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REVENUE CYCLE RESOURCES

Billing Hacks: Tips and Tricks for Success

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Disclaimer

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Agenda

Appeals Tips & Tricks

- Aetna
- BCBS
- Medicare
- United Healthcare
- Ambetter/NE Total Care
- Molina/Humana

Overpayments

- Optum tool for credit balances
- Availity
- NTC Negative Balance Report

Appeal Definitions & Purposes

Reconsideration:

- Definition: A request to review and change a decision, usually based on new evidence or a mistake in the original review.
- Process: Often submitted to the same authority or agency that made the original decision.
- Focus: Centers on errors or overlooked information in the initial decision.
- Time Frame: Typically, shorter deadlines for submitting reconsideration requests.
- Outcome: The decision-maker may uphold, revise, or overturn the initial decision.

Appeal:

- Definition: A formal request to have a higher authority review the decision made by a lower authority.
- Process: The appeal is sent to a higher body or court for a fresh review of the decision.
- Focus: Can challenge both legal grounds and factual findings in the original decision.
- Time Frame: Usually has a longer time frame for filing compared to reconsideration.
- Outcome: The appellate authority can affirm, reverse, or modify the decision, or remand it for further review.

AI Considerations

Suggested AI Systems:

ChatGPT- https://chatgpt.com/

Jasper AI (formerly Jarvis)

Copy.ai

PandaDoc

Things to consider when using AI:

1. Data Quality: Is data outdated, incomplete, or biased? AI can be inaccurate.
2. Ask your AI to give the resources it used. It could be pulling information from other states/countries, etc…
3. Medical knowledge: If appeals require extensive coding or clinical guidelines. Dx codes up-to-date?
4. Check for errors! Make the appeals your own by changing language.
4. Protect PHI – Don't Use Patients Names or anything that is individually identifiable.

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Aetna

Aetna Appeals

Appeal within 180 days of receiving the decision! 60 days to appeal a reconsideration determination.

Denials Process

- **Peer-to-peer review-** prior to appeal to present additional information.
- **Reconsiderations** – for reimbursements, coding decisions, or claims that require reprocessing. For UR, medical necessity or experimental coverage skip the reconsideration and go straight to appeal.
- **Appeals** – Requests to change a reconsideration or an initial utilization review decision or initial claim decision based on medical necessity or experimental/investigational coverage criteria.
- What is a dispute? The process for determining whether it goes to a reconsideration, or an appeal is determined by Aetna.

Aetna Appeals
Continued

- Documentation that may be required:
- A completed copy of the appropriate form
- The reasons why you disagree with our decision
- A copy of the denial letter or Explanation of Benefits letter
- The original claim
- Documents that support your position (for example, medical records and office notes)
- Dispute FAQ

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BCBS of Nebraska

BCBS of Nebraska

- **Reconsiderations**
  - Is a request to review a claim with additional information not previously provided
    - Manufactures Invoice for Pricing
    - Billing or Coding Dispute with Medical Record
    - Medical Records
    - Workers Compensation
    - Coordination of Benefits
      - No **adjustments or revisions** to timely filed claims will be accepted more than 12 months from the last date of adjudication by Blue Cross and Blue Shield of Nebraska (BCBSNE) or the specific language specified in the provider contract.

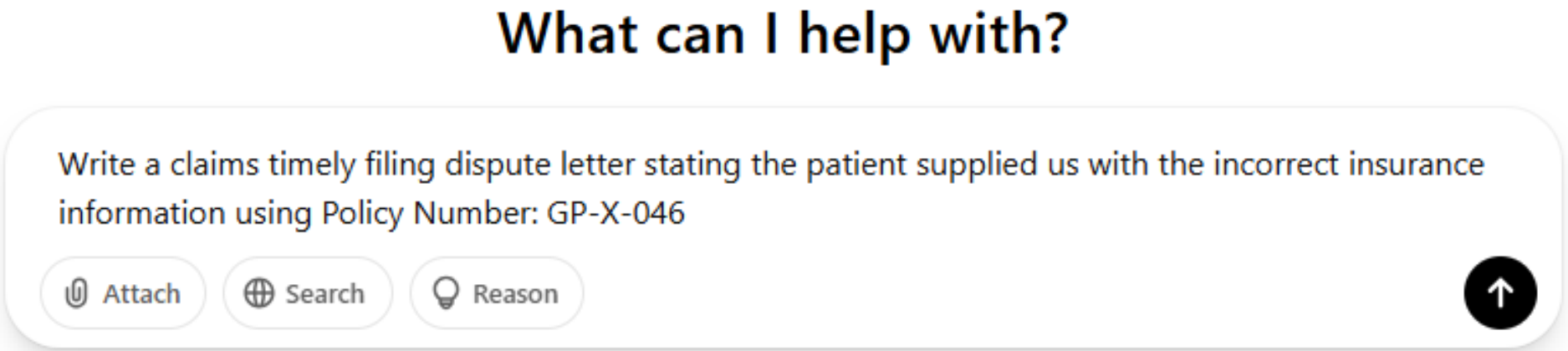
BCBS of Nebraska

- **Appeals**
  - Is a request to view a denied claim or service.
    - Denied for Medical Necessity
    - Denied for Experimental or Investigative
    - Denied for Pre Authorization
    - Contract Exclusion or Duplicate Service Date
    - High Dollar Prepayment Review
    - Cosmetic
    - Fertility
    - Routine vs. Medical
    - Assistant Surgeon
      - Allow up to 60 calendar days

BCBS of Nebraska

- **Timely Filing Disputes**
  - Valid Disputes
    - Member ID card was not obtained
    - Total OB card
    - BCBSE processing
      - Allow 30 days for Processing
  - Not Valid Disputes
    - Mistyped Member ID Number
    - Rejected or Returned claims not refiled in time
    - Provider system issues or human error

BCBS on Nebraska-
Timely Filing Dispute using ChatGPT



[Your Information]

Date: [Insert Date]

Blue Cross Blue Shield of Nebraska
Claims Department
[BCBS Nebraska Address]
[City, State, Zip Code]

Subject: Timely Filing Dispute - Incorrect Insurance Information
Policy Number: GP-X-046
Claim Number(s): [Insert Claim Number(s)]
Patient Name: [Patient's Full Name]
Date of Service: [Date(s) of Service]

Dear Claims Department,

I am writing to dispute the denial of claim(s) associated with the patient named above, regarding the above-referenced policy number (GP-X-046). The claim was denied due to "timely filing" issues, but after reviewing the situation, we believe this denial can be overturned.

At the time of the patient's visit, the patient provided incorrect insurance information. Unfortunately, this led to a delay in submitting the claim to the correct insurer. Upon realizing the error, we have taken the necessary steps to ensure the claim is submitted to the correct plan. The delay in submission was directly caused by the incorrect information provided by the patient at the time of service.

We understand the importance of timely filing, and we have made all reasonable efforts to resolve this issue. We respectfully request that you reconsider the denial based on the circumstances outlined. We have attached supporting documentation, including:

1. A copy of the patient's insurance card is provided at the time of service.
2. A corrected claim form with the accurate insurance information.
3. A statement from the patient confirming the error in providing their insurance information at the time of the visit.

