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Internal Medicine Coding Alert

Audits: Follow This 3-Step Strategy To Get Through Irrational Denials

The contract a patient signs with the insurance company holds true no matter what.

Have you been in a situation where you wanted to contest a denial by an insurance company based on irrational payer guidelines? You may be right to think this is like trying to break down a stone wall, but you are not helpless to change to situation to your favor.

Consider this typical situation:

You want to fight an insurance company for payment for 45380 (Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple) with 45385 (... with removal of tumor[s], polyp[s], or other lesion[s] by snare technique). In denying your initial claim, the insurance company states in writing the following guidelines:

"Exceptions to Modifier 59: The following endoscopic biopsy procedures will not be allowed with the associated endoscopic therapeutic procedures: 45380 with 45383-45385.

Decision: The endoscopic biopsies with endoscopic therapeutic procedures in the same anatomical area will follow standard coding logic, and no additional reimbursement will be made for these codes even when billed with modifier 59.

Rationale: The endoscopic biopsy is an integral part of the therapeutic endoscopic procedure. Generic ClaimCheck denies the endoscopic biopsy procedure when billed with a therapeutic endoscopic procedure in the same anatomical area."

What do you do then? Your steps in fighting for your claim could make or break your practice's chance for a fair reimbursement. Unfortunately, the insurance company can set any rules it wants and you are forced to play by them when your physicians sign the contracts. Still, you can break through the barriers by learning this 3-step tactic, says **Barbara Cobuzzi, MBA, CPC-OTO, CPC-H, CPC-P, CPC-I, CHCC,** president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, N.J.

Follow These Three Steps

Step 1: The first thing you have to do is to get a copy of your contract and see what degree of latitude your payer can take relative to AMA and CMS coding rules. If the insurer is violating what is set forth in the contract, use the contract in your appeal to fight this arbitrary policy and get it overturned.

Step 2: If the contract is silent on this or allows such arbitrary use of rules in favor of the payer, you should prepare to "drop the payer as one of your participating payers. Don't have cold feet -- be truly ready to drop them in this stage," Cobuzzi says.

Step 3: Get a meeting between your physicians and the medical director. Ask the medical director to justify this policy in clinical terms as to why the insurer does not reimburse a physician for the diagnostic colonoscopy and the removal of polyps when you apply modifier 59 (Distinct procedural service) to indicate different sites. Explain that breaking the colonoscopy and the biopsy into multiple sessions will make the payer incur multiple facility fees, multiple anesthesia sessions as well as the physician professional fees.