Eli's Rehab Report

Know the Five Key Steps to Successfully Appeal Denials

Insurance denials for ethically claimed services are an irritating and somewhat frequent occurrence for PM&R practices, many of which spend hours each week appealing these claims. Practices that have a person who tracks common denials and speaks directly with claims managers may find that is a better use of their time than sending standard appeal letters with a copy of the patients chart.

For example, many subscribers have told us about denials that resulted from billing for multiple trigger point (**CPT 20550**) and bursa (20600, 20605, 20610) injections performed during the same visit, despite the use of modifier -59 (distinct procedural service). Even denials for one-time procedures, such as setting up a patient with a prosthetic, occur and can be frustrating and costly. The following tips should help practices deal with appeals more effectively.

Step One: Know Your Insurers Appeals Method

According to **L. Michael Fleischman, CHC**, principal of Gates, Moore & Company, a healthcare consulting firm in Atlanta, many practices arent familiar with their insurers appeals guidelines. The appeal process may be different for each carrier but it should be in their provider manual. All you have to do is read the contract to learn how to proceed after you receive a denial. The insurance companys provider manual should be specific in spelling out the method for appealing claims, Fleischman says.

Step Two: Ensure You Billed Accurately

Many denials can stem from errors within your own practice, says **William J. Mazzocco Jr., PA-C/RN**, president of Medical Administrative Support Services, a healthcare consulting firm in Altoona, Pa. Simple things like forgetting a modifier can result in denial, so its important to review the patient information in your office before you begin any appeal process.

Mazzocco suggests that practices review patient information to ensure that procedure codes, diagnosis codes and modifiers are correct, and that the claim was sent to the correct insurer. For example, if Medicare denies a claim for a man who hurt his back lifting a box at work, instead of just appealing it, look back at your notes. You may realize that it should have been sent to workers compensation first. Or if Medicare pays only part of the claim for a stroke victim, you may realize that the patient has a secondary insurer who should receive the claim as well.

Step Three: Confirm the Reason for the Denial

After youve checked your records and youre sure your office handled the claim properly, you should call your insurers claims department directly and find out why they denied the claim, says Mazzocco. Dont just accept a coded denial explanation, because, typically, those dont provide enough detail. You should phone the insurer and find out exactly why they rejected the claim and what they need from you to correct the denial.

Step Four: Put Your Appeal In Writing

Mazzocco recommends that practices document conversations with the insurer in a letter, along with the supporting documentation that the insurer requested. If, for example, the insurer needs proof that trigger point injections in the thigh and bursa injections in the feet were performed to treat two separate conditions, the letter should begin in a manner similar to this: Referencing my conversation with your claims representative, Mary Smith, on April 20, 2000, regarding Claim #0000000, you will note that I have included herewith copies of the following:

Notes that the physician wrote during his initial evaluation of the patient on Jan.16, 2000, when he diagnosed bursitis in both feet (726.79), and muscle pain (729.1) in her left thigh.

Notes from the March 21, 2000, evaluation, when the patient complained of pain in her feet stemming from the bursitis, necessitating bilateral bursa injections, and pain in her back, necessitating the trigger point injection.

By inclusion of this information, we are requesting that you pay for both the trigger point and bursa injections. Thank you for your review of this claim.

You should never just copy the chart and send that with your appeal letter, says Mazzocco, because if the insurer is looking for specific information, they dont want to waste their time sifting through your entire chart to find the documentation theyre seeking. You have a better chance of getting a positive response if you give them exactly what they need.

Mazzocco also advises against sending standard form-letter appeals for each denial. If you send a generated appeal to them, chances are theyll send a generated denial back to you. This wastes time on both sides.

Step Five: Assess Mass Denials for Specific Procedures

Keep tabs on the number of denials and the types of denials youre receiving from your insurers, says Mazzocco. You dont have to do this perpetually for every patient, but if you do it for three to six months at a time, you might start to see patterns in the types of denials youre receiving. Any pattern you observe should spur you to do two things: First, review your own office procedures to determine if someone is miscoding a procedure consistently, and second, investigate why the insurer is denying the same things repeatedly.

Fleischman suggests that providers do not always update their systems, and, in that case, they may not have appropriate coding checks in place. He says, If youre getting the same denial on a particular number of claims with the same insurance carrier, you should gather all of those claims and request a meeting with their provider-relations representatives to determine the cause.

Show them why youre billing the procedure the way you are, which you believe is in accordance with CPT coding requirements, and get the carriers understanding of why theyre denying it. If the practice handles their appeal in the way the carrier contract specifies and they still get denied, a physician representative of the practice and the administrator or billing manager should write a letter to the insurers medical director requesting a meeting to determine the cause of the rejections.

Appealing Isnt Always the Best Option

Many practices find that often its not worth their time to appeal denials for small dollar amounts. **Barbara Shaub**, billing manager at William Beaumont Hospital in Royal Oak, Mich., states, Appealing denials usually is based on volumes or money involved. I would never try and appeal anything worth less than $100.

Mazzocco agrees. Your practice should establish a dollar amount that you will appeal, usually around $75. But, if you keep track of denials and find that youre getting the same rejection for a $40 service continually, you cant just automatically keep writing it off, because $40 over and over again adds up.

Every time your practice receives a denial, you should review the claim, says Mazzocco. This will at least give you the appropriate information about what went wrong. The money is yours until proven not, so you should at least give each denial a short screening and look at your own documents to make sure youre doing things correctly. This will help you save time and money in the future.

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The Four Levels of Appeal

Eric Sandham, CPC, compliance educator for Central California Faculty Medical Group, a group practice and training facility associated with the University of California at San Francisco in Fresno, explains that there are four levels of appeal.

1. Level one or review. The physiatrist is asking the carrier if the claim was processed correctly according to the carriers guidelines. If the carrier says that it was and refuses to pay, the physiatrist may move on to the second level of appeal.

2. Level two or fair hearing. At this stage in the process, the physiatrist may ask the carrier to take a closer look at the carriers guidelines to ensure that these guidelines were developed fairly. For example, if bundling issues are involved, it is appropriate to ask where the specific coding pair in question originated. If it is not a national Correct Coding Initiative edit, there may be a greater chance of a carrier medical director ruling in the physiatrists favor.

3. Level three or the administrative-lower-judge-level appeal. The physiatrist appears before a judge, is sworn in, and gives evidence. The judge has discretion to determine if the policies being applied are appropriate. An outside medical expert who doesnt necessarily work for the carrier may also give testimony.

4. Level four or the appeals council. It is very rare that an issue is taken to this level. If the appeals council sees that some error was made at the administrative-lower-judge level, they will not make a decision. Instead, the appeals council will remand the matter back to the administrative lower judge for a reappraisal.

Sandham reports that a recent statistic he saw stated that the administrative-lower-judge process is running 564 days from filing to decision. Taking matters to this level can become time- and cost-prohibitive for the physiatrist because an appeal must be made on each individual claim.
If a carrier enforces policies that the physiatrist believes are unfair and change cannot be effected on the carrier level, he or she may also consider getting in touch the state or national medical associations to lodge a complaint and learn if other physiatrists are facing similar problems with the carrier.

A physiatrist may also file a complaint with the states insurance bureau.