Report on
MEDICARE COMPLIANCE

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Weekly News and Analysis on New Enforcement Initiatives and Billing/Documentation Strategies

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Some Hospitals Hit by NPI Claims Denials; Problem Solving Is Key as Deadline Nears

Starting May 23, Medicare claims must contain only National Provider Identifiers (NPIs) or they will be rejected, so it's almost time for providers to bid farewell to their existing Medicare provider identification numbers. By now, providers should be testing at least small batches of claims with just the NPI to work out the kinks, as CMS has recommended. Testing is essential to flesh out problems and try to fix them before the deadline arrives, experts say. Even this late in the game, CMS says, only a small percentage of all Medicare claims are being submitted with just the NPI.

NPIs are another feature of HIPAA administrative simplification. Providers apply for NPIs from CMS's National Plan and Provider Enumeration System (NPPES).

Exclusive use of NPIs was originally set for May 23, 2007, but CMS extended the deadline a year as long as providers worked toward compliance. However, any time after May 23, 2007, providers were welcome to start submitting claims with both their Medicare provider numbers and NPIs. But in March 2008, that became a mandate. CMS told Medicare contractors to reject any claims that were submitted with anything other than an NPI in the primary provider field, says Nashville, Tenn., attorney Brandon Schirg, who is with the law firm Waller Lansden Dortch & Davis, LLP. The mandate was one of the last steps toward the final transition to the NPI-only system and has already caused some payment delays and problems for a number of providers, he says.

The first set of problems emerged with Medicare's provider-identifier crosswalk, Schirg says. The crosswalk is essentially a CMS database designed to link an NPI to an existing Medicare provider identification number. "The maddening thing for some hospitals is they would submit claims with both their NPI and provider number, and the claims would be rejected anyway," he says.

In one snafu, CMS and a fiscal intermediary (FI) were reviewing and editing information in the NPI crosswalk, and they "inadvertently deleted information for 30 to 40 hospitals. So when the facilities tried to submit their claims electronically, there was no

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With New Enrollment Forms Taking Effect, CMS Unveils Appeal Process, Model Letters

The CMS Form 855 Medicare enrollment applications that take effect July 1 have again been refined in an attempt to promote provider integrity, and CMS will no longer go easy on violators. Providers should pay close attention to filing deadlines, especially for routine updates of key organizational changes (see forms, p. 4). However, CMS recently made two moves that are seen as beneficial to providers: It clarified the existing appeals process for Medicare enrollment application denials and provider-number revocations, and it created uniform letters for all Medicare contractors to use when communicating with providers about enrollment submissions.

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Cheryl Rice, corporate director of corporate responsibility for Catholic Healthcare Partners in Ohio, tells *RMC* that CMS is trying to improve coordination and communication with providers. The developments also "reinforce the expectation that providers must play an active role in maintaining their own accountability and continuing compliance," she says.

In Transmittal 251 (Change Request 5826), issued April 11, CMS made significant modifications to the administrative appeals section of the Medicare *Program Integrity Manual* (Pub 100-08). The new language, for example, requires contractors to explain to the provider why its application is being denied (e.g., on what regulatory basis) and to provide information on how to get back in Medicare's good graces. The same process is added for provider-number revocation. What's particularly important about the transmittal, says Rice, is it informs providers that CMS may refuse to enroll providers or may revoke their provider numbers (which means their billing privileges) if they don't submit their 855 or file updates in a timely manner. "That is why meeting the deadlines is so important," she emphasizes. The appeals instructions also are "pretty clear-cut and help [providers] go step-by-step so they know what to do," she says.

In Transmittal 247 (Change Request 5832), issued March 21, CMS published model letters "for use by Medicare contractors when issuing a determination letter or request for information for Medicare enrollment issues." This information is useful because it lets providers know where they stand and eliminates contractor-to-contractor variance, Rice says. "It's a clear, consistent message of CMS's expectations" for providers, she notes. There is a variety of model letters: an acknowledgment letter, a development letter (which requests revisions and supporting documentation), a rejection letter, a returned application letter (which seems to just mean some information is missing), a series of approval letters for different types of new applicants or new information and validation letters (providers have to reapply to Medicare every five years).

