

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**DIEP CHIROPRACTIC WELLNESS, INC.,
RECEIVED UNALLOWABLE
MEDICARE PAYMENTS FOR
CHIROPRACTIC SERVICES**

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November 2013
A-09-12-02072

Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

Diep Chiropractic Wellness received at least \$708,000 over 2 years for chiropractic services that were not allowable in accordance with Medicare requirements.

WHY WE DID THIS REVIEW

In calendar years (CYs) 2010 and 2011, Medicare allowed for payment approximately \$1.4 billion for chiropractic services provided to Medicare beneficiaries nationwide. A previous Office of Inspector General review found that in 2006, Medicare inappropriately paid an estimated \$178 million (of the \$466 million reviewed) for chiropractic services that were medically unnecessary, incorrectly coded, or undocumented. After analyzing Medicare claim data for CYs 2010 and 2011, we selected multiple providers for review, including a chiropractor (selected chiropractor) who owned Diep Chiropractic Wellness, Inc. (Diep Chiropractic), in El Monte, California. Our analysis indicated that the selected chiropractor was among the five chiropractors who received the most in Medicare payments nationwide.

Our objective was to determine whether chiropractic services billed by the selected chiropractor were allowable in accordance with Medicare requirements.

BACKGROUND

Medicare covers chiropractic services provided by a qualified chiropractor. Medicare requires that these services be reasonable and necessary for the treatment of a beneficiary's illness or injury. Medicare limits coverage of chiropractic services to manual manipulation of the spine to correct a subluxation (when spinal bones lose their normal position). To receive payment from Medicare, a chiropractor must document the services as required by the Centers for Medicare & Medicaid Services' *Medicare Benefit Policy Manual* and the applicable Local Coverage Determination for chiropractic services. In addition, depending on the number of spinal regions treated, chiropractors may bill Medicare for chiropractic manipulative treatment using one of three procedure codes.

HOW WE CONDUCTED THIS REVIEW

For CYs 2010 and 2011, Diep Chiropractic received Medicare Part B payments of \$879,658 for 23,714 chiropractic services provided to Medicare beneficiaries by the selected chiropractor. We reviewed a random sample of 100 chiropractic services. We provided copies of medical records for these services to a medical review contractor to determine whether the services were allowable in accordance with Medicare requirements.

WHAT WE FOUND

Of the 100 sampled chiropractic services, 7 services were allowable in accordance with Medicare requirements. The remaining 93 services were not allowable: 70 were medically unnecessary, 11 were incorrectly coded, 9 were undocumented, and 3 were insufficiently documented. As a result, Diep Chiropractic received \$3,196 in unallowable Medicare payments.

On the basis of our sample results, we estimated that at least \$708,022 of the \$879,658 paid to Diep Chiropractic for chiropractic services, or approximately 80 percent of the total amount paid, was unallowable for Medicare reimbursement. These overpayments occurred because Diep Chiropractic did not have adequate policies and procedures to ensure that chiropractic services billed to Medicare were medically necessary, correctly coded, and adequately documented.

WHAT WE RECOMMEND

We recommend that Diep Chiropractic:

- refund \$708,022 to the Federal Government and
- establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, correctly coded, and adequately documented.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, Diep Chiropractic did not concur with our first recommendation. Diep Chiropractic concurred that some of its medical documentation was fragmented and provided information on actions that it had taken or planned to take to address the portion of our second recommendation related to inadequate documentation. However, regarding the remainder of our second recommendation, Diep Chiropractic disputed that any of the services in our review were medically unnecessary or incorrectly coded.

After reviewing Diep Chiropractic's comments, we maintain that our findings and recommendations are valid.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective	1
Background	1
Administration of the Medicare Program	1
Chiropractic Services	1
Medicare Coverage of Chiropractic Services	2
Diep Chiropractic and the Selected Chiropractor	3
How We Conducted This Review.....	4
FINDINGS	5
Chiropractic Services Were Not Allowable in Accordance With Medicare Requirements	5
Services Were Medically Unnecessary.....	5
Services Were Incorrectly Coded	6
Services Were Undocumented.....	6
Services Were Insufficiently Documented	8
Diep Chiropractic Received Unallowable Medicare Payments.....	8
Diep Chiropractic Did Not Have Adequate Policies and Procedures	9
RECOMMENDATIONS	9
AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE.....	9
Auditee Comments.....	10
Office of Inspector General Response	11
APPENDIXES	
A: Audit Scope and Methodology	12
B: Statistical Sampling Methodology	14
C: Sample Results and Estimates.....	15
D: Medicare Reimbursement Requirements for Chiropractic Services.....	16
E: Auditee Comments	18

INTRODUCTION

WHY WE DID THIS REVIEW

In calendar years (CYs) 2010 and 2011, Medicare allowed for payment approximately \$1.4 billion for chiropractic services provided to Medicare beneficiaries nationwide. A previous Office of Inspector General (OIG) review found that in 2006, Medicare inappropriately paid an estimated \$178 million (of the \$466 million reviewed) for chiropractic services that were medically unnecessary, incorrectly coded, or undocumented.¹ After analyzing Medicare claim data for CYs 2010 and 2011, we selected multiple providers for review, including a chiropractor (selected chiropractor) who owned Diep Chiropractic Wellness, Inc. (Diep Chiropractic), in El Monte, California. Our analysis indicated that the selected chiropractor was among the five chiropractors who received the most in Medicare payments nationwide.

OBJECTIVE

Our objective was to determine whether chiropractic services billed by the selected chiropractor were allowable in accordance with Medicare requirements.

BACKGROUND

Administration of the Medicare Program

The Medicare program provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Part B covers a multitude of medical and other health services, including chiropractic services. Medicare Administrative Contractors (MACs) contract with CMS to process and pay Part B claims. Palmetto GBA, LLC (Palmetto), was the MAC that processed and paid the Medicare claims submitted by Diep Chiropractic.

Chiropractic Services

Chiropractic services focus on the body's main structures—the skeleton, the muscles, and the nerves. Chiropractors make adjustments to these structures, particularly the spinal column. They do not prescribe drugs or perform surgical procedures, although they refer patients for these services if they are medically indicated. Most patients seek chiropractic care for back pain, neck pain, and joint problems.

The most common therapeutic procedure performed by chiropractors is known as spinal manipulation, also called chiropractic adjustment. The purpose of spinal manipulation is to restore joint mobility by manually applying a controlled force into joints that have become restricted in their movement as a result of a tissue injury. When other medical conditions exist, chiropractic care may complement or support medical treatment.

