

# Appendix A

## Denial Management and Negotiation Hearing Screening

Ideally, hearing screenings should be covered benefits that are separately payable by the health plan. While health plan benefits may include hearing screening services and foreign body or cerumen removal, the health plan carrier may consider them to be incidental to the office visit and therefore not separately payable but bundled with the office visit payment. Following are strategies for carrier denials and contractual issues including appeal letter templates.

**The key is to determine the level of coverage benefits by the health plan for hearing screening services.** Contact the carrier with the specific health plan information to determine whether the specific CPT code is a separately payable service (some carriers may have this information posted on its provider website). Also, review the carrier's explanation of benefits (EOB) to determine how the reported CPT code is adjudicated by the carrier's claims processing system.

Non-covered service: Carriers have different levels of health plan benefits and the family may be covered by a health plan with limited coverage that do not provide benefits for hearing screening services. In these situations, the family would be financially responsible for these services.

Bundling: Hearing screening and foreign body or cerumen removal may be bundled with the evaluation and management E/M services by the carrier. The CPT codes listed on the Hearing Screening Coding Fact Sheet represent separately identifiable services and should be reported as such. While there is no legal mandate requiring private carriers to adhere to CPT guidelines, it is considered a 'good faith' gesture for them to do so, given that the guidelines are the current standard within organized medicine. All inappropriate bundling of services should be appealed by the pediatric practice to the carrier.

### **Strategies to enhance coverage and separate payment:**

In addressing issues with carriers by the pediatric practice, strategies include filing appeals and **negotiating contractual provisions**. Sample letters to send to carriers regarding bundling are included at the end of this article.

### **Filing Appeals**

Pediatric practices can follow these general guidelines when appealing claim denials or partially paid claims (excerpted from *Appealing Claim Denials Can Improve the Bottom Line*, AAP News, June 2004):

- Review all carrier explanation of benefits (EOB). Compare the billed amount and CPT codes with the EOB to determine the level of discounts, denials, inappropriate carrier re-coding or partial payments.
- Make sure the claim was prepared properly, that all information is correct and documentation supports the CPT codes. Once assured the denial was not due to an error on the practice's part, proceed with the appeal.
- Send appeals in writing and to the right person — look up the contact person in the contract or call the carrier, explain the situation and what is coming so they can be on the lookout. If you are not satisfied with the response, contact the plan's medical director.
- Send the appeal by certified mail to verify receipt by the health plan.
- List the member's name, carrier identification number and claim number on all documentation.
- State your case in objective and factual terms. Identify the result you want and provide medical justification and CPT coding guidelines to support your case (keep in mind most claim processors

do not have a medical or coding background, so be clear and specific). Sample appeal letters that can be used as templates are available on the Member Center of the AAP Web site ([www.aap.org/moc](http://www.aap.org/moc)) under the Private Payer Advocacy page.

- Suggest how denials can be avoided in the future, particularly if it is a recurring problem.
- Monitor for a response. If the carrier does not respond within the time frame specified in your initial appeal, follow up with a second letter.
- Create a spreadsheet to track appeals to each carrier so at contract renewal time, you can determine whether to continue to work with that carrier and identify items to modify in the contract.

Each health plan should have a written statement explaining the procedures required for both first and second level appeals. If it is not excluded in the contract, and the practice has correctly coded and properly documented the services, continue to appeal. Should further action be required, contact the state department of insurance or depending on the state in which you practice, the state department of banking and insurance or state department of health. Most states have prompt pay laws. If a managed care organization violates the prompt pay law, the physician may be eligible for interest payments on the amount owed, depending on state law.

If a claim is denied and the health plan informs that it is a non-covered service or is the plan member's responsibility, bill the plan member and include a copy of the EOB and denial with the bill.

Contact your AAP chapter to keep it aware of your issues. Some chapters have pediatric councils that meet regularly with health plan medical directors and Medicaid representatives to address coverage issues. Utilize the AAP Hassle Factor Form to report problems with carriers. (Some chapters have made the Hassle Factor Form available on their Web site, or it can be accessed via the AAP Member Center, under the "More Resources" link.)

### **Negotiating contractual provisions**

In contacts with the health plans to discuss contractual issues, the key components are to:

- Address this issue with the person having authority to make decisions regarding payment. The carrier provider representative may not have the decision making authority in this type of matter.
- Focus the argument on how this is cost effective to the family and health plan as well as how it relates to quality care (provide documentation supporting your position).
- Frame your position on how it impacts the quality of care, cost effectiveness and patient satisfaction. Carriers are very conscious of quality issues, how a proposed change will affect overall expenses and efficiency, and their market share. The carrier's current policy may not cover hearing screening services and the carrier needs to be made aware of the impact to the patient, family, pediatrician and carrier. Consider notifying the family and employer since they may bring pressure onto the carrier and employer to expand health plan coverage.