Given these factors, we are requesting that you review this case and reprocess the claim as a timely submission, in accordance with your policies. If additional documentation or information is required, please do not hesitate to contact us directly.

Thank you for your prompt attention to this matter. We look forward to your favorable resolution.

Sincerely,

Also remember to include:

- Enclosures:
  - Patient's insurance card (as provided at time of service)
  - Corrected claim form
  - Patient's statement confirming the error

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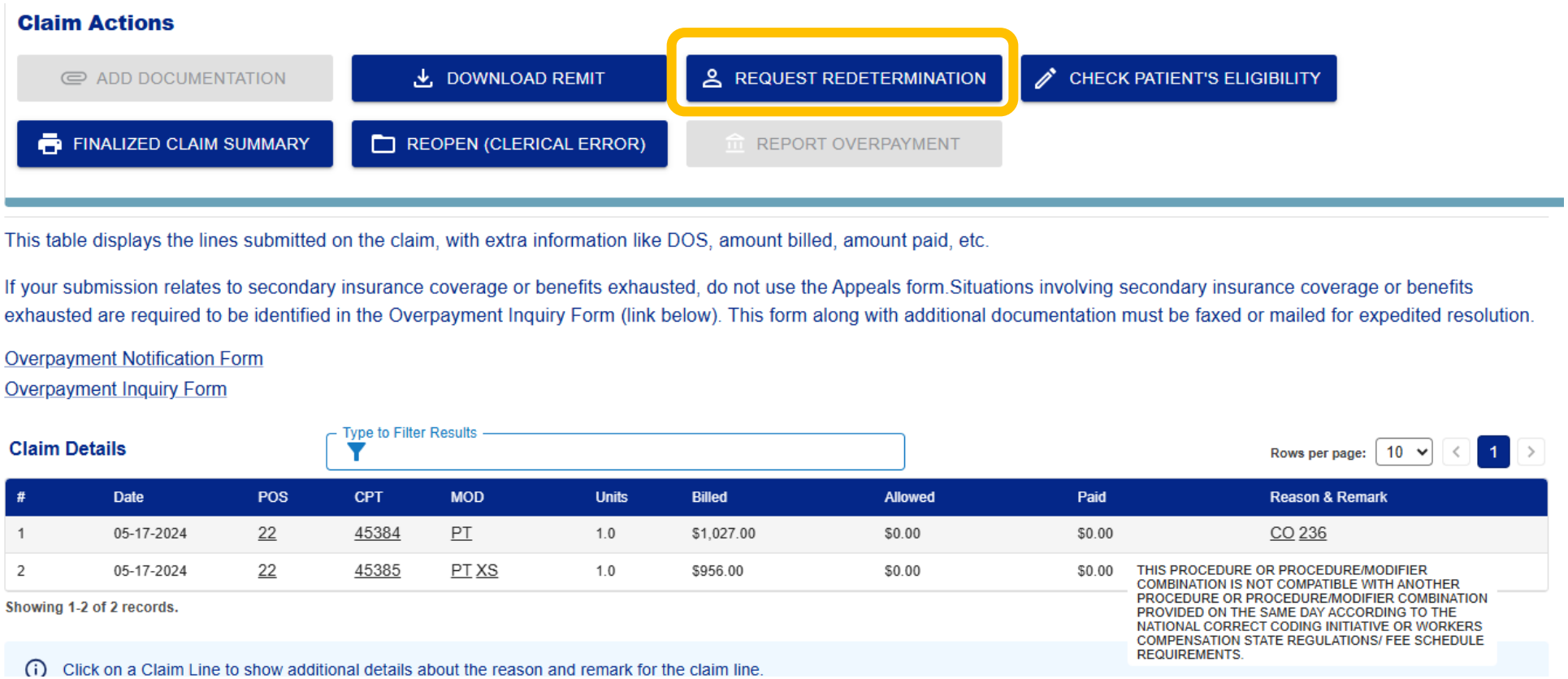
Medicare

Medicare Appeals

Level	Time Limit for Filing Request	Monetary Threshold to be Met
Redetermination	120 days from the date of receipt of the notice of initial determination	None
Reconsideration	180 days from the date of receipt of the redetermination. NOTE: If a party requests QIC review of a contractor's dismissal of a request for redetermination, the time limit for filing a request for reconsideration is 60 days from the date of receipt of the contractor's dismissal notice.	None
Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the reconsideration	Current AIC requirements can be found on the CMS website.
Departmental Appeals Board (DAB) Review/Appeals Council	60 days from the date of receipt of the ALJ hearing decision	None
Federal Court Review	60 days from date of receipt of the Appeals Council decision	Current AIC requirements can be found on the CMS website.

Use the WPS portal to file both Redeterminations & Reconsiderations!

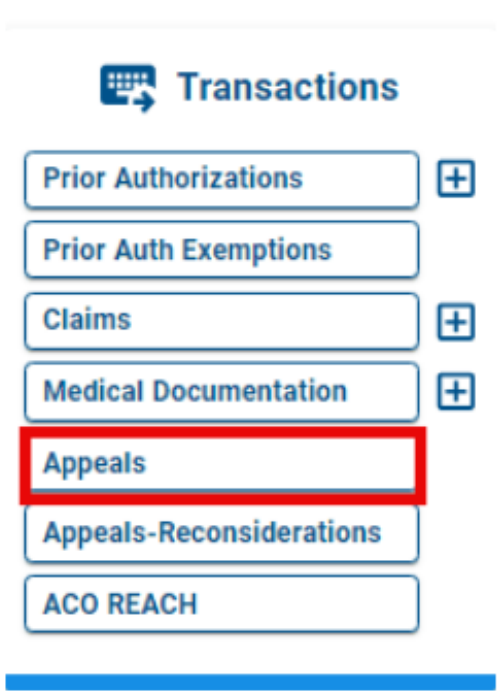
Medicare – Request Redetermination



Search for the claim & select “Request Redetermination.”

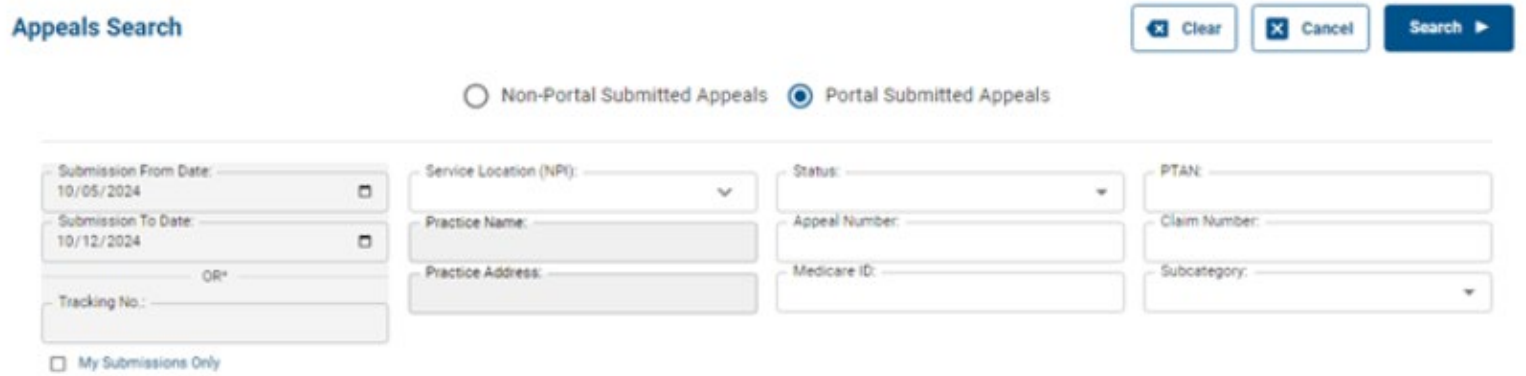
Medicare
Request Reconsideration

Step 1: Click on the Appeals button under the Transactions card.



