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

Contents



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# CMS: No Benefit Yet to Using X Modifiers; Related Challenge Arises With Packaging

There's no advantage to using the four new "X" modifiers instead of -59 until CMS puts out more guidance, but hospitals and physicians can take their pick, a top CMS program integrity official said Feb. 24. "Since we haven't put out code definitions in clinical situations, there's no real benefit to moving to the new modifiers at this point," Dan Duvall, M.D., chief medical officer in the Center for Program Integrity, said at a CMS open-door forum. The modifiers, however, "are valid" and "can be used."

Lack of clarity is the tip of the iceberg on the X modifiers and modifier -59, which explain the circumstances of separate and distinct procedures performed on the same patient on the same day, a compliance officer says. There are overarching questions on the purpose of using modifiers for procedures that are packaged under changes to the outpatient prospective payment system that took effect on Jan. 1, and related issues of medical necessity and advance beneficiary notices.

CMS in August announced it was replacing modifier -59 on Jan. 1 with more defined subsets — the four X modifiers (XE, XS, XP and XU) — to elicit more specific information on its use. But when the new year rolled around, CMS told hospitals and physicians they weren't obligated to use the X modifiers until they received more guidance, although they were free to go that route or stick with modifier -59, and Medicare administrative contractors are prepared to process claims with the new modifiers *(RMC 2/2/15, p. 1)*.

*continued on p. 6*

# Feds Move to Fine Compliance Officer $1 Million For Alleged Compliance Failures

The federal government is seeking a $1 million fine from a compliance officer in connection with the criminal case against his former employer, MoneyGram International, which paid $100 million in 2012 for a mass marketing and consumer fraud scheme.

If the U.S. Attorney's Office for the Southern District of New York gets its way, the compliance officer, Thomas Haider, would also be banned from working for a financial institution for a number of years that has yet to be determined, according to the civil complaint filed in December. Haider had until late February to respond to the civil complaint.

Although this is not a health care case, it's analogous in the sense that the compliance officer is under fire for allegedly failing to perform fundamental compliance functions, such as auditing and implementing a discipline policy, which the government alleged contributed to the company's fraud.

"It's every compliance officer's worst nightmare," says Kim Greene, chief compliance officer for Boston Medical Center in Massachusetts. "It points out how vulnerable compliance officers can be. You have all the responsibility and never enough authority."

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Haider contends the government's allegations are "unfounded," according to a statement from his attorney.

The Department of Justice first went after Dallas-based MoneyGram, which signed a deferred prosecution agreement. MoneyGram admitted to criminal activity but will not face penalties as long as it implements compliance reforms and keeps its nose clean for five years. MoneyGram is a global money transfer service that lets people send and receive money through its agents and outlets, which are independently owned. In the deferred prosecution agreement (DPA), MoneyGram admits to aiding and abetting wire fraud and failing to maintain an effective anti-money laundering program.

According to the DPA's statement of facts, MoneyGram had a call center that took complaints from people who said they were defrauded. The calls were compiled in a consumer fraud report, which was forwarded to the MoneyGram fraud department for investigation. That means MoneyGram knew that, from 2003 to 2009, certain agents "were involved in a fraud scheme that relied on a variety of false promises and other representations to the public to trick unsuspecting victims into sending money through participating MoneyGram agents and MoneyGram outlets," the statement of facts says. For example, people were "falsely" promised cash prizes, lottery winnings and loans, and high-ticket items for sale at deep discounts on the Internet if they forked over fees in advance (e.g., for taxes or processing). Some people were tricked into wiring money to relatives who was supposedly in distress. "At no time were the victims provided with what they were falsely promised by the perpetrators," the statement of facts says. MoneyGram agents and outlets collected fees on the transactions.

