Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ALLEVIATE WELLNESS CENTER RECEIVED UNALLOWABLE MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Office of Inspector General

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EXECUTIVE SUMMARY

Alleviate Wellness Center received at least $482,000 over 2 years for chiropractic services that were not allowable in accordance with Medicare requirements.

WHY WE DID THIS REVIEW

In calendar years (CYs) 2012 and 2013, Medicare allowed payment of approximately $1.4 billion for chiropractic services provided to Medicare beneficiaries nationwide. A previous Office of Inspector General review found that, in 2006, Medicare inappropriately paid an estimated $178 million (of the $466 million reviewed) for chiropractic services that were medically unnecessary, incorrectly coded, or undocumented. After analyzing Medicare claim data for CYs 2012 and 2013, we selected for review Alleviate Wellness Center (the Center), which had three offices in Southern California. Our analysis indicated that the Center's chief executive officer, a licensed chiropractor, was among the top three chiropractors who received the most in Medicare payments in California.

Our objective was to determine whether chiropractic services billed by the Center were allowable in accordance 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 subluxation (when spinal bones lose their normal position). To receive payment from Medicare, a chiropractor must have documentation to support the services, as required by the Social Security Act, the Centers for Medicare & Medicaid Services' *Medicare Benefit Policy Manual*, and the applicable Local Coverage Determination for chiropractic services. In addition, depending on the number of spinal regions treated, chiropractors may bill Medicare for chiropractic manipulative treatment using one of three procedure codes.

HOW WE CONDUCTED THIS REVIEW

For CYs 2012 and 2013, the Center received Medicare Part B payments of $498,764 for 16,343 chiropractic services provided to Medicare beneficiaries. We reviewed a random sample of 100 chiropractic services. The Center provided us with medical records for 81 services. We provided copies of those records to a medical review contractor to determine whether the services were allowable in accordance with Medicare requirements.

WHAT WE FOUND

None of the 100 sampled chiropractic services were allowable in accordance with Medicare requirements. Specifically, 56 services were medically unnecessary, 23 were insufficiently documented, and 21 were not documented. As a result, the Center received $3,034 in unallowable Medicare payments.

On the basis of our sample results, we estimated that at least $482,867 of the $498,764 paid to the Center for chiropractic services, or approximately 97 percent of the total amount paid, was unallowable for Medicare reimbursement. These overpayments occurred because the Center did not have adequate policies and procedures to ensure that chiropractic services billed to Medicare were medically necessary and adequately documented.

WHAT WE RECOMMEND

We recommend that the Center:

- refund $482,867 to the Federal Government and

- establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary and adequately documented.

AUDITEE COMMENTS

The Center informed us that it would not provide written comments on our draft report.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS REVIEW

In calendar years (CYs) 2012 and 2013, Medicare allowed payment of approximately $1.4 billion for chiropractic services provided to Medicare beneficiaries nationwide. A previous Office of Inspector General (OIG) review found that, in 2006, Medicare inappropriately paid an estimated $178 million (of the $466 million reviewed) for chiropractic services that were medically unnecessary, incorrectly coded, or undocumented.[1] After analyzing Medicare claim data for CYs 2012 and 2013, we selected for review Alleviate Wellness Center (the Center), which had three offices in Southern California.[2] Our analysis indicated that the Center's chief executive officer (CEO), a licensed chiropractor, was among the top three chiropractors who received the most in Medicare payments in California. (See Appendix A for related OIG reports on Medicare claims for chiropractic services.)

OBJECTIVE

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

BACKGROUND

Administration of the Medicare Program

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

Medicare Part B covers a multitude of medical and other health services, including chiropractic services. Medicare Administrative Contractors (MACs) contract with CMS to process and pay Part B claims. During our audit period, Palmetto GBA, LLC (Palmetto), was the MAC that processed and paid the Medicare claims submitted by the Center from January 1, 2012, through September 12, 2013. Effective September 13, 2013, Noridian Healthcare Solutions, LLC (Noridian), was the MAC that processed and paid the Center's Medicare claims.

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.

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

[2] In 2013, we issued the following report on another provider: *Diep Chiropractic Wellness, Inc., Received Unallowable Medicare Payments for Chiropractic Services* (A-09-12-02072, issued Nov. 20, 2013).

The most common therapeutic procedure performed by chiropractors 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 a result of a tissue injury. When other medical conditions exist, chiropractic care may complement or support medical treatment.

