

The Appeals Process

Whenever you receive a denial, whether it is from a typo on your end or a payer error the acupuncturist has the right to appeal the denial. Unfortunately most denied claims are never appealed but clearly 50% of appealed claims are overturned to the providers favor.

First you need to decide which 50% your claim would fall into. Claims can be denied for a number of reasons. Three commonly denied reasons are: the claim was not received in a timely fashion, the patient has used his maximum benefits, and finally the claim was denied because the diagnosis code used on the claim is not considered medically necessary. In all three of these cases an appeal would probably NOT be successful, as these are all of these are avoidable with proper verification and are in fact legitimate reasons not to pay a claim. It is the responsibility of the office to know what the time limits are for submission of a claim. In addition when done properly the verification process should uncover any diagnosis limitations. Finally while we can't be sure if the patient has seen another provider, we certainly can't appeal a claim when a patient has exhausted his benefits.

That leads us to the other half, situations for successful appeals. If an office has done their due diligence verifying benefits, they have at their disposal the necessary information to successfully fight a denial. For the most part in these situations we will be dealing with two types of reasons for the denial. #1 – The insurance carrier misquoted the coverage. #2 – The insurance carrier denies the patient has acupuncture benefits, or is covered for a specific diagnosis when in fact he indeed has coverage.

It is quite possible to get an insurance company to process and pay a claim when they have misquoted benefits. Is it easy? NO, but possible. In this situation the office has documented the verification, submitted the claim only to find that the representative who quoted benefits, quoted inaccurate coverage. Most likely they misread the patient's benefits. In other words you asked for acupuncture and they quoted occupational therapy. While we have no way of knowing exactly where they are getting their information, it has happened that they quote the patient HAS coverage for acupuncture when indeed they don't.

When this occurs it is quite possible that the patient has now been treated for a number of visits, as it could take up to 30 days for the claim to come back denied. When the denial is received a call to the carrier reveals that the office was given erroneous information. This usually happens when the carrier is an administrator for a self-funded plan. Since a major carrier can administer literally hundreds of different plans the chances of misquoting are always much greater than when a carrier quotes benefits of the plans they sell. This is for a number of reasons. First acupuncture benefits are typically consistent for all plans they sell. Secondly in the state of California we have penalties in place for late payments, plus a very strong department of Insurance, so we don't see many mistakes with true insurance plans

Self insured plans have built into them an appeals process. A lot of times this process is written on the back of the EOB. It is a two step process. The first is to file an appeal. The appeal typically goes right to the claims department, the same group that denied the claim in the first place, therefore this first appeal is ALWAYS denied as it's more of a formality. Basically you're asking the group that made the mistake to admit they made the mistake and correct their errors. Since this is the first step in a two step process their rationale is why should they? A good many providers stop there, and bill the patient, exactly what the carrier wants. So inevitably it becomes necessary to file what is called a second level appeal. At this level most plans have built in that a representative from the employer group must be involved. The second level is looked at by "a different set of eyes" not just the ones that denied the claim in the first place.

It should be said at this stage (or earlier) the patient needs to be brought into the equation. He/she must be proactive, and while it is likely he can't do anything during the first stage, however at the second stage he has access to the member services department and his own employer group and between those two can get things moving faster than a provider can. Now the rationale for the appeal is this: The representative quoted mis-information, claiming the patient had coverage. Based on this erroneous information the patient sought to receive care that by the time of the denial will now cost the patient hundreds if not thousands of dollars. The patient most definitely would not have made the decision to seek care had he known he would have to pay out of pocket, however because of the carrier's error he is now financially liable for this very same care.

Since this is a self insured plan, it is coverage that is financed in part by the patient's employer. His employer wanted him to have health coverage and hired the carrier to administer the coverage NOT penalize the patient. Most of the time at this stage the appeal will be in the hands of someone from the employer group and at the second stage it will be determined that the mistake was indeed the carriers and the carrier is told to pay the claim. Realize however, they will pay the claim only up until the time that the office received the first denial. So once the denial is received, and if the error is confirmed, the patient is should be considered a cash patient.

Sometimes the denial is still upheld. This typically happens when the employer group has not created a panel that includes one of their members at the second level stage. In other word the same group that denied the first level appeal is responsible for the second level as well. The foxes are guarding the hen house. If you have a denial at the second stage, the patient must get super proactive. He must call his HR department or whatever department handles health insurance and make them aware of this situation, because undoubtedly the carrier has not informed the employer group of the problem. They are almost always unaware of what the carrier has done and by providing documentation of the attempts for the appeal along with a phone call to the correct person even a denial at the second level can be overturned.

The second case for a denial is when the carrier denies coverage, when in fact the patient truly has benefits for acupuncture. While this seems like an open and shut case, unfortunately it usually takes getting to the second level to be resolved as well. In this

case the patient's benefits have been verified. The claim gets submitted, but denied as no coverage. A second call is made, and like the first, the patient has acupuncture benefits. In this case, while the benefit department is aware the patient has coverage, the claims department doesn't, more likely the computer system has not been properly set up to process the claim. While this seems like it could be fixed with a phone call, sadly once again you will be instructed to file an appeal, and it too most likely will be denied at the first stage. At the second stage the examiners can't just blindly "trust" the claims department's recommendation and will contact the benefit department to get the correct information.

While this seems like a lot of work, and it can be, the alternative is billing the patient, which is EXACTLY what the insurance carrier would like you to do. This however is not fair to the patient and obviously does not carry with it any sense of "good will" on the part of the office. The exact opposite is true when you take the steps necessary to get an insurance carrier to pay a claim. You have created an incredible bond with that patient, and that patient is now a patient for life, a patient that refers. In the very small chance that you exhaust all avenues and your claim remains unpaid, you have gone the distance for your patient and they will remember the hard work and dedication on their behalf, (and usually switch carriers as soon as the next open enrollment.)