

MEDICARE COMPLIANCE

Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

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Provider Runs Obstacle Course in Audit, Appeal; MAC Threatens Referral to IRS

Providers sometimes feel like they play by different rules than Medicare auditors. While providers experience claim denials if they miss deadlines for submitting documentation or filing appeals, auditors and administrative tribunals face few consequences if they blow through their deadlines for ruling on appeals or fail to explain the reasons for claim denials. That seems to be the cost of doing business with Medicare, with the upside that it's the most solvent payer on earth, as one lawyer notes.

Still, the frustration with the disparate ways that some providers and auditors approach medical reviews and appeals is mounting. "This has been a huge concern for our clients, and there seems to be a growing problem in our area," says Richelle Beckman, an attorney with the Forbes Law Group in Overland Park, Kan.

Case in point: one medical group has been waiting six months to hear the fate of its appeal of claim denials worth hundreds of thousands of dollars, Beckman says. The claim denials stem from multiple audits and the medical group has yet to get word from the first level of appeal. Medicare administrative contractors (MACs) are required to rule on appeals in 60 days, but they often miss the deadline, lawyers and providers say. Lateness is one thing, but the MAC lost "extensive records submitted for the appeal," she says. While the appeals drag on, the MAC continues to pile on the interest and penalties and then, acting on the belief the physicians never appealed at all,

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Some Short Stays May Make a Comeback; CMS Spells Out MAC Reviews Under IPPS

In new guidance, CMS raises the possibility it will cover "categories" of hospital admissions that don't cross two midnights in addition to the procedures on the inpatient-only list. The agency also delayed recovery audit contractor (RAC) audits of admission medical necessity for three more months and gave its plan for prepayment audits by Medicare administrative contractors (MACs) through March 31, 2014.

On Nov. 4, CMS posted answers to frequently asked questions that repeatedly address zero- and one-day stays, which will be the focus of auditors under the two-midnight standard in the 2014 inpatient prospective payment system regulation (*RMC 8/12/13, p. 1*). "If the physician believes that a rare and unusual circumstance exists in which an inpatient admission is warranted, but does not expect the beneficiary to require 2 or more midnights in the hospital, the physician may admit the beneficiary to inpatient status but should thoroughly document why inpatient admission and Medicare Part A payment is appropriate. CMS will work with the hospital industry and with MACs to determine if there are any categories of patients that should be added to this list of exceptions to the 2-midnight benchmark," CMS says. Forget about telemetry and the ICU, however, because either unit "by itself" is not rare and unusual enough to justify an inpatient admission, CMS contends.

continued

Potentially this would soften the two-midnight rule, says Mark Polston, former CMS deputy associate general counsel for litigation. But CMS shouldn't limit exceptions to "rare and unusual" situations, says Polston, with King & Spalding in Washington, D.C. If the reason for inpatient services is evidence-based and standard medical practice (e.g., post-stenting), why should it be considered exceptional?

Exceptions Can Muddy the Water

There is also concern that creating more exceptions will muddy the waters of the two-midnight standard, says attorney Jessica Gustafson, with The Health Law Partners in Southfield, Mich. "It makes an otherwise black-and-white rule more gray," she says.

While CMS ponders short stays, they will be denied by Medicare administrative contractors. But the main office will take a closer look at them, and if CMS establishes a category of short stays, hospitals can appeal the denials and look forward to another round of subregulatory guidance, according to the FAQs. Meanwhile, CMS is asking hospitals to send ideas to IPPSAdmissions@

cms.hhs.gov with a subject line of "Suggested Exceptions to the 2-Midnight Benchmark."

CMS Describes 'Probe and Education' Program

CMS also fleshed out the MAC probe reviews under the IPPS rule (CMS-1599-F) in two other documents posted on the website. Under the new "probe and educate" program, MACs will audit a small sample of claims for zero- and one-day stays submitted between Oct. 1, 2013, and March 31, 2014, to evaluate hospital compliance with the IPPS, although they will steer clear of stays that cross two midnights unless there is evidence of abuse, CMS says.

