Coding Corner

FAQ

1. Will you please explain to me the levels of assist used on the MDS so I understand how to code independent with a walker?

In the subacute/PPS setting the assessment tool is the MDS and it uses a 0-4 ADL score scale. The language is different from typical therapy language. As you can see below, in therapy we still use min, mod and max as it is necessary to show progression however on the MDS they will all be classified as extensive assist. It is important to point out that independent in SNF/PPS includes with or without AD/AE by MDS definition. Due to the inclusion of AD/AE in the MDS definition of independent, modified independent is not used in the SNF/PPS setting.

<table>
<thead>
<tr>
<th>Therapy Level of Assist</th>
<th>MDS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Dependence</td>
<td>Total Dependence (4)</td>
</tr>
<tr>
<td>Max, Mod, Min</td>
<td>Extensive (3)</td>
</tr>
<tr>
<td>Contact Guard</td>
<td>Limited (2)</td>
</tr>
<tr>
<td>Supervision</td>
<td>Supervision (1)</td>
</tr>
</tbody>
</table>

2. Will you please help me to understand diagnosis coding for a head injury?

An intracranial injury, without a skull fracture, caused by a trauma is coded with 907.0. A nontraumatic brain hemorrhage is coded with the appropriate late effect of cerebrovascular disease code, 438.xx.

3. When do I use V57.89?

V57.89 is used to indicate that a patient is admitted for short term rehab, and the -.89 indicates the patient will be seen by multiple therapy disciplines. When used, V57.89 must be a first listed diagnosis.

4. What are the exclusions with ICD-9 V58.78?

V58.78, aftercare following musculoskeletal surgery, excludes orthopedic aftercare coded in V54.01-V54.9 meaning aftercare for a hip fracture caused by a fall repaired in surgery with an ORIF would NOT be coded V58.78 but instead would be coded V54.13.

Decoding CPT Codes

Each quarter we focus on decoding the mystery of a specific CPT code. This quarter we will focus on CPT code 97002 – Physical therapy reevaluation and CPT 97004 – Occupational therapy reevaluation.

The reevaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment, or terminating services. Reevaluation provides additional objective information not included in other documentation, such as treatment or progress notes.

Reevaluations are distinct from therapy assessments. Assessments are considered a routine aspect of intervention and are not billed separately from the intervention. For example, a patient is being seen in physical or occupational therapy for shoulder pain and limited shoulder functional range of motion due to capsular tightness. Prior to performing shoulder joint mobilizations, the therapist assesses the patient’s ROM and pain level/pattern to determine the effect of prior treatment and, if further mobilization is warranted, to determine the appropriate mobilizations.

After the mobilizations are completed, the ROM is assessed again to determine the effects of the treatment just performed. The time required to assess the patient before and after the intervention is added to the minutes of the treatment intervention (code 97140 in this example). Continuous assessment of the patient’s progress is a component of the ongoing therapy services, and is not payable as a reevaluation.
Consider the following points when billing for a reevaluation:

- Indications for a reevaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care.
- When reevaluations are done for a significant change in condition, documentation must show a significant improvement, decline or change in the patient's diagnosis, condition or functional status that was not anticipated in the current plan of care. When a patient exhibits a demonstrable change in functional ability, a reevaluation may be necessary to revise long term goals and interventions. The plan of care may need to be revised and re-certified if significant changes are made, such as a change in the long-term goals.
- If a patient is hospitalized during the therapy interval, a reevaluation may be medically necessary if there has been a significant change in the patient's condition which has caused a change in function, long term goals, and/or treatment plan.
- Reevaluations may be appropriate at a planned discharge when documentation supports the medical necessity for the reevaluation service.
- Therapy reevaluations should contain all the applicable components of an initial evaluation and must be completed by a clinician.
- A reevaluation is not a routine, recurring service. Do not bill for routine reevaluations, including those done for the purpose of completing an updated plan of care, a recertification report, a progress report, or a physician progress report. Although some state regulations and practice acts require reevaluations at specific intervals, for Medicare payment, reevaluations must meet Medicare coverage guidelines.
- These reevaluation codes are untimed, billable as one unit.
- Do not bill for reevaluations as unlisted codes (97039, 97139, 97799) or test and measurement, ROM, MMT codes (95831-95834, 95851-95852, 97750, 97755).

