	<b>The Johns Hopkins Health System Policy &amp; Procedure</b>	<i>Policy Number</i>	BIL033
		<i>Effective Date</i>	1/4/99
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	<b>HCGH Inpatient Denials and Appeals</b>	<i>Revised</i>	7/1/05

## POLICY

This policy applies to Howard County General Hospital (HCGH).

## PURPOSE

The purpose of this policy is to provide information regarding procedures for managed care denials and appeals.

### Appeals Coordinator


Under the direction of the Director of Patient Financial Services, the Managed Care Appeals Coordinator is responsible for coordinating activities to file appeals on inpatient hospital claims denied in part, or in full, by any managed care insurers, all regular commercial carriers, Medicare and Medicaid insurers. This will include timely communication of adverse decisions, management of entire appeals process and tracking results within specified time frames.

The Appeals Coordinator will be notified of all inpatient hospital claims denied, coordinating activities among Patient Financial Services, Case Management, Health Information Management and attending physician staff to file an appeal and follow up on appeals until resolved.

The Appeals Coordinator is notified about denials via telephone calls, billing or Case Management. The responsibility of the Appeals Coordinator's work does not begin until patient is discharged from the hospital or receives formal notification by letter or Estimate of Benefits. Prior to discharge inpatient denials are the responsibility of the Case Managers. The Appeals Coordinator's knowledge of denial letters issued while patient is still in-house is for monitoring and billing purposes.

### Duties or Responsibilities:

1. When denial log is received, case is reviewed to check appeals timeframe and noted on denial worksheet.
2. Review reason for denial.
  - a. pertaining to authorization
    - work with Designated Authorization Group to obtain authorization
    - confirm lack of authorization with insurer when applicable.
    - request a copy of the medical record to provide to the insurer
    - compose and request the appropriate appeal letter
    - review the medical record for completeness

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b. acuity of services, delay in discharge and miscellaneous

- review medical record for completeness
  - make determination whether denial is appealable
  - contact Case Manager for more information, if needed
  - request copy of medical record to be scanned in Quickview
  - write letter to attending physician for dictation of appeal letters and/or further information
  - compose appropriate appeal letter
  - obtain physician’s letter from Medical Records and enclose with chart and cover letter to payor
  - all appeals are sent by certified mail by appeals secretary
3. Once the determination is made that a denial can or will be appealed, obtain all necessary data to file an appeal with insurers.
  4. Maintain file of all documentation and correspondence.
  5. If denial is upheld on appeal, determine what further action is appropriate.
    - consider second, third level of appeal if applicable
    - send case to attorney for further action
    - no further action is appropriate
    - file complaint with Maryland Insurance Administration
  6. Document all actions in B/AR system.
  7. Review open denials log monthly to follow up on appeals until resolved. Call insurers as needed.

**SPONSOR**

Director, Patient Financial Services, HCGH

**REVIEW CYCLE**

Three (3) years

**APPROVAL**

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**Director, Patient Financial Services, HCGH**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Sr. Director, Patient Financial Services, JHHS**

\_\_\_\_\_  
**Date**