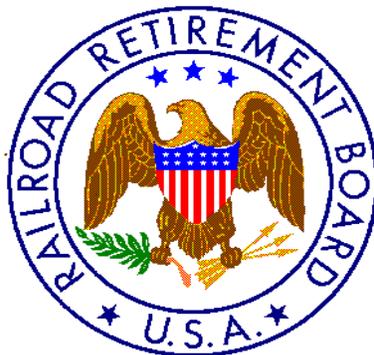


OFFICE OF INSPECTOR GENERAL
Audit Report

**Railroad Retirement Board Medicare Contract
Oversight Did Not Effectively Mitigate
Chiropractic Service Risks**

Report No. 15-07
June 4, 2015



RAILROAD RETIREMENT BOARD

EXECUTIVE SUMMARY

The Railroad Retirement Board (RRB), Office of Inspector General conducted an audit of Railroad Medicare charges for chiropractic services. The audit focused on the adequacy of controls that are in place to identify improper Railroad Medicare chiropractic service claims that do not meet Medicare's coverage requirements.

Key Findings

Our audit determined that controls are not adequate to ensure that payments for Railroad Medicare chiropractic services comply with Medicare requirements. The RRB has not effectively exercised its Railroad Medicare contract oversight authority to address known vulnerabilities in payments for chiropractic services. We estimate that from 2009 through 2013, approximately \$14 million in medically unnecessary improper payments were made for chiropractic services out of an estimated \$21 million in total paid claims. Palmetto's medical review efforts did not ensure the medical necessity of billed chiropractic services and its strategy did not adequately address the risks that often occur during the payment of chiropractic service claims including assessing (1) the frequency of chiropractic visits, (2) the use of dual modifiers, (3) commonly upcoded chiropractic services, and (4) high risk chiropractic services. Additionally, RRB and Palmetto have not established a cost effective method of post-payment recovery for when improper chiropractic service payments occur in volume.

Key Recommendations

To address the identified weaknesses, we made eleven recommendations, including that RRB work with Palmetto officials to ensure that Palmetto:

- addresses the medical necessity of chiropractic services in its medical review strategy;
- establishes a medical review process that utilizes review screens and includes an episodic approach to identify medically unnecessary chiropractic maintenance services;
- establishes a functional pre-payment edit that will initiate the medical review of chiropractic services submitted with dual modifiers;
- applies statistical analysis and stratified random sampling, where practical, based on risk level;
- modifies its medical review strategy and quarterly pre-payment reviews to address chiropractic service outliers and minimize the risk of improper payments; and
- conducts a cost benefit analysis that will identify the resources needed to maximize timely and efficient recovery of improper payments for chiropractic services over the five year recovery period.

Management's Response & Our Comments

The Office of Programs concurred with nine recommendations and did not concur with two recommendations. While concurring with our recommendations, management's response for eight of the concurred upon recommendations, did not meet the intent of our recommendations and did not address the findings presented in the report. The Office of Programs considers four of the nine recommendations already in place. As a result, there are no planned corrective actions or planned completion dates for recommendations 1, 2, 3, and 6. The planned or implemented corrective actions continue to rely more on the detection of erroneous payments already made instead of proactively preventing improper payments.

With regard to the two recommendations they did not concur with, management contends that it would not be cost effective to recover the estimated \$14 million in estimated improper payments identified in this report. However, based on our review, management did not perform a thorough cost benefit analysis on which to base this decision.

The full texts of management's responses are included in this report as Appendix I.

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INTRODUCTION

This report presents the results of the Office of Inspector General's (OIG) audit of Railroad Medicare charges for chiropractic services.

Background

The Railroad Retirement Board (RRB) is an independent agency in the executive branch of the Federal government. The RRB administers the retirement/survivor and unemployment/sickness insurance benefit programs for railroad workers and their families under the Railroad Retirement Act and the Railroad Unemployment Insurance Act. These programs provide income protection during old age and in the event of disability, death, temporary unemployment, or sickness. During fiscal year 2014, the RRB paid approximately \$12 billion in retirement, survivor, unemployment, and sickness benefits to approximately 588,000 beneficiaries.

Railroad Medicare

In May 1966, the Social Security Administration (SSA) delegated authority to the RRB to administer certain provisions of the Medicare program for Qualified Railroad Retirement Beneficiaries (QRRBs). These provisions included enrollment, premium collection, and selection of a carrier to process Medicare Part B claims. The enactment of Public Law 92-603 in October 1972 amended the Social Security Act and granted the RRB jurisdiction over all QRRBs that were receiving benefits from both the RRB and the SSA. At the end of fiscal year 2014, approximately 477,000 QRRBs were enrolled in Railroad Medicare, of whom approximately 458,000 enrolled in Part B of the program.

Within the RRB, the Office of Programs is responsible for oversight of the Railroad Specialty Medicare Administrative Contract. To conduct this oversight responsibility, the RRB's Office of Programs has one assigned Medicare Contracting Officer's Representative working at RRB headquarters and one working onsite at the contractor's facility. As part of the OIG's oversight responsibilities under the Inspector General Act of 1978, as amended, the OIG conducts audits and investigations of alleged fraud, waste, and abuse within the Railroad Medicare program.

Palmetto GBA, LLC

Since April 2000, the RRB has contracted with a nationwide contractor, Palmetto GBA, LLC (Palmetto), to process the Medicare Part B claims for QRRBs. In September 2012, Palmetto was awarded contract responsibilities as the Railroad Specialty Medicare Administrative Contractor. The RRB's contract with Palmetto states that, "[t]he contractor shall perform all carrier functions for individuals enrolled in Part B of the Railroad Medicare program throughout the United States." These carrier functions include medical review and benefit integrity, among other responsibilities.

During calendar year 2014, Palmetto processed more than 8.9 million Railroad Medicare claims, which represented approximately \$821 million in payments for Part B medical services. The Centers for Medicare and Medicaid Services (CMS) reimbursed RRB for \$32 million in Medicare program administrative expenses during fiscal year 2014.

Railroad Medicare Medical Review

Palmetto's statement of work requires the establishment of a medical review program (MR program). The MR program requires the evaluation of medical records to determine the medical necessity of Medicare claims. The goal of the MR program is to reduce the claims payment error rate by identifying, through data analysis and evaluation of other information, program vulnerabilities concerning coverage and coding made by individual providers and to prevent or address the identified vulnerabilities.

Palmetto is also required to develop an annual problem-focused, outcome-based medical review strategy (MR strategy) and Strategy Analysis Report that defines what risks to the Medicare trust fund their MR program will address and the interventions that will be used during the fiscal year in accordance with CMS' Medicare Program Integrity Manual. The Contractor shall consider OIG and Government Accountability Office (GAO) report findings and recommendations and other pertinent sources when developing and updating its MR strategy.

Palmetto must conduct medical review of claims submitted by providers or services in accordance with its MR strategy and CMS' Medicare Program Integrity Manual. Palmetto's medical review personnel are to include only nurses with active Registered Nurse licenses and complex medical review experience.

Chiropractic Services and Medicare Coverage Requirements

Chiropractic services are a form of health care aimed primarily at enhancing a patient's overall health and well-being without the use of drugs or surgery. Chiropractic services involve the use of manual manipulation to correct a subluxation or partial dislocation of the spine.