¹ *Inappropriate Medicare Payments for Chiropractic Services* (OEI-07-07-00390), issued May 2009.

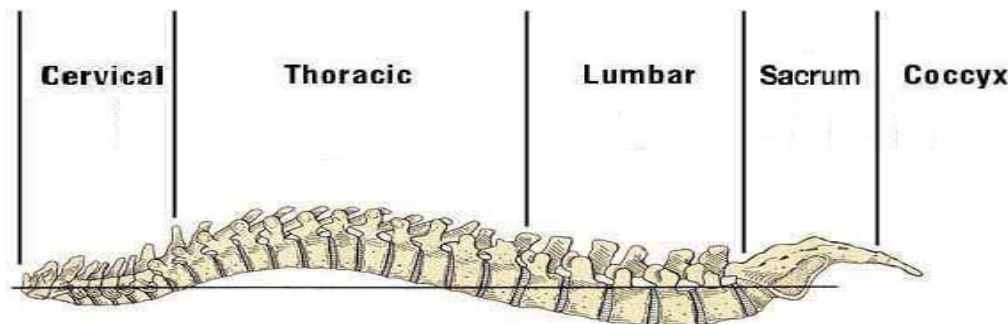
Medicare Coverage of Chiropractic Services

Medicare Part B covers chiropractic services provided by a qualified chiropractor. To provide such services, a chiropractor must be licensed or legally authorized by the State or jurisdiction in which the services are provided.²

Medicare requires that chiropractic services be reasonable and necessary for the treatment of a beneficiary's illness or injury, and Medicare limits coverage of chiropractic services to manual manipulation (i.e., by using the hands) of the spine to correct a subluxation.³ Chiropractors may also use manual devices to manipulate the spine.

To substantiate a claim for manipulation of the spine, the chiropractor must specify the precise level of subluxation.⁴ Depending on the number of spinal regions treated, chiropractors may bill Medicare for chiropractic manipulative treatment using one of three Current Procedural Terminology (CPT)⁵ codes: 98940 (for treatment of one to two regions), 98941 (for treatment of three to four regions), and 98942 (for treatment of five regions). The CPT code for extraspinal chiropractic manipulative treatment (98943) is not covered by Medicare. Figure 1 illustrates the five regions of the spine, from the cervical area (neck) to the coccyx (tailbone).

Figure 1: The Five Regions of the Spine



² CMS's *Medicare Benefit Policy Manual*, Pub. 100-02 (the Manual), chapter 15, § 30.5.

³ The Manual 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" (chapter 15, § 240.1.2).

⁴ The Manual, chapter 15, § 240.1.4, and Palmetto's Local Coverage Determination (LCD) for chiropractic services (L28249).

⁵ CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures provided by physicians and other health care professionals.

Medicare requires chiropractors to place the AT (Acute Treatment) modifier on a claim when providing active/corrective treatment for subluxation.⁶ Because Medicare considers claims without the AT modifier to be claims for services that are maintenance therapy, it will deny these claims.⁷ However, inclusion of the AT modifier does not always indicate that the service provided was reasonable and necessary.

To receive payment from Medicare, a chiropractor must document the services provided during the initial and subsequent visits as required by the Manual and the applicable MAC's LCD for chiropractic services. Medicare pays the beneficiary or the chiropractor the amount allowed for payment according to the physician fee schedule, less the beneficiary share (i.e., deductibles and coinsurance).

Diep Chiropractic and the Selected Chiropractor

Diep Chiropractic was established in May 2007 and is located in El Monte, California. The selected chiropractor is the sole owner of the company, has been a licensed chiropractor in California since May 2001, and has provided chiropractic services in El Monte since 2003.

During CYs 2010 and 2011, Diep Chiropractic employed three chiropractors. These three chiropractors and the selected chiropractor provided chiropractic services to their patients, and Diep Chiropractic billed Medicare for those services. The claim data that we reviewed identified the selected chiropractor as the performing provider for most of the services billed by Diep Chiropractic for CYs 2010 and 2011.⁸

The Medicare claim data also showed that all of the chiropractic services provided by the selected chiropractor were billed with the AT modifier. Further, the majority (82 percent) of the services were billed with CPT code 98942, which had the highest physician fee schedule amount among the three CPT codes covered by Medicare for chiropractic services. Figure 2 on the following page illustrates the percentage of services for each CPT code that the selected chiropractor billed to Medicare for CYs 2010 and 2011.

⁶ A modifier is a two-character code reported with a CPT code and is designed to give Medicare and commercial payers additional information needed to process a claim.

⁷ Maintenance therapy includes services that seek to prevent disease, promote health, and prolong and enhance the quality of life or to maintain or prevent deterioration of a chronic condition (Palmetto's LCD L28249).

⁸ Because the claim data identified the selected chiropractor as the performing provider for all of the CY 2010 claims and 87 percent of the CY 2011 claims, we focused our review on services provided by the selected chiropractor.

Figure 2: Percentage of Services by CPT Code for CYs 2010 and 2011

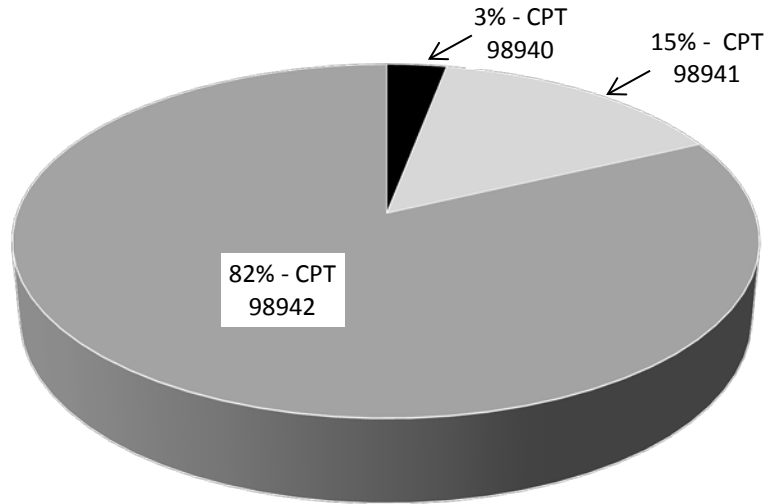


Table 1 shows the allowed amount on the Medicare fee schedule for each CPT code during CYs 2010 and 2011 for Southern California, where Diep Chiropractic was located.

