Hospital Says MAC Avoids Paying Claims For Bariatric Surgery Despite Compliance

When it comes to fighting for reimbursement, sometimes hospitals have to act like a dog with a bone.

That’s what WellSpan Health in York, Pa., is finding with some of its claims for bariatric surgery. They are being rejected even though the claims comply with national and local coverage determinations (NCDs and LCDs) for bariatric surgeries and the Medicare claims processing manual, says Becky Dennis, a nurse auditor at WellSpan. She says she has spent almost a year going back and forth with the Medicare administrative contractor (MAC) about high-dollar claims that comport with Medicare coverage rules, to no avail so far. The MAC, Novitas Solutions, keeps sending back the bariatric surgery claims as invalid based on out-of-date Medicare guidance, Dennis says. “They are quoting their own policies incorrectly.” The MAC will agree with her on one point, but then find another reason not to pay the claims, she says.

“It’s been a bit of a rollercoaster,” says Dennis.

This is another challenge in program integrity, and it worries her, because some of the claims are being “returned to provider” — RTP’d — which is different from claim

Expect More Cases, Hearings as OIG Forms Legal Team Devoted to CMPs, Exclusions

Health care organizations should brace for more administrative actions now that the HHS Office of inspector General (OIG) has created a legal squad exclusively devoted to civil monetary penalty (CMP) and exclusion cases. The 10 attorneys on the “litigation team” will dedicate all their time to pursuing providers who run afoul of any of the 40 CMP or exclusion authorities.

“We are pretty excited about it,” Robert DeConti, assistant inspector general for legal affairs, tells RMC.

The attorneys, who are the newly minted “team five” in the Office of Counsel, will fill in some of the enforcement gaps that result from the Department of Justice’s (DOJ) pursuit of larger-dollar or major patient-harm cases (RMC 7/20/15, p. 4).

OIG is “creating a dedicated cadre of attorneys and freeing up 100% of their time to work on OIG-initiated civil money penalties and exclusions,” DeConti says. “These are cases we are developing and bringing.” They are not, for example, a matter of defending an appeal from providers excluded because they lost their license.

The litigation team will build cases based on findings from data mining, the Office of Audit Services, Office of Investigations, Office of Evaluations and Inspections, reports and fraud alerts. OIG has issued a series of fraud alerts over the years, most recently on physician compensation (RMC 6/15/15, p. 1 and 7), physician-owned distributorships (RMC 4/8/13, p. 3) and financial arrangements between clinical labs and referring physicians (RMC 6/30/14, p. 1).
Sometimes, the litigation team will go after the fish who were too small to fry when DOJ netted the larger fish in a false claims settlement. “Those cases may be too small for DOJ to pursue and may not be as appealing from a jury standpoint, but we think those are as important to bring,” DeConti says. “We think cases like that help enhance the culture of compliance, and they level the playing field.” In other words, if providers aren’t playing by the rules, they are more likely to face a CMP or exclusion case from OIG than they were before. It’s usually only the deep-pocketed organizations that are party to a fraud scheme that face the consequences (e.g., the payer of the kickback, not the recipient), which left the scales of justice imbalanced and compliant organizations at a competitive disadvantage.

When the litigation team informs an organization it is bringing an exclusion or CMP action for any one of the potential violations (e.g., knowingly submitting false or fraudulent claims to a federal health care program, violating the anti-kickback statute by offering or soliciting remuneration to induce the referral of federal health care program business, billing while excluded or employing an excluded individual), DeConti expects most will enter into a settlement. “If they are a criminal masquerading as a provider, there will be an exclusion,” he says. If they are legitimate providers, “exclusion will be a very big deal” because obviously it means they can’t participate in federal health care programs for whatever period OIG proposes for the exclusion. There will be push back from targeted organizations, because exclusions are considered financial death sentences. “We will see more cases where we push for exclusion and then we take the case to a hearing,” DeConti says.

Cases the litigation team pursues also will “reinforce OIG guidance, which is a big objective.”

For a long time, OIG has signaled its hunger to pursue more exclusion and CMP cases, says former senior OIG attorney Howard Young. “OIG appears now to be gearing up to turn its desire into an action plan with the hiring of experienced litigators,” says Young, with Morgan Lewis in Washington, D.C. “In many ways, the administrative law judges who hear these appeals have very limited jurisdiction, and, as OIG knows, the administrative case law is stacked in OIG’s favor.” The worm may turn, as cases pile up and organizations challenge OIG’s enforcement actions in federal court, Young says.

