Path to Payment Resolution: Streamlining the Appeals Process

Session Presenters:
- Chris Bryan
  Senior Consultant, TruBridge
Streamlining the Appeals Process

1. Understanding Appeals
2. Streamline the Process

Understanding Appeals
Why Appeals are Important

• Are you filing effective appeals?
  • 50% of denied claims are never appealed despite a 67% recovery rate\(^1\)

---

\(^1\) HIPAA & Revenue Cycle Compliance Report - Veteran’s Administration 2009

Why Appeals are Important

• What are some of our numbers?
  • 5% to 20% of claims are denied or delayed.
  • 3% to 4% are never paid.
  • 76.6% saw an increase in claims denials and disputed claims.
  • 45.5% attributed the spike to payers being difficult and stalling.
  • 24.5% attributed it to payers not complying with the terms of the contract
Know Your Limit

- Are you appealing everything or nothing?
  - Estimates are that a single claim rework costs hospitals $25.00.
  - Appeal processes could cost as much as $118.
- What's your minimum?
- Determine if it's a "no-win"

Denial Reasons

Front End
- Member not eligible
- Benefit Maximum met
- Coverage termed
- Precertification / Authorization Required
- Non-Covered Charges
- Member Cannot be Identified
- Covered by Another Payer
- Provider out-of-network
- Pre-existing Condition

Middle
- Bundled Services
- Missing / Incorrect Modifiers
- Diagnosis Code / Service Code Mismatch
- Not Medically Necessary
- Non-Covered Service
- Claims Sent to Incorrect Payer
- Missing Claim Information
- Additional Clinical Information Required

Back End
- Additional Claims Information Required
- Duplicate Claims
- Incorrect Contractual Payment - Short Pay
- Appeal Denials
- Incorrect Denial Follow-up
- Previously Paid Claim
- Incorrect Denials
## Know What to Appeal

<table>
<thead>
<tr>
<th>Medical Necessity Denials</th>
<th>Provider Denials</th>
<th>Payer Denials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care not considered to meet medical necessity criteria</td>
<td>Timely filing</td>
<td>Service is not listed under benefit plan</td>
</tr>
<tr>
<td>Review NCD/LCD articles</td>
<td>Bundled Services</td>
<td>Treatment is experimental</td>
</tr>
<tr>
<td>Does the diagnosis support the service?</td>
<td>Frequency limit (MUE)</td>
<td>Underpayments</td>
</tr>
<tr>
<td>Review the MR to determine if it supports possibly recoding</td>
<td>Review CCI Manual for mutually exclusive / comprehensive code pairs</td>
<td>Review contract limitations/Fee Schedule</td>
</tr>
<tr>
<td></td>
<td>Payer Requirements</td>
<td>Review Payer specific medical policies</td>
</tr>
</tbody>
</table>

### Streamlining Appeals
Proactive is Best

- Obtain Pre-authorizations
- Verify Eligibility upon arrival
- Check if PCP referrals are required
- Obtain signed ABN’s on the performed procedure
- Ensure claims are coded to the highest specificity
- Ensure clear / concise documentation is in the EHR

Know Your Payers

- Keep a list of the top payers with the most appeals
- Track appeal filing limits
- Track appeals address, phone number, fax number
- Save copies of payer specific appeal letters
- Document steps to escalate to the next level
- Track trends
### Appeals by Payer Spreadsheet