Sections 1862(a)(1)(A) and 1833(e) of the Social Security Act require that all services billed to Medicare, including chiropractic manipulations, be medically necessary and supported by documentation. Medicare chiropractic coverage limits reimbursement to the treatment of subluxation conditions for which manual manipulation is the appropriate treatment. The Current Procedural Terminology (CPT) code, modifier code, and other information must be included in the claim submitted for reimbursement.¹

¹ CPT codes are standardized five-character alphanumeric codes developed by the American Medical Association that medical coders and billers use to report health care services and procedures to payers for reimbursement. Modifiers are appended to these codes to report special circumstances.

Only three CPT codes are eligible for Medicare reimbursement for chiropractic manipulative treatment: 98940 (spinal, one to two regions), 98941 (spinal, three to four regions), and 98942 (spinal, five regions). Medical record documentation for spinal manipulations must support the appropriate number of regions treated and billed.

Sec. 240.1.3 of the CMS Medicare Benefit Policy Manual requires that a chiropractor use procedural modifier code “AT” on a claim when providing active/corrective treatment to treat acute or chronic subluxation and to indicate that a service is not maintenance and is eligible for reimbursement. Conversely, CMS requires providers to use procedural modifier code “GA” when submitting claims for services they expect to be denied as not reasonable and necessary and for which they have on file an Advance Beneficiary Notice (ABN) signed by the beneficiary. The ABN informs the beneficiary that Medicare may not pay for the service or item and establishes liability for the cost of the service if Medicare does not pay for it. Medicare prohibits the routine use of ABNs.

Strategic Goal

This audit addresses 1) the RRB’s strategic goal of stewardship of agency resources, that ensures funds appropriated for agency operations are spent for their intended purposes; and 2) the agency’s responsibilities for ensuring that Palmetto performs the requirements of its contract in accordance with applicable laws and regulations to preserve the financial integrity of the Medicare program.

Audit Objective

The objective of this audit was to determine if adequate controls are in place to identify improper chiropractic service claims that do not meet Railroad Medicare’s coverage requirements.

Scope

Our audit scope included Railroad Medicare Part B providers with chiropractic service charges for QRRBs paid between January 1, 2011 through December 31, 2013 that were maintained in CMS’ Medicare system.

Methodology

To accomplish our objectives, we:

- reviewed laws and regulations addressing Railroad Medicare chiropractic service requirements;
- reviewed and documented pertinent CMS requirements and Palmetto policies and procedures;
- reviewed Palmetto’s current and prior contract terms and statements of work;
- conducted interviews with appropriate Palmetto and RRB officials;

- identified key internal controls and assessed their effectiveness;
- utilized data mining techniques and analysis to evaluate the paid chiropractic claims universe and identify potentially fraudulent billing patterns (see Appendix II);
- quantified the total Railroad Medicare chiropractic services paid and estimated improper payments made to chiropractors; and
- briefed RRB and Palmetto officials on the results of our fieldwork.

Our data analysis provided audit coverage consistent with our objective. Our analysis was designed based on knowledge and assumptions acquired during our audit planning and fieldwork. These specific assumptions included that:

- chiropractic medical necessity vulnerabilities and risk factors previously identified by the Department of Health and Human Services (HHS) OIG and CMS continued to occur during the period of our audit;
- chiropractic services within our three year paid claims history that were provided to QRRBs consisted of a single episode of treatment;
- Palmetto's widespread quarterly reviews were accurate, randomly selected by system edits, and appropriately performed by nurse clinicians; and
- Palmetto's post-payment reviews were accurate and appropriately performed by medical review staff.

Our testing methodology also considered the risks inherent with unreliable data and the availability of corroborating evidence in the form of source documents as recommended by the GAO. We determined that computer processed data was sufficiently reliable for testing purposes by comparing our data extract with the data residing in the Multi-Carrier System. Our estimation methodology utilized claims data provided by Palmetto.

We conducted this performance audit 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 findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted our fieldwork at the RRB's headquarters in Chicago, Illinois and at Palmetto's Railroad Medicare facilities in Augusta, Georgia from June 2014 to January 2015.

RESULTS OF REVIEW

Our audit determined that controls are not adequate to ensure that payments for Railroad Medicare chiropractic services comply with Medicare requirements and the RRB has not effectively exercised its Railroad Medicare oversight authority to address these vulnerabilities. We estimate that from 2009 through 2013, \$14 million in medically unnecessary improper payments were made for chiropractic services out of an estimated \$21 million in total paid claims. Palmetto's medical review efforts did not ensure the medical necessity of billed chiropractic services and its strategy did not adequately address the risks that are often observed during the payment of chiropractic service claims including assessing (1) the frequency of chiropractic visits, (2) the use of dual modifiers, (3) commonly upcoded chiropractic services, and (4) high risk chiropractic services. In addition, RRB and Palmetto have not established a cost effective means of post-payment recovery for improper chiropractic services in volume.

To address the identified weaknesses, we made eleven recommendations intended to improve program controls to both prevent and recover Medicare improper payments. The Office of Programs concurred with nine recommendations and did not concur with two recommendations. While concurring with our recommendations, management's response for eight of the concurred upon recommendations, did not meet the intent of our recommendations and did not address the findings presented in the report. The Office of Programs considers four of the nine recommendations already in place. As a result, there are no planned corrective actions or planned completion dates for recommendations 1, 2, 3, and 6. The planned or implemented corrective actions continue to rely more on the detection of erroneous payments already made instead of proactively preventing improper payments. We do not consider these recommendations implemented.

With regard to the two recommendations they did not concur with, management contends that it would not be cost effective to recover the estimated \$14 million in estimated improper payments identified in this report. However, management did not perform a thorough cost benefit analysis on which to base this decision. The full text of Management's response is included in this report as Appendix I.

The details of our findings and recommendations for corrective action follow.

Palmetto's Medical Review Efforts Did Not Ensure the Medical Necessity of Chiropractic Services

As early as 1986, HHS OIG and CMS reported serious chiropractic service vulnerabilities impacting the Medicare program. Chiropractic service claims were identified as medically unnecessary primarily because they were for chiropractic maintenance or lacked adequate supporting documentation. In prior analysis, HHS OIG determined that as the volume of chiropractic services increased, they were more likely to be medically unnecessary and not authorized by Medicare for payment. HHS OIG

and CMS concluded that for an individual beneficiary, chiropractic service visits 1 through 12 were approximately 50 percent medically unnecessary, visits 13 through 24 were approximately 67 percent medically unnecessary, and more than 24 visits were approximately 100 percent medically unnecessary.² These concerns were not reflected in Palmetto’s MR strategies.

Based on this analysis, the RRB OIG estimated that improper payments for medically unnecessary Railroad Medicare chiropractic services from 2009 through 2013 totaled approximately \$14 million out of an estimated \$21 million (67 percent) in total paid claims, as shown in Table 1 below.

Table 1: RRB OIG Estimated Improper Payments for Medically Unnecessary Chiropractic Services (512,380 total claims)

2011 to 2013 Chiropractic Services	12 or Less	13 to 24	25 or More
Estimated Medically Unnecessary Services	55,001	67,198	215,264
Average Cost Per Service	<u>\$24.81</u>	<u>\$24.81</u>	<u>\$24.81</u>
	\$1,364,575	\$1,667,194	\$5,340,697
Estimated 2011 to 2013 Questioned Costs			\$8,372,465
Estimated 2009 to 2010 Questioned Costs*			<u>\$5,581,643</u>
Total Estimated Improper Payments			\$13,954,109

Note: numbers in this table may not add up due to rounding.

*Based on average questioned costs for the available three year period.

