Codify
BY AAPC

Optometry Coding & Billing Alert

Reader Question: Cookie Cutter Appeal Letters Won't Bring In the Cash

Question: After checking to be sure we haven't made a coding or billing entry error, our practice automatically appeals payer denials using a standard letter. We don't seem to be very successful in ultimately getting payment. How can we improve our appeals process?

Louisiana Subscriber

Answer: Before you begin the appeal process, first check the payer's policies. If, for example, the payer has a policy that bundles A-scans (76519) into any E/M services performed on the same day and will not be reimbursed separately, don't appeal these. Writing appeals is time-consuming enough, so you don't want to waste time on appeals you cannot win because there is already a specific policy in place.

Next, be sure you follow the payer's appeal procedure exactly. Often, the address to submit appeals is different from the claims address, and some payers require you to send a special form with the appeal.

Get specific: Rather than sending a generic appeal letter for every denial, customize yours with the appropriate key words for each situation. For instance, suppose you submitted a claim for an E/M service and injection on the same date. On the claim, you appended modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M service code, but the payer still denied it.

Instead of sending a letter stating "the claim was submitted correctly," send a letter that addresses the specific claim and the specific reason(s) why modifier 25 was appropriate. Further, you should quote industry guidelines (such as CPT and/or CMS guidelines) and, if available, the insurance company's own guidelines. And always send the medical record documentation, copies of photos, or any other evidence to support the service that was rendered and considered medically necessary.

Tip: Composing appeal letters can be time-consuming. But you can save time by identifying your most common denials and creating fill-in-the-blank appeal letters for each of these scenarios.

For example, you may find that you receive many denials for bundling issues even when you use modifier 59 (Distinct procedural service) properly. Chances are, the letters you compose will start and end basically the same. By creating a base template, you can concentrate on filling in the details for each claim instead of writing each one from scratch. But at the end of the day, only the medical record documentation really supports unbundled services and should be included as an attachment to the appeal request.