Policy and Procedure: Use of a Matrix to Evaluate Appeal Viability

Effective Date: [Insert Date]

Reviewed/Revised: [Insert Date]

Approved by: [Insert Name/Title]

Policy Statement

Hospital appeal writers will utilize a standardized evaluation matrix to objectively determine whether to pursue an appeal for denied claims. This process ensures efficient use of resources, consistency in decision-making, and maximizes the likelihood of successful appeals.

Purpose

To provide clear guidelines for appeal writers in assessing the viability of writing an appeal, based on predetermined clinical, financial, and administrative criteria.

Definitions

Appeal: A formal request to a payer for reconsideration of a denied claim.

Matrix: A structured tool listing critical evaluation criteria with cutoff points to guide decision-making.

Procedure

1. Initial Review

Upon receipt of a denial, the appeal writer will:

- Review the denial letter and associated documentation.
- Gather all relevant clinical, administrative, and financial records.

2. Matrix Evaluation

- The writer will complete the standardized Appeal Viability Matrix for each case. The matrix may include, but is not limited to, the following criteria and suggested cutoff points:

Criteria **Cutoff Points/Guidelines**

Denial Reason: Medical necessity, coding, authorization, technical, etc.

Financial Impact: Minimum dollar threshold (e.g., >$500)

Timeliness of Appeal: Within payer's allowable timeframe

Documentation Availability: Complete documentation present (Y/N)

Clinical Merit: Meets established clinical guidelines (Y/N)

Previous Appeal History: Not previously appealed/finally denied

Likelihood of Overturn: Based on precedent or payer trends (High/Medium/Low)

Contractual Language: Denial contradicts contract terms (Y/N)

Administrative Error: Clear evidence of payer or provider error (Y/N)

Provider/Physician Support: Physician willing to provide additional information (Y/N)

3. Scoring and Decision-Making

Assign points or “Yes/No” responses to each criterion as outlined in the matrix.

Cases meeting the minimum required score or criteria (e.g., at least 3 major “Yes” responses, or a score above a set threshold) will be considered for appeal.

Document the completed matrix in the patient’s administrative file.

4. Supervisor Review (If Applicable)

For borderline or high-dollar cases, submit the completed matrix and recommendation to a supervisor or designated reviewer for final determination.

5. Documentation

Retain the completed matrix and any supporting documentation as part of the appeal record.

Note the rationale for proceeding or not proceeding with the appeal in the case management system.

6. Quality Assurance

Periodically audit completed matrices to ensure consistency and adherence to policy.

Update matrix criteria annually or as payer trends and contract terms change.