The 2015 OIG Report

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ICD-10

- ICD-10 is here!
- I hope all is going well.
- If you need help, talk to ChiroCode

Jurisdiction E Probe Review

- Noridian is initiating a wide spread service specific probe review of claims with CPT code 98942.
- There is no information on how long this probe review will last.
- Your office will be notified in the normal manner of the records required.
- You will have 45 days to submit the record.

OIG Report

- While everyone was focused on the transition to ICD-10 on September 30, the OIG released a new report on chiropractic
- The report was titled "CMS Should Use Targeted Tactics to Curb Questionable and Inappropriate Payments for Chiropractic Services".
- The report covered dates of service from 2013.
- This is not the usual "all chiropractors are probably incompetent and unethical fraudsters" that we have seen in previous OIG reports since 1986.
- This report makes an effort to identify the actual problem populations within the profession.
- Some areas are spot on and some are ambiguous, at best.
- Overall, this is an improvement from previous reports.

Objectives

- The report has 3 objectives;
- (1) To determine the extent to which Medicare made questionable payments for chiropractic services in 2013.
- (2) To identify and describe chiropractors with high questionable payments in 2013.
- (3) To determine the extent to which Medicare made inappropriate payments for chiropractic services that did not meet certain Medicare requirements in 2013.

Background

- This report is set in a background of chiropractic's consistently high Medicare error rate.
- The report states:
- In 2013, Medicare paid $502 million for chiropractic services provided by 45,490 chiropractors to almost 2 million beneficiaries.

- OIG evaluations from 2005 and 2009 found that between 40 and 47 percent of all paid chiropractic claims were for maintenance therapy.
- An OIG audit from November 2013 found that Medicare inappropriately paid over $700,000 to a California chiropractor.
- Medicare fraud cases involving chiropractors have involved services not rendered, medically unnecessary services, duplicate claims, and "upcoding," as well as fraudulently billing for other health care services, such as physical therapy.
    - In 2012, a chiropractor was sentenced to 2 years in prison for billing over $8.5 million to Medicaid and Medicare over 3 years for both chiropractic and physical therapy services.
    - In 2014, another chiropractor was sentenced to 5 years in prison for billing false claims to Medicare and private insurance by using the names of other providers whom he employed to bill for services that he was not qualified to perform.
- Chiropractic services have had the highest rate of improper payments among Part B services over the last several years.
- From 2010 to 2014, the improper payment rate for chiropractic services increased from 43.9 to 54.1 percent.
- The overall improper payment rate for Part B services remained between 9.9 and 12.9 percent.

Measures

- The OIG developed four measures to identify paid claims that were questionable.
- They based those measures on previous OIG reports and fraud investigations, interviews with experts in chiropractic practice and fraud detection, and their own analysis.
- These four measures are;
    - Treatment Suggestive of Maintenance Therapy.
        - A high average number of claims per beneficiary per chiropractor suggests billing for services that were not active treatment.
        - They determined that 20 services per beneficiary was the threshold for this measure.
        - They identified as an outlier any chiropractor whose average number of paid claims per beneficiary exceeded the threshold.
        - For these chiropractors, They identified their beneficiaries who had treatments in excess of the threshold and considered all claims associated with these beneficiaries to be questionable.
        - They identified a total of 1,787 chiropractors that were paid $33,956,039 in 2013 with this measure.
    - Potentially Upcoded Claims.
        - A high average "physician work relative value unit" for a chiropractor's claims suggests billing for services at a higher level than warranted.
        - Based on the MPFS Relative Value File, they counted CPT code 98940 as 0.45 work RVUs, CPT code 98941 as 0.65 work RVUs, and CPT code 98942 as 0.87 work RVUs.

