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ACROinsights – Denials: How to Handle Them When They Occur

The goal of this series of articles is to ensure that radiation oncologists are aware of and provided with the knowledge to ensure revenue cycle operations are being addressed in a compliant manner. This installment will review the guidelines and information related to the denial and appeals process for radiation oncology services. The information contained within this ACROinsights article is meant as general guidance and is not meant to replace authoritative guidance for coding and billing.

Understanding Payer Denial of Services

At some point, every provider will receive a denial from a payer for services rendered and billed for patient care. If a provider is not aware of any payment denials, or is not receiving this information routinely, they should determine who the appropriate person is in their revenue cycle management to ask for this information so that they can become familiar with what is being denied and from which payers. If a physician receives reports of denials, it is important the physician reviews the clinical documentation and engages billing staff in discussions about opportunities for appeal or adjustment to current documentation and billing processes.

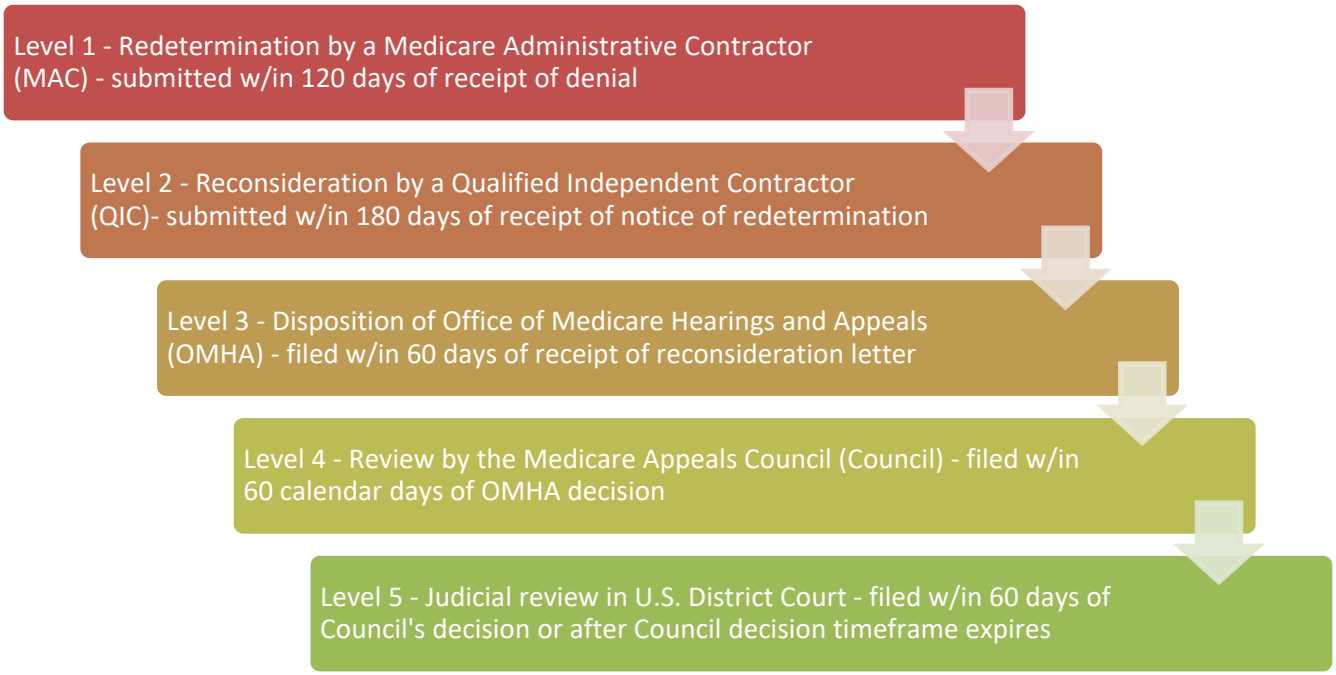
There are various reasons a denial may be received from a payer. It is important to note some denials cannot be appealed, due to billing edits, regulatory guidelines, or payer policy, as some services are either inherent in other services or simply not billable in combination with certain other services. However, there may be opportunities to appeal some denials. It is important to understand the specific reason for denial from the payer, as this is critical to understand if there is an opportunity to appeal, if something was billed in error, and/or if current processes within the facility are resulting in payer denials.

When a claim is processed there are different possible outcomes. It is important to understand that delay of payment may not mean the claim was denied.