Table 1: Medicare-Allowed Amount for Each CPT Code for Chiropractic Services

Period	CPT 98940	CPT 98941	CPT 98942
January 1 – May 31, 2010	\$26.81	\$37.05	\$48.19
June 1 – December 31, 2010	27.40	37.87	49.24
January 1 – December 31, 2011	27.59	37.83	48.70

HOW WE CONDUCTED THIS REVIEW

For CYs 2010 and 2011, Diep Chiropractic received Medicare Part B payments of \$879,658 for 23,714 chiropractic services provided to Medicare beneficiaries by the selected chiropractor. We reviewed a random sample of 100 chiropractic service line items. (A service line item represented a chiropractic service included on a claim.) The selected chiropractor provided us with copies of medical records as support for these services.⁹ We provided those copies to a medical review contractor to determine whether the 100 chiropractic services were allowable in accordance with Medicare requirements. We also interviewed seven judgmentally selected beneficiaries to obtain an understanding of the services provided to them at Diep Chiropractic.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

⁹ Although we selected 100 services that, on the basis of the claim data, appeared to have been provided by the selected chiropractor, the medical records showed that 77 had been provided by the selected chiropractor, 14 had been provided by 1 of the 3 other chiropractors, and 9 lacked documentation identifying who had provided the services.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains the details of our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D contains details on the Medicare reimbursement requirements for chiropractic services.

FINDINGS

Of the 100 sampled chiropractic services, 7 services were allowable in accordance with Medicare requirements. The remaining 93 services were not allowable: 70 were medically unnecessary, 11 were incorrectly coded, 9 were undocumented, and 3 were insufficiently documented. As a result, Diep Chiropractic received \$3,196 in unallowable Medicare payments.

On the basis of our sample results, we estimated that at least \$708,022 of the \$879,658 paid to Diep Chiropractic for chiropractic services, or approximately 80 percent of the total amount paid, was unallowable for Medicare reimbursement. These overpayments occurred because Diep Chiropractic did not have adequate policies and procedures to ensure that chiropractic services billed to Medicare were medically necessary, correctly coded, and adequately documented.

CHIROPRACTIC SERVICES WERE NOT ALLOWABLE IN ACCORDANCE WITH MEDICARE REQUIREMENTS

Services Were Medically Unnecessary

The Social Security Act (the Act) states that no payment may be made for any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (§ 1862(a)). Federal regulations state that Medicare Part B pays for a chiropractor's manual manipulation of the spine to correct a subluxation only if the subluxation has resulted in a neuromusculoskeletal condition for which manual manipulation is appropriate treatment (42 CFR § 410.21(b)).

The Manual states that (1) chiropractic maintenance therapy is not considered to be medically reasonable or necessary and is therefore not payable (chapter 15, § 30.5(B)); (2) the manipulative services provided must have a direct therapeutic relationship to the patient's condition, and the patient must have a subluxation of the spine (chapter 15, § 240.1.3); and (3) the chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration of the condition within a reasonable and generally predictable period of time (chapter 15, § 240.1.5).

Of the 100 sampled chiropractic services, 70 were medically unnecessary. The results of the medical review indicated that these services did not meet one or more Medicare requirements:¹⁰

- Subluxation of the spine was not present or was not treated or both (56 services).

¹⁰ The total exceeds 70 because 67 of the 70 services did not meet more than one Medicare requirement.

- Manual manipulation of the spinal subluxation was maintenance therapy or was not appropriate for treatment of the patient's condition or both (67 services).
- Manual manipulation of the spinal subluxation would not be expected to result in improvement within a reasonable and generally predictable period of time (69 services).

For example, Diep Chiropractic received payment for a chiropractic service provided on December 29, 2010, to a 74-year-old Medicare beneficiary. The medical review contractor determined that the medical records did not support the medical necessity of the service because manual manipulation of the spinal subluxation would not be expected to result in improvement within a reasonable and predictable length of time. This beneficiary received 47 chiropractic services during CYs 2010 and 2011.

Services Were Incorrectly Coded

Depending on the number of spinal regions treated, chiropractors may bill Medicare for chiropractic manipulative treatment using CPT codes 98940, 98941, or 98942 (Palmetto's LCD L28249).

Of the 100 sampled chiropractic services, 11 were incorrectly coded. The claims for these services were billed with a CPT code related to treatment of more spinal regions than what the medical records supported. Most of these services were billed using CPT code 98942, the code with the highest fee schedule amount.¹¹

For example, Diep Chiropractic billed for a chiropractic service provided on December 21, 2011, with CPT code 98942, indicating that five regions of the spine had been treated; however, the documentation in the medical records supported that only two regions had been treated. The medical review contractor stated that the service should have been claimed using CPT code 98940 (for treatment of one to two regions). For CY 2011, the allowed amounts on the Medicare fee schedule for CPT codes 98942 and 98940 were \$48.70 (with the paid amount of \$38.96) and \$27.59 (with the paid amount of \$22.07), respectively. The difference in the paid amounts was \$16.89 and was unallowable for Medicare reimbursement.

Services Were Undocumented

The Act states that no payment may be made to any provider of services unless information has been furnished to determine the amounts due the provider (§ 1833(e)).

The Manual and Palmetto's LCD L28249 require chiropractors to document the services provided to Medicare beneficiaries.

Of the 100 sampled chiropractic services, 9 were undocumented. Diep Chiropractic did not have any documentation for three of these services, except for patient sign-in logs indicating that the

¹¹ To calculate the unallowable amount for each service, we used the difference between the amount paid to the provider and the amount that should have been paid to the provider. The paid amount is equal to the allowed amount, less the beneficiary share (i.e., deductibles and coinsurance).

beneficiaries were in the office on the dates of service. For the remaining six services, documentation in the medical records included the date and the beneficiary's signature but not the specific services provided. For one of these services, the documentation also included the chiropractor's signature.

For example, Diep Chiropractic received payment for a chiropractic service provided on December 22, 2010, to a Medicare beneficiary during a subsequent visit.¹² Diep Chiropractic provided documentation with only the beneficiary's and chiropractor's signatures (Figure 3). It did not provide any other evidence of treatment.

Figure 3: Example of an Undocumented Subsequent Visit¹³

DOB: _____ M / F Dx: _____

DEC 21 2010 DEC 22 2010

Chief Complaints

☐ Standing ☐ Walking
☐ Sitting ☐ Driving
☐ Personal Care ☐ Sleep
☐ Lifting ☐ Recreation
☐ Concentration ☐ Work

Objective Findings

Tenderness: _____

Restriction Level _____

ROM Flexion ☐ C/S ☐ L/S _____
 ROM Extension ☐ C/S ☐ L/S _____

Progress as expected, continue the same care
 Progress not as expected, modify care
 x /week, re-exam on / /

Treatment

☐ Traction ☐ C/S ☐ L/S _____ lbs 15"
☐ ES ☐ HIP
☐ US ☐ IF ☐ Parafin
☐ Therap Exercise ☐ Neuro Ms Re-edu 15"
☐ MRT
☐ CMT

Precaution/Comments: _____

Patient's Signature _____
 Physician's Signature _____

Pain scale: 0-10 →=Same ↗=Slightly increase ↑=Significantly increase ↘=Slightly decrease ↓=Signif

The medical review contractor stated: “The only entries for this date of service are the date stamp itself and the [beneficiary’s] and chiropractor’s signatures. This does not support the existence of spinal subluxation on that date or that manual manipulation was performed.”