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.[3]

Medicare requires that chiropractic services be reasonable and necessary for the treatment of a beneficiary's illness or injury, and Medicare limits coverage of chiropractic services to manual manipulation (i.e., by using the hands) of the spine to correct a subluxation (when spinal bones lose their normal position).[4] Chiropractors may also use manual devices to manipulate the spine.

To substantiate a claim for manipulation of the spine, the chiropractor must specify the precise level of subluxation.[5] Depending on the number of spinal regions treated, chiropractors may bill Medicare for chiropractic manipulative treatment using one of three Current Procedural Terminology (CPT)[6] codes: 98940 (for treatment of one to two regions), 98941 (for treatment of three to four regions), and 98942 (for treatment of five regions).[7] The CPT code for extraspinal chiropractic manipulative treatment (98943) is not covered by Medicare. Figure 1 on the following page illustrates the five regions of the spine, from the cervical area (neck) to the coccyx (tailbone).

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

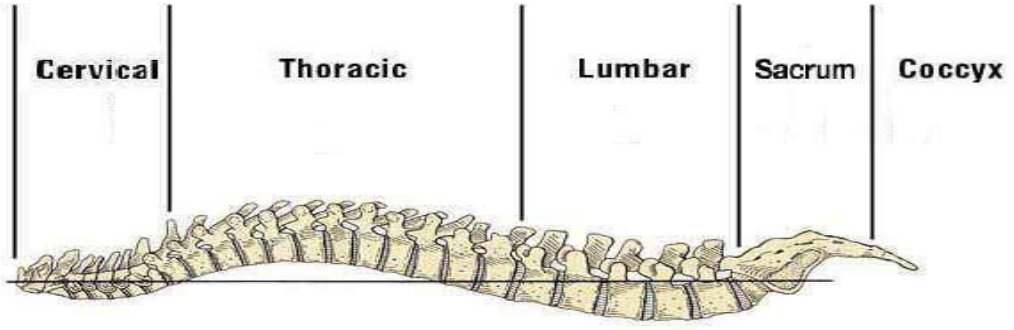
[4] The Manual defines subluxation "as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact" (chapter 15, § 240.1.2).

[5] The Manual, chapter 15, § 240.1.4, and Palmetto's and Noridian's Local Coverage Determinations (LCDs) for chiropractic services, L28249 and L33518, respectively.

[6] **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.**

[7] "Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy." Full Replacement of CR 3063," CMS Transmittal 23, Change Request 3449, October 8, 2004.

Figure 1: The Five Regions of the Spine



Medicare requires chiropractors to place the AT (Acute Treatment) modifier on a claim when providing active/corrective treatment for subluxation.[8] Because Medicare considers claims without the AT modifier to be claims for services that are maintenance therapy, it will deny these claims.[9] However, inclusion of the AT modifier does not always indicate that the service provided was reasonable and necessary.

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

Alleviate Wellness Center

The Center was established in February 2011. During our audit period, the Center had three offices, located in Garden Grove, Los Angeles, and Tustin, California. The Center's CEO has been a licensed chiropractor in California since October 2004 and is the sole owner of the Center. According to the CEO, during CYs 2012 and 2013, the Center employed six chiropractors. These six chiropractors provided chiropractic services to patients, and the Center billed Medicare for those services. The Medicare claim data showed that the CEO was the performing provider for 61 percent of the services that the Center billed for CYs 2012 and 2013.

