Audit of Chiropractor Billing Practices

Report Number 2017-13

June 11, 2018

Utah Office of
Inspector General

Gene Cottrell
Inspector General

June 11, 2018

To: Utah Department of Health

Please see the attached report, **Audit of Chiropractor Billing Practices,** Report 2017-13. An Executive Summary is included at the inception of this report. The objectives and scope of the audit are explained on page 3 of this report.

Sincerely,

Gene Cottrell
Inspector General
Utah Office of Inspector General

cc: Joseph Miner, Nathan Checketts, Shari Watkins, Emma Chacon, Tonya Hales, Janica Gines, Aaron Eliason, Melanie Henderson

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Manipulation of the Spine by a licensed Chiropractor is a covered Medicaid Service as defined in the Utah State Plan for Medicaid Health Financing. The Chiropractic Medicine Provider Manual dated October 2015 lists limits of frequency of services, provider license restrictions, and defined coverage groups. The frequency of services shows as eligible services of one per day, twelve times per year. The licensing requirements show that services must be provided by a licensed chiropractor, duly recognized by the Division of Professional License, (DOPL), for the State of Utah. The coverage groups include Early Periodic Screening, Diagnosis and Treatment (EPSDT) eligible children, ages six through twenty, and pregnant women.

The provider manual directs a provider to the Coverage and Reimbursement Code Lookup tool for coverage and limitations. The Coverage and Reimbursement Code Lookup tool lists four codes, 98940, 98941, 98942, and 98943. Each of these codes define a different section of the spine manipulated during the service. Only code 98940 shows as a covered benefit during our scope period. The other three codes are used by Medicare and may have small amounts paid by Medicaid in crossover claims.

Audit Objectives:

- Determine if Medicaid paid billed claims for services not covered under the chiropractic services policies.
- Determine if Medicaid paid billed claims for services delivered to recipients who are not eligible for chiropractic services.
- Determine if Current Procedural Terminology (CPT) codes used by providers for the scope period show as a covered service.
- Determine if the providers billing for Chiropractic Services have the adequate licensure.

Audit Findings:

Finding # 1: Medicaid Printed Policy Limits Left Out in Provider Manual Information Transfer.
Finding # 2: Medicaid Billable on Multiple Claim Lines Contradiction

INTRODUCTION

BACKGROUND

The "State Plan under Title XIX of the Social Security Act, Attachment 3.1-A" states Chiropractor's Services as covered with three limitations. Limitation number one states; "Services provided by licensed chiropractors are limited to treatment of the spine by manual manipulation, which includes x-rays of the spine. Services not related to spinal manipulation are not a benefit." Limitation number two states; "The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines: (a) that the proposed services are medically appropriate; and (b) that the proposed services are more cost effective than alternative services." Limitation number three states; "Chiropractic Services are available only to pregnant women and individuals eligible under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program." In the Chiropractic Medicine Provider Manual, updated October 2015, further limitations show frequency limits of one service per day, and twelve services within a calendar year. This provider manual also defines the covered groups as pregnant women and EPSDT eligible children ages six through twenty years of age. The Medicaid Coverage and Reimbursement Code Lookup tool lists three possible coverage programs, Traditional Medicaid, Non-Traditional Medicaid, and PCN. The Look-up tool shows Traditional Medicaid as the only covered program for manipulation of the spine.

OBJECTIVES AND SCOPE

Audit Objectives:

- Determine if Medicaid paid billed claims for services not covered under the chiropractic services policies.
- Determine if Medicaid paid billed claims for services delivered to recipients who are not eligible for chiropractic services.
- Determine if CPT codes used by providers for the scope period show as a covered service.
- Determine if the providers billing for chiropractic Services have the adequate licensure.

Audit Scope:

The scope of our audit will cover the FY2017, July 1, 2016 through June 30, 2017.

METHODOLOGY

To determine if Medicaid paid billed claims for services not covered under chiropractic services policies the Utah Office of Inspector General (UOIG):

- Reviewed the 42 Code of Federal Regulation (CFR) selected sections concerning Chiropractor billings, specifically Section 421 and Section 431.

