

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**A BROOKLYN CHIROPRACTOR
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.*



**Gloria L. Jarmon
Deputy Inspector General
for Audit Services**

**August 2017
A-02-13-01047**

Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

A Brooklyn Chiropractor received at least \$672,000 over 2 years for chiropractic services that were not allowable in accordance with Medicare requirements.

WHY WE DID THIS REVIEW

In calendar years (CY) 2011 and 2012, Medicare Part B 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 CYs 2011 and 2012 Medicare claim data, we selected for review a chiropractic practice, located in Brooklyn, New York (Brooklyn Chiropractor), which was the third highest-paid provider of Medicare chiropractic services in New York State.

Our objective was to determine whether chiropractic services provided by the Brooklyn Chiropractor complied with Medicare requirements.

BACKGROUND

Medicare Part B covers chiropractic services provided by a qualified chiropractor. Medicare Administrative Contractors contract with CMS to process and pay Part B claims. Medicare requires that chiropractic 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 are misaligned). 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 any 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.

Under section 1128J(d) of the Social Security Act and 42 CFR part 401 subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (42 CFR § 401.305(a)(2), (f) and 81 Fed. Reg. 7654, 7663) (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

HOW WE CONDUCTED THIS REVIEW

Our review covered 18,187 claims for which the Brooklyn Chiropractor received Medicare reimbursement totaling \$875,987 for chiropractic services provided during CYs 2011 and 2012. We reviewed a random sample of 100 claims. The Brooklyn Chiropractor provided us with

medical records and other documentation for all 100 claims and we provided those medical 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 sample claims complied with Medicare requirements. Specifically, the medical records did not support the medical necessity for any of the sampled chiropractic services. These unallowable payments occurred because the Brooklyn Chiropractor did not have adequate policies and procedures in place to ensure that chiropractic services billed to Medicare were medically necessary. Specifically, the Brooklyn Chiropractor did not have any written policies or procedures and indicated it used the Medicare guidelines to obtain information on how to document and bill chiropractic services.

On the basis of our sample results, we estimated that the Brooklyn Chiropractor improperly received at least \$672,805 in Medicare reimbursement for chiropractic services provided during CYs 2011 and 2012. This overpayment amount includes payment dates that are outside of the 3-year recovery period and 4-year reopening period.

WHAT WE RECOMMEND

We recommend that the Brooklyn Chiropractor:

- exercise reasonable diligence to investigate the potential overpayments totaling \$672,805 and work with the Medicare Administrative Contractor to return any identified overpayments that are outside the Medicare reopening and recovery periods in accordance with the 60-day repayment rule; and
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation.

BROOKLYN CHIROPRACTOR COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Brooklyn Chiropractor, through its attorney, did not indicate concurrence or nonconcurrence with our recommendations. Rather, the attorney submitted comments from a consulting firm. In its comments, the consultant disagreed with our findings and provided a detailed explanation for why it believes each of the 100 sample claims complied with Medicare requirements.

After reviewing the Brooklyn Chiropractor's comments, we maintain that our findings and recommendations are valid. We used an independent and qualified medical review contractor to determine whether the 100 claims contained in our sample were reasonable and necessary and met Medicare coverage requirements. Specifically, the medical review contractor was a licensed, actively practicing chiropractor, who was knowledgeable of chiropractic guidelines and protocols. The medical review contractor examined all of the medical records and

documentation submitted and carefully considered this information to determine whether the Brooklyn Chiropractor billed services in compliance with Medicare requirements. On the basis of the medical review contractor's conclusions, we determined that none of the 100 sample claims were allowable in accordance with Medicare requirements because the medical records did not support the medical necessity of the chiropractic services provided.

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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 review (OIG) 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 CYs 2011 and 2012 Medicare claim data, we selected for review a chiropractic practice located in Brooklyn, New York (Brooklyn Chiropractor), which was the third highest-paid provider of Medicare chiropractic services in New York. (See Appendix A for related OIG reports on Medicare claims for chiropractic services.)

OBJECTIVE

Our objective was to determine whether chiropractic services provided by the Brooklyn Chiropractor complied with Medicare requirements.

