APPEAL TRAINING COURSE 6

INCORRECT PAYMENTS & DEDUCTIONS

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Incorrect Payments

Insurance carriers now exercise great control over both in- and out-of-network payment through implementing fee schedules, usual, customary, and reasonable (UCR) limitations, and, more insidiously, computerized payment methodologies for applying internal bundling, downcoding, and other price control features. Often, it is difficult to even determine how a medical claim was paid and whether these payment policies are applied consistently and fairly across all similar claims.

An insurance company's duty to disclose claim information and provide denial information typically extends to partial payments; however, the explanation of benefits does not always provide clear information regarding how the benefits were calculated. Providers sometimes must demand specific information regarding the payment methodology applied to the claim in order to determine whether correct benefits have been released. A well-written disclosure demand letter can clarify whether a silent preferred provider organization (PPO) discount and incorrect discount have been unfairly applied to the payment.

As you are likely aware, coding has become increasingly complex, and so, too, has benefit calculation. Insurance companies rely on automated claim processing software with built-in, or sometimes added, editing programs to handle the many changes in reimbursement standards. Even though these programs are periodically updated, the carrier may not be using software that can readily identify specialty-specific coding combinations or newly added codes. For this reason, one of the most basic incorrect payment appeals is a letter which includes (1) a demand for a physical review by a qualified reviewer, rather than resubmission of the claim through the same automated process that denied the claim initially, and (2) detailed disclosure of the payment methodology used to calculate available benefits. Sample Appeal Letter K, "Request for Review by Certified Coder," is designed to assist medical billing professionals in demanding a manual review by a certified coder familiar with the codes in question.

Disclosure of fee schedule information

Incorrect in-network payments must be challenged with written documentation of the agreed-upon reimbursement. Most states have managed care protections, which require managed care organizations to disclose the fee schedule upon contract finalization or upon request by participating providers. States may also impose additional restrictions on modifying the fee schedule without prior notification. It is

therefore important to obtain the fee schedule and keep track of any modifications and the respective implementation dates. For codes that are individually negotiated by your organization, written documentation must be disseminated to the billing and appeal staff so that this documentation can be easily attached to appeals.

Notification language should be negotiated that prohibits fee schedule changes without advance notification to the provider. It is also important to attempt to limit fee schedule changes to an acceptable time span, such as yearly.
Once accurate, up-to-date fee schedule information is obtained, providers with high-volume billing will want to consider contract management software which can identify underpaid claims based on loaded fee schedule information.

Disclosure of payment calculation methodology
As with any other denial type, bundling denials should adhere to clearly defined reimbursement rules that are based on acceptable industry standards for correct coding. Insurers are often hesitant to explain how bundling decisions are reached, however. Bundling denials are highly problematic because various payers use different claim-editing software to assess codes for compatibility. It becomes difficult to determine why certain codes were bundled and what medical information might be persuasive in an appeal. For this reason, many bundling appeals should focus on seeking clarification regarding why the codes were bundled and what policy or plan limitation applies to the denial. The payer may be using Medicare's National Correct Coding Initiative (CCI) guidelines or may be using proprietary coding edits, but any denial should have some applicable rule or guideline that is consistently applied and available upon request.

Prior to appealing, review the medical records to make sure that all services were medically necessary and correctly coded. Remember to review your billing form to make sure that any appropriate modifiers were included. For example, modifiers -25 and -59 frequently affect which codes can be billed together.

If the codes do not appear to have been correctly paid, your bundling appeal letter should seek disclosure from the payer regarding what coding guidelines the carrier is using to assess the claim. If CCI is cited, you can review the CCI edits to determine whether you agree with the bundling by going to www.cms.hhs.gov/NationalCorrectCodInitEd/ . CCI edits are based on two different coding

combination lists. The first list contains the Column 1/Column 2 edits (formerly comprehensive/component edits) on a code-by-code basis. Check all codes in question to see whether any are considered components of the other codes. The second list contains mutually exclusive edits or edits that should never be billed together.

If the CCI edits do not appear to have been applied correctly, you can use Sample Appeal Letter L, “Request for CCI Compliance,” to request compliance with these nationally recognized edits.

Incorrect modifier payment appeals

As indicated earlier, many bundling appeals are complicated by the use of billing modifiers. Modifiers alert automated payment systems to a number of procedure-specific variations. Modifiers -25 and -57 are the most highly utilized evaluation and management (E/M) modifiers and are frequently underpaid by carriers.

