Part B Insider (Multispecialty) Coding Alert

MEDICAL REVIEW: Order Lab Tests And You May Hear From Carrier Reviewers

You now have only two weeks, instead of three, to respond to suspensions, offsets or recoupments after Medical Review.

The **Centers for Medicare & Medicaid Services** revised the Medicare Carriers Manual to say that providers have 15 calendar days, not 15 business days, to respond to MR denials. Such rebuttals must include "any pertinent information as to why the suspension of payment, offset or recoupment should not be put into effect."

Transmittal 39, issued March 14, also clarifies that MR staff should contact the provider who bills for lab services first, but reviewers also can contact the provider who orders lab services under some circumstances.

Contractors should give billing providers 30 days to respond to additional documentation requests. They can ask for documentation of the order, proof the order was processed, and any diagnostic information the billing provider gave to the ordering provider.

If the billing provider doesn't respond within 45 days, the carriers can deny the claims. Or the carriers may contact the ordering provider for more information. They can also contact the ordering provider if the billing provider's response is inadequate. Carriers may only ask the ordering provider for the parts of the medical record that pertain to the claim being investigated.

When carriers identify lab services that are being overutilized, they can establish edits to deny the services automatically if they have a clear policy to deny them. Without a clear policy, then the carriers must develop edits that don't involve utilization parameters. For example, the carriers can develop provider-specific edits to target the highest utilizers.

The memo also included other directives relating to general Medical Review. It clarified that when review staff perform a prepayment audit directed by the Benefit Integrity staff, they'll need to check with the BI people before doing anything - including answering your questions.

If the staff are looking at your records for anything other than to figure out if your services were covered by Medicare and coded correctly, then they're working under the BI staff. The BI staff may instruct them to look for evidence of false claims, for example.

If contractors choose to target you for focused Medical Review, they'll need to provide you with data on how your spending compares to that of other local providers, if such data spurred the examination.

The new transmittal also clarifies that carriers should return as unproccessable services billed with an ICD9 Codes that is missing, incorrect or truncated. It also spells out that carriers can contact beneficiaries for more information on claims, because beneficiaries aren't "third parties" in this instance.