

A blue graphic consisting of a curved arrow pointing from the top left towards the bottom right. Inside the curve of the arrow, the text "Appeal that claim" is written in a sans-serif font.

Appeal
that
claim

How to appeal inappropriate health plan claim denials

In 2002, 66% of one physician practice's total revenue came from claims originally underpaid or denied by health plans and other third-party payers. This revenue would have gone uncollected if the practice had not implemented auditing and appeal strategies. Based on this example, it is estimated that physicians are losing billions of dollars in revenue each year by not appealing inappropriate claim denials.

There are many reasons why physician practices do not appeal denied claims; the most common is that they believe appealing claims will create an increased administrative burden on the practice. However, not appealing denied or partially paid claims can be quite costly to your practice and can often result in decreased revenue. Since health plans have introduced claims editing software into their claims processing systems, they have generated an increased number of inappropriate claims denials and reductions in payment.

An effective way for your practice to combat these erroneous payment reductions and denials is to be diligent in submitting appeals.

Why appeal?

When your practice increases its appeals for wrongfully underpaid or denied claims, the health plan may correct its claims editing software and processes. This, in turn, may result in improved claims processes and appropriate payment to your practice for the provision of health care services.

The 12 steps on the back of this flyer simplify the claims auditing and appeals processes and can help to reduce your administrative burden. These processes make it easy for your practice to identify and appeal health plan claim denials when the health plan misapplies the American Medical Association Current Procedural Terminology (CPT®)* codes, guidelines and conventions or the health plan's contracted policies.

*CPT is a registered trademark of the American Medical Association.

When a physician performs a procedure or service and then reports according to CPT codes, guidelines and conventions, the health plan should recognize the physician work involved in providing this patient care. To ensure that your work is recognized, your practice should identify all inappropriate claims denials and communicate with the appropriate health plan representatives through each plan's claims appeals processes.

What is lost when your practice does not appeal?

When your practice does not audit and appeal inappropriately paid or denied health plan claims, you may lose revenue. You also may lose the opportunity to recover overhead expenses by not implementing a claims management process. This process is your practice's internal designated workflow for accurately preparing, submitting and collecting on claims. When you challenge inappropriate claim payments, you demonstrate that your practice has made an effort to correct the plan's inaccuracy. This could lead to a positive change in the health plan's business practices.

Appealing claims that are inappropriately denied by health plans can make a difference in your practice by reducing future denials.

For additional information, there are two easy ways to contact the Private Sector Advocacy (PSA) group:

- Go to the PSA Web site at www.ama-assn.org/go/psa.
- Call 800 262-3211, and ask for Private Sector Advocacy.

How to simplify the claims auditing and appeals processes

1. Know the health plan's claims appeals processes before you need to submit a claim appeal. Understanding these processes will allow you to acquire the health plan information (ie, supporting documentation, health plan language) required to prepare a claim appeal.
2. Know where to locate the following health plan policies and, if possible, include them in the health plan contract:
 - Claim adjudication procedures (ie, definitions of complete or clean claims and medical necessity)
 - Rates and reimbursement methodology, including a comprehensive fee schedule
 - Claims appeals processes
3. Document, document, document. The supporting documentation of a claim submitted to a health plan must substantiate the performance of a service by the treating physician or health care professional. If a service is not documented, it didn't happen in the eyes of the health plan, and the claim may not be paid.
4. Review and monitor all claims before submitting them to the health plan to ensure that you are filing complete and accurate claims. One way to avoid a claim denial is to correctly code the original claim. Implement a check-and-balance system between the physicians and the coding and billing professionals in your practice to determine whether claims are being coded appropriately.
5. Maintain a coding reference sheet in your practice with a list of commonly used International Classification of Disease–9th Edition–Clinical Modifications (ICD-9-CM) and CPT codes, as well as any other commonly reported codes on the standard claim form.
6. Evaluate the health plan's explanation of benefits (EOB) for accuracy (ie, potential processing errors, lack of recognition of a CPT modifier, incorrect physician fee schedule).
7. Know your contracted fee schedule rate with each health plan for procedures and services commonly performed in your practice. Review each EOB you receive to ensure the negotiated reimbursement and discount rate with each health plan is calculated appropriately.
8. Maintain a health plan follow-up log that contains the reason that the claim was partially paid, delayed or denied by the health plan and also include the internal follow-up action by the practice staff to reduce future health plan underpayments and denials.
9. When submitting a formal claim appeal letter to a health plan, thoroughly explain your rationale for challenging the health plan's claim denial. Additionally, include the appropriate documentation to support your request to reverse the denial.
10. Streamline your practice's claims auditing and appeals processes by maintaining an appeals resource file with appeal template letters, rationales and supporting documentation of previously submitted claims appeal letters that resulted in overturning the denial.
11. **Keep on appealing.** It may take more than one appeal to reverse a health plan's incorrect denial. When a procedure or service has been appropriately performed, documented and reported, be persistent to ensure your practice obtains the proper compensation based on the negotiated health plan contracted rate.
12. If the appeal is not overturned by the health plan after the appeals are exhausted, file for an external review if available through the appropriate state or federal regulatory agency.