According to the RRB’s contract, Palmetto shall develop a MR strategy that defines what risks to the Medicare trust fund their MR programs will address during the fiscal year. The Contractor shall consider OIG and GAO findings and recommendations when developing and updating its MR strategy. The MR strategy should define both pre-payment and post-payment activities designed to detect, prevent, or recover improper payments for Medicare services. Palmetto did not address the medical necessity of chiropractic services in their yearly MR strategies, although such services were at an elevated risk for improper payments. Further, there is no indication that RRB management reviewed or approved Palmetto’s MR strategy as part of its oversight responsibilities.

Prior to July 2013, Palmetto did not evaluate the medical necessity of chiropractic services during its pre-payment medical reviews. Sections 1862(a)(1)(A) and 1833(e) of the Social Security Act require that all services billed to Medicare, including chiropractic manipulations, be medically necessary and supported by documentation. Beginning in July 2013, Palmetto started performing quarterly pre-payment medical reviews that targeted ten percent of claims and assessed their medical necessity. The reviews identified a 78.10 percent charge denial rate for chiropractic services. However, the

² HHS OIG, *Chiropractic Services in the Medicare Program: Payment Vulnerability Analysis*, OEI-09-02-00530 (June 2005).

results of the quarterly reviews were not used to target known high risk chiropractors and QRRBs.

Palmetto also reported completion of 43 provider-based post-payment reviews for 2011 and 2012. This represents less than one percent of the 14,745 providers that submitted chiropractic service claims. The reviews identified an 85.15 percent claims error rate. No post-payment reviews were reported during 2013 and Palmetto did not use the results of its reviews to target known high risk providers.

Because Palmetto's pre-payment and post-payment medical reviews did not address the medical necessity of the chiropractic services, improper payments occurring between April 2000 and July 2013 were not identified and recovered.³

Recommendations

We recommend the RRB ensure that Palmetto:

1. addresses the medical necessity of chiropractic services in its MR strategy;
2. submits its MR strategy to the RRB prior to release for detailed review and approval by the RRB's Contracting Officer and Contracting Officer's Representative; and
3. utilizes the results of its pre-payment and post-payment reviews to target specific providers and QRRBs.

Management's Response & Our Comments

The Office of Programs concurred with recommendations 1, 2, and 3. However, the process described by the Office of Programs as already in place does not meet the intent of the recommendations, as further explained below. As a result, the Office of Programs considers the recommendations implemented and there are no planned corrective actions or expected completion dates for these recommendations.

Specifically, in response to recommendation 1, the Office of Programs stated that Palmetto has included chiropractic reviews in their MR Strategy since fiscal year 2008. From fiscal year 2008 through fiscal year 2012, these reviews were conducted as post-payment reviews. Starting in February 2013, Palmetto shifted chiropractic reviews to widespread pre-payment reviews. We agree that as of our September 2014 site visit, the pre-payment process included a review for medical necessity for chiropractic services. However, Palmetto's MR strategies did not require a review of medical necessity or report any denials of service based on medical necessity for chiropractic services. The MR strategy for fiscal year 2015 quotes the OIG concerns, however, it

³ The total unrecoverable improper payments for this thirteen year period could not be determined because claims data is only maintained for three years. Further, improper payments occurring more than five years ago can no longer be recovered.

does not clearly instruct nurse clinicians or describe the approach Palmetto will take to address medical necessity for chiropractic services.

In response to recommendation 2, the Office of Programs stated that RRB management follows the CMS administrative guidelines, which allows that Palmetto can assume the strategy is acceptable 30 calendar days after RRB receives the document, unless either the Contracting Officer and Contracting Officer's Representative has indicated the deliverable is unacceptable; thus, the underlying assumption of the deliverable process is negative assurance. However, the Medicare program is an Office of Management and Budget identified high-risk program. As such, we do not consider negative assurance to be an adequate method of review and approval for an important contract deliverable. Negative assurance does not provide an audit trail and it does not assure the appropriate level of oversight is provided to RRB's contractor. The RRB's contract discusses the use of negative assurance only for the acceptance of services or supplies. The use of negative assurance for the review and approval of contractor deliverables, a contract oversight function, is not in compliance with federal internal control requirements that are to include approvals and authorizations. Further, the MR strategy is a key plan that allows both RRB and Palmetto to assure that it is preventing and timely detecting fraud and abuse of this program. There is no indication on the MR Strategy that it has been reviewed and approved by RRB.

In response to recommendation 3, the Office of Programs stated that Palmetto is in compliance with CMS's Internet-Only Manual Publication 100-08, Chapter 3 – Section 3.7.1, which requires Medicare contractors to ensure actions imposed upon Medicare providers for failure to meet requirements are appropriate given the level of non-compliance. The Office of Programs explained that Palmetto analyzes results of pre-payment and post-payment reviews to determine corrective action and publishes these results on Palmetto's website. As stated in our report and in Management's response, Palmetto selects providers for post-payment review based on non-response rates to additional document requests and charge denial rates. However, the use of random sampling for selecting claims during the pre-payment review process does not allow for the targeting of high risk providers or beneficiaries and does not consider other high risk areas such as provider and QRRB service volume outliers, chiropractic service anomalies, and historical maintenance service patterns (see Appendix II).

Frequency of Chiropractic Service Visits is Not Assessed

As part of its MR strategy, Palmetto does not evaluate the medical necessity of chiropractic services where multiple service visits occurred during its medical review pre-payment process. To appropriately identify active corrective treatment and thereby distinguish it from maintenance therapy, it is useful to identify the start of a new treatment episode.

Medical review studies have demonstrated that lack of medical necessity is directly correlated to service volume. As the frequency of chiropractic care extends beyond the

12 treatment threshold, it becomes increasingly likely that the individual services are medically unnecessary. Reviewing the beneficiary's chiropractic treatment as a whole and evaluating the number of services billed enables medical reviewers to determine if payments were made for medically unnecessary maintenance services, the most common type of non-covered chiropractic service.

Chapter 15 of the Medicare Benefits Policy Manual states that chiropractic treatment must provide a reasonable expectation of recovery or improvement of function. The Manual also states that ongoing maintenance therapy is not considered to be medically necessary under the Medicare program and is, therefore, not payable. Further, CMS' Medicare Learning Network (MLN) Publication, *Misinformation on Chiropractic Services* dated October 2013, states that CMS has not established a chiropractic service cap limit but instead allows contractors, including Palmetto, to use review screens to identify excessive services considered maintenance in nature.

Palmetto is not using review screens and has not established a means of determining the number of service visits for each chiropractic treatment plan. Palmetto told us this occurred because of CMS system limitations. Specifically, CMS' Medicare chiropractic claims data does not indicate when a treatment episode began. There is no indication that RRB management is working to promote the use of review screens. Further, Palmetto has been unable to establish effective frequency-based episodic controls over chiropractic services. As a result, medically unnecessary services for chiropractic maintenance may be paid by Medicare.

Recommendation

4. We recommend the RRB ensure that Palmetto establishes a medical review process that utilizes review screens and includes an episodic approach to identify medically unnecessary chiropractic maintenance services.

Management's Response & Our Comments

The Office of Programs concurred with recommendation 4. While the description of steps taken to address this recommendation are important first steps, they will not meet the full intent of the recommendation, as further explained below.