        - They then calculated the average work RVUs for each chiropractor's claims and determined that 0.85 was the threshold for this measure.
        - That works out to billing about 98% 98942.
        - They identified a total of 4,216 chiropractors that were paid $25,724,446 in 2013 with this measure.
    - Potential Sharing of Beneficiaries.
        - A high average percentage of a chiropractor's beneficiaries who received services from other chiropractors suggests the misuse of beneficiary identification numbers.
        - OIG investigations and interviews with experts informed them that chiropractors with a high percentage of beneficiaries receiving treatments from other chiropractors may be involved with fraud schemes, such as medical identity theft or kickback arrangements.
        - To calculate this measure, for each chiropractor they determined the percentage of her/his beneficiaries who had paid services from two or more chiropractors.
        - They identified the threshold as 52.5 percent of a chiropractor's beneficiaries who received services from another chiropractor.
        - For chiropractors whose percentage exceeded the threshold, they considered all of their payments for the beneficiaries seen by other chiropractors to be questionable.
        - They identified a total of 1,450 chiropractors that were paid $21,291,936in 2013 with this measure.
    - Unlikely Number of Services per Day.
        - A high number of hours of services provided by a chiropractor on 1 day suggests billing for services of diminished quality and/or for services that were not rendered.
        - Based on CMS's 2013 Time File from the MPFS, they counted CPT code 98940 as 12 minutes, CPT code 98941 as 17 minutes, and CPT code 98942 as 21 minutes.
        - They then calculated the number of hours per day for each chiropractor's paid services.
        - They established 16 hours as the threshold for this measure.
        - They considered all of a chiropractor's claims on any day that met or exceeded the threshold as questionable.
        - They identified a total of 16 chiropractors that were paid a total of $768,964 in 2013 with this measure.
- They developed three measures to identify paid claims that did not meet Medicare requirements for payment.
- These 3 measures are:
    - Claims Lacking a Covered Primary Diagnosis.
        - These claims lacked a primary diagnosis code that was covered by Medicare based on CMS's guidance and the local coverage determination where the chiropractic service was provided.
        - They counted any claim with a 739.X primary diagnosis as appropriate except for Florida, Puerto Rico, and the Virgin Islands.

    - For chiropractic services provided in Florida, Puerto Rico, and the Virgin Islands, they counted any claim with a primary diagnosis code listed in the local coverage determination as appropriate.
    - They found a total of 17,640 chiropractors billing 808,971 claims for a total of $20,709,516 with this measure.
- Claims for Duplicate Services.
    - These claims were for services provided on the same day for the same beneficiary with the same diagnosis and procedure codes and the same chiropractor.
    - In any instance where there were two or more claims with this same information, they counted all of the duplicate claims as inappropriate.
    - They found a total of 225 chiropractors billing 970 claims for a total of $25,680 with this measure.
- Claims Lacking the AT Modifier.
    - These claims lacked the AT modifier, which indicates active treatment and is required for payment.
    - They counted any paid claim that lacked this modifier as inappropriate.
    - They found a total of 30 chiropractors billing 61 claims for a total of $1,579 with this measure.

Measures Limitations

- They did not conduct a medical record review to determine whether chiropractic services were medically necessary or had been coded correctly.
- The measures included in their analysis are not intended to be a comprehensive set of characteristics for identifying chiropractors with questionable and inappropriate payments.
- The four measures that identify questionable payments used in this study do not provide conclusive evidence of improper or fraudulent payments.
- The measures are intended to identify Medicare payments to chiropractors that exceed those of other chiropractors in ways that raise program integrity concerns.
- Further investigation would be required to determine whether these chiropractors were paid for improper or fraudulent Medicare claims for chiropractic services.

Findings

- Of the $502 million that Medicare paid in 2013 for chiropractic services, $76.1 million was for claims that were questionable based on our four measures of questionable payment.
- Payments for these claims represent 15 percent of the Medicare payments for chiropractic services in 2013.
- In total, 16 percent of chiropractors (7,191) paid by Medicare in 2013 received questionable payments for chiropractic services.
- Almost half of these payments were for claims suggestive of maintenance therapy.

- The 1,787 chiropractors (4 percent) who had questionable payments for claims suggestive of maintenance therapy provided an average of 25 services per beneficiary during 2013.
- In contrast, all other chiropractors provided an average of 8 services per beneficiary during 2013.

