Part B Insider (Multispecialty) Coding Alert

Medicare Appeals: Boost Appeals Success With 3 Expert Tips

Hint: Understand the 'why' of the appeal.

When you're a Medicare Part B provider, you're allowed to appeal claims decisions you disagree with. However, if you lose more appeals than you win, you may be missing some key steps.

Follow these expert tips to improve your chances of avoiding - or winning - appeals.

Tip 1: Check Twice, Submit Once

Before you file a Medicare claim, you should double check a few details that could lead to a denial.

Coverage: All Medicare claims rely on documentation that the procedure is medically necessary, as evidenced by the diagnosis code in the claim. Some claims, such as screening tests, also rely on frequency limits to determine coverage.

If you'd like to reduce the number of claims that are on your appeal list, take the following steps:

- Ensure that the medical record documents a diagnosis that demonstrates medical necessity for the procedure.
- Check whether the patient is in a global surgical period.
- "Prior to submitting a claim for a service that has a utilization or a frequency limit, review previous claim submission and dates and refer to the applicable LCD or NCD policies," says **Jazz Harrison,** senior provider education consultant with Part B Medicare Administrative Contractor (MAC) Palmetto GBA.
- In addition, check for National Correct Coding Initiative (NCCI) edits, and medically unlikely edits (MUEs), she advises.

"You can often avoid having to submit an appeal if you make sure that the required diagnosis code or codes are present on the claims you submit," adds **Swandra Miller,** senior provider relations representative with Palmetto. "Some services must be billed with both a primary and a secondary diagnosis to be covered by Medicare, so it's important that you look to see if the secondary diagnosis is included on the claim," she explains.

Bonus tip: Some denials are due to Medicare Secondary Payer (MSP) issues, so always check to make sure Medicare is the primary payer before you submit your claims.

"MSP provisions prevent Medicare from paying for items and services when other health insurance coverage is primary," Miller says. "When Medicare is secondary, the primary payer must pay first."

Tip 2: Know Why You're Appealing

Whether you're facing a claim denial or an overpayment request, you'll need to scrutinize the Medicare statement before you can know how to proceed.

"Read the remittance advice before you submit an appeal," Miller advises. The documentation you submit in your appeal needs to address the specific reason that Medicare denied the service.

For instance, if you've submitted two codes that are subject to an NCCI edit but the medical record shows that the

procedures involve different anatomic sites, you may need to submit the documentation and use an appropriate modifier such as 59 (Distinct procedural service) when you appeal the claim.

Overpayment: If a payer indicates that you were overpaid and requests money back, you may not always agree - but you have a right to appeal. If you do pursue this route, always include a copy of the overpayment letter with your overpayment appeal, Miller says.

"If there are multiple claims included in the overpayment letter, please make it clear which claim(s) you're appealing," she says. "The appeals department must be able to identify all of the overpayments being appealed to stop collection activities on those receivables."

Tip 3: Upcoding Request is an Appeal

If you've followed tip 1, you should rarely find yourself in the position to deal with tip 3. However, if you think you made a mistake on a claim and submitted a lower procedure code than you should have, you can file an appeal. Make sure to attach the medical records with your request.

"Upcoding requests are handled as appeals, even when they're sent with the reopening request form. They are subject to the appeals time limits and must be reviewed to determine if the higher-level code is appropriate," Miller says.

In addition, don't forget to change the billed amount on an upcode request. "If you're asking to change the HCPCS code to one that has a higher allowed amount, don't forget to request that the billed amount also be changed. The appeals department will not change the billed amount unless they are specifically asked to do so," Miller says.