Appeal in Five Easy Steps

Don't lose out on your fair share **BY CMA STAFF**

PRACTICE REVENUE is lost when claims are underpaid, delayed, or inappropriately denied. Studies have shown that only half of physician offices appeal. Yet, a California Medical Association survey found that 68 percent of physicians who do appeal receive additional monies. Here are five easy steps for getting more of the reimbursement you are due.

1 Review the Explanation of Benefits to determine why the claim was denied, adjusted, or contested. Payors must provide an accurate and clear written explanation of the specific reasons for denying, adjusting, or contesting a claim within 30 days of receipt of a PPO claim, or 45 days for an HMO claim.

2 Determine if the payer requires the use of a specific appeal form. If not, create a template or use the sample letters available in the CMA On-Call documents listed at the end of this article. Health plans and insurers must inform the physician of the availability of the provider dispute resolution mechanism and procedures for filing a dispute, including instructions on how to file a dispute. This information can typically be found on the EOB or in the payer's provider manual.

3 Prepare your appeal. State in the subject line that this is an appeal. Explain clearly the reason why you believe the claim was not paid appropriately. For a chart detailing the most common types of denials and underpayments and a brief description of how to respond to them, see the CMA's "Know Your Rights: Quick Guide for Appeals," which can be found on the CMA's website.

Appeals for medical necessity should always be written by the physician and directed to the attention of the plan's medical director. Request that the claim be reviewed by a physician of the same specialty.

Appeal letters should include the following basic information:

- Patient name
- Date of birth
- Patient insurance identification
- Claim number
- Date of Service
- Total charges and/or balance due
- A copy of the original CMS 1500 form
- A clear and concise explanation of why the claim is being disputed and the outcome desired
- A copy of all supporting documentation, including medical records, if appropriate
- A copy of the EOB with the denial information

4 File your appeal as soon as possible and no later than the time frame indicated below.

PAYER TYPE	TIME FRAME FOR APPEAL
PPOs and other insurers	Refer to contract or provider manual
Knox-Keene Plans (HMOs, Anthem Blue Cross PPO, and Blue Shield of California PPO, and their contracting medical groups/IPAs)	Within 365 days after the payer's action or, in the case of inaction, within 365 days after the deadline to contest or deny claims (45 days for HMOs, 30 days for PPOs).
ERISA	Appeal rights lie with the patient.
Medi-Cal	Within 90 days of the action/in-action.
Medicare	Within 120 days from date of original determination. Second level appeal within 60 days from date of initial redetermination decision.
Workers' Comp	No timeline for appeal

The information in this table is subject to change. Consult the provider manual or contact the payer for the most up-to-date information.

5 If your appeal is unsuccessful, consider a second level appeal and file a formal complaint with the appropriate regulator. Continue to appeal inappropriately denied care and inaccurate reimbursement. It may take more than one appeal to reverse a payer's incorrect denial. You have the right to be paid for services that have been appropriately performed, documented and reported! ■

"A pessimist sees difficulty in every opportunity; an optimist sees the opportunity in every difficulty."

—WINSTON CHURCHILL