

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**HUNDREDS OF MILLIONS IN MEDICARE
PAYMENTS FOR CHIROPRACTIC
SERVICES DID NOT COMPLY WITH
MEDICARE REQUIREMENTS**

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EXECUTIVE SUMMARY

For 2013, an estimated \$359 million in Medicare payments for chiropractic services did not comply with Medicare requirements.

WHY WE DID THIS REVIEW

For calendar year (CY) 2013, Medicare Part B paid approximately \$439 million for chiropractic services provided to Medicare beneficiaries nationwide. A 2005 Office of Inspector General (OIG) evaluation found that as chiropractic care for a beneficiary extended beyond 12 treatments in a year, it became increasingly likely that individual services were medically unnecessary, with an even greater likelihood that services were medically unnecessary after 24 treatments. In addition, four more recent OIG reviews of individual chiropractors (with reports issued between 2013 and 2016) found that Medicare made improper payments for chiropractic services that were medically unnecessary, incorrectly coded, insufficiently documented, or not documented. We conducted this review to determine whether these issues occurred nationwide.

Our objective was to determine whether Medicare payments for chiropractic services complied with Medicare requirements.

BACKGROUND

Medicare Part B 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 spinal subluxation (when spinal bones are misaligned).

Medicare covers chiropractic services for active/corrective treatment for subluxation of the spine but does not cover maintenance therapy. Guidance from the Centers for Medicare & Medicaid Services (CMS) states that acute conditions may require as many as 3 months of treatment and that chronic conditions may require a longer treatment time. The guidance also states that when further clinical improvement cannot be reasonably expected from continuous ongoing care, the treatment is considered maintenance therapy. CMS guidance requires chiropractors to place the AT (Acute Treatment) modifier on a claim when providing active/corrective treatment for subluxation. Because CMS considers claims without the AT modifier to be claims for services that are maintenance therapy, it will deny these claims. However, inclusion of the AT modifier does not always indicate that the service provided was reasonable and necessary.

To be paid by Medicare, a chiropractor must have documentation to support the services, as required by Federal law and regulations and CMS guidance. CMS guidance requires chiropractors to enter on a claim the date of the initial treatment, which serves as the chiropractor's affirmation that all required documentation is being maintained on file.

CMS does not limit the number of covered chiropractic services that a beneficiary may receive. Since 2012, however, 2 Medicare administrative contractors (MACs), which process and pay Part B claims under contracts with CMS, have limited the number of chiropractic services that

Medicare will reimburse per beneficiary to 25 and 30 per year within their respective jurisdictions.

HOW WE CONDUCTED THIS REVIEW

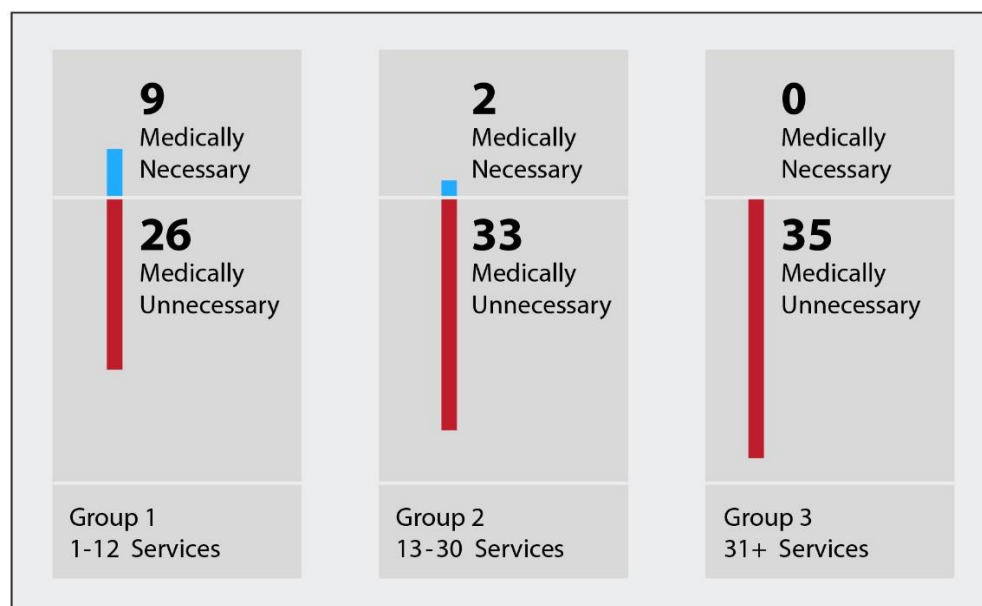
We included in our review chiropractic services for CY 2013 for which Medicare Part B paid \$438.1 million. (Our review excluded services that were provided by a chiropractor under investigation and services that were reviewed by the recovery audit contractors.) We divided these services into three groups (i.e., strata) by sorting the services by beneficiary and date of service, numbering the services for each beneficiary in chronological order, and placing each service in the appropriate group: group 1 contained the 1st through 12th services, group 2 contained the 13th through 30th services, and group 3 contained the 31st and subsequent services. We reviewed a stratified random sample of 105 services, consisting of 35 services from each group. Medicare paid \$2,712 for these 105 services. We used the sample results to estimate the amount paid for chiropractic services that did not comply with Medicare requirements.

WHAT WE FOUND

Most Medicare payments for chiropractic services did not comply with Medicare requirements. Of the 105 sampled chiropractic services, 11 were allowable in accordance with requirements. However, the remaining 94 services were not allowable because they were medically unnecessary. As a result, the chiropractors who billed for these services received \$2,447 in unallowable Medicare payments.

The figure below shows the number of medically necessary and medically unnecessary services by group. The number of medically unnecessary services was higher in group 2 than in group 1. All of the services in group 3 were medically unnecessary.

Figure: Sample Results by Group



The chiropractors submitted claims for all 105 services with the AT modifier and initial treatment date, indicating that the services were for active/corrective treatment for subluxation and all documentation required by Medicare was being maintained on file. However, the documentation provided by the chiropractors for 94 services did not support the medical necessity of the services; 37 of these services had more than 90 days (approximately 3 months) between the date of initial treatment and the date of service, which may indicate that the services were maintenance therapy.

