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Part B Insider (Multispecialty) Coding Alert

Appeals: NGS: You Can Add Modifiers, Op Notes Only During This Stage of Appeal

One Part B MAC illuminates the five appeal stages in crystal clear detail.

It happens from time to time—you submit a claim, but realize after you get a rejection letter in the mail that you missed a key detail that would have prompted the payer to reimburse you for the claim. Fortunately, you can add that information during the first level of appeal, said NGS Medicare's **Gail O'Leary** during the MAC's March 15 webinar, "The Appeals Process and How to Avoid Appeals."

How Redetermination Can Work for You

There are five levels of Medicare claim appeals, O'Leary said, with the first being redetermination. "This is performed by the MAC," O'Leary said. "Redeterminations must be submitted within 120 days from the receipt of your initial claim determination, and there is no minimum dollar amount in controversy requirement." The MAC will typically make a decision within 60 days of receiving your redetermination request.

At the redetermination level, you should attach supporting documentation such as operative notes and progress reports to help back up your claim for payment, O'Leary added. "You don't have to submit a separate request for each line on a claim, so if you're appealing a claim with five lines of service, you would submit one request appealing all five lines on that claim. This is a much faster process for you because you only have to complete one request form and it's faster for our processors because they can work the appeal on the entire claim in one request."

During the redetermination stage, you can add modifiers such as 22, 52, 53, GA, GY and GZ to the claim if you forgot to add them the first time around. "Additional documentation will need to be provided to warrant the addition of that modifier," O'Leary said. In fact, anything requiring a deeper analysis such as modifiers or op reports should be sent during the redetermination level because clinical staff members are available to review the information at this stage of appeal.

Documentation can help appeal things like denials for cosmetic surgery—which is typically not covered—in cases where the patient's service should actually be paid, such as cosmetic reconstruction after cancer surgery.

Know before you go: Of course, CMS contractors urge practices to avoid having to appeal at all—you can do this by researching policies before you bill in the first place. "I can't stress enough the importance of researching the NCDs and LCDs before you bill for a service," O'Leary said. "There are certain procedures and diagnosis codes that are covered, and reviewing the NCDs and LCDs before you bill can have significant outcome on your initial claims decision."

Get to Know the Other Four Appeal Stages

The next appeal level after redetermination is reconsideration, which is performed by the qualified independent contractor (QIC). "Requests for the second level of appeal must be submitted within 180 days of receipt of the redetermination decision, and like a redetermination, there is no minimum dollar amount in controversy requirement," O'Leary said. You should get a decision within 60 days at this stage.

The third level is when the claim goes to an administrative law judge (ALJ) for a hearing. "ALJ requests must be submitted within 60 days of receipt of the decision by the QIC, and at least $150 must remain in controversy to appeal at this level." You'll get the ALJ's decision within 90 days of the hearing request.

Stage four is a review by the Medicare Appeals Council. "A request must be submitted within 60 days of receipt of the ALJ decision, and there is no monetary threshold to be met at this level," she said. You'll get a response within 90 days.

The final appeal level is judicial review in a federal district court. You have 60 days to file at this level after getting a decision of the Appeals Council, and at least $1,500 must remain in controversy to file at this fifth level of appeal, O'Leary added.

What's a Reopening?

You may have noticed that none of the five levels of Medicare appeals included the term "reopening"—but contractors talk about this process frequently. What's the difference?

"Reopening is a process for correcting a minor error or omission on a claim without having to go through the formal appeals process," O'Leary said. "It's a completely separate process from Medicare appeals."

You would launch a reopening for issues such as asking the MAC to fix a clerical error you had on your claim or if you realized you put the wrong rendering provider's number on the claim form. You can also change the charge for a service, the date of service (as long as it's in the same calendar year), change the place of service, or fix an incorrect CPT® or ICD-10 code, O'Leary said. You can even add a modifier to indicate the service is not a duplicate of another service on the same date, she added.

Unfortunately, you can't use reopening to add a line of service that wasn't on the original claim, claims that have already started the appeals process, or claims that require the date of service's year to be changed, among other issues.

Use Your Judgement for 'X' Modifiers

Because many denials (and therefore appeals) are rooted in billing code pairs together that are restricted by CCI edits, NGS reps touched on the subject of modifiers during the call.

As most practices are aware, CMS issued four new "X" modifiers last year to provide more specificity than modifier 59 (Distinct procedural service) offers, which can be particularly helpful when billing services together that are normally bundled. "CMS is still continuing to recognize the 59 modifier in many instances, but we always try to tell providers if your coding combination meets the definition of a distinct modifier, you would want to use that in place of the 59 modifier," said NGS's **Lori Langevin** during the March 15 webinar. The "X" modifiers are as follows:

XE: Separate encounter
XS: Separate structure
XP: Separate practitioner
XU: Unusual non-overlapping service

"If you feel that they are more specific than the 59 modifier, then that's what you should use on the second procedure code in a [CCI] listing," Langevin added.