TOP 5 DENIAL REASONS IN 25 MINUTES

BUST COMMON MISTAKES THAT TRIGGER MEDICAL CLAIM NONPAYMENTS

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The Cost of Denials

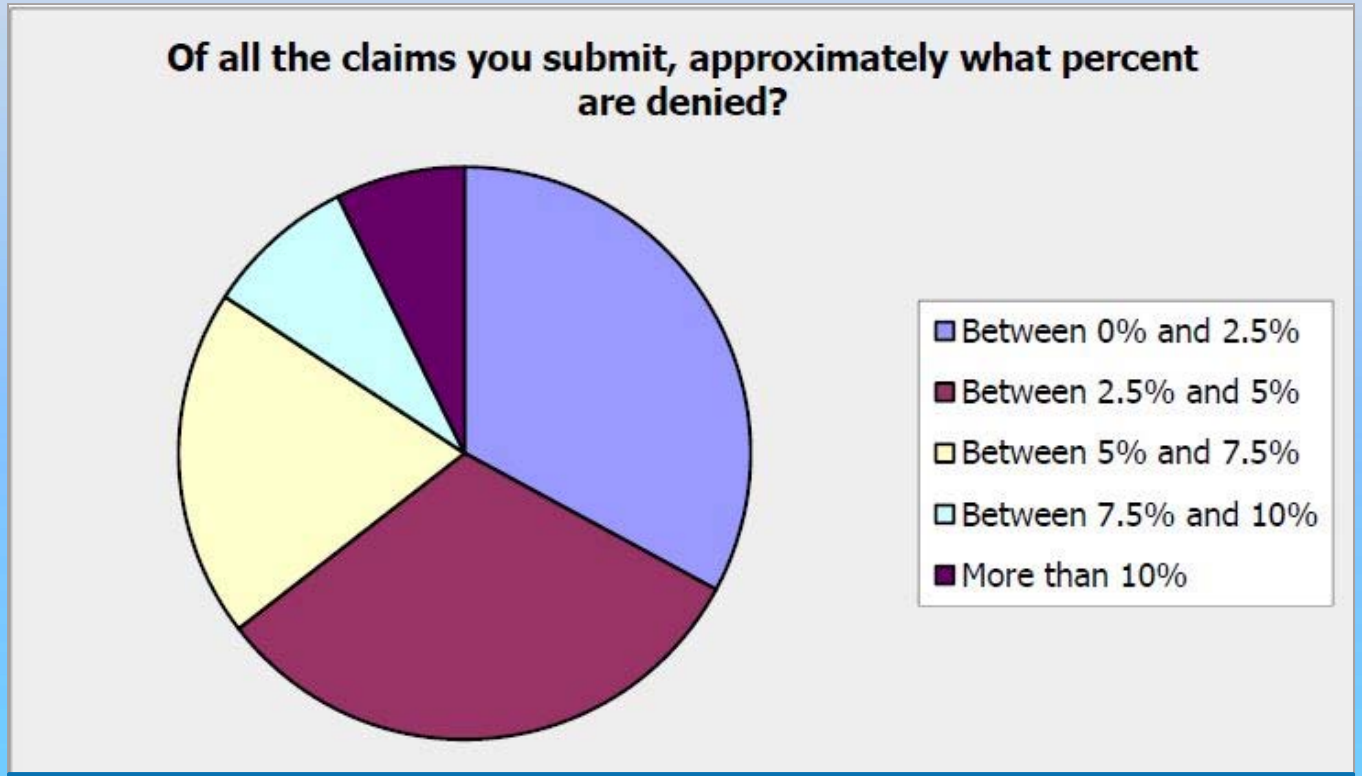
3.9% of all claims are denied

Source: AMA's 2009 National Health Insurance Report Card analysis

Estimated 4.5 billion physician claims filed each year

= approximately 181 million denials of payment

Source: Frank Cohen's 2010 Denials and Appeals Survey



3.8% of all claims are denied

Source: Frank Cohen's 2010 Denials and Appeals Survey

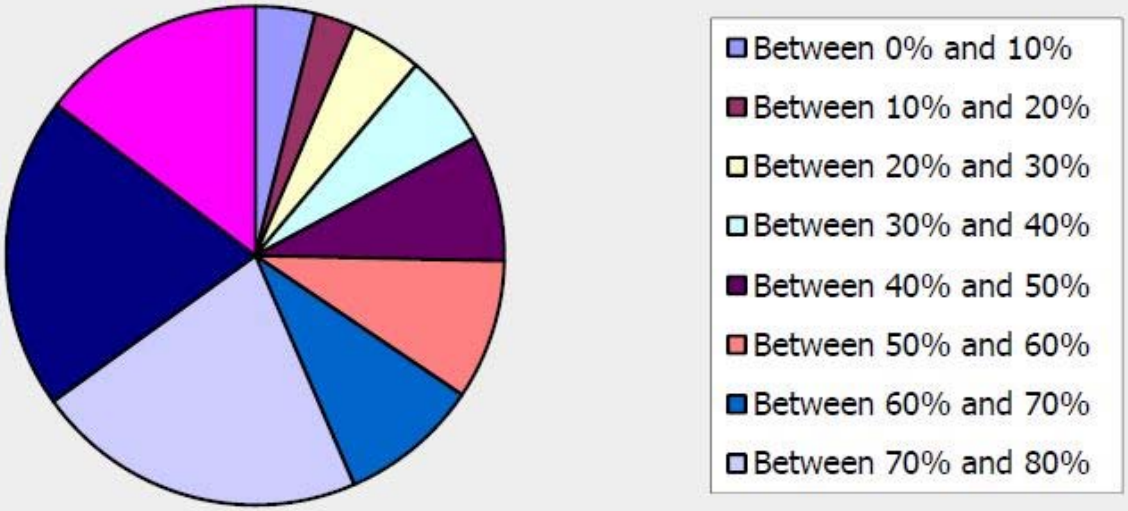
$17 Billion in Waste

$5 billion rework (providers)

$12 billion rework (payer)

Source: Frank Cohen's 2010 Denials and Appeals Survey

Of the claims you do appeal, approximately what percent of those end up being reversed (you eventually get paid all or a portion of the billed amount)?



3.8% of all claims are denied

Source: Frank Cohen's 2010 Denials and Appeals Survey

1. Eligibility

"**Eligibility alone**

accounts for nearly **one third**

of all denials."

-- ***Frank D. Cohen, MBB, MBA***

Denials and Appeals Survey

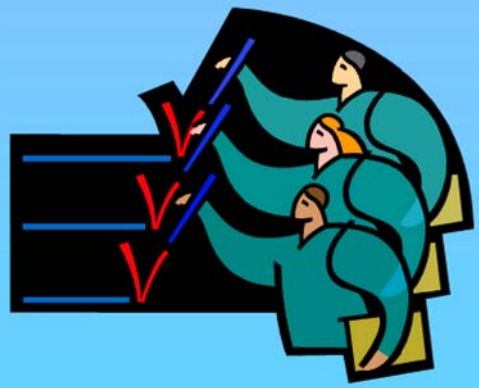
March 22, 2010

Top Recommendations

Leesa A. Israel, CPC, CUC, CMBS

Take a three-prong approach to eligibility verification:

1. Verify as soon as possible.
2. Figure out how you'll verify.
3. Copy the card every time.



Verify ASAP

When should you perform the eligibility check?

- Before the patient comes in
- At check-in
- While the patient is with the physician
- After the appointment.

Leesa's answer: *Verify the patient's benefits before he/she ever sets foot in your office.*

Figure Out How You'll Verify

A patient's **insurance company name/plan** and **ID number** are all you should need to verify benefits.

1. Call the patient or ask for the insurance info when he makes the appointment.
2. Call the payer or use the payer's Web site to verify benefits.

Tip: *Call during off-peak hours and batch processes. Take time each day to call insurance companies to verify insurance for the next day's patients. Verify for several patients with the same insurer at one time.*

Copy the Card Every Time

Copy or check the patient's insurance card every time she comes into your office.

- Check the dates on the card to ensure the coverage is still valid.
- Match the patient's information to the information on the card.

