Billing Challenges

65th AAMA Conference

With Lauren Solomon

Course Expectations

Participate!

Questions

Specific Examples during Q&A

Agenda

- Your Role in the Revenue Cycle
- What triggers Denials?
- Using Modifiers for Multiple procedures
- Telephone Reconsiderations
- Submitting Supporting Documentation
- Writing an Appeal

What is Revenue Cycle?

- All Clinical and Administrative functions that contribute to the capture and management of patient service revenue.

Revenue Cycle

Denial Triggers

- Missing or Incorrect Registration
- Missing Authorizations and Referrals
- Timely Filing
- Same Procedures Same Date
- Experimental Procedures
- Billing for Global Services

Using Modifiers

What is a modifier?

A two-digit code consisting of letter and/or numbers that identifies why a particular procedure should be considered for separate payment from other lines on the claim.

Using Modifiers

When to use modifiers?

When two or more physicians of the same specialty are billing for the same CPT code on the same day (Surgery)

When two or more identical charges are added to a patient's claim for the same date. (EKG Reads)

When the same CPT code should be used but the procedure was performed on different areas of the patient's body. (Imaging, Therapy)

Common Professional Billing Modifiers

- 26 Professional Component
  - Certain procedures are a combination of a physician component and a technical component. Used when the physician component is reported separately
- 59 Distinct Procedural Service
- 76 Repeat Procedure or Service by Same Physician
- 77 Repeat Procedure by Another Physician

Source
https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00144515

Does the scenario require a Modifer?

- Dr. Washington, a surgeon, was assisted by Dr. Wilson, a surgeon, on 8/27/2021
  - **YES**
- Patient Matthew was seen by Dr. Jones, a PCP, and Dr. Ahmad, a Cardiologist, on the same day.
  - **NO**
- Patient Carla underwent a CT of the Head and a CT of the Brain the same day
  - **YES, but…**
- Patient Henry was seen for Cardiac Rehab for 4 days in a row.
  - **NO**

Disputing Denials

Gathering Information

- Understand the Denial
- **Gather** Supporting Documentation **(if any)**
- Check Timely Filing Limits

Best Practices

Use Websites

Don’t stay on Hold Too Long

Drive the Conversation

Have Several Claims or Denials to Discuss

Denials that will Require a Replacement Claim

Bundling or Global

- CPT or DX codes should be changed

Missing Information

- Pt Name
- Taxonomy
- Referring Provider

Telephone or Website Reconsiderations

Processing Errors

- Duplicates
- COB Issues
- Eligibility Issues

Remember to get a Reference Number!!

Denials that Require Supporting Documentation (Pending Claims)

- Medical Records
- Primary EOB
- Anesthesia Start and Stop Times
- Sterilization Consent Form

Submitting Supporting Documentation

Specific Claim Details

- Patient's Name
- Patient’s Subscriber ID
- Date(s) of Service
- Claim Number or ICN

Writing a Cover Letter

Provider Name
Provider Address
Provider Phone number

Provider Contact Info

Payer Name
Payer Address

Payer Contact Info

Patient Name
Subscriber ID
Claim Dates of Service
Claim or ICN

Claim Reference Info

Body

To Claims Department,

We have received a request for additional documentation on the above refereneced claim. Enclosed is the requested (EOB, OP report, Medical record). Please have the claim reprocessed for payment.

