Arkansas Health Care Reform Task Force

Analysis of Behavioral Health for Multiple Claims on a Day—Three Programs
TSG Update Report
February 17 2016

The Question

The Stephen Group was asked to investigate additional questions concerning Behavioral Health claims:

1. Are multiple programs (RSPMI, CHMS, DDTCS*) billed in the same day and/or on the same child routinely?
2. Consider the effect of modifiers. For example 97530 is for Occupational Therapy services. Add U1 modifier it becomes Day Treatment. Change that to U2 it becomes DD. What is the effect of including modifiers in our analysis

Rehabilitative Services for Persons with Mental Illness (RSPMI), Child Health Management Services (CHMS), Developmental Day Treatment Clinic Services (DDTCS)

Executive Summary

- TSG found evidence that providers are infrequently claiming across three programs, $17MM of $554MM. This represents only 3% of claims
- For about 1,000 recipients, the multiple claims on a day across programs are large – as much as $50,000 in a year
- Five vendors account for 78%. (One vendor is 22%)
- Claim patterns show a complex set of situations—understanding these will require pattern analysis and reviewing patient records
- Modifiers are very complex, but do not change the findings

Providers *are* claiming across programs in a few cases—the Agency should develop analyses leading to policy to prevent this from becoming a bigger problem

Question 1: Effect of Multiple Claims on the Same Day, Across Programs

To set up the analysis, TSG did the following:

- Reviewed claim codes (and modifiers) in the three programs. We found that there is much overlap in codes—some codes have a different meaning by Program
- Considered the effect of modifiers for the different programs and codes
- Reviewed the time and rate per unit across codes, programs and modifiers
- Developed a method of using the claim record to identify which program the service is provided under
- Defined the scope of consideration as only those codes (with modifiers that are associated with minutes per claim

Claim Codes and Modifiers

- We found 39 Behavioral Health codes shared across the 3 programs
- 20 Codes are used in only one program, 19 in 2 programs and none in all 3 programs
- When combined with modifiers and different use across programs, this represents 111 different types of service. At the extreme, H2011, 97150 and 90887 have 8 different modifiers
- Most codes are for services that do not vary in duration or rate across the modifiers (List available)

TSG Looked at Claims on a Daily Basis

- 105,957 unique recipients made claims to one or more programs
- Claims were made on 4.3 million person/days
- Unique claims:
  - RSPMI: 4.0 million claims totaling $292MM
  - CHMS: 1.4 million claims totaling $104MM
  - DDTCS: 1.2 million claims totaling $158MM
  - Total: 6.6 million claims totaling $554MM

Findings: Multiday Claims Across Program

- 178,000 times providers made multiple claims on a day involving two or more programs
- Of the 38MM* possible days on which there could be multiple claims across programs, we found only 89,000 days on which providers made multiple claims for a recipient. That is 0.2% of possible (38MM) claim days
- Of 105,000 recipients with time-based claims, 3,431 had multiple claims across programs...3.2%
- Of the $554MM in claims for codes with minutes, $17MM are for multiple claims across programs...3.1%