**PPS Updates & Review: Change of Therapy (COT) policy change effective 10/1/2014**

The Change of Therapy (COT) Other Medicare Required Assessment (OMRA) is used to classify a resident into a new resource utilization group (RUG) when, based on the therapy services provided during the previous seven days, the resident no longer qualifies for the RUG into which they are currently classified for payment. Under the current regulation, if a patient falls out of a rehab RUG, a COT cannot be used to bring the patient back into a rehab RUG. Instead, you have to wait for the next scheduled assessment or Non-COT unscheduled assessment as appropriate (EOT/SOT, etc).

Mr. Green qualified for an RUB on his 30 day assessment. On Day 37, a COT checkpoint was reviewed and the patient did not receive enough therapy days to qualify for a Rehab RUG (4 distinct days of treatment) and there was no Restorative Nursing, so the patient was classified into a nursing RUG while therapy continued to treat. Under the current regulation, he will continue with a Nursing RUG until next scheduled assessment or Non-COT unscheduled assessment as appropriate (EOT/SOT, etc).

**BEGINNING OCT. 1,** providers will be permitted to use the COT OMRA to reclassify a resident into a therapy RUG from a non-therapy RUG, but only in certain limited circumstances. The revision is intended to capture only rare cases where the resident had qualified for a RUG-IV therapy group on a prior assessment during the resident’s current Medicare Part A stay and had no discontinuation of therapy services between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the patient into a RUG-IV therapy group. Under the policy, while a COT OMRA may be used to reclassify a resident into a therapy RUG in the circumstances described above, it may not be used to initially classify a resident into a therapy RUG.

**For example:** Under the new Oct 1 COT policy, Mr. Green qualified for an RUB on his 30 day assessment. On Day 37, a COT checkpoint was reviewed and the patient did not receive enough therapy days to qualify for a Rehab RUG (4 distinct days of treatment) and there was no Restorative Nursing so Mr. Green was classified into a nursing RUG. Therapy continues to treat and a COT checkpoint was done on Day 44 showing the patient qualified for an RVB, meeting the day and minutes criteria during the COT lookback. Under the new policy, a COT OMRA is completed, allowing the RVB to be billed.

To meet this criteria, the ARD for the COT OMRA must be on or after October 1, 2014.
Keeping Straight on the Regulation Road

CMS Issued Final Rule for Fiscal Year (FY) 2015 for Skilled Nursing Facilities

The Centers for Medicare & Medicaid Services (CMS) issued the final rule outlining Fiscal Year (FY) 2015 Medicare payment rates for skilled nursing facilities (SNFs). The final rule FY 2015 essentially finalized the proposed rule that had been issued in May:

Changes to Payment Rates under the SNF Prospective Payment System (PPS)
Aggregate payments to SNFs will increase by $750 million, or 2.0 percent, from payments in FY 2014, which represents a higher update factor than the 1.3 percent update finalized for SNFs last year. This estimated increase is attributable to 2.4 percent market basket increase, reduced by the 0.4 percentage point multi-factor productivity adjustment required by law. However, in looking at payment rates providers must also consider the impact of the wage index update.

Wage Index Update
On February 28, 2013, the Office of Management and Budget (OMB) issued OMB Bulletin No. 13-01, which contained a number of significant changes related to the delineation of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and guidance on uses of the delineation of these areas.

To align with these changes, CMS revised the wage index based on the newest OMB delineations for the FY 2015 SNF PPS wage index. CMS also used the new OMB delineations to identify a provider’s urban or rural status for the purpose of determining which set of rate tables would apply to the provider. This is consistent with other Medicare payment rules which will also include similar revisions this year as a result of the new OMB delineations. In an effort to mitigate the potential negative wage index impacts for some providers of this proposed adoption of the revised OMB delineations, CMS is implementing these changes by providing a one-year transition with a blended wage index for all providers.

