documentation of local coverage determination policies, Internet-based provider education materials, and other outreach materials. Additionally, we reviewed CERT reports from 2003–2007 to examine sample methodologies and error rates for chiropractic services.

Standards

This study was conducted in accordance with the “Quality Standards for Inspections” issued by the President’s Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

F I N D I N G S

Medicare inappropriately paid \$178 million for chiropractic claims in 2006, representing 47 percent of claims meeting our study criteria

In 2006, Medicare inappropriately paid a total net \$178 million (out of \$466 million) for chiropractic claims for services that were

maintenance therapy (\$157 million), miscoded (\$11 million), or undocumented (\$46 million). These claims represent 47 percent of all allowed chiropractic claims that met the study criteria of chiropractors providing more than 12 services to the same beneficiary during 2006. Seventeen percent of the reviewed claims, representing \$36 million, had multiple errors. Table 1 groups the improperly paid claims projected to the population.

Table 1: Inappropriately Paid Chiropractic Claims in 2006

Type of Error	Claims	Claims (percentage)	Allowed Amount
Maintenance Therapy			
Did not accurately reflect active/corrective treatment	4,217,352	32	\$141,651,849
Did not provide a reasonable expectation of recovery or functional improvement	3,940,804	30	\$134,174,001
(Overlapping errors for maintenance therapy)	(3,525,983)	(27)	(\$119,136,032)
Total maintenance therapy	4,632,173	36*	\$156,689,819*
Miscoded			
Upcoded	1,728,423	13	\$17,896,089
Downcoded	553,095	4	(\$6,534,821)
Total miscoded	2,281,518	18*	\$11,361,268 (net)
Undocumented			
Nonresponse	483,958	4	\$14,078,349
Claim lacked documentation of treatment	898,780	7	\$31,626,679
Total undocumented	1,382,738	11	\$45,705,028
Total errors (gross)	8,296,429	64	\$213,756,116*
(Overlapping errors)	(2,212,381)	(17)	(\$35,579,928)
Total errors (net)	6,084,048	47	\$178,176,188*

Source: OIG medical review of 2006 chiropractic services.

*Note: Numbers do not sum as expected because of rounding.

F I N D I N G S

Medicare inappropriately paid \$157 million for maintenance therapy

The medical reviewers identified 36 percent of the chiropractic claims allowed in 2006 that met the study criteria, totaling \$157 million, as maintenance therapy, for which Medicare does not pay. We found that 25 percent of the reviewed treatment episodes that included maintenance therapy were identified as maintenance at the initial visit. This indicates that for these entire treatment episodes, no functional improvement could have been expected. All of the inappropriate payments for maintenance therapy reflect the medical reviewers' determination based on their review of medical records, not insufficient documentation. When certain required documentation was unavailable, the medical reviewers relied on other available documentation (such as objective measures of treatment effectiveness over time) to determine the appropriateness of the AT modifier.

We could identify no relationship between the area of the spine diagnosed with a subluxation(s) and the incidence of maintenance therapy. In addition, we did not identify any significant correlations between the incidence of maintenance therapy and a given diagnosis. We identified 73,936 claims amounting to \$2.4 million that were paid without the AT modifier being listed as the primary or secondary modifier.

Medicare inappropriately paid a net \$11 million for miscoded claims

The medical reviewers identified 18 percent of the chiropractic claims allowed in 2006 that met the study criteria, totaling \$79 million in allowed claims, as spinal manipulation claims that reflected the incorrect number of regions of the spine. The net cost to the program was \$11 million. Coding errors generally involved upcoding, which is billing a more complex and higher paid service than the one documented in the medical record. Approximately 41 percent of allowed claims in our sample for spinal manipulation on five regions (CPT code 98942) were upcoded, and 15 percent of allowed claims for manipulation on three to four regions (CPT code 98941) in our sample were upcoded. The medical reviewers noted:

[M]any records . . . did not meet the Medicare guidelines in determining a chiropractic subluxation for each area of the spine treated. The records would indicate a problem in one area of the spine which was examined, but indicated treatment to three to four areas of the spine and charged according to procedure without correlation to diagnosis.

FINDINGS

Similarly, carriers noted trends in upcoding for chiropractic claims based on targeted medical review in their jurisdictions. Staff from one carrier explained that in one specific geographic area, “Three to four years ago we looked at distribution among three codes, looking at those using 98942 frequently. The percentage of abuse with 98942 was 80 percent or greater.”

