



U.S. Department of Health and Human Services Office of Inspector General



MEDICARE NEEDS BETTER CONTROLS TO PREVENT FRAUD, WASTE, AND ABUSE RELATED TO CHIROPRACTIC SERVICES

February
2018

An OIG Portfolio

A-09-16-02042

This portfolio presents an overview of program vulnerabilities identified in prior Office of Inspector General (OIG) audits, evaluations, investigations, and legal actions related to chiropractic services in the Medicare program. It consolidates the findings and issues identified in that work and discusses recommendations from prior reports that have not been implemented or have been implemented ineffectively. In addition, this portfolio provides information to help the Centers for Medicare & Medicaid Services understand the need for effective controls over chiropractic services and offers recommendations to help Medicare prevent fraud, waste, and abuse related to those services.

The OIG work referenced throughout this portfolio was conducted in accordance with the Quality Standards for Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency, generally accepted government auditing standards, and investigative and legal professional standards, as applicable.

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nation-wide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Why a Portfolio?

The Centers for Medicare & Medicaid Services' (CMS's) Comprehensive Error Rate Testing program, which measures improper Medicare fee-for-service payments annually, identified chiropractic services as having the highest improper payment rates among Medicare Part B services from 2010 to 2015. The improper payment rate for chiropractic services ranged from 43.9 percent to 54.1 percent, and the estimated overpayments per year ranged from \$257 million to \$304 million. Further, since 2005, the Office of Inspector General (OIG) has conducted numerous evaluations and audits of chiropractic services and identified hundreds of millions of dollars in overpayments. Despite these findings, CMS has not implemented or effectively implemented all of our recommendations, and controls over chiropractic services remain inadequate to prevent fraud, waste, and abuse. This overview of Medicare program vulnerabilities identified in prior OIG audits, evaluations, investigations, and legal actions related to chiropractic services illustrates the need for better controls over those services to protect the Medicare Trust Funds, help reduce the risk of fraud, and prevent beneficiaries from paying millions of dollars in coinsurance for chiropractic services that are not reasonable or necessary. Further, chiropractic services that are not reasonable or necessary can potentially harm Medicare beneficiaries.

PORTFOLIO HIGHLIGHTS



Medicare continued to make hundreds of millions in improper payments for chiropractic services.



Chiropractic fraud, waste, and abuse is a concern.



CMS's controls have not fully prevented improper payments.



Establishing a medical review threshold for chiropractic services could save millions by reducing payments for medically unnecessary services without compromising beneficiary access to reasonable and necessary services.

What Action Is Needed?

To help Medicare reduce fraud, waste, and abuse related to chiropractic services and ensure that chiropractors provide medically necessary services to protect the health and safety of Medicare beneficiaries, we recommend that CMS implement our prior recommendations that remain unimplemented or have been implemented ineffectively. In addition, to further strengthen program integrity and facilitate the full implementation of our prior recommendations, CMS should (1) work with its contractors to educate chiropractors on the training materials that are available to them; (2) educate beneficiaries on the types of chiropractic services that are covered by Medicare, inform them that massage and acupuncture services are not covered by Medicare, and encourage them to report to CMS chiropractors who are providing non-Medicare-covered services; (3) identify chiropractors with aberrant billing patterns or high service-denial rates, select a statistically valid random sample of services provided by each chiropractor identified, review the medical records for the sampled services, estimate the amount overpaid to each chiropractor, and request that the chiropractors refund the amounts overpaid by Medicare; and (4) establish a threshold for the number of chiropractic services beyond which medical review would be required for additional services. CMS's comments on these recommendations and our responses are included in this portfolio.

TABLE OF CONTENTS

BACKGROUND	1
Chiropractic Services	1
Medicare Coverage of Chiropractic Services	1
Recent Statutory Changes for Oversight of Chiropractic Services.....	2
Historical Medicare Payments for Chiropractic Services	2
Medicare Improper Payment Rates for Chiropractic Services.....	2
ISSUES	4
Medicare Continued To Make Hundreds of Millions in Improper Payments for Chiropractic Services.....	4
CMS's Controls Have Not Fully Prevented Improper Payments	6
The Requirement To Include the AT Modifier on Claims Has Not Fully Prevented Payments for Maintenance Therapy	6
The Requirement To Include the Initial Treatment Date on Claims Has Not Ensured That Services Are Adequately Supported	7
Provider Education Has Not Fully Prevented Improper Payments to Chiropractors	7
Reviewing Medical Records To Determine Whether Chiropractic Services Met Medicare Requirements Has Not Been a High Priority for Contractors.....	8
Chiropractic Fraud Is a Concern.....	9
Establishing a Medical Review Threshold for Chiropractic Services Could Save Millions by Reducing Payments for Medically Unnecessary Services Without Compromising Beneficiary Access to Reasonable and Necessary Services	10
CMS Guidance on Limits for Chiropractic Services.....	10
Private Insurance's Limits on Chiropractic Services.....	11
The Greater the Number of Chiropractic Services Received by a Beneficiary, the More Likely That the Services Are Medically Unnecessary.....	11
Medicare and Its Beneficiaries Could Achieve Cost Savings if Medicare Established a Medical Review Threshold for Chiropractic Services.....	12
RECOMMENDATIONS FROM PRIOR OFFICE OF INSPECTOR GENERAL REPORTS THAT REMAIN UNIMPLEMENTED OR HAVE BEEN IMPLEMENTED INEFFECTIVELY	14
Unimplemented Recommendations.....	14
Ineffectively Implemented Recommendations	15
CONCLUSION	16
RECOMMENDATIONS.....	17
CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE.....	18
CMS Comments.....	18

Office of Inspector General Response.....	19
APPENDIX A: PRIOR OFFICE OF INSPECTOR GENERAL REPORTS.....	20
APPENDIX B: CMS COMMENTS	21
ENDNOTES	24

What does Medicare Part B cover?

Medicare Part B covers medical and other health care services, including chiropractic services.

How much does Medicare pay yearly for chiropractic services?

Since 2010, Medicare has paid more than \$450 million per year for chiropractic services.

What are the coverage rules for chiropractic services?

Medicare covers reasonable and necessary chiropractic services provided by a qualified chiropractor to correct spinal subluxation by means of manual manipulation of the spine. Medicare does not cover chiropractic maintenance therapy. To receive payment from Medicare, a chiropractor must have documentation to support the services provided.

Is there a limit to the number of covered chiropractic services that a beneficiary may receive?

Medicare does not limit the number of covered chiropractic services that a beneficiary may receive per month or per year. Many private insurance companies impose coverage limits.

Chiropractic Services

Chiropractic is a form of alternative medicine. Chiropractic services focus on the diagnosis and treatment of disorders of the musculoskeletal system, especially the spine. The most common therapeutic procedure that chiropractors perform is spinal manipulation. 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 a result of an injury to the tissue.

