2020

Medical Billing Training: Certified Professional Biller (CPB™)

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Chapter 13

Commercial Insurance Carriers

In this chapter, commercial insurance carriers such as Aetna, UnitedHealthcare, and Cigna will be reviewed.

The objectives for this chapter include:

- Understanding common denials from insurance companies
- Explain the appeals process for Aetna, UnitedHealthcare, and Cigna

Common Denials/Rejections

A biller must understand the causes of common commercial payer denials and rejections to:

- Implement front office policies and procedures to reduce front end errors that cause denials and rejections
- Understand when corrected claims and appeals are warranted
- Submit effective appeals

A rejected claim is a claim not containing the necessary information for adjudication. Once the missing or incorrect information is identified and updated on the claim, the claim can be resubmitted, and it will be reprocessed by the insurance carrier. Because the rejected claim was not reviewed for coverage determination, the appeals process is not applicable.

A denied claim differs from a rejected claim. A denied claim is one that passed through the payer's initial claim processing but was determined not to be a covered service or procedure based on the payer's coverage criteria. This prompts a claim denial, which is identified on the Remittance Advice (RA) form sent to the provider. The trained medical biller reviews the RA and determines if denial is appropriate or if an appeal should be made.

Incorrect Patient Information

Submitting incorrect patient demographic information to the insurance payer is one of the leading reasons a claim is rejected. Misspelling the patient's name or using the patient's nickname (for example, Charlie instead of Charles) in the patient name field, incorrect date of birth, an invalid or missing subscriber number, or group number are all examples of key information that must be accurately captured and properly reported to avoid claim rejection. Accurate intake information is imperative to avoid typographical errors. Delays in claim payment are typically greatly reduced when medical billers communicate the importance of this information to the front office staff.

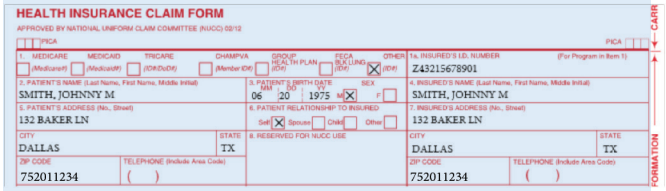
ABC Health
ABC Health Classic
Managed Choice
Open Access

ID Z432156789
Name
01 John M. Smith
HEALTH PLAN (80452) 8130860054
GRP: 123456-010-00001
PCP: AAPC Family Practice

RX Bin# 205016

02 Jill R. Smith
PCP: AAPC Family Practice
03 Jane M. Smith
PCP: AAPC Family Practice

EXAMPLE


HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12
PICA
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
1a. INSURED'S I.D. NUMBER
Z43215678901
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
SMITH, JOHNNY M
3. PATIENT'S BIRTH DATE SEX
06 20 1975 M
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
SMITH, JOHNNY M
5. PATIENT'S ADDRESS (No., Street)
132 BAKER LN
6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
132 BAKER LN
CITY
DALLAS
STATE
TX
8. RESERVED FOR NUCC USE
CITY
DALLAS
STATE
TX
ZIP CODE
752011234
TELEPHONE (Include Area Code)
( )
ZIP CODE
752011234
TELEPHONE (Include Area Code)
( )
CARR
FORMATION

In this example, the insurance card states the patient's name is John M Smith; however, the claim states the patient's name is Johnny M Smith. This claim would be denied by ABC Health Insurance carrier for incorrect patient information. The patient's name would need to be corrected to John M Smith as stated on the insurance card, and the new claim, with the correct information, submitted to the insurance carrier.

Eligibility Expired

Another common denial occurs when the patient's coverage was not in effect on the date of service submitted for reimbursement. Insurance benefits should be verified before services are rendered to avoid this type of denial. Eligibility verification identifies if a patient has other insurance or relies on self-pay. Training the front office staff to follow this procedure with each patient encounter will assist in avoiding these types of denials. Patients should be asked to verify insurance or be asked for a copy of their insurance card at each

visit. Simply asking, "Has anything changed since your last visit?" usually draws a negative response from patients even though coverage changes have occurred. Some patients may have been issued new insurance cards months prior and don't think about it at the time of the encounter, so asking for proof of insurance each time guarantees the correct information is collected and the proper insurance is billed for the services provided.

Although insurance cards typically have an effective date, they do not contain the termination date. This is only found by verifying eligibility. Many insurance carriers allow verification of eligibility online.

