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Jeffrey Restuccio, CPC, CPC-H, MBA,
President of Ritecode.com

On the topic:
Winning Carrier Denial Appeals
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Winning Carrier Denial Appeals Webinar

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Winning Carrier Appeals / Denied Claims

1. Updated for 2018
2. Credentialing and out-of-network denials
3. Twelve steps to winning Carrier Denial Appeals
4. This review will cover:
   • Sample appeal letters
   • Most common reasons claims are denied
   • Medical necessity
   • Modifiers
   • LCD’s
   • HCPC codes
   • All the fundamental concepts
   • Appeal tips and tricks you won’t learn anywhere else
Credentialing Denials

Credentialing should be viewed as an integral part of the revenue cycle because if you are not enrolled correctly, you will not be paid correctly. Below are five tips to ensure credentialing isn’t draining your time or money.

1. **Review all applications** and contracts prior to submission to the carriers to ensure all information is accurate and up to date – this will help avoid errors in the health plan databases.

2. Manage credentialing by being aware of health plan re-credentialing timelines (software such as CAQH) so you can ensure no provider has a lapse in participation.

Credentialing Denials (cont.)

3. **Only Medicare** allows retroactive effective dates to be awarded (up to 30 days prior to the date they receive the application).

4. Maintain a scheduled approach to follow up during all application processes – health plans can take over six months to enroll a provider at times, but there may be additional information needed to complete enrollment. Constant thorough follow-up is the best way to ensure the application is consistently being worked.

5. Manage your providers **Days In Enrollment** – keeping track of an average of how long the health plans are taking to enroll a provider can be a good key indicator for how early you want to submit enrollment applications.
Blue Cross / Blue Shield (BC/BS)

- If you work in a state with a lot of migratory patients (New England or Florida) then a lot of your patients may be out of network.
- Each Blue Cross Blue Shield entity, by state, is separate! Some allow you to cross state lines (MS, TN, AR).
- Some states have more than one BCBS (New York).
- Each BCBS entity has multiple plans.

I'm already credentialed with BCBS-[add your state here] but I bill BCBS-[other state here]. Do I need to be credentialed with every out of state BCBS to have their claims process as in-network?

- The answer to this question relies 100% on the where services are rendered. If you render services within your state, you’d need to be credentialed with every out-of-state BCBS to be considered in-network.
- If you, however, render your services entirely in your state, even though a vast majority of your patients may be out-of-state you would only need to be contracted and submitting claims to your in-state BCBS because that is where services are being rendered.
- For a more detailed explanation of how out-of-state claims are handled, see the BCBS Professional Provider Policy and Procedures Manual online. Section 2 is all about the BlueCard Program; this is the program that defines how out-of-state providers can bill the BCBS of their State to get claims processed quickly and at in-network levels.
Timely Filing Period

- Know the **timely filing period** of all your carriers.
- Some are 365, 180, 120 or 90 days. You must ask or find the information in the carrier manual.
- Some contracts specifically state the **Provider is not allowed to bill the patient when the provider misses the timely filing period.** (Example: Cigna TN)
- If you sent the claim to the wrong carrier, send the correct carrier proof that the claim was sent (in this case to the wrong carrier). Most carriers will pay with this additional documentation.
- I do know of rare instances where claims were paid past timely filing.

National Association of Insurance Commissioners (NAIC) (1 of 3)

- Standards were established by the **National Association of Insurance Commissioners (NAIC).**
- States are encouraged to make changes in their external appeals laws to adopt these standards. The NAIC standards call for:
  - **External review of plan decisions** to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
National Association of Insurance Commissioners (NAIC)  (2 of 3)

- **Clear information** for consumers about their right to both internal and external appeals—both in the standard plan materials, and at the time the company denies a claim.
- **Expedited access** to external review in some cases—including emergency situations, or cases where their health plan did not follow the rules in the internal appeal.

