Internal Medicine Coding Alert

Read EOBs Before Responding to Denials

What 'noncovered service' really means to your office

You can't streamline your appeals process unless you can decipher explanations of benefits (EOBs). Review these common EOB denials and the proper responses to them. Details come from **Thomas Kent, CPC, CMM**, president of Kent Medical Management in Dunkirk, Md.

Denial: Noncovered service
Response: Bill the patient; no appeals necessary.

This is the simplest denial to handle, because it doesn't require you to deal with the carrier. A noncovered denial means that according to the patient-insurer contract, the insurance won't cover the patient's cost for this service.

When you see this EOB on a denial, send the responsible party a bill for the balance - along with a letter explaining the situation. To help the patient, include in the letter contact information for the insurance company's representatives in the case.

Denial: Nonallowed cases
Response: Appeal, if your contract doesn't support the denial.

When you receive this denial, the insurance carrier is telling you that it is not contractually obligated to pay for this service. Review your contract with the insurer first; find explicit mention of the service, and see what the contract says about it.

If it's a denied service in the contract, you won't get paid no matter how many times you appeal. Your best option is to remember the denial and bring it up when negotiating the next contract with the insurer.

If the contract does not deny the service, commence the appeals process. Send a letter to the insurer explaining that you cannot find the denial in the contract and ask for the carrier's reason for denial and how the contract justifies its refusal to pay.

Denial: Not medically necessary
Response: Check your diagnosis codes.

This denial code tells you that the diagnosis on the claim doesn't support the service. Insurance companies may say a diagnosis doesn't support a particular level of service, but they can't determine a level of service based on a diagnosis code without looking at documentation. Appeal these claims, but check to see that you're using the most specific diagnoses codes for all documentation, and avoid unspecified diagnosis codes.

Denial: Bundled services
Response: Check the National Correct Coding Initiative (NCCI) edits.

Check any denial against the most recent CPT and NCCI edits. If carriers appear to be bundling services not on the CPT or NCCI books, you should appeal. Of course, if your office approves a contract that includes unconventional bundles, then the carrier can continue to bundle those services. The NCCI edits are often a factor in a denial due to bundled services. Look out for denials for bundled services that the most recent quarter of NCCI edits affected. If your carrier simply overlooked a new edit, the problem can be easily rectified.

Codify
BY AAPC