Foundation for Vertebral Subluxation

Policy ~ Research ~ Education ~ Service

A Review and Analysis of the Office of Inspector General's Report:

INAPPROPRIATE MEDICARE
PAYMENTS FOR
CHIROPRACTIC SERVICES

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Introduction

The Office of the Inspector General of the Department of Health and Human Services released a report dated May 2009 entitled: Inappropriate Medicare Payments for Chiropractic Services. The stated objective of the report was to:

> 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,
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> (3) claims data can be used to identify maintenance therapy, and
>
> (4) chiropractic claims were documented as required.

According to the OIG report, Medicare inappropriately paid $178 million for chiropractic claims in 2006. This was out of $466 million in total claims paid. According to the medical claims reviewers hired by the OIG to conduct this investigation, the bulk of the inappropriate payments were for maintenance therapy which amounted to $157 million. Miscoded and undocumented claims accounted for the rest.

This is not the first time the OIG has asserted that there were "significant vulnerabilities" related to Medicare payments for chiropractic care. Reports in 1986, 1998 and 1999 also alleged problems related to payment for maintenance therapy.

According to this most recent OIG report the previous studies recommended frequency edits or caps on the number of chiropractic claims allowed. In 2005 the OIG stated that 40 percent of allowed chiropractic claims were for maintenance therapy and they asserted that any visits over 12 in a year were likely to be for maintenance care.

As a result, the OIG recommended that carriers conduct routine reviews of chiropractic services, implement frequency-based controls, target high-volume services for review and educate chiropractors on Medicare documentation requirements. This is what led to the massive effort in the profession to hold continuing education programs on Medicare and the PART system.

There are several concerns with this most recent report from the OIG that include methodology, bias, and most distressing – perhaps a complete lack of understanding regarding the nature of the management of vertebral subluxation. The remainder of this report will outline these concerns and make recommendations to address them.

Methodological Concerns

Medical Reviewers

According to the OIG Report the primary method used to achieve their objectives was "medical review of records" supporting chiropractic claims. In order to do that they contracted with a "medical review contractor" that assisted them in "…data collection, selecting medical reviewers, and reviewing medical records."

The medical reviewers were chiropractors selected by the OIG and the contractor who had "…previous experience in reviewing chiropractic services provided to Medicare beneficiaries…"

It was these chiropractors, presumably paid for their medical review role and presumably already working with the carriers in a review capacity, who determined whether each sampled claim was considered active/corrective treatment or maintenance therapy. These presumably paid reviewers also determined whether the use of the AT modifier was supported by the documentation, and whether there was proper coding and documentation.

The OIG report contains some very serious accusations and statements concerning the practice of chiropractic. It is disturbing to say the least that the basis for these accusations stems from the opinions of chiropractors acting as paid reviewers for the OIG. Also disturbing is the very real possibility that the chiropractors hired to perform these reviews are already working within the medical review field generally and for the Medicare carriers specifically. Given the highly biased statements made by carrier staff and documented in this OIG report one has to be concerned that these reviewers also share this bias.

Further to the concerns regarding the chiropractic reviewers is that we have no knowledge of the political, professional and philosophical perspectives of these reviewers. There is not a chiropractor in the profession, nor likely a layperson, who is not aware that there are contentious issues surrounding the concept of vertebral subluxation. The profession is also generally aware that those chiropractors who contend that there is debate as to the significance and even existence of vertebral subluxation tend to be chiropractors who gravitate toward working in the medical review business.

If the chiropractors hired by the OIG to conduct these reviews have personal and worldviews that suggest that subluxations are insignificant or even non existent then clearly this would potentially taint their findings and thus call into question the results of this evaluation.

It is recommended that the profession request the identities and qualifications of the chiropractors who participated as medical reviewers in this evaluation. Further, it is recommended that the profession demand that these reviewers reveal how much of their income is derived from medical review activities and how much of their time is spent in

active practice. If they care for Medicare beneficiaries it is suggested that a random sample of their records and claims be reviewed to ensure that they are indeed following the same standards that they are opining on regarding their colleagues. The profession should also request the identity of the medical review contractor hired to participate in this investigation.

Carrier Staff Interviews

The process for evaluation utilized by the OIG included structured interviews with carrier staff. The OIG report includes a number of direct quotes from those structured interviews that are used to buttress the OIG argument regarding the inappropriate management by the chiropractors in their sample. It is concerning that there are no positive comments from the carrier staff or medical reviewers. In fact, some of the comments seem blatantly inappropriate coming from someone charged with such responsibilities. Some statements by staff include non referenced statistical data that cannot be verified in the report so the reader (the public) is left to assume it must be factual given it is contained in a government report.

