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Medical Billing Appeal Process

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Appeal Process

Every claim denied by the insurance company cannot be appealed. So first segregate the denied claims according to their appealing eligibility.

When encountering medical billing disputes, the most efficient initial step in the appeals process involves placing a phone call to the payer. By doing so, you can directly communicate with a representative to discuss the issue at hand and explore potential resolutions. If the matter cannot be resolved through the call, seek guidance from the representative on how to initiate the formal appeal or reconsideration process.

Especially when dealing with commercial payers, they might provide a reconsideration form on their website, which healthcare providers can utilize to challenge a payment decision in a more structured manner.

Opting for a phone call as the first approach is advantageous for several reasons. Firstly, writing appeal letters takes time, and it further extends the timeline when the recipient needs to read the letter, verify the argument, and then take action to correct the claim. On the other hand, making a phone call allows for direct interaction, expediting the process and potentially achieving a prompt resolution.

If the issue at hand is straightforward and uncomplicated, a simple phone call to the payer might be sufficient to have the claim sent back for correction without the need for formal written communication. This approach not only saves time and resources but also showcases the importance of clear and concise communication in resolving medical billing discrepancies efficiently.

By proactively engaging with payers through phone calls and utilizing online tools like reconsideration forms, healthcare providers can take proactive steps to address medical billing disputes, ensuring timely resolution and proper reimbursement for the services they provide to patients.

Before discussing the claim with you, the provider representative — the person employed by the payer to work with you regarding disputes —verifies your need to know.

- Your name (as the person reaching out about the claim issue).
- The name of your billing company and either the tax ID number or NPI number.
- The patient's ID, name, and date of birth.

- The date of service in question.
- The billed amount of the claim (the total dollar amount billed).

When contacting the provider representative, you can explain the reason for the claim issue, and the representative can review the claim and the contract to determine the necessary action. If necessary, they can then send the claim back to the processor with instructions for reprocessing.

Example: Imagine a ABC healthcare provider, ABC Medical Clinic, submits a batch of insurance claims to various insurance companies for services provided to their patients. Among these claims, some are denied by the insurance companies for different reasons. Now, the clinic needs to segregate these denied claims according to their appealing eligibility.

Denied Claim 1

Patient: John Smith

Date of Service: July 15, 2023

Reason for Denial: The insurance company states that the procedure code billed is not covered under John's insurance plan.

Appealing Eligibility: This denied claim can be appealed, as the clinic has proper documentation and evidence to support that the procedure performed was medically necessary for John's condition.

Denied Claim 2

Patient: Mary Johnson

Date of Service: August 5, 2023

Reason for Denial: The insurance company states that Mary's policy has lapsed, and the services provided are not covered.

Appealing Eligibility: This denied claim cannot be appealed, as Mary's policy was not active at the time of service, and the clinic cannot provide any evidence to prove otherwise.

Denied Claim 3

Patient: Robert Anderson

Date of Service: September 10, 2023

Reason for Denial: The insurance company states that the diagnosis code billed does not match the procedure code submitted.

Appealing Eligibility: This denied claim can be appealed if the clinic can provide additional supporting documentation to prove that the diagnosis and procedure were accurately coded and appropriately billed.

Denied Claim 4

Patient: Susan Lee

Date of Service: October 20, 2023

Reason for Denial: The insurance company states that the claim was submitted after the allowed filing deadline.

Appealing Eligibility: This denied claim cannot be appealed, as it was rejected due to a late submission, and the clinic cannot provide valid reasons or extenuating circumstances for the delay.

Why Claims Are Denied

- Lack of medical necessity. Medical necessity is the determining factor for payment based on the codes submitted for the procedure and its relationship to the diagnosis.
- Therapy goals that are too ambitious (trying to take the patient to a level higher than before their injury or illness).
- The patient met goals but therapy continued.
- Noncoverage
- Incorrect codes. Errors in coding include upcoding or under coding or simply codes that do not correctly convey the meaning of the diagnosis.
- Therapy not reasonable and necessary.
- Illegible documentation.
- Skilled services not required, etc.

- Preauthorization and Precertification (Precertification is the approval of a procedure or hospital stay)
- ICD-10-CM Coding denials
  - No diagnosis is provided.
  - The diagnosis given is inconsistent with the service or procedure provided.
  - The diagnosis doesn't substantiate the need or level of service provided.
- CPT/HCPCS Denials
  - Wrong procedure code
  - Modifier error
  - Unlisted procedure code
  - NDC code
  - NCCI Edits.

***Prevent denials in the first place.*

Note: Arrange the appeals according to their value. The greater the amount of the claim, greater is the chance for it to get paid.

ABC Medical Center has submitted several insurance claims for services provided to different patients. Among these claims, some have been denied by the insurance company. Now, the medical center needs to prioritize and arrange the appeals based on the value of each claim. The general principle is that higher-value claims have a greater chance of getting paid upon appeal.

Denied Claim 1

- Patient: John Smith
- Date of Service: July 15, 2023
- Amount of Claim: $500
- Reason for Denial: The insurance company states that the procedure code billed is not covered under John's insurance plan.

Denied Claim 2

- Patient: Mary Johnson
- Date of Service: August 5, 2023
- Amount of Claim: $1,200
- Reason for Denial: The insurance company states that Mary's policy has lapsed, and the services provided are not covered.

Denied Claim 3

- Patient: Robert Anderson
- Date of Service: September 10, 2023
- Amount of Claim: $800
- Reason for Denial: The insurance company states that the diagnosis code billed does not match the procedure code submitted.

