

## Optometry Coding & Billing Alert

### Build a Better Business: Improve Appeals Success With Loophole-Free Documentation

Get the ball rolling on your claims with this bulletproof checklist.

Even when you think you've done everything right -- double-checked diagnosis codes, included detailed patient information, gotten a signed advance beneficiary notice (ABN), etc. -- Medicare may still deny your claim.

When you know that Medicare should pay, use these checklists to get all the money your practice deserves.

#### Checklist 1: Determine the Payer Made an Error

If you receive a denied or underpaid claim, you first have to make sure that the denial isn't a result of the way you filed the claim. To do so, follow these steps outlined by **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CENTC, CHCC**, president of CRN Healthcare Solutions in Tinton Falls, N.J.:

- Read denial codes on the remittance advice to determine the payer's reason for denial or underpayment.
- Audit and review all the coding documentation.
- Ensure the documentation supports what was billed.
- Determine that the payer made an error.

Once you've determined that the payer made an error, you can write a letter expressing why you think your carrier should pay the claim. Just remember that Medicare requires that you file your request within 120 days of the date of the initial determination notice. Check with private payers to find out their time limits.

#### Checklist 2: Follow Medicare's Style

Medicare prefers that you follow certain guidelines when you write appeal letters, so start off on the right foot by writing your letter correctly. Be sure to use the following guidelines:

- Keep the language simple.
- Do not use abbreviations or jargon.
- Write in a positive, not negative, tone. Avoid words or phrases that emphasize what cannot be done.
- Avoid one-sentence paragraphs and uneven spacing between paragraphs.

#### Checklist 3: Use the Correct Letter Format

Correct formatting allows the reviewer to get to the heart of your letter -- your appeal -- more easily.

Implement these style conventions to ease the appeals process:

- Use the format April 20, 2007, instead of 4/20/07.
- Use at least a 12-point font size, and stick with the Universal or Times New Roman fonts.

- Use bullet points to clarify lengthy or complicated subject matter.
- Use headings to break up a long letter. For example, headings like "Decision," "Background" and "Rationale" are acceptable.
- Associate the code with the procedure name when citing procedure codes.
- Don't use span dates for one date of service.
- Avoid using all capital letters because it makes your correspondence appear impersonal and computergenerated.

#### Checklist 4: Structure Your Letter's Content Wisely

Next, you should focus on the content. Make sure you do the following in your appeal letter:

- Include a contact person and her phone and fax numbers.
- Explain what Medicare underpaid or didn't pay.
- Explain why the coding was correct and why the claim should have been paid.
- Explain which rule you based the appeal on.
- Include any documentation to support your point, including coding information from books, or rules and regulations as set by federal and state government and from local carriers.

Bottom line: Getting the money you've earned is a top priority. Stay on top of the tricky appeals process by referring to these checklists whenever you're hit with a denial or an underpayment.