BACKGROUND

Administration of the Medicare Program

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

Medicare Part B covers a multitude of medical and other health services, including chiropractic services. Medicare Administrative Contractors (MACs) contract with CMS to process and pay Part B claims. National Government Services (NGS) was the MAC that processed and paid the Medicare claims submitted by the Brooklyn Chiropractor.

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.

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.¹

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 are misaligned).² 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.³ Depending on the number of spinal regions treated, chiropractors may bill Medicare for chiropractic manipulative treatment using one of three Current Procedural Terminology (CPT)⁴ codes: 98940 (for treatment of one to two regions), 98941 (for treatment of three to four regions), and 98942 (for treatment of five regions).⁵ The CPT code for extraspinal chiropractic manipulative treatment (98943) is not covered by Medicare. Figure 1 illustrates the five regions of the spine, from the cervical area (neck) to the coccyx (tailbone).

¹ CMS's *Medicare Benefit Policy Manual*, Pub. 100-02 (the Manual), chapter 15, § 30.5.

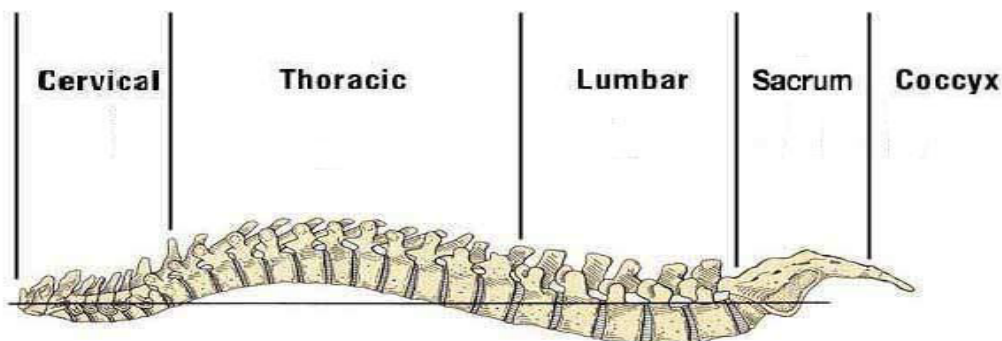
² The Manual defines subluxation "as a motion segment in which alignment, movement integrity, and/or physiological function of the spine are altered, although contact between joint surfaces remains intact" (chapter 15, § 240.1.2).

³ The Manual, chapter 15, § 240.1.4, and NGS's Local Coverage Determination (LCD) for chiropractic services (L27350).

⁴ **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.**

⁵ "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.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 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).

Under section 1128J(d) of the Act and 42 CFR part 401 subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (42 CFR § 401.305(a)(2), (f) and 81 Fed. Reg. 7654, 7663) (Feb. 12, 2016)). OIG believes that this audit report constitutes credible information of potential overpayments.

The Brooklyn Chiropractor

The Brooklyn Chiropractor was established in March 2009 with multiple locations throughout Brooklyn, New York. The Brooklyn Chiropractor's sole owner has been a licensed chiropractor in New York State since July 2009. During CYs 2011 and 2012, the Brooklyn Chiropractor employed three chiropractors. The three chiropractors and the owner provided chiropractic services to patients, and billed Medicare for those services under one tax identification number.

⁶ 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.

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 (the Manual, chapter 15, §§ 30.5(B) and 240.1.3(A)).

In December 2012, after operating for more than 3 years, the Brooklyn Chiropractor closed its offices. The Medicare claim data showed that the owner was the performing provider on 67 percent of the claims that the Brooklyn Chiropractor received Medicare reimbursement for services provided in CYs 2011 and 2012.

The Medicare claim data also showed that all of the chiropractic services provided by the Brooklyn Chiropractor were billed with the AT modifier. The Brooklyn Chiropractor did not submit any claims for chiropractic services with CPT 98942, the code with the highest Medicare fee schedule amount. Rather, the Brooklyn Chiropractor billed the majority (78 percent) of services with CPT code 98941, which had the second-highest fee schedule amount among the three CPT codes covered by Medicare for chiropractic services. The remaining services were billed with CPT code 98940.