¹² During CYs 2010 and 2011, Diep Chiropractic received a total of \$2,729 for 70 chiropractic services provided to this beneficiary.

¹³ The beneficiary’s and physician’s signatures have been redacted.

Services Were Insufficiently Documented

The Manual and Palmetto's LCD require that the initial visit and all subsequent visits to the chiropractor meet specific documentation requirements. See Appendix D for the initial visit documentation requirements. The following must be documented for subsequent visits: (1) patient history, including a review of the chief complaint, changes since the last visit, and a system review if relevant;¹⁴ (2) physical examination of the area of the spine involved in the diagnosis, an assessment of change in the patient's condition since the last visit, and an evaluation of treatment effectiveness; and (3) the treatment given on the day of the visit (the Manual, chapter 15, § 240.1.2(B), and LCD L28249).

Of the 100 sampled chiropractic services, 3 were insufficiently documented for subsequent chiropractic visits. The medical review contractor determined that the medical records for the three subsequent visits did not meet the documentation requirements as specified in the Manual and Palmetto's LCD L28249.

For example, Diep Chiropractic received payment for a chiropractic service provided on January 24, 2011, to a Medicare beneficiary.¹⁵ The medical review contractor stated:

From the [medical] chart, there is again failure to follow the guideline requested by Medicare for all subsequent office visits. ... The note for 1/24/2011 does not contain all of the following three elements and their components: History (chief complaint, changes since prior visit, and system review if relevant) and physical examination (exam of area of spine involved, assessment of changes, evaluation of treatment effect), and treatment given on date of visit. All elements are missing.

The medical review contractor also stated that this service "did not meet Medicare coverage criteria."

DIEP CHIROPRACTIC RECEIVED UNALLOWABLE MEDICARE PAYMENTS

Diep Chiropractic received \$3,196 in unallowable Medicare payments for the 93 chiropractic services that did not meet Medicare requirements. On the basis of our sample results, we estimated that at least \$708,022 of the \$879,658 paid to Diep Chiropractic for chiropractic services, or approximately 80 percent of the total amount paid, was unallowable for Medicare reimbursement.

¹⁴ A system review is an inventory of body systems that the chiropractor obtains by asking the patient a series of questions to identify signs or symptoms that the patient may be experiencing or has experienced.

¹⁵ During CYs 2010 and 2011, Diep Chiropractic received a total of \$878 for 32 chiropractic services provided to this beneficiary.

DIEP CHIROPRACTIC DID NOT HAVE ADEQUATE POLICIES AND PROCEDURES

The overpayments occurred because Diep Chiropractic did not have adequate policies and procedures to ensure that chiropractic services provided to Medicare beneficiaries and billed to Medicare were medically necessary, correctly coded, and adequately documented. The selected chiropractor stated that Diep Chiropractic did not have written policies and procedures and used Palmetto's LCD L28249 to obtain information on how to document and bill for chiropractic services.

The selected chiropractor also stated that he and other chiropractors at Diep Chiropractic provided only active and corrective treatment to patients. Therefore, Diep Chiropractic submitted all Medicare claims with the AT modifier. However, the Manual and Palmetto's LCD L28249 specifically state that inclusion of the AT modifier on a claim does not always indicate that the service was medically necessary.

Diep Chiropractic had an in-house biller who was responsible for submitting each Medicare claim on the basis of information contained in a record referred to as a "superbill."¹⁶ Before billing Medicare, the biller compared the superbill with the patient sign-in log but not the medical record. If the service provided was different from the service provided on a previous visit, the chiropractor had to indicate on the superbill the CPT code that should be billed. Otherwise, the staff used the same CPT code that had previously been used to bill Medicare.

The selected chiropractor stated that he reviewed selected medical records at random to ensure that chiropractic services were documented in accordance with the LCD's requirements. However, it was unclear how often he conducted these reviews because there was no specific review schedule or documentation of his reviews.

RECOMMENDATIONS

We recommend that Diep Chiropractic:

- refund \$708,022 to the Federal Government and
- establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, correctly coded, and adequately documented.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Diep Chiropractic did not concur with our first recommendation. Diep Chiropractic concurred that some of its medical documentation was fragmented and provided information on actions that it had taken or planned to take to address the portion of our second recommendation related to inadequate documentation. However, regarding the remainder of our second recommendation, Diep Chiropractic disputed that any of

¹⁶ A superbill is an itemized form that some health care providers use to show which services were provided. A superbill is the main data source for creating a health care claim.

the services in our review were medically unnecessary or incorrectly coded. Diep Chiropractic's comments are included in their entirety as Appendix E.

AUDITEE COMMENTS

In response to our first recommendation to refund \$708,022 to the Federal Government, Diep Chiropractic had the following comments:

- Diep Chiropractic stated that our conclusions were based on a “limited sample” and that our findings were applied to all services provided in 2010 and 2011 “despite the relatively small statistical sample used.”
- Diep Chiropractic stated that the 70 services were medically necessary because (1) although the records may be fragmented, the combined medical records demonstrate that each patient was properly diagnosed with subluxation of the spine (by x-ray or physician's exam) and treated for subluxation of the spine and (2) a review of the entire medical record for each patient reveals that the treatment was appropriate for the patient's condition and was not maintenance therapy. Regarding our example of a patient who received 47 services over a 2-year period, Diep Chiropractic stated that the number of services alone cannot form the basis for denial of a claim and that many of its patients “had a significant diagnosis and condition that would warrant longer term care”
- Diep Chiropractic stated that the 11 services were properly coded because the records from the initial exam for each patient demonstrated that there was a proper diagnosis of all 5 spinal regions to warrant the use of CPT code 98942. Diep Chiropractic also stated that, during our audit period, it was using an “electronic charting program” that would not allow its chiropractors to enter a diagnosis for all five spinal regions and that the improperly coded services were merely clerical errors due to software limitations.
- Diep Chiropractic stated that the nine undocumented services were related to inadequate documentation, which it addressed in its response to our last finding about three insufficiently documented services, and did not represent fraudulent or false claims.
- Diep Chiropractic stated that the three insufficiently documented services had documentation that “may be fragmented” but that most of the records clearly showed an improvement of the patient's condition over time. Diep Chiropractic also stated that in “some instances, the element that was missing or that would need correction was relatively minor.”