## Management Refused to Take Steps Needed

MoneyGram customers filed about 63,814 fraud reports between 2004 and 2008 with the company worth about $128 million. In response, the fraud department suggested to senior management that certain agents and outlets be kicked out. But its then-senior management refused, the statement of facts says. Even after MoneyGram got a civil investigative demand from the Federal Trade Commission, senior leaders spurned the fraud department's push to terminate 32 MoneyGram outlets in Canada that were described as "the worst of the worst," the statement of facts says. The fraud department also tried to implement policies that required termination of agents or outlets that had too many consumer fraud reports. "These reports were repeatedly rejected by the sales side of the business," the statement of facts says.

Things started to turn around in 2009, when MoneyGram replaced its senior management team and upped the number of compliance employees by 100%. At the request of the U.S. Attorney's Office for the Middle District of Pennsylvania, MoneyGram closed 400 outlets and agents believed to be involved in consumer fraud. It created two new positions: senior vice president/associate general counsel, global regulatory and chief privacy officer and senior vice president for global security and investigations. The DPA required more rigorous compliance mechanisms, including oversight by an independent monitor and creation of a compliance and ethics committee of the board that directly oversees the compliance officer and program.

The DPA and $100 million payment is not the end of the MoneyGram story. Now its former chief compliance officer, who also supervised the fraud department, is feeling the government's wrath over the misconduct. The U.S. attorney in Manhattan wants to hold Haider personally accountable for what happened at MoneyGram. In a complaint filed on behalf of the Treasury Department's Financial Crimes Enforcement Network, the U.S. attorney alleges Haider violated the Bank Secrecy Act.

As a money transmitter, MoneyGram has to have an effective anti-money laundering (AML) program and file "suspicious activity reports [SARs] when it suspected or

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knew its money transfer system was used to enable criminal activity." The chief compliance officer is responsible for running the anti-money laundering program and satisfying SAR obligations, the complaint says. Haider, who was MoneyGram's chief compliance officer from 2003 to May 23, 2008, allegedly "failed to ensure that MoneyGram implemented and maintained an effective AML program and fulfilled its obligation to file timely SARs." He allegedly failed to:

- Audit agents and outlets effectively,
- Implement a discipline policy for agents and outlets that were suspected of fraud and/or money laundering,
- Ensure MoneyGram dumped agents and outlets that were thought to be involved in fraud and/or money laundering,
- Conduct sufficient due diligence of agents and outlets, and
- File SARs promptly.

The government's pursuit of the compliance officer is frazzling nerves. "If we start penalizing compliance officers, it will hurt our ability to attract people into the profession," says Roy Snell, CEO of the Health Care Compliance Association. There are exceptions, he notes. "If compliance officers personally gain and are involved in inappropriate behavior they should be considered for some sort of penalty," Snell says. And sometimes compliance officers cross over into operations. "Instead of being the reviewer, they are doing a job that should be reviewed, and that's the problem," he says. "By definition, a compliance officer should not have any tasks that are possible to be penalized — they should be auditing, monitoring, developing policies and educating. Wrongdoing occurs in operations, not in the oversight process."

### Government Is Sending a Message to COs

The government is sending a message to the compliance officer that he should pay a price for his company paying "lip service" to compliance, says Julie Chicoine, senior assistant general counsel at Wexner Medical Center at the Ohio State University Medical Center in Columbus. In this case, in addition to the $1 million being sought, the government wants to bar him from working for a financial institution that operates in America or a foreign financial institution that does business here. "It's the equivalent of Medicare exclusion," she says.

Chicoine doesn't think every compliance officer "will be in the government's crosshairs." But prosecutors have warned they will increasingly nail executives and officers for health care fraud instead of always letting the corporate entity take the rap. In fact, the government previously took a stab at penalizing a health care compliance officer in connection with her job. The infamous false claims lawsuit against Christi Sulzbach, former compliance officer and general counsel for Tenet Healthcare Corp., was dismissed in April 2010. The Department of Justice alleged that even though Sulzbach knew physician agreements at a Tenet-owned hospital in Florida violated the Stark law, she twice signed Tenet's corporate integrity agreement attestations that it complied with all legal requirements *(RMC 9/24/07, p. 1)*. But the U.S. District Court for the Southern District of Florida threw the case out on summary judgment, saying it was barred by the statute of limitations.

