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Trump's HHS Targets Chiropractors in Fight Against Medicare Fraud

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- Trump administration likely to require prior authorization for chiropractors
- Medicare agency plans to test prior authorization in more services

The Trump administration is broadening its battle against Medicare fraud by requiring chiropractors with high rates of claim denials to get the agency's OK before providing services to patients.

The Centers for Medicare & Medicaid Services is likely to release a proposed rule this fall that would require prior authorization for the 15 percent of chiropractors who had the worst rate of claims denials, according to a semiannual list of rules that federal agencies are pursuing.

This is the first time the agency will require prior authorization for health-care professionals in traditional fee-for-service Medicare, a CMS spokesperson told Bloomberg Law. The CMS, part of the Department of Health and Human Services, has required prior authorization or pre-claim review for certain drugs, medical equipment, and home health services in recent years.

Prior authorization requires health-care professionals and other providers to submit a request for coverage of a service before providing that service. It differs from pre-claim review, in which providers submit the request for coverage after initial assessment and intake procedures are completed, but prior to the final claim being submitted.

The Medicare agency's actions in prior authorization have been targeted so far at tracking fraud, Erica Breese, a director in the provider practice at the Washington-based consulting firm Avalere Health, told Bloomberg Law.

Other health-care professionals and providers could be in line for additional scrutiny, a CMS spokesperson told Bloomberg Law. They range from non-emergency ambulance services to rehabilitation services to durable medical equipment, prosthetics/orthotics and supplies.

Fear of Fraud as Health Costs Soar

The efforts to combat Medicare fraud come as health-care spending continues to balloon. Health-care spending will take up 19.7 percent of the U.S. economy by 2026, up from 5 percent in 1960, according to the CMS.

Meanwhile, an estimated 30 percent of health-care spending is a "waste" due to fraud, abuse and other losses—a total of $765 billion—according to a 2012 estimate from the National Academy of Medicine, a quasi-governmental organization that advises federal and international health-care agencies.

Combating fraud is one of the top goals of the HHS Office of Inspector General (OIG).

A representative of the top group representing chiropractors said his organization recognized that additional scrutiny was inevitable, and that it is willing to work with CMS to make sure chiropractors can live with the solution.

This regulation is a "sensible approach to help chiropractors document better while at the same time ensuring patient access," John Falardeau, senior vice president of public policy and advocacy at the American Chiropractic Association, told Bloomberg Law.

Chiropractors had an improper payment rate of 41.7 percent in 2017, according to the HHS, the highest rate of any specialty in Medicare Part B. Medicare Part B covers outpatient services, including laboratory services, durable medical equipment, and flu shots.

Meanwhile, investigations of alleged chiropractic fraud by the HHS OIG since 2005 have resulted in approximately $7.6 million in restitution and settlements and the incarceration of 11 chiropractors.

In one 2018 case, a chiropractor in Tennessee agreed to pay $1.45 million to settle charges he billed Medicare for services that either were unnecessary or not eligible for reimbursement.

Who's Next?

If the CMS continues to expand prior authorization, it is going to look at specialties that have higher rates of claims denials, Breese said.

The agency is going to "look for something relatively narrow to really prevent any signs that they're trying to delay care," she said.

The agency plans to start a pre-claim review demonstration for home health at the end of this year, a CMS spokesperson said. The CMS plans to begin in Illinois in December 2018 and later extend it to Ohio, North Carolina, Florida, and Texas. The agency previously had a pre-claim demonstration for home health that ended in April 2017.

The CMS is determining whether to expand a current prior authorization model for non-emergency ambulance services to all states, a spokesperson said. The agency is also looking into potentially using prior authorization for some providers who order advanced imaging services, a spokesperson said.

President Donald Trump's 2019 budget request included a proposal to expand prior authorization for durable medical equipment, prosthetics/orthotics and supplies, which the CMS is considering, a spokesperson said.

The CMS could also turn its attention next to inpatient rehabilitation services for prior authorization. Physician medicine and rehabilitation was one of the specialties with the next highest improper payment rates, according to the HHS.

The HHS Inspector General recommended the CMS consider pre-authorization for IRF claims in an October report that found $5.7 billion in unnecessary payments to inpatient rehabilitation facilities.

Problems With Implementation

The home health demonstration had a messy rollout, Breese said, so a rollout of the prior authorization program for chiropractors could also have problems. The agency wasn't clear on what documentation was needed in the home health demonstration, she said.

The success of this program will depend on whether the agency's expectations are understood, Breese said. It also will depend on if the timeline of the rollout is appropriate and if the CMS can handle making authorizations for services in a timely manner.

Prior authorization can give people greater confidence that their services will be covered by Medicare, Kathleen Holt, associate director of the Center for Medicare Advocacy, told Bloomberg Law. It just needs a specified review time frame and parameters around emergencies, she added.

Prior authorization for chiropractors wouldn't kick in until after the twelfth visit, as stipulated in the Medicare Access and CHIP Reauthorization Act of 2015, Falardeau said. Chiropractors would have the option to seek prior authorization earlier.

The CMS was directed to work with the American Chiropractic Association in developing this prior authorization protocol under MACRA, but Falardeau said the organization has had little interaction with the agency on the upcoming proposed rule.

Falardeau said his organization has had a few phone calls with the CMS, but only to discuss where the agency was in the process. The last call was sometime in the spring, he added.

To contact the reporter on this story: Shira Stein in Washington at sstein@bloomberglaw.com

To contact the editor responsible for this story: Fawn Johnson at fjohnson@bloomberglaw.com