Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# MEDICARE IMPROPERLY PAID PROVIDERS FOR ITEMS AND SERVICES ORDERED BY CHIROPRACTORS

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**Report in Brief**
Date: July 2018
Report No. A-09-17-03002

U.S. Department of Health & Human Services
Office of Inspector General

# Medicare Improperly Paid Providers for Items and Services Ordered by Chiropractors

## Why OIG Did This Review

The Centers for Medicare & Medicaid Services (CMS) allows physicians and specific nonphysician practitioners to order certain items or services for Medicare beneficiaries. On September 1, 2011, CMS clarified that chiropractors are not included in these practitioner types. Coverage of chiropractic services is specifically limited to treatment through manual manipulation. For example, Medicare does not cover diagnostic services, such as x-rays, ordered by a chiropractor.

Our objective was to determine whether Medicare payments for selected items and services ordered by chiropractors complied with Federal requirements.

## How OIG Did This Review

Our review covered $6.7 million in Medicare payments for 65,855 claims for items and services that we identified as having been ordered by chiropractors and that had dates of service during calendar years 2013 through 2016 (audit period). Our review covered claims only for imaging services; clinical laboratory services; durable medical equipment, prosthetics, orthotics, and supplies; and home health agency services.

To select these claims for review, we used CMS's provider enrollment records to obtain a listing of the National Provider Identifiers (NPIs) of chiropractors and identified claims on which an NPI of a chiropractor was indicated as having ordered the items or services.

## What OIG Found

Medicare payments for selected items and services ordered by chiropractors did not comply with Federal requirements. Specifically, for our audit period, Medicare improperly paid providers $6.7 million. As of the publication of this report, this improper payment amount includes claims outside of the 4-year claim-reopening period.

Medicare overpaid providers because CMS's claims processing edits were not fully effective in preventing overpayments. Although CMS began using claims processing edits on October 5, 2009, to issue an informational message to alert a billing provider that a chiropractor was not eligible to order an item or a service billed, CMS did not begin using these edits to deny claims until January 6, 2014. Of the $6.7 million in improper payments for our audit period, $5.9 million (89 percent) were for items and services in calendar year 2013, before CMS's implementation of the January 2014 edits.

## What OIG Recommends and CMS Comments

We recommend that CMS direct the Medicare contractors to recover the portion of the $6.7 million in overpayments to providers for claims that are within the reopening period. We also recommend that CMS instruct the Medicare contractors to notify providers of potential overpayments so that those providers can exercise reasonable diligence to investigate and return any identified similar overpayments and identify and track any returned overpayments. Finally, we recommend that CMS revise the claims processing edits to ensure that all claims for items and services ordered by chiropractors are denied.

CMS concurred with our first and second recommendations and provided information on actions that it planned to take to address those recommendations. However, CMS did not concur with our third recommendation and stated that the existing claims processing edits already deny payment for the majority of improper payments related to ordering chiropractors. Although CMS's implementation of the 2014 edits significantly reduced the number of claims that Medicare paid for items or services ordered by chiropractors, revising the edits would identify additional claims that were unallowable for payment.

The full report can be found at https://oig.hhs.gov/oas/reports/region9/91703002.asp.

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# INTRODUCTION

## WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) allows physicians and specific nonphysician practitioners to order certain items or services for Medicare beneficiaries.[1] On September 1, 2011, CMS clarified that chiropractors are not included in these practitioner types. To determine whether Medicare made improper payments, we reviewed selected items and services that were ordered[2] by chiropractors.

## OBJECTIVE

Our objective was to determine whether Medicare payments for selected items and services ordered by chiropractors complied with Federal requirements.

## BACKGROUND

### The Medicare Program and Medicare Payment Requirements

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS administers the program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services.

Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act § 1862(a)(1)(A)).

CMS contracts with Medicare contractors to, among other things, process and pay Medicare claims submitted for services, conduct reviews and audits, and safeguard against fraud and abuse.

