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On the topic:

Payer Denials and Appeals Management

Tom Stevens, CMC, CMIS, CMOM, CCS-P, CPC
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Payer Denials and Appeals Management

Presented by
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Introduction

• There are many reasons why claims are denied. In many instances, practices are overwhelmed and do not have the staff or time to fight denials and underpayments effectively.

• Implementing an organized method in your practice to keep your staff informed of the complexities of insurance coding, filing, and follow-up helps to insure that the practice will be operating efficiently.

• Not establishing a mechanism for training and sharing this information in your offices can place your clinic in financial jeopardy.

NATIONAL HEALTH INSURER REPORT CARD (NHIRC) AND PROMPT PAY LAWS
National Health Insurer Report Card (NHIRC)

- The American Medical Association’s (AMA) National Health Insurer Report Card (NHIRC) provides physicians and the general public a reliable source of critical metrics concerning the timeliness, transparency and accuracy of claims processing by health insurance companies.
- The 2013 NHIRC analyzed patient responsibility for the first time, including deductibles, co-pays, and coinsurance. For February and March of 2013, patients paid an average of 23.6 percent of the amount that health insurers set for paying physicians.

Prompt Pay Laws

- There are limits to what insurance companies can do as far as payment delays without consequences.
- Each state has its own individual laws in regards to the time allowed for:
  - Paper Claims
  - Electronic Claims
  - HMO Claims
  - Non-HMO Claims
  - All Claims
DENIAL MANAGEMENT

Typical Payer Administrative System Workflow

• **Step 1: Electronic claim received in system**
  – The payer may receive the claim directly from the provider or through an intermediary, such as a billing service or clearinghouse.
  – The claim is pre-screened for missing information.

• **Step 2: Patient’s eligibility and benefit level determined**
  – A patient’s benefit level, medical necessity, and covered and non-covered services and procedures are determined based on the patient’s health benefit plan.

• **Step 3: Contractual discount applied**
  – The payer then reduces the provider’s billed charges on the submitted claims to their individually-contracted discounted fee-schedule rate or “maximum allowed payment.”
Typical Payer Administrative System Workflow

• Step 4: Payer payment rules and claim edits applied
  – The payer further adjusts the payment by applying “payment rules,” such as adjustment for modifiers, taxonomy, multiple procedures or global payment rules that either increase or decrease the payment amount.
  – Simultaneously, the payer makes adjustments to the claim using payer claim edits that include customized payer-specific edits. These claim edits determine which of the specific codes listed on a claim are eligible for payment and which will be denied.

• Step 5: Auto-adjudication completed
  – The final payment on the claim is determined

• Step 6: EOB or ERA generated and payment sent
  – An Explanation of Benefits (EOB) or Electronic Remittance Advice (ERA) is sent to both the provider and the patient, detailing the paid amount for the medical service.

Common Reasons for Denials

• Denials frequently result from eligibility issues
  – Six of the seven insurers in the 2010 AMA data (over 20% of claims denials), the denials occurred as a result of eligibility issues, such as services being provided before coverage was initiated or after coverage was terminated.

• Insurers also deny pre-authorizations and claims as a result of judgments about the appropriateness of the service.
  – the service was not medically necessary (Dx)
  – experimental or investigational
10-Step Approach to Improve Denial Management

1. Avoid errors originating before claim submission.
2. Assign someone to be responsible for claims review.
3. Utilize accounts receivable (A/R) reports.
4. Incorporate proper claims follow-up.
6. Utilize all health insurer’s auditing resources.
7. Identify and monitor the reasons for denial.
8. Review postings for underpayments.
10. Track and report improvements on a regular basis.

MEDICAL NECESSITY
Medical Necessity

- If a third-party payer determines the service is not medically necessary, they will deny the pre-certification request or claim.
- Medical necessity is defined as accepted healthcare services and supplies provided by healthcare entities, appropriate to the evaluation and treatment and consistent with the applicable standard of care.
- A provider who bills Medicare for services which he/she should know are not medically necessary can be prosecuted for fraud by the OIG.
- If Medicare or other payers determine that services were medically unnecessary after payment has already been made, the services are treated as an overpayment and the money must be refunded, with interest.