EXAMPLE

ABC Health Coverage Status as of Today's Date 06/01/20

Name	Relationship	Date of Birth	Coverage Began	Coverage Ended
Caroline Williams	Subscriber	05/15/1968	01/01/2017	01/01/2019
Johnny Williams	Dependent	03/02/2002	01/01/2017	01/01/2019

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) [X]
1a. INSURED'S I.D. NUMBER (For Program in Item 1): 12345678956
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Williams, Caroline
3. PATIENT'S BIRTH DATE: 05 15 1968 SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Williams, Caroline
5. PATIENT'S ADDRESS (No., Street): 123 Randolph Rd
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 123 Randolph Rd
CITY: Dallas STATE: TX
8. RESERVED FOR NUCC USE
CITY: Dallas STATE: TX
ZIP CODE: 752011234 TELEPHONE (Include Area Code): ( )
ZIP CODE: 752011234 TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: 32145
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: ABC Health
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, complete items 9, 9a, and 9d.
12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE: 06012020
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: Signature on File
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 06 01 20 QUAL. 431
15. OTHER DATE QUAL.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. I119 B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06	01	20				11		99213		A	160 00	1		NPI	123456789I
2															

CARRIER — PATIENT AND INSURED INFORMATION — INFORMATION

In this example, the claim will be denied as member not eligible because the member's coverage with ABC Health terminated 01/01/2019 and the date of service is 06/01/2020.

Prior Authorization/Referral Not Received

A claim will also be denied if prior authorization or precertification data is missing on the claim. Many claims related to non-emergency treatment require prior authorization with commercial insurance plans, including non-emergent procedures, non-emergent inpatient admissions, and radiology services. If not obtained, a denial will be received from the payer. If the service was rendered under medical emergency, an appeal may be successful. Retroactive authorization may be considered within 24 to 72 hours of the service being rendered, depending on the payer's guidelines. This is another denial that is fully preventable on the front end if the payer's policy is known. Querying patients on their payer's policies may also cut down on these types of denials.

This type of denial may frequently occur with HMO patients. Enrolled members may need services that require an authorization and referral from the member's primary care provider (PCP). If that authorization is neither given nor entered on the claim, it will be denied. The authorization number is entered in item 23 on the CMS-1500 claim form:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. K432 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
65431896452

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 01 XX		22		49560		A	150 00	1		NPI	1234567890

Claim Not Covered by Insurer

Non-covered services provided to a patient will result in a payer denial. Exclusions or non-covered services refer to certain medical services excluded from the payer's health insurance coverage under the patient's plan. The patient will be responsible for 100 percent of the fee for such services. It is poor customer service to balance bill a patient for services without making them aware that they may be responsible for the charges prior to the service being performed. This may be avoided by contacting the insurer prior to the service being rendered. If the payer states the service is non-covered under the contract, an appeal will be futile. A biller cannot be expected to know every exclusion each plan carries but should be aware of the most common exclusions in the major plans their office contracts with to ensure avoidance of this issue, when possible. Whenever a major service is going to be performed, it is advisable for staff to verify coverage prior to the event. Some payers offer real-time verification of coverage through their online databases.

EXAMPLE

A patient goes to the optometrist and orders contacts. According to the benefits list below, the plan does not cover contacts. The charge for the contacts is transferred to patient responsibility.

Service	Copay	Deductible	Patient Responsibility	Comments
Office Injections	$0	$0	0%	
Vision/Contacts	$0	$0	100%	NOT COVERED
Vision/Glasses	$0	$0	100%	NOT COVERED

Request for Medical Records Not Received

In some cases, a payer may request medical records to adjudicate a claim. This usually occurs after the initial claim is submitted, but if a provider is on pre-payment audit, then the records will need to be sent with the original claim. In any case, if the records requested by the payer are not received, the payer will have no option but to delay or deny the claim. The portions of the medical record requested may vary depending on the payer and type of procedure performed, but could include:

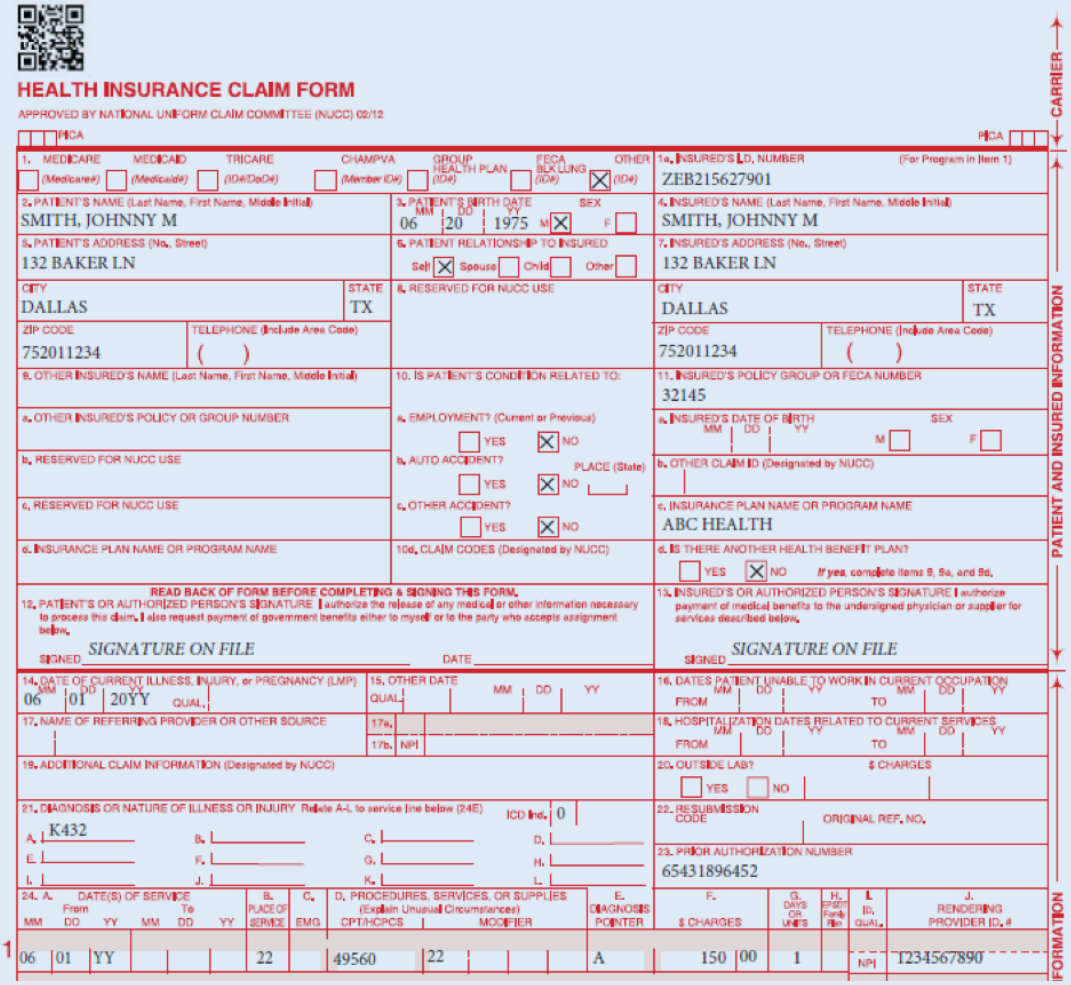
- Patient's medical history
- Patient's physical exam reports
- Physician's consultation reports
- Patient's discharge summary
- Radiology, pathology, and laboratory reports
- Operative reports

When records are requested by payers, the request should be completed quickly to keep the adjudication process moving forward and avoid a denial. Always remember the minimum necessary rule for HIPAA treatment, payment, or operations (TPO). Only send the specific information the insurance carrier is requesting. Do not send any extra or additional information that is not requested or needed to process the claim.

EXAMPLE

ABC Health Policy: Modifier 22 - Increased Procedural Services

To be considered for additional reimbursement when reporting modifier 22, thorough medical records or reports and a separate document containing a concise statement about how the service differed from the usual service or procedure is required. The documents must indicate the substantial additional work performed and the reason for the additional work which may include increased intensity or time, technical difficulty of procedure that is not described by a more comprehensive procedure code, severity of the patient's condition, or increased physical and mental effort required.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): ZEB215627901

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JOHNNY M

3. PATIENT'S BIRTH DATE: 06 20 1975 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SMITH, JOHNNY M

5. PATIENT'S ADDRESS (No., Street): 132 BAKER LN

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 132 BAKER LN

CITY: DALLAS STATE: TX

8. RESERVED FOR NUCC USE

CITY: DALLAS STATE: TX

ZIP CODE: 752011234 TELEPHONE (Include Area Code): ( )

ZIP CODE: 752011234 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 32145

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ABC HEALTH

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 01 20YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. K432 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 65431896452

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06	01	YY				22		49560	22	A	150 00	1		NPI	1234567890

CARRIER

PATIENT AND INSURED INFORMATION

FORMATION

This claim form filed electronically without medical records or a completed modifier 22 form will result in a request for medical records. If the records are not sent in time, the claim will be denied for medical records not received.

