PRACTICE MANAGEMENT CENTER

AMA AMERICAN MEDICAL ASSOCIATION

Appeal that Claim

Be informed. Be approved.

Taking an active approach to the claims management revenue cycle

Table of contents

Checklists, figures and tables

Letter templates

Administrative

Medical necessity

Prompt payment

This document is a revised version of the 2003 *Appeal that Claim* booklet developed by the Private Sector Advocacy (PSA) unit of the American Medical Association (AMA) in consultation with Kristie L. Martinez, CMM, CCS-P, Northwestern Nasal+Sinus Associates, John T. McMahan, MD, FACS, principal.

Visit the AMA Practice Management Center (PMC)* Web site at *www.ama-assn.org/go/psa* for more information. You can also send questions or concerns about claims appeals and other practice management issues via e-mail to the AMA PMC at *practicemanagementcenter@ama-assn.org* Please include the physician name and his or her AMA member ID number.

Note that this document contains links to several AMA members-only publications and tools. For more information on becoming an AMA member, please visit the AMA Member Center. Please be aware that PMC documents are in PDF format (PDF files require Adobe® Reader®, which you can download free of charge).† Some of the links contained in this document will take you to non-AMA Web sites. The AMA is not responsible for the content of other Web sites.

This document does not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed.

† The AMA is not responsible for the content of other Web sites.

Introduction

When a physician practice assumes that the reimbursement it receives from health insurers is always accurate, the practice may lose revenue. Even when a practice codes claims correctly, health insurers may still inappropriately deny, delay or significantly reduce payments. By implementing claims auditing processes, you can ensure that health insurers pay your practice appropriately for your physician procedures and services.

The first step in assuring proper payment is to streamline your **claims management revenue cycle**—your practice's internal designated workflow, including the steps you take to prepare, submit, and collect the claim—to make sure you submit every claim correctly. *Prepare that Claim*, another document in this series, discusses these processes.

The second step is to streamline your claims audit and appeals procedures—that is, your practice's internal controls that detect health insurer payment errors on submitted claims and perform the appropriate collection efforts to ensure that the health insurer processes, adjudicates and pays the claims accurately.

This document explains how you can simplify your claims audit and appeals processes by reducing the administrative burden and demystifying the health insurer claims appeals processes. The American Medical Association (AMA) strongly encourages you to consider appealing denied health insurer claims that have been appropriately filed according to the health insurer's payment policies and the AMA Current Procedural Terminology (CPT®)* codes, guidelines and conventions.

The bottom line: Physician practices are entitled to payment for the procedures and services they provide when they have coded and documented the procedure or service appropriately. Therefore, the AMA recommends that you bring all inappropriate denials of claims to the health insurer's attention through its claims appeals processes.

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Overview

In today's challenging economy, physician practices struggle to maintain financial viability. Health insurance premiums are rising as physician reimbursement is declining, resulting in thin profit margins for many physician practices. Collecting health insurer reimbursement and ensuring the amount collected is correct is not easy, but it is critical to the practice's financial soundness. Today, physician practices require more staff and demand individuals who are educated and experienced in coding and billing practices. It is now more important than ever for practices to monitor reimbursements and ensure that payers submit them appropriately. Your practice can overcome industry pressures and achieve financial success with a well-trained and educated staff—and by implementing effective claims auditing and appeals processes to ensure appropriate physician payment.

There are many reasons that practices do not appeal denied claims; among the most common is a belief that appealing claims will create an increased administrative burden on the physician practice. However, not appealing denied or partially paid claims can be quite costly and result in decreased revenue for your practice.

Can your practice afford to audit and appeal claims?

One practice in Chicago could have recovered **as much as $91,000** for a single type of procedure over a period of three years if it had effectively audited and appealed its claims.

Since health insurers have introduced claims-editing software into their claims processing systems, the AMA has received an increased number of complaints from physicians regarding inappropriate claims denials and reductions. **An effective way for your practice to combat erroneous payment reductions and denials is to diligently submit appeals.**

Benefits of claims auditing processes

If you appeal wrongfully underpaid or denied claims, the health insurer may be more likely to correct its claims-editing software and processes. This, in turn, may result in improved claims processes and health insurers paying the practice appropriately for health care services. Streamlining your claims management revenue cycle and auditing processes will decrease your practice's overhead expenses and increase staff efficiency and communication. The health insurer will also save on administrative costs by processing the claim correctly the first time, instead of incurring the added cost of processing disputed claims.

In addition to saving money spent on unnecessary administrative efforts, your practice can collect significantly greater sums for its health care services.

How can auditing and appealing claims benefit your practice?

One practice in Chicago recovered **$19,000** over 6 months from appealing a single type of underpaid claim.

Why claims appeals are a critical practice component

To determine whether a reimbursement you receive is accurate, auditing health insurer payments is essential. In the long term, auditing health insurer payments will help secure your practice's financial viability. Many practices lose revenue every day due to partially paid, delayed and denied health insurer claims that the practice does not challenge or even notice.

One surgical practice in Chicago was recently interviewed regarding its claims auditing processes. This practice did not closely monitor the payments it collected from health insurers until the practice realized it was not performing as it ought to financially. The practice began auditing claims and appealing partially paid, delayed or denied claims. The outcome of their efforts is captured in the following textbox.

Why audit and appeal claims?

Within five months of implementing an effective auditing and appeals process, one practice in Chicago was already recovering as much as **$100,000 per month**.

Assuming this example is typical, physicians across the nation lose enormous amounts of revenue each year from claims that health insurers underpay or deny.

If you employ effective claims auditing and appeals processes, you may significantly increase your practice's potential for financial soundness. When you appeal inappropriately paid claims, you send health insurers a clear message that your practice will not tolerate inappropriately denied, delayed, or partially paid claims. Your efforts demonstrate that you are committed to pursuing every avenue to collect proper payment for procedures and services rendered.

What is lost when practices do not appeal

Health insurers save money when they partially pay, delay or deny a claim payment because only a small percentage of physician practices routinely pursue an appeal. When you do not audit and appeal health insurers' inappropriately paid or denied claims, your practice loses not only revenue but also the opportunity to recover overhead expenses. Challenging inappropriate payment of claims through the health insurer's appeal process also demonstrates that you have made an effort to correct the health insurer's inaccuracy. Appeals efforts could lead to a change in the health insurer's business practices.

What might your practice gain from appealing claims?

Health insurers consistently underpaid one practice in Chicago **$928.50 per claim** for a commonly performed procedure. Implementing a claims auditing and appealing strategy could enable this practice to obtain accurate payment on these claims.

Implementing claims auditing and appeals processes

The challenge most practices face is effectively implementing claims auditing and appeals processes. Whether your practice is small, with one or two physicians, or large, representing 10 or more physicians, you can implement procedures that track health insurer payments for services rendered. The information in the following sections outlines the key elements of the claims auditing and appeals processes.

Checklist 1

Checklist for appealing a claim

- ❑ STEP 1: Determine who will be responsible for auditing health insurer payments
- ❑ STEP 2: Collect recommended health insurer auditing resources
- ❑ STEP 3: Run monthly collection reports
- ❑ STEP 4: Review the health insurer explanation of benefits (EOB)/remittance advice (RA)
- ❑ STEP 5: Identify the health insurer basis for the denied, delayed or partially paid claim:
  - ❑ Inadvertent practice errors (sample letter)
  - ❑ Health insurer processing errors (sample letter)
  - ❑ Lack of recognition of modifier 25 (sample letter)
  - ❑ Lack of recognition of modifier 59 (sample letter)
  - ❑ Health insurer incorrectly downcoded CPT (sample letter)
  - ❑ Health insurer applied a PPO discount when a contract does not exist (sample letter)
  - ❑ Medical necessity denials (sample letters)
- ❑ STEP 6: Gather supporting documentation
- ❑ STEP 7: Develop a claim appeal letter and resubmit the claim
  - Claim appeal letter templates
- ❑ STEP 8: Maintain a follow-up log
- ❑ STEP 9: Hold claims processing and review meetings
- ❑ STEP 10: Continue to appeal inappropriately denied, delayed or partially paid claims

Step 1: Determine who will be responsible for auditing health insurer payments

Educate your team

Each staff member in your practice is a crucial part of your team. Beginning with the first phone call a patient makes to the office and the information the receptionist gathers, each staff member makes a critical contribution toward submitting a claim and receiving appropriate payment in the claims management revenue cycle. Each position in the practice affects the outcome of a claim. Be sure to educate each staff member on the importance of the information they gather and report, from the check in/check out staff to the nurse and/or assistant and from the physician to the billing department.

Appoint designated auditing staff

For best results, physicians and practice staff should all participate in the audit process. Your practice is entitled to appropriate payment for the procedures and services it provides when you have coded and documented appropriately. Most invaluable to a successful internal audit are physicians and practice staff with a strong knowledge of CPT codes, guidelines and conventions; the Resource-Based Relative Value Scale (RBRVS); and the payer's medical payment policy, contracts, fee schedules and reimbursement guidelines.

Practice Management Center (PMC) resource tip

The AMA, with cooperation from the American Academy of Neurology, developed the educational resource "How to perform a physician practice internal billing audit"* to help physician practices understand both the need for an internal billing audit and how to perform an internal billing audit to yield improved claims management processes, cash flow, and compliance with applicable laws and regulations.

* This tool is available to AMA members. For more information on becoming an AMA member, please visit the AMA Member Center.

Physician practices are not often interested in the audit process and may feel they are too busy to participate. But understanding payment problems is a powerful motivation to ensure that documentation is sufficient for payment. For example, a health insurer might downcode a CPT code because you have not coded the ICD-9 at its highest level of specificity, or your practice might receive inappropriate payment for a patient encounter that is prolonged by extensive face to face counseling if your documentation does not mention the reason for the prolongation.

Physicians do not need to be involved in the routine claims audit process, but it is best if they participate initially and periodically. You can combine this claims audit process with a medical documentation review and go a long way toward satisfying Medicare Fraud and Abuse compliance plan requirements.

Depending on the size or complexity of your practice, hire or appoint one or more practice staff with coding knowledge and experience to be responsible for auditing health insurer payments and performing appeals. Though your practice has a hectic schedule, you can successfully find time to appeal claims by managing staff time and resources. Allocate existing staff time for these important tasks. For instance, set aside scheduled time to work on appeals (e.g., one afternoon per week, the last hour of everyday, etc.) or identify a fixed time each day to post health insurer explanations of benefits (EOBs) when you can focus without too many interruptions.

You might also consider hiring a consultant who specializes in billing and collections to assist in specified audit tasks. Be sure the consultant signs a HIPAA Business Associate agreement as well as their underlying contract.* This ensures confidentiality and compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

* This tool is available to AMA members. For more information on becoming an AMA member, please visit the AMA Member Center.

Step 2: Collect recommended health insurer auditing resources

As your practice's designated staff for claims auditing, you will find it necessary to have reference sources, including current copies of:

- *Current Procedural Terminology (CPT)* book
- Healthcare Common Procedure Coding System (HCPCS)
- ICD-9-CM coding books:
  - *Medicare RBRVS: The Physicians' Guide 2007*
  - *Principles of CPT Coding*
  - Principles of ICD-9-CM Coding
  - Medicare's National Correct Coding Guide

Similar resources might also help you when auditing claims. The AMA *CPT Assistant* and *CodeManager* are additional resources you might find helpful in developing a claim appeal. You can find answers to specific coding questions by accessing the CPT Network Web site to view the Knowledge Base (KB), which contains answers to frequently asked questions, along with clinical vignettes.

It is important to have access to all health insurer contracts and relevant source documents your physician or physician group has signed, along with the patient's benefit verification information. This information is critical to understanding the coverage and payment policies in each health insurer contract and the patient's benefit verification information.

You will find it beneficial to locate and record the following information from each contracted health insurer in your health insurer reference log:

- Contract effective date
- Fee schedule (e.g., fee-for-service, discounted fee-for-service)
- Reimbursement methodology
- Name of claims-editing software, if applicable
- Multiple procedure/service payment policy
- Bilateral procedure payment policy
- Claims prompt payment policies and penalties in the contract
- Claims submission policies, including the timely filing limits specified in the contract
- Medical review policies
- Claims appeals processes
- Medical necessity definition
- Global period definition
- Health insurer contact information

You should obtain a copy of your fee schedules during the contracting process. If you do not have access to the fee schedule, call each health insurer to obtain the current fee schedule payment for your 20 most commonly used CPT codes. Getting this in writing or via e-mail from each health insurer will prove extremely helpful for future compliance challenges and for documentation to submit with appeal letters.

Obtaining copies of *each* health insurer contract and keeping them filed in a centralized place will assist you in your claims auditing and appeals processes. When tracking down contract agreements, there may be copies filed in the physician's office or home and that you cannot locate. If so, call the health insurer's provider relations department to request a copy.

Because your state prompt processing and/or payment laws and regulations help ensure that health insurers pay in a timely manner, the AMA encourages you to familiarize yourself with them as well. Today, 47 states and the District of Columbia have laws and/or regulations requiring that health insurers and other third-party payers pay claims in a timely manner. You may also visit the National Association of Insurance Commissioners (NAIC) Web site to review the laws specific to your state.* You can obtain additional information related to contracting with a health insurer by downloading the National Managed Care Contract.

* The AMA is not responsible for the content of other Web sites.

Step 3: Run monthly collection reports

Running a monthly report using your practice management software is a critical component of the claims auditing and appeals processes. The report should list each claim that the health insurer has not paid in more than 30 days or beyond the state statutory requirements, as well as detailed information regarding the claim. Depending on the software, the Accounts Receivable (A/R) report may be based on the patient's date of service or the claim bill date. If your practice management software allows user-defined state prompt payment policies, then you can create a report of delinquency based on that time frame.

This report will help you detect a health insurer's chronic non-payment that may warrant further action. Consider maintaining a health insurer follow-up log, which lists all claims not paid in the designated time frame, according to the state prompt processing and payment laws and the health insurer contract. If you have not received the EOB, call the health insurer to obtain the claim status.