Also, through March 31, 2014, there will be no RAC audits of the medical necessity of admissions in terms of site of service and no other MAC reviews. However, RACs and MACs are free to audit MS-DRG coding and the medical necessity of the services themselves.

In the MAC audits, 10 claims will be audited at most hospitals and 25 at larger hospitals. Noncompliant claims will be denied, with the reasons explained in letters from the MAC. However, CMS will escalate the response depending on the hospital's relative compliance (see chart, p. 3). Hospitals that are dropping the two-midnight ball will face greater scrutiny, with the MAC reviewing 100 to 250 claims. "We will also instruct the MACs to offer individualized phone calls to those providers with either moderate/significant or major concerns," CMS says.

Hospitals will take a financial hit, at least temporarily, because these are prepayment reviews, says Stephanie Burnside, the RAC analyst for a hospital in Louisiana. Until the reviews are completed — which typically takes the MACs 60 to 90 days — hospitals aren't reimbursed for their services. "The best way to get these claims paid is to make sure the documentation is there. As long as hospitals have the admission order and certification and maybe go beyond [in supporting medical necessity], they shouldn't have a problem," Burnside says.

Two-Midnight Forms Are Not Required

Speaking of certification, CMS states that physicians don't need to sign a special form expressing their expectation the patient requires a two-midnight stay, echoing language in Sept. 5 subregulatory guidance on inpatient orders and certifications (*RMC 9/16/13, p. 1*). In the new guidance, CMS says it "does not anticipate that physicians will include a separate attestation of the expected length of stay, but rather that this information may be inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes." But Gustafson says hospitals protect themselves by creating a separate certification form with space for a signed and dated order and the other requirements (*RMC 9/2/13, p. 1*). "They don't want

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the RACs hunting through their medical records, leaving compliance possibly open to interpretation," she says.

MACs will audit hospitals according to the two-midnight benchmark, Gustafson says. In the IPPS rule, CMS introduced two medical review policies related to the two-midnight rule: a two-midnight "presumption" and a two-midnight "benchmark." The former refers to the presumption that a hospitalization crossing two midnights after an inpatient order is written is medically necessary, as long as hospitals aren't playing games. However, the two-midnight benchmark may be applied to those cases where the entirety of a hospital stay crosses two midnights, but some of the time spent in the hospital was in observation or for other outpatient services.

CMS also clarified when the clock starts ticking for purposes of crossing two midnights. Although hospitals get credit for the time patients spend receiving observation and outpatient services before the inpatient admission order is written, CMS is excluding "wait times prior to the initiation of care," including triage (e.g., taking vital signs before providing medically necessary ser-

vices). "People may be unhappy about that, but CMS is drawing a line so it's important to know," Polston says. He predicts something more ominous: audits of whether observation was appropriate instead of sending the patient home.

Other parts of the guidance "give me heartburn," he says. CMS was evasive on whether two-midnight stays will be considered medically necessary when patients are waiting for a test or procedure (e.g., over a weekend), but it's not safe to send the patient home. CMS has repeatedly stated it doesn't cover social admissions or hospital stays for convenience's sake, but Polston says it is still dancing around the question of whether admission is medically necessary if patients are too sick to discharge while they await the right specialist or test. "In the future, you will see RAC audits on that kind of thing," he says.

Contact Polston at mpolston@kslaw.com, Gustafson at jgustafson@thehlp.com and Burnside at Stephanie.Burnside@stfran.com. View the three new CMS documents at <http://tinyurl.com/kwtb29t>. ♦

CMS to 'Probe and Educate' Under IPPS Rule

In guidance posted Nov. 4, CMS explains its graduated approach to small-sample prepayment reviews under the two-midnight benchmark that will be conducted by Medicare administrative contractors (MACs). Visit <http://tinyurl.com/lvu26aw>.

