Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ETHEREDGE CHIROPRACTIC RECEIVED UNALLOWABLE MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES

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

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A-04-16-07064

Office of Inspector General

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Report in Brief
Date: September 2018
Report No. A-04-16-07064

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Etheredge Chiropractic Received Unallowable Medicare Payments for Chiropractic Services

Why OIG Did This Review

In calendar years (CYs) 2014 and 2015, Medicare allowed payments of approximately $1.3 billion for chiropractic services provided to Medicare beneficiaries nationwide. Previous OIG reviews found that Medicare inappropriately paid for chiropractic services that were medically unnecessary, incorrectly coded, or undocumented. After analyzing Medicare claims data for CYs 2014 and 2015, we selected for review Etheredge Chiropractic (Etheredge), in Fruitland Park, Florida. Our analysis indicated that Etheredge was among the top five chiropractors in Florida based on three Current Procedural Terminology codes billed to Medicare for chiropractic services.

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

How OIG Did This Review

For CYs 2014 and 2015, Etheredge received Medicare Part B payments of $659,877 for 21,961 chiropractic services provided to Medicare beneficiaries. We excluded 536 chiropractic services that were reviewed by the recovery audit contractors and other review entities (such as the Medicare administrative contractors). We also excluded services with payments less than $20. From the remaining 21,425 services, totaling $656,051 in Medicare payments, we selected 100 services using a simple random sample.

What OIG Found

Some chiropractic services that Etheredge billed were not allowable in accordance with Medicare requirements. Of the 100 chiropractic services in our sample, 67 were allowable in accordance with Medicare requirements. However, the remaining 33 were not allowable: 31 services were medically unnecessary and 2 were not documented. As a result, Etheredge received $1,042 in unallowable payments. On the basis of our sample results, we estimated that Etheredge received unallowable Medicare payments of at least $169,737 for CYs 2014 and 2015. As of the publication of this report, this unallowable amount includes claims outside of the 4-year claims reopening period.

These unallowable payments occurred because Etheredge did not have adequate policies and procedures to ensure that the chiropractic services billed to Medicare were medically necessary and adequately documented in the medical records.

What OIG Recommends and Etheredge Comments

We recommend that Etheredge: (1) refund to the Federal Government the portion of the estimated $169,737 overpayment for claims for chiropractic services that did not comply with Medicare requirements and are within the 4-year claims reopening period; (2) exercise reasonable diligence to identify and return the overpayments in accordance with the 60-day rule, for the remaining portion of the estimated $169,737 overpayment for claims that are outside of the reopening period, and identify any returned overpayments as having been made in accordance with this recommendation; (3) 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; and (4) establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary and adequately documented.

In written comments on our draft report, Etheredge partially concurred with our recommendations and described the actions it has taken to address them. Regarding the 33 claims that were not allowable in accordance with Medicare requirements, Etheredge disagreed that 31 claims were medically unnecessary. It stated that it would go through the Medicare Part B appeals process. We maintain that our audit results are valid because we, with the assistance of an independent medical reviewer, determined whether each service was allowable in accordance with Medicare requirements.

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INTRODUCTION

WHY WE DID THIS REVIEW

In calendar years (CYs) 2014 and 2015, Medicare allowed payments of approximately $1.3 billion for chiropractic services provided to Medicare beneficiaries nationwide. Previous Office of Inspector General (OIG) reviews found that Medicare inappropriately paid for chiropractic services that were medically unnecessary, incorrectly coded, or undocumented.[1] After analyzing Medicare claims data for CYs 2014 and 2015, we selected for review Etheredge Chiropractic (Etheredge), in Fruitland Park, Florida. Our analysis indicated that Etheredge was among the five highest-billing chiropractors in Florida based on three Current Procedural Terminology (CPT)[2] codes billed to Medicare for chiropractic services.

OBJECTIVE

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

BACKGROUND

Administration of the Medicare Program

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

Medicare Part B covers a multitude of medical and other health services, including chiropractic services. Medicare administrative contractors (MACs) contract with CMS to process and pay Part B claims. First Coast Service Options, Inc. (First Coast), was the MAC that processed and paid the Medicare claims submitted by Etheredge.