Chiropractors with High Questionable Payments

- After calculating the total amount of questionable payments paid to each chiropractor, we identified chiropractors who received high amounts of questionable payments.
- In 2013, 962 of the 45,490 chiropractors paid by Medicare received $38 million of the $76 million in questionable payments.
- These 962 chiropractors (hereinafter, chiropractors with high questionable payments) received 9 percent ($43.6 million) of all Medicare payments for chiropractic services in 2013.
- 87 percent of their payments were identified as questionable.
- On average, chiropractors with high questionable payments provided chiropractic services to twice the number of beneficiaries compared to all other chiropractors.
- In addition, the chiropractors with high questionable payments had about 4 times the number of paid chiropractic claims compared to all other chiropractors.
- 53 percent of their claims were suggestive of maintenance therapy.
- Twenty-eight percent of paid services provided by chiropractors with high questionable payments were for 98942.
- 30 percent of the chiropractors with high questionable payments received 95 percent or more of their Medicare payments for CPT code 98942.
- In contrast, only 5 percent of paid services provided by all other chiropractors were for this CPT code.
- There are 14 counties with 10 or more chiropractors with high questionable payments. Those counties are;
    - Queens County, New York
    - Los Angeles County, California
    - Cook County, Illinois
    - Kings County, New York
    - Wayne County, Michigan
    - Maricopa County, Arizona
    - Orange County, California
    - Oakland County, Michigan
    - Macomb County, Michigan
    - Suffolk County, New York
    - San Diego County, California
    - Sedgwick County, Kansas
    - Du Page County, Illinois
    - Nassau County, New York

- 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.
- Moreover, 90 percent of the $10.6 million in payments for same-day therapy services was paid to therapists in Medicare Fraud Strike Force areas, and Medicare paid just over half of this amount to only 16 therapists.

Recommendations

- The OIG made 5 recommendations to CMS. They are;
    - Establish a more reliable control for identifying active treatment.
    - Develop and use measures to identify questionable payments for chiropractic services.
    - Take appropriate action on the chiropractors with questionable payments.
    - Collect overpayments based on inappropriately paid claims.
    - Ensure that claims are paid only for Medicare-covered diagnoses.
- Two of these recommendations are of particular interest;
    - Collect overpayments based on inappropriately paid claims
        - CMS should collect the $20.7 million in payments that resulted from the inappropriate claims we identified.
        - **In a separate memorandum, we will refer these claims to CMS for collection**.
    - Take appropriate action on the chiropractors with questionable payments
        - We identified 7,191 chiropractors with questionably paid claims, 962 of whom received half of the questionable payments.
        - **In a separate memorandum, we will provide CMS with information on chiropractors with high questionable payments, so that it may take action.**
        - **CMS and/or its contractors should review their claims and take appropriate action.**
        - Such actions could include:
            - (1) recouping inappropriate payments;
            - (2) educating providers on proper billing;
            - (3) making referrals to law enforcement;
            - (4) imposing payment suspensions;
            - (5) revoking billing privileges; or
            - (6) taking no action, if the payment is determined to be appropriate.

Action Steps

- If you are one of the 17,751 chiropractors that received an inappropriate payment in 2013 for lack of a correct primary diagnosis, duplicate service, or lack of an AT modifier, expect that you will receive a request (demand) to return the money.
    - Simply pay the money back.
    - Review your Medicare documentation, coding and bill policies and procedures to ensure that they are in compliance with Medicare's laws, rules, and regulations.

- If you could be one of the 962 chiropractors that received high questionable payments, get help immediately!
    - You will potentially fall within this category if;
        - You averaged billing over 20 visits per Medicare patient in 2013,
        - You billed a large number of 98942 services,
        - You use a nurse practitioner or other medical provider to offer physical therapy, occupational therapy, or usually non-covered services to Medicare beneficiaries.
    - If you fall within this category;
        - Review your Medicare documentation, coding, and billing policies and procedures.
        - Review your legal arrangements with any medical practitioners.
        - Develop and implement an office compliance program.
    - I recommend that you hire a certified compliance specialist to do this work for you.
    - You need the objectivity of an outside consultant to ensure that everything is covered.
    - The most dangerous thing that you can do in this situation is be complacent.

Summary

- Unlike previous reports, this on focuses narrowly on a specific group of chiropractors.
- I expect that this group will come under very close scrutiny in the near future.
- Now is the time to take steps to protect yourself if you believe that you are in this group.

For questions regarding compliance and Medicare, you can contact Dr. Short at chiromedicare@gmail.com.