You should then identify the submitted health insurer claims that are more than 30 days past due on the collection report. The next step in the claims auditing process is to review the health insurer EOB and identify the reason for non-payment.

Some clearinghouses may offer features to support you in this process by providing a detailed list of claims submissions by date. Features include: inquiries for eligibility, claim status, and secondary billing services. Clearinghouses may also be able to provide reports regarding claim submission and payment to ensure appropriate claim follow-up.

Practice Management Center (PMC) resource tip

Are you considering selecting a clearinghouse to handle your practice's claims process and submission functions? If so, you are encouraged to review the "What is a clearinghouse?"* resource developed by the AMA Practice Management Center (PMC) unit and the Kentucky Medical Association. Designed to educate physicians and practice staff about the clearinghouse function, this resource explains the nuances that relate to the submission and transmission of the physician practice's claim information by an outside clearinghouse.

* This tool is available to AMA members. For more information on becoming an AMA member, please visit the AMA Member Center.

Step 4: Review the health insurer EOB/RA on each claim identified on the collection report

By understanding and closely reviewing the health insurer's explanation of benefits (EOB), you will see the health insurer's rationale for their partial payment, delay or denial of the claim. The EOB may also be referred to as the explanation of medical benefits, explanation of Medicare benefits (EOMB), remittance advice (RA) or provider claim summary.

A major challenge physician practices face is the amount of administrative time and effort needed to uncover the explanation for the health insurer's payment adjustment or denial. Your first priority in determining the basis of a claim denial is to identify each EOB that lists a zero amount as the approved charge for a procedure or service. This means the health insurer did not make a payment for the claim you submitted. Next, you need to find out why the health insurer determined a charge for the submitted claim was not allowable by reviewing the EOB's remarks or description field. Your second priority is to review the claims that list a payment adjustment and determine whether the health insurer made the appropriate adjustment.

Checklist of questions for reviewing an EOB

You can determine whether the health insurer's adjustment was appropriate based on the health insurer discounted payment fee schedule. Be wary of rental network Preferred Provider Organizations (PPOs) taking an inappropriate discount. Keeping a health insurer reference log that lists the agreed upon discounts for each health insurer may prove helpful in identifying rental network PPO activity and other inappropriate discounts. (See a sample health insurer reference log.)

Checklist of questions for reviewing an EOB

- ❑ Determine the name of the third-party payer making the payment— i.e., who is paying for the service?

  _____

- ❑ Does your practice have a contract with this third-party payer?
  - ❑ Yes: Look up the contracted discount and appropriate payment and make sure that you have been paid accordingly. If the third-party payer did not pay you according to your contract, determine the reason for underpayment and whether you should send an appeal letter.
  - ❑ No: Because you do not have a contract, you are not under obligation to accept the reduced payment. Send an appeal letter for appropriate payment.
- ❑ Compare the total amount paid for the service(s) to the contracted fee schedule.

  Amount Paid: _____

  Contracted Rate: _____
  - ● If the total amount paid for a line item or the entire claim is less than the contracted rate or zero, review the claim to determine why the third-party payer did not consider the payment.
- ❑ Was the non-payment because of a third-party payer provision, such as the deductible or policy exclusion, or was it an error?
  - ❑ Deductible or policy exclusion: If the third-party payer did not pay your claim due to the patient's deductible or policy exclusion, you will need to collect this amount directly from the patient.
  - ❑ Error: If the third-party payer processed the claim in error, appeal the claim.
- ❑ Check whether the EOB lists any of the procedure and services as not covered.
- ❑ Yes: If procedures and services are listed as not covered, you will need to collect this amount directly from the patient, and do additional research to identify and address the actual reason for non-payment and appeal any inappropriate denials.

The information on the health insurer EOB can help you understand the insurer's claims processes. Some states have standardized form requirements that may make it easier for practices to submit claims and read the health insurer EOBs. For example, the State of Missouri requires a health insurer EOB form to contain the following: name of insured patient, identification number of insured patient, date of service, amount of charge, explanation for any denial, amount paid, patient's full name and health insurer phone number to contact for questions about the EOB.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) establishes a number of "standard transactions." One of these transactions is the electronic remittance, or payment advice (referred to in the regulation as the "ASC X12 835 Health Care Claim Payment Advice"). The HIPAA standard also defines the code sets (such as claim adjustment reason code) that should be used on an 835 remittance. Health insurers are increasingly making their EOB or remittance advice available as an electronic HIPAA standard transaction (indeed, the law requires them to provide an 835 transaction to any HIPAA-covered entity who requests it). Health insurers' use of the 835 should make the process of reviewing the payment more consistent because all health insurers are required to use the HIPAA standard transaction and code sets. However, with over 200 claims adjustment reason codes alone (this code describes why a line item may have been denied, pended, reduced and so forth), inconsistencies in how payments are described continue.

Furthermore, some code sets, such as allowed amount or patient responsibility amount, are either optional (allowed amount) or not required (patient responsibility amount) at the line item level. This makes it difficult to determine patient responsibility from an 835 transaction.

Nevertheless, the 835 transaction will provide greater consistency among health insurers. If your practice management software is capable of importing and applying the 835 transaction (or you have a clearinghouse's assistance), you will also be able to automatically apply the electronic 835 payments (at least those payments without any adjustments), saving your practice significant time and resources.

The complete code sets as HIPAA defines them are available on the Washington Publishing Company Web site.* You may find the two code sets, claim adjustment reason codes and remittance advice remark codes* most beneficial. On addition, you might also find referencing Table 1: Claims filing indicator code set list of value. You should be able to readily locate and understand the codes and descriptions each health insurer uses on their electronically transmitted payment and remittance advice transaction.

* The AMA is not responsible for the content of other Web sites.

Table 1

Claims filing indicator code set list	
12	Preferred Physician Organization (PPO) *Use this code for Blue Cross/Blue Shield par arrangements.*
13	Point of Service (POS)
14	Exclusive Physician Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
AM	Automobile Medical
CH	Champus
DS	Disability
HM	Health Maintenance Organization
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program *Use this code for the Black Lung Program.*
TV	Title V
VA	Veteran Administration Plan
WC	Workers' Compensation Health Claim

Step 5: Identify the health insurer basis for the denied, delayed or partially paid claim

You can receive the appropriate contracted reimbursement for your practice's procedures and services through careful analysis of each EOB from the health insurer. When you accurately audit the EOB, you can both identify the reason the initial claim you submitted was either inappropriately reimbursed or inappropriately denied, delayed or partially paid and begin appealing the health insurer's response to your claim.

Common reasons health insurers deny, delay or partially pay a claim include:

- Physician practice processing error(s) and/or lack of supporting documentation
- Health insurer processing error(s)
- Application of a CPT modifier, code, or guideline for each procedure the physician performed (e.g., downcoding, bundling, lack of recognition of a modifier)
- Application of fee schedule allowance when you have a contract with the health insurer
- Application of PPO discount when you do not have a contract with the health insurer (e.g., rental network PPO)
- Medical necessity denial

Physician practice processing errors

Understanding the importance of providing the health insurer with accurate information on the original claim form is critical. If you provide accurate claims information up front, it will reduce the time you would have spent correcting an erroneous entry or omission and help the health insurer adjudicate the claim appropriately and promptly. This will usually translate into a more timely payment to your practice.

Contact the health insurer representative to determine the appropriate method to reconcile an incomplete or inaccurate claim submission. Some health insurers may allow a representative to make claim corrections through a telephone review for minor adjustments, such as date of service, amount billed, CPT code or appending CPT modifiers; calling will expedite the process of correcting and paying the claim. Otherwise, you must resubmit the claim to the health insurer and identify it as a corrected claim for reconsideration.

If the health insurer requires documentation, sending that documentation in a timely manner will help prevent the health insurer from delaying or denying payment. The longer you take to respond to the health insurer's request for additional information, the longer your practice will wait for payment of that claim.

Health insurer request for supporting documentation

If the EOB indicates that the health insurer requires additional supporting documentation before they can process the claim, review the original claim for incomplete and/or inaccurate information. If you are unsure why the health insurer is requesting additional supporting documentation, call the health insurer representative for an explanation of the claim denial and confirmation of the necessary steps to reverse the health insurer's decision.

Health insurers involved in a Multi-District Litigation (MDL) settlement are required to pay claims within thirty (30) calendar days following the health insurer's receipt of all documentation needed to process the claims. If they do not, you may file a compliance dispute. You should note that the MDL settlements also generally provide that if state law offers more protection than a particular settlement, then state law applies. You should be aware of relevant state laws and regulations, particularly in the area of prompt payment of claims, to ensure you receive all available protections. For more information on the MDL settle-

ments and the protections they offer you, please visit www.ama-assn.org/go/settlements to view educational fliers that contain various business practice changes for each health insurer involved. The fliers do not summarize all of the protections provided in the settlements. You may visit www.hmosettlements.com to view the settlements in their entirety.*

Health insurer processing errors

Sometimes the health insurer claim reviewer may make a keystroke error or simply misread an entry on the submitted claim. In this situation, the practice should telephone the claim reviewer or health insurer representative to determine the appropriate method of resolution (e.g., telephone correction, request claim review in writing, etc.).

You might also ask for assistance from a health insurer claims supervisor or manager who has the authority to correct the health insurer's claim error without requiring a resubmission or written request, thus expediting the processing and payment of the corrected claim.

Tricks of the trade: telephone correction

- Ask your peers the name of the person with whom they speak at the health insurer to resolve claims issues. If your peers have found a specific person at the health insurer helpful, this person will likely be a good starting point for resolving your claims issues. You can save time by getting to know specific people at the health insurer who can quickly answer your questions and address your claims issues.
- Keep the contact's name and contact information in your health insurer reference log. You might call this person directly to help resolve future issues with the health insurer.

Health insurer incorrectly applied a CPT code, modifier or guideline for a procedure

This section will help you identify, understand and address a health insurer's bundling, downcoding or lack of recognition of a CPT modifier on the EOB.

The health insurer EOB should contain the ICD-9-CM, CPT, HCPCS and other related codes that designate the procedures and services as submitted on the health insurer's claim form. The EOB delineates how much of the charged amount for each service the health insurer approved, reduced, or denied and provides a reason for an adjustment. It also shows how much of the charged amount the health insurer applied to the patient's co-payment and/or deductible.

Bundling

Bundling occurs when a practice submits a claim for two or more separate, distinct CPT procedures and services performed on a patient during a single visit. The health insurer considers the two or more separate, distinct procedures and services as one and reimburses the practice for only one procedure or service performed—often the one with the lowest reimbursement—or reduces payment for the two or more procedures and services. This happens in a variety of ways, most commonly through the use of claims-editing software and by ignoring CPT modifiers when appropriately appended to CPT codes for procedures and services.

Claims-editing software may contain revised or added CPT code pair edits that physician practices do not known about, commonly called "black box" edits. These edits may not be consistent with AMA CPT codes, guidelines and conventions. The AMA has policy opposing public and private payers' inappropriate bundling of CPT codes for the purposes of reducing or denying payment.

Many practices have reported increased instances of health insurers inappropriately bundling CPT codes. Bundling has become more widespread because health insurers have increased their use of code-editing software. Health insurers not only integrate these code-editing software programs into their claims review cycle but also add another layer of confusion by modifying the program's standard code-pair edits to fit their own medical payment policies. You may not have access to these policies.

The health insurer's decision to bundle a CPT code may occur when a code-editing software program flags a CPT code as an "incidental" procedure. The health insurer then labels the "flagged" procedure as an integral component of the primary procedure performed during the same operative session. The health insurer then denies the "flagged" procedure.

* The AMA is not responsible for the content of other Web sites.

Conversely, you may be faced with the health insurer denying a procedure because it is "unbundled." Simply stated, unbundled means the practice has indicated that two or more procedures reported on a claim were performed separately and are distinct from each other. In many cases, the health insurer determines that the procedures were inclusive and bundles the two or more procedures into one of the reported CPT codes—and reimburses only for one code.

Bundling and unbundling mean basically the same thing from two different viewpoints. The controversy over this issue involves health insurer payment policies that label specific CPT codes as incidental procedures not warranting separate recognition for payment.

A common reason that health insurers "flag" and bundle a surgical procedure is that they determined that the physician performed the procedure to gain access to another anatomic site or surgical area. Many code edits contain CPT coding combinations for procedures that are commonly performed for site access and are therefore considered incidental to another procedure. However, there are times when the physician does not perform the procedure for site access but to treat a specific medical condition.

Bundling also occurs when you report a CPT evaluation and management (E/M) code with CPT modifier 25 along with a procedure. You report CPT modifier 25 to indicate the service was separate from the other service or procedure performed on the same date of service. For example, if you report a 99242-25—*office consultation for a new or established patient*— with a CPT 11600—*Excision, malignant lesion including margins, trunk, arms, or legs*—the health insurer will likely bundle the CPT codes together, stating the service/procedure is included in the E/M service. The health insurer will thus only reimburse one CPT code—often the one with the lowest reimbursement. Since the E/M is separate from the procedure and the health insurer did not recognize modifier 25, sending an appeal letter to the health insurer will help produce a more favorable outcome.

Practice Management Center (PMC) resource tip

The AMA developed the educational resource "The effect a payer's claim edits can have on the repricing and payment of your claim"* to raise awareness of how a claim edit applied by a payer could affect the physician practice's bottom line. This resource also highlights how a negotiated fee with a payer for a specific service performed does not necessarily translate into payment of that fee for that service on a claim.

* This study is available to AMA members. For more information on becoming an AMA member, please visit the AMA Member Center.

Lack of recognition of CPT modifiers 25 and 59

You should always correctly code your practice's procedures and services. This may include adding a modifier that indicates that two or more of the procedures and services submitted on a single claim and performed on the same day are indeed separate, distinct and separately reimbursable. For this purpose, physician practices most often use CPT modifiers 25 and 59. However, one of the most common ways health insurers bundle is to ignore CPT modifiers altogether, which leads them to bundle or inappropriately reduce separate and distinct procedures and services physicians have performed.

CPT modifier 25

According to CPT codes, guidelines and conventions, CPT modifier 25 is appropriately appended to the E/M service when a "physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service(s) provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier 25 to the appropriate level of E/M service."