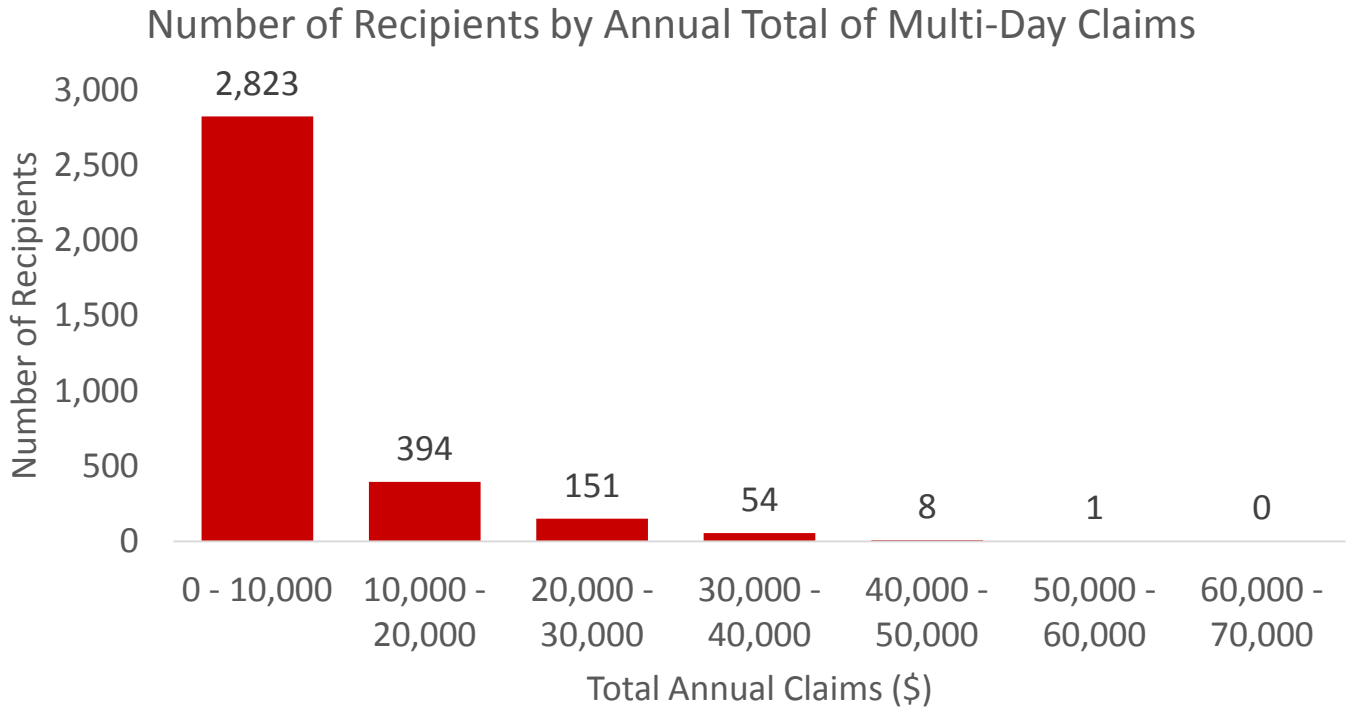
* 105K recipients * 365 days in the year

Multiple Claims *within* a Program is Far More Prevalent than *across* Programs

- When there is an RSPMI claim, 75% of the time there is more than one claim For RSPMI on that day. For CHMS 55% and for DDTCS 76% of the time
- When there are claims for more than one program on a day:
  - 55% of the time they include RSPMI & CHMS
  - 29% RSPMI & DDTCS
  - 18% CHMS & DDTCS
  - 2% of claims involve all three programs