Word to the wise: *Keep a current copy of the patient's insurance card in her medical record – a scanned, electronic file or a paper copy. This makes coverage and copay checks easy for the front office staff.*

Bottom Line: Verify, Verify, Verify

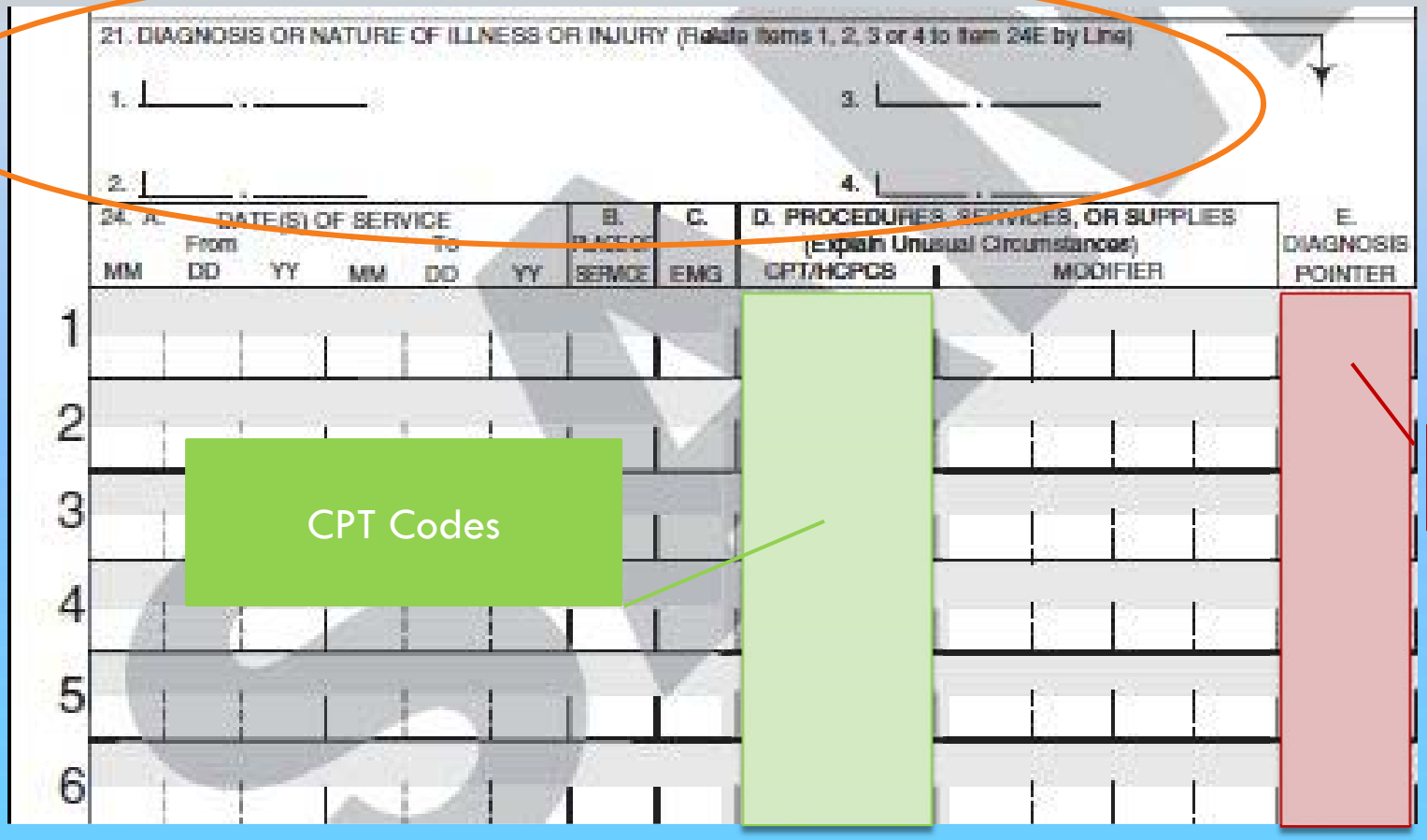
Check every patient, every time

If the patient is scheduled for a particular service, make sure you confirm:

