Centers for Medicare & Medicaid Services
Special Open Door Forum:

Manual Medical Review of Therapy Claims

Monday, October 22, 2012
2:00pm – 3:30 pm Eastern Time
Conference Call Only

The purpose of this Special Open Door Forum (ODF) is to provide an opportunity for **providers** to ask questions about the mandated manual medical review of therapy services from October 1-December 31, 2012 that was enacted by the Middle Class Tax Relief and Job Creation Act of 2012.

During this Special Open Door Forum, CMS will discuss therapy documentation requirements and answer any questions providers may have. CMS requests providers' participation who order or provide therapy services nationally. The therapy cap applies to all Part B outpatient therapy settings and providers including:

- private practices,
- Part B skilled nursing facilities,
- home health agencies (TOB 34X),
- rehabilitation agencies (outpatient rehabilitation facilities-ORFs), and
- comprehensive outpatient rehabilitation facilities.

Beginning this year, the therapy cap will also apply to therapy services furnished in hospital outpatient departments (HOPDs) until December 31, 2012. Before 2012, therapy provided in hospital outpatient departments did not count towards the therapy cap.

Participants may submit questions prior to the Special ODF to therapycapreview@cms.hhs.gov.

We look forward to your participation.

Special Open Door Participation Instructions:

Participant Dial-In Number(s):

- Operator Assisted Toll-Free Dial-In Number: (866) 501-5502

- Conference ID: 44803009

NOTE: In order to join this conference call, you will be required to provide the Conference ID Number listed above.

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the Special Open Door Forum website at http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) please visit our website at http://www.cms.gov/opendoorforums/ .

Thank you for your interest in CMS Open Door Forums.

Audio File for Transcript:
http://downloads.cms.gov/media/audio/10.22.12TherapyClaimsSODFAudioFile.mp3
File Size: 20.2 MB

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**Moderator: Matthew Brown**
**October 22, 2012**
**2:00 p.m. ET**

Operator: Good afternoon. My name is (Adam), and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Manual Medical Review of Therapy Claims Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during that time, simply press star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Matthew Brown, you may begin.

Matthew Brown: Thank you, (Adam). Good afternoon and good morning to those joining us on the West Coast. I'm Matthew Brown with the Office of Public Engagement.

I just have two quick announcements before we begin this special open door forum. The Medicare open enrollment period is October 15 to December 7 when all people with Medicare can change their Medicare health plan and prescription drug coverage for 2013. Please advise your patients that information on 2013 plans is now available by calling 1-800-MEDICARE or visiting www.medicare.gov. If they're satisfied that their current plan will meet their needs for next year, they do not need to do anything.

Also, it's flu season again and we need your help promoting awareness about the new Med – excuse me – vaccine – need to vaccinate Medicare and Medicaid beneficiaries against influenza. Annually, there are over 200,000 hospitalizations from influenza, 36,000 deaths due to influenza and its complications. Most are people 65 years of age and over. As we are sure you are already aware, Medicare and Medicaid case for the influenza vaccine, CMS has developed materials that you may find helpful, and you can find them on www.cms.gov/immunizations.

Also, beyond our beneficiaries, it's important that each of us and our families get vaccinated annually. Not only does it help us stay healthy. It helps prevent the spread to others. Thank you.

George Mills with our Office of Financial Management will begin this special open door forum.

George Mills: Thank you. And welcome, everybody.

My name is George Mills. I am the director of the Provider Compliance Group in the Office of Financial Management here at the Centers for Medicare and Medicaid Services. I also have a number of experts in the room with me, including staff from the Center for Medicare, to deal with any potential billing or issues.

I'd like to give a brief overview of the agenda for today. We'll be going over – I'll be going over some main points and an overview. Then, we felt that it would be useful to have representatives from our Medicare claims processing contractors talk about what they're seeing at the local level and tips for providers about how to ensure that their – if they're getting an exception request, that it's getting in and it's being set up for review. And they can give you a first-hand account of what they're seeing on a daily basis.

And we've got three medical review managers. One is Darlene Higginbotham from First Coast, (Donna Blythe), who is from Novitas and, also, (Amy Brokaw), who is our Medicare medical review manager at WPS. So, they'll give you some bird's eye view of what' going on. Then, we'll turn it over to FAQ updates as well as our links. And then, we'll open it up for questions.

So, again, let me go over what is being discussed today, which is outpatient therapy cap and the exceptions process. This was required by an act of Congress contained in the Middle Class Tax Relief and Job Creation Act of 2012, which was H.R. 3630. And it was signed into law on February 22, 2012.

The law extended the outpatient therapy cap process through December 31. But, it also, at the same time, established a manual medical review of the process which begins at $3,700 where either the provider can provide the service, bill the claim and then the bill would be stopped and medically reviewed or they can request an advance exception.

I know there was some question we got from some of the members of Congress about "Could you please reiterate how far in advance someone could make a request?" And, again, our instruction, which was sent to the Medicare contractors, was that a request for an exception, if you choose to go that route, can be made 15 days in advance. And the MAC, upon receipt of all required documentation, has 10 business days to make a decision.

So, 15 days in advance. So, what that means is for providers who were designated to be in phase three which starts effective November 1, they could

start – I mean, phase two that starts November 1, they could have started making requests already as of this date.

So, again, we – I in terms of phasing in the manual medical review, we established three phases of providers. There was phase one which started October 1, phase two which is November 1 and phase three which is December 1, where, you know, providers in those phase can start sending in their exceptions. And if they don't send in an exception, their claim would be stopped and subject to pre-pay medical review. So, providers that are in phase two, you can now start submitting requests and could have as of a few days ago.

Now, the other question is, "How far below the $3,700 threshold can a submission be made?" Our instruction to the MACs is to allow an exception request to be sent in if, based on the services being requested to be approved in advance, based on that, the beneficiary would be over the $3,700. Now, what we're hearing from providers is some people are saying, "Well, the MACs keep sending it back. But I know they're going to be over."

So, one of the things we're looking into is just establishing a set threshold amount by type of provider assuming that you're getting 20 service days in terms of sending in the exceptions since people are concerned about this and they believe that exception requests are being returned just because it looks like they're going to be way under the cap.

But, some providers are saying, “Well, you know, the bene is sitting at $2,200 and I know I'm going to give more than $2,000,” but the MAC is telling me, “Oh no, it's too early.” So, we'll work with the MACs to establish some sort of threshold and get that published and work with the MACs on that by the type of provider to eliminate any concerns about that.

But, again, the process is that you can do one of two things. You can request an exception in advance or do nothing and any claim above 3,700 will be stopped and subject to medical review. We see in some places people have said, "I can't do anything until the exception request has been decided upon."

Again, you're under no obligation to submit an exception request. The only thing that will happen is that any claim above $3,700 will be stopped.

So, I don't understand why people are saying, "Well, we can't provide services to someone because you haven't made up your mind." There's no real requirement that you even request exception. You can provide the service but, again, what will happen is that it will be stopped for manual medical review if it's above 3,700.

And I'd like to also point out that even if Medicare says no, you can still provide the service. And then, you can deal with it on appeal after providing the service. That way – you can go into the appeal rights.

So, there's many ways to get the services provided. So, if you don't agree with the MAC, you can go ahead and provide the service and deal with that on appeal. The pre-approval is just to give people a sense in advance of what they think Medicare is going to do. But, again, if you disagree with that, you can always provide the service and then the claim will be then potentially – you can make your point on appeal. So, we wanted to give that and go through that.