Chiropractic Services

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

[1] See Appendix B for a list of related OIG reports on Medicare claims for chiropractic services.

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

Medicare Coverage of Chiropractic Services

Medicare Part B covers chiropractic services provided by a qualified chiropractor. To provide such services, a chiropractor must be licensed or legally authorized by the State or jurisdiction in which the services are provided.[3]

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

To substantiate a claim for manipulation of the spine, the chiropractor must specify the precise level of subluxation.[5] Depending on the number of spinal regions treated, chiropractors may bill Medicare for chiropractic manipulative treatment using one of three CPT[6] codes: 98940 (for treatment of one to two regions), 98941 (for treatment of three to four regions), and 98942 (for treatment of five regions). The figure on the following page illustrates the five regions of the spine, from the cervical area (neck) to the coccyx (tailbone).

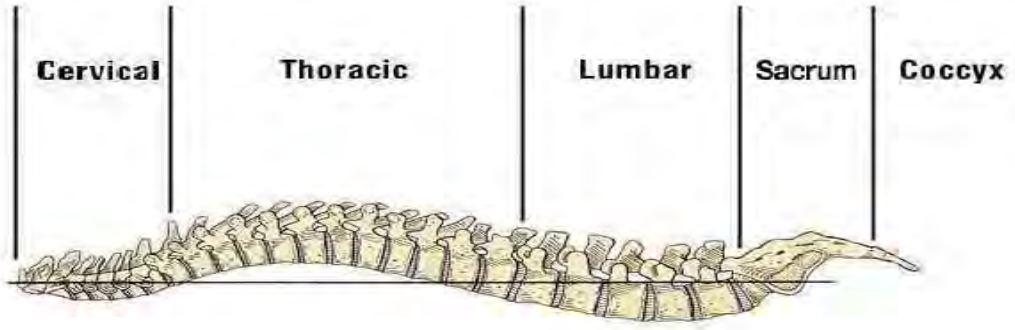
[3] CMS's *Medicare Benefit Policy Manual,* Pub. 100-02 (the Manual), chapter 15, § 30.5.

[4] Subluxation is a condition in which spinal bones are not in their normal position. The Manual defines subluxation "as a motion segment in which alignment, movement integrity, and/or physiological function of the spine are altered, although contact between joint surfaces remains intact" (chapter 15, § 240.1.2).

[5] The Manual, chapter 15, § 240.1.4, and First Coast's Local Coverage Determination (LCD) for chiropractic services, L33840 (retired), which was in effect during our audit period. First Coast's current LCD for chiropractic services is L36617.

[6] **The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2014-2015 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.**

Figure: The Five Regions of the Spine



Medicare requires chiropractors to place the AT (Acute Treatment) modifier[7] on a claim when providing active or corrective treatment for subluxation. Because Medicare considers claims without the AT modifier to be claims for services that are maintenance therapy, it will deny these claims.[8] 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 chiropractor the amount allowed for payment according to the physician fee schedule, less the beneficiary share (i.e., deductibles and coinsurance).

Medicare Requirements to Identify and Return Overpayments

OIG believes that this audit report constitutes credible information of potential overpayments. Providers who receive notification of these potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).[9]

[7] 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.

[8] 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), and First Coast's LCD L33840).

[9] The Social Security Act (the Act) § 1128J(d); 42 CFR part 401 subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

Etheredge Chiropractic

Established in April 2001, Etheredge is in Fruitland Park, Florida. During CYs 2014 and 2015, Etheredge employed four chiropractors who provided chiropractic services. Etheredge billed Medicare for those services under one tax identification number.

The Medicare claims data that we reviewed indicated that Etheredge billed all of its chiropractic services using the AT modifier. Further, it billed the majority (82 percent) of its services using CPT code 98941, which had the second highest physician fee schedule amount among the three CPT codes covered by Medicare for chiropractic services.