- Reviewed the Utah State Plan for Medicaid for coverage for Chiropractor services. Used the coordination of services for Medicaid and Medicare section for crossover claims.
- Reviewed the Chiropractic Medicine and the Children Health Evaluation and Care (CHEC) Services Provider Manuals for coverage definitions and limits.
- Requested a sample of paid claims to review to confirm policy applications from steps 1-3.

To determine if Medicaid paid billed claims for services delivered to recipients who are not eligible for chiropractic services the UOIG:

- Requested data for all paid claims using the four Chiropractic codes during the scope year FY 2017, (July1, 2016 to June 30, 2017).
- Upon receipt of the data file, copied the data file to a working file and sorted by Aid Category code.
- Inserted a column and inputted a short description of each Aid Category.
- Identified crossover claims using CPT code, aid category, gender, and age. Isolated claims for Traditional Medicaid covered recipients for analysis.
- Analyzed carved out claims against policy. Asked Bureau of Coverage and Reimbursement Policy (BCRP) questions about age restrictions, gender restrictions, CPT code restrictions, and frequency restrictions.
- Identified test claims to evaluate in Medicaid Management Information System (MMIS).

To determine if CPT codes used by providers for the scope period show as a covered service the UOIG:

- Looked up codes in the Medicaid Coverage and Reimbursement Code Lookup tool using provider code 69 and dates of 07/01/2016 and 06/30/2017.
- Used the MMIS Reference file, to look up the same codes and select coverage dates that cover the scope period. Identified areas of concern.

To determine if the providers billing for chiropractic services had the required licensure the UOIG:

- Selected the top 15 providers and asked Provider Enrollment in the Bureau of Medicaid Operations (BMO) to see what license information they had.
- Researched the company websites of these 15 providers to obtain Physicians names.
- Used the Division of Occupational and Professional Licensing (DOPL) website and looked up the names of Physicians to validate licensure.
- Met with Provider Enrollment to ask general licensure questions.
- Based on answers and other discussion items identified other questions. Met with BMO again and asked these additional questions.

FINDING 1 — Medicaid Printed Policy Limits Left Out in Provider Manual Information Transfer.

In the Utah State Plan, under Title XIX of the Social Security Act, Attachment 3.1-A attachment 6c Limitation 3 it states; "Chiropractic services are available only to pregnant women and individuals eligible under the Early Periodic Screening, Diagnosis, and Treatment (EPSTD) program." In the State Plan there is no mention of age for the eligible EPSDT children. In the CHEC Services Provider Manual, updated July 2015, in the first paragraph in Section 1, CHEC Services, we read; "The Child Health Evaluation and Care (CHEC) program is Utah's version of the federally mandated Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. CHEC is an integral part of the Medicaid program. All Medicaid individuals who are enrolled in Traditional Medicaid and are ages *birth through twenty* may receive CHEC services." However, The Chiropractic Medicine Provider Manual states in paragraph 2 of section 1, General Information; "Chiropractic medicine, as described in this manual, is a benefit of the Utah Medicaid Program for Early Periodic Screening Diagnosis Treatment (EPSDT) eligible children age six and older and pregnant women."

In the reference file section of MMIS under the procedure code 98940 the Age Indicator clearly shows Min Age of 6 and Max Age of 20 which agrees with the Chiropractic Medicine provider manual. Also the Coverage and Reimbursement Code Look-up tool using provider type 69 and procedure code 98940 also shows ages 6 through 20 which also agrees with the Chiropractic Medicine provider manual. All of the analyzed claims clearly show that billings for individuals outside this age range denied.

When Medicaid archived the Chiropractic Medicine Provider Manual in October 2017, the printed policy limits of frequency of services, age limits of one of the covered groups, and licensure requirements of the provider, did not transfer. The Chiropractic Medicine provider manual, dated October 2015, a five-page manual, listed not only age limitations for children but also frequency limits for services. This information did not transfer to the CHEC Services provider manual nor the Physicians Services provider manual. The CHEC Services manual and the Physicians Services manual includes four sentence in the paragraph titled 3.5 Chiropractic Services in the CHEC Services Manual and paragraph 8-18 in the Physicians Services Manual. Paragraph 3.5 in the CHEC Services manual and paragraph 8-18 in the Physicians Services manual does not list limitations of covered groups, frequency, or licensure.

