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POLICY

This policy/procedure applies to the Johns Hopkins Health System (JHHS) and the following affiliated entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center, Inc. (JHBMC), and Howard County General Hospital (HCGH).

PURPOSE

To outline the process for referring accounts to an external attorney/agency for further collection activity when internal appeal efforts have failed.

RESPONSIBILITIES

JHH/JHBMC/HCGH Utilization Management/Appeals Unit:

Determine the suitability of a denied case to be referred to the external attorney/agency for pursuit of a denial reversal. Typical criteria would include:

- Internal appeal activities exhausted
- External appeal (MIA/DHMH) activity exhausted
- History of appealing a certain type of denial with a payer has been unsuccessful

PROCEDURES


Responsible Party

UM/Appeals
Coordinator

1. Each week create a list of accounts (for each hospital) that are to be forwarded to external attorneys/agencies with the following information for each account:
 - Patient account number
 - Medical record number
 - Patient name
 - Total charges
 - Account balance (if available)
 - Appeal amount (if available)
 - Number of days denied
 - Date appealed
 - Payer name
2. If an account is time-sensitive, it will be sent immediately via facsimile.
3. The Director of the area/Director of Revenue Cycle will sign-off on the account listing.

UM/Appeals Team
Member

4. The Utilization/appeal team will attach to that listing the medical records needed for the appeals process; all Keane notes or HDM notes (whichever is applicable to the specific denial); all imaged documents from the WEBX

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application; any internal notes they would like the attorney/agency to be aware of, and a copy of the denial letter or denial notification.


If the Utilization/appeal team has not received a copy of the medical records needed for a medical necessity appeal within 7 days of the request, then the appeal information will be sent the next day and the medical records will be forwarded when they become available. If the timeline is nearing statute, EPR records should be forwarded so that the initial appeal may be filed and appeal rights preserved.

This package will be sent directly to the attorney/agency. A copy of the case listing will concurrently be sent to:

Associate Director of Patient Financial Services
Alpha Commons
Suite 100
Bayview Campus


or sent via 5300
email to his
attention

- | | |
|--------------------------------|--|
| PFS Manager | 5. The listing for accounts that are to be turned over will be distributed to the patient account managers to confirm the appeal amounts for each of their payers. |
| PFS Manager | 6. An adjustment form will be created without a T-code/non-charge procedure code and forwarded to the Associate Director. This form will adjust balances up to the "appeal amount." |
| Associate Director or designee | 7. Assign unique transaction code/non-charge procedure code and forward for data entry. |
| Associate Director or designee | 8. Update listing for attorney/agency to the correct appeal amounts. |
| | 9. Submit for write-off to the new attorney/bad-debt agency. |
| | 10. On the 15 th of each month and on the last day of each month, forward revised list with correct appeal amount, copies of the UB04 itemized bills, and account comments for each account to the attorney/agency. |
| | 11. On a monthly basis, send an attorney/agency ATB to: <ul style="list-style-type: none"> • Attorney/agency • Hospital UM Director |

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- PFS Appeals Manager, JHH

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|--------------------------------|-----|---|
| Collections Liaison | 12. | On a biweekly basis, receive and validate confirmation listing from attorney/agency. |
| | 13. | On a daily basis, report payments to the attorney/agency, Hospital UM Director and PFS Appeals Manager, JHH |
| Attorney/Agency | 14. | Send a biweekly billing/payment listing for payments reported and payments received directly to Associate Director, PFS. |
| | 15. | Send a monthly list of accounts closed the previous month. |
| | 16. | Send monthly status report to UM/Appeals Coordinators. |
| Associate Director or designee | 17. | Validate payments and process for payment if appropriate. |
| PFS Legal Counsel | 18. | Upon receipt of request for authorization of suit or arbitration, the following shall be done: <ul style="list-style-type: none"> • Contact Risk Management Department to ascertain if there is possible medical incident • Contact office of Managed Care to advise of suit request and to determine if there is any reason to deny suit authorization • Within two days of receipt of request for suit authorization, contact Senior Director of PFS and advise of responses from Risk Management and Office of Managed Care |
| Senior Director | 19. | Within two days of receipt of information from Legal Counsel, the request for suit authorization along with responses from Risk Management and the Office of Managed Care shall be reviewed and a decision to deny or authorize suit will be made in writing and forwarded to Legal Counsel. |
| PFS Legal Counsel | 20. | Upon receipt of response from Senior Director, suit authorization or denial will be conveyed to attorney/agency. |
| Associate Director | 21. | On a monthly basis the attorney/agency monthly status report will be reviewed. |
| | 22. | On a monthly basis the attorney/agency monthly list of accounts closed will be reviewed and forwarded to PFS managers to close the listed accounts. |

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23. On a biweekly basis the attorney/agency billing statement will be reviewed and forwarded to Senior Director or designee for approval.

Senior Director 24. Forward attorney/agency billing statement to Accounts Payable.

SPONSOR

Senior Director, Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years

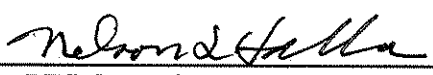
APPROVAL



 Senior Director, JHHS

12/15/08

 Date



 Director, PFS Operations, JHHS

12/15/08

 Date