Michigan Medical Billers Association

Capturing Revenue through Appeals

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Judy B Breuker, CPC, CPMA, CCS-P, CHCA, PCS, CEMC, CHC, CHAP, AHIMA-Approved ICD-10-CM/PCS Trainer

judy@judybreuker.com

Notifications

To the knowledge of the presenter the course material was current at the time it was written. Every reasonable effort has been made to assure the accuracy of the information. Proper coding may require analysis of statutes, regulations or carrier policies and as a result, the proper code result may vary from one payer to another.

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Judy's disclaimer

- The information contained in this presentation is based on my personal experience. I owned and operated a medical billing service for 15 years and now serve as a revenue consultant to a variety of practices.
- Please visit the conference exhibitors for more ways to increase your revenue.
- NETWORK!

Agenda

- Why do we examine our billing process?
- The claim has been submitted – now what?
- Sample appeal situations

Three parts of the revenue cycle

- Activities related to the time of service
  - Obtaining correct information from the patient
  - Verifying insurance coverage
  - Establishing a clear and concise financial policy
- Collection of the account
  - Co-pays, deductibles, clean claims
- Monitoring the accounts receivable
  - Follow up……..

Why?

- OIG Compliance Program for Individual and Small Group Physician Practices
  - Federal register Vol. 65, No. 194, October 5, 2000
  - *A well-designed compliance program can:*
    - *Speed and optimize proper payment of claims*
    - *Minimize billing mistakes;*
    - *Reduce the chance that an audit will be conducted by CMS or the OIG; and*
    - *Avoid conflicts with the self-referral and anti-kickback statues*

More from the OIG

- *When physicians discover that their billing errors, honest mistakes, or negligence result in erroneous claims, the physician practice should _____ the funds erroneously claimed, but without penalties. In other words, absent a violation of a civil, criminal or administrative law, erroneous claims result _____ in the return of funds claimed in error.*

OIG…..

- *It is reasonable for physicians (and other providers) to ask: what duty do they owe the Federal health care programs?*
- *The answer is that all health care providers have a duty to reasonably ensure that the claims submitted to Medicare and other Federal health care programs are _____ and _____. The OIG continues to engage the provider community in an extensive, good faith effort to work cooperatively on voluntary compliance to minimize errors and to prevent potential penalties for improper billings before they occur.*

OIG….recommends _____

- *The practice's self-audits can be used to determine whether:*
  - *Bills are accurately coded and accurately reflect the services provided (as documented in the medical records);*
  - *Documentation is being completed correctly;*
  - *Services or items provided are reasonable and necessary; and*
  - *Any incentives for unnecessary services exist.*
- *A baseline audit examines the claim development and submission process, from patient intake through claim submission and payment, and identifies elements within this process that may contribute to non-compliance or that may need to be the focus for improving execution.*

Example from OIG

- In 2010, Health and Humans Services (HHS) reported Medicare improper payments totaling $_____. Of that total, $34.3 billion is attributable to Medicare Fee-for-Service (10.5-percent error rate) and $13.6 billion is attributable to Medicare Part C (14-percent error rate).
- Some but not all improper payments are the result of _____. Improper payments can also result from medically unnecessary claims, miscoded claims, eligibility errors, or insufficient documentation. Examples of improper payments include payments made to an ineligible recipient, duplicate payments, or payment for services not received. For example, OIG recently identified $3.6 million in improper Medicare Part D payments on behalf of deceased beneficiaries.

- GAO July28,2011 Reported Medicare Estimates and Key Remediation Strategies

Paymentaccuracy.gov

How?

A lot of money left on the table

- Only ____% of claims are paid the first time they're submitted, according to research by CMS.
- The other 30% of claims are either denied (20%) or lost or ignored (10%). And of those claims, 60% of them are never resubmitted to payers. That means medical practices never collect on a full _____ of claims.

Published by: www.carecloud.com

Statistic

- Commercial insurers have an average claims error rate of _____ percent and only _____ *percent of providers appeal denied claims, so you're leaving money on the table if your billing staff doesn't start the appeal process as soon as you receive a denial.*
  - Hyden, M. (2011, December 21). Insurance denials: Is your practice to blame? In *MGMA In Practice Blog*.