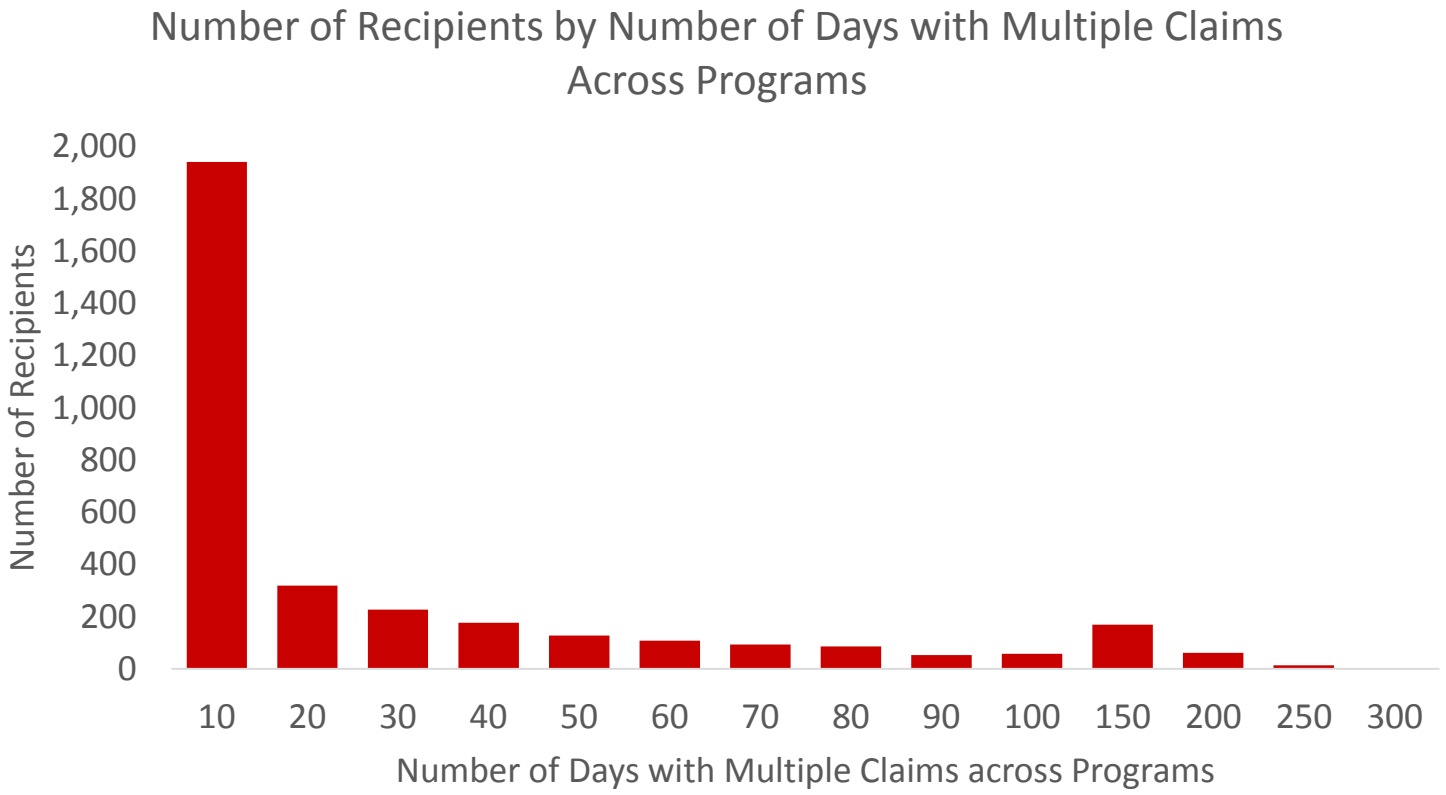
When there are Multiple Claims, the Numbers are Large

- 608 recipients had multiple day claims across programs that totaled over $10,000 in the year: 63 of those totaled over $30,000