A common example of health insurer bundling includes:

- CPT code series 99381-99387 and 99391-99397—*preventive medicine services*—bundled into CPT codes 99201-99215 25—*office or other outpatient visit for the evaluation and management of an established patient*.

According to CPT codes, guidelines and conventions, coders should appropriately append CPT modifier 25 to the CPT code series 99201-99215 to identify that the office or other outpatient visit services are not typically performed with the preventive medicine visit for E/M services, as stated in the CPT book:

> "If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then

the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported."

If a health insurer bundles CPT code series 99381-99387 and 99391- 99397 with an E/M service, or vice versa, even though you had appropriately provided and coded the services, then the code bundling is inconsistent with CPT codes, guidelines and conventions. In this instance, you should review the health insurer's medical policies for consistency with AMA CPT codes, guidelines and conventions. If the policies are consistent with CPT codes, guidelines and conventions, you should send an appeal letter for the lack of recognition of CPT modifier 25 to the health insurer, requesting reconsideration of the bundling of these codes based on CPT.

If the health insurer's medical policies are inconsistent with CPT codes, guidelines and conventions, reviewing the health insurer policy will help you determine whether the health insurer applied it appropriately. Health insurers should develop medical policy that recognizes the physician work involved in providing these procedures and services and appropriately compensate physician practices for their provision of care.

If the health insurer does not recognize CPT modifier 25, revisit the health insurer's medical policies for clarification or consult the health insurer directly to determine individual claim submission requirements. The health insurer may ask you to submit claims directly to independent medical review to avoid the initial denial and payment delay from the code-editing software's automatic edits. The health insurer may also request the clinical rationale for the identified procedures and services the physician performed together, along with supporting documentation to assist in claims processing and adjudication.

If the health insurer requires documentation, sending that documentation in a timely manner will help to prevent the health insurer from delaying or denying payment. The longer you take to respond to the health insurer's request for additional information, the longer your practice will wait for payment of that claim.

CPT modifier 59

CPT modifier 59 was developed to identify procedures not typically performed together. Unfortunately, health insurers commonly ignore CPT modifier 59, often resulting in inappropriately bundled services and reduced payment.

- You may need to append modifier 59 to indicate that because of certain circumstances, a procedure or service was distinct or independent from other procedures performed on the same day.

A common example of health insurer bundling is:

- CPT code 30130 59—*excision inferior turbinate, partial or complete, any method*—and CPT code 30140 59—*submucous resection inferior turbinate, partial or complete, any method*—bundled into CPT code 31276—*nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus*.

According to CPT codes, guidelines and conventions, you would appropriately append CPT modifier 59 to the CPT codes 30130 and 30140 to identify that these procedures are not typically performed with a sinus endoscopy. If the physician excised the turbinate or performed a resection to correct the hypertrophy that caused the nasal airway obstruction, report CPT code 30130 or CPT code 30140 separately, in addition to the sinus surgery code. In this scenario, you would need to send an appeal letter for the lack of recognition of CPT modifier 59 to the health insurer and clarify that the turbinate surgery was not performed to gain access to a sinus but to correct the turbinate itself. Your operative report should document this surgical technique appropriately. Though contrary to AMA policy, the health insurer may request that you report the ICD-9-CM code to support the medical necessity of this procedure.

The above example illustrates that you should be aware of the health insurer's requirements for procedure reporting and, when appropriate, provide information detailing that the procedure or service was not merely incidental. In this example, the practice staff would need to provide the health insurer with sufficient information to demonstrate that the physician did not perform the surgical procedure only to gain site access. The practice staff of this example would need to highlight the operative report by stating how the surgery was performed (surgical technique) and why (what medical condition the physician treated). The ICD-9-CM code for the procedure in question should typically be different from the diagnostic code reported for the primary procedure. Accurately listing the ICD-9-CM code may support your argument that the physician actually performed the procedure that the health insurer bundled in order to remedy a specific condition.

If the health insurer does not recognize CPT modifier 59, revisit the health insurer's medical policies for clarification or consult the health insurer directly to determine individual claim submission requirements. The health insurer may ask you to submit claims directly to independent medical review to avoid the initial denial and payment delay from the code-editing software's automatic edits. The health insurer may also request the clinical rationale for the identified procedures the physician performed together, along with supporting documentation to assist in claims processing and adjudication.

If the health insurer requires documentation, sending that documentation in a timely manner will help prevent the health insurer from delaying or denying payment. The longer you take to respond to the health insurer's request for additional information, the longer your practice will wait for payment of that claim.

Lack of recognition of CPT modifier 57

In addition to denying CPT modifiers 25 and 59, health insurers commonly deny modifier 57.

- According to the CPT book, you should append CPT modifier 57 to the appropriate level of E/M service to indicate that the E/M service resulted in the initial decision to perform surgery.

When a health insurer denies CPT modifier 57, your first step is to determine the health insurer's definition of the global period from the health insurer contract or medical payment policies, which you may want to keep in your health insurer reference log. Following is the CMS definition of the use of CPT modifier 57:

> "Use of the modifier 57 is limited to operations with 90-day global periods. Modifier 57 allows separate payment for the visit at which the decision to perform the surgery was made, if adequate documentation is submitted demonstrating that the decision for surgery was made during a specific visit."

Identifying the health insurer's definition of the global period during the contracting processes is important because that definition may affect the payments you receive for services performed. You might find it helpful to know the health insurer-assigned global period for all procedures. If you list each health insurers' definition of the global period in your health insurer reference log, you will have it available to easily reference. If the health insurer does not specify global periods, you might consider following the commonly-used CMS-assigned global periods.

If the health insurer's definition of the global period is inconsistent with the CMS definition and the global period begins when the decision for surgery is made, then the health insurer will not recognize this CPT modifier. As a result, the health insurer will not pay for the E/M service that prompted the decision for surgery because they consider the service to be in the global period of the primary procedure.

Tricks of the trade: global period

Other modifiers can be used when reporting services and/or procedures within a global period, whether they are related or unrelated. Refer to the modifier section of the CPT book and be sure to check the CPT Network Web site for more information.

Other methods for appealing bundled claims

There are other successful methods for appealing claims the health insurer bundled and therefore denied. The following are not mutually exclusive:

- Refer to other resources, such as the AMA CPT book, *CPT Assistant*; *Code Manager*; CPT Network or other coding references. Supportive documentation from other sources—such as written descriptions that detail when a procedure is considered separate and not part of another procedure—may help you explain and support the rationale for the specific code use and for the appeal justification.
- Refer to chart documentation and operative reports that support the CPT codes you used.
- Contact the health insurer claims manager or health insurer representative and request assistance with the specific claims submissions.

Example: Detecting bundling on an EOB

The health insurer EOB shown in Figure 1: XYZ PPO explanation of benefits is an example of what you should look for when determining why a health insurer denied payment for a procedure or service. If you review an EOB that lists the amount paid for a procedure or service as zero and the reason code description states that the payment is included in the allowance for the basic service/procedure, then the health insurer has apparently bundled the procedures.

Because the health insurer's payment rules in this example are inconsistent with CPT codes, guidelines and conventions, the practice staff knew the bundling of these two procedures was incorrect. Using fictitious codes but a real example, if the practice staff had not noticed the bundling of the CPT codes XXXX1 and XXXX2, the practice would have lost $1,500 for this one claim. The practice staff appealed this health insurer determination, which resulted in the successful reversal of the claim denial. The practice received the appropriate payment for this procedure through the health insurer's appeal processes.

Figure 1

XYZ PPO explanation of benefits

Date of Service	Service Code	CPT Code	Total Charge	Ineligible	Reason Code	Network Savings	Eligible Amount	Benefit Co-Pay	Deductible Amount	Balance	Paid %	Amount Paid
Xxxxxx	2	xxxx1	$1645	0	1	$429	$1216	0	0	$1216	100%	$1216
Xxxxxx	1	xxxx2	$1500	0	2	$1500	$0	0	0	$0	0%	$0
Xxxxxx	2	xxxx3	$835	0	1	$125	$710	0	0	$710	100%	$710
Xxxxxx	2	xxxx4	$480	0	1	$125	$355	0	0	$355	100%	$355
			$4460			$2179	$2281	0	0	$2281		$2281

Service Code	Reason Code Description	Amount Paid	$2281
1 Medical Services	1 Discount agreed to in Preferred Provider contract	Other Carrier Payments	0
2 Outpatient Surgeon/Assist	2 Payment is included in the allowance for the basic service/procedure	Total Net Payments	$2281
		Patient Responsibility	0

* Note that this sample EOB contains column headings names for example only. Though the types of information each EOB contains will be the same regardless of which health insurer issued the EOB, the names of the EOB headings will depend upon each health insurer's preference.

Detecting claim underpayments

Downcoding occurs when a health insurer unilaterally reduces the level of complexity of an E/M service or procedure. Example:

> A practice submits a claim for a patient visit based on a CPT code definition (e.g., CPT code 99204—a level-4 new-patient visit code), and the health insurer automatically recodes the claim to a lower level of complexity (e.g., CPT code 99203—a level-3 new-patient visit code) within or across code series and then reimburses at a lower rate.

The health insurer may base the downcoding solely on the diagnostic code listed with the service reported, or they may have additional documentation requirements for E/M services beyond the CMS E/M guidelines. Typically, practices do not receive any explanation for the change in E/M service and simply receive lower reimbursement. For ways to detect the downcoding of the E/M service, see the checklist below for detecting and addressing claim underpayments.

Health insurers still arbitrarily downcode E/M services, despite efforts by the AMA, national medical specialty societies, and state medical associations to prevent this type of practice through state legislation and contract prohibitions. Health insurers often base their decision to downcode on the details of the claim alone (i.e., CPT and ICD-9-CM codes) without reviewing the actual medical record documentation practices have provided. Thus, it is important for you to review the EOB to make sure the CPT code billed matches the CPT code listed for reimbursement on the EOB. The health insurer should also report the correct fee allowance for the CPT code listed on the EOB.

Health insurers often base their payment on a lower valued (and lower complexity) E/M code instead of the higher valued (and higher complexity) E/M code originally reported for payment on the claims submission. The health insurer may state that the CPT code was replaced or changed on the EOB. If so, the following checklist can guide you through the process of detecting and addressing claim underpayments.

Checklist 3

Checklist for detecting and addressing claim underpayments

- ❑ **Review** the health insurer EOB/remittance advice (RA).
- ❑ **Confirm** the CPT code billed matches the CPT code listed for reimbursement on the EOB.
- ❑ **Compare** the fee schedule to the amount indicated on the EOB; the contracted fee schedule should be reflected for the CPT code listed on the EOB.
- ❑ **Review** the downcoded/underpaid claim to determine whether
  - the health insurer downcoded the E/M CPT code in error,

  or

  - your practice reported the service provided at the wrong level.
- ❑ **Gather** supporting documentation to accompany the appeal, including the medical record documentation of the disputed E/M services according to the health insurer guidelines.
- ❑ **File** an appeal to the health insurer for any E/M code inappropriately downcoded in error.

Two important actions for you to take when challenging downcoded claims are:

1. Determine which set of CMS E/M coding guidelines—the 1995 or 1997 version—the health insurer follows under its medical review guidelines. (Note: you may download the 1995 or 1997 CMS E/M guidelines from CMS Web site. The health insurer might be using one set of E/M coding guidelines, while you might be using the other.
2. Review the medical record documentation to ensure that your practice met and appropriately documented all required components of the E/M service based on CPT codes, guidelines and conventions that the set of CMS E/M coding guidelines followed.

Be prepared to submit an appeal letter justifying that the level of service billed is appropriate, as the medical record documentation substantiates. Include copies of all applicable medical records that meet the E/M code criteria.

Downcoding is not isolated to E/M services. The AMA has received reports of health insurers automatically downcoding claims for complicated procedures (e.g., CPT code 10121—*incision and removal of foreign body, subcutaneous tissues: complicated)* to a lower level of complexity (e.g., CPT code 10120—*incision and removal of foreign body, subcutaneous tissues: simple)* without ever reviewing the supporting documentation.

Lack of recognition of CPT modifier 50

Health insurers commonly reimburse bilateral procedures at the unilateral rate or underpay for these procedures. Such inappropriate payment primarily occurs when the health insurer overlooks CPT modifier 50 or miscalculates reimbursement of a bilateral procedure. Knowing the contracted fee arrangements for every health insurer your practice participates in will enable you to verify whether you received the correct claim payment. It is also important to know the health insurer's preferred method for reporting bilateral procedures. (If you keep this information in your health insurer reference log, you will be able to access it easily.)

Here are examples of two methods of reporting bilateral procedures:

- **Single-line entry.** For CPT code 31237—*nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)*—performed bilaterally, list CPT modifier 50 (appended when the physician performs a bilateral procedure during the same operative session) on the same line as the procedure performed bilaterally:

  CPT code 31237 50

- **Double-line entry.** For CPT code 31237—*nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)*—performed bilaterally, list the CPT modifier 50 as the second line item:

  CPT code 31237
  CPT code 31237 50

If you do not report the bilateral procedure according to the method the health insurer requires, you may receive inappropriate payment. Typically, the health insurer reimburses a bilateral procedure in error as a unilateral procedure. If you do not audit the EOB thoroughly, you could unknowingly write off a portion of the charge that is actually due for reimbursement. You can request a corrected claim payment simply by contacting the health insurer representative.

Lack of recognition of CPT add-on codes

You should be familiar with CPT and health insurer guidelines relating to the reporting of CPT add-on codes. Health insurers may have varying coding rules on reporting CPT add-on codes. It is important to pay close attention to the health insurer's coding rules for each CPT add-on code because the policy may differ by code or circumstance.

According to the CPT book, an add-on code denotes a procedure and/or service performed in addition to the primary procedure by the same physician. The CPT book explains that "add-on codes describe additional intra-service work associated with the primary procedure [e.g., additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s)]." Add-on codes always denote procedures and services performed in addition to the primary service or procedure. You must never report them as a stand-alone code, and they are exempt from modifier 51, the multiple-procedure concept. You can find a list of add-on codes in Appendix D of the CPT book. Add-on codes are followed by parentheticals that indicate the appropriate primary procedure code(s) with which you should report the add-on code on the claim form. The following example illustrates what to look for in the EOB to detect when the health insurer does not recognize the add-on code.

