WHITE PAPER

INSURANCE

AUTOMATING THE APPEALS AND GRIEVANCES PROCESS

CHRISTINA LUCERO

DIRECTOR, HEALTHCARE PRODUCT MANAGEMENT AND STRATEGY, INSURANCE, FIS

Introduction – Automation matters for the appeals and grievances process

The appeals and grievances process is highly regulated, scrutinized and monitored. While state-level guidelines stipulate swift dispatch and effective management, the Centers for Medicare and Medicaid Services (CMS) has set specific requirements for timely response, escalation, prioritization, tracking and reporting that healthcare payers must adhere to.

To avoid significant fines and penalties for non-compliance, healthcare payers are seeking process efficiencies that add value where they need it most. Minimizing the number of filed appeals or grievances is the ultimate goal. But more efficient management of appeals and grievances means insurers can resolve cases more rapidly and reduce operational costs and errors – ultimately contributing to both increased member satisfaction and higher profit margins.

Increased automation is absolutely key to improving efficiency. And the appeals and grievances process lends itself perfectly to automation – especially when using state-of-the-art solutions for document management, business process management and business activity monitoring. Read on to find out the four key benefits of automating the appeals and grievances – and how it could help improve both your services and your profits.

1. Streamline communications

State and federal regulations require certain appeals and grievances notifications to take place within specific timeframes and meet appropriate standards. But reviewing subtle variations in content can jeopardize deadlines.

Using best practice templates, innovative technology solutions can guide coordinators through their communications with members and providers. By ensuring uniform language and messages, you can minimize manual effort as well as standardize the creation of traditional correspondence items, such as a request-for-signature form, reminders for about-to-close and determination letters. Automation of these procedures will increase visibility via real-time tracking of communications, documents and resolution.

2. Simplify file management

After the initiation of appeals and grievances, a multitude of additional data – often in multiple formats – must be quickly absorbed into the overall case file.

A well-coordinated combination of process and content management technologies can automatically alert you to the arrival of physician reports, supporting documents and other material information and attach them to the rest of the case file for review. Automated systems can help minimize your paper burden with digital capture of data that offers time stamps, file location data and integration with core administration systems.

SIGNED, SEALED AND DELIVERED

An appeal needs a signature form before it can proceed. Automated processes can send a standardized letter requesting the signature, referencing the relevant case and member numbers. When the form arrives, it is entered into the system via scan, fax, email or other method. Within seconds of receipt, the system automatically attaches it to the correct appeal and advances it to the next stage of review. If a form takes too long to arrive, the system advances the case to the next step for escalation or closure, depending on the pre-configured rules and process design.

3. Save time

With automated, flexible rules-based workflows that cover most data collection and case tracking tasks, you can ensure timely, consistent processes that minimize manual intervention – and gain a rapid return on investment in new technology.

Streamline routing for expedited cases

Expedited processes can provide abbreviated workflows, but with all the same alerting, reporting and staff efficiency advantages. For example, you can give an expedited flow a higher priority in the work queue. Or you could assign a phone call to replace the slow exchange of letters in an expedited situation.

Align the right people with the right tasks

At each stage of processing, an automated system can select the appropriate work queue or group to manage it. By selecting a pre-defined work queue or group, you can ensure the case is routed to the appropriate people with specific expertise or the next available staff member rather than sit with an individual person who may hold up the process. Using business rules, the system can make determinations quickly and without human involvement.

Support decision making

When a number of disparate systems are aligned with different functional areas or tasks, it can take a long time to gather all the information you need to make a decision. Automating the ability to pull and push information from these systems into a single view speeds up processing and allows skilled workers to focus on their expertise rather than navigating a complex technology landscape.

Populate data systems with ease

Manual data entry is time consuming and prone to error. By tracking appeals and grievances on an electronic form that integrates with your core administration system, you can transfer information in one step and with complete accuracy, often in a matter of seconds.

4. Minimize risk

As appeals and grievances requirements change over time, one constant remains: the need to provide a full case history accurately and consistently from beginning to end and reproduce all associated communication. You must also be able to accurately age key milestones or deadlines and ensure document security.

Centralize processing

An automated appeals and grievances system centralizes all elements of the process for different types of reporting. For greater reliability than paper checklists, the system provides a detailed, long-term record that is backed up frequently for every case. An aging calendar and continual monitoring of milestones and deadlines will support consistent adherence to updated compliance requirements.

Reinforce security

With electronic copies of documentation stored securely, automated content management features can protect any document or selected sub-types of documents as soon as they become part of an appeal case. By automatically associating new documents with the appropriate appeal or grievance, you can also prevent unauthorized access.

Streamline reconciliation

Automated systems can create a temporary security vault where you can store pending cases while you await additional information. As new data arrives, in any format, the intelligent document will automatically reconcile the vaulted case files with the new information in seconds, saving a significant amount of end-to-end case processing time and staff effort. Automated time and staff identification stamps create an electronic record of who accesses information and when, creating a complete audit trail to help meet Health Insurance Portability and Accountability Act (HIPAA) and other security requirements.

ALERTED TO DELAYS

A Medicaid appeal is required within three days. Alerts are set for notification of delayed processing. Emails and other notifications are automatically sent to appropriate queues to alert the staff of the problem. A member of staff can review the case directly and take appropriate action which, in turn, causes the system to automatically advance the case to the next stage.

CASE CLOSED

A letter must be sent to indicate that a commercial appeal will close if there has been no response to a request for information within 40 days. By automating this process, it eliminates the need for someone repeatedly checking the case status to decide when to send a letter; the system creates a task when the designated time arrives.

Conclusion – Improve satisfaction and your bottom line

A positive customer experience is key to business growth. Accelerating resolution of issues and ensuring consistency in the process are key to keeping the customer happy.

From case creation through resolution, customizable libraries of best practice workflows, electronic forms and pre-defined rules, healthcare payers can quickly and more effectively manage all aspects of the appeals and grievances process. Automation of these processes translates into efficiencies and faster case resolution, helping improves member satisfaction and identifies opportunities for processing improvements to reduce appeals and grievances.

Are you ready to rise to the challenge?

About FIS' Healthcare Solutions

FIS has been helping healthcare payers succeed for more than twenty years. Our award-winning Healthcare Insurance Suite of solutions are trusted in a wide range of operational areas including claims, member/provider service, enrollment, appeals, authorizations, contracting, marketing, legal and many others. Healthcare payers also depend on FIS' Financials solutions for comprehensive accounting and reporting to meet ever-changing regulatory demands. Our healthcare payer clients cover the spectrum of size and specialty from managed care to indemnity, individual and group products, from fully funded to TPA financial models. With hundreds of healthcare implementations, FIS complements core platforms from other third-party vendors and enhances home-grown applications.

About FIS

FIS is a global leader in financial services technology, with a focus on retail and institutional banking, payments, asset and wealth management, risk and compliance, consulting and outsourcing solutions. Through the depth and breadth of our solutions portfolio, global capabilities and domain expertise, FIS serves more than 20,000 clients in over 130 countries. Headquartered in Jacksonville, Florida, FIS employs more than 55,000 people worldwide and holds leadership positions in payment processing, financial software and banking solutions. Providing software, services and outsourcing of the technology that empowers the financial world, FIS is a Fortune 500 company and is a member of Standard & Poor's 500® Index. For more information about FIS, visit **www.fisglobal.com**

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