ANALYSIS OF SECTION 514 - OVERSIGHT OF MEDICARE COVERAGE OF MANUAL MANIPULATION OF THE SPINE TO CORRECT SUBLUXATION OF THE SGR REPEAL ACT

By
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This report is a thorough analysis of Section 514 of the SGR Repeal Act. This section specifically relates to chiropractic and has been the cause of many rumors. I will take this section item by item and explain exactly what is happening and what this means to you. At the end of this analysis, I will give you my opinion and some action steps that you can take now to be ready.

Quote from the Act:
"(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:
''(z) MEDICAL REVIEW OF SPINAL SUBLUXATION SERVICES.—
''(1) IN GENERAL.—The Secretary shall implement a process for the medical review (as described in paragraph (2)) of treatment by a chiropractor described in section 1861(r)(5) by means of manual manipulation of the spine to correct a subluxation (as described in such section) of an individual who is enrolled under this part and apply such process to such services furnished on or after January 1, 2017, focusing on services such as—
''(A) services furnished by a such a chiropractor whose pattern of billing is aberrant compared to peers; and
''(B) services furnished by such a chiropractor who, in a prior period, has a services denial percentage in the 85th percentile or greater, taking into consideration the extent that service denials are overturned on appeal."

Analysis:
The reviews discussed in the next section apply to those doctors who (1) have a pattern of billing that is aberrant compared to their peers or (2) have an 85% error rate for claims in a prior period.

The wording of "have a pattern of billing that is aberrant compared to their peers" may relate to the Comparative billing reports that were issued in previous years. These reports did identify those doctors that had more visits per Medicare patient than the state or national averages or had more Medicare patients per year than the national or state averages. There are several legitimate reasons for these statistics or they could represent a pattern of billing that is aberrant compared to your peers.

The 85% error rate is simple, if you only have 15 or fewer Medicare claims paid out of every 100 submitted, you fall into this group. If you appeal these denials (as you should) and get them overturned to the point that you the denial rate falls below 85%, you will not be included in this group. The term "prior period' has yet to be defined.

All of this will start on or after January 1, 2017.

Quote from the Act:
''(2) MEDICAL REVIEW.—
''(A) PRIOR AUTHORIZATION MEDICAL REVIEW.—''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall use prior authorization medical review for services described in paragraph (1) that are furnished to an individual by a chiropractor described in section 1861(r)(5) that are part of an episode of treatment that includes more than 12 services. For purposes of the preceding sentence, an episode of treatment shall be determined by the underlying cause that justifies the need for services, such as a diagnosis code.

‘‘(ii) ENDING APPLICATION OF PRIOR AUTHORIZATION MEDICAL REVIEW.—The Secretary shall end the application of prior authorization medical review under clause (i) to services described in paragraph (1) by such a chiropractor if the Secretary determines that the chiropractor has a low denial rate under such prior authorization medical review. The Secretary may subsequently reapply prior authorization medical review to such chiropractor if the Secretary determines it to be appropriate and the chiropractor has, in the time period subsequent to the determination by the Secretary of a low denial rate with respect to the chiropractor, furnished such services described in paragraph (1).
‘‘(iii) EARLY REQUEST FOR PRIOR AUTHORIZATION REVIEW PERMITTED.—Nothing in this subsection shall be construed to prevent such a chiropractor from requesting prior authorization for services described in paragraph (1) that are to be furnished to an individual before the chiropractor furnishes the twelfth such service to such individual for an episode of treatment.
‘‘(B) TYPE OF REVIEW.—The Secretary may use prepayment review or post-payment review of services described in section 1861(r)(5) that are not subject to prior authorization medical review under subparagraph (A).
‘‘(C) RELATIONSHIP TO LAW ENFORCEMENT ACTIVITIES.— The Secretary may determine that medical review under this subsection does not apply in the case where potential fraud may be involved.

Analysis:
If you are one of the doctors identified in the first section (more than an 85% error rate or a pattern of billing that is aberrant compared to their peers) then you will need to get prior authorization for more than 12 visits in an episode of care. The episode of treatment will be determined by “the underlying cause that justifies the need for services, such as a diagnosis code.” This could also include functional assessments, ortho-neuro exams, and history.