A lot of money left on the table

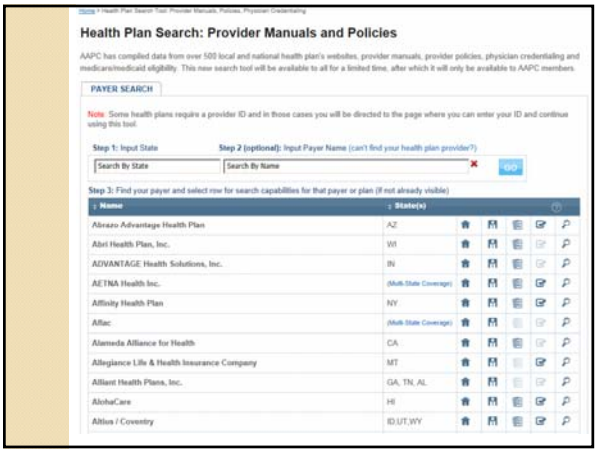
- The Medical Group Management Association (MGMA) estimates that payers underpay practices in the U.S. by an average of 7% - 11%.
- So if you add a _____% underpayment to the 18% of claims that aren't paid at all, **that means medical practices are failing to collect, on average, at least 25% of the money they've earned by treating patients.**
- That translates to a total of $_____ billion left on the table every year by American medical practices.

Published by: www.carecloud.com

GET YOUR TOOLS

A favorite tool

- AAPC Health Plan Search: Provider Manuals and Policies
  - Complied data from over 500 local and national health plan's websites, provider manuals, provider policies, physician credentialing and Medicare/Medicaid eligibility.
  - http://www.aapc.com/provider-manual/



Sign up for secure payer Web sites or portals

- _____
- Claim Status
- Claim corrections
- _____
  - Create a file on your computer to list your top payers appeal policies

Electronic Transactions

- _____
- Eligibility verification
- Electronic Remittance Advice
- Electronic Funds _____
- Pre-certification/prior authorization
- ePrescribing

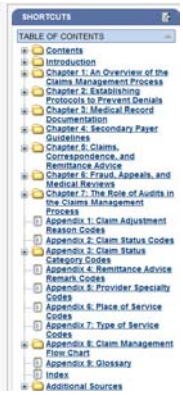
AppealLettersOnline.com

- http://www.appeallettersonline.com/
  - Appeal Letters
  - Audio Conferences
  - Download Library
  - State Specific Resources
  - _____ sample letters

Electronic Tools

- Maximize the use of electronic resources
- http://www.medicalreferenceengine.com/mre/

MEDICAL REFERENCE ENGINE includes the contents of the Ingenix Auditing and Denial book



Print resources

- AMABookstore.com
  - Reimbursement Management and Maximizing Billing and Collections package includes
    - Reimbursement Management: Improving the Success and Profitability of Your Practice
    - Maximizing Billing and Collections in the Medical Practice

BC Advantage

- www.billing-coding.com
- Annual subscription to magazine and a very robust website is very affordable.

AAPC National Conference

- Vendors!

Reports…reports…reports

Reports

- Standard report
  - Total charges, dollar amount submitted payment, amounts paid/adjusted/written off
    - Breakdown by physician, _____, CPT/RVUs, payer
- Aging
  - Check the parameters
    - Aging by date of _____
    - Aging by the date the last resubmission
      - Can give false information if rebilling

Reports

- Charge _____ time
  - Average number of days from date of service to posting date
  - Benchmark < _____ days
  - One of my clients found a "suspended claim report" with over _____ _____ of claims
- Denial reports
  - Run by Remittance Advice Remark Codes
  - http://www.wpc-edi.com/reference/

Example next slide

Claim Adjustment Reason Codes

www.wpc-edi.com

Remittance Advice Remark Codes

www.wpc-edi.com

Another source

Understanding the Remittance Advice for Professional Coders

- Free web-based training course through Medicare Learning Network
- **Goal**
  The goal of this course is to provide institutional providers and their billing staff with general RA information. This course provides instructions to help you interpret the RA received from Medicare and reconcile it against submitted claims. It will give guidance on how to read Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices (SPRs), as well as information on balancing an RA. The course also provides an overview of software that Medicare provides free to providers for viewing ERAs.