Medicare Coverage of Chiropractic Services

Medicare covers chiropractic services for active/corrective treatment for subluxation of the spine (when spinal bones are misaligned) by means of manual manipulation of the spine.¹ Medicare does not cover chiropractic maintenance therapy, however, because it prohibits payment 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.² 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. The Centers for Medicare & Medicaid Services (CMS) guidance 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.”³

Medicare requires chiropractors to place the Acute Treatment (AT) modifier on a claim when providing active/corrective treatment for subluxation.⁴ Because Medicare considers claims without the AT modifier to be claims for services that are maintenance therapy, it denies these claims. However, inclusion of the AT modifier does not always indicate that the service provided was reasonable and necessary.⁵

In addition, Medicare requires chiropractors to enter the date of the initial treatment on a claim. By entering the date, the chiropractor affirms that all documentation required by Medicare is being maintained on file.⁶

CMS contracts with Medicare administrative contractors (contractors) to process and pay Medicare Part B claims, which include claims for chiropractic services. The contractors use system edits to determine whether these claims are complete and payable.⁷ Each contractor makes coverage decisions for services provided in its jurisdiction.

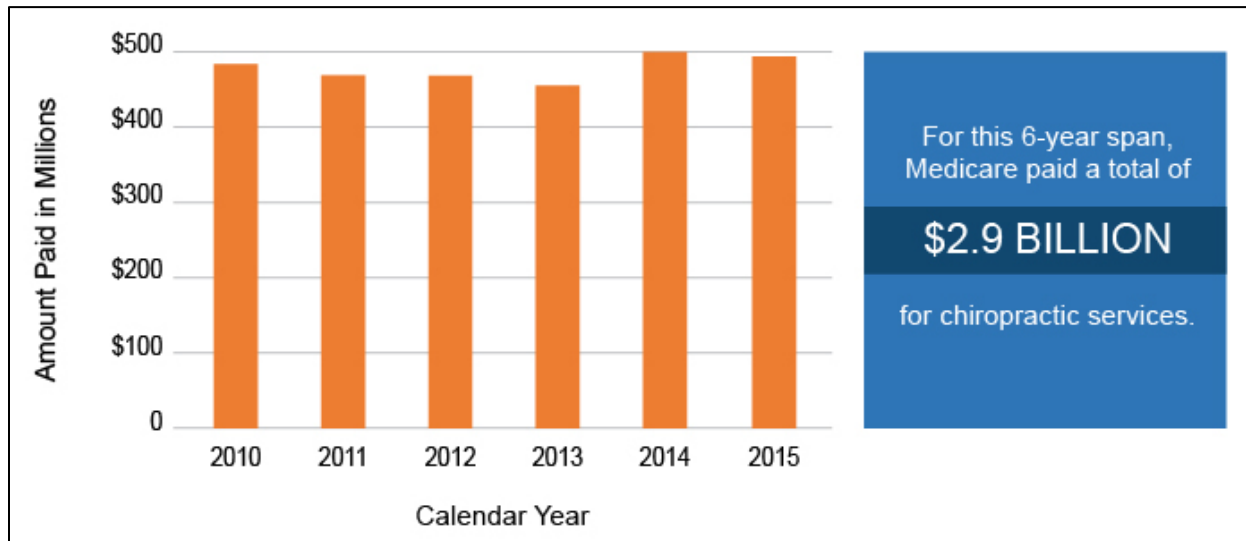
Recent Statutory Changes for Oversight of Chiropractic Services

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) contains provisions for oversight of chiropractic services.⁸ The MACRA requires that the Secretary of Health and Human Services implement a prior-authorization process for certain chiropractic services provided on or after January 1, 2017. Specifically, those services must be part of a course of treatment that includes more than 12 services, focusing on services such as those provided by chiropractors with aberrant billing patterns⁹ and by chiropractors who, in a prior period, had a service-denial percentage in the 85th percentile or greater.¹⁰ The law also requires that the Secretary develop and make publicly available by January 1, 2016, educational and training programs to improve a chiropractor’s ability to provide documentation demonstrating that services are reasonable and necessary.¹¹

Historical Medicare Payments for Chiropractic Services

From calendar years (CYs) 2010 through 2015, Medicare consistently paid more than \$450 million per year for chiropractic services (Figure 1). In this 6-year span, Medicare paid a total of \$2.9 billion for chiropractic services.

Figure 1: Paid Amounts for Chiropractic Services, CYs 2010–2015

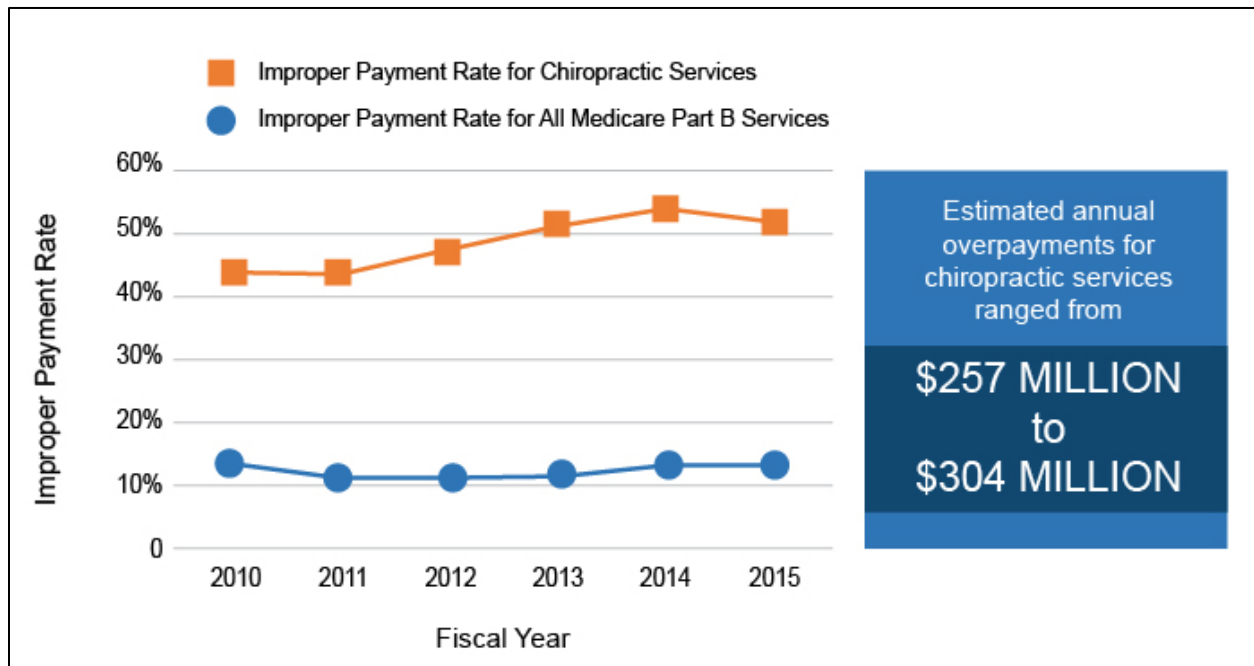


Medicare Improper Payment Rates for Chiropractic Services

CMS’s Comprehensive Error Rate Testing (CERT) program, which measures improper Medicare fee-for-service payments annually, identified chiropractic services as having the highest improper payment rates among Medicare Part B services from fiscal years 2010 through

