About This Manual

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CPT codes used in this manual are excerpts from the current edition of the CPT (Current Procedural Terminology) book, are not intended to be used to code from and are for instructional purposes only. It is strongly advised that all providers purchase and maintain up to date copies of CPT. CPT is copyrighted property of the American Medical Association.
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Agenda

• Managing and Preventing Claim Denials

• EOB Analysis
Managing & Preventing
Claims Denials

Let’s Look At:

• Claim Submission

• Insurance Follow Up

• EOB Analysis

• Denial and Appeal Process

• Open Claims
Compliant Claim Submission

By Payer

Claim Is Submitted

- Claim Is Paid Correctly
- No Response from the Insurance Carrier
- Paid at $0 or Incorrectly

First one or reason...
Get the Claims Paid so you don't have to deal with the Denials/Appeals
Claim Submission

• Review charges prior to release
  – Manual Review
    • Scheduling Staff
    • Charge entry staff
    • Insurance follow-up staff

• Automated review via claims scrubber

Assuring Compliant Claim Submission

• Know the requirements of **EACH** payer
• Adhere to Billing Time Limits
• Fill out claim correctly
  – Field 1a (ID)
  – Fields 9 and 9D – other insurance
  – Field 10d
  – Field 11 – insurance info (a-d)
- Fields 12 and 13
  - Medicare no longer requires assignment of benefits signature
- Fields 17 and 17B
- Field 23
- Fields 24E, 24G, 24J
- Field 31
- Field 32
- Field 33
Claim Submission

• Ensure charges are going through
  – Electronic clearinghouse
  – Direct to carrier
  – Be on alert for failed batches

• Work Error Reports
  – Set Benchmarks – ie *all errors corrected and claim resubmitted within 48 hours*

Paid

• Post *meticulously*
• Underpayments
  – Know your allowables
  – Not just $$; adjudicated as in-network when it should have been out-of-network
• Non-Payments…
  – By line item
The Purpose of an RA / EOB

- Payments

- Adjustments
  - Denied Claim
  - Zero Payment
  - Reduced Payment
  - Penalty Applied
  - Additional Payment
  - Supplemental Payment
Denial Management

• Top Five Reasons for Denials*
  – Eligibility/Patient Responsibility
  – Lack of Authorization/Referral
  – Medical Necessity
  – Coding
  – Duplicates

*Not in order; may vary by practice and specialty

Denial Management

• Explanation of benefits (EOB)
• By line item
• Reason code
  – List: www.wpc-edi.com
Denial Management

• Eligibility and Patient Responsibility
  – Focus on the front end
    • Complete, accurate information (from card)
    • To avoid COB issues, ask “Do you/Does the patient have other insurance coverage?”
  – Verify insurance and check benefits (optional)
  – If non-covered service, and have an ABN, waiver or agreement, transfer to patient

Denial Management

• Eligibility and Patient Responsibility
  – Check prior (and post) insurance
  – Check Medicaid eligibility
  – Check hospital registration system
  – If no information, bill patient ASAP
Denial Management

- Lack of authorization/referral
  - Check records
  - Check with payer
  - Check with referring physicians office
  - Check documentation for emergency

Denial Management

- Medical Necessity
  - Let Medicare’s NCD/LCD be your guide
    - http://www.cms.hhs.gov/mcd
    - Use them in your appeals with all payers
  
  - Know every payer’s definition

  “Cigna: Medical Necessity—Medical necessity is a term used to refer to a course of treatment seen as the most helpful for the specific health symptoms you are experiencing. The course of treatment is determined jointly by you, your health professional and CIGNA HealthCare. This course of treatment strives to provide you with the best care in the most appropriate setting.
Denial Management

- **Medical Necessity**
  - Supporting documentation
    - Office visit, operative report, interpretation
    - Referring physician’s documentation
    - Referring physician request
    - Medical literature
    - Specialty society policy treatment
    - Medicare- NCD/LCD

