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Practice Management Tips and Tools – Building a Strong Appeal

You have reviewed your claim denials and found a denial with which you disagree? What do you do next? This Timely Topic presents factors in building a strong appeal, an essential tool for your practice management toolkit.

First step – Identify why the service was denied for payment

A quick review of the Explanation of Benefits or Remittance Advice (EOB/RA) will identify the Claim Adjustment Reason Code (CARC). As discussed in [EOBeware](#) and [Denial Management 101](#), CARCs provide information on why a claim line denied. The CARC assigned can help you identify what payer policy or claim requirement may not have been met.

Does the payer have a policy specific to your patient's clinical scenario? This could be a clinical coverage policy, a coding requirement, a medical necessity issue, or even a provision specific to this patient's insurance plan regarding covered benefits. As you review the policies identified by the CARC you may find you disagree with the assigned CARC, believe that the payer made a mistake, or perhaps feel that the clinical scenario specific to this patient warrants exception to the payer's policies. When this happens, you may decide to continue pursuing for claim payment by appealing the claim denial.

Next step – How to pursue payment of the claim

It is important to know the payer's reconsideration and appeals process. Each payer can have its own requirements and processes that you must follow to pursue payment after a denial. For example:

- Does the payer require a specific form?
- Where do you send the appeal?
- What are the filing timelines?

The [Medicare appeals process](#) was covered in a previous Timely Topic. Many payers, such as Medicare, will allow some options for claims reprocessing with a phone call or corrected claim. Starting with a telephone call may save you the time and paperwork of going through the formal appeals process. Keeping a record of calls, contacts, and points of discussion may assist you with next steps in the process.

If the issue is not resolved via a telephone conversation, and further action is necessary, start with the payer's required elements, e.g., fill out the correct form. When completing the form, make sure all information is accurate and legible and that you clearly indicate the claim number, patient demographics, codes along with the dollar amounts denied.

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Typically, a copy of both the original claim form and the EOB/RA should be included with the appeal form. Including these items also makes it easier to identify specific elements by field number.

Provide documentation of the service rendered. That documentation should include all related records supporting the service that was denied, diagnostic records referred to within the primary documentation and any other ancillary records that may be relevant, such as referrals, scripts and preauthorizations. One common mistake is to only provide the record from the individual date of service but not to include prior dates of service, initial assessments, or other summary records that provide additional context for the clinical services provided.

Include a custom cover letter with your documentation that clearly and concisely identifies what was denied, why it was denied and why you feel it should be paid. Use the payer's language. If the claim denied for CARC 40 "*Charges do not meet qualifications for emergent/urgent care*", then the cover letter should use that same statement plus an explanation as to why the services provided were emergent or urgent care.

If there is a specific policy relevant to the denial, quote from that policy and address in your cover letter how the service provided meets the terms of the policy. Attach a copy of that policy and highlight the relevant sections. Review our Timely Topic on [payer policies](#) for examples of more resources that can be used in building appeals, such as coding manuals, billing manuals, clinical coverage policies and especially ASA resources. Any resource utilized in supporting your reasons for payment should be listed in your cover letter and then attached to the appeal for easy reference by the payer's appeals representative.

It may also be possible to appeal services that fall outside of written payer policy if you can demonstrate the service met [medical necessity](#). In your cover letter include a request that the services and claim be reviewed "based on medical necessity" by a physician anesthesiologist or a pain medicine physician. Including this phrase should route your appeal to a physician with experience and expertise in the services under review rather than to a coding or other administrative representative. A letter and/or summary written by the treating physician may lend weight to your appeal. Points to note could include:

- Why the service was medically necessary for this patient's condition
- What other services have been tried
- What led to this decision or plan of care
- Anything unique in the patient's presentation.

The cover letter should specifically list and address all the appeals attachments and records, and how they support payment for the service rendered. Do not assume that the payer's appeals representative will know why you attached each item and how it applies. Any cover letter should be professional and keep to the facts and your reasons why the service should be paid.

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If your appeal is rejected, you may still have additional avenues for possible payment. First, review the information provided in the rejection notice. You can file a second level appeal, but make sure to review your previous appeals documentation first. Can you reword your appeal or attach additional documentation to more clearly support your case for appeal?

Again, make sure to be aware of and comply with all appeal process requirements. For example, the next level appeal may go to a different address, require a different form, or have a different timeline. Missing any of these components could invalidate your right to an appeal.

If you have followed the appeals process and have not reached a satisfactory resolution you also have a right to an independent review. This external review is by a third party and was established as a consumer protection in the [Affordable Care Act](#). The payer is required to include on their final appeals rejection notice information on how to file an external/independent review.

Knowing and following your payer appeals processes can help the anesthesia and pain medicine practice get paid for their medically necessary services.

One Last Tip:

You may find it valuable to utilize a two-pronged approach by enlisting the patient in appealing to the payer. A patient appeal can sometimes go through different departments and representatives and may improve your chances of having the appeal accepted and the claim paid.