On the basis of our sample results, we estimated that \$358.8 million, or approximately 82 percent, of the \$438.1 million paid by Medicare for chiropractic services was unallowable. These overpayments occurred because CMS's controls requiring chiropractors to include the AT modifier and initial treatment date on claims were not effective in preventing payments for medically unnecessary chiropractic services. Our claim data analysis and audit results suggest that chiropractors submitted claims with the AT modifier regardless of whether the services were for active/corrective treatment for subluxation. Further, chiropractors submitted claims with the initial treatment date, affirming that all required documentation was being maintained on file, even though they did not document the medical necessity of the services as required by Medicare. Finally, CMS's education of chiropractors on Medicare requirements for chiropractic services may not have been effective in preventing payments for medically unnecessary chiropractic services. Although a variety of educational materials were available on CMS's and the MACs' Web sites, chiropractors billed for chiropractic services that did not meet Medicare requirements.

Strong controls to prevent improper payments for chiropractic services are important to program integrity. The high payment error rate (82 percent) and the increase in payment error rates as the number of services provided to a beneficiary increased demonstrate that additional controls are needed to ensure that chiropractic services paid by Medicare are medically necessary. For example, CMS could consider taking appropriate action to limit the number of chiropractic services that Medicare will reimburse to a specified maximum (e.g., 30 per beneficiary per year). If such a limit had been in place during our audit period, it would have prevented chiropractors from billing a high number of medically unnecessary services. None of the 35 medically unnecessary services in group 3 (the 31st and subsequent services) were processed by either of the 2 MACs that limited the number of chiropractic services provided to beneficiaries. Although we recommended in one of our prior reports on chiropractic services (OEI-01-14-00200) that CMS establish a more reliable control for identifying maintenance therapy, CMS did not concur with our recommendation, citing significant obstacles to developing such a control. Unless CMS implements strong controls, it is likely to continue to make improper payments to chiropractors.

WHAT WE RECOMMEND

We recommend that CMS do the following, which could have saved Medicare an estimated \$358.8 million for CY 2013:

- Determine a reasonable number of chiropractic services that are necessary to actively treat spinal subluxation and implement a system edit to identify services for review in excess of that number.

- Determine whether there should be a limit for the number of chiropractic services that Medicare will reimburse; if so, take appropriate action to put that limit into effect, and implement a system edit to disallow services in excess of that limit.
- Improve education of chiropractors on Medicare coverage requirements for chiropractic services and the proper use of the AT modifier to ensure that only medically necessary chiropractic services are billed to Medicare.
- Specifically identify significant obstacles to developing a more reliable control for identifying maintenance therapy and work to establish such a control. (For example, CMS could determine a reasonable length for a chiropractic treatment episode and implement a system edit to identify services for review when the number of days between the date of initial treatment and the date of service exceeds that length.)

CMS COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS concurred with our first and third recommendations and provided information on actions that it had taken or planned to take to address those recommendations. However, CMS did not concur with our second recommendation as stated in our draft report; i.e., that it determine a reasonable limit for the number of chiropractic services Medicare will reimburse. CMS stated that it would need to develop a National Coverage Determination to implement the recommendation and that it was not aware of medical evidence to support such a determination. CMS did not comment on our fourth recommendation and, in a separate communication, informed us that it had responded to the same recommendation in a prior OIG report (OEI-01-14-00200).

After reviewing CMS's comments, we refined two of our recommendations. Specifically, we refined our second recommendation to indicate that CMS should determine whether there should be a limit for the number of chiropractic services that Medicare will reimburse and, if so, should take appropriate action to put that limit into effect. Regarding CMS's comments on implementing our second recommendation, CMS should consider taking other appropriate actions to put such a limit into effect. We also refined our fourth recommendation to specifically address CMS's comments on the recommendation in our prior report.

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
Previous Office of Inspector General Reviews of Chiropractic Services	4
How We Conducted This Review.....	5
FINDINGS	6
Federal Requirements	7
Chiropractic Services Were Medically Unnecessary.....	7
Medicare Made Unallowable Payments for Chiropractic Services	8
CMS’s Controls and Chiropractor Education Were Not Always Effective in Preventing Payments for Medically Unnecessary Chiropractic Services.....	9
CONCLUSION.....	10
RECOMMENDATIONS	11
CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	11
APPENDIXES	
A: Related Office of Inspector General Reports.....	13
B: Audit Scope and Methodology.....	14
C: Statistical Sampling Methodology	16
D: Sample Results and Estimates	18
E: CMS Comments	19

INTRODUCTION

WHY WE DID THIS REVIEW

For calendar year (CY) 2013, Medicare Part B paid approximately \$439 million for chiropractic services provided to Medicare beneficiaries nationwide. A 2005 Office of Inspector General (OIG) evaluation found that as chiropractic care for a beneficiary extended beyond 12 treatments in a year, it became increasingly likely that individual services were medically unnecessary, with an even greater likelihood that services were medically unnecessary after 24 treatments.¹ In addition, four more recent OIG reviews of individual chiropractors (with reports issued between 2013 and 2016) found that Medicare made improper payments for chiropractic services that were medically unnecessary, incorrectly coded, insufficiently documented, or not documented. We conducted this review to determine whether these issues occurred nationwide. (See Appendix A for a list of related OIG reports on Medicare claims for chiropractic services.)

OBJECTIVE

Our objective was to determine whether Medicare payments for chiropractic services complied 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. CMS contracts with Medicare administrative contractors (MACs) to process and pay Part B claims. In CY 2013, 8 MACs covered 12 Medicare Part B jurisdictions nationwide.

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 that chiropractors perform is spinal manipulation, also called chiropractic adjustment. The purpose of this procedure is to restore joint mobility by manually applying a controlled force into joints that have become restricted in their movement as

¹ *Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis* ([OEI-09-02-00530](#)), issued June 5, 2005.

a result of a tissue injury. When other medical conditions exist, chiropractic care may complement or support the treatment of those conditions.

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 spinal subluxation (when spinal bones are misaligned).³ Chiropractors may also use manual (i.e., handheld) devices to manipulate the spine.

Medicare covers chiropractic services for active/corrective treatment for subluxation of the spine but does not cover maintenance therapy. CMS guidance states that acute subluxation problems (e.g., strains or sprains) may require as many as 3 months of treatment, but some require very little treatment, and that chronic spinal joint conditions may require a longer treatment time, but not with higher frequency.⁴ CMS guidance also states: "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."⁵ Because chiropractic maintenance therapy is not considered to be medically reasonable or necessary under Medicare, it is not payable.