MAC Actions Following Patient Status Probe Reviews

	Number of Claims in Sample That Did NOT Comply with Policy (Dates of Admission October – March 2014)		
	No or Minor Concerns	Moderate to Significant Concerns	Major Concerns
10 claim sample	0-1*	2-6*	7 or more*
25 claim sample	0-2*	3-13*	14 or more*
Action	For each provider with no or minor concerns, CMS will direct the MAC to: <ol style="list-style-type: none"> Deny non-compliant claims Send summary letter to providers indicating: <ul style="list-style-type: none"> What claims were denied and the reason for the denials That no more reviews will be conducted under the Probe & Educate process. That the provider will be subjected to the normal data analysis and review process Await further instruction from CMS 	For each provider with moderate to significant concerns, CMS will direct the MAC to: <ol style="list-style-type: none"> Deny non-compliant claims Send detailed review results letters explaining each denial Send summary letter that: <ul style="list-style-type: none"> Offers the provider a 1:1 phone call to discuss Indicates the review contractor will REPEAT Probe & Educate process with 10 or 25 claims Repeat Probe & Educate of 10 or 25 claims with dates of admission January – March 2014 	For each provider with major concerns, CMS will direct the MAC to: <ol style="list-style-type: none"> Deny non-compliant claims Send detailed review results letters explaining each denial Send summary letter that: <ul style="list-style-type: none"> Offers the provider a 1:1 phone call to discuss Indicates the review contractor will REPEAT Probe & Educate process with 10 or 25 claims Repeat Probe & Educate of 10 or 25 claims with dates of admission January – March 2014 If problem continues, Repeat Probe & Educate with increased claim volume of 100 – 250 claims

*NOTE: If the provider claim submissions do not fulfill the requested sample, the error rate shall be calculated based on percentage of claims with findings.

SOURCE: CMS

CMS System Finds Overpayments For Incarcerated Beneficiaries

In October guidance, CMS reminded providers that Medicare doesn't cover goods or services provided to beneficiaries who are incarcerated and that its Medicare administrative contractors are recouping payments to providers for incarcerated beneficiaries. Sometimes, however, there are mistakes and MACs take back money for people who aren't incarcerated. CMS said in July it is developing a method to make providers whole without their lifting a finger, but there's no word on when it will be ready.

Recoupment for incarcerated beneficiaries is not an obscure matter. A February report from the HHS Office of Inspector General said Medicare improperly paid \$33.6 million to providers for services rendered to 11,619 incarcerated beneficiaries from 2009 through 2011 (*RMC 2/4/13, p. 8*). When beneficiaries are "in custody," Medicare is off the hook and it's up to providers to bill the state or local government responsible for the cost of their care, says Ronald Hirsch, M.D., vice president of the Regulations and Education Group at Physician Advisory Services (*RMC 7/22/13, p. 3*). Medicare defines "custody" broadly, according to a new Medicare Learning Network fact sheet, to include people who "are under arrest; incarcerated; imprisoned; escaped from confinement; under supervised release; on medical furlough; required to reside in mental health facilities; required to reside in halfway houses; required to live under home detention; or confined completely or partially in any way under a penal statute or rule." Hospitals that bill Medicare for services provided to people who are in custody will receive a remittance advice that explains the reason for the denial (remittance advice remark code N103).

In case it's unclear when beneficiaries are in custody, hospitals can verify their eligibility status through a 270/271 eligibility query in the HIPAA Eligibility Transaction System and by using the MAC's interactive voice response units and provider internet portals. But that only gets providers so far because the systems will give the dates when beneficiaries are inactive, not the reason why. CMS says hospitals can use the MAC contact center

to check whether Social Security Administration (SSA) records indicate that beneficiaries were incarcerated when items or services were provided, but that's not foolproof either. Sometimes there's a time lag before the SSA finds out beneficiaries are incarcerated and updates its records, which, in turn, updates Medicare records. "During this time, Medicare Fee-For-Service claims for items and services may be erroneously paid because the beneficiary's entitlement data in the Enrollment Database is not up to date when claims are adjudicated," CMS says.

