

## **Understanding the Private Insurer Appeal Process: Getting Your Claims Paid**

Nothing is more frustrating than submitting a claim for payment and having the claim denied. Whether the reason is as simple as an incorrect beneficiary name, inappropriate bundling or a question of medical necessity, this initial determination of a claim from the carrier is the bane of existence for many urologists' offices. It takes time and effort of the billing staff to determine if the determination was appropriate. In order to get these denied claims paid, there are certain appeals processes for both Medicare and commercial insurers which are different and must be followed.

Each private insurer has its own process in place for appealing denied claims. It is essential that your staff develop a protocol for appealing claims to each carrier. Most private insurers will have their appeals process provided either in writing to a provider's office or available on line. It is recommended that your staff collect the information on each private insurer your office is contracted with to establish how denied claims need to be appealed.

### **Private Insurers and their appeal process**

Here are just some examples for major payers. Check with each carrier to verify the appeals process requirements for denied claims.

#### **Aetna**

Aetna has their appeals process posted on their [provider page](#).

#### **Blue Cross/Blue Shield**

Each specific state carrier has the appeals process posted on its web site as well as the forms necessary to request the appeal.

#### **Cigna**

Cigna has their appeal policy and procedures posted on their [web site for providers](#). The necessary forms and instructions are included on this provider page.

#### **United Healthcare**

United Healthcare also provides the appeals process and appropriate forms on their password-protected [web site](#).

Also there is a document that states United appeal process: see attachment.

#### **Appeal: Is It Worth It?**

When appealing a claim, it is important to consider how long it would take a staff person to file the appeal and how much the claim is worth. If it is determined that the claim is worth more than the resources it takes to file the appeal, then proceed with the appeal. It is important to research the original claim to make sure the carrier's denial is appropriate. Make sure all the information was correct and that the medical necessity is appropriate for the service(s) billed. Make sure to check edit packages to see whether multiple services are allowed to be billed separately. If there seem to be a number of similar claims which need to be appealed, it might be beneficial to design a template to fill in claim specific information to reduce the time it takes to file the claim. Contact the carrier to see if it is possible to submit multiple appeals with one request.

Below is additional information to assist you in the appeal of your denied claims. In all cases, it is important that you include the claim number, the patients name and ID as well as the date of service on each page of submitted documentation.

**For concurrent care denials:** Submit the narrative documentation to support that the physician is a different specialty/subspecialty and treating a different body system. You will also need medical documentation, which supports the need for the services (e.g. office records and progress notes).

**For overutilization denials:** Submit medical documentation that clearly shows why the patient required more than the standard number of services during the specified time period.

**For services not medically necessary based on a diagnosis code:** Submit specific ICD-9 diagnosis codes or narrative documentation outlining why the services were medically necessary.

**For routine screening denials:** Submit ICD-9 codes or narrative showing the sign, symptom, complaint or diagnosis, which warranted the service.

**For surgery within the postoperative period of another surgery:** Submit corrected billing which denotes either modifier -78, *Return to the Operating Room for a Related Procedure During the Postoperative Period*, or modifier -79, *Unrelated Procedure or Service by the Same Physician During the Postoperative Period*.

**For a visit on the same day or within a postoperative period of surgery:** If the visit was performed on the same day as the surgical procedure and it was a *significant, separately identifiable service from the surgery*, submit a review request with modifier -25, *Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of the Procedure or Other Service*. If the visit was during the postoperative period and was unrelated to that procedure, the appeal should be filed with modifier -24, *Unrelated E&M Service by the Same Physician During a Postoperative Period*, and should include narrative documentation to support the need for the visit. A separately identifiable ICD-9 diagnosis code submitted on the Medicare claim would suffice as documentation.