New Year, New Form, New Changes

The newest set of changes to the enrollment forms was released March 14 and implemented by Medicare contractors April 14. CMS told providers (with the exception of specialty hospitals) to start using the new applications immediately, though Medicare contractors will continue to accept the current version until July 1, 2008, according to an *MLN Matters* article (SE0810).

There are multiple forms tailored to different types of entities (e.g., 855A is for institutions), plus there's a form for reassignment of Medicare benefits.

Since the enrollment process became a program-integrity tool — a way to block bad apples from Medicare and detect other problems — the 855 has undergone substantial revisions.

"Years ago, enrollment forms were very complex. Fiscal intermediaries did not enforce strict adherence to time frames for filing or reporting content changes," Rice says. Then CMS overhauled the 855 in 2006 to raise the bar for more compliant timely filing and processing of enrollment applications.

For one thing, CMS implemented "very specific timeframes" for all providers submitting enrollment applications and informing CMS of important changes at their facilities, Rice says. According to CMS, providers are required to tell Medicare (usually within 90 days) about changes in: (1) legal business name/tax identification number, (2) "doing business as" (DBA) name, (3) practice location, (4) ownership, (5) authorized/delegat-

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ed officials (e.g., board members, senior executives), and (6) payment information (e.g., electronic funds transfer information). "In addition, you are required to report any adverse legal actions, including felony convictions, license suspensions and debarments and exclusions," CMS says.

Also in 2006, CMS added an attestation to the enrollment forms. The CEO and a "delegated official" — usually an operational person — must sign a statement certifying that the form is accurate and complete, Rice says.

And for 2008, CMS again has raised the enrollment bar, hoping to further heighten its ability to sniff out unscrupulous providers and activities. For one thing, in 2008 CMS incorporated new supplier requirements for both independent diagnostic testing facilities and durable medical equipment, prosthetics, orthotics and supplies suppliers as part of the form and supports the new reporting time frames for some elements under both IDTFs (855-B) and DMEPOS (855-S). "CMS requires IDTFs and DMEPOS to communicate changes in their practices in an accelerated way, from 90 days to 30 days," Rice says.

New Compliance Risk

This indirectly triggers a compliance risk for hospitals and other providers. Now that IDTFs and DMEPOS have different enrollment submission deadlines (30 days) than providers do, CMS deleted the deadlines from the forms and substituted generic language — "within certain timeframes" — along with the regulatory citation. In other words, providers have to look up the deadline for submitting changes to CMS. That is less convenient than in the previous application, which just spelled it out. The problem with this, says Rice, is that "people might think CMS dispensed with the deadline." On the contrary, she says, not only are deadlines here to stay, but there's no more Mr. Nice Guy when it comes to missing them.

CMS clarified and implemented punitive damages and corrective actions for providers that fail to report changes by established deadlines. In addition to the corrective action plans it already offers for failing to promptly report changes in enrollment status, CMS announced it may deny or revoke a provider's Medicare billing privileges, says Rice. "They are saying if you persistently delay and/or are unable to comply, we will disenroll you, and you would have to go through the enrollment process all over again," she explains.

The new 855 for institutions also has a box that must be checked if the enrollee is a specialty hospital. A new set of instructions explains the definition of a specialty hospital.

The Medicare online *Program Integrity Manual* (Pub. 100-08, Chapter 10) includes specific instructions on completing the various 855 applications and provides guidance and review tips to help providers understand what CMS officials want included on the provider enrollment application, Rice notes.

In some of the other changes to the 855 enrollment form, CMS:

◆ ***Revised language to implement a regulation governing DMEPOS.***

◆ ***Expanded some fields to let health systems provide more detailed reporting*** of multiple provider locations, Rice says.

◆ ***Killed some supportive documentation within the application.*** Examples: a copy of the National Provider Identifier notification from the National Plan and Provider Enumeration System and a copy of the W-2 form for designated officials.

◆ ***Mandated reporting and use of nine-digit ZIP codes on all addresses reported on the 855.***

Rice also notes that CMS will be monitoring DBA information against the Qualifier.net database. "If the DBA is different from the Qualifer.net information, the provider can expect to get a model letter," she says.