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Diep Chiropractic's comments, we maintain that our findings and recommendations are valid. Our responses to Diep Chiropractic's comments are as follows:

- OIG used a sample size of 100, and the Departmental Appeals Board and Federal courts have upheld samples that are relatively small in comparison to their population sizes.¹⁷ Moreover, OIG recommends recovery at the lower limit of the confidence interval, which benefits the auditee. We fully disclosed the lower and upper limits of the confidence interval in Appendix C.
- The medical review contractor found that the 70 services were medically unnecessary on the basis of its review of all the medical records provided by Diep Chiropractic for each sampled service. The medical records included, but were not limited to, initial and subsequent visit documentation, if any, for the entire course of treatment related to the sampled service.¹⁸ To ensure that Diep Chiropractic provided all supporting documentation, we requested that it review the medical records we had obtained and provide (1) additional documentation to support the sampled services or (2) a written statement indicating that the records were complete and that there was no additional documentation to provide. Diep Chiropractic responded to our request only by providing additional documentation for 92 of the 100 services. We submitted to the medical review contractor all of the medical records that Diep Chiropractic had provided to us. We based our findings on the results of the contractor's review of those records, not on the number of services provided to each beneficiary.
- The medical review contractor evaluated the medical records, including the initial visit documentation, provided by Diep Chiropractic and found that the 11 services were claimed with a CPT code related to treatment of more spinal regions than what the records supported.¹⁹ Diep Chiropractic provided handwritten documentation for 10 of these services. The remaining service had electronic documentation, which had a section listing 11 diagnoses. Therefore, the software limitation described by Diep Chiropractic was not the cause of these errors.
- For the nine services, Diep Chiropractic did not document the services provided. These services were unrelated to the three insufficiently documented services discussed in our last finding.
- For the three services, the Manual's specific documentation requirements for subsequent visits were not met.

¹⁷ See, e.g., Anghel v. Sebelius, 912 F. Supp.2d 4 (E.D.N.Y. 2012) (upholding a sample size of 95 claims).

¹⁸ The course of treatment begins with the initial visit (as documented in the Medicare claim) and includes all of the subsequent visits related to the diagnosis or treatment plan established during the initial visit.

¹⁹ Ten of these services were claimed with CPT code 98942 (for treatment of five spinal regions), and one service was claimed with CPT code 98941 (for treatment of three to four spinal regions).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For CYs 2010 and 2011, Diep Chiropractic received Medicare Part B payments of \$879,658 for 23,714 chiropractic services provided to Medicare beneficiaries by the selected chiropractor. We reviewed a random sample of 100 chiropractic services. The selected chiropractor provided us with copies of medical records as support for these services. We provided those copies to a medical review contractor to determine whether the 100 chiropractic services were allowable in accordance with Medicare requirements.

We did not review the overall internal control structure of Diep Chiropractic. Rather, we limited our review of internal controls to those that were significant to the objective of our audit.

We conducted our audit from July 2012 to March 2013 and performed fieldwork at the office of Diep Chiropractic in El Monte, California.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed CMS and Palmetto officials to obtain an understanding of Medicare reimbursement requirements and claim processing procedures for chiropractic services;
- interviewed the selected chiropractor and an employee of Diep Chiropractic, who was responsible for billing, to obtain an understanding of Diep Chiropractic's procedures for (1) providing chiropractic services to beneficiaries, (2) maintaining documentation for services, and (3) billing Medicare for services;²⁰
- obtained from the CMS's National Claims History (NCH) file the Medicare Part B claims for chiropractic services provided by the selected chiropractor, with service dates ending in CYs 2010 and 2011;
- created a sampling frame of 23,714 chiropractic services from the NCH data and randomly selected a sample of 100 services;

²⁰ During the interview with the selected chiropractor and the employee, the selected chiropractor's attorney was present. After obtaining the results from the medical review contractor, we met with the selected chiropractor and his attorney to share our findings and clarify our understanding of the policies and procedures. The attorney stated that the selected chiropractor was no longer willing to answer any of our questions. Therefore, our conclusions on Diep Chiropractic's lack of adequate policies and procedures were based on information obtained during the initial interview.

- obtained medical records and other documentation from the selected chiropractor for the 100 sampled services and provided them to the medical review contractor, who determined whether each service was allowable in accordance with Medicare requirements;
- reviewed the medical review contractor's results and categorized each sampled service determined to be unallowable as one of four error types: medically unnecessary, incorrectly coded, undocumented, or insufficiently documented;
- estimated the amount of the unallowable payments for chiropractic services; and
- shared the results of our review with the selected chiropractor.

See Appendix B for the details of our statistical sampling methodology and Appendix C for our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of chiropractic services that the selected chiropractor provided during CYs 2010 and 2011.

SAMPLING FRAME

The sampling frame consisted of 23,714 service line items for chiropractic services for CYs 2010 and 2011 for which we identified the selected chiropractor as the performing physician. Diep Chiropractic received Medicare payments of \$879,658 for these line items. A service line item represented a chiropractic service included on a claim. We obtained the claim data from CMS's NCH file, updated as of June 2012.

SAMPLE UNIT

The sample unit was a chiropractic service.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

The sample size was 100 chiropractic services.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units in the sampling frame from 1 to 23,714. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of the unallowable payments for chiropractic services.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Services	Value of Unallowable Services
23,714	\$879,658	100	\$3,716	93	\$3,196

Table 3: Estimated Value of Unallowable Services
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$757,914
Lower limit	708,022
Upper limit	807,805

APPENDIX D: MEDICARE REIMBURSEMENT REQUIREMENTS FOR CHIROPRACTIC SERVICES

Medical Necessity

The Act states: “...no payment may be made ... for any expenses incurred for items or services— (1) (A) which ... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (§ 1862(a)).

Federal regulations state: “Medicare Part B pays only for a chiropractor’s manual manipulation of the spine to correct a subluxation if the subluxation has resulted in a neuromusculoskeletal condition for which manual manipulation is appropriate treatment” (42 CFR § 410.21(b)).

The Manual states:

Under the Medicare program, Chiropractic maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable.... When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy (chapter 15, § 30.5(B)).

The Manual also states: “... the manipulative services rendered must have a direct therapeutic relationship to the patient’s condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam...” (chapter 15, § 240.1.3).