Services Not Medically Necessary

Medicare has selected general areas that are deemed not medically necessary. These include:

1. Experimental procedures not yet proven in government programs or not generally accepted in the medical community as safe and effective.
2. Procedures performed by methods no longer accepted.
3. Procedures deemed by the carrier as beyond what was reasonably necessary for the patient's care.
4. Mandated prepayment screens set up in carrier software programs.
Services Not Medically Necessary

A provider is restricted from collecting any money from patients when the claim was denied for a not medically necessary service UNLESS:

1. The provider could not reasonably have known that the service would be deemed not medically necessary; or

2. The patient was informed in advance that the service might be deemed not medically necessary and agreed to pay for the service(s), in writing, prior to service(s) being rendered.
Medicare Coverage Determination

• Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury.

• National Coverage Determinations (NCDs)
  – Made through an evidence-based process, with opportunities for public participation

• Medicare Coverage Database (MCD)
  – Contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), local articles, and proposed NCD decisions

• Medicare contractors
  – Fiscal Intermediaries (FIs)
  – Carriers
  – Medicare Administrative Contractors (MACs)
Non-Covered Service Requirements

Items and services that are not covered under the Medicare Program:
1. Services and supplies that are not medically reasonable and necessary
2. Non-covered items and services
3. Services and supplies denied as bundled or included in the basic allowance of another service
4. Items and services reimbursable by other organizations or furnished without charge
Advance Beneficiary Notice (ABN)

- ABN Form CMS-R-131
  - May be used to provide voluntary notification of financial liability
  - Should eliminate any widespread need for the Notice of Exclusion from Medicare Benefits (NEMB) in voluntary notification situations
  - NEW (March 2017): The ABN Form and form instructions were approved by the Office of Management and Budget (OMB) for renewal. While there are no changes to the form itself, providers should take note of the newly incorporated expiration date on the form.
  - With the 2016 PRA submission, a non-substantive change has been made to the ABN. ...the form has been revised to include language informing beneficiaries of their rights to CMS nondiscrimination practices and how to request the ABN in an alternative format if needed.
  - The effective date for use of this ABN form is 6/21/2017.
Sections and Blanks

- **Header**
  - Blank (A) Notifier(s)
  - Blank (B) Patient Name
  - Blank (C) Identification Number

- **Body**
  - Blank (D)
    - Item
    - Service
    - Lab Test
    - Test
    - Procedure
    - Care
    - Equipment
  - Blank (E) Reason Medicare May Not Pay
  - Blank (F) Estimated Cost
  - Blank (G) Options
  - Blank (H) Additional Information
  - Blank (I) Signature
  - Blank (J) Date

- **Disclosure Statement**
  - Required in the footer of notice

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NATIONAL CORRECT CODING INITIATIVE (NCCI)
National Correct Coding Initiative

- NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services. The edits are used for carrier processing of physician services under the Medicare Physician’s Fee Schedule (MPFS).

- The national edits are developed based on:
  - Coding conventions are defined in the AMA CPT® manual
  - Current accepted standards of medical and surgical coding
  - Input from several of the specialty societies
  - Analysis of current coding practices

National Correct Coding Initiative

- The NCCI provides an online database that allows for lookup of code edits.

- The database contains several columns.
  - The first two columns identify the procedure code as either Column 1 or Column 2 codes.
  - Each pair is assigned a “modifier” indicator, which gives additional information about the use of modifiers.
How to Use the Medicare NCCI Tools

- **NCCI Procedure-to-Procedure (PTP) code pair edits** are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

- The NCCI also includes a set of edits known as **Medically Unlikely Edits (MUEs)**.
  
  - An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary.

