The Appeal Letter

Combat Denied Claims & Get Paid What You Deserve!

Appeal Your E/M "Level of Care" Denials By Asking For In-depth Coder Review

Evaluation and Management code selection often comes under intense scrutiny by payers.

However, just as any other denial, these denials can be appealed.

Payers provide little guidance regarding how E/M audits and denials are triggered. However, a well-worded appeal letter can seek information from the payer regarding their E/M reviews as well as information regarding the reviewer's coding credentials.

As coders know, the correct code for an e/m visit generally is tied to the complexity of the visit. Complexity is determined by the number of problems and the extent to which each problem is addressed. This assessment requires careful manual review of the clinical documentation.

View The Appeal Letter Here. . . .

AppealTraining.com Featured

Letters

We have a new appeal letters specific to collecting payment for medical records processing. Please see the following new letters under the topic: Stalled Claims and the subcategory: Medical Records Reimbursement:

Category: Stalled Claims
Subcategory: Medical Records Reimbursement

- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Missouri

Let us know if you have a specialty-specific appeal scenario which is not covered by our content. We are always growing our appeal letter database.

Visit AppealTraining.com's Database of 1600+ Letters

Medicare Advantage Expedited Decisions: How Many Days Can Payers Take for Written Notification?

Medicare Advantage appeals can be challenging due to the variation among payer review processes. However, there are important regulations that apply to all Medicare Advantage plans.

For example, the Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeal Guidance contains strict timeframes for decision-making by Part C & D payers and has released some clarification regarding calculating timeframes.

In particular, the guidance clarifies when MA plans must provide the written notice regarding expedited decisions as follows:

If the plan initially provides verbal notification, then written confirmation must occur within 3 days of the verbal notification.

Q: Is the first day to provide written notification the day of or the day after verbal notification is provided?

A: Day one is the day after verbal notification is provided.

See the following link for more Medicare Advantage Appeals and Grievances Information:

Medicare Advantage Appeals & Grievances Info...

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