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National Association of Insurance Commissioners (NAIC)  (3 of 3)

- **Health plans must pay the cost of the external appeal under State law**, and States may not require consumers to pay more than a nominal fee.
- **Review** by an **independent body assigned by the State**. The State must also ensure that the reviewers meet certain standards, keep written records, and are not affected by conflicts of interest.
- **Emergency processes** for urgent claims, and a process for experimental or investigational treatment.
- Final decisions must be binding so, if the consumer wins, the health plan is expected to pay for the benefit that was previously denied.
Working Denials Versus a Formal Appeal

- For most, calling the carrier, getting a clear reason why the claim was denied, making the correction and resubmitting the claim, will be sufficient to get paid.
- Hopefully, you will not have to work the formal appeals process but if you are very clear that you are familiar with the appeal process and indicate that you are going to work it until you get paid, often the carrier will reimburse you— if you have a valid point.
- The information you collect for the denial process is the same as the appeal process. However, for a higher level appeal, you may have to include standards of care, clinical guidelines and explanations of what was performed.
- Private carriers and Medicaid will have their own appeals process. Medicare has a formal appeal process.

Most common reasons claims are denied
(source Medi-Cal)

1. 0139 - Procedure/service is invalid for claim type on date of service
2. 0314 - Recipient is not eligible for month of service billed
3. 0036 - RTD (Resubmission Turnaround Document) was either not returned or was returned uncorrected; therefore, your claim is formally denied
4. 0002 - The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
5. 0033 - The recipient is not eligible for the special program billed and/or restricted services billed.
6. 0392 - Rendering provider number/license number is not on the Provider Master File. Contact rendering provider to verify number.
7. 0042 - Date of service is missing or invalid.
8. 0062 - The facility type/Place of Service is not acceptable for this procedure.
9. 0351 - Additional benefits are not warranted per Medi-Cal regulations.
10. 0010 - This service is a duplicate of a previously paid claim.
Medicare: Novitas Solutions Feb 2018

The Top Claim Submission / Reason Code Errors and resolutions for February 2018 for Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas are now available. Please take time to review these errors and avoid them on future claims.

These are updated every month on the Novitas Website.

Issues, Denials, Rejections & Top Errors

- Claim Corrections & Help with Denied Claims
  - Correct Claims via the Appeals Center
  - Tips for Researching Denied Claims

- Open and Resolved Claim Issues
  - The ‘Open Claim Issues’ link provides you with the most current status of claim processing issues that have been identified. We are actively working with the necessary entities to resolve these issues. If your claim issue is not identified below, please reference top inquiries on claim status, claim denials, and other topics. Please review this information prior to contacting the Customer Contact Center.
    - Open Claim Issues
    - Past / Resolved Claim Issues
    - Quality Reporting Payment Reductions Showing Incorrectly on Remittances

- Top Claim Errors, by State (Updated Monthly)
  - Arkansas
  - Colorado, New Mexico & Oklahoma
  - Louisiana
  - Mississippi
  - Texas

[Return to the Claims Center]
### Texas Top Claim Submission / Reason Code Errors - February 2018

<table>
<thead>
<tr>
<th>#</th>
<th>Explanation of Medicare Benefits Message</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>96</td>
<td>Non-covered charge</td>
</tr>
<tr>
<td>2</td>
<td>109</td>
<td>Claim not covered by this payer/contractor</td>
</tr>
<tr>
<td>3</td>
<td>18</td>
<td>Duplicate claim/service</td>
</tr>
<tr>
<td>4</td>
<td>50</td>
<td>These are non-covered services because this is not deemed a 'medical necessity' by the payer</td>
</tr>
</tbody>
</table>

### Colorado, New Mexico, Oklahoma Top Claim Submission / Reason Code Errors - February 2018

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<td>3</td>
<td>18</td>
<td>Duplicate claim/service</td>
</tr>
<tr>
<td>4</td>
<td>97</td>
<td>The benefit for this service is included in the payment or allowance for another service or procedure that has already been adjudicated [different]</td>
</tr>
<tr>
<td>5</td>
<td>26</td>
<td>Expenses incurred prior to coverage.</td>
</tr>
<tr>
<td>6</td>
<td>B7</td>
<td>This provider was not covered by Medicare when patient received this service</td>
</tr>
</tbody>
</table>
### Louisiana Top Claim Submission / Reason Code Errors - February 2018