HOW WE CONDUCTED THIS REVIEW

Our review covered 18,187 claims for which the Brooklyn Chiropractor received Medicare reimbursement totaling \$875,987 for chiropractic services provided during CYs 2011 and 2012. We reviewed a random sample of 100 claims. The Brooklyn Chiropractor provided us medical records and other documentation for all 100 claims and we provided those medical records to a medical review contractor to determine whether the services were allowable in accordance with Medicare requirements.

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

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

FINDINGS

None of the 100 sample claims complied with Medicare requirements. Specifically, the medical records did not support the medical necessity for any of the sampled chiropractic services. These unallowable payments occurred because the Brooklyn Chiropractor did not have adequate policies and procedures in place to ensure that chiropractic services billed to Medicare were medically necessary. Specifically, the Brooklyn Chiropractor did not have any written policies or procedures and indicated it used the Medicare guidelines to obtain information on how to document and bill chiropractic services.

On the basis of our sample results, we estimated that the Brooklyn Chiropractor improperly received at least \$672,805 in Medicare reimbursement for chiropractic services provided during

CYs 2011 and 2012.⁸ This overpayment amount includes payment dates that are outside of the 3-year recovery period and 4-year reopening period.⁹

CHIROPRACTIC SERVICES WERE NOT MEDICALLY NECESSARY

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.¹⁰ Additionally, 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.¹¹

Chiropractic maintenance therapy is not considered to be medically reasonable or necessary and is therefore not payable under the Medicare program.¹² In addition, manipulative services must have a direct therapeutic relationship to the patient's condition, and the patient must have a subluxation of the spine.¹³ Finally, 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.¹⁴

None of the 100 sample claims were allowable in accordance with Medicare requirements because services associated with the claims were medically unnecessary. Specifically, the results of the medical review indicated that these services did not meet one or more Medicare requirements:¹⁵

- Manual manipulation of the spinal subluxation would not be expected to result in improvement within a reasonable and generally predictable period of time (96 claims).
- Manual manipulation of the spinal subluxation was maintenance therapy or was not appropriate for treatment of the patient's condition (95 claims).
- Subluxation of the spine was not present or was not treated with manual manipulation (15 claims).

⁸ To be conservative, we estimated improper payments 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.

⁹ Section 1870(b) of the Act and 42 CFR § 405.980(b).

¹⁰ Section 1862(a) of the Act.

¹¹ 42 CFR § 410.21(b).

¹² The Manual, chapter 15, § 30.5(B).

¹³ The Manual, chapter 15, § 240.1.3.

¹⁴ The Manual, chapter 15, § 240.1.5.

¹⁵ The total exceeds 100 because 95 of the services did not meet more than one Medicare requirement.

For example, the Brooklyn Chiropractor received payment for chiropractic services provided on April 25 and 27, 2012, to an 83-year-old Medicare beneficiary. The medical review contractor determined that the medical records did not support the medical necessity of these services because manual manipulation of the spinal subluxation would not be expected to result in improvement within a reasonable and predictable length of time. During CYs 2011 and 2012, the Brooklyn Chiropractor received Medicare reimbursement totaling \$2,557 for 88 chiropractic services provided to this beneficiary.

CONCLUSION

On the basis of our sample results, we estimated that the Brooklyn Chiropractor improperly received at least \$672,805 in Medicare reimbursement for chiropractic services provided during CYs 2011 and 2012 that did not comply with Medicare reimbursement. This overpayment amount includes payment dates that are outside of the 3-year recovery period and 4-year reopening period.

RECOMMENDATIONS

We recommend the Brooklyn Chiropractor:

- exercise reasonable diligence to investigate the potential overpayments totaling \$672,805, that are outside the Medicare reopening and recovery periods and work with the MAC to return any identified overpayments in accordance with the 60-day repayment rule; and
- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation.

BROOKLYN CHIROPRACTOR COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

BROOKLYN CHIROPRACTOR COMMENTS

In written comments on our draft report, the Brooklyn Chiropractor, through its attorney, did not indicate concurrence or nonconcurrence with our recommendations. Rather, the attorney submitted comments from a consulting firm. In its comments, the consultant disagreed with our findings and provided a detailed explanation for why it believes each of the 100 sample claims complied with Medicare requirements.