The wage index for each provider will consist of a blend of 50 percent of the FY 2015 wage index using the current OMB delineations and 50 percent of the FY 2015 wage index using the revised OMB delineations. A similar transition wage index was used when CMS adopted the OMB’s Core-Based Statistical Area (CBSA) definitions in FY 2006.

Change of Therapy Assessment Policy Update
The Change of Therapy (COT) Other Medicare Required Assessment (OMRA) is used to classify a resident into a new resource utilization group (RUG) when, based on the therapy services provided during the previous seven days, the resident no longer qualifies for the RUG into which they are currently classified for payment. CMS is revising the current COT OMRA policy to permit providers to use the COT OMRA to reclassify a resident into a therapy RUG from a non-therapy RUG, but only in certain limited circumstances.

The revision is intended to capture only rare cases where the resident had qualified for a RUG-IV therapy group on a prior assessment during the resident’s current Medicare Part A stay and had no discontinuation of therapy services between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the patient into a RUG-IV therapy group. Under the revised policy, while a COT OMRA may be used to reclassify a resident into a therapy RUG in the circumstances described above, it may not be used to initially classify a resident into a therapy RUG.

SNF Therapy Research Project (Part A)
CMS contracted with Accumen, LLC and the Brookings Institution to identify potential alternatives to the existing methodology used to pay for therapy services received under the SNF PPS. CMS completed the first phase of the research project, including a literature review, stakeholder outreach, and a review of options for a viable alternative to the current therapy payment model. The report was complete in September 2013. Also in September, CMS began further development of the options outlined in the report and performing more comprehensive data analysis to determine which option would work best to replace the current model. They will also engage a Technical Expert Panel to gauge stakeholder feedback on the research so far.
Observations on Therapy Utilization Trends

CMS highlighted therapy trends using data from FY 2013 which demonstrates that the percentage of billed service days in the RU RUG groups has increased to over 50 percent. These revised data are presented in a slightly different format than they have been presented in the past, which is to show how, over the course of the past 3 years since October of 2010, the percentage of residents classified into one of these Ultra-High Rehabilitation groups has not only increased, but done so rather steadily. CMS also points out that their data shows that the amount of therapy reported on the MDS is just enough to surpass the relevant therapy minute threshold for a particular RUG category. The rule explains that there is no policy changes related to these trends, which CMS has tracked since revising therapy billing policies in 2012. However, the agency will continue to monitor billing patterns and might adjust policies accordingly in the future. This information can also be found in a memo posted to the SNF PPS website (available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Spotlight.html)

Congress Passes the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

Both the U.S. Senate and House passed the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (H.R. 4994/S. 2553), by unanimous consent. Now the legislation is headed to President Barack Obama and he is expected to sign the legislation into law. The Act mandates that post-acute settings begin reporting quality measures starting on October 1, 2016, and standardized patient assessment data by October 1, 2018. It is widely perceived that this information is necessary to the development of Medicare PAC payment reform. This legislation will have a significant impact on expediting CMS’ use of data to compare quality, cost and other factors across settings.

RAC Update

Region A: Performant Recovery
Region B: CGI Federal, Inc
Region C: Connolly, Inc
Region D: HealthDataInsights, Inc.

The following is an overview of the proposed policy and payment changes to the Medicare Physician Fee Schedule for Calendar Year 2015:

**Sustainable Growth Rate (SGR)**

Although Medicare physician and Part B provider pay rates are due to be cut by at least 20 percent under the SGR, the proposed rule does not include proposals or announcements on the PFS update or SGR as these calculations are determined under a prescribed statutory formula that cannot be changed by CMS. The final figures are announced in the final rule in November. The Protecting Access to Medicare Act (PAMA) of 2014 provides for a zero percent PFS update for services furnished through March 31, 2015.

