 JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTH SYSTEM	The Johns Hopkins Health System Policy & Procedure	<i>Policy Number</i>	FIN065
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POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) and the following affiliated entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center, Inc. (JHBMC), Johns Hopkins Community Physicians (JHCP), Johns Hopkins Home Care Group (JHHCG) and Howard County General Hospital (HCGH).

Purpose

The purpose of this policy is to ensure that JHHS and its affiliates handle third party payment denials in a consistent and appropriate manner. For the purposes of this policy, a payment denial is defined as the rejection of payment by any third party for a valid billed claim (i.e., covered services) submitted by a JHHS affiliate. This policy applies to both inpatient and outpatient services, Home Care services and claims, including those originating in the Ambulatory Surgery Department and the Emergency Department.

Classification

In order to standardize reporting and improve the ability to compare and analyze data across affiliates, all JHHS affiliates shall uniformly classify losses resulting from payment denials in the following categories:

- Pre-authorization/Authorization
- Technical/administrative billing denials
- Medical necessity.

The Patient Financial Services Department is responsible for technical billing denials. The hospital entities are typically responsible for authorization and medical necessity denials. Patient Financial Services and the office of Managed Care are responsible for maintaining awareness and understanding of all applicable payor billing requirements to ensure that complete billing, demographic and clinical information is collected.


JHH/JHBMC

The Utilization Management/Case Management Department is responsible for the appeal of payment denials associated with medical necessity issues. UM will coordinate appeals with the Corporate Legal Department when appropriate. The PFS – Appeals Department is responsible for the appeal of payment denials associated with pre-authorization issues at JHH and at JHBMC, Case Management performs the function.

All JHHS entities will promote and strive to improve communication and cooperation among the Patient Financial Services, Admitting, Outpatient Registration, UM/Case Management, Corporate Legal, Social Work and Medical Records Departments in order to provide better service to patients and decrease the number of payment denials received.

HCGH

The Revenue Cycle Appeals group is responsible for appeal of inpatient and outpatient authorization and medical necessity denials.

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REFERENCES

JHHS Finance Policies and Procedures Manual


- Policy No. FIN034 - JHHS Financial Assistance Program
- Policy No. FIN041 - Estimating Inpatient Payment Requirements
- Policy No. FIN045 - Verification of Insurance Benefits - Inpatient and JHCP Services
- Policy No. FIN063 - Self-Pay Collections
- JHCP Cash Collections Reference Manual

RESPONSIBILITIES - JHH/JHBMC

Patient Financial Services Representative	Payment denials received and documented. Denials should be worked within 5 business days. PFS to forward copies of denials to UM/Case Management upon receipt where appropriate.
Case Management/UM	Review payment denials/report and determine appropriateness of denials. Notify Patient Financial Services Department of results of review.
Administrative Secretary, UM	Receive notification of denial and forward to UM Senior Coordinator/Manager. Enter denials into log.
Senior Coordinator/Manager, UM	Review denial for possibility of appeal and process in appropriate manner. Reports appeal status to Patient Financial Services. Determines action for next appeal level.
Corporate Legal or Collections Attorney	Review denials for possibility of appeal when submitted for legal review by UM.
JHBMC Community Psychiatry	<p>For preauthorization denials, billing staff will first check to determine if the authorization was received through all available Community Psychiatry resources (payer web site, web-x etc). If authorization is found, the bill will be immediately resubmitted.</p> <p>Information concerning those denials for which authorization cannot be found will be forwarded to Community Psychiatry Managers/Supervisors. The Program manager will advise: 1) write off charge or 2) provide the valid documentation of authorization, 3) obtain an additional auth. The information shall be returned to the billing staff by e-mail or fax.</p> <p>The billing staff will then rework the claim or write off the charges. Trending is available through use of collection rate reporting.</p>

RESPONSIBILITIES - JHHCG

Follow-up payment denials received as appropriate and complete revenue cycle in accordance with outcome of denial appeal process.

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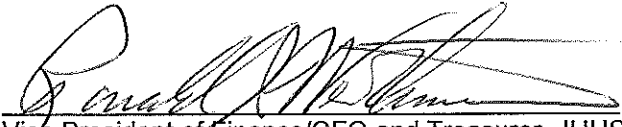
SPONSOR

Senior Director, Patient Finance (JHH, JHHS, JHBMC, HCGH)
 Senior Director of Finance (JHCP)
 CFO (JHHCG)


CYCLE REVIEW

Three (3) year

APPROVAL


 Vice President of Finance/CFO and Treasurer, JHHS

7-9-09
 Date

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PROCEDURES - JHH/JHBMC/HCGH

A. Inpatient Collections Cases


1. Patient Financial Services Representative
 - a. Document all actions in the automated billing system.
 - b. Continue collection efforts for any part of claim not denied.
 - c. If original denial is not appealed or if appeal is rejected and not continued, determine if other appropriate billing alternatives exist for claim, e.g., billing to another appropriate payor or billing to patient. If other billing alternatives are appropriate, complete billing and collection cycle. If alternatives are not appropriate, write-off account and classify denial type correctly.

