Identifying and Appealing Health Insurance Claim Payment Issues

Despite an industry shift placing an increased amount of financial responsibility on patients, physicians generally collect the majority of their revenue from health insurers. To maximize revenue and maintain financial viability, physician practices need to ensure that health insurers are properly adjudicating their claims and be prepared to address/appeal any improper health insurer payment adjustments. In order to properly ensure claim payment, the AMA suggests physicians and practice staff utilize the following steps:

I. Identify claims payment issues

To ensure correct payments from health plans, it is important for your practice to implement and maintain a consistent claim review process. Practices should assign a staff member to routinely review all submitted claims and their payment status. For all claims that have been adjudicated but not paid or paid an amount less than that which was billed, practices should review the remittance information (i.e., explanation of payment) to determine the health insurance rationale for partial payment or denial of the claim. The AMA Electronic Remittance Advice Toolkit can help practices understand the information contained in remittance information. Using relevant resources, including the most recent Current Procedural Terminology (CPT) book and the Healthcare Common Procedure Coding System (HCPCS), staff should review and validate health plan payment adjustment rationale. Additionally, claims still pending health plan adjudication should be reviewed against any prompt-pay laws or contractual terms.

II. Take action on improperly adjudicated/paid claims

Once your practice has determined that a claim was improperly reduced or denied, or processing has been significantly delayed, it's time to take action. This will often involve filing an appeal with the health plan.

In order to successfully appeal a claim, your practice should gather information that supports your position on the service in question. Persuasive sources that should be referenced include:

- Contractual information with the health insurer
- CPT guidelines
- HCPCS/Centers for Medicare and Medicaid Services (CMS) guidelines
- Laws and regulations
    - Physicians can look up state laws and regulations to copy and paste into their appeal letters by using the AMA's National Managed Care Contract Database
- Prior adjudication from the same insurer in which your claim was processed properly
- Screenshots or transmission information establishing specific time of claim submission (for claims denied for failure to timely file)
- Diagnostic coding guidelines (ICD-9/ICD-10)

Disclaimer: This document does not provide legal advice. Consultation with legal counsel may be appropriate to help identify and pursue claims that should be appealed.

The following chart walks through some of the more common payment issues facing physicians:

Common Physician Payment Issues		
Issue Type	**Specific Issue**	**Action/Resolution**
Bundling	When adjudicating claims, health plans often bundle procedures and services performed on the same day into a single, reduced payment. However, in certain situations, such as when CPT modifiers 25 and 59 are applicable, multiple services performed on the same day are separate, distinct and each deserving of payment.	Practices should review the health insurer's medical policies to ensure recognition/consistency with CPT codes and guidelines. If the policies recognize and follow CPT codes and guidelines, practices should submit an appeal letter citing a lack of recognition of a particular CPT modifier applicable to the improperly bundled claims.
Underpayment / Downcoding	Downcoding occurs when health insurers reduce the level of service on a claim to a lower-complexity (and reimbursement level) CPT code.	Practices should review their medical record documentation to ensure that they have met all components of the coded service based on CPT codes/guidelines and should submit an appeals letter with documentation supporting a higher service level for any improperly reduced claims.
Contract Issue	Health insurers may sometimes apply Preferred Provider Organization (PPO) discounts to a provider claim when either the PPO discount reported is not appropriate for the claim or when the physician does not have a contract with the PPO.	Practices should review the electronic remittance advice (ERA)/explanation of payment on which "PPO Discount" is the justification for the reduction in payment and determine whether a valid PPO contract exists and applies to the claim. If the discount is invalid, practices should notify the insurer that it will not honor the improper PPO discount. Practices should also notify the patient of the issue, as the patient's out-of-pocket expenses may have been incorrectly calculated by the plan.
Medical Necessity	Health insurers may deny a claim because they deem the service as not medically necessary based on the plan's definition of "medical necessity."	Ideally, a physician's office will know the health insurer's medical necessity requirements, which can be obtained by contacting the insurer's benefits department, in advance of patient treatment. In order to challenge medical necessity denials that have been received, practices can submit an appeals letter to the health plan specifying the justification for the procedure and supporting documentation. Additionally, practices should consider referring the claim to the independent/external review process, as established under Section 2719 of the Affordable Care Act (ACA).
Prompt Pay	Health insurers may fail to adjudicate and pay a claim within the statutory limit of the state in which the service was provided.	Providers should obtain and reference any prompt-pay regulations in their state using the AMA's National Managed Care Contract. If a health plan fails to adhere to the regulation timeline, practices should send a letter to the plan seeking immediate payment, and any additional penalty or interest payments to which they may be entitled. Practices can also consider contacting their state's insurance commissioner, especially when the same plan has failed to promptly pay on multiple separate claims.

Upon gathering supporting documentation, practices should develop and submit an appeal letter. The letter should clearly establish the specific payment adjustment made, indicate why your practice believes the health plan incorrectly limited or denied the payment and specifically reference and include the supporting documentation. In order to help physicians develop these letters, the AMA offers sample appeal letters for AMA members to use as a template.

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III. Follow-up with health plans on pending appeals

After submitting an appeal, it is important for your practice to monitor your appeals and follow-up with health plans. It is best to maintain a log for all outstanding appeals and to continually review outstanding claims in order to ensure correct and prompt payment.

IV. Consider Additional Action on Unsuccessful Appeals

If you believe your claim was improperly reduced or denied and your subsequent appeal is unsuccessful, your practice may wish to pursue additional recourse available through external decision makers. Accordingly, your practice may consider the following options:

- **External Medical Necessity Review:** If your claim was reduced or denied due to plan determinations regarding medical judgment, your practice has the right to request an external review of your claim. Section 2719 of the ACA requires health plans to provide external review processes that conform to the National Association of Insurance Commissioners Uniform External Model Review Act. This will enable your claim to be reviewed by a clinically informed, nonbiased party to determine the appropriate payment. Importantly, this regulation subjects self-insured plans, which had previously been exempt from many state-based external review processes, to external review requirements.

- **Contractual Arbitration / Small Claims Court:** When faced with a disagreement that has not been resolved through the health plan internal system of review, network physicians can turn to the provisions of their contract. Health plan contracts often contain binding arbitration provisions that can be exercised in order to resolve disputes between the health plan and the network provider. This arbitration will turn the issue over to a third party for an unbiased determination on the issue.

  If binding arbitration is not required or a provider is not in a contractual relationship with the health plan, the provider has the right to pursue resolution of the issue through small claims court or other state/federal legal venues. In order to explore these options, consultation with legal counsel may be appropriate.

With claims payments accounting for the majority of revenue for many physician practices, practices should understand how to verify the accuracy of health plan payments and appeal improper payment decisions, when necessary. Taking the above steps to identify and dispute inappropriate claim reductions or denials can protect your practice's bottom line.

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