CMS guidance requires chiropractors to place the AT (Acute Treatment) modifier on a claim when providing active/corrective treatment for subluxation.⁶ Because CMS 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.

² CMS's *Medicare Benefit Policy Manual*, Pub. No. 100-02 (Benefit Manual), chapter 15, § 30.5.

³ Subluxation is a motion segment (i.e., a functional unit of the spinal column) in which alignment, movement integrity, or physiological function of the spine are altered, although contact between joint surfaces remains intact (Benefit Manual, chapter 15, § 240.1.2).

⁴ Benefit Manual, chapter 15, § 240.1.5.

⁵ Benefit Manual, chapter 15, § 30.5(B).

⁶ Benefit Manual, chapter 15, § 240.1.3. A modifier is a two-character code reported with a procedure code and is designed to give Medicare and commercial payers additional information needed to process a claim.

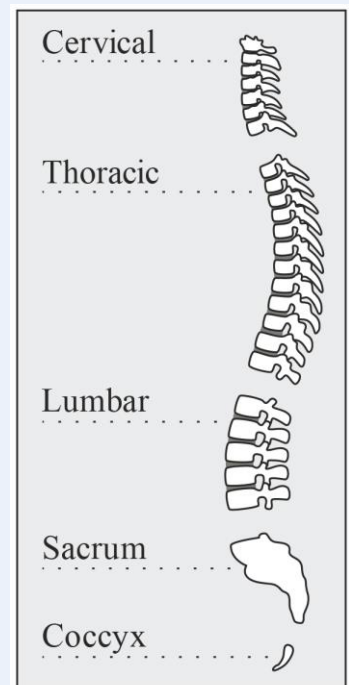
⁷ Maintenance therapy includes services that seek to prevent disease, promote health, and prolong and enhance the quality of life or to maintain or prevent deterioration of a chronic condition (Benefit Manual, chapter 15, §§ 30.5(B) and 240.1.3(A)).

To receive payment from Medicare, a chiropractor must document the services provided during the initial and subsequent visits as required by the Benefit Manual and the applicable Local Coverage Determinations (LCDs) for chiropractic services.⁸ CMS guidance requires chiropractors to enter on a claim the date of the initial treatment, which serves as the chiropractor's affirmation that all documentation required by Medicare is being maintained on file.⁹

To substantiate a claim for manipulation of the spine, a chiropractor must specify the precise level of subluxation.¹⁰ Depending on the number of spinal regions treated, chiropractors may bill Medicare for chiropractic manipulative treatment using one of three Current Procedural Terminology (CPT)¹¹ codes: 98940 (for treatment of one or two regions), 98941 (for treatment of three or four regions), and 98942 (for treatment of all five regions).¹² Figure 1 illustrates the five regions of the spine, from the cervical area (neck) to the coccyx (tailbone).

According to CMS's Medicare Learning Network booklet *Chiropractic Services* (the booklet), Medicare does not limit the number of services that beneficiaries may receive for covered chiropractic care provided by chiropractors who meet Medicare's licensure and other requirements, as specified in the Benefit Manual.^{13, 14} Further, the booklet states that MACs may specify a

Figure 1: The Five Regions of the Spine



⁸ An LCD is a decision by a Medicare contractor, such as a MAC, whether to cover a particular item or service on a contractorwide basis in accordance with section 1862(a)(1)(A) of the Social Security Act (the Act).

⁹ Either the date of the initial treatment or the date of exacerbation of the existing condition must be included on a claim for chiropractic services (*Medicare Claims Processing Manual*, Pub. No. 100-04 (Claims Manual), chapter 12, § 220.C).

¹⁰ Benefit Manual, chapter 15, § 240.1.4.

¹¹ **The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2002–2013 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

¹² “Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy,” full replacement of Change Request (CR) 3063, CMS Transmittal 23, CR 3449, Oct. 8, 2004.

¹³ ICN 906143, issued October 2013. The booklet was intended to provide a general summary of Medicare coverage of chiropractic services, not to replace either Federal law or regulations.

¹⁴ Unlike Medicare, in CY 2014, 161 of the 262 private insurance plans (61 percent) in the Federal Employees Health Benefits Program covered a limited number of chiropractic services per beneficiary per year (with an average limit of 21 services per year), and the limits ranged from 10 to 60 services. Twelve plans (5 percent) did not provide any coverage for chiropractic services. The remaining 89 plans (34 percent) covered an unlimited number of chiropractic services per year; however, 47 of the plans required prior authorization.

number of visits for which a review of documentation may be required, but limits are not allowed. However, the Benefit Manual and the Claims Manual do not include information on limits on chiropractic services. Despite the information in the booklet, since 2012 some MACs have established LCDs that set a limit on chiropractic services within their jurisdictions. During our audit period, 1 MAC had an LCD that limited the number of chiropractic services provided to a beneficiary to 12 per month and 30 per year. Another MAC had an LCD that limited the number of chiropractic services provided to a beneficiary to 25 per year.

CMS and the MACs have included on their Web sites a variety of educational materials that contain the Medicare requirements for chiropractic services.

Previous Office of Inspector General Reviews of Chiropractic Services

OIG has conducted various reviews of Medicare payments for chiropractic services. Four reviews of individual chiropractors (with reports issued between 2013 and 2016) found that Medicare made improper payments for chiropractic services that were medically unnecessary, incorrectly coded, insufficiently documented, or not documented, resulting in overpayments of an estimated \$2.3 million.¹⁵

A recent evaluation also found that Medicare made improper payments for chiropractic services.¹⁶ We analyzed paid claims totaling \$502 million for chiropractic services provided in CY 2013 and found that Medicare paid \$76.1 million for questionable claims and \$20.7 million for claims that did not meet Medicare requirements.¹⁷ We made five recommendations to CMS to address the vulnerabilities that we identified.

One of the recommendations was to establish a more reliable control for identifying maintenance therapy. For example, we suggested that CMS examine the initial treatment date for a particular diagnosis reported on a claim to determine the length of a beneficiary's chiropractic treatment and identify treatments likely to be maintenance therapy. CMS did not concur with our recommendation, citing significant obstacles to developing such a control. Instead, CMS stated that it would implement prior authorization medical review of services provided by certain chiropractors as required by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. At the time, we were uncertain that such a review would address our concerns with

¹⁵ The audit period for our review of Alleviate Wellness Center (A-09-14-02027) was CYs 2012 and 2013, which overlapped the audit period for our nationwide review (CY 2013). The chiropractic services provided by Alleviate Wellness Center were part of our nationwide review; however, none of those services were included in our sample.