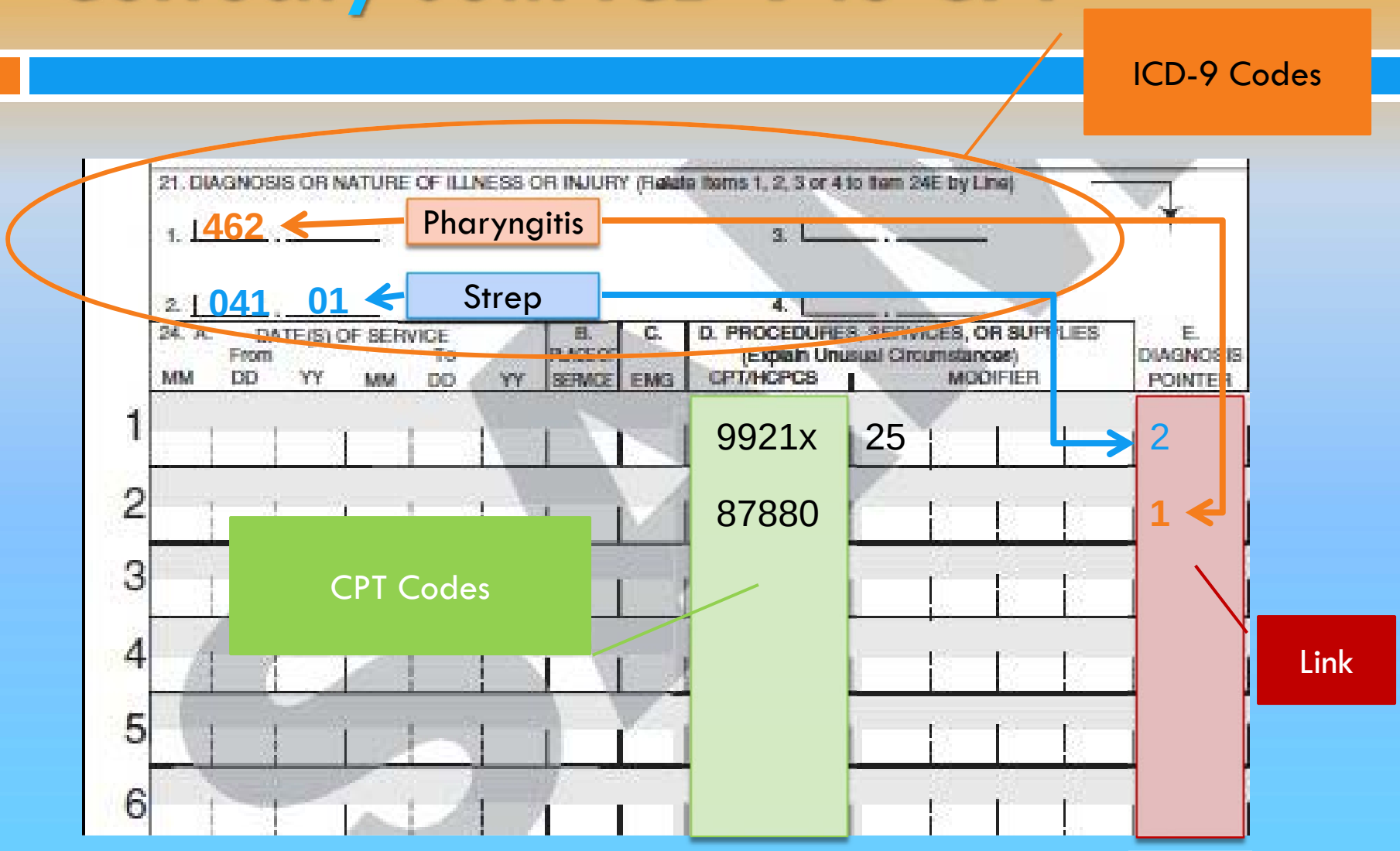
- ✓ *eligibility*
- ✓ *copay amount*
- ✓ *limitations on the policy*
- ✓ *precertification, if necessary.*

This way you'll know before the patient arrives if you need an advance beneficiary notice (ABN) and how much money the patient needs to pay.

Correctly Join ICD-9 to CPT



Correctly Join ICD-9 to CPT



ICD-9 Position 1 Problem

"**Failure** of the payers **to read past the first ICD-9 code** and/or modifier results in unnecessary **denials**."