Figure 2: XYZ explanation of benefits excerpt is an example in which the health insurer EOB identifies an inappropriately applied multiple-procedure discount rule to an add-on code.

Figure 2

XYZ PPO explanation of benefits excerpt

Description of Service	Date		Provider Charge	Charge Allowed	Not Covered	Pending	Deductible	Co-Pay	Co-Insurance	Remarks	Benefit
	From	Through									
12345	01/01	01/01	$900	$900				100%			$900
1234X	01/01	01/01	$450	$225	$225			50%		3	$225
Totals			$1350	$1125	$225						$1125
Reason Code 3 The charge was reduced due to the multiple procedure rule.											

An inappropriately applied multiple-procedure discount rule to an add-on code

* Note that this sample EOB contains column headings names for example only. Though the types of information each EOB contains will be the same regardless of which health insurer issued the EOB, the names of the EOB headings will depend upon each health insurer's preference.

Health insurer payment inconsistencies

You should review the appropriateness of the discounts and fee schedule the health insurer applied to the CPT codes listed on the EOB that identify the physician procedures and services. The claim payment you receive from a health insurer does not guarantee that the payment amount listed on the EOB is in accordance with the contracted health insurer rate. The physician practice that assumes the health insurer reimbursement for a particular procedure or service is always correct may be in for a surprise: health insurers often misapply fee schedule rates and discounts. By writing off inappropriate adjustments, your practice can lose significant revenue.

You should know the fee schedule for each health insurer in whose network your physician participates. There may be a **discount fee-for-service** arrangement whereby the health insurer reimburses the physician's billed charges at a discounted rate, such as 85% of the full billed charge. You can easily determine whether you have received the correct payment when there is a **discount fee-for-service** arrangement with a health insurer. Simply multiply the physician's billed charge by the health insurer's negotiated reimbursement rate.

Figure 3

Example 1 explanation of benefits				
CPT code	**Billed Amount**	**Discount Amount**	**Patient Responsibility**	**Paid Amount**
XXXXX	$120.00	$18.00	$0.00	$102.00*

* Paid at 85% of billed charges

- **Calculate the correct payment:** If your practice bills $120 for CPT code XXXXX, and the health insurer reimbursement schedule pays claims at 85% of the physician's billed charges, the correct calculation is: $120 x 0.85 = $102. Therefore, the correct payment for code XXXXX is $102.
- **Determine the discount:** Figure out the negotiated health insurer discount that will be adjusted or written off the patient's account. In this example, the appropriate health insurer discount is 15% of the physician's billed charge. The correct calculation is: $120 x 0.15 = $18. Because the physician is contracted with the health insurer, your practice should not bill the patient for the negotiated health insurer discount.
- **Make the appropriate adjustment:** In this example, your practice should adjust (write off) an $18 health insurer discount from the patient's account. Please note that co-insurance and deductibles may apply.

A **fixed-fee** schedule (i.e., fee-for-service) is another possible reimbursement option between the practice and the health insurer. A fixed-fee schedule payment method reimburses the physician based on a fixed fee agreed upon in the contract between the physician practice and the health insurer. This type of fee arrangement often calculates an individual fee schedule allowance for each CPT code the physician practice reports. These allowances are typically based on the Resource-Based Relative Value Scale (RBRVS) as designated in the Medicare physician fee schedule. For such contracts, you should obtain an actual copy of the health insurer's fee schedule that includes every CPT code that your practice bills. You should also know which RBRVS payment methodology (e.g., conversion factor, geographic adjustment, limits on balance billing) the health insurer uses to calculate the payment. You will find this information beneficial when you need to appeal a claim because the RBRVS payment methodology will vary among health insurers.

Figure 4

Example 2 explanation of benefits				
CPT code	**Billed Amount**	**Discount Amount**	**Patient Responsibility**	**Paid Amount**
XXXXX	$120.00	$15.40	0	$104.60*

* Paid at contracted rate

- **Calculate the correct payment:** If your practice bills $120 for CPT code XXXXX, and the health insurer contract allowed amount is $104.60, then the correct payment for code XXXXX is $104.60.
- **Determine the discount:** Figure out the negotiated health insurer discount that will be adjusted (written off) the patient's account. In this example, the appropriate health insurer discount is $15.40. The correct calculation is: $120 - $104.60 = $15.40. Since the physician is contracted with the health insurer, your practice should not bill the patient for the negotiated health insurer discount.
- **Make the appropriate adjustment:** In this example, your practice should adjust (write off) the $15.40 health insurer discount from the patient's account. Please note that co-insurance and deductibles may apply.

When you know the reimbursement rates in advance, you can easily audit the health insurer's payment from the EOB to ensure that you have received the correct amount. The four most important areas to audit on the health insurer EOB include: CPT code, charge, provider discount and payment. If you note an underpayment, you may make the correction by calling the health insurer's provider representative. In most instances, the health insurer will not require you to draft a formal appeal letter for a claim underpayment issue resulting from a health insurer's error for claims repricing. You may contact the health insurer's representative for its policy regarding correction of incorrect repricing of submitted claims.

Figure 5: XYZ PPO explanation of benefits is an example of inconsistent health insurer payments a practice received for an identical service they provided to the same patient on different dates. CPT modifier 50 designates a bilateral procedure, so the practice appended it to the appropriate procedure code during the practice's claim submission, in accordance with the health insurer's requirements.

After close review of the health insurer EOB, the practice staff uncovered a payment differential for the same procedure. For illustrative purposes only, the health insurer paid the claims at $675, $900 and $750, respectively. The contract provides that the health insurer's payment of the claim for these procedures and services should have been $900 each time the practice reported the procedure. Note that the health insurer calculated the bilateral deduction differently for the same patient on different occasions. This type of inappropriate payment should serve as an alert to examine all paid claim amounts and compare them with the health insurer's fee schedule. The reduction can quickly become a significant amount of lost revenue for your practice, especially if your practice commonly performs these procedures.

Figure 5

XYZ PPO explanation of benefits

Participant (patient):		Why Me								
Procedure performed:		Date, 2008								
Claim number:		0000001								
	Date	**Total Charge**	**Exclusions**			**Co-Pay**	**Deductible Amount**	**Covered Expenses**	**Pay %**	**Amount Payable**
			Ineligible	**CD**	**Discount**					
Date of service A	My Physician		Surgery							
	01/23/08	$450								
	Procedure Code	12345	Patient Number: 0000001					$450	100%	$450
	01/23/08	$450	$225	AA						
	Procedure Code	12345 50	Patient Number: 0000001					$225	100%	$225
	Totals	**$900**	**$225**					**$675**		**$675**
Date of service B	My Physician		Surgery							
	02/06/08	$450								
	Procedure Code	12345	Patient Number: 0000001					$450	100%	$450
	02/06/08	$450								
	Procedure Code	12345 50	Patient Number: 0000001					$450	100%	$450
	Totals	**$900**						**$900**		**$900**
Date of service C	My Physician		Surgery							
	02/23/08	$450								
	Procedure Code	12345	Patient Number: 0000001					$450	100%	$450
	02/23/08	$450	$150	AA						
	Procedure Code	12345 50	Patient Number: 0000001					$300	100%	$300
	Totals	**$900**	**$150**					**$750**		**$750**

If this claim has been partially or fully denied, the plan member may appeal this decision. To appeal, please consult the appeals processes listed on the back of this form. The plan member must send a written request for review within 60 days.

Base Deductible Amount
Other Carrier Adj.
Total Paid **$xxx.xx**

Description Codes as used above and applicable Miscellaneous Comments
AA Payment reduced for bilateral procedures

* Note that this sample EOB contains column headings names for example only. Though the types of information each EOB contains will be the same regardless of which health insurer issued the EOB, the names of the EOB headings will depend upon each health insurer's preference.

Detecting a health insurer discount when a contract does not exist

Auditing EOBs is a very detailed task that requires a great deal of time and technical skill. If you do not audit an EOB thoroughly, your practice can lose revenue. Such loss can occur when practice staff write off an erroneous health insurer discount on the patient's account instead of appealing the claim. In some cases, the discounts may be minimal and occur seldom; in other cases, the discounts may be quite substantial and occur frequently. In either case, however, the practice loses due revenue. The only way to detect this type of underpayment scheme is to audit the EOB.

When auditing the EOB, review the area commonly listed as "PPO discount" and refer to the EOB remark section, usually located at the bottom of the EOB. Be suspicious of any EOB that lists a PPO discount but does not include the name of the contracted PPO, if different from the company or health insurer sending the EOB. If the name of the PPO is missing from the EOB, reference the patient's insurance card to determine whether it includes a PPO identifier. When contacting the health insurer for benefit verification, determine what benefits the health insurer quoted and verify the name of the contracted PPO. Contact the health insurer directly if any patient benefit information is missing or inconsistent to determine the correct reimbursement. You need to answer two questions:

1. Does a valid PPO discount apply to the claim?
2. Did the health insurer take the PPO discount in error on the claim because no contract exists between the PPO and the physician?

If the health insurer applied the PPO discount inappropriately, the health insurer may owe a corrected payment at the traditional fee-for-service rate. In this case, advise the health insurer that you will not honor the PPO discount. Also, notify the patient when a health insurer applies a PPO discount in error, because the patient may receive an erroneous EOB from the health insurer. This kind of error can result in lower or higher out-of-pocket patient costs. The practice staff can maintain good patient relations by discussing and clarifying with the patient any EOB revision a health insurer error caused.

Another factor to consider when auditing EOBs for inappropriate PPO discounts is the use of provider networks. In some cases this may be authorized by the contract you signed with the health insurer, PPO plan or network (such as an IPA), and in other cases the discount may not be authorized.

It is common practice in the health insurance industry to "rent" physician and provider networks to a variety of organizations. One common example is self-insured employer health plans, in which the third-party administrator or benefits consultant the self-insured employer hires typically makes the arrangement with the health insurer. In other cases, health insurers themselves provide administrative service only ("ASO") services to self-insured employer health plans. In such cases, the health insurer rents its physician network and provides claims processing, member services and related administrative support.

To determine whether a health insurer, PPO or network can include you in its rented networks, review your signed agreement. The contract must have specific language to authorize such an arrangement. In some cases, the contract may have a paragraph that is buried in the agreement and not easily noticed.

If this language does exist in your contract, review the compensation terms to determine whether your practice will be paid the same compensation when your practice is included in a provider network type contract. If your contract contains language that authorizes your practice's inclusion in an affiliate type contract, expect to see EOBs with names of health insurers or plans that you are not familiar with and are different from the name of the health insurer or PPO with whom you originally contracted.

Remember, if the agreement you signed does not specifically authorize your inclusion in provider networks, and you receive payment as if you had authorized inclusion, you can appeal the payment. In this case, you are entitled to reimbursement at your fee for service billed rate, since you are an "out of network" provider. Of course, your patient may have a greater share of cost or responsibility in this case as well.

Tricks of the trade: patient insurance card

- Always make a copy of the front and back of a patient's insurance card.
- Keep this copy on file to reference during the claims process

Figure 6: XYZ PPO explanation of benefits and Figure 7: Health Plan Insurance Company explanation of benefits are examples of EOBs that show actual instances of inaccurate discounts health insurers took. These examples point out areas of an EOB that you need to closely monitor to verify that health insurers reimburse appropriately.

When your practice's registration staff reviews a patient's health insurance card, you should pay particular attention to the PPO identifier on the card. This alerts you to the PPO in which the patient participates.

Carefully review payments you receive from health insurers to confirm that they include discounts for healthcare services provided only to patients entitled to such discounts.

You can access additional information on how to protect your practice from inappropriate discounts by downloading the National Managed Care Contract.

AMA policy "advocates that medical services agreements between physicians and preferred provider organizations (PPOs) should adhere to the following principles:

- Discounts shall be extended only to enrollees of PPOs who have cards identifying them as such.
- All PPO members eligible for discounts shall be subject to mechanisms that will direct patients to the physician's practice.
- The types of entities that can be added to the network shall be identified in advance, and providers shall receive timely notice when payers or employers are added.
- All members added to the PPO shall be subject to the same mechanisms to direct patients to the physician's practice.
- Any discounts applicable to a PPO enrollee shall be disclosed at the time coverage is verified.
- The sale or other unauthorized use of contract rate information shall be specifically prohibited."

Contact the AMA/State Medical Society Litigation Center at *www.ama-assn.org/go/litigationcenter* if you are experiencing improper discounts by third-party payers. You can also access the AMA Health Plan Complaint Form (HPCF) to submit a complaint.

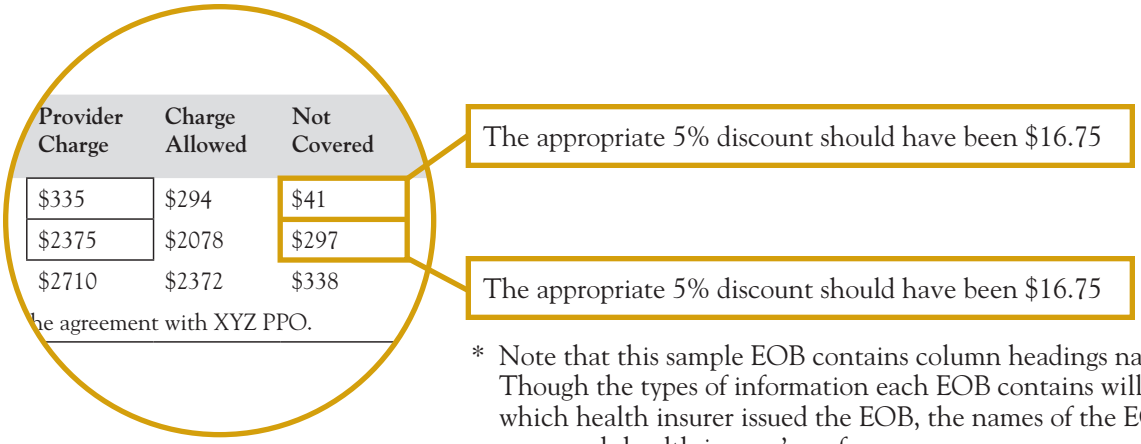
Figure 6

XYZ PPO explanation of benefits

Participant (patient):	Patient A. Patient
Claim Number:	000001
XYZ PPO	
Service Provider	Doctor USA

Description of Service	Dates		Provider Charge	Charge Allowed	Not Covered	Pending	Deductible	Co-Pay	Co-Insurance	Remarks	Benefit
Surgery	1/01	01/01	$335	$294	$41				100%	1	$294
Lab Service	1/01	01/01	$2375	$2078	$297				100%		$2078
Totals			$2710	$2372	$338						$2372

1 The charge was reduced by $338 based on the agreement with XYZ PPO.



* Note that this sample EOB contains column headings names for example only. Though the types of information each EOB contains will be the same regardless of which health insurer issued the EOB, the names of the EOB headings will depend upon each health insurer's preference.

