Part B Insider (Multispecialty) Coding Alert

Appeals: 10 Denials You Should Always Appeal - No Matter What

Make sure you're getting your fair share by paying attention to the basics

If you're taking denials lying down, you could be letting Medicare roll over you to the tune of thousands of dollars per year in well-deserved reimbursement.

The reason why many claims get denied may surprise you, says **Quinten Buechner**, president of Wisconsin-based **ProActive Consultants**. A conversation with an assistant director of a Medicare carrier finally shed some light on the rejections process for Buechner. "I mentioned to him that 95 percent of the appeals that I processed to them were paid." So, if the carrier kept losing at fair hearings, why didn't it just "straighten up the rules?" Quin asked.

The answer: Medicare never sees 93 percent of the services the program rejects in appeal. "Nobody appeals them, nobody sends them back" and so policies remain unchanged, explains Buechner, who recently presented the teleconference, "Mastering Non-Physician Practitioner **Coding Compliance and Reimbursement** ," for **Eli Research** and **The Coding Institute**. Claims that involve NPPs tend to hit more snags "simply because not everybody is caught up to the 21st century," Buechner notes.

Warning: If your billing services are not involved in appeals, you better find somebody who is, because "you are losing money," he says.

Key: If Medicare is denying your claims because they fall under one of these "top 10" rejections, then here's when Buechner says you can - and should - appeal:

no documentation of service;

no signature or authentication;

always assign the same LOS;

consult vs. outpatient/office visit;

invalid codes due to old resources;

unbundling of procedure codes;

misinterpreted abbreviations;

no chief complaint listed or reflected;

global fee service billed separately; and

inappropriate or no modifier used.