2015 (which includes claims from April 1, 2009, through June 30, 2014). During this period, the improper payment rate for chiropractic services ranged from 43.9 percent to 54.1 percent compared with 9.9 percent to 12.9 percent for all Part B services (Figure 2), and the estimated overpayments for chiropractic services ranged from \$257 million to \$304 million.¹² The CERT program identified that improper payments were made for services that were medically unnecessary, billed with an incorrect procedure code, not documented, or insufficiently documented.

Figure 2: Comparison of Improper Payment Rates for Chiropractic Services and All Medicare Part B Services



The contractors told us that they have also reviewed claims for chiropractic services and found similar issues. According to the contractors we interviewed, claims for chiropractic services were typically denied because the services were medically unnecessary, billed with an incorrect procedure code, not documented, or insufficiently documented.

Our evaluation and audit reports have identified hundreds of millions in overpayments for chiropractic services that did not meet Medicare requirements. Our investigations and legal actions involving chiropractors have demonstrated that chiropractic services are also susceptible to health care fraud.

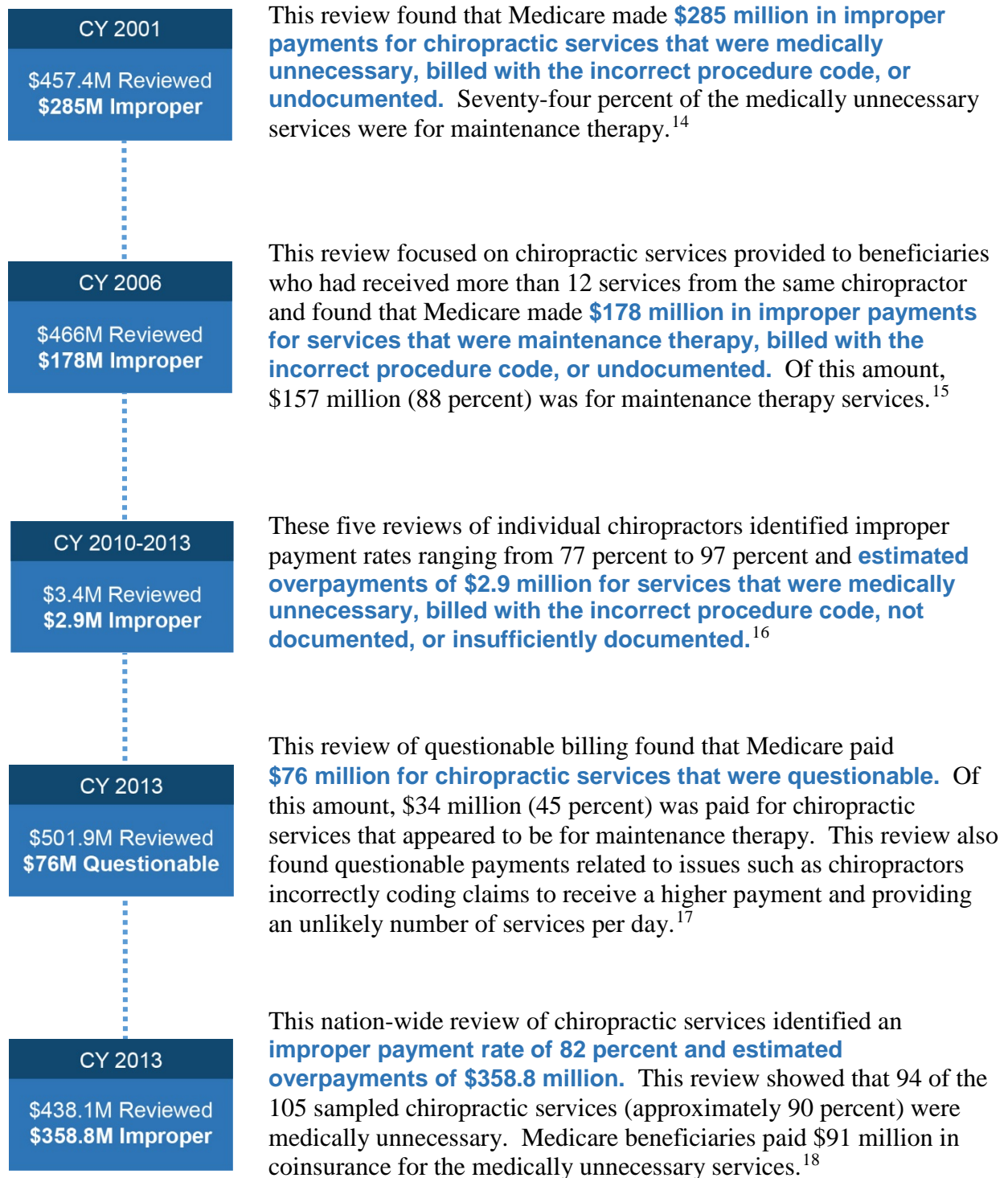
By analyzing our prior work on chiropractic services, we identified the following issues:

- Medicare continued to make hundreds of millions in improper payments for chiropractic services.
- CMS's controls have not fully prevented improper payments.
- Chiropractic fraud is a concern.
- Establishing a medical review threshold for chiropractic services could save millions by reducing payments for medically unnecessary services without compromising beneficiary access to reasonable and necessary services.

Medicare Continued To Make Hundreds of Millions in Improper Payments for Chiropractic Services

The results of our work and that of the CERT program showed that since CY 2001 Medicare continued to make hundreds of millions in improper payments for chiropractic services. The majority of the improper payments that we identified were for services that Medicare considers medically unnecessary, including maintenance therapy, which is not covered by Medicare. Further, Medicare beneficiaries continued to pay millions of dollars in coinsurance for unallowable chiropractic services.¹³ Figure 3 on the following page provides key findings from our prior reviews of chiropractic services. (Appendix A contains a list of the reports.)