<table>
<thead>
<tr>
<th>Insurance</th>
<th>Letter on file?</th>
<th>Appeals Address</th>
<th>Phone#</th>
<th>Fax#</th>
<th>Filing Limit</th>
<th>Response Timeframe</th>
<th>Provider Rep</th>
<th>Escalation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>Yes</td>
<td>Provider Resolution Team P.O. Box 14020 Lexington, KY 40512</td>
<td>888-632-3862</td>
<td>251-405-2380</td>
<td>Within 60 days of denial. - 180 days for UR or Med Nec.</td>
<td>60 days from receipt</td>
<td>Ima Knew</td>
<td>1) Level 1 appeal 2) Level 2 appeal 3) External appeal</td>
</tr>
<tr>
<td>United Healthcare</td>
<td>Yes</td>
<td>Provider Appeals P.O. Box 30559 Salt Lake City, UT 84130</td>
<td>877-842-3210</td>
<td>NA</td>
<td>Within 60 days of denial</td>
<td>60 days from receipt</td>
<td>NA</td>
<td>1) Reconsideration 2) Level 1 appeal 3) External appeal</td>
</tr>
<tr>
<td>Florida Blue</td>
<td>No</td>
<td>Provider Disputes Dept. P.O. Box 44232 Jacksonville, FL 32231</td>
<td>800-727-2227</td>
<td>NA</td>
<td>180 days from initial denial date</td>
<td>60 days from receipt of appeal</td>
<td>Eileen Dover</td>
<td>Not stated on website. Need to call</td>
</tr>
</tbody>
</table>

### Who should file?

- **Appoint knowledgeable staff**
  - Experienced billers
  - Coding experts
  - Reimbursement analysts
BE SPECIFIC

- Letter of intent on company letterhead
- Include documents and how they support your appeal
- Leave no room for interpretation
- Ask the physician to provide a paragraph detailing out why the procedure was performed

---

Letter of intent on company letterhead

Include documents and how they support your appeal

Leave no room for interpretation

Ask the physician to provide a paragraph detailing out why the procedure was performed

---

Letter of intent on company letterhead

Include documents and how they support your appeal

Leave no room for interpretation

Ask the physician to provide a paragraph detailing out why the procedure was performed

---

Letter of intent on company letterhead

Include documents and how they support your appeal

Leave no room for interpretation

Ask the physician to provide a paragraph detailing out why the procedure was performed
Letter Contents

- Date of your letter
- Name of the particular individual to whom you are addressing your appeal.
- Complete Address
- Reason for the letter

Letter Contents

- Subscriber information
  - Subscriber Name
  - Patient Name
  - Date(s) of Service
  - Pre-Certification Number
  - Internal Patient Account Number
- Amount of Claim Being Appealed
Letter Contents

- Scan it
- Documentation Consistency:
  - Payer specific letters
  - Same font
  - Same font size
  - Clear and clean logo
  - All typed (or printed)
  - Be professional.

Packet contents

- Payer specific appeal letter
- Letter of Intent on company letterhead
- Copy of the original UB/1500 form
- Supporting medical records
- Proof of timely filing (if applicable)
- Original EOB
- Primary EOB (if applicable)
- Account notes/itemized statement (if applicable)
Packet contents

- Correspondence from the payer
- Copy of payer’s provider manual, billing policy or contract
- Copy of the payer’s fee schedule
- Copy of the insureds’ ID card or eligibility (if applicable)
- *Number each page*

SUBMIT THE APPEAL

- Before submitting the appeal, make a copy for your records
  - Submit before filing limit is exceeded
- Mailing
  - Submit the entire packet to the appeals address - **certified**
  - Keep record of the tracking number
  - Follow-up once delivery is confirmed
SUBMIT THE APPEAL

• Fax
  • Submit the entire packet to the appeals fax number
  • Keep record of the confirmation fax and call the payer to ensure it was received

• Encrypted Email
  • Return receipt requested

2018 Certified Mail Rates:

• Certified Mail Fee - $3.45
• First Class Postage (1 oz.) - $0.47
• Electronic Delivery Confirmation - $0.80
• Plus an additional:
  • Return Receipt (Green Card) - $2.75
  • Return Receipt (Elect. Signature PDF) - $1.50
FOLLOW UP

• Stay organized
• Set calendar reminders for 30, 45, 60 days
• Ask for a “Document Image Number”
• Use your tracking number/confirmation
• Don’t settle for “we never received it”
• Be persistent

TRACK IT

• Tag the account in the EHR for reporting purposes
TAKE IT TO THE NEXT LEVEL

- Internal appeal
- Level 2 appeal
- External appeal

IN CONCLUSION

- Avoid “no win” situations
- Use minimum dollar limit
- Be proactive
- Know your payers
- Be specific
- Be persistent
- Stay organized
- Follow-up
- Escalate to the next level
Path to Payment Resolution: Streamlining the Appeals Process