Meanwhile, he expects the real-world result of the litigation team will be more affirmative enforcement against physicians, corporate health care executives and corporations where OIG sees an opportunity to, in its eyes, “send a message” to the industry “where it believes it has or can readily develop reliable evidence to support its cases.”

Robert Penezic, deputy branch chief in the OIG Office of Counsel, will head the litigation team.

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Despite Risks of No FCA Release, Some Favor OIG Self-Disclosure

For the first time, a veteran attorney is rethinking whether the Department of Justice (DOJ) is the go-to place for self-disclosures of potential violations of the False Claims Act. Maybe, just maybe, his clients would fare better with the HHS Office of Inspector General (OIG), even if it means losing the ironclad protection of a written release from a False Claims Act lawsuit. Some other lawyers have arrived at the same conclusion, says the attorney, who declines to be identified.

The reason, he says, is that recently, assistant U.S. attorneys seem to insist on double damages or more when organizations self-disclose their purported misconduct. In other words, they don’t get enough of a break for com-
ing forward with their violations, he says. “[Prosecutors] are more likely to treat you almost the same way as if they discovered the matter themselves or a whistleblower did,” he says. “You end up looking at a multiplier that starts with double and goes up instead of down.” This harder line from DOJ, he says, contravenes the purpose of self-disclosure, which is supposed to offer organizations reduced liability as an incentive to come clean about possible misconduct that perhaps the government would never have identified itself, and then they can fix things going forward. In contrast, OIG’s Self-Disclosure Protocol offers a 1.5 multiplier on damages, although it reserves the right to require something higher. “I am starting to change my thinking about how I advise clients,” he says.

Is Formal FCA Release Always Necessary?

He used to avoid OIG’s Self-Disclosure Protocol because it seemed too “inside the Beltway,” favoring a local U.S. attorney who knew his client. Now, however, he’s more inclined to recommend the Self-Disclosure Protocol even though it won’t result in a False Claims Act release. OIG has jurisdiction over civil monetary penalty (CMP) laws and exclusion, so organizations get a release only from administrative liability. But there is a longstanding memo of understanding between DOJ and OIG, which essentially says DOJ must decline interest in a case before OIG moves forward with its CMP and exclusion authorities. “That enables me to tell clients that if you go to OIG and they give you an administrative release, it would be pursuant to a declination of interest by DOJ, which is a pretty good indication you don’t have to worry about a false claims lawsuit,” the attorney says. And that probably means a 1.5 multiplier instead of two times or more, he says. “There’s no authority I can point to,” he tells them, “but trust me, it more or less forecloses false claims lawsuits.” However, it doesn’t mean providers are free of whistleblowers. Even if a whistleblower pursues a case, DOJ probably will decline to intervene, the attorney says, and he believes the court won’t look favorably on the whistleblower seeking recoveries for the same allegations brought forth in the self-disclosure by the organization, which already settled an administrative case. “The court probably isn’t going to be too inclined to allow it to move forward,” he says.

Notwithstanding the potentially higher damages, some organizations want the false claims release no matter what, the attorney notes.

Other attorneys say a variety of factors affect the decision to self-disclose to the Justice Department, including the personality of the assistant U.S. attorney. And U.S. attorneys don’t necessarily start at a damages multiplier of two or more. Anyway, other expenses affect the settlement amount, which reduces the impact of the multiplier, one attorney says.

“I agree the Department of Justice and assistant U.S. attorneys are taking a much harder line,” says Washington, D.C., attorney Linda Baumann, with Arent Fox. It depends, though, on which prosecutor you draw, and the circumstances of the case. “Some people are known to be fair,” she says. Baumann agrees it’s unlikely that DOJ will pursue a case that ends in an OIG administrative settlement, but there are still whistleblowers to contend with, and judges are wild cards. “It often feels like the cards are stacked against you,” Baumann says, and no one wants to be perceived as pro-fraud. Ideally, organizations can nip things in the bud by returning overpayments to Medicare administrative contractors, if they don’t rise to the level of deliberate indifference or reckless disregard, which is the standard of proof for a False Claims Act violation. She also wouldn’t be so sanguine about OIG. The Self-Disclosure Protocol says the 1.5 multiplier is the “minimum.”