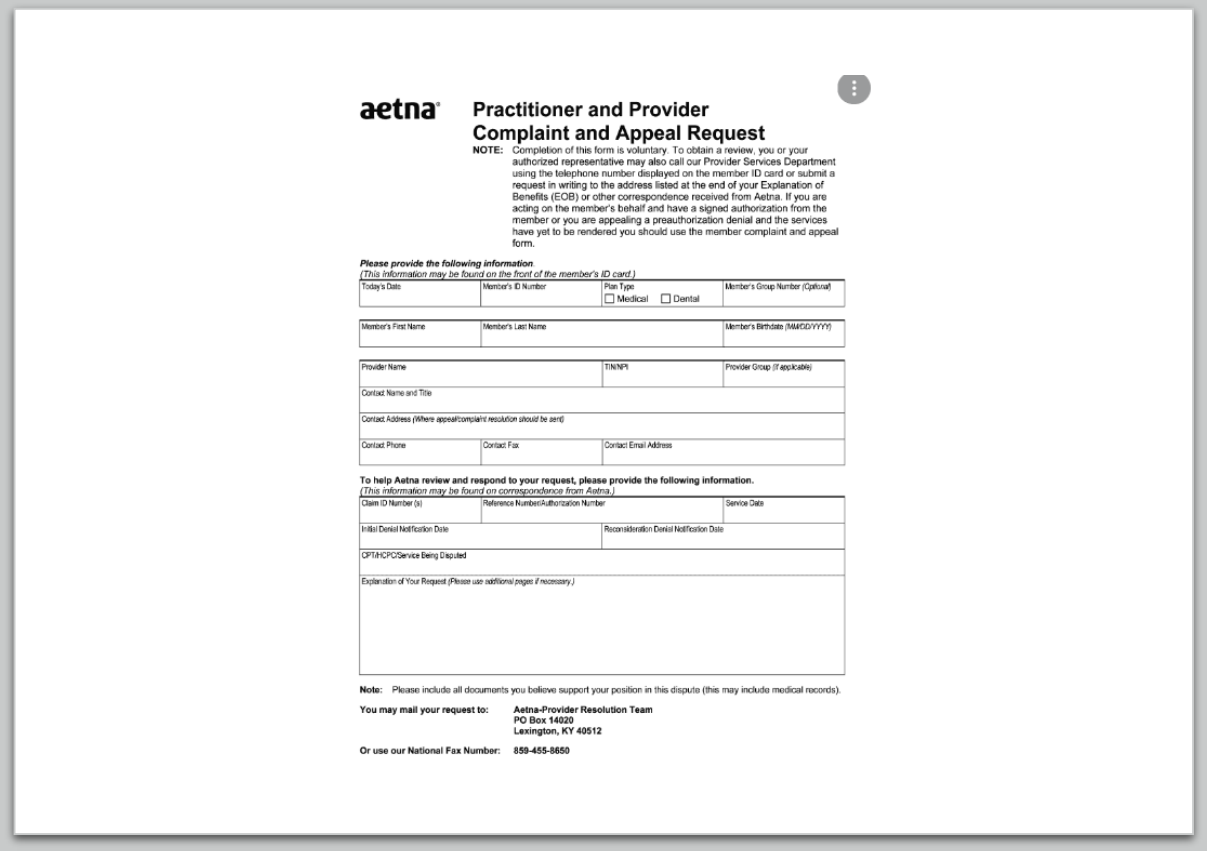
About Appeals

Levels

Medicare	Managed Care
Reconsideration	Level 1
Redetermination	Level 2
Level 2-External	External Review
	Texas Department of Insurance

Reconsideration Forms

- BC/BS
- Aetna
- Cigna
- UHC
- Humana
- Medicare



aetna

Practitioner and Provider Complaint and Appeal Request

NOTE: Completion of this form is voluntary. To obtain a review, you or your authorized representative may also call our Provider Services Department using the telephone number displayed on the member ID card or submit a request in writing to the address listed at the end of your Explanation of Benefits (EOB) or other correspondence received from Aetna. If you are acting on the member's behalf and have a signed authorization from the member or you are appealing a preauthorization denial and the services have yet to be rendered you should use the member complaint and appeal form.

Please provide the following information.
(This information may be found on the front of the member's ID card.)