¹⁶ *CMS Should Use Targeted Tactics To Curb Questionable and Inappropriate Payments for Chiropractic Services* (OEI-01-14-00200), issued September 29, 2015. The claim data for this evaluation were obtained in October 2014, whereas, the claim data for our nationwide review were obtained in July 2014. Because CMS allows providers to submit claims 12 months after the date of service, chiropractors may have submitted additional claims for chiropractic services provided in 2013 after we had obtained the data for our review. Therefore, for our evaluation, we analyzed paid claims totaling \$502 million, and for this nationwide review, we analyzed paid claims totaling \$438 million.

¹⁷ A medical record review was not conducted to determine whether chiropractic services were medically necessary or coded correctly. The report stated that the measures used to identify questionable payments did not provide conclusive evidence of improper or fraudulent payments.

payments for maintenance therapy. The medical reviews under MACRA would target a narrow group of chiropractors with aberrant billing or high rates of claim denial, who would not necessarily be chiropractors receiving payments for maintenance therapy.

HOW WE CONDUCTED THIS REVIEW

Medicare Part B paid \$438,709,032 for 17,043,147 chiropractic services for CY 2013.¹⁸ We divided these services into three groups (i.e., strata) by sorting the services by beneficiary and date of service, numbering the services for each beneficiary in chronological order, and placing each service in the appropriate group: group 1 contained the 1st through 12th services, group 2 contained the 13th through 30th services, and group 3 contained the 31st and subsequent services.¹⁹ We excluded from our review 28,340 services that were provided by a chiropractor under investigation and 32 services that were reviewed by the recovery audit contractors;²⁰ the excluded services totaled \$645,795. From the remaining 17,014,775 services, totaling \$438,063,237, we reviewed a stratified random sample of 105 services, consisting of 35 services from each of the 3 groups. Medicare paid \$2,712 for these 105 services. We used the sample results to estimate the amount paid for chiropractic services that did not comply with Medicare requirements.

The chiropractors that performed the selected services provided us with medical records. We provided copies of these medical records to an independent medical review contractor to determine whether the services were allowable in accordance with Medicare requirements.

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 contains our audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

¹⁸ We obtained the claim data in July 2014. Because CMS allows providers to submit claims 12 months after the date of service, chiropractors may have submitted additional claims for chiropractic services provided in 2013 after we had obtained the data.

¹⁹ For the first group, we used a threshold of 12 services because our 2005 evaluation (OEI-09-02-00530) found that as chiropractic care for a beneficiary extended beyond 12 treatments in a year, it became increasingly likely that individual services were medically unnecessary. For the second group, we used a threshold of 30 services because the MAC for Jurisdiction L had an LCD that limited the number of chiropractic services that a beneficiary could receive to 30 per year.

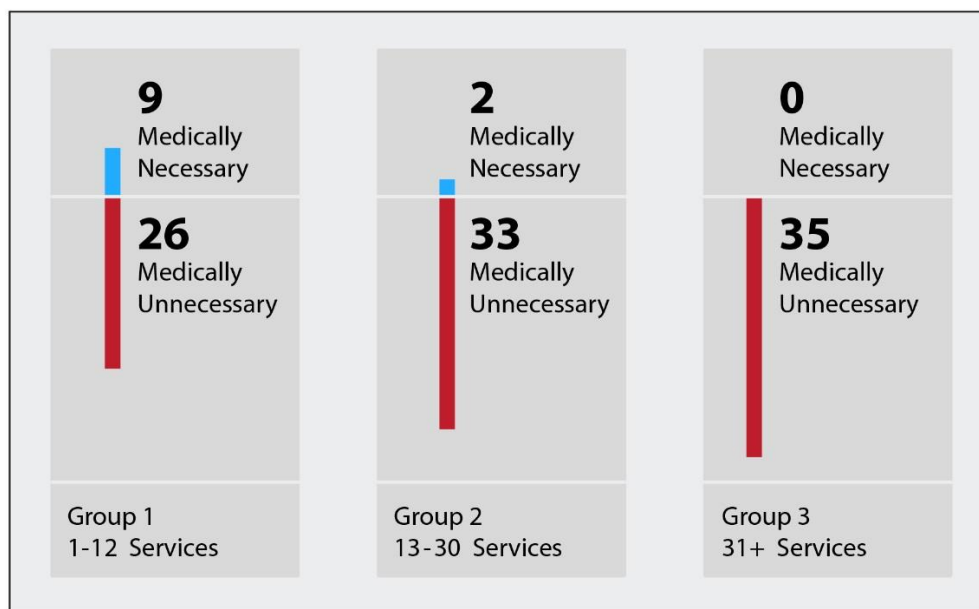
²⁰ Recovery audit contractors are responsible for identifying overpayments and underpayments in a geographically defined area. They are also responsible for informing CMS of common billing errors, trends, and other Medicare payment issues.

FINDINGS

Most Medicare payments for chiropractic services did not comply with Medicare requirements. Of the 105 sampled chiropractic services, 11 were allowable in accordance with requirements. However, the remaining 94 services were not allowable because they were medically unnecessary.²¹ As a result, the chiropractors who billed for these services received \$2,447 in unallowable Medicare payments.²²

Figure 2 shows the number of medically necessary and medically unnecessary services by group. The number of medically unnecessary services was higher in group 2 than in group 1. All of the services in group 3 were medically unnecessary.

Figure 2: Sample Results by Group



On the basis of our sample results, we estimated that \$358,800,549, or approximately 82 percent, of the \$438,063,237 paid by Medicare for chiropractic services was unallowable. These overpayments occurred because CMS's controls requiring chiropractors to include the AT modifier and initial treatment date on claims were not effective in preventing payments for medically unnecessary chiropractic services. In addition, CMS's education of chiropractors on Medicare requirements for chiropractic services may not have been effective in preventing payments for medically unnecessary services.

²¹ We provided to CMS the information for these 94 services so that it may take action as it deems appropriate.