Looking Up PTP Code Pair Edits

### Related Links

- **Hospital PTP Edits v23.1 effective April 1, 2017 (462,972 records):** 0001M/80500 — 27894/06471
- **Hospital PTP Edits v23.1 effective April 1, 2017 (463,718 records):** 2600/02131 — 56666/80570
- **Hospital PTP Edits v23.1 effective April 1, 2017 (363,015 records):** 50016/02131 — 79666/30000
- **Hospital PTP Edits v23.1 effective April 1, 2017 (190,135 records):** 80002/00002 — 80015/80070
- **Practitioner PTP Edits v23.1 effective April 1, 2017 (474,500 records):** 0001M/30591 — 25931/06471
- **Practitioner PTP Edits v23.1 effective April 1, 2017 (502,446 records):** 26010/01810 — 39908/20001
- **Practitioner PTP Edits v23.1 effective April 1, 2017 (485,387 records):** 27140/02131 — 30590/04713
- **Practitioner PTP Edits v23.1 effective April 1, 2017 (501,223 records):** 01000/02131 — 80017/80070
## Column Information

1. Indicates payable code.
2. Contains the code that is not with this particular Column 1 code, unless a modifier is permitted and submitted.
3. Indicates if the edit was in existence prior to 1996.
4. Indicates if the effective date of the edit (year, month, date).
5. Indicates the deletion date of the edit (year, month, date).
6. Indicates if use of a modifier is permitted.
7. Provides the underlying basis for each PTP edit.

### Modifier Indicator Table

<table>
<thead>
<tr>
<th>Modifier Indicator</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 (Not Allowed)</td>
<td>There are no modifiers associated with NCCI that are allowed to be used with this PTP code pair; there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider.</td>
</tr>
<tr>
<td>1 (Allowed)</td>
<td>The modifiers associated with NCCI are allowed with this PTP code pair when appropriate.</td>
</tr>
<tr>
<td>9 (Not Applicable)</td>
<td>This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactively.</td>
</tr>
</tbody>
</table>
Selecting MUE Provider Type

Medically Unlikely Edits

Notice: The MUE file for the third quarter of 2014 was updated to contain two additional fields of information. One field indicates whether each MUE is a claim line or date of service edit. (See MUE 164142.) The second field provides the rationale for each MUE. Information about MUE estimates is available in the National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 1, Section V (Medically Unlikely Edits). Although the usual formalized version of the MUE file published July 1, 2014 and the updated version published July 3, 2014 are available on the CMS website in the third quarter of 2014, only the updated MUE file format will be available after that date.

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/PT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/PT codes do not have an MUE.

MUE was implemented January 1, 2007 and is utilized to adjudicate claims at Carriers, Fiscal intermediaries, and DME MACs.

Downloads

MUE Publication Announcement Letter [PDF, 51KB]

Related Links

Practitioner Services MUE Table – Effective 4/1/17
Facility Outpatient Services MUE Table – Effective 4/1/17
DME Supplier Services MUE Table – Effective 4/1/17
NCIC Edit FAQs

Practitioner Services MUE Table

<table>
<thead>
<tr>
<th>HCPCS/ CPT Code</th>
<th>Practitioner Services MUE Values</th>
<th>MUE Adjudication Indicator</th>
<th>MUE Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001M</td>
<td>1 Line Edit</td>
<td>Nature of Analyte</td>
<td></td>
</tr>
<tr>
<td>0002M</td>
<td>1 Line Edit</td>
<td>Nature of Analyte</td>
<td></td>
</tr>
<tr>
<td>0003M</td>
<td>1 Line Edit</td>
<td>Nature of Analyte</td>
<td></td>
</tr>
<tr>
<td>0006M</td>
<td>2 Date of Service Edit: Policy</td>
<td>Nature of Analyte</td>
<td></td>
</tr>
<tr>
<td>0007M</td>
<td>2 Date of Service Edit: Policy</td>
<td>Nature of Analyte</td>
<td></td>
</tr>
<tr>
<td>0008M</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Nature of Analyte</td>
<td></td>
</tr>
<tr>
<td>0042T</td>
<td>3 Date of Service Edit: Clinical</td>
<td>Nature of Service/Procedure</td>
<td></td>
</tr>
<tr>
<td>0051T</td>
<td>2 Date of Service Edit: Policy</td>
<td>Anatomic Consideration</td>
<td></td>
</tr>
<tr>
<td>0052T</td>
<td>2 Date of Service Edit: Policy</td>
<td>Anatomic Consideration</td>
<td></td>
</tr>
</tbody>
</table>