**Potentially Misvalued Services Under the PFS**

CMS has been engaged in a multi-year effort to identify and review potentially mis-valued codes and to make adjustments where appropriate. In this year’s proposed rule, CMS is proposing to add about 80 codes to its list of potentially mis-valued codes, 65 of which account for the majority of spending under the Physician Fee Schedule. CMS identified codes by reviewing high-expenditure services by specialty that have not been recently reviewed. Codes under review include those used in therapy such as 97032 Electrical stimulation, 97035 Ultrasound therapy, 97110 Therapeutic exercises, 97112 Neuromuscular reeducation, 97113 Aquatic therapy/exercises, 97116 Gait training therapy, 97140 Manual therapy 1/> regions, 97530 Therapeutic activities and G0283 Elec stim other than wound.

**Geographic Practice Cost Indices (GPCIs)**

CMS is required to review and revise the GPCIs at least every 3 years and phase in the adjustment over 2 years (if there has not been an adjustment in the past year). For CY 2015, CMS is not proposing any revisions related to the data or the methodologies used to calculate the GPCIs except in regard to the Virgin Islands. The CY 2015 GPCI reflects the application of the statutorily mandated 1.5 work GPCI in Alaska, and 1.0 work GPCI floor for all other Physician Fee Schedule areas and the 1.0 Practice Expense GPCI floor for frontier states (Montana, Nevada, North Dakota, South Dakota and Wyoming). However, given that the statutory 1.0 work GPCI floor is scheduled to expire under current law on March 31, 2015, CMS has included two sets of GPCIs and geographic adjustment factors (GAFs) for CY 2015 - one set for January 1, 2015 through March 31, 2015, and another set for April 1, 2015 through December 31, 2015. The April 1, 2015 through December 31, 2015 GPCIs and GAFs reflect the statutory expiration of the 1.0 work GPCI floor.

**Conditions Regarding Permissible Practice Types for Therapists in Private Practice**

Based on CMS’ recent review of regulations for services furnished by therapists in private practice, including basic qualifications necessary to qualify as a supplier of occupational therapy (OT), physical therapy (PT), and speech-language pathology (SLP), CMS is concerned that the language is not as clear as it could be, especially with regard to the relevance of whether a practice is incorporated. The regulations appear to make distinctions between unincorporated and incorporated practices, and some practice types are listed twice. CMS is proposing changes to the regulatory language to remove unnecessary distinctions and redundancies within the regulations for OT, PT and SLP. To consistently specify the permissible practice types (a solo practice, partnership, or group practice; or as an employee of one of these) for suppliers of outpatient therapy services in private practice (for occupational therapists, physical therapists and speech-language pathologists), CMS proposes to replace the regulatory text at §410.59(c)(1)(ii)(A) through (E), §410.60(c)(1)(ii)(A) though (E), and §410.62(c)(1)(ii)(A) through (E).

**Senate Special Committee on Aging Roundtable: The Medicare claims review process is unfairly burdening healthcare providers and failing to improve program integrity, due in part to the payment system for certain auditors**

Lawmakers from both sides of the aisle slammed the Centers for Medicare & Medicaid Services’ anti-fraud efforts at the Senate Special Committee on Aging roundtable. CMS has increased audits but the improper
Evergreen Rehabilitation interviews, and analyzed claims, auditing and contract information to compile the report. It recommended that CMS take a number of steps to tighten oversight of contractors and simplify their compliance, such as by issuing more complete guidance. CMS concurred with the recommendations.

In addition to RACs, post-payment reviews are done by Medicare Administrative Contractors, Zone Program Integrity Contractors and Comprehensive Error Rate Testing Contractors. The Centers for Medicare & Medicaid Services does keep a database to track Recovery Audit Contractor activity and prevent them from reviewing the same claim multiple times; however, the three other types of auditors do not consistently enter information into this database. Lack of coordination among the various auditors has led to problems in other areas, the GAO determined. For instance, the different contractors have varying requirements for what has to be in post-payment review correspondence with providers. And contractors have varying levels of compliance with the requirements; most include information about what issues led to overpayment, but GAO found "low compliance rates" for including information about what rights the provider can exercise in the review process.

The SNF inpatient improper payment rate increased from 4.8 percent during the 2012 reporting period to 7.7 percent during the 2013 report period.