Not all prosecutors require double damages to secure a false claims release, notes Robert Trusiak, former head of the affirmative civil enforcement unit in the U.S. Attorney’s Office for the Western District of New York. “It’s my experience some assistant U.S. attorneys will consider less than double damages,” Trusiak says. Anyway, the multiplier is not the only economic factor. There’s interest on the dollar amount of the settlement, as well as the time period of the alleged offense, which affects the piling on of fines and penalties. Then there are net losses. Will the government take into account what the provider should have received if it correctly coded (e.g., billed evaluation and management level of service three instead of four or observation services instead of an inpatient admission)? “It’s my belief that in a self-

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**CMS Transmittals and Federal Register Regulations**

**July 17 – July 23**

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. 100-07, State Operations Manual**
  - Revisions to Chapter 9 Exhibits, Trans. 142SOMA (July 17; eff./impl. July 17, 2015)

- **Pub. 100-08, Medicare Program Integrity Manual**
  - Medical Review of Home Health Services (R), Trans. 603PI, CR 9189 (July 21; eff./impl. Aug. 11, 2015)

**Federal Register Regulations**

- None published
disclosure, you get a much more generous reception from the government on the calculation and mitigation of damages,” says Trusiak, a principal of Health Care Compliance Support in Buffalo.

He thinks providers ought to get their hands on False Claims Act releases. “There is no jurisdictional bar in the False Claims Act that would support a motion to dismiss based on an administrative release.”

A lot of variables go into the self-disclosure decision, he notes. Who, specifically, would consider the self-disclosure in the U.S. attorney’s office? What’s the level of trust? How much money was implicated? Who knew about incorrect billing internally and discussed it in email, threatening law enforcement contact? Do employees have an ax to grind? The existence of emails characterizing the conduct as fraud foreshadows whistleblower actions and requires a deliberate assessment of the need to secure False Claims Act release now to bar a later filed qui tam, Trusiak says.

“If you have a series of emails where people used the ‘F’ word — fraud — to describe conduct, it means those people are potential whistleblowers,” he notes. “If you choose to disclose the matter and don’t get a False Claims Act release, and you have people who used very culpable terminology, even if the Department of Justice doesn’t intervene, relator’s counsel could proceed with an independent false claims action. No court will simply sua sponte dismiss something.” Sua sponte is a legal term meaning the court acts unilaterally.

Keep in mind that the government wants to reward organizations that show they are serious about compliance. But a lone disclosure doesn’t do the trick, he says. Repayments to Medicare and Medicaid should be routine and “demonstrate a genuine commitment to compliance allowing for, at least, a conversation about a False Claims Act release at less than double damages. The DOJ in my experience, rewards providers with a demonstrated commitment to compliance,” Trusiak says.

CMS’s self-referral disclosure protocol (SRDP) is a possibility if you are dealing only with Stark violations. But it won’t lead to a quick resolution because the program is swamped, with providers waiting for years to hear from CMS whether they’ve even been accepted into the protocol, Baumann says. That should change eventually if Stark reforms in the proposed Medicare physician fee schedule regulation take effect Jan. 1 (RMC 7/20/15, p. 1). Those reforms would eliminate the need to report various types of contractual “technical” noncompliance as violations of the law. For now, the risk in taking your chances outside the SRDP is that DOJ and CMS may interpret Stark differently to the detriment of providers, Baumann says. In two cases she’s aware of, CMS disagreed on the record with DOJ about what the Stark law requires. The cases concerned DOJ’s position that it’s not commercially reasonable for hospitals to pay employed physicians a certain level of compensation if the hospitals won’t make a profit on their practices, counting only the revenue the physicians generate for their professional services. Commercial reasonableness is a requirement for compliance with the Stark law’s employment exception that most hospitals rely on if they employ physicians who will refer patients to them.

Because the SRDP doesn’t include a False Claims Act release, DOJ conceivably could pursue a case despite an organization’s resolution with CMS, Baumann says. But she thinks that’s unlikely. CMS is supposed to coordinate with DOJ and OIG when it gets an SRDP submission, so presumably DOJ would take over if the matter appeared to rise to the level of a false claim. “In fact, the SRDP makes the point that providers should carefully consider to whom they want to disclose since CMS may use an SRDP submission as the basis for contacting DOJ and the OIG,” Baumann says.