There were also questions about, "Do I need to continue to put the KX modifier on the claim if I'm billing for service above 3,700?" And any service that you're trying to get paid, whether you have an advance approval or not, above the 1,880 cap, if there's no KX modifier, it would get denied exclusively for the missing of 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 the 1,880 cap.

Other questions – I'm just going to go over some generic things. "How long do the contractors have to – may review the request?" And it's 10 business days.

"Are there any automated exceptions?" And the answer is, well, there is automated …

Matthew Brown: George, did we lose you?

(Latesha): I think you did.

Matthew Brown: Operator, (Adam)? Excuse me. Operator?

George Mills: (Inaudible) and then the next …

Matthew Brown: Excuse me. George?

George Mills: … (inaudible) subject. Yes?

Matthew Brown: I think we lost you for about 15 seconds or so.

George Mills: OK. OK. I'll go back.

So, there's been a lot of questions about which provider – what number we use to do the audits. And it's billing provider number. And then, people have said, "Well, what happens if I move, you know, from billing under this person because we're in a group and this person is in phase one and then the person x is in phase three. Well, what happens then?"

Well, we go back to billing provider number. But, I will say that, on a post-payment basis, that's one of the things we're going to be looking for – is where people all of a sudden were billing under X and then move to Y right around this time. And we actually do – have a post-pay contractor that's going to be – we're reviewing these things retroactive to look for that kind of scenario where it looks like there has been some change in billing pattern that looks like it's solely devised to evade the therapy threshold reviews in terms of the phases.

Come December 1, everybody is in the same boat. Everybody is being reviewed above the $3,700. So, we expect this to continue at least through the end of the year. We've got a number of e-mails in to the box asking what going to happen next year. I don't have any idea of – that's up to Congress.

As it currently stands, this review is for claims between October 1 and December 31. Going forward, you know, it depends on what Congress puts in

the law. Just because the period of the claim is December 31 doesn't mean that the MACs are going to pick up shop and not do any review after that. Again, this – these are claims for date of service between October 1 and December 31.

So, it doesn't mean come December 31, 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, that doesn't mean that you won't be medically reviewed. So – and it doesn't mean even if we pay the claim that someone, if we haven't prior authorized it – that someone isn't going to come back on a post payment basis and take a look at the claims either.

But, hopefully, people are submitting exception requests and they're supplying enough information for the MACs to make a decision. And so, we just wanted to make sure that people realize you have – you can submit a request 15 days in advance. And we will come out and provide a numeric number above – when somebody is at this or above, you can send an exception request because I know that's a concern. And we'll work with the MACs to do that.

Some people have asked like, "How do we ensure that the MACs are complying with the 10 days?" And it's – we're doing it the same way we do on any requirement. We have reporting. We do oversight reviews. We do monitoring. So, we're watching that closely. So, we are looking into how they're doing it.

So, the next thing now I want to move into is the contractor overview. And so, these are MR Managers. And they – I wanted them to talk today because I know everybody is saying, "Oh, the contractors aren't doing this" or "They aren't doing that."

Well, I'd like to get – give everyone on the phone a picture of what the MACs are seeing and what are the problems because some of these problems start with bad requests coming in. So, I'm going to turn it over first to Darlene, who is with First Coast in Florida, and to give an overview of what she's seeing in the Florida area in terms of this and some tips about how to get this

through. And I'll turn it over to Darlene because she'll give you the bird's eye view from there.

So, Darlene, why don't you take it? Go through your stuff.

Darlene Higginbotham: OK. Thanks, George.

First Coast – I'll begin by just introducing First Coast. First Coast is a MAC for Jurisdiction Nine, which includes Florida, Puerto Rico and the U.S. Virgin Islands. I'd like to take this opportunity to thank CMS for inviting us to participate on this call. I do plan to cover some of the major issues that we're seeing in the review for the pre-approval request as well as some of our major reasons for dismissal, reasons for denial and some tips to help providers moving forward.

One of the initial steps here in First Coast that we take as a claims processor is to validate that the request that we're receiving contains the necessary information that's needed to process the request. Some of the primary reasons for denial is that we see providers are submitting requests before their phase. And, as George mentioned, you can request a pre-approval up to 15 days before the phase starts.

So, we are seeing requests from providers that are in phase three. At the end of September, we were seeing requests from providers that are – were in phase two. So, you know, I really encourage providers to check what phase they are in.

Providers creating their own pre-approval request form, which often lack the required information. So, when we go through tips, we'll kind of cover some of that.

Invalid or missing HIC numbers, invalid or missing provider numbers, failure to submit any therapy record documentation. So, sometimes we're getting just the request form without any documentation attached. So, that's some of the reasons. That is not enough information for us to even be able to process the request. So, those are deemed to be dismissals.

We have created a response for dismissal. So, you get a response whether – even if it is a dismissal. So, you'll get a dismissal – a response whether it's approved, denied, a partial approval or a dismissal. You'll always get a response within the 10 days.

Once we deem that the request is valid, then our PTs, OTs or nurses that are reviewing these records make a determination to either approve, partial approve or deny the request. Some of the primary reasons for denial include failure to submit the therapy plan of care, the therapy plan of care isn't signed by the physician, therapy goals are not measurable, services represent maintenance care.

Particularly, we're seeing a lot of expenses prior to therapy, oftentimes with the patient at this point has been in months of physical therapy. Missing critical elements to substantiate the medical necessity of additional services and unable to determine the functional deficit based on the documentation that was submitted.

So, some tips that I would suggest for our providers here in Jurisdiction Nine – and most of these would apply to any provider nationally, I would assume – is to check the CMS listing to verify your phase, have someone validate the HIC provider number before you hit the Submit, include the medical record items included on the documentation checklist. Our form has a checklist to make sure you include. Also I know CMS's (MLM) Matters article included a list of the records that are required.

We see a lot of duplicate requests here at First Coast. So, please, we would ask do not submit the same request. Wait for 10 business days to receive decision. And I know we have a couple of our staff who do a lot of outreach with providers one-on-one. When we see patterns of dismissals or denials, we're actually calling and giving feedback and working one-on-one with a number of providers.

And one thing – one issue that we've seen raised is providers are saying they haven't received the decision within 10 days. And when we looked at those individual cases, what we find is the date on the request form, it may have

been 10 business days since that date. However, the form was not – and the records were not actually faxed on that date that's on the form. The provider didn't fax it sometime until two or three or sometimes a week after that date.

So, we – the contractor has 10 business days from the date that we receive the request, not the date on the form. So, you need to kind of pay attention to when you're actually – and keep records of when you're faxing or mailing the request. If there may be a delay from when you complete it and when it actually gets sent out, you need to somehow designate in your file when it was actually submitted to the contractor.

For First Coast, the quickest way to get your decision is to fax your request. We do accept fax. Your contractor's Web site will tell you how they will accept your request either fax, mail and some – or may accept fax as well. We accept fax and that the quickest way to get your response from us is to fax your request and be sure and include a fax number of where you would like your decision sent back to.

Not always is that the same fax number from which the request was sent from. From fax numbers are only outgoing faxes. And when we try to send the decision back to that same fax number, it doesn't accept incoming faxes. And if you have not put a fax number for you to receive your decision, then we have a really difficult time getting that decision back to you.