<table>
<thead>
<tr>
<th>#</th>
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<td>Claim not covered by this payer/contractor</td>
</tr>
<tr>
<td>3</td>
<td>18</td>
<td>Duplicate claim/service</td>
</tr>
<tr>
<td>4</td>
<td>170</td>
<td>Payment is denied when performed/billed by <strong>this type of provider</strong>. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This segment is the 835 EDI file where you can find additional information about the denial.</td>
</tr>
<tr>
<td>5</td>
<td>26</td>
<td>Expenses incurred prior to coverage</td>
</tr>
</tbody>
</table>

### Mississippi Top Claim Submission / Reason Code Errors - February 2018

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<td>3</td>
<td>B7</td>
<td>This provider was not covered by Medicare when patient received this service</td>
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<tr>
<td>4</td>
<td>97</td>
<td>The benefit for this service is included in the payment or allowance for another service or procedure that has already been adjudicated</td>
</tr>
<tr>
<td>5</td>
<td>109</td>
<td>Claim not covered by this payer/contractor [much lower]</td>
</tr>
</tbody>
</table>
Error Code 97

• Bundling/NCCI Error

| The benefit for this service is included in the payment or allowance for another service or procedure that has already been adjudicated. | Medicare does not pay for this service because it is part of another service that was performed at the same time. The patient should not be billed separately for this service. |

• But what if the inclusion is not an NCCI edit? For example a diagnostic service with an office visit not in the national database?

Error Code: 109
Claim not covered by this payer/contractor

• This denial indicates that the service is one that is processed or paid by another contractor. [sent to wrong carrier and address].

Examples of these types of service are:

• Durable Medical Equipment
• Hospice related services
• Medicare Advantage
• You must send the claim to the correct payer/contractor
Noridian: Duplicate Claims: Jan 2018

- PDF of a PP Presentation
- Top 5 billing error
- Highly recommended for coders and management
- Incorrect use of modifiers
- MOD-76: Repeat procedure by same physician
- MOD-77: Repeat procedure by same physician
- MOD-91: Repeat clinical diagnostic lab test

- 53 slides

Noridian Duplicate Claim Tips:

Submitting Duplicate Claims may lead to or result in:
- Delay in payment
- Identification as abusive biller
- Fraud investigation if pattern of duplicate billing established

TIP - Verify reason initial claim was denied
- Do not resubmit to correct denial

TIP - Submit [formal] appeal
- Indicate services not duplicate
- Submit documentation with redetermination request

TIP - Do not:
- Resubmit claims while identical claim is pending
- Add or delete diagnosis codes and/or modifiers for purpose of payment
- Split claims for resubmission
- Resubmit entire claim when partial payment made
Twelve Appeal Steps

1. Eliminate the obvious: duplicate claim, wrong carrier type
2. Identify a rejection VS denial
3. Identify the Carrier / Gather the manual or LCD
4. Is this in-network?
5. Is this a non-covered service?
6. Is pre-authorization always required?
7. ICD-10 Linking
8. NCCI Edit?
9. Correct Modifier?
10. Is this a Carrier-Specific Rule?
11. Is this worth appealing? Can you win?
12. Appeal as many times (levels) as necessary to get paid
1. Eliminate the Obvious

- Most of these are front-office mistakes
- Patient not eligible
- Wrong specialty
- Duplicate claim
- Wrong carrier (Medicare Advantage)

2. Rejection VS Denial

- **First** identify a **Rejection from a Denial**. There is a difference.
- A **rejection** is for a “global reason” and the claim is rejected either by your clearinghouse, your practice management software or a “claims scrubber.”
- Rejections reasons include: a violation of an NCCI edit or an incorrect modifier.
- **Denials** occur after the claim is received by the carrier.
- Denials are identified in the EOB or explanation of benefits provided by the carrier. There is no **global list** of denial codes. These are carrier-specific. Many are for medical necessity. Also, often the denial code will be vague and not accurately reflect actually why the claim was denied.
3. Identify the Carrier / Gather the manual or LCD

- Obtain your Insurance Carrier manual if available. Have your current CPT, ICD-10 and HCPCS manuals available.
- Verify the specific codes and documentation.
- Is there any precedent for any carrier paying on the service/procedure.
- Confirm if they have in writing unique code combinations not paid on the same DOS that are not NCCI edits.
- Is this service worth (the time) to appeal?