Figure 3: Prior Office of Inspector General (OIG) Reviews of Chiropractic Services



CMS's Controls Have Not Fully Prevented Improper Payments

Our work shows that CMS's controls have not fully prevented improper payments for chiropractic services:

- The requirement to include the AT modifier on claims has not fully prevented payments for maintenance therapy, which are unallowable.
- The requirement to include the initial treatment date on claims has not ensured that services are adequately supported.
- Provider education has not fully prevented improper payments to chiropractors.
- Reviewing medical records to determine whether chiropractic services met Medicare requirements has not been a high priority for contractors.

What Is CMS's Role in Medicare Oversight?

One of CMS's key responsibilities is to protect Medicare from fraud, waste, and abuse. To ensure the integrity of Medicare, CMS issues program manuals and guidance and implements controls to prevent improper payments. Some of these controls are implemented by the contractors.

The Requirement To Include the AT Modifier on Claims Has Not Fully Prevented Payments for Maintenance Therapy

In response to our CY 2001 review, CMS stated that it had implemented the use of the AT modifier for chiropractic services to help chiropractors bill correctly. Effective October 1, 2004, Medicare required chiropractors to place the AT modifier on a claim when providing active/corrective treatment for subluxation.¹⁹ Because Medicare considers claims without the AT modifier to be claims for services that are maintenance therapy, it denies these claims. However, the requirement to include the AT modifier has not been effective in fully preventing payments for maintenance therapy.

What Did the CY 2015 Payment Data Show?

Claims for all but 30 of the nearly 14 million chiropractic services paid by Medicare had the AT modifier.

Our work showed that almost all claims for chiropractic services had the AT modifier regardless of whether the services were for active/corrective treatment for subluxation. For example, our CY 2013 questionable billing review found that every claim that appeared to be for maintenance therapy included the AT modifier. Further, all of the 105 sampled chiropractic services included in our CY 2013 nation-wide review were on claims that had the AT modifier, and 94 of those services, or 90 percent, were medically unnecessary, which included services for maintenance therapy.

The medical reviewers and contractor staff whom we interviewed for the CY 2006 review agreed that the AT modifier did not prevent inappropriate payments for maintenance therapy. A staff member from one contractor stated: "By putting an AT modifier on a claim, chiropractors are getting paid, and they know they will get paid." In addition, the medical reviewers for the CY 2006 review noted that the requirement to include the AT modifier did not appear to affect chiropractic billing patterns. Finally, a biller, who had worked for one of the five individual

chiropractors whom we audited for the CYs 2010 through 2013 reviews, informed us that the computerized program used to bill Medicare for chiropractic services automatically included the AT modifier on the claim form.

The Requirement To Include the Initial Treatment Date on Claims Has Not Ensured That Services Are Adequately Supported

Medicare 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. Seven of the eight contractors informed us that there was a system edit to ensure that the initial treatment date was included on claims and that claims without that date would be denied. However, the requirement to include the initial treatment date on claims has not been effective in ensuring that chiropractic services are adequately supported.

Our analysis of the claim data for the 652 sampled services that we reviewed as part of the CY 2013 nation-wide review and five reviews of individual chiropractors for CYs 2010 through 2013 showed that chiropractors submitted all of the claims with the initial treatment date, affirming that the required documentation was being maintained on file. However, the chiropractors did not document the medical necessity of 559 services (86 percent) as required by Medicare; an additional 56 services (9 percent) were either not documented or insufficiently documented. These results are consistent with our CY 2001 review, which found that 94 percent of chiropractic services reviewed lacked some or all of the supporting documentation that CMS's *Medicare Benefit Policy Manual* requires. The results of our analysis indicate that chiropractors included the initial treatment date on claims to ensure that the claims would get paid regardless of whether the services were adequately documented.

Provider Education Has Not Fully Prevented Improper Payments to Chiropractors

CMS and the contractors published on their websites Medicare policies and educational materials to provide information on Medicare requirements for chiropractic services. However, providing these materials has not been effective in fully preventing improper payments to chiropractors. The high improper payment rates in both the CERT and OIG reviews suggest that many chiropractors did not use these materials to get a better understanding of how to properly bill for chiropractic services. One contractor stated that many chiropractors did not know the Medicare requirements outlined in the Local Coverage Determinations and that the chiropractors in its jurisdiction were resistant to education and not willing to change their billing patterns.²⁰

Does CMS Provide Education to Beneficiaries on Chiropractic Services?

CMS publishes educational materials on its website Medicare.gov: *Medicare & You* and *Your Medicare Benefits*. These publications explain that the Medicare benefit for chiropractic services is limited to manipulation of the spine if it is medically necessary to correct a subluxation. Neither publication mentions maintenance therapy nor indicates that maintenance therapy is not covered by Medicare.

CMS sends *Medicare & You* to beneficiaries annually; however, beneficiaries whom we interviewed did not know that the services they received from chiropractors would not be covered by Medicare. One beneficiary with degenerative disc disease told us that the oil-based massages and electric stimulation treatment he got during his visits to the chiropractor did not help his symptoms. Another beneficiary with arthritis said that the massages she received at the chiropractor's office helped her relax.

The MACRA required educational and training programs for chiropractors, both to improve their ability to document services and to increase their compliance with Medicare policies. To address this requirement, on December 23, 2015, CMS made available a training video entitled “[Improving the Documentation of Chiropractic Services](#)” on the CMS YouTube channel. CMS stated that this video would help to reduce the improper payment rate by helping chiropractors to properly document services provided. However, many chiropractors have not accessed this training. As of January 2, 2017, the video had been viewed only 8,898 times. In CY 2016, 41,012 chiropractors submitted claims to Medicare for chiropractic services. CMS could work with its contractors to educate chiropractors on the training materials that are available to them.

Reviewing Medical Records To Determine Whether Chiropractic Services Met Medicare Requirements Has Not Been a High Priority for Contractors

Most Medicare claims are processed and paid without a review of the underlying medical records to support the claim.

Medicare can use medical review, including prepayment or postpayment reviews, to determine whether a claimed service was reasonable and necessary or otherwise satisfied Medicare coverage and payment requirements. Medical review is an effective tool for identifying services that do not meet

Medicare requirements and educating chiropractors on those requirements. However, the contractors have not widely used medical reviews because, according to CMS, the contractors have targeted their efforts on services that pose the greatest financial risk to the Medicare program, and they have limited resources. In addition, improper payments for chiropractic services have accounted for less than 1 percent of the total improper payments in Medicare fee-for-service. Finally, chiropractic services have relatively small payments when compared with other Medicare-covered services. The payments for a chiropractic service ranged from \$29 to \$54 in CY 2016.

What Is Medical Review?

Medical review is the collection of information and review of medical records to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements.

