

**AMERICAN CHIROPRACTIC ASSOCIATION (ACA)
RESPONSE TO THE OFFICE OF INSPECTOR GENERAL REPORT:
INAPPROPRIATE MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES
(MAY 2009: OEI-07-07-00390)**

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SUMMARY

In May of 2009, the Department of Health and Human Services Office of Inspector General (OIG) released the Report “Inappropriate Medicare Payments for Chiropractic Services” (OEI-07-07-00390). The objectives stated in the Report were to determine the extent to which: 1) chiropractic claims allowed in 2006 for beneficiaries receiving more than 12 services from the same chiropractor were appropriate, 2) controls ensured that chiropractic claims were not for maintenance therapy, 3) claims data can be used to identify maintenance therapy, and 4) chiropractic claims were documented as required.

The OIG came to four conclusions: 1) Medicare inappropriately paid \$178 million out of \$466 million for chiropractic claims in 2006, 2) Efforts to stop payments for maintenance therapy have been largely ineffective, 3) Claims data lack information to identify maintenance therapy, 4) Chiropractors often do not comply with Medicare documentation requirements.

It is the opinion of the American Chiropractic Association that the May 2009 OIG Report fails to provide the information necessary to evaluate the appropriateness of the claims review methodology they used to arrive at key conclusions regarding the level of inappropriate Medicare payments to doctors of chiropractic. It is probable that the methods used resulted in an overestimate of inappropriate claims paid. Further, the ACA feels that the window of time between the release of the 2005 OIG Report and the initiation of data collection in 2006 for this Report did not allow sufficient time for meaningful change to occur within the chiropractic profession, and that it is too soon to conclude that efforts to stop Medicare payments for maintenance care have been unsuccessful. Numerous chiropractic organizations took immediate action to address issues of documentation standards and maintenance care in 2005 and we believe that significant progress has been made since that time. This premise is supported by the fact that 1) the documentation error rate identified in the 2009 OIG Report was significantly lower than that presented in the 2005 Report and 2) CMS CERT Reports saw a drop in overall error rates from 16 percent in 2006 to 11 percent in 2007 for chiropractic services.

BACKGROUND, DATA COLLECTION METHODS AND FINDINGS (excerpted from the OIG Report) *As required by the Social Security Act, Medicare pays only for medically necessary chiropractic services, which are limited to active/corrective manual manipulations of the spine to correct subluxations. Chiropractors must use the acute treatment (AT) modifier to identify services that are active/corrective treatment and must document services in accordance with the Centers for Medicare & Medicaid Services' (CMS) "Medicare Benefit Policy Manual" (the Manual) when submitting claims. When further improvement cannot reasonably be expected from continuing care, the services are considered maintenance therapy, which is not medically necessary and therefore not payable under Medicare. We identified allowed claims with the AT modifier for beneficiaries with more than 12 claims from the same chiropractor in 2006. We then contracted with a medical review contractor to review medical records from a simple random sample of 188 claims. For each treatment episode, the medical records were reviewed to identify the initial visit and subsequent visits (if relevant) to determine whether each sampled claim was active/corrective treatment or maintenance therapy, the extent to which chiropractors supported their use of the AT modifier with proper documentation indicating active/corrective treatment, whether claims were coded properly, and whether documentation met the Manual requirements. FINDINGS: 1) Medicare inappropriately paid \$178 million out of \$466 million for chiropractic claims in 2006, 2) Efforts to stop payments for maintenance therapy have been largely ineffective, 3) Claims data lack information to identify maintenance therapy, 4) Chiropractors often do not comply with Medicare documentation requirements.*

ACA REPOSENSE TO OIG FINDINGS

1) Medicare inappropriately paid \$178 million out of \$466 million for chiropractic claims in 2006, representing 47 percent of all allowed chiropractic claims that met the study criteria

A) It is important to note that the OIG restricted data collection to those episodes of chiropractic care that resulted in claims for more than 12 visits by the same doctor of chiropractic. This is a subpopulation of chiropractic claims they have previously identified as significantly more likely to meet their definition of maintenance care. Chiropractic claims account for 0.15% of total Medicare claim expenditures. CMS' 2006 National Claims History Part B Carrier file shows 22,964,790 chiropractic claims with a total allowed amount of \$762,148,017. A random sample from this more representative population of chiropractic claims would have yielded a significantly smaller estimate of inappropriate claims paid.

B) Estimates of inappropriate Medicare payments for chiropractic claims are based entirely on review of medical records, yet the Report does not provide information on development and standardization of documentation review protocols, or training and certification of medical reviewers. There are two areas of the claims review process used in this Report that require rigorous methods to ensure the results are credible – assessment of maintenance care and the use of appropriate documentation standards. The protocol for determining the distinction between appropriate documentation of

maintenance care, which is not a benefit currently covered by Medicare, and documentation of acute/chronic care, which is a covered benefit, using medical records, must be clearly operationalized through the use of standardized record review criteria. There is no indication in the Report that this occurred. The second area pertains to the general documentation standards used to assess chiropractic claims for new and returning patients. The Report provides no information regarding how medical reviewers were trained and certified to assess the appropriateness of documentation pertaining to history, examination, presentation of present illness, and treatment plan records. Of particular concern are the standards used to determine documentation of a complete patient history, complete description of present illness, complete physical examination, and complete treatment plan. It is not clear what standards were used to determine that documentation was “complete,” given the majority of claims reviewed did, in fact, include a patient history, description of present illness, physical examination findings, and a treatment plan. The ACA has placed a Freedom of Information Act request for copies of the protocols, training tools, and credentialing standards used by medical reviewers for this study.