The Office of Inspector General believes that this audit report constitutes credible information of potential overpayments. Providers who receive notification of these potential overpayments

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[1] The terms "order," "refer," and "certify" are often used interchangeably within the health care industry. CMS guidance uses the term "order/refer" in materials directed to a broad provider audience. For the purposes of this report, we use the term "order" to denote an action that a provider takes to order or certify an item or service for a beneficiary or to refer a beneficiary to another provider or supplier.

[2] The ordering provider is not generally the same as the provider who furnishes the service ordered. For example, a physician may order for a beneficiary a diagnostic x-ray, which is then furnished by a radiologist.

must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).[3]

**Medicare Requirements for Items and Services Ordered by Physicians and Eligible Professionals**

For a provider[4] to receive Medicare payment for covered imaging services, clinical laboratory services, and DMEPOS items, the items or services must have been ordered by a physician or, when permitted, an eligible professional[5] (42 CFR § 424.507(a)(1)(i)). The claim from the provider must contain the legal name and National Provider Identifier (NPI) of the physician or eligible professional who ordered the item or service (42 CFR § 424.507(a)(1)(iii)). To receive payment for covered Medicare Parts A or B home health services, the ordering physician must be identified on the provider's home health services claim (42 CFR § 424.507(b)). A Medicare contractor denies a claim from a provider if it does not meet those requirements (42 CFR § 424.507(c)).

All diagnostic tests, including x-rays and laboratory tests, must be ordered by the physician who is treating the beneficiary; that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in managing that problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary (42 CFR § 410.32(a)).

**Restrictions on Orders by Chiropractors**

CMS provides a list of physicians and specific nonphysician practitioners, such as physician assistants, who are permitted "to order or certify items or services for Medicare beneficiaries" (*Medicare Program Integrity Manual,* Pub. No. 100-08, chapter 15, § 15.16.1). On September 1, 2011, CMS clarified that chiropractors[6] are not included in these practitioner types (CMS's Transmittal 387, Change Request 7097, Sept. 1, 2011).

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[3] The Act § 1128J(d); 42 CFR part 401, subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

[4] Providers subject to these requirements include suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items.

[5] An eligible professional is a physician; any of the practitioners described in section 1842(b)(18)(C) of the Act, e.g., a physician assistant or nurse practitioner; a physical or occupational therapist or a qualified speech-language pathologist; or a qualified audiologist (42 CFR § 424.506(a) and the Act § 1848(k)(3)(B)).

[6] In general, services provided by chiropractors focus on diagnosing and treating disorders of the musculoskeletal system, especially the spine. Most patients seek chiropractic care for back pain, neck pain, and joint problems. The most common therapeutic procedure that chiropractors perform is spinal manipulation.

Medicare Part B does not pay for x-rays or other diagnostic or therapeutic services furnished or ordered by a chiropractor (42 CFR § 410.21(b)(2)).

The *Medicare Benefit Policy Manual,* Pub. No. 100-02 (Policy Manual), states: "Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, i.e., by use of the hands" (chapter 15, § 240.1.1). Medicare does not cover any other diagnostic or therapeutic service provided by a chiropractor or under a chiropractor's order (Policy Manual, chapter 15, § 240.1.1).

**Medicare Guidelines for Billing Imaging Services**

Medicare allows imaging services, such as diagnostic x-rays, to be divided into technical and professional components:[7]

- The **technical component** of a service includes the technician who operates the equipment and imaging equipment used in performing the imaging service.

- The **professional component** of a service is for work done by a physician, which includes interpreting the image and preparing a written report.

When these components of imaging services are furnished by more than one provider, the components are billed separately to the Medicare contractor. However, when these components of imaging services are furnished by the same provider, generally they are not billed separately.

**Medicare Claims Processing Edits**

CMS developed claims processing edits[8] for Medicare claims that billing providers submit for imaging services, clinical laboratory services, DMEPOS items, and home health agency (HHA) services.[9] These edits determine whether the ordering provider on the claim (1) has a current Medicare enrollment record and the record contains a valid NPI and (2) is of a provider type that is eligible to order items or services.

