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Chiropractic Coding & Compliance Alert

Reimbursement: Appeal the Right Way to Reverse Your Denied Claims

Is the denial administrative or clinical? Prepare accordingly.

You don't need to fret over denied claims any more, thanks to advice from the American Chiropractic Association (ACA) on the common reasons for denials and how to overcome them. "Read the denials and know what they mean. If you are unsure reach out to the payers for help," says **Doreen Boivin, CPC, CCA,** with Chiro Practice, Inc., in Saco, Maine.

Read on for a lowdown on survival strategies in this world of denials.

Know the Type of Denial First

The first thing to know is which type of denial you are faced with, whether an administrative denial or a denial on a clinical basis. Then you can act accordingly, as each requires a different strategy to resolve.

An administrative denial is actually not that big a challenge; you can go back and correct the mistake in the system, and reprocess the claim.

Resubmitting claims: You can resubmit a claim if you realize that you missed some details in the first appeal.

Example: Many insurers will deny claims that include an E/M and a CMT code on the same day. In such a case you need to use the 25 modifier (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service). If you forget to put that on the claim form, you can send a letter with an explanation and a corrected form. Read "Safeguard Your E/M Services Payment for the New Patient" in Chiropractic Coding and Compliance Alert (Volume2, Number 3) to know how to code in this scenario.

Many insurance companies are requiring prior authorization for certain treatments, which you may sadly be unaware of. And once the arrow has left the bow, i.e. if you've already sent in a claim, you can't go back and submit an authorization in retrospect.

"Always verify the patient insurance benefits prior to the visit so you know before the visit if a prior authorization is needed," explains Boivin. " This way it's a good thing for the patient and your office."

Diagnose the Denial Grounds

Here are the three top reasons for Medicare claims denials as found in an ACA Special Study audit:

- 75 percent of the time, requested records are not sent in.
- Lack of proper provider signatures.
- Issues about the medical necessity of certain treatments.

Know how: ACA also cautions DCs of a new trend. Medicare now wants a feasible mechanism of injury to be documented that justifies the injury or disease diagnoses. Some Medicare contractors believe that the injury cannot occur with the usual safe activities of daily living.

Example: Suppose a patient wakes up in the morning with neck pain. Medicare may not pay for the claim as sleeping is a usual innocuous activity of daily living, which can not cause an injury.

The way out: "Document what the patient presents to your office with and perform the applicable tests to show medical necessity," advises Boivin. She adds that, "just because the patient slept wrong doesn't mean the condition wasn't there

prior to the patient sleeping. The sleeping just aggravated it. The provider needs to perform the necessary evaluation to determine and justify his/her diagnoses."

Armor Your Appeals the ACA Way

According to ACA, upon receiving a denial, you should prepare well to create foolproof and error-free documentation for your appeal. You may want to make use of the following tips:

- Ensure you are coding correctly.
- Review your documentation to ensure the procedures billed are supported in the patient health record.
- Make sure your documentation shows the patient's progress or clearly explains why there is no progress yet, and record how you're adapting the treatment plan to facilitate progress in the future.
- Do a bit of research before sending in your appeal letter.
- Look for sources, such as standard protocols or evidence based practice that can support your treatment plan.

Tip: If the insurers find a medical necessity issue with your treatment, your best defense appeal would be to provide precedence or a source or guideline that can justify the medical necessity.

"Follow the guidelines in documentation put out by the ACA and you can't go wrong," tells Boivin. "If you receive a denial follow the steps outlined for your appeal."

Plus: Remember to visit the state insurance regulations page to determine if any of the information supports your appeal.

Meanwhile, follow the insurer's instructions for a second-level appeal, if you receive no response. Further on you may notify your Department of Insurance and provide it with all correspondence from the insurer, if you still don't receive a response.

Climbing Up the Appeals Ladder

There are five levels of appeals for Medicare denials, ACA says.

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 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."

"Most often staff won't appeal because it's time consuming or they don't have time," observes Boivin. "When we do this we are basically lying down and taking it so to speak. The payers know they can get away without paying because staff won't do the work to get the reimbursement even if they know they should. When we are appealing we need to be a bulldog and not back down."

To know more, you can refer to www.acatoday.org/appeals.