But now CMS has a way to figure out whether it should pay for the services. Its new "informational unsolicited response" (IUR) tracks down claims for services that were provided on dates of service that partly or fully overlap with a beneficiary's incarceration.

There Are Telltale Signs of Felons

It should be obvious to hospitals and physicians when certain patients are in custody. "I remind them that if their patient is in handcuffs and/or there is a person in uniform in the room with a gun, that most likely means their patient is incarcerated and they should send their bill to the agency that's detaining the patient and not to the government," Hirsch says. There's an upside: If providers are not under contract to provide services to people in custody, they can bill full fees to the state or local government that has custody, he says.

CMS has acknowledged that MACs sometimes improperly recoup money from providers for services that seem like they were rendered to incarcerated beneficiaries. Fixing that problem will not be easy, according to answers to frequently asked questions on the CMS website. "The resolution of this situation will require a series of complex actions including the restoration of the original data on the Medicare Enrollment Data Base, the identification of the overpayments that will need to be abated or refunded, and the creation of claims processing system utilities to effectuate the necessary changes. We do not yet have a firm target date, but anticipate that the process will not be completed before October," CMS said. At least providers won't have to resubmit the claims. However, when claims are denied through the IUR, providers must appeal the old-fashioned way (42 CFR 405 (subpart I)).

As for escaped convicts, because they are still "in the custody of penal authorities" (42 CFR 411.4(b)), "I'm sure it's a relief to prisoners planning an escape that they will not have to navigate the problem-plagued HealthCare.gov website since their jailers are still responsible for paying for their health care while they're on the run," Hirsch jokes. On a more serious note, he says there is an "ethical dilemma" inherent in caring for an escapee. If there was no violent crime, it could be considered a HIPAA viola-

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tion for the hospital or clinic to report the escaped convict to the prison, he says. But “consent is not needed to release PHI for payment purposes, so calling the prison to find out where to send the bill for the services provided to their escaped prisoner is permitted.”

Contact Hirsch at rhirsch@accretivehealth.com. View the Medicare Learning Network document at <http://tinyurl.com/jvzb7pl> and the FAQs at <http://tinyurl.com/kwl7nyw>. ✧

HHS Discourages Hospital Premium Supports, Despite Sebelius Letter

Hospitals that considered the idea of paying insurance premiums for certain patients on HealthCare.gov have to think again in the wake of a Nov. 4 CMS statement.

CMS addressed premium payments five days after HHS Sec. Kathleen Sebelius said Oct. 30 that the definition of “federal health care programs” does not extend to qualified health plans (QHPs) available through health insurance exchanges even when people use federal subsidies to buy them. In a letter to Rep. Jim McDermott (D-Wash.), Sebelius basically put to rest the fear that providers and suppliers serving patients insured by these plans faced liability under certain fraud and abuse laws, such as the anti-kickback statute (*RMC 11/4/13, p. 5*). QHPs are sold by commercial insurers, such as Aetna Inc. and Anthem Blue Cross and Blue Shield, and Sebelius maintains QHPs don’t fall under the very broad definition of “federal health care programs.”

“Sebelius’s letter cleared the way to treat exchanges like commercial payers vis-à-vis the anti-kickback statute,” says Mac Thornton, former chief counsel to the HHS Inspector General. As a result, some hospitals may have started thinking about paying the QHP premiums for certain uninsured patients, such as the “frequent fliers” who may have received a lot of uncompensated medical care, says Thornton, who is with Dentons US LLP in Washington, D.C.

Also, pharmaceutical manufacturers may have seen an opening to give co-pay coupons and discounts to QHP enrollees for purchasing certain medications. Under the anti-kickback statute, these practices are generally considered inducements in federal health care programs and potentially subject to civil money penalties.