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**Consider Business, Legal Risks Of PSAs as Popularity Grows**

After selling hospitals their practices, some physicians skip the familiar employment route and negotiate professional service agreements (PSAs) with hospitals instead. It’s a path that’s getting more popular in some places, experts say, but it carries its share of legal, regulatory and business risks.

“PSAs are increasingly used as a vehicle for integration,” says Minneapolis attorney Jim Platt, with Fredrikson & Byron. “Lately I am seeing more of the PSA model than employment.”

PSAs are agreements between two providers for the provision of medical services, he says. Health systems enter into PSAs with physicians for medical directorships, emergency room services or a service line, such as oncology. PSAs also are used as part of an asset purchase.
Physicians like PSAs because they are apprehensive about becoming employees [of hospitals], especially in rural areas,” he says. The physicians know the hospital executives and may work well with them “but don’t fancy becoming employees of the hospital CEO,” Platt says. The practice contracts with the hospital. “It gives some insulation,” he notes.

As employees of their own medical group, physicians have the advantage of collectively renegotiating PSA terms with the hospital, Platt says. If they were separately employed by the hospital after the practice’s acquisition, the hospital would be able to “pick and choose how to sweeten compensation for particular doctors,” he says.

There are other upsides of PSAs. They streamline billing because the health system bills payers for the physician and hospital services. PSAs also allow hospitals and physicians to venture into new specialty service lines because the hospital will bear financial risks that physicians wouldn’t or couldn’t on their own.

**Reconsider Long-Term Contracts**

Here are a few key contractual issues to address when entering into PSAs:

- **Term:** It’s a no-brainer that medical directorships or service-line agreements will be a year or two, but it’s tempting to enter into long-term PSAs for a whole practice. Platt says that conventional wisdom may not be so wise amid all the transformation underway in health care. “It’s hard to know for sure if this model will be the kind of model people will want five years from now,” he says. A related issue is whether contracts should be evergreen or have a hard stop. The danger with hard stops is providers “blow right past them, not realizing the contract has terminated,” Platt says. Money keeps changing hands without a valid contract, “so you have a potential Stark problem.” With evergreen contracts, “one side or the other has to say, ‘we want it to end.’ Otherwise, it will continue to renew.”

- **Termination rights:** All PSAs have a “for-cause” termination clause, which means the hospitals can throw out the PSA if the doctors don’t perform, although there’s usually a “cure provision” giving the group a chance to fix the problem. But things can get “cumbersome and tricky” when only one physician is dropping the ball. Since the physician is not an employee, the route to termination is circuitous. The hospital can threaten to kill the PSA with the group if it doesn’t get rid of the errant physician while it uses its medical staff process to address privileges.

- **Exclusivity:** Will the medical group be the exclusive provider of primary-care services, or will the hospital be able to employ other primary-care providers? This can be a challenge now that nonphysician practitioners are major players “on the front lines” and are more affordable than physicians and often easier to recruit in some areas, Platt says. Hospitals should think twice about tying their hands with exclusivity agreements and maybe instead give the clinic the right of first refusal. “We typically say if the hospital has a need for additional primary care providers, such as nonphysician practitioners, and the clinic doesn’t want to provide them, the hospital can do it on its own nickel,” he says. **Consider Meaningful Use**

When structuring PSAs, there are also legal and regulatory considerations, says Katie Douglas, also with Fredrikson & Byron. For one thing, providers are not allowed to reassign Medicare payments to a third party, she says. There are exceptions, however. Non-employed physicians can reassign the right to receive payments to an entity with which the physician has a contractual relationship, as long as the physician and entity are jointly and severally liable for overpayments, and they have joint access to claims submitted in connection with the reassignment, Douglas says.

Meaningful-use payments add a twist with PSAs. They’re generally made to individual practitioners, not to entities that employ physicians or that have a PSA with physicians, she says. “But Medicare allows eligible providers to assign meaningful-use payments if the eligible provider has a contractual relationship with the entity,” she says. It’s essential to address this in the PSA because eligible providers can assign meaningful-use payments to only one entity (i.e., either their clinic or the hospital).

Tax exemption is another regulatory risk. For example, “there are significant penalties if tax-exempt hospitals engage in transactions where more than fair-market value is paid,” Platt says. For instance, sometimes PSAs are designed to reward physicians when hospitals achieve certain financial goals. “You have to be careful you are not agreeing to pay above the net income of the hospitals,” he says. “It can’t inure to the benefit of private individuals — physicians — so be careful how you design your benefits.”