### **AAP Activities**

Some AAP chapters have created pediatric councils that meet with carrier medical directors to discuss pediatric issues. AAP members may contact their chapter to report issues related to coverage for hearing screening services with carriers. While the AAP, chapters and pediatric councils cannot negotiate fees with carriers due to antitrust provisions, pediatric councils can advocate and educate carriers on quality, access, cost issues impacting pediatricians and pediatrics.

Members may also report carrier issues using the AAP Hassle Factor Form, available on the AAP Member Center ([www.aap.org/moc](http://www.aap.org/moc)) under the "More Resources" link. The data is reported to the AAP and chapter to facilitate discussions with carriers.

The AAP Private Payer Advocacy Advisory Committee is addressing coverage and payment issues for pediatricians including bundling, coverage and payment for screenings including hearing screens. Letters on bundling and appropriate reporting of screening services have been sent to carriers. In addition, appeal letter templates are available for chapters and members to send to local and regional carriers. These letters are included below. Additional appeal letter templates can be access on the Member Center ([www.aap.org/moc](http://www.aap.org/moc)), link to “Private Payer Advocacy.”

*For more information on coding and coverage issues, contact the AAP Division of Health Care Finance and Quality Improvement at [dhcfqi@aap.org](mailto:dhcfqi@aap.org).*

**Sample Appeal Letter for Hearing Screening:**

To: Claims Processing Department or Health Plan Medical Director

RE: Hearing Screening

Claim # \_\_\_\_\_

To Whom It May Concern:

I would like to clarify the fact that CPT guidelines indicate that code 92551 (*Screening test, pure tone, air only*) is not incidental to the preventive medicine services codes (99381-99397). Unfortunately, many carriers are unaware of when it is appropriate for providers to report hearing screenings.

According to the American Medical Association's CPT guidelines, audiometric tests implying the use of calibrated electronic equipment would be reported separately (CPT 2006, page 375). This is further supported by the preventive medicine services CPT guidelines, which outline that "...screening tests identified with specific CPT codes are *reported separately*" {emphasis added} from the preventive medicine codes (CPT 2006, page 30). These statements clearly indicate that hearing screening is a separate service from the preventive medicine service and, therefore, should be recognized as such.

The aforementioned CPT guidelines are applicable to any other screening tests or procedures that are identified with a specific CPT code, such as audiometry, vision, intramuscular injection of antibiotics, immunization administration, or cerumen removal. Therefore, providers are also correct in reporting such services separately from any accompanying evaluation and management service. While there is no legal mandate requiring private carriers to adhere to CPT guidelines, it is considered a 'good faith' gesture for them to do so, given that the guidelines are the current standard within organized medicine. Those separately reportable services that are not recognized by a carrier should be designated non-covered benefits and billable to the patient.

Enclosed is a copy of the original claim that was submitted with a request that you process reimbursement as indicated on the claim. I look forward to receiving your response. If you have any questions, please feel free to contact me at \_\_\_\_\_.

**Sample Appeal Letter for Cerumen Removal:**

To: Claims Processing Department or Health Plan Medical Director

RE: Cerumen Removal

Claim # \_\_\_\_\_

To Whom It May Concern:

The above referenced claim inappropriately denied payment for cerumen removal. I would like to clarify the CPT guidelines encompassing the appropriate reporting of the service of cerumen removal (CPT code 69210), namely that it is appropriate to separately report an evaluation and management (E/M) service that may occur on the same date of service as cerumen removal.

If an evaluation and management (E/M) service is provided on the same date of service as cerumen removal, it is appropriate to report each service separately. Some insurance carriers incorrectly apply the CPT Surgical Package definition to the service of cerumen removal. They read the bullet point that includes "one related E/M encounter on the same date immediately prior to or on the date of the procedure" (CPT 2006, professional edition, page 45) and deny claims for cerumen removal and an E/M service on the same day. You will note, however, that the phrase in CPT immediately preceding that clause is "subsequent to the decision for surgery." This phrase indicates that the one related E/M encounter is only included in the CPT Surgical Package when it occurs subsequent to the decision for surgery. If the E/M service occurs prior to the decision to remove the impacted earwax, it is not included in the CPT Surgical Package. And, in pediatrics, cerumen removal is typically performed only after the physician has conducted the necessary evaluation and management to make sure that the patient is not contraindicated for the procedure. Therefore, the bundling of the E/M and cerumen removal codes would be unwarranted.

Enclosed is a copy of the original claim that was submitted with a request that you process reimbursement as indicated on the claim. I look forward to receiving your response. If you have any questions, please feel free to contact me at \_\_\_\_\_.

Note: A pediatric practice in New Jersey reports that appeals have been successful when it was explained that without cerumen removal (CPT code 69210) the hearing evaluation and ear exams cannot be completed. The carrier changed its policy and is paying for cerumen removal.

The Centers for Medicare and Medicaid Services (CMS) has assigned relative value units to CPT code 92551 (screening test, pure tone, air only). Physicians should check with the carriers that base payments on the Medicare Resource Based Relative Value Scale (RBRVS) that they have a fee assigned to hearing screens. If the carrier does not have an assigned fee, this becomes a contractual issue to negotiate for payment for hearing screens.