1. Contains codes with an MUE value.
2. Represents the maximum UOS that a practitioner would report under most circumstances for a single beneficiary on a single date of service.
3. Describes type of MUE.
4. Provides underlying basis for each MUE.
Global Surgery

- Global Surgical Package
  - Includes all necessary services normally furnished by a surgeon before, during, and after a procedure.
  - Medicare payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty.
  - Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.
Global Surgery Classification

- **Zero-Day Post-Operative Period**
  (endoscopies and some minor procedures)
  - No pre-operative period
  - No post-operative days
  - Visit on day of procedure is generally not payable as a separate service.

- **10-Day Post-Operative Period**
  (other minor procedures)
  - No pre-operative period
  - Visit on day of procedure is generally not payable as a separate service.
  - Total global period is 11 days. Count the day of the surgery and 10 days following the day of the surgery.

- **90-Day Post-Operative Period**
  (major procedures)
  - One day pre-operative included
  - Day of procedure is generally not payable as a separate service.
  - Total global period is 92 days. Count 1 day before the day of the surgery, the day of the surgery, and the 90 days immediately following the day of surgery.

Global Surgery Indicators

- Codes with “000” are endoscopies or some minor surgical procedures (zero day postoperative period).
- Codes with “010” are other minor procedures (10-day post-operative period).
- Codes with “090” are major surgeries (90-day post-operative period).
- Codes with “YYY” are contractor-priced codes, for which contractors determine the global period. The global period for these codes will be 0, 10, or 90 days. (Note: not all contractor-priced codes have a “YYY” global surgical indicator. Sometimes the global period is specified as 000, 010, or 090.)
- “ZZZ” surgical codes are add-on codes that you must bill with another service. There is no post-operative work included in the MPFS payment for the “ZZZ” codes.
- Codes with “XXX” indicate that the global concept does not apply.
Services Included in Global Surgery Payment

- Pre-operative visits after the decision is made to operate.
- Intra-operative services that are normally a usual and necessary part of a surgical procedure.
- All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room.
- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery.
- Post-surgical pain management by the surgeon.
- Supplies, except for those identified as exclusions.
- Miscellaneous services.

Services NOT Included in Global Surgery Payment

- Services of other physicians related to the surgery, except where the surgeon and the other physician(s) agree on the transfer of care.
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery.
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiological procedures.
- Clearly distinct surgical procedures that occur during the post-operative period which are not re-operations or treatment for complications.
Services NOT Included in Global Surgery Payment

• Treatment for post-operative complications requiring a return trip to the operating room
• If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately
• Immunosuppressive therapy for organ transplants
• Critical care services (Current Procedural Terminology (CPT) codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician
Common reasons insurance companies deny, delay, or partially pay a claim include:

- Medical practice processing error(s) and/or lack of supporting documentation
- Insurance company processing errors
- Application of a CPT® modifier, code, or guideline for each procedure/service performed
- Application of fee schedule allowance when a contract exists
- Application of a PPO discount when no contract exists
- Medical necessity

Every medical practice should develop policies and procedures on how to address insurance claims processing errors that should include:

1. Requests for additional documentation
2. Identification of a claims processing error
3. Bundling
4. Lack of CPT® modifier recognition
STEPS FOR SUCCESSFUL DENIAL MANAGEMENT

Accounts Receivables (AR)

- When you bill out claims, these unpaid services become part of your Accounts Receivables
- Patient monies that are not collected become part of your AR.
- Monthly AR Reports reveal everything that is outstanding; can be broken down by:
  - Pending Insurance Claims
  - Pending Patient Money
  - Insurance Carrier/Case Type
  - Age of Outstanding Balance
Know how to run AND analyze these reports!