The anti-kickback law is another risk because compensation paid to physicians under the PSA could appear to be hospital payments for referrals. “The concern is the hospital will pay physicians extra, or the payments will influence physicians to refer more patients to the hospital” or incentivize them to order services, Douglas says.
Bariatric Surgery Claims Denied
continued from p. 1
denials. RTPs can be fixed and resubmitted for payment, but they can’t be appealed through the usual five-level administrative appeals process unless they are denied. WellSpan made a few mistakes on the claims — inaccurate codes and dates of service — and can easily correct them. Much more infuriating has been the MAC’s use of antiquated Medicare policy, Dennis says, and the inability to get this rectified. “I can’t get one straight answer,” she says.

In the case of one expensive bariatric surgery, if the MAC drags its feet long enough, it will be too late to bill it because of the one-year timely filing deadline, Dennis says. “I think it can happen with anything you put out there.”

According to the national coverage determination (100.1), Medicare covers certain bariatric surgeries — Roux-en-Y gastric bypass, biliopancreatic diversion with duodenal switch or gastric reduction duodenal switch, adjustable gastric banding and sleeve gastrectomy. Although it defers to MACs, Medicare is willing to pay for stand-alone laparoscopic sleeve gastrectomy for patients with a body mass index (BMI) of 35 and at least one comorbidity related to obesity who have been unsuccessful with medical treatment for obesity. “NCDs normally trump local coverage determinations, but they are leaving it to the MACs to determine coverage for these,” Dennis says.

Patient Is Obvious Candidate

In Pennsylvania, the language in Novitas’ LCD seems to contradict itself, Dennis maintains. The LCD states that “surgical treatment for primary obesity is not a covered Medicare service,” then says, “CMS national policy dictates that surgery for morbid obesity is covered for Medicare beneficiaries who have all of the following: A body mass index of 35 or higher; at least one comorbidity related to obesity and previous unsuccessful medical treatment for obesity.” That indicates Novitas is not covering bariatric surgery for morbid obesity alone. There is coverage for specific surgical procedures, but the patient must meet additional criteria. The MAC also agreed to cover “Laparoscopic Sleeve Gastrectomy as a stand-alone procedure — not part of staged procedure or failed attempt that moves to an open procedure.”

Against that backdrop, Dennis has been going back and forth with Novitas over a number of Medicare claims for patients who have received bariatric surgery. For example, one patient who was considered “super morbidly obese” underwent a laparoscopic sleeve gastrectomy, Dennis says. “She meets the written standards under the NCD.” The patient’s weight was 315 pounds.

PSAs Must Meet Stark Exception

The Stark law is another risk for PSAs. It forbids Medicare payments to entities that furnish designated health services (e.g., inpatient and outpatient services) referred by physicians who have a financial relationship with the DHS entity, unless an exception applies. In terms of a Stark analysis, the question isn’t whether the PSA involves the provision of DHS, Douglas says. It’s whether physicians in the PSA make referrals to the entity that has a PSA with the physicians. “So we want to look at the types of services referred to the entity,” she says. Under Stark, only compensation relationships — not an investment interest — are worrisome with PSAs.

If DHS are referred to the entity that has a PSA with the referring physicians, it will have to comply with a Stark exception. There’s a Stark exception for PSAs, and it’s similar to the safe harbor for PSAs, she says.

To qualify for the Stark exception, the PSA must be in writing, specify and cover all services and last for at least a year. Also, services can’t go beyond what’s reasonable and necessary to accomplish legitimate business purposes, and can’t involve illegal activity, and compensation must be set in advance, not exceed fair-market value and be unrelated to the volume or value of referrals. Even though the term of the PSA must be a year, “you are not locked into it” for a year, Douglas says. But if you terminate it after three months, for example, “you can’t enter into another one for a year” from the original date. Also, she notes, setting compensation in advance doesn’t mean citing actual dollar figures. Only the formula must be established in advance, Douglas says.

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with a 55.8 BMI. She has three comorbid conditions: benign essential hypertension, obstructive sleep apnea and lumbar canal stenosis. And she had been treated for obesity. “I have documentation where the patient had monthly appointments with WellSpan medical weight management. She had some weight loss recorded, but it wasn’t successful enough to make a huge difference,” Dennis says. In addition, the patient had been cleared for the operation with the cardiac, pulmonary and psychiatric departments and dietitians. “She had the surgery, and Novitas rejected the claim,” Dennis says. “I am getting 20 different reasons why they processed the claim that way.”

