

Medicare Denials & Appeals

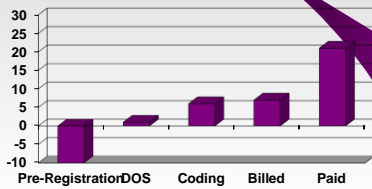
WMCA Annual, 2011
Presented by Lori Zindl



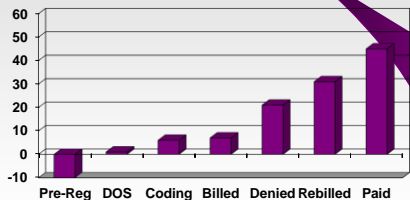
Discussion Topics

- Timeline of paid versus denied claims
- Payment turnaround times
- Critical denial points in billing process
- Changing denials into edits
- Medicare RTP Process
- ADR Monitoring.
- Appeals and Reconsiderations
- Handling specific denials
- Questions

Timeline of a Paid Claim



Timeline of a Denied Claim



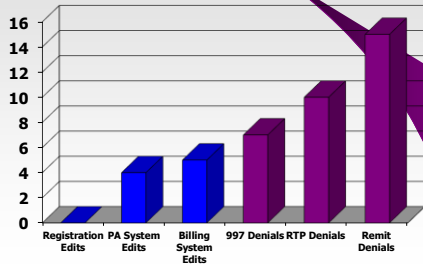
Payment turnaround times

- If you bill Medicare correctly, they will pay.
- If you bill Medicare correctly, they will pay claims in 14 days.
- If you bill most of your claims correctly, GDRO in the 30's is easy!
- Reporting and doing something with denials is CRITICAL!
- Don't just keep correcting claims and rebilling denials – Do something to STOP them!

Critical Denial Points

- Edits (before claim leaves)
 - Registration edits
 - Patient Accounting system edits
 - Billing system edits
- Denials (after claim leaves)
 - 997/Payer electronic denials
 - Return to Provider denials (Medicare)
 - Remit denials

Timeline of Critical Denial Points



Change Denials into Edits

- Start with Remit Denials since they delay payment turnaround the longest
- Add RTP and 997 Denials to process
- When changing Denials to Edits, shoot for the earliest possible point in the timeline (Registration)
- Prioritize issues by dollar and volume

5 Top Reasons to Stop Denials

- You get paid faster
- A claim that gets billed without anyone touching – PRICELESS – I mean COSTLESS!
- A/R, GDRO and aging improves.
- Write offs decrease – cash improves
- Decrease FTE staffing in Business Office

Rebilling is for Losers

- **Don't rebill a claim without doing something different.** Why didn't it get paid the first time? Do something to make sure it gets paid this time.
- **Always try to think – Is there a way to stop this denial from happening again?** Think of edits, warnings, claim or process changes that we can add to prevent future claims from denying.
- **Three strikes – you are out.** If you have rebilled a claim twice (see rule #1) and it is still not paid, time to give up. Get the patient involved or refer it to your supervisor.

Top RTP Reason Codes

RTP Reason Codes	Volumes
32200	14,744
38038	8,534
19301	8,267
7C900	6,277
31715	4,789

*CMS/NHIC statistics from 11/09-1/10

Top RTP Denials

- 32200 – DX V0481 or V0382 without CC A6.
 - Verify the DX codes are correct and add A6.
 - Billing system should edit for this
 - Better yet – automatically add when vaccine is being billed.
- 38038 – Overlap with Same Provider
 - Find overlapping visit date and adjust previously processed claim to add charges/ coding.
 - Patient accounting and/or Billing System should edit for this.
- 19301 – Operating physician is required
 - Add operating physician name and NPI
 - Billing system should edit for this
 - Better yet – automatically add to claim during import

Top RTP Denials

- 7C900 – RTP'd to determine if has all applicable DX codes.
 - Verify the DX codes are correct and release with accurate codes
 - Billing system should edit for this prior to billing.
- 31715 – MUE - Units exceed medically reasonable daily allowable frequency
 - Verify the units being billed. Correct units.
 - If you believe units are correct, you will need to reduce units to get it to process via RTP and then do reconsideration appeal to try to get additional ones paid (doubtful)
 - Patient accounting and/or Billing System should edit for this.
- Top 5 reasons are avoidable – amazing!

RTP Denials

- Add edits in billing system to prevent RTP
- Track these along with normal rejections
- Add edits in billing system to prevent RTP
- RTP should be less than .5% of claims billed.
- Did I mention, you should add edits in your billing system to prevent RTP
- Questions on other RTP issues?