But along came the CMS Center for Consumer Information and Insurance Oversight with its answer to a frequently asked question. It posted the following: “Q: Are third party payors permitted to make premium payments to health insurance issuers for qualified health plans on behalf of enrolled individuals? A: The Department of Health and Human Services (HHS) has broad

authority to regulate the Federal and State Marketplaces (e.g., section 1321(a) of the Affordable Care Act). It has been suggested that hospitals, other healthcare providers, and other commercial entities may be considering supporting premium payments and cost-sharing obligations with respect to qualified health plans purchased by patients in the Marketplaces. HHS has significant concerns with this practice because it could skew the insurance risk pool and create an unlevel field in the Marketplaces. HHS discourages this practice and encourages issuers to reject such third party payments.” CMS says the practice will be monitored and if necessary, action will be taken.

The FAQ “throws a bucket of cold water” on premium support and discount coupons with regard to QHPs, Thornton says. However, he notes an FAQ is not binding law. But “this probably pulls the rug out from under QHP premium support and pharmaceutical discount coupons because the risks have been increased.”

Contact Thornton at mac.thornton@dentons.com. ✧

Misconduct Will Cost Johnson & Johnson Executives Their Bonuses

Certain executives at Johnson & Johnson and its pharmaceutical affiliates will soon lose their bonuses if they engage in “significant misconduct” related to manufacturing, sales or marketing, according to its new corporate integrity agreement. The five-year CIA is part of J&J’s \$2.2 billion settlement of criminal and civil allegations related to its prescription drugs Risperdal, Invega and Natrecor, the Department of Justice said Nov. 4.

The settlement originated with whistleblower lawsuits filed with the U.S. Attorney’s Office for the Eastern District of Pennsylvania and other districts. The multi-faceted case involves allegations of the promotion of drugs for uses not approved by the FDA and kickbacks to physicians and the drug supplier at nursing homes. For example, in a plea agreement, DOJ said that Janssen Pharmaceuticals Inc., a subsidiary of Johnson & Johnson, admitted to promoting the anti-psychotic drug Risperdal to providers to treat symptoms of psychosis in elderly, non-schizophrenic dementia patients. In a False Claims Act complaint, DOJ alleged that from 1999 through 2005, Janssen marketed Risperdal for use in children even though it was not approved for that purpose until 2006. The False Claims Act settlements also partly stemmed from Johnson & Johnson allegedly paying kickbacks to a national pharmacy company that dispensed medication to nursing home patients, DOJ said.

In addition to the astounding dollar figure, the CIA’s emphasis on executive compensation shows the HHS Office of Inspector General is reaching more deeply into organizations to try to change their behavior, says

a health care consultant who asked not to be identified. OIG, which negotiates CIAs, included an “executive financial recoupment program” in Johnson & Johnson’s extensive CIA. It applies to “covered executives” who are current employees or who worked there at the time of the noncompliance. The pharmaceutical manufacturer is required to withhold or recover bonuses if covered executives engage in a “triggering event,” which the CIA defines as “significant misconduct” (e.g., violations of regulations, laws or Johnson & Johnson policies on manufacturing, sales or marketing of pharmaceutical products by the covered executive or subordinate employees).

Typical CIAs require the compliance officer and board to attest to the effectiveness of the compliance program and to the organization’s compliance with laws and regulations. But this is a “deeper reach,” the consultant says. “It demonstrates the OIG’s commitment to ensuring the message permeates throughout the entire organization, including the sales force.”

OIG linked executive compensation to compliance once before. Last year, it imposed a CIA on GlaxoSmith-

Kline in its \$3 billion fraud settlement that also included an “executive financial recoupment program” (*RMC* 7/9/12, p. 3). It put three years of performance pay at risk of forfeiture if executives or their subordinates engage in “significant misconduct.”

