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MDS Alert

Medicare Reimbursement: Medical Reviews of Medicare Outpatient Therapy Claims Will Continue in the New Year

Don't expect MACs to cease reviews while awaiting further Congressional action.

If you've been counting down the days till December 31st eager for the manual medical review of Medicare Part B therapy claims over $3,700 to come to an end, you may be in for a big disappointment.

"Just because the period of the claim is December 31st doesn't mean that the MACs are going to pack up shop and not do any review after that," warns **George Mills**, director of the Provider Compliance Group in the Office of Financial Management at the **Centers for Medicare and Medicaid Services (CMS)**.

Although the law, which extended the outpatient therapy cap process through December 31, 2012, calls for manual medical reviews for claims over $3,700 between October 1 and December 31, Mills says this doesn't mean that come December 31st all the reviews are going to stop. "Because if you didn't request an exception and it's above $3,700, and the claim is filed in February [2013], that doesn't mean that you won't be medically reviewed," Mills explained during the October 22nd CMS Special Open Door Forum.

What's more: If a claim has not been prior authorized, even if it has been paid, it could still be reviewed on a post-payment basis. CMS has a post-pay contractor that is going to be reviewing claims on a retroactive basis. In particular, they will be looking for scenarios "where it looks like there has been some change in billing pattern that could be devised solely to evade the therapy threshold in reviews in terms of the [three different] phases," Mills emphasized.

Use the appeals process for denied exceptions

Providers who are denied their exception requests, or who are waiting to hear back from their MACs, can still provide the service and deal with billing on appeal. "The pre-approval is just to give people a sense in advance what they think Medicare is going to do. But, again, if you disagree with that, you can always provide the service and then . . . you can make your point on appeal," Mills noted.

You should also make sure that you continue to put the KX modifier on the claim if billing for service above $1,880, whether you have advance approval or not. "If there's no KX modifier, it will get denied exclusively for the missing the KX modifier. So, regardless of whether you requested an exception or not, you should always continue to put the KX modifier if you believe in your mind it's reasonable and necessary above $1,880." Mills added.

Check to make sure all required information is included

Quite a few exceptions requests are being denied because they are submitted with invalid or missing HIC numbers, invalid or missing provider numbers or failure to submit any therapy record documentation, added **Darlene Higginbotham**, a medical review manager with **First Coast**, a MAC for Jurisdiction Nine, which includes Florida, Puerto Rico and the US Virgin Islands. "There is not enough information for us to even be able to process the request. So those are deemed to be dismissals," she explained.

Some providers mistakenly think that the HIC automatically is the resident's Social Security number with an A at the back end, but it's not, noted **Amy Brokaw**, medical review manager for **WPS**, a MAC for Jurisdiction 5, which includes Kansas, Iowa, Missouri and Nebraska. Mills explained that the Medicare claim number consists of a Social Security number plus a beneficiary identification code (BIC), which can be many things.

Know your ABCs: "A majority of people are in "A," which means that the individual is entitled to benefits off of their

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own work record. But, when you use an SSN, if someone is eligible for benefits off another party's work record, it's their SSN followed by a BIC such as a "B," a "C," a "D," or a "W." A "B" means a spouse, a "C" is a disabled adult child, a "D" is a widower, and a "W" is a disabled widower. So make sure you have an accurate HIC number," Mills emphasized.

Donna Blythe, the manager of medical review Part A and B for **Novitas Solutions**, a MAC for Jurisdiction 12, which includes Delaware, Maryland, New Jersey, Pennsylvania and DC, agrees. "We're seeing a lot of what we would call sloppy-type admissions where they're just missing very critical pieces of information that we need to process these reviews, such as lack of, or incorrect, HIC numbers or NPIs," she said.

Prior to submitting your exception request, Higginbotham recommends that someone validates the HIC provider number and include the medical record items included on the documentation checklist as specified in the CMS' MLM Matters article. "We're seeing a lot of homemade forms, which is perfectly fine if they have all the correct information on them," Blythe notes. "But unfortunately, there is key pieces of information missing from the forms that are being created and we cannot process these," she added.

Don't submit duplicate requests

Duplicate submissions are also bogging down the exceptions process. Some providers are resubmitting their requests if they haven't gotten a decision from their MAC within the required 10 business days. The contractor has 10 business days from the date that they receive the request, not the date on the form, Higginbotham noted. "We often find that the date on the request form is not the same as when the request was actually faxed or submitted, which sometimes can be up to a week later than the date on the form. So providers are jumping the gun and resubmitting the request, which is actually delaying the process even more," she said.

Wait till the time is right: Some providers are also causing problems by submitting their exceptions requests too soon. "We have been receiving requests where it's obviously a new therapy like a recent hip surgery or knee surgery where it's stating that there are new issues and no history is being reported. So, in this case, we're really questioning whether this beneficiary is even anywhere near the cap," Blythe noted. "The exceptions are really only for beneficiaries that have reached the cap or are very close to the cap. All these unnecessary requests that we're getting just further bogs the system down," she explained.

Include a contact name and number

You should also make certain that you are including a name and phone number of a point of contact for your facility. "We take every effort to try to get the information back to you in the most expeditious manner. But, oftentimes, there is not a contact number to reach out and get the correct person," Higginbotham said.

Brokaw reiterated the need for a contact name and number. "When we can, we do try to reach out to you. If your submission is just missing one piece, we want to do our best to get this processed as quickly as possible. We don't want to reject them, but we have to sometimes if we can't get a hold of someone. So make sure you have a good contact information on there."

Editor's note: Additional resources, including a Therapy Cap Factsheet and Q&As, are available at the CMS medical review Website at http://go.cms.gov/MedRev.

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