If you are placed on prior authorization, you can get removed by demonstrating a low denial rate. If you are removed from prior authorization that does not mean that you can go back to your old ways. If you demonstrate more than an 85% error rate or a pattern of billing that is aberrant compared to your peers, you can be placed back on prior authorization again.

If you know that the episode of care will last more than 12 visits, you can request the prior authorization of more visits before you reach the 12th visit.

Just because you are not subject to prior authorization review does not mean that you will not be reviewed. Medicare can still use both pre-payment and post-payment reviews as they deem necessary. Should they feel that potential fraud is involved, they can skip all forms of review and refer the case directly to law enforcement agencies.

Quote from the Act:
‘‘(3) NO PAYMENT WITHOUT PRIOR AUTHORIZATION.—With respect to a service described in paragraph (1) for which prior authorization medical review under this subsection applies, the following shall apply:
‘‘(A) PRIOR AUTHORIZATION DETERMINATION.—The Secretary shall make a determination, prior to the service being furnished, of whether the service would or would not meet the applicable requirements of section 1862(a)(1)(A).
‘‘(B) DENIAL OF PAYMENT.—Subject to paragraph (5), no payment may be made under this part for the service unless the Secretary determines pursuant to subparagraph (A) that the service would meet the applicable requirements of such section 1862(a)(1)(A).

Analysis:
If you are subject to a prior authorization review and you do not get prior authorization for care when the episode exceeds 12 visits, you will not be paid even if the service would qualify as medically necessary otherwise

Quote from the Act:
''(4) SUBMISSION OF INFORMATION.—A chiropractor described in section 1861(r)(5) may submit the information necessary for medical review by fax, by mail, or by electronic means. The Secretary shall make available the electronic means described in the preceding sentence as soon as practicable.
''(5) TIMELINESS.—If the Secretary does not make a prior authorization determination under paragraph (3)(A) within 14 business days of the date of the receipt of medical documentation needed to make such determination, paragraph (3)(B) shall not apply.
''(6) APPLICATION OF LIMITATION ON BENEFICIARY LIABILITY.—Where payment may not be made as a result of the application of paragraph (2)(B), section 1879 shall apply in the same manner as such section applies to a denial that is made by reason of section 1862(a)(1).

Analysis:
If you are under prior authorization review, you will be able to submit the necessary information by mail, fax or electronically. Medicare will develop a process to submit the information by internet as soon as possible. This will allow for easier submission of a request.

Once Medicare receives the request for prior authorization review, they have 14 business days to make a determination or they cannot deny payment. Medicare cannot "hold you hostage" to a decision for an indefinite period of time.

The Advanced Beneficiary Notice of Noncoverage applies in this situation. If you have reason to believe that Medicare will not authorize further care, you may issue an ABN to the patient and be able to collect for the care should it not be authorized by Medicare.

Quote from the Act:
''(7) REVIEW BY CONTRACTORS.—The medical review described in paragraph (2) may be conducted by Medicare administrative contractors pursuant to section 1874A(a)(4)(G) or by any other contractor determined appropriate by the Secretary that is not a recovery audit contractor.
''(8) MULTIPLE SERVICES.—The Secretary shall, where practicable, apply the medical review under this subsection in a manner so as to allow an individual described in paragraph (1) to obtain, at a single time rather than on a service-by-service basis, an authorization in accordance with paragraph (3)(A) for multiple services.
''(9) CONSTRUCTION.—With respect to a service described in paragraph (1) that has been affirmed by medical review under this subsection, nothing in this subsection shall be construed to preclude the subsequent denial of a claim for such service that does not meet other applicable requirements under this Act.
''(10) IMPLEMENTATION.—
''(A) AUTHORITY.—The Secretary may implement the provisions of this subsection by interim final rule with comment period.
''(B) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to medical review under this subsection.''.

Analysis:
The prior authorization review can be conducted by the Medicare administrative contractor or any designated subcontractor except for a recovery audit contractor. This is very good since recovery audit contractors are paid on commission and would have a financial incentive to deny authorization.