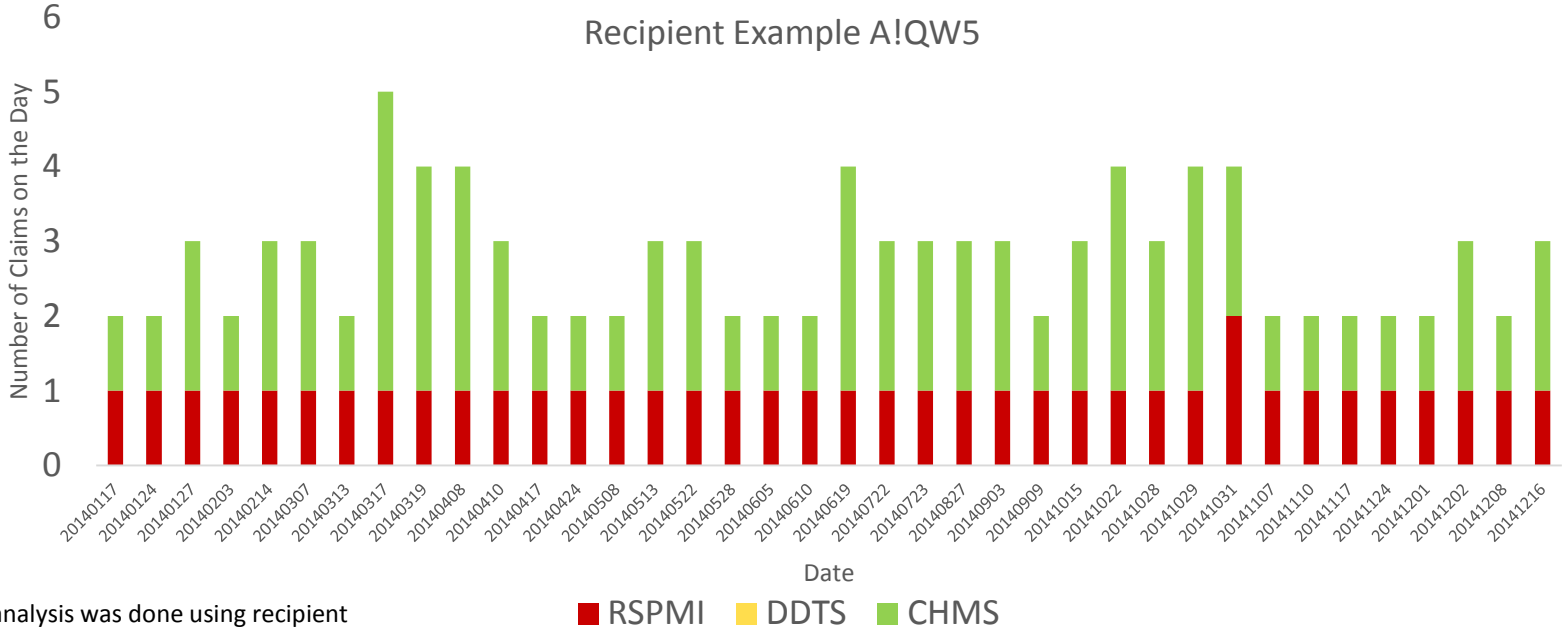
When there are Multiple Claims, the Numbers are Large

