

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ADVANCED CHIROPRACTIC SERVICES
RECEIVED UNALLOWABLE
MEDICARE PAYMENTS FOR
CHIROPRACTIC SERVICES**

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Office of Inspector General

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EXECUTIVE SUMMARY

Advanced Chiropractic Services received at least \$737,000 over 2 years for chiropractic services that were not allowable in accordance with Medicare requirements.

WHY WE DID THIS REVIEW

In calendar years (CYs) 2011 and 2012, Medicare allowed approximately \$1.4 billion of payments 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 CY 2011, we selected multiple providers for review, including Advanced Chiropractic Services (ACS), based in Lawrence, Kansas.

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

BACKGROUND

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

HOW WE CONDUCTED THIS REVIEW

For CYs 2011 and 2012, ACS received Medicare Part B payments of \$764,953 for 22,471 chiropractic services provided to Medicare beneficiaries. We reviewed a sample of 105 chiropractic service line items. (A service line item represents a service included on a claim.) We provided copies of medical records for these services to a medical review contractor to determine whether the services were allowable in accordance with Medicare requirements.

WHAT WE FOUND

None of the 105 chiropractic service line items that we sampled were allowable in accordance with Medicare requirements. Specifically, the medical records did not support the medical necessity for any of the 105 sampled chiropractic service line items. As a result, ACS received \$3,529 in unallowable Medicare payments.

On the basis of our sample results, we estimated that ACS received overpayments of at least \$737,111 for CYs 2011 and 2012. This amount included claims outside of the 3-year claims recovery period. Of the total estimated overpayments, at least \$369,335 was received within the 3-year claims recovery period. These overpayments occurred because ACS did not have adequate policies and procedures to ensure that the medical necessity of chiropractic services billed to Medicare was adequately documented in the medical records.

WHAT WE RECOMMEND

We recommend that ACS:

- refund to the Federal Government \$369,335 in estimated overpayments for claims incorrectly billed that were within the 3-year claims recovery period,
- work with Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor that processed and paid the Medicare claims submitted by ACS) to return overpayments outside of the 3-year claims recovery period in accordance with the 60-day repayment rule, and
- establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are adequately documented in the medical records.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, ACS did not concur with our recommendations to refund overpayments to the Federal Government. ACS concurred in part with our third recommendation and described corrective actions that it said it had taken to enhance its internal compliance related to Medicare claims. However, ACS did not concur with the remainder of our third recommendation and stated that the medical records for all chiropractic service line items found in error contained the necessary documentation and that the services themselves were medically necessary.

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

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INTRODUCTION

WHY WE DID THIS REVIEW

In calendar years (CYs) 2011 and 2012, Medicare allowed approximately \$1.4 billion of payments 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 CY 2011, we selected multiple providers for review, including Advanced Chiropractic Services (ACS), based in Lawrence, Kansas.

OBJECTIVE

Our objective was to determine whether chiropractic services billed by ACS 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 permanent kidney 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. Wisconsin Physicians Service Insurance Corporation (WPS) was the MAC that processed and paid the Medicare claims submitted by ACS.

Chiropractic Services

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

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

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

Medicare Coverage of Chiropractic Services

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

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

To substantiate a claim for manipulation of the spine, the chiropractor must specify the precise level of subluxation.⁴ Depending on the number of spinal regions treated, chiropractors may bill Medicare for chiropractic manipulative treatment using one of three Current Procedural Terminology (CPT)⁵ codes: 98940 (for treatment of one to two regions), 98941 (for treatment of three to four regions), and 98942 (for treatment of five regions). Figure 1 on the following page illustrates the five regions of the spine, from the cervical area (neck) to the coccyx (tailbone).

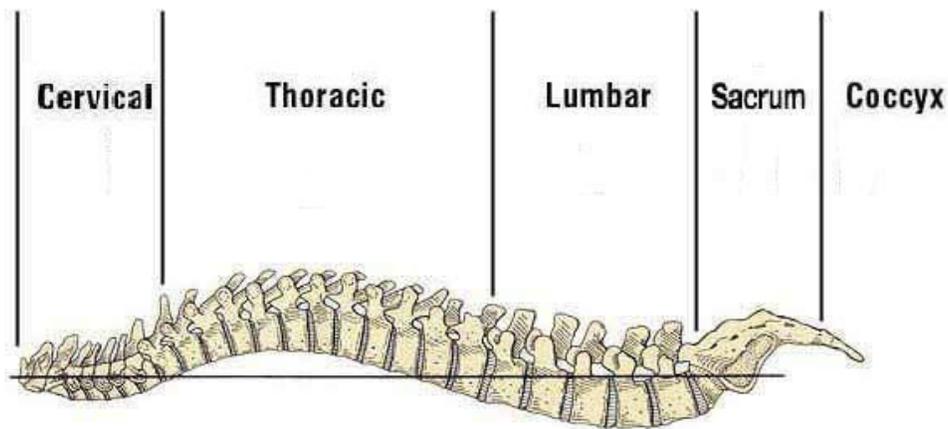
² CMS's *Medicare Benefit Policy Manual*, Pub. 100-02 (the Manual), chapter 15, section 30.5.

³ The Manual defines subluxation "as a motion segment in which alignment, movement integrity, and/or physiological function of the spine are altered, although contact between joint surfaces remains intact" (chapter 15, § 240.1.2).