Step 2: Using the below search criteria find your Level 1 Appeal.

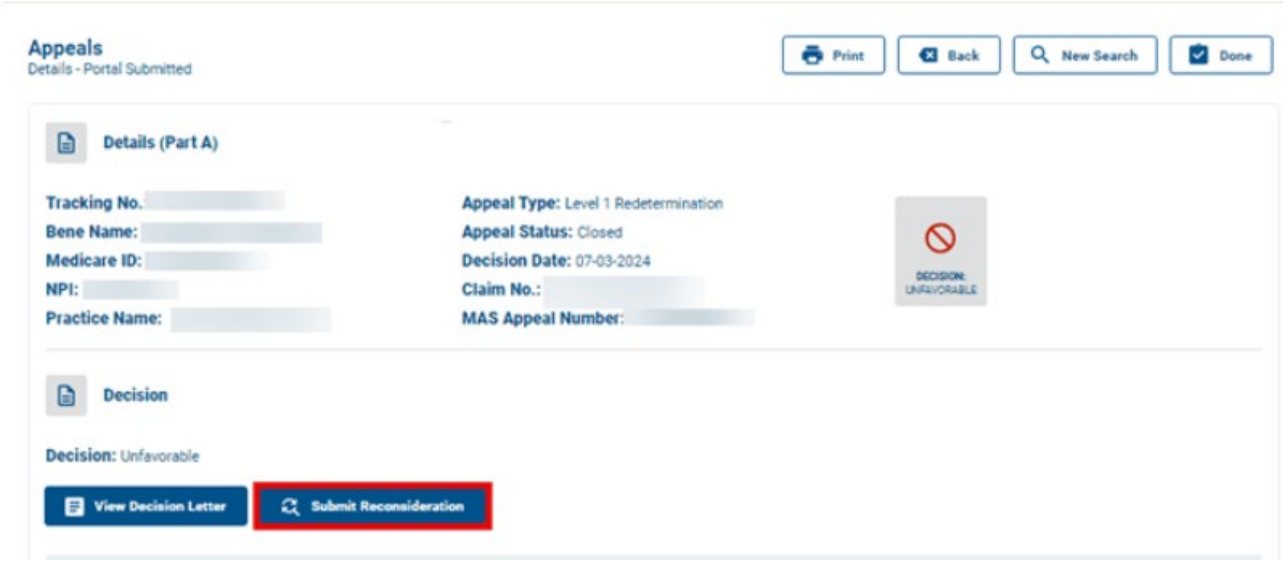
Portal Submitted Appeals:



Medicare
Request Reconsideration Continued

Step 3: Click on the Eye icon to open the Level 1 Appeal.

Step 4: Click on the Submit Reconsideration button.



From here, select claim lines or the whole claim to appeal.

There will be an opportunity to upload one document 100MBs or less.

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What can I help with?

Please write a letter appealing denial from Medicare stating CPT codes 45384 and 45385 and modifier XS is not compatible

Attach Search Reason

Sample AI Appeal

Case Details:

- **Patient Name:** [Patient's Full Name]
- **Medicare ID:** [Medicare Beneficiary Number]
- **Claim Number:** [Claim Number]
- **Date of Service:** [Date of Service]
- **CPT Codes:** 45384 (Colonoscopy, flexible, diagnostic), 45385 (Colonoscopy, flexible, with biopsy)
- **Modifier:** XS (Separate structure)

Appeal Explanation:

CPT codes 45384 and 45385 were appropriately used for the services provided, as the patient required both a diagnostic colonoscopy (CPT 45384) and a subsequent biopsy (CPT 45385). Additionally, the modifier XS was applied correctly to indicate that these procedures were performed on separate structures, which is consistent with Medicare's guidelines for reporting distinct procedural services.

In reviewing the denial reason, I believe there may have been a misunderstanding regarding the compatibility of these codes when billed together with modifier XS. According to the National Correct Coding Initiative (NCCI) and CMS guidelines, when performing distinct procedures on different structures, modifier XS should be used to show that the procedures were not bundled and were, in fact, separate and medically necessary.

Both CPT codes 45384 and 45385 are recognized by Medicare, and the use of modifier XS is appropriate and supports the accurate billing of the services rendered. I have attached the relevant clinical documentation, including the operative notes, which clearly demonstrate the need for both procedures and support the separate nature of the services provided.

Also remember to include:

- **Supporting Documentation:**
  - Operative Report
  - Detailed Medical Records
  - Payment Policy Guidelines related to modifier XS and CPT codes 45384 and 45385
  - Any other relevant documentation

Medicare Appeal WIN!!

Epoetin (Procrit)

Injection, epoetin alfa, (for non-ESRD use), 1000 units

- **J0885**
- **Appropriate Modifier Added**
- **MUE 60**

Provider ordered 80 units due to the patient continued low lab levels

Claim denied for MUE

Redetermination Filed

Please reconsider the three above marked charges: The document labeled “XXXXXXXX “ reflect lab values highlighted in the red block with values below expected levels. Due to this continued low level, the provider ordered 80,000 units of Epoetin alpha (Procrit) (see attached order) to address the patients monoclonal gammopathy due to multiple myeloma that has not achieved remission. Thank you

Documents Included

- Orders
- Lab results
- Oncology Notes
- **MARS (VERY IMPORTANT)**

MUE Tips for Success

- “Since MUEs are auto-deny edits, denials may be appealed. MACs adjudicating an appeal for a claim denial for a HCPCS code with an MAI of “1” or “3” may pay correctly coded correctly counted medically necessary UOS more than the MUE value.”

HCPCS/ CPT Code	Outpatient Hospital Services MUE Values	MUE Adjudication Indicator	MUE Rationale
J0885	60	3 Date of Service Edit: Clinical	Prescribing Information
J0887	360	3 Date of Service Edit: Clinical	Prescribing Information
J0888	360	3 Date of Service Edit: Clinical	Prescribing Information
J0890	0	3 Date of Service Edit: Clinical	Drug discontinued

- See more MM8853 (PDF) for more information.

Medicare Timely Filing Override

Reasons to file a timely filing override:

1. If the provider can show good cause for the delay in filing the claim. Typically, this would be an administrative error on Medicare's part, backdated Medicare entitlement, Member ID error in CWF.