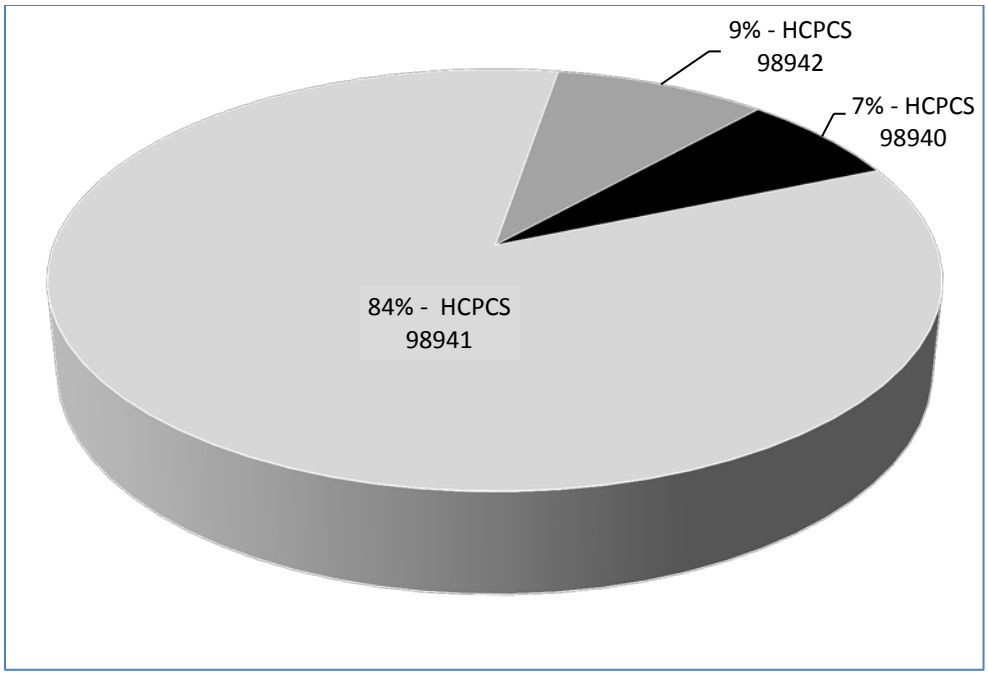
The Medicare claim data also showed that all of the chiropractic services that the Center provided were billed with the AT modifier. Further, the majority (84 percent) of the services were billed with CPT code 98941, which had the second highest physician fee schedule amount among the three CPT codes covered by Medicare for chiropractic services.

[8] The Manual, chapter 15, § 240.1.3. A modifier is a two-character code reported with a CPT code and is designed to give Medicare and commercial payers additional information needed to process a claim.

[9] 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 Manual, chapter 15, §§ 30.5(B) and 240.1.3(A)).

Figure 2 below illustrates the percentage of services for each CPT code that the Center billed to Medicare for CYs 2012 and 2013.

Figure 2: Percentage of Services by CPT Code for CYs 2012 and 2013



HOW WE CONDUCTED THIS REVIEW

For CYs 2012 and 2013, the Center received Medicare Part B payments of $498,764 for 16,343 chiropractic services provided to Medicare beneficiaries. We reviewed a random sample of 100 line items for chiropractic services. (A service line item represented a chiropractic service included on a claim.) The Center provided us with medical records for 81 services.[10] We provided copies of those records to a medical review contractor to determine whether the chiropractic 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 describes our audit scope and methodology, Appendix C describes our statistical sampling methodology, and Appendix D contains our sample results and estimates. Appendix E describes the Medicare reimbursement requirements for chiropractic services.

[10] The Center's CEO stated that all of the medical records for the beneficiaries who had received the remaining 19 services had been lost.

FINDINGS

None of the 100 sampled chiropractic services were allowable in accordance with Medicare requirements. Specifically, 56 services were medically unnecessary, 23 were insufficiently documented, and 21 were not documented. As a result, the Center received $3,034 in unallowable Medicare payments.

On the basis of our sample results, we estimated that at least $482,867 of the $498,764 paid to the Center for chiropractic services, or approximately 97 percent of the total amount paid, was unallowable for Medicare reimbursement.[11] These overpayments occurred because the Center did not have adequate policies and procedures to ensure that chiropractic services billed to Medicare were medically necessary and adequately documented.

CHIROPRACTIC SERVICES WERE NOT ALLOWABLE IN ACCORDANCE WITH MEDICARE REQUIREMENTS

Services Were Medically Unnecessary

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

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

Of the 100 sampled chiropractic services, 56 were medically unnecessary. The results of the medical review indicated that these services did not meet one or more Medicare requirements:[12]

- Subluxation of the spine was not present or was not treated with manual manipulation or both (46 services).

- Manual manipulation of the spinal subluxation was maintenance therapy or was not appropriate for treatment of the patient's condition or both (55 services).

[11] Although 100 percent of the chiropractic services in our sample were unallowable, we did not recommend a refund of the total amount paid to the Center ($498,764) because our policy is to recommend recovery of overpayments at the lower limit, as described in Appendix B.

[12] The total exceeds 56 because 55 of the 56 services did not meet more than 1 Medicare requirement.

- Manual manipulation of the spinal subluxation would not be expected to result in improvement within a reasonable and generally predictable period of time (55 services).

