



Top Five Tips for Successful Appeals

1. **Avoid obvious mistakes:** Payers will tell you (and audits confirm) that a staggering number of denials are the result of obvious errors, such as missed timely filing deadlines; illegible claims; claims not properly filled out (e.g., incorrect patient identifier info); failure to obtain pre-auth; and wrong, insufficient or non-existent documentation. These errors can be avoided easily by double-checking claims prior to submission. It's worth the time.

2. **Code only what documentation supports:** If you are billing a surgery, review the body of the operative report to be sure that all the procedures reported actually were performed. A common mistake is to code from the "list of procedures performed" at the beginning of the operative note. As payers and auditors know, these lists often do not accurately reflect what occurred in the operating room. A careful reading of the operative report might even reveal separately reportable procedures that would have been missed if relying only on the note summary. Similarly, coders shouldn't rely on a physician's recommended coding, but should instead review the documentation to be sure they are reporting the correct codes. If necessary, the physician should be prepared to amend the record to better reflect the nature of the service and/or the patient's condition.

3. **Be prepared:** Anyone speaking with the carrier regarding an appeal – whether coder, biller, office manager or physician – should have the knowledge and specific information necessary to discuss that appeal in full. The caller should be able to review the operative report with the payer, to explain the rationale for the coding/billing and to demonstrate why the claim should have been treated differently. **NOTE:** Payers do not consider a telephone call to be an appeal, so if, by contract, you have a deadline for submitting appeals, you may be in danger of falling out of the timely guidelines and your claim could be denied if your telephone calls are not being followed up on.

4. **Correct the claim before you appeal:** If the original claim was incorrect, appealing with the same claim will not change your results. Double-check the claim's EOB, CPT coding, diagnoses and documentation to be sure it is correct. Be absolutely certain you are applying modifiers appropriately. When the claim has been reviewed, make the necessary changes before resubmitting.

5. **Write a proper appeal letter:** Don't just send an EOB with a balance bill. The payer shouldn't have to guess the problem. Instead, you should spell out for the payer exactly what you wish them to review (such as fees, coding denials, etc.). You will have to spend a few extra minutes to put your request in writing, but it can make a big difference. Make sure you are sending your appeal to the proper address and send it via certified mail, return receipt requested.