Oftentimes, on our form, we have the point of contact for the facility or for the Part B provider. Be sure you put the name and the phone number because we will try to call. 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 fax number.

The First Coast form has a place for you to indicate whether you're a Medicare Part A which, in this case, it would the B of A, so the outpatient facility type services, of course, the OPT, the SNF, the outpatient hospital or whether you're a Medicare you're a Medicare Part B provider. That helps us make sure we get the request in the right path. As you know, as a Medicare provider, claims are submitted – Part A claims come through the FISS system,

Part B claims come through the MCS system. And they go down different paths internally as we're processing and implementing edits to operationalize your pre-approval decisions.

So, it's really helpful if you make sure you indicate on the form whether – correctly whether you're a Part A provider or a Part B provider. We're getting a lot of Part A providers who are indicating they're Part B providers. There is also unique fax numbers for Part A versus Part B. So, again, it just helps. Your request gets in the queue in the fastest, most expeditious manner possible if you get it correctly noted on the form and sent to the correct fax number.

First Coast request – and we would assume most other MACs would ask the same thing – that you include the pre-approval request form as the first page when you're faxing or mailing your request. Again, that helps us identify up front that this is a pre-approved. We contractors received hundreds of thousands of pieces of mail monthly. So, that helps us identify these and get them into the right work queue and get them processed quickly.

And then, we also have to – for First Coast, that you fax the form and the medical record together in the same fax. And I would assume that would apply to other contractors who are accepting the pre-approval request via fax submission. We have this feed into our imaging system. So, when you separate – send the request in one fax and the records in another fax, that creates two separate images that have to then be tied together to – into one record. So, again, it's very beneficial if you include both the form and the record together in the same fax when you're faxing.

Including accurate beneficiary address information in the designated section of the form. We're getting a lot of return beneficiary letters because, as you know, we're required to send both you, the provider, and the beneficiary a letter with the findings of our review. And we're getting a lot of return beneficiary letters. So, please make sure that you're including accurate beneficiary address information.

That covers the main points that I wanted to point out for First Coast. I don't know if CMS – if you want me to turn it back over to you?

George Mills: OK. Got it. That's good. Thank you, Darlene.

Next, I'm going to turn it over to (Donna Blythe) from Novitas to talk about what they are seeing there in their jurisdiction.

(Donna Blythe): Good afternoon. My name is (Donna Blythe), and I'm the manager of medical review Part A and B for Novitas Solutions.

Just a little of background about Novitas, we are J12, which consists of Delaware, District of Columbia, Maryland, New Jersey and Pennsylvania. More recently, J8, where we would be responsible now for Arkansas, Louisiana and Mississippi Part A.

Really, I don't have anything to add to what Darlene said. I mean, it's, you know, exactly what she said. 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, lack of HIC numbers, incorrect HIC numbers, lack of NPIs, incorrect NPIs. And, again, this is very critical information for us to input into the system in order to process this.

We are getting probably between 500 and 600 a day, which means we don't have the luxury to go back and try to figure out somebody's correct number and look them up. We're getting a lot of duplicate submissions, which are further bogging us down. More recently, we started receiving requests where it's obviously a new therapy like a recent hip surgery or knee surgery where it's stating that there is new issues and no history is being reported.

So, in this case, as you know, we're really cautioning whether this beneficiary was even anywhere near the cap. So, just because the provider is selected, it's really for only beneficiaries that have reached that cap or very close to that cap. So, again, all these unnecessary requests that we're getting just further bogs that system down.

Some tips that we would say along the same lines that Darlene has stated, really review the Web site information carefully. We put a lot of time and effort in putting the information out there. Look at your number, your NPI number, and make sure that you're actually out there on the CMS Web site because, if you're not, you don't need to be submitting the pre-request. And we are getting a lot of provider requests where the provider is not even in a phase period or they may be in phase three at some point but they're certainly not in one or two.

Again, just ensure the beneficiary is at the cap. Use the correct transmittal sheet. That transmittal sheet takes it to a specific fax area where (we) receive this. And if you're creating your own form based on the elements that are required on the transmittal sheet, be sure that you're including all of the boxes that need to be on there. We're seeing a lot of homemade forms, which is perfectly fine if they have all the correct information on them.

But, unfortunately, there is key pieces of information missing from the forms that are being created. And, again, we cannot process these. These, like a claim, would be considered not clean. And we do not have a responsibility to respond within that 10-day period if we have no idea what's, you know, being requested here.

The other thing that we're seeing a lot of is the date range. And just make sure that the date range you're looking or your expected dates of services are within that phase. We cannot accept it if it's prior to the phase. It's just not something that we're going to review after the fact.

So, that's pretty much everything that I have.

George Mills: Yes. Thank you, Donna.

The other thing, this is – there's a lot of this discussion about making sure you got the right fax number and you're sending it in and it's complete. Let me tell people we've getting requests for exceptions mailed here because that was the return address on the envelope telling you what phase to be put in. And that will do nothing but slow the process up.

So, do not send it to our office here. We ended up getting over about 10,000 pieces of mail. So, don't send stuff to us. Make sure you send it to your MAC. They have all the instructions about how to file an appeal. Anything that we got we've been forwarding on.

But, basically, what we've seen is, first of all, you're not sending it at the right place. And when it's not the right place, that's the first error. But then, the second error is its missing a lot of requested and required information, too. So, I can personally vouch that I've seen them on the ones that were sent to us. So, again, file them.

But, last, I'd like to turn it over to (Amy Brokaw), our MR Manager from WPS and have her give an update on what WPS is seeing out there.

I'll turn it over to you, Amy.

(Amy Brokaw): Hi. Thank you, George.

This is (Amy Brokaw). And, as George said, I'm the medical review manager for WPS, so – the Part A. But, I'm also very involved with this project from the Part B side so can, hopefully, speak to that and may help answer any questions you may have after this.

For WPS, we have J5, which is Kansas, Iowa, Missouri and Nebraska and J8, which is Michigan and Indiana. We also have with – starting today, is called the J5 national for the Part A providers, previously known as legacy and, before that, the Mutual of Omaha Part A. So, there's a few name changes for you there. And then, on the Part B side as well, we have Wisconsin, Illinois and Minnesota.

So, I would like to just echo what Darlene and Donna already said. At WPS, we're seeing a lot of the same types of issues. We're always working on getting the input also from providers. So, we do welcome your comments on any things that we can do to help you with the form. I think most of the problem that we see have to do with the actual submission of the pre-approval form, as you've already heard from Darlene and Donna.

The performing providers seem to be an issue that is the billing provider. And I know George touched on that earlier. So, make sure that this NPI, when it says performing provider, it's really the billing provider. That's who is going to process your claim. And that whose responsibility it is to submit this pre-approval form. So, make sure that your NPI that's on there is accurate, as well as the address for the performing provider.

And, as someone mentioned before – I think it was Darlene – the contact information is important, too, because when we can, we do try to reach out to you. If it's 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 – you know, we have to sometimes if we can't get a hold of someone. So, make sure you have a good contact information on there.

We, too, have seen some problems with HICs. And, just as a reminder, a Social Security number is not a HICs. But, people just think it's the Social Security number with an A at them (back end). And it's not. So, make sure that those are – they're accurate. That's a key piece of information.