### Executives Will Be Scrutinized More in Future

"We are entering a new era of corporate governance," Chicoine says. "As the government increasingly scrutinizes arrangements, I think they will look to executive leadership to see what they failed to do." That may get scary, as health care organizations go out on a limb to experiment with innovative arrangements, she says. "The rules aren't always clear in terms of how the relationships might be accomplished," she says. "We are moving into uncharted territory with accountable care organizations and other business models."

Greene calls it "remarkable" that the MoneyGram compliance officer was singled out. "Compliance is not just the compliance officer's responsibility. They don't build compliance programs by themselves," she says. "They have to have the support of senior leadership and their boards."

If they get pushback on legal and regulatory compliance — for example, MoneyGram salespeople overrode the fraud department's recommendation to terminate certain agents — "you can never give up trying," Greene says. "Every business has the same kind of pressure and health care is not immune from being a financially viable organization." Compliance officers can go directly to the board if they face resistance to addressing a compliance issue. The problem, however, is that it's probably "going to impair your relationships with people you work with," Greene says. "You can't take a problem directly to the board that you haven't worked internally first."

A lesson from the MoneyGram case is that compliance officers invite trouble when they ignore red flags, Chicoine says. For example, employees sent emails "suggesting a looming compliance problem." According to Chicoine, "a compliance officer's role is to tell senior leaders what they have to hear, not just what they want to hear." Sometimes, when compliance officers have worked at an organization for a long time, their chumminess with senior leaders may interfere with their objectivity. "But their goal should always be to protect the organization," she says.

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Snell hopes the Haider case will resolve itself "in that the enforcement community will understand the delineation between those who are committing fraud and those who are trying to find and stop fraud."

Attorney Ian Comisky, who represents Haider, said in a statement he believes this is the first time a compliance officer was personally held responsible for anti-money laundering compliance failures by his or her employer. When Haider was at the compliance helm of MoneyGram, it had a "comprehensive anti-money laundering compliance program" that was audited by external experts and the IRS, said Comisky, who is with Blank Rome LLP.

Contact Snell at roy.snell@corporatecompliance.org, Chicoine at julie.chicoine@osumc.edu and Greene at kim.greene@bmc.org. ✧

## CMS Transmittals and *Federal Register* Regulations
### Feb. 20 – Feb. 26

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

### Transmittals

(R) indicates a replacement transmittal.

**Pub. 100-03, National Coverage Determinations**

- National Coverage Determination for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers, Trans. 179NCD, CR 9078 (Feb. 20; eff. Aug. 13, 2013; impl. July 6, 2015)

**Pub. 100-04, Medicare Claims Processing Manual**

- Revisions to Medicare Claims Processing Manual for Foreign, Emergency and Shipboard Claims, Trans. 3199CP, CR 8940 (Feb. 20; eff./impl. April 21, 2015)
- Healthcare Provider Taxonomy Codes April 2015 Code Set Update, Trans. 3201CP, CR 8993 (Feb. 20; eff. April 1; impl. April 1, July 6, 2015)
- Automation of the Request for Reopening Claims Process (R), Trans. 3203CP, CR 8581 (Feb. 20; eff. Oct. 1; impl. Oct. 10, 2015)
- National Coverage Determination for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers, Trans. 3204CP, CR 9078 (Feb. 20; eff. Aug. 13, 2013; impl. July 6, 2015)

**Pub. 100-07, State Operations Manual**

- Revisions to State Operations Manual Exhibit 138 EMTALA Physician Review Worksheet revisions, Trans. 134SOMA (Feb. 20; eff./impl. Jan. 13, 2015)

**Pub. 15-1, The Provider Reimbursement Manual – Part 1**

- Part 1, Chapter 14, Reasonable Cost of Therapy and Other Services Furnished by Outside Suppliers, Trans. 467PR1 (Feb. 20, 2015)

