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Chiropractic Coding & Compliance Alert

Reimbursement/Compliance: OIG Questions $76 Million Payment to Chiropractors in 2013, CMS to Take Action

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Only 2 percent of DCs responsible for HALF of the questionable payment, and more.

The U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) released a report in late September on vulnerabilities in Medicare payments for chiropractic services provided nationwide in 2013.

Previous OIG work identified questionable and inappropriate payments for chiropractic services as a longstanding concern.

"The issue is real and it must be addressed head-on," stated American Chiropractic Association (ACA) President **Anthony Hamm, DC,** in an ACA press release. "Proper documentation is integral to our work moving forward to further integrate the essential services provided by chiropractic physicians in Medicare. Poor documentation is not only a black eye on the profession; more importantly, it reflects poorly on the deliverance of quality-driven care for our patients."

In 2013, Medicare paid $502 million for chiropractic services provided by 45,490 chiropractors to almost 2 million beneficiaries. Read on for a lowdown on the OIG's major findings.

Watch for Services OIG Deems Questionable

15 percent of the Medicare payments for chiropractic services in 2013, amounting to $76.1 million, were questionable.

Maintenance therapy wrongly paid: Almost half of these payments were for claims suggestive of maintenance therapy. In fact, four percent of these chiropractors were found to provide 25 services per beneficiary, as compared to an average trend of 8 services per beneficiary during 2013.

OIG cites numerous examples, including a Michigan chiropractor whose average number of patient visits soared to 50 per patient. This could be because of "lack of training and understanding for the provider and staff," feels **Doreen Boivin, CPC, CCA,** with Chiro Practice, Inc., in Saco, Maine.

AT modifier abuse: CMS requires AT modifier (Acute treatment) to indicate active treatment**.** However, this modifier has been unscrupulously used so much so that in 2013, 96 percent of all chiropractic claims, maintenance therapy or not, were submitted with the AT modifier.

Sharing of beneficiaries: OIG identified 4,216 DCs who shared more than 50 percent of their patients with other chiropractors. Patients may choose to receive services from multiple chiropractors, but the average percentage of this overlap did not cross 14 percent in 2013. This alarmingly high percentage potential sharing of beneficiaries may be connected to fraud, medical identity theft, or kickback arrangements.

Upcoding of claims: Medicare paid $21.3 million to chiropractors whose payments had high average physician work relative value units (RVUs), which reflect the relative time and skill associated with furnishing services under the Medicare Physician Fee Schedule. The predominant code was the highest level chiropractic CPT® code 98942 (Chiropractic manipulative treatment (CMT); spinal, 5 regions) which is an adjustment of all five regions of the spine.

Incredible services per day: OIG questioned the chiropractors who claimed to have provided services more than16 hours per day, as quality of care would go down, and whether the therapist did actually provide the service at all. In fact,

OIG even cited an Illinois chiropractor who received $302,729, for those 115 days in 2013, where he filed claims on an average of 88 chiropractic services per day.

Don't Join This Two Percent

In 2013, 962 of the 45,490 chiropractors paid by Medicare received $38 million of the $76 million in questionable payments. These DCs were high volume providers, rendering chiropractic services to twice the number of beneficiaries with four times the number of claims, compared to all other chiropractors. Fifty-three percent of their claims were suggestive of maintenance therapy, compared to just 3 percent of the claims for all other chiropractors paid by Medicare in 2013.

ACA expressed grave concern on this fraction of DCs that are responsible for the chronic error rates that plague the profession, in an ACA press release dated Oct. 7.

On second thought, could it be this much hyped high chiropractic documentation error rates is more of a statistical than real issue, where a few number of wrong doers are affecting the reputation of the chiropractic community at large? Boivin is of the opinion that "the providers who are high volume practices can skew the percentages significantly causing issues for the chiropractic community as a whole."

Tune In to the Markers of the Fatal Flaw

Fifty-nine percent of the chiropractors, who received a third ($23.8 million) of all questionable payments in 2013 seem to be concentrated in seven states: California, Michigan, Illinois, New York, Kansas, Florida, and New Jersey. Each of these states had more than 50 chiropractors with high questionable payments.

Match the strike force areas: Moreover, quite a few DCs with questionable payments belong to the Medicare Fraud Strike Force (Strike Force) areas. The Strike Force operates in locations considered to be "hot spots" for Medicare fraud and targets suspicious billing patterns.

Claims for other services alongside: Thirteen percent of beneficiaries who had a paid claim for a service from a chiropractor with high questionable payments also had one or more paid claims for physical/occupational therapy (hereinafter, therapy services) on the same day, as compared to 4 percent benchmark otherwise.

Matter of habit: Most chiropractors with high questionable payments in 2013 also had questionable payments in a prior year. The chiropractors with high questionable payments in 2013 also received a total of nearly $100 million in questionable payments from 2009-2012. Boivin agrees that probably these are the people who have been affecting the findings of previous OIG reports as well. Now that's an eye opener.

Chiropractic services lacking a covered primary diagnosis Thirty-nine percent of chiropractors received a total of $20.7 million for claims that lacked a covered primary diagnosis code.

Get Ready For the OIG Directives to CMS

OIG suggests that CMS should use specific targeted tactics to recognize and prevent inappropriate payment in future, such as:

1. Establish a more reliable control for identifying active treatment: OIG has asked CMS to devise a reliable method for identifying active treatment, such as examining the date of initiation of treatment. However, CMS said that it will implement prior authorization medical review required by MACRA instead, to resolve the issue.

2. Develop and use measures to identify questionable payments for chiropractic services: CMS is to develop new measures help its contractors identify and review potentially upcoded claims and revise its current strategy identifying chiropractic fraud, waste, and abuse.

3. Take appropriate action on the chiropractors with questionable payments: OIG identified 7,191 chiropractors with questionably paid claims. OIG suggests the CMS should appropriately act on these by recouping payments;

educating providers, making referrals, imposing suspensions or revoking billing privileges. CMS stated that it will consider chiropractors OIG identified when it develops post payment review under MACRA.

4. Collect overpayments: CMS will collect the $20.7 million in payments for the inappropriate claims, after analyzing and reviewing the list from the OIG.

5. Ensure that claims are paid only for Medicare-covered diagnoses: CMS will work with the MACs to ensure that claims are paid only for the diagnosis codes that meet Medicare coverage requirements.

ACA Has Been Working Hard All Through

This OIG report, however, fails to cite work ACA has been conducting for the last two years regarding Medicare documentation education and training. Since 2013, ACA representatives have traveled around the country to work with Medicare Administrative Contractors (MACs) specifically on the subject of improving and harmonizing documentation. In addition to the MACs, ACA is working with HHS to implement provisions called for under the Protecting the Integrity of Medicare Act (PIMA), passed as part of Medicare reimbursement reform earlier this year. Under PIMA, HHS is charged to collaborate with ACA and the MACs to develop and implement an education program dedicated to chiropractic documentation in Medicare. That education program, by statute, is to become available early next year.

The road ahead: The situation is not as grim as it portrays to be. Remember, for those handful 2 percent of DCs that bring forth the profession in poor light, the remaining 98 percent of the community need to roll up the sleeves; come together, and end this documentation issue once and for all. "Get trained, be aware, and take charge of your documentation," reiterates Boivin.