We've seen there's still have a lot of confusion with providers' understanding of their Part A or their Part B. Part A is for what we call Part B of A for this type of service. And so, if the facility is the one that's submitting the bill, that it – that would come to Part A. If it's an individual practitioner with an individual NPI number, then that would go to Part B. So, make sure that you sort that out at the beginning so that you're using correct contact information for all the contractors to send it to the right side of the house for them.

A reminder on the amount of treatment days – I think it's important. It's a maximum of 20 treatment days per service per request. And these are treatment days. We've seen some coming in asking for 90 days. We've seen some coming in for six weeks. Kind of all over the board. We are only to approve up to 20 treatment days per service. So, even if you put 90 on there, we're not going to give you 90 anyway. The maximum you would receive would be 20. So, please remember that on your request.

I think Donna mentioned this as well. But, it – I think it bears repeating on that expected date range. We're still seeing a lot of old dates. So, we're into October and I'm still seeing some come 10/1. I've even seen some that say July. These are pre-approvals and not retrospected. So, please make sure that those are current dates that you're giving to us working forward.

For WPS providers, I'd like to encourage you to combine your services on one pre-approval request. So, if you have one beneficiary and you're asking for, let's say, 10 day of OT and 20 days of PT, you can put those on one request. And we would prefer that. And they can even have different expected date ranges for each service. So, please do that. It cuts down on administrative work for us and for you. You can consolidate that for the one beneficiary.

If you're submitting additional documentation, we've started to receive some of that. So, if your original pre-approval request was denied and you're sending an additional documentation, please attach a cover letter for us or – that indicates that this is additional documentation and a copy of the prior denial letter is also encouraged. That just helps us to really readily identify what that is and get that processed faster for you.

And we would like to still continue to encourage providers to give the beneficiaries ABNs as we do see some of these come through and we'd like to encourage you to continue to do that.

I would also like to say that remember that the pre-approvals do not have appeal rights under the traditional sense of the word. You can send in an additional documentation as I've stated before. And, again, that should only be additional and you should not be submitting to us what you've already submitted.

An example would be if we denied something because you forgot to talk about or submit the prior level of function. You would submit that again, let us know that that's what it is and who it's for, another pre-approval request form and a cover letter stating that's what it is. And we'll just simply match up the prior level for function. Now, that's for WPS providers. I would

encourage you to follow directions for your particular contractor if they would like it a different way.

One other problem we've really seen – and this is, in particular, for some nationwide providers out there – is that make sure that the facilities have a point of contact so that when we're sending out the denial or approval letters, that it is routed to the correct person at the facility. We've received some request from providers where, you know, we've mailed it or we faxed it back and the facility just can't find it, and multiple ones. So, make sure you have a good internal process for identifying these letters coming from the contractors and getting those to the right people.

We also do see some duplicate requests come in. And it would be really helpful if you had an internal process to help decrease the duplicate pre-approval request submissions that come in. I think that's going to help everybody out with that.

As far as the medical documentation piece, some of the missing documentation and some reasons for denial we've seen hinge around a well-established prior level of function that's specific, measurable and comprehensive. Make sure you're also giving the history and the reason for the decline or the need for therapy. We're not always getting a good picture of the patient and why they need the therapy in the first place to understand why they would need continued therapy.

Make sure that the goals are realistic and specific and measurable. And make sure the needs are recent and relate to the therapy being requested. We've received some that are asking for more therapy and the latest notes were back in April. Those – that is not a current picture of the patient and what's been going on. We need the most up-to-date information that you have on that – on that patient.

One tip that I could give you that is very helpful is if you include prior and current weekly summaries to show the goals and the current progress and status, you'd just simply send in the minutes that show what the patient has received in therapy isn't helpful. What we're looking for is what's the prior

level of function, why is the patient needing the therapy, why do they need continued therapy and how are they doing and how have they done to show whether they've plateaued or if they're still making progress.

Make sure that any of your submitted evaluations are recent and also show current status. We've, again, have some evaluations that are coming in, while comprehensive are maybe two or three months old and no longer reflect what should really be going on with the patient two or three months later.

And, lastly, we have had some issues with legibility. So, please make sure no matter how you're sending your information into the contractor that it is legible. Our reviewers are really good about being able to pick things out. But, some of the things that have been coming through just really aren't readable. So, make sure that whoever is submitting it for you – make sure that we can read it.

And I think that is all I have.

George Mills: OK. Thanks, Amy. Yes.

I just wanted to reiterate a couple of points that Amy made. Check your phase. You can go to data.cms.gov and the phasing is there. We have all the part – phase one and phase two providers are listed there. Anybody that is not listed there is in phase three.

So, if you're – any doubt with you – so, if you go there and you put in your – the billing NPI and it comes up and it doesn't show that you're in the database, that means that you're in phase three because what is posted is everybody in phase one and phase two. And anybody that's not in there is in phase three.

I also want to reiterate the point about the SSN is not a HIC. Many people make this mistake that the Social Security number is not the HIC. The – a Medicare claim number consist of a Social Security number plus a BIC, a beneficiary identification code, which is – can be many things.

A majority of people are in A, which means that the individual is entitled to benefits off of their 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 or a C or a D. And so – or W – like a P means as a spouse and a C is a disabled adult child and a D is as a widower and a W is as a disabled widower.

So, in the case of those HIC numbers, the Social Security that is there is not the individual Social Security number but the Social Security number of the worker from whom they're entitled for. I know people make a big deal about this and there has been a lot of press about taking the Social Security number off the Medicare card but not in every instance is the Social Security that is listed there the Social Security number of the individual recipient.

It's the individual Social Security number of the individual worker from whom the benefit applies. But, yes, in most cases, it is the individual's SSN. But, not in every case.

And then, if you've got a situation where you're dealing with a railroad beneficiary, their numbers are – numbering scheme for recipients is totally different than Medicare. So, there is a Social Security number on theirMedicare card. So, I just wanted to reiterate that to everybody – that those two things that Amy brought up.

You know, one of the other questions we keep getting is, "Well, how do I figure out where the bene is on the cap and on the threshold?" And that's available through the MACs on the HETS system. So, that's there. It now has all the data and it's so – and it – it's a running total.

So, as the person gets more and more, the total will be added together. It's additive. It's not just an indicator of where they are like what's previously. So, now, it's a running total within the therapy jurisdiction.

So, if you have any questions or don't have any idea what that system is, you need to contact your MAC because that's how you get connected for checking that. But, that has now been loaded and should be working. So, you need to check with the MAC on that.

So, with that, I'm going to turn it over to Charlene Harven here in OFM and – to do some FAQ updates. And then, after that, we'll open it up to Q&A. So …

Charlene Harven: Yes. So, first off, I just want to reiterate, as we've been talking about this 10-day approval from the MACs. The MACs – we do state that the MAC has 10 days to approve to disapprove a pre-approval request. But, of course, we've also mentioned that that doesn't mean you'll get your response back in 10 days.

The letter from the MAC must be dated within 10 days of receipt of the request. But, it may take another week to get that response. And you've asked about how do you get the tracking number that's required on the claim. The tracking number will be part of the response that you receive from the MAC. So, you have to wait to get that from the MAC.

And now, you asked when can you get – when you obtain the authorization form of the pre-approval request. And, for that, you go – you visit the Medicare administrative contract of the MAC to whom you submit your billing. I know some of you have been claiming that that's not very easy to do.