Coordination of Benefits Issues

Coordination of benefits (COB) is the process of determining which of two or more insurance policies will have the primary responsibility for paying a claim, and the amount that the other policies will contribute. These types of denials may be due to a claim being submitted to a secondary insurance without the primary insurance EOB information. A COB denial may be related to the fact that a secondary insurance was billed as a primary insurance by mistake. Sometimes patients may not advise the practice that they are covered by more than one plan or they may not know which one is primary. Billers must be sure that all insurance information has been obtained from a patient to bill the correct insurer first.

Many payers allow the secondary claims to be submitted electronically. The carrier's website will provide the information required electronically for COB processing.

EXAMPLE

UnitedHealthcare provides the following tips on submitting electronic COB claims:

COB electronic specifications

For secondary professional or institutional claims to be paid electronically, the COB information must be submitted in the applicable Loops and Segments. Loops include:

- LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION
- LOOP ID - 2330A OTHER SUBSCRIBER NAME
- LOOP ID - 2330B OTHER PAYER NAME
- LOOP ID - 2330C OTHER PAYER REFERRING PROVIDER
- LOOP ID - 2330D OTHER PAYER RENDERING PROVIDER
- LOOP ID - 2330E OTHER PAYER SERVICE FACILITYLOCATION
- LOOP ID - 2330F OTHER PAYER SUPERVISING PROVIDER
- LOOP ID - 2430 LINE ADJUDICATION INFORMATION

Consult your vendor, 837p/837i Implementation Guide, or refer to HIPAA Companion Guides for eCOB specifications for submitting secondary/COB claims electronically to UnitedHealthcare.

Commercial electronic COB claim requirements:

- Primary Payer Paid Amount—Submit the primary paid amount for each service line reported on the 835 payment advice or EOB. The paid amount on institutional claims can be submitted at the claim level.
- Adjustment Group Code—Submit other payer claim adjustment group code as found on the 835 payment advice or as identified on the EOB. Deductible, co-insurance, copayment, contractual obligations, and/or non-covered services are common reasons why the other payer paid less than billed.
- Adjustment Reason Code—Submit other payer claim adjustment reason code as found on the 835 payment advice or as identified on the EOB. Deductible, co-insurance, copayment, contractual obligations, and/or non-covered services are common reasons why the other payer paid less than billed.
- Adjustment Amount—Submit other payer adjustment monetary amount.
- Preference—Submit professional claims at the line level if primary payer provides, and institutional claims at either line or claim level. The service level and claim level should be balanced. UnitedHealthcare follows 837p/837i guidelines.

Claim Covered by Other Insurer

Similar to a coordination of benefits denial, this type of denial occurs when the claim is a liability case. When a patient has had an auto or work-related accident, the commercial insurance plan will most likely deny coverage until the workers' compensation, auto insurance, or other liability carrier has been billed. This type of issue can be avoided with a thorough intake of the patient at the time of the visit. It should not be assumed that just because there is a commercial insurance card on file that it should always be billed. If a patient is seen for any kind of acute injury, a full history of the issue should be performed, including how the accident occurred, what the patient was doing at the time of the accident, and most importantly, where the accident occurred. If a patient presents and states they were injured at work, a biller should query the employer before submission of any claims. Information on filing workers' compensation or other liability carriers is covered in chapter 14 of this curriculum.

