	The Johns Hopkins Health System Policy & Procedure	<i>Policy Number</i>	BIL033
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POLICY

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

PURPOSE

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

Appeals Coordinator

Under the direction of the Director of Revenue Cycle, the 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, Patient Financial Services, denial letters, or Case Management. Hard copies of denials from PFS arrive via the courier. PFS also sends a list of denials submitted to HCGH Appeals department via email on an excel spreadsheet. Hard copy and excel spread sheet is reconciled to ensure all denials are received.

The responsibility of the Appeals Coordinator's work does not begin until patient is discharged from the hospital. Prior to discharge inpatient denials are the responsibility of the Case Managers and Physician Advisor. If a denial letter is received while the patient is still in-house, Case Management and the Physician Advisor are notified. A copy of the denial letter is forwarded to Case Management. 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 notification of a denial is received either by explanation of benefits or denial letter, the case is reviewed for duplication and appeal timeframe. Denied/Unauthorized admission worksheet is printed from Meditech. Medical record request form completed and faxed to HIM. Medical records are scanned into Healthport and printed as received. The completed worksheet, along with eob and/or denial letter and medical record request is given to the Outpatient Appeals coordinator to enter into the ACCESS data base. Outpatient Appeals Coordinator returns worksheet to Appeals Nurse after denial is entered into data base. Denial worksheets are placed with medical records and arranged by appeal due date.
2. Denial Types
 - a. Administrative Denials
 - work with Dedicated Authorization Group to obtain authorization (if possible and supporting documentation for an appeal.)
 - confirm lack of authorization with insurer when applicable.
 - compose and print the appropriate appeal letter

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- review the medical record for completeness
 - Appeal package given to Revenue Cycle Clerk to send to insurer via certified mail, return receipt.
- b. Clinical Denials
- review medical record for completeness
 - make determination whether denial is appealable
 - contact Case Manager for more information, if needed
 - Review Physician Advisor Forms if applicable
 - write letter to attending physician for dictation of appeal letters and/or further information
 - compose and print appropriate appeal letter
 - obtain physician's letter from Medical Records and enclose with chart and cover letter to payor
 - Appeal package given to Revenue Cycle Clerk to send to insurer via certified mail, return receipt.
3. Follow up: Review monthly open denial log with BAR to determine if denial is overturned and/or paid. Contact insurer 45-60 days after appeal submitted. Communicates with Patient Financial Services via email regarding overturned denial, nonpayment of previously overturned denials and contractual write-off errors. All overturned denials are followed by Appeals Department until paid.
 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
 - refer case to attorney for further action
 - no further action is appropriate/available. Closed/Unappealable Inpatient Denial Form completed for review by Director of Revenue Cycle.
 - 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

Sr. Director, Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years

APPROVAL



 Sr. Director, Patient Financial Services, JHHS

10/5/09

 Date