Table 1 shows the allowed amount for Lake County, Florida, on the Medicare fee schedule for each CPT code during CYs 2014 and 2015.

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

Period	CPT 98940	CPT 98941	CPT 98942
January 1—December 31, 2014	$28.04	$41.48	$53.54
January 1—June 30, 2015	27.90	40.74	53.24
July 1—December 31, 2015	28.04	40.95	53.51

HOW WE CONDUCTED THIS REVIEW

For CYs 2014 and 2015, Etheredge received Medicare Part B payments of $659,877 for 21,961 chiropractic services provided to Medicare beneficiaries. We excluded 536 chiropractic services that were reviewed by the recovery audit contractors (RACs) and other review entities (such as the MACs). We also excluded services with payments less than $20. From the remaining 21,425 services, totaling $656,051 in Medicare payments, we selected 100 chiropractic services using a simple random sample. Etheredge provided us with copies of medical records as support for these services. In turn, we provided those copies to an independent medical review contractor to determine whether the 100 chiropractic services were allowable in accordance with Medicare requirements.

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

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

FINDINGS

Some chiropractic services that Etheredge billed were not allowable in accordance with Medicare requirements. Of the 100 chiropractic services in our sample, 67 were allowable in accordance with Medicare requirements. However, the remaining 33 were not allowable:

- 31 services were medically unnecessary and
- 2 were not documented.

As a result, Etheredge received $1,042 in unallowable payments. On the basis of our sample results, we estimated that Etheredge received unallowable Medicare payments of at least $169,737 for CYs 2014 and 2015. As of the publication of this report, this unallowable amount includes claims outside of the 4-year claims reopening period.[10] These unallowable payments occurred because Etheredge did not have adequate policies and procedures to ensure that the chiropractic services billed to Medicare were medically necessary and adequately documented in the medical records. Had their policies and procedures been more effective, Etheredge may not have submitted claims for unallowable payments for chiropractic services.

CHIROPRACTIC SERVICES WERE NOT ALLOWABLE IN ACCORDANCE WITH MEDICARE REQUIREMENTS

Services Were Medically Unnecessary

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, for chiropractic services to be reimbursable, (1) they must have a direct therapeutic relationship to the patient's condition, (2) the patient must have a subluxation of the spine (chapter 15, § 240.1.3), (3) the chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration of the condition within a reasonable, and (4) generally predictable period of time (chapter 15, § 240.1.5). See Appendix E for these requirements.

[10] 42 CFR § 405.980(b)(2) (reopening for good cause).

Of the 100 sampled chiropractic services, 31 were medically unnecessary. The results of the medical review indicated that these services did not meet one or more of the following Medicare requirements:[11]

- Subluxation of the spine was not present or was not treated with manual manipulation or both (13 services).

- Manual manipulation of the spinal subluxation was maintenance therapy or was not appropriate for treatment of the patient's condition or both (25 services).

- Manual manipulation of the spinal subluxation would not be expected to result in improvement within a reasonable and generally predictable period of time (25 services).

For example, Etheredge received payment for a chiropractic service provided to a 69-year-old beneficiary. The independent medical review contractor found that the medical records did not indicate that the beneficiary had spinal subluxation. Therefore, the contractor concluded that the services were not medically necessary.

Services Were Not Documented

Payment must not be made to a provider for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (the Act § 1833(e)).

Of the 100 sampled chiropractic services, 2 were not documented. Etheredge provided the medical records for the beneficiaries who received these services; however, the records contained no documentation for the selected services.

For example, Etheredge received payment for a chiropractic service provided on November 4, 2015, for a Medicare beneficiary. The medical records that Etheredge provided for this beneficiary contained documentation for multiple services from years 2012, through 2016, but they did not contain any documentation for November 4, 2015. The independent medical review contractor stated that "the patient's medical record as submitted does not contain a record of chiropractic care on this date . . . . Upon further request for record of this care, none was produced."