-- ***Frank D. Cohen, MBB, MBA***

Denials and Appeals Survey

March 22, 2010

Payer	% of total records w/ reason codes	RARC	Remark code description
Aetna Coventry HCSC Humana	61 15 33.2 6.1	N130 N514	Consult plan benefit documents/guidelines for information about restrictions for this service
Coventry	10	N59	Please refer to your provider manual for additional program and provider information.
Humana Medicare UHG	22.9 23.04 16.3	N115	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD). An LMRP/ LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms/hhs.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LMRP/LCD
UHG	9.7	N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at A copy of this policy is available at www.cms/hhs.gov/mcd,/search.asp. If you do not

AMA's National Health Insurer Report Card Metric 12 Remark Codes
Data source: Frank Cohen's 2010 Denials and Appeals Survey

Payer	% of total records w/ reason codes	CARC	Reason code description
Anthem BCBS CIGNA HCSC Humana UHG	7.3 27 14.9 40.8 9.1	96	Noncovered charges(s). At least one Remark Code must be provided
Aetna CIGNA Coventry Humana	6.4 6.7 10.0 6.4	197	Precertification/authorization/notification absent
Anthem BCBS Coventry	11.6 6.3	204	This service/equipment/drug is not covered under the patient's current benefit plan.
Aetna	8.8	55	Procedure/treatment is deemed experimental/investigational by the payer
HCSC	8.4	B5	Coverage/program guidelines were not met or were exceeded

AMA's National Health Insurer Report Card Metric 12 Reason Codes
Data source: Frank Cohen's 2010 Denials and Appeals Survey

Abbreviation	Term	Status	Issued by	Hierarchy
LCD	Local Coverage Determination (LCD)	Replaced LMRP	Contractor (state level)	2
LMRP	a local medical review policy (LMRP)	New name for LCD	Contractor (jurisdiction level)	2
NCD	National Coverage Determination	NCD	National Medicare	1 
Plan benefit documents/ guidelines	NA	NA	Third party payer	1 
Provider manual	NA	NA	Third party payer	1 

Read Policies

Insurer	Web site
Medicare	Search NCD and or LCD at www.cms.gov/mcd/search.asp?clickon=search
Aetna	www.aetna.com/healthcare-professionals/policies-guidelines/cpb_alpha.html
Anthem	www.anthem.com/cptsearch_shared.html www.anthem.com/wps/portal/ca/culdesac?content_path=provider/f2/s3/t0/pw_a111727.htm&label=By Alpha &rootLevel=1&name=onlinepolicies
CIGNA	www.cigna.com/customer_care/healthcare_professional/coverage_positions/index.html
Humana	http://apps.humana.com/tad/tad_new/home.aspx?type=provider
UHG	www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=422fe7a1e193b010VgnVCM100000c520720a____

A Policy Covers A Lot …

LCD Policy

Indication | Bill Type Codes | Revenue Codes | Diagnoses support | Diagnoses don't support | Documentation requirement | Appendices | Utility guideline | Last review | Status | CMS coverage policy | Revenue Paragraph

Contractor Name: National Government Services, Inc.

Contractor Number: 00630

Contractor Type: Carrier

State: Indiana

LCD ID Number: 28170

Title: Cerumen (Earwax) Removal

Determination number: L28170 (R3)

Original determination date: 2008-07-18 00:00:00

Revision Effective date: 2010-04-01 00:00:00

Indication:

Abstract:

Cerumen impaction is a condition in which earwax has become tightly packed in the external ear canal to the point that the canal is blocked. Extraction requiring methods beyond simple irrigation or removal by Q-tip or cotton-tipped applicator may require a physician's skill. This LCD identifies the indications and limitations of Medicare coverage and reimbursement for these services.

Cerumen, or ear wax, is the product of desquamated skin mixed with secretions from the adnexal glands of the external ear canal. It provides lubrication, acts as a vehicle for the removal of contaminants away from the tympanic membrane and prevents dessication of the epidermis.

Though usually asymptomatic, cerumen can accumulate and become impacted causing **such symptoms as conductive hearing loss, pain, itching, cough, dizziness, vertigo, and tinnitus**. Hearing impairment can further contribute to stress, social isolation, and depression. Impacted cerumen can also impede the evaluation and management of other otologic conditions

MUE & CCI Denial Combaters

Modifier 63 on a 100-lb baby?

Suzanne Leder, CPC, COBGC

MUE Fast Facts:

Purpose: Medically Unlikely Edits (MUEs) reduce the paid claims error rate for Part B claims.

Definition: Maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.