ADR Requests

- Additional Development Requests
- Issued when a contractor cannot make a coverage or coding determination from the information on the claim.
- ADR process also used for focus reviews. (Therapy Modifier 25, etc.)
- ADR is separate from RAC, QIO or CERT requests
- Important to return records timely to avoid reconsiderations and appeals.
- Monitor due dates electronically on FISS to avoid denials.

Denied Claims (D Status)

- These are claims that have been medically denied for a variety of reasons.
- Denied claims cannot be rebilled or adjusted with claim corrections.
- The Reconsideration and Appeal process must be used to overturn the denial.
- NOTE: There can be medically denied charges on P status claims too. Appeal would be needed to get the line item denial overturned.

Denials VS Rejections- Actions to Take

Claim Condition	Solution
Full rejection by ACPIS (Status code R on FISS) or FISS converted DCN	Submit electronically
Full or partial denial in FISS (Status code D or P with partially denied charges) Exceptions: If the review indicated a partial denial of services as a billing error, a paper adjustment is acceptable. If the adjustment does not affect the line item denied by Medical Review, an online adjustment should be done page 4 should have statement "Not contesting denied charges"	Submit reconsideration form within 60 days for Part A entitlement cases (inpatient). Submit a Request for Review within 120 days for Part B entitlement cases (outpatient).
Duplicate claims: Full rejection in FISS (Status code R) as a duplicate If the claim is submitted twice in the same day and both reject as duplicates, resubmit a new claim. If resubmission rejects as duplicate, then try to adjust one of the original rejected claims on line. (See Medicare Denial Procedure)	<ul style="list-style-type: none"> • Correct dates of service to ensure no overlapping and correct, if necessary. Submit as a new claim. • If service dates are correct, determine if late charge or adjustment to original claim is appropriate.
MSP Claims: Full rejection in FISS (Status code D) when claim was submitted with Medicare as the primary payer and fully rejected	<p>If you feel that the MSP information is incorrect, you must provide Provider Education with appropriate documentation to allow them to correct the MSP files. Once the MSP file is correct, resubmit the claim as an adjustment claim.</p> <p>If the MSP information is correct, submit claim to the primary payer. After processing by primary, resubmit as an adjustment claim</p>

Claim Condition

The ANSI rejection code may indicate whether an appeal or adjustment is required. The ANSI code is provided on page four of the FISS claim and the description can be found in the Inquiry screen.

The Med Tec field located on page 2 will also indicate whether an appeal or adjustment is required. Go to page 2 in FISS. Place the cursor on the non-covered charge and press F2. Refer to the initials under "Med Tec" located on the bottom right hand of the screen. If no initials listed, an adjustment is required. If the initials "M" or "S" are listed, an appeal is required.

The Appeal Department does NOT do corrections on coding errors. Appeals submitted on these rejected claims will be returned to the provider. Adjustment claims are required on these types of denials.

Solution

MA01 is a rejection code that indicates an appeal is required.
MA130 indicates an appeal is not necessary.

Examples of these rejection codes on FISS that should be adjusted rather than appealed are below.

70089 70074 70080 30041 39008 38039 34009 34022 34158 34350 39001
24016 30074 34057 70088 34250 34002 52313 C7080 C7010 E8301
N5052 32400 15211 73011 34257 70085 70093 32403 70164 32404
34366

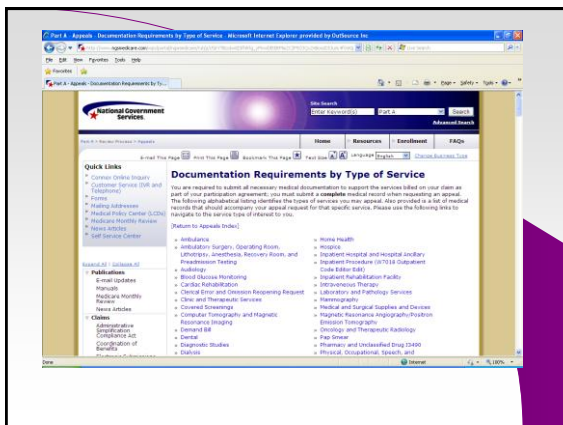
Additional reason codes on partially denied claims:
98236 98235 98238 98234.

AOR Form on Appeals

- Provider outpatient appeals can only be filed on medical denials for which the provider is liable.
- The patient must appeal denials for charges that are excluded for which the patient is responsible. They may also complete an AOR.
- The Appointment of Representative (AOR) form will be sent to the patient when required and included with the appeal. If/when the patient returns the AOR form, fill out the Waiver of Payment (WOP) form and include with the appeal.