The consultant stated that it believed that the medical records for each of the sample claims supported the medical necessity for all of the sampled chiropractic services; therefore, Medicare coverage for all 100 sample claims should be allowed. Specifically, the consultant stated that our medical review contractor did not use or understand NGS's LCD for chiropractic services and that it held the Brooklyn Chiropractor to its own documentation standards. In addition, the consultant stated that there were inconsistencies in the medical review contractor's findings and that information identified by the medical review contractor as not provided was either in the

patient notes or was information that was not required. The consultant also indicated that although the medical review contractor consistently found that the provider's notes were not legible, this issue was never raised and a legend or transcript of the provider's notes was never requested. According to the consultant, had such a request been made, the medical review contractor would have found the services medically necessary. Finally, the consultant stated that it was concerned that the medical review contractor could not find one sample claim that complied with Medicare requirements even though these same 100 claims were previously included in a CMS pre-audit and found acceptable.

A portion of the Brooklyn Chiropractor's written comments are included as Appendix E. We did not include the detailed comments related to each of the 100 sample claims because they were too voluminous and contained personally identifiable information. We will separately provide the Brooklyn Chiropractor's comments in their entirety to CMS.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Brooklyn Chiropractor's comments, we maintain that our findings and recommendations are valid. We used an independent and qualified medical review contractor to determine whether the 100 claims contained in our sample were reasonable and necessary and met Medicare coverage requirements. Specifically, the medical review contractor was a licensed, actively practicing chiropractor, who was knowledgeable of chiropractic guidelines and protocols.

The medical review contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Brooklyn Chiropractor billed services in compliance with Medicare requirements—not its own standards. On the basis of the medical review contractor's conclusions, we determined that none of the 100 sample claims were allowable in accordance with Medicare requirements because the medical records did not support the medical necessity of the chiropractic services provided. Further, no claims were found unallowable because the provider's notes were not legible. Finally, the consultant's assertion that the visits associated with our sample claims were previously found to be acceptable by CMS is not accurate. We obtained a list of the Brooklyn Chiropractor's claims that were included in a CMS pre-audit review, compared those claims to our sample claims, and determined that none of the 100 sample claims were subject to this review.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply With Medicare Requirements</i>	<u>A-09-14-02033</u>	10/18/2016
<i>A Michigan Chiropractor Received Unallowable Medicare Payments for Chiropractic Services</i>	<u>A-07-14-01148</u>	8/8/2016
<i>CMS Should Use Targeted Tactics To Curb Questionable And Inappropriate Payments For Chiropractic Services</i>	<u>OEI-01-14-00200</u>	9/29/2015
<i>Alleviate Wellness Center Received Unallowable Medicare Payments for Chiropractic Services</i>	<u>A-09-14-02027</u>	7/22/2015
<i>Advanced Chiropractic Services Received Unallowable Medicare Payments for Chiropractic Services</i>	<u>A-07-13-01128</u>	5/27/2015
<i>Diep Chiropractic Wellness, Inc., Received Unallowable Medicare Payments for Chiropractic Services</i>	<u>A-09-12-02072</u>	11/20/2013

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 18,187 claims for which the Brooklyn Chiropractor received Medicare reimbursement totaling \$875,987 for chiropractic services provided to Medicare beneficiaries during CYs 2011 and 2012. These claims were extracted from CMS's National Claims History (NCH) file.

We did not review the overall internal control structure of the Brooklyn Chiropractor. Rather, we limited our review of internal controls to those applicable to our objective. Specifically, we obtained an understanding of the Brooklyn Chiropractor's policies and procedures related to chiropractic services. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the NCH file, but we did not assess the completeness of the file.