Claim Outcome	Reason Claim Not Paid	Examples	Appeal Action
Claim is paid	N/A	N/A	N/A
Claim is denied	Regulatory or other coding guidelines prohibit billing of services together	• National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edit states code 77014 (treatment planning CT) cannot be billed on same date as code 77295 (3D plan). • CPT®/HCPCS code definition states the code 77307 (isodose plan) includes basic dosimetry calculation(s) (77300); due to this code 77300 cannot be billed with 77307. • NCCI Policy Manual and private payer policies state code 77301 (IMRT plan) includes the verification simulation service, code 77280 (simple simulation) cannot be billed when the course is planned with IMRT.	N/A
Claim is returned	Could not be processed due to incomplete or invalid data	• Patient information on the claim is not correct per the information the payer has on file.	Submit corrected claim to the payer for consideration of payment

Claim is pending	Payer has requested additional information or clarification is requested	• Services billed are invoice cost, payer requests documentation of the invoice to support charge(s) • Payer requests documentation of services billed for a pre-payment review	Submit requested information to the payer to support services and for consideration of payment

If an appeal is going to be made to Medicare for denial of payment, there are 5 levels to the appeals process. A first level appeal to the Medicare Administrative Contractor (MAC) or request for redetermination, if denied, is not the end of the story since there are four other levels which can be used for attempt at payment. Note, Medicare requires appeals to be made in writing and in the defined order. Steps cannot be skipped, and deadlines must be followed. Appeals made to commercial payers will require similar levels of documentation to support services provided, but may have limited mechanisms for appeal, and largely be determined per the specific contracts and beneficiary coverage plan with the payer. These could vary greatly from the appeal levels listed below specific to Medicare.



If an appeal is made, or documentation is being submitted for a pending claim, it is extremely important the correct information is submitted to the payer. This includes documentation that may be housed in different electronic health records (i.e., hospital EHR vs. the radiation oncology EMR). As a rule, no level of appeal will allow for introduction of documentation not available in the original patient records. For example, if a treatment plan is denied or additional information is requested by the payer, it is recommended to submit the evaluation and management (E/M) visit note, the physician clinical treatment plan, and the dosimetry treatment plan. Notations and comments can be added to the pdf of the dosimetry treatment plan to highlight and identify the various components of the treatment plan. It is insufficient to submit only the specific documentation related to the code(s) denied or the code(s) about which additional information was requested. Documentation of the services leading up to the service which support the orders and medical necessity are essential. Documentation which supports or shows the thought process or related items to provide additional context to the reason the service was provided over another may assist in providing necessary additional support. Because employees of the payers providers may be working with to appeal the denial cannot or will not be able to change the payment

policy, it is important the provider approach the appeal proving the patient was different and supported the need for the services provided. Rather than expending time and energy to change the policy, focus instead on the current patient and what can be done for them to secure payment.

If an ordered service for a primary Medicare beneficiary is not considered medically necessary and will not be covered, an Advanced Beneficiary Notice (ABN) may be utilized. ABNs are not permitted with Medicare Advantage beneficiaries or commercial payers. The ABN notification lets the patient know of the possible non-coverage for services ordered by the physician. If a patient chooses to receive the services not covered by Medicare and signs the ABN, they are now personally responsible for the payment of services, not Medicare. An ABN cannot be utilized for services which are denied due to the quantity billed, such as the Medically Unlikely Edits (MUEs), or some published regulatory reason for which the physician does not follow. The ABN form and instructions can be located on the CMS website, http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html.

Denial of services for Medicare beneficiaries are frequently based on a MAC's interpretation of specific Local Coverage Determinations (LCDs). These interpretations may be significantly flawed based on narrow interpretation of the documents and should be reviewed carefully for potential differences in interpretation. For radiation oncology treatment administration for modalities such as IMRT and SRS/SBRT, LCDs will typically have two sections of medical indications: one will list specific ICD-10-CM codes that are appropriate for the modality, but a second section will list clinical indications that may specifically over-ride the ICD-10-CM list:

Example: LCDs for IMRT will typically list straightforward cancers of the facial and head/neck skin as being exclusions for IMRT, but when these lesions are advanced, i.e., with involvement of lymph nodes, deep muscle, parotid gland, etc., they would be included among IMRT indications as head/neck cancers.

The Take Home Message

It is critical for physicians and staff in hospitals and freestanding centers to be aware that denials for services billed frequently occur and it is important to understand the precise nature of those denials to ensure prompt and timely response. As payers continue to question and deny services, the lack of response in scenarios where the services are clearly supported sets a precedent that the service may not have been medically necessary and impact the entire specialty of radiation oncology. In addition, if documentation and/or billing processes are inefficient, or creating issues with services provided, an internal review may identify where changes can be made to improve those processes and result in fewer payer denials.