ETHEREDGE CHIROPRACTIC RECEIVED UNALLOWABLE MEDICARE PAYMENTS

Etheredge received $1,042 in unallowable Medicare payments for the 33 sampled chiropractic services that did not meet Medicare requirements. On the basis of our sample results, we estimated that Etheredge received unallowable Medicare payments of at least $169,737 for CYs

[11] The total errors listed in the bullets exceed 31 because some of the services had more than one error.

2014 and 2015. As of the publication of this report, this unallowable amount includes claims outside of the 4-year claims reopening period.

ETHEREDGE CHIROPRACTIC DID NOT HAVE ADEQUATE POLICIES AND PROCEDURES

The unallowable Medicare payments occurred because Etheredge did not have adequate policies and procedures to ensure that the chiropractic services billed to Medicare were medically necessary and adequately documented in the medical records. Had their policies and procedures been more effective, Etheredge may not have submitted claims for unallowable payments for chiropractic services.

RECOMMENDATIONS

We recommend that Etheredge:

- refund to the Federal Government the portion of the estimated $169,737 overpayment for claims for chiropractic services that did not comply with Medicare requirements and are within the 4-year claims reopening period;[12]

- exercise reasonable diligence to identify and return the overpayments in accordance with the 60-day rule, for the remaining portion of the estimated $169,737 overpayment for claims that are outside of the reopening period, and identify any returned overpayments as having been made in accordance with this recommendation;

- 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; and

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

[12] OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to Department of Health and Human Services action officials. Action officials at CMS, acting through a MAC or other contractor, will determine whether a potential overpayment exists and will recoup any overpayments consistent with its policies and procedures. If a disallowance is taken, providers have the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). The Medicare Part A/B appeals process has five levels, including a contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a decision by the Office of Medicare Hearings and Appeals. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of appeal. An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

ETHEREDGE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

Etheredge Comments

In written comments on our draft report, Etheredge partially concurred with our findings and recommendations. Etheredge stated that it strengthened its controls to ensure strict compliance with applicable Medicare chiropractic requirements.

Specifically, in Etheredge's comments regarding the 33 services that we identified as not allowable in accordance with Medicare requirements, it disagreed with our finding that 31 services were medically unnecessary and indicated that it would defend this fact-specific allegation in a Medicare Part B appeal after this rebuttal. For the remaining two services that were not documented, Etheredge agreed with our findings and concluded that the records were missing due to the electronic medical records and hardcopy transition that took place between 2014 and 2015.

Furthermore, Etheredge disagreed that it did not have adequate policies and procedures to ensure that chiropractic services billed to Medicare were medically necessary and adequately documented. It stated that it conducted routine staff training on Medicare compliance matters including billing, coding, and documentation.

Etheredge's comments are included in their entirety as Appendix F.

Office of Inspector General Response

We maintain that our findings and recommendations are valid. In response to Etheredge's disagreement that the 31 services were not reasonable and necessary, we contracted an independent medical reviewer to determine whether each service was allowable in accordance with Medicare requirements, and our report reflects the results of that review.

Regarding Etheredge's exception to our statement that it did not have adequate policies and procedures to ensure that the chiropractic services billed to Medicare were medically necessary and adequately documented in the medical records, we reassert our statement on the basis of our findings.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For CYs 2014 and 2015, Etheredge received Medicare Part B payments of $659,877 for 21,961 chiropractic services provided to Medicare beneficiaries. We excluded 536 chiropractic services that were reviewed by the RACs and other review entities (such as the MACs). We also excluded services with payments less than $20. From the remaining 21,425 services, totaling $656,051 in Medicare payments, we selected 100 services using a simple random sample. Etheredge provided us with copies of medical records as support for these services. In turn, we provided those copies to an independent medical review contractor to determine whether the 100 chiropractic services were allowable in accordance with Medicare requirements.