We performed fieldwork at the office of the Brooklyn Chiropractor's attorney in Westbury, New York.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed NGS officials to obtain an understanding of Medicare reimbursement requirements and claim processing procedures for chiropractic services;
- interviewed the sole owner of the Brooklyn Chiropractor to obtain an understanding of the Brooklyn Chiropractor's policies and procedures for providing chiropractic services to beneficiaries, maintaining documentation for services provided, and billing Medicare for such services;
- extracted from the CMS's NCH file a sampling frame of 18,187 chiropractic service claims, totaling \$875,987 for CYs 2011 and 2012;
- selected a random sample of 100 chiropractic service claims from the sampling frame;
- reviewed data from CMS's Common Working File and other available data for the sampled claims to determine whether the claims has been cancelled or adjusted;
- obtained medical records and other documentation from the Brooklyn Chiropractor for the 100 sample claims and provided them to the medical review contractor, who determined whether each service was allowable in accordance with Medicare requirements;

- reviewed the medical review contractor’s results and summarized the reason a claim was determined to be unallowable;
- used the results of the sample to estimate the amount of the unallowable Medicare payments made to the Brooklyn Chiropractor for chiropractic services;
- discussed the results of our review with the Brooklyn Chiropractor.

See Appendix C for the details of 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 all Medicare Part B chiropractic service claims paid to the Brooklyn Chiropractor for services provided during CYs 2011 and 2012.

SAMPLING FRAME

The sampling frame is an Access database containing 18,187 chiropractic service claims, totaling \$875,987 paid to the Brooklyn Chiropractor for services provided during CYs 2011 and 2012. The claims data was extracted from the CMS's NCH file.

SAMPLE UNIT

The sample unit was a chiropractic service claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

The sample size was 100 chiropractic service claims.

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 18,187. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to calculate our estimates. We estimated the total unallowable Medicare reimbursement paid to the Brooklyn Chiropractor during CYs 2011 and 2012 at the lower limit of the 90-percent confidence interval.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Sample Results

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Claims	Value of Unallowable Claims
18,187	\$875,987	100	\$4,194	100	\$4,194

Estimated Value of Unallowable Claims
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	\$762,808
Lower Limit	\$672,805
Upper Limit	\$852,811

APPENDIX E: BROOKLYN CHIROPRACTOR COMMENTS



DBP Audit Consulting, Defense And Compliancy

P.O. Box 513
Sugar Loaf, N.Y 10981
Tel: (845) 782-5084
Fax: (845) 610-3699
drpinkus@optonline.net

David Pinkus DC CPC MCS-P CBCS
Certified Professional Coder
Certified Medical Compliance Specialist
Certified Billing and Coding Specialist

Lawrence J Kobak DPM JD
190 Willis Avenue
Mineola, NY 11501

[REDACTED]

*

Dear Mr. Kobak,

Thank you for the opportunity to be a part of this OIG counter audit to CMS's and the administrative law judge's findings.

Biography:

David Pinkus, D.C. CPC MCS-P CBCS. Private practice for 32 years.

President of DBP Audit Consulting and Compliance. Certified Medical Compliance Specialist (MCS-P), Certified Professional Coder (CPC) and a Certified Billing and Coding Specialist (CBCS). I lecture throughout the United States on chiropractic guidelines and protocols at level 2, in the area of the treatment under review.

Mario Fucinari D.C. CPC MCS-P. Private practice for 32 years.

Mario P. Fucinari D.C., CCSP, DAAPM, CPCO, MCS-P
Certified Chiropractic Sports Physician®
Certified Professional Compliance Officer (CPCO)
Certified Medical Compliance Specialist (MCS-P)
Decatur Back and Neck Center
3350 N. Water Street, Suite A
Decatur, IL 62526

David Smith, D.C. Private practice for 35 years.

President, Chiropractic Fellowship of PA. Seminar instructor for documentation and ICD-10 coding, extension faculty for Sherman College of Chiropractic.

Issue:

Whether the following visits that were previously found to be acceptable and paid by CMS's pre-audit reviewer and the administrative law judge were medically necessary, or if they should be overturned based on the Medical Professional Reviewer's (MPR) analysis.

*** Office of Inspector General Note:** We redacted the name of the provider throughout this report because it is personally identifiable information. Also, neither CMS or an administrative law judge have issued findings regarding this review. We note that the Brooklyn Chiropractor may appeal our determinations through the Medicare appeals process.

In reviewing the MPR's "facts" and "analysis" of Dr. [REDACTED] charts it seems that the reviewer is holding the treating chiropractor to his/her own documentation standards rather than the NGS, LCD Chiropractic services ID L27350. Dr. [REDACTED] is only obligated to follow Medicare's written documentation according to LCD's guidelines for the years in question.