- 244 recipients had more than 100 days of multiple claims



Multiple Claims Occur in Complex Patterns – Example 1

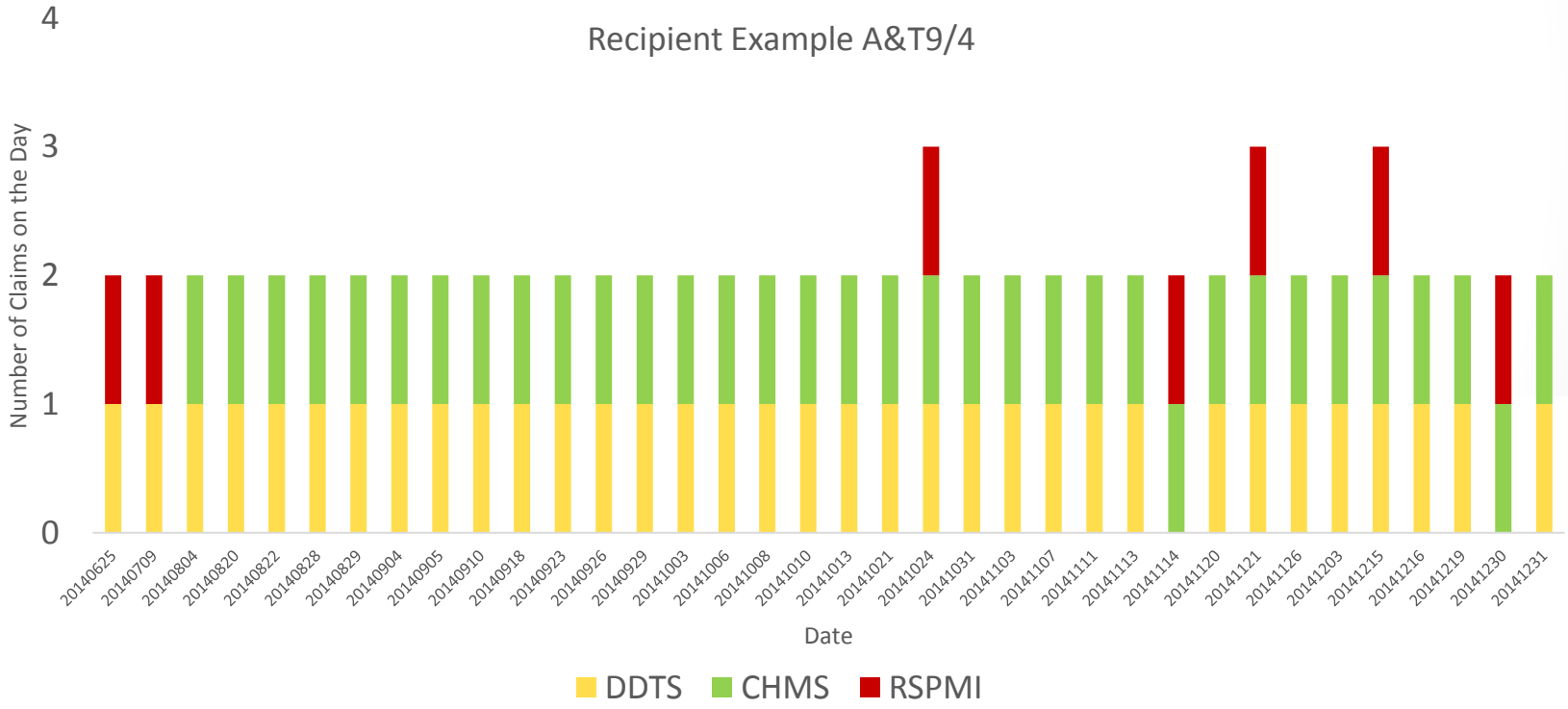
- Actual recipient. Name is encrypted* for confidentiality
- Constant levels of RSPMI with variations in CHMS (no DDTCS)
- Note that recipient *only* receives CHMS services on the same days as RSPMI. Why two RSPMI claims on just that one day—is that a claiming error?



* TSG analysis was done using recipient names encrypted with 256K encryption. Encrypted "name" is truncated for presentation in this report

Example 4: Variation in Services

- Consistent use of DDTCS and CHMS, with occasional RSPMI
- This is one of only 2% of recipients with multiple claims against all three programs on any one day