Although Medicare payments for chiropractic services are relatively small, since CY 2010 Medicare has paid more than \$450 million per year for these services. In addition, our CY 2013 nation-wide review, which used a medical review contractor to determine the medical necessity of services, found that Medicare paid almost \$359 million for chiropractic services that were not allowable in accordance with Medicare requirements. This demonstrates that medical review is effective in detecting improper payments for chiropractic services. However, CMS and its contractors have not prioritized conducting medical review on chiropractic services because the Medicare payment per service is relatively low when compared with other services. For a chiropractor with questionable billing practices or high service-denial rates, the contractor could review a statistically valid sample of claims submitted by the chiropractor for the year and estimate the amount overpaid for the year.

Chiropractic Fraud Is a Concern

We have completed investigations of 28 chiropractic fraud cases since 2005. To defraud the Federal Government, chiropractors:

- submitted claims for services that were never provided,
- submitted claims for medically unnecessary services,
- offered incentives to patients to receive unnecessary services,
- provided services without a valid chiropractic license,
- falsified patient records, and
- billed for chiropractic services but provided services not covered by Medicare (e.g., massage and acupuncture).

These investigations resulted in incarceration for 11 chiropractors and approximately \$7.6 million in restitution and settlements. Some of the investigations that did not result in incarceration resulted in the chiropractors being excluded from participating in Medicare.²¹

In addition to these investigations, we have imposed program exclusions and civil monetary penalties on chiropractors for submitting false or fraudulent claims. For example, on December 16, 2016, we excluded a chiropractor from participating in Medicare for 40 years for submitting claims for chiropractic services that were not medically necessary and not provided as claimed. From CYs 2005 through 2016, we excluded 542 chiropractors from Medicare for various periods.²²

Fraudulent chiropractic services can potentially cost Medicare millions of dollars and compromise the health and safety of Medicare beneficiaries. For example, beneficiaries may be injured by receiving chiropractic services that are medically unnecessary or provided by an individual without a valid chiropractic license.

Investigation Found Chiropractor Committed Fraud, Leading to Prison Time and Restitution

We contacted a chiropractor to obtain medical records for an audit. Before the scheduled review, the chiropractor falsely reported to the police that he had been robbed and that the patient files that we had requested had been stolen from his car. These events led to a fraud investigation against this chiropractor.

When we interviewed the chiropractor's patients, most of them described the treatment they received as a "massage," which is not a Medicare-covered service. For example, a beneficiary told us that a driver employed by the chiropractor provided a massage that did not help the beneficiary's condition. Another beneficiary described the services she received as "soft" massages and said that she stopped seeing the chiropractor because her symptoms did not improve.

The chiropractor pleaded guilty to health care fraud and filing a false police report. He was sentenced to 63 months in Federal prison and ordered to pay full restitution of more than \$1 million. He was also excluded from participating in Medicare for 23 years.

Establishing a Medical Review Threshold for Chiropractic Services Could Save Millions by Reducing Payments for Medically Unnecessary Services Without Compromising Beneficiary Access to Reasonable and Necessary Services

Medicare does not cover chiropractic maintenance therapy because Medicare prohibits payment 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. CMS guidance 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.”²³

The majority of the improper payments that we identified in our prior reviews were for services that Medicare considers medically unnecessary, including maintenance therapy. Our work shows that Medicare could save millions of dollars by establishing a threshold beyond which chiropractic services would be covered only if supported by medical review. For example, CMS could set a threshold for the number of chiropractic services that a beneficiary may receive per year and require medical review for services in excess of that threshold. This approach could save Medicare millions of dollars without compromising beneficiary access to reasonable and necessary services in excess of that threshold.

Does Medicare Have Medical Review Thresholds for Other Types of Services?

Medicare has a medical review threshold for outpatient therapy services (as authorized by the Social Security Act § 1833(g)). For example, the threshold for payments per beneficiary per year for outpatient physical therapy and speech-language pathology services combined was \$1,920 for CY 2014. There are exceptions for exceeding the threshold for therapy services that are reasonable and necessary, but combined services above \$3,700 are subject to medical review.

CMS Guidance on Limits for Chiropractic Services

The *Medicare Benefit Policy Manual* and the *Medicare Claims Processing Manual* do not include information on limits for chiropractic services. According to CMS’s Medicare Learning Network factsheet *Misinformation on Chiropractic Services*, Medicare does not limit the number of services that beneficiaries may receive for covered chiropractic care.²⁴ The factsheet states that contractors may specify a number of services for which a review of documentation may be required, but limits are not allowed.

Do Medicare Contractors Have Guidance on Medical Review Thresholds?

Since 2012, two of the Medicare contractors set medical review thresholds for chiropractic services within their jurisdictions. One contractor’s threshold was 12 services per beneficiary per month but not more than 30 per year, and the other contractor’s threshold was 25 services per beneficiary per year. Services in excess of these thresholds may be paid if the chiropractor submits additional documentation to support the medical necessity of the services.

Private Insurance's Limits on Chiropractic Services

Similar to Medicare, some private insurance companies provide coverage for chiropractic services. For example, many of the private insurance companies that participate in the Federal Employees Health Benefits (FEHB) program provide coverage for chiropractic services, and most of them limit the number of chiropractic services they will pay for. However, Medicare must cover reasonable and necessary services and follow certain statutory rules that do not apply to private insurance companies, including those that participate in the FEHB program.

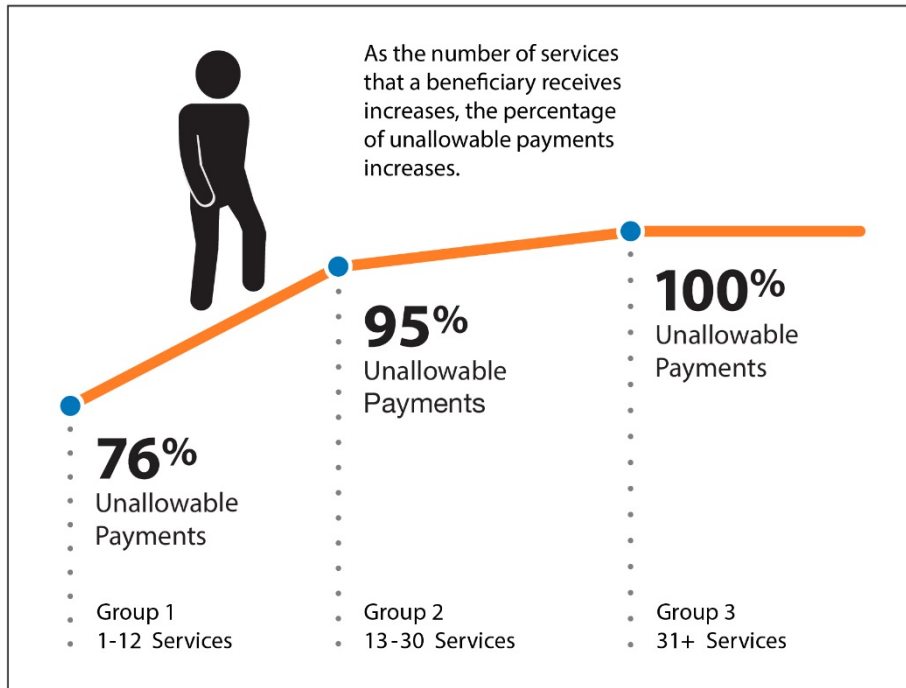
To understand the coverage limits imposed by private insurance companies and how medical review thresholds similar to these limits might result in cost savings for Medicare, we analyzed the private insurance plans offered to Federal employees by the FEHB program in CY 2014 and found that 61 percent of the plans limited the number of chiropractic services covered per beneficiary per year. The maximum number of chiropractic services that these plans covered averaged 21 per year and ranged from 10 to 60 per year. The most common limit was 20 services per year. The FEHB brochures for the plans with limits did not indicate whether these plans would allow additional services on the basis of medical necessity. Some plan brochures specifically stated that the insured is responsible for paying for services in excess of the limit.