Here's How MUE Edits Work

Provider billed CMS for

30 units of J9010

(*Injection, alemtuzumab, 10 mg*)

rather than **3** units.

- **CMS has MEUs in place to catch these types of errors before overpayments are made.**

Make Your Own MUEs

- Set up internal limits for code.
- Alert on … +10 units for an alemtuzumab injection.
- Manually review flagged claims before submitting.

Guidance Only Once

MUE Example 1: You want to report guidance code 76942 x 2 for e encounter.

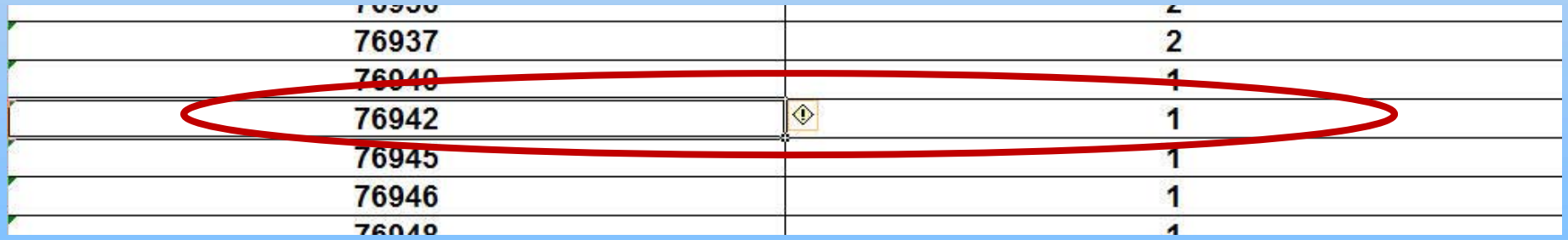
Remember:

1. Guidance codes have a 1 unit limit.
2. >1 unit of 76942 = Denial

Source: CMS, Medically Unlikely Edits

MUE Example 1 (cont'd)

Here's what the MUE looks like on the spreadsheet.



76937	2
76940	1
76942	1
76945	1
76946	1
76948	1

Source: CMS, Medically Unlikely Edits

You Can Override MUE - Sometimes

MUE Example 2:

Noninvasive physiologic studies article recommends reporting **93923 x 2** for multiple-level bilateral studies of the arms and legs.

Problem: Per Medicare carrier, **93923 has an MUE of 1**.

MUE Example 2 (cont'd)

AMA supports reporting 93923 (*Noninvasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study [e.g.,segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia]*) x 2 when you perform "**multiple level** segmental Doppler waveform analysis of **both the lower and upper limbs**."

Bottom line: Report the code **twice**.

Source: CPT Assistant, June 2001

MUE Example 2 (cont'd)

"Since each line of a claim is adjudicated separately against the MUE value for the code on that line, the appropriate use of Current Procedural Terminology (CPT) modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE value.

CPT modifiers such as -76 (repeat procedure by same physician), -77 (repeat procedure by another physician), anatomic modifiers (e.g., RT, LT, F1, F2), -91 (repeat clinical diagnostic laboratory test), and -59 (distinct procedural service) will accomplish this purpose. Modifier -59 should be utilized only if no other modifier describes the service."

Source: CMS, MUE FAQ

MUE Example 2 (cont'd)

If your documentation supports overriding the MUE, report:

- 93923
- 93923-59

- Because you are reporting **93923 once** for the **upper limbs** and **once for the lower**, **modifier 59** is the most appropriate choice.

Suzanne's CCI Basics

A payer blames claim denial on the Correct Coding Initiative (CCI) bundles. Does that mean …

What is a CCI Edit?

- CCI quarterly puts out a list of code pairs that Medicare -- and many private payers -- follow for payment
- CCI edits list pairs of CPT and HCPCS codes that payers will not pay on when you bill them together.
- Apply to services for same provider, same beneficiary, on same date of service.

Decipher Columns

Column 1 Code	Column 2 Code
00140	92100
64450	20550
95863	95920
95864	95920

What is a CCI Edit?

"The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported."

Source: CMS, Web site

Facility Coders:

- Hospital edits run one quarter behind physician CCI edits.
- Pay attention to the **start/stop dates.**

Why Are There 2 Types of Edits?