A major source of improper payments stems from SNFs failure to obtain certification and recertification statements from physicians or NPPs. Newly released MLN Matters® Special Edition (SE) 1428 alerts providers that a major reason for claims being denied is failure to obtain certification and recertification statements from physicians or NPPs. The routine admission order established by a physician is not a certification of the necessity for post hospital extended care services for purposes of the program. SNFs can minimize error rates by referring to and following the requirements detailed in SE1428 – Comprehensive Error Rate Testing (CERT): Skilled Nursing Facility (SNF) Certifications and Recertifications, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1428.pdf

ALJ Backlog Continues With No End In Sight

The expansion of the Recovery Audit Contractor program in the last few years has been linked to a spike in Medicare claims appeals from long-term care and other provider types. This has swamped administrative law judges, who have been receiving as many as 16,000 appeals a week. Options to cut down the existing backlog are limited. Hiring temporary administrative law judges could be part of the solution, but they can only come from other agencies or a pool of retired ALJs. The Office of Medicare Hearings and Appeals was not successful when it asked other agencies for temporary ALJs this spring. The retiree pool only has about 100 people, and nearly 400 would be needed to resolve the backlog within a year. OMHA recently announced an alternative dispute resolution process, which offers providers a way to potentially reach a settlement through a mediator.

The Centers for Medicare & Medicaid Services also is taking action to alleviate the backlog. For instance, under new RAC contracts, the auditors will be required to offer providers and suppliers a 30-day discussion period to reach a resolution before the claim is referred to other contractors for collection.

GAO Report: Long-term care providers pay the price for CMS’ poor auditor oversight

Long-term care and other providers could be facing unfair burdens due to ineffective government oversight of Medicare auditors, according to a new GAO report. The investigators examined policy manuals, conducted interviews, and analyzed claims, auditing and contract information to compile the report. It recommended that CMS take a number of steps to tighten oversight of contractors and simplify their compliance, such as by issuing more complete guidance. CMS concurred with the recommendations.
Evergreen Rehabilitation consisted of all payments made for a beneficiary on the same date of service.

The review findings are summarized below:
• 97 claims did not meet Medicare’s plan of care requirements,
• For 95 claims, the goals were not measurable or pertained to identified functional impairments. For example, the therapist received payment for physical therapy services provided on June 9, 2011, to a 72-year-old Medicare beneficiary. The therapist provided a plan of care that was generally vague with short term goals to decrease the level of chronic pain and long term goals to improve the patient’s range of motion, strength, tone and gait/balance. However, the patient received nearly 6 months of repetitive therapy with no objective evidence of measurable progress or need of services of a skilled therapist.
• For 74 claims, the therapist’s signature did not meet Medicare requirements. Specifically, 73 of these claims relate to electronic medical records that did not contain a contemporaneous signature at the time the plan of care was prepared. At the time of the audit, the therapist used an unsecured rubber stamp to manually stamp these claims. Stamp signatures are not an allowable form of signature. For the remaining manual claim, the therapist did not sign the plan.
• For five claims, the plan of care was missing or incomplete.
• 95 claims did not meet Medicare’s treatment note requirements,
• For 93 claims, the treatment notes did not indicate the specific interventions/modalities provided to verify that the correct HCPCS codes were billed. For example, the therapist received payment for physical therapy services provided under HCPCS code 97110 on June 9, 2011, to a 72-year-old Medicare beneficiary. The therapist provided a plan of care that was generally vague with short term goals to decrease the level of chronic pain and long term goals to improve the patient’s range of motion, strength, tone and gait/balance. However, the patient received nearly 6 months of repetitive therapy with no objective evidence of measurable progress or need of services of a skilled therapist.
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All Eyes on Therapy

Therapy remains the focus of many Medicare Administrative Contractors (MACs)/Fiscal Intermediaries (FIs) as well as the Regulatory and Law Enforcement Agencies of the Federal Government as the commitment to deterring fraud, waste and abuse in the Medicare and Medicaid systems has increased.

