Streamlining
The Appeals Process

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Financial Interest

E. Ann Rose is President of Rose & Associates and acknowledges a financial interest in this subject matter

Overview

• Do you currently have claims auditing and appeal process in place?
  – If not, might be good time to create one
    • Auditing claims payments and exercising appeals rights is critical for any practice
    • Assures practice optimizes reimbursement
    • Identifies billing errors
    • May also help avoid audits
Overview

• Claims auditing more important than ever with implementation of ICD-10
  – Effective date will be October 1, 2014
    • Submitting new ICD-10 diagnosis codes will be bit of a challenge in itself
    • Monitoring denials daily will be next biggest challenge
    • Make sure you have staff in place to handle this process

Overview

• Common mistakes practices often make
  – Assume reimbursement received from Medicare or other payer is always accurate
  – No one assigned to review denied claims
  – No one assigned to handle appeals
• These mistakes can cause lost revenue regardless of size of practice

Overview

• Providers are entitled to:
  – Payment for procedures and services they provide
    • When documented and coded properly
    • Medically necessary, medically justified, medically reasonable
• Payers make mistakes too
  – Inappropriately denied claims should be brought to Medicare’s (or other payer’s) attention
Overview

- Appealing underpaid/denied claims
  - Medicare more likely to correct claims-editing process with provider appeals
    - May result in improved claims processing and payments
  - In long run, both provider and payer benefit from claims appeals
  - The following steps can help build a good appeals process

Streamlining Appeals

- Step 1
  - Select person responsible for auditing Medicare payments and other payers
  - Make sure that person has a very good understanding of coding and claims auditing
  - Allocate time for this person to conduct these audits on a regular basis
    - One afternoon a week, the last hour of every day, etc.
    - During ICD-10 transition, do this every day

AMA: Appeal That Claim

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- Step 2
  - Make sure your claims auditor has good auditing/appeals resources
    - Current CPT Coding Manual
    - HCPCS Coding Manual
    - CMS National Correct Coding Edits
      - Can access on CMS website
    - CMS local and national medical policies
      - Requires internet access to Medicare contractor website
    - ICD-9 and ICD-10 Coding Manuals
Streamlining Appeals

– For commercial payers and HMOs
  • Have access to all health insurer contractors and relevant source documents
  • Including patient benefit verification information
  – May assist auditor in understanding contract payment policies
  – When possible auditor should locate and record the following information for each contract
    • Contract effective date

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• Fee Schedule
• Multiple procedure payment policy
• Bilateral payment policy
• Claims submission guidelines
  – Including timely filing limits specified in contract
• Medical review policies
• Claims appeals process
• Global period definitions
• Health insurer contact information

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• Step 3
  – Run monthly collection reports
  – Report should list
    • Each claim insurer has not paid in more than 30 days or beyond state statutory requirements (if applicable)
      – If PM software can show claim bill date
        • Run report of delinquency based on that time frame
    • Detailed information regarding the claim
Streamlining Appeals

- If EOB not received, call insurer to obtain claim status
- Identify claims that are more than 30 days past due on the report
  - Conduct cursory review of EOB and identify the reason for non-payment
  - Some clearinghouses may be able to provide this information

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- Step 4
  - Conduct detailed review of EOB/EOMB/RA for each claim identified on collection report
    - Determine insurer’s rationale for partial payment, delay or denial of claim
    - Identify each EOB that lists a zero amount as approved charge
    - Review EOB remarks to see why claim was reduced or denied
    - Determine if insurer made correct determination

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- Step 5
  - Identify basis for denied, delayed or partially paid claim
  - Common reasons for denials
    - Your claims processing error
      - Date of service
      - Amount billed
      - Wrong code or wrong modifier
    - Some payers allow telephone review for minor errors such as these

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- **Bundling Errors**
  - Submitting bundled services under CCI or payer edits
    - Most often, only the one with the lowest reimbursement is paid
  - Commercial payers may let you appeal these claims via phone review
    - May just need appropriate -25, -57, or -59 modifier
  - There are no appeal rights on CCI bundling errors
  - Review the CCI edits with staff to prevent this from occurring in the future