Medicare inappropriately paid \$46 million for undocumented claims

Eleven percent of claims allowed in 2006 that met the study criteria, totaling \$46 million, were undocumented. The chiropractors for 7 percent of claims provided us with records that did not document that any service was rendered on the date claimed. Additionally, despite repeated requests, chiropractors did not provide the documentation related to 4 percent of the sampled claims. In both cases, claims that lack sufficient documentation to show that care was provided do not meet Medicare requirements.

Efforts to stop payments for maintenance therapy have been largely ineffective

CMS, carriers, and PSCs use a number of strategies to deter inappropriate payments for

maintenance therapy, including use of the AT modifier to indicate active/corrective treatment, provider education, frequency-based control edits (caps), and focused medical review. Despite these efforts, carriers and PSCs continue to report high error rates for chiropractic claims.

The AT modifier does not prevent inappropriate payments for maintenance therapy

Table 2 demonstrates that the number of chiropractic claims submitted and allowed changed little since the requirement of the AT modifier for active/corrective treatment. Because the 2005 OIG study identified 40 percent of all 2001 allowed chiropractic claims as maintenance therapy, there should have been a decrease—not an increase—in the number of allowed claims if CMS’s AT modifier requirement effectively prevented inappropriate payments for maintenance therapy.

Instead, allowed claims increased 3.7 million, or 19 percent, between 2003 (1 year before the AT modifier guidance) and 2005 (the year after the AT modifier guidance). The AT modifier was used on 99.8 percent of allowed chiropractic claims in 2005, up from 6.1 percent in 2003.

Table 2: Estimates of Chiropractic Claims Volume 2001–2006

Calendar Year	Submitted Claims	Mean Claims Submitted per Beneficiary	Allowed Claims	Percentage of Allowed Claims With AT Modifier	Percentage of Submitted Claims Allowed
2001	19,531,700	10.5	15,920,500	6.2	81.5
2002	21,220,800	10.6	18,111,800	5.9	85.3
2003	22,521,600	10.9	19,407,300	6.1	86.2
2004	25,151,800	11.6	21,200,000	34.6	84.3
2005	26,121,100	11.5	23,075,800	99.8	88.3
2006	25,845,478	11.3	22,964,790	99.7	88.9

Source: OIG analysis of estimates from the 1-percent beneficiary sample Part B claims file, 2008.

Carrier staff, PSC staff, and medical reviewers for this study agreed that the AT modifier did not prevent inappropriate payments for maintenance therapy. Carrier staff readily indicated, “By putting an AT modifier on a claim, chiropractors are getting paid, and they know they will get paid.” During its review of trends in chiropractic claims in excess of 12 claims per year, one PSC identified two chiropractors with 100-percent error rates. Staff from another PSC investigating suspicious chiropractic claims said, “from a [targeted] medical review standpoint, we see lots of chiropractors billing with the AT modifier when not appropriate. I would say at least 95 percent of AT modifier use is wrong. It is a big issue.” Further, the medical reviewers for this study noted that the requirement for the AT modifier did not appear to affect chiropractic billing patterns.

Provider education does not prevent inappropriate payments for maintenance therapy

In response to comments from the chiropractic industry indicating that the definition of maintenance therapy was confusing, CMS revised the definition of maintenance therapy in the Manual before our review period. This revision was made in addition to requiring the AT modifier to indicate active/corrective treatment. CMS allowed carriers flexibility in educating chiropractors on the revised Medicare requirements.

Chiropractors continue to submit claims for maintenance therapy with the AT modifier even though all 16 carriers indicated that they provided education to chiropractors on the correct use of the AT modifier. Fourteen carriers reported developing educational programs or publishing important information on their Web sites regarding appropriate AT modifier usage. Ten carriers volunteered that they provided education at conferences or other seminars, and five

volunteered that they used collaboration with chiropractic associations to increase awareness and promote the appropriate use of the AT modifier. Eight carriers volunteered that they published material or manuals to send to chiropractors.