Medicare Local Coverage Determination

- Have at least one Local Coverage Determination for every procedure you perform.
- Medicare carriers and fiscal intermediaries (FIs) make coverage decisions in their area about what items or services are reasonable and necessary.
- These are not nationally mandated rules and will vary from Medicare carrier. These determinations are called local coverage determinations (LCD’s). An NCD is a national coverage determination.

There are
- Final Policies (active)
- Draft Policies
- Archived Policies (retired)
4. Is this in-network?

- This relates to customers policy, credentialing, carrier-specific rules (BCBS) and other factors.
- Ensure front office is trained to ask the right questions.

Twelve Steps (continued)

5. Is this a **non-covered** service? This information should be in the carrier manual but sometimes is not or difficult to find. Be sure to check the ICD-10 linking, the NCCI edits, their manual then be very clear that it should be paid.

6. Is **pre-authorization** always required? This should be clearly stated in their carrier manual but check anyway if there is a problem with any carrier. Failure to obtain the prior authorization will result in a denial. These are difficult to appeal. There have been instances where authorization was given and then the procedure was *still denied*. For rare or unusual procedures attempt to get written confirmation or an e-mail.
7. ICD-10 and Medical Necessity

- There is always a one-to-one linking of the ICD-10 code to the CPT procedure code or E & M code.
- Sometimes, if two codes are required per the ICD-10 manual, two codes will be required in Box 24E.
- Sometimes, sequencing of the ICD-10 codes will impact reimbursement. For example, for a screening of long-term use of the drug Plaquenil (hydroxychloroquine) instead of linking the Z79.899 code first, link rheumatoid arthritis code (M06.9) first.
- The best source of medical necessity information is your Medicare carrier’s Local Coverage Determination. If you cannot find one for your carrier, then we recommend any LCD is better than no LCD.

Chest pain R07.9 unspecified

Supported procedures:
- Upper GI endoscopies... (many codes 43235 - 43258)
- CT Chest (71275 and more)
- 93000 EKG (more)
- 93015- Stress tests (more)
- 93320 Doppler echocardiography

- Always strive for a more specific ICD-10 code.
**Additional chest pain codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R07.1</td>
<td>Chest pain on breathing</td>
</tr>
<tr>
<td>R07.2</td>
<td>Precordial pain</td>
</tr>
<tr>
<td>R07.81</td>
<td>Pleurodynia</td>
</tr>
<tr>
<td>R07.82</td>
<td>Intercostal pain</td>
</tr>
<tr>
<td>R07.89</td>
<td>Other chest pain</td>
</tr>
<tr>
<td>R07.9</td>
<td>Chest pain, unspecified</td>
</tr>
</tbody>
</table>

8. National Correct Coding Initiative Edits

- NCCI edits outline bundled and unbundled CPT Codes. For years unbundling was a target for OIG audits.
- There are thousands of CPT code combinations that cannot reported together on the same DOS.
- NCCI edits are **not** (all) in the CPT manual.
- Invalid code combinations are available in manual form, in computer software or from the Medicare website: [http://www.cms.hhs.gov](http://www.cms.hhs.gov)
- Most claim scrubber software will kick out NCCI edit violations.
9. Modifiers

- Modifier 24: Use during global period for an unrelated Procedure.
- Modifier 25: Use for E & M separate from reason for procedure.
- Modifier 52: Use when performing a bilateral procedure on one ear or eye. (Some procedures are inherently bilateral)
- Modifiers 76 and 77: Repeat Procedure
- Modifier 59: Use when performing two procedures listed as mutual exclusive. Breakable versus Unbreakable Edits.
- Modifier 79: Use for co-management. For example: cataract surgery on second eye during global period of the other eye.
- Modifier 76: Use for a repeat procedure (not a duplicate claim)

Sometimes you will need to submit your progress notes if denied.

Twelve Steps (cont.)

10. Is this a carrier-specific rule? Does this rule only apply to this carrier? These must be tracked.

11. Is this worth appealing? Sometimes its better to perform the service on a separate DOS than appeal. However, once you learn the appeal process, it gets progressively easier and your carriers will respect you more. You should work at least one or more appeal.