The MPR states throughout the review that the notes are illegible. It's interesting how CMS's pre-audit reviewer and the administrative law judge made no indication that there was a problem with legibility. **By the MPR making the subjective comment that "the notes were illegible" without requesting a legend or a transcript of the provider's notes it's easy to see how one could interpret the visits as being not medically necessary.** There is no doubt in my mind that if the MPR requested a transcript or a legend, read what we read and followed the LCD guidelines as we did, they too would have deemed these visits medically necessary. It is also important to note, that at the time the charts were copied by CMS' investigators, at the offices of Kern Augustine Conroy & Schoppmann, PC, the issue of illegibility was never raised to Mr. Kobak, Dr. [REDACTED] attorney who was present at all times the charts were being copied by the government in his office where he is a partner.

The MPR's "Analysis" reads the same for almost all 100 charts.

Rather than cut and paste, the sometimes-long repetitive response to each of the MPR's findings I made a legend as it pertains to the MPR's Chiropractic Elements findings.

The following response to the MPR's Chiropractic Elements #1-4 was based on:

NGS LCD Chiropractic Services ID L27350

Original Effective Date for services performed on or after 11/15/2008

Revision Effective Date for services performed on or after 09/01/2014

Revision Ending Date 09/30/2015

Legend:

1) On the vast majority of claims, the MPR continuously states that something is not present. **In the chart, the items that the MPR claims are not present are clearly documented.**

2) Chiropractic Element #2

Subluxation of the spine was treated with manual manipulation.
The MPR states in the note that a specific chiropractic technique was not mentioned.

There is nothing noted in the LCD that requires the technique to be documented. They only ask for the level of subluxation. Manipulation is what chiropractors do to adjust the spine.

Throughout the review the MPR states a manipulation was "not given, unknown or could not tell". In the chart notes, it states a manipulation was given. The Initial Intake form clearly reads "Spinal manipulation."

Diversified Technique is the only technique used in Dr. [REDACTED] office. It is the most commonly used of all chiropractic techniques and is the one most familiar to patients.

The **Diversified Technique** is the original chiropractic technique developed in 1895 by D.D. Palmer, 'father' of chiropractic care. This technique is taught in chiropractic colleges around the world and is the root of the chiropractic profession.

Under some of the MPR's "Facts", the MPR acknowledged that Dr. [REDACTED] billed for a Chiropractic manipulation treatment.

Manipulation of the spine in chiropractic is defined by the American Medical Association as CPT codes 98940, 9894X, 98942 and 98943. In Medicare, coverage of the chiropractic manipulation is limited to manipulation of the spine (98940-98942). These codes represent the manual manipulation of a joint or joints to influence neurophysiological function. Per the AMA, the code descriptions for 98940 – 98943 are "98940, Chiropractic manipulative treatment (CMT); spinal, 1 - 2 regions; 9894X spinal, 3 - 4 regions; 98942 spinal, 5 regions" (CPT-4 2014, AMA 2014).

The LCD for manipulation indicates that documentation must be present to state that the service, manipulation of the spine, was performed but does not require that the specific technique used by the physician be documented (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.1). It also refers to it as "Manipulation *delivered by the physician during manipulation.*"

The MPR stated in their review under Chiropractic Elements #2 that a manipulation was performed but could not tell if the provider treated the subluxation with manual manipulation. In Chiropractic Element #3 the MPR states that the "Manual Manipulation" of the spinal subluxation was not appropriate.

It seems as though the MPR is contradicting themselves. First they stated that it is unknown, yet they wrote that the "Manual Manipulation" was not appropriate.

As per CMS National Carrier Determination (NCD) and Local Carrier Determination (LCD): Coverage of chiropractic services is specifically limited to treatment by means of manual manipulation (i.e., by use of the hands or device) of the spine to correct a subluxation. Subluxation is defined 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. Manual devices (those that are hand-held, with the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. No additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself. Add addendum.

As per Maitland grades of Mobilization, a chiropractor does grade 5.

Manipulation: A passive, high velocity, low amplitude thrust applied to a joint complex within its anatomical limit* with the intent to restore patient motion, function and/ or to reduce pain.