Use of frequency-based controls does not prevent all inappropriate payments for maintenance therapy; carriers welcome stricter measures

Soft caps. At the time of our review, half of the carriers used soft caps for chiropractic claims based on the frequency of services for a particular diagnosis as their primary means of limiting inappropriate payments. Staff from one carrier explained, “Diagnoses are split into different categories and different numbers of services are permitted. This [practice] originated many years ago and became available as a ‘model policy’ to all carriers.” Staff from another carrier noted in reference to their postpayment review process, “As we continue to do complex medical review, we continue to deny about 90 percent of reviewed claims.” One carrier reported difficulty in implementing an internal frequency threshold. After the carrier adjusted its frequency threshold, some chiropractors changed their billing behavior by submitting claims up to the threshold to avoid review.

Hard caps. Although 4 carriers had hard caps for chiropractic claims in the past, none of the 16 carriers currently have them. Carrier staff explained that they no longer have hard caps because of guidance from CMS and opposition from the chiropractic community. A CMS staff member noted, “Years ago, some [carriers] had auto-deny limits and one by one, they got rid of them because of political pressure.” Although CMS has hard caps in other disciplines, staff indicated that the lack of clinical evidence would make establishing frequency thresholds for chiropractic claims difficult. However, staff from 10 carriers indicated that they would welcome hard caps on chiropractic claims. Similarly, the 2005 OIG report noted that six carriers would like hard caps.

PSCs’ use of focused medical review does not prevent inappropriate payments for maintenance therapy

PSCs based medical review strategies and processing of referrals on their individual program integrity priorities, which are generally the service areas with the greatest potential for overpayment recovery. Though chiropractors submitted claims for more than \$1 billion in 2006, individual chiropractic claims may be considered small. The average allowed charge for a chiropractic claim in 2006 was only \$33, while the same for a physician office visit was \$62. Staff from a PSC responsible for program integrity in five major cities across 16 States explained,

“We have to prioritize our work by the most egregious crimes. We don’t look at chiropractic claims and the AT modifier specifically because the money is not [significant when reviewing] individual providers.”

Claims data lack initial visit dates for treatment episodes, hindering the identification of maintenance therapy

To appropriately identify active/corrective treatment and thereby distinguish it from maintenance therapy, it

is useful to identify the start of a new treatment episode. Because claims data do not indicate when a treatment episode began, we asked sampled chiropractors and the medical reviewers to identify when an episode began and ended. Overall, only 50 percent of all treatment episodes remained active/corrective throughout the treatment episode. For the remaining treatment episodes that included maintenance, the mean number of claims between the initial visit and the first visit determined to be maintenance therapy was 14, with the median number being 9 claims. Additionally, 78 percent of those treatment episodes that became maintenance therapy did so by the 20th visit.

The 2005 OIG study found that the likelihood of services being medically unnecessary increased to approximately 67 percent for claims between the 13th and 24th visit during a calendar year and 100 percent for claims beyond the 24th visit. Combined with our present findings, these results indicate that the greater the number of visits after the initial visit, the greater the likelihood that a claim will be for maintenance therapy. However, chiropractic claims lack an indicator to reflect which visits are the initial visits for treatment episodes.

The initial visit for treatment episodes may not always be a beneficiary’s first visit to a chiropractor. A beneficiary may experience a recurrence or an exacerbation of a previously treated condition that may necessitate the start of a new treatment episode.²⁶ One reviewer explained, “Because Medicare covers patients that are predominantly 65 years or older, the chiropractor is often faced with chronic or recurrent conditions. The AT modifier, when applied appropriately,

²⁶ According to carriers’ local coverage determinations, a recurrence is a return of symptoms from a previously treated condition that has been quiescent for 30 or more days. An exacerbation is a temporary, marked deterioration of the patient’s condition because of an acute flareup of the condition being treated.

FINDINGS

should indicate expectation of functional improvement, regardless of the [chronic nature] or redundancy of the problem.”

Currently, the expectation of functional improvement can be determined only from a complete medical review of the treatment episode. In contrast, the CERT paid claims error rate used by CMS is based on a review of a single claim, which limits its ability to detect maintenance therapy and may underestimate errors in claims for chiropractic services.

Chiropractors often do not comply with the Manual documentation requirements

Separate from the completely undocumented claims previously discussed as errors in the first

finding of this study, 83 percent of chiropractic claims failed to meet one or more of the documentation requirements. Consequently, the appropriate use of the AT modifier could not be definitively determined through medical review for 9 percent of sampled claims, representing \$39 million. See Table 3 for summary information regarding the extent to which records for the sampled claims did not meet the documentation requirements for initial visits and subsequent visits and Appendix B for detailed information regarding specific documentation requirements not met for sampled claims.