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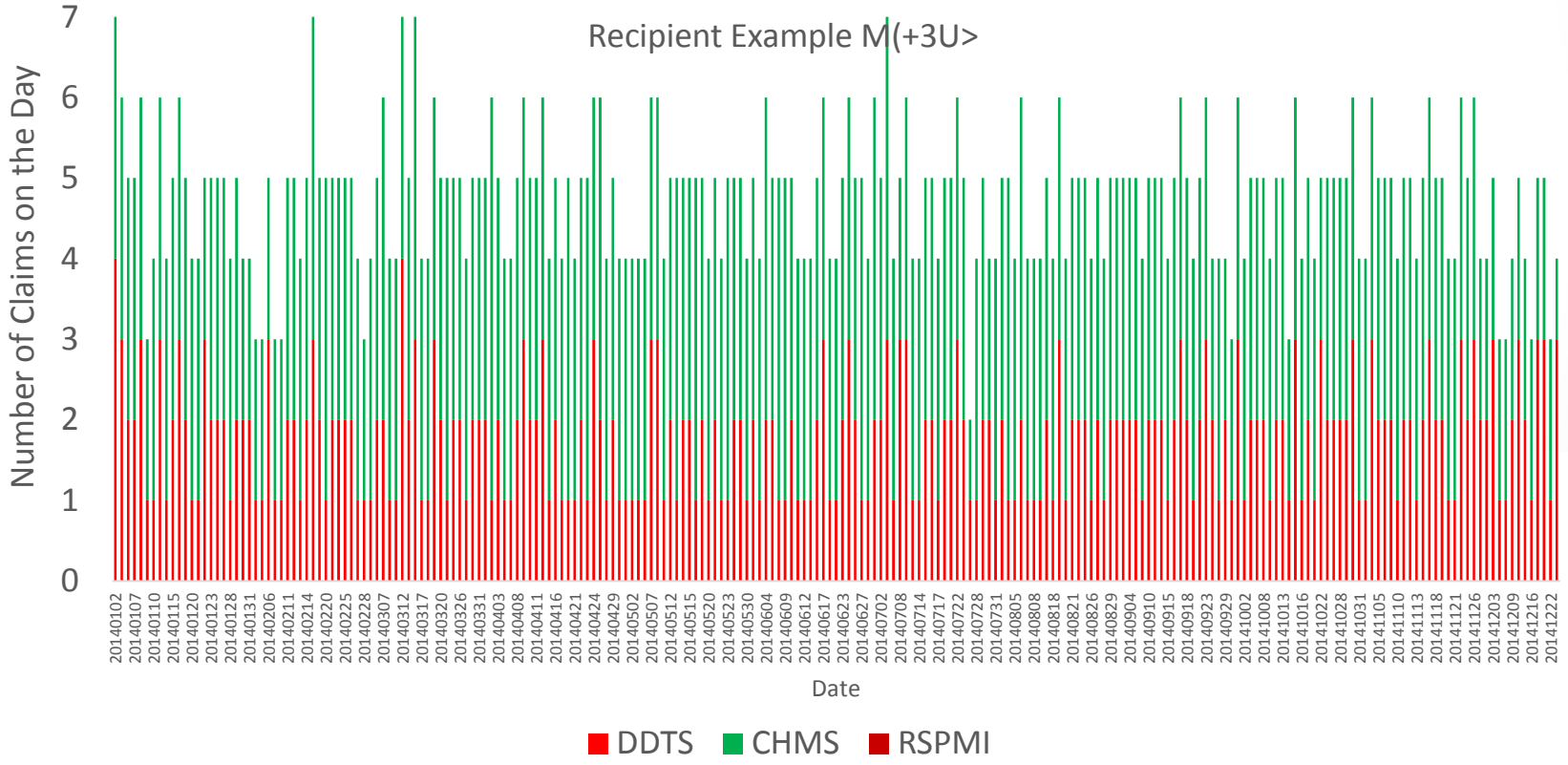
Example 5: Variation in Services

- Frequent flier--326 days of multiple claims; total multiple claims of $43,853 for the year; between 3 & 7 claims per day
  Always claims CHMS and DDTCS together, never claims RSPMI



Thus, TSG Found a Complex Picture of Multiple Claims

- Claims data does not tell us whether the recipient had a medical need that justified the unexpected claim pattern
- Understanding the underlying situation will require:
  - Looking at patterns in claims data (as TSG started with the 5 examples shown here)
  - Investigating the actual patient files
- The case for further investigation goes beyond the $17MM being claimed this way today. *If* providers have found a way to circumvent program limits, they might expand their use of the approach

78% of Multiple Claims Across the Three Programs were Paid to 5 Vendors

	Paid Claim Amount	
Provider A	$7,032,578	41%
Provider B	2,633,867	15%
Provider C	1,657,352	10%
Provider D	1,125,287	6%
Provider E	1,076,741	6%
Other	3,827,328	22%
Total	$17,353,153	100%

Question 1: Findings

- In total, multiple claims across the three program in one day represents 3% of total claims, $17MM out of $554MM
- 3,431 recipients had multiple claims across the three programs on a day
  - No apparent systemic pattern
  - Fewer than 1,000 with very high claims for the year
- 5 providers account for 78% of multiple claims across the programs
- Determining whether there is actual abuse will require looking at hundreds of services patterns, and into patient medical files

Providers are potentially charging through two programs to avoid limits—in a small number of cases. Without clear policy and meaningful controls, this is *could become* a substantial cost issue

Question 2: How Do Modifiers Affect the Findings?