Others of the quotes reveal a complete and blatant disregard on the part of the carrier staff to even utilize the very parameters being evaluated in this investigation with one stating, remarkably, that its not worth it financially because the amount of money involved is negligible.

The following are selected quotes and statements from carrier and medical review staff contained in the OIG report:

> "Three to four years ago we looked at distribution among three codes, looking at those using 98942 frequently. The percentage of abuse with 98942 was 80 percent or greater."
>
> Carrier staff, PSC staff, and medical reviewers for this study agreed that the AT modifier did not prevent inappropriate payments for maintenance therapy. Carrier staff readily indicated, "By putting an AT modifier on a claim, chiropractors are getting paid, and they know they will get paid."
>
> Staff from another PSC investigating suspicious chiropractic claims said, "from a [targeted] medical review standpoint, we see lots of chiropractors billing with the AT modifier when not appropriate. I would say at least 95 percent of AT modifier use is wrong. It is a big issue."
>
> Staff from another carrier noted in reference to their post payment review process, "As we continue to do complex medical review, we continue to deny about 90 percent of reviewed claims."

One carrier reported difficulty in implementing an internal frequency threshold. After the carrier adjusted its frequency threshold, some chiropractors changed their billing behavior by submitting claims up to the threshold to avoid review.

Carrier staff explained that they no longer have hard caps because of guidance from CMS and opposition from the chiropractic community. A CMS staff member noted, "Years ago, some [carriers] had auto-deny limits and one by one, they got rid of them because of political pressure."

Although CMS has hard caps in other disciplines, staff indicated that the lack of clinical evidence would make establishing frequency thresholds for chiropractic claims difficult. However, staff from 10 carriers indicated that they would welcome hard caps on chiropractic claims. Similarly, the 2005 OIG report noted that six carriers would like hard caps.

Staff from a PSC responsible for program integrity in five major cities across 16 States explained, "We have to prioritize our work by the most egregious crimes. We don't look at chiropractic claims and the AT modifier specifically because the money is not [significant when reviewing] individual providers."

Carrier staff indicated that documentation for chiropractic claims was poor. Staff at one carrier stated, "Several providers blatantly tell us that they don't have time to document the way we want."

Staff at another carrier stated that chiropractors do not agree with documentation requirements and believe them to be too time consuming.

A staff member from one carrier explained that: When reviewing a specific service, we often don't get a treatment plan if it was created at the first visit for the episode-this is no more than what we ask from [medical doctors]. The general trend is that [the patient will] be treated for several months, three to four times per month, but there's no documentation of a treatment plan or any goals.

One of the medical reviewers explained that it is common for chiropractors to have treatment plans that include frequency, duration, and goals but that these treatment plans often are verbal and consequently not always documented.

Another medical reviewer indicated, "In my 29 years of practice, I rarely saw documentation of a plan which included frequency,

> duration, goals, and objective measures. While these guidelines are in the [Medicare] Manual, they apparently have not been incorporated into the profession."

Presumably the quotes and comments included in the report are not a complete record of statements gathered. There is no way to know based on the report whether these quotes represent the majority of those gathered in the structured interviews or whether quotes that supported the contentions of the OIG were the ones that were used.

Based on these concerns it is recommended that the profession request a copy of the structured interview questions that were utilized in this investigation and that all responses received during the evaluation be provided so that a full review can be made and these quotes/statements can be put in context with the totality of the interviews.

Review of Literature

The OIG report states that they also accomplished their objectives by reviewing recent chiropractic literature. However there is no discussion of that literature in the report and an Appendix, Reference section or Bibliography listing that literature is not provided. Considering that a good amount of literature has been published in the past several years related to the management of vertebral subluxation it seems reasonable that we would want to be assured that this was not a limited review that was conducted and that those conducting the review possess appropriate credentials.

It is therefore recommended that the profession request a detailed description of the methodology used to conduct the literature review, that a complete list of the literature reviewed be provided and an explanation given for literature, guidelines and other documents that were not included. The identity and qualifications of those who conducted the review should be provided. Finally, the OIG should explain how the literature informed their evaluation.

Management of Vertebral Subluxation

The OIG report contains the following statement:

> 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.