²² Depending on the number of spinal regions treated, chiropractors may bill Medicare for chiropractic manipulative treatment using CPT codes 98940, 98941, or 98942. For one sample item, a chiropractor billed for a service by using the incorrect procedure code (98940) and received \$20. This amount was less than the \$28 that he would have received if he had billed the service by using the correct procedure code (98941). We included the difference (i.e., the underpayment of \$8) in the results of our sample. We did not perform a separate estimate for the underpayment.

FEDERAL REQUIREMENTS

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 (the Act § 1862(a)(1)(A)). 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 Benefit Manual states that a subluxation of the spine may be demonstrated by an x-ray or by physical examination and provides specific information that must be documented to demonstrate that a subluxation was present (chapter 15, § 240.1.2). It further 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 improve the condition or arrest or retard deterioration of it within a reasonable and generally predictable period of time (chapter 15, § 240.1.5).

The Benefit Manual defines maintenance therapy as (1) a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life or (2) therapy that is performed to maintain or prevent deterioration of a chronic condition (chapter 15, § 30.5(B)). In addition, the Benefit Manual states: "Acute subluxation (e.g., strains or sprains) problems may require as many as three months of treatment but some require very little treatment. ... Chronic spinal joint condition[s] ... may require a longer treatment time, but not with higher frequency."

The Claims Manual requires that the date of the initial treatment or date of exacerbation of the existing condition be entered in item 14 of Form CMS-1500. This serves as affirmation by the chiropractor that all documentation required by Medicare is being maintained on file (chapter 12, § 220.C).

CHIROPRACTIC SERVICES WERE MEDICALLY UNNECESSARY

Of the 105 sampled chiropractic services, 94 were medically unnecessary. The results of the medical review indicated that these services did not meet one or more Medicare requirements:²³

- Subluxation of the spine was not present or was not treated or both (43 services).²⁴
- Manual manipulation of the spinal subluxation was maintenance therapy or was not appropriate for treatment of the patient's condition or both (93 services).

²³ The total exceeds 94 because 93 of the 94 services did not meet more than 1 Medicare requirement.

²⁴ For 37 of the 43 services, subluxation was not present and was not treated. For the remaining six services, subluxation was present, but the medical records did not indicate that it was treated by manual manipulation.

- Manual manipulation of the spinal subluxation would not be expected to result in improvement within a reasonable and generally predictable period of time (93 services).

For example, a chiropractor received payment for a chiropractic service provided on May 13, 2013, to a 73-year-old Medicare beneficiary.²⁵ The chiropractor submitted a claim for this service with the AT modifier, indicating that the service was for active/corrective treatment for subluxation, not for maintenance therapy. The chiropractor also entered the initial treatment date on the claim, affirming that all required documentation was being maintained on file. However, the medical review contractor determined that the medical records did not support the medical necessity of the service because none of the Medicare requirements listed above had been met. The medical review contractor stated: "... the patient did not have evidence of a spinal subluxation.... Additionally, the patient was receiving supportive maintenance care. The care, therefore, does not meet Medicare criteria."

The chiropractors submitted claims for all 105 services with the AT modifier and initial treatment date, indicating that the services were for active/corrective treatment for subluxation and all documentation required by Medicare was being maintained on file. However, the documentation provided by the chiropractors for 94 services did not support the medical necessity of the services; 37 of these services had more than 90 days (approximately 3 months) between the date of initial treatment and the date of service, which may indicate that the services were maintenance therapy.

MEDICARE MADE UNALLOWABLE PAYMENTS FOR CHIROPRACTIC SERVICES

Medicare made \$2,447²⁶ in unallowable Medicare payments for the 94 chiropractic services that did not meet Medicare requirements. On the basis of our sample results, we estimated that \$358,800,549, or approximately 82 percent, of the \$438,063,237 paid by Medicare for chiropractic services was unallowable for Medicare reimbursement (Table 1).

Table 1: Estimated Unallowable Payments by Group

Group	Total Payment	Estimated Unallowable Payments	Percentage of Unallowable Payments
1	\$302,448,057	\$228,717,325	76
2	106,917,420	101,385,465	95
3	28,697,760	28,697,760	100
Total	\$438,063,237	\$358,800,549²⁷	82

²⁵ Our sample included only one service for this beneficiary, for which Medicare paid \$30. The sampled service was the 37th service that the beneficiary received in CY 2013. During CY 2013, Medicare paid a total of \$2,776 for 98 chiropractic services provided to this beneficiary.

²⁶ This amount includes the underpayment of \$8 for one sample item that a chiropractor billed with an incorrect procedure code.

²⁷ Because of rounding, the sum of the estimated unallowable payments for the three groups (i.e., strata) does not equal the estimated unallowable payments for the entire sample.

In the report issued in June 2005,²⁸ we stated: “As chiropractic care extends beyond 12 treatments in a year, it becomes increasingly likely that individual services are medically unnecessary. The likelihood of a service being medically unnecessary increases even more significantly after 24 treatments.” The evaluation’s finding is consistent with our finding that 95 percent of the payments for the second group (the 13th through 30th services) and 100 percent of the payments for the third group (the 31st and subsequent services) were made for services that were not medically necessary.

Further, none of the 35 medically unnecessary services in group 3 were processed by either of the 2 MACs that limited the number of chiropractic services provided to beneficiaries to 25 and 30 per year, respectively. If CMS had had a limit of 30 chiropractic services per beneficiary per year that was applicable nationwide, chiropractors would not have been able to bill a high number of medically unnecessary services and receive estimated unallowable payments of \$28.7 million.

CMS’S CONTROLS AND CHIROPRACTOR EDUCATION WERE NOT ALWAYS EFFECTIVE IN PREVENTING PAYMENTS FOR MEDICALLY UNNECESSARY CHIROPRACTIC SERVICES

The overpayments occurred because CMS’s controls were not effective in preventing payments for chiropractic services that were medically unnecessary. Specifically, the requirements to include the AT modifier and initial treatment date on claims did not prevent Medicare payments for these services. In addition, CMS’s education of chiropractors on Medicare requirements for chiropractic services may not have been effective in preventing payments for medically unnecessary services.

CMS informed us that there was a system edit to deny claims without the AT modifier. However, our claim data analysis and audit results suggest that chiropractors submitted claims with the AT modifier regardless of whether the services were for active/corrective treatment for subluxation. All but 29 of the more than 17 million chiropractic services included in our review were on claims that had the AT modifier, and of the 105 sampled chiropractic services, 94 were not medically necessary.