12. Appeal as many times as necessary. There are multiple levels of appeal we will discuss later.
HCPC Codes often Denied (Examples)

- Urological supplies A4314, A4315, A4316 ...(more)
- Heating pads and heat lamps E0210 (covered, NHIC)

DME-MAC Supplies
Wheelchair seating E2607, E2625 etc...

Glucose monitors
- E0607 HOME BLOOD GLUCOSE MONITOR
- E0620 SKIN PIERCING DEVICE FOR COLLECTION OF CAPILLARY BLOOD, LASER, EACH
- E2100 BLOOD GLUCOSE MONITOR W/ INTEGRATED VOICE SYNTHESIZER
- E2101 BLOOD GLUCOSE MONITOR W/ INTEGRATED LANCING/BLOOD SAMPLE

- You may need a pre-authorization.
- Always refer to the Medicare Local Coverage Determination.

Private Insurance Denial

- Once you have the denial notice, file an appeal with the insurance company immediately. Send it in writing and be sure to include:
  - The patient’s full name and policy number
  - Exact name of the service your provider requested
  - Over what time period the service was requested (for example, from March 12, 2018 through March 15, 2018)
  - Reasons you think the insurance company should change its decision.

- How long will my appeal take?
  - A private insurance company must decide within 30 business days of when it received your appeal.
Denied Claims Appeal Process

New healthcare plans must have an internal appeals process that:

• Allows consumers to appeal when a health plan denies a claim for a covered service or rescinds coverage;
• Gives consumers detailed information about the grounds for the denial of claims or coverage;
• Requires plans to notify consumers about their right to appeal and instructs them on how to begin the appeals process;
• Ensures a full and fair review of the denial; and provides consumers with an expedited appeals process in urgent cases.

Common Denials

• A diagnostic procedure reported with an E & M code on the same DOS. I would always appeal these and ask if this is listed as a non-covered service in their carrier manual.
• Check to see if there are any national, NCCI edit of E & M codes and diagnostic procedures for your specialty.
• However, 99211, a non-physician encounter, is listed as an NCCI edit with most all diagnostic (9xxxx) procedures.
• Also be very clear that you will appeal this and that the office visit and diagnostic procedure were both necessary.
• Note that this does not apply to small surgical procedures as they already include an E & M (office visit) component related to the procedures (i.e., skin tag removal, FB removal or joint injections [20610])
E & M, Septoplasty and excision of nasal polyp

30520

Use for unlisted codes, co-management and unique situations

30110 was not paid as “Not payable with 30520 - NCCI Edit”

Screening submitted with a lab

87809 is only paid on ICD-10 code B30.1 so only list a D in box 24 E and refile.

87809 is only paid on ICD-10 code B30.1 so only list a D in box 24 E and refile.
Pain in Eye, FB found

92250 is not paid on 379.91. Would need different ICD-10 Code

Blue Cross / Blue Shield (TX)

Technically, each BCBS office is separate.

- There are two (2) levels of claim reviews available to BCBS of TX Providers.
- For the following circumstances, the 1st claim review must be requested within the corresponding timeframes outlined below:

<table>
<thead>
<tr>
<th>Dispute Type</th>
<th>Timeframe For Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audited Payment</td>
<td>Within 30 days following the receipt of written notice of</td>
</tr>
<tr>
<td></td>
<td>request for refund due to an audited payment</td>
</tr>
<tr>
<td>Overpayment</td>
<td>Within 45 days following the receipt of written notice of</td>
</tr>
<tr>
<td></td>
<td>request for refund due to overpayment</td>
</tr>
<tr>
<td>Claim Dispute</td>
<td>Within 180 days following the check date/date of the</td>
</tr>
<tr>
<td></td>
<td>BCBSTX-Explanation of Payment (EOP), or the date of the</td>
</tr>
<tr>
<td></td>
<td>BCBSTX Provider Claims Summary (PCS), for the claim in</td>
</tr>
<tr>
<td></td>
<td>dispute</td>
</tr>
</tbody>
</table>
Appeal Letters