Great Article!

- Go to the AAPC Physician Services website www.aapcpcs.com and read the article by Jim Denny dated December 18, 2012 titled
  - Managing Four Key Revenue Cycle Metrics to Improve your Practices Financial Health.

Accounts Receivable Formulas

- Gross Collections
  - Payments ÷ Charges
    - Dependent on how high your charges are.
- _____ **Collection Ratio**
  - Total net collections less patient refunds ÷ gross charges less contractual adjustments
  - Net collection ratio shows the % of total collections after factoring in contractual adjustments and refunds.
    - Do not include noncontractual adjustments (late filing, lack of authorization, etc)
  - MGMA net collection ratio is _____

Formulas

- _____ in Accounts Receivable
  - How long it takes to collect your money
  - Total Accounts Receivable (minus credits owed by the practice to others) ÷ Average daily charges for the past 90 days (the previous 3 months in charges divided by the total number of working days during that period)
    - Some divide it by 30 days or 365 days, just **be consistent**
    - This can also be calculated by _____

Claim Processing

- File claims _____ if possible
- Research errors and correct
- Post payments
- Update accounts
- Work your _____ reports
  - Credits can make your receivable report look better than it really is.

Cleaning up your account receivables

- Do not "clean up" your AR by _____.
  - Monitor adjustments
    - Require _____ people to sign off on adjustments over $x
  - Routine waiver of copay and deductible
    - Misrepresenting the charge to the payer
    - Violates your payer agreements
    - See OIG Fraud Alert in 1994

Great article to read:
If You Identify Overpayments, You Should Refund
www.aapcps.com
By: Michael D. Miscoe, Esq., CPC, CASCC, CUC, CCPC, CPCO, CHCC

_____ balances

- Review credit balances monthly
  - Research the account thoroughly
  - How did the need for the refund happen?
  - Who gets the money? The patient or payer?
  - Unclaimed refunds
    - Follow your state's escheat guidelines
  - Follow payer guidelines

NOW THE WORK BEGINS……APPEALS

Setting up your appeal _____

- What $ amount is your minimum?
- Who is responsible for the appeals?
- How do you determine which claims to appeal?
- Do you have a policy or a procedure to enlist the assistance of the patient?
- How do you _____ your pending appeals?

Some areas to consider appeals

- _____ Payment Laws
- Coding Issues
- Medical Necessity
- _____

Appealing claims with Prompt Payment Laws

Prompt Payment Laws by State & Sample Appeal Letter

State	Payment Timeframe	Penalty(ies)	Contact
Alabama	30 working days for electronic claims; 45 paper	DOI fine	Alabama Department of Insurance, Life and Health Division 334-269-3550 http://www.aldoi.gov/
Alaska	Paper: 20 working days Electronic: 10 working days	< $250: 5 % payment or $5, whichever is less > $250: 2 % of the payment	Alaska Division of Insurance (907) 465-2515 http://www.dced.state.ak.us/insurance/
Arizona	All claims types: 30 days after claim approved	Legal interest rate	Arizona Department Of Insurance (602) 912-8456 http://www.id.state.az.us/index.html
Arkansas	Paper: 45 calendar days Electronic: 30 calendar days	12% annually	Arkansas Insurance Department (501)371-2600 or 1-800-282-9134 http://www.state.ar.us/insurance/
California	Non-HMOs: 30 working days HMO's: 45 working days	15% annually; $10 additional non-inclusion of interest with payment	California Department of Insurance (800) 927-HELP (4357) (213) 897-8921 http://www.insurance.ca.gov/

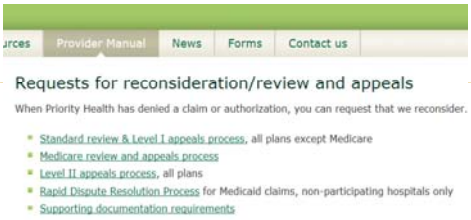
Woodcock & Associates www.elizabethwoodcock.com

Example: Michigan Prompt Payment Statutes

- Prompt Payment of Claims
  - Clean claims must be paid in _____ days
- Prompt Payment of Worker's Compensation Claims
  - Claims should be paid within _____ days

Follow payer guidance

- Example: Priority Health



Beginning the appeal process

- Carefully read the EOB/RA
  - The EOB/RA will show the _____ for the partial payment, delay or denial.
  - Do _____ automatically modify the claim and re-submit for payment.