The OIG report continues:

> As required by the Social Security Act (the Act), Medicare pays only for reasonable and necessary chiropractic services, which are limited to active/corrective manual manipulations of the spine to correct subluxations. A chiropractic service "must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function." The Centers for Medicare & Medicaid Services (CMS) "Medicare Benefit Policy Manual" (the Manual) allows chiropractors an opportunity to produce functional improvement or arrest or retard deterioration for subluxations within a reasonable and generally predictable period of time. When further improvement cannot reasonably be expected from continuing care and the services become supportive rather than corrective, the services are considered maintenance therapy. The Manual provides that maintenance therapy is not considered a medically necessary chiropractic service and is therefore not payable under Medicare.

Any reasonable person reading these statements would understand this to mean that the primary management goals when addressing vertebral subluxation are to arrest or retard deterioration for subluxations. Once a subluxation is reduced or taken to a point where no further improvement can be made then the care is considered maintenance. Other than arguments regarding the non therapeutic nature of some types of chiropractic care – such statements are more likely than not thought to be reasonable by those who consider vertebral subluxation to be a pathophysiological process which can be objectively identified and amenable to intervention.

Thus, Medicare specifically states that they will only pay for care that is directed at "correcting" vertebral subluxations and additionally, Medicare has repeated references to functional improvement related to the correction, reduction, or arrest of vertebral subluxation. This could not be any clearer.

The issue becomes muddy where Medicare states this must be done "… within a reasonable and generally predictable period of time." It is suggested that this nexus, between the mandate Medicare is giving to the chiropractic profession relative to its responsibility toward correcting subluxation and its insistence that there is some known reasonable and predictable period of time in which this happens, is a significant reason for the ongoing disconnect between the OIG and the clinicians.

There is no clinical research that reveals this "reasonable and predictable period of time" yet Medicare insists there is, the carriers assume it is around 12 visits and the medical reviewers reinforce this absolute figment of everyone's imagination.

In addition to this issue we have the on-going issues where Medicare is holding the chiropractic profession to a standard which it does not hold medical providers to. Medicare routinely pays for medical services to address chronic conditions such as heart disease, diabetes and others without considering this "maintenance therapy."

The only thing we know for sure is that vertebral subluxations can be reliably identified using objective means and that reduction of vertebral subluxation can thus be identified through reliable means. Further, functional outcome assessments including objective measures of the components of vertebral subluxation, physiological abnormalities secondary to vertebral subluxation and quality of life issues affected by subluxation can all be objectively measured.

It is these objective measures that must be used to determine whether or not a Medicare beneficiary has obtained a correction or stabilization of their subluxation(s) and not whether or not they have had more than 12 visits or whether or not the patient has a disease, disorder or syndrome tied to the vertebral subluxation. It is suggested that most chiropractors would contend that subluxations in and of themselves are detrimental and that even in the absence of a related condition they should be arrested or corrected. This fundamental confusion and disconnect between what typical chiropractors are trying to accomplish clinically and what Medicare is trying to force them to do poses serious ethical issues for the chiropractor. And we see this reflected in the frustration of the writers of the OIG report, the comments by the carrier staff and the medical reviewers.

These issues have repercussions beyond the OIG report both in Medicare and in any debate surrounding chiropractic inclusion in health plans – specifically management of vertebral subluxation.

Therefore, this fundamental disconnect must be resolved in order to put to rest the ongoing issues related to reimbursement for chiropractic services. In order to do that it is recommended that a rethinking of the role of chiropractic in Medicare be undertaken. At a time when the chiropractic profession is struggling to even remain relevant in the the discussion of a national health plan it should use this as an opportunity to stake its claim on its unique and strategic competitive advantage.

While jockeying to try and make sure chiropractic is included in Medicare or any other national health plan such that the profession is able to provide any and all services that are within its scope, the profession must demand, *without compromise,* that at a minimum those services include the identification and management of vertebral subluxation. Further, that such management include care that is directed toward the arrest or correction of subluxation and include whatever means are generally accepted within the profession to accomplish such clinical goals. Additionally, whatever outcome measurement tools have been established as valid and reliable in objectively documenting the existence of a subluxation and its reduction must also be included - otherwise the profession is given a mission without the necessary resources to accomplish it.

Finally, any determination of the reasonableness or necessity of chiropractic care by a third party must include consideration of whether or not the subluxation has been arrested or corrected and such determinations must be made by reviewing objective assessments of outcome.

Screens and Caps

There can be no mistaking that the OIG is strongly advocating for the implementation of caps on the number of visits paid to chiropractors. This is suggested numerous times throughout the report. While CMS suggests that such action will not be taken in the short run it is suggested that without a vigorous response to this report such a recommendation will eventually be entertained – whether in Medicare and/or in the coming national health plan.