**Pub. 100-20, One-Time Notification**

- Renaming PPS-FLX6- PAYMENT Field in the Inpatient Prospective Payment System Pricer Output (R), Trans. 1471OTN, CR 9031 (Feb. 18; eff. July 1; impl. July 6, 2015)

### *Federal Register* Regulations

**Final Rule: Corrections**

- Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Physician-Owned Hospitals: Data Sources for Expansion Exception; Physician Certification of Inpatient Hospital Services; Medicare Advantage Organizations and Part D Sponsors: CMS-Identified Overpayments Associated With Submitted Payment Data; Corrections, 80 Fed. Reg. 9629 (Feb. 24, 2015)

## ICD-10 Probably Won't Be Delayed Again; Focus Is on Documentation

Because they were burned last year when ICD-10 was delayed for a year, some hospitals may be gun shy about their investment in preparation for the Oct. 1, 2015, implementation of the new codes. But it looks more and more like ICD-10 will happen this fall, with CMS putting out resources for providers, payers and vendors, and end-to-end testing under way for a sample of volunteer Medicare fee-for-service providers.

"I believe Congress will let the implementation deadline of October 2015 remain," says Emily Evans, a partner in Obsidian Research Group in Nashville, and others agree. "While the AMA and others have raised objections, the fact remains that billions of dollars have been spent in good faith getting ready for the switch. Any additional delay would present a hardship for those that have already invested in new systems, training and the necessary additional human resources. Furthermore, ICD-10 is good public policy. Congress appears to recognize all these things and I do not anticipate they will intervene again," according to Evans.

### 'Someone Threw a Party and No One Came'

Despite what seems like destiny, hospitals are wary after they staffed up their coding departments, engaged consultants and trained physicians only to watch Congress suspend the Oct. 1, 2014, ICD-10 compliance deadline even though the U.S. is already way behind other countries in using the coding system. "Someone threw a party and no one came," says Jon Elion, M.D., a clinical associate professor at Brown University and president of ChartWise Medical Systems. Hedging their bets, some hospitals are outsourcing some of their coding instead of hiring more coders in-house, he says. "It's a great strategy to shift risk from the hospital to coding companies," he says. "This is what many hospitals are doing to respond to ICD-10 uncertainties." These companies typically hire registered nurses who are trained as coders and many have their own coder training academies.

Hospitals and physicians should welcome ICD-10 because it presents a "massive opportunity" to improve reimbursement and explain mortality rates, Elion says.

"We are trying to show patients are sick and get an equitable distribution of resources." CMS itself seems bent on finally making the move to ICD-10. In a Feb. 25 update, the agency noted that ICD-9 is 35 years old and many code categories are full. After years of preparation — CMS first proposed the ICD-10 regulation in 2008 — it says it's ready to move on to ICD-10, which has 68,000 diagnosis codes and 87,000 inpatient procedure codes compared to ICD-9's 13,000 diagnosis codes and 3,000 procedure codes.

CMS says it completed two "successful acknowledgement testing weeks" with providers, who got electronic confirmation that test claims were accepted or rejected. Providers, suppliers, billing companies, and clearinghouses can do acknowledgement testing any time, CMS said, but there will be two special acknowledgment testing periods in March and June. Also, CMS is offering three end-to-end testing weeks for a sample of volunteer Medicare fee-for-service providers and suppliers. The purpose is to submit test Medicare claims with ICD-10 codes and get back a remittance advice explaining how the claims were processed.