Today's Date	Member's ID Number	Plan Type ☐ Medical ☐ Dental	Member's Group Number (Optional)

Member's First Name	Member's Last Name	Member's Birthdate (MM/DD/YYYY)

Provider Name		TIN/NPI	Provider Group (If applicable)
Contact Name and Title			
Contact Address *(Where appeal/complaint resolution should be sent)*			
Contact Phone	Contact Fax	Contact Email Address	

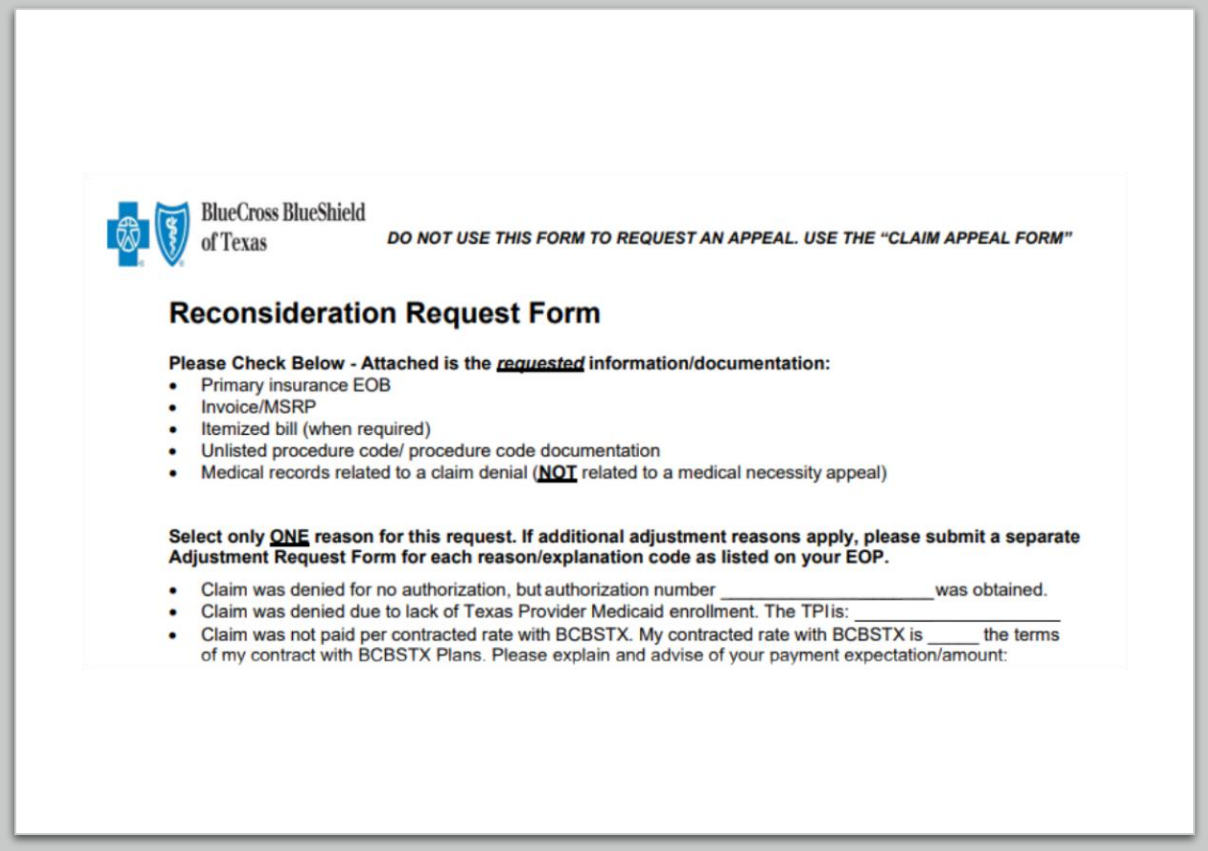
To help Aetna review and respond to your request, please provide the following information.
(This information may be found on correspondence from Aetna.)

Claim ID Number (s)	Reference Number/Authorization Number	Service Date
Initial Denial Notification Date	Reconsideration Denial Notification Date	
CPT/HCPC/Service Being Disputed		
Explanation of Your Request *(Please use additional pages if necessary.)*		

Note: Please include all documents you believe support your position in this dispute (this may include medical records).

