SOP Template:
Denial Management and Appeals Submission Procedures

This SOP details the **denial management and appeals submission procedures**, covering the identification and documentation of claim denials, root cause analysis, timely appeal preparation and submission, communication with payers, tracking appeal statuses, and continuous process improvement to reduce future denials. The goal is to optimize revenue recovery and ensure accurate reimbursement through effective management of denied claims and structured appeals.

1. Purpose

To define standardized processes for managing claim denials and submitting appeals, aiming to maximize revenue recovery and minimize future denials.

2. Scope

This SOP applies to all staff responsible for revenue cycle management, denial processing, and appeals submission.

3. Definitions

- **Denial:** Rejection of a claim or payment by a payer.
- **Appeal:** Formal request for reconsideration of a denied claim.
- **Root Cause Analysis:** Examination to identify underlying reasons for denials.

4. Responsibilities

- **Billing/Revenue Cycle Staff:** Identify, document, and initiate denial resolution.
- **Appeals Coordinator:** Prepare and submit appeals.
- **Management:** Monitor denial and appeal trends, support process improvement.

5. Procedure

1. **Denial Identification and Documentation**
    - Monitor EOBs/ERAs and payer portals for denial notifications.
    - Record denial reasons, codes, and payer information in the denial management system.
2. **Root Cause Analysis**
    - Review claim details and payer denial codes.
    - Determine root causes (e.g., coding errors, eligibility issues, missing documentation).
3. **Appeal Preparation**
    - Collect all necessary documentation (medical records, claim forms, prior authorizations, etc.).
    - Draft appeal letter addressing payer-specific requirements and denial reasons.
    - Obtain provider signatures or supporting statements as needed.
4. **Appeal Submission**
    - Submit appeal via payer-specified methods (mail, portal, fax, etc.) within specified timeframes.
    - Document the appeal submission date and confirmation in the tracking system.
5. **Communication with Payers**
    - Follow up regularly to confirm receipt and request status updates.
    - Respond promptly to payer inquiries for additional information.
6. **Tracking and Monitoring**
    - Update appeal statuses in the denial management system.
    - Escalate unresolved appeals as needed.
7. **Resolution and Reconciliation**
    - Record final outcome of each appeal (approved, partially paid, or denied).
    - Adjust patient accounts and revenue records as required.
8. **Process Improvement**
    - Analyze denial and appeal outcomes to identify trends.
    - Implement corrective actions to reduce recurring denials.
    - Educate staff based on findings.

6. Documentation

- All denials, appeal actions, and communications are to be recorded in the designated tracking system/EHR.
- Maintain copies of submitted appeals and supporting documents.

7. Related Forms and Resources

- Appeal letter template
- Denial tracking log
- Payer-specific appeal submission guidelines

8. Revision History

Version	Date	Description	Author
1.0	2024-06-03	Initial SOP creation	[Your Name]