The remaining 39 percent of the FEHB plans did not provide any coverage for chiropractic services or covered an unlimited number of them per year. Many plans that covered an unlimited number of services required prior authorization or required the enrollee to pay significant out-of-pocket costs.

The Greater the Number of Chiropractic Services Received by a Beneficiary, the More Likely That the Services Are Medically Unnecessary

The results of our CY 2001 review and CY 2013 nation-wide review demonstrate that the greater the number of chiropractic services received by a beneficiary during the year, the more likely that the services are medically unnecessary. Figure 4 on the following page shows the results of our CY 2013 nation-wide review.

Figure 4: Results of CY 2013 Nation-wide Review



None of the services in group 3 (the 31st and subsequent services) were medically necessary. Also, none of these services were processed by either of the 2 contractors that established medical review thresholds of 25 and 30 services per beneficiary per year, respectively.

Medicare and Its Beneficiaries Could Achieve Cost Savings if Medicare Established a Medical Review Threshold for Chiropractic Services

Table 1 shows the amounts that Medicare could have potentially saved in CYs 2013 through 2015 if there had been a threshold of 12 and 30 chiropractic services per beneficiary per year, respectively, and medical review had been required for services in excess of those thresholds.

Table 1: Potential Cost Savings to Medicare in CYs 2013–2015 With Medical Review Thresholds for Chiropractic Services

Medical Review Threshold for Chiropractic Services	Potential Savings in CY 2013	Potential Savings in CY 2014	Potential Savings in CY 2015	Total Potential Savings in CYs 2013–2015
12	\$135,615,180	\$157,960,368	\$153,267,127	\$446,842,675
30	\$28,697,760	\$33,629,675	\$32,778,844	\$95,106,279

Establishing a medical review threshold for chiropractic services could also potentially save beneficiaries millions in coinsurance payments for medically unnecessary services. Table 2 shows the amounts that Medicare beneficiaries could have potentially saved in CYs 2013 through 2015 if there had been a threshold of 12 and 30 chiropractic services per beneficiary per year, respectively, and medical review had been required for services in excess of those thresholds.

Table 2: Potential Cost Savings to Medicare Beneficiaries in CYs 2013–2015 With Medical Review Thresholds for Chiropractic Services

Medical Review Threshold for Chiropractic Services	Potential Savings in CY 2013	Potential Savings in CY 2014	Potential Savings in CY 2015	Total Potential Savings in CYs 2013–2015
12	\$34,545,604	\$40,278,962	\$39,084,796	\$113,909,362
30	\$7,319,043	\$8,577,961	\$8,361,033	\$24,258,037

RECOMMENDATIONS FROM PRIOR OFFICE OF INSPECTOR GENERAL REPORTS THAT REMAIN UNIMPLEMENTED OR HAVE BEEN IMPLEMENTED INEFFECTIVELY

A key component of effective oversight of chiropractic services is monitoring chiropractor billing and establishing methods to prevent and detect fraud, waste, and abuse. In prior reports, OIG made numerous recommendations to address vulnerabilities, and in some instances CMS took action to implement our recommendations and strengthen controls over billing for chiropractic services. However, Medicare continues to make hundreds of millions in improper payments for chiropractic services.

As the agency charged with administering and overseeing chiropractic services, CMS is responsible for improving the effectiveness of controls over chiropractic services and protecting Medicare beneficiaries. We are highlighting the following recommendations made to CMS in previous OIG reports that remain unimplemented or have been implemented ineffectively. We encourage CMS to continue taking actions to implement our recommendations and strengthen controls over billing for chiropractic services.

Unimplemented Recommendations

CY 2006
Review

Recommendation: *Implement and enforce policies to prevent future payments for maintenance therapy (e.g., by implementing a new modifier for chiropractic claims to indicate the start of a new treatment episode so that contractors can identify aberrant treatment patterns through claims data).*²⁵

CMS did not indicate whether it concurred with this recommendation but stated that it would consider implementing a modifier to indicate the start of a new treatment episode if it were feasible. As of January 2017, CMS had not implemented such a modifier.

CY 2013
Questionable
Billing
Review

Recommendation: *Establish a more reliable control for identifying active treatment.*²⁶

CMS did not concur with this recommendation, citing significant obstacles to establishing a more reliable control for identifying active treatment. CMS stated that it would implement a medical review process for preauthorizing certain chiropractic services as required by the MACRA, which it believed would help address the concerns we identified. Because the MACRA provision focuses on chiropractors with aberrant billing patterns and high service-denial rates, it would not be effective in preventing improper payments made to other chiropractors who bill for medically unnecessary chiropractic services. In addition, our CY 2013 nation-wide review demonstrated that improper payments were not limited to chiropractors with

aberrant billing patterns or high service-denial rates and were a widespread issue for all chiropractors.

**CY 2013
Nation-wide
Review**

Recommendation: *Determine a reasonable number of chiropractic services that are necessary to actively treat spinal subluxation and implement an edit to identify for review services in excess of that number.*²⁷

CMS concurred with this recommendation and stated that it would monitor the results of its effort to implement medical review for preauthorizing certain chiropractic services as required by the MACRA and would determine whether further action was warranted. However, CMS's proposed action would not adequately address our concerns because, as previously stated, this MACRA provision focuses on chiropractors with aberrant billing patterns and high service-denial rates.

**CY 2013
Nation-wide
Review**

Recommendation: *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 an edit to disallow services in excess of that limit.*²⁸

CMS did not concur with this recommendation. In our report related to our CY 2006 review, we made a similar recommendation that CMS implement a cap on the number of chiropractic services that a beneficiary may receive per year. CMS did not indicate then whether it concurred with that recommendation and commented that the objective data required to implement a national cap did not exist.