Once you get to the site, it's confusing how to find that. Well, you can search by the word "therapy" or you can search by pre-approval request when you – once you get to the MAC's site. And then, you should be able to get their pre-approval process once you're there.

If you don't know who your MAC or Medicare Administrator Contractor is, you can go to the following Web site with your state information, wherever the state that you're billing from, and that site can locate who your contractor is. There is an interactive map there and you just click on the state that you're interested in. And that site is http://go.cms.gov/IMAP.

At the end of some of these FAQs, I'm going to give you one link in particular where all of these Web sites are located so you don't have to remember all of these links that I'm going to talk about.

Then, you also asked, "If an individual reaches their $3,700 threshold in April, for instance, or earlier in the year and then, in October, they have a need for additional therapy, will the therapy evaluation that perhaps in completed in October be paid my Medicare Part B without the need for manual review prior to the evaluation being completed?" And the answer is yes.

The therapy evaluation will be paid my Medicare if it meets all of Medicare's requirements and if it's furnished to determine it's medically necessary therapy services – if these therapy services are necessary. That has to be paid even if – once this – the evaluation is done, it's determined that it's not medically necessary. And you, you won't continue with the services. But, that evaluation just still will be paid by Medicare.

Now, you asked "How is the 10-business-day deadline counted? Is it about the date that is printed on the letter from the MAC or the date of the postmark on the letter?" And the 10-business-day deadline is counted as follows.

Day one is the day the MAC receives the request. The MAC then has 10 business days to pre-approve or deny the request. The date on the letter must be within 10 business days. Don't now use the postmark date on the letter that you receive from the MAC.

What is the appeals process if the claims are denied after you receive approval? The appeals process is the same as has been for all the other therapy services. That hasn't changed. If your claim is denied, you can appeal. However, the pre-approval request is not subject to appeal.

George Mills: Again, to go over that, that's an important point that we want to reiterate. So, if the MAC says, "We don't – we don't – we're not going to give approval for this in advance and you disagree, the way to get into the appeals process is to provide the services or services, the claim will come in and then you'll have to go through the appeals process. That's how you enter the appeals process.

Or, as the MACs have indicated, you – they might say, "Well, there's no plan of care." Well, if they denied for that, you can go back and submit additional documentation which is not an appeal but is more of a documentation support to the original request. But, there – the appeal system starts with the claim.

Charlene Harven: Is it possible to FTP our pre-authorization review and documentation versus faxing it or mailing it? Well, really, all of these – the way to submit the pre-approval request is up to the discretion of the MAC. So, you contact them for the method that they are requesting that you submit and it's up to their discretion.

Do federal holidays count in or against the 10 business days the MAC or (F.I.) has to respond to your request? Federal holidays do not count toward the 10 business days if the MAC is not open due to the holiday.

A visit is good for 20 calendar days or 20 visits regardless of dates of service. If 20 visits are approved, they have – do they have to be spread within 20 days? Or, can they be spread out 30 or 60 days? Well, therapy dates are good for 23 treatment days regardless of the amount of time it takes to use the days.

We talked – you asked about – in terms of resources, the links where you can get all of these information. I'm going to give you a short link to go to the medical review Web site. And it's http://go.cms.gov/MedRev. That is our medical review Web site. http://go.cms.gov/MedRev.

Once you go to that Web site, you could go on Therapy Services. Once you click on Therapy Services, you'll have a list of downloads. Including on that list is Therapy Cap Factsheet, the Q&As. And we're going to be updating. For instance, all of the questions and answers that I just posed will be updated on the FAQ list as well. We're going to have that on the Web site.

We already have phase one – the provider letters for phase one, two and three. You've asked for that – a copy of the provider letter, as well as a copy of a sample of beneficiary letter that's on there.

The open – remember, on September 5, we had an open door forum called – where Dr. Handrigan did a PowerPoint presentation on documentation requirements. That is all – that documentation requirements PowerPoint is available in a PDF on the therapy cap Web site. And that's on the download as well.

Then, we have other links in terms of the provider – where you can find the provider phase information as well as the PCG interactive (map) that I just talked about and other related links as well. So, that Web site, the medical review Web site which also – once you click that on your – click on Therapy, you'll get access to the other Web sites that I – that I talked about.

Now, at this time, I think we're going to go to the – to the providers and ask you what your questions are.

Matthew Brown: Yes.

(Latesha): Hi, Matthew. It's Latesha. Could we – could you call the contractor – tell the contractor – I'm sorry. The operator …

Matthew Brown: Sure. That's OK. Yes.

(Latesha): (Inaudible) for questions, please?

Matthew Brown: Got you. (Adam), if you would remind the callers how to enter the queue to ask their questions?

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star, then one, on your telephone keypad. If you would like to withdraw your question, press the pound key. Please limit your questions to one question and one follow up to allow other participants time for questions. If you require any further follow ups, you may press star one again to rejoin the queue.

Your first question comes from the line of (Catherine de Silva) from Community Rehab Care. Your line is open.

(Catherine de Silva): Yes. Hi. Thank you. I work at an outpatient therapy setting with several other therapists. And one of the things that we've been noticing, it's very challenging to submit request to the physician to sign our plan of care after we've done an initial evaluation.

And, at times, the physician – you know, there's a lag time with a few days before the physician is getting that signed for us in order for us to then send to

the MAC our finalized – all the paperwork. By the time that happens and then 10 business days go by, the plan of care is more than halfway done before we're finding out whether or not we've been approved for additional visits.

I guess my first question is, is there any updates on how to expedite the process with PCPs and then whether or not claims can be backdated if we are waiting two weeks before the physician signs the plan of care? Can we have a claim backdated to that initial date that we requested?

George Mills: Well, that – OK. So, people in the room are not completely understanding the question. So, could you restate the question just so we make sure we really have got it?

(Catherine de Silva): Sure.

So, for example, if I did an evaluation today dated 10/22 and fax that evaluation off to the PCP for the plan for care to be signed in order to send my request to my MAC, the PCP, obviously because they're busy, is taking additional days before we are receiving that signed plan of care back to us to then send the formal request for therapy. And we've been getting some denials based on requests being sent outside of the plan of care time.

So, if I sent my request – I did my evaluation today. And then, by the time the physician signed the paperwork, it was the 29th and I'm faxing it to my MAC on the 29th, it's not getting – then, we've kind of been having to wait another week before we actually kind of initiate the plan of care with the – with the patient because we – we're waiting on the (person). Does that make sense?

George Mills: Yes. Well, you know – I mean, to me, the general comment is, you know, that you got many parties involved and there's a lag here. And so, I can appreciate that. But, I don't have an easy answer for you other than on, you know, we need to get and make sure all the data is in and it's in the proper format. And I understand people – you know, the doctor might not sign it for a few days. But, I definitely wouldn't backdate anything. I don't know.

(Latesha): I guess – I'm sorry …

George Mills: Any of the MACs out there, do you – do you have any suggestions here from your standpoint on the ground? Like Amy or Darlene?

(Amy Brokaw): Well, this is Amy. I guess, well, I'll jump in.

Well, I think my first thought was kind of where George is going to is that you're going to have to make sure and get the physician more engaged in the process in understanding the need for that. I guess my other thought on that, too, is first of all, this is a pre-approval. And, as George said before, they shouldn't be holding up care for you. You should still be giving the care that the patient needs based on this pre-approval.