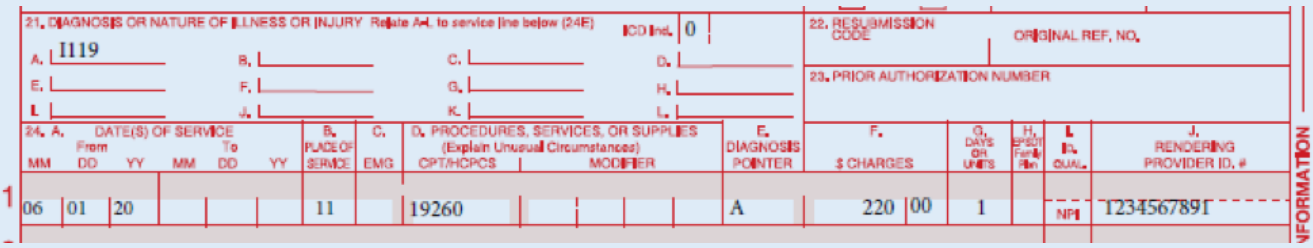
Missing or Invalid CPT®, HCPCS Level II, or Diagnosis Code

Errors in coding will result in a claims denial. These include:

- Incorrect code (for example, CPT® code submitted rather than required HCPCS Level II code on a Medicare claim)
- Diagnosis codes linked to wrong CPT® codes
- Deleted code submitted on claim form
- Incorrect or missing modifier or code
- Invalid code usage (for example, Category III codes not accepted by a payer)

Current coding materials (books, software, encoders, etc.) should always be used to ensure that the most current codes are assigned on a claim. A biller needs to understand when other codes are required by a payer, such as HCPCS Level II by Medicare or other carriers and Category III codes versus unlisted or other CPT® codes. A quality assessment of coding should be performed on a routine basis for all staff who assign codes. Offer education on coding and billing so staff can keep up with the latest methodologies. If this type of denial is received, the medical record should be pulled and reviewed along with the charge entry to assess if the claim was coded and submitted correctly.

EXAMPLE


21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. I119 B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #
1 06 01 20 11 19260 A 220 00 1 NPI 1234567891
INFORMATION

This claim has procedure code 19260 reported for a 2020 date of service. In the CPT® code book, 19260 is a deleted code for 2020. The coding department should determine if the medical records support a different code.

Timely Filing

Each payer has a timely filing limit that is published to make all providers aware of the time that is granted to submit a claim for payment. Some payers have a 90-day timely filing limit, some 180 days, some one year, and some are specified by individual contract. Filing all claims in a timely manner will avoid this type of denial. Some have limits that begin when a primary payment has been made or when an appeal has been denied. Billers must keep informed of these different time limits so that reimbursement is not lost due to a claim or appeal being filed too late.

Duplicate Claim

If a claim has been adjudicated and a decision made, the claim is closed by the payer. If the claim is then resubmitted by the provider, a duplicate claim denial will be sent. Keeping track of outstanding claims and timely posting of payments should decrease this type of denial. Automatically resubmitting outstanding claims can cause a delay in payment and additional follow-up processing for a provider's office. Best practice is to check with the insurance carrier on the claim status for any claim that has been submitted to the insurance carrier but does not yet have a response.

Medical Necessity Not Met for Service

Medical necessity is defined by each payer, but when a medical necessity denial is received, it indicates the diagnosis code submitted with the procedure code does not meet coverage guidelines. Payers publish coverage determinations similar to Medicare's Local Coverage Determinations, in which the payer indicates the circumstances for coverage for services and procedures. They indicate applicable procedure and diagnosis codes. These types of denials will have to be investigated to see if they should be written off or if they should be appealed. Review of the health plan's coverage determination regarding the service, will also assist in determining if charges should be appealed or written off. Review the medical policy information in chapter 7 of this curriculum.

Termination of Coverage

If services were provided to a patient after their coverage was terminated for any reason (patient changed insurances, patient cancelled insurance, etc.), a rejection will be received for termination of coverage. The patient will need to be contacted for correct insurance information, so a claim may be submitted to the proper insurer. If the patient no longer carries insurance, he or she will need to be changed to a self-pay patient in the system and payment will need to be requested for the services already rendered. This is another example of how important it is to update demographic information on patients at each visit. A denial like this unnecessarily lengthens the time it takes the office to capture reimbursement.

Bundled Service

If a service is billed that is bundled into another service, or falls under the global surgery package, it will be denied. For bundled service and global surgery denials, RBRVS and CPT® guidelines should be reviewed to determine if the services are bundled. Some payers do not follow RBRVS, so payer-specific contracts or policies may need to be reviewed for this information. If the service is bundled, or is part of the global surgery package, it should be written off.