### ICD-10 Is a 'Massive Opportunity'

ICD-10 demands a new level of documentation specificity, and there will be no defaulting to "NOS" — not otherwise specified — an ICD-9 code that still generates reimbursement when documentation doesn't give a coder much to go on, he says. For example, when surgeons perform a laparoscopic procedure called lysis of adhesions to free up something that's caught in the bands of scar tissue, their documentation of "laparoscopic lysis of peritoneal adhesions" is adequate to code ICD-9 54.51. But an equivalent doesn't exist in ICD-10, he says. The new coding methodology requires the surgeon to specify what was released in the surgery. Two possible options are 0DN84ZZ (Release Small Intestine, Percutaneous Endoscopic Approach) and 0DNE8ZZ (Release Large Intestine, Percutaneous Endoscopic Approach). "Failure to provide documentation of what was freed up would result in the inability to code for the procedure at all," Elion says.

Hospitals often use clinical documentation improvement (CDI) programs to encourage physicians to document in a way that coders can capture codable diagnoses for the sake of reimbursement and quality reporting, but Elion questions whether they measure CDI effectiveness properly. "Hospitals are losing millions because they are not measuring the right thing," a problem that will be compounded when ICD-10 goes live. For example, CDI specialists query physicians for more details on diagnoses and report the metrics on the physician response rate, Elion says. But that's not really the data you need, he says. What matters is the percentage of queries that are answered fast enough to allow the hospital to drop the properly coded bill promptly — ideally within six to 10 days of discharge. Otherwise, hospitals submit a claim with a more general code and then adjust it later, after the physician answers the query in 30 or 60 days. If they resubmit too many revised claims, hospitals put an audit target on their back.

It's more useful for CDI programs to measure the response rate and time, Elion says. "Make sure you are measuring things where you can have an impact," such as the percentage of queries that can be answered before the bill is dropped. "People are drowning in data but thirsty for knowledge."

View the CMS ICD-10 page at www.cms.gov/ICD10. Contact Elion at jElion@chartwisemed.com. ✧

## Winning Appeals Won't Free Claims From CMS 68% Settlement Process

When they win appeals of Medicare claim denials for inpatient admissions during the 68% settlement process, participating hospitals have to forget about them, a CMS official said on Feb. 25.

"If you received a decision on the claim but it was already in the settlement, it stays in the settlement," Mark Korpela, director of the Division of Provider Audit Operations in the CMS Office of Financial Management, said at an open-door forum. "It will not be effectuated…if it really was a patient-status denial. Once the claim is in the administrative agreement, it is part of the agreement."

Korpela walked hospitals through the "critical steps in the appeals settlement process" in conjunction with the release of a document by the same name on the CMS web site. The document explains where hospitals go from here if they still have some issues to resolve in the settlement process.

The settlement process is CMS's solution to the backlog of appeals of claims denials for inpatient admissions that allegedly should have been outpatient or observation services. On Aug. 29, CMS announced it would offer hospitals 68% of the net allowable amount of denied claims for inpatient admissions if they dropped their appeals *(RMC 9/8/14, p. 1)*. It was available to acute-care and critical-access hospitals that appealed denials of claims with dates of admission before Oct. 1, 2013, when the two-midnight rule took effect. Once hospitals signed up for the settlement process, they had to include all "eligible" claim denials — patient-status cases — and couldn't cherry pick. To set it in motion, hospitals had to complete an administrative agreement and spreadsheet with a list of eligible claims and appeals by Oct. 31, although they had a *de facto* two-week extension.

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There are two major steps in the process. "We broke this into two rounds so we could get payment to hospitals for initial claims," he said. Medicare administrative contractors (MACs) validate claims information submitted by hospitals, and if it all matched, hospitals have received a check for 68% of the entire amount. Round one is complete for many hospitals, Korpela said, but "there are round one payments still in process for various reasons."

Round two is designed to resolve differences about potentially ineligible claims. CMS has created three new tabs for the spreadsheet for round two: a tab for claims the MAC and hospitals agree are eligible for the 68% payment, a tab they agree are ineligible and a tab for claims that are in dispute and unresolvable (assuming they exist). "After round two is completed, any appeals for claims not in the settlement will be resumed," Korpela said.