In a statement on its website, Johnson & Johnson said the company and its subsidiaries “have robust compliance programs that have been continually strengthened and that will continue as part of this agreement. The CIA is largely consistent with existing compliance programs, and reflects the companies’ commitment to ensuring integrity in the delivery of essential medicines to patients.”

For more information, view the Johnson & Johnson CIA at <http://go.usa.gov/WZnJ>. ♦

Appeals Can Be Exasperating

continued from p. 1

threatened to refer the overpayment to the Department of Treasury for debt collection, Beckman says. “It’s gotten to an almost ridiculous point,” she says.

The saga began early this year, when the MAC informed the medical group it faced postpayment provider-specific expanded targeted medical reviews because the MAC’s analysis showed potentially inappropriate billing. The MAC gave the physicians 30 days to produce hundreds of medical records — physician orders, history and physicals, progress notes, admission and discharge summaries, nurse assessments and other documentation to support the medical necessity of the claims — even though providers are entitled to 45 days, according to the Medicare manual, Beckman says.

It was impossible to comply with the 30-day timeframe, although the medical group did its best, she says. As a result, the MAC denied and/or downcoded many of the claims. When the physicians sent the rest of the medical records, they got a second chance through a re-opening, which is separate from the appeals process. But many of the medical group’s claims were still denied or downcoded. According to the MAC’s re-opening decision, “the acuity of the patient’s condition at the time of the visit does not support the medical necessity of the level of E&M service performed” or the documentation didn’t support “a significant change in the patient’s condition requiring an assessment and medical decision making from the billing provider.”

The re-opening letter failed to explain how or why the level of history, exam and medical decision making fell short of coding and documentation guidelines, says Beckman, who is also a certified coder and former compliance officer for a health system’s medical group. And the medical group had plenty of grounds to appeal. For

CMS Transmittals and Federal Register Regulations

Nov. 1 — Nov. 7

Live links to the following documents are included on *RMC*’s subscriber-only Web page at www.AISHHealth.com. Please click on “CMS Transmittals and Regulations” in the right column.

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Changes to the Laboratory National Coverage Determination (NCD) Software for ICD-10 Codes, Trans. 2806CP, CR 8494 (Nov. 1, 2013; eff. Oct. 1, 2014; impl. Jan. 6, 2014)

Pub. 100-20, One-Time Notification

- Denial for Power Mobility Device (PMD) Claim from a Supplier of Durable Medical, Orthotics, Prosthetics, and Supplies (DMEPOS) When Ordered By a Non-Authorized Provider, Trans. 13050TN, CR 8239 (Nov. 6, 2013; eff. April 1, 2014; impl. April 7, 2014)
- MREP and PC Print Updates for Operating Rules Phase III 360 Rule Compliance, Trans. 13080TN, CR 8479 (Nov. 6, 2013; eff. April 1, 2014; impl. April 7, 2014)
- FISS Claims Processing Update for Ambulance Services, Trans. 13090TN, CR 8251 (Nov. 6, 2013; eff. April 1, 2014; impl. April 7, 2014)

Federal Register Regulations

Notices

- Medicare & Medicaid Programs: Application From the Accreditation Commission for Health Care for Continued CMS-Approval of Its Hospice Accreditation Program, 78 Fed. Reg. 66364 (Nov. 5, 2013)
- Medicare Program; Solicitation of Five Nominations to the Advisory Panel on Hospital Outpatient Payment, 78 Fed. Reg. 65660 (Nov. 1, 2013)

example, in one case the MAC concluded that a physician's visit to a SNF patient weeks after discharge from the hospital for a hip replacement was medically unnecessary. The diabetic patient was 80 years old and taking a blood thinner, and there were red flags for a post-op infection (e.g., fever, elevated white blood cells, oozing infection site). But the physician made a fatal mistake in his documentation. The physician's first sentence was "the patient feels OK today" and then he explained the reason for the visit and concerns about infection. "The auditors focused on the first sentence and then noted in their findings 'the patient has no complaint so the visit was not necessary,'" Beckman says.

