RELI Group
7125 Ambassador Drive, Suite 100
Windsor Mill, MD 21244

January 31, 2023

First Last, Credential
Address
City, State, Zip

CBR #: CBR202301
Chiropractic Manipulative Treatment (CMT) of the Spine
NPI #: 1234567890
Fax #: 1-XXX-XXX-XXXX

Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with the RELI Group to develop this Comparative Billing Report (CBR) and to support providers with its use.

CMS routinely distributes an educational tool, known as a CBR, to the provider community in a variety of Medicare Fee-for-Service service areas. A CBR reflects a specific provider's billing and/or prescribing patterns as compared to his/her peers' patterns for the same services in his/her state or specialty, and nationwide. The CBR is intended to enhance accurate billing and/or prescribing practices and support providers' internal compliance activities. The report is not an indication of wrongdoing, and can support internal compliance review efforts, especially those related to coding and billing of code sets. Receiving a CBR is not an indication of, or precursor to, an audit, and it requires no response on a provider's part. Selected providers, however, may be referred for additional review and education as a part of CMS' routine CBR Program.

This CBR provides data regarding your claims submission, as compared to other providers' claims submission within your state, and in the nation.

Please carefully review this report. You may wish to check your records against data in CMS' files and review Medicare guidelines to ensure compliance. Contact your Medicare Administrative Contractor (MAC) with specific billing or coding questions. As appropriate, please share this CBR with others who may benefit from and/or assist with interpreting the data provided in the report.

**To access an electronic copy of your CBR:** Visit the secure CBR portal at https://cbrfile.cbrpepper.org/. Populate the fields, and in the "validation code" field, enter your unique validation code: Access_CD

**For more information:** Please access a recorded webinar and additional resources at CBR.CBRPEPPER.org. Register for a live webinar on February 8, 2023, 3 p.m. ET.

**To request assistance or submit questions:** Contact the CBR Help Desk at https://cbr.cbrpepper.org/Help-Contact-Us.

Sincerely,

The CBR Team

REMINDER: Please ensure your email address and fax number are updated in the following systems:

- National Plan and Provider Enumeration System (NPPES): https://nppes.cms.hhs.gov/#/
- Provider Enrollment, Chain, and Ownership System (PECOS): https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

THIS PAGE LEFT INTENTIONALLY BLANK

**Chiropractic Manipulative Treatment (CMT) of the Spine**

## Introduction

*CBR202301* focuses on rendering providers with specialty 35 (chiropractic) that submitted claims to Medicare Part B for CMT of the spine. The analysis will focus on Current Procedural Terminology® (CPT®) codes 98940, 98941, and 98942, as well as modifier AT (Acute Treatment). For the purposes of this document and analysis, these CPT® codes will be referred to as "CMT of the spine."

The CBR analysis was based on claims extracted from the Integrated Data Repository, based on the latest version of claims available on November 14, 2022. The analysis includes both paid and unpaid claims with dates of service from July 1, 2021, through June 30, 2022. For the trend analysis presented in Figure 1 and 2, the data represents dates of services between July 1, 2019 and June 30, 2022; the data in Figure 3 represents dates of service between July 1, 2021 through June 30, 2022.

The *2022 Medicare Fee-for-Service Supplemental Improper Payment Data* report reflects an improper payment rate of 31.3% for chiropractic services, which represents $161,340,225 in improper payments. The types of error that comprise the improper payment rate for Medicare Part B chiropractic services include an 88.5% improper payment rate attributed to insufficient documentation and an 4.1% improper payment rate attributed to medical necessity errors.

In the *2021 Healthcare Common Procedure Coding System (HCPCS) Level II Expert*, modifier AT is defined as follows: "append this modifier with specific chiropractic manipulative treatment, or CMT, spinal codes when the provider performs treatment of the acute or chronic spinal subluxation." The explanation for modifier AT reads as follows: "The provider uses modifier AT with chiropractic manipulative treatment codes such as 98940 to 98942 to indicate the acute or active nature of treatment. The patient's medical records should also support the active nature of chiropractic treatment in that the record should reflect the anticipated result of the chiropractic manipulation is either an improvement in, or a complete arrest of the progression, of the patient's condition."

After review of and research into the improper payment rate, this CBR was created to analyze the possible threat associated with chiropractic services to the Medicare Trust Fund. The expectation is that providers that perform CMT will maintain proper documentation and appropriate use of modifier AT.