- Codes and Modifiers are used for different purposes in the different programs. This is a practice bound to cause confusion and errors, and should be eliminated
- TSG found several instances of modifiers that consequentially change the meaning of a code. This is a practice bound to cause confusion and errors, and should be eliminated
- Codes and modifiers are not created in a logical, consistent manner. This is a practice bound to cause confusion and errors, and should be eliminated

To the Specific Example in the Question is 97150

Program	Code	Modifiers	Description from Agency
CHMS	97150		Group Physical Therapy by Physical Therapist, max 4 per group
CHMS	97150	UB	Group Physical Therapy by Physical Therapist Assistant, max 4 per group
CHMS	97150	U2	Group Occupational Therapy by Occupational Therapist, max 4 per group
CHMS	97150	UB, U1	Group Occupational Therapy by Occupational Therapist, max 4 per group
CHMS	97150	U1	???????????
DDTCS	97150	UB, U1	Group Occupational Therapy by OT assistant, 4 client max per group
DDTCS	97150	U2	Group Occupational Therapy by Occupational therapist, 4 client max per group

Modifiers change the code from PT to OT
This can only lead to errors and confusion

TSG Review Found Two Other Examples of Major Change in Meaning

Program	Code	Modifiers	Description from Agency
DDTCS	T1015	U1	Pre-School Services
DDTCS	T1015	U4	Early Intervention Services,
DDTCS	T1015		Adult Development Services
RSPMI	H2015	HA, U1	Adult Day Rehabilitative Day Service
RSPMI	H2015	U2	Medication Administration by a Licensed Nurse
RSPMI	H2015	HA, U1	Adult Day Rehabilitative Day Service
RSPMI	H2015	U2	Medication Administration by a Licensed Nurse

Claim codes should be recreated using a logical construction:
- Easier for the provider/coder to understand
- Useful for analytics
- Extensible as the program changes

Given the Focus of the TSG Analysis, Modifiers do not Affect the Findings

- The most consequential is T1015, which is both a very significant total dollar value, and has three different meanings, depending on the modifier: Preschool, Early Intervention and Adult Development
- However,
  - If the recipient is a child, the difference between “early intervention” and “preschool” is not significant to the TSG analysis. If a recipient could receive both, then they are sufficiently similar in the nature of service that they should be considered to be multiple claims
  - A recipient should never have a claim for adult and pre-school services. But, finding this is not the intent of the current analysis

Question 2: Finding

- The lack of built-in logic to the codes and modifiers does not impact the analysis of multiple day claims
- Unfortunately, the BH codes are not designed with inherent logic:
  - Even the agency struggles to understand the meaning of combinations of program, code and modifier
  - The Manual includes a description of codes and modifiers, but these descriptions cannot really distinguish them
- This might be in part because the Agency has created codes outside the normal ICD code structure
- When the Agency moves to ICD-10-CM, care should be taken not to create codes/modifiers that are not part of the nationally-accepting coding schema

Summary Findings

- TSG found evidence that providers are infrequently claiming across three programs, $17MM of $554MM. This represents only 3% of claims
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Recommendations

- BH services claimed on the basis of service time is a $455MM business. The Agency needs better visibility and policy to avoid further abuse
- Agency should have personal assigned to review claims for questions such as these. The Agency currently lacks personnel, tools and methods to investigate this question
- Specifically, the Agency should:
  - Regularly review all BH claims data for unusual patterns. Modern pattern recognition software could enable this on a systematic basis
  - Review recipient case files on a sampling basis to assure that services patterns are supported by outcomes as described in Master Treatment Plans
  - Develop policy that sets appropriate limits on BH claims across the 3 programs