Other claims shared the same fate. The explanations for that make no sense, Dennis says, and are based on outdated instructions that have been superseded by more recent Medicare guidance. Here are three reasons the MAC gave Dennis for the bariatric surgery rejection for this patient and why she says they are unfounded:

◆ **The MAC cited MLN 5013, which states that “when services are performed in an unapproved facility, Medicare will deny the claim with a claim reason adjustment code of 58.”** That referred to the fact that for a long time, CMS covered bariatric surgeries only when they were performed at a Level 1 Bariatric Surgery Center or a Bariatric Surgery Center of Excellence. But Dennis had a foolproof rebuttal for them. In 2013, CMS issued Change Request 8484, which stated that it “has determined that the evidence is sufficient to conclude that continuing the requirement for certification for bariatric surgery facilities would not improve health outcomes for Medicare beneficiaries. Therefore, CMS removes this certification requirement, effective with dates of service on or after September 24, 2013.” It was moot anyway, because WellSpan York Hospital is accredited through the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program and is designated a Bariatric Center of Excellence, Dennis notes. Infallible or not, her arguments are falling on deaf ears, she says.

◆ **The MAC said WellSpan provided one procedure code, but had to add two more based on Chapter 32 of the Medicare Claims Processing Manual (Sec. 150.3).** “Procedures Codes for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity.” That’s true for two other bariatric procedures — biliopancreatic diversion with duodenal switch or gastric reduction duodenal switch, Dennis says. “That’s not what the patient had,” she explains. The patient had a laparoscopic sleeve gastrectomy, which is a stand-alone procedure that doesn’t require additional procedure codes.

◆ **The MAC maintained the procedure wasn’t reimbursable unless one of the comorbid conditions was Type 2 diabetes mellitus.** “I agreed this was a comorbid condition, but it is not the only comorbid condition that’s covered,” she says. LCD L34495 has a list of secondary and tertiary codes that cover several pages.

But Dennis has been tilting at windmills. When this claim RTP’d, it had a Medicare remark code of MA44, which means there are no appeal rights. There has been no other explanation. “When it came back as rejected, I thought, ‘you’ve got to be kidding me,’” Dennis says. With no elaboration, and with every phone conversation with Novitas concluding with different reasons for rejection, “it has become quite a challenge.” Dennis says. WellSpan made mistakes too. After working and re-working the account for almost a year, the audit team realized the procedure code the hospital submitted was wrong, she says. “Notwithstanding the errors on our part, the MAC has made the process of determining their reasons for rejection somewhat of a loser’s game,” she contends. “The kicker is, the date of service was Aug. 27, 2014, so we’re coming up to a year,” Dennis says. When a year passes, it will be too late to resubmit it. For now, “I’m not one to back down.” There’s a lot of money at stake — Medicare pays hospitals almost $11,000 for this particular type of bariatric surgery, she says.

Dennis offers suggestions for hospitals that feel they are backed by Medicare policies, but the MAC RTPs claims or outright denies them:

◆ **Dive deep into the NCD and LCD, she says.**

◆ **When on the phone with MAC customer service agents, ask them to direct you to the exact requirements they cite in their denial.** Is it an NCD or LCD? Maybe an MLN Matters article? Are they drawing from the Medicare Claims Processing Manual? “Have them point out the reasons within their reference. There is a great deal of repetitive information as well as contradictory information if you are not using the most recent guidelines,” Dennis says.

◆ “**Take notes and tell them you will review their requirements and be back in touch.** Let them know you are not giving up.”

◆ **Research the requirements provided by customer service reps from the MAC.** “Don’t automatically assume that they have given you an absolute decision or the best answer,” Dennis says. Are they the most recent guidelines? Are they contradictory? Are they referencing the correct procedure code? Do you have the necessary documentation to prove the account should be paid? There is far too much information for any one person to know all of it, even for the MACs.

◆ **Use the resources available to you.** Invite your hospital’s billers and coders to take a second or third look, Dennis says.