Maitland categorizes grades of movement by the following (1, 2):

- Grade I: small amplitude, short of resistance
- Grade II: large amplitude, short of resistance
- Grade III: large amplitude to 50% of R1 – R2
- Grade IV: small amplitude to 50% of R1 - R2
- Grade V: small amplitude, high velocity thrust at end of available range

Spinal manipulation/s to the Subluxated areas is clearly documented.

3) Chiropractic Element #3

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

Under the Medicare program, Chiropractic maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy that is performed to 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. §240.1.3.

Because clinical functional improvement was demonstrated, the doctors continued with continuous/active care, proving that this was not supportive or maintenance care.

4) Chiropractic Element #4

Manual manipulation of the spinal subluxation would be expected to result in improvement within a reasonable and predictable length of time.

Please note that this is the MPR's interpretation. Please find the complete treatment parameters as was written by Medicare below.

240.1.5 - Treatment Parameters (Rev. 23, Issued 10-08-04, Effective: 10-01-04, Implementation: 10-04-04) B3-2251.5 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. 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.

As per the Treatment Parameters (Rev. 23, Issued 10-08-04, Effective: 10-01-04, Implementation: 10-04-04) B3-2251.5 the chiropractors took the opportunity and improved the patients ADLs (Certain patient's condition may have required a longer treatment time, but not with higher frequency.)

5) The MPR states on numerous occasions that the chiropractor did not reexamine the patient. (Sometimes even 2 days after the initial exam.)

The Medicare carrier's Local Carrier Determination does not specify that the re-evaluation be specifically performed. Since this is a non-covered service, the billing of an evaluation and management (E&M) code would be a financial burden on the patient. To aid the patient and practitioner in the billing of such services, the physician has been instructed under the National Correct Coding Initiative Edits (NCCI) that a low complexity E&M code has been bundled into the manipulation code. The comprehensive notes on objective findings, beyond the evaluation of the

concerned area (the P.A.R.T) demonstrate a re-examination each visit, also with an evaluation of improvement or not.

- 6)** The MPR continuously refers to the fact that there were no degrees for the ROM.

There are no bulletins from Medicare that states ROM is only valid if given in degrees. For documentation purposes, the MPR failed to recognize the initial exam's ROM was in degrees and the SOAP notes were documented as increase or decrease.

- 7)** "The medical record does not support the chiropractic treatment on the said dates. No evidence of physical reexamination, which describes the condition of the patient including the past history, current history and a review of trauma related to the initial injury or the date of service was provided."

The comprehensive notes on objective findings, beyond the evaluation of the concerned area (the P.A.R.T) demonstrate a re-examination on each visit, also with an evaluation of improvement or not. There is no trauma information required in order to treat. The initial exam requirements ask to document any mechanism of trauma if present, but it is not a requirement.

- 8)** The MPR states, "There was no review of trauma information related to the initial injury or the date of service provided."

There is no trauma required in order to treat. The initial exam requirements ask to document any mechanism of trauma, but it is not a requirement. After reviewing the notes by the provider, I found that the mechanism of trauma was clearly documented.

- 9)** The MPR states, "There were no outcome assessments, functional index ratings, activity of daily living or completed physical examinations or re-examinations to prove that the treatment on said date would result in an improvement of the patient's condition."

"Outcome assessments were established by evaluation of ROM (in the P.A.R.T), documented changes in ADLs, and improvement in the objective findings on the physical examination of each subsequent visit. There are no required functional index ratings listed in the LCD; the chiropractor may use his preferred method to evaluate function. Re-examinations of a more comprehensive nature are established by the treating chiropractors' clinical judgment."

- 10)** A complete clinical evaluation was not documented and therefore there is no evidence to prove that the adjustments on said dates were medically necessary.

"A complete clinical evaluation is not a documentation requirement of subsequent visits according to the LCD in effect at the time of the treatment."

- 11)** The fact that subluxations and tissue changes and pain are present is not sufficient documentation of medical necessity without correlation showing the causal relation to the patients symptoms and expectation for improvement.

"Medical necessity by correlation was established on the initial exam. It is not a documentation requirement of subsequent visits of an established care plan."

- 12)** The working diagnosis does not have a direct relationship to the patient's symptoms or the clinical review.

