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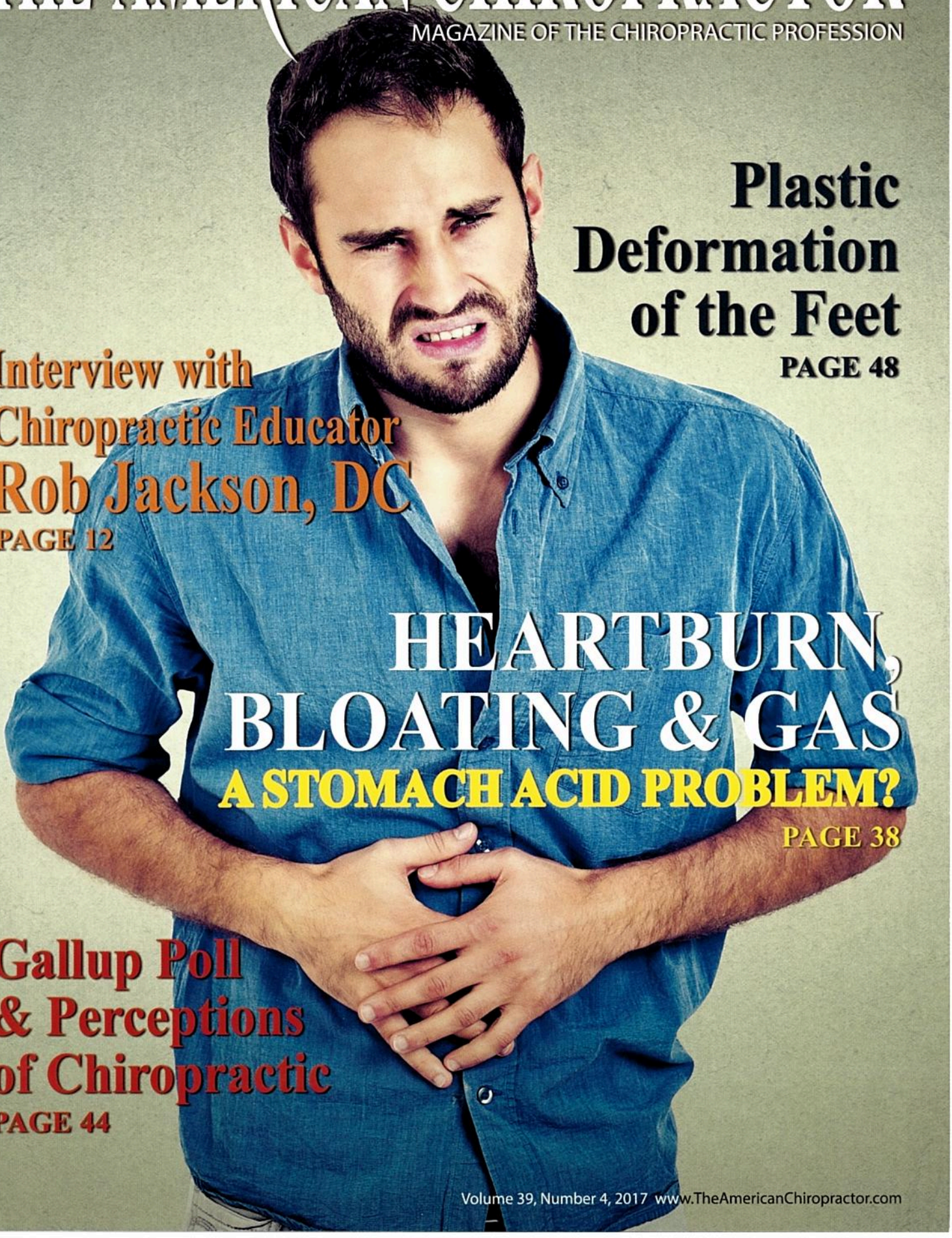

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Prescription for Chiropractors: Are Your Medicare Billing Procedures Out of Alignment?