To provide CMS additional data, we conducted our CY 2013 nation-wide review, which found an 82 percent improper payment rate, resulting in \$358.8 million in overpayments. In addition, this review showed that as the number of chiropractic services received by a beneficiary increased, the improper payment rate also increased. Specifically, services in excess of 30 per beneficiary per year were all unallowable. When we recommended in our draft report that CMS address these issues with, among other recommendations, a limit to services, it stated that to implement our recommendation it would need to develop a National Coverage Determination (NCD) and was unaware of medical evidence to support such an NCD.²⁹ In response to CMS's comments, we refined our final report for the CY 2013 nation-wide review to include the recommendation above. We suggested that if CMS was unable to obtain the evidence needed to support an NCD, CMS should consider taking other appropriate actions.

Ineffectively Implemented Recommendations

**CY 2001
Review**

Recommendation: *Ensure that chiropractic services comply with Medicare coverage criteria.*³⁰

CMS concurred with this recommendation and stated that it had implemented the use of the AT modifier for chiropractic services to help chiropractors bill correctly. However, our work shows that the

AT modifier has not been fully effective in ensuring that chiropractic services comply with Medicare coverage criteria. Specifically, it has not been fully effective in preventing payments for maintenance therapy, which are unallowable for Medicare reimbursement. It is apparent that many chiropractors use the AT modifier to ensure that their claims get paid regardless of whether the services were for active/corrective treatment for subluxation.

**CY 2013
Nation-wide
Review**

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.*³¹

CMS concurred with this recommendation and stated that since CY 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.

Our work shows that despite CMS's efforts (e.g., provider education and the requirement to include the initial treatment date on claims), many chiropractors have continued to bill for services that are medically unnecessary or not adequately supported. In addition, this portfolio shows that many chiropractors have not accessed CMS's resources. From December 2015 to January 2017, a training video that CMS developed to help chiropractors properly document services had been viewed only 8,898 times. This is a relatively low number compared with the 41,012 chiropractors who submitted Medicare claims for chiropractic services in CY 2016.

CONCLUSION

Our evaluations and audits over a 13-year period from CYs 2001 through 2013 identified that Medicare paid hundreds of millions for chiropractic services that did not meet Medicare requirements, including the requirement that services be medically necessary. We also identified vulnerabilities in the oversight of chiropractic services and made many recommendations to CMS to address those vulnerabilities. In addition, our investigations and legal actions demonstrated that chiropractic services were susceptible to Medicare fraud.

CMS has taken actions to address program vulnerabilities in chiropractic services, but these actions have not always been effective. Our work demonstrates that CMS's controls (i.e., the requirements to include the AT modifier and initial treatment date on claims) have not fully prevented improper payments for chiropractic services. In addition, provider education that CMS has provided has been ineffective in eliminating improper payments for chiropractic services. Although medical review has been effective in reducing improper payments for various services in Medicare, it has not been commonly used for chiropractic services.

CMS has implemented some of our recommendations, but others remain unimplemented. For example, CMS has not taken actions to determine a reasonable number of chiropractic services that are necessary to actively treat spinal subluxation and identify for review services in excess

of that number, a control that has been used by two of CMS's contractors. Medicare has also used such a control for outpatient physical therapy and speech-language pathology services. Our work shows that if CMS established a threshold for the number of chiropractic services beyond which medical review would be required for additional services, Medicare could save millions of dollars by reducing payments for medically unnecessary services without compromising beneficiary access to reasonable and necessary services. Specifically, if the threshold had been 30 services per beneficiary per year and medical review had determined additional services to be unnecessary, Medicare could have potentially saved an estimated \$95.1 million for CYs 2013 through 2015, and Medicare beneficiaries could have potentially saved \$24.3 million during that period by not having to pay coinsurance for medically unnecessary services.

RECOMMENDATIONS

To help Medicare reduce fraud, waste, and abuse related to chiropractic services and ensure that chiropractors provide medically necessary services to protect the health and safety of Medicare beneficiaries, we recommend that CMS implement the recommendations from prior OIG reports that were not implemented or were ineffectively implemented. In addition, to further strengthen program integrity and facilitate the full implementation of our prior recommendations, CMS should:

- work with its contractors to educate chiropractors on the training materials that are available to them;
- educate beneficiaries on the types of chiropractic services that are covered by Medicare, inform them that massage and acupuncture services are not covered by Medicare, and encourage them to report to CMS chiropractors who are providing non-Medicare-covered services;
- identify chiropractors with aberrant billing patterns or high service-denial rates, select a statistically valid random sample of services provided by each chiropractor identified, review the medical records for the sampled services, estimate the amount overpaid to each chiropractor, and request that the chiropractors refund the amounts overpaid by Medicare; and
- establish a threshold for the number of chiropractic services beyond which medical review would be required for additional services.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on the new recommendations in our draft portfolio, CMS concurred with our first and second 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 third and fourth recommendations. CMS also provided technical comments on our draft portfolio, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix B.

CMS Comments

Before addressing our specific recommendations, CMS provided information on its Fraud Prevention System to identify aberrant and suspicious billing patterns and commented that several chiropractic models within that system analyze claims to detect potential fraud, waste, and abuse. CMS also commented that, although it shares our concern regarding the improper payment rate for chiropractic services, the improper payments for these services account for less than 1 percent of the total improper payments for Medicare fee-for-service. CMS stated that it is committed to using its resources to most efficiently address fraud, waste, and abuse and considers multiple factors, including potential savings, when targeting program integrity resources for specific services.

CMS's comments on our new recommendations were as follows:

- Regarding our first recommendation, CMS stated that it would “continue to work with its contractors to promote education and training materials to chiropractors.”
- Regarding our second recommendation, CMS stated that it provides information on [Medicare.gov](https://www.medicare.gov) and in written materials, such as the *Medicare & You* handbook and the *Your Medicare Benefits* booklet, to educate beneficiaries on covered and noncovered Medicare services, including chiropractic services. In addition, CMS stated that it had recently updated [Medicare.gov](https://www.medicare.gov) to highlight that acupuncture is not a covered chiropractic service and to encourage beneficiaries to report suspected fraud by chiropractors. CMS also stated that it would make the same updates to the next editions of *Medicare & You* and *Your Medicare Benefits*.
- Although CMS did not concur with our third and fourth recommendations, CMS stated that it would share the results of our portfolio with its contractors for their consideration as they develop their medical review workloads. However, CMS stated that the contractors design their program integrity activities to most effectively target the highest priority issues in their jurisdictions given their limited resources. In addition, CMS stated that it would support the program integrity activities its contractors identify that best meet CMS's goals for the program, including protecting the Medicare Trust Funds and limiting the burden on providers.

