



**CERTIFICATION PROGRAM
CERTIFIED PROFESSIONAL IN DENIAL & APPEAL MANAGEMENT
(CPDAM)**

Overall Learning Objectives:

At the completion of this program, participants should be able to:

1. Identify the challenges inherent to interpreting the payer payment systems, denial management and how to have your facilities prepared for success with appeals.
2. Communicate the historical perspective on the evolution of the healthcare payment system with a focus on denials and appeals.
3. Understand the changing state of today's healthcare system, as related to the important trends toward required compliance activities to prevent claims denials.
4. Identify the educational needs for healthcare personnel regarding the significant changes in the healthcare reimbursement field and how these impact the denials a organization will confront.
5. Identify important methods of, and how to manage, organizational acceptance and "buy-in" to improve the denial management and appeals processes.
6. Describe the goals, key benefits, and strategies of having an on-site based denial management and appeals program.
7. Identify effective techniques to communicate with both clinicians and non-clinical staff in order to appeal current denials and prevent future denials.
8. Apply techniques to develop and implement a structured Denial Management and Appeals Improvement Program within hospitals.
9. Identify compliance methods on auditing, monitoring, and evaluating the effectiveness of your denial management program.
10. Identify the new role of Recovery Audit Contractors (RACs) and how to prepare your organization for them.

Agenda

**Program Faculty Chair –
Jua'nese L. Williams, PhD, MBA, BS, CPUR, IQCI, C-CDI, CPC**

DAY ONE

7:00 AM-8:00 AM Registration and Continental Breakfast

Session 1 (1 hour)

8:00 AM-9:00 AM Introduction to Denial Management: An Historical Perspective

Objectives:

- Communicate the evolution of the healthcare denials and appeals management from the perspective of reimbursement, beginning with the third party payer reimbursement system and the strict business model of claims payment followed by most payers today.
- Identify the roles claims compliance, medical necessity/quality initiatives, and technology govern and directly impact all aspects of the denial management process.

Session 2 (1.25 hours)

9:00 AM-10:15 AM The Revenue Cycle: How Healthcare Gets Paid

Objectives:

- Review the development of contracts with payers (government-Federal & State and private-commercial payers) and how different payment methodologies impact reimbursement (case rate, per diem, percentage of costs, etc.)
- Review the Medicare Conditions of Participation and the provider responsibilities to receive proper payment.
- Examine specific provider reimbursement methodologies – Physician Fee Schedules (E&M, CPT, etc.), Diagnosis Related Groups (DRGs), and Ambulatory Payment Classifications (APCs).
- Explore the issues within the various Patient Financial Services divisions – Patient Access/Registration, Health Information Management/Coding, and Patient Accounting/Billing – which directly impact the success of the Revenue Cycle.

10:15AM-10:30 AM Break

Session 3 (1.5 hours)

10:30 AM-12:00 PM Understanding Your Payers

Objectives:

- Examine the payers high-risk / target areas for denials in each of the following areas of practice:
 1. Physicians
 2. Durable Medical Equipment (DME)
 3. Home Health Agencies (HHA)
 4. Outpatient Hospital
 1. Diagnostic Services (Lab / Radiology)
 2. Surgical / Same Day Services
 5. Independent Diagnostic Imaging Centers
 6. Wound Care Centers
 7. Infusion Centers
 8. Ambulatory Surgery Centers
 9. Behavioral/Mental Health (Psychiatry)
 1. Outpatient / Clinic / Private Office
 2. Partial Hospitalization
 3. Inpatient Units / Distinct Part
 10. Skilled Nursing Facilities
 11. Long-Term Care
 12. Inpatient Rehabilitation
- Review high-level data mining techniques to identify the high risk targets in your own facility.

12:00 PM-1:00 PM Lunch to be provided

Session 4 (1.25 hour)

1:00 PM-2:15 PM Program Integrity & Denial of Healthcare Services

Objective:

- Identify the most common “Top 10” reasons for claims denials and how internal activities impact the volume of denials for a organization.
- Explore the current Program Integrity initiatives in place by Federal and State governments and their impact on claims denials and appeals options.

Session 5 (1.0 hour)

2:15 PM-3:15 PM The Compliance Aspect of Denial Management & Beyond: Legal Liabilities, Fraud, & Abuse

Objective:

- Summarize the False Claims Act and the impact claims submission errors can have on an organization.
- Communicate the other tools regulatory agencies use to enforce the regulations.
- Understand how denial management can function as a “knowledge base” to identify risk areas and implement change for effective compliance.