You may mail your request to: **Aetna-Provider Resolution Team**
PO Box 14020
Lexington, KY 40512

Or use our National Fax Number: **859-455-8650**



BlueCross BlueShield of Texas

DO NOT USE THIS FORM TO REQUEST AN APPEAL. USE THE "CLAIM APPEAL FORM"

Reconsideration Request Form

Please Check Below - Attached is the *requested* information/documentation:

- Primary insurance EOB
- Invoice/MSRP
- Itemized bill (when required)
- Unlisted procedure code/ procedure code documentation
- Medical records related to a claim denial (**NOT** related to a medical necessity appeal)

Select only ONE reason for this request. If additional adjustment reasons apply, please submit a separate Adjustment Request Form for each reason/explanation code as listed on your EOP.

- Claim was denied for no authorization, but authorization number _____ was obtained.
- Claim was denied due to lack of Texas Provider Medicaid enrollment. The TPI is: _____
- Claim was not paid per contracted rate with BCBSTX. My contracted rate with BCBSTX is _____ the terms of my contract with BCBSTX Plans. Please explain and advise of your payment expectation/amount:

Writing Appeals

Common Types of Written Appeals

MEDICAL NECESSITY

RETRO AUTHORIZATION

TIMELY FILING

DUPLICATES

First Level Appeal

Provider Name
Provider Address
Provider Phone number

Provider Contact Info

Payer Name
Payer Address

Payer Contact Info

Patient Name
Subscriber ID
Claim Dates of Service
Claim or ICN

Claim Reference Info

Body

To Claims Department,

The above referenced claim was denied for timely filing.

Body of an Appeal

- How you know the claim denied
- Why did the claim deny?
- What do you want them to do?
- Explain your position
- Include an agree statement
- Thank the claims department representative
- Include your business office contact information

Sample Body of an Appeal

We received an EOB dated 8/20/2021 stating our claim denied as not medically necessary. I am writing at this time to request a review of the included documentation for medical necessity for rendered services.

Please review the health information for determination of medical necessity and pay the claim accordingly.

Based on the enclosed documentation, we contend that your members' services were medically necessary and that the care was "**within the confines of prevailing medical practices and standard"**

Attached are the medical records for review and completion of the claims processing. If there is anything additional that you may need, please contact me at 1800-800-0000 ext 12345.

Thank you for your time and consideration toward this appeal.

Looking for Supporting Documentation

- Medical Necessity
  - Pre Op, Post Op report, H&P
- Retro Authorization
  - Referral Records, Notes, Insurance Verification and Benefit Information
- Timely Filing
  - Notes, Clearinghouse Records, Certified Mail Records

Write an Appeal

- UHC insurance denied CPT 49665 PR LAP, INCISIONAL HERNIA REPAIR as not medically necessary.
- **Diagnosis:** SBO (small bowel obstruction) (HCC) [K56.609],Essential hypertension, Gastroesophageal reflux disease, Postoperative anemia
- The history states: 74-year-old lady who presented to the emergency with complaints of 1 day of worsening abdominal pain found to have incarcerated abdominal hernia with small bowel obstruction underwent laparoscopic incisional hernia repair with mesh. Postoperative course essentially unremarkable and patient remained hemodynamically stable. Pain controlled with oral analgesic regimen. Hemoglobin dropped noted from 13 g on the day of admission to 9.9 range and has remained stable over the course of last 24 hours without any evidence of bleeding from any site. Patient has tolerated full liquids diet prior to discharge , she will gradually advance the diet upon discharge and is to follow-up with surgery in 2 weeks.

Getting Started

Provider Name
Provider Address
Provider Phone number

Payer Name
Payer Address

Patient Name
Claim Dates of Service
Claim or ICN

To Claims Department,

The above referenced claim was denied for.... We are appealing for…

Diagnosis: SBO (small bowel obstruction) (HCC) [K56.609],Essential hypertension, Gastroesophageal reflux disease, Postoperative anemia
The history states: 74-year-old lady who presented to the emergency with complaints of 1 day of worsening abdominal pain found to have incarcerated abdominal hernia with small bowel obstruction underwent laparoscopic incisional hernia repair with mesh.

Questions and Answers