Evaluating the EOB (See Figure 6)

1. **Identify the health insurer that has negotiated the discount.**

   In the example found in Figure 6: XYZ PPO explanation of benefits, the health insurer the physician practice has a contract with is XYZ PPO.

2. **Identify the health insurer discount according to the fee schedule for the patient setting and the physician's provision of patient care services.**

   Typically, the practice staff obtains this information through the benefit verification process with the health insurer. Because the physician in this example is in the health insurer's PPO network, the practice staff verified with representatives of XYZ PPO that the patient's benefit coverage is 95% payment (or a 5% discount) of the physician's charges for an outpatient physician visit and surgery rates.

3. **Review the health insurer EOB to determine whether they took the appropriate negotiated discount.**

   XYZ PPO has taken a discount for the services rendered. However, further review shows that XYZ PPO applied a 12.5% discount to the charges for physician procedures and services. The contracted discount was 5% of the physician's charges for an outpatient doctor visit and surgical procedure, since the practice is in the health insurer's PPO network. XYZ PPO took an additional 7.5% discount that was not allowable—which would have resulted in a $202.50 practice revenue loss if the practice had not appealed the error.

   The practice staff identified the incorrect discount calculation in Figure 6: XYZ PPO explanation of benefits in the following manner: They calculated XYZ PPO's contracted 95% payment (or 5% discount) of the physician's billed charge of $335 for the surgery and $2,375 for the laboratory service. The appropriate 5% discounts should have been **$16.75** (i.e., **335** x 0.05) and **$118.75** (i.e., **2,375** x 0.05), for a total discount of $135.50 to the health insurer. In this example, the practice reversed their $202.50 ($338-$135.50) revenue loss through the XYZ PPO claims appeals processes.

Rental network PPO

A rental network PPO is another behind-the-scenes issue of which a physician practice contracting with a health insurer should be aware. A rental network PPO refers to a situation in which, without the knowledge of the contracting physicians, a health insurer "sells" or "rents" its PPO physician network to a third party (typically, an administrator, insurance broker, smaller PPO or self-insured employer). Under this arrangement, the third party gets the advantage of whatever discount the health insurer has negotiated with the physician practice.

Practices generally become aware of a rental network PPO only after providing services to a patient whom the contracted PPO does not cover. After filing a claim for services with the patient's health insurer, the practice receives less than the expected full payment and an EOB referencing the discount with the contracted health insurer PPO. A busy practice may have difficulty spotting this anomaly on an EOB and may or may not be able to appeal, based on the contract with the health insurer. Figure 7: Health Plan Insurance Company explanation of benefits is an EOB that illustrates a rental network PPO or an inappropriate discount.

In this example, many physician billing departments would have posted the paid amount of $215 for CPT code XXXXX to the patient's account as payment in full from the respective health insurer. The practice staff would have most likely written off the amount of $120 listed on the EOB as the PPO adjustment. Frequently, practice staff assume this information is correct because it appears on the health insurer EOB. You should audit all payments on claims you receive. Never assume that the PPO discounts a health insurer applies on an EOB are correct.

The discount applied in this EOB example resulted in the health insurer underpaying the claim by 36% of the appropriate full payment rate.

Figure 7

Health Plan Insurance Company explanation of benefits

Insured Name:	Patient	Account #:	123456
Soc. Security No:	xxx-xx-xxxx	Account Name:	Healthy Employer
		PPO Network:	

Ln #	CPT Code	Date of Service	Charged Amt.	PPO Adjustment	Repriced Amt.	Insured Co-Pay	Ineligible Amt.	Msg #	Applied to Deductible	Balance Amt.	Paid % Amt.
1	XXXXX	05/18/08	$335	$120	$215			1,2	0	$215	$215

Remarks

1 PPO Adjustment

2 Allowed charge amount reflects an **average discount** for this PPO Network. For reconsideration, please submit claim with the correct discount amount marked for **"reconsideration needed."** In order to prevent future processing delays, please submit claim directly to PPO Network for re-pricing.

* Note that this sample EOB contains column headings names for example only. Though the types of information each EOB contains will be the same regardless of which health insurer issued the EOB, the names of the EOB headings will depend upon each health insurer's preference.

Warning signs that the health insurer is using a rental network PPO or an inappropriate discount (See Figure 7: Health Plan Insurance Company explanation of benefits)

"PPO Network"

The upper right portion of the EOB in Figure 7: Health Plan Insurance Company explanation of benefits notes "PPO Network." However, the PPO network name is missing.

"PPO Adjustment" and "Repriced Amount"

In the EOB of Figure 7: Health Plan Insurance Company explanation of benefits, there are two columns with fee data listed as "PPO Adjustment" and "Repriced Amount." Because the EOB does not note a PPO network name, these fields should alert your suspicion. Further evaluate the EOB to determine whether the health insurer inappropriately applied the PPO discount noted.

"Average Discount" and "Reconsideration Needed"

In the example of Figure 7: Health Plan Insurance Company explanation of benefits, the EOB message section includes language indicating a rental network PPO or inappropriate discount.

- An "average discount" does not exist in valid PPO contracts.
- If the health insurer asks you to resubmit the claim with the correct discount marked for "reconsideration needed," this should alert you that the PPO discount the health insurer took was invalid.

You may encounter additional warning signs:

- Patient's insurance card has several health insurer logos or networks
- Health insurer takes a PPO discount without mentioning the PPO
- Health insurer takes a PPO discount on the EOB with the reason code stating "usual, customary, and reasonable (UCR)" guidelines
- You do not have an agreement with the PPO

Typically, you do not need to provide a PPO with the contracted discount information when submitting PPO claims for payment. You do not need to submit these discounts to legitimate health insurers or PPO networks with valid physician contracts. Health insurers should have the participating physician's contracted fee schedule or reimbursement rates in their participating physician files.

Most EOB message or remark sections will not provide rental network PPO or health insurer networks language as clearly as in this example. However, the more you review the EOB, the easier it will become to detect an inappropriate discount. Remember to keep track of your claims in your health insurer follow-up log. You can quickly reference the log

for the appropriate payment amount to determine whether you received appropriate payment. If the payment amount is incorrect, you will know to address the problem, sending a claim appeal letter if necessary or even flagging certain types of claims that a health insurer consistently denies or partially pays.

To determine whether the health insurer applied an inappropriate discount that resulted in claim underpayment, complete the following two tasks.

Task 1: Review the patient's health insurance card

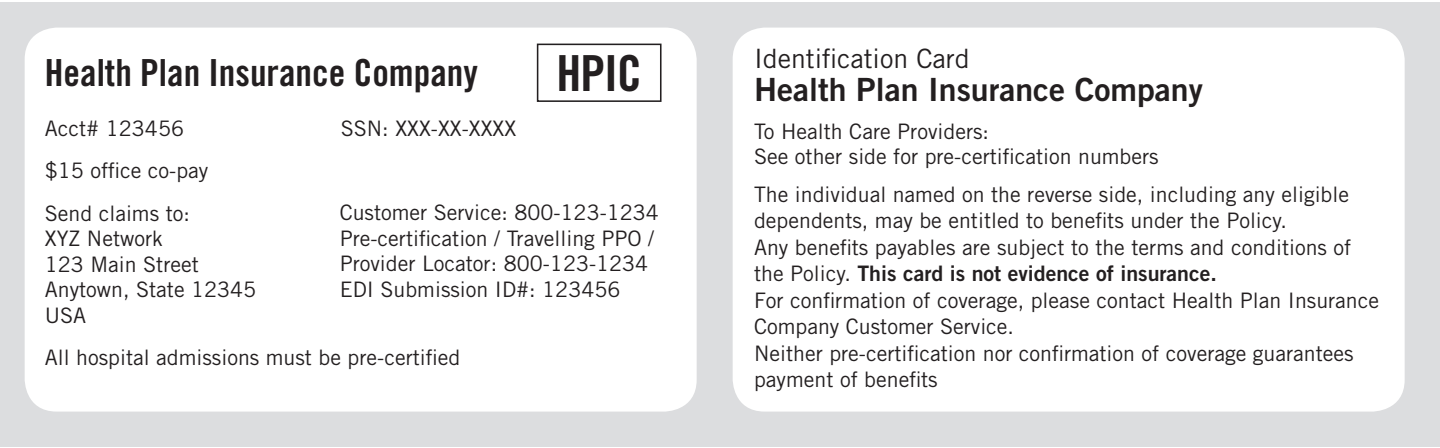
If a PPO network name is not noted on the EOB but the health insurer took a PPO discount, refer to the patient's health insurance card to verify whether it identifies a valid PPO. The health insurance card may identify the PPO network, but the network represented might not be one in which your physician participates. In Figure 8: Health Plan Insurance Company identification card, XYZ Network, located in Anytown, State, is listed.

The patient's $15 office co-payment is also noted. If it is from a managed care health insurer (e.g., PPO, HMO, POS), the patient's health insurance card generally includes co-payment information. However, in this scenario, the physician practice does not participate in XYZ Network. Based on this fact alone, the practice staff should be alerted that the health insurer accessed a PPO network in order to reprice the claim. Also, no "PPO" identifier is listed on this health insurance card example, so it is uncertain whether the health insurer is a PPO or another type of managed care health insurer.

The term "Traveling PPO" in the health insurance card example in Figure 8: Health Plan Insurance Company identification card should alert the practice staff. Most likely, the Traveling PPO represents a network of other PPOs affiliated with XYZ Network. When the patient travels out of state, the health insurer accesses another PPO network to reprice the claim and ultimately reduce claim payment by indicating a PPO discount on the EOB that they want the physician practice to write off. This is a complicated scenario, yet it represents one of the most common types of examples in which physicians lose substantial revenue by writing off charges that the health insurer actually should have paid.

The PPO should list the name and state of each legitimate rental network PPO (also called network, wrap plan or travel) on the patient's health insurance card or give the practice a list of these provider networks prior to signing the contract. When you submit a claim to the appropriate PPO network, the discount that your physician agreed upon with the original health insurer will apply. In this example, a physician has an agreement that Health Plan Insurance Company will apply a 5% discount to the physician full fee schedule. The physician practice staff notices on the patient's insurance card that Traveling PPO is a Health Plan Insurance Company provider network. Therefore, in this instance, the Traveling PPO is not considered a rental network PPO and is allowed to apply the 5% discount on the physician full fee schedule.

Figure 8



Task 2. Review the patient's health insurance benefits

When the health insurer information on the patient's EOB is inconsistent with the patient's insurance card, you should contact the health insurer for benefit verification or a quote of benefit coverage. You should verify whether the patient's health insurer is a PPO or a traditional fee-for-service health insurer. A traditional fee-for-service health insurer policy will quote the patient's benefits, often the 80/20 benefit rate (i.e., the health insurer pays 80% of the physician's full fee, and the patient is responsible for the remaining 20% co-insurance portion). Under this type of policy, the health insurer EOB should not have any PPO discounts because the health insurer does not have any contracted discount with the physician. The patient is responsible for the remaining balance as stated on the EOB.

In another scenario, when a non-participating physician submits a claim to a health insurer and a PPO discount is inappropriately applied to the claim using a participating provider discounted fee schedule, the physician practice does not need to accept the discount since the physician is non-participating. The claim should have been processed using the out-of-network reduced reimbursement rate without any PPO discount, and the patient would then be responsible for the remaining physician fee. Third-party payers can also rent their physician networks. Physicians need to watch for broad definitions of "payer" or "affiliate" that may permit the renting of their negotiated discount rates. An example is a definition that describes a payer as "any other entity which has contracted with the company to use the company's provider network." Under this arrangement, the third-party payers that contract with the rental network PPO usually gain the advantage of having access to any and all discount agreements that the rental network PPO has negotiated with the physician, and usually without the physician's prior knowledge or permission. A rental network PPO, which "sells" or "rents" its physician network to a third-party payer, generally takes no financial risk and does not pay claims or ensure that any associated physician claims are paid. You should not accept any inappropriately applied participating physician discounted fees or any other discounted fees if your physician practice is not contracted with that PPO.

Practice Management Center (PMC) resource tip

Multiple payers could be taking advantage of your lowest contracted payment rate through the use of a rental network preferred provider organization (PPO). The AMA developed the booklet "Read your contracts: Is your practice losing revenue though rental network PPOs?"* to educate physicians about how to identify and protect their practices from inappropriate discounts.

* This booklet is available to AMA members. For more information on becoming an AMA member, please visit the AMA Member Center.

You should make auditing EOBs a top priority. Applying these auditing steps will help you identify inappropriate PPO discounts and other claim underpayments so you can take immediate action to collect the appropriate reimbursement. You should also remain alert to other situations in which payment received is less than that negotiated in the contract.

Medical necessity denials

The AMA has numerous policies regarding medical necessity. AMA policy reinforces the need for health insurers to have adequate claims appeals processes in order to address patients' disputes about determining medically necessary care, along with a medical necessity definition that emphasizes quality and clinical effectiveness.