These claims processing edits were implemented in two phases:

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[7] *Medicare Claims Processing Manual,* Pub. No. 100-04, chapter 13, §§ 20–20.2.3 and 150.

[8] An edit is programming within the standard claims processing system that selects certain claims; evaluates or compares information on the selected claims or other accessible sources; and, depending on the evaluation, takes action on the claims, such as paying them in full, paying them in part, denying payment for them, or suspending them for manual review.

[9] MLN Matters Number: SE1305 Revised, October 21, 2015.

- **Phase 1** (effective October 5, 2009): An informational message alerts the billing provider that the NPI of the ordering provider is missing, incomplete, or invalid or that the ordering provider is not eligible to order an item or a service. This message does not result in a denial of the claim. The billing provider is not prompted to rebill the claim, and the claim is processed normally.

- **Phase 2** (effective January 6, 2014): If the ordering provider specified on the claim does not pass the edits, the claim is denied.

For imaging services ordered by a noneligible professional, such as a chiropractor, the claims processing edits apply to the technical component of these services, and the professional component is excluded from the edits. As a result, if the technical and professional components are billed separately, the edits deny the technical component, but the professional component is processed normally. However, if the technical and professional components are not billed separately (i.e., the same provider performed both components), the entire claim for the imaging service is denied.

## HOW WE CONDUCTED THIS REVIEW

Our review covered $6,682,531 in Medicare payments for 65,855 claims for items and services that we identified as having been ordered by chiropractors[10] and that had dates of service during calendar years (CYs) 2013 through 2016 (audit period).[11] To select these claims for review, we used CMS's provider enrollment records to obtain a listing of NPIs of chiropractors[12] and identified claims on which an NPI of a chiropractor was indicated as having ordered the items or services.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

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[10] A chiropractor may have additional specialties (e.g., a chiropractor may also be an M.D.) that would qualify the chiropractor to order items or services for Medicare beneficiaries. We excluded chiropractors that had additional qualifying specialties from our review.

[11] Our review covered claims only for imaging services, clinical laboratory services, DMEPOS items, and HHA services.

[12] The enrollment record includes a code that indicates the individual provider specialty.

## FINDING

Medicare payments for selected items and services ordered by chiropractors did not comply with Federal requirements. Specifically, for our audit period, Medicare improperly paid providers $6,682,531. As of the publication of this report, this improper payment amount includes claims outside of the 4-year claim-reopening period.[13] Medicare overpaid providers because CMS's claims processing edits were not fully effective in preventing overpayments.

### FEDERAL REQUIREMENTS

Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary (42 CFR § 410.32(a)). Medicare Part B does not pay for x-rays or other diagnostic or therapeutic services furnished or ordered by a chiropractor (42 CFR § 410.21(b)(2)).

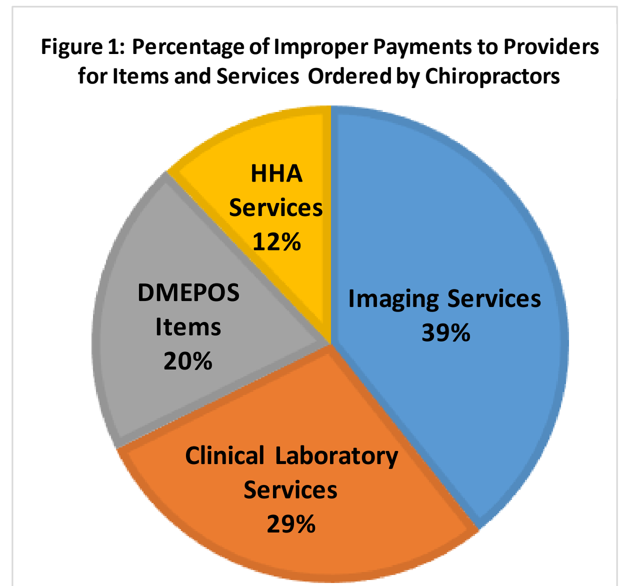
The Policy Manual states:

> Coverage of chiropractor service is specifically limited to treatment by means of manual manipulation, i.e., by use of the hands. . . . No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered. This means that if a chiropractor orders, takes, or interprets an x-ray, or any other diagnostic test, the x-ray or other diagnostic test, can be used for claims processing purposes, but Medicare coverage and payment are not available for those services [chapter 15, § 240.1.1].

