UPTAKE

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SNMMI-TS is dedicated to the advancement of molecular and nuclear medicine technologists by providing education, advocating for the profession, and supporting research to achieve clinical excellence and optimal patient outcomes.

The Medicare Claim Has Been Denied—What Do I Do Now?

By Denise A. Merlino, CPC, CNMT, MBA, FSNMMI-TS

Does your facility or office have a standardized claims resolution process in place? Do you provide formal training to your billing personnel on how to organize and prioritize denials? At what point in the process does the billing staff decide the claim cannot be collected and must be written off? If you do not have answers to these questions, you are not alone. There is wide variability and little standardization for claims review and follow-up. Don't let these unanswered questions cost your practice money.

Here are some **MUST-DO TIPS** for those responsible for claims denials:

1. The "First Task" of the day should be to handle **correspondence** for those claims with **minor clerical issues**, such as missing information, dates and misspelled names, to list a few. These are the administrative claims denials we call the "low-hanging fruit," which can often be handled quickly to get the claim paid and off your to-do list.
2. **Identify "Zero Pay" transitions daily**. These are the claims denials that are not covered services or are eligibility issues. Either re-file to the insurance company, bill the patient or, if necessary, write the claim off. If the claim is not entered as zero pay, that claim will not move to the next step in the process. In the case of writing the claim off, valuable time can be wasted on claims that are clearly known to be non-covered services.
3. **Utilize advanced billing software or prepare and maintain a spreadsheet** listing the denials, including the date of service, the claim tracking number, the Medicare reason for the denial and columns for tracking the status, including date, time and name of person you spoke to. Make sure the software or the spreadsheet provides sorting capabilities to prioritize your workload. Sorting by date of service, account balance, automatic refiling and denials can contribute significantly to

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Message from the President

By Scott Holbrook, BS, CNMT, FSNMMI-TS

SCOTT HOLBROOK, BS, CNMT, FSNMMI-TS

Over the past six months, the SNMMI-TS made great strides to begin working toward an expanded educational future. A Graduate-Level Curriculum Subcommittee was created, chaired by David Gilmore, MS, CNMT, RT(N), FSNMMI-TS, and was charged with exploring options for advanced-level education and programs for nuclear medicine and molecular imaging technologists. The subcommittee held a stakeholders meeting on December 15, 2013, to get input from experts in the field. In addition, a Technologist Advisory Board (TAB) was created, chaired by Elizabeth Hackett, RT(N)(CT), PET, FSNMMI-TS, and charged with identifying core areas within the field that are in need of additional resources for technologists. The TAB held its first meeting on January 11, 2014.

The SNMMI-TS spent many years researching and creating a position for a middle-level provider of nuclear medicine services—the nuclear medicine advanced associate (NMAA)—and developing a curriculum for that position. Now, several years later, the SNMMI-TS understands the importance of creating additional master's-level programs that will provide advanced-level educational opportunities to our members. During the Graduate-Level Curriculum Subcommittee meeting this past December, a statement was developed that was presented during the SNMMI Mid-Winter Meeting for approval (See related article on page 6). The statement outlines the Technologist Section's position on graduate-level education and our stake in future programs. In addition, the subcommittee also agreed to focus on the following areas over the next several months:

- Survey NMAA graduates concerning practice issues, etc.

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your site's bottom line.

4. Take **denied claims through all levels of appeals (see table below)** if you believe the claims are being denied improperly. For instance, the June 11, 2013, FDG PET national coverage policy changed, and at the time of writing, the Centers for Medicare and Medicaid Service (CMS) has not yet published full transmittal instructions for these newly covered services for the Medicare contractors on a local level. This has resulted in some newly covered claims being denied for payment. It is recommended that sites prepare a spreadsheet of these denied claims and share them with the local Medicare contractor and policy staff. The contractor will also have added work to resolve these denied claims; therefore, starting the dialog is important as well as following through all levels of the appeal process.
5. **Monitor high-volume local payers' websites, and keep a book of all medical policy coverages for the procedures that you perform**. Assign a designated person and backup person to check websites weekly for updates, deletions or additions.
6. **Attend local Medicare training and open Medicare carrier advisory committee meetings**. This is a great opportunity to ask your questions and to meet key local contractor staff to develop good relationships with these individuals who might be of assistance with claims processing as well as answer medical policy coverage questions.
7. **Communicate with the medical director**. If you have identified a need to provide payers with clinical or cost data for any service, share these data with the medical director via letter and ask for a follow-up phone call or face-to-face meeting. Be persistent! Medical directors are busy; be respectful of their time and they will respond accordingly.

Five Levels of Appeal

- **Level One:**
  - **Type:** Redetermination
  - **Time Limit for Filing Appeal:** 120 days from date of receipt of the notice initial determination
  - **Amount in Controversy (monetary threshold to be met):** No minimum (none)
- **Level Two:**
  - **Type:** Reconsideration (Qualified Independent Contractor [QIC])
  - **Time Limit for Filing Appeal:** 180 days from date of receipt of the redetermination
  - **Amount in Controversy:** No minimum (none)
- **Level Three:**
  - **Type:** Administrative Law Judge (ALJ)
  - **Time Limit for Filing Appeal:** 60 days from the date of receipt of the reconsideration
  - **Amount in Controversy:** For requests filed on or after January 1, 2013, at least $140 must remain in controversy
- **Level Four:**
  - **Type:** Medicare Appeals Council (MAC)
  - **Time Limit for Filing Appeal:** 60 days from the date of receipt of the ALJ hearing decision
  - **Amount in Controversy:** No minimum (none)
- **Level Five:**
  - **Type:** Federal Court Review
  - **Time Limit for Filing Appeal:** 60 days from date of receipt of MAC decision or declination of review by MAC
  - **Amount in Controversy:** For requests filed on or after January 1, 2013, at least $1,400 must remain in controversy

Tips to Consider for Claims Denials:

- Don't simply re-file bad information: "Garbage in, garbage out."
- Timeliness and organization are key. Don't simply re-date for further action, and don't create a pile that is not worked on at least weekly.
- Select a point person and backup person to promptly track, appeal and follow up on denials. Designating a primary person and an alternate person as responsible for discovering denials ensures timely collection of data.
- Evaluate reasons for denials. The reasons can be varied, but each should be evaluated and prioritized to determine if there are any matters to be addressed with staff or with certain payers.
- Know the entire appeal process. Attend a Medicare Appeal educational program.

