|  |  |  |
| --- | --- | --- |
| Claims Submission and Denial  | **Last Revision:** |  April 2019 |
| **Last Reviewed:** |  April 2020 |
| **Applies to the following THA Group of Companies:**  | * Island Health Care
* Island Hospice
* Palliation Choices
* RightHealth®
* Independent Life at Home
 |
| **Included in the following THA Manual:** | Administrative Policies & ProceduresFinance |

#### **POLICY**

THA Group submits all claims promptly according to guidelines established by each carrier.

**PROCEDURES**

1. Commercial/Medicaid/Indigent/Self Pay claims will be batched and submitted on the 1st and 16th of each month.
2. Claims may not be submitted to a carrier until they have been reviewed.
3. For claims that are filed electronically and for which a confirmation is received, the confirmation should be reconciled against each batch when received. Discrepancies between the confirmation and the original claims submission should be investigated and resolved as soon as possible.
4. Medicare and Medicare Advantage claims will be batched and submitted on a daily basis.
5. Professional claims for Palliation Choices will be batched and submitted on the 1st and 16th of each month.
6. Deductibles and co-insurance balances are transferred to Self Pay as soon as the payment from the primary payor has been posted.
7. If a denial is received on a claim, Finance will determine the proper procedure for correcting or obtaining information to resubmit the claim for payment.
	1. **Denied – incorrect ID number:** Finance will re-verify the ID number in the electronic health record. If the ID number is the same, Finance will follow up with the patient and/or referral source to obtain correct payor information.
	2. **Denied** – **No Authorization:** Once the claim has been denied for no authorization or exceeds authorization, Finance will check the authorization information entered in the electronic health record. If it appears that the authorization was not obtained or more visits given than authorized, a retro-authorization will be obtained if approved by the insurance company; otherwise, the balance will be subject to write-off.
	3. **Denied – Insurance changed:** If the commercial claim denies because the primary insurance indicates that their coverage terminated, then Finance will call the patient to obtain the information on the new insurance, verify, and obtain pre-authorization (if necessary). If the patient has Medicare primary and they deny for other insurance, then Finance will check CMS Common Working File to obtain the insurance information from their web site. The payor will be changed from Medicare to the new insurance in the electronic health record, and Finance staff will verify eligibility and obtain pre-certification if necessary.
8. **Appeals:** If a claim denies for no authorization and we have confirmation of the approved visits, Finance will call the insurance company to see if they will reprocess from our telephone conversation. If an appeal is needed, then Finance will initiate the proper paperwork. If a patient changes payors during the course of our visits, then Finance will file an appeal indicating that we were not aware of the change by the patient.