Recommendation

1.1 The CHEC Services Provider Manual and the Physician Services Provider Manual are the only printed source for information for Chiropractors in the State of Utah. Medicaid should include, in these manuals, the limitations on covered groups with age definitions identified clearly, frequency limits by day and year, and licensure of provider.

FINDING 2 — Medicaid Billable on Multiple Claim Lines Contradiction.

Medicaid uses the Medicaid Coverage and Reimbursement Code Lookup tool as the preferred tool for providers to receive instruction on billing Medicaid for medical procedures. Coverage information as well as limitations show in the lookup tool. CPT Code number 98940 shows coverage for Traditional Medicaid with several limitations. Included in the descriptive terms, one line titled, "Billable on Multiple Claim Lines", shows as "No" under Traditional Medicaid.

Data for chiropractic services codes pulled from the data warehouse listed 4,555 claim lines from 3,572 individual claims. Of the 3,572 claims, 546 claims showed two or more claim lines. The data listed 83 providers that accounted for all 3,572 claims. Of the 83 providers, 21 showed zero claims with multiple claim lines, 19 showed one to three claims with multiple claim lines. The remaining 43 providers showed ranges from 4 to 46 claims with multiple claim lines. Of the 83 providers, 16 providers showed more than 10 claims with multiple claim lines and one of those providers showed 46 claims with multiple claim lines.

Claims with multiple claim lines show ranges of service dates using the start date and the end date. When analyzing paid claims, we use the services start date and the services end date for benchmarks by claim. With stated limits of one service per day and twelve services in a rolling year, having correct start and end dates by claim to use for comparison becomes critical. Analysis becomes suspect when the start dates and end dates by claim show date ranges rather than one day.

Recommendation

2.1 Medicaid should clarify the coverage and Reimbursement Code Lookup tool to eliminate the contradiction of Multiple Claim Lines between provider billings and the Lookup tool information.

Note: When Medicaid Coverage and Reimbursement learned of this situation the line about multiple claim lines on the Lookup tool changed effective 4/14/2018.

Observation 1	Medicaid Chiropractor Group Practice Licensure Verification.

U. S. Senate Bill 421 dated February 24, 1993, amends title XVIII of the Social Security Act to provide coverage under such title for certain chiropractic services authorized to be performed under State law, and for other purposes. Section 1 of this bill reads; "Coverage of certain chiropractic services authorized to be performed by State law. (a) In General – Section 1861 of the Social Security Act (42 U.S.C. 1395 x(r)) is amended in the first sentence by amending clause (5) to read as follows: (5) a chiropractor who is licensed as such by the State, and who meets uniform standards promulgated by the Secretary, but only for purposes of subsection (s)(1), (s)(2)(A), and (s)(3), and only with respect to diagnostic x-rays, diagnostic physical examinations, and treatment by means of manual manipulation of the spine (for conditions demonstrated by an x-ray or physical examination to exist) which such chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided." Also, in the Chiropractic Medicine provider manual, section 2 we read; "A chiropractic physician must hold a current professional license in the State of Utah and be enrolled as a Medicaid provider to be eligible for Medicaid reimbursement."

In field-testing, the UOIG reviewed Medicaid Information Bulletin (MIB) 15-100; "Effective October 1, 2015, Utah Medicaid will no longer utilize the Chiropractic Health Plan (CHP) to issue chiropractic prior authorizations. Providers must re-enroll with Utah Medicaid to receive reimbursement for claims for services performed on or after October 1, 2015. Claims for services performed on September 30, 2015, or prior will continue to be reimbursed to CHP." The UOIG requested enrollment information on 15 providers who accounted for over 50% of the reimbursements for chiropractic medicine for the scope period, from the Bureau of Medicaid Operations' (BMO) provider enrollment section. Of these 15 providers, nine were for group practices where multiple physicians practice under a common organization. In a meeting with Medicaid Provider Enrollment, they stated that Medicaid does not require license information for group practices on enrollment since DOPL issues licenses only to individuals. Later the UOIG learned that Medicaid must individually screen physicians practicing in a group practice and a separate contract set up.