This denial is also received on valid claims in some instances when modifiers are not appended to the procedure to indicate that the global surgical package or bundling issue should not apply. For example, a patient is under a 10-day global period for an intermediate wound repair performed on his trunk, CPT® code 12034. On the third day, the patient presents to the office with complaints of asthma exacerbation. A claim for an E/M service is submitted but denied due to bundling issues. When the claim is reviewed, it is determined that modifier 24 can be applied to indicate the service was unrelated to the

global service. Modifier 24 was not appended to the E/M code on the original claim submission. When lack of modifiers is identified as the reason for denials, an appeal should be made, and the claim resubmitted with the appropriate modifier appended to the denied service or procedure. Other modifiers that are important to appropriately bypass bundling denials are:

Modifier 25—Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional on the Same Day of the Procedure or Other Service

Modifier 58—Staged or Related Procedure or Service by the Same Physician or other Qualified Healthcare Professional During the Postoperative Period

Modifier 59—Distinct Procedural Service

Modifier 78—Unplanned Return to the Operating/Procedure Room by the Same Physician or other Qualified Healthcare Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

Modifier 79—Unrelated Procedure or Service by the Same Physician or Other Qualified Healthcare Professional During the Postoperative Period

Section Review 13.1

1. A rejected claim is?

   A. A claim that has passed through the payer's initial claim processing and was determined not to be a covered service based on coverage criteria.

   B. A claim that does not contain the necessary information for adjudication.

   C. Both A & B

   D. None of the above

2. Which modifier is used to indicate that an E/M service is unrelated to the global service?

   A. 24

   B. 25

   C. 59

   D. 79

3. Which denial occurs when the claim is a liability case and was submitted to the health insurance?

   A. Coordination of Benefits

   B. Request for medical records

   C. Claim not covered by insurer

   D. Claim covered by other insurer

4. Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service is which modifier?

   A. 50

   B. 25

   C. 33

   D. 24

5. Which of the following denials is one of the leading reasons a claim is denied and can be prevented by accurate intake information being collected every time?

   A. Medical necessity

   B. Coordination of Benefits

   C. Request for medical records not received

   D. Incorrect patient information

Appeals and the Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) provides provisions for the appeals process. Under Section 2719, a health insurer offering group or individual coverage must implement an effective appeal process for appeals of coverage determinations and claims. The appeals process must include at least:

- An internal claims appeal process
- Notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the appeals process
- Allowance for an enrollee to review their file and present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process
- An external review process

Each insurer's website contains information on their specific appeals process, both internal and external.

Appeals

If a claim is denied, investigated, and found to be in error, file an appeal. Different health plans have different timelines and policies regarding their appeal processes. A biller needs to have a solid knowledge of each plan to which they appeal, including filing deadlines. A valid appeal that is lost due to missing a filing deadline is unacceptable. In this section, Aetna, UnitedHealthcare, and Cigna's appeals processes will be reviewed.

Aetna Appeals Process

Aetna has a dispute and appeals process when a provider does not agree with a claim or utilization review decision. The appeals process is open to any healthcare professional that provides services to an Aetna member. The process includes:

Reconsiderations: These are formal reviews of claims reimbursements if a provider believes he or she was paid at an incorrect rate or not according to contract, coding decisions if a provider believes that Aetna did not assess the codes correctly or claims that require reprocessing if Aetna indicated additional substantiating documentation is necessary.

Appeals: These are written or verbal requests that are submitted by a provider to change:

- An adverse reconsideration decision
- An adverse initial claim decision based on medical necessity or experimental/investigational coverage criteria. Claims decisions are all decisions made during the claims adjudication process (for example, payment policy decisions, contract decisions, processing errors, etc.).
- A denial for non-inpatient hospital services that were denied for not receiving prior approval
- An adverse initial utilization review decision. Utilization review decisions are decisions made during precertification, concurrent, or retrospective review processes for services that require precertification. The member must appeal pre-service medical necessity decisions, while the provider appeals are subsequent to the service being rendered.

Below is Aetna's timeframe for submission and response to reconsiderations and appeals, along with the acceptable method of submission.