Contact Rice at clrice@health-partners.org. To view the transmittals, visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "CMS Program Transmittals/Change Requests." The new enrollment applications are posted at www.cms.hhs.gov/MedicareProviderSupEnroll. ✧

Summary of 855 Enrollment Form Changes

These two forms describe the Medicare enrollment-form changes for institutions (855A) and clinics (855B) (see story, p. 1). They take effect July 1. These summaries were prepared by Cheryl Rice, corporate director of corporate responsibility at Catholic Healthcare Partners in Cincinnati. There are also changes for suppliers and for reassigning Medicare benefits. Contact Rice at clrice@health-partners.org.

Name of Form: CMS-855A. Type of Applicant: Institutions.

Section with Change	Page	Type of Change	Nature of Change
Who Should Submit This Application	1	Addition	Change of ownership or control reporting within 30 days.
Billing Number Information	1	Deletion	Online Survey Certification and Reporting System (OSCAR) number information.
Billing Number Information	1	Addition	Important notice for definition of Type 1 and Type 2 providers.
Obtaining Medicare Approval #2	2	Addition	Provide copy to the CMS regional office.
Section 1: Basic Information — Change of Information	4	Addition	New reporting requirements in accordance with 42 CFR 424.520(b).
Section 2: Identifying Information — Special Enrollment Notes	7	Addition	New required calculation of first year of hospital operation's projected inpatient discharges in cardiac (MDC-5) or orthopedic (MDC-8) or surgical care. Projections [are that] 45% or more of all inpatients require hospital-specialty block Section 2A2 to be checked.
Section 2: Identifying Information — B. Identification Information	8	Deletion	Eliminated reporting of Medicare year-end cost report date.
Section 4: Practice Location Information — Instructions	15	Addition	Important notice for listing and definition of "primary practice location" and reporting of National Provider Identifier (NPI) for Medicare billing.
Section 4: Practice Location Information — A. Practice Location Information	17	Addition	Multiple Medicare Identification Number (MIN) and NPI lines added for enhanced reporting.
Section 7: Chain Home Office Information	28	Deletion	Eliminated narrative defining chain organizations and home office. Listed instead only citation 42 CFR 421.404.
Section 15: Certification Statement	26	Revised	Adjusted reporting timeframe from 90 days to "within timeframes established in 42 CFR 424.520(b)."
Section 15: Certification Statement — A. Additional Requirements for Medicare Enrollment #1	37	Revised	Adjusted reporting timeframe from 90 days to "within timeframes established in 42 CFR 424.520(b)."
Section 15: Certification Statement — A. Additional Requirements for Medicare Enrollment #2	37	Revised	Adjusted statement from "denial or revocation of [MIN]" to "denial or revocation of Medicare billing privileges."
Section 17: Supporting Documents — Mandatory for All Providers/Supplier Types	41	Deletion	Eliminated need for Copy of NPI notification that was received from provider and National Plan and Provider Enumeration System (NPPES) to be sent with application.
Section 17: Supporting Documents — Mandatory if Applicable	41	Deletion	Eliminated need for copy of delegated official's W-2 if have delegated official to be sent with application.

Name of Form: CMS-855B. Type of Applicant: Clinics, Group Practices and Certain Other Suppliers.

Section with Change	Page	Type of Change	Nature of Change
Who Should Submit This Application	1	Deletion	Eliminated voluntary health/charitable agency from list.
Who Should Submit This Application	1	Revised	Adjusted reporting timeframe from 90 days to "within timeframes established in 42 CFR 424.520(b)" and added specific guidance for Independent Diagnostic Testing Facility (IDTF) timeframes per 42 CFR 410.33.
Billing Number Information	1	Revised	MIN information to include new Provider Transaction Access Number (PTAN) or legacy number information.
Billing Number Information	1	Addition	Important notice for definition of Type 1 and Type 2 providers.
Section 1: Basic Information — Enrolled Medicare Suppliers Change of Information	3	Addition	New reporting requirements in accordance with 42 CFR 424.520(b) and IDTF timeframes under 42 CFR 410.33.
Section 1: Basic Information — Attachment 2 — IDTF Only Required Section	6	Addition	Added checkbox for reporting of liability insurance information and application instructions.
Section 2: Identifying Information — A. Type of Supplier	7	Deletion	Eliminated voluntary health/charitable agency from list.
Section 2: Identifying Information — B. Identification Information	8	Deletion	Eliminated reporting of Medicare year-end cost report date.

