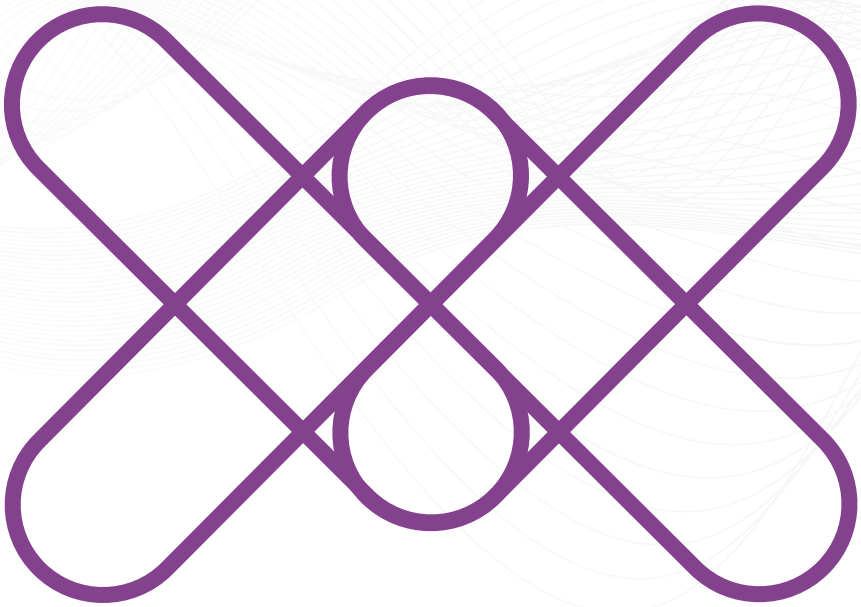
Denials Management & Appeals Reference Guide

A comprehensive resource to maximize your revenue and streamline your appeals process

SECOND EDITION



AAPC

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Disclaimer

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2233 South Presidential Drive, Suite F, Salt Lake City, Utah 84120
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Introduction

Now's the time to get the upper hand on denials and appeals!

Denials Management & Appeals Reference Guide equips you to fend off denials, collect the revenue your practice deserves, and climb out of the appeals abyss once and for all.

Map out a plan for pre-claim review, optimize your revenue with face-to-face documentation tips, learn when you can "reopen" a claim to fix an error, wield proven strategies for appeals that win your earned income, and much more.

We've compiled expert tips and handy references in this guide, designed to become a vital resource full of critical tips and tools you'll rely on day after day. Plus enjoy bonus features including user-friendly guidance and proven strategies, and a quick reference to regulations you need to succeed.

With **Denials Management & Appeals Reference Guide,** you'll conquer correct prior authorizations, learn tips for improving documentation to avoid denials, nail down how to respond to overpayment demands, and get a leg up on correct coding and billing.

Put an end to rework and revenue loss. Denial mayhem can be defeated with the **Denials Management & Appeals Reference Guide.**

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National Correct Coding Initiative (NCCI)

NCCI, also shortened to CCI, is an automated edit system used to indicate specific CPT® code pairs and whether they can be reported on the same date of service for the same beneficiary by the same provider. CMS implemented the NCCI to promote correct coding methodologies and to control improper assignment of codes resulting in inappropriate reimbursement. NCCI coding policies are based on:

- Analysis of standard medical and surgical practice
- Coding conventions included in CPT®
- Coding guidelines developed by national medical specialty societies through the CPT® Advisory Committee (committee members include representatives of major medical societies)
- Local and national coverage determinations
- Review of current coding practices

The edits are updated quarterly by CMS, and the policy manual is updated annually.

NCCI is used by professional coders and billers to determine codes considered by CMS to be bundled for procedures and services deemed necessary to accomplish a major procedure. Bundled procedure codes are not reported separately. The components of a bundled procedure are included in the comprehensive procedure code.

Local CMS carriers (MACs) began using the NCCI edits on January 1, 1996. Since October 2010, the Patient Protection and Affordable Care Act § 6507 (ACA) required state Medicaid programs to incorporate NCCI methodologies into their claims processing. Many commercial health plans also utilize the NCCI edits in their claims processing.

MACs are entities (third-party payers, insurance companies) that contract with the federal government to adjudicate and process claims in the geographical region for which they have been given jurisdiction. The MAC is responsible for making coverage decision policies and protecting the integrity of the Medicare program. Each MAC and the jurisdiction they are responsible for may have differing policies.

NCCI edits were originally developed to assist MACs in processing Medicare Part B claims. In August of 2000, NCCI edits were added to the Outpatient Code Editor (OCE) to assist MACs in processing Part B claims for outpatient hospital services.