Preparing your appeal

- Review your _____ with the payer.
- Include all of the patient's information.
- Clearly state why you are appealing the claim. Do not just send the documentation.
- Support your case with authoritative references.
- Include your _____ information.

Appeal Coding Issues

Verify the correct codes were used.

- _____ issues
  - Follow the Official Coding Guidelines
- _____ issues
  - Carefully read the CPT manual, especially the guidelines and the notes.
  - Use CPT Assistant to clarify the intention of the code
  - Use the RBRVS Data Manager.

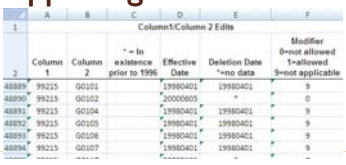
Appealing Underpayments

- Downcoding?
  - Not limited to _____ services
    - Lack of recognition of modifier -50
    - Procedures can be downcoded from the code which contains the word "complex" to the code that contains the word "simple".
    - Add-on code not recognized.
    - _____ not recognized.
  - It can be easily missed if your payments are being automatically posted or even manually posted.

Appealing claims by _____

- Do you have access to the policies and procedures page?
- Do you have _____ to medical policy
- Is there an electronic process for appeals using the payer's website
- Don't forget the payers provider relations department
- Are you sure your practice has a participating agreement with the payer?

Appealing bundled claims



Column1/Column 2 Edits

	Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
48889	99215	G0101		19980401	19980401	9
48890	99215	G0102		20000605	*	0
48891	99215	G0104		19980401	19980401	9
48892	99215	G0105		19980401	19980401	9
48893	99215	G0106		19980401	19980401	9
48894	99215	G0107		19980401	19980401	9

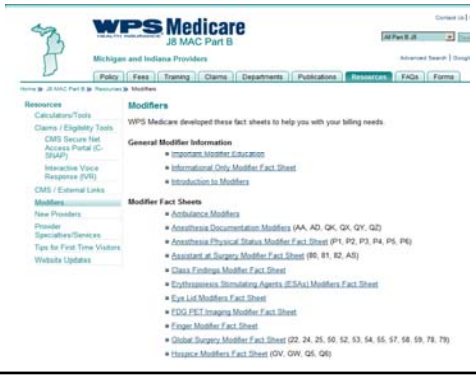
CMS Website – 18 page .pdf file

Updated January 2012 (revision in process)

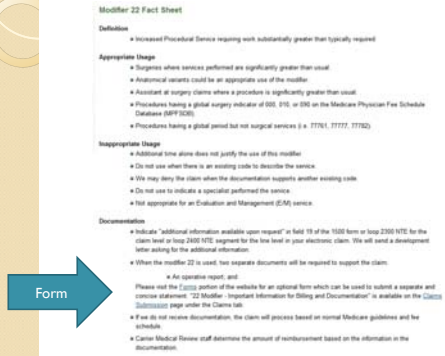
Appeals involving _____

- First – Verify the documentation supports the use of modifiers.
- Check if the payer has information on the use of modifiers on their website.
- _____ the payer received the claim with the modifier attached.

Appeals involving modifiers



Get the details


Modifier 22 Fact Sheet

Definition

- Increased Procedural Service requiring work substantially greater than typically required

Appropriate Usage

- Surgeries where services performed are significantly greater than usual
- Anatomical variants could be an appropriate use of the modifier
- Assistant at surgery claims where a procedure is significantly greater than usual
- Procedures having a global surgery indicator of 000, 010, or 090 on the Medicare Physician Fee Schedule Database (MPFSDB)
- Procedures having a global period but not surgical services (i.e. 77761, 77777, 77782)