- Example- claim denied for Part A benefits in 2021, patient had backdated Part B coverage at some point and secondary recouped payment.
- Patient responsibility of 20% of allowable could still be collected when a claim is denied for late filing. Patient is not responsible for the total billed amount.
- Cannot be done to overcome 3rd party payment errors or recoupments.

How to File a Waiver to Extend the Timely Filing Limit

Providers who believe they meet the qualifications for "good cause" must submit a hardcopy adjustment along with the following items to request a waiver of timely filing.

- An original UB-04 claim form, submitted as a hardcopy adjustment claim (xx7), plus any documentation needed to process the claim;
- A letter explaining why you filed the claim late;
- Documentation proving you met "good cause" for late filing (e.g., a copy of the beneficiary's retroactive Medicare entitlement letter from the Social Security Administration or Medicaid recoupment letter).

It is important that the request for a waiver of timely filing and documentation supporting the request accompany their claim. The Claims staff will review the request to determine whether good cause exists, as defined by CMS. We will notify providers of the outcome of their request via their remittance notice when we process the adjustment. Providers should mail their adjustment, waiver request, and supporting documentation to the attention of the Claims Manager at the appropriate state specific address below.

Since claims denied for timely filing do not have appeal rights, the WPS Government Health Administrators Appeals area cannot grant any waiver to the timely filing deadline after we process the claim. Therefore, **do not send your request to WPS Government Health Administrators using the Redetermination Request Form**.

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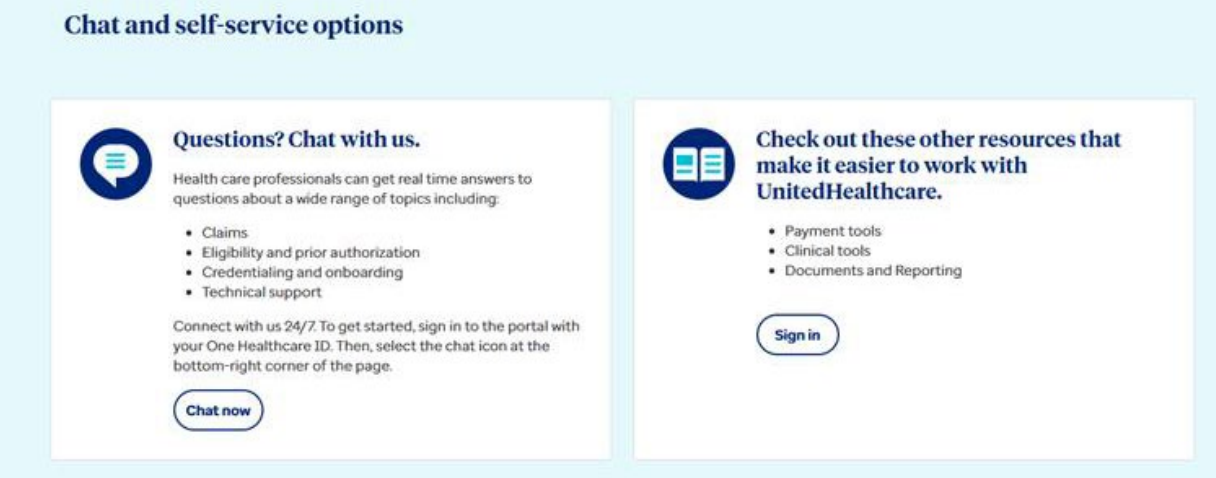
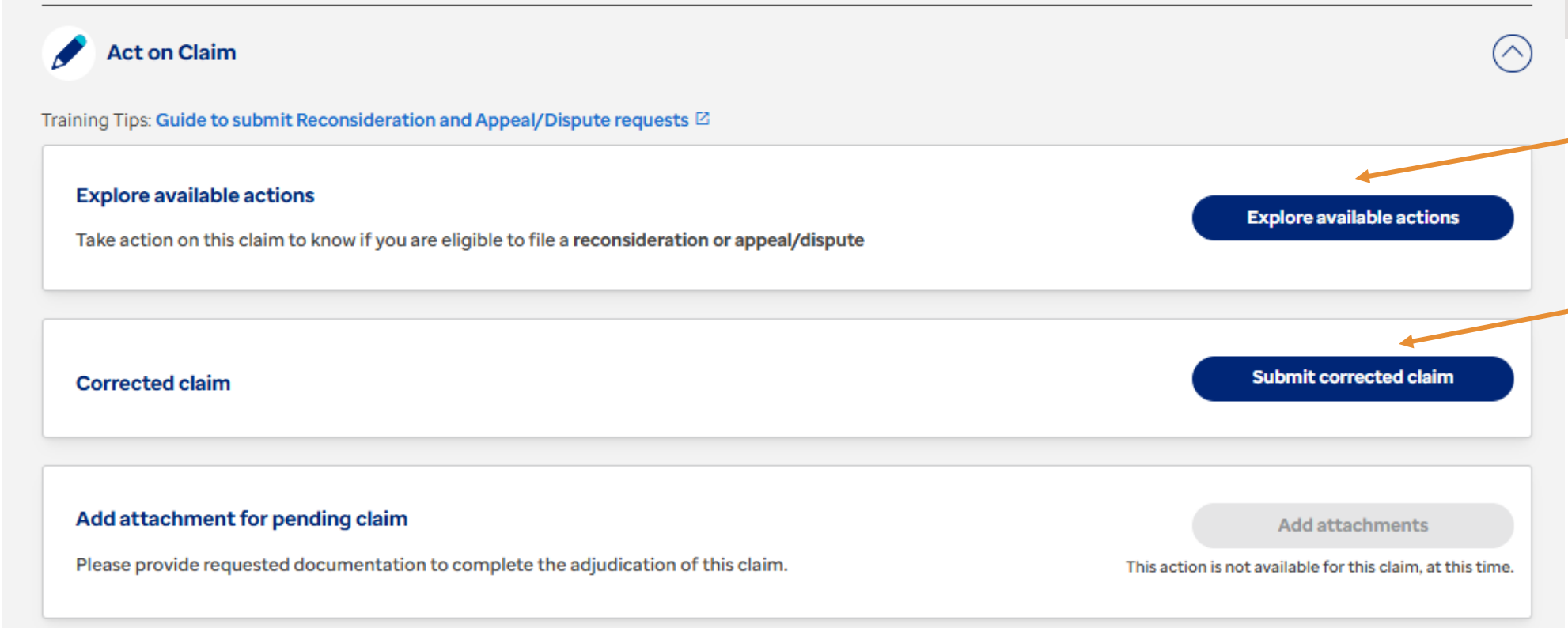
United Healthcare

UnitedHealthcare Provider Portal resources | UHCprovider.com



2025 UnitedHealthcare Care Provider Administrative Guide for Commercial, Exchange, and Medicare Advantage (Page 136)

As a reminder:
Step 1. Reconsideration
Step 2. Appeal



Reconsiderations and Appeals

Submit a corrected claim via portal – (Commercial Only)

