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POLICY

This policy applies to the Johns Hopkins Health System (JHHS) Patient Financial Services (PFS) Division and the following entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center (JHBMC), and Howard County General Hospital (HCGH).

PURPOSE

To accurately coordinate the benefits on every admission, outpatient encounter, or start of care, and to evaluate claims to ensure that complete and accurate information has been supplied on each claim in accordance with Medicare billing guidelines.

REFERENCES


JHHS Finance Policies and Procedures

- Policy No. FIN044 – Inpatient Admissions and Financial Responsibility
- Policy No. FIN045 – Verification of Insurance Benefits-Inpatient and JHMSC
- Policy No. FIN064 – Third Party Billing Practices
- Policy No. FIN091 – Medicare Secondary Payer Requirements
- Policy No. FIN118 – Policy on Advance Beneficiary Notices

PROCEDURE

A. To establish correct coordination of benefits


1. Identify accounts that contain potential conflicts between Medicare Secondary Policy (MSP) responses and primary-payer assignments.
2. Process Medicare claims electronically to Medicare through the hospital electronic billing vendor, using the appropriate occurrence, conditions, and value codes. When appropriate, document in remarks (UB04 field locator 80) any specific comments relating to the claim's billing period that are needed for accurate bill review and payment.
3. For complete billing instructions, refer to the Medicare IOM (Internet-Only Manual): www.cms.hhs.gov/manuals/iom/List.asp
4. When the primary payer denies or delays payment, the hospital will bill Medicare for a conditional payment for the following reasons:
 - a) Services are covered by a liability insurer
 - b) Case is in litigation, or reasonable attempts to obtain payment from third party have encountered lengthy delays of more than 120 days
 - c) Beneficiary is appealing the case
 - d) Because of physical or mental incapacity of the beneficiary, the hospital was unable to file a claim with the primary insurer in time

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5. When a Medicare beneficiary has primary coverage with a managed care provider, *before submitting the secondary claim to Medicare*: insert the appropriate value codes in UB04 field locators 39 through 41 and report condition codes in UB04 field locators 18 through 28.
 - a) If the managed care organization makes a reduced payment because the provider is not in the network, or because the inpatient service rendered is a newly covered service that is not paid by the HMO, submit a claim to Medicare and report the amounts along with the appropriate value codes in UB04 field locators 39 through 41.
6. Automobile medical or no-fault insurance claims are to be reviewed by the Patient Financial Services Rep prior to submission to Medicare—following these guidelines and completing the appropriate UB04 fields:
 - a) Any claims received by the billing staff that contain accident or trauma diagnosis codes should be reviewed for accuracy of the primary-payer assignment and forwarded to the appropriate billing personnel for submission of the claim to the automobile medical or no-fault insurance.
 - b) When a payment or denial notice is received, submit a claim to Medicare with all the applicable codes (condition codes, occurrence codes, value codes) and remarks (UB04 field locator 80).
7. *For Medicare beneficiaries who have Black Lung Disease, are 65 or older and covered by an EGHP, are receiving services due to a work-related illness, injury or disease, or are eligible for Medicare due to End-Stage Renal Disease*: use the HIQA (Health Insurance Query Part A) eligibility information screens, related account reviews, MSP questionnaire responses, and follow the billing guidelines in the Medicare Hospital Manual established for correct identification and submission of claims.

B. For UB04 review to determine completeness of claims

1. Review UB04 to verify that all required data elements for Medicare billing are complete.
2. Review UB04 to ensure that all applicable occurrence codes, condition codes, and value codes have been supplied to accurately report services to Medicare.
3. Every day, staff should report missing and/or inaccurate data on error-tracking report for submission to registration management for feedback and corrective action.
4. Use automated edits in the electronic billing system to identify any coding conflicts with Medicare's Local Coverage Determination (LCD) and Medicare's National Coverage Determination (NCD).
 - a) For policy conflicts, staff will check claim for the assignment of occurrence code 32. The assignment of occurrence code 32 by the service area acts as notification to the PFS department than an Advanced Beneficiary Notice (ABN) was signed, and that a copy is on file in the department. If an ABN exists, staff will process the claim in

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accordance with the Medicare Hospital Manual instructions for complete and accurate billing.

- b) *If no ABN was signed and services are less than \$100.00*, the service must be submitted to the unit supervisor for write-off consideration as a provider liability. The claim should be submitted to Medicare with all charges associated with the LCD conflict reported under the covered column on the Medicare claim. The claim must also contain documentation (in the remarks section of the UB04; field locator 80) that includes the CPT and/or HCPC code that has been identified as a potential non-covered service.
- c) *If services exceed \$100.00 and no ABN has been signed*, a claim review by departments and/or medical records must be requested; an evaluation of coding on disputed accounts should be completed before the PFS Rep can submit the claim for write-off consideration as a provider liability.
- d) For Correct Coding Initiative conflicts, *before submitting the claim to Medicare staff* will check the crosswalk list provided by lab management for any lab codes with approved coding corrections and revise the claim. *If charges were not identified on correct coding crosswalk and charges are less than \$100.00*, the service should be submitted for reversal of revenue charge.

All other coding conflicts must be held in the Billers' suspense file within the electronic billing system; the UB04, along with the itemized charge detail, should be forwarded to departments and compliance for corrective action.

C. Follow-Up Procedures

1. Every day, review the FISS for claims that fail transmission and require investigation and correction.
2. Every month, review all accounts—including collector queue/reminders as well as special monthly reports (e.g., >\$10,000); research and resolve claims that remain unpaid beyond dollar/aging standards.
Unpaid claims will appear in the PFS Rep's collector queue every 30 days for follow-up.



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SPONSOR

Senior Director, Patient Financial Services, JHHS

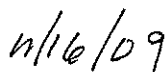
REVIEW CYCLE

Three (3) years

APPROVAL




Senior Director, JHHS



Date



Director, PFS Financial Support, JHHS



Date