Karen Robinson, revenue integrity nurse for Mercy Medical Center in Canton, Ohio, said it has received the initial 68% check. "I was very impressed by how well the first round went," she says. "It's just a waiting game getting everyone to round two." She used tabs she created herself before CMS posted its own, with claims that Mercy Medical considers eligible and the MAC does not, and vice versa. "You go through line by line and say 'yes' or 'no,'" Robinson says. "Some on their disagreement list were not eligible for settlement because I have a decision number from the ALJ." If hospitals won their appeals before the 68% settlement deadline, the claims didn't have to be included in the settlement process, she says. It's a little dicier, but appeals of claims that have already been scheduled for an ALJ hearing were not included on the spreadsheet for the settlement process, Robinson says. The hearings occurred just prior to the deadline for the settlement submission.

For more information, contact Robinson at Karen.Robinson@cantonmercy.org. ✧

## More X Modifier Guidance Is Coming

*continued from p. 1*

What's different about the X modifiers is they were developed as a program integrity initiative, both to reduce overpayments stemming from overuse of modifier -59 and to decrease payment variances for the same services, Duvall said. "We see two facilities providing the same services but getting different payments because one facility is cautious in its use of modifier -59 and another facility is liberal in its use," he said. Guidance will be forthcoming over the next year, as CMS, through the National Correct Coding Initiative, "looks for specific codes and groups of codes and combinations of codes" with a high variance in payment and determines how the new modifiers could reduce that variation. "We would come out with specific instructions in the NCCI manual coupled with specific edits that would apply the new modifiers in certain situations," Duvall said. Meanwhile, providers should think of the X modifiers as "synonyms" for the -59 modifier.

Modifier -59 is appended to HCPCS codes when providers perform a separate and distinct procedural service on the patient on the same day as another procedural service that is *not* an evaluation and management service. It allows providers to bypass National Correct Coding Initiative edits that normally block a separate payment, which means that the modifier can generate more reimbursement. The four new modifiers are:

- ***XE: Separate Encounter*** (a service that is distinct because it occurred during a separate encounter).
- ***XS: Separate Structure*** (a service that is distinct because it was performed on a separate organ/structure).
- ***XP: Separate Practitioner*** (a service that is distinct because it was performed by a different practitioner).
- ***XU: Unusual Non-Overlapping Service*** (the use of a service that is distinct because it does not overlap usual components of the main service).

CMS reiterated in the open-door forum that modifier -59 and the X modifiers remain the modifiers "of last resort," which means "all other modifiers that provide greater specificity to the circumstances should continue to be used first," says Amy Gendron, manager of integrity and compliance at Trinity Health, a Livonia, Mich.-based health system. For example, modifiers -76 and -77 may be better choices. While similar to modifier -59, modifier -76 is appended to a code for a procedure repeated on the same patient on the same day by the same physician and modifier -77 is appended to a code for the same reason, but when a different physician gets the job done. The modifiers may get mixed up, according to Wisconsin Physician Services (WPS), a Medicare administrative contractor. Medicare has denied a lot of claims with modifier -59, and "WPS Medicare researched these denied claims and found that Modifier -76 would be the appropriate modifier to use for several of the denials," according to its website.

Knowing X modifiers are modifiers of last resort doesn't remove the ambiguity, Gendron says. For example, providers are questioning the "hierarchy" of X modifier use. Until clear definitions materialize, she suggests providers continue to use modifier -59. Suppose procedures are performed on two distinct lesions, one in the right upper lobe of a patient's lung and another in the right lower lobe that creates an NCCI edit. Is it better to use modifier -RT (right side) on the first claim line for the comprehensive (column 1) procedure, followed

by modifiers –RT and -XS (separate structure) on the column 2 code or should the second line have -RT and -59? Or maybe providers shouldn't report a second line with a procedure or modifier other than a column 1 code with -RT because the structures are contiguous within the same organ, Gendron says. "That is the type of guidance providers will be looking forward to in future NCCI updates," she says.

