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Is Failure to Document Giving Chiropractic a Black Eye?

OIG ISSUES REPORT ON MEDICARE BILLING FOR CHIROPRACTIC SERVICES

Editorial Staff

A new report from the Office of the Inspector General (OIG) of the Department of Health & Human Services, *Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis*,[1] offers a number of less-than-complimentary observations on the medical necessity and appropriateness of chiropractic services billed to Medicare, including that "supporting documentation for chiropractic services rarely [meets] all *Medicare Carriers Manual* requirements."

The 31-page report details the Inspector General's findings, based primarily on review of a random sample of Medicare claims. Reviewers identified the chiropractor listed on each claim and requested records for the beneficiary's entire course of treatment. Key points from the OIG report are summarized as follows:

1. Maintenance services. "Maintenance services were the most common type of noncovered chiropractic services that Medicare paid for in 2001." The *Medicare Carriers Manual*, which outlines coverage criteria for chiropractic services billed to Medicare, does not consider "ongoing maintenance therapy" to be medically necessary under the Medicare program; thus, it is an uncovered service.

   The OIG report states that "although billed with an allowable code, 57 percent of these services did not meet Medicare coverage criteria." Additionally, 16 percent of services were miscoded or billed at the incorrect level of spinal manipulation; and six percent were undocumented.
   According to the report, the majority of inappropriate paid services were for maintenance care, resulting in $186 million in payments for uncovered services by chiropractors. Another $65 million was paid for medically unnecessary services not related to maintenance care, $24 million for "services billed with a spinal manipulation code that were actually extraspinal manipulations or non-manipulative treatment," and $15 million in upcoding errors.

2. Supporting documentation. According to the *Medicare Carriers Manual* (section 2251.2), the existence of a subluxation must be documented by physical examination or X-ray, and chiropractic services must be provided as part of a written plan of care that includes specific goals/measures to assess efficacy. The OIG report determined that "nearly 94 percent of chiropractic services ... lacked at least one of the supporting documentation elements listed in section 2251.2 of the Manual."

3. Medical necessity. The OIG report correlates lack of medical necessity with service volume: "As chiropractic care extends beyond 12 treatments in a year, it becomes increasingly likely that individual services are medically unnecessary. The likelihood of a service being medically unnecessary increases even more significantly after 24 treatments." The report suggests that caps be placed on the number of times Medicare can be billed for chiropractic services for an individual patient.[2]

4. Potential for overutilization. "Carrier controls to prevent overutilization are inconsistent," despite some mechanisms by all carriers to prevent and recoup improper payments for chiropractic services.

Recommendations

The OIG report concludes: "Based on the volume of medically unnecessary, undocumented, and noncovered services allowed, chiropractic services represent a significant vulnerability for the Medicare program." The report recommends that the Centers for Medicare and Medicaid Services (CMS) implement the following:

> Ensure that chiropractic services comply with Medicare coverage criteria. Given the strong correlation between the number of services a beneficiary receives and the likelihood a service is not medically necessary, CMS should implement a national frequency edit to target high-volume services - which are especially likely to be medically unnecessary - for medical review. Carriers or Program Safeguard Contractors should then obtain and review the records of beneficiaries targeted by the frequency edit in order to identify and collect overpayments.
> Many services that would not exceed even a very low frequency threshold were medically unnecessary, undocumented, not spinal manipulation, or miscoded. Therefore, in addition to whatever frequency control is chosen, CMS should require that its carriers or Program Safeguard Contractors conduct routine service-specific reviews of chiropractic services. When conducting reviews of individual providers, it is imperative that reviewers collect the entire records associated with services selected as part of a service-specific review. Several records we reviewed would have appeared legitimate for any one particular day of service; however, that day's documentation was repeated verbatim for the entirety of the patient's treatment.
> Require that its carriers educate chiropractors on *Medicare Carriers Manual* requirements for supporting documentation. Many chiropractors seem unaware of the specific documentation requirements outlined in section 2251.2 of the Manual. CMS should address this lack of knowledge by directing its carriers to issue provider bulletins reminding chiropractors of their responsibilities. Due to the relationship we found between the lack of treatment plans and medically unnecessary services, the bulletins should especially emphasize this requirement.

So, are chiropractors providing unnecessary care, or are they simply failing to document the necessary care they provide to their patients? The American Chiropractic Association (ACA) issued an official response[3] following the release of the OIG report, which states, in part: "It is the opinion of the [ACA] that the findings in the report issued by the Department of Health and Human Services, Office of the Inspector General reflect a universal problem in physician documentation and do not represent a concerted effort by doctors of chiropractic to over bill the government for non-reimbursable Medicare services. ... In far too many instances, chiropractic providers are simply failing to adequately document the medically necessary care provided." [Emphasis ours] The ACA release also addresses the OIG report's finding that the medical necessity of care declines after 12 visits, and the recommendation that CMS implement a "national frequency edit" to target high-volume services: "Medicare beneficiaries have the right to receive care which is reasonable and necessary ... placing arbitrary limits - or caps - on care is not an appropriate solution."

Perhaps the most important point the ACA makes refers to last year's CMS requirement that chiropractors utilize the "-AT" (Active Treatment) modifier to indicate that a service is non-maintenance; only claims to which this modifier are attached are payable. The ACA response to the OIG report notes: "It is unfortunate that the Inspector General's report, drawn from 2001 data, provided only passing reference to a program initiated in October 2004 that specifically addresses the very problems mentioned in this report."

Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis, is available online at http://oig.hhs.gov/oei/reports/oei-09-02-00530.pdf.

References

1. *Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis*. Department of Health and Human Services, Office of the Inspector General. Report issued June 2005.
2. Taxpayers overbilled for chiropractic work. Associated Press, June 21, 2005.
3. American Chiropractic Association issues statement in response to inspector general's report. Press release issued June 23, 2005.

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