I know it's hard right now because you're trying to anticipate when you're going to go over. But, I think taking a closer look and a common working file and understanding when you're starting to get close and predict the need so that you're working ahead a little bit to say, "OK, I know in a couple of weeks we're really not probably not going to be where the patient's needs to be and I'm going to start working on that now."

Getting that physician engaged, that will probably going to look at some extended therapy. With or without this requirement which we have right now with the pre-approval, I think that makes good sense. And, normally, you would want to do that and get the physician engaged if therapy was going to be prolonged like that. Regarding the things you needed to submit …

George Mills: Yes. I mean, that's the thing. I mean, we – you know, going to other contacts, people say, "Oh, it takes so long to get this from the doc" or "It takes that to get this from the doc" or "The doc works midnight and, you know, if he misses it -" I mean, we hear that a lot. And we appreciate that. But, I don't think there is an easy answer other than trying to do it with some advance planning as Amy was pointing out.

The only thing I can say is that this is only for a very limited number of people. So, you know, it's going to happen. But, it shouldn't happen at a tremendous frequency. So – but, we understand where you're coming from and we appreciate it. I just don't have a really good answer beyond better coordination. So …

(Catherine de Silva): OK. And I guess a more specific example would be if the evaluation was completed on 10/22 but the pre-approval request was faxed out on 10/29 because that was pending, can we put 10/22 as the start date for requesting?

George Mills: Well.

(Amy Brokaw): This is …

George Mills: Go ahead.

(Amy Brokaw): Can I answer that, George? This is Amy.

I would say if 10/22 is the date that you expect that the patient is going to go over that $3,700 cap, that would make sense. I think that's one of the issues we've seen with the pre-approvals coming in. It's when does that start?

(Catherine de Silva): Yes.

(Amy Brokaw): And so, you have to – you can give us a date on the expected date range that they are going to be going over the $3,700 or within that 20 days that you're doing. So, again, I think that there's going to be some communication with your individual contractor as well.

(Catherine de Silva): OK. Thank you.

George Mills: Yes. But, what – but, this is a good question. And we'll take it back and consult and put out an FAQ on this because this is a good question. But, again, you know, at the end of the day, there is two options here. You could provide whatever service you want without getting the pre-approval. The only difference is that's just going to be stopped before it's paid. So, if anyone feels like, "Well, I'd rather do it that way," that's another option. And so, the pre-approval was just – we designed that because denials, when there is a denial, it's pending liability when it's above the 1,880 cap.

And this was really as a beneficiary protection that we were trying to do the advanced approval so that people then provide thousands of dollars in services. But, there's no law that makes you do that – request the advance

exception. You could always provide the service and then you have it medically reviewed. So, I just want to make sure that that's clear.

So, next question, now. Thank you, though.

Operator: And your next question comes from the line of (Shirley Knowles) from TMC.

Your line is open.

(Shirley Knowles): Hi. We're calling regarding …

Female: We have a few letters that have past the business 10 days by another business 10 days and we're being told that we just have to wait. We haven't gotten any response and we were told that they are still processing. And this isn't just one MAC. It's three different MACs.

(Latesha): Yes.

Female: So, the question is, what do we – what do we do in that case because now, we're waiting not only the 10 business days but 20 business days and still do not have a response? And we've put the patient on hold? It takes a lot longer to (find) an ADR and it does to get the approval? So, our process is we're going to do the extension request and we're waiting for that to come back and we're just not getting it. What's our recourse?

(Latesha): And – hi. Have you worked with your MAC?

Female: We have called and they told us that they're still processing that. And this one was due back on the 8th, which was a holiday. And this is from the date that we got the confirmation of the fax. So, we know – we counted that date. The holiday was the 8th. That's the day it technically was back.

So, we went to the 9th because it was a holiday. And here, today, it's the 22nd and we still do not. And we've called several times and they said it's still in process. So, I'm concerned on what's our recourse, then, because, now, the MACs aren't following the guidelines and the patients and the providers are being held up, unless we want to risk having a two-year fight on an ADR.

(Latesha): Well, yes. And then, unfortunately, it sounds like that's your next recourse.

Female: Well, but the bad part is that we have to comply. Why didn't the CMS – why didn't the MACs have to comply?

(Latesha): Well, our standing rule is that the contractor has the 10 days for the (MAC to approve).

Female: All right.

(Latesha): So, without that – without that approval letter, (information) on the claim. Unfortunately, it doesn't (inaudible) precarious situation.

Female: So, what recourse do we have? Where can we, maybe, like file a complaint if we can't get them done? Or because even the patients are upset because they're – you know, they're being told in ABN and they could be responsible for all this.

So, you know, (they're gone shy), too, but they need this therapy because they've had – like the one patient who had a massive stroke, he needs this help. So, our question is, what is our recourse short of taking the long road and then we have to go back and fight something that we shouldn't have to because we did what we were supposed to do?

(Latesha): Have you – have you heard confirmation from your MAC that the service was (inaudible) approved or is it just still waiting for that approval (inaudible)?

(Shirley Knowles): We're still waiting for that approval. We should have had it the 9th and we do not have it. And the other two, we should have had it the 12th and we do not have. And when we called to ask if it was approved or denied or where it is in the process, they pulled it up and they tell us, "Oh, it's still pending." But, that's way past our 10 business days. And we can't just assume it's going to be approved because that's an automatic ADR.

(Latesha): Correct. How about could you send an e-mail to the mailbox? We'll deal with this offline.

(Shirley Knowles): OK.

(Latesha): I'll help support you offline.

(Shirley Knowles): Thank you.

Operator: Your next question comes from the line of (Sheryl Hanes) with (Inaudible). Your line is open.

(Sheryl Hanes): I really appreciate everything the previous caller said. That's pretty much was going to be my question. In a way, I was going to say that if we don't receive something within three weeks, your comment about there are possible errors and you don't respond to them, could we make an assumption that there is possibly an error on the cover letter or something else wrong if something isn't received within three to four weeks' time? Because she's absolutely right.

It's extremely expensive to have to go through the appeal process. And most industries – we're a penny industry – and it's a – it's a big issue to us. So, it – absolutely, we'd like to have that addressed, as well as what to do about a new patient. You kind of addressed it previously. But, you didn't cover the fact that we do everything right.

We see a new patient, we check that they, in fact, have exceeded the $3,700 especially at this time of year. We want to get the paperwork in and we don't know even what the minimum paperwork is that you would accept to process something. So, could you also put that information up on what the minimum requirement is for a brand new patient to us that has exceeded the $3,700?

(Latesha): So, each of our contractors should have contact information on their Web site to help support you with doing this process if it's falling outside of this 10-day window. Well, we don't – we can't absolutely promise that you'll have that response within the 10 days. We recognize that there will be some additional time.

CMS will have to provide you some other guidance as to how we're going to deal with so many issues that are coming up that the time frame was much longer than what we would have expected. So, all I could suggest is continue to work with your contractors. And for those falling outside, say, of a 20-, 25-

day time frame, send us an e-mail to the mailbox and we can support you and help you work through your contractors.

(Sheryl Hanes): I don't – when you say send an e-mail to the – to the box, I have no idea what you're talking about.

(Latesha): OK. That link was provided earlier. I'll turn it over to Charlene so that she can repeat it.

Charlene Harven: It's the therapycapreview@cms.hhs.gov.