⁴ The Manual, chapter 15, section 240.1.4, and WPS's Local Coverage Determination (LCD) for chiropractic services (L30328).

⁵ CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures provided by physicians and other health care professionals. The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2010 and 2011 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 Federal Acquisition Regulation System/Defense Federal Acquisition Regulation Supplement apply.

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.⁶ Because Medicare considers claims without the AT modifier to be claims for services that are maintenance therapy, it will deny these claims.⁷ However, inclusion of the AT modifier does not always indicate that the service provided was reasonable and necessary.

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

Advanced Chiropractic Services

ACS was established in September 1995 and has a total of three offices: in Lawrence, Bonner Springs, and Valley Falls, Kansas. During CYs 2011 and 2012, ACS employed five chiropractors. These five chiropractors provided chiropractic services to their patients, and ACS billed Medicare for those services under one tax identification number.

The Medicare claim data that we reviewed showed that all of the chiropractic services provided by ACS were billed with the AT modifier. Further, almost all (98 percent) of the services were billed with CPT code 98942, which had the highest physician fee schedule amount among the three CPT codes covered by Medicare for chiropractic services.

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

⁷ Maintenance therapy includes services that seek to prevent disease, promote health, and prolong and enhance the quality of life or to maintain or prevent deterioration of a chronic condition (WPS's LCD L30328).

Table 1 below shows the allowed amount on the Medicare fee schedule for each CPT code during CYs 2011 and 2012 for Kansas, where ACS is located.

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

Period	CPT 98940	CPT 98941	CPT 98942
January 1 – December 31, 2011	\$24.29	\$33.64	\$43.47
January 1 – December 31, 2012	24.27	33.97	43.39

HOW WE CONDUCTED THIS REVIEW

For CYs 2011 and 2012, ACS received Medicare Part B payments of \$764,953 for 22,471 chiropractic services provided to Medicare beneficiaries. We reviewed a sample of 105 chiropractic service line items. (A service line item represents a service included on a claim.) We judgmentally selected five service line items based on the number of services provided to the beneficiaries. We selected the other 100 service line items using a simple random sample. ACS provided us with copies of medical records as support for these service line items. In turn, we provided those copies to a medical review contractor to determine whether the 105 chiropractic service line items 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 A contains the details of our audit scope and methodology, Appendix B contains the details of our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D contains details on the Medicare payment requirements for chiropractic services.

FINDINGS

None of the 105 chiropractic service line items that we sampled were allowable in accordance with Medicare requirements. Specifically, the medical records did not support the medical necessity for any of the 105 sampled chiropractic service line items. As a result, ACS received \$3,529 in unallowable Medicare payments.

On the basis of our sample results, we estimated that ACS received overpayments of at least \$737,111 for CYs 2011 and 2012. This amount included claims outside of the 3-year claims recovery period. Of the total estimated overpayments, at least \$369,335 was received within the

3-year claims recovery period.⁸ These overpayments occurred because ACS did not have adequate policies and procedures to ensure that the medical necessity of chiropractic services billed to Medicare was adequately documented in the medical records.

CHIROPRACTIC SERVICES WERE NOT ALLOWABLE IN ACCORDANCE WITH MEDICARE REQUIREMENTS

Medicare Requirements

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

The Manual states that (1) chiropractic maintenance therapy is not considered to be medically reasonable or necessary and is therefore not payable (chapter 15, § 30.5(B)); (2) the manipulative services provided must have a direct therapeutic relationship to the patient's condition, and the patient must have a subluxation of the spine (chapter 15, § 240.1.3); and (3) the chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration of the condition within a reasonable and generally predictable period of time (chapter 15, § 240.1.5). The Manual and WPS's LCD require that the initial visit and all subsequent visits to the chiropractor meet specific documentation requirements. See Appendix D for these requirements.

The following must be documented for subsequent visits: (1) patient history, including a review of the chief complaint, changes since the last visit, and a system review if relevant;⁹ (2) physical examination of the area of the spine involved in the diagnosis, an assessment of change in the patient's condition since the last visit, and an evaluation of treatment effectiveness; and (3) the treatment given on the day of the visit (the Manual, chapter 15, § 240.1.2(B), and LCD L30328).

⁸ Our audit report represents the results for all claims within our audit period (CYs 2011 and 2012). Section 1870(b) of the Social Security Act (the Act) governs the recovery of excess payments. This section provides that excess payments identified are barred from recovery 3 years after the year in which the original payment was made. In addition, the provider is responsible for reporting and returning overpayments it identified to its MAC. The 2010 Patient Protection and Affordable Care Act requires the reporting and return of Medicare overpayments along with written notice of the reason for the overpayment within 60 days after the overpayment was identified (60-day repayment rule). Failure to meet this deadline subjects providers to potential False Claims Act and Civil Monetary Penalty Law liability.

⁹ 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.

Medical Records Did Not Support Medical Necessity

The medical records did not support the medical necessity for any of the 105 sampled chiropractic service line items. Specifically, results of the medical review indicated that these services, as documented in the medical records, did not meet Medicare requirements for the following reasons:

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

Further, the medical review contractor determined that none of the medical records for any of the 105 sampled service line items met the documentation requirements as specified in the Manual and WPS's LCD L30328.