Inappropriate Usage

- Additional time alone does not justify the use of this modifier
- Do not use when there is an existing code to describe the service
- We may deny the claim when the documentation supports another existing code
- Do not use to indicate a specialist performed the service
- Not appropriate for an Evaluation and Management (E/M) service

Documentation

- Indicate "additional information available upon request" in field 19 of the 1500 form or loop 2300 NTE for the claim level or loop 2400 NTE segment for the line level in your electronic claim. We will send a development letter asking for the additional information
- When the modifier 22 is used, two separate documents will be required to support the claim:
  - An operative report, and
  - Please visit the Forms portion of the website for an optional form which can be used to submit a separate and concise statement. "22 Modifier - Important Information for Billing and Documentation" is available on the Claims Submission page under the Claims tab
- If we do not receive documentation, the claim will process based on normal Medicare guidelines and fee schedule.
- Carrier Medical Review staff determine the amount of reimbursement based on the information in the documentation.

Form

Medical _____ appeals

- Find out which services are subject to medical necessity review.
- Enlist the help of your physician or your physician's specialty society.

Basics

- **Medical Necessity**
  - *Services are _____ and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.*
  - Chief complaint, nature of the presenting problem, issues/problems expressed by the patient or discovered by the provider

The Medicare Appeals Process

- **First** Level of Appeal: Redetermination
  - 120 days from the date of receipt of the initial claim determination.
  - A minimum monetary threshold is not required to request a redetermination.
  - Go to the CMS website for the redetermination form.

The Medicare Appeals Process

- **Second** Level of Appeal: Reconsideration
  - If you are dissatisfied with the redetermination file a reconsideration request within 180 days of receipt of the redetermination.
  - A QIC (Qualified Independent Contractor) will conduct the reconsideration.
  - No minimum monetary threshold.
  - Use the form included with your Medicare Determination Notice.

The Medicare Appeals Process

- **Third** Level of Appeal: Administrative Law Judge Hearing
  - At least $130 in controversy following the QIC's decision.
    - The $ amount increases annually with the consumer price index
  - Request ALJ hearing within 60 days of receipt of the reconsideration.
  - Generally held by video-teleconference or by telephone

The Medicare Appeals Process

- **Fourth** Level of Appeal: Appeals Council Review
  - The request for Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ's decision.
  - Usually the AC will issue a decision within 90 days of receipt of a request for review.

The Medicare Appeals Process

- **Fifth** Level of Appeal: Judicial Review in U.S. District Court
  - At least $1,350 in controversy.
  - File the request for review within 60 days of receipt of the Appeals Council's decision

APPEAL EXAMPLES

ANATOMY OF AN APPEAL

The documentation supported a separate E/M for treatment of HTN and COPD.

Initial submission - 69210 Was denied as inclusive to the E/M provided. After initial appeal, 69210 was paid and the E/M payment was recouped.

99213-25	401.9, 496
69210	380.4

Appeal 69210 using CPT Assistant Online

Appeal 69210 with RBRVS Data Manager

Appeal 69210 using the specialty society

Finalize the appeal

- Include definition of modifier -____ and what documentation supported the separate E/M
- Include the explanation of what is included in the 69210
- In the interest of high _____ patient care the chronic conditions (COPD, HTN) needed to be managed and the impacted cerumen needed to be removed.

EXAMPLE #2

ANATOMY OF AN APPEAL

36 claims in 6 months - Workers comp company bundling the steroid medication into 64483 (Injection, anesthetic agent and/or steroid, transforaminal, epidural, with imaging guidance; lumbar or sacral, single level)

64483	722.10
J1040	722.10

Displacement of lumbar intervertebral disc without myelopathy

RBRVS DATA MANAGER

CodeManager Online

Include _____ information

integral to another procedure with that procedure.

Many NCCI edits are based on the standards of medical/surgical practice. Services that are integral to another service are component parts of the more comprehensive service. When integral component services have their own HCPCS/CPT codes, NCCI edits place the comprehensive service in column one and the component service in column two. Since a component service integral to a comprehensive service is not separately reportable, the column two code is not separately reportable with the column one code.