You should carefully review the health insurer's medical service agreement for their specific definition of medical necessity and enter that into your health insurer reference log. Health insurers, and even employer groups, may have their own definitions of medical necessity. The language defining medical necessity can usually be found in the denial letter the health insurer sent to the patient and attending physician, but you should know their definition prior to receiving a claim denial.

AMA policy defines medical necessity as:

> "Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health insurers and purchasers or for the convenience of the patient, treating physician, or other health care provider."

If the health insurer's medical necessity definition and/or their reason for denying the service is not clear, you may wish to send a pre-appeal letter. This letter requests additional information from the health insurer to aid in preparing the formal claim appeal letter that requests claim reconsideration. The pre-claim appeal letter should ask the health insurer for the following information:

- Medical necessity definition or clarification
- Source and content of the information on which the health insurer based the medical necessity denial (e.g., allocation guidelines)
- Description of the information the health insurer needs to approve the treatment/service
- Copies of any expert medical opinions the health insurer has secured regarding treatment/service and its efficacy

Challenging medical necessity denials

Physician practices receive health insurer claims denials with remarks or codes on the EOB indicating "service/procedure deemed not medically necessary by the payer." Health insurer denials on the basis of medical necessity are one of the most common types of denials physician practices encounter. They are also one of the most difficult to challenge because the definition of medical necessity varies from health insurer to health insurer. In the past, all a practice needed to do to challenge a medical necessity denial was to provide a letter outlining why a particular service or procedure was necessary and how the patient benefited from it. With that information, health insurers usually allowed payment. But health insurers' medical necessity denials have become more complicated due to factors such as:

- Health insurer claim-editing software that screens the primary ICD-9-CM code to determine whether it appropriately matches the CPT code billed or units for the quantity of procedures
- Health insurer cost-containment measures that limit benefit coverage for newer or advanced technologies
- Controversy over appropriate medical management options between health insurer medical reviewers and treating physicians

To effectively handle medical necessity claim issues, you should conduct pre-treatment benefit verifications for all special procedures and services the patient will incur. This includes, but is not limited to, specialized testing, radiology services, and in-office and outpatient procedures. The health insurer's benefits department may notify you regarding procedures and services that are subject to medical necessity review. Often, these types of procedures and services must meet specific criteria for the health insurer to consider paying for them. You should ask the health insurer to specify the requirements for confirming medical necessity.

You should also maintain and regularly update each health insurer's medical necessity criteria for each service your practice provides in your health insurer reference log. In some cases, the health insurer representative may not know, may not provide the medical necessity requirements or may give inaccurate information. The following steps may help lessen your number of health insurer claims denials based on medical necessity and assist you in challenging a claim denial.

Before submitting claims to a health insurer

1. Ask each health insurer which specialized procedures and services are subject to medical necessity review.
2. At least quarterly, update your health insurer reference log with each health insurer's name and the medical necessity requirements for each procedure and service your practice provides, since each health insurer may have different review processes. You should recognize that some employers may have their own requirements for determining medical necessity. However, the health insurer should provide you with this information.
3. Ask to speak with a claims manager or medical reviewer from the health insurer to determine what criteria need to be met for them to consider a physician procedure and service medically necessary. The health insurer may require a specific diagnosis (i.e., ICD-9-CM code) on the claim submission, or it may exclude coverage if the patient has a specific pre-existing condition. If the patient has a pre-existing condition, the procedure and/or service may not be covered.

Step 6: Gather supporting documentation to corroborate reversal of the health insurer's determination through the claims appeals processes

Review the recommended health insurer auditing resources collected in Step 2. These resources will help develop the supporting rationale for the appropriateness of the procedures recorded on the initial submitted claim, such as the:

- Health insurer contract or medical payment policy that supports the procedures listed
- CPT guideline you can reference
- Operative note that explains the separate and identifiable procedures and services reported
- CMS guideline you can reference

You can cite previously approved claims that are similar to the denied claim to support overturning a health insurer's frequent partial payments or denials.

Tricks of the trade: proof for timely filing

- If a health insurer asks you to prove that you sent the claim within the health insurer's timely filing period (e.g., 90 days, 180 days), submit a screen shot of the practice management (PM) system that shows the date you either printed or electronically sent the claim. The PM system should show the exact date you sent the claim. Submitting a screen shot with the date you sent the claim may assist in a more favorable outcome.
- How to do a screen shot: Depending on your software system, you may be able to capture and print a picture of your computer screen. If you are printing from a PC, open the PM system screen so that it shows the patient's name, date of service and date you sent the claim and press the "Print Screen" key on the keyboard. Your computer settings may allow you to print the screen directly, or you might need to open a blank Word document and paste the image of the PM system screen before printing. (Note: you might need to change your software settings to enable this function.)

Step 7: Develop a claim appeal letter and resubmit the claim to the health insurer

Correct the error and/or submit with appropriate documentation

After you identify an inappropriate health insurer rationale for partial claim payment, delay or denial, it is time to appeal the claim. Instead of initially sending a formal claim appeal letter, your first attempt to resolve the matter should be to contact the health insurer claims manager or representative if your practice participates in the health insurer's managed care product. In some cases, the representative will review the initial claim for accuracy or review the case approval history. The representative will then process a request to the claims department for prompt claim payment or request additional documentation they need to process the claim.

Tricks of the trade: review/appeal forms

- Find out whether the health insurer requires a special reconsideration/review request form to accompany the appeal.
- If so, complete and attach the form to the front of the claim appeal letter and its supporting documentation to assist the health insurer's review and reconsideration of the claim for

10 steps for developing and submitting an appeal letter

If your telephone call to reverse the claim denial is unsuccessful, you will need to develop an effective claim appeal letter, based on the template in Figure 9: Sample claim appeal letter. The following steps may help if the health insurer requires a formal appeal letter:

Step 1. If your practice participates in the health insurer's managed care product (e.g., PPO, HMO or POS), **review your contract** for the claims appeals processes and monitor the health insurer's compliance. Some health insurers may require specific forms for submitting claims appeals.

Step 2. **Prepare an appeal letter** that includes the patient's name, subscriber's name, health insurer identification and insurer numbers, date of service and the reason that you are challenging the health insurer denial.

Step 3. **Thoroughly support and document your argument.** Use both subjective information (i.e., patient's chief complaint, physician's personal comments) and objective data (i.e., medical record findings) and gather supporting documentation.

You can obtain additional supportive documentation through the AMA (e.g., CPT book, *CPT Assistant*, CPT Network, *Medicare RBRVS: The Physicians' Guide*, etc.), national medical specialty societies, state and county medical associations and Centers for Medicare and Medicaid (CMS) to substantiate the physician service.*

* The AMA is not responsible for the content of other Web sites.

Figure 9: Sample claim appeal letter

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Sample generic appeal letter

[*Date*]
Attn:_____
Provider Appeals Department
[*Address*]
[*City, State, ZIP Code*]

Re:_____
Insured/Plan Member:_____
Health Insurer Identification Number:_____
Group Number:_____
Patient Name:_____
Claim Number:_____

Dear [*Health insurer*]:

We are appealing your decision and request reconsideration of the attached claim that you denied on [*date*].

We feel these charges should be allowed for the following reason(s):
[*insert reasons*]

Thank you for reviewing and reversing this claim denial. If you require any additional information, please contact [*staff name*] at [*telephone number*] between the hours of [*insert time period that staff is available to answer calls, e.g., 8:00 a.m.–5:00 p.m.*].

Sincerely,

[*Physician*]
Or
[*Practice Manager*]

Step 4. Once you prepare the claim appeal letter, **ask the treating physician to review** it for appropriateness, along with the supporting documentation, before signing the letter. Make sure you include the physician's signature and credentials in the claim appeal letter. In the case of a medical necessity or a chronic inappropriate administrative denial, you may choose to forward all relevant documentation to all involved parties. (See sample notification letters.)

Step 5. **Identify the name** of the health insurer's contact person who should receive the claim appeal for review.

Be sure to address the claim appeal letter to the appropriate health insurer representative so that a specific person will be responsible for a reply. If you do not know a contact person, call the health insurer and request the name and address of the health insurer representative or department to which you should address the claim appeal. Also, ask the health insurer representative the expected time frame for processing the claim appeal letter. This information will help you determine the appropriate time frame for follow-up procedures.

Step 6. **Request a review of the claim appeal letter** by a physician of the same specialty.

Typically, the reviewing physician from the health insurer will phone the treating physician to discuss the case and determine whether medical necessity approval is warranted. Whether a physician reviewer or other health insurer medical review staff determines an approval, you should record the reviewer's name and the case reference number in the file and in your health insurer follow-up log. This information will be critical if the health insurer subsequently denies the claim as not medically necessary.

The health insurer may still deny a claim based on medical necessity, despite the fact that you obtained pre-approval and correctly coded the claim with the ICD-9-CM code the health insurer representative indicated as the covered condition for the CPT code billed. The physician reviewer may perform a telephone review to avoid a formal written appeals process for these types of denials. Written appeals can be time-consuming for both the health insurer and your practice, resulting in lengthy review processes that can extend for three months or longer.

Step 7. **Consider faxing the documentation**—determine whether the health insurer will accept a faxed claim appeal letter and supporting documentation.

Submitting a faxed claim may expedite the health insurer review and auditing processes. When sending a fax, keep a copy of the fax confirmation report that indicates the health insurer successfully received the fax.

Step 8. If the health insurer does not accept faxes, **send the claim appeal letter** and supporting documentation via certified mail, return receipt requested.

You may find a return receipt with a signature from a health insurer representative may prove helpful, especially if the health insurer does not acknowledge the claim appeal letter.

Step 9. **Consistently follow up** with the health insurer representative on the status of the claim appeal review until you receive appropriate payment.

Step 10. Take a proactive approach—**maintain a file** that contains the common claims denials that are based on medical necessity and other common administrative denials and supporting documentation and keep claim appeal letter templates that will help simplify your appeals process.

For easier reference as you go through the appeals process, keep track of the steps you have taken in your health insurer follow-up log.

Develop a claim appeal letter and request physician review

Medical necessity

You should respond to a medical necessity claim denial with a claim appeal letter prepared with specific details of the patient's diagnosis and treatment. Although the practice staff will submit supporting documentation with the claim appeal letter, the health insurer representatives reviewing the claim may overlook the most important elements of the documentation. These key documentation elements support the treating physician's argument for the treatment's medical necessity, and if the health insurer representative overlooks them, the health insurer may again deny the claim.

The claim appeal letter justifying the treating physician's decision of medical necessity should include:

- The patient's current medical condition, supported by both subjective and objective findings, including the patient's chief complaints, physical exam findings, and any correlating diagnostic test findings
- Medical management options that have been tried and which, if any, have failed to alleviate the patient's symptoms or condition, requiring additional treatment or management options

- Whether the patient has met the medical necessity criteria that the health insurer medical policy outlined

The AMA encourages physician practices to assist their patients when a health insurer issues a medical necessity denial that is counterintuitive to the treating physician's assessment of the service's necessity. If a health insurer does not have a medical necessity definition, the AMA definition may be a good reference source.

The patient may appreciate receiving a copy of the claim appeal letter that you sent to the health insurer. Keep the patient informed, in any event, of the physician's efforts to resolve the health insurer's payment denial for patient services.

Step 8: Maintain a health insurer follow-up log

You should maintain a master health insurer follow-up log that identifies each claim you submit and contains the health insurer's rationale for partially paying, delaying or denying a claim on first submission, along with the outcome of your collection efforts.

Tricks of the trade: address multiple claims in one call

- You can often save time by addressing numerous inquiries simultaneously when calling a health insurer for the status of a claim or appeal.
- Because each health insurer differs, ask the health insurer representative whether they limit the number of claims inquiries they will handle during one call. Some health insurers will limit you to five inquiries per call.
- Be sure to have several claims for the same health insurer available so the representative can check on their status during your phone call.
- Even if you need to be transferred to another office or department on one claim, you will save time by inquiring about the status of the remainder of the claims you prepared before the representative transfers you.
- Be sure to use your health insurer follow-up log to record names of people you spoke with, their contact information and what has taken place during these calls.

The health insurer follow-up log should include:

- Health insurer name
- Reason for originally partially paying, delaying or denying a claim
- Dates of appeal attempts
- Health insurer staff contact(s)
- Outcome of your collection efforts (such as fully or partially overturned)
- The reason the claim was not paid in full (if applicable)

You can reduce the number of claims health insurers deny by tracking routinely denied claims. This is especially true when health insurers deny claims as a result of incomplete claims submissions or insufficient supporting documentation. Tracking the reasons for health insurer claims denials is critical to improving your claims management revenue cycle. Use this information to improve internal processes and to ensure that you meet the health insurer's requirements for submitting a specific type of claim.

Step 9: Hold claims processing and review meetings

Your claims management and audit team should hold weekly, monthly or quarterly meetings to discuss the reasons that health insurers have inappropriately denied, delayed or partially paid your claims. When you use this information as an educational tool, you can reduce the number of preventable claim-submission errors. This information can also help you determine the appropriate action to resolve future errors. For instance, in your health insurer follow-up log, your practice's claims management and audit team can reference how they were able to have the original underpayment or denial overturned to prevent the same issue from reoccurring.

The claims processing and review meetings can help your practice achieve a number of goals and results, such as:

- Identifying common problems with claims payment that are a result of inaccurate or insufficient data. (For example, a health insurer might begin to use more stringent claims edits and downcode evaluation and management codes based on the ICD-9 submitted. You can use your meeting to determine ICD-9 codes with greater specificity and educate staff and physicians on the value of using these more specific codes.)
- Identifying new problems with a particular health insurer that require more timely eligibility and benefits validation prior to procedures and services being performed.
- Identifying new problems with a particular health insurer that require your practice to change the way you collect co-payments or treat patient responsibility.

Step 10: Continue to appeal inappropriately denied, delayed or partially paid claims

The AMA supports grievance and appeals systems, including rapid internal and external appeals mechanisms for patients whose health insurers unjustly and inappropriately deny them treatment.

Physician practices and their patients should exercise their right to appeal an inappropriately denied claim through the health insurer claims appeals processes. If the physician and patient have exhausted the internal health insurer appeals processes, an external review of the denied claim may be available to the patient. The patient's employer or health insurer may be able to provide assistance and instruction on the appropriate external appeals processes.