- When looking for Insurance AR that is at its MOST collectable, target unpaid claims in the 45-90 day range.
- Break down AR by carrier to improve efficiency.
- Look for largest balances and work your way down to smallest balance.
- Working AR from A-Z may not be the most effective method, especially if you have hundreds of pages to go through.
- New AR report should be run EVERY MONTH. If you don’t get through your AR in a month, generate a new report. Don’t work off the same AR for four months!

Working Old AR (over 90 days)

- Don’t work your AR from oldest to newest. The older the AR, the less likely you are to collect.
- Old AR is mostly cleanup work.
- Allocate a certain number of hours/week to address AR. STOP once you have reached that threshold.
- Larger practices/clinics with multiple employee billing departments may want dedicate one or several employees to clean up old AR.
- Never put your clinic in a position of constantly chasing old AR. Divide and conquer!
Analyzing Your AR

• Look for GROUPS of non-payment first. This will allow you to collect on multiple accounts at once.
• Look for patterns. For example:
  – You have a bunch of claims from one particular billing date that did not get paid. (Problem at Clearinghouse, problem with the claim batch)
  – You have a carrier that has not paid in over 30 days. (Credentialing issue, holding claims due to audit)
• Identify your targets and get to work.

Investigation – Unpaid Claims

• Have a game plan/procedure for investigating unpaid claims. Many times, a phone call is not necessary. If you have a claim that has not been paid:
  1. Go to Practice Management Software
     a) Was claim billed correctly from the software (has it left the building)?
     b) Are there already notes in the account about this claim? Don’t repeat your work, take good notes, and document your efforts!
  2. Go to the Clearinghouse
     a) Was claim received at Clearinghouse?
     b) Was claim rejected at Clearinghouse (Level 1)?
     c) Was claim rejected back to Clearinghouse (Level 2)?
     d) Is Remit waiting at Clearinghouse?
Investigation – Unpaid Claims

3. If you direct bill to Carrier:
   a) Check carrier sites for the same types of reports/rejects/payments as you would the Clearinghouse.

4. Carrier Site
   a) Go to Carrier Site and look for claim status.
   b) No claim on record:
      1. Go back to Clearinghouse, look for acceptance report from payer. If no acceptance report, work you way backward until you find out where the claim got hung up.
   c) Claim on record:
      1. If paid, download Remit.
      2. If pending with anticipated pay day, follow up when indicated.
      3. If pending with no explanation, call Carrier.

Carrier Phone Calls

• Get Organized!
  – Multiple claims investigations in one call
    • Different patients, same carrier
    • Same patient, multiple DOS
  – WHEN are you going to do this?
    • Allocate certain hours each week to do NOTHING but calls.
    • Uninterrupted time
    • Cannot be done at the front desk
    • Cannot be done if you are floating.
    • Do not disturb!
Carrier Phone Calls

• Documentation system
  – Have all paperwork and documentation handy
    • AR Report
    • Clearinghouse Reports
    • Carrier Reports
    • Past EOBs
    • Documentation previously requested by carrier
  – Write down EVERYTHING you are told.
    • Time of call
    • Name of representative
    • Reference Number
  – Don’t just ask about status:
    • Where is my claim?
    • Why wasn’t it paid? (if applicable)
    • What do I need to do about it? (if applicable)

Call Guidelines/Advice

• The person on the other end of the line maybe having a bad day. BE NICE and you accomplish more.
• Use the same conversation format for each call so you don’t miss any key information. You don’t want to have to call back!
• Call on as many patients/claims at once as possible
• Ask for immediate transfer if you don’t understand them
• Ask for supervisor if you are not getting the answers you want or representative is not being helpful
• Document conversation/results of investigation in a way AND PLACE that is easy for EVERYONE to understand. The margins of the AR report are NOT the place!
• Document TIME spent on each call.
An Ounce of Prevention

- The most successful AR program is not to have one.
- GARBAGE IN…..GARBAGE OUT
  - Patient data/demographics keyed in correctly
  - Correct coding
  - Collect from Patient at TOS
  - Catch Billing errors BEFORE they go out (claims scrubbing)
  - Monitor progress of claims continually
  - Jump on improperly paid claims as soon as you receive them