The Manual further states: “The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time” (chapter 15, § 240.1.5).

Coding

Palmetto’s LCD identifies three CPT codes that may be used to bill Medicare for chiropractic services (LCD L28249). Depending on the number of spinal regions treated, chiropractors may bill Medicare for chiropractic manipulative treatment using CPT codes 98940, 98941, or 98942.

Documentation

The Act states: “No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period” (§ 1833(e)).

The Manual requires that the initial visit and all subsequent visits meet specific documentation requirements (chapter 15, § 240.1.2).

The following must be documented for initial visits:

1. History
2. Description of the present illness including:
 - Mechanism of trauma;
 - Quality and character of symptoms/problem;
 - Onset, duration, intensity, frequency, location, and radiation of symptoms;
 - Aggravating or relieving factors;
 - Prior interventions, treatments, medications, secondary complaints; and
 - Symptoms causing patient to seek treatment.
3. Evaluation of musculoskeletal/nervous system through physical examination.
4. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.
5. Treatment Plan: The treatment plan should include the following:
 - Recommended level of care (duration and frequency of visits);
 - Specific treatment goals; and
 - Objective measures to evaluate treatment effectiveness.
6. Date of the initial treatment.

The following must be documented for subsequent visits:

1. History
 - Review of chief complaint;
 - Changes since last visit;
 - System review if relevant.
2. Physical exam
 - Exam of area of spine involved in diagnosis;
 - Assessment of change in patient condition since last visit;
 - Evaluation of treatment effectiveness.
3. Documentation of treatment given on day of visit.

APPENDIX E: AUDITEE COMMENTS



CARLSON & JAYAKUMAR LLP
ATTORNEYS AT LAW

August 15, 2013

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit services, Region IX
90-7th Street, Suite 3-650
San Francisco, CA 94103

Re: Report Number A-09-12-02072

Dear Ms. Ahlstrand,

Diep Chiropractic Wellness, Inc. ("DCW") has retained Carlson & Jayakumar LLP to represent it with respect to the Office of the Inspector General's ("OIG") Audit Report A-09-12-02072. Diep submits the following response to the OIG's draft report entitled *Diep Chiropractic Wellness, Inc., Received Unallowable Medicare Payments for Chiropractic Services*.

In the draft report, the OIG recommended that DCW:

1. Refund \$708,022 to the Federal Government; and
2. Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, correctly coded, and adequately documented.

DCW has set forth its statement of concurrence and non-concurrence below, as well as a statement of the corrective action plan taken or planned for each statement of "concurrence" as requested by the OIG.

General Comments

DCW was first notified on January 23, 2012 that the OIG intended on conducting a preliminary review of chiropractic claims. DCW has been more than cooperative and accommodating to the OIG's requests as DCW is not culpable of any fraudulent or other deceptive billing practices. Despite having no obligation to do so, DCW has voluntarily provided the OIG with interviews, information and records.

Based on the draft report, it appears that the primary issues the OIG has identified with respect to DCW relates to or stems from purported inadequate documentation. The DCW urges

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the OIG to take into account its continued cooperation with respect to this matter, as well as the information set forth below, for resolution purposes. In addition, DCW requests that the OIG take into consideration the fact that the amount of reimbursement requested from DCW would create a financial hardship for DCW and may cause it to go out of business.

DCW urges the OIG to allow DCW to move forward with a focus towards investing its resources in compliance activities. DCW has not engaged in any improper, fraudulent or unethical billing practices. DCW further requests that the OIG provide it with an opportunity to submit transcribed notes of the patient files reviewed by the OIG for clarity and fairness and to further discuss this matter once it has had the opportunity to review this response.

OIG Recommendation

Refund \$708,022 to the Federal Government.

Diep's Response

DCW does not concur with this recommendation.

The OIG conducted an audit for calendar years 2010 and 2011. The OIG states that DCW was paid \$879,658 for 23,714 chiropractic services provided to Medicare beneficiaries. The OIG conducted a review of 100 chiropractic services out of the 23,714 identified over this two-year period. Based on this limited sample, the OIG concluded that of the 100 chiropractic services sampled, only 7 services were allowable in accordance with Medicare requirements. According to the OIG, the remaining claims were deficient for one of four reasons: (1) they were medically unnecessary; (2) they were incorrectly coded; (3) they were undocumented; or (4) they were insufficiently documented.

The OIG then applied its findings based on these 100 services to all claims provided in 2010 and 2011, despite the relatively small statistical sample used in reaching such findings. DCW disagrees with the OIG's opinion that 93% of the claims were improperly paid.

I. Medical Necessity

Of the 100 services sampled, the OIG found that 70 of the services were medically unnecessary. Of the 70 services identified as "medical unnecessary", the OIG contends that the services did not meet one or more Medicare requirements in that:

1. Subluxation of the spine was not present and/or was not treated (56 services);
2. Manual manipulation of the spinal subluxation was maintenance therapy and/or was not appropriate for treatment of the patient's condition (67 services); and/or

3. Manual manipulation of the spinal subluxation would not be expected to result in improvement within a reasonable and generally predictable period of time (69 services).

The Claims DCW Submitted Were Proper—Each Patient Was Properly Diagnosed and Treated for Subluxation of the Spine

All of DCW's patients are examined and x-rayed and many receive a spinal surface EMG and thermal scan to detect spinal misalignment. While DCW admits that some of the documentation is fragmented, if combined, it evidences medical necessity for the treatment rendered. While DCW's records may be fragmented, it is entirely proper for an x-ray to demonstrate the medical necessity for the treatment rendered. The Centers for Medicare and Medicaid Services ("CMS") provides that subluxation may be demonstrated by x-ray or by a physician's exam.¹ The CMS manual states the following:

"An x-ray may be used to document subluxation. The x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated."

It is important to note that the OIG looked at 100 separate services during its review. As set forth above, DCW admits that its records may be fragmented, however, if combined, would support the diagnosis of subluxation of the spine. DCW has not submitted any claims to Medicare for patients who were not being treated for subluxation of the spine, or who were never diagnosed with subluxation of the spine. It appears, based on the report and DCW's acknowledgement that some of its records may be fragmented, that the heart of the issue is not a false or erroneous claim being submitted, but rather an issue with fragmented documentation.

With respect to physical therapy services, the Claims Benefit Manual mandates that "Contractors shall consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary."² The same policy should hold true for chiropractic services. Based on the entire record, there is a showing of medical necessity for the services rendered by DCW.

¹ Medicare Benefit Policy Manual, Chapter 15, §240.1.2.