For example, ACS received a payment for a chiropractic service provided on April 11, 2012, to a 76-year-old beneficiary. The medical review contractor determined that the medical records did not support the medical necessity for this service because at this point in the patient's care, chiropractic manual manipulation was not likely to result in improvement in the patient's condition in a reasonable period. In addition, the medical records did not contain a clinical record of treatment, progression of the patient's condition, or reassessment by objective measurements that would prove the medical necessity of ongoing chiropractic care. This sampled claim was the 241st chiropractic service of 273 chiropractic services that the beneficiary received from ACS during CYs 2011 and 2012.

ADVANCED CHIROPRACTIC SERVICES RECEIVED UNALLOWABLE MEDICARE PAYMENTS

ACS received \$3,529 in unallowable Medicare payments for the 105 sampled chiropractic service line items that did not meet Medicare requirements. On the basis of our sample results, we estimated that ACS received overpayments of at least \$737,111 for CYs 2011 and 2012, of which at least \$369,335 was received within the 3-year claims recovery period.

ADVANCED CHIROPRACTIC SERVICES DID NOT HAVE ADEQUATE POLICIES AND PROCEDURES

The overpayments occurred because ACS did not have adequate policies and procedures to ensure that the medical necessity of chiropractic services billed to Medicare was adequately documented in the medical records. Specifically, ACS did not have procedures to adequately document, in the medical records, clinical findings showing that the treatment actually improved the condition of the patient. ACS also did not have procedures to document qualitative or quantitative measures by which it could be proven that future progression of care would demonstrate treatment effectiveness.

RECOMMENDATIONS

We recommend that ACS:

- refund to the Federal Government \$369,335 in estimated overpayments for claims incorrectly billed that were within the 3-year claims recovery period,
- work with WPS to return overpayments outside of the 3-year claims recovery period in accordance with the 60-day repayment rule, and
- establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are adequately documented in the medical records.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

AUDITEE COMMENTS

In written comments on our draft report, ACS did not concur with our recommendations to refund overpayments to the Federal Government. ACS concurred in part with our third recommendation and described corrective actions that it said it had taken to enhance its internal compliance related to Medicare claims. Moreover, ACS acknowledged that its extensive use of the CPT code 98942 may have been inappropriate and that the claims may need to be corrected. ACS added that nevertheless, these errors were not intentional. However, ACS did not concur with the remainder of our third recommendation and stated that the medical records for all chiropractic service line items found in error contained the necessary documentation and that the services themselves were medically necessary.

In response to our recommendation to refund \$737,111 to the Federal Government, ACS stated "... that all of the treatment provided to the Medicare beneficiaries reviewed by OIG was medically necessary based on CMS guidelines." In this regard, ACS had the following comments:

- ACS stated that it "... believes that the care provided to the Medicare beneficiaries recorded in the audited documents from 2011 and 2012 were in fact medically necessary treatments and not defined as maintenance care [therapy]." ACS also stated that maintenance therapy "... is not defined or should be used as a default denial if the reviewer cannot find a specific item or a phrase that is missing in the documents prepared by the chiropractor to the care was AT [active treatment]." ACS requested that we reconsider our determination that 100 percent of the service line items that we reviewed should be classified as maintenance therapy.
- ACS disputed the results of the medical review and said that the "[m]annual manipulation of the spinal subluxation resulted in improvement within a reasonable and generally predictable period of time." ACS also said "... that many of the 105 denied claims involved Medicare beneficiaries with chronic subluxations that would require an extended period of time to correct the condition."

- ACS stated that “[i]t is of great concern to ACS that not a single visit of the 105 service line items reviewed was at a level to pass a medical necessity criteria set by OIG.” ACS presented details of the treatments provided to two sampled beneficiaries to demonstrate that the chiropractic services that it provided were medically necessary.
- ACS stated that the majority of the 105 sampled chiropractic line services were classified as subsequent visits for which it contended that the minimum requirements related to documentation were present in its medical records. To this point, ACS proposed:
 - ... that the 100% denial of all claims determined by the contracted medical reviewer was not due to the fact that all of the encounters were not properly documented, but instead the 100% denial potentially was the result of a medical review criteria that was set at a level that could have the unintended effect of exclusion of valid abbreviations used for documenting the patient encounter.

ACS’s comments are included in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

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

- The medical review contractor found that the medical records did not support medical necessity for any of the 105 sampled chiropractic service line items. For each medical record that ACS submitted, the contractor considered chiropractic treatment standards, Medicare requirements, and each beneficiary’s individual circumstances before assessing the medical necessity of the service provided. Further, the contractor did not reach a default conclusion that a service was maintenance therapy when the medical necessity elements for Medicare coverage were not met. Rather, the contractor’s individual reviews of the records led it to classify each service as maintenance therapy, which is not payable as stated in chapter 15, section 30.5(B) of the Manual.
- The medical review contractor found, for all 105 sampled chiropractic service line items, that the medical records did not indicate that the services provided a direct therapeutic relationship to, and correlation of treatment with, the beneficiary’s symptoms. Specifically, the contractor found that the services did not provide a reasonable expectation of recovery or improvement, which is required by chapter 15, section 240.1.3, of the Manual.
- With regard to the two sampled beneficiaries for whom ACS presented details of treatments provided, the medical review contractor sent the respective medical records to a second reviewer without disclosing the results of initial reviews. For both beneficiaries, the second reviewer found that the care was not medically necessary. Specifically, the reviewers noted that there was no quantifiable change in the two patients’ conditions to support the necessity of treatment.

