Comparative Billing Reports 2016

By

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OIG Work Plan 2017

- The Office of Inspector General for Health and Human Services has released their 2017 Work Plan.
- Chiropractic has made it in again this year.
- We have two categories that the OIG will focus on.
- Both are hold-overs from previous years.
- The first is Part B Payments for Noncovered Services.
- "We will review Medicare Part B payments for chiropractic services to determine whether such payments were claimed in accordance with Medicare requirements."
- This report is due in 2017.
- The second is a Portfolio Report on Medicare Part B Payments.
- "We will compile the results of prior OIG audits, evaluations, and investigations of chiropractic services paid by Medicare to identify trends in payment, compliance, and fraud vulnerabilities and offer recommendations to improve detected vulnerabilities."
- This report is expected in 2017.

New Subluxation Diagnoses

- Noridian has added new subluxation diagnoses to their Local Coverage Determination.
- The codes M99.10 through M99.15 are now considered covered diagnoses for Vertebral Subluxation.
- These codes are now considered ICD-10 codes that support medical necessity in states serviced by Noridian.

OIG Report

- Last month the Office of Inspector General for Health and Human Services released a new report on chiropractic.
- To say that this report was a disappointment would be a gross understatement.
- This report contains the same old tired results, the same old tired conclusions, and the same old tired recommendations.
- The new report states that 82% of the money paid to chiropractors in 2013 was paid for services that were unallowable.
- The problem with this figure is that it contradicts the CERT report for the same year that states that the improper payment rate for chiropractic was 51.7%.
- Another problem with this report is that the sample size was 105 dates of service representing a total of over 17 million dates of service.
- The biggest problem is that the recommendations in this report are a repeat of the same old tired recommendations of past reports.
- To paraphrase; "The majority of errors take place after 12 visits therefore restrict chiropractors to only 12 visits in a year."

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- This recommendation does not take into account multiple episodes of care in a single year or patients with chronic conditions.

Comparative Billing Report

- In September of this year 8,500 Comparative Billing Reports were faxed and mailed to chiropractors across the country.
- Given the changes that are taking place in Medicare, there has been considerable concern regarding the implications of receiving one of these reports.
- The first paragraph of the introduction to the report states; "CBRs provide comparative data on how an individual health care provider's billing and payment patterns for selected topics compare to his/her peers."
- So the stated purpose of this report is to give you, the doctor the information to determine how you compare to your peers (or at least to the averages of your state and the nation).
- The only dates of service considered in these reports were those billed with the AT modifier and paid by Medicare.
- The CBRs were sent to providers that had at least one significantly higher comparison when compared to their states and/or nation.
- Additionally, these providers are in the 50^{th} percentile in distinct beneficiaries (35) and allowed charges($10,831.27) for the CPT codes included in the CBR.
- There are four metrics discussed in this report:
    - Total utilization (payments) for 2015.
    - Average allowed services per beneficiary.
    - Percentage of beneficiaries with over 24 visits.
    - Percentage of CMT spinal services billed with CPT code 98942.
- Total utilization (payments) for 2015.
    - Why is this important?
    - To be in the Quality Payment Program for 2017 you must bill Medicare more than $30,000 per year and provide care to more than 100 Medicare patients per year.
    - This metric will give you an indication of whether you meet these two thresholds.
- Average allowed services per beneficiary.
    - Why is this important?
    - This compares your average number of services per Medicare patient to the national and state average.
    - If you are over it indicates that you are an outlier.
- Percentage of beneficiaries with over 24 visits.
    - Why is this important?
    - The OIG believes that if an episode of care exceeds 24 visits the likelihood of the care not being medically necessary dramatically increases.
    - This measure does not take into account the possible reasons for having over 24 visits in the year.

- Percentage of CMT spinal services billed with CPT code 98942.
    - Why is this important?
    - According to the OIG the vast majority of CMT services billed with the 98942 code are improperly coded.
    - There is an increased likelihood of these services being reviewed or audited.
- With this information having been gathered and compiled there is some concern that it will be used by CMS or the OIG in some way to harm the doctor or trigger an audit.
- The following questions and answers are taken from a presentation by the CBR contractor on October 19:
    - Q. Will the Office of Inspector General (OIG), CMS or MACs receive copies of the information in the CBR?
        - A. No. To ensure privacy, CBRs are only mailed to individual providers. They are not sent to the OIG, CMS, or MACs.
- Some other answers that we received:
    - The CBR will not be used to place doctors on pre-authorization review as specified in Section 514 of MACRA.
    - The only metrics reviewed were;
        - Average allowed services per beneficiary
        - Percentage of beneficiaries with services over 24 visits per year
        - Percentage of CMT spinal services billed with CPT code 98942
    - There may be a follow-up CBR next year.
    - But that has yet to be determined.
    - At this time the current CBR was not compared to the 2011 CBR

Summary

- Based on all of the information that I can find, the current CBR has just gone to the individual doctor for educational purposes and will not be used to initiate reviews or audits.
- If you received a CBR you should review the information provided and review your Medicare policies and procedures.
- Ensure that your Medicare documentation supports the services that you billed.