By Christopher McLamb and Mary Inman

In 1972, Congress amended the Social Security Act to make chiropractors eligible for reimbursement under Medicare Part B.[1] Since then, Medicare expenditures on chiropractic services have mushroomed from just $19 million in 1975[2] to nearly $440 million in 2013.[3] Medicare covered over 17 million chiropractic treatments in 2013 alone.[4]

Unfortunately, an equally large rise in improper payments for chiropractic services has tainted this growth. According to a new report by the Department of Health and Human Services' Office of Inspector General (OIG), more than 80% of all Medicare payments for chiropractic services in 2013 went toward medically unnecessary procedures.[5] As a result, the government spent nearly $359 million on unnecessary care.

Following this staggering report, chiropractors' billing practices are certain to fall under increased government scrutiny. Indeed, OIG has recently reviewed a number of individual practices, in each case discovering hundreds of thousands of dollars in improper payments. To avoid ending up in the government's crosshairs, chiropractors and their employees should be aware of the pitfalls that lead to improper payments.

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The Basics of Medicare Billing

Under the Social Security Act, chiropractors may bill Medicare only for manual manipulation to correct a subluxation or malfunction of the spine.[6] Like all services billed to Medicare under the act, these chiropractic treatments must be medically necessary and supported by appropriate documentation.[7]

The Centers for Medicare and Medicaid Services (CMS), which administers Medicare, has further refined the program's requirements for chiropractors. Under CMS regulations, Medicare only reimburses chiropractic treatments when "subluxation has resulted in a neuromusculoskeletal condition for which manual manipulation is appropriate treatment."[8] *The Medicare Benefit Policy Manual* issued by CMS requires that this subluxation be demonstrated by an X-ray or physical examination.[9]

Medicare only covers "active/corrective treatment" of spinal subluxation, meaning "services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function."[10] Active/corrective treatment is indicated by placing an acute treatment (AT) modifier on a claim for Medicare reimbursement. In contrast, "maintenance therapy" is explicitly excluded from Medicare coverage. *The Medicare Benefit Policy Manual* defines maintenance therapy as "services that seek to prevent disease, promote health, and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition."[11] CMS treats claims without an AT modifier as maintenance therapy and, thus, denies all such claims.

In addition, chiropractors must record and maintain specific documentation at the outset of any course of treatment and at each subsequent service.[12] Among other requirements, these records must specify the precise level of subluxation by referencing the parts of the spine in which the condition is located. Each claim for reimbursement must include the date of the patient's initial treatment or the date of exacerbation, which serves as an affirmation that the chiropractor has maintained all required documentation on file.[13]

Improper Payments

OIG's report estimated that a stunning 82% of all payments for chiropractic services under Medicare Part B violated these requirements.[14] To conduct the report, OIG randomly sampled 105 claims for chiropractic services in 2013. Each claim included an AT modifier and an initial treatment date, affirming that the services were for active/corrective treatment and that the chiropractors had maintained all required documentation.

An independent medical review found that 94 of these claims were for medically unnecessary services. In 93 cases, the chiropractic manipulation was maintenance therapy, inappropriate for the patient's condition, or both. In 37, spinal subluxation was not even present. And in six, although spinal subluxation was present, there was no evidence the chiropractor treated the condition by manual manipulation.

OIG also examined the claims longitudinally, sorting them based on the number of chiropractic services between the claim at issue and the patient's initial treatment. The study found that the percentage of improper payments increased as services extended further from the date of the initial treatment. Specifically, OIG found that after a patient's twelfth treatment, 95% of claims were medically unnecessary. After 30 treatments, none of the sampled claims satisfied Medicare's requirements.

Ominously, the problem of improper payments appears to have only worsened over time. In a similar 2005 report, OIG sampled 400 claims submitted by chiropractors and found that 67% had been improperly paid, costing the government $285 million.[15] As in the 2016 study, the proportion of medically unnecessary services increased significantly once a patient surpassed 12 treatments, reaching 100% after 23 treatments.

OIG has corroborated these findings through reviews of individual practices. In four reviews conducted between 2013 and 2016, OIG discovered $2.3 million in payments for services that were medically unnecessary, incorrectly coded, or lacking adequate documentation.[16] Taken together, OIG's studies and investigations point to the troubling conclusion that improper Medicare payments have become the rule, rather than the exception, for chiropractic services.