² Claims Benefit Manual, Chapter 15, §

The combined records demonstrate that DCW's patients were properly diagnosed with subluxation of the spine per CMS's criteria (via x-ray or physician's exam) and were treated based on that diagnosis. The patients that were treated have already received the benefit, as has CMS, and thus any reimbursement to CMS would result in unjust enrichment.

Despite the fact that CMS's beneficiaries have benefited from the treatment received, the OIG has recommended DCW reimburse CMS for a benefit already conferred upon it and its beneficiaries. The general concept of the doctrine of unjust enrichment is that the law requires a person who has been unjustly enriched at the expense of another to make restitution to the other.³ It is clear that any reimbursement by CMS for the proven benefits already received by its members would result in CMS being unjustly enriched, as CMS and its beneficiaries have already received the benefit. General principles of fairness and equity prevent CMS from receiving such a benefit, and then seeking reimbursement for it afterwards.

Based on the entire record, it is clear that the treatment provided to DCW's patients were medically necessary per CMS's guidelines. Thus, DCW disputes the OIG's request for a refund based on its allegation that the treatment was "medical unnecessary." Moreover, a review of the entire medical record for each patient reveals that the treatment was appropriate for the patient's condition, and was not maintenance therapy.

The Treatment Rendered to the Beneficiaries Was Appropriate

The OIG notes only one example in its draft report in support of its opinion that DCW's services constituted maintenance therapy and/or were not expected to result in improvement within a reasonable and generally predictable period of time. The example is of a 74-year-old beneficiary who received 47 chiropractic services over a two-year period (2010 to 2011). However, there is no explanation as to why the medical review contractor believed that such services "would not be expected to result in improvement within a reasonable and predictable length of time" aside from the amount of services noted.

The number of services alone cannot form the basis for a denial of claim. First, CMS has not imposed a "cap" imposed on the number of chiropractic services that a chiropractor can provide to a beneficiary. Furthermore, the Medicare Benefits Manual specifically states, "acute subluxation (e.g., strains or sprains) problems may require as many as three months of treatment..."⁴ The Manual goes on to state that "chronic spinal joint condition implies, of course, that condition existed for a longer period of time and that, in all probability, the involved joints have already 'set' and fibrotic tissue has developed. This condition may require longer treatment time..."⁵

Thus, CMS agrees that longer treatment times may be necessary for patients with chronic conditions. In addition, in its previous opinion entitled *Inappropriate Medicare Payments For*

³ *Enterprise Leasing Corp. v. Shugart Corp.* (1991) 231 Cal.App.3d 737.

⁴ Medicare Benefits Manual, Chapter 15, §240.1.5.

⁵ *Id.*

Chiropractic Services, the OIG recommended “implementing a cap on all chiropractic claims[.]” CMS responded to this recommendation indicating that it 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. To date, CMS has not imposed a cap on the number of chiropractic services that a chiropractor could provide to a Medicare beneficiary.

Moreover, there is no indication in the OIG’s draft report one way or the other whether this beneficiary suffered a recurrence and/or exacerbation of his or her condition over this two-year period that would have prompted additional treatment. Local coverage determinations (LCD) are defined in Section 1869(f)(2)(B) of the Social Security Act (the Act). This section states: “For purposes of this section, the term ‘local coverage determination’ means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with section 1862(a)(1)(A).”

Per the Palmetto (California Medicare Intermediary) LCD 28249, the following is used to indicate medical necessity:

1. **Acute subluxation:** A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.
2. **Chronic subluxation:** A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as in the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

For Medicare purposes, a chiropractor **must** place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, contractors may deny, if appropriate, after medical review.

3. **Maintenance therapy:** Maintenance therapy includes

services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. *When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. The AT modifier must not be placed on the claim when maintenance therapy has been provided. Claims without the AT modifier will be considered as maintenance therapy and denied. Chiropractors who give or receive from beneficiaries an ABN shall follow the instructions in Pub. 100-04, Medicare Claims Processing Manual, Chapter 23, section 20.9.1.1 and include a GA (or in rare instances a GZ) modifier on the claim.*

Maintenance therapy is not a covered benefit.

4. Exacerbations: An exacerbation is a temporary marked deterioration of the patient's condition due to flare-up of the condition being treated. This must be documented on the claim form and must be documented in the patient's clinical record, including the date of occurrence, nature of the onset or other pertinent factors that will support the reasonableness and necessity of treatments for this condition.

5. Recurrence: A recurrence is a return of symptoms of a previously treated condition that has been quiescent for 30 or more days. This may require the reinstitution of therapy.

Many of DCW's patients had a significant diagnosis and condition that would warrant longer term care particularly based on exacerbation and flare ups of chronic conditions. 47 visits over a two-year period is not unusual or unreasonable when a patient has a significant secondary diagnosis and exacerbation. In fact, many of the patients that DCW treats have been diagnosed with sciatica. Per the Palmetto LCD 28249, sciatica is a category III diagnosis that may require long term treatment.

In addition, in all of DCW's charts, the SOAP method was maintained. To demonstrate the efficacy of care, DCW charted the patient's progress using arrows. For example, per the Medicare documentation requirements for subsequent visits, the providers reviewed the patient's chief complaint. "The review is as simple as asking the patient, "How does your low back pain

(neck pain, etc.) feel today?”⁶ DCW would document the review of the chief complaint utilizing arrows. An arrow pointed down would indicate a decrease, an arrow pointing up would indicate an increase, and an arrow pointing across would indicate no change. The same arrow system was used to document any changes since the last visit. Furthermore, documentation of treatment on the date of the visit was charted using an arrow pointing across to indicate that the providers treated the same regions as the previous visit.

The arrows used demonstrate a measured and quantified improvement as a result of the care, which validates the effectiveness of the treatment. The arrows charted demonstrate the corrective nature of the treatment provided by showing decreased subjective complaints and improvement in objective factors that demonstrate the effectiveness and necessity of care. The records demonstrate, based upon the daily chart notes utilizing the arrows, coupled with the re-examination notes, that treatment was medically necessary.

“Medicare clearly indicates that they consider each visit to be part of a treatment episode concerned with a specific condition or series of conditions.”⁷ Thus, the course of treatment as a whole should be reviewed to determine medical necessity, as opposed to looking at a small sample of individual dates of service. When the treatments are viewed as a whole (including initial exam and re-exams), it demonstrates that the treatment was corrective in nature and not maintenance care. As long as the assessments continue to demonstrate improvement in function, Medicare considers the care medically necessary.⁸

While the charting method of using arrows may not be the most effective method, it does demonstrate the necessity for the treatment provided. However, given the OIG’s draft report and recommendation regarding documentation set forth below, DCW is implementing changes in its policies to provide more information than merely arrows to indicate progression of care. The specific changes that are being implemented are set forth below.