OIG Report: An Illinois Physical Therapist in private practice improperly claimed at least $634,837 in Medicare reimbursement for physical therapy services

A recent OIG report found that a therapist claimed Medicare reimbursement for outpatient physical therapy claims that did not meet Medicare reimbursement requirements. Specifically, of the 100 claims in the random sample, the therapist improperly claimed Medicare reimbursement on 99 claims, all of which contained more than 1 deficiency. The therapist properly claimed Medicare reimbursement on the remaining claim.

These deficiencies occurred because the therapist did not have adequate policies and procedures in place to ensure that the therapist billed services that met certain Medicare requirements. On the basis of the sample results, the OIG estimated that the therapist improperly received at least $630,000 in Medicare reimbursement for outpatient physical therapy services that did not comply with certain Medicare requirements.

The review covered 4,298 Medicare outpatient physical therapy services totaling $645,966, provided by a therapist from January 1 through December 31, 2011. A claim consisted of all payments made for a beneficiary on the same date of service.

The review findings are summarized below:
• 97 claims did not meet Medicare’s plan of care requirements,
• For 95 claims, the goals were not measurable or pertained to identified functional impairments. For example, the therapist received payment for physical therapy services provided on June 9, 2011, to a 72-year-old Medicare beneficiary. The therapist provided a plan of care that was generally vague with short term goals to decrease the level of chronic pain and long term goals to improve the patient’s range of motion, strength, tone and gait/balance. However, the patient received nearly 6 months of repetitive therapy with no objective evidence of measurable progress or need of services of a skilled therapist.
• For 74 claims, the therapist’s signature did not meet Medicare requirements. Specifically, 73 of these claims relate to electronic medical records that did not contain a contemporaneous signature at the time the plan of care was prepared. At the time of the audit, the therapist used an unsecured rubber stamp to manually stamp these claims. Stamp signatures are not an allowable form of signature. For the remaining manual claim, the therapist did not sign the plan.
• For five claims, the plan of care was missing or incomplete.
• 95 claims did not meet Medicare’s treatment note requirements,
• For 93 claims, the treatment notes did not indicate the specific interventions/modalities provided to verify that the correct HCPCS codes were billed. For example, the therapist received payment for physical therapy services provided under HCPCS code 97110 on February 10, 2011, to a 71-year-old Medicare beneficiary. The therapist provided treatment notes stating that the “therapeutic exercise applied to: the lumbar back, the trunk, and the lower extremities bilaterally (30 minutes).” However, the treatment notes did not indicate what specific therapeutic exercises were performed to warrant the billing of HCPCS code 97110.
• For 75 claims, the treatment notes did not support the number of units billed. For 71 of these claims, the treatment notes did not document total minutes as required by Medicare for timed HCPCS codes. For the remaining 4 claims, more units were billed than were supported by the treatment notes.
• For 73 claims, the treatment notes did not have a valid therapist signature as required by Medicare policy. Specifically, these claims related to electronically kept medical records that did not contain a contemporaneous signature at the time the treatment notes were prepared. For these claims, the therapist used an unsecured rubber stamp to manually stamp the claims at the time these claims were provided to us for audit. Stamp signatures are not an allowable form of signature.
• For seven claims, the therapist billed a code for services that were not prescribed by the plan of care.
• 49 claims had progress reports that were untimely or not contained in the medical record. For 42 claims, progress reports were not made at least once every 10 treatment days or at least once during each 30 calendar days, whichever was less. For an additional seven claims, there were no progress reports as required by Medicare regulations.
• 44 claims had therapy services that were not medically necessary, and
  • Goals in plans of care were not measurable (35 services).
  • Invalid or missing certification of the plans of care (35 services).
  • Overall medical record documentation failed to support medical necessity (25 services).
  • Physical therapy was repetitive with no evidence that skilled therapy services were needed (24 services).
• 39 claims did not meet Medicare’s physician certification requirements.
  • For 22 claims, the physician certification on the initial plan of care or the recertification for subsequent therapy services was missing.
  • For 17 claims, the physician certification was not dated to determine whether the physician certification was timely.
  • For one claim, the physician certification of the beneficiary’s initial plan was untimely.