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Internal Medicine Coding Alert

Restructure Appeals With These 6 Steps

Get organized for easier, more productive appeals

When your practice receives a denial on a claim, do you have a plan of action for dealing with it? If not, you could be losing out on reimbursement you might win back rather easily with a streamlined appeals process.

Reporting proper CPT and ICD-9 codes is the most vital responsibility of the coder, but knowledge of denials and appeals is also important. Even if appeals aren't your direct responsibility, cleaning up your reporting can help your office's bottom line.

Practices lacking an appeals strategy should implement one immediately. Use this six-step plan as your guide to formulating an effective appeals process. If your office already has an appeals procedure, check it against this plan to see if your practice is getting everything it can out of appeals.

1. Focus Your Appeal Efforts

Review past data on appeals and determine patterns that have led to repeated denials in specific areas, says **Rebecca Buegel, RHIA**, director of HIM and privacy officer at Casa Grande Regional Medical Center in Casa Grande, Ariz.

For example, if you are having consistent trouble with a carrier paying for placement of a central venous catheter and a separate E/M service during the same visit, concentrate on forming an appeal for this situation.

2. Respond Appropriately to Denials

Denials are classified using one of four Explanations of Benefits (EOBs); one EOB will appear on each refused claim. Refer to "Read EOBs Before Responding to Denials" on page 3 for tips on dealing with EOBs from payers.

3. Document, Then Document Some More

The more information you present in your appeal, the more likely it is that your claim will be accepted upon resubmission. Appeals should always include supporting documentation for your coding and billing choices, and information from outside sources backing up your claim is also helpful.

Insurers are more likely to consider appeals evidence from sources such as the CPT manual, the ICD-9 manual, CPT Assistant, the Coder's Desk Reference, the National Correct Coding Initiative edits (even though they technically apply to Medicare, they support your arguments), Medicare carriers' local medical review policies (even though they don't bind insurers, they support your arguments), and your national specialty society.

Use specific cases as examples, but deal with the encompassing issue - bundling, E/M requirements, etc. - so you can't be denied on the service again.

4. Get Personal Without Getting Mean

Before you resubmit a claim, call the insurance company you are appealing to and ask who will be handling the case. Make every effort to talk to that person on the phone before submitting your appeal.

Buegel calls this human connection "incredibly important. If there's someone at the company you know and work well with, you'll want to deal with that person as much as possible" for future denials.

Talk to the carrier's representative to let him know what you are appealing. Address your appeal letter to the person you speak with, not just to the insurance company or to a generic claims department. Don't undervalue this step; it holds a person responsible for your appeal rather than an anonymous department.

Buegel says to be sure that your letter includes the physician's notes, documentation from earlier evaluations, reasons you chose the codes you did, and your explanation as to why it is a legitimate claim.

The letter should state exactly how the insurer should pay the claim, especially if your contract supports your position. In the conclusion of the letter, include the filing deadline for clean claims in your state, just to let the insurance carriers know that you know the rules of the game.

Don't let your frustration get the best of you when writing an appeals letter. Be tactful and gentle with your words; a peeved payer will be less sympathetic to your cause than a payer you have treated politely.

5. Get the Patient Involved

According to **Thomas Kent, CMM, CPC**, of Kent Medical Management in Dunkirk, Md., the approval of a patient can help support your cause during an appeal. When you send your appeal to the insurance company, send a copy of the appeals letter to the patient explaining the situation. If you don't, the insurer may talk to the patient first, and the first side to make contact is very often the side that the patient ends up supporting.

6. Keep Up With Appeals

Rejected claims should be tracked in order to reduce trouble with future claims. Keeping records of each patient's services - and keeping those records under the appropriate appeals category - is the best way to stay organized. The record can be paper or electronic, but should include the patient's name, the date of service you're appealing, a brief overview of the appeal, and the date you sent it.