UHC Actions on Claims

Reconsiderations

- **You should submit a reconsideration request if you believe a claim was paid incorrectly. This includes but is not limited to:**
- **Amount is different than what provider expected**
- **Claim was filed in a timely manner (provider must provide documentation of timely filing)**
- **Claim was denied for no authorization (provider must provide authorization number)**
- **Difference in coordination of benefits (COB) information**
  - Must file with 65 days of denial or reimbursement request

Appeals

- **You should submit an appeal when you wish to challenge a decision or request an exception.**
  - Must file with 65 days of denial or reimbursement request

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Ambetter & NE Total Care

Reconsiderations

- Denied for Global / Unbundled
- Denied for Timely
- Denied for Authorization
- Claim Paid at incorrect Amount
- Coordination of Benefits
- Co- In / Co-Pay / Deductible Applied incorrectly
- Emergency Dept Service
- Consent Form
- Denied Related to Itemized Bill
- Audit- Medical Records Requested
  - **Ambetter: Par 180 Calendar Days / Non – Par 90 Days from EOB**
  - **Nebraska Total Care- 90 Days from EOB or denial**

Appeals

- You should submit an appeal when you wish to challenge a decision or request an exception.
  - **Ambetter: Par 180 Calendar Days / Non – Par 90 Days from EOB**
  - **Nebraska Total Care- 60 Days from EOB or denial**

NE-AMB-Claim-Dispute-Form (002).pdf

Ambetter
Attn: Claims Disputes / Appeals
Po Box 10341
Van Nuys, CA 91410

HERITAGE HEALTH nebraska total care

DENIED

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Review denials via portal under claims search:

Filter Claims

Details

- ○ Billed Amount Greater Than
- ○ Billed Amount Less Than
- ○ All

Status

- ◉ Denied
- ○ Paid
- ○ Pending
- ○ Reconsideration In Progress
- ○ Reconsideration Completed
- ○ All

Type

- ○ Institutional
- ○ Professional
- ○ All

Claims: Recent

Search: Date Range : 02/15/2025 to 03/15/2025 Change dates

Filter | Search

CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED/PAID	CLAIM STATUS
[redacted]	Institutional	[redacted]	02/20/2025 - 02/20/2025	$551.00 / $0.00	Denied
[redacted]	Institutional	[redacted]	03/14/2025 - 03/14/2025	$538.00 / $0.00	Denied

All results displayed. Please adjust your Search or Filter criteria to see more.

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What can I help with?

Write a reconsideration for Ambetter of Nebraska regarding a global procedure payment reduction for CPT code 10040. Payment was reduced due to Payment Code 59 stating multiple procedure reduction guidelines when in fact this was the only procedure done.

Attach Search Reason

Sample AI Appeal

Dear Claims Department,

I am writing to formally request a reconsideration of the payment reduction for CPT code 10040, as related to the claim number [insert claim number]. The payment was reduced based on the use of Payment Code 59, which cites multiple procedure reduction guidelines. However, I believe that this reduction was applied in error, as CPT code 10040 represents a single procedure performed during the patient's visit, with no additional procedures performed that would warrant such a reduction.

The specific situation involves [briefly describe the procedure or treatment, including any relevant patient history, if necessary]. No other procedures were performed during this visit that would qualify for the multiple procedure reduction, as stated under the guidelines tied to Payment Code 59. As such, we respectfully request that the full payment for CPT code 10040 be reinstated.

We understand that the Payment Code 59 is generally applied when multiple procedures are performed during the same session; however, in this case, only the procedure associated with CPT code 10040 was completed, making this reduction inappropriate.

Please review the details of this case and, upon your evaluation, adjust the payment accordingly. If you require additional documentation or clarification to assist with this process, do not hesitate to contact me directly at [your phone number] or via email at [your email address].

Thank you for your prompt attention to this matter. We look forward to your reconsideration and the resolution of this claim.

Also remember to include:

- **Any supporting documentation**
- **All medical records**

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Molina / Humana

Molina Appeals

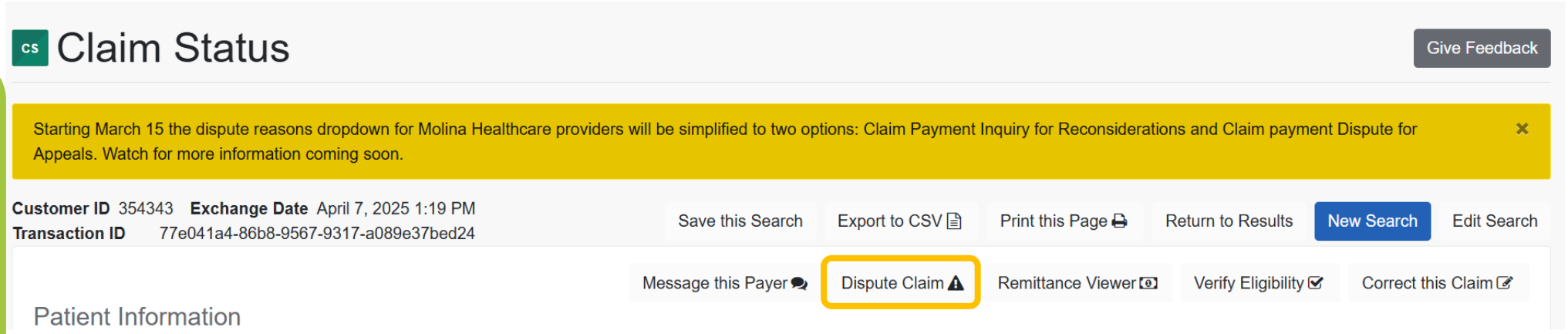
Note: claims denied for missing or additional documentation requirements such as consent forms, invoices, explanation of benefits from other carriers, or itemized bills are not considered claim appeals.

To process your claim, these documents, along with a claim, must be received by the claims department within timely filing requirements. Do not include a provider appeal form with a claim submission. Please mail claims denied for missing or additional documentation to: • Molina Healthcare of Nebraska PO Box 93218 Long Beach, CA 90809-9994

https://www.molinahealthcare.com/members/ne/en-us/mem/Medicaid/quality/cna/appeal.aspx

A dispute is a reconsideration

File here, but documentation cannot be uploaded.



