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On the topic: Navigating Appeals and Billing Disputes

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Navigating Appeals and Billing Disputes

Presented by:
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Agenda

• Introduction
• Why Are Claims Denied
• How to Combat Denials and WIN!
• Resources
Introduction

Top Denial Reasons

- Registration (incorrect payer, cannot identify patient)
- Charge Entry (invalid procedure or diagnosis codes)
- Information from Patient (insurance verification/COB)
- Referrals and Pre-authorizations
- Non-covered Services
- Duplicates
- Medical Necessity (ICD and CPT mapping)
- Documentation
- Bundled/Non-covered (modifiers)
- Timely Filing
Did You Know?

• Only 35% of providers appeal denied claims (MGMA)
• Data indicates that coverage denials, if appealed are frequently reversed in the consumer’s favor (GOA)
• 4 or 6 states: 39% - 59% of appeals reversed the denial

How to Avoid Denials

• Read and understand your provider manual
• Know if your provider is in or out of network
• Understand what is covered & not covered under the patient’s policy
• Questions to ask
  – Is the patient eligible for services?
  – Was a referral/pre-authorization needed?
  – Is patient demographic information correct?
  – Is the claim complete?
  – Has the service been coded properly?
  – Are the codes out dated?
  – Was the code coded to the highest degree of specificity?
  – Does the line item diagnosis & procedure match on the claim form?
  – Have modifiers been applied appropriately?
  – Was the secondary carrier claim filed first?
# How to Appeal a Denied Claim

1. Examine the EOB  
2. Review the appeal process  
3. Review the state and federal  
4. Involved the patient/patient’s employer  
5. Document contact with the carrier  
6. File an external complaint  
7. File a complaint with the State Insurance Commissioner

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# Results-Oriented Appeals

1. Know the carrier’s appeal process  
2. Read and understand the EOB  
3. Carefully word your appeal  
4. Gather supporting documents  
5. Time is the essence  
6. Don’t give up
## Results-Oriented Appeals

### Medicare: 5 Levels in the Part B Appeals Process

<table>
<thead>
<tr>
<th>Level</th>
<th>Timeframe</th>
<th>Dollar Amount</th>
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</thead>
<tbody>
<tr>
<td>First Level Appeal</td>
<td>120 days from receipt of the initial determination</td>
<td>No required dollar amount</td>
</tr>
<tr>
<td>Second Level Appeal</td>
<td>180 days from receipt of the re-determination</td>
<td>No required dollar amount</td>
</tr>
<tr>
<td>Third Level Appeal</td>
<td>60 days from receipt of the reconsideration</td>
<td>At least $150 remains in controversy</td>
</tr>
<tr>
<td>Fourth Level Appeal</td>
<td>60 days from receipt of the ALJ decision</td>
<td>No required dollar amount</td>
</tr>
<tr>
<td>Fifth Level Appeal</td>
<td>60 days from receipt of the Appeals Council Review</td>
<td>At least $1500 or more remains in controversy</td>
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</tbody>
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### Inadvertent Practice Errors
- Specialist/Facility is Out-of-Network
- Procedure is a “non-covered service"
- Concurrent care denials
- Overutilization denials
- Routine screening denials
- Procedure is “experimental"
- Procedure/Treatment is not “medically necessary”
Results-Oriented Appeals

Health plan processing errors

The AMA has noted an increased number of complaints from physicians regarding inappropriate claims denials and reductions since payers have introduced claims-editing software into their claims processing systems.

• When the insurance carrier's claims processors make mistakes (e.g., keystroke errors, line entry misreads, etc.), contact the carrier to determine the best method of resolution.

• To expedite the process, ask for assistance from a claims supervisor who has the authority to correct the claim without resubmission or written appeal.

Opportunities for Improvement

1. Complete and accurate registration
2. Verification of eligibility and benefits
3. Coding education
4. Utilize current resources
5. Managerial review of clearinghouse/AR Reports
6. Cross-train front and back office
7. Communicate industry updates to all team members
8. Identify “cause for denials” and “corrective measures”
RESOURCES

PMI Programs:
• Certified Medical Insurance Specialist (CMIS)
• Appeals, Refunds, and Recoupments
• Certified Medical Coder (CMC)

National Association of Insurance Commissioners:
http://www.naic.org/state_web_map.htm


Questions?

Thank you for your attendance!

Get your questions answered on PMI's Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp

Contact information: savecilla@pmimd.com