External independent grievance mechanism

The majority of states have enacted laws and/or regulations requiring health insurers to implement an external independent grievance mechanism that patients can access when a health insurer denies coverage for medically necessary care. Through this mechanism, patients have the opportunity to appropriately resolve their grievances.

Keep on Appealing

Physician practices and patients should follow up and continue to appeal appropriately submitted claims a health insurer has denied. It may take more than one appeal to reverse a health insurer's incorrect denial. When you have appropriately performed, documented and reported a procedure or service, persistence is appropriate to ensure that your practice obtains the proper compensation based on the negotiated health insurer contracted rates. Implementing the steps of the claims audit and appeals process will help protect your practice and ensure appropriate payment for services rendered. Keep on appealing inappropriately denied care and inaccurate reimbursement, and never stop improving your claims, submission, audit and appeals processes.

AMA members can download an interactive copy of this letter to use in their practices.

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Sample generic appeal letter

[*Date*]
Attn:_____
Provider Appeals Department
[*Address*]
[*City, State, ZIP Code*]

Re:_____
Insured/Plan Member:_____
Health Insurer Identification Number:_____
Group Number:_____
Patient Name:_____
Claim Number:_____

Dear [*Health insurer*]:

We are appealing your decision and request reconsideration of the attached claim that you denied on [*date*].

We feel these charges should be allowed for the following reason(s):
[*insert reasons*]

Thank you for reviewing and reversing this claim denial. If you require any additional information, please contact [*staff name*] at [*telephone number*] between the hours of [*insert time period that staff is available to answer calls, e.g., 8:00 a.m.–5:00 p.m.*].

Sincerely,

[*Physician*]
Or
[*Practice Manager*]

AMA members can download an interactive copy of this letter to use in their practices.

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Sample letter for inadvertent coding error

[*Date*]
Attn**:**_____
Provider Appeals Department
[*Address*]
[*City, State, ZIP Code*]

CORRECTED CLAIM

Re: Claim reprocessing request

Insured/Plan Member:_____
Health Insurer Identification Number:_____
Group Number:_____
Patient Name:_____
Claim Number:_____
Claim Date:_____

Dear [*Mr./Ms.*]_____:

An incorrect code for [*a/an*] [*name of procedure*] was inadvertently submitted in error for the date of service listed above on [*date*].

[Example incorrect ICD-9 diagnosis code]

This [*name of procedure*] should have been submitted with the diagnosis code of [*correct ICD-9-CM code(s)*] rather than [*previously submitted ICD-9-CM code(s)*].

[Example incorrect CPT procedure code]

The procedure performed, [*name of procedure*], should have been submitted as [*correct CPT code*] rather than [*previously submitted CPT code*].

Please correct this coding error and reprocess the attached corrected claim for payment.

Sincerely,

[*Physician*]
Or
[*Practice Manager*]

AMA members can download an interactive copy of this letter to use in their practices.

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Sample letter for claims underpayment

[*Date*]
Attn:_____
Provider Appeals Department
[*Address*]
[*City, State, ZIP Code*]

Re: Claims underpayment
Insured/Plan Member:_____
Health Insurer Identification Number:_____
Group Number:_____
Patient Name:_____
Claim Number:_____
Claim Date:_____

Dear [*Health insurer*]:

I am writing on behalf of [*physician name*] to address claim adjudication errors involving the payment processed for [*patient name*]'s charges on [*date of service*].

[*Example bilateral denial text*]

Please be advised that the following services were provided and [*patient name*] received [*list of procedure(s) and/or service(s)*]. Each additional [*procedure*] was filed with the CPT modifier 50 to indicate a bilateral procedure was performed. Evidently, the additional procedures [*insert CPT codes*] were paid as unilateral in error, and CPT codes [*insert codes*] were erroneously denied as incidental, resulting in a total claim underpayment of [*$*].

[*Example partial payment text*]

According to our participating provider contract with [*health insurer*], all fees are subject to the negotiated fee schedule allowance. Since payment methodology is based on [*insert appropriate health insurer's payment methodology, e.g., Medicare's RBRVS*], all fees are subject to [*insert appropriate health insurer's multiple payment guidelines and global periods, e.g., CMS's multiple procedure payment guidelines and global periods*].

As such, the first procedure is to be paid at [%] of the fee allowance and the second through fifth procedures at [*%*] of the scheduled fee allowance. Therefore, as the contract provides, the following procedures should be paid as follows:

AMA members can download an interactive copy of this letter to use in their practices.

CPT Code	Our Fee	[*Health Insurer*] Rate	[*Health Insurer*] Paid	Amount Due
[*CPT code*] x2	$	$	$	$
[*CPT code*] x2	$	$	$	$
[*CPT code*] x2	$	$	$	$

Total Due: $

Other [*health insurer*] patient EOBs have been referenced that show past payment allowed for these exact procedures. Documentation is included revealing the correct [*health insurer*] rates as listed above were paid on other claims processed by [*health insurer*]. Apparently, claims are not being processed consistently for [*health insurer*].

[*The rationale for the appeal needs to be specific, similar to the following template for a separate procedure that also includes laboratory testing.*]

Concerning the denial of CPT [*code*]x2, this issue has been addressed numerous times by our office. The CPT modifier 59 was reported with CPT [*code*]x2 to alert that this procedure is separate from the other procedures and therefore, not inclusive to another procedure. As such, CPT [*codes*] are not subject to computer editing [*insert software package, if known*] and warrant manual review. Since CPT [*code*] was performed [*reason procedure or service was performed*], it cannot be denied as incidental. The operative report we provided clearly identifies [*reason procedure or service was performed*].

The ICD-9-CM codes reported, [*ICD-9-CM codes*], justify the medical necessity of this procedure. Therefore, the basis of [*health insurer*]'s denial of CPT [*code*] as incidental is not only invalid but also unsupported. Please refer this claim to a board-certified [*specialty*] physician for additional review.

We will expect payment in the amount of [*$*] to be released promptly in accordance with the [*state prompt payment act*].

Sincerely,

[*Practice Manager*]

AMA members can download an interactive copy of this letter to use in their practices.

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Sample letter for lack of recognition of CPT modifier 25

[*Date*]
Attn:_____
Provider Appeals Department
[*Address*]
[*City, State, ZIP Code*]

Re: Claim adjudication, lack of recognition of CPT modifier 25

Insured/Plan Member:_____
Health Insurer Identification Number:_____
Group Number:_____
Patient Name:_____
Claim Number:_____
Claim Date:_____

Dear [*Health insurer*]:

The following information is being provided to clarify our use of the CPT modifier 25 reported with the CPT evaluation and management (E/M) code to indicate that a distinct and separately identifiable E/M service was performed warranting separate reimbursement.

Please be advised that the [*procedure name*] was not a planned procedure. The decision to proceed with this procedure occurred after the patient's history and examination were completed. Since this E/M service was separate from the procedure and necessary to evaluate the etiology of the patient's chronic symptoms of [*specify symptoms*], separate recognition of the office visit is warranted.

*According to the AMA's guidelines for the appropriate use of the CPT modifier 25, it is not necessary that separate ICD-9-CM codes be reported. Copies of the CMS-1500 claim form, procedure report and progress notes are included for review. Additionally, according to CPT codes, guidelines and conventions, Modifier 25 is appended to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management (E/M) service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure performed. The appropriateness of appending modifier 25 on the E/M CPT code [code] is clearly documented in the patient chart and should be recognized by [*health insurer*] and eligible for payment.*

Based on the circumstances of this case, we request that the E/M code be considered for separate reimbursement and not bundled under payment for the procedure. Attached are the (*medical records, operative report, and/or pathology report)* to assist you in the review of this claim. Please forward this information to your medical review staff for an independent determination to prevent a computer-generated denial based on coding edit software that commonly occurs with CPT modifier 25 claims.

Not allowing a patient to obtain the necessary care during the original visit and requiring the patient to come back for a subsequent visit jeopardizes quality patient care and safety, and threatens the patient-physician relationship.

Thank you for your consideration. Please contact [*staff name*] at [*telephone number*] in our office should you have any questions regarding this claim.

Sincerely,

[*Physician*]
Or
[*Practice Manager*]

AMA members can download an interactive copy of this letter to use in their practices.

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Sample letter for lack of recognition of CPT modifier 59

[*Date*]
Attn:_____
Provider Appeals Department
[*Address*]
[*City, State, ZIP Code*]

Re: Claim adjudication, lack of recognition of CPT modifier 59

Insured/Plan Member:_____
Health Insurer Identification Number:_____
Group Number:_____
Patient Name:_____
Claim Number:_____
Claim Date:_____

Dear [*Health insurer*]:

The following information is being provided to clarify our use of the CPT modifier 59 reported with [*procedure name*] CPT *[code]* to indicate that the services are not typically performed together and warrant separate reimbursement.

The CPT modifier 59 was developed by the American Medical Association explicitly for the purpose of identifying services not typically performed together. According to CPT codes, guidelines and conventions, CPT modifier 59 is appended to indicate that under certain circumstances the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. According to the CPT Book, "Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under these circumstances." [*reason procedure or service was perform*ed.]

The appropriateness of appending modifier 59 on CPT [*procedure code*] is clearly documented within the patient's chart (attached) and should be recognized by [*health insurer*].

Based on the circumstances of this case, we are requesting that CPT code *[code]* be considered for separate reimbursement and not bundled under payment for the procedure. Please forward this information to your medical review staff for an independent determination to prevent a computer generated denial based on coding edit software that commonly occurs with CPT modifier 59 claims.

AMA members can download an interactive copy of this letter to use in their practices.

Thank you for your consideration. Please contact [*contact name*] at [*telephone number*] in our office should you have any questions regarding this claim.

Sincerely,

[*Physician*]
Or
[*Practice Manager*]

AMA members can download an interactive copy of this letter to use in their practices.

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Note: Physicians should check with their personal attorney before cashing a check that includes a restrictive endorsement such as "payment in full," as such language may be binding and prohibit the physician from seeking any further payment from the health insurer or the patient.

Sample appeal letter PPO discount taken when a contract does not exist

[*Date*]
Attn:_____
Provider Appeals Department
[*Address*]
[*City, State, ZIP Code*]

Re: PPO discount taken when a contract does not exist

Insured/Plan Member:_____
Health Plan Identification Number:_____
Group Number:_____
Patient Name:_____
Claim Number:_____
Claim Date:_____

Dear [*Health Insurer*]:

For the date of service listed above, [*health insurer*] incorrectly applied a PPO discount to the claim when there is no contract between [*physician or group name*] and [*health insurer*]. Because [*physician or group name*] does not have a contract with [*health insurer*], we are under no obligation to accept a reduced payment and will not honor the PPO discount.

[When EOB states that the patient is not responsible for the balance]

The patient is legally responsible for payment of our services. We are accepting your payment as a partial payment on behalf of the patient. We intend to bill the patient for the balance. We request that you send a corrected EOB/RA to us and to the patient correctly stating that the patient is responsible for this remainder.

[for rental network]

[*Physician or group name*] has no record of a contract with the health insurer or network listed on the patient's identification card. If your records indicate otherwise, please provide a copy of the contract agreement which is being referenced.

AMA members can download an interactive copy of this letter to use in their practices.

Since [*physician or group name*] is an "out-of-network" provider, [*he/she*] is entitled to payment at our fee-for-service billed rate. We request that you send a corrected EOB/RA to the practice and to the patient.

Thank you for your consideration. Please contact [*staff name*] at [*telephone number*] in our office should you have any questions regarding this claim.

Sincerely,

[*Physician*]
Or
[*Practice Manager*]

AMA members can download an interactive copy of this letter to use in their practices.

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Sample appeal letter for inappropriate E/M downcoding

[*Date*]
Attn:_____
Provider Appeals Department
[*Address*]
[*City, State, ZIP Code*]

Re: Inappropriate downcoding of CPT evaluation and management (E/M) code

Insured/Plan Member:_____
Health Plan Identification Number:_____
Group Number:_____
Patient Name:_____
Claim Number:_____
Claim Date:_____

Dear [*Health Insurer*]:

[For E/M downcoding]

On the date of service listed above, the CPT E/M code for [*a/an*] [*name of service*] was reported with [*CPT* code]. [*Health insurer*] has inappropriately downcoded the CPT E/M code submitted and changed the code to [*new code*], resulting in the inappropriate reduction of payment for delivered medical care.

Under [*health insurer*] medical review guidelines, [*health insurer*] follows the CMS E/M coding guidelines [*1995 or 1997*] version. [*Physician name*] has billed according to the [*1995 or 1997*] CMS E/M guidelines accurately.

Downcoding of CPT E/M codes is not appropriate without review of medical record documentation. The American Medical Association (AMA) strongly opposes automatic downcoding and states:

> *"The AMA vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers."*

The appropriateness on the reported level of the CPT E/M [*CPT code*] is clearly documented within the patient's chart (attached) and should be recognized by [*health insurer*]. Based on the circumstances of this case, we are requesting that CPT E/M code *[code]* be paid and not be inappropriately downcoded.

Thank you for your reconsideration. Please contact [*contact name*] at [*telephone number*] in our office should you have any questions regarding this claim.

Sincerely,

[*Physician*]
Or
[*Practice Manager*]

[For procedure downcoding]

On the date of service listed above, the CPT code for [*a/an*] [*name of procedure*] was reported with [*CPT* code]. [*Health insurer*] has inappropriately downcoded the CPT code submitted and changed the code to [*new code and name of procedure*], resulting in the inappropriate reduction of payment for delivered medical care.

Downcoding of CPT codes is not appropriate without review of medical record documentation. The American Medical Association (AMA) strongly opposes automatic downcoding and states:

> *"The AMA vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers."*

The level of complexity for the procedure performed CPT [*code*] was reported appropriately and is clearly documented within the patient's chart (attached) and should be recognized by [*health insurer*]. Based on the circumstances of this case, we are requesting that CPT code [*code*] be paid and not be inappropriately downcoded.