### MEDICARE IMPROPERLY PAID PROVIDERS FOR ITEMS OR SERVICES ORDERED BY CHIROPRACTORS

Medicare improperly paid providers $6,682,531 for 65,855 claims for items or services that were ordered by chiropractors, consisting of:

- $2,626,768 for imaging services (37,822 claims);
- $1,898,257 for clinical laboratory services (23,014 claims);
- $1,350,436 for DMEPOS items, e.g., back braces (4,737 claims); and
- $807,070 for HHA services (282 claims) (Figure 1).

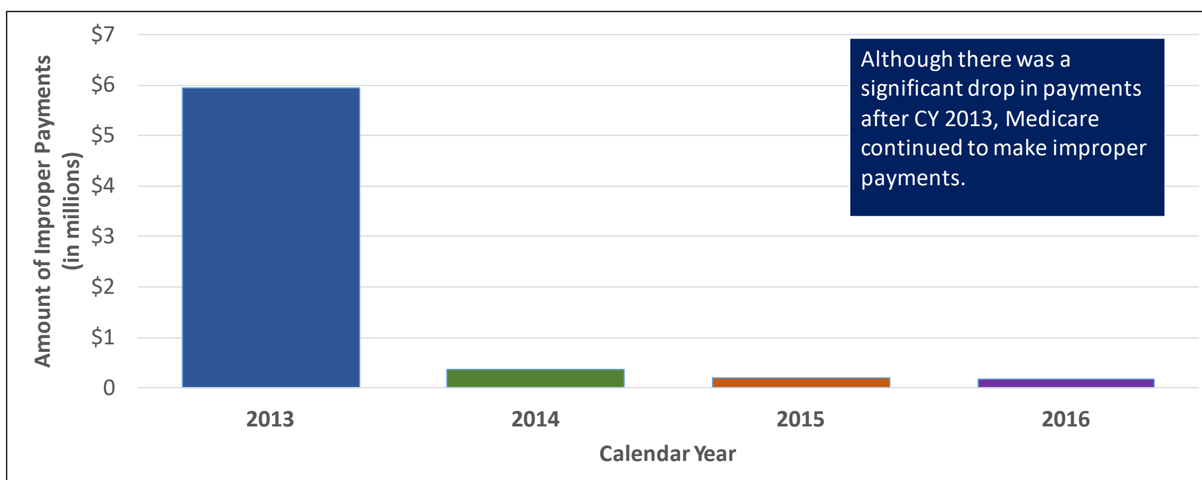



[13] 42 CFR § 405.980(b)(2) (reopening for good cause).

## CLAIMS PROCESSING EDITS WERE NOT FULLY EFFECTIVE IN PREVENTING OVERPAYMENTS

Medicare overpaid providers because CMS's claims processing edits were not fully effective in preventing overpayments. Although CMS began using claims processing edits on October 5, 2009, to issue an informational message to alert a billing provider that a chiropractor was not eligible to order an item or a service billed (phase 1), CMS did not begin using these edits to deny claims until January 6, 2014 (phase 2). Of the $6,682,531 in improper payments for our audit period, $5,944,838 (89 percent) were for items and services in CY 2013, before CMS's implementation of phase 2 of the edits. Figure 2 below shows the amount of improper payments identified over the audit period.

**Figure 2: Improper Payments to Providers for Items and Services Ordered by Chiropractors (CYs 2013 Through 2016)**




### Edits Excluded the Professional Component of Imaging Services

The implementation of phase 2 of the claims processing edits in CY 2014 significantly reduced the number of claims that Medicare paid for items or services ordered by chiropractors. However, these edits did not deny claims for the professional component of imaging services when the services were ordered by a chiropractor. Instead, these edits excluded the professional component from evaluation when it was billed separately, allowing this part of the imaging services to bypass the edits. Had the edits included the professional component of imaging services, they would have identified additional claims that were unallowable for payment.