Vetting Your Bills/Claims

- Coders/Doctors
  - Before claims are sent to billing department for transmission, make sure you’ve coded properly
    - Procedure Codes
    - Number of Units (MUE)
    - Modifiers
    - ICD-10-CM Codes
- Billers
  - Print/view a pre-billing report. Look for coding and claims errors…scour your claims first!
  - Common errors
    - Missing patient information
    - Incorrect CPT/HCPCS Codes/modifiers
    - Missing CPT codes
    - Incorrect ICD-10-CM codes
Vetting Your Bills/Claims

• Billers, continued
  – VERIFY that the claim batch MATCHES the number of claims billed
  – VERIFY that the claims were all accepted by the clearinghouse. Correct Level 1 rejections immediately
  – VERIFY that the claims were all accepted by the carrier. Correct Level 2 rejections immediately
    • It is important to go to the clearinghouse DAILY to find these reports. They don’t all come in at once.
  – Check for claims that need to be filed on paper (secondary, non crossover claims, auto/work comp claims, union policies, etc.)

When a Claim Is Not Paid Properly

• Prepare for Dispute
  – Find similar claims that were paid properly, use for comparison
  – Call carrier and find out why claim was processed incorrectly (if you can’t tell from the EOB)
  – Find out what needs to be done to rectify the situation
  – Don’t just REBILL the claim, unless you know the rules – may need a telephone reopening/appeal, may need additional documentation. If you rebill, find out how the carrier wants it done, so the claim does not flag as a duplicate
  – Track that claim! Have a tickler system to follow up on claims that are under appeal or need to be resubmitted.
Consequences of Bad Billing Procedures

- Once you have to touch an improperly paid/processed claim more than once, you will have to touch it at least FOUR times, maybe more. Your goal is to end the process at #2.
  1. Bill It
  2. Post Payment/correct denial – IF NOT PAID/DENIED PROPERLY, then
  3. Investigate
  4. Rebill/Appeal
  5. Possible Second Level appeal
  6. Post payment/denial
  7. Notify patient/provider

Follow-Up System – Old School

- Create Billed Claims File
  - Billed claims Reports, E-Claims Transmissions or Copies of CMS 1500 Forms
- Create Disputed/Unpaid Claims Binder (Suspense File Format) (31 Tabs for Days of Month and 12 Tabs Jan-Dec)
- Create Priority (72 Hour) Follow Up Folder
- Date Received Stamp for EOB’s
- Insurance Communication Logs
- As office gets larger, create separate dispute binders by billing profile (Medicare/BCBS/PI/WC etc.)
Follow-Up System – Old School

• Once claims are filed and/or transmitted:
  – Print Billed Claims Report, file in Billed Claims Folder
  – Print Transmission Reports, check to see all claims accepted, file in Billed Claims Folder
  – (Your PROOF Claim was submitted)

• When an EOB/PAYMENT is received:
  – Electronic EOB’s-Print remit notice (from clearinghouse – for 835 files/auto posting)
  – Electronic EOB’s – Print remit (for manual posting)
  – Paper EOB’s - Stamp EOB on DATE RECEIVED
  – Check EOB CAREFULLY.
    • Make sure DOS and Amount Billed = the Billed Claims Report/Insurance Log
    • Make sure payment/denial in accordance with patient’s insurance verification info

• Post Payment/Denial to Software
  – Apply Payments CORRECTLY
  – Apply ZERO payments so amount remaining is kicked over to the patient’s responsibility

Follow-Up System – Old School

• When a Claim is Paid CORRECTLY
  – File EOB in Paid Claims Binders or Folders (By carrier, most recent on top) Do not file in patient charts
  – PAPERLESS OPTION: Scan EOB to shared folder on computer (Desktop, cloud based, etc.) and shred paper EOB.
  – Highlight Claim, or Mark Off from the Billed Claims Report