Education

Repeatedly the OIG refers to educational sessions that were undertaken by them in an effort to reinforce the documentation, billing and coding rules that have become such a contentious issue. In fact, the OIG at times seems exasperated that so much education was done yet the results of the evaluation reveal a worsening of the situation. Yet the OIG sees only one side of the issue and asserts that it's the chiropractors who must not be getting it - and the statements by the carrier staff even suggest that chiropractors are simply ignoring these mandates on purpose. This is quite disturbing considering that any fair evaluation has to take into consideration whether or not the educational programs were effective. Why isn't this possibility entertained by the OIG? Were any of the programs offered by the OIG or the carriers evaluated? If so what were the results of those evaluations? If not – why not?

There have been numerous anecdotal reports form the profession of a great deal of frustration arising at these "educational sessions" stemming from the perception on the part of the chiropractors that the M edicare representatives were uninformed at best and ignorant at worst regarding the nature of the chiropractic clinical landscape. Other stories include outright contempt towards chiropractors being displayed by the carrier representatives. It would be disturbing to say the least if these anecdotes have any basis in fact.

It is recommended that the profession seek to gather reports from attendees at these educational sessions to substantiate these anecdotes and the profession should attempt to gather any and all course evaluations that were completed by providers of these programs in order to assess learner concerns about them. Many of them were sponsored by the post graduate departments of chiropractic institutions so evaluation data should be readily available.

Documentation

As outlined in the OIG report the Medicare Manual provides documentation requirements as follows:

> Initial visit.
>
> 1. Subluxation(s) demonstrated by x-ray or physical examination (physical examinations must demonstrate at least two of the four following criteria: pain/tenderness, asymmetry/misalignment, abnormal range of motion, and tissue/tone changes, one of which must be either asymmetry/misalignment or abnormal range of motion),
> 2. Diagnosis of subluxation(s),
> 3. Patient history (lists such items as symptoms and past health history),
> 4. Description of present illness,
> 5. Treatment plan (includes a recommended level of care, specific treatment goals, and objective measures to evaluate treatment effectiveness),
> 6. Physical examination, and
> 7. Date of initial treatment.
>
> Subsequent visit.
>
> 1. Patient history (lists such items as changes since last visit),
> 2. Physical examination, and
> 3. Documentation of treatment provided at each visit.

The interpretation of clinical records and the judgment used to determine whether or not a particular threshold has been met to state with certainty that some review criteria was met is extremely subjective. For example, the OIG report itself states:

> For example, even if not all visits included patient histories and descriptions of present illnesses, which are required by Medicare, the records were still reviewed.

If one looks at the documentation rules there is no requirement that descriptions of present illnesses be included in follow-up visits. However, this statement from the OIG report suggests that there is. If the OIG report reveals such confusion about the medical review criteria one can only imagine the discrepancies that arose amongst the reviewers themselves once the process got underway.

The OIG report does not state whether or not the chiropractic reviewers followed a structured review process when evaluating the sample records. There is also no explicit description of the review process. For example were files reviewed only by one chiropractor or was each file reviewed by multiple reviewers followed by additional reviews to resolve any discrepancies and to arrive at a consensus? If such a process was

not followed this calls into serious question the validity and reliability of the review process itself. Was there any training required for the chiropractors prior to the beginning of the review process? Coupled with potential conflicts of interest and potential bias - a flawed review process may have tainted any conclusions arrived at in this report.

It is recommended that the profession inquire as to the nature of the review process and that an explicit description of that process be provided.

Involvement of Stakeholders

Best practices in program evaluations suggest that all stakeholders should be included in the process. Clearly, this evaluation did not include input or feedback from the chiropractors whose records were evaluated, the patients or the profession itself. Based on comments by carrier staff and medical reviewers there are concerns that they are highly biased. It should be of concern to the profession that all stakeholders were not included and that that at least two of the major participants in the evaluation itself may be biased and may have financial conflicts of interest.

It is recommended that the profession strongly voice its objection to the lack of involvement of all stakeholders and that the profession seriously question the objectivity of an evaluation based upon potentially biased participants.

Quality Standards for Inspections

In their work, the Inspectors General apply the Quality Standards for Inspections http://www.ignet.gov/pande/standards1.html and the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency encourage the consistent application of these standards throughout the Inspector General community.

The following are several instances where this Medicare OIG report may have failed to abide by those standards.