Table 3: Documentation Errors

Documentation Requirements Not Present in Record	Percentage
Initial Visit	
1. Subluxation demonstrated by x-ray or physical exam	11
2. Diagnosis of subluxation	13
3. Complete patient history	70
4. Complete description of present illness	66
5. Complete treatment plan	63
Subsequent Visits	
1. Complete patient history	29
2. Complete physical exam	43
3. Documentation of treatment provided	15

Source: OIG medical review of year 2006 services by practicing chiropractors, 2008.

F I N D I N G S

Chiropractors provided documentation that varied widely.

Documentation provided by chiropractors ranged from comprehensive standardized forms to “travel cards,” which include no more than simple checkboxes.²⁷ At times, handwritten notes were illegible and computer-generated notes were unchanged from one visit to the next.

Carrier staff indicated that documentation for chiropractic claims was poor. Staff at one carrier stated, “Several providers blatantly tell us that they don’t have time to document the way we want.” Staff at another carrier stated that chiropractors do not agree with documentation requirements and believe them to be too time consuming.

Documentation for treatment plans was insufficient

The medical reviewers indicated that treatment plans are an important element in determining whether the chiropractic treatment was active/corrective in achieving specified goals. The goal may change throughout the treatment episode, but it should be documented in the medical record to demonstrate active/corrective treatment. Of the 76 percent of records that reviewers indicated contained some form of treatment plan, 43 percent lacked treatment goals, 17 percent lacked objective measures, and 15 percent lacked the recommended level of care. A staff member from one carrier explained that:

When reviewing a specific service, we often don’t get a treatment plan if it was created at the first visit for the episode-this is no more than what we ask from [medical doctors]. The general trend is that [the patient will] be treated for several months, three to four times per month, but there’s no documentation of a treatment plan or any goals.

One of the medical reviewers explained that it is common for chiropractors to have treatment plans that include frequency, duration, and goals but that these treatment plans often are verbal and consequently not always documented. Another medical reviewer indicated, “In my 29 years of practice, I rarely saw documentation of a plan which included frequency, duration, goals, and objective measures. While these guidelines are in the [Medicare] Manual, they apparently have not been incorporated into the profession.”

²⁷ See Appendix C for examples of documentation for chiropractic services.



R E C O M M E N D A T I O N S

Medicare continues to pay inappropriately for maintenance therapy despite acknowledging this vulnerability in response to previous OIG work and subsequent efforts aimed at prevention. In 2006, Medicare inappropriately paid \$178 million for chiropractic claims, representing 47 percent of all allowed chiropractic claims that met the study criteria. Claims for maintenance therapy accounted for \$157 million of these inappropriately paid claims. Efforts to prevent inappropriate payments for maintenance therapy have been largely ineffective, and the lack of initial visit dates in claims data hinders the ability to identify maintenance therapy. The expectation of functional improvement can be determined only from a complete medical review of the treatment episode. In contrast, the CERT paid claims error rate used by CMS is based on a review of a single claim, which limits its ability to detect maintenance therapy and may underestimate errors in claims for chiropractic services. Further, chiropractors often do not comply with the Manual documentation requirements.

Therefore, we recommend that CMS:

Implement and Enforce Policies To Prevent Future Payments for Maintenance Therapy

CMS can achieve this through implementing (1) a new modifier for chiropractic claims to indicate the start of a new treatment episode so that carriers/Medicare Administrative Contractors (MAC) can identify aberrant treatment patterns through claims data and/or (2) a cap on allowed chiropractic claims based on recommendations from a consortium of clinical providers.

Review Treatment Episodes Rather Than Individual Chiropractic Claims To Strengthen the Ability of the CERT To Detect Errors in Chiropractic Claims

CMS should consider expanding the CERT review from a single sampled claim to a treatment episode that includes all claims from the initial visit to the sampled claim for a sample of (1) all chiropractic claims or (2) chiropractic claims for beneficiaries receiving 12 or more services per year because of their increased vulnerability. Under this review, CMS would continue to sample claims in the current CERT process but would also request associated claims before the sampled claims to augment the medical review.

R E C O M M E N D A T I O N S

Ensure That Chiropractic Claims Are Not Paid Unless Documentation Requirements Are Met

CMS can achieve this by requiring carriers/MACs to (1) withhold payment on reviewed claims when required documentation is absent or (2) perform prepayment review of claims from chiropractors who repeatedly fail to meet documentation requirements.