Denial Management

- **Medical Necessity**
  - Evaluate payer policies: Don’t appeal- or decide to dispute at a higher level if not within policy guidelines
Denial Management

• Coding
  – Correct any mistakes
    • -51 instead of a -59?
    • Overlooked a diagnosis
    • Incorrect linkage of diagnosis and CPT code
  – Be more specific
    • Avoid xx999 (unlisted) codes
    • Avoid “not elsewhere classified (NEC)"
    • Avoid “not elsewhere specified (NOS)"

Denial Management

• Coding
  – Review the position of the “source of authority”
    • American Medical association
      – www.ama-assn.com
  • E.g., “CPT changes: An insider’s View”, “CPT Assistant”, and “Modifiers Made Easy”
  • Current CPT and ICD-9 code books
Denial Management

• Coding
  – Bundling
    • Correct Coding Initiative
      http://www.cms.hhs.gov/NationalCorrectCodInitEd/
    • Use these in your appeals to other carriers

Denial Management

• Duplicates
  – Is it really a dup?
  – Automatic rebills
  – Rebills as “appeals”
  – Ignoring automatic crossovers
  – Staff-productive(?)
  – Payer’s administrative problem; address at a high level
Denial Management

• Source of authority
  – Medical Necessity=
    • Medicare
    • Specialty Society
  – CPT codes= AMA
  – Bundling= Medicare (CCI)

Denial Management

• Decide if a denial is inevitable
  – Print to paper
  – Attach letter of “review requested”
  – Examples:
    • Certain payers (e.g., Workers Comp)
    • “Unlisted” procedure codes
      – Indicate “most like” code with pricing in letter
    • “Unspecified” diagnosis code
    • Correct use of modifiers
    • Multiple procedures or tests in one day
    • Complex surgical case
    • Other extenuating circumstances
  – Automate it
Denial Management

The Good News:

- According to data from Medicare, 65% or the claims carriers reviewed on appeal result in increased payments.
- Experts: 70 to 80% of appealed claims are eventually paid.

It’s Worth Your Time!

Denial Management

- Is it “appeal” – able?
  - Did you code correctly?
    - CPT (procedure) and ICD-9 (diagnosis)
    - Correct use of modifier, -59, -25, -57
  - Did you code AND provide the service according to the payer’s reimbursement guidelines?
  - Do you have the documentation to support your appeal?

- Is it worth your time?
  - Dollar amount v. Staff effort

*If the answer is “no” to any of these questions then Write-It Off. Make sure to track write-off codes/reasons and run monthly report.*
Denial Management

• Call and request reconsideration over the telephone

• If verbal reconsideration is not an option, appeal in writing
  – Process?
  – Address?

19 - Denial and Appeal Management
Involves Paper & Electronic Claims

Review EOB
Complete AR Form

Some FFs tables were paid and some Denied
All Services Denied
Claim Rejected Denied

First Level Appeals (2)

Unprocessable Claim?

Yes

Resubmit, call or write (?)

No

Writer Appeal

Phone Appeal

Refer to Payment Posting Process

Second Level Fair Hearing (3)

Refer to Payment Posting Process

Third Level Administrative Law Judge (4)
No Response

- Run an ‘open claims’ report
  - Over 30 days (45-60 if behind)
  - Hierarchical order
  - Appeal non-payment
Other tips

• “Unbilled” report (e.g., pending MCD)

• Work accounts in hierarchical order

• Adjustment/ Write-off codes

Account Follow-Up
Performance Workload Ranges

• Research correspondence * and resolve by telephone: 5-10 min/account; 6-12/hour

• Research correspondence* and resolve by appeal: 15-20 min/account; 3-4/hour

• Check status of claim (telephone/online) and rebill: 1-5 min/account; 12-60/hour

• Assuming 1/3,1/3,1/3= 113 accounts/day

*Including reviewing correspondence from payer that shows denial and/or underpayment, identifying cause of denial or underpayment, pulling medical documentation and/or other support and developing a case for reconsideration of payment.
Payment Posting
& EOB Analysis

Payment Posting & EOB Analysis Process

• ERA and fund transfer
• Batch mail payments
• Bank deposit is prepared and reconciled
• Match patient, date of service and CPT codes from EOB against system
• Apply payment and contractual adjustments to individual line item
• Post zero payment
• Appeal underpayment or zero pays line items
• Transfer balance to secondary or patient balance
• Print statements and secondary claims
EOB Information...