Summary of 855 Enrollment Form Changes (continued)

Name of Form: CMS-855B. Type of Applicant: Clinics, Group Practices and Certain Other Suppliers. (continued)

Section with Change	Page	Type of Change	Nature of Change
Section 4: Practice Location Information — A. Practice Location Information	14	Addition	Explanation outlining need for correct association between Medicare legacy numbers and NPI for each individual practice location.
Section 4: Practice Location Information — A. Practice Location Information	14	Addition	Multiple MIN and NPI lines added for enhanced reporting.
Section 15: Certification Statement	29	Revised	Adjusted reporting timeframe from 90 days to "within timeframes established in 42 CFR 424.520(b)" and added specific guidance for IDTF timeframes per 42 CFR 410.33.
Section 15: Certification Statement — A. Additional Requirements for Medicare Enrollment #1	30	Revised	Adjusted reporting timeframe from 90 days to "within timeframes established in 42 CFR 424.520(b)" and added specific guidance for IDTF timeframes per 42 CFR 410.33.
Section 15: Certification Statement — A. Additional Requirements for Medicare Enrollment #2	30	Revised	Adjusted statement from "denial or revocation of [MIN]" to "denial or revocation of Medicare billing privileges."
Section 17: Supporting Documents — Mandatory for All Providers/Supplier Types	34	Deletion	Eliminated need for copy of NPI notification that was received from provider and NPPES to be sent with application.
Section 17: Supporting Documents — Mandatory if Applicable	34	Deletion	Eliminated need for copy of delegated official's W-2 if have delegated official to be sent with application.
Section 17: Supporting Documents — Mandatory if Applicable	34	Addition	Required submission of copy of comprehensive liability insurance policy for IDTFs only.
Attachment 2: IDTF	38-39	Addition	Complete listing of new IDTF performance standards 1-15, which included the requirement of at least $300,000 comprehensive liability insurance and new reporting timeframes of changes in application information.
Attachment 2: IDTF	40	Deletion	Elimination of instructions regarding ambulatory surgical centers.
Attachment 2: IDTF	40	Deletion	Elimination of instructions regarding service performance (replaced by pages 38-39).
Attachment 2: IDTF	40	Addition	Required submission of copy of comprehensive liability insurance policy for IDTFs only and outline ramifications of failing to maintain insurance at all times — including retroactive recoupment of billing number and payments.

Stark-Based FCA Case Slams Pay To Employed MDs at Nonprofit

A nonprofit hospital's payments to the hospital's affiliated nonprofit medical group came under fire in a Stark law-based False Claims Act (FCA) lawsuit, which was resolved late last month with a $5.08 million settlement. Memorial Health University Medical Center in Savannah, Ga., agreed to settle the case, which also included a three-year certificate of compliance agreement (CCA), the Department of Justice (DOJ) announced April 24. The hospital denied the allegations in a press release.

The case serves as a reminder that compliance with fair-market-value compensation is just as essential at nonprofits, even when all the entities have a common owner so ownership is not relevant. Interestingly, the settlement came down shortly after CMS took a stab at modifying the Stark stand-in-the-shoes provision *(RMC 5/5/08, p. 1)*, which was aimed at the kind of fact pattern raised in this lawsuit.

The lawsuit was initiated by ophthalmologist-turned-whistle-blower Ryan Boland, M.D., who previously worked for Georgia Eye Institute (GEI), a subsidiary of Memorial. DOJ later intervened in Boland's lawsuit, though it never filed its own complaint.

Memorial is a nonprofit academic medical center with two subsidiaries: Provident Eye Physicians, Inc., which employs ophthalmologists, and GEI, which provides services to patients. "Ophthalmologists are important commodities for hospitals because when they make referrals, it's for high-dollar procedures, like cataract surgery," says Marlan Wilbanks, the whistle-blower lawyer who drafted the complaint.

According to the complaint, in 2003 Memorial negotiated new contracts with GEI physicians. This time around, the hospital changed physician compensation so it was based on productivity and no longer factored in "non-remunerative work," such as indigent care and teaching. Some GEI physicians didn't like this idea and hinted at quitting.