Dispute level	Doctor/Provider submission timeframe	Aetna response timeframe	Contacts
Reconsideration	Within **180 calendar days** of the initial claim decision	Within **3-5 business days** of receiving the request. Within **30 business days** of receiving the request if review by a specialty unit is needed.	**Call** **Write** **Submit online**
Appeals	Within **60 calendar days** of the previous decision.	Within **60 business days** of receiving the request. If additional information is needed, within **60 calendar days** of receiving that information.	**Call** **Write**

Source: *https://www.aetna.com/health-care-professionals/disputes-appeals/disputes-appeals-overview.html*

Below is an Aetna Provider Appeal Form.

aetna®

Practitioner and Provider Complaint and Appeal Request

NOTE: Completion of this form is mandatory. To obtain a review submit this form as well as information that will support your appeal, which may include medical records, office notes, discharge summaries, lab records and/or member history (this is not an all-inclusive list) to the address listed on your Explanation of Benefits (EOB) or other correspondence received from Aetna.

Please provide the following information.
(This information may be found on the front of the member's ID card.)

Today's Date	Member's ID Number	Plan Type ☐ Medical ☐ Dental	Member's Group Number *(Optional)*

Member's First Name	Member's Last Name	Member's Birthdate *(MM/DD/YYYY)*

Provider Name	TIN/NPI	Provider Group *(if applicable)*
Contact Name and Title		
Contact Address *(Where appeal/complaint resolution should be sent)*		

Contact Phone	Contact Fax	Contact Email Address

To help Aetna review and respond to your request, please provide the following information.
(This information may be found on correspondence from Aetna.)
You may use this form to appeal multiple dates of service for the same member.

Claim ID Number (s)	Reference Number/Authorization Number	Service Date(s)

Initial Denial Notification Date(s)	Reconsideration Denial Notification Date(s)
CPT/HCPC/Service Being Disputed	
Explanation of Your Request *(Please use additional pages if necessary.)*	

Note: If you are acting on the member's behalf and have a signed authorization from the member or you are appealing a preauthorization denial and the services have yet to be rendered, use the member complaint and appeal form.

You may mail your request to:

Aetna-Provider Resolution Team
PO Box 14020
Lexington, KY 40512

Or use our National Fax Number: 859-455-8650

GR-69140 (3-17) **CRTP**

UnitedHealthcare Appeals Process

UnitedHealthcare offers Claim Reconsideration Requests for a processed claim in which the provider does not agree with the outcome of the original payment/corrected claim.

UnitedHealthcare will review:

- Whether a claim was paid correctly (underpaid, paid to incorrect provider, etc.)
- Whether the provider information and/or contract are set up correctly

A Reconsideration Request may be filed on the phone, electronically, or on paper. Below is the UnitedHealthcare Reconsideration Request Form. The Claim Reconsideration must be submitted within twelve months of the date of the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). Some states (for example, California, Oregon, and Washington) may have different regulations based on state legislation. Always check your provider agreements and contracts. If the Claim Reconsideration is denied, a formal appeal request may be submitted.

https://www.uhcprovider.com/en/admin-guides/administrative-guides-manuals-2019/ch9-our-claims-process-2019/claim-rec-pro-res-dis-ch9-guide-2019.html

Below is the Claim Reconsideration/Appeal form for UnitedHealthcare.

UnitedHealthcare®

Single Paper Claim Reconsideration Request Form

This form is to be completed by physicians, hospitals or other health care professionals for paper Claim Reconsideration Requests for our members.

NOTE

- **Please submit a separate Claim Reconsideration Request form for each request.**
- **No new claims should be submitted with this form.**
- **Do not use this form for formal appeals or disputes. Continue to use your standard appeals process for formal appeals or disputes.**

Please refer to the attached Claim Reconsideration Reference Guide, your provider administrative manual or our provider website for additional details including where to send paper Claim Reconsideration Requests. You may verify the member's address using the eligibility search function on the website listed on the member's health care ID card.

☐ Physician ☐ Hospital ☐ Other Health Care Professional (Lab, Durable Medical Equipment (DME), etc.)

Member information **Date form completed** _____

Member ID	Control / Claim #	Date of Service		Billed Amount
Member Last Name		First Name		MI
Street Address		City	State	Zip
Patient: Last Name		First Name		MI

Physician/Health care professional information

Tax Identification Number (TIN): _____ Phone Number (with area code): _____

Email Address: _____

Physician or other Health Care Professional Name(as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB)

Last Name _____ First _____ MI _____

Street Address _____ City _____ State _____ Zip _____

Facility/Group Name _____ Contact Person _____

Expected amount owed _____ Contact Fax Number (with area code) _____

Reason for request: ***(More information on the definition reasons listed below and what documentation needs to be submitted can be found on the Claim Reconsideration Request definition sheet on UnitedHealthcareOnline.com)***