You will be able to request authorization for multiple services instead of on a service-by-service basis. This will allow you to be more efficient in your requests and be less intrusive on the episode of care.

If you get the service authorized as a result of the prior authorization review it can still be denied if you do not document or bill the care correctly. Prior authorization does not relieve you of your responsibility to comply with all of the other applicable laws, rules, and regulations of Medicare.

This law will be implemented by regulation that will have a comment period attached to them. This will give us an opportunity to have input in the final rules. USC 44, Chapter 35 relates to coordination of information and is a technical provision in this law.

Quote from the Act:
(b) IMPROVING DOCUMENTATION OF SERVICES.—
(1) IN GENERAL.—The Secretary of Health and Human Services shall, in consultation with stakeholders (including the American Chiropractic Association) and representatives of Medicare administrative contractors (as defined in section 1874A(a)(3)(A) of the Social Security Act (42 U.S.C. 1395kk–1(a)(3)(A))), develop educational and training programs to improve the ability of chiropractors to provide documentation to the Secretary of services described in section 1861(r)(5) in a manner that demonstrates that such services are, in accordance with section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
(2) TIMING.—The Secretary shall make the educational and training programs described in paragraph (1) publicly available not later than January 1, 2016.
(3) FUNDING.—The Secretary shall use funds made available under paragraph (10) of section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)), as added by section 505, to carry out this subsection.

Analysis:
Medicare is directed to bring together the Medicare administrative contractors with representatives from chiropractic (including the American Chiropractic Association) to develop educational and training programs to teach us to document medically necessary care better. This program is to be in place by January 1, 2016. This program is to be paid for by a portion of the funds recovered by Recovery Audit Contractors.

Quote from the Act:
(c) GAO STUDY AND REPORT.—
(1) STUDY.—The Comptroller General of the United States shall conduct a study on the effectiveness of the process for medical review of services furnished as part of a treatment by means of manual manipulation of the spine to correct a subluxation implemented under subsection (z) of section 1833 of the Social Security Act (42 U.S.C. 1395l), as added by subsection (a). Such study shall include an analysis of—
(A) aggregate data on—
(i) the number of individuals, chiropractors, and claims for services subject to such review; and
(ii) the number of reviews conducted under such section; and
(B) the outcomes of such reviews.
(2) REPORT.—Not later than four years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1), including recommendations for such legislation and administrative action with respect to the process for medical review implemented under subsection (z) of section 1833 of the Social Security Act (42 U.S.C. 1395l) as the Comptroller General determines appropriate.

Analysis:
The General Accounting Office is directed to conduct a study of the reviews conducted on chiropractic claims and the results of those reviews. This report is to be submitted to Congress four years after the enactment of this law.

Overall Analysis:
First, the American Chiropractic Association is to be applauded for their work in developing this legislation and getting it enacted. Of course, there are yet to be rules and regulations developed before we can see the full effect of this legislation, but it has a great deal of promise. If done properly, we as a profession can benefit greatly. However, if a single group (such as the ACA) takes it upon themselves to try and dominate this process, we could be stuck with errors that could take years to correct.

Something this important to the profession needs to have a consensus of the best and the brightest (and by that I mean those that are trained and certified in related areas such as compliance and/or coding) to formulate the best program available. The ACA could take the lead on this but, unfortunately they do not have anyone on their Medicare committee that is trained and certified in compliance or coding. But they can pull together those that are, and I encourage them to do so. If you are an ACA member and agree with me, call them and tell them. If you are an ACA member and disagree with me, call them and tell them that. They need to hear from you, the member about how you feel on important issues like this. If you are not an ACA member, I encourage you to become one.

As I stated before, there are still rules and regulations to be written. These usually include a comment period so I will keep you informed as to what is happening. If you are not a subscriber to me list, then please follow this link to become one.

Action Steps:

- Get your Medicare documentation and procedures in order NOW. The best way to do this is to use my Medicare Documentation System available through the ChiroCode store.
- If you are a member of the ACA, call them and let them know your opinion about how this should be handled.
- If you are not a member of the ACA – join today. Then call and give them you opinion.

NOTE: Hit control then click on the links to follow them.