Information Routinely Found on EOB's

- Patient Name
- Date of Service
- Physician (Service Provider)
- Patient Account Number
- Patient Group Number
- Subscriber (Insured)
- Charge Amount
- Amount Allowed (Negotiated Rate)
- Amount Paid (Negotiated rate minus deductible)
- Deductible, Co-insurance &/or Co-payment Amount
- Contractual Adjustment Amount
- Patient Responsibility (Including co-pays, co-ins & deductible)

Information routinely found in EOBs (Explanation of Benefits)

- Patient Name
- Date of Service
- Physician (service provider)
- Patient account number
- Patient group number
- Subscriber (insured)
- Charges at 100%
- Amount allowed (negotiated rate)
- Amount paid (negotiated rate minus deductible)
- Deductible
- Contractual adjustment amount
- Patient responsibility (including co-payment and deductible)
Why audit EOBs?

- If you have not approached the denial issue previous, a great starting option is to conduct your own EOB audit as a means of measuring denial occurrences.

- Denials are not part of the fee that providers have contractually agreed to write off with payers. Rather denials need to be accounted for separately, just like bad debt, refunds and other adjustments to charges.

- An EOB audit ensures that posters are not manually entering denials and zero-dollar paid claims as contractual allowances. This posting error removes the provider’s ability to identify, rework, and resubmit these claim line items. It is also clearly improper from a reporting perspective; it masks denials under the contractual adjustment bucket. Lack of standards and consistency in posting of denials and zero-dollar payments causes the available data to misrepresent the extent of denials, their causes, and the amount of unrecovered revenue.
GOALS of EOB Audit

- Denials often are hidden on the explanation of payment or remittance advice.
- An EOB allows providers to establish a baseline denial rate.
- For those starting out, the goal of an EOB audit is not necessarily to conduct a statistically significant sample that definitively quantifies the extent of the denial problem within the organization.
- You can also use it to get a handle on claim pends since these will show up as a zero dollar payment on the EOB.

Two areas that are not tracked through the EOB audit are:

- Underpayments that are not zero dollars
- Claims that fail to be processed by the payer either electronically (EDI edits/rejections) or via paper processing.
Silent PPO
Be Ware!

What is a Silent PPO?

- Silent PPOs are illegal, fraudulent schemes that every year take millions of dollars out of the pockets of physicians and health care providers.

- The term Silent PPO refers to the scheme where insurers, who do not offer PPO policies, apply your contracted PPO discount rates to bills for patients who are not PPO members. Insurers who operate Silent PPOs are typically indemnity insurers, such as automobile insurers and workmen’s compensation insurers, that have no way of referring patients to you.
• Medical providers join PPOs to increase patient volume. Legitimate PPOs increase patient volume by entering into agreements with Payers, most often group health insurers. These group insurers offer PPO policies that contain steerage mechanisms to in-network providers, such as lower co-payments, lower deductibles or lower premiums. Also, legitimate Payers distribute provider directories that identify the preferred providers in the network. These directories are given to patients when they purchase their insurance and receive their PPO member ID cards. In exchange for increased patient volume, providers give legitimate Payers steep discounts on their bills, sometimes as much as 50% off their usual charges.