With respect to episodic reviews, the Office of Programs stated that Palmetto is unable to review episodic treatments on a pre-payment basis due to system limitations within the Multi-Carrier System and the potential delay in making payments to providers. Palmetto included episodic post-payment reviews of code 98942 in its MR strategy for fiscal year 2015. We continue to believe that effective pre-payment episodic reviews are important to prevent improper payments and RRB and Palmetto should seek methods to identify episodes of chiropractic care to identify unusually high usage of service. Further, while our office agrees that Palmetto's 2015 strategy states that Palmetto will perform episodic post-payment reviews of code 98942, the planned approach does not address the higher volume codes 98940 or 98941. Finally, with respect to review

screens, the Office of Programs stated that Palmetto will assess the feasibility of establishing review screens and discuss this approach further with CMS. However, because the Office of Programs has not completed its planned feasibility study on the use of prepayment review screens and only plans to address a single chiropractic service code on a pay and chase basis, we do not consider this recommendation implemented.⁴

Dual Modifiers Were Generally Not Reviewed

As part of its MR strategy, Palmetto did not review chiropractic claims submitted by the provider as both Medicare covered and medically unnecessary—those with both the AT and GA modifiers. Providers use this method of billing to ensure payment by the beneficiary if Medicare denies payment. When billing with the GA modifier, an ABN is issued prior to care to inform the beneficiary that Medicare may not pay for the service or item.⁵ Use of both the AT and GA modifiers is contradictory with regard to the medical necessity of the service performed by the chiropractor. If services that include both modifiers are not reviewed, chiropractors may receive payment for services that are not reasonable or medically necessary. According to HHS OIG, historically, chiropractic service claims submitted with the GA modifier were the second most abused Part B service category.⁶

Palmetto's medical review pre-payment edits were not designed to identify services with contradictory dual modifiers. An effective pre-payment edit would suspend payment for a service that included both the AT and GA modifiers for medical review. Palmetto officials stated that they cannot build an edit that would suspend services submitted with the dual modifiers. However, CMS allows contractors to develop medically unlikely pre-payment edits such as this. While Palmetto's medical review pre-payment edits did not prevent payment of claims with dual modifiers, Palmetto stated that they will check for dual modifiers if a service is randomly selected for pre-payment medical review.

We analyzed historical paid claims data, provider data, and QRRB data over a three year period from January 1, 2011 through December 31, 2013. From this three year period we identified 53,786 chiropractic claims totaling \$1,345,281 that were submitted with both AT and GA modifiers and not subject to pre-payment review unless selected randomly. Table 2 provides an analysis of modifiers for chiropractic claims during this time.

⁴ The term “pay and chase” refers to Medicare paying claims quickly and then chasing after those providers whose claims were later found to be fraudulent.

⁵ CMS, *Advance Beneficiary Notice of Noncoverage*, MLN Publication (August 2014) and CMS, *Fee Schedule Administration and Coding Requirements*, Medicare Claims Processing Manual Chapter 23 (December 2014).

⁶ HHS OIG, *Memorandum Report: Medicare Payments for Part B Claims with G Modifiers*, OEI-02-10-00160 (May 2013).

Table 2: Analysis of Modifiers - Chiropractic Claims Paid from January 1, 2011 through December 31, 2013

Category	Claims	Total Detailed Paid
AT Modifier Only	450,318	\$11,164,916
AT and GA Modifiers	53,786	\$1,345,281
AT with Modifiers other than GA	7,758	\$189,286
Multiple Modifiers	66	\$1,657
No Modifier	9	\$226
GA Modifier Only	4	\$100
No Allowable Modifier	4	\$84
Totals	511,945	\$12,701,549

Numbers in this table may not add up due to rounding.

Recommendation

5. We recommend the RRB ensure that Palmetto establishes a functional pre-payment edit that will initiate the medical review of chiropractic services submitted with both AT and GA modifiers.

Management's Response & Our Comments

The Office of Programs concurred with recommendation 5 and stated they will request that Palmetto conduct a sample post-payment review on claims with an AT/GA modifier that were not selected in the pre-payment review process. In addition, Palmetto will add AT/GA modifier combination reviews to their fiscal year 2016 MR strategy as post-payment complex reviews. Based on this response, Palmetto appears to continue to rely on post-payment reviews as opposed to establishing a more effective pre-payment edit. While concurring with this recommendation, the planned steps do not meet the intent of the recommendation and leave the RRB's Medicare program at continued risk of improper payments for chiropractic services. The determination to not implement a pre-payment edit along with the RRB's historic hesitation to seek recoveries of improper payments from Medicare providers leaves Medicare funds at risk.

Commonly Upcoded Chiropractic Services Have Not Been Reviewed

As part of its MR strategy, Palmetto has not conducted a review of the medical necessity of chiropractic service claims submitted under CPT code 98942, chiropractic manipulative treatment (spinal, five regions). HHS OIG's payment vulnerability analysis

reported that 69 percent of services billed for 98942 are upcoded.⁷ Chiropractic service upcoding involves billing for a more complex service than the one documented in the medical record and results in a greater reimbursement amount per claim. The average 2011-2013 reimbursement amount per claim for 98942 was \$34.15, as compared to \$19.17 and \$26.41 for 98940 and 98941, respectively. However, reimbursement for the procedure requires claim documentation to support manipulative treatment that occurred in five regions of the spine rather than fewer regions as with codes 98940 and 98941. As shown in Table 3, we estimate that RRB Medicare paid \$2.3 million in claims using this procedure code between 2009 and 2013.

Table 3: Estimated RRB Medicare Chiropractic Claims for Procedure Code 98942

Year	Amount Paid	Number of Claims
2011 - 2013 (Actual)	\$1,394,875	40,841
2009 - 2010 (Estimate)	\$933,333*	27,277*
Totals	\$2,328,208	68,118

*Based on average amount paid and number of claims for the available three year period.

The RRB’s contract with Palmetto requires that its MR strategy be developed based on risk. However, the potential upcoding of procedure code 98942 was not included in the MR strategy. Palmetto explained that this occurred because it considered procedure code 98942’s limited comparative claims volume rather than the procedure code’s inherent risk. There is no indication that RRB management reviewed or approved Palmetto’s MR strategy decision for this procedure code. As a result, Railroad Medicare payments for medically unnecessary chiropractic services may not be detected. Based on the estimated five year total of chiropractic claims for procedure code 98942 and HHS OIG’s reported upcoding rate of 69 percent, RRB OIG estimates that Palmetto’s improper chiropractic service payments for this procedure code were approximately \$1.6 million from 2009 through 2013.

Recommendation

6. We recommend the RRB ensure that Palmetto modifies its MR strategy to include risk-based, pre-payment and post-payment reviews of services for chiropractic procedure code 98942 and the recovery of identified improper payments.

Management’s Response & Our Comments

The Office of Programs concurred with recommendation 6. However, the process described by the Office of Programs as already in place does not meet the intent of the

⁷ HHS OIG, *Chiropractic Services In The Medicare Program: Payment Vulnerability Analysis*, OEI-09-02-00530 (June 2005).

recommendation. The Office of Programs stated that Palmetto included code 98942 in their strategy for fiscal year 2015. Due to the total potential dollars at risk for this service, Palmetto's initial reviews will be conducted on a post-payment basis. In addition, Palmetto will conduct post-pay episodic treatment reviews on procedure code 98942. However, Palmetto does not plan to conduct pre-payment reviews of code 98942. Prepayment reviews are more effective and potentially minimize improper payments. Palmetto previously performed limited post-payment reviews of code 98942. As of fiscal year 2012, Palmetto halted these post-payment reviews of code 98942. Palmetto plans on resuming these less effective reviews during fiscal year 2015. As a result of these actions, the Office of Programs considers the recommendations implemented and there are no planned corrective actions or expected completion dates for these recommendations. We believe that continued implementation of risk-based, pre-payment reviews are important to prevent the payment of improper claims under procedure code 98942.

