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Documentation Issues Aren't Going Away

LATEST OIG REPORT OUTLINES IMPROPER CHIROPRACTIC CLAIMS PAID BY MEDICARE; ACA CALLS REPORT FLAWED.

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The fifth Office of Inspector General (OIG) review of chiropractic claims submitted to Medicare suggests at least three things right off the bat: Many chiropractors are continuing to submit incomplete, error-laden or otherwise inappropriate claims; Medicare is continuing to reimburse DCs for many of those claims; and the OIG is intent on making sure something's done about it. The report, "Inappropriate Medicare Payments for Chiropractic Services," determined that Medicare "inappropriately paid $178 million for chiropractic claims in 2006," that nearly half of the claims meeting the study criteria should not have been paid, and that many claims had multiple errors. Errors noted in the report included billing for maintenance therapy: did not accurately reflect active/corrective treatment and/or did not provide a reasonable expectation of recovery or functional improvement; coding errors: upcoded or downcoded; and documentation errors: claim lacked documentation of treatment. These findings led OIG to make the following observations regarding chiropractic documentation and billing of services under Medicare:

Efforts to stop payments for maintenance therapy have been largely ineffective. CMS, carriers, and program safeguard contractors (PSC) use a number of strategies to deter inappropriate payments for maintenance therapy, including use of the AT modifier to indicate active/corrective treatment, provider education, frequency-based control edits (caps), and focused medical review. Despite these efforts, carriers and PSCs continue to report high errors for chiropractic claims. Carrier staff, PSC staff, and medical reviewers for this study agreed that the AT modifier did not prevent inappropriate payments for maintenance therapy because chiropractors continued to submit claims for maintenance therapy with the AT modifier.

Claims data lack initial visit dates for treatment episodes, hindering the identification of maintenance therapy. To identify active/corrective treatment and thereby distinguish it from maintenance therapy, it is useful to identify the start of a new treatment episode. However, claims data do not indicate when an episode begins. Thus, we asked sampled chiropractors and the medical reviewers to identify when an episode began and ended. Overall, only 50 percent of all treatment episodes remained active/corrective throughout the treatment episode. In addition, 78 percent of those treatment episodes that became maintenance therapy did so by the 20th visit. The Comprehensive Error Rate Testing (CERT) paid claims error rate used by CMS is based on a review of a single claim, which limits its ability to detect maintenance therapy and may underestimate errors in claims for chiropractic services.

Chiropractors often do not comply with the [CMS Manual] documentation requirements. Separate from the undocumented claims counted as errors above, 83 percent of chiropractic claims failed to meet one or more of the documentation requirements. Consequently, the appropriate use of the AT modifier could not be definitively determined through medical review for 9 percent of sampled claims, representing $39 million.

As reported in *DC* several years ago, previous OIG studies (1986, 1998 and 1999) noted significant issues with chiropractic claims, particularly concerning Medicare payments for maintenance

therapy. Each study recommended frequency edits or caps on the number of chiropractic claims allowed. The 2005 OIG study, based on data from 2001, found that 40 percent of allowed chiropractic claims were for maintenance therapy and that when DCs provided more than 12 services per year to a beneficiary, the likelihood that some of those services were maintenance therapy increased significantly. OIG recommended that CMS require carriers or PSCs to conduct routine service-specific reviews of chiropractic services and implement frequency-based controls to target high-volume services for review; and to require carriers to educate DCs on documentation requirements.

The 2009 report makes the following recommendations regarding how the Centers for Medicare and Medicaid Services (CMS) should deal with these ongoing documentation problems:

Medicare continues to pay inappropriately for maintenance therapy despite acknowledging this vulnerability in response to previous Office of Inspector General work and subsequent efforts aimed at prevention. Because of high error rates and poor documentation, we recommend that CMS:

Implement and enforce policies to prevent future payments for maintenance therapy. CMS can achieve this by implementing a new modifier for chiropractic claims to indicate the start of a new treatment episode and/or implementing a cap on allowed chiropractic claims.

Review treatment episodes rather than individual chiropractic claims to strengthen the ability of the CERT to detect errors in chiropractic claims. CMS should consider expanding the CERT review from a single sampled claim to a treatment episode that includes all claims from the initial visit to the sampled claim for a sample of (1) all chiropractic claims or (2) chiropractic claims for beneficiaries receiving 12 or more services per year because of their increased vulnerability. Under this review, CMS would continue to sample claims in the current CERT process but would also request associated claims prior to the sampled claims to augment the medical review.

Ensure that chiropractic claims are not paid unless documentation requirements are met. CMS can achieve this by requiring carriers, whose responsibilities will transition to Medicare Administrative Contractors (MAC) by 2011, to withhold payment on reviewed claims when required documentation is absent or requiring carriers/MACs to perform prepayment review of claims from chiropractors who repeatedly fail to meet documentation requirements.

The report also recommends that "appropriate action [be taken] regarding the undocumented, medically unnecessary, and miscoded claims identified in our sample."

The American Chiropractic Association (ACA), which has been working with other chiropractic organizations over the past several years to educate chiropractors on appropriate documentation procedures, has called the 2009 report "flawed" and "strongly disagrees that the data noted in the report supports the policy proposals set forth by the OIG, and will relay these concerns to policymakers." As of press time, the ACA is analyzing the report and formulating a response. Look for further details in an upcoming issue of *DC*.

Is the OIG biased against chiropractic? A comparison of the 2009 report on chiropractic and a similar report on "Medicare Payments for Facet Joint Injection Services" suggests so. For more information, read Donald Petersen Jr.'s Report of Findings in the June 17 issue.