Part B Insider (Multispecialty) Coding Alert

How The New Guidance Is Especially Positive for Therapy Appeals

Understand how review limitation will affect your over-cap therapy claims.

If you're concerned about appealing therapy claims, here's why the recent guidance is good news for you.

Limiting the scope of contractors' reviews of appealed claims may end up turning the tables for therapy providers who are now receiving the results of manual medical review of therapy over the $3,700 threshold. Therapy providers are particularly interested in appealing unfavorable decisions, including institutional providers billing on the UB04 claim form, according to an Aug. 29 blog posting by **Nancy Beckley, MS, MBA, CHC,** president of Nancy Beckley & Associates LLC.

This is especially true because redetermination is the first level in the CMS appeals process, and reconsideration is the second level of appeals, Beckley noted. And when you're trying to survive the manual medical review of your over-cap therapy claims, you don't need contractors finding "new" problems and using them as a reason for denial.

Keep in mind, however, that claims for therapy appeals submitted prior to Aug. 1, 2015 aren't applicable to the new guidance. Also, Medicare Administrative Contractors (MACs) and Qualified Independent Contractors (QICs) may still find new issues and deny your appeal for pre-payment claims denials.

Example: "If your MAC is doing a service-specific probe of 97022 for whirlpool, which includes fluidotherapy (as the J6 NGS is currently doing), and you appeal the denial of 97022, the MAC and the QIC can review for other issues than the denial of 97022 for medical necessity," Beckley explained.

Mistake: Double-Duty Won't Double Your Chances

Remember: When you're working on your Medicare claims, you must choose to either submit an appeal (or reopening) or submit a new claim for the service you cannot do both, according to a recent bulletin from **Palmetto GBA.** The contractor has seen a recent increase in the number of incidents where providers are requesting an appeal/reopening on a claim and submitting a new claim for the service at the same time.

"As a result, when the appeal is worked, there is a claim for the same service being processed in our system," Palmetto says. "During the early stages of processing, it is impossible to determine whether or not the service will be paid. Therefore, the appeal request must either be dismissed or held open until the claim completes processing."

Also, the clock for the appeal deadline starts ticking on the date of the first remittance you receive with a specific type of denial, Palmetto notes. "If you decide to submit a new claim for the same service and again receive a denial, you risk missing the time limit for an appeal."