Further, chiropractors submitted claims with the initial treatment date, affirming that all required documentation was being maintained on file, even though they did not document the medical necessity of the services as required by Medicare. All of the claims for the 105 sampled chiropractic services had the initial treatment date, but the medical necessity of 94 of those services was not documented. Seven of the eight MACs informed us that there was a system edit to ensure that the initial treatment date was included on claims. However, these MACs’ claim-processing systems did not compare the initial treatment date with the date of service to determine whether the length of the treatment episode was reasonable.²⁹

²⁸ *Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis* ([OEI-09-02-00530](#)), issued June 5, 2005.

²⁹ Two MACs informed us that they took into consideration the initial treatment date when evaluating the medical necessity of the services.

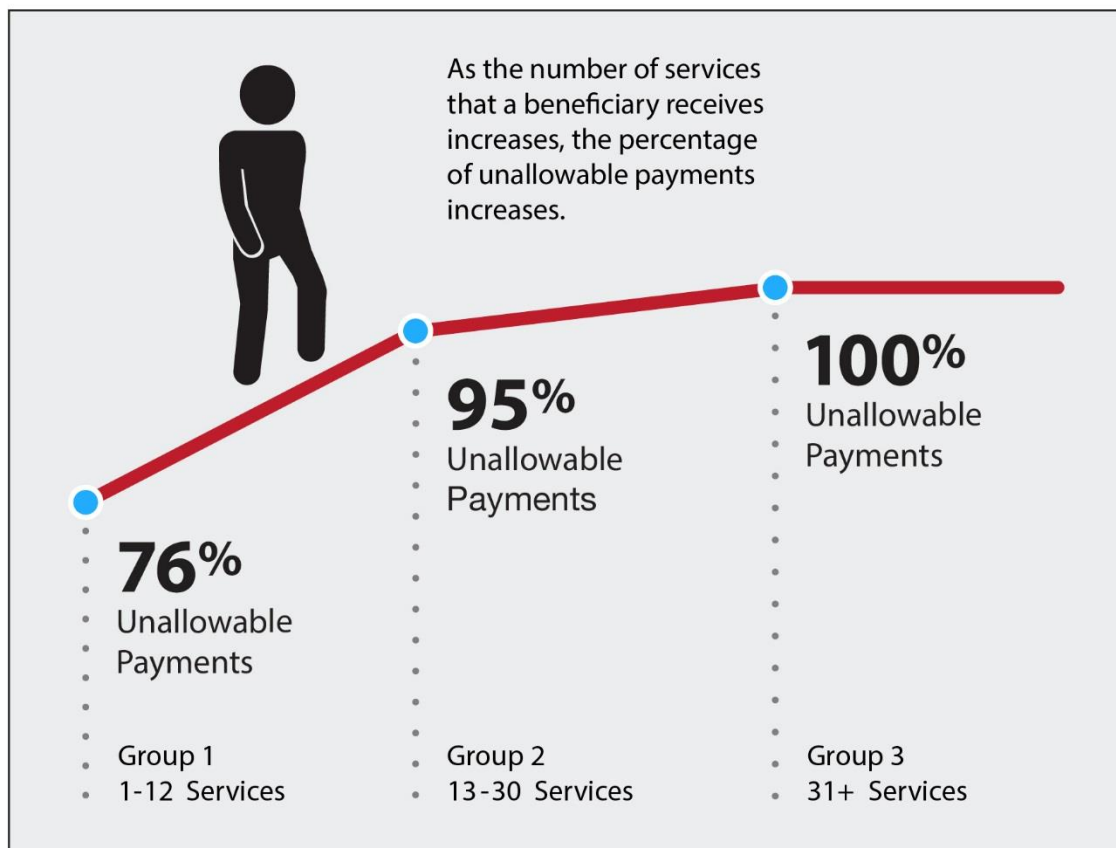
Finally, CMS published educational materials, such as *Medicare Learning Network Matters* articles, that included information on Medicare requirements for chiropractic services. These materials, along with Medicare policies, were available on CMS's Web site. The MACs also included on their Web sites educational materials related to chiropractic services, such as presentation slides from Web-based seminars provided by the MACs, articles, and fact sheets. Although a variety of educational materials were available on CMS's and the MACs' Web sites, chiropractors billed for chiropractic services that did not meet Medicare requirements.

CONCLUSION

CMS could have saved Medicare an estimated \$358,800,549 for CY 2013 if it had had effective controls to ensure that Medicare paid only for chiropractic services that were medically necessary. Strong controls to prevent improper payments for chiropractic services are important to program integrity.

The high payment error rate (82 percent) that we identified in this review demonstrates that additional controls are needed to ensure that chiropractic services paid by Medicare are medically necessary. Further, the increase in payment error rates as the number of services provided to a beneficiary increased also demonstrates the need for additional controls (Figure 3).

Figure 3: Chiropractic Service Payment Error Rate by Group



CMS could strengthen controls for chiropractic services in various ways. For example, CMS could consider taking appropriate action to limit the number of chiropractic services that Medicare will reimburse to a specified maximum (e.g., 30 per beneficiary per year). If such a limit had been in place during our audit period, it would have prevented chiropractors from billing a high number of medically unnecessary services. None of the 35 medically unnecessary services in group 3 (the 31st and subsequent services) were processed by either of the 2 MACs that limited the number of chiropractic services provided to beneficiaries. Although we recommended in one of our prior reports on chiropractic services³⁰ that CMS establish a more reliable control for identifying maintenance therapy, CMS did not concur with our recommendation, citing significant obstacles to developing such a control. Unless CMS implements strong controls, it is likely to continue to make improper payments to chiropractors.

RECOMMENDATIONS

We recommend that CMS do the following, which could have saved Medicare an estimated \$358,800,549 for CY 2013:

- Determine a reasonable number of chiropractic services that are necessary to actively treat spinal subluxation and implement a system edit to identify services for review in excess of that number.
- Determine whether there should be a limit for the number of chiropractic services that Medicare will reimburse; if so, take appropriate action to put that limit into effect, and implement a system edit to disallow services in excess of that limit.
- Improve education of chiropractors on Medicare coverage requirements for chiropractic services and the proper use of the AT modifier to ensure that only medically necessary chiropractic services are billed to Medicare.
- Specifically identify significant obstacles to developing a more reliable control for identifying maintenance therapy and work to establish such a control. (For example, CMS could determine a reasonable length for a chiropractic treatment episode and implement a system edit to identify services for review when the number of days between the date of initial treatment and the date of service exceeds that length.)