Take Appropriate Action Regarding the Undocumented, Medically Unnecessary, and Miscoded Claims Identified in Our Sample

We will forward information on these claims to CMS in a separate memorandum.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the report, CMS agreed with the second recommendation and described actions it would take to address the fourth recommendation. CMS did not indicate agreement or disagreement with the first and third recommendations.

In response to the second recommendation, CMS indicated that it recently began reviewing 6 months of claims prior to sampled claims in response to a recommendation from a prior OIG report. The CERT program reported an increased error rate from 8.9 percent in 2005 to 15.3 percent in 2006 because of this change. However, this new process allows for the review of claims only up to 6 months prior to sampled claims and may not include the entire chiropractic treatment episode. CMS indicated it would have to conduct a cost-benefit analysis to determine the utility of expanding this review to include claims beginning with the first claim of the treatment episode. CMS indicated that expanding the review would cost an additional \$150,000–\$200,000 and would increase the burden on providers, who would need to furnish additional medical documentation. We encourage CMS to conduct this analysis because the intent of CERT is to determine error rates, identify programs at risk, and prevent future overpayments. OIG has repeatedly found overpayments for maintenance therapy.

In response to the fourth recommendation, CMS stated that it would instruct the contractors to take any necessary corrective actions with respect to the sampled claims that this study identified in error.

In response to the first recommendation, CMS indicated that the objective data required to impose a national cap on the number of

R E C O M M E N D A T I O N S

chiropractic services does not currently exist. CMS stated that it will review any research studies as they become available. CMS also stated it will consider implementing an additional modifier after it works through the policy and operational implications. We encourage CMS to ensure that such studies and policy reviews are conducted.

In response to the third recommendation, CMS described the current process contractors use to review provider claims with a greater likelihood of payment error. However, CMS indicated no change in future practice to prevent claims without required documentation from being paid in error.

We ask that in its final management decision, CMS more clearly indicate whether it concurs with our first and third recommendations and what steps, if any, it will take to implement them.

The full text of CMS's comments can be found in Appendix D.

A P P E N D I X ~ A

Table A-1: Documentation Errors for Sampled Records

Documentation Requirements Not Present	n	Point Estimate (percentage)	95-Percent Confidence Interval
<i>Initial Visit</i>			
1. Subluxation demonstrated by x-ray or physical exam	188	11	7–17
2. Diagnosis of subluxation	188	13	9–19
3. Complete patient history	188	70	63–77
Any patient history	188	6	3–11
• symptoms causing patient to seek treatment	176	2	0–5
• family history, if relevant	176	2	1–6
• past health history	176	40	33–48
• mechanism of trauma	176	29	22–36
• quality and character of symptoms	176	13	8–19
• onset, duration, intensity, frequency, location, and radiation of symptoms	176	22	16–29
• aggravating or relieving factors	176	41	34–49
• prior interventions, treatments, medications, and secondary complaints	176	42	35–50
4. Complete description of present illness	188	66	59–73
Any description of present illness	188	7	4–12
• mechanism of trauma	175	29	23–36
• quality and character of symptoms	175	14	9–20
• onset, duration, intensity, frequency, location, and radiation of symptoms	175	22	16–29
• aggravating or relieving factors	175	40	33–48
• prior interventions, treatments, medications, and secondary complaints	175	43	36–51
• symptoms causing patient to seek treatment	175	2	0–5
5. Complete treatment plan	188	63	55–70
Any treatment plan	188	12	8–18
• recommended level of care	142	15	9–22
• specific treatment goals	142	43	35–52
• objective measures to evaluate effectiveness	142	17	11–24
<i>Subsequent Visits</i>			
1. Complete patient history	174	29	23–37
Any patient history	174	24	18–31
• review of chief complaint	146	7	3–12
• changes since last visit	146	9	5–15
• system review, if relevant	146	0	0–3
2. Complete physical exam	174	43	35–50
Any physical exam	174	22	16–29
• exam of area of spine involved in diagnosis	149	3	1–8
• assessment of change in patient condition since last visit	149	15	9–22
• evaluation of treatment effectiveness	149	28	21–35
3. Documentation of treatment provided	188	15	11–21

Source: Office of Inspector General (OIG) analysis of chiropractic claims data, 2008.