• When a Claim is NOT Paid Correctly
  – Attach Insurance Communication Log to EOB
  – Place in Priority Follow Up Folder
  – Make a note in the patient’s account that claim is delayed or denied and why.
  – CALL Insurance Co within 72 hours (3 Business Days of Receipt)
Follow-Up System –
Office Manager

- **Daily**: Check suspense file for follow up calls and/or activities that are due. Any unfinished business is forwarded to the next day/next follow up day
- **Weekly**: Make sure billing has been done, and all issues in clearinghouse have been resolved
- **Weekly**: Make sure patient accounts, including insurance demographics, dx codes, etc. are current
- **Weekly**: Go to clearinghouse and carrier websites to pull all EOB’s delivered electronically
- **Weekly**: Print/View Unpaid claims reports, look for claims that should have been paid by now
- **Monthly**: Print AR each month and look for claims with NO activity that have aged over 30 days.

CLAIMS APPEALS PROCESS
Appeals

• An appeal is a request to change a previous adverse decision made by a third-party payer.
• Medical practices should appeal inappropriately-denied claims through the insurer’s appeals process.
• If you need to submit a corrected claim, note on the claim that this is a corrected claim when sending via paper or attach a letter stating what the corrections were.

Appeals

• It is worth the time and effort to appeal claim denials.
• State and other data has indicated that coverage denials, if appealed, were frequently reversed in the consumer’s favor.
• The data on the outcomes of external appeals also indicated that the rate at which denials are reversed, if appealed, may vary depending on the reason for the denial and the type of service denied.
• Federal and state data indicated that appeals and complaints related to coverage denials sometimes resulted in financial recoveries for consumers.
Appeals Process

• Appeals must be made within a designated time frame as indicated by each insurance carrier of receipt of the adverse benefit determination.
• For adverse benefit determinations involving group health plans, a claimant must be provided with at least 180 days to appeal.
• Plans must establish and maintain reasonable claims processing procedures that do not inhibit or impede the claimant’s ability to submit a claim.

Requests for an appeal should include:

1. An appeal letter. When submitting a letter, include all the information that is requested on forms provided by the insurance carrier.
2. A copy of the original claim and explanation of benefit (EOB), or initial adverse decision letter, if applicable.
3. Any documentation supporting your appeal.
4. Send the appeal by certified or registered mail to ensure it is received by the payer.
5. All appeals should be submitted in a timely fashion.
Step 1: Examine the EOB

• Determine why the claim was paid incorrectly or denied.
• Contact the insurance carrier for a detailed explanation for the reason of the denial.
• When calling, have all applicable documents ready and be knowledgeable in the coding guidelines and rationale for the procedure or service provided.
• Request information on the re-consideration or appeal process.
• Ask for reconsideration of the claim by phone, if possible.

Step 1: Examine the EOB

• Request and understand any additional information that needs to be included in the reconsideration or appeal documentation.
• Ask if there is a specific person to whom the appeal is to be sent, along with their name, telephone number and extension.
• Determine if the appeal can be faxed. Make sure to keep additional copies of all correspondence on file.
• Understand how long the appeal process will take and when payment can be expected, make sure to follow up to ensure the process is adhered to by the carrier.
Step 2: Involve the Patient and/or the Patient’s Family

- For non-covered charges inform the patient of denied claim and that you are working to appeal to keep them from being responsible for the charges.
- Be sure to review the EOB, plan benefits, contract provisions, carrier policies and medical records.
- When an appeal is initiated, include a cover letter with a detailed explanation of why the claim was denied incorrectly or inaccurately paid.
- Include the EOB and any supporting information, as well as any authorizations, pre-certifications or referrals.

Step 3: Notify the Patient’s Employer

- The patient’s employer will have someone in the human resources department dedicated to assisting employees with benefits.
- The employer will definitely be interested in any problems the employee experiences as this will determine if that particular carrier will be utilized when it’s time to renew the policy.
- Insurance companies will respond quickly to their corporate clients, who are the entities that purchase their coverage.
Step 4: Understand Your State Laws and the Allowances for Carriers to Respond to Claims

• Go to your local Department of Insurance’s website for detailed information.
• Make a stamp and put it on the claims, “Unless paid or rejected in XX days, we will file a complaint with the State Insurance Commissioner.”