Aetna recently announced that it would stop bundling E/M codes submitted on the same date of service in two circumstances. Aetna will now pay physicians for problem-oriented E/M services provided during a preventive services visit, when billed with modifier -25. Aetna will also reimburse physicians for E/M services when billed with modifier -57, performed on the same day as a decision for major surgery (global, 90-day procedure). These changes are consistent with current procedural terminology (CPT) coding guidelines. See the Aetna press release giving state-by-state billing instructions at *www.aetna.com/provider/payment_policy.html*.

According to information at the California Medical Association (CMA) Web site, Aetna’s payment revisions were recommended by Aetna’s Physicians Advisory Board, which was created as part of Aetna’s RICO lawsuit settlement, established after more than a dozen state medical associations sued over payment policies alleging fraud and racketeering. Aetna’s settlement of the lawsuit included the agreement that “if a bill contains a CPT code for performance of an evaluation and management code appended with a modifier -25 and a CPT code for performance of a non-evaluation and management service procedure code, both codes shall be recognized and eligible for payment.”

CMA provides a partial list of codes likely to be affected by this change as follows:

Modifier -25: This modifier is used when there was a significant, separately identifiable E/M service provided by the same physician on the same day as another procedure or service. For example, you see an Aetna patient for her annual well-woman checkup and during the visit she mentions that she's been having significant neck pain. You can bill for the well-woman exam and for your E/M services related to the neck pain, with a modifier -25 attached to the latter code. The codes affected by this policy change are 99381–99387, 99391–99397, 99201–99205, and 99211–99215.

Modifier -57: This modifier is used on E/M services that resulted in a decision to perform major surgery. For example, an Aetna patient comes in complaining of neck pain. You examine the patient, diagnose a fractured clavicle, and decide that surgery is indicated to treat the closed fracture. You can bill for the examination (with modifier -57) and for the decision for surgery.

Note: Some Aetna settlement compliance disputes are pending that may result in additional payments for modifier -57 claims with dates of service prior to August 15, 2005. The settlement language requires that "no global periods for surgical procedures shall be longer than any period than designated on a national basis by [the Centers for Medicare & Medicaid Services] for such surgical procedures." CMA believes that this provision entitles physicians to reimbursement for modifier -57 claims that are consistent with Medicare payment rules with dates of service on or after May 21, 2003 (the date the Aetna settlement became final).

(Source: *www.calphys.org/html/cc133.asp*)

Modifier -25/-57 appeals should, as any other appeal, focus on seeking disclosure of the basis of the denial and review by a qualified coder. Your appeal may require submission of the medical record with specific references to the E/M billing requirements documented in the medical record. See Sample Appeal Letter M, "Request for E/M –25 Review," for an example of E/M modifier -25 appeal.

Disclosure of UCR payment calculation methodology

Failing to appeal usual and customary denials is similar to leaving money on the table. But appealing such denials requires providers to justify each charge—a task many have found problematic.

The pricing transparency movement in healthcare has led to the development of quality indicators and cost information in a publicly accessible format. More organizations are turning to outside pricing resources and consultants for assistance with setting prices.

Appeals related to usual and customary denials should first address what your organization offers in quality assurance measures. If information is available to show that your pricing is consistent with similar organizations in your area, it should be presented.

The **Prevailing Healthcare Charges System (PHCS)**, available through Ingenix, Inc., is one of the largest healthcare charge data sources and is used by a number of carriers to calculate UCR prices. A number of lawsuits, however, including lawsuits initiated by the American Medical Association (AMA) and the American Dental Association (ADA) on behalf of their members, have alleged that the PHCS calculations are not a true reflection of average prices. These organizations outline the flaws in PHCS's UCR calculations:

- Systematic under-reporting of the actual number of procedures performed in a geographic area, and elimination of highest charges for each type of medical procedure maintained in the PHCS database
- Inclusion of charges for medical procedures from other, and non-comparable, geographic areas, in which provider charges were lower
- Failure to segregate procedures performed by providers of the same or similar skill and experience level, but rather, indiscriminately lumping together all provider charges by procedure code without regard to skill or experience level
- Inclusion of charges for various procedures that incorporate in-network providers' discounts to their usual charges, thus skewing the data below the true UCR rates

(Sources: *The American Medical Association et al. v. Metropolitan Life Insurance Company, United Healthcare Corporation and United Healthcare Services, Inc. www.ama-assn.org/ama/pub/category/8100.html*, and *American Dental Association, et al. v. Aetna, Inc., www.ada.org/prof/advocacy/legal/leg_010815_aetna.pdf*)

Although these cases have faced challenges because of legal standing and Employee Retirement Income Security Act of 1974 (ERISA) preemption challenges, these suits provide guidance on

challenging calculations on a case-by-case basis. In particular, many state and federal disclosure laws require carriers to explain the methodology used to calculate UCR rates and to disclose any source of information used in the calculation. Disclosure of such information allows providers to assess the flaws as outlined by the AMA and the ADA. If disclosure is refused, your Level II appeals should demand disclosure of the requested information in order to determine the carrier's performance in regard to calculating such benefits fairly; it should also cite any of the preceding points which may be of particular concern to you in regard to the denial.