The NCCI includes two types of edits:

1. Procedure to Procedure (PTP) edits

   PTP edits apply to code pairs that should not be billed together because one service inherently includes the other. In certain situations, an appropriate modifier may be allowed and used.

   Mutually exclusive edits (MEE) are included in the PTP edits. These edits include code pairs that, for clinical reasons, are unlikely to be performed on the same patient on the same date of service. For example, two different types of laboratory testing that would produce the same result as one test.

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Global Surgery			
Modifier	**Description**	**Appropriate Examples**	**Examples/ Rationale No Modifier**
78	**Unplanned Return to the Operating/ Procedure Room by the Same Physician or Other Qualified Healthcare Professional Following Initial Procedure for a Related Procedure During the Postoperative Period**: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure.	A patient returns to surgery for possible abdominal bleeding on the same day following a colon resection performed earlier by the same surgeon (49002-78).	Patient in the global period of a laceration repair of the thigh has developed a small hematoma. The incision is opened 1 inch and the hematoma is drained in the office (99024). 10140-78 is not reported because the procedure did not require a return to the operating room.
79	**Unrelated Procedure or Service by the Same Physician or Other Qualified Healthcare Professional During the Postoperative Period:** The physician or other qualified healthcare professional may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79.	A patient returned to surgery for a closed reduction of a left ankle fracture while the patient was recovering from an open reduction to a right ankle performed by the same surgeon (27808-79).	

Questions & Answers: The Global Surgical Package

Question:For *a postoperative, related E/M visit within the global surgery period, should I still submit the claim to the payer despite the inevitable denial? Or is it common practice to code the claim and then immediately write it off?*

Answer: In the case of postoperative E/M visits, you should check your practice's guidelines as to whether or not it typically bills for (related) postoperative claims within the global period. Whether or not you end up submitting to the payer, you should use code 99024 *Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was*

For these patients identified in B2, a formal shared decision-making encounter must occur between the patient and a physician (as defined in Section 1861(r)(1) of the Social Security Act (the Act)) or qualified nonphysician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa)(5) of the Act) using an evidence-based decision tool on ICDs prior to initial ICD implantation. The shared decision-making encounter may occur at a separate visit.

3. Patients who have severe, ischemic, dilated cardiomyopathy but no personal history of sustained VT or cardiac arrest due to VF, and have NYHA Class II or III heart failure, LVEF < 35%. Additionally, patients must not have:
   - Had a CABG, or PCI with angioplasty and/or stenting, within the past three (3) months; or,
   - Had an MI within the past 40 days; or,
   - Clinical symptoms and findings that would make them a candidate for coronary revascularization.

For these patients identified in B3, a formal shared decision-making encounter must occur between the patient and a physician (as defined in Section 1861(r)(1) of the Actor qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa)(5) of the Act) using an evidence-based decision tool on ICDs prior to initial ICD implantation. The shared decision-making encounter may occur at a separate visit.

4. Patients who have severe, non-ischemic, dilated cardiomyopathy but no personal history of cardiac arrest or sustained VT, NYHA Class II or III heart failure, LVEF < 35%, been on optimal medical therapy for at least three (3) months. Additionally, patients must not have:
   - Had a CABG or PCI with angioplasty and/or stenting, within the past three (3) months; or,
   - Had an MI within the past 40 days; or,
   - Clinical symptoms and findings that would make them a candidate for coronary revascularization.

For these patients identified in B4, a formal shared decision-making encounter must occur between the patient and a physician (as defined in Section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa)(5) of the Act) using an evidence-based decision tool on ICDs prior to initial ICD implantation. The shared decision-making encounter may occur at a separate visit.

5. Patients with documented, familial or genetic disorders with a high risk of life-threatening tachyarrhythmias (sustained VT or VF, to include, but not limited to, long QT syndrome or hypertrophic cardiomyopathy.

For these patients identified in B5, a formal shared decision-making encounter must occur between the patient and a physician (as defined in Section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa)(5) of the Act) using an evidence-based decision tool on ICDs prior to initial ICD implantation. The shared decision-making encounter may occur at a separate visit.

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For example, when documentation is requested by a payer for processing of a claim, only documentation pertinent to that service should be sent to the payer. Sending the entire medical record would be a violation of minimum necessary.

Medical billers often receive requests for medical records for processing claims. A medical biller should respond to the request for records by providing only the dates of service requested, or the minimum necessary.

Question and Answer: Documentation and the Medical Record

Question: *My provider is consistently behind in documentation; can I bill for services prior to the provider completing the documentation?*

Answer: Many of us already know this familiar phrase: "If it has not been noted in the record, then it never happened." A procedure must be indicated and substantiated on the chart and included in the EMR for the payers (and auditors) to accept a claim for that service.

Bottom line: Regardless of what procedures the physician performs — and how mandatory or integral it is that the procedure be performed in line with the rest of the documented services — if a particular procedure is not documented, it does not get reimbursed. Period.