Other Chiropractic Service Fraud Indicators Were Not Targeted

Palmetto's MR strategy did not apply a risk-based approach to the chiropractic claims pre-payment review process that would identify potential fraud indicators. Instead, Palmetto management made a decision to use random sampling exclusively to select services for pre-payment review and those providers who did not respond to additional documentation requests to select providers for post-payment review. There is no indication that RRB management reviewed or approved the sampling methodology within Palmetto's MR strategy. Because of this approach, Palmetto failed to consider:

- provider and QRRB outliers, such as those with excessive chiropractic service volume, as discussed in Appendix II;
- chiropractic service anomalies that are unlikely to occur in medical practice. For example, providers that treat an unusually high number of QRRBs each day and QRRBs that receive multiple chiropractic services in a single day; and
- historical data that would identify service patterns that indicate a high probability of the occurrence of maintenance services.

In order to define outliers within our population, we identified those QRRBs who had received more than 25 services, as shown in Table 4.

Table 4: Chiropractic Visits by QRRBs from January 1, 2011 to December 31, 2013

Number of Visits Over 3 Years	Number of QRRBs	Percentage of RRB Population
0 to 24	28,896	81%
25 to 48	4,833	14%
49 to 192	1,784	5%
Totals	35,513	100%

Approximately 19 percent of the QRRBs in the RRB's three year population incurred more than 24 chiropractic visits and were considered to be at high risk of being medically unnecessary.

The RRB requires Palmetto to develop a risk based MR strategy, specifically the contract states: the goal of the Contractor's MR program is to reduce the claims payment error rate by identifying, through data analysis and evaluation of other information, program vulnerabilities concerning coverage and coding made by individual providers, and by taking the necessary action to prevent or address the identified vulnerabilities.

Our analysis compared Palmetto's three year claims history data set with the results of Palmetto's quarterly widespread medical reviews. Specifically, we looked at QRRBs with 25 or more services, which represented 19 percent of the universe. Of those 6,617 QRRBs, Palmetto did not review 42 percent in their widespread medical reviews of chiropractic services. This resulted in payment of chiropractic services to 2,815 high risk QRRBs without a pre-payment review. The remaining 58 percent of the high risk QRRBs reviewed by Palmetto resulted in an average service error rate of 78 percent. Additionally, Palmetto did not review all of the services for each QRRB selected for pre-payment review.

Recommendations

We recommend the RRB ensure that Palmetto:

7. applies statistical analysis and stratified random sampling where practical to the high volume risk categories; and
8. modifies its MR strategy and quarterly pre-payment reviews to address provider and QRRB outliers and chiropractic service anomalies utilizing historical data to identify maintenance service patterns and minimize the risk of improper payments.

Management's Response & Our Comments

The Office of Programs concurred with recommendations 7 and 8. While concurring, the planned steps do not meet the intent of the recommendations. In addressing both recommendations, the Office of Programs stated they will have Palmetto explore options to make the random sampling of claims more stratified, where practical. This will include the utilization of review screens for beneficiaries and post-payment review for providers. In addition, Palmetto will continue to factor the high risk indicators into the selection of prioritized vulnerabilities within their MR strategy.

As this report states, Palmetto's approach was limited to the selection of chiropractic manipulations as a targeted vulnerability for review. However, other high risk factors and anomalies within the chiropractic service universe were not targeted for review. For example, the top 100 high volume providers and beneficiaries are not guaranteed to be selected for pre-payment or post-payment medical review. In addition, RRB states in their management response that Palmetto documents the high risk indicators in the MR strategies that drive Palmetto's prioritized vulnerabilities selection (e.g., Chiropractic Manipulations, Ambulance Transport, and Drugs & Biologicals). However, the MR strategies do not address or document the high risk indicators and methodology used to select the underlying chiropractic claims. According to GAO, risk assessment is the identification and analysis of relevant risks associated with achieving the objectives, and forming a basis for determining how risks should be managed.⁸

Palmetto Has Not Established an Adequate Means for Recovering Improper Chiropractic Service Payments

Palmetto has not established an adequate method for recovering the estimated \$14 million (Table 1) in chiropractic improper payments occurring within the congressionally mandated five year recovery period.⁹ During our audit, we requested that RRB prepare a cost benefit estimate for the recovery of the estimated improper payments and any associated potential fines and penalties. RRB officials developed a cost benefit estimate using costs based on Palmetto's medical review pre-payment review rates. Based on this cost benefit estimate, RRB officials indicated that it would not be cost effective to review and recover improper payments related to chiropractic services. RRB estimated that it would cost \$1.05 for each \$1.00 of improper chiropractic service payments recovered. However, the cost benefit estimate was incorrectly computed using pre-payment review rates instead of the more appropriate post-payment review rates. In response to our request to do so, the RRB did not provide a

⁸ GAO, Standards for Internal Controls in the Federal Government, GAO/AIMD-00-21.3.1 (Washington, D.C., November 1999). A newer version, effective beginning in fiscal year 2016, has been published, GAO 14-704-G (Washington, D.C., September 2014).

⁹ Effective January 2013, Section 638 of the American Taxpayer Relief Act of 2012 requires Medicare contractors to recover Medicare improper payments for unallowable services occurring during the previous five years.

corrected estimate. We believe that by using the correct rates, it would be cost effective to recover these improper payments.

Once a determination of an overpayment has been made, the amount is a debt owed to the United States Government. Under the Federal Claims Collection Act of 1966, each agency of the Federal Government must attempt collection of claims of the Federal Government arising out of the activities of the agency. When the agency's contractor determines that an overpayment has been made it must attempt recovery of overpayments in accordance with CMS regulations. The Federal Claims Collection Act requires timely and aggressive efforts to recover overpayments, including efforts to locate the debtor where necessary, demands for repayment, and establishment of repayment schedules.¹⁰

In addition to recovery of the improper payments, under 42 U.S.C. §1320a-7a, the OIG is authorized to seek civil monetary penalties and assessments for these types of violations. The OIG may seek a penalty of up to \$10,000 for each item or service improperly claimed and an assessment of up to three times the amount improperly claimed after January 1, 1997. Thus, in addition to the potential unrecoverable improper payments, lost penalties of \$10,000 per improperly claimed service and assessments from unprocessed investigative referrals are valued at an upper limit of approximately \$5.6 billion for the five year recovery period. This maximum of penalties and assessments assumes that none of the potential improper payments will be appealed and overturned. RRB officials did not include any potential penalties or assessments in their cost benefit estimate.

RRB management had not requested assistance from CMS to recover the improper payments or to determine if Recovery Audit Contractors or Zone Program Integrity Contractors contract would be beneficial.¹¹ There is no indication that additional funding had been requested to respond to the potential overpayment recovery workload.

Recommendations

We recommend that the RRB work with Palmetto and CMS to:

9. conduct a thorough cost benefit analysis that will identify the resources needed to maximize timely and efficient recovery of improper payments for chiropractic services over the five year recovery period;
10. recover the improper chiropractic service payments for the five year period, where determined to be cost effective based on an accurate cost benefit analysis; and

¹⁰ CMS, *Overpayments*, Medicare Financial Management Manual Chapter 3 (September 2013).