(Sheryl Hanes): It's the med review?

Charlene Harven: therapycapreview, which is all one word – therapycapreview@cms.hhs.gov.

(Sheryl Hanes): OK. therapycap – I'm sorry.

Charlene Harven: Review.

(Sheryl Hanes): I'm sorry. I don't understand …

Charlene Harven: R-E-V-I-E-W.

(Sheryl Hanes): R-E – OK. And then – and then, would – is someone going to put on also the minimum requirement for a new patient? We have yet to see anything on that. Is that also going to be available?

Charlene Harven: OK. Did you look at our PowerPoint documentation requirements that's available on our Web site yet? The September 5 call. We put that PowerPoint on. It had documentation requirements and references to guidelines on that.

(Sheryl Hanes): OK. And that's for brand-new patients also? Because I got it – the way I read it, it was more with patients that you had a history with. So, that also covers new patients also?

(Latesha): Amy or Donna or Darlene, do you understand what she's asking? We're all looking a little stumped here. So, maybe we're missing something. But, maybe you got it.

(Donna Blythe): Yes. This is Donna Blythe from Novitas. And I think this gets back to the issue of what we were saying earlier where it's a new incident for this patient, say, a recent hip fracture for which we anticipate therapy and which would probably otherwise be approved. The problem is the patient is nowhere near the cap. They haven't even begun or they've had one or two …

(Sheryl Hanes): Yes. This is someone who has had – this is someone that we have checked. They have (a common working file) and they have used up $3,700 already in the year. They are new patients to us.

(Donna Blythet): OK.

(Sheryl Hanes): What's the minimum requirement for that?

(Donna Blythet): So, I think what she's saying is another provider. The beneficiary reached the cap under another provider, a different provider. And now, there's a second provider coming along.

(Sheryl Hanes): Yes.

Darlene Higginbotham: Yes. And this is Darlene with First Coast. I think, you know, I know that the (MLM) Matters article identify the different documentation that's required as well as I know our form and our tips articles on our Web site for First Coast lists a different documentation that's required. And you're correct. It listed various documentation which some of those items would apply to an existing patient.

For a new patient, you would submit what you would have available for a new patient. So, the evaluation, the certified plan of care. You know – obviously, you would not have treatment encounter notes if treatment hasn't begun yet. So, you would submit what you have available at that point of the encounter with that patient.

(Sheryl Hanes): OK. That's terrific. OK. Thank you, all, very much. WPS, I miss you.

Operator: Your next question comes from the line of Miles Holyfield from Agentive Healthcare. Your line is open.

Miles Holyfield: Good afternoon. I have two quick questions on a few letters that we've received which has actually have been approved on the prior – on the pre-approval process. We have a medical reviewer number but there's not a tracking number on the letter. So, what do we do in instances like that? And then, also, where does that tracking number go on the claim?

(Latesha): Yes. Hi. We will – in that particular case, we'll encourage you to work with your contractor because there should be that tracking number on your letter. And they would be the only ones who'd be able to provide that to you.

Miles Holyfield: OK. What about the instance where we call the contractor and asked is it – it just state it's been approved it doesn't necessarily state that it was approved for the OT portion or the PT and speech portion? And they really weren't able to give us an answer either way. There is an assumption that just the 20 visits are approved for both.

(Latesha): Again, you have to work with your contractor. Unfortunately, we wouldn't have that information here in central office. So, we'll have …

Miles Holyfield: Where do we go if we're not getting answers from our contractor?

(Latesha): Well, I would encourage you to send an e-mail to our mailbox again. But, it's really imperative that the contractor provide that information to you because you'll need that information to supply when you – when you submit your claim.

Miles Holyfield: Yes. I agree.

(Latesha): And, ultimately, we have to get back – to get back to the contractor. So, I would encourage you to send us an e-mail and we can facilitate – we can facilitate that. But, again …

Miles Holyfield: And if we do have that tracking number, where does it go on the claim?

(Latesha): You'll have to work with your contractor. Unfortunately, we – I don't have that information here in front of me. I don't know Wil – do you – no. OK.

Female: Each contractor has their own discretion (to, say) how they're going to do the tracking system. So, you would have to contact your MAC directly and find out where they wanted that. They should have included that on the letter that they send you. It should have said where to put that tracking number.

Miles Holyfield: OK. Thank you.

Operator: Your next question comes from the line of (Darlene Elman) from PRN. Your line is open.

(Darlene Elman): Hi. Yes. This is (Darlene Elman). And my question is regarding the voluntary ABN. And we're aware of all the content et cetera. However, the question is with the ABN actual regulatory instructions. And it says you should not – since this is a statutory exclusion over the 1,880 – you should not ask the beneficiary to sign dates or check a box. And that's in the actual ABN regulation. Can the facility simply annotate on that voluntary ABN the route of delivery whether they've mailed it, talked to the beneficiary or hand-delivered it et cetera?

Hello. Hello.

(Latesha): Amy or Darlene or Donna, have you guys seen a circumstance like this and can, at least, give us a little bit of direction as to what she should do about that? I'm not sure.

(Amy Brokaw): Hi. This is Amy. I'm just going to try and understand her question first. Are you saying because the ABN for this particular service is not required, then it has the stipulation that you should not ask them to sign or check the box?

(Darlene Elman): Yes. And the actual – if you go into that regulation for the ABN – I believe it's in the Medicare Claims Processing Manual …

(Amy Brokaw): Yes.

(Darlene Elman): … (inaudible) voluntary ABN that you should not ask the beneficiary to sign, date or check a box for instance this is a statutory exclusion and as was discussed MACs. There is no true appeal process unless a claim is actually

submitted, a pre-approval request has been done, and the claim has actually been submitted. They just can't request an appeal through the normal Medicare appeal route.

(Amy Brokaw): Well, yes. This is Amy, again. I think what – and CMS can chime in one here. I think the importance of this whole process is making sure that the beneficiary is aware that once you go above the cap – even above the 1,880 – that, you know, there is not guarantee on payment for that and that they might be held liable if Medicare doesn't pay. So, it's really important that the beneficiary is notified. And that's why, for this pre-approval, we also send out the letter to the beneficiary …

(Darlene Elman): Yes.

(Amy Brokaw): … explaining to them, you know, what happened. I think I need to defer to CMS on what they should do. I think the one that we have seen just has a statement from the facility that they issued an ABN, basically told the beneficiary that this may not be covered by Medicare but they're submitting it in the pre-approval.

(Darlene Elman): OK. Thank you. That's exactly what our understanding was as well.

And then, I just have a quick second question on evaluation. Will an evaluation be paid for even if the pre-approval request is denied? Or, is that something that is – I'll have you answer the question, I guess.

(Amy Brokaw): This is Amy again. And the answer to that is yes. The evaluation is noted to be necessary to determine whether someone needs therapy or not. Therefore, you have to do it.

(Darlene Elman): Right.

(Amy Brokaw): And so, I would have to say, though, that you need to also be aware – if you read the manual for the – for that piece – and I don't have it in front of me or the citation. So, I apologize for that. But, it does need to be – the evaluation will need to be medically reasonable and necessary and that the patient needed an evaluation.

But, then, after the evaluation is done, if it's determined that more therapy, really, wouldn't be beneficial for the patient, then the evaluation piece would be paid but subsequent – let's say, then, you didn't submit a pre-approval. And a claim went in anyway and it was subject to a pre-pay medical review.