3:15 PM-3:30 PM Break

Session 6 (1.5 hours)

3:30 PM-5:00 PM Keys to Avoid Denials and Investigations

Objectives:

- Review the impact on denials and the potential for investigations involving the following:
 1. Government Payers:
 1. Advanced Beneficiary Notice (ABN)
 2. Important Message from Medicare (IM)
 3. HINN
 4. Quality Improvement Organization (QIO) reviews and investigations
 5. National Coverage Determinations (NCD) and Local Coverage Determinations (LCD)
 6. Comprehensive Error Rate Testing (CERT)
 7. Recovery Audit Contractors (RAC)
 8. Office of Inspector General (OIG) and Office of Medicaid Inspector General (OMIG)
 2. Private Payers:
 1. Authorizations and Medical Necessity
 2. Coverage Positions
 3. New Technologies and Off-Label Drug Use/Treatments

DAY TWO

7:15 AM-8:00 AM Registration and Continental Breakfast

Session 7 (1.75 hours)

8:00 AM-9:45 AM Building a Successful Denial Management Program

Objectives:

- Understand the Medicare Appeals processes – Five (5) Levels
- Review the additional elements of the Medicare RAC appeals process
- Compare the similarities and differences between Medicare/Medicaid/Government Payer appeals processes and Private/Commercial appeals processes.
- Building a “Denial Management & Appeals Library”

9:45 AM-10:00 AM Break

Session 8 (2.0 hours)

10:00 AM-12:00 PM Writing a Winning Appeal

Objective:

- Case studies and practice writing appeals for various types of denials including Technical and Complex denials.

12 PM-1:00 PM Lunch to be provided

Session 10 (1 hour)

1:00 PM-2:00 PM Conclusion, Wrap Up, and Q&A

Objectives:

- Option for Interactive Study Group or Independent Study Time

2:00 PM-5:00 PM **Professional in Denials and Appeals Management Certification Examination** – Optional
No CE credit associated

Accreditation:

Total Accreditation Hours per type:

ACCME/ANCC/CCMC/AAPC-xxx; AHIMA-xxx; HCCB-xxx

ACCME:

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME), and is jointly sponsored by Creative Educational Concepts, Inc. (CEC), and DocuEd Healthcare. Creative Educational Concepts, Inc. is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

CEC designates this activity has been applied for a maximum of *12.5 AMA PRA Category 1 Credits.[™]* Physicians should only claim credit commensurate with the extent of their participation in the activity.

ANCC:

This continuing nursing education activity has been applied for by the Tennessee Nurses Association (TNA), an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

TNA designates this educational activity for 12 contact hours.

CCMC:

This activity has been applied for by the Commission for Case Managers certification for up to 12 clock hours of continuing education credit.

AAPC:

This program has been applied for by the American Academy of Professional Coders for 12 Continuing Education Units. Granting of this approval in no way constitutes endorsement by the Academy of the program, content or the program sponsor.

AHIMA:

This program has been applied for 12 continuing education units for use in fulfilling the continuing education requirements of the American Health Information Management Association (AHIMA). Granting prior approval from AHIMA does not constitute endorsement of program content or its program sponsor.

HCCB:

This program has been applied for 12.5 Health Care Certification Compliance (HCCB) Continuing Education Units in Compliance Training and Education and Auditing and Monitoring for Compliance. Granting of prior approval in no way constitutes endorsement by HCCB of the program content or the program sponsor.

Statements of credit will be issued to participants who sign-in and attend the activity and complete a CE request form. Unless otherwise noted, all statements of credit will be mailed within ten business days.

Statement of Need:

According to the April 2009 Government Accountability Office report on *IMPROPER PAYMENTS: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments*, agencies reported improper payment estimates of \$72 billion for fiscal year 2008, which represented about 4 percent of the \$1.8 trillion of reported outlays for the related programs. This represents a significant increase from the fiscal year 2007 estimate attributable to (1) a \$12 billion increase in the Medicaid program's estimate and (2) 10 newly reported programs with improper payment estimates totaling about \$10 billion.

More and more frequently, third party payers are denying medical claims, leaving healthcare providers without the education nor understanding of the reasons behind the claim denial. Providers often have no idea why the claim was denied or disagree with the reason for the denial. Providers then must begin the arduous task of defending the claim to the payer. Denials can range from technical (e.g., eligibility) to complex (e.g., medical necessity). This program will help providers adequately identify the root causes of denials, implement steps to prevent future denials and appeal cases that can be defended. Without this educational program, healthcare organizations may face a steady increase in improper payment recoupments. If provider organizations do not have the skill set or proven strategies in overturning denials, assessing payer compliance with claim processing law and ultimately preventing future denials, reimbursement can be significantly impacted.

With the implementation of the Permanent Medicare Recovery Audit Contractors by 2010, all healthcare providers need to implement efficient and effective denial and appeals management programs to get to the root cause and reduce submission of improper claims that would ultimately decrease improper payment recoupments and/or denials.

In addition to the national need for education, numerous providers and healthcare organizations have requested this training specifically for themselves and staff and have requested continuing education credit where appropriate.

Intended Audience:

This program was developed specifically for those health care professionals who are involved in maintaining knowledge and compliance with claims processing, reimbursement systems, and the appeals processes within their organization, including, but not limited to:

- Billing Staff
- Coding Staff
- HIM/DRG Dispute Coordinator
- Case Management/Utilization Review
- Physician Advisors

- Clinical Documentation Specialists
- Finance/Reimbursement
- Physicians and Clinicians who have claims submitted on their behalf
- Program Integrity Coordinators – RAC, MIC, CERT, etc.
- Billing Services
- Denial Management Coordinators
- Appeals Coordinators