

TIPS TO WRITING WINNING APPEALS

Step 1: Appeal Timely

Industry experts estimate that more than 70% of denials can be overturned. Despite that encouraging statistic, the greatest challenge most medical billing professionals face is timely appeal submission. Medicare appeals must be filed within 120 days of the claim decision; most commercial insurers require appeals within 180 days from the denial. Due to the sheer volume of claims most offices file, deadlines often pass before action is taken. If the appeal is filed late, the likelihood of success is significantly reduced. In order to meet appeal deadlines consistently, medical offices must have an appeal letter database where letters can be selected and quickly customized for any type of appeal.

Attempting to provide a detailed Level appeal is often a stumbling block to timely appeal submission. AppealLettersOnline.com has developed a collection of appeal letters to allow you to appeal on time and in a professional manner designed to overturn the denial or, in the minimum, demand a full disclosure regarding the basis of the decision.

Step 2: Appeal Twice

Most denials require two appeals for two reasons: first, insurance carriers do not always provide credentialed professionals for the initial review and second, insurance carriers often provide details in the Level I appeal response which may require further discussion. Level I appeal responses should be scrutinized for legal and contractual compliance. Some of the potential questions you should ask include:

- Has the insurer provided the internal rules, guidelines or review criteria applicable to the denial? If not, is the carrier in compliance with potentially applicable denial disclosure laws?
- If provided, does the internal rules, guidelines or review criteria cited by the insurance carrier actually apply to the treatment in question? Do the internal rules, guidelines or review criteria conflict with your internal quality care standards?
- Has the insurer provided review by a credentialed professional familiar with the type of treatment and has that credentialed reviewer suggested appropriate alternative care which has equal likelihood of efficacy?
- If the appeal involves a question of medical coding, has the insurer provided review by licensed coder familiar with the type of treatment?
- If the appeal involves a managed care contract or fee schedule, is the most current contract or fee schedule being utilized?

AppealLettersOnline.com has numerous appeal letters discussing all of the above aspect of claim review. Level II appeals should address all details regarding the justification for payment and should also address the shortcoming or inapplicability of the information cited in the Level I appeal response. Finally, citing applicable regulatory information in appeal letters assures you that the appeal will also be considered from a compliance standpoint.

AppealLettersOnline.com has more than 1500 appeal letters which cite state and federal claim processing mandates to assist you with generating Level II appeals.

Step 3: Cite Compliance Issues In Appeals

Perhaps most challenging can be the necessity of citing compliance issues in your appeal and AppealLettersOnline.com is the only resource to present you with such information in a usable format. Compliance obligations are the most compelling aspect of your appeal and are likely to get the attention of the appeal claim reviewer. It is critical to your success to reference a carrier's legal and contractual duties in regards to claim review.

A wide range of claim processing laws and regulations may apply.

AppealLettersOnline.com has letters citing state and federal mandates which dictate mandatory coverage for certain procedures and outline consumer protections in regards to managed care.

Finally, if compliance issues are not fully addressed in the carrier response to the appeal, you may be able to elevate the appeal to a higher authority for review and we have abundant information regarding such efforts. Third level efforts may include the following options depending on the type of coverage and type of denial:

- Requesting an independent review through your state's independent review process or the Medicare Administrative Law Judge process
- Requesting an independent review through the fiduciary (often the employer) on ERISA claims
- Requesting an executive level or legal review with the insurance company on matters of contract compliance

Effective Level III appeals require careful review of the claim to determine jurisdiction. Personnel responsible for Level III appeals should have an opportunity for training on state and federal claim processing regulations and how they apply to medical claims. Further, Level III appeals must often contain all the information to support the claim including medical records and even patient account, precertification and verification of benefits information depending on the type of denial.