- The medical review contractor assessed ACS's records according to the coverage elements for chiropractic services specified in Medicare requirements. Further, the medical review contractor used actively practicing licensed chiropractors to perform its reviews.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For CYs 2011 and 2012, ACS received Medicare Part B payments of \$764,953 for 22,471 chiropractic services provided to Medicare beneficiaries. We reviewed a sample of 105 chiropractic service line items. We judgmentally selected 5 service line items and used a simple random sample to select the other 100 service line items. ACS provided us with copies of medical records as support for these service line items. In turn, we provided those copies to a medical review contractor to determine whether the 105 chiropractic service line items were allowable in accordance with Medicare requirements.

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

We conducted our audit from June 2013 to May 2014 and performed fieldwork at ACS's office in Lawrence, Kansas.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed WPS officials to obtain an understanding of Medicare payment requirements and claim processing procedures for chiropractic services;
- interviewed ACS officials to obtain an understanding of ACS's procedures for (1) providing chiropractic services to beneficiaries, (2) maintaining documentation for services, and (3) billing Medicare for services;
- obtained from the CMS's National Claims History (NCH) file the Medicare Part B claims for chiropractic services provided by ACS, with service dates ending in CYs 2011 and 2012;
- created a sampling frame of 22,471 chiropractic service line items from the NCH data and selected a stratified random sample of 105 service line items;
- obtained complete medical records and other documentation from ACS for the 105 sampled service line items and provided them to the medical review contractor, who determined whether each service was allowable in accordance with Medicare requirements (for chiropractic services initially determined to be medically unnecessary

by a claims review analyst, the medical record review was completed by a clinical reviewer to make the final determination);¹⁰

- reviewed and summarized the medical review contractor's results;
- estimated the amount of the unallowable payments for chiropractic services;
- used the results of the sample to estimate the total Medicare overpayments to ACS for CYs 2011 and 2012;
- used the results of the sample to estimate the Medicare overpayments to ACS for CYs 2011 and 2012 that were within the 3-year claims recovery period; and
- shared the results of our review with ACS during a meeting held on May 1, 2014.

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

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

¹⁰ We incorrectly described the medical record review process in our draft report. For this final report, we have clarified our description of the process that the medical record reviewer used to make its determinations.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of chiropractic service line items that ACS billed for services that were provided during CYs 2011 and 2012.

SAMPLING FRAME

The sampling frame was a listing of 22,471 chiropractic service line items CYs 2011 and 2012. Those 22,471 service line items totaled \$764,953 in Medicare payments to ACS. We obtained the claim data from CMS's NCH file.

SAMPLE UNIT

The sample unit was a chiropractic service line item.

SAMPLE DESIGN

We used a stratified random sample consisting of two strata. Stratum 1 consisted of 5 judgmentally selected service line items. Stratum 2 consisted of the remaining 22,466 service line items.

SAMPLE SIZE

The sample size was 105 chiropractic service line items:

- Stratum 1 – 5 service line items
- Stratum 2 – 100 service line items

We reviewed all service line items in stratum 1.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We judgmentally selected 5 service line items from the original population of 22,471 service line items. After removing these 5 service line items, we consecutively numbered the sample units in the remaining sampling frame from 1 to 22,466. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used RAT-STATS to estimate the amount of the unallowable payments for chiropractic services.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Services	Value of Unallowable Services
1	5	174	5	\$174	5	\$174
2	22,466	\$764,779	100	\$3,355	100	\$3,355

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

Point estimate	\$754,005
Lower limit	737,111
Upper limit	770,898

**Table 4: Estimated Value of Unallowable Services
Paid Within the 3-Year Claims Recovery Period (After December 31, 2011)
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$431,475
Lower limit	369,335
Upper limit	493,615

APPENDIX D: MEDICARE PAYMENT 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).

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 reviews if relevant.

2. Physical exam

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

3. Documentation of treatment given on day of visit.

APPENDIX E: AUDITEE COMMENTS

DeWitt :

July 7, 2014

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit services, Region VII
601 East 12th Street, Room 0429
Kansas City Mo., 64106

RE: Report Number A-07-13-01128

Dear Mr. Cogley:

The office of DeWitt Ross and Stevens has been retained by Advanced Chiropractic Services (ACS) to represent it with respect to the recent Office of the Inspector General Audit report.

Advanced Chiropractic Services is comprised of three chiropractic clinics located in Lawrence, Bonner Springs and Valley Falls Kansas. ACS employed five chiropractors during the OIG review of chiropractic claims billed to Medicare.

The Audit report entitled *Advanced Chiropractic Services Received Unallowable Medicare Payments For Chiropractic Services* provides a series of discussions and conclusions related to the review of medical necessity of chiropractic care delivered and recorded on 105 separate chiropractic service line items by ACS.

ACS was provided a draft report and allowed the opportunity to provide views on the validity of the facts and reasonableness of the recommendations made in the OIG report. ACS was allowed to provide written comments in concurrence or nonconcurrence with each recommendations found in the report. Additional comments are to include corrective actions taken for each concurrence with the OIG determination. For each nonconcurrent viewpoint, ACS was allowed to provide specific reasons for the nonconcurrence and any alternative action taken or planned.