Provider Enrollment has developed an adequate system to take information from DOPL showing expired licenses and matching this information against the provider detail in Provider Reimbursement Information System for Medicaid (PRISM). PRISM generates a monthly report of expired licenses for oversight review. Then weekly, PRISM sends email notices of expired licenses that Medicaid reviews individually. Medicaid reviews whether the provider has an open contract with Medicaid that requires licensure. Medicaid sends a letter to a provider with an expired license and gives 30 days to correct the deficiency. If the provider does not respond, Medicaid sends a second letter allowing an additional 10 days to correct the deficiency. Provider Enrollment closes the provider's contract if there is still no response after the second letter.

Observation

3.1 Chiropractors obtain licenses on an individual basis. BMO provider enrollment screens individual physicians on an individual basis. BMO assigns individual provider numbers for each physician individually. Chiropractic group practices can allow physicians practicing within the group practice to affiliate with the group provider number, recorded in Prism. An individual chiropractor could let their license lapse and the contract closed without affecting the group practice. The system works and no further action recommended

GLOSSARY OF TERMS

Term	Description
BCRP	Bureau of Coverage and Reimbursement Policy
BMO	Bureau of Medicaid Operations
CFR	Code of Federal Regulations
CHEC	Child Health Evaluation and Care
CHP	Chiropractic Health Plan
CPT	Current Procedural Terminology
DOPL	Division of Occupational and Professional Licensing
EPSDT	Early Periodic Screening, Diagnosis and Treatment
MMIS	Medicaid Management Information System
PRISM	Provider Reimbursement Information System for Medicaid
UOIG	Utah Office of Inspector General

MANAGEMENT RESPONSE

State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

JOSEPH K. MINER, MD, MSPH, FACPM
Executive Director

Division of Medicaid and Health Financing

NATE CHECKETTS
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

June 27, 2018

Gene Cottrell
Inspector General
Office of the Inspector General of Medicaid Services
P.O. Box 14103
Salt Lake City, Utah 84114

Dear Mr. Cottrell:

Thank you for the opportunity to respond to the audit entitled *Audit of Chiropractor Billing Practices* (Report 2017-13). We appreciate the effort and professionalism of you and your staff in this review. Likewise, our staff spent time collecting information for your review, answering questions, and planning changes to improve the program. We believe that the results of our combined efforts will make a better, more efficient program.

We concur with recommendation 2.1 and do not concur with recommendation 1.1. Please see our complete response in the enclosed Response to Recommendations.

The Department of Health is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need improvement.

Sincerely,

Emma Bacon for
Nate Checketts

Nate Checketts
Deputy Director, Department of Health
Division Director, Medicaid and Health Financing

UTAH DEPARTMENT OF HEALTH

288 North 1460 West · Salt Lake City, UT
Mailing Address: P.O. Box 143101 · Salt Lake City, UT 84114-3101
Telephone (801) 538-6689 · Facsimile (801) 538-6478 · www.health.utah.gov

Audit of Chiropractor Billing Practices **(Report 2017-13)**
Response to Recommendations

Recommendation 1.1

The CHEC Services Provider Manual and the Physician Services Provider Manual are the only printed source for information for Chiropractors in the State of Utah. Medicaid should include in these manuals the limitations on covered groups with age definitions identified clearly, frequency limits by day and year, and licensure of provider.

Department response:

The Department does not concur with Recommendation 1.1.

The CHEC Services Provider Manual and the Physician Services Provider Manual are not the only source for information for chiropractors in the State of Utah. The Section 1: General Information Provider Manual contains information applicable to all provider types and the Utah Medicaid Coverage and Reimbursement Code Lookup contains code specific information that clearly identifies the chiropractic service limitations for providers.

Both the CHEC Services Provider Manual and the Physician Services Provider Manual have clear language directing providers to the Utah Medicaid Coverage and Reimbursement Code Lookup for code specific information. The Department has intentionally organized this provider content in this manner in order to improve clarity for chiropractic providers and to avoid information discrepancies across policy resources.

Contact: John Curless, Bureau Director, Bureau of Coverage and Reimbursement Policy, 801-538-6149
Implementation Date: Not applicable

Recommendation 2.1

Medicaid should clarify the coverage and reimbursement code lookup tool to eliminate the contradiction of multiple claim lines between provider billings and the lookup tool information.

