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Congressional Committees

Medicare: Status of HHS's Implementation of Required Prior Authorization Medical Reviews and Provider Education for Chiropractic Services

In fiscal year 2016, Medicare spent approximately $540 million on chiropractic services. This represents less than 1 percent of the nearly $700 billion Medicare spent for health services for its 57 million elderly and disabled beneficiaries.[1] Chiropractic services focus on the diagnosis and treatment of disorders of the musculoskeletal system, especially the spine, and Medicare pays for certain treatments involving manual spinal manipulations.[2] In fiscal year 2016, about 44,000 health care providers submitted claims to Medicare for chiropractic services provided to beneficiaries. The Centers for Medicare & Medicaid Services (CMS)—an agency within the Department of Health and Human Services (HHS)—is responsible for administering the Medicare program and ensuring that the services for which it pays, including chiropractic services, are reasonable and medically necessary.

Chiropractic services have a relatively high rate of improper payments, although this rate has declined in recent years and the amount represents a small percentage of the overall Medicare fee-for-service improper payment amount.[3] From fiscal year 2014 to fiscal year 2017, the Medicare improper payment rate for chiropractic services decreased from approximately 54.1 percent (or about $304 million) to an estimated 41.7 percent (or about $235 million).[4] The improper payment rate for chiropractic services, however, remains high compared to the overall improper payment rate for the Medicare fee-for-service program, which was estimated to be 9.5 percent (approximately $36.2 billion) in fiscal year 2017. The improper payment amount for chiropractic services is also a small percentage (less than 1 percent) of the overall Medicare fee-for-service improper payment amount. According to CMS in 2016, the majority of the errors for chiropractic services are due to insufficient documentation or other documentation errors.

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[1]Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2017 Annual Report of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: July 13, 2017).

[2]Medicare pays for a subset of chiropractic services—specifically, services involving active and corrective spinal treatments.

[3]An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payment for services not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. See Improper Payments Information Act of 2002, Pub. L. No. 107-300, 116 Stat. 2350, as amended and codified at 31 U.S.C. § 3321 note.

[4]Department of Health and Human Services, *2017 Medicare Fee-for-Service Supplemental Improper Payment Data*, (Washington, D.C.: January 2018); Department of Health and Human Services, *The Supplementary Appendices for the Medicare Fee-for-Service 2014 Improper Payments Report*, (Washington, D.C.: December 2014).

Since 2005, the HHS Office of Inspector General (OIG) has issued several reports highlighting the high improper payment rate for chiropractic services.[5] In its reports, the OIG has recommended that CMS take additional steps to prevent improper payments by ensuring that chiropractors provide only medically necessary services to Medicare beneficiaries. CMS uses several approaches to reduce improper payments for chiropractic services, including provider education and post-payment medical reviews. Under post-payment medical reviews, Medicare contractors review claims and related documentation from providers after a payment has been made to ensure that the payment was made only for services that are medically necessary and meet all of Medicare's coverage, payment, and coding requirements.[6] Another approach CMS has used for reducing improper payments for other items and services is prior authorization medical reviews, in which prior to furnishing an item or service to a beneficiary and submitting a claim to Medicare for payment, a provider submits documentation to demonstrate compliance with applicable coverage and payment rules.[7] We have reported that prior authorization may be used to reduce expenditures, unnecessary utilization, and improper payments.[8]

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) includes a provision requiring HHS to implement a prior authorization medical review process for chiropractic services furnished on or after January 1, 2017.[9] Specifically, Section 514 of MACRA requires HHS to conduct prior authorization medical reviews for chiropractic services that are furnished by a chiropractor to an individual as part of an episode of treatment that includes more than 12 services, focusing on services (1) provided by chiropractors with aberrant billing patterns; and (2) provided by chiropractors who in a prior period had a claim denial percentage in the 85th percentile or greater, after adjusting for claims denials that were overturned by appeal. Additionally, MACRA required HHS to consult with stakeholders and CMS contractors to develop by January 1, 2016, educational and training programs to improve the ability of chiropractors to provide proper documentation.[10]

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[5]See for example, Department of Health and Human Services, Office of Inspector General, *Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply With Medicare Requirements* (Washington, D.C.: October 2016) and *CMS Should Use Targeted Tactics to Curb Questionable and Inappropriate Payments for Chiropractic Services*, (Washington, D.C.: September 2015).

[6]For example, CMS conducts post-payment medical reviews of chiropractic claims for the purposes of measuring the Medicare fee-for-service improper payment rate under the Comprehensive Error Rate Testing program.

[7]CMS has begun using prior authorization for selected items and services with high levels of unnecessary utilization and improper payments, including certain scooters and power wheelchairs. For additional information, see GAO, *Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending*, GAO-18-341 (Washington, D.C.: April 20, 2018).

[8]GAO-18-341.

[9]Pub. L. No. 114-10, § 514(a), 129 Stat., 87, 171 (adding, 42 U.S.C. § 1395l(z)). This provision also authorizes HHS to use pre-payment review or post-payment review of services that are not subject to prior authorization medical review. For purposes of this report, we focus on the status of the prior authorization medical reviews required by MACRA.