In the draft report, the OIG recommended the following actions be taken by ACS:

1. Refund \$737,111 to the Federal Government and
2. Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are adequately documented in the medical records.

1

Opening Comments:

Upon notice of the OIG review, Advance Chiropractic Services has been openly cooperative and accommodating to every OIG request for documentation or supporting information. The ACS chiropractors voluntarily provided not only initial requested documentation, but participated in all OIG requested interviews and subsequent request for information. The ACS chiropractors are not culpable of any fraudulent or deceptive billing practices.

It is also important to note:

1. Every chiropractic service billed to Medicare was actually provided by the chiropractors at ACS to Medicare beneficiaries.
2. The ACS medical records demonstrate that Medicare Beneficiaries primarily presented with significant pain symptoms as a result of falls, accidents and other injuries.
3. The ACS medical records demonstrate that vertebral subluxations were properly noted and interpreted by the ACS chiropractors to correlate to the beneficiaries' symptoms.
4. The ACS medical records demonstrate the chiropractic care provided to the Medicare Beneficiaries resulted in functional improvement and reduction of pain symptoms.
5. ACS has implemented a new EHR document system that creates a narrative format record as opposed to the handwritten abbreviation format reviewed by OIG during the audit period.
6. Subsequent to the initiation of the audit process, the ACS chiropractors have attended Medicare educational programs to increase their understanding of Medicare rules, coding and regulations.

Upon review of the draft report the primary points of OIG concern relate to two main issues:

1. The use of the CPT code 98942 and,
2. The determination that every visit reviewed was billed with the AT modifier signifying the care was for Active Treatment of the patient's condition.

ACS will address both OIG points of concern in the body of this document below.

In regards to the request for repayment of \$737,111, ACS respectfully requests that OIG take into serious consideration mitigating factors that ACS has taken in regards to compliance and improvements in medical documentation when releasing its final determination. ACS has not been engaged in any fraudulent or unethical billing practices. All of the services reviewed by OIG were actually provided to Medicare Beneficiaries. All of the services reviewed by OIG assisted in the functional improvement and relief of the Medicare beneficiaries' painful conditions.

2

The initial OIG financial determination requesting a repayment equivalent of 96% of two years of Medicare payments will result in a devastating financial hardship on the clinics and the Medicare beneficiaries that they serve.

ACS urges OIG to allow it to instead use its limited resources towards increased compliance programs and activities.

OIG RECOMMENDATION

Refund \$737,111 to the Federal Government.

ACS Response

ACS does not concur with this recommendation.

OIG conducted an audit for calendar years 2011 and 2012. During that specific two-year timeframe the three clinics and five chiropractors comprising ACS collected \$764,953 for 22471 chiropractic services provided. This amount equates to roughly 34 treatments or \$1500.00 per week per chiropractor. This specific level of services provided to Medicare Beneficiaries is well within the normal standards for chiropractic offices throughout the United States.

OIG requested 105 service line items on random patients. ACS promptly provided OIG with all of the medical records and documentation associated with each requested visit and patient.

Of the 105 service line items reviewed, OIG determined that 100% of the requested service line items reviewed were medically unnecessary resulting in an overpayment of \$3529. OIG then applied an extrapolation process based on the small 105 sampling amount to all services provided by ACS during the 2011 and 2012 review timeframe concluding that 96% of all services provided were not medically necessary.

ACS respectfully disagrees with the final OIG extrapolation determination that over 96% of the services provided to all Medicare beneficiaries in 2011 and 2012 were medically unnecessary.

OIG contends that the Medical records did not support medical necessity primarily based on three reasons:

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

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3. The medical review contractor determined that none of the medical records for any of the 105 sampled service line items met the documentation requirements as specified in the manual and WPS's LCD L30328.

Manual manipulation of the spinal subluxation was not maintenance therapy and was appropriate for treatment of the patient's condition.

The Centers for Medicare and Medicaid Services (CMS) provide guidance for review of chiropractic benefits.¹ The CMS manual states the following:

Chiropractic Services – General: Implementation of the chiropractic benefit requires an appreciation of the differences between chiropractic theory and experience and traditional medicine due to fundamental differences regarding etiology and theories of the pathogenesis of disease. Judgments about the reasonableness of chiropractic treatment must be based on the application of chiropractic principles. So that Medicare beneficiaries receive equitable adjudication of claims based on such principles and are not deprived of the benefits intended by the law, carriers may use chiropractic consultation in carrier review of Medicare chiropractic claims.

OIG contends in its report that 100% of the 105 services items actually reviewed and through extrapolation 96% of all services provided by ACS over a two-year timeframe were in fact maintenance care and not medically necessary.

The Centers for Medicare and Medicaid Services (CMS) provide a definition of maintenance care.² The CMS manual states the following:

A. Maintenance Therapy

Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. The AT modifier must not be placed on the claim when maintenance therapy has been provided. Claims without the AT modifier will be considered as maintenance therapy and denied. Chiropractors who give or receive from beneficiaries an

¹ Medicare Benefits Policy Manual Chapter 15, Section 240 - Chiropractic Services - General (Rev. 1, 10-01-03) B3-2250, B3-4118

² Medicare benefits policy manual Chapter 15, section 240.1.3 - Necessity for Treatment (Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)

ABN shall follow the instructions in Pub. 100-04, Medicare Claims Processing Manual, chapter 23, section 20.9.1.1 and include a GA (or in rare instances a GZ) modifier on the claim.