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our first and third recommendations and provided information on actions that it had taken or planned to take to address those recommendations. However, CMS did not concur with our second recommendation as stated in our draft report; i.e., that it determine a reasonable limit for the number of chiropractic services Medicare will reimburse. CMS did not comment on our fourth recommendation and, in a separate communication, informed us that it had responded to the

³⁰ *CMS Should Use Targeted Tactics To Curb Questionable and Inappropriate Payments for Chiropractic Services* ([OEI-01-14-00200](#)), issued September 29, 2015.

same recommendation in a prior OIG report (OEI-01-14-00200). CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix E.

CMS's comments on our first three recommendations were as follows:

- Regarding our first recommendation, CMS stated that the Medicare Access and CHIP Reauthorization Act of 2015 requires prior authorization for specified chiropractic services furnished on or after January 1, 2017, by a chiropractor whose pattern of billing is aberrant and for episodes of treatment that included more than 12 services. CMS stated that it will monitor the results of this effort and determine whether further action is warranted.
- Regarding our second recommendation, CMS stated that to implement the recommendation, it would need to develop a National Coverage Determination and that it was not aware of medical evidence to support such a determination.
- Regarding our third recommendation, CMS stated that since 2013 it has published several resources to educate providers on the coverage and billing requirements for chiropractic services, including proper use of the AT modifier. CMS also stated that it has discussed chiropractic coverage and billing requirements through local education activities.

After reviewing CMS's comments, we refined two of our recommendations. Specifically, we refined our second recommendation to indicate that CMS should determine whether there should be a limit for the number of chiropractic services that Medicare will reimburse and, if so, should take appropriate action to put that limit into effect. Regarding CMS's comments on implementing our second recommendation, CMS should consider taking other appropriate actions to put such a limit into effect. We also refined our fourth recommendation to specifically address CMS's comments on the recommendation in our prior report.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>A Michigan Chiropractor Received Unallowable Medicare Payments for Chiropractic Services</i>	<u>A-07-14-01148</u>	8/8/2016
<i>CMS Should Use Targeted Tactics To Curb Questionable and Inappropriate Payments for Chiropractic Services</i>	<u>OEI-01-14-00200</u>	9/29/2015
<i>Alleviate Wellness Center Received Unallowable Medicare Payments for Chiropractic Services</i>	<u>A-09-14-02027</u>	7/22/2015
<i>Advanced Chiropractic Services Received Unallowable Medicare Payments for Chiropractic Services</i>	<u>A-07-13-01128</u>	5/27/2015
<i>Diep Chiropractic Wellness, Inc., Received Unallowable Medicare Payments for Chiropractic Services</i>	<u>A-09-12-02072</u>	11/20/2013
<i>Inappropriate Medicare Payments for Chiropractic Services</i>	<u>OEI-07-07-00390</u>	5/5/2009
<i>Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis</i>	<u>OEI-09-02-00530</u>	6/5/2005

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered \$438,063,237 that Medicare Part B paid for 17,014,775 chiropractic services for CY 2013.³¹ Our review excluded certain services that were provided by a chiropractor under investigation and a small number of services that were reviewed by the recovery audit contractors. We selected a stratified random sample of 105 services for which Medicare paid \$2,712.

We did not review the overall internal control structure of CMS. 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 2014 to June 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed CMS officials to obtain an understanding of Medicare reimbursement requirements for chiropractic services;
- obtained from CMS's National Claims History (NCH) file the Medicare Part B claims for chiropractic services paid nationwide with dates of service ending in CY 2013³² and sorted the services by beneficiary and date of service and numbered the chiropractic services for each beneficiary in chronological order;³³
- created a sampling frame of 17,014,775 chiropractic services, totaling \$438,063,237, and selected a stratified random sample of 105 services (Appendix C);

³¹ The Medicare claim data showed that all but 29 of the chiropractic services that were paid nationwide for CY 2013 included the AT modifier, indicating that the services were for active/corrective treatment for subluxation. Medicare paid for the 29 services that were billed without the AT modifier. On June 24, 2015, we provided CMS with information on the claims for these 29 services.

³² We obtained the claim data in July 2014. Because CMS allows providers to submit claims 12 months after the date of service, chiropractors may have submitted additional claims for chiropractic services provided in 2013 after we had obtained the data.

³³ After numbering the chiropractic services for each beneficiary, we removed 28,340 services provided by a chiropractor under investigation and 32 services that had been reviewed by the recovery audit contractors.

- obtained medical records and other documentation from the chiropractors who delivered the 105 sampled services³⁴ and provided them to the independent medical review contractor, who determined whether each service was allowable in accordance with Medicare requirements;
- reviewed the medical review contractor's results to determine whether the services were allowable;³⁵
- estimated the amount of the unallowable payments for chiropractic services (Appendix D); and
- shared the results of our review with CMS officials.

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.

³⁴ We requested supporting documentation for 6 months before and 3 months after the date of service. We specified that supporting documentation should consist of all required documentation, including documentation required by the LCD applicable to chiropractic services (e.g., initial visit documentation, treatment plan, subsequent visit documentation, and evidence of subluxation). We also requested a copy of the Medicare Part B claim form (CMS-1500) for the selected service; patient intake form; copies of x-ray and magnetic resonance imaging results, if any; and any other documentation that would support the medical necessity of the chiropractic service.

³⁵ First, the contractor reviewed medical records to determine whether a service was medically necessary. If the service was medically necessary, the contractor then determined whether the service was properly documented. If the service was properly documented, the contractor then determined whether the service was correctly coded. When the contractor concluded that a service was medically unnecessary, it did not provide its conclusion on whether the service was documented or coded in accordance with Medicare requirements.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of chiropractic services paid by Medicare Part B that were received by Medicare beneficiaries nationwide in CY 2013.

SAMPLING FRAME

The sampling frame consisted of 17,014,775 chiropractic services for CY 2013.³⁶ Medicare paid a total of \$438,063,237 for these services. We obtained the claim data from CMS's NCH file.