### Edits Did Not Deny All Improper Claims for Payment for Other Items and Services

For the remaining claims for all other imaging services, as well as clinical laboratory services, DMEPOS items, and HHA services, the implementation of phase 2 of the claims processing edits significantly reduced the number of claims that Medicare paid for items or services ordered by chiropractors but did not deny all of the claims when they were submitted by the provider. The

edits relied on Medicare contractor determinations of whether items or services were subject to ordering requirements; these determinations may have been inconsistent across different contractors.

## RECOMMENDATIONS

We recommend that CMS:

- direct the Medicare contractors to recover the portion of the $6,682,531 in overpayments to providers for claims that are within the reopening period in accordance with CMS's policies and procedures;

- instruct the Medicare contractors to notify providers of potential overpayments so that those providers can exercise reasonable diligence to investigate and return any identified similar overpayments in accordance with the 60-day rule, and identify and track any returned overpayments as having been made in accordance with this recommendation; and

- revise the claims processing edits to ensure that all claims for items and services ordered by chiropractors are denied.

## CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our first and second recommendations and provided information on actions that it planned to take to address those recommendations. However, CMS did not concur with our third recommendation. CMS's comments are included in their entirety as Appendix B.

### CMS COMMENTS

Before addressing our recommendations, CMS stated that its claims processing edits exclude the professional component of imaging services "because the interpreting provider is often several steps removed from the order and should not reasonably be expected to know the specialty of the ordering practitioner."

CMS had the following comments on our recommendations:

- CMS concurred with our first recommendation. However, with respect to imaging services, CMS concurred only to the extent that the recommendation applied to the technical component of imaging services. CMS stated that it would instruct its Medicare contractors to recover the identified overpayments consistent with CMS's policies and procedures.

- CMS concurred with our second recommendation. However, with respect to imaging services, CMS concurred only to the extent that the recommendation was consistent with its edits and applied to the technical component of imaging services. CMS stated that, on the basis of our claim data, it would select appropriate providers to notify of potential overpayments to report and return in accordance with the 60-day rule.

- CMS did not concur with our third recommendation. CMS stated that the existing claims processing edits already deny payment for the technical component of imaging services, DMEPOS items, and HHA items and services ordered by chiropractors and that these payments represent the "majority of improper payments related to chiropractors who order and refer."

**OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing CMS's comments, we maintain that our recommendations are valid. Although CMS stated that its claims processing edits exclude the professional component of imaging services because the interpreting provider is often several steps removed from the order, Federal regulations prohibit payment for these services when ordered by a chiropractor.

Regarding our first and second recommendations, the results of our audit showed that claims for the professional component of imaging services contained an NPI of a chiropractor, which substantiated that the diagnostic service was ordered by a chiropractor. In addition, CMS's claim processing edits currently deny the professional component of imaging services when the technical and professional components are not billed separately. We encourage CMS to include claims for the professional component when implementing these recommendations.

Regarding our third recommendation, although the implementation of phase 2 of the claims processing edits significantly reduced the number of claims that Medicare paid for items or services ordered by chiropractors, revising the edits would identify additional claims that were unallowable for payment, such as claims for the professional component of imaging services.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our review covered $6,682,531 in Medicare payments for 65,855 claims for items and services that we identified as having been ordered by chiropractors[14] and that had dates of service during CYs 2013 through 2016.[15] To select these claims for review, we used CMS's provider enrollment records to obtain a listing of NPIs of chiropractors[16] and identified claims on which an NPI of a chiropractor was indicated as having ordered the items or services.

We limited our review of CMS's internal controls to those that were applicable to the selected claims because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History file, but we did not assess the completeness of the file. We did not evaluate the medical records for the items or services ordered.