Appeal - Redetermination

- Redetermination must be filed within 120 days of the original denial/remittance advice date.
- Claims beyond this timeframe cannot be appealed and must be written off.
- First level of appeal is submitted on CSM-20027 MEDICARE REDETERMINATION REQUEST FORM
- Include a corrected claim (if coding has changed), remittance advice and any supporting documentation (medical records)
- nsgmedicare.com – Part A. Review Process, Appeals has a list of documents needed to appeal by specific procedures.



Medical Redetermination Notice

- Provides an explanation of the decision rendered on the appeal.
- Contains summary of facts on the claim information received **Verify this lists everything you thought you sent. If items missing, could be the reason for a denial.
- Identifies who is responsible (typically provider)
- Gives instructions on further appeal steps

Appeal-Reconsideration

- Reconsideration must be filed within 180 days of the original redetermination decision date.
- Claims beyond this timeframe cannot be appealed and must be written off.
- Second level of appeal is submitted on CSM-20033 MEDICARE RECONSIDERATION REQUEST FORM
- Review sent to the QIC
- Make sure all documents submitted with this appeal as provider will not be allowed to submit additional evidence at an ALJ hearing if reconsideration is denied.
- Decisions should be received within 60 days and contain further appeal instructions if denied.

Further appeals

- Third level of appeal (ALJ Hearing)
 - Must be submitted within 60 days of QIC's reconsideration notice.
 - Cannot appeal amounts less than \$130.
 - Complete form CMS-20034 REQUEST FOR MEDICARE HEARING BY AN ADMINISTRATIVE LAW JUDGE
- Fourth level of appeal (Departmental Appeals Board)
 - Must be submitted within 60 days of ALJ decision.
 - Complete form DAB-101 REQUEST FOR REVIEW OF ADMINISTRATIVE LAW JUDGE (ALJ) MEDICARE DECISION / DISMISSAL
- Fifth level of appeal (Federal Court Review)
 - Must be submitted within 60 days of DAB decision
 - Cannot appeal amounts less than \$1,260

Appeals Chart

Appeal Level	Time Limit to File*	Dollar Threshold
Redetermination	120 days from remit	None
Reconsideration (QIC)	180 days from Redetermination Notice	None
ALJ Hearing	60 days from Reconsideration Notice	\$130
DAB Review	60 days from ALJ decision	None
Judicial Review	60 days from DAB decision	\$1,260

**There are circumstances providers can appeal filing limits based on good cause*

Bundling/OCE Error/CCI edit

- Claims billed via billing system should NOT reject for this.
- Report these denials to System Administrator to find out why they did not edit.
- Request review for modifier or adjust off the bundled charge.
- OCE edit – Report these to System Administrator if payer other than Medicare is denying on claims. Have OCE edits turned on for other payers.

Modifier missing or incorrect

- Claims billed via electronic billing system should NOT reject for this.
- Report these denials to System Administrator to find out why they didn't edit.
- Have claim reviewed for appropriate modifier and rebill with corrections.

Other insurance primary

- Check HIQA to show what coverage is on file.
- Nothing can be done via billing to update COB on HIQA. The COB department must be contacted (and typically by the patient) to update data.
- If patient says no other coverage – they need to clear up with the payer.
- Often it's faster to just bill what the payer has on file to get rejection.
- Employers will also assist in getting COB updated.

Liability primary

- Edits on accident occurrence codes or accident indicators:
 - Occurrence code 01-04 cannot be on Medicare claim if billing Medicare primary.
 - Accident DX codes require occurrence code 05 and remarks if not billing liability primary
- *When the patient has an open liability on file but services are not related, a condition code 05 will be required with the remarks "Services rendered are not related to the open liability file". Claim does not need to be billed first to the liability. Any indication from the patient and/or liability that is not related can be billed with condition code 05 and remarks.*

Duplicate claim

- Patient account system should check for overlapping visit dates – daily report of visits with overlapping dates.
- Billing system should also check for overlapping dates and duplicate claims prior to submission.
- Sometimes just the result of some loser just rebilling a claim without making necessary corrections
- Make sure corrected claims are identified – xx7 TOB.
- Need to know what can be rebilled versus what needs adjustment.

Other Hospital/Facility

- Hospice info is on HIQA
- Call NGS for SNF or other hospital information
- Bill the other facility.
- If not related to Hospice care, rebill with condition code 07.
- Report back as Registration issue – MSP questionnaire and Registration process should catch if patient is from another facility

Not Medically Necessary

- Claims billed via billing system should NOT reject for this.
- Report these denials to System Administrator to find out why they didn't edit.
- Request review for additional coding to support services.
- If no additional coding, request write off.
- If new coding, send corrected claim with new codes and records asking for reconsideration.