Attorneys Can Be Reps for Providers

The medical group appealed many of the claim denials, Beckman says. In fact, recoupment is supposed to be put on hold by MACs when providers submit a rebuttal and appeal by the 30th day after they receive the MAC's demand letter. But so much has gone wrong, she says. Five months after the physicians appealed hundreds of claim denials, the MAC returned a decision on six of them — and disavowed knowledge of the rest, Beckman says. "We have copies of all documentation submitted clearly showing all records were sent," she says. While the interest and penalties are piling up, Beckman has escalated the matter to the MAC's legal department, which is trying to determine the status of the claims in this audit.

Also, Medicare allows attorneys to serve as the appointed representatives for providers in audits and appeals. As their proxies, appointed representatives may get their hands on "appeal information about the claim to the same extent as the party" (*Medicare Claims Processing Manual* 100-04, Chapter 29, Sec. 270.1.4). But Beckman says many MAC customer service representatives seem unaware of this provision. As a result, providers and their attorneys may experience a delay in retrieving documentation they need for appeals.

Then came a letter invoking the IRS's name for reasons that got eyeballs rolling back in Beckman's head. The MAC informed the medical group in early November that because it had not repaid the overpayment or appealed the claim denials, its debt was "delinquent." While the 1996 Debt Collection Improvement Act requires federal agencies to refer delinquent debts to the Department of Treasury so they can recoup money other ways — for example, the IRS could keep tax refunds or Medicaid payments — Beckman says that's premature because the medical group has appealed the claim denials. "We just sent responses to those letters indicating that the claims should be in appeal status and therefore were not eligible for referral [to the Treasury Department]," she says. "Our right to submit this response is a

due process procedure described in the Medicare manuals." Perhaps the MAC thinks the Treasury Department referral makes sense since the records were misplaced or lost, Beckman says. No matter what, the MAC should have sent the medical group three demand letters before resorting to the intent to refer letter, but the physicians only got one, Beckman says, and it failed to explain the provider's due process rights.

As much as lawyers would like to wave a wand and make the troubles disappear, there isn't one. "Medicare is the most solvent payer you deal with. In exchange for dealing with the most solvent payer on the planet, you sometimes have to wait forever for your money," says Washington, D.C., attorney Andy Ruskin, with Morgan Lewis. There are no direct penalties for Medicare contractors that miss deadlines, he says, "and you will never get to the point where CMS will take action against a MAC based on [its behavior toward] an individual provider." CMS's expectations for audits and appeals are set forth in their contracts with CMS, but the terms are not made public.

Suggestions for Steps Providers Can Take

Here are the few tips lawyers have for providers in light of these realities:

- ◆ **Contact the CMS regional office for help** if the MAC is too far out of bounds, Ruskin says.
- ◆ **Document every call to your contractor**, including the name of the person you spoke with, Beckman suggests.
- ◆ **Interact with the MAC in writing as much as possible**, Beckman says. Sometimes you have to remind the MAC about the procedures they should follow. The MAC is made up of people, Ruskin notes, and some are more knowledgeable than others. For example, when Medicare contractors decline to discuss clients' claims with Beckman, she sends a copy of the letter in which clients appointed her their representative along with the manual language illuminating her right to the paperwork. "I don't think the refusal to release information is malicious, but based on HIPAA concerns for patients and privacy concerns for providers."
- ◆ **"Stop focusing on what you think is yours and recognize the balance of power is all on the other side.** The best thing you can do is be as nice as possible to everyone because contractors know there are no consequences for failure to act timely," Ruskin says.
- ◆ **"Be appropriate and persistent,"** he says. "Present your case, including the timeliness rules, but don't complain. The second you start complaining, they will ignore you. You can't tie the government's hands. You can't even sue the government for missed deadlines. Just about every suit against a MAC for its [alleged] misconduct has failed. They are not the proper party." HHS or

CMS is the proper party, but to file a suit, providers first have to exhaust their administrative appeals.