We conducted our audit from June 2016 to October 2017.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- obtained a listing of NPIs of chiropractors from the provider enrollment records;
- used computer matching, data mining, and data analysis techniques to identify claims in CMS's National Claims History file for imaging services, clinical laboratory services, DMEPOS items, and HHA services identified as having been ordered by chiropractors for which Medicare payments were made during our audit period;
- interviewed CMS officials and reviewed documentation provided by them to understand how the claims processing edits work and to determine why Medicare made payments for items and services ordered by chiropractors;

[14] A chiropractor may have additional specialties (e.g., a chiropractor may also be an M.D.) that would qualify the chiropractor to order items or services for Medicare beneficiaries. We excluded chiropractors that had additional qualifying specialties from our review.

[15] Our review covered claims only for imaging services, clinical laboratory services, DMEPOS items, and HHA services.

[16] The enrollment record includes a code that indicates the individual provider specialty.

- provided to CMS our complete list of improperly paid claims for items and services that we identified as having been ordered by chiropractors; and

- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX B: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

**DATE:** APR 26 2018

**TO:** Daniel R. Levinson
Inspector General

**FROM:** Seema Verma SV.
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid Providers for Items and Services Ordered by Chiropractors (A-09-17-03002)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the draft report from the Office of Inspector General (OIG). CMS is committed to protecting the Medicare Trust Funds by combatting fraud, waste, and abuse. To achieve this objective, CMS uses a comprehensive program integrity strategy to prevent improper payments through predictive analytics, claims processing edits, and provider education, among other tools, as well as to recoup overpayments that have already been made.

Under federal law and regulations, Medicare coverage of chiropractic services is limited to treatment by means of manual manipulation. No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered. As a result, Medicare does not cover imaging services; durable medical equipment; prosthetics, orthotics, and supplies; or home health agency items and services ordered by chiropractors.

To ensure that Medicare does not pay for claims for certain services ordered or referred by practitioners who are not enrolled in Medicare, CMS implemented claims processing edits in two phases. Phase one, effective in October 2009, was an informational claims edit alerting the billing provider that the ordering practitioner was not eligible to order an item or service and that claims submitted by the provider in the future would be denied. Phase two, effective in January 2014, denied claims for items and services ordered by chiropractors and other providers ineligible to order and refer services. Only 11 percent of the payments that OIG identified as improper occurred after phase two was implemented. CMS excludes the interpretation of imaging services from the edit because the interpreting provider is often several steps removed from the order and should not reasonably be expected to know the specialty of the ordering practitioner. As written, the edit already prevents the majority of improper payments related to ordering and referring.

OIG's recommendations and CMS's responses are below.

**OIG Recommendation**

We recommend that CMS direct the Medicare contractors to recover the portion of the $6,682,531 in overpayments to providers for claims that are within the reopening period in accordance with CMS's policies and procedures.

**CMS Response**

CMS concurs with this recommendation. With respect to imaging services, we concur with this recommendation to the extent that it applies to the technical component of imaging services. CMS will instruct its Medicare contractors to recover the identified overpayments consistent with the agency's policies and procedures.

**OIG Recommendation**

We recommend that CMS instruct the Medicare contractors to notify providers of potential overpayments so that those providers can exercise reasonable diligence to investigate and return any identified similar overpayments in accordance with the 60-day rule, and identify and track any returned overpayments as having been made in accordance with this recommendation.

**CMS Response**

CMS concurs with this recommendation. With respect to imaging services, we concur with this recommendation to the extent that it is consistent with our edits and applies to the technical component of imaging services. We will analyze OIG's referral to select appropriate providers to notify of potential overpayments to report and return in accordance with the 60-day rule. CMS will instruct its Medicare contractors to notify these providers and track any returned overpayments consistent with the agency's policies and procedures.

**OIG Recommendation**

We recommend that CMS revise the claims processing edits to ensure that all claims for items and services ordered by chiropractors are denied.

**CMS Response**

CMS does not concur with this recommendation. Current edits already deny payment for the technical component of imaging services, durable medical equipment, prosthetics, orthotics, and supplies, or home health agency items and services ordered by chiropractors and to the suppliers billing tests ordered by chiropractors. These represent the majority of improper payments related to chiropractors who order and refer.