SAMPLE UNIT

The sample unit was a chiropractic service.

SAMPLE DESIGN

We used a stratified random sample. To accomplish this, we separated the sampling frame into three strata as shown in Table 2.³⁷

Table 2: Sampling Frame Strata

Stratum	Description	Number of Services in Stratum	Total Payment for Services in Stratum
1	Included 1 st through 12 th services received by beneficiaries during CY 2013	11,847,829	\$302,448,057
2	Included 13 th through 30 th services received by beneficiaries during CY 2013	4,088,227	106,917,420
3	Included 31 st and subsequent services received by beneficiaries during CY 2013	1,078,719	28,697,760
Total		17,014,775	\$438,063,237

³⁶ We did not include 28,340 services provided by a chiropractor under investigation or 32 services that had been reviewed by the recovery audit contractors.

³⁷ For the first group, we used a threshold of 12 services because our 2005 evaluation (OEI-09-02-00530) found that as chiropractic care for a beneficiary extended beyond 12 treatments in a year, it became increasingly likely that individual services were medically unnecessary. For the second group, we used a threshold of 30 services because the MAC for Jurisdiction L had an LCD that limited the number of chiropractic services that a beneficiary could receive to 30 per year.

SAMPLE SIZE

We selected a total of 105 chiropractic services, consisting of 35 services from each of the 3 strata.

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 stratum 1 from 1 to 11,847,829, the sample units in stratum 2 from 1 to 4,088,227, and the sample units in stratum 3 from 1 to 1,078,719. After generating 35 random numbers for each stratum, 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 D: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

Stratum	Number of Services in Stratum	Value of Stratum	Sample Size	Value of Sample	Number of Unallowable Services	Value of Unallowable Services
1	11,847,829	\$302,448,057	35	\$852	26	\$634
2	4,088,227	106,917,420	35	885	33	838 ³⁸
3	1,078,719	28,697,760	35	975	35	975
Total	17,014,775	\$438,063,237	105	\$2,712	94	\$2,447

Table 4: Estimated Value of Unallowable Services
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$358,800,549
Lower limit	322,206,727
Upper limit	395,394,372

³⁸ This amount includes the underpayment of \$8 for one sample item that a chiropractor billed with an incorrect procedure code.

APPENDIX E: CMS COMMENTS




DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: JUN 24 2016

TO: Daniel R. Levinson
Inspector General

FROM: Andrew M. Slavitt 
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply With Medicare Requirements" (A-09-14-02033)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to protecting the Medicare Trust Funds by combatting fraud, waste, and abuse.

To combat fraud, waste, and abuse in Medicare, CMS is using a comprehensive program integrity strategy to educate providers, recoup improper payments, and protect taxpayer dollars. Specific to chiropractic claims, CMS released several educational materials in 2015 on chiropractic benefits to educate providers on the coverage and billing requirements for chiropractic services.^{1,2,3,4} The published materials discuss billing requirements for spinal manipulation and proper use of the Active Treatment (AT) modifier. These materials also make clear that Medicare does not provide payment for chiropractic maintenance therapy. In addition, since January 2013, CMS has discussed these topics over 1,000 times through local education activities on the chiropractic benefit, Medicare coverage criteria, compliance with Medicare program rules, and proper use of the AT modifier.

CMS has implemented the Fraud Prevention System (FPS), which applies predictive analytic technology to claims prior to payment to identify aberrant and suspicious billing patterns. The FPS runs predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service (FFS) claims, including chiropractic claims. CMS uses the FPS to target

¹ *Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits*, Medicare Learning Network, SE1601, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1601.pdf>

² *Use of the AT modifier for Chiropractic Billing (new information along with information in MM3449)*, Medicare Learning Network, SE1602, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1602.pdf>

³ *Educational Resources to Assist Chiropractors with Medicare Billing*, Medicare Learning Network, SE1603, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1603.pdf>

⁴ *Improving the Documentation of Chiropractic Services*, CMSHHSgov Youtube Channel, <https://www.youtube.com/watch?v=tMiw1X9KvDA>

investigative resources to suspicious claims and providers and swiftly impose administrative action if warranted. Currently, CMS has several chiropractic models within the FPS that analyze claims to detect fraud, waste, and abuse. Since CMS implemented the technology in June 2011, \$1 billion in inappropriate payments has been identified through new leads or contributions to existing investigations. Also, in 2015, CMS marked its first-ever national return-on-investment of \$11.50 for every dollar the federal government spends on this program integrity system.

Section 514 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to implement prior authorization for certain services furnished on or after January 1, 2017 by certain chiropractors. Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before certain services are furnished to a beneficiary and before a claim is submitted for payment. Prior authorization helps ensure that applicable coverage, payment and coding rules are met before services are rendered.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

Determine a reasonable number of chiropractic services that are necessary to actively treat spinal subluxation and implement a system edit to identify services for review in excess of that number.

CMS Response

CMS concurs with OIG's recommendation. Section 514 of MACRA requires prior authorization for specified chiropractor services furnished on or after January 1, 2017 by a chiropractor whose pattern of billing is aberrant compared to peers and, in a prior period, has a services denial percentage in the 85th percentile or greater after appeal. The prior authorization requirement is for episodes of treatment that include more than 12 services. CMS will monitor the results of this effort and determine if further action is warranted.

OIG Recommendation

Determine a reasonable limit for the number of chiropractic services that Medicare will reimburse, take appropriate action to put that limit into effect, and implement a system edit to disallow services in excess of that limit.

CMS Response

CMS does not concur with OIG's recommendation. In order to implement this recommendation, CMS would need to develop a national coverage determination establishing a limit on the number of chiropractic services that are reasonable and necessary. CMS is not aware of medical evidence that would support such a determination.

OIG Recommendation

Improve education of chiropractors on Medicare coverage requirements for chiropractic services and the proper use of the AT modifier to ensure that only medically necessary chiropractic services are billed to Medicare.

CMS Response

CMS concurs with OIG's recommendation. This report examined chiropractic services claims for calendar year 2013. Since then, CMS has published several resources to educate providers on the coverage and billing requirements for chiropractic services. The published materials discuss billing requirements for spinal manipulation and proper use of the Active Treatment (AT) modifier. These

materials also make clear that Medicare does not provide payment for chiropractic maintenance therapy. CMS has also discussed chiropractic coverage and billing requirements through extensive local education activities.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.