For example, the Center received payment for a chiropractic service provided on December 6, 2013, to a 56-year-old Medicare beneficiary.[13] 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. Further, the medical review contractor stated: "… the patient did not have evidence of a spinal subluxation…. The care therefore does not meet Medicare criteria."

Services Were Insufficiently Documented

The Manual and Palmetto's and Noridian's LCDs require that the initial visit and all subsequent visits to the chiropractor meet specific documentation requirements. (See Appendix E for the documentation requirements for the initial visit.) The following must be documented for subsequent visits: (1) patient history, including a review of the chief complaint, changes since the last visit, and a system review if relevant;[14] (2) physical examination of the area of the spine involved in the diagnosis, an assessment of change in the patient's condition since the last visit, and an evaluation of treatment effectiveness; and (3) the treatment given on the day of the visit (the Manual, chapter 15, § 240.1.2(B), and LCDs L28249 and L33518).

Of the 100 sampled chiropractic services, 23 were insufficiently documented for subsequent chiropractic visits. We determined that the medical records for these subsequent visits did not meet the documentation requirements specified in the Manual and Palmetto's and Noridian's LCDs. The Center documented these services in a log that included dates and patient signatures; however, the log did not include the specific services provided to the beneficiaries. The Center did not provide any other documentation to support these services.

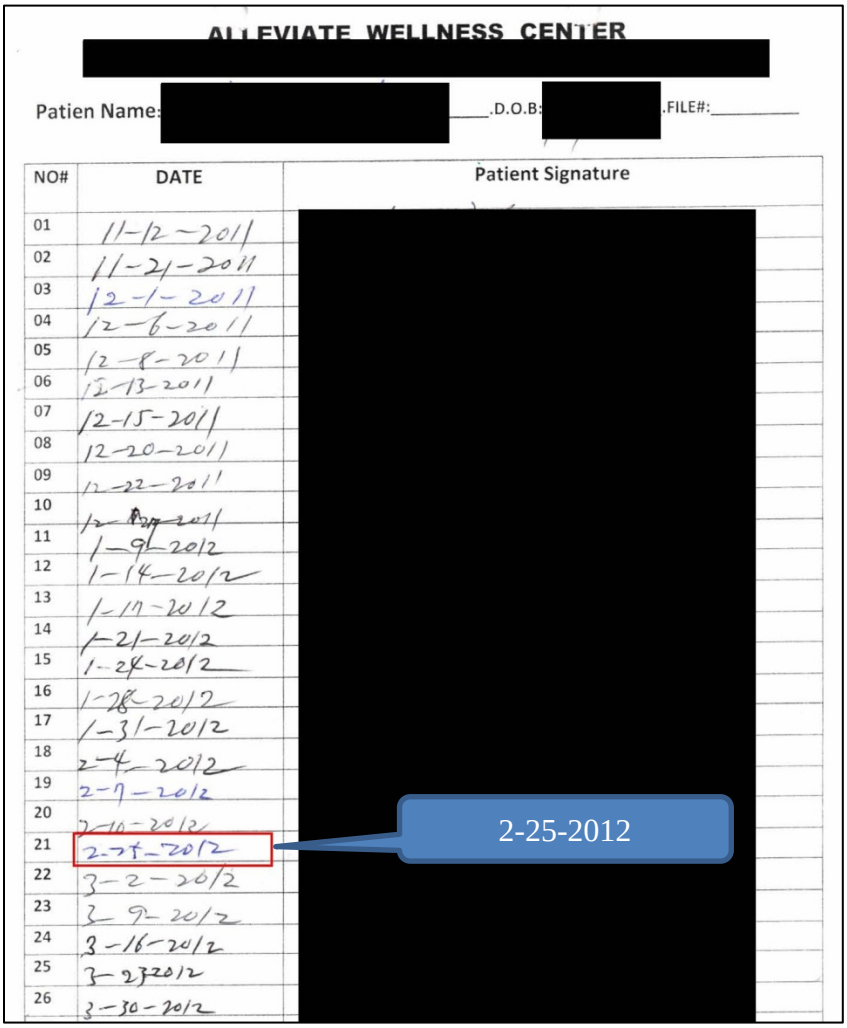
For example, the Center received payment for a chiropractic service provided on February 25, 2012, to a Medicare beneficiary.[15] After reviewing the medical records provided, the medical review contractor stated: "There are no clinical findings available for review for the date of service 2/25/12. The care therefore does not meet Medicare criteria." Figure 3 on the following page shows the log that the Center used to support this service.