¹¹ Recovery Audit Contractors identify and correct, on a commission basis, improper payments for claims of health care services provided to Medicare beneficiaries. Zone Program Integrity Contractors are comprised of dedicated teams of investigators, data analysts, and medical reviewers – all performing a range of actions to examine potential fraud.

11. share information identified during the post-payment reviews as appropriate with the Recovery Audit Contractors and Zone Program Integrity Contractors where it can be used to identify improper or fraudulent non-Railroad Medicare chiropractic service payments.

Management's Response & Our Comments

The Office of Programs did not concur with recommendations 9 and 10. The Office of Programs stated a preliminary cost benefit analysis reflected an estimated cost of \$7.3 million to recover the 511,945 claims mentioned in Table 2. They went on to explain that this estimate did not consider other costs such as quality assurance, appeal requests, and claims processing activities. Thus, the Office of Programs concluded that expending over \$7.3 million to potentially recover estimated improper payments would not be cost effective and would negatively impact the Medicare Trust Fund. We disagree with this conclusion. First, recommendation 9 was for RRB to conduct a thorough cost benefit analysis, which, by definition, should include all associated costs and identify and categorize high risk claims that should be the focus of the recovery effort. Our office has already identified certain high risk claims for RRB management. Further, recommendations 9 and 10 are aimed at collecting the nearly \$14 million in potentially improper payments found in Table 1. Based on the RRB OIG's estimated number of medically unnecessary chiropractic services, the cost to recover these 337,463 high risk claims is estimated to be between \$3.4 to \$4.8 million; resulting in a return on investment of approximately 175 percent. Finally, while the RRB's estimate does not consider other costs, the cost-benefit estimate provided also does not consider the deterrent effect that seeking repayment of improper payments would have on future claims. Recovering such improper payments would allow Palmetto to not only educate chiropractic providers but also serve to deter future upcoding or improper billing of Medicare; thus, protecting the Medicare Trust Fund. We reiterate recommendations 9 and 10 and remain concerned with the RRB's unwillingness to collect OIG identified improper payments, not only in this report but in a previous audit.¹² Once a thorough cost benefit analysis is completed, RRB can work with Palmetto and CMS to recover the improper chiropractic service payments for the five year period, where determined to be cost effective.

The Office of Programs concurs with recommendation 11. The Office of Programs stated the current Statement of Work requires Palmetto to participate in information sharing sessions, meetings and conferences, in addition to working with other Medicare contractors and Zone Program Integrity Contractors. The Office of Programs is currently working with CMS to establish a joint operating agreement to establish a more formal system of communication and information sharing. The RRB will discuss with CMS the feasibility of sharing Palmetto's post-payment chiropractic review results with the Recovery Audit Contractors, as deemed appropriate.

¹² RRB OIG, *Audit of Payment Controls over Railroad Medicare Claims Submitted by Physical Therapists*, Report No. 14-07 (May 16, 2014).



UNITED STATES GOVERNMENT

MEMORANDUM

APR 22 2015

TO: Heather J. Dunahoo, Assistant Inspector General for Audit

FROM: Michael Tyllas, Ph.D., Director of Programs *Michael A. Tyllas Ph.D.*

SUBJECT: Restricted Distribution Draft Audit Report – Railroad Retirement Board Medicare Contract Oversight did Not Effectively Control Chiropractic Service Risks

Recommendation 1: We recommend that the RRB ensure that Palmetto address the medical necessity of chiropractic services in its MR strategy.

Concur. Based on funding prescribed by CMS under the legacy contract, Palmetto did include chiropractic reviews in their Medical Review Strategy (MRS) since FY 2008. From FY 2008 – FY 2012, these chiropractic reviews were conducted as post-payment probes. Beginning with the Base Year MRS (February 2013), and in line with CMS program integrity strategy moving beyond “pay and chase” reviews, Palmetto shifted chiropractic reviews to widespread pre-payment review. The table below highlights the associated review volumes since FY 2008 for chiropractic reviews.

Contract Period	In MRS	Prioritized Problem #	Chiro Reviews Completed	Total Post-Pay Reviews (All Services)	% of Annual Post-Pay Workload	OIG Report Referenced in MRS	HCPCS Code
Fiscal Year 2008	✓	5	1,149 claims	2,719 claims	42.3%	None	98940-98942
Fiscal Year 2009	✓	3	1,073 claims	2,922 claims	36.7%	None	98940-98942
Fiscal Year 2010	✓	3	726 claims	2,411 claims	30.1%	2009	98940-98942
Fiscal Year 2011	✓	3	1,024 claims	2,563 claims	40.0%	2009	98940-98942
Fiscal Year 2012	✓	3	588 claims	1,520 claims	38.7%	2009	98940-98942

Since transitioning to the SMAC contracting environment, we have had Palmetto significantly increase the number of chiropractic claims reviewed for medical necessity. The chart below highlights the chiropractic sample rates since the Base Year period of the RRB SMAC contract.

RRB SMAC Chiropractic Claim Sample Rates

Contract Period	Chiropractic Claims Eligible to be Sampled	Chiropractic Claims Sampled	Sample Rate
Base Year	75,826	52,610	69.38%
Option Year 1	105,501	46,174	43.77%
Option Year 2 YTD	41,999	31,177	74.23%
SMAC Totals	223,326	129,961	58.19%

For the extensive time period that Palmetto has been conducting chiropractic reviews, they have ensured that all clinical decisions are based on medical necessity and follow the coverage guidelines within the Centers for Medicare and Medicaid Manual (CMS), Internet-Only Manual (IOM). In the MRS, the rationale for adding a review to the problem list includes reasons why medical necessity may not be met for a service. For example, in the Option Year 2 MRS (see below), Palmetto references their historical data, the 2014 HHS OIG work plan, and national CERT data to show the most common medical necessity related denial reasons for chiropractic services:

B.2. Chiropractic Manipulations

Chiropractic services continue to represent a Major Risk for Railroad Medicare. Palmetto GBA’s historical review findings for these services continue to show heightened charge denial rates for all levels of chiropractic manipulations.

In addition to our historical findings, the OIG continues to expand its interest in the review of chiropractic services. In the Fiscal Year (FY) 2014 HHS OIG Work Plan, the OIG states, “we will determine the extent of questionable billing for chiropractic services. We will also identify trends suggestive of maintenance therapy billing. Context—Previous OIG work has demonstrated a history of vulnerabilities relative to inappropriate payments for chiropractic services, including recent work that identified a chiropractor with a 93-percent claim error rate and inappropriate Medicare payments of about \$700,000. Although chiropractors may submit claims for any number of services, Medicare reimburses claims only for manual manipulations or treatment of subluxations of the spine that provides ‘a reasonable expectation of recovery or improvement of function.’ Moreover, Medicare does not reimburse for chiropractic maintenance therapy. (CMS’s Medicare Benefit Policy Manual, Pub. No. 100 02, Ch. 15, § 30.5B.)”

In line with Palmetto GBA’s historical findings and the OIG’s heightened interest in the review of chiropractic manipulations, CERT has also included Chiropractic Services in its Medicare FFS 2013 Improper Payments Report. According to the CERT, the improper payment rate for chiropractic services was 51.7 percent, accounting for 0.7 percent of the overall Medicare FFS improper payment rate. The projected improper payment for chiropractic services during the 2013 report period was \$273.5 million.” The CERT report proceeds to discuss the top error reasons identified for chiropractic services, “Improper payments for chiropractic services are usually due to insufficient documentation. There are specific documentation requirements for chiropractic patient visits. Often the following items are missing from the documentation:

- *An adequate description of the service billed*
- *The date of service*
- *The name of the beneficiary*
- *The treatment plan (at the initial visit) with objective measures to evaluate treatment effectiveness*
- *A legible provider signature*

The CERT's error analysis is consistent with the results of the chiropractic reviews that have been conducted since the Base Year period of the RRB SMAC contract.