- **Medical Necessity Denials**
  - This is most common type denial
  - Usually means wrong diagnosis used
  - Need to review claim and chart note to see what diagnosis should have been billed
    - Don’t be afraid to ask doctor if you can’t identify correct diagnosis from chart
  - Can often do telephone review for this type error

- **Step 6**
  - Gather supporting documentation needed to move forward with appeals
    - Payer payment policies
    - Medicare LCDs
    - CPT guidelines
    - Operative Note or Chart Note
    - CMS guideline or National Coverage guideline you can reference
Streamlining Appeals

– Proof for timely filing
  • Sometimes a payer may ask you to prove when you sent the claim
  • You can submit a screen shot from your Practice Management system for the date you printed the claim or sent it electronically
    – PM system should show exact date claim was sent
  • Submitting screen shot may assist in more favorable outcome with commercial payers

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• Step 7
  – Develop Claim Appeal Letter or Resubmit Claim
    • Your first attempt should be to do a telephone review
    • May be able to resubmit claim with corrected information
    • May need to complete appeal form or send appeal letter to get it resolved

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– Make sure appeal letter or form includes everything needed for the appeal
  • Patient name, subscriber's name
  • HIC number and/or insurer number
  • Date of service
  • Reason you are challenging denial
  – Be sure to include supporting documentation
  – Ask the treating physician to review the appeal for appropriateness
Streamlining Appeals

– Request a review of the claim by a physician of the same specialty
– May be able to fax information
  • Find out – this sometimes speeds up process
– Consistently follow-up with payer on status of appeal
– Don’t forget to keep a copy for your files
  • Include any telephone conversations with names and emails or phone numbers

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• Step 8
  – Maintain a Follow-up Log
    • Should identify each claim you submit and background information
  – Particularly important during ICD-10 transition
    • May get overwhelmed if you don’t
    • Losing control of denials and appeals won’t help anyone

AMA: Appeal That Claim

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• Step 9
  – Hold Claims Processing and Review Meetings
    • You should have weekly, monthly, or quarterly meetings
    • Discuss reasons for denials and steps needed to correct problems
  – Will help identify existing or new problems with claims payment
    • Particularly October 1 and after

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• Step 10
  – Continue appealing denied, delayed or partially paid claims
    • You should always exercise your right to appeal claims
    • It may take more than one appeal to overturn the denial or error
  – Appeals are a big step in making sure practice gets paid appropriately for services they provide

Medicare Appeals

• There are 5 levels of Medicare Appeals
  – Level 1 - Redetermination
    • By CMS contractor (carrier, fiscal intermediary or Medicare Administrative Contractor (MAC))
  – Level 2 - Reconsideration
    • By a Qualified Independent Contractor (QIC)
  – Level 3 - Administrative Law Judge Hearing
    • With the Office of Medicare Hearings and Appeals
Medicare Appeals

– Level 4 - Review by Appeals Council
  • With the Departmental Appeals Board
– Level 5 - Judicial Review
  • In Federal District Court
• Most practices very seldom need to go past first two levels of appeal
  • Redetermination
  • Reconsideration by QIC

Redetermination

• Appeal must now be made in writing
  • No more over the phone
  • No more in-person appeals where doctor can plead his/her case
– Must file within 120 days from date of receipt of initial denial
  • Can follow directions on Remittance Advice (RA)
  • Can file on CMS-10027 form available from Medicare
    – Eliminates need for appeal letters

Redetermination

– If form not used, appeal letter must include:
  • Beneficiary Name
  • Medicare HIC number
  • Specific service and/or item(s) for which a redetermination is being requested
  • Specific Dates of Service
  • Name and signature of the patient or the representative of the patient
  • Attach any supporting documentation necessary to reverse denial
Redetermination

