

CLAIMPOWER

(Questions/Actions that need to be asked/taken for the following denials)

Timely Filing

If claims are being denied for timely filing.

Ans –

Step 1 – Ask the insurance whether the dr is participating or non participating and what is the timely filing limit for both (par & non-par).

Step 2 - check when we received the billing from the dr (by going to PDF History).

Step 3 - check when it was 1st sent to the ins. (In Print Details).

Step 4 - then ask when the insurance received the claim from us.

Step 5 - if they received the claim within the timely filing limit then inform them that they

are incorrect and if they received the claim after the timely filing limit then add zero receive with denial code 29.

Step 6 – If the claim was submitted to some other insurance before and later we submitted claims to the new ins after the filing limit, then ask user Lateefah to send an appeal with a proof of timely (i.e denial EOB from the 1st ins or proof of timely from Md-Online).

OR

If we received the billing from the dr's office after a timely filing limit then also add Zero received with denial code 29.

No Auth/Pre-cert

If claims are being denied for no authorization / per-certification (if we are billing for hospital service).

Ans –

Step 1 – Check how we are billing (Inpatient or Outpatient).

Step 2 – Ask the rep to check how the facility had billed (POS 03 or 04) or if they have paid their claims. If the rep says that, the facility was paid and our claims POS is matching with their POS then request the rep to review the claim by using the same auth, which was used for the facility. If the facility claims were paid but our POS is not matching then we need to send a corrected claim with the same information as the facility is billing (POS 03, 04 or 05).

Step 3 – If the rep says that the facilities claim was also denied for no auth then check with the facility/hospital if they got paid or if they have appealed the denial with the ins. If they have appealed the claim then we can also appeal the denial, before appealing we need to check if we have medical notes for DOS/CPT. If we do not have then add 'HN' and get the address where we need to send it.

OR

If claims are denied even after appealing then add a Zero receive with a denial code of 62 or 197.

No Referral

If claims are denied for a referral. (This will only be denied if the dr is a specialist).

Ans –

Step 1 – If the insurance is denying the claim for no referral and that too for a dr whose specialty is Internal Medicine then they are wrong. Claim will be denied for a referral only if the dr is a specialist (like - Cardiologist, Radiologist, etc).

Step 2 – If the dr is a specialist then get the member's PCP information. (his/her name, phone number, address, etc).

Step 3 – Call the PCP's office and check if they have issued any referral for the patient. If yes then ask them to fax the referral to us and if no referral was issued then request them to issue a backdated referral or a paper referral to us, if possible.

OR

If we cannot get a referral (even backdated) then check with the ins if we can bill the patient, if the patient can be billed then add a Primary Payment Denied & if we cannot bill the patient then add a zero receive with denial code 165.

Inclusive/Incidental/Bundled

If claims are being denied saying it is included, incidental, or bundled to other code billed on the same day.

Ans –

Step 1 - Check with the insurance company to which code they are denying the claim (code) inclusive to.

Step 2 – Check in Encoder if we can bill the code with any modifier like 25 or 59. This modifier states that the services performed should not be denied, as it was a separate procedure performed on the day.

Step 3 – If the claim was denied even after submitting a modifier along with it then check the CCI edits in Encoder whether both the code can be billed together or not. If they can be billed together then check if we have medical notes, if not then add a 'HN' to appeal the denial.

OR

If the CCI edits state that both the CPT code cannot be performed together on the same day then add a zero receive with denial code N19.

Policy Inactive

If claims are being denied for member's policy not active.

Ans –

Step 1 – Check with the insurance company when the policy was terminated and also request them to do a name search and check if the member has any other active policy.

Step 2 – Try searching a member's relative in the same dr's database with the last name search (if you get any patient with the same address then check his/her insurance and take action accordingly).

Step 3 – You could also find the patient in another dr's database by searching the member in 'Claimpower Search'. If you get the patient in another dr's db then verify them with the DOB and go to that dr's database and see if we have any other insurance.

Step 4 – Any of the above tricks is not useful and the insurance tells you that the policy is not active then get in touch with the member and get the correct details (only for front office clients).

Step 5 – If you don't get any positive response from the member then '**Bill**' the member by terminating the policy or posting '**Primary Payment denied**' with a denial code of **26, 27** or **28** with a '**BILL NOTE**'.

COB Denial

If the insurance denies the claim saying covered by another payer.

Ans –

Step 1 – Check with the insurance if the member has updated any COB (coordination of benefit) with them. If they say that, they are secondary and some other insurance is primary then check if you can get the primary insurance information from them. If not then try the tricks below.

Step 2 – Try searching a member's relative in the same dr's database with the last name search (if you get any patient with the same address then check his/her insurance and take action accordingly).