☐ 1. Previously denied / closed as "Exceeds Filing Time"
☐ 2. Previously denied / closed for "Additional Information"
☐ 3. Previously denied / closed for "Coordination of Benefits" information
☐ 4. Resubmission of a corrected claim
☐ 5. Previously processed but rate applied incorrectly resulting in over/underpayment (Network Providers - Check your fee schedules)
☐ 6. Resubmission of "Prior Notification Information"
☐ 7. Resubmission of a claim with "Bundled" services
☐ 8. Medical Records Submission
☐ 9. Other *(explain below)*

Please include what you are expecting from UnitedHealthcare regarding this Claim Reconsideration Request to close this out in your practice management system, including dollar amount if possible.

Comments

Required attachments
• Copy of PRA or EOB
• Claim Form is **ONLY** required for Corrected Claims Submissions
• Other required attachments as listed above

You may have additional rights under individual state laws. Please review the provider website, your provider administrative guide or your provider agreement/contract if you need more information.

Doc#: PCA11850_20140312

Cigna Appeals Process

Many claims that have been denied due to claim processing errors or missing claim information can be resolved informally by contacting Cigna HealthCare.

Contractual disputes for denials and payment disputes are resolved through single-level appeals. A single-level provider payment review must be initiated within 180 calendar days from the date of the initial payment or denial decision from Cigna. Times may differ by provider agreement. The appeal will be performed by a reviewer not involved in the initial decision. The reviewer will decide based on the provider's agreement terms and/or the patient's benefit plan within 60 days. After exhausting the internal appeals process, the healthcare provider may go through arbitration.

Cigna holds a 90-day timely filing period for participating providers and 180 days for out-of-network claims.

https://www.cigna.com/es-us/health-care-providers/coverage-and-claims/appeals-disputes/how-to-submit

To file an appeal to Cigna, submit the original EOB, a completed appeal form, and documentation that justifies why the decision should be reversed. Multiple forms can be found on Cigna's website for billing dispute resolutions, appeal requests, and provider payment reviews. Some states have specific forms, so it is always best to check your provider contract for the proper process.

Section Review 13.2

1. According to the policy above, how many steps is in the Aetna dispute and appeals process?

   A. 5
   B. 4
   C. 3
   D. 2

2. According to the policy above, if a denial is received on a UnitedHealthcare claim, a reconsideration must be submitted within _____ of the date of the EOB or PRA.

   A. 12 months
   B. 180 days
   C. 90 days
   D. 60 days

3. When submitting an appeal to Cigna for timely filing, which of the following must be included?

   A. Original EOB
   B. Completed appeal form
   C. Valid proof of timely filing
   D. All of the above

4. Which of the following includes provisions for the appeals process?

   A. Patient Protection and Affordable Care Act
   B. Peer Review Improvement Act
   C. Omnibus Budget Reconciliation Act
   D. Federal Claims Collection Act

5. If a provider wishes to submit for a single level provider payment review from Cigna, what is the timeframe for this type of dispute?

   A. 60 days

   B. 90 days

   C. 180 days

   D. 365 days

Glossary

Appeal—A request filed for reconsideration of a claim.

Bundled service—A method by which the insurance company decides to combine payment for two or more medical services.

Claim—A request for payment by a medical provider for a given medical service or item.

Coordination of Benefits (COB)—The process of determining which of two or more insurance policies will have the primary responsibility of processing a claim and the extent to which the other policies will contribute.

Covered service—A medical procedure or item that is deemed payable by the insurance plan.

Denied claim—The refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for healthcare services obtained from a healthcare professional due to specific coverage-related reasons.

Duplicate claim—Any claim submitted by a physician or provider for the same service provided to an individual on a specified date of service.

Medical necessity—Accepted healthcare services and supplies provided by healthcare entities, appropriate to the evaluation and treatment of a disease, condition, illness, or injury and consistent with the applicable standard of care.

Non-covered service—A service not covered under the limits of the patient's health insurance contract. These amounts are the patient's responsibility to pay.

Pre-authorization—The approval of or concurrence with the treatment plan proposed by a participating provider before the provision of service.

Rejected claim—An electronically submitted claim that is unable to be processed due to missing or invalid information required by the payer. The claim is "returned" or not accepted electronically in the claims processing system.

Timely filing deadline—Timeframe an insurer allows for submission of claims or appeals.