The criteria for receiving a CBR are that a provider:

1. Is significantly higher compared to either state or national average or percentages in any of the three metric calculations (i.e., greater than or equal to the 90th percentile), and
2. Has at least 60 beneficiaries with paid claims submitted for CMT of the spine, and
3. Has at least $20,000 in total charges for CMT of the spine.

## Coverage and Documentation Overview

Table 1 identifies the CPT® codes used in the CBR analysis.

**Table 1: CPT® Code Descriptions**

| CPT® Codes | Description |
|---|---|
| 98940 | Chiropractic manipulative treatment (CMT); spinal, 1-2 regions |
| 98941 | Chiropractic manipulative treatment (CMT); spinal, 3-4 regions |
| 98942 | Chiropractic manipulative treatment (CMT); spinal, 5 regions |

Table 2 provides summaries of your utilization of CPT® codes for CMT of the spine.

**Table 2: Summary of Your Utilization of CPT® Codes for CMT of the Spine Between July 1, 2021, and June 30, 2022**

| CPT® Codes | Allowed Charges | Units | Beneficiary Count* |
|---|---|---|---|
| 98940 Without Modifier AT | $0 | 0 | 0 |
| 98940 With Modifier AT** | $576 | 21 | 13 |
| 98941 Without Modifier AT | $0 | 0 | 0 |
| 98941 With Modifier AT** | $29,994 | 770 | 108 |
| 98942 Without Modifier AT | $0 | 0 | 0 |
| 98942 With Modifier AT** | $0 | 0 | 0 |
| **Total** | **$30,570** | **791** | **110** |

*A beneficiary is counted once per row of CPT® code level. The total "Beneficiary Count" is not the sum total; it represents unique beneficiaries for all the CPT® codes for the 12-month period.
** Rejected or denied claims with Modifier AT were included in the utilization calculation

## Metrics

This report is an analysis of the following metrics:

1. Average allowed services, per beneficiary
2. Percentage of allowed services of CMT of the spine billed with CPT® code 98942
3. Percentage of claims submitted with modifier AT

The CBR analysis focuses on rendering providers with specialty 35 (chiropractic) that submitted claims for CMT of the spine. Statistics were calculated for each provider, all providers in the state, and all providers in the nation. The state and national peer groups are defined as follows:

- The state peer group is defined as all rendering Medicare providers practicing in the individual provider's state or territory with allowed charges for the procedure codes included in this study.
- The national peer group is defined as all rendering Medicare providers in the nation with allowed charges for the procedure codes included in this study.

Each provider's values are compared to his/her state peer group values and to the national values. Your metrics were compared to your state [State Code] and the nation. There are four possible outcomes for the comparisons between the provider and his/her peer groups:

1. Significantly Higher — Provider's value is greater than or equal to the 90th percentile from the state or national mean.
2. Higher — Provider's value is greater than the state or national mean.
3. Does Not Exceed — Provider's value is less than or equal to the state or national mean.
4. Not Applicable (N/A) — Provider does not have sufficient data for comparison.

## Methods and Results

There are 43,790 rendering providers nationwide that have submitted claims for CMT of the spine. The total allowed charges for these claims were over $677 million during the analysis timeframe.

### Metric 1: Average Allowed Services, per Beneficiary

Metric 1 is calculated as follows:

- The total number of allowed services for CMT of the spine is divided by the number of unique beneficiaries for whom allowed services for CMT of the spine were submitted.

**Table 3: Average Allowed Services, per Beneficiary**

| Numerator | Denominator | Your Average | Your State Average | Comparison with Your State | National Average | Comparison with National Average |
|---|---|---|---|---|---|---|
| 783 | 109 | 7.18 | 8.41 | Does Not Exceed | 8.85 | Does Not Exceed |

### Metric 2: Percentage of Allowed Services of CMT of the Spine Billed with CPT® Code 98942

Metric 2 is calculated as follows:

- The total number of allowed services for CPT® code 98942 is divided by the total number of allowed services for all claims for CMT of the spine.

**Table 4: Percentage of Allowed Services of CMT of the Spine Billed with CPT® Code 98942**

| Numerator | Denominator | Your Percent | Your State Percent | Comparison with Your State | National Percent | Comparison with National Percent |
|---|---|---|---|---|---|---|
| 0 | 783 | 0.00% | 4.47% | Does Not Exceed | 5.18% | Does Not Exceed |

**Metric 3: Percentage of Claims Submitted with Modifier AT**

Metric 3 is calculated as follows:

- The total number of unique claims submitted for CMT of the spine with modifier AT is divided by the total number of unique claims submitted for all claims for CMT of the spine.