- State the facts
- Research the carrier before sending the letter
- Be clear on your credentials or background
- Be clear that you understand the appeals process
- The more informed you are (and appear) the more likely you will get paid

Sample Appeal Letters

- Numerous websites offer sample appeal letters. Some are much better than others.
  - https://appealtraining.com
- Subscription service with numerous templates. Many are administrative errors (such as timely filing).
  - https://www.acep.org/Clinical---Practice-Management/Templated-Letters-for-Appealing-Denied-Claims/#sm.001u5noofqm0czc11e627yvpzx62
- ACEP.ORG lists over a dozen free sample appeal letters for coding errors. MOD-25, concurrent care, Bundled codes (NCCI edits), ICD-10 errors, special services.
Dear Sir/Madam:

The following information is provided to clarify the charge for Ultrasound interpretation provided by [Emergency Medicine Physician], Emergency Medicine Department, as a distinct and separate service identifiable from the Evaluation/Management services also provided during the patient encounter.

The original claim for the insured patient identified above was submitted correctly for both Ultrasound interpretation and Evaluation/Management services provided in the Emergency Department. The Ultrasound interpretation was medically necessary due to the patient's presenting problem. In addition to the Ultrasound interpretation, this patient also received separately billable E/M services including history, examination, and medical decision making in the Emergency Department. The E/M code, [9928x], was billed with a -25 modifier indicating the significant, separately identifiable Evaluation/Management service.

CPT® is the designated code set determined by HIPAA. CPT® states, “The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code.”

Please forward this information to your medical review staff for an independent determination to prevent a computer-generated denial based on coding edit software that routinely occurs with these claims.

Thank you for your consideration. Please contact [staff name] at [telephone number] in our office should you have any questions regarding this claim.

Sincerely,

[Physician Name]
Medical-CA Appeal Instructions

- When sending an appeal for eligibility, also send the Proof of Eligibility (either the internet print-out or physical copy).
- If the recipient has no BIC and no SSN, contact the regional Social Services Office and they will be able to look-up the BIC number for you.
- If you miss the 90 day appeal, submit a CIF (Claims Inquiry Form) and get a fresh denial in order to re-appeal.
- If it passes 6 months, send a CIF.
- The full Medi-Cal provider manual is online.

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:
  1. **First Level of Appeal**: Redetermination by a Medicare carrier, fiscal intermediary (FI), or Medicare Administrative Contractor (MAC).
  2. **Second Level of Appeal**: Reconsideration by a Qualified Independent Contractor (QIC)
  3. **Third Level of Appeal**: Hearing by an Administrative Law Judge (ALJ) in the Office of Medicare Hearings and Appeals
  4. **Fourth Level of Appeal**: Review by the Medicare Appeals Council
  5. **Fifth Level of Appeal**: Judicial Review in Federal District Court
First Level of Appeal: Redetermination by a Medicare carrier, fiscal intermediary (FI), or Medicare Administrative Contractor (MAC) (1 of 2)

Requesting a Redetermination in Writing

- A request for a redetermination must be filed either on Form CMS-20027 or in writing. To link to this form, scroll down to "Related Links Inside CMS." A written request not made on Form CMS-20027 must include the following information:
  - Beneficiary name
  - Medicare Health Insurance Claim (HIC) number
  - Specific service and/or item(s) for which a redetermination is being requested

First Level of Appeal: Redetermination by a Medicare carrier, fiscal intermediary (FI), or Medicare Administrative Contractor (MAC) (2 of 2)

- Specific date(s) of service
- Signature of the party or the authorized or appointed representative of the party
- The appellant should attach any supporting documentation to their redetermination request. The FI, carrier, or MAC will generally issue a decision (either in a letter, a revised remittance advice, or a Medicare Summary Notice) within 60 days of receipt of the redetermination request.
Second Level of Appeal: Reconsideration by a Qualified Independent Contractor (QIC)  (1 of 2)

• A written reconsideration request must be filed with a QIC within 180 days of receipt of the redetermination. To request a reconsideration, follow the instructions on your Medicare Redetermination Notice (MRN). A request for a reconsideration may be made on the standard form CMS-20033. This form is mailed with the MRN.