No completion date is included as this recommendation is already in place.

Recommendation 2: We recommend that the RRB ensure that Palmetto submits its MR strategy to the RRB prior to release for detailed review and approval by the RRB's Contracting Officer and Contracting Officer's Representative.

Concur. The RRB management follows the CMS administrative guidelines in deliverables such as the Medical Review Strategy. The MRS is submitted for RRB detailed review. The underlying assumption of the deliverable process is "Negative Assurance". The SMAC can assume that a deliverable is deemed acceptable 30 calendar days after receipt unless either the CO or COR has indicated, in writing, that the deliverable is unacceptable.

No completion date is included as this recommendation is already in place.

Recommendation 3: We recommend that the RRB ensure that Palmetto utilizes the results of its pre-payment and post-payment reviews to target specific providers and QRRBs.

Concur. Palmetto has always utilized the results of pre-payment and post-payment reviews. Both pre-payment and post-payment review results are closely analyzed in order to determine if Progressive Corrective Action (PCA) is warranted. This analysis is conducted on a quarterly basis and results are published on Palmetto's website via edit effectiveness articles. The Cognitive Medical Review System (CMRS) also allows for real time charge denial rate analysis. Having access to this data in a real-time fashion allows Palmetto to easily increase or reduce the interventions needed for a particular area of focus or concern.

An important point to consider, which has been overlooked in this audit report is Palmetto's utilization of the PCA process to identify aberrant providers. Palmetto is in compliance with the PCA process as outlined in Publication 100-08, Chapter 3, Section 3.7.1 of the CMS IOM. PCA is an operational principle upon which all medical review activities are based. PCA involves data analysis, error detection, validation of errors, provider education, determination of review type, sampling claims and payment recovery. It serves as an approach to performing medical review and assists contractors in deciding how to deploy medical review resources and tools appropriately. Based on the overall charge denial rate for a service, Palmetto determines the next appropriate course of action. This could include, but is not limited to, any one of the following actions:

Pre-Payment Review

- Continue pre-payment review of providers who show no improvement in their overall charge denial rate.
- Removing providers from pre-pay review if they show an improvement in their individual charge denial rate.
- Moving providers with 100% non-response rates to medical records requests to post-payment review.
- If the overall error rate for the entire service is above the desired threshold, Palmetto will continue the service wide pre-payment review.
- Refer providers to Provider Outreach and Education (POE).
- Providers who continue to show improper billing habits or continue to be non-compliant with requests for medical records are referred to the Benefit Integrity Unit for possible fraud investigation.
- Specific educational forums such as webinars or Ask-the-Contractor teleconference calls may be conducted if a widespread pattern of billing errors or documentation compliance issues are observed.

Post-Payment Review

- Based on the results of post-payment probe charge denial rates, Palmetto may move a service to a targeted service specific pre-payment review.
- Refer providers to POE.
- Providers who continue to show improper billing habits or continue to be non-compliant with requests for medical records are referred to the Benefit Integrity Unit for possible fraud investigation.
- Specific educational forums such as webinars or Ask-the-Contractor teleconference calls may be conducted if a widespread pattern of billing errors or documentation compliance issues are observed.

Completion date is not included as this recommendation is already in place.

Recommendation 4: We recommend that the RRB ensure that Palmetto establishes a medical review process that utilizes review screens and includes an episodic approach to identify medically unnecessary chiropractic maintenance services.

Concur. With respect to **episodic** reviews, due to system limitations within the MCS system, Palmetto is unable to review episodic treatments on a pre-payment basis. This would require them to suspend live claims for unknown periods of time until providers submitted all of the claims in the treatment episode. Holding claims for unknown periods of time would cause undue hardships on providers as it would interrupt their normal cash flow. It may also cause undue hardship on the beneficiary as well. Due to the interrupted cash flow, providers may seek out payment directly from the beneficiary in order to keep their operations running. Palmetto will address these situations through post-payment review after treatment has been concluded.

As a result of discussions with CMS, Palmetto included episodic post-payment reviews of HCPCS code 98942 in its Option Year 2 MRS. Based on the charge denial rates associated with these reviews, Palmetto will move forward with implementing PCAs if applicable.

Completion date is not included as this recommendation is already in place.

With respect to **review screens**, Palmetto will assess the feasibility of establishing review screens and discuss this approach further with CMS.

We plan to have this assessment completed by January 31, 2016.

Recommendation 5: We recommend that the RRB establishes a functional pre-payment edit that will initiate the medical review of chiropractic services submitted with both AT and GA modifiers.

Concur. All claims that are selected for review based on a pre-payment chiropractic edit are also reviewed for the AT/GA modifier combination. We will, however, request Palmetto to conduct a sample post-payment review on those claims that have an AT/GA modifier that were not selected in the pre-payment review process. Palmetto will add AT/GA modifier combination reviews to their Option Year 3 MRS as post-pay complex reviews.

This will be completed with submission of the OY3 MRS in August 2015.

Recommendation 6: We recommend that the RRB modifies its MR strategy to include risk-based, pre-payment and post-payment reviews of services for chiropractic procedure code 98942 and the recovery of identified improper payments.

Concur. Palmetto conducted post-payment review of procedure code 98942 from FY 2008 – FY 2012. The decision was made to remove this procedure from the MRS for the Base Year after review of the FY 2012 Global Data Analysis report. While this audit indicates that only claims volume was considered in removing this service, in reality, Palmetto reviewed multiple high risk factors before making this decision. After reviewing their internal data analysis report and analyzing some of the major internal risk factors, they identified a decrease across the board in several of the major risk categories. The risk factors assessed include, but are not limited to, provider paid amount, number of allowed services, number of claims submissions and number of beneficiaries.

Palmetto has included code 98942 in the MRS for Option Year 2. Due to the total potential dollars at risk for this service being \$381,697, Palmetto's initial reviews will be conducted on a post-payment basis. The total provider reimbursement per claim for this procedure is \$34.00. A total of 11,289 claims were submitted during the time period of the report.

We will be conducting post-pay episodic treatment reviews on this procedure code. Any identified improper payments will go through the recovery process. Based on the resulting charge denial rate for these reviews, Palmetto may shift these services to pre-payment review in Option Year 3.

Completion date is not included as this recommendation is already in place.

Recommendation 7: We recommend that the RRB ensure that Palmetto applies statistical analysis and stratified random sampling where practical to the high volume risk categories; and

Concur. Palmetto's approach to conducting medical review is in compliance with instructions provided in CMS Publication 100-08, Chapter 3. Palmetto routinely assesses several of the major risk categories associated with improper payment analysis. The high risk factors assessed include, but are not limited to provider paid amount, number of allowed services, number of claims submissions and number of beneficiaries.

Palmetto will continue to factor these high risk indicators into the selection of prioritized vulnerabilities for our MRS. Where practical, we will have Palmetto explore options to make the random sampling of claims more stratified. This will include the utilization of review screens for beneficiaries and post-payment review for providers. We will continue to document the high risk indicators that drive our prioritized vulnerabilities within our MRS and SAR each option year.

We anticipate a completion date with the submission of the SAR for Option Year 3 in May 2016.