It is important to note that maintenance treatment is a very specific type of care and only provided when the treating chiropractor determines after proper evaluation of the entire series of treatments that the proposed care to be provided will no longer have a reasonable expectation of functionally improving the patient's condition.

Maintenance care is not defined or should be used as a default denial if the reviewer cannot find a specific item or a phrase that is missing in the documents prepared by the chiropractor to prove the care was AT. In fact, the documentation supplied on each visit should be considered as part of a series of chiropractic treatments for a specific condition. The visit should be looked at not in fragmented individualized segments, but instead reviewed with the concept of a series of chiropractic treatments demonstrating overall functional improvement. If the documentation clearly demonstrates that patient's functional progress is now at a plateau and not generating a reasonable expectation of further functional improvement, then the proposed future care would be considered maintenance care.

Maintenance definitions also need to be closely compared to the CMS definition of chronic subluxations.³ The CMS policy manual defines chronic subluxation as:

Chronic Subluxation: A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

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

The Treatment Rendered to the Beneficiaries was Appropriate and Medically Necessary and not maintenance care:

³ Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3 - Necessity for Treatment (Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04)

□

It is of great concern to ACS that not a single visit of the 105 service line items reviewed was at a level to pass a medical necessity criteria set by OIG. It is difficult to understand the nearly impossible statistical probability that over the course of two years of patient encounters and treatments provided to multiple different Medicare beneficiaries by five different chiropractors OIG could determine that every single chiropractic treatment provided to the Medicare beneficiaries would be classified as medically unnecessary.

ACS believes that the care provided to the Medicare beneficiaries recorded in the audited documents from 2011 and 2012 were in fact medically necessary treatments and not defined as maintenance care.

For example, please review the course of care for Patient N.B.:

N. B. presented to the ACS office on 5/11/2012. N.B was seeking treatment for injuries suffered from a fall in October of 2011. N.B related in her history that she had fallen down a flight of 4 stairs. She complained of pain in her low back, left hip, down her left leg, neck pain and headaches.

Examination of N.B. revealed subluxations found at the following levels: Both SI joints, sacrum, coccyx, L 5,4,3, T8, 7, C7 and C-1. Her lumbar range of motion was decreased left and right flexion and left and right rotation with pain in the right SI joint during right flexion.

Chiropractic care was determined to be of benefit for N.B. and she was provided a treatment plan.

On her fourth visit, the ACS chiropractor recorded functional improvement in the case indicating that N. B. was better and now rated her pain 2/10 in the morning and 6-7/10 in the evening.

On her fifth visit, she reported that although she was improving, she had tried to do a little too much and aggravated her left SI joint while picking strawberries and her pain level was increased back to 8/10.

On her tenth visit, 7/5/2012-the service date reviewed by OIG, N.B. complained of neck pain and left SI joint pain. N.B was demonstrating functional improvement in her condition. Her VAS levels had improved noting a 2/10 pain level. She presented with subluxations at both SI joints, sacrum, L4, 3, T3, 2,1, C7 and C1 that were found using Activator leg length analysis and isolation tests. The treatment provided to the above noted subluxations delivered relief and functional improvement in her condition.

She received three more treatments and was released from active care on 08/10/2012.

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This case clearly demonstrates a Medicare beneficiary date of service, 7/5/2012, that was properly classified as AT. The patient suffered a significant neuromusculoskeletal injury by falling down 4 stairs. The five levels of subluxations found by the ACS chiropractor directly correlated to the patient's multiple pain symptoms. Even with the exacerbation noted on the fifth visit, the patient still experienced overall functional improvement in her condition and was released from active care on the 13th visit.

ACS requests that OIG reconsider its current determination that 100% of the claims reviewed should be classified as medically unnecessary maintenance care. While the above example is a single case that was reviewed, the vast majority of the 105 claims denied follow a similar pattern of patient reporting with injuries, ACS examinations revealing correlating subluxations and the ACS medical records that document that the treatment provided increased functional improvement. Once further improvement was not reasonably expected, the ACS chiropractors released the patients. These chiropractic treatment protocols clearly allow the care provided to be classified as AT not maintenance care.

Manual manipulation of the spinal subluxation resulted in improvement within a reasonable and generally predictable period of time

The CMS benefit policy manual provides general estimates of length of care for acute and chronic subluxations, but does not set limits on the number of chiropractic treatments that a Medicare beneficiary can receive.⁴ The Medicare benefit policy manual 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.

Acute subluxation (e.g., strains or sprains) problems may require as many as three months of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

Chronic spinal joint condition implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

⁴ Medicare benefits policy manual Chapter 15, section 240.1.5 - Treatment Parameters

ACS specifically notes that many of the 105 denied claims involved Medicare beneficiaries with chronic subluxations that would require an extended period of time to correct the condition. However, it should be noted that all of the claims contained either a chronic or acute subluxation as a result of a significant neuromusculoskeletal condition. ACS would also like to note that the OIG reviewer documents concurred that ACS had properly demonstrated a correlating subluxation to the neuromusculoskeletal condition on each visit.