Office of Inspector General Response

We strongly encourage CMS and its contractors to take actions to implement our third and fourth recommendations. Implementing these recommendations would not only help Medicare reduce fraud, waste, and abuse related to chiropractic services but would also help CMS meet its goal of protecting the Medicare Trust Funds. In addition, implementing these recommendations may help CMS (1) focus its program integrity resources on chiropractors with aberrant billing patterns or high service-denial rates and chiropractors who provide an excessive number of chiropractic services, which may be medically unnecessary, and (2) limit the burden on chiropractors without these characteristics.

After reviewing CMS's comments, we refined our fourth recommendation and now recommend that CMS establish a threshold for the number of chiropractic services beyond which medical review would be required for additional services.

APPENDIX A: PRIOR OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>A Brooklyn Chiropractor Received Unallowable Medicare Payments for Chiropractic Services</i>	A-02-13-01047	8/9/2017
<i>Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply With Medicare Requirements</i>	A-09-14-02033	10/18/2016
<i>A Michigan Chiropractor Received Unallowable Medicare Payments for Chiropractic Services</i>	A-07-14-01148	8/8/2016
<i>CMS Should Use Targeted Tactics To Curb Questionable and Inappropriate Payments for Chiropractic Services</i>	OEI-01-14-00200	9/29/2015
<i>Alleviate Wellness Center Received Unallowable Medicare Payments for Chiropractic Services</i>	A-09-14-02027	7/22/2015
<i>Advanced Chiropractic Services Received Unallowable Medicare Payments for Chiropractic Services</i>	A-07-13-01128	5/27/2015
<i>Diep Chiropractic Wellness, Inc., Received Unallowable Medicare Payments for Chiropractic Services</i>	A-09-12-02072	11/20/2013
<i>Inappropriate Medicare Payments for Chiropractic Services</i>	OEI-07-07-00390	5/5/2009
<i>Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis</i>	OEI-09-02-00530	6/5/2005

ENDNOTES

¹ In this portfolio, a chiropractic service refers to a single treatment for subluxation of the spine.

² Social Security Act § 1862(a)(1)(A).

³ CMS's *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 15, § 30.5(B).

⁴ Subluxation is “a motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact” (*Medicare Benefit Policy Manual*, chapter 15, § 240.1.2).

⁵ *Medicare Benefit Policy Manual*, chapter 15, § 240.1.3.

⁶ Medicare guidance states that 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, chapter 12, § 220.C).

⁷ An edit is programming within the standard claims processing system that selects certain claims; evaluates or compares information on the selected claims or another accessible source; and, depending on the evaluation, takes action on the claims, such as paying them in full, paying them in part, or suspending them for manual review.

⁸ Medicare Access and CHIP Reauthorization Act of 2015, P.L. No. 114-10 (enacted Apr. 16, 2015), § 514. CHIP stands for the Children's Health Insurance Program.

⁹ The MACRA does not define aberrant billing patterns.

¹⁰ MACRA § 514(a). As of July 5, 2017, CMS had not implemented the prior-authorization process.

¹¹ MACRA § 514(b). In 2015, CMS developed a public broadcast entitled “Improving the Documentation of Chiropractic Services” to implement the education and training program required by the MACRA.

¹² CMS's *Supplementary Appendices for the Medicare Fee-for-Service Improper Payment Reports for 2010–2015*.

¹³ Medicare requires beneficiaries to pay a coinsurance amount equal to 20 percent of the amount allowed by Medicare for chiropractic services and pays the chiropractor the remaining 80 percent (42 CFR §§ 489.30(b) and 410.152(b)). However, not all beneficiaries pay out-of-pocket for coinsurance. Some beneficiaries have secondary insurance coverage (e.g., Medicaid) that will pay the coinsurance.

¹⁴ *Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis* (OEI-09-02-00530), issued June 5, 2005.

¹⁵ *Inappropriate Medicare Payments for Chiropractic Services* (OEI-07-07-00390), issued May 5, 2009.

¹⁶ *Diep Chiropractic Wellness, Inc., Received Unallowable Medicare Payments for Chiropractic Services* (A-09-12-02072), issued November 20, 2013. *Advanced Chiropractic Services Received Unallowable Medicare Payments for Chiropractic Services* (A-07-13-01128), issued May 27, 2015. *Alleviate Wellness Center Received Unallowable Medicare Payments for Chiropractic Services* (A-09-14-02027), issued July 22, 2015. *A Michigan Chiropractor Received Unallowable Medicare Payments for Chiropractic Services* (A-07-14-01148), issued August 8, 2016. *A Brooklyn Chiropractor Received Unallowable Medicare Payments for Chiropractic Services* (A-02-13-01047), issued August 9, 2017.

¹⁷ *CMS Should Use Targeted Tactics To Curb Questionable and Inappropriate Payments for Chiropractic Services* (OEI-01-14-00200), issued September 29, 2015. A medical record review was not conducted to determine whether the services were medically necessary or billed with the correct procedure code.

¹⁸ *Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply With Medicare Requirements* (A-09-14-02033), issued October 18, 2016.

¹⁹ “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.

²⁰ A Local Coverage Determination is a decision by a Medicare contractor of whether to cover a particular item or service on a contractor-wide basis in accordance with section 1862(a)(1)(A) of the Social Security Act.

²¹ OIG exclusions are not limited to Medicare. Excluded individuals and entities are excluded from participation in all Federal health care programs, including Medicare, Medicaid, and all other plans and programs that provide health care benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits program).

²² OIG has the authority to exclude individuals and entities from federally funded health care programs and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals and Entities (LEIE). The LEIE database on the OIG website (https://oig.hhs.gov/exclusions/exclusions_list.asp) contains all exclusions in effect. We reviewed the database that was updated in December 2016.

²³ *Medicare Benefit Policy Manual*, chapter 15, § 30.5(B).

²⁴ CMS’s Medicare Learning Network factsheet *Misinformation on Chiropractic Services* (ICN 006953), issued March 2015. This factsheet was intended to provide a general summary of Medicare coverage of chiropractic services, not to replace either Federal law or regulations.

²⁵ *Inappropriate Medicare Payments for Chiropractic Services* (OEI-07-07-00390), issued May 5, 2009.

²⁶ *CMS Should Use Targeted Tactics To Curb Questionable and Inappropriate Payments for Chiropractic Services* (OEI-01-14-00200), issued September 29, 2015. A similar recommendation was made in the report entitled *Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply With Medicare Requirements* (A-09-14-02033), issued October 18, 2016.

²⁷ *Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply With Medicare Requirements* (A-09-14-02033), issued October 18, 2016.

²⁸ *Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply With Medicare Requirements* (A-09-14-02033), issued October 18, 2016.

²⁹ CMS develops NCDs to describe the circumstances in which Medicare will cover specific services, procedures, or technologies on a national basis.

³⁰ *Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis* (OEI-09-02-00530), issued June 5, 2005.

³¹ *Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply With Medicare Requirements* (A-09-14-02033), issued October 18, 2016.