Some services are integral to large numbers of procedures. Other services are integral to a more limited number of procedures. Examples of services integral to a large number of procedures include:

- Cleansing, shaving and prepping of skin
- Draping and positioning of patient
- Insertion of intravenous access for medication administration
- Insertion of urinary catheter
- Sedative administration by the physician performing a procedure (see Chapter II, Anesthesia Services)
- Local, topical or regional anesthesia administered by the physician performing the procedure
- Surgical approach including identification of anatomical landmarks, incision, evaluation of the surgical field,

Revision Date (Medicare): 1/1/2012
I-9

CPT _____ Package

« Previous Section | Next Section »

CPT Surgical Package Definition

The services provided by the physician to any patient by their very nature are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services "included" in a given CPT surgical code, the following services are always included in addition to the operation per se:

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Subsequent to the decision for surgery, one related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of procedure (including history and physical)
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
- Writing orders
- Evaluating the patient in the postanesthesia recovery area
- Typical postoperative follow-up care

WC Health Care Services Manual

Global Procedure (Package)

The payment for surgical procedures is based upon a global package concept. Global payment requires that the service(s) performed be identified and billed using the fewest possible CPT® codes ("unbundling" is not allowed).

The global surgical procedure includes:

- The immediate preoperative care (a consultation or an evaluation in an emergency situation to evaluate the need for surgery is not considered part of the global procedure)
- Local anesthesia, such as infiltration, digital, or topical anesthesia
- The surgical procedure and application of the initial dressing, cast, or splint, including skin traction, unless excluded by the CPT® book
- Normal, uncomplicated follow-up care (follow-up days noted in the manual).

One more thing……

- *Please furnish the name and credentials of the _____ professional who reviewed the treatment records.*

EXAMPLE #3

Example of another appeal

- Payer contacted an office to demand a refund of over $23,000 in E/M services rendered on the same day as urodynamic procedures (51725-51792) for a 9 month period.
  - Demand letter was dated Dec 15 with full payment required in 30 days.
  - E/M visits were submitted with a modifier -25
  - Letter quoted OIG Nov. 2005 article on modifier -25

Example of an appeal – my story

- The quote used by the payer…….
- *Medicare **payments for medical procedures include payments for certain evaluation and management (E/M) services** that are necessary prior to the performance of a procedure. The Centers for Medicare & Medicaid Services (CMS) does not normally allow additional payments for separate E/M services performed by a provider on the same day as a procedure. However, if a provider performs an E/M service on the same day as a procedure that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure, modifier 25 may be attached to the claim to allow additional payment for the separate E/M service.*

The story continues

- Client contacts me in a panic – should we just send the $ back?

My story …..continued

- I told the client to ask for an extension since the _____ day period included Christmas and New Years. The extension was _____.
- I requested all of the records

My story …..continued

- _____ of the records supported an additional E/M with the -25 modifier except one record.
- Using 51798 as the example
  - *Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging*

My example

- The appeal letter begins
  - According to the _____ physician fee-schedule look-up the procedure has XXX global days.
  - I used the RBRVS _____ _____ to show the vignette of what portion of E/M is included in the procedure.
    - PRE-SERVICE: Ask the pt. to empty his bladder…turn on the ultrasound machine
      - What is missing? The initial history of the present illness, the physical examination the decision of what tests are medically necessary

Continuing the appeal letter

- _____: The procedure itself
  - I included the description
- _____: The machine notes the scan with the largest volume. Print the bladder image with the volume of urine in milliliters.
  - What is missing? Medical decision making regarding next steps. Explaining the results. Does the patient need surgery? More testing?

Continuing the appeal

- The RBRVS stated pre-service time was _____ minutes and intra-service time was _____ minutes and the post-service time was _____.

Continuing the appeal letter

- I included the CPT descriptions of modifier -25
- Since the urodynamic procedures are diagnostic procedures I included the CPT language in the surgery guidelines
  - *Follow-up care for diagnostic procedures includes _____ that care related to the recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure procedure was performed….is _____ included.*

Wrapping up the appeal letter

- I went to the American Urological Association website. The website includes _____ letters to address payers bundling the urodynamic procedures.
- Also included on the website was a letter regarding the inappropriate edit of bundling _____ services into a procedure designated as XXX.