A P P E N D I X ~ B

Table B-1: Point Estimates and Confidence Intervals for Reported Statistics

Description	Point Estimate (n=188)	95-Percent Confidence Interval
Sampled service did not accurately reflect active/corrective treatment (dollars)	\$141,651,849	\$111,533,439–\$171,770,260
Sampled service did not accurately reflect active/corrective treatment (services)	4,217,352	3,339,500–5,095,203
Sampled service did not accurately reflect active/corrective treatment (percent)	32	26–39
Sampled service did not provide a reasonable expectation of recovery (dollars)	\$134,174,001	\$104,191,663–\$164,156,339
Sampled service did not provide a reasonable expectation of recovery (services)	3,940,804	3,078,963–4,802,645
Sampled service did not provide a reasonable expectation of recovery (percent)	30	24–37
Overlapping errors for maintenance (dollars)	\$119,136,032	\$90,389,067–\$147,882,997
Overlapping errors for maintenance (services)	3,525,983	2,692,302–4,359,663
Overlapping errors for maintenance (percent)	27	21–34
Total maintenance (dollars)	\$156,689,819	\$125,616,059–\$187,763,579
Total maintenance (services)	4,632,173	3,734,157–5,530,189
Total maintenance (percent)	36	29–43
Upcoded (dollars)	\$17,896,089	\$10,927,509–\$24,864,670
Upcoded (services)	1,728,423	1,091,748–2,365,098
Upcoded (percent)	13	8–18
Downcoded (dollars)	(6,534,821)	(\$1,876,340)–(11,193,301)
Downcoded (services)	553,095	174,622–931,569
Downcoded (percent)	4	1–7
Sampled service was coded at the wrong level (net dollars)	\$11,361,268	\$2,693,506–\$20,029,031
Sampled service was coded at the wrong level (services)	2,281,518	1,568,210–2,994,826
Sampled service was coded at the wrong level (percent)	18	12–23
Allowed claims miscoded (gross dollars)	\$79,443,841	\$53,932,302–\$104,955,380
Undocumented because of nonresponse (dollars)	\$14,078,349	\$3,667,275–\$24,489,422
Undocumented because of nonresponse (services)	483,958	128,947–838,970
Undocumented because of nonresponse (percent)	4	1–6
Undocumented because of claim lacking documentation (dollars)	\$31,626,679	\$14,572,367–\$48,680,992
Undocumented because of claim lacking documentation (services)	898,780	423,067–1,374,493
Undocumented because of claim lacking documentation (percent)	7	3–11
Total undocumented services (dollars)	\$45,705,028	\$26,193,289–\$65,216,768
Total undocumented services (services)	1,382,738	804,611–1,960,866
Total undocumented services (percent)	11	6–15

Source: Office of Inspector General (OIG) analysis of chiropractic claims data, 2008.

Table B-1: Point Estimates and Confidence Intervals for Reported Statistics, continued

Description	n	Point Estimate	95-Percent Confidence Interval
Total errors - gross (dollars)	188	\$213,756,116	\$171,388,169–\$256,124,062
Total errors - gross (services)	188	8,296,429	6,840,140–9,752,719
Total errors - gross (percent)	188	64	53–75
Overlapping errors (dollars)	188	\$35,579,928	\$17,625,483–\$53,534,373
Overlapping errors (services)	188	2,212,381	1,432,138–2,992,624
Overlapping errors (percent)	188	17	11–23
Total errors - net (dollars)	188	\$178,176,188	\$146,394,603–\$209,957,773
Total errors - net (services)	188	6,084,048	5,148,437–7,019,659
Total errors - net (percent)	188	47	40–54
Services that were maintenance at the initial visit (percent)	56*	25	14–38
Claims coded at 98941 that were upcoded (percent)	118	15	9–23
Services that remained active/corrective throughout treatment episode (percent)	181	50	43–58
Number of claims from initial visit to maintenance therapy (mean)	56*	14	9–19
Number of claims from initial visit to maintenance therapy (median)	56*	9	7–11
Appropriate use of acute treatment (AT) modifier could not be determined (percent)	181	9	5–14
Appropriate use of AT modifier could not be determined (dollars)	181	\$38,780,967	\$20,119,585–\$57,442,349
Claim failed to meet one or more of the documentation requirements (percent)	188	83	77–88
Record includes a treatment plan (percent)	188	76	69–82

Source: OIG analysis of chiropractic claims data, 2008.

