Dynamic Chiropractic

Dr. Hulsebus Testifies before Congress

DETAILS MEDICARE'S POSTPAYMENT REVIEW POLICIES THAT "TARGET THE CHIROPRACTIC PROFESSION"

Editorial Staff

On July 11, 2001, Michael Hulsebus,DC, from Rockford, Illinois, presented personal testimony on dealing with the "regulatory morass" of the Health Care Finance Administration's Medicare program before the House Committee on Small Business. In particular, Dr. Hulsebus focused on the "postpayment" review policies that he said "target the chiropractic profession," and the adoption of guidelines that "further restrict the scope of acceptable services."

Dr. Hulsebus told the committee that chiropractic's inclusion in Medicare has been significantly restricted. "While the nature of the actions taken by the individual carriers differs slightly, a clear pattern has developed that reflects a conscious effort to target the chiropractic profession, and with the intent to eventually eliminate it from the Medicare program."

Dr. Hulsebus directed the committee's attention to the U.S. Office of Inspector General's September 1998 published report on chiropractic in the Medicare program. That report noted a potential for $447 million in chiropractic overcharges across the country over a period of five years, but stated that chiropractic accounts for less than one percent of total Medicare costs. The report specified: "Medicare, Medicaid, and private insurers do not consider control of chiropractic benefits a high priority or an area of major concern. All commented that more could be done to control utilization of the benefit but that resources are better spent controlling other more costly benefits."

Postpayment Reviews

As a personal example, Dr. Hulsebus recounted his ordeal with postpayment reviews of his clinic. In March 1999, Dr. Hulsebus received a letter from the Wisconsin Physicians' Service (WPS) that demanded the charts of his 28 Medicare patients treated during 1998. After complying, he received a letter which stated that a substantial number of services were "maintenance care of a chronic spinal condition and not chiropractic manipulative treatment"; that some of his services were not properly documented; and that not all of the services were payable under Part B of the Medicare program. He was told that extrapolating from the percentage of his alleged errors to the services reviewed, he owed them $70,000.

Dr. Hulsebus was given a number of options by the government, which included outright admission of fault, paying the amount specified, or subjecting his practice to review by the same consultant who had already concluded that errors existed. Instead, Dr. Hulsebus retained counsel, and submitted all of his documentation for review by an independent chiropractic consultant. The consultant's investigation included personal interviews of the patients.

Dr. Hulsebus also sought help from Representative Donald Manzullo (R-IL) and other members of Congress. With their assistance, he was able to get a meeting with representatives of HCFA and WPS in February of 2000. The result was that the director of HCFA's office of financial management found errors on the part of WPS:

- improper requests for medical records from two of the clinics;
- improper extrapolation of overpayments;
- improper restriction of the rights to appeal;
- lack of communication as to the requirements and the interpretation of the guidelines.

A subsequent meeting was held at the request of Rep. Manzullo in April of this year, which resulted in additional admissions by HCFA and WPS of errors and failure to meet federal regulations.

"Beyond this," Dr. Hulsebus pointed out to the committee, "there remains the fact that these proceedings were initiated through the fraud coordinator for HCFA and continued through a fraud and abuse investigator employed by WPS. The stigma involved and the continuation of quasi-criminal proceedings, with no indication of potential outcome, have played a dramatic and obvious role in my dealings with the patients, colleagues and the community at large."

After a costly two years of defending himself from alleged overpayments, hiring independent consultants, intervention from members of Congress, and losing significant time away from his patients, the nightmare is still not over. An amount of the "actual overpayment" was finally established and Dr. Hulsebus sought to pay that amount in full to WPS, which was a requirement of the original option plan. WPS, however, rejected the payment, demanding instead to withhold future payments.

"The imposition of withholding would result in a delay in payment according to HCFA guidelines," Dr. Hulsebus explained to the committee. "The current interest rate is 13.25 percent for every 30-day period or portion thereof. The original draft submitted in full payment has not been refunded. With objections being posed, no response has yet been received from WPS."

While waiting for a hearing date with HCFA and WPS, new guidelines took effect April 1, 2000. Dr. Hulsebus told the committee that those guidelines contained significant revisions on chiropractic policy, but that there has been "no consultation with the profession or advisors as required by federal regulations. These revisions represent substantially more than mere clarification of prior guidelines. Rather, they appear to be a further effort to restrict or control chiropractic benefits.

"There has not been an effective effort to educate the profession regarding these guidelines," he told the committee. At a Michigan seminar, two representatives from WPS handed out an 80-page manual, but would not respond to specific questions, as they were not familiar enough with the revised guidelines.

"The current requests for prepayment review seek to impose the obligations of the new guidelines, while HCFA and the providers have blatantly failed to meet their obligation of communication and education. In all probability, the pre-payment reviews will result in a significant percentage of rejection based upon this failure."

"I am also speaking here on behalf of America's small business operators who must deal with a growing mountain of red tape and procedural wrangling to survive."

Dr. Hulsebus told the committee of his additional concerns:

"The existence of 'incentives' issued by HCFA for the review and limitation of specific benefits and services."

"The methods utilized for the identification of chiropractors for postpayment review based solely upon numbers, as opposed to comparisons with other similarly situated physicians as patient population, size of practice, number of physicians in practice and other factors that carry greater significance in a proper statistical analysis.

"The apparent efforts to target the chiropractic profession in postpayment reviews and the adoption of guidelines that further restrict the scope of services acceptable.

"The fact that, in spite of there being a national policy as to the profession's involvement in Medicare programs, the interpretation of that policy varies from state to state and consultant to consultant;

"The admitted failure to properly communicate and educate the profession as to the guidelines and requirements imposed.

"The legitimate concern that what constitutes acceptable forms of documentation today will not tomorrow.

"There exists no basis for an arbitrary limit on the number of chiropractic visits.

"The past and current experience reflects the presence of an intent to substantially restrict and potentially eliminate chiropractic benefits under Medicare.

"For a profession that constitutes such a small fraction of Medicare benefits paid and which the inspector general has concluded is not an area of major concern, the actions represent an obvious onslaught, if not targeting of the profession. These actions range from the unjustified quasi-criminal nature of the proceedings, to actions such as refusing to accept a draft in full payment of an alleged overpayment pending appeal. Unfortunately, relief has been obtained only when members of Congress have become involved. There has been minimal cooperation from HCFA or the providers until force is applied.

"This series of events is in contravention of the congressional intent and directives that created the Medicare programs. The actions seek punishment and not the goals of the program. With the new guidelines now in place, it must be expected that the situation will not improve. Rather, the profession must expect an increase in situations involving both pre- and postpayment reviews. The known violations of program integrity must be used to offset these actions and to provide both the physicians and the patients the benefits the program was created to serve."

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