Memorial didn't want to lose the physicians, so, the complaint states, the hospital started giving GEI lump-sum payments of $500,000 a year between 2003 and 2005 and

$600,000 in 2006 — "purportedly for teaching services and indigent care services." But things allegedly got out of whack when it came to divvying up the goodies. "The payment was not distributed among the GEI physicians on the basis of which physicians performed these [teaching and indigent care] services. Instead, it was distributed only to a small number of physicians in a manner that was designed to retain them as Memorial employees," the complaint alleges.

Because the payments weren't handed out based on who provided the teaching and indigent services, "the arrangement and payment were commercially unreasonable," the complaint adds. Similarly, "the allocation of the payment to physicians in a manner that did not take into account who performed the services rendered the payment and the compensation of the physicians in excess of fair-market value," the complaint alleges. Also, the complaint contends, "because the payment was designed to retain the physician employees at GEI, the payment took into consideration the value of the referrals made by those physicians."

Commercial reasonableness, fair-market value and a link to the volume or value of referrals are hallmarks of the Stark ban. More specifically, the only way to qualify a compensation relationship for a Stark exception is to meet certain conditions, and these are always three of them.

Subsidies at Issue in Stark Proposal

Then the lawsuit makes the jump to the false claims allegations, with the assertion that Memorial submitted false claims when it billed Medicare for services ordered by physicians who received money from the hospital's annual lump-sum payment.

Memorial "disagreed" with the DOJ's allegations, according to its press release, and "cooperated fully with the government's investigation."

The CCA is a sign of the strength of Memorial's compliance program, which was implemented in 1995, says the medical center's attorney, Glenn Reed, who is with King & Spaulding in Atlanta. The HHS Office of Inspector General agrees to a CCA instead of the more burdensome, expensive corporate integrity agreement (CIA) only if OIG believes the hospital has an effective compliance program *(RMC 4/21/08, p. 1)*. "Memorial has an extensive corporate compliance program, with a significant staff and budget, and with a self-auditing capability," Reed says.

This lawsuit is striking for tax and Stark reasons, says Boston attorney Larry Vernaglia, who is with the law firm Foley & Lardner. Memorial is nonprofit, which means the physicians are not owners of the hospital or medical group. In fact, they are employed by the nonprofit medical group, so they qualify for the Stark employment exception. But still compensation has come under DOJ fire in the kind of arrangement that triggered the stand-in-the-shoes provision under the Stark ban, Vernaglia says.

Based on what the complaint alleged, he says, "These weren't payments to outside, independent referring physicians. The payments at issue appear to be precisely the types of subsidy payments CMS intended to insulate in the one-year delay to the stand-in-the-shoes rule and in the proposed revisions [in the proposed inpatient prospective payment system regulation]." It is not clear, he says, that the payments at issue would not have been protected under one of several possible Stark exceptions. The complaint alleges that some physicians' compensation was in excess of "fair market value," though there is no specific explanation of this conclusion, nor is there a clear articulation of the alleged Stark violation. "Despite the availability of potential defenses, the lesson here is to be mindful of fair-market value even within employed-physician scenarios to maintain Stark compliance," Vernaglia says.

Contact Wilbanks at mbw@hsbw.com, Reed at gareed@kslaw.com and Vernaglia at lwv@foley.com. ✧

CMS Overpaid Nursing Facilities With DPNAs $5 Million in 2004

CMS overpaid nursing facilities a total of $5 million during fiscal year (FY) 2004 because they processed denials of payment for new admissions (DPNAs) incorrectly, OIG says in an Office of Evaluations and Inspections report (OEI-06-03-00390) posted May 2.

CMS has two solutions for nursing facilities that are found not to be in compliance with federal requirements for participation in Medicare and Medicaid, the report explains. The first is considered very severe and involves denying payment for services provided to all beneficiaries. "This remedy would likely cause existing nursing home residents to be relocated. As such, this remedy is rarely used," OIG says.

The less severe solution is to deny payments only for the services provided to beneficiaries who are new to the facility. CMS is required to impose a DPNA in two cases, the report says: "extended noncompliance" and "repeated instances of substandard quality of care."

CMS imposes the DPNAs, but fiscal intermediaries (FIs) identify and deny the payments, the report says.