Remember: Payers determine eligibility for payment through the documentation submitted to substantiate the claim. Providers should ensure that their documentation accurately and meticulously reflects a full picture of the encounter. This will, in turn, maximize reimbursement and revenue.

Evaluation and Management Denials

Specific information is required to describe the patient encounter each time the patient presents for medical services. Clinicians may review past records or speak with other healthcare professionals, gather specific information from the patient through a series of questions, and physically assess the patient. The clinician will then summarize their findings and create a plan to treat the patient. Each encounter will generally contain:

- The chief complaint is a description of why the patient is presenting for healthcare services. It can also be referred to as the reason for the patient visit.
- The history of present illness (HPI) is how the patient describes the symptoms they are experiencing, and which have prompted the patient to seek medical attention.
- The physical examination is performed by the healthcare provider through a series of assessments and observations, focused around the symptoms described by the patient.

The healthcare provider makes a determination (also known as a diagnosis) about the cause of the symptoms, which is the provider's assessment of the problem. Based on that assessment, the provider creates a plan to relieve or resolve the patient's symptoms.

The most common format used in medical records is the SOAP format:

S — Subjective: where the patient provides information about their symptoms and what, if anything, they have done to relieve the symptoms.

O — Objective: indicates the physical exam findings of the provider.

A — Assessment: the provider's assessment of the patient's condition, and where the provider indicates either a definitive or working diagnosis. In absence of a diagnosis, signs and symptoms may be documented until further testing can be performed.

P — Plan: the provider's plan is documented in direct relation to the assessment above. In cases where a definitive diagnosis has not been reached, the documentation should reflect tests that are being ordered, with an indication of the provider's thought process.

Regardless of the format used by the provider, it is imperative the documentation of an evaluation and management visit accurately reflect the work performed during the visit.

If a minor office procedure is performed during an evaluation and management service, the documentation for that procedure can be included in the notes for the evaluation and management service. It is not necessary to have a separate operative report.

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Fact 2: 24 Only Applies to E/M Codes

If you report an E/M service that's unrelated to the surgery, you'll append modifier 24 to the E/M code — but you should *never* append modifier 24 to a procedure code. It only applies to E/M codes. Therefore, if the physician performs a surgical procedure that has a 10- or 90-day global period and then sees the patient for an unrelated E/M service during that global period, you can report the service when you append modifier 24 to the E/M code.

Fact 3: Auditors Examine Whether Visit Was Related to Surgery

If your documentation shows that somehow the visit is related to the surgery, do not use the 24 modifier.

Remember, documentation drives your modifier use. You want to be sure you're documenting exactly what's going on with the patient in case an auditor reviews your record. If the auditor finds that your provider only documents a postoperative visit and nothing else, you will have the claim denied.

In addition, if the documented diagnosis for the E/M visit is the same as the surgical diagnosis, auditors would take a closer look. You aren't required to have separate diagnoses, but thanks to the specificity of ICD-10-CM, using the same diagnosis will make auditors double-check the diagnosis.

Of course, if the patient suffers from a condition that has a nonspecific diagnosis code, using the same diagnosis might be appropriate.

Myth: Returning Patients to the OR Warrants Modifier 24

Complications of surgery can be billable during the global period if the patient must return to the operating room — but 24 is not the right modifier in this situation.

If the physician must return to the OR to treat a postop complication, both Medicare and private payers will pay at a reduced rate when you attach modifier 78 to the code.

Question: *How do I use modifier 25?*

Modifier 25 is probably one of the most used, and one of the most misused, modifiers that you can employ in your coding.

If you read the modifier's descriptor closely, you can begin to see some of the problems you can encounter when using it. Simply put, if the procedure or other service is not on the same day, if the E/M service is not significant or separate from the procedure, and if the same physician or qualified healthcare professional (QHP) did not perform both the E/M service and the procedure (or if either service was performed by someone other than a physician or QHP), then you have incorrectly applied the modifier.

Example: Your office schedules a patient for a leg lesion removal, and your provider performs 11401 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm.* Billing a separate E/M service with modifier 25 in this scenario would not be appropriate because the lesion removal was the sole reason the patient came to the office. The provider did not perform a significant or separately identifiable E/M service, so you cannot charge for it.

1. Denials Tracking Worksheet

Denials Tracking Worksheet

Clinic: _____

MONTH: _____

	Patient's Name	Med Rec#	DOS	Doctor	CPT® Code	ICD-10-CM Code	$ Charged	Insurance Co.	Corrected/ Refiled	Denial Reason/Additional Comments
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.										
16.										
17.										
18.										
19.										
20.										
21.										
22.										
23.										
24.										
25.										
	Total									

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