Understand the Medicare Appeal Process

Appeals: Your right to appeal a Medicare claim determination is important. This section is available to assist you in reviewing your rights, the basic requirements, the suggested forms and tips on filing an appeal.

Filing an Appeal: See the table which lists the various levels of appeals available, including time limitations for filing and, where applicable, the minimum amount in controversy requirements. Note: If a decision was not issued at a previous level, an appeal to a higher level will be dismissed back to the appropriate prior level for review.

First Level of Appeal—Redetermination

Providers, physicians or suppliers with appeal rights must submit a redetermination request in writing, indicating what they are appealing and why. There are two acceptable ways of doing this:

- Complete the CMS-20027 Medicare Redetermination Request Form. All applicable fields should be completed and all necessary attachments should be attached.
- Submit a written request. The written request must contain the following information:
  - Beneficiary name
  - Medicare health insurance claim number (HICN)
  - Specific service(s) and/or item(s) for which the redetermination is being requested
  - Specific date(s) of the service
  - Name and signature of the party or the representative of the party

Note: The signature must be on the request for redetermination. Signatures contained on medical records are not acceptable as valid signatures for redetermination requests.

Requests for redetermination of nonassigned claims must include either a completed CMS-1696 Appointment of Representative form or a written statement from the beneficiary giving authorization for you to submit the redetermination request on

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his/her behalf.

Check for Online Inquiry Options

Payers often allow providers to initiate claim reopening and submit redeterminination requests securely online. Look for access to a wide array of Medicare tools and information, such as:

- Initiate reopening and/or redetermination requests
- Beneficiary eligibility and entitlement information
- Query for your claims status
- View your provider/supplier demographic information
- Query for your financial data
- Obtain the status of all redetermination/reopening requests

Check for Telephone Reopening Options

Providers may request a reopening of the original claim processing decision by contacting telephone reopening units (TRUs). Phone numbers and hours of availability are usually posted on payers' websites. TRU representatives will typically assist you with up to three claims each time you call. The TRU can be used to revise the initial determination or redetermination of a specific service or claim for minor clerical errors. If you have a general question or need to talk to someone about an issue that cannot be reopened, please contact the provider contact center (PCC) which is another name for general customer service. TRU representatives can typically reopen claims to correct minor, uncomplicated, provider or carrier clerical errors or omissions. However, TRU representatives cannot typically add items or services that were not previously billed.

Note: If a telephone reopening is requested by the provider, it is typically at the contractor's discretion as to whether that reopening is granted.

What Information Is Needed When I Call?

Please be prepared to provide the following information when you call:

- Beneficiary's name
- Medicare Health Insurance Claim Number (HICN)
- Your full name (first and last name)
- Your phone number
- Provider's name and PTAN
- Item or service in question
- Date(s) of service in question
- Reason for request

What Issues Cannot Be Handled?

- Redetermination requests (these must be submitted in written form)
- Medicare Secondary Payer (MSP) pricing issues
- Disputes involving a refund request that was previously requested
- Adding modifiers AQ, AR, QU, QB, 22, 23, 51, 52, 53, 62, 66, GA, GY, and GZ
- Year of service changes
- New patient visit denials
- Adding a line of service that was not on the original claim
- Any claim that requires additional documentation
- Dispute of an entitlement denial
- Unprocessable/returned claims (this situation is identified as message MA-130 located on your provider remittance statement)
- Status of an appeal (redetermination or reconsideration)
- Pending claim status or check status

Note: Any of the above issues must be submitted in writing as a request for review. Please submit all written redetermination requests to the appropriate appeals mailing address—usually found on the payers' websites.

Examples of Medicare Appeals Forms

- Appointment of Representative Form (CMS-1696)
- NGS—Medicare Part B Appeals Request Form
- Medicare Reconsideration Request Form (CMS-20033)
- Request for Medicare Hearing by an Administrative Law Judge (CMS-20034)
- Transfer of Appeal Rights ■

VOICE Box

Elizabeth C. Hackett, RT(N)(CT)(ARRT), PET, FSNMMI-TS, Chair SNMMI-TS Continuing Education Committee, and Caroline A. Krystek, SNMMI Senior Manager of Accreditation

Roadshows!!

It's that time of year again when the applications roll in for the roadshows offered by the SNMMI-TS! This year we have a great theme "Broadening Your Horizons." The presentations focus on ways to help technologists improve their careers.

Two of the talks are on alternate career pathways, such as transitioning from clinical technologist to working in clinical trials or to doing research on nuclear cardiology. Another presentation covers the types of postgraduate degrees that are available to nuclear medicine technologists, and how they can help in career development and lead to different avenues. The final talk is a great one on how to build your curriculum vitae and present yourself at an interview. This is a great chance to brush up your CV writing skills and interview techniques, and it is applicable to technologists at all levels.

Like last year's presentations, all of the talks will be given by leaders in their specific fields of nuclear medicine. The price of the roadshows is still the same as well—$25 for four credits. It is a great deal for earning CE credits and meeting local leadership and speakers from the national level. Please come to a roadshow in your area! ■