Step 3 – You could also find the patient in another dr's database by searching the member in 'Claimpower Search'. If you get the patient in another dr's db then verify them with the DOB and go to that dr's database and see if we have any other insurance.

Step 4 – Any of the above tricks is not useful and the insurance tells you that they are secondary then get in touch with the member. If you do not get any positive response from them then bill the patient by posting a '**Primary Payment Denied**' with a **denial code of 109**.

Pre-existing Clause

If a claim is denied for a pre-existing clause.

Ans –

Step 1 - Check with the insurance from whom the information is being requested, from the doctor or from the member?

Step 2 – If the rep says that they need information from the doctor then ask them when the letter was sent and if they got any reply from the office. Also check how we need to send the requested information by mail or fax.

Step 3 – If the rep says that they need information from the member then check if any letter was sent & when it was sent and also if they got a response from the member for it. If they have received the information from the member then they should review the claim and issue payments to us.

Step 4 – If the member has not updated the information then we can try calling the member (if we are a front office client) and request the member to update the files as soon as possible.

OR

Step 5 – If the patient fails to update the file then we have an option of billing the member by posting a '**Primary Payment Denied**' by going to the payment screen with a **denial code of N179**.

Step 6 – If the information was requested by the doctor and he had forwarded the notes to the insurance and then the claim was denied then we can add a '**Zero Received**' with a **denial code of 51**.

Not Covered Under Patient Benefit Plan

If claim (code) is denied for not covered under the patient's benefit plan by the insurance.

Ans –

Step 1 - If we have this denial then we should check if we ever got any payment from the insurance for the code previously for the patient.

Step 2 - If they had paid the code earlier then request them to check if the member's benefit plan was changed or not? If the plan was changed then get the date from when it was changed.

Step 3 - If it was paid before and the benefit plan was not changed then we should dispute with them as to why they are not paying this time.

Step 4 – If it is a valid denial and the patient is liable for the charges then bill the patient by going to the payment screen and posting '**Primary Payment denied**' with **denial code of 46 or 204** OR If they are not liable then add a **Zero Received**.

Not Provided by Designated Provider

If claims are denied for services not provided by designated provider (no auth).

Ans –

Step 1 – Check dr's participating status with the insurance and member's plan.

Step 2 – If the dr is non-par then check, if the member has any out of network benefit. If he/she has out of network benefit or if the dr participate with the insurance then the claim should be reviewed

Step 3 - If the member doesn't have an out of network benefit then ask the ins if we can bill the member for the services done. If the member has Medicare or Medicaid plan then add a '**Zero Received**' with **denial code of 38** OR if we can bill then post a **Primary Payment Denied**.

Deductible

If Insurance Company says that the claim was applied towards member's deductible?

Ans –

Step 1 – If the ins says that the claim was applied towards patients deductible then you need to ask them whether it was an In-network deductible or Out of network deductible.

Step 2 – If the insurance says that it was applied towards In-network deductible then take down the amount applied towards deductible and go to the payment screen and post the amount given by them as 'Primary Deductible' along with 'Primary Adjustment' and note the account in detail. For example if the ins said they applied \$50.00 towards in-network deductible for a claim charged of \$100 then we would post \$50 as 'Primary Deductible' and \$50 as 'Primary Adjustment'.

Step 3 – If the ins said that the claim was applied towards Out of network deductible then get the amount and in this case we just need to post 'Primary deductible' with no 'Primary Adjustments'. For example if the ins applied \$50 towards out of network deductible for a claim charged of \$100 then just go to the payment screen and post \$50 as 'Primary deductible' with no adjustments.

Patient enrolled in Hospice

What is Hospice Care?

Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure. The goal is to enable patients to be comfortable and free of pain so that they live each day as fully as possible. Mostly this program is provided by Medicare

Normally HMO plans deny the claims when the patient is enrolled in Hospice care, In such a scenario, we need to bill the denied claim to Medicare with GV or GW modifier. Medicare denies the claim if we do not submit with GV or GW modifiers

GV Modifier

The GV modifier is used when a physician is providing a service that is related to the diagnosis for which a patient has been enrolled in hospice. This physician is not associated with the hospice and is providing services as the attending physician.

GW Modifier

The GW modifier is used when a physician is providing a service that is not related to the diagnosis for which a patient has been enrolled in hospice. This physician is not associated with the hospice and is providing services as the attending physician.

Step 1: Get the start date and end date of the enrollment of the hospice. Try to obtain a Medicare ID from the HMO itself / Check ERA or Call the patient. Unless and until we don't have the Medicare ID we cannot get paid.