Out of 697 DPNAs that were in effect during FY 2004, 74% had processing or payment errors, OIG found. Forty percent of those resulted in inappropriate payments exceeding $5 million (the other 34% had errors, but did not result in paid claims).

OIG found that many of the errors happened because FIs did not receive appropriate instructions from

CMS. As a result, FIs could not create edits in time to suspend claims. "The other leading causes of error involved communication breakdowns between CMS and the FIs and CMS sending the processing instructions to the wrong FIs," the report says.

OIG points out that recent changes, such as Medicare Administrative Contractors (MACs) assuming FI duties, could potentially improve the situation. But it recommends that CMS (1) manage DPNAs to ensure that instructions are sent quickly and that FIs and MACs review cases to correct errors, (2) address communication problems by using a standard format to notify FIs and MACs that a DPNA has taken effect, and (3) update guidance on coding readmissions and verifying readmission status for DPNA claims.

Nursing facilities should also be watching their calendars during an enforcement cycle, says Chicago attorney Matthew Murer, who is with the law firm Foley & Lardner, LLP. This report shows that CMS and FIs can make mistakes, but it is the facility that pays at the end of the day, he says. Providers usually have three months to correct compliance issues. They should "really review in detail the cover letters for survey enforcement cycles" from CMS and state agencies, he says. "I have seen a good provider with a good history get stuck in a cycle, and the state or CMS is saying 'Don't worry, you just have minor things to correct.' But one minor thing triggers the remedy. So I have seen people get reassured, and it quickly adds up to hundreds of thousands of dollars," Murer says.

In a response included in OIG's report, CMS says it agrees with the findings and recommendations. It adds that it has already taken some actions, including developing new internal procedures to warn FIs and MACs about DPNAs more quickly.

Contact Murer at mmurer@foley.com. Visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Office of Evaluations and Inspections Reports." ✧

Snafus Mark Move to Mandatory NPI

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information on the crosswalk," says Schirg. "Their claims were rejected even though they had done everything correctly."

In another incident, a clearinghouse mistakenly switched a provider's NPI and provider number so they appeared in opposite fields. As a result, the hospital's claims were rejected. Fortunately, the FI quickly diagnosed the problem, which enabled the hospital and claims clearinghouse to correct it.

WellSpan Health in York, Pa., is hustling to collect the NPIs of all physicians who are not employed by the health system but refer patients there for outpatient services (e.g., lab work, diagnostic testing), says Linda Sheaffer, director of patient administrative services. The ordering physician's NPI has to be on the claim form — regardless of whether he or she is a community physician or an employee. Though WellSpan has worked toward NPI compliance for the past year and began testing NPI-only claims in early April, Sheaffer was surprised by the volume of community physicians who refer patients to the hospital. In particular, WellSpan gets an unexpectedly large number of referrals from out-of-area physicians — from as far away as northern Maryland.

That poses an unanticipated challenge to NPI compliance. "Many hospitals will be faced with the fact that out-of-area physicians are not loaded in the master file, and will have their claims rejected," she says. (The master file is the billing system's computerized list of physicians and their demographic data, including medical-license number and provider number/NPI.) WellSpan discovered this problem when claims lacking out-of-area physicians' NPIs were stopping in the health system's clearinghouse.

In theory, hospitals should be able to get any physician's NPI from the NPPES Web site if they have the identifying information. But it often doesn't prove fruitful, Sheaffer says. For example, if more than one doctor has the same name, and none of the addresses match the one the hospital has, "I have to call the practice" to ask for the doctor's NPI, she says.

One way or the other, hospitals have to get their hands on this information. "Right now, we are looking up hundreds of out-of-area physicians every day to get their NPI," Sheaffer says. "We are calling their practices and reloading claims to send" to the FI. She also says it's important to keep tabs on when your state Medicaid plan and various private payers will require use of the NPI. Many payers — but not all — are following Medicare's lead as far as the May 23 deadline goes, she says.

Verify NPPES Information

Schirg says he has also seen providers' claims rejected for the equivalent of typographical errors.

For example, if providers put information on their claim forms that doesn't match the information they reported when applying to the NPPES for their NPI, the claims will kick back. CMS has indicated that another common problem is that many providers haven't listed the correct legal name of the provider in NPPES, he says.