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Government Reforms

In its 2016 report, OIG outlined several "strong controls" to curb CMS's unwarranted expenditures, including a ceiling on the number of chiropractic services that Medicare would reimburse. OIG projected that a cap of 30 services per year would have prevented almost $29 million in unnecessary spending in 2013 alone. CMS rejected this recommendation in its written response to OIG's draft report, arguing that there was no medical evidence to support a hard cap on such services.

In addition to this fixed limit, OIG advised CMS to develop a more reliable control for distinguishing maintenance therapy from active/corrective treatment. Specifically, OIG recommended that CMS determine the number of services necessary to actively treat spinal subluxation and isolate claims above that number for additional review. In response, CMS noted that new legislation, effective January 2017, requires prior authorization for specified services provided by chiropractors with aberrant billing patterns. CMS stated that it planned to monitor this program to determine whether further steps are justified. CMS also noted that its Fraud Prevention System—a data analytics program used to detect suspicious billing patterns—incorporates several chiropractic-specific models to identify waste.

Finally, OIG encouraged CMS to better educate chiropractors on Medicare's billing procedures and coverage requirements. CMS concurred with this recommendation and cited numerous efforts it had made to better educate chiropractors since 2013, including several publications,[17] an instructional YouTube video,[18] and more than 1,000 local education activities.

Know the Red Flags

With chiropractic services now under a microscope, practices should carefully review and familiarize themselves with

Medicare's eligibility and billing requirements. Common issues in billing for chiropractic services include the following:

- **Proof required:** CMS guidance requires proof of spinal subluxation by an X-ray or physical examination. Typically, the X-ray must have occurred no more than 12 months before, or three months after, the chiropractor begins treatment. Older X-rays may be sufficient if the condition is permanent. Proof by physical examination requires an evaluation of four criteria: pain/tenderness, asymmetry/misalignment, range of motion abnormality, and tissue tone, texture, or temperature abnormality. The examination must reveal at least two of these criteria, of which one must be asymmetry/misalignment or range of motion abnormality.[19]
- **Keep a record:** For each Medicare claim, chiropractors must affirm that they are maintaining all documentation required by CMS guidance. For an initial treatment, chiropractors must record the patient's medical history and physical examination results, a description of the present illness, a primary diagnosis of subluxation, the date of initial service, and a treatment plan detailing the recommended level of care, specific treatment goals, and objective measures for evaluating effectiveness. For subsequent services, chiropractors must document the patient's medical history, the results of a follow-up physical examination, and the treatment given on the day of the visit.[20]
- **Active treatment only:** Medicare only covers "active/corrective treatment" of spinal subluxation, which the chiropractor indicates by placing an AT modifier on claims for reimbursement. The services rendered must "provide reasonable expectation of recovery or improvement of function." Chiropractors should not submit claims with an AT modifier for "maintenance therapy," where no improvement in the patient's condition reasonably can be expected.[21]

Providers should be on the lookout for these issues as they prepare and submit claims for Medicare payments. Otherwise, they run the risk of adverse consequences down the line.

Stopping Fraud and Waste at the Front Lines

Despite CMS's efforts to improve detection and prevention of unnecessary payments, the true power to eliminate this waste of taxpayer dollars rests with those on the front lines. Chiropractors and employees of chiropractic offices with firsthand knowledge of questionable billing practices occupy a unique position. Employees should be able to raise concerns about their practice's Medicare claims internally to a compliance department, or by following other internal reporting guidelines. Speaking up can help resolve compliance issues before government action is required, protecting a practice's resources and reputation.

However, if the organization is not responsive to an employee's concerns, the employee may have to go outside the practice. As whistleblowers, employees can serve as the eyes

and ears of the government and as a first line of defense in its efforts to combat Medicare fraud. The federal False Claims Act empowers anyone who knows about fraud against the government to take action.

Between 2009 and late 2015, the federal government recovered more than $26 billion under the False Claims Act, of which nearly $16.5 billion related to Medicare and other governmental healthcare programs.

Whether working internally with a compliance department to straighten out billing practices or depending on employees to take action through a False Claims Act suit, only healthcare professionals have the expertise and access to ensure the integrity of our healthcare system. Ultimately, chiropractic professionals who do not undergo an adjustment to ensure that their billing practices are aligned with Medicare regulations risk finding themselves whiplashed if caught.

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5. *2016 OIG REPORT, at 5.*
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11. *Id.*
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20. *Id.*
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