Optometry Coding & Billing Alert

Build a Better Business: Master the Art of Working With -- or Around -- Problem Payers

Follow this 3-step path and get results from every payer.

Streamline your collections system and get your deserved money faster with these practice management tips. Optometrists: Clip and give this monthly section to your claims specialist.

At some point in her career, every biller deals with them. They are problem payers -- and they can wreak havoc on your billing and on your practice's income. Payment delays, improper denials, and claim rejection errors cause more work for you and can be a serious hurdle in getting the timely payment your physicians deserve. Take a look at the three steps the experts recommend you take to work with problem payers to successfully -- and hopefully painlessly -- bring in the money for your physicians' services.

Step 1: Research the Original Claim

Your first step when you discover that you have a problem with a payer is to do research. If you're facing payment delays, find out why. If you're receiving improper denials, look at the denial reasons the payer is giving you on your explanations of benefits (EOBs).

"My first step is to ascertain and review the status of that claim. I try to gain the 'what and why' of the situation and then address the particular issue," explains **Cheryl Nash,** director of operations and senior account rep at American Physician FinancialSolutions in Colorado Springs, Colo.

Payment delays: Check online to see if you can find any relevant information about current problems with particular payers.

Example: Cigna has been delaying payment for all Illinois patients, says **Gaye Pratt,** coder/biller for Vincent P. Miraglia, MD, in Stuart, Fla. "I have claims from December that still haven't been paid," Pratt laments. "Cigna has posted a letter on their Web site, dated 2/23/09, stating the delay is because the State of Illinois can't pay their bills. And although that letter was dated 2/23/09, when I called Cigna [recently], they stated the claims were still on hold since they still had not received money from the State of Illinois to date."

Improper denials: You first need to determine if the payer made an error. If you receive a denied or underpaid claim, you have to make sure that the denial isn't a result of the way you filed the claim. To do so, follow these steps:

1. Read denial codes on the remittance advice to determine the payer's reason for denial or underpayment.

2. Audit and review all the coding documentation.

3. Make sure the documentation supports whatwas billed.

4. 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 payer should pay the claim. Just remember that Medicare requires you to file your request within 120 days of the date of the initial determination notice. Check with private payers to find out their time limits for payment appeals.

Step 2: Contact the Payer

CPT® 2023 American Medical Association. All rights reserved.

Your second step should be to contact your payer. Call either the provider relations number or your payer representative to discuss the issues your practice is facing. "I have found that 90 percent of denials, improper payment amounts, delayed payment, etc., can be turned over by a simple (or notso-simple) phone call," Nash says. "The reps at the payer are not as well-trained as we would like to think, but we are." Usually by just quoting terms of your provider's contract, Correct Coding Initiative (CCI) edits, proper coding, timely processing and review guidelines, etc., you can get your claim issues taken care of, experts say. You may also want to ask to speak to the provider representative's supervisor.

Don't be shy: Persistence is often the key in billing and collections efforts. "If you know you are right, then you have to fight for it," Nash says. "Call and demand that any issue be addressed. Insist on speaking with people that have authority to make changes."

Have a set schedule in your practice that establishes when you will follow up on a claim and when you will follow up with a payer about payment issues and appeals as well. Also, make sure you know what you're talking about. "Knowing how something works is more than half the battle," Nash says. "Remember, the reps at the insurance company do not have the experience or education that the coders/billers have. You are the expert."

Important tip: Document as much information as you can, Nash stresses. "The name of the rep, reference number for [the] call, everything they told you, etc. These are your 'weapons' for later use in the appeals process." If possible, get the rep's e-mail address, and send her a confirmation e-mail restating the final resolution of your call, so that you have everything in writing relating to your follow-up.

You should also remember that if the payer made the mistake and incorrectly processed your claim, you should not have to appeal. "If the insurance incorrectly processed a claim, due to incorrect contract rate, improper bundling, etc., it is their responsibility to process it correctly according to the CPT/ ICD-9 rules," Nash explains.

However, if the payer refuses to reprocess, you may have to appeal. If this is the case, experts recommend that you copy your state medical society and possibly your state department of insurance or equivalent department. In the letter you can state that you should not have to be appealing, since the payer incorrectly processed the claim, but that you understand that this is the only way to get the claim paid.

If the payer denied your claim due to issues with medical necessity, improperly quoted benefits, etc., you will have to appeal. "Most appeals are won at the second level, and this takes time," Nash warns. However, they can still be won -- and paid. "I just got one [paid] that was one-and-a-half years old," he says.

Step 3: Refile If Necessary

Whether the issue is a payment delay or an improper denial, you will likely want to refile your claim. For a payment delay, resend your claim, and include a letter explaining when you sent the first claim and telling the payer you expect timely payment. You can also include a proof of timely filing from your clearinghouse. You should be receiving a report from your clearinghouse confirming receipt of the claim by the payer. This report is called a 997 Acknowledgement of Receipt. "My first step is to send a second claim with the notation that I will report untimely claim payments to the state insurance commissioner," Pratt says. "Usually this works."

If you're appealing a denial, follow these steps:

• Identify the incorrect processing so you can appeal the incorrect or non payment.

• Pull any supporting documentation (the original patient chart, notes regarding the treatment and medical necessity, etc.).

• Call the payer to verify whether you can refile the claim by phone or fax or if you need to mail a hard copy with a written appeal and the documentation to the carrier.

• If the payer does not accept appeals by phone or fax, mail in the documentation with an appeal letter.Include a copy of the original claim and the EOB(remittance advice) that shows the incorrect reimbursement, along with a cover letter explaining why the insurer should reimburse the claim differently.

CPT® 2023 American Medical Association. All rights reserved.

• If you refile the claim by phone or fax, expect the carrier to take about 10 days before responding; allow a month for responses to appeals you mail.Once that time period has passed, begin following up until the payer responds.

Caveat: You should not automatically submit identical, duplicate claims to payers when you don't think you're getting timely payment. Duplicate billing tops most payers' lists of billing errors. Some insurance companies, including Medicare, consider duplicate billing worthy of fraud investigation. Additionally, a claim that a payer has already processed and that you are just resubmitting will be returned as a duplicate payment/claim, and not receive the attention that you wish it to be given.

Best bet: If you have not received payment after 30 days and are concerned about your payment, contact the payer. A call to the customer service department or to your payer representative should get you answers and will avoid future hassles from duplicate billing. Also, review your electronic system logs (997 Acknowledgment of Receipt Reports which should be reviewed as they are received) to confirmthat the payer received your claim.

CPT® 2023 American Medical Association. All rights reserved.