CHIROPRACTIC SUMMIT ISSUES – FOURTH MEDICARE BRIEFING

MEDICARE AUDITS – WHAT THE CHIROPRACTOR NEEDS TO KNOW

First convened in September 2007, the Chiropractic Summit represents leadership from some 40 organizations within the profession. The Summit meets regularly to collaborate, seek solutions, and support collective action to address challenges with the common goal of advancing chiropractic.

A major focus of the Summit is to improve practitioner participation, documentation, and compliance within the Medicare system. The article that follows below is the fourth in a series developed by the Chiropractic Summit Documentation Committee, and it focuses on Medicare audits. This article, as well the one which will follow, will cover audits, subsequent denials, and appeals, as well as misinformation and misconceptions about the Medicare appeal process. With the significant increase in chiropractic providers across the country being audited by Medicare, there appears to be much confusion and uncertainty in how best to respond. We hope this article will help.

First, the Summit encourages all DCs to appeal improperly denied claims. Remember that appealing is not only a service to your patient, who has the right to be reimbursed, but is also a service to our profession.

Second, the Summit recognizes many DCs are unaware (or even unconcerned) about the Medicare Medical Review process until they receive notice of audit. This article is to help inform the profession about this process BEFORE notice of an audit is received and to give guidance for follow-up. It is strongly encouraged that you retain these articles on file for discussion with your staff and patients.

There are several types of audits/reviews within the Medicare system. Most practitioners have heard of Comprehensive Error Rate Testing (CERT) reviews and Office of Inspector General (OIG) reviews. However, these articles are purposely focused on different types of review—the reviews that may result in denials requiring repayment to the Medicare fund and the appeals of those denials. Most of these reviews are referred to as “Probe” reviews; however, they are not the only reviews that may result in refunds by doctors to Medicare.

To understand the Medicare Medical Review process, certain Medicare basics are needed. I It is important to know that the Centers for Medicare & Medicaid Services (CMS) is a division/agency of the Department of Health and Human Services (HHS), a department of the executive branch of the federal government. CMS, formerly known as Health Care Financing Administration (HCFA), is the federal agency responsible for administering Medicare, as well as Medicaid, CHIP (Children's Health Insurance Program), HIPAA (Health Insurance Portability and Accountability Act), CLIA (Clinical Laboratory Improvement Amendments), and several other health-related programs.

From Medicare’s inception, the federal government has used private insurance companies to process claims and perform related administrative services for the program’s beneficiaries and health care providers. Today, CMS relies on a network of contractors to process nearly one billion Medicare claims each year from more than one million health care providers. In addition to processing claims, the contractors, in conjunction with other entities, enroll health care providers in the Medicare program and educate them on Medicare billing requirements, process claims appeals, answer beneficiary and provider inquiries, and detect and prevent fraud and abuse.

Most, if not all, DCs' interaction with Medicare is with Medicare "contractors." Chiropractic and other types of private provider offices interact almost exclusively with contractors known as PART B "carriers" or "A/B MACs" (Medicare Administrative Contractors). All contractors are required to perform certain functions which include defending the integrity of the Medicare Trust Fund.

CMS is required by the Social Security Act to ensure payment is made only for reasonable and necessary healthcare services. To meet this requirement, CMS contracts with carriers/MACs and Program Safeguard Contractors (PSCs) to perform claim data analysis which will identify atypical billing. After data analysis, the contractors must verify any billing problems through probe reviews. The contractor then determines the severity of the problem and the appropriate actions to be taken, such as further Medical Review.

This article and the article(s) to follow are intended to provide a general overview of the Medical Review (MR) program to assist chiropractic Medicare providers in gaining a better understanding of the MR process. Medical Review is an important part of the Medicare Integrity Program which requires contractors to identify inappropriate billing and develop interventions to correct the problem. MR is defined as a review of claims to determine whether services provided are reasonable and necessary, as well as to follow up on the effectiveness of previous corrective actions.

Atypical billing patterns and/or specific errors can prompt MR, as well as just arbitrary/random selection. Contractors can perform MR functions on any claim appropriately submitted to a carrier or MAC in meeting their contractual obligation to CMS. Whether you are a participating provider or a non-participating provider (non-par), accepting or electing not to accept assignment, your claims are subject to the review process. The assumption that non-par providers or providers that choose not to accept assignment are exempt from this process is a common misunderstanding within the chiropractic profession.

Through data analysis and information evaluation (e.g., complaints), suspected billing problems are identified by contractors. These contractors then use Progressive Corrective Action (PCA) to ensure that MR activities are targeted to problem areas and that the imposed corrective actions are appropriate in the context of the severity of the problem. Before assigning significant resources to potential claim problems, contractors must validate claim errors through the use of probe reviews.

The next article will continue discussion on the contractor-provider relationships, including the rationale for audit, the MR process, and the appeal process available for denied claims.

The members of the Summit Subcommittee on Documentation are Dr. Carl Cleveland III, Dr. John Maltby, Ms. Susan McClelland, Dr. Peter Martin, Dr. Ritch Miller, Mr. David O'Bryon, and Dr. Frank Nicchi. Dr. Ritch Miller served as principal author of this article with contributions from members of the subcommittee.

For further information on these subjects and others please refer to the sources for this article which include: CMS articles, publications and the CMS manual system, the ACA web site, (www.acatoday.org/medicare) and the ICA website, (www.chiropractic.org).