Mutually Exclusive

- Pair procedures or services that the physician could not reasonably perform at the same session on the same beneficiary.
- **Example:** 60252 is mutually exclusive of 60260. The physician could not perform a total thyroidectomy and remove tissue following a previous removal of a portion of thyroid at the same session.

Column 1/Column 2

- previously known as comprehensive/component
- describe "bundled" procedures. Column 2 code is a component of the more extensive column 1 procedure.
- **Example:** CCI bundles biopsy code 11100 into lesion excision code 11403.

Get the Least

Column 1 Code	Column 2 Code
00140	92100
64450	20550
95863	95920
95864	95920

Can You Ignore CCI Edits?

Check the "modifier indicator" -- column F

- 0 -- **cannot** unbundle the two codes under any circumstances
- 1 -- **may** use a modifier to override the edit if the clinical circumstances warrant separate reimbursement

Examples:

- ✓ separate encounter on the same date
- ✓ separate anatomical site
- ✓ separate indication

Use a modifier to **override a bundle only if** your documentation supports using the modifier.

Bypass Edit in 2 Steps

1. Append modifier 59 (*Distinct procedural service*) to the column 2 code or "component" code.
2. Without modifier 59, the payer apply the CCI edit and deny your claim

Watch Your POS Selection

				LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.	04/01/04
UHG	2010	N174	14.7%	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.	Start: 02/28/2003
UHG	2010	M77	14.5%	Missing/incomplete/invalid place of service.	Start: 01/01/1997 | Last Modified: 02/28/03
UHG	2010	MA130	10.6%	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	Start: 10/12/2001
UHG	2010	N386	9.7%	This decision was based on a National Coverage Determination	Start: 04/01/2007

Mary Compton, PhD, CPC

ID Inpatient vs Outpatient

Look to **admission status** to determine POS for services.

Service	EM Code		POS
consult performed in the ED	CPT	99241-99245	23
	Medicare	99221-99223	
inpatient consultation	CPT	99251-99255	21
	Medicare	99221-99223	

Resource: POS codes and corresponding definitions
www.cms.gov/PlaceofServiceCodes/Downloads/posdatabase110509.pdf

POS Do's and Don'ts

Do match codes to test location and verify with payers.

- Medicare restricts certain tests to hospital inpatients
- Expect denials if you report tests in other locations.

Don't look at POS to determine new versus established patient

- POS does not indicate whether patient is new or established
- Based on CPT's established patient definition, new versus established refers only to the patient's relationship to the physician, not his relationship to the practice or its location.

9 Checks Combat Denial

- Verify benefits as soon as possible.
- Figure out how you'll verify.
- Copy the patient's insurance card every time.
- Check diagnostic links.
- Research policy allowances.
- Adhere to MUEs.
- Follow CCI edits.
- Base POS on patient admission status.
- Stick to test POS restrictions.

Resources

- AMA, “2009 National Health Insurer Report Card”. www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/heal-claims-process/national-health-insurer-report-card/2009-nhirc.shtml
- AMA, “2009 National Health Insurer Report Card Comment Definitions”**.** www.ama-assn.org/ama1/pub/upload/mm/368/2010-hirc-carcs-rarcs.pdf
- AMA, *CPT Assistant*, June 2001
- CMS, “Medically Unlikely Edits”. www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp
- CMS, “MUE FAQ”
- CMS, Correct Coding Initiative. www.cms.hhs.gov/NationalCorrectCodInitEd
- *CPT 2010*
- Frank D. Cohen, MBB, MBA. “Denials and Appeals Survey”. March 22, 2010. www.frankcohen.com/DandA_Survey.pdf
- POS codes and definitions. www.cms.gov/PlaceofServiceCodes/Downloads/posdatabase110509.pdf

Save the Date!

Be ready for the **ICD-9 2011 revisions**

you can't live without.

FREE Webinar

Tuesday, Sept 21

12:00 pm EST

Register at:
www.supercoder.com/events/webinars/

Speakers: Mary Compton, PhD, CPC

Jen Godreau, BA, CPC, CPEDC

Suzanne Leder, M.Phil., CPC, COBGC

Get a speed run through of top changes impacting more than 13 specialties.

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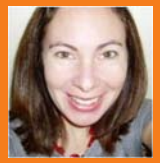

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Ob-Gyn Coding Alert

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