Denied Claim 4

- Patient: Susan Lee
- Date of Service: October 20, 2023
- Amount of Claim: $200
- Reason for Denial: The insurance company states that the claim was submitted after the allowed filing deadline.

Arranging the Appeals

Based on the value of each denied claim, ABC Medical Center decides to prioritize and arrange the appeals as follows:

Denied Claim 2 - Mary Johnson

- Amount: $1,200
- Appeal Priority: High
- Reason: The claim for Mary Johnson is of higher value, and it represents a significant potential reimbursement for the medical center. As such, the medical center considers this appeal as a top priority and allocates more resources to gather supporting documentation and evidence to challenge the denial.

Denied Claim 3 - Robert Anderson

- Amount: $800
- Appeal Priority: Medium
- Reason: The claim for Robert Anderson has a substantial value, and winning this appeal would result in a significant reimbursement for the medical center. While it is not as high as Claim 2, the medical center still considers it important and dedicates adequate resources to appeal this claim.

Denied Claim 1 - John Smith

- Amount: $500
- Appeal Priority: Medium
- Reason: The claim for John Smith represents a decent reimbursement value, and the medical center considers it worth appealing to recover the payment. While not as high as Claims 2 and 3, the medical center gives it a medium priority.

Denied Claim 4 - Susan Lee

- Amount: $200
- Appeal Priority: Low
- Reason: The claim for Susan Lee has a relatively lower value compared to the other denied claims. While the medical center may still decide to appeal it, it assigns it a lower priority due to the lower potential reimbursement amount.

By prioritizing the appeals based on the value of the claims, ABC Medical Center can effectively allocate its resources and efforts to pursue the higher-value claims first, increasing the chances of recovering significant reimbursements and maximizing its revenue.

What information should be included in the appeal letter?

Appeal letters may vary depending on the specific type of appeal, but there are essential details that should be included in the letter to avoid any future complications. These details consist of:

- Healthcare provider's name who provided the services.
- NPI (National Provider Identifier) number of the concerned provider.
- Tax ID of the clinic or the provider organization.
- Date of the service in question.
- Patient's name.
- Demographic details of the patient.
- Insurance ID number of the patient.
- Amount of the medical bill stated in the original claim.
- A well-defined argument supporting the claim's acceptance, including
- relevant federal or state rules applicable to the case.

There are 5 levels of appeals (Medicare Only)

- Level-1 Redetermination (submit request to the Part B contractor) 120 days from the date of receipt of the notice of the initial determination.
- Level-2 Reconsideration 180 days from the date of receipt of the redetermination.
- Level-3 Administrative Law Judge (ALJ) Hearing 60 days from the date of receipt of the reconsideration.
- Level-4 Departmental Appeals Board (DAB) Review 60 days from the date of receipt of the ALJ hearing decision.
- Level-5 Federal Court Review 60 days from the date of receipt of DAB decision or declination of review by DAB.

Appealing a denied claim or an incorrectly paid claim, for those carriers that are contracted with the Provider, can be very extensive and time consuming, hence make sure clean claims are submitted. Examples of denials are:

(1) Timely Filing

(2) Inclusive

(3) Medically Necessary

(4) Payment less than the contracted amount

(5) Retroactive Denials

Appeal letters - standard appeals for denials related to invalid code, incorrect subscriber name, or incorrect modifier, which can be found on payer websites. These should include essential details like the type and date of service for efficient processing. However, for denials related to medical necessity, a customized appeal letter might be necessary, where referencing ICD-10-CM/CPT/CMS guidelines or the payer's guidelines could expedite the claim processing. Failing to provide all required information in the appeal letter could prolong the process, creating additional work for the billing team.

Create a spreadsheet with information about each appeal: date each appeal is submitted, payer to whom each appeal is sent, filing requirements of each payer

Example: ABC Medical Center has received multiple claim denials from different payers and needs to keep track of each appeal they submit. They decide to create a spreadsheet to manage the appeal process efficiently.

Spreadsheet Columns:

1. Appeal Date: This column records the date on which each appeal is submitted to the payer.
2. Payer Name: Here, ABC Medical Center mentions the name of the insurance company or payer to whom the appeal is sent.
3. Filing Requirements: In this column, they note the specific filing requirements of each payer, such as appeal forms, specific documentation, or guidelines that must be followed.

Sample Spreadsheet

APPEAL DATE	PAYER NAME	FILING REQUIREMENTS
2023-07-10	XYZ Insurance	Online appeal form, Attach medical records
2023-07-12	ABC Health Plan	Appeal letter, Medical necessity documentation
2023-07-15	DEF Assurance	Appeal form, Provide detailed explanation

In this example, ABC Medical Center can easily track each appeal they submit, including the date, the payer it's sent to, and the specific filing requirements of each payer. This organized approach helps them stay on top of their appeal process, ensuring that all necessary information is provided to the payers for prompt consideration and resolution.

Visit: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20027.pdf for Medicare Level-1 Appeal form

All levels appeal forms
https://www.medicare.gov/basics/forms-publications-mailings/forms/appeals

Source:

https://www.cgsmedicare.com/jb/redeterminations/appeals-process.html

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c29pdf.pdf

https://www.cgsmedicare.com/jb/claims/appeals/decision_tree.html

https://journal.ahima.org/page/claims-denials-a-step-by-step-approach-to-resolution

https://www.medicare.gov/claims-appeals/how-do-i-file-an-appeal

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