Schirg and Sheaffer suggest hospitals begin sending in some claims immediately with only the NPI. "Test claims before it is required," Sheaffer says. "Then check reimbursement after May 23 to ensure it's accurate."

continued

If claims are rejected during testing, "the provider has a couple of weeks to address the issue before cash flow will be adversely affected," Schirg says. Until problems are resolved — as long as it's before May 23 — claims can still be submitted with both the provider number and NPI.

Schirg believes most hospitals will transition to the NPI-only system without incident. However, "if you experience a problem, the impact can be significant," he says. One hospital experienced more than $1 million in claims denials because of what amounted to a typo, he says. Thankfully, he says, it was resolved "in fairly short order." But it can take several days or even weeks to identify and fix a particular problem, especially if it involves filing a Medicare enrollment application.

To problem solve claims denials, Schirg recommends that hospitals verify the accuracy of the information they have on file with NPPES (e.g., taxpayer identification number, legal business name and Medicare provider numbers). CMS, he says, reports that one of the biggest problems with NPI claims processing stems from providers incorrectly listing their provider numbers in NPPES.

Contact Schirg at brandon.schirg@wallerlaw.com and Sheaffer at lsheaffer@wellspan.org. Visit the following CMS Web sites for NPI resources: https://nppes.cms.hhs.gov/NPPES/Welcome.do; www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp; www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf; www.cms.hhs.gov/MLNMattersArticles/downloads/SE0744.pdf. ✧

NEWS BRIEFS

◆ **Four cardiologists have agreed to settle allegations that they improperly took salaries from the University of Medicine and Dentistry of New Jersey (UMDNJ),** the U.S. Attorney's Office for the District of New Jersey said May 7. The four separate settlements total $387,000. UMDNJ started a program to bring in more cardiac surgery patients through part-time employment contracts with some local cardiologists, the feds have said. The feds allege that the doctors did little work, but UMDNJ contracts with the cardiologists required them to work part-time as clinical assistant professors, and to teach, provide on-call coverage and support research efforts, among other things. Ed Dauber, attorney for Michael Benz, M.D., who is paying $30,000, says no fraud allegations were part of Benz's settlement. The other physicians' attorneys could not be reached for comment before *RMC* deadline. Two cardiologists already paid civil settlements *(RMC 5/05/08, p. 8)*, and two others recently pleaded guilty to embezzlement charges *(RMC 3/10/08, p. 6)*. Visit www.usdoj.gov/usao/nj.

◆ **A New York oncologist and his wife will pay $275,000 in damages to the government to resolve allegations that they submitted false Medicare claims for cancer drugs that were imported from Canada,** the U.S. Attorney's Office for the Eastern District of New York said April 24. Kee Shum, M.D., and Li Shum did not admit liability as part of the settlement. The parties settled to avoid the delay, uncertainty, inconvenience and expense of litigation, the settlement says. The government began investigating after another physician filed a whistle-blower lawsuit, saying that doctors across the country are importing cheaper oncology drugs from Canada and profiting through reimbursements from the government. The patients are not seeing any financial benefits and are not being told that they are given an imported drug, the suit claims, according to the feds. Kee Shum also entered a corporate integrity agreement with OIG. Richard Willstatter, an attorney representing Kee Shum, says the oncologist did not know that the imported drugs did not qualify for Medicare reimbursement. He says the feds threatened to file a False Claims Act lawsuit, which would have subjected the Shums to treble damages, so they decided to settle. Visit www.usdoj.gov/usao/nye.

◆ **Daniel Maynard, D.O., has been permanently excluded from federal health care programs and will pay $253,000 to resolve allegations that he submitted false claims to Medicare and Texas Medicaid between 1999 and 2003,** the U.S. Attorney's Office for the Northern District of Texas said April 30. The feds and the state allege that on 32 separate days, Maynard billed the programs for patient encounters that added up to his spending more than 24 hours each day seeing and treating patients. He claimed to have seen more than 100 beneficiaries on six occasions, the feds say. Maynard denies wrongdoing and liability as part of the settlement, the feds add. An attorney representing Maynard could not be reached for comment. Visit www.usdoj.gov/usao/txn.

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