### MAC Example Defies Logic

She also is concerned about MAC guidance on X modifiers that may not comport with NCCI definitions. Novitas Solutions, for example, fleshed out the X modifiers with examples, one of which raises more questions. In example five, Novitas says "Treatment of posterior segment structures in the eye constitutes treatment of a single anatomic site":

◆ 67210 – Destruction of localized lesion of retina (e.g., macular edema, tumors), 1 or more sessions; photocoagulation.

◆ 67220 – Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photocoagulation (e.g., laser), 1 or more sessions.

"Modifier -59 should not be reported with 67220 if both procedures are performed during the same operative session because the retina and choroid are contiguous structures of the same organ," the guidance says. "Novitas Solutions' suggestion: Beginning January 1, 2015, modifier XU may be more appropriate."

The logic doesn't follow, Gendron says. "If modifier -59 is not appropriate, why would XU be applicable, if performed during the same session? This seems to conflict with NCCI edits. If the procedures were performed at different sessions, or encounters, it seems XE would be a better choice. Or if the procedure were performed on the contralateral side, then anatomical modifiers RT or LT would be more suitable," she says. Also, it would help to have guidance on the definition of "encounter," Gendron says. "Does the patient physically have to leave the hospital or office and return later in the day, which seems clear that XE would be appropriate? Or, in the event of a lengthy stay, does the definition change?"

While Gendron appreciates CMS's circumspect approach to X modifiers, unless providers are using them, she is concerned how CMS will get the data it needs to give guidance on the modifiers' application to specific clinical situations. To help with this, she hopes CMS sets up a dedicated email address for suggestions from providers on X modifier use similar to other e-boxes.

There are larger issues at stake. Straining hospital and physician brains is how modifiers are relevant now that many procedures are packaged under OPPS. Medicare packages outpatient payments for 25 comprehensive APCs (C-APCs) within 12 clinical families and packages payments for certain ancillary services that are integral, supportive, dependent or adjunctive to a primary service *(RMC 11/10/14, p. 3)*. "The overarching picture is with the revamping of OPPS and the packaging of ancillary services, the requirements of the new modifiers and how they play out with NCCI edits," Gendron says. "It adds a new twist because most ancillary services have moved to a status indicator of Q1. Do we even bother modifying if and when we know they will be packaged? It adds another layer of confusion for providers."

### Consider ABNs Despite Packaging

OPPS status indicators, which are assigned to every HCPCS code, communicate how Medicare will or will not reimburse providers for a service. A Q1 status indicator will package the payment when billed on the same date of service as codes with S, T or V status indicators.

Gendron says Medicare still wants hospitals to report all services separately, even though many of them will be packaged in a soup-to-nuts payment. She encourages providers to continue to run medical-necessity checks on ancillary services — matching diagnosis and procedure codes on local or national coverage decisions — even if it won't affect the packaged payment. "CMS guidelines are to check for medical necessity first, but does medical necessity trump packaging and bundling and overall payment?"

A concern is when one of the ancillary services that would otherwise be packaged isn't covered for the diagnosis on the physician's order. If the hospital knows the service doesn't meet medical necessity, should it obtain an ABN from the beneficiary so he or she is financially responsible for the service when Medicare doesn't pay for it? "If you don't have medical necessity, have a patient sign an ABN. You could potentially receive greater reimbursement, because the provider can collect from the beneficiary," Gendron says. "Is that fair to the beneficiary? Should we collect? These are the questions our providers are asking."

Contact Gendron at gendrona@trinity-health.org. ✧

## NEWS BRIEFS

◆ **CMS has accepted Yorkville Endoscopy LLC's plan of correction, so it will remain in Medicare and Medicaid,** according to a Feb. 20 letter from J. William Roberson, director of the CMS Northeast Division of Survey & Certification. Yorkville Endoscopy is the Manhattan ambulatory surgery center that was scheduled for Medicare and Medicaid termination on Jan. 31 for not complying with some of the ASC conditions for coverage *(RMC 1/19/15, p. 1)*.