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

We performed our audit, which included onsite fieldwork at Etheredge's office in Fruitland Park, Florida, from September 2016, to September 2017.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed Etheredge officials to obtain an understanding of their procedures for (1) providing chiropractic services to beneficiaries, (2) maintaining documentation for services, and (3) billing Medicare for services;
- obtained from CMS's National Claims History (NCH) file the Medicare Part B claims for chiropractic services provided by Etheredge, with service dates ending in CYs 2014 and 2015;
- created a sampling frame of 21,425 chiropractic services from the NCH data and randomly selected a sample of 100 services;
- obtained medical records from Etheredge for the 100 sampled services and provided them to the independent medical review contractor, who determined whether each service was allowable in accordance with Medicare requirements;
- reviewed and summarized the independent medical review contractor's results;
- estimated the amount of the unallowable payments for chiropractic services; and

- shared the results of our review with Etheredge officials.

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

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Needs Better Controls To Prevent Fraud, Waste, and Abuse Related to Chiropractic Services	A-09-16-02042	2/12/2018
A Brooklyn Chiropractor Received Unallowable Medicare Payments for Chiropractic Services	A-02-13-01047	8/9/2017
Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply With Medicare Requirements	A-09-14-02033	10/18/2016
A Michigan Chiropractor Received Unallowable Medicare Payments for Chiropractic Services	A-07-14-01148	8/8/2016
CMS Should Use Targeted Tactics To Curb Questionable And Inappropriate Payments For Chiropractic Services	OEI-01-14-00200	9/29/2015
Alleviate Wellness Center Received Unallowable Medicare Payments for Chiropractic Services	A-09-14-02027	7/22/2015
Advanced Chiropractic Services Received Unallowable Medicare Payments for Chiropractic Services	A-07-13-01128	5/27/2015
Diep Chiropractic Wellness, Inc., Received Unallowable Medicare Payments for Chiropractic Services	A-09-12-02072	11/20/2013
Inappropriate Medicare Payments for Chiropractic Services	OEI-07-07-00390	5/5/2009
Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis	OEI-09-02-00530	6/5/2005

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of chiropractic services provided during CYs 2014 and 2015, for which Etheredge received Medicare payment.

SAMPLING FRAME

For CYs 2014 and 2015, Etheredge received Medicare Part B payments of $659,877 for 21,961 chiropractic services provided to Medicare beneficiaries. We excluded 536 chiropractic services that were reviewed by the RACs and other review entities (such as the MACs). We also excluded services with payments less than $20. The resulting sampling frame contained 21,425 services, totaling $656,051 in Medicare payments to Etheredge.

SAMPLE UNIT

The sample unit was a chiropractic service for which Etheredge received a payment from Medicare.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

The sample size was 100 chiropractic services.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units in the sampling frame from 1 to 21,425. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

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

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Services	Value of Unallowable Services
21,425	$656,051	100	$3,077	33	$1,042

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

Point estimate	$223,332
Lower limit	169,737
Upper limit	276,927

APPENDIX E: 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 LCD also states: "[T]he 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 and First Coast's LCD further state: "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 and LCD L33840).

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 and First Coast's LCD require that the initial visit and all subsequent visits meet specific documentation requirements (chapter 15, § 240.1.2 and LCD L33840).

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 or, according to the LCD, date of exacerbation or reinjury of existing condition.

The following must be documented for subsequent visits:

1. History

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

2. Physical exam

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

3. Documentation of treatment given on day of visit.

The Health Law Offices of
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May 31, 2018
Via Federal Express and Email to Denise.Novak@oig.hhs.gov

DENISE NOVAK, ASSISTANT REGIONAL INSPECTOR GENERAL
OFFICE OF INSPECTOR GENERAL, AUDIT SERVICES

RE: ETHEREDGE CHIROPRACTIC, PA
RESPONSE TO OIG DRAFT REPORT NO. A-04-16-07064

Dear Denise:

As you know, the Health Law Office of Anthony C. Vitale, P.A. represents Etheredge Chiropractic, PA (hereinafter "Etheredge Chiropractic") with regard to the OIG Draft Report (hereinafter "the Report") entitled "Etheredge Chiropractic Received Unallowable Medicare Payments for Chiropractic Services."