Step 2: Once we have the Medicare ID checked the eligibility on IVR if the patient is enrolled in hospice the IVR will give the dates and Name of the hospice program

Step 3: Once we have the Hospice name, check the rendering Dr is employed by the Hospice (This info can be found in Generic notes)

Step 4: Once the doctor's employment with hospice is determined we need to bill with an appropriate Modifiers

OR

If the provider is enrolled in Hospice, need to add a zero received.

Insurance specific: If this type of denial occurs for clover health insurance and we don't have medicare id number to resubmit the claim. We can get medicare id numbers from clover health provider portal login.

As of 2019, New medicare id cards have been issued with a new id format. If we need the new id number. we can login to medicare website and do MBI look up and get the new id number.

Note: patient SSN, correct name and DOB is needed to pull the new id number.

Duplicate

Duplicate service denial is indicated when the same service was performed on the same patient on the same date and by the same provider.

Three reasons a claim may be denied as duplicate:

1 - The service was performed more than once on the same day.

If the service was performed more than once on the same day it may be eligible for a modifier. Modifier 50 or RT and LT modifiers appended would indicate the same procedure performed bilaterally and may clear up the confusion. If the code is billed twice and it's not eligible for 50, LT & RT modifiers add a zero

2 - The service was performed once but billed twice.

If the service was billed twice check the original claim was paid. If the original claim is not paid have the original claim processed and void the duplicate claim

3 - Another physician performed the same service on the same date and submitted a claim with the same CPT code you did, which was processed prior to your claim.

If another provider has performed the same service and was paid while your claim was denied you may need to speak to your insurance representative to determine the proper method of appeal required by the insurance. Methods of appeal may vary by insurance.

**** A denial for duplicate service does not mean the claim will never be paid. Do a little research and see if any of the scenarios above fit your particular situation and then act accordingly ****

PCP Not Selected

Only HMO plans require the patient to select a Primary Care Physician (PCP).

Who is PCP?

A primary care physician (PCP) is a physician who provides both the first contact for a patient with an undiagnosed health concern as well as continuing care of varied medical conditions

One of the important duties of a primary care physician is to make referrals to specialists as the patient's condition indicates. In these cases, the primary care physician is also responsible for managing the overall care of the patient and communicating with the specialist or specialists as needed.

Scenario 1: If the insurance says the patient has not selected any PCP

Action- Call the patient, check the patient's PCP once the PCP is confirmed, ask the patient to call his/her insurance and update the PCP.

If the patient does not answer our call leave them a voicemail and bill the patient with appropriate bill note

Scenario 2: If the insurance says someone else is the PCP

Action- Check who is the PCP listed.

Call the patient, check if the PCP given by the insurance is correct. If it's incorrect, ask the patient to update the correct PCP. If the patient has someone else as PCP, informing them their insurance requires a referral if the services are rendered other than the PCP.

If the patient does not answer our call, leave them a voicemail and bill the patient with an appropriate bill note.

Medical Necessity

So what is Medical Necessity?

Essentially, what they are saying is that the treatment does not meet a certain level of severity to be considered medically important enough to warrant that treatment.

When Medicare or Medicare HMO denies the claim for medical necessity (remark code CO 50).

Mostly it's related to diagnosis denial. They want us to refer to LCDs (Local Coverage Determination) or NCDs (National Coverage Determination) maintained by CMS. These LCDs or NCDs can be found on [cms.gov](https://www.cms.gov)

Call the insurance and ask for the LCD or NCD number to the insurance. Visit [cms.gov](https://www.cms.gov) or state MAC (Medicare Administrative Contractor) website. locate the LCD/NCD number and it will provide you the description, number of frequency allowed and list of Dx that are approved for medical necessity, etc.

If dx listing is accurate as per LCD or NCD on the claim, get it reprocessed or if its not aligned as per LCD or NCD. Arrange the dx order correctly and resubmit a corrected claim.

If Dx listed on LCD or NCD is not on the claim, ask lovina mam whether any changes can be done or it should appeal with medical records.

(Below info can also be applied to Commercial insurances denial for medical necessity)

Sometimes medical necessity denial will only be in place for the request of medical notes. Ask for fax number or mailing address for it. Check whether notes are available, if yes request the concerned person to submit medical records. If not, then add an HN modifier to get the notes from the provider. Medicare needs to fax it with a redetermination form.

Note: For medicare and medicare hmo's Claim should have primary Dx as one of the diagnosis listed in paragraph one for diagnosis and sometimes we have to refer to Dx paragraph 2 as well and so on to meet the medical necessity, based on the dx criteria mentioned on the LCD/ NCD number.

Client Rules: For MDM if claim is denied for medical necessity/medical records or need to appeal it. Add a zero received with denial M127 and mark it on the web.