> *Competency*
>
> The inspection organization needs to ensure that the personnel conducting an inspection collectively have the knowledge, skills, abilities, and experience necessary for the assignment…
>
> When reviewing technical or scientific topics, it may be appropriate to use the services of a subject matter expert.

As outlined in the foregoing report there is no assurance that the personnel involved in this investigation possess the requisite knowledge, skills, abilities and experience to conduct such an investigation. Further, considering the technical and scientific issues surrounding vertebral subluxation - the very entity that the investigation centered on – there is no information provide as to whether or not subject matter experts were involved

in the process. Given the highly bias nature of the carrier and reviewer staff comments the level of concern on this issue is heightened.

Independence

> Inspectors and inspection organizations have a responsibility to maintain independence so that opinions, conclusions, judgments, and recommendations will be impartial and will be viewed as impartial by knowledgeable third parties. The independence standard should be applied to anyone in the organization who may directly influence the outcome of an inspection and includes both Government and private persons performing inspection work for an OIG.
>
> Having preconceived ideas toward individuals, groups, organizations, or objectives of a particular program that could bias the inspection. (f) Having biases, including those induced by political, ideological, or social convictions, that result from employment in or loyalty to a particular type of policy, group, organization, or level of government.

As pointed out in the foregoing report there are numerous instances of biased and derogatory comments towards chiropractors on the part of carrier staff and reviewers involved in the inspection. There can be no question based on these comments alone that individuals involved in the process were biased. Additionally, as stated in this review of the OIG report, the chiropractic profession includes individuals who actually question the existence or the significance of vertebral subluxation. Were some of these individuals involved in the reviewing aspect of this inspection this would have inserted significant ideological convictions into the process. The OIG should provide information including vitae concerning those individuals utilized as paid reviewers for this inspection.

Professional Judgment

> Evidence is gathered and reported in a fair, unbiased, and independent manner and report findings, conclusions, and recommendations are valid and supported by adequate documentation…

Beyond the blatant biased and derogatory comments by carrier staff and medical reviewers involved in this inspection there is no evidence provided which substantiates the numerous statements by these individuals – especially with regard to statistics quoted and given as facts which are nothing more than hearsay? Clearly there was a lack of judgment in this regard.

Planning

> Research—Consistent with the inspection objectives, inspection research includes a review of existing data, discussions with program and other appropriate officials, literature research, and a review of pertinent

> websites and other internet accessible materials to gather information that will facilitate understanding of the program or activity to be inspected. Research should help to identify the criteria applicable to the evaluation of the program or activity. Examples of possible criteria include: laws, regulations, policies, procedures, technically developed standards or norms, expert opinions, prior periods' performance, performance of similar entities, performance in the private sector, and best practices of leading organizations. Research should attempt to identify the results of previous reviews that may be relevant to the inspection, and inspectors should follow up on known significant findings and recommendations that directly relate to the current inspection. Inspectors need to assess the validity and reliability of the data gathered.

While the OIG report suggests that it reviewed the literature in regard to the topic of this investigation there is no evidence provide regarding what literature was reviewed, what type of review was conducted, who conducted it or how that literature informed the framers of the report. One can have no confidence that this quality standard was followed absent that information. Additionally, there is no evidence provided that the validity and reliability of the data gathered was assessed.

Data Collection and Analysis

> The sources of information should be described in the supporting documentation in sufficient detail so that the adequacy of the information, as a basis for reaching conclusions, can be assessed. Information should be of such scope and selected in such ways as to address pertinent questions about the objectives of the inspection and be responsive to the informational needs and interests of specified audiences. The procedures and mechanisms used to gather information should ensure that the information is sufficiently reliable and valid for use in meeting the inspection objectives. For example, inspectors need to ensure the validity and reliability of data obtained from computer-based systems that is significant to the inspectors' findings. Inspectors will use professional judgment in determining whether information is sufficiently reliable and valid.
>
> Qualitative and quantitative information gathered in an inspection should be appropriately and logically presented and documented in work papers, to ensure supportable interpretations.

As previously stated literature was not cited, the structured interview survey was not provided and professional judgment was not brought to bear in regards to the statements put forward as facts by carrier staff and medical reviewers.

Evidence

> The following guidelines should be considered regarding evidence:

1. Evidence should be sufficient to support the inspection findings. In determining the sufficiency of evidence, inspectors should ensure that enough evidence exists to persuade a knowledgeable person of the validity of the findings.