Result

EXAMPLE #4

I received a call from a physician who I never met.

- He was a Maternal Fetal Medicine physician.
  - He was so upset I could barely understand him.
- A payer requested documentation of 5 _____ visits
  - The payer responded that the claims were being denied for **medical necessity** since the provider did not document a comprehensive examination.
  - Based on the limited physical examination the claims were being reduced to _____.

Maternal-Fetal Medicine Audit

- The physician called the payer and he was told the payer was initiating a recovery for _____ 99205's submitted in the last three years and they were going to perform prepayment audits on all _____s and _____s.
- The payer restated that these were considered medical necessity audits.

MFM and 99205s

- The physician stated that his biller said the payer was _____ since the documentation guidelines _____ a comprehensive physical examination.

MFM 99205s

- I requested the documentation of the 5 original charts sent to the payer
- Each note was ___ pages long and extremely detailed.
  - The only physical examination documentation was the patient's _____ and mood/affect.
- I stated I would send my thoughts on the appeal.
- Ideally the time spent in counseling would have been documented but he was not aware of the need to do this.

I outlined the plan for an appeal addressing medical necessity

- Describe the _____
  - **Maternal & Fetal Medicine**
    An obstetrician/gynecologist who cares for, or provides consultation on, patients with complications of pregnancy. This specialist has advanced knowledge of the obstetrical, medical and surgical complications of pregnancy and their effect on both the mother and the fetus. The specialist also possesses expertise in the most current diagnostic and treatment modalities used in the care of patients with complicated pregnancies. American Board of Medical Specialties

Outline of the appeal

- "Documentation Guidelines for Evaluation and Management Services"
  - *For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below **may be** _____ to account for these _____ circumstances in providing E/M services.*

More from the Documentation Guidelines

- Documentation Guidelines: "For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and _____ _____ may have additional or modified information recorded in each history and examination area…….Although not specifically defined in these documentation guidelines, these patient group **variations on history and examination are** _____."

More from the Documentation Guidelines

- *The extent of examinations performed and documented is dependent upon _____* ***judgment*** *and the _____* ***of the presenting problem(s)****.*

Outline of the appeal

- Per MCM 100-04 C12 S 30.6C
  - Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. **The _____ of documentation should _____ be the primary influence upon which a specific level of service is billed.**

Outline of the appeal

- Example of one of the patients
  - **Advanced Maternal Age**.
  - **The patient had 3 miscarriages**
  - **Pregestational Diabetes**
  - **Chronic Hypertension**
  - **High risk behavior**

Ask yourself…….

- Before looking any further – does this visit appear to support the _____ of 99205?

Outline of the appeal

Nature of the presenting problem

- **Exceeds** the Nature of the Presenting Problem associated with a _____.
  - Per CPT: Moderate severity: A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.
  - **High severity: A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.**

MFM Appeal

- The results and interpretation of the ultrasound was documented.
- Each of the patient's diagnoses was listed with a full paragraph describing the _____ with each one, how it was explained to the patient and the patient's response or questions
- Summary paragraph explained the risk of all of the diagnosis together and outlined the detailed _____ for _____ for the pregnancy

Final paragraph in the appeal

- *Please provide the name and credentials of the physician of the _____ specialty who states the documentation and condition of the patient does _____ support the medical necessity of the intent of 99205.*

Ready to appeal

- I sent all of the information to the manager and outlined every step of the appeal.

Results of my appeal

A RECAP…..

Summary of appeals

- OIG recommends auditing your billing practices
- Use online and print tools
- Use reports to identify claims needing appeals
- Know the rules
- Sample appeals

CEU#

_____

Thank you for your time and attention!

~ Judy

Thank you for your time and attention ~Judy

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on Facebook

Sources and Resources

- AAPC *BillingInsider* (e-Newsletter)
- American Medical Association practice management center
- BC Advantage Magazine http://www.billing-coding.com/
- Centers for Medicare and Medicaid Services
- *The Medicare Appeals Process*, Medicare Learning Network, ICN: 006562 June 2012
- www.elizabethwoodcock.com
- AMA Coding Online http://commerce.ama-assn.org/store/

- Don't forget to visit the vendors during conference for more great tools!