Second Level of Appeal: Reconsideration by a Qualified Independent Contractor (QIC)  (2 of 2)

If the form is not used, the written request must contain all of the following information:

• Beneficiary's name
• Beneficiary's Medicare health insurance claim (HIC) number
• Specific service(s) and item(s) for which the reconsideration is requested, and the specific date(s) of service
• Name and signature of the party or representative of the party
• Name of the contractor that made the redetermination
• The request should clearly explain why you disagree with the redetermination.
Third Level of Appeal: Hearing by an Administrative Law Judge (ALJ) in the Office of Medicare Hearings and Appeals

- Appellants must send notice of the ALJ hearing request to all parties to the QIC for reconsideration
- ALJ hearings are generally held by video-teleconference (VTC) or by telephone.
- The ALJ will generally issue a decision within 90 days of receipt of the hearing request.

Fourth Level of Appeal: Review by the Medicare Appeals Council

- If a party to the Administrative Law Judge (ALJ) hearing is dissatisfied with the ALJ’s decision, the party may request a review by the Medicare Appeals Council. There are no requirements regarding the amount of money in controversy. The request for Medicare Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ’s decision, and must specify the issues and findings that are being contested.
- Filing a Request for Medicare Appeals Council Review
  - Refer to the ALJ decision for details regarding the procedures to follow when filing a request for Medicare Appeals Council review.
  - Generally, the Medicare Appeals Council will issue a decision within 90 days of receipt of a request for review. That timeframe may be extended for various reasons, including but not limited to, the case being escalated from the ALJ level.
Fifth Level of Appeal: Judicial Review in Federal District Court (1 of 2)

- If $1,400 or more is still in controversy following the Medicare Appeals Council's decision, judicial review before a Federal District Court judge may be requested. The appellant must request a Federal District Court hearing within 60 days of receipt of the Medicare Appeals Council's decision.
- You may view the Federal Register notices on the latest amounts in controversy by clicking on the links in the "Related Links Outside CMS" section on the CMS website.

Fifth Level of Appeal: Judicial Review in Federal District Court (2 of 2)

Filing a Request for Judicial Review

- The Medicare Appeals Council's decision will contain information about the procedures for requesting judicial review.
- Please note that the amount in controversy required to request a judicial review is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers.
More on Appealing Denied Claims

- Appealing a denied claim will often be in your best interest.
- A recent Government Accountability Office (GAO) report found that more claims problems stemmed from straightforward billing and eligibility issues than from disagreements over whether care was medically appropriate. What’s more, the odds are about 50/50 that if you appeal an insurer’s decision, you’ll win.
- Did You Know? If you refile 100 denied claims, without any modification or correction, what will happen? What is the risk?
- In virtually every live billing seminar I teach, someone will assert that they never get paid on a particular procedure yet another attendee will declare they are always paid. Why is this?

Appeal Tips and Tricks you won’t learn anywhere else (1 of 2)

- When calling your carrier always get the person’s name.
- Chat them up and compliment them on how hard they work.
- Be very nice; try to get their name and email address if possible.
- When you ask them what modifier to use they will usually say, “we cannot tell you how to code.”
- Always work to find a carrier rep for your top carriers (Medicare, Medicaid, Blue Cross). Be sure to ask.
- Always get any unique instructions in writing. Ask for their E-mail address and send them an overview of the discussion and have them reply.
Appeal Tips and Tricks you won’t learn anywhere else  

(2 of 2)

• If you call about a denial, have your facts straight and reference either CPT, ICD-10 or clinical guidelines when asking to be reimbursed for the service.

• If you have coding credentials announce them up front.

• Sometimes the provider can get a claim paid on appeal whereas a staff worker will not.

• Request that a “medical peer” review the codes and documentation for payment.

• Appeal by the pound–send as much information as possible, as long as it is relevant.

More Resources

• The CMS website has a webpage with appeal information.  

• Appeallettersonline.com  
Summary

- Know the basics—including the front-office staff
- Be organized
- Always work appeals
- Work the 12 steps
- Understand the process for every carrier
- Track everything
- Don’t give up

Winning Carrier Denial Appeals Webinar

Questions?

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