(Darlene Elman): Yes.

(Amy Brokaw): Then, that claim would be denied, but not the previous evaluation.

(Darlene Elman): OK. Thank you. And it's been answered very clearly. Thank you.

(Amy Brokaw): OK. Sure.

Operator: Your next question comes from the line of (Dianne Desmu) from Hallmark Rehab. Your line is open.

(Dianne Desmu): Hi, there. I think a lot of my questions are similar to previous questions I asked. I'm feeling on the call that many of you don't really realize some of the situations that we're having to be faced here in the field such as the patient with the new evaluation. And I hope I can help explain this – was that, you know, we have this new patient who has (met) their $3,700 cap. Certain MACs and their processors are saying we need to have the certification signed prior to submitting our pre-authorization. However, our Benefit Manual says that we don't required a cert before providing services.

So, my question on that is, if we have an evaluation and treat order from the physician that says it's indicated we have the evaluation and we know the patient is over the $3,700, why are we needing to wait for for a signed certification to submit to our MAC contractor?

(Latesha): Amy or Donna or Darlene?

(Amy Brokaw): Well, this is Amy. I guess I'll jump in. I would have you probably do a little look into the certification issue a little bit more because I don't have that in front of me to know whether that is a requirement or now. I hear that you're saying that it is. I believe you.

But, I can, at least from a WPS perspective toward the documentation – what we're looking for is for you to paint a picture for us for that patient whether they're new to you or not and to show that that patient has been evaluated by a physical therapist, is having oversight and a signed physician order from the physician stating they need therapy and all applicable Medicare requirements are met for that particular situation.

So, if you're looking at a situation where a certification is not required, we wouldn't require that for that situation. So, I think the documentation requirement and the ones that we have out for WPS, too, are probably geared more towards the idea that it's the same provider that has been providing service.

So, I think it would be a good idea for us to go back and probably put a little more information in there to say, "OK, if this is someone new, here's what we're looking for" versus someone who's, maybe, been on services with that same provider. But, I think it's important to look at each situation as it presents because, as we know – you know, everybody is different.

All the situations are different. And if I tell you one thing, then that would cover one situation. It wouldn't all. And so, whenever you have someone who's going to go over that cap, you need to be submitting documentation that gives a clear picture to the reviewer so they understand the reason why that person is needing the therapy, whether it's for a new condition, an old condition, one that had therapy before or haven't so the reviewer understand exactly what is being asked for and why.

And then, that reviewer would then apply the applicable Medicare certifications or documentation for that service. So, I think that's how we would look at it at WPS. But, I would let Darlene or Donna add anything or subtract anything that I've said.

Darlene Higginbotham: First Coast would agree with you, Amy.

(Donna Blythe): As with Novitas.

(Amy Brokaw): Did I answer your question OK?

Operator: And your next question comes from the line of (Danielle Allen) from Atlantic Orthopedics. Your line is open.

(Danielle Allen): Hi. Thank you for taking my question. I understand the medical review process. My question is more billing-related. We're having a problem that our beneficiaries are getting their approval letters and then we're not getting ours. So, we're calling our MAC and they are able to tell us that, yes, we've been approved.

But, we don't have access to that tracking number. So, we are sitting and waiting and waiting and waiting for letters and holding submitting our claims because we don't have the tracking number. So, I guess, my question is how long are we supposed to do that? And, if we do file the claim, will CMS not pay it without that tracking number?

(Latesha): Well, first, if you – if you file – I'm sorry. Who is going to speak?

(Amy Brokaw): This is Amy. I was just going to maybe clarify that depending – and this might be what you're going to say, (Latesha). But, I think it really – you'll have to work with your contractor on how they're going to use that tracking number …

(Danielle Allen): OK.

(Amy Brokaw): … because everyone uses that differently. So, for instance, for WPS, we have a case I.D. number just to help us identify within our database. But, it's not attached to the claim in any way and you can submit your claim without it. But, I can't speak to all contractors because they may have a different system set up. So, you'd need to work with your contractor to find out the significance of that tracking number.

(Latesha): And then – thanks, Amy. Another thing I was going to add was that it's really concerting that the bene is getting the letter and you're not receiving it. So, I think, more fundamentally, when you speak with the contractor or – I would recommend that you contact the contractor just to ensure that they have the most up-to-date and current address for you.

(Danielle Allen): Well, when we call, we are confirming that the address that we've sent is what they have on file for us. But, the problem is that this has happened on a couple of different patients.

(Amy Brokaw): This is Amy. If I might speak to that, we've had some issues with the mail. We've had – we've encountered a few different things. I think, first of all, it's important to know that all the contractors are dealing with a large amount here.

(Danielle Allen): Sure. I understand that.

(Amy Brokaw): So when you're looking at a huge amount going on. I've had some mail come back that got queued up somehow in the post office machine somewhere. I've had issues – maybe I've got stuff in the envelope backward. These are kind of onesies, twosies things. Other things to check is that – we've had happen – is we've had certain facilities that have stated they did not receive their letters. But, they have some internal processes where they were misrouting it within their own facility or within their own corporation.

(Danielle Allen): Sure.

(Amy Brokaw): So, that's also something important to look at – is trying to set that process (up, too), so that you can identify this and get this to the right people because we went into that issue as well.

(Danielle Allen): OK. I mean, our MACs have been great. Their turnaround has been much shorter than the 10 days. So, I have no complaints at that. I just – we want to be able to submit the claims though.

OK. Thank you for the suggestions.

(Amy Brokaw): Thank you.

Matthew Brown: I think we have time for one more question.

Operator: Your next question comes from the line of Nancy Beckley from Nancy Beckley & Associates. Your line is open.

Nancy Beckley: Hi. Thank you. My question is for George. At the beginning of the call, you made a reference to that having post-pay contractors take a look at change in billing patterns. And I'm curious if you have a patient at the same clinic that was seen early in the year by therapist A, and now the patient returns for a second episode. Can they be seen by therapist B? Or, will this constitute a compliance issue if they're in different phases? Or, is your reference to a compliance issue having to do with transfer of therapist care while care is in progress during this particular period of MMR?

(Debbie): Hi. This is (Debbie). I think it – George was – the concern was that the patient would be transferred from therapist A to B to avoid the billing.

Nancy Beckley: I understand that. But, do you mean …

(Debbie): But, if they were treated by A earlier and now are treated by B, that's fine. But during the same episode of care, if it goes from A to B just to avoid the billing, that's what they would be looking for.

Nancy Beckley: Thank you. That clarifies my question. Thank you very much.

Matthew Brown: Thank you.

And, with that, I will ask George Mills if he has any closing remarks.

(Latesha): Hi, Matthew. It's (Latesha). George had to step out.

Matthew Brown: OK.

(Latesha): But, we have (Wil Gehne) and (Pam West) here. Any closing remarks for you?

(Wil Gehne): No.

(Latesha): No, OK. So, none here. We just thank everybody for supporting CMS in this project. And we are taking back lots of action items for ourselves and we will follow up and share some of what you've told us today with our contractors.

And, with that, George just came back in the room. George, any ending remarks?

George Mills: No. No. Sounds good.

(Latesha): OK. George said, "Sounds good." Thank you, everybody. Enjoy your afternoon.

Operator: This concludes today's conference call. You may now disconnect.

END