- Contractors generally issue a decision within 60 days of receipt of the redetermination
- Can correct incomplete or invalid claims without formal appeal
  - Unclean claims
    - Missing or incorrect information
      - Provider name, patient name, HIC #, wrong NPI, etc.
    - Just submit corrected claim

Redetermination

- Reopening Claims
  - Can change determinations or decision resulting in overpayments or underpayments
    - A Reopening is NOT an appeal right
  - Can also request change in clerical errors
    - Wrong diagnosis code that caused claim to deny
      - Must be made within 1 year of date of notice of initial determination
      - If good cause exists, can have as long as 4 years

Reconsideration

- If dissatisfied with Redetermination can request Reconsideration
  - Allows for independent review of initial determination by QIC
    - QIC not employee of MAC or bound by contractor policies
    - May include review of medical necessity issues by physicians or other health care professionals
    - Must also have enough medical knowledge to make decision on medical evidence submitted
Reconsideration

• Must file reconsideration within 180 days of receipt of denial
  – Must submit position paper and evidence why you believe denial is wrong
    • Can request reconsideration from Medicare on Form CMS-20033
    • Attach original denial and other supporting documentation
    • Some commercial payers also have forms on their websites

Reconsideration

– If form not used, written appeal must include:
  • Beneficiary name
  • Medicare HIC number
  • Specified service(s) and/or item(s) for which reconsideration is requested
  • Specific date(s) of service
  • Name and signature of patient or authorized or appointed representative of patient
  • Name of contractor that made the redetermination

Reconsideration

– Should explain reason for disputing redetermination
  • Position paper with documentation
  • Include copy of RA and any other useful documentation
    – LCDs, NCDs, National Standards
  • Missing or late information may result in extension of timeframe for QIC’s decision
    – Could also cause appeal to be excluded
Reconsideration

- Reconsiderations are conducted on-the-record
  - QIC will send decision to all parties within 60 days of receipt of request for reconsideration
    - Will contain information regarding further appeal rights
  - If QIC cannot complete decision in applicable timeframe
    - Will inform you of right to escalate case to ALJ

ALJ Hearing

- Administrative Law Judge (ALJ) Hearing
  - Can make new arguments, but no new evidence allowed
  - ALJ Hearings now conducted by Department of Health and Human Services
    - Agency that runs Medicare
  - No longer conducted by Social Security Administration

Final Levels of Appeal

- Appeals Council
- Judicial Review in U.S. District Court
  - These should be done through a healthcare attorney
    - Highly suggest attorney has experience with ophthalmology practices and CMS payment policies
### Be Proactive

- **If medical policy used by Medicare as basis of denial**
  - Review documentation first to make sure it complies with the LCD requirements
  - If not, you might want to think about not appealing denial at all
  - If physician has peer review articles from medical journals to support position
    - May still want to appeal

### Be Proactive

- **Contact patient**
  - What reasons were given to him/her for the denial
    - What goes to patient and what goes to provider can be different
  - May gather information from patient to assist in your appeal of the denial

### Be Proactive

- **Conduct in-service training on a regular basis**
  - Keep physicians and staff informed of any new policy changes that might affect documentation/code selection
- **Conduct external audits every 1-2 years**
  - Can help with documentation deficiencies
  - Can help prevent potential denials
  - Can also use data as basis for internal audits
Be Proactive

- New ICD-10-CM diagnosis codes effective October 1, 2014
  - Have your claims/appeals process in place before then
    - Make sure you have someone assigned to work on denials on a daily basis
      - Will probably need more than one person initially
    - Make sure staff has knowledge and tools to determine why claims were denied

Be Proactive

- Talk to physicians and technicians about the importance of documenting and coding
  - Let them know coders/billers may be coming to them for additional information
  - Stress importance of being cooperative during this time
    - They are only trying to do their job too
  - Talk to billers about approaching physicians for additional information
    - Cornering physician in hall between patients not a good time

Be Proactive

- CMS Claims Processing Manual good source of information

- Medicare appeals information