2) Efforts to stop payments for maintenance therapy have been largely ineffective.

The American Chiropractic Association feels it is too soon to assess whether or not efforts to stop payments for maintenance therapy have been effective. First, the use of the AT modifier was not widely implemented until 2005, only one year before the data provided in this report was collected. It is unclear if adequate training occurred during this early implementation period. Second, because of the lack of information provided in the Report regarding claims review protocols, it is unclear to what extent the OIG findings are based on actual claims paid for maintenance care versus active care that was insufficiently documented. Finally, the Report makes several references to the 2005 OIG report. The 2005 Report, based on 2001 data, found that 67% of chiropractic claims were paid inappropriately, with the majority of this (40%) attributed to claims identified as maintenance care. The 2009 OIG report, based on 2006 data, found that 47% of chiropractic claims were inappropriately paid, with less than 34% attributed to maintenance care. It is important to note that, in the 2005 Report, the sampling frame for the claims review was global chiropractic claims, while the 2009 Report limited data collection to those claims with 12 or more visits, a group which they had previously identified as more likely to be problematic in this area. If, in fact, the problem with inappropriately billed maintenance care claims is getting worse, as the 2009 OIG Report suggests, these numbers from 2001 to 2006 should have substantially INCREASED, rather than DECREASED.

3) Claims data lack information to identify maintenance therapy. The American Chiropractic Association disagrees that claims data lack information to identify maintenance therapy. We believe that the AT modifier is the appropriate tool to use for this purpose. Gaps in appropriate use of the AT modifier identified in the Report can be attributed to 1) an understandable learning curve for the chiropractic profession in learning to use the AT modifier correctly from 2005 to 2006, 2) documentation errors, which continue to be seriously addressed by the profession. It is also important to note the OIG Report states that, in order *to identify active/corrective treatment and thereby*

distinguish it from maintenance therapy, it is useful to identify the start of a new treatment episode. However, claims data do not indicate when an episode begins. This information is already required in box 14 of the CMS claims form completed by doctors of chiropractic.

4) Chiropractors often do not comply with Medicare documentation requirements.

The OIG Report released in June 2005 found that nearly 95% of chiropractic claims reviewed contained documentation errors. The response of the chiropractic profession, including the American Chiropractic Association (ACA), was immediate. A Task Force on this issue was formed as a collaborative effort between the ACA, the Association of Chiropractic Colleges (ACC), the Federation of Chiropractic Licensing Boards (FCLB) and the Congress of Chiropractic State Associations (COCSA). The ACA created a documentation manual and made it available to the profession, at cost, for two years. A webinar was created and made available to the profession at no charge and documentation standards were added to the ACA web site, which is also open to the profession. The ACC tightened up documentation standards requirements in chiropractic educational institutions, emphasizing Medicare requirements, and also distributed Medicare education articles. The FCLB encouraged member boards to require hours in documentation for re-licensure, and COCSA encouraged member associations to emphasize Medicare and documentation educational seminars. In addition, all four organizations met with CMS to discuss documentation requirements and attended a presentation by CMS contractors regarding medical review standards for chiropractic claims. These efforts were largely put into effect in 2006, too late to be reflected in the OIG claims review, which also occurred in 2006. This position is supported by the fact that 1) the documentation error rate identified in the 2009 OIG Report was significantly lower than that presented in the 2005 Report and 2) CMS CERT Reports saw a drop in overall error rates from 16 percent in 2006 to 11 percent in 2007 for chiropractic services.

In Summary, it is the opinion of the American Chiropractic Association that the May 2009 OIG Report fails to provide the information necessary to evaluate the appropriateness of the claims review methodology they used to arrive at key conclusions regarding the level of inappropriate Medicare payments to doctors of chiropractic. It is probable that the methods used resulted in an overestimate of inappropriate claims paid. Further, the ACA feels that the window of time between the release of the 2005 OIG Report and the initiation of data collection in 2006 for this Report did not allow sufficient time for meaningful change to occur within the chiropractic profession, and that it is too soon to conclude that efforts to stop Medicare payments for maintenance care have been unsuccessful. Numerous chiropractic organizations took immediate action to address issues of documentation standards and maintenance care in 2005 and we believe that significant progress has been made since that time. This premise is supported by the fact that 1) the documentation error rate identified in the 2009 OIG Report was significantly lower than that presented in the 2005 Report and 2) CMS CERT Reports saw a drop in overall error rates from 16 percent in 2006 to 11 percent in 2007 for chiropractic services.