[10]Pub. L. No. 114-10, § 514(b),129 Stat., 173 (codified at 42 U.S.C. § 1395l note). In developing these programs, HHS was required to consult with stakeholders, including the American Chiropractic Association, and Medicare Administrative Contractors to develop these materials. Medicare Administrative Contractors process and pay claims, conduct claims reviews, and educate providers, among other things.

MACRA also includes provisions for us to review the effectiveness of HHS's medical review process 4 years after MACRA's enactment, or by April 2019.[11] This report describes the status of HHS's efforts to implement prior authorization medical reviews and develop educational and training programs for chiropractic services, as required by MACRA.

To describe HHS's efforts to implement prior authorization medical reviews and develop educational and training programs to improve the ability of chiropractors to provide documentation for chiropractic services, we reviewed CMS guidance, relevant legislation, HHS OIG publications, training and educational materials developed by CMS, and our prior work. We also interviewed CMS and HHS OIG officials and professionals from the American Chiropractic Association to obtain information on their involvement in developing these materials.

We conducted this performance audit from March 2018 to July 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our finding based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our finding based on our audit objective.

CMS Has Not Implemented a Prior Authorization Medical Review Process for Chiropractic Services, but Has Developed Educational and Training Materials

As of June 2018, CMS had not implemented a process for the prior authorization medical reviews for chiropractic services provided on or after January 1, 2017, as required by MACRA. CMS has indicated that it will issue a notice of proposed rulemaking in December 2018 to begin to establish the prior authorization process.[12]

CMS has conducted activities and developed materials in response to the MACRA requirement to make educational and training programs for chiropractic services available by January 1, 2016. On September 24, 2015, CMS held a forum, "Improving Documentation of Chiropractic Services," for the purpose of requesting input from the chiropractic stakeholder community on specific training needs.[13] In response to stakeholders' requests for educational materials at the forum, CMS published a series of three educational articles. Aimed at chiropractors and other practitioners who submit Medicare claims for chiropractic services, these articles identify a range of information, such as Medicare's rules for coverage and medical record documentation

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[11]Pub. L. No. 114-10, § 514(c), 129 Stat. 174.

[12]See Department of Health and Human Services, Prior Authorization Process as a Condition of Medicare Payment for Services Provided by Certain Chiropractors, *Spring 2018 Unified Agenda of Federal Regulatory and Deregulatory Actions*, (CMS-6070-P), RIN 0938-AS68 accessed June 7, 2018, http://www.reginfo.gov. Most agencies, including HHS, are required to submit significant regulations to the Office of Information and Regulatory Analysis (OIRA) for review prior to publication, and OIRA generally has 90 days to review such regulations. As of June 7, 2018, HHS had not yet submitted its planned notice of proposed rulemaking (NPRM), which the agency has identified as "significant," to OIRA for review. Additionally, once an NPRM is published, the rulemaking process generally provides interested persons an opportunity to participate by submitting their views on the NPRM for consideration and results in publication of a final rule accompanied by a statement of its basis and purpose (including the agency's response to comments received on the NPRM) at least 30 days before it becomes effective. See 5 U.S.C. § 553. Because HHS has yet to implement a prior authorization medical review process for chiropractic services, we were unable to review the effectiveness of this process.

[13]According to CMS officials, most of the Medicare Administrative Contractors' staff and chiropractors attended the *Improving Documentation of Chiropractic Services* forum. The American Chiropractic Association also told us that a representative of their organization attended the forum.

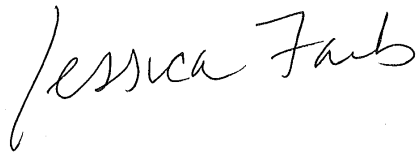
for chiropractic services and resources to help chiropractors bill Medicare correctly for covered services.[14] CMS also published a 20-minute video on its YouTube channel titled "Improving the Documentation of Chiropractic Services" on December 23, 2015.[15] In the video, CMS officials answer questions about documentation requirements for chiropractic services, such as how to determine if a claim's documentation supports Medicare's requirements for submitting claims for chiropractic services, where to find Medicare's requirements and limitations for manual spinal manipulations, and which documentation problems are the most common and the steps chiropractors can take to avoid those problems. According to CMS officials, the video was published to satisfy the MACRA requirement. As of the issuance of this report, the educational articles and video are available on CMS's website.

Agency Comments

We provided a draft of this correspondence to HHS for review and comment. The department did not have any comments.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or farbj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Other key contributors to this report included Leslie V. Gordon (Assistant Director), Laura Sutton Elsberg (Analyst-in-Charge), George Bogart, Krister Friday, Hannah Grow, Corissa Kiyan-Fukumoto, and Rich Lipinski.



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[14]CMS's Medical Learning Network (MLN) provides educational materials for health care professionals on CMS programs, policies, and initiatives. See Centers for Medicare & Medicaid Services, "Medicare Coverage for Chiropractic Services-Medical Record Documentation Requirements for Initial and Subsequent Visits," *MLN Matters,* SE1601 (2016); "Use of the AT Modifier for Chiropractic Billing," *MLN Matters*, SE1602 (2016); "Educational Resources to Assist Chiropractors with Medicare Billing," *MLN Matters,* SE1603 (2016).

[15]Official Channel for the Centers for Medicare & Medicaid Services. *Improving the Documentation of Chiropractic Services, YouTube,* accessed June 7, 2018, https://www.youtube.com/watch?v=tMiw1X9KvDA.

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