Recommendation 8: We recommend that the RRB ensure that Palmetto modifies its MR strategy and quarterly pre-payments reviews to address provider and QRRB outliers and chiropractic service anomalies utilizing historical data to identify maintenance service patterns and minimize the risk of improper payments.

Concur. Please refer to response Number 7.

Recommendation 9: We recommend that the RRB ensure that Palmetto conduct a thorough cost benefit analysis that will identify the resources needed to maximize timely and efficient recovery of improper payments for chiropractic services over the five year recovery period.

Non-concur. A preliminary cost benefit analysis reflects the return on investment unlikely. As indicated in Table 2 of the audit report, the estimated total claims paid from January 1, 2011 through December 31, 2013 are 511,945. It is estimated that a clinician will be able to review 3.5 aged claims per hour. The total number of clinician hours needed to review 511,945 claims is 146,270 hours ($511,945/3.5 = 146,270$ hours). Using a clinician's hourly salary rate of \$50.00 (rate includes benefits); the cost to review 511,945 claims would be estimated at \$7.3 million. The estimate only includes direct labor costs for clinicians. It does not include the ripple effect and workloads listed below:

- Indirect costs,
- Quality assurance hours ,
- Claims processing activities (i.e., restoring of claims history from purged files, adjudicating claims, etc.),
- Document control activities (i.e., indexing, document control, etc.),
- Provider and beneficiary inquiries (written and phone),
- Appeal requests,
- Congressional complaints,
- Overpayments and/or financial activities,
- Increased suspense volume due to potential beneficiary or provider eligibility changes,

- Benefit Integrity activities,
- Postage and supply costs, and
- Undeliverable mail volumes.

In addition, the estimated \$7.3 million only include costs for three years and not five years as requested in the recommendation. A claim count for 2009 and 2010 was not provided in the audit report; therefore, costs could not be calculated. To expend over \$7.3 million to *potentially* recover *estimated* improper payments is not cost effective and negatively impacts the Medicare Trust Fund.

Recommendation 10: We recommend that the RRB ensure that Palmetto recover the improper chiropractic service payments for the five year period where determined to be cost effective based on accurate cost benefit analysis; and

Non-concur. Please refer to response Number 9.

Recommendation 11: We recommend that the RRB ensure that Palmetto share information identified during the post-payment reviews as appropriate with the Recovery Audit Contractors and Zone Program Integrity Contractors where it can be used to identify improper or fraudulent non-Railroad Medicare chiropractic service payments.

Concur. The current Statement of Work requires that the SMAC participate in information sharing sessions, meetings and conferences as part of these coordination activities. The SMAC also works with the other Medicare Administrative Contractors and ZPICs to share ideas and coordinate program integrity efforts as necessary. We are currently working with CMS to establish a joint operating agreement to establish a more formal system of communication and information sharing.

The RRB will discuss with CMS the feasibility of having CMS share the results of Palmetto's post payment chiropractic reviews to the RACs as CMS deems appropriate.

We anticipate a completion date of June 30, 2015.

cc: Keith B. Earley, Director of Administration
Micheal Pawlak, Director of Unemployment and Programs Support Division
Yolanda Rocha, Medicare Contracting Officer's Representative

CHIROPRACTIC SERVICES AUDIT UNIVERSE AND MEDICAL REVIEW COVERAGE

This appendix highlights data statistics and anomalies observed during our analysis of Palmetto's chiropractic service claims universe for QRRBs.

RRB Medicare Chiropractic Services Paid From 2011 Through 2013

The providers in our audit universe performed an average of 35 chiropractic services over a three year period. However, we identified one provider who conducted 1,891 services. This is more than 50 times greater than the universe average. Similarly, the 189 chiropractic services received by a single QRRB were more than 13 times greater than the universe average of 14 services. A total of 4,277 (29 percent) paid services to a chiropractor and a total of 11,886 (34 percent) chiropractic services received by QRRBs exceeded the QRRB averages, as detailed in tables 5 and 6.

The top 15 chiropractic providers represent less than one percent of the RRB chiropractic provider population. However, the number of chiropractic services performed exceeds 18 times the average. Palmetto's effective denial rate for the top 15 QRRBs subject to random pre-payment medical review was 67 percent. However, as shown in Table 5, only three of these QRRBs were subject to post-payment medical reviews. The three post-payment reviews identified an average error rate of 79 percent.

Table 5: Top 15 High Volume Railroad Medicare Chiropractic Providers

	Services Performed by Chiropractor	Number of Services Reviewed by Palmetto During Post-payment	Palmetto's Medical Review Denial Rate
1	1891	<i>Not Reviewed</i>	<i>Not Determined</i>
2	1424	<i>Not Reviewed</i>	<i>Not Determined</i>
3	1294	80	100%
4	1075	<i>Not Reviewed</i>	<i>Not Determined</i>
5	959	40	100%
6	958	47	36%
7	830	<i>Not Reviewed</i>	<i>Not Determined</i>
8	768	<i>Not Reviewed</i>	<i>Not Determined</i>
9	748	<i>Not Reviewed</i>	<i>Not Determined</i>
10	727	<i>Not Reviewed</i>	<i>Not Determined</i>
11	704	<i>Not Reviewed</i>	<i>Not Determined</i>
12	676	<i>Not Reviewed</i>	<i>Not Determined</i>
13	660	<i>Not Reviewed</i>	<i>Not Determined</i>
14	655	<i>Not Reviewed</i>	<i>Not Determined</i>
15	643	<i>Not Reviewed</i>	<i>Not Determined</i>
Totals	14012	167	

The 18 QRRBs that received the most chiropractic services represent less than one percent of the RRB population. However, the number of chiropractic services received exceeds eight times the average, which is 14 services. Palmetto’s effective denial rate for the top 18 QRRBs subject to random pre-payment medical review was 73 percent. However, as shown in Table 6, only one of these QRRBs was subject to a post-payment medical review. The single post-payment medical review identified an error rate of 100 percent.

Table 6: Top 18 Beneficiaries to Receive Railroad Medicare Chiropractic Services

	Chiropractic Services Received by QRRB	Number of Services Reviewed by Palmetto During Post-payment	Palmetto’s Medical Review Denial Rate
1	189	<i>Not Reviewed</i>	<i>Not Determined</i>
2	174	<i>Not Reviewed</i>	<i>Not Determined</i>
3	164	<i>Not Reviewed</i>	<i>Not Determined</i>
4	158	<i>Not Reviewed</i>	<i>Not Determined</i>
5	147	<i>Not Reviewed</i>	<i>Not Determined</i>
6	147	<i>Not Reviewed</i>	<i>Not Determined</i>
7	145	<i>Not Reviewed</i>	<i>Not Determined</i>
8	144	<i>Not Reviewed</i>	<i>Not Determined</i>
9	144	<i>Not Reviewed</i>	<i>Not Determined</i>
10	138	<i>Not Reviewed</i>	<i>Not Determined</i>
11	132	<i>Not Reviewed</i>	<i>Not Determined</i>
12	131	<i>Not Reviewed</i>	<i>Not Determined</i>
13	130	<i>Not Reviewed</i>	<i>Not Determined</i>
14	130	17	100%
15	127	<i>Not Reviewed</i>	<i>Not Determined</i>
16	123	<i>Not Reviewed</i>	<i>Not Determined</i>
17	122	<i>Not Reviewed</i>	<i>Not Determined</i>
18	122	<i>Not Reviewed</i>	<i>Not Determined</i>
Totals	2567	17	