Step 5: Document all Correspondence

• On any contact with the carrier, it is imperative that you make notations as to whom you spoke with and exactly what was said.
• Make the carrier representative responsible for any time or information stated and follow up.
• If payment does not come, call the person who promised payment and specify the date and time of this call.
• Let them know that they are being held responsible for the non-payment and the expectation is that they will “fix it.”
• By following up consistently, the carrier will be more likely to do what they say, and the claim will be paid correctly and promptly.
Step 6: Develop a Policy in Regard to “Administrative Fee for Additional Information"

- In the case that the carrier continually asks for additional information that has been repeatedly sent, state the practice’s policy on administrative fees.
- Send a letter stating the requested information was submitted with the initial claim or with previous correspondence.
- Prior to sending the additional requested information, let the carrier know that there will be an administrative fee of $______.

Step 7: Utilize External Appeals Mechanisms

- If you and the patient have exhausted the internal health insurer appeals process, an external review of the denied claim may be available to the patient.
- The patient’s employer or health insurer may be able to provide assistance and instruction on the appropriate external appeals process.
- The majority of states have enacted laws and/or regulations requiring health insurers to implement an external independent grievance mechanism that patients can access when a health insurer denies coverage for medically necessary care.
Step 8: If all Previous Efforts Fail, File a Complaint with the State Insurance Commissioner

- Before filing the complaint, review all the information available and inform the payer that you have no other recourse but to file a complaint with the Insurance Commissioner.
- Include a cover letter stating the problem, the actions taken, and submit a formal complaint, sending a copy to the carrier.
- Even if the Commission does not act on the complaint, carriers do not want an audit by the Commission and do not wish to lose a corporate client due to the mishandling of a claim.

Underpayments Due to Downcoding E/M Level

- Downcoding occurs when a payer unilaterally reduces the level of complexity of an E/M service or procedure.
- Health insurers still arbitrarily downcode E/M services, despite efforts by the AMA, national medical specialty societies, and state medical associations to prevent this type of practice through state legislation and contract prohibitions.
Medicare Appeals Process

Once an initial claim determination is made, beneficiaries, providers, and suppliers have the right to appeal Medicare coverage and payment decisions. There are five levels in the Medicare Part A and Part B appeals process. The levels are:

<table>
<thead>
<tr>
<th>First Level of Appeal</th>
<th>Redetermination by a Medicare carrier, fiscal intermediary (FI), or Medicare Administrative Contractor (MAC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Level of Appeal</td>
<td>Reconsideration by a Qualified Independent Contractor (QIC)</td>
</tr>
<tr>
<td>Third Level of Appeal</td>
<td>Hearing by an Administrative Law Judge (ALJ) in the Office of Medicare Hearings and Appeals</td>
</tr>
<tr>
<td>Fourth Level of Appeal</td>
<td>Review by the Medicare Appeals Council</td>
</tr>
<tr>
<td>Fifth Level of Appeal</td>
<td>Judicial Review in Federal District Court</td>
</tr>
</tbody>
</table>

Appeal Letters

- When writing your appeal letter you should include:
  - Your identification
  - The reason for the denial that they provided in the denial letter
  - The correct information
  - Why you believe the decision was wrong
  - What you are asking the insurance company to do
Don’t Give Up!

The bottom line is that healthcare providers need to be reimbursed for the services being rendered. Be sure to:

• Establish a claims denial and appeals auditing program within the practice
• Gather resources for proper claims processing
• Implement policies and procedures aimed at reducing processing errors
• Know each payer’s guidelines,
• Review all EOBs thoroughly, and
• APPEAL with an effective and powerful letter.
• Utilize a pier to pier call for the provider when necessary

Questions?

• Thank you for your attendance!

• Get your questions answered on PMI’s Discussion Forum: http://www.pmiMD.com/pmiForums/rules.asp