2. Utilization Management/ Case Management/ Appeals
 - a. Receive written notification of denial from payor and record information in system. Determine if denial is appealable.
 - b. If denial will be appealed, prepare letter and medical record documentation according to payor's appeal process and forward to payor.
 - c. Monitor status of appeal on a regular basis (at least every 30 days).
 - d. Review outcome of appeal and determine whether further appeal is warranted. For further appeal, submit additional information or documentation to promote favorable resolution and continue to monitor appeal status.
 - e. Notify PFS of overturned cases.
 - f. Maintain a database of denied days and overturned days and coordinate with Patient Financial Services to assign a dollar value to denials and overturned cases.

3. Patient Financial Services Representative
 - a. Establish receivable on overturned cases and pursue collections.

B. Outpatient Collections – Pre-Authorization Claims

1. Patient Financial Services Representative
 - a. Rebill payor for improperly denied claims with supporting documentation. Bill patients if appropriate according requirements of third party payer.
 - b. Write off properly denied and unbillable claims to appropriate allowance account.


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C. Outpatient Collections – Technical Billing Denials

1. Patient Financial Services Representative
 - a. For Medical Records Denials, send UB04 and medical records (within payor's appeal time period requirements) to payor's appeals unit.
 - b. If rebilled claim denied, write off to appropriate allowance account.
 - c. If Non-Covered Service Denial, bill patient for services in accordance with JHHS Finance Policy No. FIN063 - Self-Pay Collections and complete billing and collections cycle and/or adjust off to appropriate allowance account.
 - d. If Incorrect Information denial, research case to obtain correct information. Contact patient in accordance with Patient Financial Services policies. Bill corrected claims to payor and uncorrected claims to patient in accordance with JHHS Finance Policy No. FIN063 - Self-Pay Collections.
 - e. If Patient Deductible and co-payment denial, rebill patient in accordance with JHHS Finance Policy No. FIN063 - Self-Pay Collections.
 - f. Collection efforts must continue on overturned cases until claim(s) are paid.

D. Utilization Management/Case Management

1. Administrative Secretary, UM
 - a. Receive notification of denial and forward to UM Senior Coordinator/Manager. Enter denials into report.
2. Senior Coordinator/ Manager, UM
 - a. Enter denials into automated billing system and review medical record to determine if appealable. If not to be appealed, notify Patient Financial Services department or codes account in billing system so that other billing alternatives can be pursued. If case is to be appealed, prepare documentation and send to payor's appeals unit. Coordinate with Corporate Legal as appropriate.
 - b. Monitor appeal and send denials or partial denials to Inpatient Collections for alternative billing.
 - c. Prepare report detailing results of appeal activities for Director of UM and VP of Finance/Chief Financial Officer. Forwards copy of appeal report to Patient Financial Services department bi-weekly for review.
3. Corporate Legal Department
 - a. Review denials for possibility of appeal when submitted for legal review by UM.

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PROCEDURES - JHHCG


Collections Staff

- a. Document all actions in the billing system.
- b. Rebill payor for improperly denied claims with supporting documentation. Bill patients if appropriate according to requirements of third party payer.
- c. Write off properly denied and unbillable claims to appropriate allowance account.
- d. Continue collection efforts for any part of claim not denied.
- e. If original denial is not appealed or if appeal is rejected and not continued, determine if other appropriate billing alternatives exist for claim, e.g., billing to another appropriate payor or billing to patient. If other billing alternatives are appropriate, complete billing and collection cycle. If alternatives are not appropriate, write-off account and classify denial type correctly.
- f. Receive oral or written notification of denial from payor and record information in billing system. Determine if denial is appealable.
- g. If denial will be appealed, prepare financial and medical record documentation according to payor's appeal process and forward to payor.
- h. Monitor status of appeal on a regular basis (at least every 30 days).
- i. Review outcome of appeal and determine whether further appeal is warranted. For further appeal, submit additional information or documentation to promote favorable resolution and continue to monitor appeal status.
- j. Maintain reporting of denial activity for trending and analysis.

PROCEDURES - JHBMC CPP

All Billing Staff
 Community Psychiatry Management

- a. Rejections/denials will be entered on the individual accounts. All rejections/denials are to be worked within one week from the posting date.
- b. For denials due to technical or administrative reasons, the staff

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person will research the problem and rebill within one week.

- c. For authorization denials, billing staff will first check to determine if the authorization was received through all available resources (payer website, web-x etc.).
- d. If authorization is found the bill will be resubmitted immediately.
- e. If authorization cannot be found, information concerning these denials will be sent to Program Manager by e-mail. The managers will meet with the responsible staff person(s) to review the problem. The Program Manager will indicate what further action needs to be done: 1) write off the charge if no authorization obtained and unable to do a retro authorization or 2) provide the valid proof of authorization. 3) obtain a retro authorization and provide information to billing staff. The Manager will provide this information by e-mail or fax copy of authorization within two days. If billing staff has not heard back within two days they will contact the Program Manager a second time for an update. Staff will continue to work with Program Manager on a continual basis until resolution.
- f. The billing staff then reworks the claim or writes off the charges.
- g. All actions are recorded in the system and will be used to determine Performance Improvements activities.
- h. Receive oral or written notification of denial from payor and record information in billing system. Determine if denial is appealable.
- i. If denial will be appealed, prepare financial and medical record documentation according to payor's appeal process and forward to payor. If medical records are required monitor the timeliness of receipt of these records.
- j. Monitor status of appeal every 30 days. For paper Medical Assistance claims every 60 days.
- k. Review outcome of appeal and determine whether further appeal is warranted. For further appeal, submit additional information or documentation to promote favorable resolution and continue to monitor appeal status.
- l. Review denial trending on the collection rate reports.