Department response:

The Department concurs with Recommendation 2.1.

As noted in the report, the Department has already corrected the Utah Medicaid Coverage and Reimbursement Code Lookup to address this identified concern. That change was effective April 14, 2018.

Contact: John Curless, Bureau Director, Bureau of Coverage and Reimbursement Policy, 801-538-6149
Implementation Date: April 14, 2018

UTAH DEPARTMENT OF HEALTH

288 North 1460 West · Salt Lake City, UT
Mailing Address: P.O. Box 143101 · Salt Lake City, UT 84114-3101
Telephone (801) 538-6689 · Facsimile (801) 538-6478 · www.health.utah.gov

EVALUATION OF MANAGEMENT RESPONSE

Thank you for your response to the Audit Report, Chiropractor Billing Practices # 2017-13. We appreciate your efforts in reviewing this report and preparing your response.

In your response, you indicate that you did not concur with recommendation number 1.1, but you concurred with recommendation number 2.1.

There is disagreement with recommendation number 1.1. During the scope period of our audit, the Chiropractic Medicine Provider Manual identified three separate limitations on coverage. The first limit is the covered groups. Only EPSDT eligible children ages 6-20 and pregnant women are covered. The second limit is the frequency of service. One service per day and 12 services per rolling year. The third limit is that the provider must be a licensed Chiropractor in the State of Utah. This provider manual was archived in October of 2017 with the entire 5 pages of provider instructions becoming inaccessible. The providers were directed to the Coverage and Reimbursement Code Lookup Tool on the Medicaid website to understand coverages and limits. The providers were also directed to two other Utah Medicaid Provider Manuals, the CHEC Services manual and the Physicians Services manual that both discuss Chiropractor Services being covered and billable but neither indicate the limits as explained above.

The entire Medicaid system works on a system of limitations in coverages, provider requirements and frequencies of services. To manage the system there are inclusion/exclusion limits, there are service indicators that are turned on or off based on criteria, there are modifiers and of course ultimately edits. This system works on an assumption that those who are submitting claims know the inclusion/exclusion limits, what indicators will be turned on or off and what modifiers need to be associated so the edits will not flag the claim to be denied. The question then becomes where does a provider or a billing clerk in a provider office obtain this information to submit claims properly? Previously the source of this information has been the Medicaid Provider Manual published for the discipline that the service falls under. Recently there is a shift in direction by Medicaid to encapsulate all of this information into the Coverage and Reimbursement Code Lookup Tool. What happens when a question about coverage or limits is not answered with the information contained in the Coverage and Reimbursement Code Lookup Tool? The Lookup Tool refers the provider to the provider manual. "For additional information regarding specific billing requirements and coverage or rates not managed in this Lookup tool, please consult the Medicaid Provider Manuals or Contact Us." These same limits of coverage including age, frequency of services, and required licensure of providers have been stripped from the provider manuals, leaving the provider to use the lookup tool for questions. Our recommendation suggested that Medicaid list the limits of covered groups, clarifying the covered ages, licensure requirements and the frequency of services in a provider manual. We believe that this is the simplest method of achieving the solution of clarifying the limits that govern this program.

The other recommendation, number 2.1, recommends that Medicaid correct a mistake in the information in the Coverage and Reimbursement Code Lookup Tool. When Medicaid became aware of this problem early on in the Audit Fieldwork, they immediately corrected the problem. The change in the lookup tool was made in April of 2018. Inasmuch as Medicaid addressed this concern, there was not much discussion about this recommendation. We identified an area of concern and Medicaid corrected the finding.

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

UTAH OIG CONTACT

David P. Stoddard, CIGA
Auditor

Neil Erickson
Audit Manager

UTAH OIG MISSION STATEMENT

The Utah Office of Inspector General of Medicaid Services, on behalf of the Utah Taxpayer, will comprehensively review Medicaid policies, programs, contracts and services in order to identify root problems contributing to fraud, waste, and abuse within the system and make recommendations for improvement to Medicaid management and the provider community.

ADDRESS

Utah Office of Inspector General
Martha Hughes Cannon Health Building
288 N 1460 W
Salt Lake City, Utah 84116

OTHER

Website: http://www.oig.utah.gov/
Hotline: 855.403.7283