	The Johns Hopkins Health System	<i>Policy Number</i>	BIL021
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	Rejection/Denial Processing and Follow Up	<i>Revised</i>	12/8/05

POLICY:


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

PURPOSE: The purpose of this policy is to ensure that JHHS and its affiliates communicate and process third party payment denials in a consistent, appropriate and timely 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 and claims.

PROCEDURES:

INPATIENT DENIALS:

1. PFS notifies UR/Appeals Specialists at JHH of clinical denial information and notifies Financial Staff in front offices of administrative (authorization related) denials. For BMC and HCGH, appeals staff is notified.
 - a) Copies of rejection reports, EOB's and denial letters are forwarded to UR/Appeals Specialists with an appeal request form "grid" (see exhibit A).
 - b) When denial info is obtained via follow up telephone calls or online payor inquiry systems, the "grid" appeal request form is completed and faxed along with copies of hospital system screen prints to the appeals departments.
 - c) When denial info is provided on the CFS (BX/HMO) rounder log the denial is documented in hospital systems, the account balance is adjusted prior to billing and an appeal request form "grid" is not processed as the appeals departments already have the CFS rounder logs and receive denial letters directly from CFS.
2. PFS adjusts inpatient account "insurance" balances down to \$25.13 for JH accounts, \$25.25 for JH Transplants and \$.00 for BMC and HCGH.
3. Appeals departments enters the clinical denial info into the shared on line database that tracks denials for inpatients. For JHH C-View is only updated monthly. JHH and BMC provide weekly reports of new denials, overturns, and uphelds for immediate follow up in PFS. Overturned cases for HCGH are coordinated through the administrative assistant responsible for maintaining the log.
4. PFS Representatives review accounts monthly via the collector work queue follow up systems. In addition a monthly report is produced of accounts with a balance of \$25.13 for JHH.
 - a) Upheld denials: the JH \$25.13 balance should be adjusted to .00.
 - b) Overturns: supporting documentation of the overturns will be e-mailed to the appropriate

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Manager/Supervisor and they will receive copies of the overturned documentation from either the Administrative or Clinical appeals unit. Billing staff will review documentation and reverse previous allowance to restore accounts to the amount now due.

- c) A report will be produced of all overturns by month that will show the detailed patient information including current account balance. This report will be used to ensure that all overturns are correctly reinstated to the ATB.
- d) Appeals: The account is pending a response from the payor and the UR department regarding if the denial is overturned or upheld.

OUTPATIENT DENIALS:

1. For JHH and BMC rejection/denial reasons are received via EOB's, letters and electronic rejection reports. HCGH submits a grid for any E/R or Outpatient denial. In addition JHH submits a grid for outpatient accounts >\$5,000.
2. UR receives electronic rejection reports for selected payors and dollar amounts.
3. PFS reduces account balances to .00, minus patient co-payment or deductible amounts.

EMERGENCY ROOM DENIALS:


1. ED denials are reviewed via EOB's, remits, and/or electronic rejection reports. Non-emergent visit denials are written off taking payors, co-pays, etc., into consideration. Copies of rejections are sent to the ED Coordinator (for both JH and BMC) for review and possible appeal and to the HCGH outpatient appeals coordinator.

ADDITIONAL INFORMATION REQUESTS:

NOTE:

Payors often indicate additional information requests on the EOB's and remittances (itemized bills, treatment plans, pharmacy profiles, medical records, etc.) .

1. For JHH and BMC PFS Representative should first check EPR (electronic patient record) for immediate access of info to expedite information request process. For HCGH PFS Representative should check PCI.
2. If the information cannot be located in EPR a request must be submitted via the on line MRRS (medical record request system). For HCGH if not located in PCI a request must be faxed to Medical Records.
3. If an IP medical record is requested without a denial, PFS should contact the payor and based on information received, forward to appeals unit.
4. For JHH PFS Representatives should look in IBM initially for pharmacy profiles, or request that the data entry team perform a BDM inquiry for the pharmacy information. If the information is not available a request for information will have to be submitted to medical records or pharmacy.

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5. Any special requests for focused reviews or audits from Federal agencies (Medicare, Medicaid, Champus/Tricare) must be routed to the Compliance Department for review and guidance. Please refer to policy FIN111).

OTHER:

1. Reports are generated to identify when payor payment is .00., when a copy of the rejection is not received from a payor or cash applications. PFS Representatives review the accounts on these reports to determine why the payor did not make payment (denial, patient responsibility, etc.) and access WebX for the payer remit if needed.
2. If no rejection or no .00 payment is received the accounts appear in the collector work queues and on high dollar and aging reports for review and follow up.

Review Cycle

Three (3) years

Approval

Senior Director, JHHS

Date

Director, PFS Operations, JHHS

Date

PATIENT FINANCIAL SERVICES

4940 Eastern Avenue
5300 Alpha Commons, Suite 200
Baltimore, Maryland 21224



The Johns Hopkins Hospital • Johns Hopkins Bayview Medical Center • Howard County General Hospital
Facsimile Transmittal

Unit:

To: HCGH Appeals Department
5755 Cedars Lane
Columbia, Md. 21044
Phone:
Fax: 410-740-7731

From:

Phone:
Fax:

• • • • • • • • • •

Date: / /

Dear
Please begin the appeal process for the following patient:

Patient Name	Med Rec # Patcom #	Dates of Service	Payer & Address	Denial Reason	Medical Service	Dates Denied	<u>F/C</u>	Denied \$ Amt.

If you should require any additional information, contact PSC Rep _____ at extension _____.

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