2. To be competent, evidence should be reliable and the best obtainable by using reasonable collection and evaluation methods. The following presumptions are useful in judging the competency of evidence: (a) Evidence obtained from an independent source may be more reliable than that secured from an organization being inspected. (b) Evidence developed under an effective system of internal controls generally is more reliable than that obtained where such controls are lacking or unsatisfactory. (c) Evidence obtained through direct physical examination, observation, or computation may be more reliable than evidence obtained through less direct means. (e) Testimonial evidence obtained from an individual who is not biased or who has complete knowledge about the area usually is more competent than testimonial evidence obtained from an individual who is biased or has only partial knowledge about the area.

This standard is not met to the extent that a knowledgeable person familiar with the issues is not persuaded of the validity of the findings. The medical reviewers were paid chiropractors who were hired based upon their history of having previously served as paid reviewers for carrier staff. There is no convincing argument that these reviewers were independent. Statements made by carrier staff and medical reviewers that are damaging, with some even suggesting criminal behavior - along with unverified statistics, were used in this report as if factual without verifying their veracity.

Records Maintenance

All relevant documentation generated, obtained, and used in supporting inspection findings, conclusions, and recommendations should be retained for an appropriate period of time.

It is hoped that this standard was upheld and that appropriate documents as outlined in this review will be made available to the profession for review.

Measurement

Mechanisms should be in place to measure the effectiveness of inspection work.

Previous inspections of a similar nature have been conducted on this issue and the OIG has stated that previous reports and training have not resulted in what they suggest is an appropriate change in behavior of the part of practicing chiropractors. Given this contention what evaluation has been done of the effectiveness of the inspection work done thus far by the OIG? The bold assumption is made by the drafters of this OIG report

that fault lay at the feet of chiropractors however, what of the alternate suggestion that perhaps the policies and procedures of the OIG, HHS, carrier staff and medical reviewers are ineffective, obtuse, contradictory and not based on sound science. The profession should call for an evaluation of the effectiveness of this program and its staff that takes into consideration this alternate view.

Recommendations

Based upon the foregoing review of the OIG report the following recommendations are made:

1. It is recommended that the profession request the identities and qualifications of the chiropractors who participated as medical reviewers in this evaluation.
2. It is recommended that the profession demand that the medical reviewers involved in the evaluation reveal how much of their income is derived from medical review activities (including but not limited to Medicare) and how much of their time is spent in active practice as some states have rules and regulations governing this activity.
3. If the chiropractic reviewers provide care for Medicare beneficiaries it is suggested that a random sample of their records and claims be reviewed to ensure that they are indeed following the same standards that they are opining on regarding their colleagues.
4. The quotes and comments of carrier staff and medical reviewers appear to be biased and there is no way to know if these quotes represent the majority of those gathered in the structured interviews or whether quotes that supported the contentions of the OIG were the ones that were used. Based on these concerns it is recommended that the profession request a copy of the structured interview questions that were utilized in this investigation and that all responses received during the evaluation be provided so that a full review can be made and these quotes/statements can be put in context with the totality of the interviews.
5. It is recommended that the profession request a detailed description of the methodology used to conduct the literature review.
6. It is recommended that a complete list of the literature reviewed be provided and an explanation given for literature, guidelines and other documents that were not included.
7. The identity and qualifications of those who conducted the literature review should be provided.
8. The OIG should explain how the literature reviewed actually informed their evaluation.
9. It is recommended that the OIG address the fundamental confusion and disconnect between what typical chiropractors are trying to accomplish clinically and what Medicare is trying to force them to do. This disconnect is reflected in the frustration of the writers of the OIG report, the comments by the carrier staff and the medical reviewers and should not be ignored.
10. It is recommended that the profession seek to gather reports from attendees at educational sessions related to the previous OIG reports and recommendations. The profession should attempt to gather any and all course evaluations that were

completed by providers of these programs in order to assess learner concerns about them.

11. It is recommended that the profession inquire as to the nature of the medical review process and that an explicit description of this process be provided. Questions regarding the nature of the file reviews, how discrepancies were resolved, and training of the reviewers are examples of specific issues that should be addressed.
12. It is recommended that the profession strongly voice its objection to the lack of involvement of all stakeholders and that the profession seriously question the objectivity of an evaluation based upon potentially biased participants.
13. It is recommended that the profession demand, *without compromise,* that Medicare services include the identification and management of vertebral subluxation at a minimum and that other diseases, disorders and syndromes not be required to be present in order for this to take place.
14. The profession should vigorously oppose the implementation of caps on the number of visits paid to chiropractors.