**Table 5: Percentage of Claims Submitted with Modifier AT**

| Numerator* | Denominator | Your Percent | Your State Percent | Comparison with Your State | National Percent | Comparison with National Percent |
|---|---|---|---|---|---|---|
| 791 | 791 | 100.00% | 97.97% | Significantly Higher | 96.31% | Significantly Higher |

*Rejected or denied claims with modifier AT were included in the metric calculation

Figures 1 and 2 illustrate the trend over time analysis for the number of beneficiaries who had claims submitted for CMT of the spine with and without modifier AT. Figure 3 illustrates the number of paid claims submitted for CMT of the spine, per month, for year 3. Year 1, Year 2, and Year 3 are defined as follows:

- **Year 1:** July 1, 2019 – June 30, 2020
- **Year 2:** July 1, 2020 – June 30, 2021
- **Year 3:** July 1, 2021 – June 30, 2022

**Figure 1: Total Number of Beneficiaries Who Had Claims Submitted for CMT of the Spine With Modifier AT, Trend Over Time**

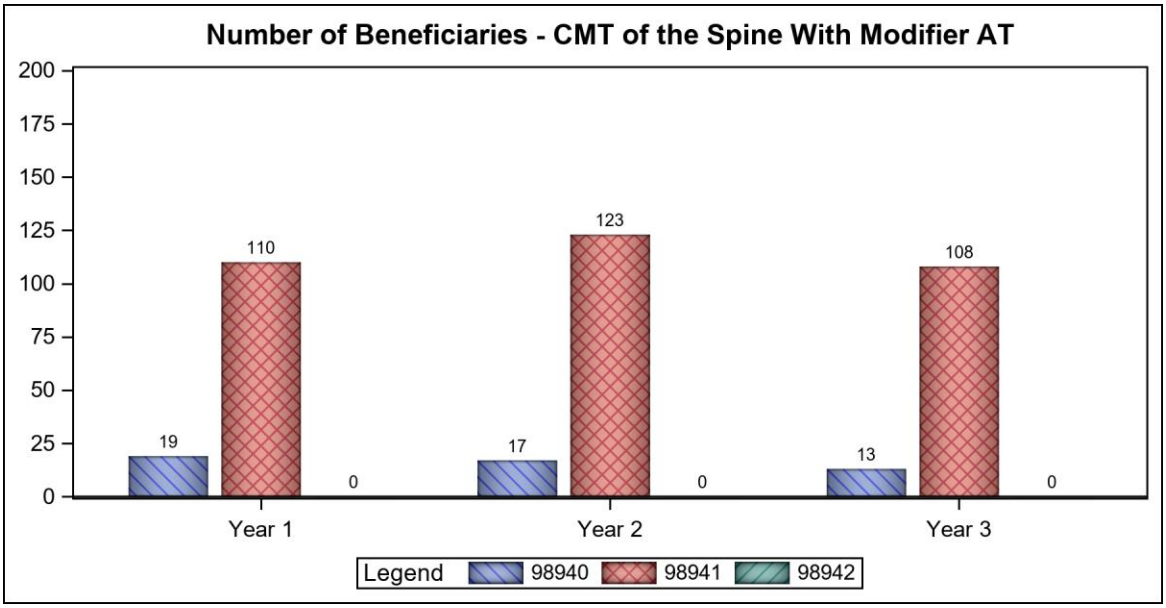


**Figure 2: Total Number of Beneficiaries Who Had Claims Submitted With CMT of the Spine Without Modifier AT, Trend Over Time**

