Outpatient Facility Coding Alert

Reimbursement: Deal With Your Denials in the Right Way

Understand the different level of appeals and prepare your claims!

You don't need to fret over denied claims anymore. Read the denials and know what they mean so you can file an educated appeal. If you are unsure how to do this, reach out to the payers for help.

Know How to Go Up the Appeals Ladder

There are five levels of appeals for Medicare denials, Affordable Care Act (ACA) says. Understanding how these levels build on each other is your first step toward understanding the appeals process.

Level 1: Redetermination: You can submit the appeal with proper paperwork within 120 days. The only hitch here is that this would go to the Medicare contractor that first denied the claim, so you can only keep your fingers crossed.

Level 2: Reconsideration: This time, you have to submit the appeal within 180 days from the date you received the redetermination. A Qualified Independent Contractor (QIC) reviews the claim. You stand a better chance of having a successful appeal here.

Level 3: Administrative Law Judge (ALJ) Hearing: No respite at level 2? You can go on to file a request within 60 days of the reconsideration. The QIC prepares the case file and forwards it to the HHS Office of Medicare Hearings and Appeals. CMS assigns cases, and they have 90 days to decide on the appeal. DCs have a chance to appeal to a live, impartial person rather than to an insurance carrier.

Level 4: Medicare Appeals Council (MAC) Review: No success at the ALJ? You may then go ahead and file a request to the Department Appeals Board (DAB) for a MAC review within 60 days from the date of the ALJ hearing decision.

Level 5: Federal Court Review: Fight until the end! You may file a request for a federal court review within 60 days of the DAB's decision.

ACA is working on creating a national database of appeals to determine trends or find examples of what has worked in the past.

Takeaway message: "Always appeal. Even the smallest amounts," says **Steven Conway, DC, DACBOH, Esq.,**a member of ACA's Medicare Committee in an article in ACA NEWS. "If we don't, the insurance companies and Medicare contractors will assume that we agree with their decisions and we'll never be able to move the profession forward."

Staff often won't appeal a denial because it's time consuming and they might not have the time to devote to the process. The payers know they can sometimes get away without paying claims because staff won't do the work to get the reimbursement, even if they know they deserve the payment. When you are appealing you need to be a bulldog and not back down.

Understand the Reason for Top Outpatient Denials

It also helps to be aware of outpatient services that are frequently denied so you can prepare accordingly. These denials are some listed in Jurisdiction 11 Part A: Top Denial Codes Outpatient Services (2014).

5D164/5H164 - Documentation Does Not Support Medical Necessity: Medicare pays for only those services that are considered reasonable and necessary. All tests your providers conduct should be needed in order to diagnose and manage the patient's illness or injury, or to improve the function of a malformed body part. The provider should submit

complete documentation to substantiate the services rendered.

To prevent this denial, ensure your providers document the following:

- All diagnoses and diagnosis codes in the medical records for the patient
- Signs and symptoms that prompted the services/tests billed
- Reason to justify the frequency of services above the accepted standard (such as any applicable information regarding medication changes, recent changes in the disease process, etc.).

Example: Increased frequency of thyroid testing would be payable more than two times a year if documentation supports changes in treatment or when documentation of exacerbation of disease is present.

56900 Auto Deny - Requested Records not Submitted: Medical records were not received in response to an ADR (Alternative Dispute Resolution) in the required time frame; therefore, we were unable to determine medical necessity.

To prevent this denial, monitor your claims status and keep a watch for any ADR returns that will be time-sensitive. Gather all information needed to reverse the denial and submit everything together. Include a copy of the ADR request and any supporting documents to each individual claim.

Return the medical records to the address on the ADR within 30 days of the ADR date. Be sure to include the appropriate mail code to ensure your responses are promptly routed to the Medical Review Department.

5D169 - Services Not Documented: Claims might be partially or fully denied because the provider billed for services/items not documented in the medical record submitted.

To prevent this denial submit all documentation related to the services billed. Also ensure that results submitted are for the date of service billed, the correct beneficiary and the specific service billed. For more information, refer to the Code of Federal Regulations, 42 CFR Sections 410.32 and 424.

5D164/5H164 - No Documentation of Medical Necessity: These claims are fully or partially denied because the documentation submitted for review does not support the medical necessity of some of the services billed.

To prevent this denial, submit all documentation related to the services billed which support the medical necessity of the services. Verify that you're using the most appropriate ICD-9 diagnosis codes to identify the patient's medical diagnosis.

The key take away message is never give up, always appeal and fight though the process even if it is painstaking and time consuming. And needless to say, you need to ensure your claims are correctly prepared and are processed timely.