"Subluxation is the primary diagnosis that was established on the Initial Exam. The syndrome is secondary to the condition as evidenced by the symptoms and signs. It was established by the physical findings of the subluxation/s on subsequent visits."

13) The MPR states that specific treatment goals were not documented in the soap notes.

Goals are to be determined on the initial exam. It is not a documentation requirement of subsequent visits. The MPR may refer to the initial exam for goals. As per the LCD, goals do not have to be listed on subsequent visits.

14) The Objective findings in #3 substantiated the continuation of active care and that the treatment was effective. Treatment continued due to the improvement of the ADLs and/or the objective findings which demonstrated that this was active care.

15) Not-adequately-documented neuro-musculoskeletal/nervous system evaluation through a complete physical examination was provided, that fully documents specific orthopedic analysis, neurological evaluation (e.g., tingling, shooting and throbbing issues), motor, sensory and deep tendon reflex analysis, range of motion in specific degrees, postural and gait analysis and specific tissue assessments. This appears to be the MPR standards rather than the guidelines.

It is up to the treating chiropractor how extensive the exam is to evaluate the patient. Routinely re-examining for "fully documents specific orthopedic analysis, neurological evaluation (e.g., tingling, shooting and throbbing issues), motor, sensory and deep tendon reflex analysis, range of motion in specific degrees, postural and gait analysis and specific tissue assessments." would be an extra expense that is not required for Subsequent Visits. It would be a financial burden on any patient to be subject to orthopedic re-exam, neurologic evaluation with DTRs, sensory testing, motor strength testing, ROM with an electronic inclinometer, postural analysis, gait analysis, and soft tissue analysis every Subsequent Visit to have the medical decision making that treatment is effective. It is likely that Medicare would be disturbed by overcharging the patient for unnecessary testing that is paid out of pocket to a chiropractor.

16) In addition, while notation is made within the SOAP notes of positive orthopedic tests, the side of the finding is not specified. No analysis of these findings are documented.

Certain tests do not require laterality such as Valsalva's. For any that did not mention the side of laterality naturally it would be positive on the patient's symptomatic side.

17) Measurable, quantitative and qualitative measures (i.e.: specific tissues, degrees of motion, time parameters, tolerance of activities that had previously been provocative factors, increase to distance with walking, and other activities of daily living) were not documented.

Qualitative measures need not be documented every visit. The expectation of functional improvement is what makes the care medically necessary.

Concerns

I have serious concerns regarding the auditor finding inconsistencies from one chart to another. The MPR states on file that information is not there, and on the next chart with the same information and format, states it is there.

I have serious concerns regarding the information that the MPR states is not there and does not need to be there to establish medical necessity as per the CMS or LCD guidelines. It implies that the provider left something out. i.e.: "The chiropractor saw the patient on 10/8/2012. This was a

follow-up visit in a period of illness that began on 9/5/2012. No documentation was provided to show that the patient was re-examined between these dates. A re-examination was not necessary as per the CMS LOCD guidelines.”

I have serious concerns regarding the MPR’s continuous statement that the information is not provided when in fact it is in the note.

I have serious concerns where the MPR could not find one out of the 100 charts that met the requirements when CMS and the ALJ did find them acceptable.

I have serious concerns that the OIG MPR is unfamiliar with orthopedic testing. I.e. The MPR stated “Partick/Fabere” is for the HIP and not for the SI (It is spelled Patrick/Fabere)

The MPR is constantly inconsistent with the claim review findings from one note to the other.

“As per the MPRs ending comment ‘Based upon the information set forth above and review of the entire file provided, I have determined that the chiropractic care on MM/DD/YYYY did not meet Medicare coverage criteria. Therefore, Medicare coverage of this care should be overturned.’ After reviewing the files, the Medicare coverage should not be overturned.”

It appears that the MPR did not review the entire files in question objectively, nor did they use or understand the LCD for the time period in question. †

†

[Redacted text block containing multiple lines of blacked-out content]

† **Office of Inspector General Note:** We redacted information on this page and did not include pages 8 through 212 of the Brooklyn Chiropractor’s comments because they were too voluminous and contained personally identifiable information. We will separately provide the comments in their entirety to CMS.