◆ **Consider leapfrogging appeals, although this is hardly a win-win**, says Jessica Gustafson, an attorney with The Health Law Partners in Southfield, Mich. In her experience, the qualified independent contractor (QIC), which does second-level Medicare appeals, has been delayed more over the past year and it may be worth skipping them altogether. If providers are fed up, they can send the QIC, Maximus, a letter saying they are jumping ahead to the administrative law judge. The QIC then has five days to either rule on the appeal or honor the provider's request. ALJs are a preferred audience for appeals

because providers consider them more open-minded to medical-necessity arguments. But Gustafson cautions that escalating appeals may just accomplish a hurry-up-and-wait situation. "ALJs are way too busy" and provider appeals will just sit for a year there anyway.

Attorneys say they don't believe MACs are intentionally making life hard for providers. But the end result is time and money wasted on the back and forth.

CMS didn't respond to RMC's request for comment on the problems.

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NEWS BRIEFS

◆ **SSM Health Care of Oklahoma, Inc., which owns St. Anthony Hospital in Oklahoma City, will pay \$475,000 to resolve claims around its billing for inpatient services that allegedly should have been outpatient services**, according to the U.S. Attorney's Office for the Western District of Oklahoma. The hospital allegedly billed for inpatient admissions when patients presented for planned medical procedures or in the emergency room and could have been billed as outpatients, the U.S. attorney contends. SSM did not admit liability in the settlement. For more information, visit <http://tinyurl.com/mflyogy>.

◆ **The former CEO of the prestigious Hospital for Special Surgery in Manhattan was sentenced to 18 months in prison in connection with his July 2013 plea to one count of wire fraud and one count of making false statements to a law enforcement agent** (RMC 7/22/13, p. 1), the U.S. Attorney for the Southern District of New York said Nov. 7. John R. Reynolds was CFO for 11 years at the Hospital for Special Surgery, the oldest orthopedic hospital in the nation, before taking the CEO reins in 1997. After serving as the employed CEO through 2006, he held the same position for the next two years as a contractor. Reynolds was accused of demanding almost \$300,000 from an employee who worked in the materials management department of the operating room. The hospital assigned the employee to mediate its royalty dispute with a company that specializes in joint replacement technology. The employee resolved the dispute, with the company agreeing to pay the hospital \$26 million over 10 years, the indictment alleged. As a result, Reynolds got the materials management employee an annual bonus, but allegedly told the employee he expected

to share it. The employee paid Reynolds \$298,500 between March 13, 2000, and around Sept. 9, 2005, "fearing that failure to do so would lead to [the employee's] termination," the indictment alleged. Also, after being interviewed by an OIG agent in a Beverly Hills hotel room in 2008, Reynolds called the agent in Manhattan and allegedly "falsely stated" that he had never worked with the employee in any capacity that would have led to the employee paying Reynolds.

◆ **On Jan. 6, 2014, CMS will turn on edits to prevent payments for certain services ordered by physicians who lack a national provider identifier**, CMS said in *MLN Matters* SE1305. Medicare doesn't pay for clinical lab tests, imaging, Part A home health care and durable medical equipment unless they are ordered or referred by physicians who have established their "Medicare enrollment record with a valid NPI" and practice in a specialty that is eligible to order and refer, CMS says. "If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name." Read the *MLN Matters* at <http://tinyurl.com/aq8ufzs>.

◆ **The HHS Office of Inspector General has clarified that the definition of "immediate family" for purposes of the List of Excluded Individuals/Entities includes family members of lawfully married same-sex spouses**. OIG posted a frequently asked question on its website to explain the impact on the definition of the Supreme Court's ruling on the Defense of Marriage Act. For more information, visit <http://go.usa.gov/WCaW>.

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