State and federal disclosure laws require insurance carriers to unambiguously outline the coverage terms so that policy holders are aware of the benefits available for medical care. Many states have passed specific legislation directing insurance carriers and plan administrators to release information regarding how benefits are calculated or reduced. ERISA, which governs most group health benefit plans, has widely applicable disclosure requirements and stipulates that UCR data be released upon request by a qualified beneficiary and/or requestor. The U.S. Department of Labor issued an advisory opinion specifically instructing a group health benefits plan to release the schedule of usual and customary fees even if that schedule is drawn from a proprietary database.

According to Advisory Opinion 96-14A, the legislative history of ERISA suggests that plan participants and beneficiaries should have access to documents that directly affect their benefit entitlements under an employee benefit plan, including "studies, schedules or similar documents that contain information and data, such as information and data relating to standard charges for specific medical or surgical procedures, that, in turn, serve as the basis for determining or calculating a participant's or beneficiary's benefit entitlements under an employee benefit plan." This letter, available at *www.dol.gov/ebsa/programs/ori/advisory96/96-14a.htm*, makes a very good attachment to any UCR appeals involving a group health benefit plan as it helps to clarify the carriers' legal obligation to provide such documentation.

Despite clear mandates that encourage transparency in the rate calculation process, insurance carriers still routinely refuse to give such information to providers. Providers who file appeals for such information are routinely reassured that "benefits were calculated according to the UCR fee schedule" but are not provided with details regarding the data used to make the calculation or provided with the UCR applicable policy definition as it appears in the policy or plan booklet.

Appeals of usual and customary denials should seek complete disclosure of the UCR fee schedule and how it is calculated, as well as provide any information regarding competitive pricing efforts or research conducted by your facility to establish prices. Compiling such evidence requires research and preparation, but could substantially pay for itself when this information is applied to a number of denied claims.

Submission of published coding standards

Carriers employ a number of claim coding edits which are often not fully explained at the time of the denial. Coding appeals can focus on seeking the specific coding standard used by the carrier in making the decision; however, such appeals will be even stronger if the billing professional submits specialty-specific published coding standards that support full payment.

Incorrect contractual appeals/Silent PPO assessments

Silent PPO discounting refers to situations in which a managed care organization sells or rents the established network of negotiated fee schedule pricing and discount agreements to a third party. Organizations that establish PPO networks are typically able to offer providers incentives, such as patient volume and marketing exposure, in exchange for the agreed-upon discounts, but a third-party rental arrangement does not provide such benefits to providers and typically involves a smaller organization "riding the coattails" of an organization with more negotiating power. Although most major health plan contracts contain provisions that specially allow for such activity, providers need to be aware of such provisions and attempt to negotiate limits such as:

- Identification of the PPO on all patient identification cards, which gives assurance to providers that there is some effort by the PPO to drive more volume to the participating providers
- Limitations that allow the contracting organization to sell or lease to large-volume accounts only

Sample Appeal Letter N, "Silent PPO," provides wording on appealing a Silent PPO reduction by explaining the lack of a contract with the discounting organization and demanding a detailed explanation of how the reimbursement was determined as well as a copy of the coverage provisions, benefits, and exclusions related to out-of-network benefits.

References

California Medical Association. "CMA Advocacy Works! Aetna Changes Reimbursement Policy, Recognizes Modifiers -25 and -57 in Certain Situations; Physicians Urged to Resubmit Previously Denied Claims." *www.calphys.org/html/cc133.asp*.

Advisory Opinion 96-14A, PWBA Office of Regulations and Interpretations, *www.dol.gov/ebsa/programs/ori/advisory96/96-14a.htm*.

The American Medical Association et al. v. Metropolitan Life Insurance Company, United Healthcare Corporation, and United Healthcare Services, Inc. *www.ama-assn.org/ama/pub/category/8100.html*.

American Dental Association, et al. v. Aetna, Inc., www.ada.org/prof/advocacy/legal/leg_010815_aetna.pdf.