Thank you for your reconsideration. Please contact [*contact name*] at [*telephone number*] in our office should you have any questions regarding this claim.

Sincerely,

[*Physician*]
Or
[*Practice Manager*]

AMA members can download an interactive copy of this letter to use in their practices.

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Sample appeal letter medical necessity denial—Option A

[*Date*]
Attn:_____
Provider Appeals Department
[*Address*]
[*City, State, ZIP Code*]

Re: Medical necessity denial

Insured/Plan Member:_____
Health Insurer Identification Number:_____
Group Number:_____
Patient Name:_____
Claim Number:_____
Claim Date:_____

Dear [*Health insurer*]:

This letter confirms our conversation today about the care of [*patient name*] and requests a review of this clinically inappropriate denial. As a physician, I have an ethical and legal duty to advocate for any care I believe will materially benefit my patients. As you will recall, I recommended [*describe procedure, course of treatment referral etc*.], which I believe is medically necessary for the following reasons: [*reason procedure or service was perform*ed].

[*Health insurer*] has made a decision to deny this care. I will inform the patient in writing of this decision, including alternative treatment options: [*list alternative treatment options*]. In addition, I will include this letter as part of the patient's medical record.

If this is not accurate, please advise me promptly. Again, I believe this [*procedure, test, course of treatment*] is medically necessary. In my clinical judgment, [*health insurer*]'s denial of coverage is not in the best interest of the patient.

In the event that [*patient name*], the family, or employer wish to hear your reasoning, I will refer them directly to you to avoid any misrepresentation.

Sincerely,

[*Physician*]

AMA members can download an interactive copy of this letter to use in their practices.

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Sample appeal letter medical necessity denial—Option B

[*Date*]
Attn:_____
Provider Appeals Department
[*Address*]
[*City, State, ZIP Code*]

Re: Medical necessity denial appeal request

Insured/Plan Member:_____
Health Insurer Identification Number:_____
Group Number:_____
Patient Name:_____
Claim Number:_____
Claim Date:_____

Dear [*Health insurer*]:

The following information is being submitted to support the medical necessity of [*name of procedure(s) or service(s)*][*CPT code(s)*] that was recommended to evaluate [*patient name*]'s symptoms after evaluation.

[*Include the following in the body of the text*.]
[*subjective findings*]
[*objective findings confirming functional impairment*]
[*argument to support that the condition will be remedied by the proposed treatment*]

Copies of the medical records including test results are enclosed for your review. You will note that [*procedure or test*] findings were indicative of [*diagnosis*]. Based on the information provided, I am requesting the [*procedure or test*] be reconsidered for payment since medical necessity was established. Please forward this information to a board-certified [*indicate specialty, if applicable*] physician for medical review. Should further information be required, please contact [*practice staff*] at [*phone number*] in my office.

Sincerely,

[*Physician*]

[*Include medical record copies and request physician-specialist review*]

AMA members can download an interactive copy of this letter to use in their practices.

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Sample letter for patient notification of appeal

[*Date*]
[*Mr./Mrs./Ms.*]_____
[*Address*]
[*City, State, ZIP Code*]

Dear [*Patient*]:

This letter is being sent to notify you that your health insurer denied the following service [*procedure name*] that was provided to you on [*date*].

Our office filed an appeal challenging your health insurer's position, and we are requesting that the claim be reconsidered for payment. A copy of the appeal letter is enclosed for your reference.

Although our office will follow up on the status of the appeal, we request that you contact your health insurer regarding this matter. Our experience has proven that health insurers are most responsive to the patient's request. Your contacting the health insurer will increase the expediency of the review process as well as the likelihood of the claim payment. If your health insurance company refuses to issue payment despite our appeal efforts, you may need to pursue the matter further with assistance from your company's benefits department and/or state commissioner's office.

We appreciate your cooperation through this appeal process. Should you have any questions, please contact [*staff name/department*] at [*telephone number*].

Sincerely,

[*Practice Manager*]
Or
[*Practice Staff/Department*]

AMA members can download an interactive copy of this letter to use in their practices.

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Sample letter to health insurer regarding late payment

[*Date*]
Attn: _____
[*Health Insurer*]
[*Address*]
[*City, State, ZIP Code*]

Re: Late payment of claims

Dear [*Health insurer*]:

I am writing in regards to the attached claims I have submitted to [*name of health insurer*]. These claims, which were submitted between [*date*] and [*date*], have not been paid, and I have not received any explanation for this delay in payment.

Please contact my office at your earliest convenience to explain the reason for this delay and to indicate when I will receive payment.

Optional sentence 1 *(For states with regulations/laws requiring payment within a specified timeframe):*

Under [*pertinent state law/regulation*], claims must be paid in [*x*] days or [*describe any penalty*]. Please include the appropriate interest amount in the payment.

[*Document any contact between your office and the health insurer about this matter*]

Note: The following sentences should be added only if the physician is comfortable with a more adversarial tone.

Optional sentence 2 *(**Do not** include this sentence if your contract prohibits you from billing patients directly for claims that are the payer's responsibility):*

I do not want to be put in the untenable position of billing my patients for the care they have contracted for through their insurance policy with [*state name of health insurer*].

Optional sentence 3:

Because I know the issue of delayed payment is of increasing concern to many physicians, I intend to report this delay and lack of explanatory information to the state insurance commissioner if the situation is not rectified within [*x*] days.

AMA members can download an interactive copy of this letter to use in their practices.

Thank you for your prompt attention to this matter.

Sincerely,

[*Physician*]
Or
[*Practice Manager*]

(*optional cc: Patient/insured, patient's health insurer sponsor*)

AMA members can download an interactive copy of this letter to use in their practices.

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Note: If your state's Department of Insurance has a formal process for filing complaints, you should use that process rather than sending a letter.

Sample letter to state insurance commissioner or other entity that regulates various health insurers regarding late payment

[*Date*]
Attn:_____
[*Commissioner/Appropriate Contact State Regulatory Agency*]
[*Address*]
[*City, State, ZIP Code*]

Re: Late payment of claims

Dear [*Commissioner/Mr./Ms.*] _____:

Attached is correspondence I have sent to [*health insurer*] on [*date*] regarding the late payment of my claims. I have received no response from [*health insurer*].

As you may know, the physician community is increasingly concerned about the chronic late payment of claims. This is a troubling practice that makes it extremely difficult to run a practice. We are extremely concerned with our ability to continue to contract with payers that are seriously delinquent in claims payment. This concerns us a great deal, as a termination of our relationship with such payers would interfere with established relationships with patients. Why should premium-paying patients in this state suffer because their payer fails to meet its obligations?

Optional sentence *(for states with laws/regulations regarding late payment):*

Under [*cite law/regulation*], payment is required within [*x*] days. I am requesting that your agency enforce this provision as to [*health insurer*].

I hope your agency will act quickly to ensure an end is put to this practice. Thank you for your consideration of this matter.

Sincerely,

[*Physician*]
Or
[*Practice Manager*]

Enclosure

(optional cc: Patient/insured, patient's health insurer sponsor)

AMA members can download an interactive copy of this letter to use in their practices.

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Sample letter to patient's employer or health plan sponsor regarding late payment

[*Date*]
Attn: _____
Employer/Plan Sponsor
[*Address*]
[*City, State, ZIP Code*]

Re: Late payment of claims

Dear [*Employer*]:

I wanted to alert you to a situation occurring with [*health insurer*]. We treat a number of your employees under [*name of health insurer*]. Our practice is experiencing significant delays in payment of claims from [*name of health insurer*]. [*Add any details of your particular situation*]. As I am sure you can understand, this makes it very difficult to run a medical practice.

We are extremely concerned with our ability to continue to contract with health insurers that are seriously delinquent in payment of claims. This concerns us a great deal, for termination of our relationship with [*name of health insurer*] would interfere with established relationships with our patients, your employees. Why should premium-paying patients suffer because their payer fails to meet its obligations?

It would be very helpful to us if you could bring this issue to the attention of the representatives from [*health insurer*] with whom you contract. The problem is becoming increasingly chronic in our area.

Thank you for your consideration of this matter.

Sincerely,

[*Physician*]
Or
[*Practice manager*]

AMA members can download an interactive copy of this letter to use in their practices.

These tools do not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed. Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for additional information.

Note: Many states have prompt payment requirements. Check your state law to determine whether it establishes a shorter period.

Sample letter to health insurer regarding late payment of claims in violation of contract

[*Date*]
Attn:_____
[*Health Insurer*]
[*Address*]
[*City, State, ZIP Code*]

Re: Late payment of claims

Dear [*Health insurer*]:

This letter is being sent to notify you of the prompt-payment provision agreed in our provider contract with [*health insurer*].

According to the contract, payment is to be issued within [*45*] days of receipt of a clean claim; otherwise, the provider discount is forfeited and full-billed charges are due. Attached is a copy of the [*claim form*] that has been reviewed for accuracy. Applicable medical record copies also are attached to prevent this claim from being delayed for additional information.

Please be advised that provider discounts applied on claims paid after the [*45*]-day requirement will not be honored. In such cases, the patient will be notified regarding the breach of contract.

We are willing to make every effort to ensure that you receive adequate claim information to facilitate the adjudication process. Likewise, we request your cooperation in paying our claims accurately and in a timely manner as the contract permits.

Thank you for your prompt attention to this matter.

Sincerely,

[*Physician*]
Or
[*Practice Manager*]

Glossary

Claims repricing The process of adjusting payment of a claim to meet health insurers' complex contracts and fee schedules.

Current Procedural Terminology (CPT) A systematic listing and coding of procedures and services physicians and other providers perform. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies services reporting. With this code set, physician practice staff as well as health insurers can accurately identify and read the procedure or service the physician or other provider rendered.

Explanation of benefits (EOB) An explanation specific to one patient's reimbursement, detailing the total vs. covered (allowed) charges, the deductible and co-pay amounts the insured owes, any applicable contractual adjustments and the amount the payer pays. EOB format, as well as the information presented, varies from payer to payer.

Global Period The Centers for Medicare and Medicaid (CMS) global guidelines are listed in the AMA *Medicare RBRVS: The Physician's Guide*, published each year. To order call 800-621-8335.

Healthcare Common Procedure Coding System (HCPCS) A uniform method for healthcare providers and medical suppliers to report professional services, procedures and supplies. HCPCS was developed by the Centers for Medicare and Medicaid Services (CMS) in 1983.

International Classification of Disease–9th Edition–Clinical Modification (ICD-9-CM) The standard diagnosis coding system for health care claims, coordinated by the National Centers for Vital and Health Statistics (NCVHS). ICD-9-CM codes assist physicians in transforming verbal descriptions of diseases, injuries, conditions and certain procedures into numerical destinations (diagnostic coding).

Medicare's National Correct Coding Initiative The Centers for Medicare and Medicaid (CMS) developed the National Correct Coding Initiative (CCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the AMA CPT book, current standards of medical and surgical coding practice, input from national medical specialty societies and analysis of current coding practice. AMA publication *Medicare Correct Coding Guide* can help in reporting Part B procedures and services.

Rental network PPO A rental network PPO is not a managed care product offered by a payer to its clients. Rather, a rental network PPO exists to market a physician's contractually discounted rates primarily to third-party payers, such as insurance brokers, third-party administrators, local or regional PPOs, or self-insured employers. Here is how a rental network PPO generally works: a physician contracts with a rental network PPO and accepts a discounted rate in exchange for identification as a network physician in the PPO directory. Under this arrangement, the third-party payers that contract with the rental network PPO usually gain the advantage of having access to any and all discount agreements that the rental network PPO has negotiated with the physician, and usually without the physician's prior knowledge or permission. A rental network PPO, which "sells" or "rents" its physician network to a third-party payer, generally takes no financial risk and does not pay claims or ensure that any associated physician claims are paid.

Health insurer follow-up log instructions

Go to health insurer follow-up log. (Excel, 78KB, for AMA members only)

1. Open the Excel workbook, "Health Insurer Follow-up Log."
2. Go to File, and click on Save As.
3. Save the workbook, either as "Health Insurer Follow-up Log," or a more specific name that you will remember and others will recognize.
4. Arrange the columns in the order of your preference.
5. Each worksheet in the workbook is for a different health insurer. Double click on the tab to insert the name of the health insurer you will keep track of in that worksheet. (For example, you might double click on "Health Insurer #2" and enter "Blue Cross Blue Shield.")
6. Each row in the worksheet is for a separate claim, so each time you file a claim, enter the relevant information in each pertinent column.
7. As you follow through the claims and appeals processes, update the information for that claim.
8. Keep track of what you've entered. Use this workbook as a record of which claims the health insurer has denied or inappropriately paid, and make sure that you follow through with appropriate appeals processes.
9. Periodically sort your entries by category to determine a given health insurer's payment habits. (For instance, you might sort by "Reason for Denial" and find that over half the claims that the health insurer denied are bilateral procedures. You may need to address this issue with the health insurer, or you may notice that the health insurer did appropriately pay certain bilateral procedure claims. You can look at the claims and appeals process for those successful claims to determine whether certain methods produce better results.)

Health insurer reference log instructions

Go to health insurer reference log. (Excel, 869KB, for AMA members only)

1. Open the Excel workbook, "Health Insurer Reference Log."
2. Go to File, and click on Save As.
3. Save the workbook, either as "Health Insurer Reference Log," or a more specific name that you will remember and other staff members will recognize.
4. Arrange the columns in the order of your preference.
5. Each worksheet in the workbook is for a different health insurer. Double click on the tab to insert the name of the health insurer you will keep track of in that worksheet. (For example, you might double click on "Health Insurer #2" and enter "Blue Cross Blue Shield.")
6. Enter as much information as possible about each health insurer.
7. As you continue to audit, file and appeal claims with that health insurer, make sure you update the information for that health insurer. The more specific information you have, the better equipped you will be to ensure your physician practice receives appropriate payment.
8. Keep track of what you've entered. Use this workbook as a reference when submitting claims and filing appeals. Use the information you and other staff in the practice have already gathered and the nuances of the claims and appeals processes you have already encountered to save you time and make your current and future claims and appeals more effective.