◆ **In new reports, the HHS Office of Inspector General says two more hospitals were overpaid for Kwashiorkor, a form of severe protein malnutrition that is rare in the United States.** OIG audited 102 inpatient claims submitted from 2010 to 2013 by 1,422-bed Baptist Health System in San Antonio, Tex., with the diagnosis code 260 for Kwashiorkor. All were coded incorrectly, OIG said. "The Hospital used diagnosis code 260 for Kwashiorkor but should have used either a code for another form of malnutrition or no malnutrition code at all," the report said. As a result, the hospital was overpaid $477,334. In the second report, OIG said 1,585-bed Methodist Hospital, also located in San Antonio, was overpaid $440,496 for DRGs billed with the Kwashiorkor diagnosis code. OIG concluded that all of the 124 claims it audited, which were submitted from 2010 to 2013, were noncompliant. These are two of a series of OIG audits of Kwashiorkor *(RMC 3/17/14, p. 1)*. Read the Baptist report at http://tinyurl.com/kuadlg8 and the Methodist report at http://tinyurl.com/ls6t2q6.

◆ **The American Coalition for Healthcare Claims Integrity, a trade group that represents recovery audit contractors, has rebranded itself the Council for Medicare Integrity.** "The Council is also launching a new website (www.medicareintegrity.org), which will be a one-stop repository of all the verified data and reports about Medicare integrity programs," it announced. "The site will also include an Integrity Resource Center, which seeks to aggregate a wide array of resources to assist the provider community in their efforts to properly bill Medicare...."

◆ **A report in the *Journal of Hospital Medicine* says there has been almost a three-fold rise in the number of RAC hospital overpayment determinations between 2011 and 2013.** Hospitals are challenging and winning a greater percent every year, the study found. One third of overpayment findings were resolved in the discussion period, according to the findings, which indicate the need for RAC reform. Visit http://onlinelibrary.wiley.com/doi/10.1002/jhm.2332/abstract.

◆ **A New Jersey family physician was arrested on Feb. 23 and charged with defrauding Medicare, Medicaid and private payers by billing for office visits that allegedly never happened, the U.S. Attorney for the District of New Jersey said.** Albert Ades, 60, of Englewood, was indicted by a federal grand jury in Newark on one count of health care fraud and 35 counts of making false statements relating to health care matters. According to the indictment, Ades billed insurers for face-to-face visits when he only wrote prescriptions, authorized refills, or did other tasks without seeing the patients on the dates of the visits. Allegedly, "Ades altered, and instructed individuals working at his medical practice to alter, patients' medical charts by inserting fabricated blood pressure readings, among other notations, to make it appear as if patients had visited Ades's office on dates for which Ades had billed their insurance plans," the U.S. attorney's office said. Ades allegedly billed payers for the office visits from 2005 through June 2014. Visit www.justice.gov/usao/nj.

◆ **The House Ways and Means Committee on Feb. 26 approved a bipartisan program-integrity bill, the Protecting the Integrity of Medicare Act of 2015 (H.R. 1021).** The bill was introduced by Ways and Means Health Subcommittee chairman Kevin Brady (R-Tex.) and ranking member Jim McDermott (D-Wash.). Among the provisions, the bill deletes Social Security numbers from Medicare cards; expands outreach by Medicare contractors; requires home health agencies to get $50,000 surety bonds to enroll in Medicare; eases restrictions on gainsharing so hospitals could reward physicians for more efficient use of resources; and requires HHS to issue a report on the best way to establish a hospital-physician gainsharing program. Visit http://tinyurl.com/kef866h.

◆ **Dickson Medical Associates in Dickson, Tenn., agreed to pay $500,000 to settle false claims allegations,** the U.S. Attorney for the Middle District of Tennessee said on Feb. 23. The feds alleged that a physician billed for the drug Reclast, which is used to treat osteoporosis and bone damage, when the physician actually prescribed to patients a foreign version of the drug that was not approved for use in the United States. Visit www.justice.gov.usao/tnm.

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