• That is not what happens with Silent PPOs. Under a Silent PPO scheme, Payers who do not offer PPO policies obtain the database of preferred provider rates from your PPO or from a middleman called a "discount broker." Then they apply those discounts to your bills. You get nothing in return. In fact, it's impossible for you to get increased patient volume from such insurers because they have no PPO policy, they provide no directories, and they give out no PPO ID cards. The patient does not even know the name of the PPO whose discounts were applied to the bill. As part of the Silent PPO scheme, insurers try to pass off the discount as legitimate on Explanation of Benefit forms.
• The result? You lose a tremendous amount of money — and, most likely, never discover that you have been defrauded. The AMA estimates that medical providers lose tens of millions of dollars per year based on the Silent PPO scheme.

How a Silent PPO Scheme Works

1. Office Visit. A patient chooses to treat with a certain medical provider. The patient is not referred or steered to the provider by an insurer. The primary type of insurance coverage responsible to pay the bill is a form of indemnity insurance, such as automobile insurance, worker's compensation, disability insurance or the out-of-network portion of a PPO policy.

2. The Insurance Claim. The medical provider bills the insurance company based on their usual and customary charge for the service provided.
3. The “Re-pricing” of Your Bill. The patient’s insurance company receives your bill and does one of two things. It either:

- runs your tax ID number on your bill through a PPO discount database it leased from a PPO, or
- provides a discount broker (also called a bill re-pricing company) with a copy of your bill.

The discount broker searches for a PPO “hit” by running your tax ID number through its database of PPO discounts. After a successful “hit,” your bill is “re-priced” based on the PPO discounts that were accessed.

4. The Deceptive EOB. After applying the discount, the insurance company states on the EOB that you agreed to reduce your bill based on your contract with the PPO. This is usually FALSE because your preferred provider contract, if you had one with that PPO, allowed only Payers with PPO policies or plans to access your discounts.

5. The Write-Off. The medical provider accepts the insurer’s statement on the EOB and writes the discount off — never knowing that the discount was invalid.
How to Audit Claims Payments and Recover Your Money

• **Step #1: Know the Contents of Your PPO Contracts.** Examine all your PPO contracts and the payer lists for each contract. See if there is room in those contracts for payers who do not offer preferred provider plans or policies to gain access to your discounts. If the nine terms discussed above are not in your PPO contract, you’re leaving yourself open to problems.

• **Step #2: Scrutinize All EOBs With PPO Discounts.** Beware of the following red flags: (1) the insurer taking the discount is an automobile insurer or a workmen’s compensation insurer; (2) failure to name the PPO whose discount was accessed; (3) you have no PPO agreement with the PPO indicated; (4) the PPO discount is indicated on the check but not on the EOB; (5) the PPO is identified but you terminated the contract a while ago; (6) the EOB comes on a bill re-pricing company’s letterhead, rather than the insurer’s letterhead, and references the bill re-pricing company’s agreement with a PPO, rather than the insurer’s agreement with the PPO.
• **Step #3: Cross-check the EOB Against Your PPO Contract for that PPO.** Check your contract to see if the payer is listed and what the contract requires.

• **Step #4: Cross-check the EOB Against the Insurance Information You Received From the Patient.** When you questioned the patient at the time of intake, if the patient did not mention the PPO indicated on the EOB, that should be a red flag. For all suspect EOBs, contact the payer and ask if they offer a PPO policy or plan with in-network and out-of-network features. Also, ask if the patient bought a PPO policy and whether the Payer has an agreement with your facility to discount your bills. Ask for a letter confirming both of these in writing.
• **Step #5: Contact the PPO and the Payer to Discuss the Discrepancy.** If the PPO participated in the illegal discount, perhaps by selling the information to an improper payer, they may work with you to settle the claim with the payer. You can also make an oral or written demand on the payer for payment of the discounted amount. Don’t hold your breath for payment.

• **Step #6: Hire an Experienced Health Care Law Firm to Conduct a Mini-audit of Your EOBs and to Recoup Silent PPO Discounts.**
Questions?