Molina Appeals Continued

Claim Inquiries / Reconsiderations

- **If you have a question on how a claim processed, you can submit a claim inquiry through Availity Essentials or call Provider Services (844) 782-2678.**
- **If you disagree on how a claim is processed, you will need to do a reconsideration or an appeal.**
- **When submitting a reconsideration in Availity you cannot send in an attachment. If you feel an attachment is needed to process this claim, you will need to send in an appeal. If you send in an attachment, you will receive a notice that says we cannot process your request as an attachment was received and it will be closed with no review.**
- **Requests received via Availity are processed within 30 days of the request and you can check the status on your dashboard. When a final determination is made, and you are not satisfied with the outcome or have questions you can contact Provider Services as noted on the response. If you still are not satisfied with the outcome, then you will want to put the information on the claim escalation form and include the details / outcome and what you are expecting the outcome to be.**

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Overpayments

Overpayments

Before requesting a refund, make all possible attempts to get the insurance to take back their own money. Here are some suggested steps to try before refunding:

1. Pull all EOBs and make sure all payments/adjustments are posted correctly.
2. Verify there was not an FB (forwarding balance) or unposted WO (withholding). These may also be called PLB (Provider Level Balance) Adjustments.
3. Can the charge or claim be voided on the payer's portal?
4. Can a corrected claim be billed, or a voided claim billed to create a payer-initiated recoupment?
5. Call the payer to request that the money be recouped. If the representative says it cannot be recouped, please get the related policy (i.e., cannot recoup on balances over 180 days, do you need to include a letter) & the name/address of where to issue the refund. Ask the representative to verify the amount due. Note the account with this information.
6. Fill out the "Refund Request" form and submit to your supervisor with any EOBs, Denial Letters, Refund request letters, etc.… Note the account with this information.
7. Allow one month for processing. The supervisor will approve and pass on to cash posting to mail out a refund check or refund to a credit card.

Ambetter
Overpayments

Refunds and Overpayments

Refund(s)

Ambetter routinely audits all claims for payment errors. Claims identified as underpaid or overpaid will be reprocessed appropriately. Providers are responsible for reporting overpayments or improper payments to Ambetter. Providers have the option of requesting future offsets to payments or may mail refunds and overpayments, along with supporting documentation (copy of the remittance advice along with affected claims identified), to the following address:

Ambetter
Attn: Claims Dept — Refunds and Overpayments
P.O. Box 5010
Farmington, MO 63640-5010

Blue Cross Blue Sheild

Overpayments

BCBS Overpayment form

to notify and/or submit checks.

Policy GP-X-017

BCBSNE will not initiate refund requests beyond the time specified in the applicable Provider Agreement except in specific situations.

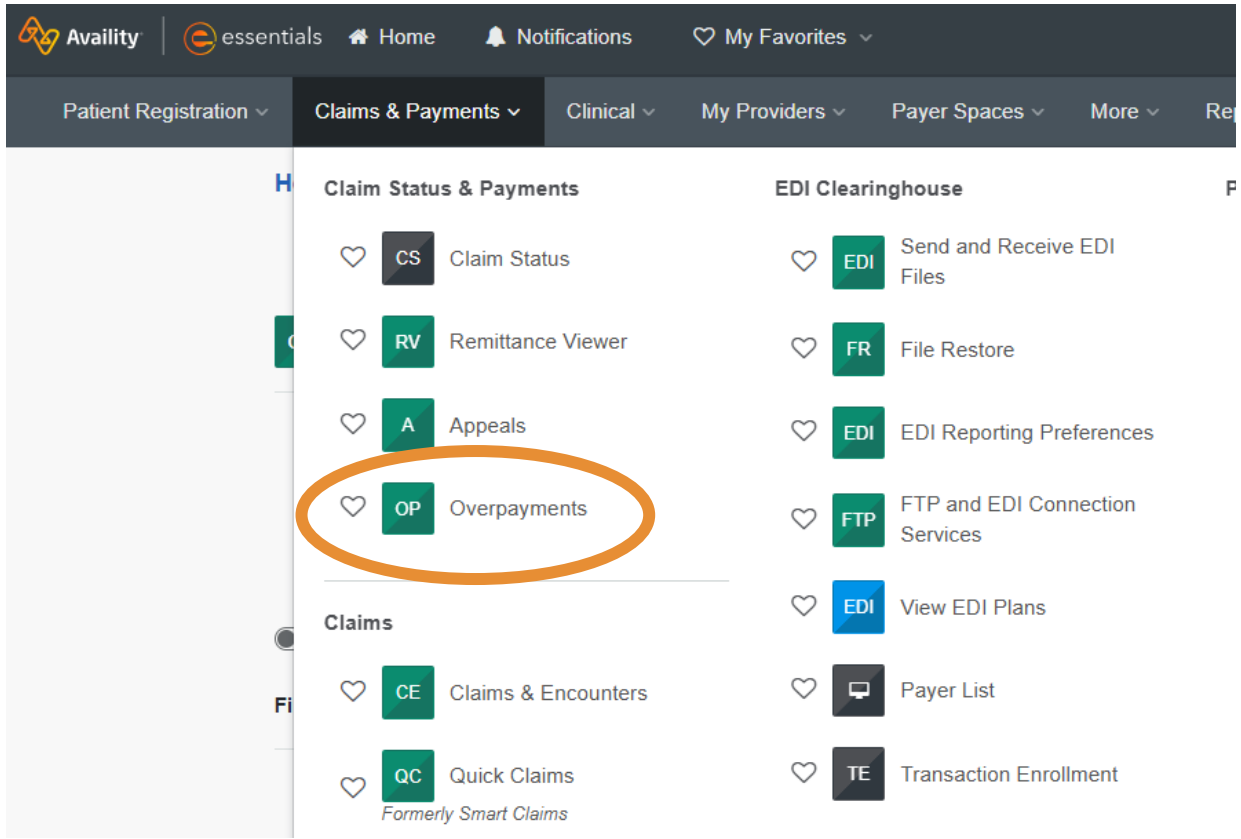
Beginning June 1, 2021, internal initiated adjustments will have an overpayment threshold of $40.00. Adjustments will not be made unless they exceed the $40.00 threshold. This applies to dental, Medicare supplement, local and FEP claims.

TIP:

Ask BCBS for a "Overpayment Detail and Recovery Information" letter for forwarding balances.

Humana & Molina- Submit via Availity
Overpayments

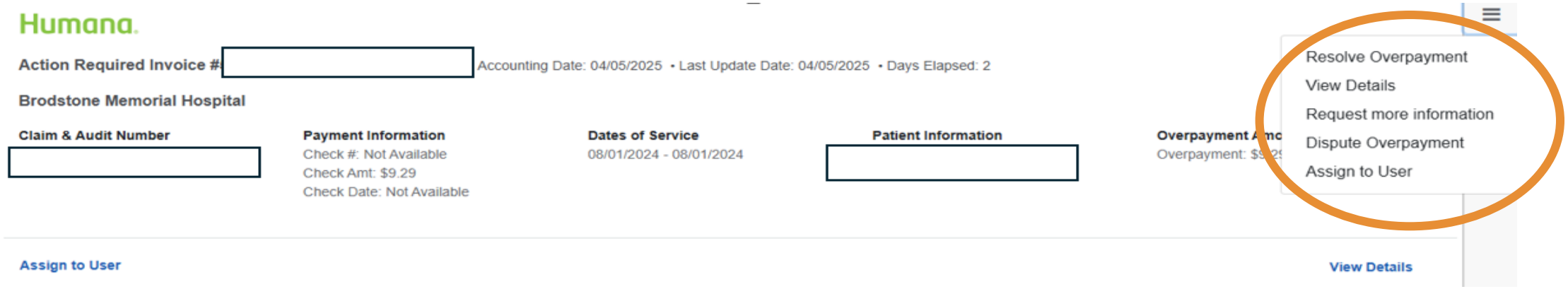
1. Log into Availity.
2. Click “Claims & Payments”
3. Click Overpayments to view a list of all pending overpayments. Dating back to over 100 days.



