APPEAL TRAINING
COURSE 1

INTRODUCTION TO APPEALS

COURSE
HANDOUT

AppealTraining.com

Appeals Introduction

Healthcare's denial management era has resulted in departmental reengineering, reams of reports, and for many, recovered revenue achieved through a more aggressive appeal effort. Healthcare organizations now keep a well-trained eye on their denied claims, looking for clues to what carriers are paying, stalling, or denying this quarter. Even organizations that achieve a high rate of recovery struggle to maintain their current level of performance. Those who have missed projected recovery goals must assess what additional changes are needed and why the appeals aren't generating revenue.

Denied claim reports give managers extensive information regarding how well the registration, utilization/case management, and patient financial services departments are functioning. However, in the shorter-term view, denied claims simply beg for immediate attention. Denials once written off or moved to patient responsibility are now sitting in a queue awaiting your attention. You must initiate these appeals within impending payer-specified deadlines. You have to gather all relevant information and develop a persuasive argument. Furthermore, many of these denied claims involve ambiguous contract and payment terms upon which you and the payer hold sharply divided views and perspectives.

Now that healthcare organizations have undertaken the task of managing denials, the real challenge is to do so professionally and effectively. Initial results of denial management initiatives span the extremes from immobilizing shock over the denial numbers to numbing disbelief at the complexity of the appeals that must be generated on a claim-by-claim basis. Much attention is given to appeals at professional meetings, from sample appeal letter distribution to how-to advice.

The ongoing challenge is to determine why one appeal works and another fails. Inevitably, healthcare organizations find that some carriers respond to appeals professionally and others will not respond at all. As so often happens, the effectiveness of the organization's denial management efforts depends on developing effective strategies for circumstances commonly viewed as beyond your immediate control, such as carrier non-response and poor contracting

ramifications. Ongoing staff training with constant attention to incorporating and securing legal protections through appeals can be a large asset in dealing with problematic appeal review. Simple form letter appeals often don't accomplish high rates of recovery.

Educational resources and training are increasingly important for effective denial management. Organizations with insufficient training and staffing for the scope of the project will generally fall back on rebilling denied claims en masse. The result of rebilling a previously rejected claim is a ballooning of accounts on the denied claim report and no revenue to show for the extra effort. For better-prepared organizations, initial appeal efforts on identified accounts were positive; however, even these organizations over time often experienced a drop in claim recovery. Furthermore, carrier claim review policies have not remained stagnant while providers geared up to appeal denials. Instead, carriers have strengthened contract language, giving them greater discretion over network claim adjudication, and they have implemented efforts to better control large-balance out-of-network liabilities, such as direct payment to policyholders and drastic usual, reasonable, and customary reductions.

Most healthcare organizations are pleased with the better communication, coordinated effort, and accountability, which, as a result of denial management efforts, affect every medical claim sent out. Yet the consensus of many involved in denial management is that ongoing claim recovery is both challenging and ever-changing. Once a scenario is identified that results in numerous appeals, those who are tasked with solving the problem are often caught between the two opposing goals of providing the quality that healthcare patients expect and providing care at the efficiencies demanded of payers. Healthcare organizations find themselves in the often adversarial role of arguing over coverage technicalities and ambiguities involving medical necessity, correct coding, and contract interpretation, which used to be the task of the patient's attorney. The success of denied claim negotiations and appeals often has repercussions for future claims. It is extremely important that these efforts are not in vain but are undertaken in the most professional, most effective manner possible.

In the end, denial management does not automatically equate to benefit recovery. Effective appeals result in denied claim recovery. Effective appeals result from knowing your

organization's legal rights, understanding the payer's rights, and finding ways to resolve differences without compromising the quality and efficiency necessary for everyone.

How the AppealTraining.com Courses Will Help

So, what is to be done with the Denied Claim Management report? How can you advance the most effective appeal possible related to these denied claims and secure overturned denials? Can denial management personnel avoid chasing after money that, despite their best efforts, will not get released? How should you use the appeal process to achieve larger goals than simple one-time recovery of a single claim? How should you deal with blatantly poor appeal review and response to well-written appeals?

Addressing these questions is the next step in effective denial management. These courses focus on appeals, providers' rights related to appeal review, and how payers' obligations may affect the final decision. Extensive information is provided on how to conduct appeals to achieve a transparency in claim review so that all parties are privy to the information dictating coverage.

Unfortunately, appeal responses often vary in terms of quality in direct proportion to the quality of the appeal. Simply put, a form letter type of appeal will often garner a form letter rejection. A detailed appeal outlining a persuasive argument and demanding disclosure of the basis of the claim denial will often result in a more thorough response referencing pertinent policy, plan limitations, or exclusions. Although this information may or may not be favorable, obtaining complete denial information is critical to developing your Level II appeal or, alternatively, determining how to proceed with future claims of that nature.

Lastly, these courses will discuss upper-level appeal efforts and how to improve success on upper-level appeals. Legal rights and responsibilities are at the crux of most appeals, but provider appeals typically focus on clinical issues alone without sufficient discussion of compliance issues. Healthcare organizations must seek up-to-date information on the legal responsibilities and liabilities of healthcare providers and carriers, or they may find themselves at the mercy of the insurance carrier's appeal process and the inherent fairness, or lack of fairness, that is provided by the payer.