10 STEPS FOR STREAMLINING THE APPEALS PROCESS

E. Ann Rose

Do you currently have a claims auditing and appeals process in place? If not, now is a good time to create one.

The Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General (OIG) are more aggressive than ever about collecting any overpayments that may have been made to providers in error. Audits by Medicare Administrative Contractors (MACs), Recovery Auditors (RAs), Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs) are definitely on the rise, including OIG audits.

One of the most common mistakes a practice often makes is assuming that payments from Medicare and other payers are always correct. As a result, there is no one assigned to review the denied claims or handle appeals if the payer is incorrect. Medicare and other payers make mistakes too. A majority of the time, this can be corrected by simply filing a new claim. If not, the inappropriately denied claim should always be brought to the attention of the payer via the appeals process.

There are several steps in creating an appeals process that may make the job a little easier.

STEP 1

Select a 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 regularly, usually one afternoon a week, the last hour of every day, or (for larger practices) the end of every day.

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

For commercial payers and HMOs, have access to all health insurer contractors and relevant source documents, including patient benefit verification information. This may assist you in understanding the contract payment policies for each payer. When possible, the audi-

tor should locate and record the contract effective date for each active contract.

STEP 3

Run monthly collection reports. The report should list each claim the insurer has not paid in more than 30 days or beyond state statutory requirements (if applicable). If the practice management software can show the claim billed date, then run a report of delinquent payments (or submissions) based on that time frame.

STEP 4

Conduct a detailed review of denials identified on the Remittance Advice (RA) report. Determine the rationale for partial payment or delay or denial of the claim. Be sure to identify each claim that lists a reduced or zero amount as an approved charge, and review any RA remarks to see why the claim was reduced or denied. Then determine if Medicare or other payer made the correct determination.

STEP 5

Identify the basis for a denied, delayed, or partially paid claim. Common reasons for denials include:

Your claims processing error

- Date of service
- Amount billed
- Wrong code or wrong modifier

Bundling errors

- Submitting all services performed to Medicare even though some CPT codes are bundled under the Correct Coding Initiative (CCI). When this occurs, Medicare only pays the code with the lowest reimbursement, which could result in huge loss of income.

Medical necessity denials

- This is the most common type of denial and usually means a wrong ICD-10 diagnosis code was submitted on the claim. You will need to review the claim and chart note(s) to see what diagnosis should have been billed, then file a corrected claim.

STEP 6

Gather supporting documentation needed to move forward with appeals:

- Payer payment policies
- Medicare LCDs (local coverage determinations)
- CPT guidelines
- Operative Note or Chart Note
- CMS guideline or National Coverage guideline you can reference

STEP 7

Your first attempt should be to do a telephone review. You may be able to just resubmit a new claim with the corrected information. If not, complete an appeal form which can be found on your Medicare contractor web page, or send an appeal letter to get the claim resolved.

Make sure the appeal letter or form includes everything needed for the appeal:

- Patient name, subscriber's name
- HIC number and insurer number
- Date of service
- Reason you are challenging denial

Ask the treating physician to review the appeal for appropriateness. You can also request a review of the claim by a physician of the same specialty or sub-specialty. You should consistently follow-up with Medicare or other payer on the status of the appeal; don't forget to keep a copy of all correspondence for your files. Include any telephone conversations with names and emails or phone numbers.

STEP 8

Maintain a follow-up log that identifies each claim you submit and any background information. You may get overwhelmed in a large practice if you don't do this.

STEP 9

Hold claims processing and review meetings (weekly, monthly, or quarterly). Discuss the reasons for the denials and steps needed to correct any problems.

STEP 10

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 the provider gets paid appropriately for services they provide. The different levels of appeals can be found on your Medicare contractor website.

KEY POINTS

Always be proactive. If a Local Coverage Determination (LCD) is used by Medicare as the basis of a denial, review the documentation first to make sure it complies with the medical policy requirements. If not, you might want to think about not appealing the denial at all. If the physician has peer-reviewed articles from medical journals to support your position, use those as well.

Conduct in-service training regularly. Keep physicians and staff informed of any new policy changes that might affect documentation or code selection. Conduct external audits every 1–2 years to help identify documentation or coding deficiencies. External audits can then be used as a basis for conducting your internal audits. ***AE***

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