Frequently Asked Questions
Recovery Auditor – Outpatient Therapy Claims
As of April 17, 2013

1. Q. Why is CMS conducting manual review on therapy claims?

A. On January 2. 2013 President Obama signed into law the American Taxpayer Relief Act of 2012. This law extends the Medicare Part B Outpatient Therapy Cap Exceptions process through December 31, 2013. Section 603 of this Act contains a number of Medicare provisions which directly impacts outpatient therapy caps and manual medical review (MR) threshold. Revisions of the Financial limitations for Outpatient Therapy Services – Section 3005 of the Middle Class Tax Relief and job Creation Act of 2012 requires Original Medicare to temporarily apply therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital between the dates January 1, 2013 through December 31, 2013.

2. Q. How do providers request exceptions for therapy services subject to manual medical review?

A. Providers shall submit claims with the KX modifier to request an exception for services above the threshold. Claims for services at or above the therapy cap or thresholds for which an exception is not granted will be denied as a benefit category denial for which the provider will be liable.

3. Q. What triggers the manual medical review process?

A. Claims at or above $3700 where the beneficiaries therapy services have exceeded the threshold cap for the year will require manual medical review. The trigger of one or both of two separate thresholds initiates this process. The separate caps are:

- A $3700 cap for Occupational Therapy (OT) services per year, per beneficiary.
- A $3700 combined cap for Physical Therapy (PT) and Speech Language Pathology (SLP) services per year, per beneficiary. Note that although PT and SLP services are combined for triggering the threshold, the medical review will be conducted separately by discipline.

4. Q. What settings apply to the therapy caps?

A. All Part B Outpatient Therapy settings and providers include:

- Private Practices
- Part B skilled nursing facilities
- Home Health Agencies (TOB 34x)
- Outpatient Rehabilitation Facilities (ORFs)
- Rehabilitation Agencies (Comprehensive Outpatient Rehabilitation Facilities)
- Hospital Outpatient Departments (HOPDs)

5. Q. Are all Hospital Outpatient Departments affected?

A. The therapy cap only applies to outpatient hospitals as detected by:

- TOB 12X (excluding CAHs) or 13x
- Revenue code or 042X or 44X
- Modifier GN, GO, or GP; and
- Date of Service on or after January 1, 2013

6. Q. What role will the Medicare Administrative Contractor (MAC) and Recovery Auditor play in the manual medical review process?

A. MACs

- Providers will continue to submit claims to the MACs for claims processing. MACs will conduct prepayment review on claims reaching the $3700 threshold and processed between January 1, 2013 and March 31, 2013. CMS requested MACs conduct these manual medical reviews within 10 days.

Recovery Auditors

- Providers will continue to submit claims to the MACs for claims processing. Beginning April 1, 2013, the Recovery Auditors will complete manual medical review on claims reaching the $3700 threshold. The Recovery Auditors will conduct both pre and post payment review.

  Prepayment Review:
  - If a claim is submitted in a Recovery Auditor Prepayment Review Demonstration state, the Recovery Auditor will conduct prepayment review. These states are Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina and Missouri.
  - All claims will continue to go to the MACs, but in these states, the MAC will send an Additional Documentation Request to the provider requesting the additional documentation be sent to the Recovery Auditor.
  - The Recovery Auditor will conduct prepayment review within 10 business days of receiving the additional documentation and will notify the MAC of the payment decision.

  Post-payment Review:

  - In the remaining non Demonstration states, the Recovery Auditors will conduct immediate post-payment review.
  - All claims will continue to go to the MAC (same as it happens today) and once received the MAC will pay the claim.
  - The Recovery Auditor will then issue an Additional Documentation Request letter and to the provider.
  - The Recovery Auditor will complete manual medical review within 10 business days of receiving the additional documentation and will notify the MAC of the payment decision.

7. Q. What are the 11 states participating in the Recovery Audit Prepayment Review Demonstration?

A. The states participating in the Recovery Audit Prepayment Review Demonstration are as follows: Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina, and Missouri.

8. Q. For manual medical review will only the charges over $3700 be reviewed, or only the unpaid charges including those over $3700, or services above the therapy cap ($1900), or is the entire episode of care subject to review from dollar 1? Does requesting medically necessary care for a beneficiary over $3700 automatically trigger a Recovery Audit?

A. All claims at or exceeding the $3700 threshold are required to be reviewed. At this time no Recovery Auditor is approved for therapy review between $1900 and $3700, however these reviews could occur outside of this mandate in the future. It is possible that another review contractor could review claims less than $3700.

