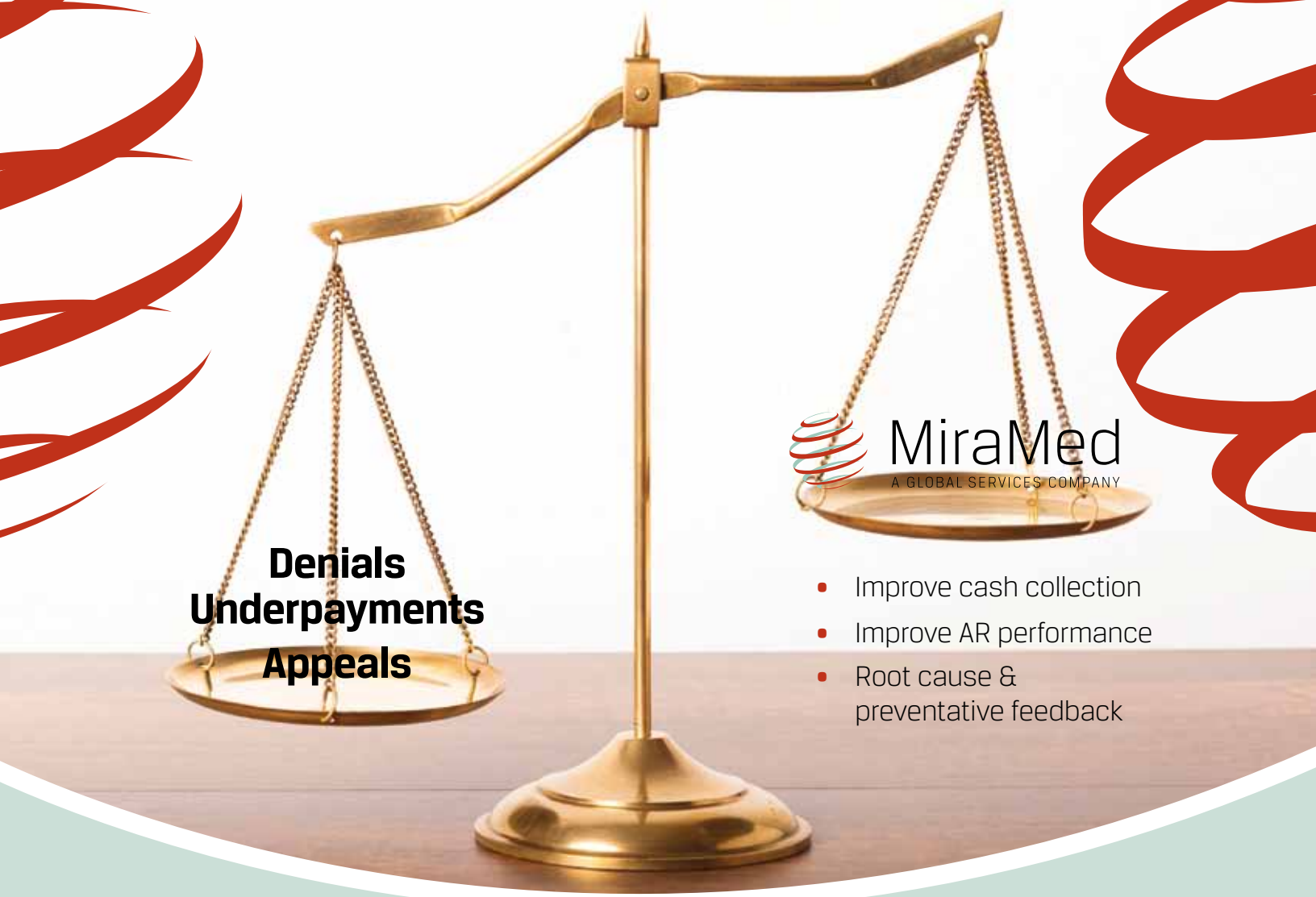
# Denial Recovery & Management




- Improve cash collection
- Improve AR performance
- Root cause & preventative feedback

## Are Denials & Underpayments Affecting Cash Collections?

MiraMed's denial management program enables our clients to realize expected contractual revenue from payers. Our processes ensure all claims are thoroughly reviewed and all appeals are filed timely. We continue to follow-up with the various insurance companies until a payment is obtained or a determination is reached. Our Denial Team is comprised of experienced revenue cycle, clinical and legal professionals who are capable of handling every aspect of the claim appeal.

**www.miramedgs.com**

MiraMed
A GLOBAL SERVICES COMPANY

## Our Process

**Upon receipt of an underpaid or denied claim, we review the claim and all necessary documentation to determine the variance in payment or reason for non-payment. We contact the payer to verify the timely filing guidelines for an appeal and initiate the appeal process.**

After thoroughly reviewing the account and denial details, an appeal is prepared and submitted to the carrier along with all supporting documentation. The accounts are loaded in our proprietary system, AR Tracker, and scheduled for aggressive follow-up based on payer appeal and contract guidelines. AR Tracker automates denial management and provides unique stratification, workflow, follow-up, account management and reporting to assist healthcare providers versus what is often a manual and time-consuming effort for healthcare providers.

If the first level appeal is denied, a second level appeal is initiated. The second appeal along with supporting documents is re-sent to the carrier for review. If the first level denial is overturned, the account is notated and monitored for timely receipt of the payment. If the first level denial is upheld, we request the carrier provide the reason for upholding the denial, credentials of individuals involved in the review process and information on how to pursue the appeal externally.

As appropriate, MiraMed will escalate third and fourth level appeals to National Payer Review teams, the Office of Medicare Hearings and Appeals (OMHA) and other agencies as determined by state and payer guidelines. If a decision is upheld at this level, MiraMed will return the claim to the client for determination of self-pay process or adjustment according to contract terms.

## Examples of Denials:

- Pre-certification
- Non-referrals
- Length of stay
- Non-covered care
- Medical necessity
- Timely filing

## Upon Referral of a Partial or Full Claim Denial, the Denial Team:

- Determines the reason for the denial/underpayment
- Obtains appeal procedures and appeal guidelines according to contract terms
- Reviews claim history and account details
- Verifies expected reimbursement & account adjustments against payment/denial and contract terms
- Requests a copy of the medical records or other supporting documentation (if necessary)
- Appeals & requests for reconsiderations of the claim is made in writing
- Follow-up activities & monitoring through claim adjudication

## Process Improvements:

- Strict contract enforcement sends a message to all payers
- Identification of recurring contract term denials to assist with preventative managed care contracting
- Reports by payer, denial type and department help identify recurring denial trends
- Customized AR Tracker reports to identify trends
- Improved cash collections & AR performance
- Reallocate staff to greater ROI & patient satisfaction areas

**866.544.6647 info@miramedgs.com www.miramedgs.com**

**The MiraMed Global Services, Inc. Family of Companies**

MiraMed A GLOBAL SERVICES COMPANY | MiraMed Revenue Group | Virtual Recovery, LLC A MiraMed Global Services Company | MiraMed On Call A GLOBAL SERVICES COMPANY