*Because some treatment episodes last years, some maintenance claims were excluded because we were unable to determine when the initial visit occurred.

Figure C-1: Sample Documentation—Travel Card

YEAR '06 CARD # INITIAL VISIT 55-1-06	X-RAY ANALYSIS														
	CERVICAL					THORACIC					LUMBAR				
	Phase					Phase					Phase				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1. 5-1-06	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT
2. 5-3-06	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT
3. 5-5-06	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT
4. 5-8-06	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT
5. 5-10-06	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT
6. 5-12-06	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT
7. 5-15-06	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT
8. 5-17-06	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT
9. 5-19-06	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT
10. 5-27-06	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT
11. 5-31-06	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT
12. 5-26-06	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT	CT

Figure C-2: Sample Documentation—Standardized Form

Re: Ms. [REDACTED]
Daily Progress and Procedural Notes

DOB: [REDACTED]

HIC: [REDACTED]

July 10, 2006 - Attending Physician: [REDACTED]

SUBJECTIVE

[REDACTED] states during her appointment today that her primary complaints are as follows: The patient is afflicted by a moderate level of frequent pain with stiffness in her lower back on both sides. She is having a mild level of frequent pain with stiffness in both sides of her neck. The patient is experiencing in the right knee a moderate degree of frequent pain. In the left hip she is suffering from intermittent sharp pain. On a visual analog scale of 0 to 10 with 0 being no pain and 10 being the worst pain possible, the patient says her overall pain is a 6. She indicates that her symptoms are worse in the morning and when she is walking or standing for too long.

OBJECTIVE

The leg length evaluation confirms the right leg is 1/4 of an inch shorter than the left leg due to functional pelvic deficiency and postural compromise. A palpatory assessment of the spine and pelvic range shows the following results: Misalignment is detected with concomitant tenderness located in the left upper cervical region. Signs of tender deep paraspinal musculatures are evident overlying the right upper cervical region. Apparent subluxation is present with concomitant tender muscles located at the left lower cervical range. The presence of tender musculatures are located specific to the right lower cervical spine. Evidence of malalignment is noted with tender deep paraspinal musculatures localized to the left upper thoracic area. Pain to palpation is identified in the right upper thoracic area. The presence of malalignment is apparent together with tender muscles of the left middle thoracic range. Tenderness is detected at the right middle thoracic region. Signs of misalignment are noted together with spasm and pain to palpation located in the left lower lumbar area. The presence of tenderness is apparent at the right lower lumbar range. Malalignment is evident with associated tender deep paraspinal musculatures localized to the left and right pelvic range. The shoulder is high on the left and the hip is high on the right are noted from visual postural observation. The patient stood with anterior translation in the cervical and lumbar spine. The ranges-of-motion, consistent with clinical findings, are diminished with mild pain in the cervical spine and restricted with moderate pain in the dorsolumbar spine.

ASSESSMENT

The patient stated that she felt fine, improvement in her neck and upper back after the last visit until the last two days after doing housework, causing lower back and sacroiliac pain. Her diagnosis now is 739.5, 846.1, 739.3, 724.2 and 739.1.

PLAN

The patient's appointment frequency calls for call as needed. Her home management direction now consists of ice.

TODAY'S TREATMENT

As called for by the clinical examination, the management this session consists of a light metered force adjustment to decrease segmental dysfunction and increase mobility in the pelvis, L4, T1, T3, T7, C2, and C5. [REDACTED]

Pg-1

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: MAR 07 2009

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera
Acting Administrator *Charlene Frizzera*

SUBJECT: Office of Inspector General (OIG) Draft Report: "Inappropriate Medicare Payments for Chiropractic Services," (OEI-07-07-00390)

Thank you for the opportunity to comment on the OIG draft report entitled, "Inappropriate Medicare Payments for Chiropractic Services." The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources the OIG has invested to research and report on this issue. Based on a 2005 OIG report on this same topic, CMS is pleased to report that we made appropriate changes to the current claims processing operations to review claims during the episode of care, specifically with the Comprehensive Error Rate Testing (CERT) program. Per your 2005 recommendation to help CMS identify claims for non-covered maintenance therapy CERT has been reviewing 6 months of claims data associated with each sampled chiropractic claim giving CMS a better view of the episode of care. This change to our claims process has been worthwhile and has helped us to identify inappropriate billings for maintenance therapy. While we concur with your current recommendation to expand this 6 month review to the entire treatment episode back to the initial visit to help identify other potentially inappropriate claims for maintenance therapy, we want to analyze the costs and benefits before we fully implement the recommendation in the most recent report.