[13] During CYs 2012 and 2013, the Center received a total of $2,550 for 85 chiropractic services provided to this beneficiary.

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

[15] During CYs 2012 and 2013, the Center received a total of $483 for 16 chiropractic services provided to this beneficiary.

Figure 3: Example of an Insufficiently Documented Subsequent Visit[16]



Services Were Not Documented

To receive payment from Medicare, a chiropractor must have documentation to support the services. No payment may be made to any provider of services unless information has been furnished to determine the amounts due the provider (the Act § 1833(e)). Further, the Manual and Palmetto's and Noridian's LCDs require chiropractors to document the services provided to Medicare beneficiaries (the Manual, chapter 15, § 240.1.2, and LCDs L28249 and L33518).

Of the 100 sampled chiropractic services, 21 were not documented. The Center could not find the medical records for the beneficiaries who received 19 of these services. For the remaining two services, the Center provided the medical records for the beneficiaries who received these services; however, there was no documentation for the selected services.

[16] The office address and the patient's name, date of birth, and signature have been redacted.

For example, the Center received payment for a claim with a service date of April 10, 2012, for a Medicare beneficiary.[17] The medical record that the Center provided for this beneficiary contained a service log that listed the service dates March 13, 2012, and April 17, 2012, but did not contain any documentation for April 10, 2012. The medical review contractor stated: "There was no clinical treatment record provided for the date of service."

ALLEVIATE WELLNESS CENTER RECEIVED UNALLOWABLE MEDICARE PAYMENTS

The Center received $3,034 in unallowable Medicare payments for the 100 chiropractic services that did not meet Medicare requirements. On the basis of our sample results, we estimated that at least $482,867 of the $498,764 paid to the Center for chiropractic services, or approximately 97 percent of the total amount paid, was unallowable for Medicare reimbursement.

ALLEVIATE WELLNESS CENTER DID NOT HAVE ADEQUATE POLICIES AND PROCEDURES

The overpayments occurred because the Center did not have adequate policies and procedures to ensure that chiropractic services billed to Medicare were medically necessary and adequately documented. The Center did not have written policies and procedures. The CEO stated that he referred the other chiropractors to "the online Medicare handbook" to obtain information on how to document chiropractic services.[18]

The Center had an in-house biller who was responsible for submitting Medicare claims on the basis of information contained in a record referred to as a "superbill."[19] According to the biller, the program used to bill Medicare for chiropractic services automatically put the AT modifier on the claim form. Therefore, the Center submitted all chiropractic Medicare claims with the AT modifier. However, the Manual (chapter 15, § 240.1.3) and the MACs' LCDs state: "For Medicare purposes, a chiropractor must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation…. The AT modifier must not be placed on the claim when maintenance therapy has been provided."

The biller stated that, in addition to the superbill, she needed the beneficiary's name, address, and Medicare number to prepare the claim. The biller said that the Center's CEO provided this information for patients from the Garden Grove office. For patients from the Los Angeles office, the biller obtained this information from the medical records.[20] According to the biller, she did not review the medical records for anything else.

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[17] During CYs 2012 and 2013, the Center received a total of $928 for 30 chiropractic services provided to this beneficiary.

[18] The handbook that the CEO referred to was a document on Noridian's Web site, which provided documentation guidelines for chiropractic services.

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

[20] According to the CEO, Medicare beneficiaries were not treated at the office in Tustin, California.

According to the Center's CEO, no one at the Center reviewed medical records to ensure that services were adequately documented before services were billed to Medicare. The only person who reviewed the medical records was the chiropractor who performed the services. In addition, the CEO stated he was unable to find the medical records for 19 chiropractic services in our sample because, when he closed the Los Angeles office in May 2014, all of the belongings "were packed hastily, disorderly and sent to places in a chaotic manner."

RECOMMENDATIONS

We recommend that the Center:

- refund $482,867 to the Federal Government and

- establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary and adequately documented.