Humana & Molina- Continued
Overpayments

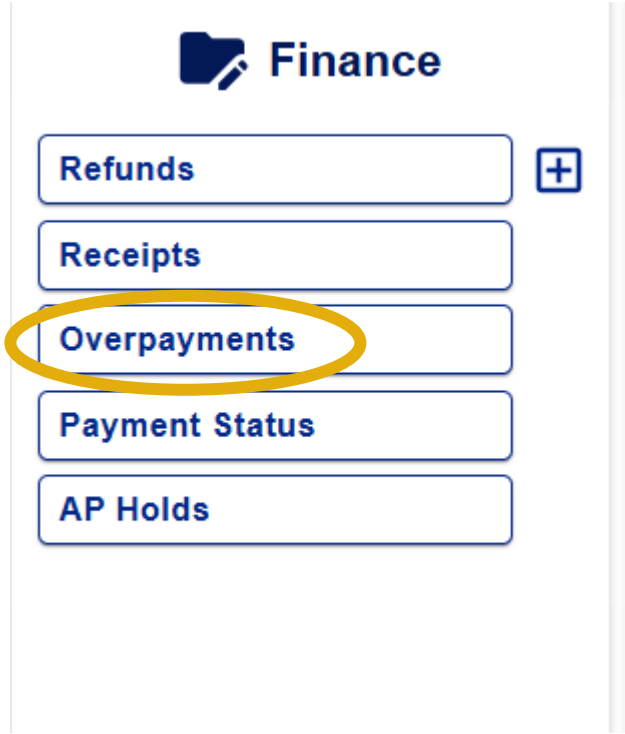
Options Include

- Viewing Details of overpayment.
- Assigning to a user within your facility.
- Resolving Overpayment
- Request more information
- Dispute overpayment



Overpayments Medicare

WPS- Approve or refund existing overpayments here:



- Part B does not allow cancellation of claims. These can be voided via the portal. To report a timely overpayment or send a refund check use the Overpayment notification form here: https://www.wpsgha.com/forms/view/463

- Part A - report a timely overpayment or send a refund check use the Overpayment notification form here: https://www.wpsgha.com/forms/view/463

Nebraska Total Care
Overpayments

Ask a provider executive for a Negative Balance Report for overpayment FB/WOs.

- Shows take back amount & where its going to.

Nebraska Total Care - Explanation of Negative Balance

Recoupment Date	Claim Number	Service Date	Original Paid Date	Mem First Name	Mem Last Name	Medicaid Number	Partient Control Number	Take Back	Payout	Net Adjustment	Paid Portion
4/26/2024								(50.88)	0.00	(50.88)	0.00
4/26/2024								(498.20)	0.00	(498.20)	0.00
4/26/2024								(1,166.00)	1,166.00	0.00	0.00
4/26/2024								(3,974.13)	0.00	(3,974.13)	0.00
4/26/2024								(1,236.07)	0.00	(1,236.07)	0.00
4/26/2024								(350.52)	0.00	(350.52)	0.00
4/26/2024								0.00	112.32	112.32	0.00
4/26/2024								0.00	112.32	112.32	0.00
4/26/2024								0.00	112.32	112.32	0.00

NE Total Care submit refunds to:
Nebraska Total Care Attn: Refunds
PO Box 3713
Carol Stream, IL 60132-3713.
No specific refund form required.

UHC Overpayments

UHC Overpayments have a specific form here: https://www.uhcprovider.com/content/dam/provider/docs/public/claims/Claims-Overpayment-Refund-Form.pdf

Overpayment refund/notification form

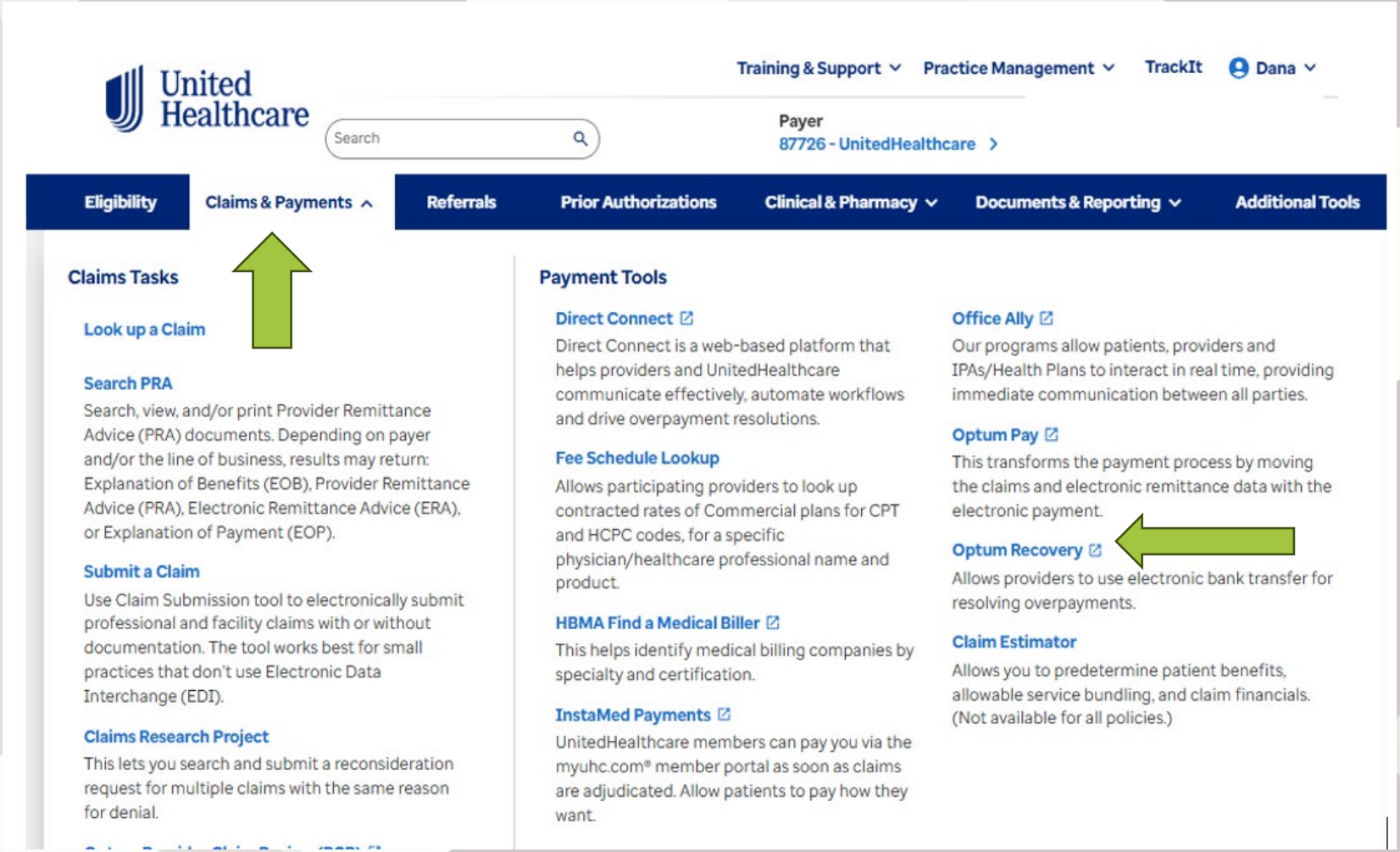
Please download the form, complete each field and print. Include the form with your refund so we can properly apply the refund and record the receipt. If you include a check, please make it payable to UnitedHealthcare and submit it with supporting documentation.