◆ **Be persistent, and then after that, don’t give up.***
When hospitals feel they can’t get traction with their MACs, “their first stop should be the CMS regional office,” says Washington, D.C., attorney Andy Ruskin, with Morgan Lewis. They also could appeal through normal channels — the five-level Medicare appeals process available for actual claim denials — if they are worried about the one-year timely filing deadline. “If they make every effort to a clean claim and it is RTP’d as opposed to denied, I would file an appeal anyway,” Ruskin advises. “They will do battle regarding jurisdiction because the MAC will say the hospital never filed a claim. It might seem like a Hail Mary pass, but you do whatever you can to reserve your appeal rights.” If the appeal continues to be rejected as lacking jurisdiction at all levels, then the hospital may find itself in court, but Ruskin thinks the court will be “very receptive to an argument” that a claim was rejected despite its consistency with Medicare policies, and that the purported lack of jurisdiction is based on CMS’s own mistake. But the whole experience, of course, “can be frustrating.”

Contact Dennis at bdennis@wellspan.org and Ruskin at aruskin@morganlewis.com. View the NCD at http://tinyurl.com/qzpfb8q, the LCD at http://tinyurl.com/qbx8f8, Chapter 32 of the Medicare Claims Processing Manual at http://tinyurl.com/7f9tmw and Change Request 8484 at http://tinyurl.com/ndrugkx.

NEWS BRIEFS

♦ CMS has released the latest edition of its Medicare quarterly compliance newsletter for providers. The issue, dated July 2015, addresses billing, documentation and medical necessity problems in 10 areas, including lumbar spinal fusion. Visit http://tinyurl.com/onl4ger.

♦ Two of CMS’s procedures apparently are effective at keeping ineligible or potentially fraudulent providers out of Medicare, but there are weaknesses in two other enrollment screening procedures, the Government Accountability Office (GAO) said in a report (15-448) released July 23. When providers enroll through the Provider Enrollment, Chain and Ownership System (PECOS), they have to submit their practice locations. GAO found about 22% of the 2013 practice locations’ addresses are “potentially ineligible” (e.g., vacant, mailbox store), and software that CMS uses doesn’t flag them. Also, physicians enrolling in Medicare must have an active license and report any adverse actions, which must be verified by Medicare contractors. “GAO found 147 out of about 1.3 million physicians listed as eligible to bill Medicare who, as of March 2013, had received a final adverse action from a state medical board for crimes against persons, financial crimes, and other types of felonies but were either not revoked from the Medicare program until months after the adverse action or never removed,” the report said. Visit www.gao.gov/assets/680/671561.pdf.

♦ The U.S. Attorney’s Office for the Eastern District of Pennsylvania filed a false claims lawsuit (No. 11-2756 (LFS)) against several community mental health clinics on July 20 involving an exclusion and inflated billing. The defendants are Melchor Martinez and his wife, Melissa Chlebowski, both of Allentown, Pa., and their businesses, Northeast Community Mental Health Centers in Philadelphia; Lehigh Valley Community Mental Health Centers in Allentown, Easton and Bethlehem; and North Carolina Community Mental Health Centers in Raleigh, N.C. The U.S. attorney’s office says Martinez was excluded from federal health care programs because of a 2000 Medicaid fraud conviction, which meant he could not own, manage or receive payments from a federally funded provider. Notwithstanding this restriction, “Martinez, assisted by his wife Chlebowski, continued to own and operate the Northeast and Lehigh Valley clinics, and that, in 2009, while his exclusion was ongoing, he started up the North Carolina clinic in Raleigh,” the feds allege. Visit http://tinyurl.com/nzcsdfk.

♦ A Baltimore man who served as chief financial officer to three companies was indicted by a grand jury on charges he fraudulently obtained $1.6 million from them, the U.S. Attorney’s Office for the District of Maryland said July 23. Christopher C. Camut was accused of ripping off a company that makes products for the medical industry and two others, said the U.S. attorney’s office, which didn’t identify the companies. Embezzlement is not uncommon in the health care industry, and in one recent hospital case, the compliance officer was critical to the resolution of a scheme (RMC 3/30/15, p. 1). In the Maryland case, “from January 2008 to May 2014, Camut created engagement letters, agreements and invoices to make it appear as if financial institutions had provided services to the companies,” the U.S. attorney’s office alleges. “He caused the companies to issue checks payable to financial institutions, which Camut then deposited into his personal bank accounts.” Visit http://tinyurl.com/nh3pndp.
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