II. Incorrectly Coded

The OIG indicated that 11 of the 100 services it reviewed were improperly coded. However, the fact of the matter is that there was a proper diagnosis of all five spinal regions to warrant the use of CPT 98942. The initial report for each patient demonstrates the diagnosis of all five spinal regions to warrant the use of CPT 98942. During the audit review period, DCW was using an electronic charting program that contained certain limitations, one of which was a limitation on the number of spinal regions that could be inputted. Thus, the program would simply not allow DCW’s providers to enter a diagnosis for all five spinal regions. The records from the initial exam, however, do demonstrate the diagnosis of all five spinal regions which would warrant the use of the CPT 98942.

⁶ *Medicare Compliance Manual for Chiropractors*, The Schad Group, LP (2009-2011).

⁷ *Id.*

⁸ *Id.*

As such, it is clear that there have been no false or erroneous claims submitted based on coding. The situation merely amounts to, at a maximum, a clerical error, due to the software limitations. Clerical error is defined to include, “human or mechanical errors on the part of the party or the contractor such as—(i) Mathematical or computational mistakes; (ii) Inaccurate data entry; or (3) Denials of claims as duplicates.”⁹ Medicare recognizes that clerical errors occur, including incorrect data items and inaccurate data entry. In fact, the Medicare Claims Processing Manual Provides the following:

We believe that it is neither cost efficient nor necessary for contractors to correct clerical errors through the appeal process. Thus, § 405.927 and §405.980 (a)(3) require that clerical errors be processed as reopenings rather than appeals. CMS defines clerical errors (including minor errors or omissions) as human or mechanical errors on the part of the party or the contractor, such as:

- Mathematical or computational mistakes;
- Transposed procedure or diagnostic codes;
- Inaccurate data entry;
- Misapplication of a fee schedule;
- Computer errors; or,
- Denial of claims as duplicates which the party believes were incorrectly identified as a duplicate.
- Incorrect data items, such as provider number, use of a modifier or date of service.¹⁰

Given the above, DCW disputes the OIG’s request for a refund based on its allegation that 11 of the 100 services were improperly coded.

III. Undocumented

Again, all of the services provided by DCW and submitted to CMS were medically necessary and proper. The fact that some patients had undocumented reports relates to inadequate documentation, addressed below, and do not represent any fraudulent or false claims. DCW is committed to improving its policies and procedures related to documentation and has already begun implementing a corrective action plan as set forth below.

IV. Insufficiently Documented

In all of DCW’s charts, the SOAP method was maintained. To demonstrate the efficacy of care, DCW charted the patient’s progress using arrows. DCW admits that some of its documentation may be fragmented, however, in most of the records independently reviewed by DCW, the records clearly showed an improvement of the patient’s condition over time. In some

⁹ 42 C.F.R. 405.980(a)(3).

¹⁰ Medicare Claims Processing Manual, Chapter 34, Section 10.4.

instances, the element that was missing or that would need correction was relatively minor. DCW has already begun addressing the issues regarding its documentation policies and procedures and will continue to work toward constant improvement in this area.

OIG Recommendation

Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, correctly coded, and adequately documented.

DCW's Response

DCW disputes that any of the claims submitted to CMS were not medically necessary or correctly coded. As set forth above, the claims at issue involve patients who were all properly diagnosed, and treated, for subluxation of the spine.

That being said, DCW concurs that some of its medical documentation is fragmented. In order to address this issue, DCW has implemented various protocols to ensure compliance with Medicare's guidelines. DCW is dedicated to ensure that all of DCW's employees and contractors are educated and trained on new and existing CMS policies. The following is a summary of the corrective action plan that DCW has begun implementing.

1. All providers are required to document patient visits within 24 hours of the visit.
2. DCW's providers and personnel are required to attend from time to time, seminars and webinars on Medicare documentation requirements. DCW will continue to attend additional educational seminars and webinars and continue to implement the information obtained from these programs into its policies and procedures. To date, DCW has attended the following programs put on by the Chirocode Institute:
 - a. Wellness Care vs. Medically Necessary Care (September 28, 2011)
 - b. Medicare Reviews, What Do They Want Now? (November 17, 2011)
 - c. Medicare Update: Reviews and Audits (December 15, 2011)
 - d. Proving Medical Necessity and Functional Improvement (February 16, 2012)
3. DCW will require more detailed chart notes and will supplement the "arrow system" set forth above with more detailed notes. Several parameters will be incorporated into DCW's policies, including the following:
 - a. The treatment plan established for each patient will be set forth with the planned scope and course of care, including the defined and quantifiable elements to measure that the goals of care are being achieved.
 - b. Follow-up examinations will be provided and documented at least every 30 days.
 - c. The providers will be required to document outcome assessment tools such as neck and low back disability indexes.
 - d. Providers will be required to document subjective and objective factors relevant to the patient's progress in quantifiable methods.

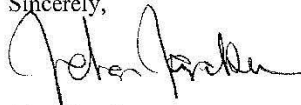
- e. In addition to the use of arrows, written details shall be provided to document the patient's progression over the course of treatment.
- 4. Staff will be required to ensure that chart notes are complete and dates are included prior to submitting any claims to CMS.

Conclusion

DCW opened its doors approximately eight years ago and since that time has focused its practice on helping seniors with disabling spinal degenerative conditions and sciatica without the use of drugs or expensive and risky surgical procedures. Such a substantial refund, as recommended by the OIG, would result in severe financial hardship to DCW and may even cause DCW to go out of business, thus, leaving its patient's without access to the care that they require. DCW has acted in good faith in submitting its claims to CMS and has been more than cooperative with respect to the OIG's audit.

The allegations contained in the draft report relate to or stem from issues with inadequate documentation, and DCW is committed to correcting any deficiencies in this regard. DCW requests that the OIG accept is resolution of using its resources to implement an appropriate corrective action plan to address these issues, rather than submit reimbursement for the amount set forth in the draft report. As demonstrated above, this amount is overbroad given that the services rendered were in fact medically necessary and resulted in a valuable benefit being conferred onto CMS's beneficiaries. At a minimum, DCW requests that the OIG significantly reduce the amount of refund that has been requested based on the totality of the circumstances. DCW requests that the OIG provide it with an opportunity to further this discuss this matter once it has had the opportunity to review this response.

Sincerely,



Jehan Jayakumar
Alicia Dragoo
CARLSON & JAYAKUMAR LLP

AD/JNJ