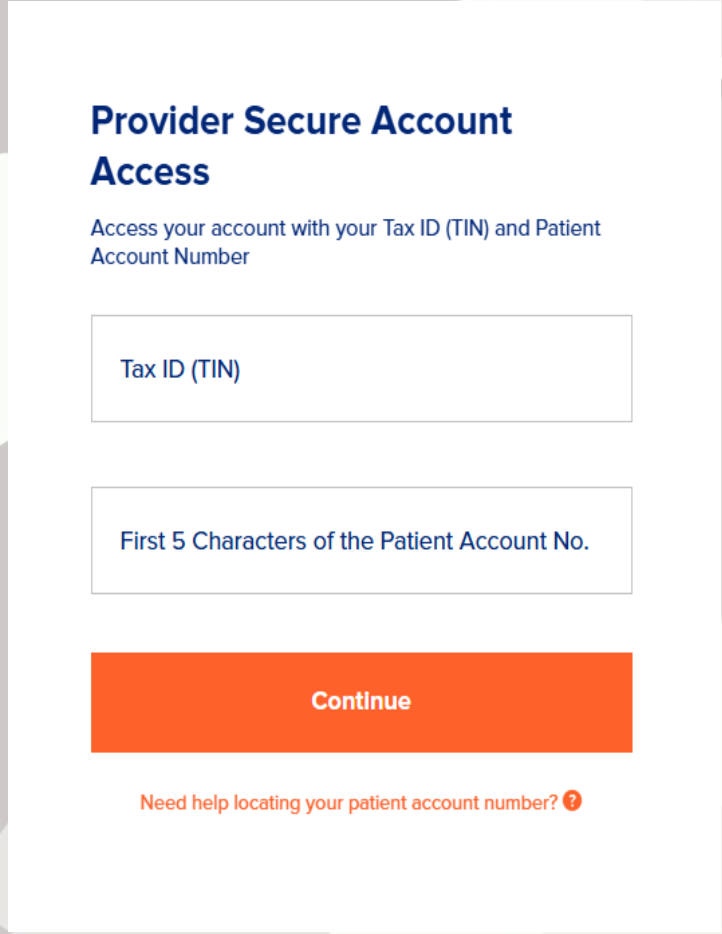
Mail to:

UnitedHealthcare Insurance Company
P.O. Box 101760
Atlanta, GA 30392-1760

UnitedHealthcare Insurance Company - Overnight Delivery
Lockbox 101760
3585 Atlanta Avenue
Hapeville, GA 30354-1705

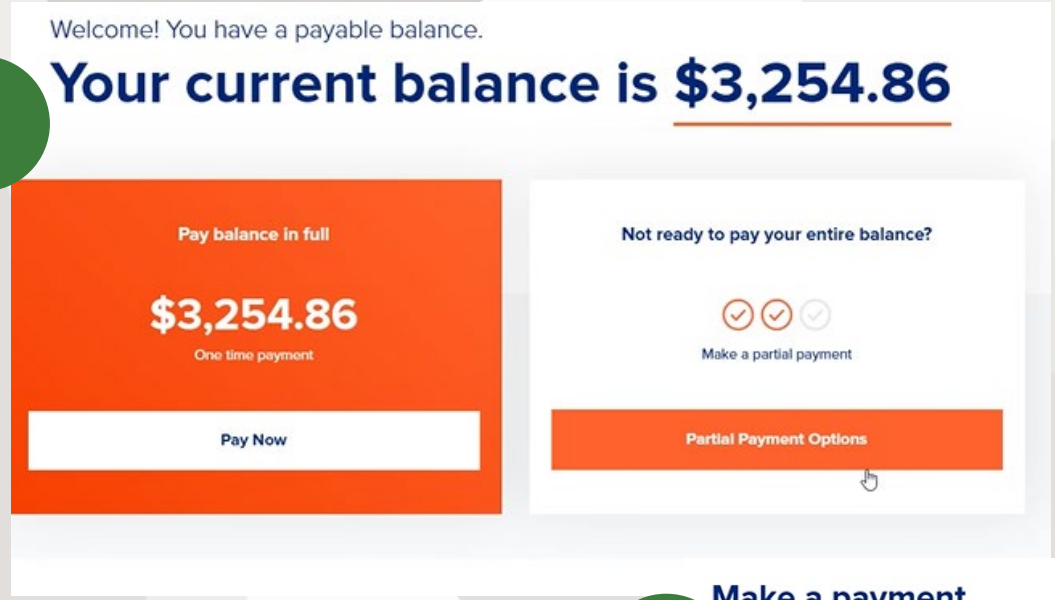
United Healthcare Optum Recovery





United Healthcare Optum Recovery

1



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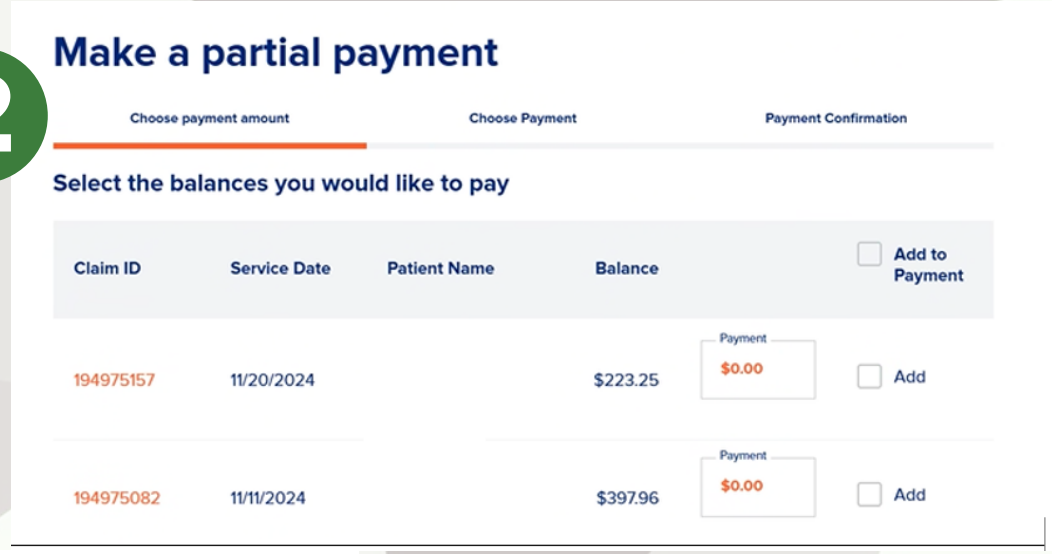

3