Part B Insider (Multispecialty) Coding Alert

Denial Management: Respond Appropriately to These 5 Common EOB Denials

Know the denial codes and then set a course for appeal when applicable.

All explanations of benefits (EOBs) for denials are not alike, and if you can't distinguish between them, your appeals could be worthless. Review these common EOB denials and respond adequately to ensure that you don't let any reimbursement opportunities fall through the cracks.

N643 Denial: The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule

Your response: Don't appeal. Bill the patient if you have an ABN.

You don't have to worry about appealing denials with the "non-covered" denial. It means the contract between the subscriber (that is, the patient) and insurer says that the insurance won't cover the patient's cost for this service. Your insurer hasn't short-changed you or violated your contract. If you see this denial code on your EOB, you can bill the patient, but only if you had the patient sign an advance beneficiary notice (EOB) at the time of service.

M81 Denial: You are required to code to the highest level of specificity

Your response: Check your ICD-9 codes. Appeal if there are no higher levels.

Correct coding requires that you code as specifically as possible. That means your physician should assign the most precise ICD-9 code to a service. You cannot justify a service with a four-digit diagnosis code when ICD-9 requires a more specific five-digit code to describe the patient's condition.

Using the fourth or fifth digit when it is required--or just when you do have that information--is an important concept to follow. Make sure you review the entire record when determining the specific reasons for the encounter and the conditions the physician treated.

Don't assume what isn't in the medical record. For instance, If you are coding for deep vein thrombosis (DVT), you cannot simply report 453.4 because four digits alone don't make for a complete diagnosis. Instead, you must specify a fifth digit of 0 (for DVT of unspecified vessels of lower extremity), 1 (for DVT of proximal lower extremity) or 2 (for DVT of distal lower extremity). If the medical record does not allow you to code to the required level of specificity, check with the reporting physician for guidance.

ICD-10 heads up: If you're prepping now to eliminate this rule under ICD-10, think again. The new diagnosis coding system, much like the current one, will require you to always code to the highest level of specificity as well.

N661 Denial: Documentation does not support that the services rendered were medically necessary.

Your response: Check your diagnosis codes. If the denial appears as a downcoded claim, appeal it.

This denial code tells you that the physician's notes don't support the service, and this can often be tracked back to a diagnosis code that isn't considered payable under the CPT codes you reported. An example of improperly diagnosed claims would be an encounter form listing a sprained ankle diagnosis first, and fever second, to justify a urinalysis. The fever and any other applicable symptoms need to occupy the primary diagnosis spot to support medical necessity for the urinalysis.

Appeal "not medically necessary" denials on downcoded claims. Insurance companies may say a diagnosis doesn't support a particular level of service, but they can't determine a level of service based on a diagnosis code without looking at documentation. Appeal these claims, but check to see that you're using the most specific diagnoses codes for all documentation, and avoid unspecified diagnosis codes.

M15 Denial: Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

Your response: Check the National Coding Correct Initiative (NCCI) edits.

Make sure insurers are following CPT and the NCCI edits on these claims. Insurance companies shouldn't make up their own bundles, unless, of course, they explicitly add them to a contract you approve.

Look out for denials for bundled services that the most recent quarter of NCCI edits rescinded. Check to see if your payers are up-to-date on what the NCCI edits have withdrawn as well as bundled.

MA22 Denial: Payment of less than $1.00 suppressed

Your response: Wait for your next payment and ensure that the money is in it.

When your MAC sends you this denial code, it means that the payment due to you is below one dollar, and therefore the MAC is holding the payment. However, it doesn't mean that you can say goodbye to that pocket change, since every practice knows that these amounts can add up to significant cash over time. Instead, your payer will simply hold the money until the next time you're due a reimbursement payment. The money should be included in that next check.

Therefore, if you get this denial code, sit tight. Before appealing or contacting your payer, wait to see if the money is included in your next reimbursement check. If not, then contact the MAC.