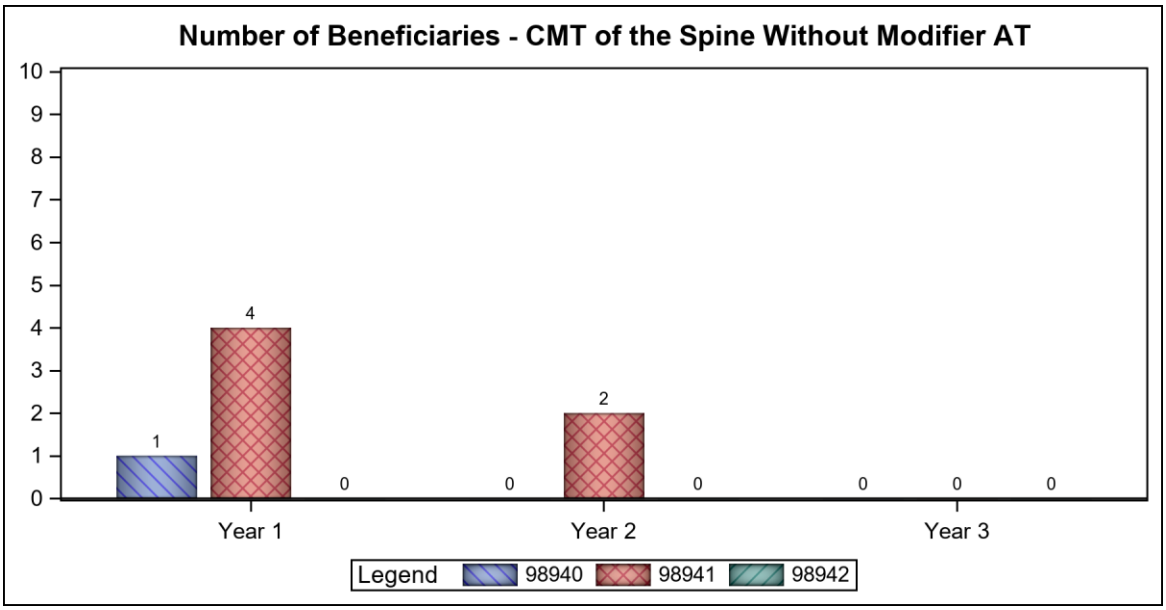
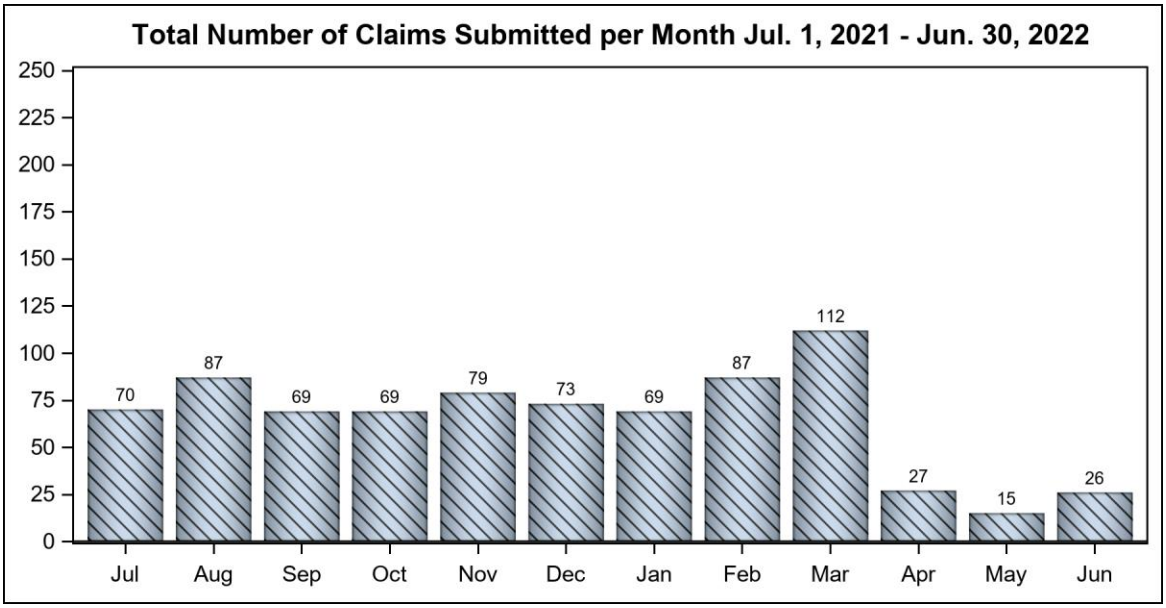



**Figure 3: Total Number of Paid Claims Submitted for CMT of the Spine, per Month, for Year 3**




## References and Resources

*CPT® 2021 Professional Edition.* American Medical Association.

*2021 HCPCS Level II Expert*. American Academy of Professional Coders.

*2022 Medicare Fee-for-Service Supplemental Improper Payment Data*. U.S. Department of Health and Human Services (HHS). CMS.gov.