9. Q. Will Critical Access Hospitals (CAHs) with dates of services between January 1, 2013 through December 31, 2013 be included?

A. No. CAHs will not be included.

10. Q. When does the review requirement begin?

A. The review requirement begins once claims for a beneficiary reach and/or exceed the $3,700 Therapy Cap.

11. Q. What will the review look like?

A. The reviews will be per claim.

12. Q. How will the Recovery Auditors be paid?

A. Recovery Auditors are paid a contingency fee based on the amount recovered or avoided.

13. Q. Will providers be able to submit the information to the Recovery Auditors electronically and get a confirmation of receipt, or will it require submission by fax or mail? Is there a tracking system in place by the Recovery Auditors or the MACs for the status of the review?

A. All four Recovery Auditors use the esMD system. The Recovery Auditors also accept fax, mail and CDs. In addition, Recovery Auditors have claim status portals. In the claim status portals Recovery Auditors post information such as if the additional documentation has been received and if the review results letter has been issued.

14. Q. For multi-state providers who have a single MAC, how will there claims be assigned to the Recovery Auditors? Will it be based on the process, pre-payment or post-payment review, the state that the individual facility submitting the claim is located in, or based on the residency of the patient?

A. Providers located in a prepayment demonstration state that are serviced by the primary MAC in that state will have prepayment review conducted. Providers located in a prepayment demonstration state that are serviced by another MAC will have postpayment review conducted. The provider location and the MAC will determine the type of review.

15. Q. Are the Recovery Auditors operating under the same rules for the manual medical review as they do for services that are not reasonable and necessary or are new rules under development? Will the Recovery Auditors be offering specific guidance for the manual medical review process on their websites?

A. CMS will follow the same rules already in place for manual medical review of therapy claims. There are no new rules under development. This process will operate under the same rules the MACs follow today using the same coverage, coding and billing policies, documentation requirements, established medical necessity criteria, timeliness standards, etc. The same documentation guidelines and policy requirements in place today are applicable here.

16. Q. Who will conduct the reviews for the Recovery Auditors?

A. The Recovery Auditors are required to use Registered Nurses or therapists when conducting coverage/medical necessity determinations and certified coders when making coding determinations.

17. Q. Part of the Manual Medical Review process in 2012 was the requirement to provide specific details regarding the denied request for additional visits. Is this same requirement still in effect? Will the Recovery Auditor be required to provide specific details to the provider regarding any denied claims and will this explanation come direct from the Recovery Auditor or from the MAC?

A. A detailed review results letter will be sent to the provider by the Recovery Auditor.

18. Q. Is it possible for the MACs/Recovery Auditors to identify multiple dates of service for review and bundle those services, as opposed to requesting the review claim-by-claim?

A. The MACs and Recovery Auditors will review based on how the claim was submitted. Each claim will be reviewed individually and the additional documentation request will be claim by claim.

19. Q. Will the Recovery Auditor established additional documentation limits be honored, or will there be an override for cases over the limits? Will providers be reimbursed for submission of medical records up to the $25 max that is allowed?

A. Current additional documentation limits will not apply to therapy pre and postpayment reviews. Providers will not be reimbursed for records.

20. Q. How is the transition from MAC review to Recovery Auditor review being managed? If the MAC reviews the March claim, and there are additional charges in April, will the Recovery Auditor review the April charges for the same episode of care, given that the MAC previously reviewed the same chart? If a claim is reviewed for April at $3700, and the provider keeps treating without knowing the review results, will the claim be reviewed again for the May billing?

A. Each claim is reviewed individually. The March claim will be reviewed, then the April and all subsequent claims. This will occur no matter who is reviewing the claim.

21. Q. Will providers be able to appeal, and if so, will it be the same process currently used? In order to address the efficiency of the appeals process is it possible the appeals for the therapy services be bundled by beneficiary, instead of the individual claim as it is currently being processed? Is the assumption that if the first claim is denied, all subsequent services will also be denied and require appeal?

A. The appeals process remains unchanged and will continue to function as it does today. Appeals will continue thru the MACs. All claims will be evaluated on its own merits.

22. Q. Will the Recovery Auditor discussion period be allowed for manual medical review?

A. The Recovery Auditor discussion period will be allowed for post payment reviews. The Recovery Auditor discussion period will not be available for prepayment reviews.

23. Q. Who should I contact if I have questions?

A. All therapy questions should be submitted to the therapy cap mailbox at therapycapreview@cms.hhs.gov.