The following example involves a reviewed case where the patient suffered from an acute subluxation and was released from care within approximately 2 months.

Patient B. J. presented to the ACS office on 10/16/2012 with injuries as a result of falling down the stairs the previous week. She complained of head pain, low back pain, and bilateral foot pain. She rated her pain at a level of 8/10 and indicated the pain was constant.

Examination revealed subluxations at both SI joints, sacrum, both pubic bones, L5, 4,3,1, T12, 3,2,1, and C7-1.

On 11/2/2012, the service date reviewed by OIG, she complained of head pain, pain in her left arm, tailbone pain, and bilateral foot pain. She had subluxations in both SI joints, sacrum, coccyx, L3, 1 T12, 8,7,3,2,1, and C7-1.

The patient continued to be treated and functionally improved to a level that she could be released from active care for this injury on 12/21/2012.

This specific case clearly demonstrated improvement as a result of chiropractic spinal manipulations to a significant injury from falling down stairs. The patient was correctly treated and released within approximately a two-month timeframe, well within the Medicare estimates for an acute subluxation condition. This example also clearly demonstrates that the chiropractors at ACS correctly provided AT service of an acute subluxation and released the patient within a normal period of time.

Referring back to the previous example involving N.B., this patient also had suffered from falling down a flight of 4 stairs. She was improved from the chiropractic treatment provided at ACS and was released within approximately three months from the initial date of treatment.

Both examples demonstrate that the chiropractic treatment provided at ACS for the dates of service reviewed were medically necessary and the OIG opinion of medically unnecessary should not apply to all 105 reviewed claims.

o

The medical review contractor determined that none of the medical records for any of the 105 sampled service line items met the documentation requirements as specified in the manual and WPS's LCD L30328.

ACS denies the OIG allegation and opinion of the medical review contractor. ACS medical records contained the necessary documentation related to a subsequent visit

The majority of the 105 claims reviewed by OIG were classified as subsequent visits. The Medicare benefits policy manual and WPS concurred in their LCD guidelines the definitions that specifically outline the three documentation requirements to properly record the treatment provided to the Medicare beneficiary on a specific date.⁵

The Medicare benefit manual states that the following documentation requirements apply for a subsequent visit whether the subluxation is demonstrated by x-ray or by physical examination:

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

Upon review of the draft document submitted by OIG and subsequent review of the medical records in question, ACS contends that the minimum requirements related to documentation for a subsequent visit were present in the ACS medical records.

ACS acknowledges that the abbreviation format previously used for documenting the Medicare beneficiary encounter is not as voluminous in wording as the currently used narrative EHR format, but contends that the basic information related to the three items listed above; history, physical exam and treatment given to demonstrate the subsequent visit encounter was AT remains intact.

Relating back to the previous example provided, patient N.B. date of service reviewed did contain the three components of a subsequent visit.

1. History Review of chief complaints; Changes since last visit;
The ACS chiropractor correctly noted the current complaints and indicated positive changes in the patient's condition.
N.B. complained of neck pain and left SI joint pain. N.B was demonstrating functional improvement in her condition.

⁵ Medicare benefits policy manual Chapter 15, section 240.1.2 (B). Documentation Requirements: Subsequent Visits

2. Physical exam; Exam of area of spine involved in diagnosis;
Assessment of change in patient condition since last visit;
The ACS chiropractor correctly noted the positive changes in the patients VAS pain level and the current examination results for subluxations.

N.B.'s VAS levels had improved noting a 2/10 pain level. She presented with subluxations at both SI joints, sacrum, L4, 3, T3, 2,1, C7 and C1 that were found using Activator leg length analysis and isolation tests.

3. Documentation of treatment given on day of visit.
The ACS chiropractor noted on the travel card the specific spinal levels that were adjusted on this date of service.
The treatment provided to the above noted subluxations delivered relief and functional improvement in her condition.

Aside from the single date of service reviewed that by itself properly documented medical necessity, the overall review of the entirety of the N.B. example demonstrates that the service provided on the single date reviewed was in fact medically necessary.

ACS respectfully proposes that the 100% denial of all claims determined by the contracted medical reviewer was not due to the fact that all of the encounters were not properly documented, but instead the 100% denial potentially was the result of a medical review criteria that was set at a level that could have the unintended effect of exclusion of valid abbreviations used for documenting the patient encounter. There also may have been the potential to isolate out an individual date of service and deny the entire visit if a single item may not have been understood or missing from one of the components of the subsequent visit notations.

Review of the ACS travel card abbreviation documentation format demonstrates that although brief, the information for subsequent visit was accurately recorded on each date of service reviewed by OIG.

OIG example case:

In the OIG draft report, a single case was isolate out as a potential reflection of the remaining 105 cases reviewed. ACS through this response would like to provide additional information to balance out the limited information provided in the draft report. ACS admits that this case was the exception and not the normal type of case seen in the ACS offices. ACS acknowledges that this specific case did require extensive but not excessive treatment to assist the patient through the patient's last two years of life. The specific case cited involved a patient who was in the last stages of life battling the pain and effects from leukemia. The chiropractic care provided at ACS to the subluxations noted was not intended in anyway to treat the leukemia, but the chiropractic services did provide continual functional improvements and pain relief

from the associated painful neuromusculoskeletal conditions and correlating subluxations to allow the patient to sustain a level of comfort prior to the cancer taking the patient's life.