I. THE REPORT

The Report provides the OIG's conclusions as to its review of 100 chiropractic services for which 67 were allowed and 33 were denied for a total unallowable amount of $1,042. Of the 33 denied services, 31 services were deemed medically unnecessary and 2 services were deemed to be not documented. The Report in Brief recommends the following actions be taken by Etheredge Chiropractic:

- Refund to the Federal Government the portion of the estimated $169,737 overpayment for claims for chiropractic services that did not comply with Medicare requirements and are within the 4-year claims reopening period;
- For the remaining portion of the estimated $169,737 overpayment for claims that are outside of the reopening period, exercise reasonable diligence to identify and return the overpayments in accordance with the 60-day rule, and identify any returned overpayment as having been made in accordance with this recommendation;
- 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; and

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

II. OPENING COMMENTS

Upon receipt of the OIG's audit, Etheredge Chiropractic fully cooperated and has been completely transparent with all OIG requests. Etheredge Chiropractic submitted all requested documentation within its possession and participated in the OIG's requested interviews and site visit.

IV. THE OIG' S 3 GENERAL ALLEGATIONS OF NON-COMPLIANCE

OIG ALLEGATION OF NON-COMPLIANCE	ETHEREDGE CHIROPRACTIC REBUTTAL
"Of 100 Chiropractic services in our sample, … 33 were not allowable: These unallowable payments occurred because Etheredge did not have adequate policies and procedures to ensure that the chiropractic services billed to Medicare were medically necessary and adequately documented in the medical records. Had their policies and procedures been more effective, Etheredge may not have submitted claims for unallowable payments for chiropractic services."	Etheredge Chiropractic disagrees with the Reports assertion that the practice "did not have adequate policies and procedures…". Etheredge Chiropractic possessed medical records, HIPAA, staff training, compliance, and claims submission Policies and Procedures during sample years 2014 and 2015. Etheredge Chiropractic conducted routine staff training on Medicare compliance matters including, billing, coding and documentation. Dr. Etheredge personally attended 31 straight years of Florida Chiropractic Association seminars including 20 hours per year on Medicare compliance.
"Of the 100 sampled services 31 were medically unnecessary • Subluxation of the spine was not present or was not treated with manual manipulation or both (13 services) • Manual manipulation of the spinal subluxation was maintenance therapy or was not appropriate for the treatment of the patient's condition or both (25 services)	• This fact-specific allegation will be defended in the Medicare Part B appeal to follow this rebuttal. • This fact-specific allegation will be defended in the Medicare Part B appeal to follow this rebuttal.

OIG ALLEGATION OF NON-COMPLIANCE	ETHEREDGE CHIROPRACTIC REBUTTAL
• Manual manipulation of the spinal subluxation would not be expected to result in improvement within a reasonable and generally predictable period of time (25 services)"	• This fact-specific allegation will be defended in the Medicare Part B appeal to follow this rebuttal.
"Of the 100 sampled chiropractic services, 2 were not documented. Etheredge provided the medical records for the beneficiaries who received these services; however, the records contained no documentation for the selected services."	Etheredge Chiropractic replaced its EMR platform between 2014 and 2015. Upon retrieval of the 100 patient records requested by the OIG, Etheredge Chiropractic concluded that 2 of the 100 records were missing due to the EMR/hardcopy transition.

V. CONCLUSION

Etheredge Chiropractic concurs in part and denies in part with the OIG's conclusions. The OIG recently provided Etheredge Chiropractic with its statistical support regarding its audit and extrapolation methodology. Etheredge Chiropractic is currently reviewing this data and will address the methodology areas of non-compliance within the overpayment appeals process. Prior to the Report being published, Etheredge Chiropractic strengthened its controls to ensure strict compliance with applicable Medicare chiropractic requirements.

On behalf of Etheredge Chiropractic, thank you for the OIG's time and attention to this matter.

Sincerely,

Christopher A. Parrella, J.D., CHC, CPC, CPCO
CParrella@vitalehealthlaw.com
For the Firm

CP/mm