OIG Recommendation

Implement and enforce policies to prevent future payments for maintenance therapy by implementing a cap on all chiropractic claims based on recommendations from a consortium of clinical providers and developing a new modifier.

CMS Response

The OIG recommends that CMS implement a cap on allowed chiropractic claims based on recommendations from a consortium of clinical providers. CMS would need objective data and studies in order to impose a national cap on the number of sessions a chiropractor could provide to a Medicare beneficiary. Although we do not believe

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sufficient studies or data currently exist, CMS will continue to review any such research studies as they become available.

The OIG also recommends that CMS develop a new modifier for providers to use to report to CMS that a different episode of care is beginning. We appreciate the suggestion and are working through the policy and operational implications of requiring an additional modifier and will consider implementing it if it is feasible.

OIG Recommendation

Review entire treatment episodes rather than individual chiropractic claims to strengthen the ability of the CERT to detect errors in chiropractic claims.

CMS Response

As we noted earlier, the CMS agrees with OIG's recommendation that the CERT contractor should review medical records that precede the service date of the chiropractic claim being reviewed to look for possible non-covered maintenance therapy. For several months now, the CERT contractor has been reviewing 6 months of medical records for each chiropractic claim included in the CERT sample looking to be sure that the sampled claim could not be considered a maintenance visit. CERT considers claims that are maintenance visits to be errors.

This change was implemented in response to the OIG's June 2005 report, which looked at chiropractic claims submitted in 2001. After CMS consulted with its contractors and the chiropractic associations, CMS determined that a review of 6 months of medical records would provide sufficient information to determine if the service billed was maintenance therapy. In fact, as a result of your recommendation and the implementation of the 6 month requirement, the CERT program reported an increase in the errors for chiropractic claims. From 2005 to 2006, the chiropractic claims error rate increased from 8.9 percent to 15.3 percent.

Again, while we concur that a full review of the entire treatment episode would further help identify potential errors, expanding the CERT review to include the initial claim would require additional funding. Based on our research, it would cost the CERT program an additional \$150,000-\$200,000 per year to expand our reviews of chiropractic episodes from 6 to 12 months and more if we were to include the beginning of the episode. In addition, CMS would have to consider the burden on the providers to furnish additional medical documentation. CMS would have to conduct a cost benefit analysis of expanding the review.

OIG Recommendation

Ensure that chiropractic claims are not paid unless documentation requirements are met.

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CMS Response

Based on data analysis, contractors identify providers that have a likelihood of a sustained or high level of payment error. For those providers, the contractor will review the provider's claims based on the contractor's medical review strategy. When performing this review, contractors may collect documentation, such as claims information, related to the patient's condition before and after the service in order to get a more complete picture of the patient's clinical condition.

In accordance with current practice, a provider's claims that are reviewed before the claim is paid will not receive payment until the contractor receives sufficient documentation to determine that payment should be made. Since a lack of sufficient documentation often causes an increase in the provider's denied claims, the likelihood increases that the provider may be selected for further review. Delaying payment indefinitely while waiting for all requested documentation would prevent the contractor from processing the claims in a timely manner.

OIG Recommendation

Take appropriate corrective action regarding the undocumented, medically unnecessary, and miscoded claims in our sample.

CMS Response

We will advise our contractors to continue to emphasize that appropriate documentation must be maintained. We will inform our contractors of the findings in this OIG report and request that they include the information contained in this report as part of the data they consider when prioritizing their strategies. In addition, the contractors will be instructed to take any necessary corrective actions, including determining overpayments, when appropriate.

The CMS thanks the OIG for its efforts on this report and for highlighting this potential vulnerability in the Medicare program. CMS is committed to continually reviewing and refining our processes to improve the Medicare program, and we will take the findings of this report under consideration as we continue to strengthen our oversight efforts to further reduce improper payments in the Medicare program. We look forward to continuing to work with the OIG to identify and prevent fraud, waste, and abuse in the Medicare program.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Brian Whitley served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Kansas City regional office who contributed to the report include Michael Barrett, Megan Buck, and Julie Dusold; central office staff who contributed include Rob Gibbons and Kevin Manley.