98% of services provided by ACS were billed with CPT code 98942

OIG notes in its report, the high level of 98942 codes used by ACS. Upon notice by OIG and attendance at subsequent educational programs ACS concurs that the use of the 98942 code by ACS chiropractors may involve the need for correction.

ACS's coding and procedures were based on an interpretation of the CPT guidelines for chiropractic manipulative services. ACS interpreted that the five regions of subluxations they were adjusting casually related in a functional manner to the symptom presented by the patients. ACS operated under the assumption that they were properly following all CPT coding rules and procedures for a 98942 service. There was no intent to falsify any code used. Thus, the ACS chiropractors are not culpable of any fraudulent or deceptive billing practices. However, they are willing to discuss with OIG solutions to ensure all coding accurately reflects the Medicare interpretation for causal correlation.

Conclusion:

After careful review of all of the records, it is ACS's conclusion that all of the treatment provided to the Medicare beneficiaries reviewed by OIG was medically necessary based on CMS guidelines. Patients presented with significant injuries requiring chiropractic services. Chiropractic treatments resulted in functional improvements in the patient's condition. ACS respectfully disputes OIG's request for a full refund based on the allegations that all of the care provided was not medically necessary. However, ACS notes that its documentation although containing the minimum required levels to demonstrate medical necessity of a subsequent visit could be improved. ACS also specifically notes that while all five regions of the spine were actually adjusted on every visit coded 98942, ACS concurs that the interpretation of CPT coding for Medicare subluxations may result in the need for re-review for those dates of service to ensure the coding properly reflects the Medicare interpretation for coding of "causally related" subluxations.

OIG RECOMMENDATION

Establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are adequately documented in the medical records.

ACS response:

ACS contends that all of the claims reviewed were medically necessary. As noted above all of the claims involved a significant neuromusculoskeletal condition, were properly diagnosed with correlating subluxations and through chiropractic treatment improved the function of each of the Medicare beneficiaries.

With the above statement noted, ACS concurs that its documentation through the use of travel cards and abbreviations could be improved. The abbreviations and notations are fully understood by the ACS chiropractors, but ACS also understands that there could be difficulties for an outside source reviewing the documentation to fully comprehend the totality of the information documented. As a result, ACS has taken successful steps to establish a new narrative format for all future documentation. While the abbreviation and notations basically contain the same information as the narrative format, ACS acknowledges that the new narrative format would be easier for outside review sources to understand the documentation recorded.

ACS concurs that educational programs related to documentation, coding as well as Medicare policies and procedures would be of benefit to the five chiropractors who provide services to Medicare beneficiaries. ACS has taken the following actions to enhance its internal compliance related to Medicare claims:

1. Attended educational programs related to Medicare rules and regulations
2. Upgraded through the purchase of an electronic health record system to provide a more narrative documentation format.

Conclusion

The ACS chiropractors have served the communities of Lawrence, Bonner Springs and Valley Falls Kansas providing quality caring treatment to many Medicare beneficiaries who have suffered significant injuries. The treatment provided by the ACS chiropractors resulted in functional improvements in the Medicare beneficiary's conditions assisting them to lead healthier and more productive lives. ACS acted in good faith when submitting billings for services provided to Medicare beneficiaries. ACS contends that the submitted billings accurately reflected the chiropractic services provided to improve the patients condition and were medically necessary. ACS has been very cooperative with all of the OIG requests for information and interviews.

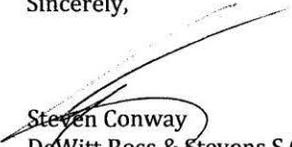
The primary issues or allegations contained in the draft report relate to interpretations of inadequate documentation and the use of the CPT code 98942. ACS is fully committed to improving or correcting any deficiencies related to the OIG allegations.

As noted above in the body of this response, the current draft report conclusion that 100% of all claims reviewed were not medically necessary appears to be overbroad and potentially based on a review criteria that could have the effect of excluding valid documentation to demonstrate medical necessity. This would lead to the conclusion that there is the potential for multiple claims that were adequately documented by ACS as medically necessary which would result in a significant decrease in the initial determinations for repayment calculations.

In good faith and as part of its compliance actions, ACS has purchased and implemented a new EHR medical documentation software system that will now record all services provided in a narrative format. ACS believes that this action will assist in the review of all services provided to Medicare beneficiaries. In addition ACS chiropractors have attended educational seminars related to coding, documentation and Medicare guidelines to gain further information for improvement in ACS's policies and procedures.

Because there is a strong probability that the initial 100% denial of all claims reviewed could be based on a review criteria that excluded valid claims, ACS respectfully requests that OIG accept its proposed resolution of using its limited resources to improve its documentation and compliance procedures rather than submitting a payment that would financially devastate ACS. This action will have the effect of improving compliance, rather than submitting the reimbursement set out in the initial draft that will have the devastating effect of potentially closing all three offices. At a minimum, ACS requests that OIG allow ACS the opportunity to further discuss with OIG the validity of the denied claims and significantly reduce the amount of payment requested.

Sincerely,



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