

## Part B Insider (Multispecialty) Coding Alert

### Appeals: Thoroughly Investigate Your Denials with These Expert Tips

**Hint: Back up your claims with solid evidence.**

Maybe you've always wanted to do some private investigation work, or perhaps you enjoy watching sleuthing shows on television - either way, you can put these skills to the test if you have some denials on your desk. By being the lead investigator of your own appeals process, you can find the reasons behind your denials and hopefully reverse them.

#### Review Remark Codes

It's easy to miscommunicate if you're speaking a different language. Make sure you understand exactly what a payer requires - and then format your appeal letter and claim accordingly.

"Look at the remarks codes on the explanation of benefits and address those specific edits," says **Terry Fletcher, BS, CPC, CCC, CEMC, CCS, CCS-P, CMC, CMSC, CMCS, ACS-CA, SCP-CA**, owner of Terry Fletcher Consulting Inc. and consultant, auditor, educator, author, and podcaster at CodeCast, in Laguna Niguel, California.

"Don't hand them back the same medical record; they're just going to deny it again. Address the remarks codes; the missing information and bundled services are a lot of the common reason for claims denials. Payers often look for additional diagnostic information or an additional op report or lab report or result and won't pay the claim until they receive this documentation," she says.

The explanation of benefits (EOB) or explanation of Medicare benefits (EOMB) will be your compass rose in navigating the error codes or denial codes that you need to understand and utilize in order to get your claim and appeal processed successfully. The error or denial codes are often at the bottom of the EOB or EOMB, Fletcher says.

#### Check Bundling Issues

Many claims are denied because of incorrect coding - due to bundling. This could be another example of accidentally not speaking the same "language" as the payer, and it's easy enough to correct.

Do a mini investigation, asking, "Is this actually bundled? Is this something we should have billed? Did we use the right modifier?" she suggests.

Fletcher continues, "Address those edits, those specific denial codes, and when you look at those you'll actually be heading in the right direction."

#### Utilize Regulations, Correct Citations for Context and Support

While making sure that your appeal is legitimate, your responsibility includes due diligence on research. Citing proof that you're playing within the rules protects you and boosts your appeal, but it also means holding up your contractual obligations.

"You also want to make sure, if you are going to give an appeal letter or cite an appeal letter, that you're giving regulation. There's nothing worse than when I see a practice saying, 'You need to pay me because you didn't pay me before,'" she says.

"I had a practice that didn't like their fee schedule; there was nothing wrong with the claim, they got paid what their contract was, but they said 'Yeah, they didn't pay us enough, so we went ahead and rebilled it and asked for money,'" Fletcher recounts. This is inappropriate, and you should avoid it.

**Bottom line:** "We want to make sure we are using that regulatory information, citing CPT® language, and that's one of the best ways to fight claims. It tells you directly what you can and can't do and it also basically gives you the language to use within your appeal letter," Fletcher says.

### **Bring in the Patient**

One may forget that the patient is central to the whole claim/denial/appeal process. If you stay on top of your denials and appeals, you have more time to involve the patient, if necessary, which could mean a better outcome for both the patient and your practice.

"Remember you're appealing on the behalf of the patient, who's the actual subscriber, so ask for specific internal criteria on which the payer is basing the denial. This information goes beyond the reason-denial code, and it can also help providers craft an argument to fight the denial," she says.

### **Know Your Contractual Rights**

Figure out who is reviewing the claim and issuing the denial. If the reviewer's credentials don't necessarily suggest a knowledge base or background that are qualifying to understand the procedure or encounter in question, you have an avenue forward.

"Demand a peer review" in these cases, Fletcher advises.

Many denial letters are signed by nurse case managers, but nurses may not always have the expertise to really understand the minutiae and nuance of the specialty encounter. In cases like these, you may need to get a physician involved.

"It's in every payer contract: A physician in the same specialty with the same credentials reviews the appeal," she says. If your physician can make a case for medical necessity, demand a peer review and use the extra time to make sure your physician documented everything comprehensively and properly.

"Instead of relying just on the nurse case manager, make sure you're looking for the peer review, because that's going to make a huge difference when it comes to getting the outcome that you want in that collection process," she says.

### **Be Timely in Your Appeals**

While the timeline ceiling for getting appeals in may seem expansive, you're doing your patients and practice a disservice - and creating more headaches for yourself - if you let the denials languish on your desk.

"File your appeals within 45-60 days after you receive the denial. This may go beyond a payer contract or against many consultants that I know who will tell offices 180 days; I disagree with that. The fresher the claim denial, the better chance you have of it not being archived in the payer system," Fletcher says.

Starting early gives you the time you need to pursue all avenues of research and preparation. This may involve researching regulations - including provisions of the Affordable Care Act, for example - as well as speaking to the patient, pulling reports, scrutinizing documentation, and fully understanding what you're looking at.

"Have all of your ducks in a row before you submit the information," Fletcher stresses.

### **Send to the Correct Department**

If you're sending your appeal requests to the same place you're sending initial claims, yet not hearing back, your requests may be getting lost in the system. Luckily, there's an incredibly simple fix: double-check the address for the particular department you're trying to reach.

"Make sure you're not sending appeals to the claims post office box where you'd submit a claim. There's a different department for this, so that will get lost in the shuffle and they will not address that issue. Always keep that in mind,"

Fletcher says.