AUDITEE COMMENTS

On April 30, 2015, we issued our draft report to the Center and requested that it provide us with written comments within 30 days. On July 6, 2015, the Center informed us that it would not provide written comments.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Advanced Chiropractic Services Received Unallowable Medicare Payments for Chiropractic Services	A-07-13-01128	5/27/2015
Diep Chiropractic Wellness, Inc., Received Unallowable Medicare Payments for Chiropractic Services	A-09-12-02072	11/20/2013
Inappropriate Medicare Payments for Chiropractic Services	OEI-07-07-00390	May 2009
Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis	OEI-09-02-00530	June 2005

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

For CYs 2012 and 2013, the Center received Medicare Part B payments of $498,764 for 16,343 chiropractic services provided to Medicare beneficiaries. We reviewed a random sample of 100 line items for chiropractic services. (A service line item represented a chiropractic service included on a claim.) The Center provided us with medical records for 81 services.[21] We provided copies of those records to a medical review contractor to determine whether the services were allowable in accordance with Medicare requirements.

We did not review the Center's overall internal control structure. Rather, we limited our review of internal controls to those that were significant to our objective.

We conducted our audit from June 2014 to February 2015 and performed fieldwork at the Center's office in Garden Grove, California.

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;
- interviewed the Center's CEO and the Center's in-house biller to obtain an understanding of the Center's procedures for (1) providing chiropractic services to beneficiaries, (2) maintaining documentation for services, and (3) billing Medicare for services;
- obtained from CMS's National Claims History (NCH) file the Medicare Part B claims for chiropractic services paid to the Center, with service dates ending in CYs 2012 and 2013;
- created a sampling frame of 16,343 chiropractic services from the NCH data and randomly selected a sample of 100 services;
- obtained medical records and other documentation from the Center for 81 of the 100 sampled services and provided them to the medical review contractor, who determined whether each service was allowable in accordance with Medicare requirements;

[21] The Center's CEO stated that all of the medical records for the beneficiaries who had received the remaining 19 services had been lost.

- reviewed the medical review contractor's results and categorized each sampled service determined to be unallowable as one of three error types: medically unnecessary, insufficiently documented, or not documented;

- estimated the amount of the unallowable payments for chiropractic services; and

- shared the results of our review with the Center's CEO.

See Appendix C for our statistical sampling methodology and Appendix D for our sample results and estimates.

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

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of chiropractic services that the Center billed for CYs 2012 and 2013.

SAMPLING FRAME

The sampling frame consisted of 16,343 line items for chiropractic services for CYs 2012 and 2013 for which the Center received Medicare payments of $498,764. A service line item represented a chiropractic service included on a claim. We obtained the claim data from CMS's NCH file.

SAMPLE UNIT

The sample unit was a chiropractic service.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

The sample size was 100 chiropractic services.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units in the sampling frame from 1 to 16,343. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of the unallowable payments for chiropractic services. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total at least 95 percent of the time.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Services	Value of Unallowable Services
16,343	$498,764	100	$3,034	100	$3,034

Table 2: Estimated Value of Unallowable Services
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$495,768
Lower limit	482,867
Upper limit	508,669

APPENDIX E: MEDICARE REIMBURSEMENT REQUIREMENTS FOR CHIROPRACTIC SERVICES

Medical Necessity

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

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

The Manual states:

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

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

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

Coding

Palmetto's and Noridian's LCDs identify three CPT codes that may be used to bill Medicare for chiropractic services (LCDs L28249 and L33518). Depending on the number of spinal regions treated, chiropractors may bill Medicare for chiropractic manipulative treatment using CPT codes 98940, 98941, or 98942.[22]

[22] **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.**

Documentation

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

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

The following must be documented for initial visits:

1. History

2. Description of the present illness including:

   Mechanism of trauma;
   Quality and character of symptoms/problem;
   Onset, duration, intensity, frequency, location, and radiation of symptoms;
   Aggravating or relieving factors;
   Prior interventions, treatments, medications, secondary complaints; and
   Symptoms causing patient to seek treatment.

3. Evaluation of musculoskeletal/nervous system through physical examination.

4. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.

5. Treatment Plan: The treatment plan should include the following:

   Recommended level of care (duration and frequency of visits);
   Specific treatment goals; and
   Objective measures to evaluate treatment effectiveness.

6. Date of the initial treatment.

The following must be documented for subsequent visits:

1. History

   Review of chief complaint;
   Changes since last visit;
   System review if relevant.

2. Physical exam

   Exam of area of spine involved in diagnosis;
   Assessment of change in patient condition since last visit;
   Evaluation of treatment effectiveness.

3. Documentation of treatment given on day of visit.