	The Johns Hopkins Health System	<i>Policy Number</i>	BIL007
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	Managed Care Billing Procedures	<i>Revised</i>	11/29/07

POLICY

This policy applies to the Johns Hopkins Health System (JHHS) Patient Financial Services (PFS) Department.

DEFINITION

The purpose of this policy is to establish a consistent and uniform method of bill submission to payers for all patients receiving services at JHHS affiliates.

REFERENCE

JHHS Financial 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 – Inpatients and JHMSC Services

RESPONSIBILITIES

Patient Financial Services
 Representative

Review all claims generated by the affiliate(s) billing system and research and correct any missing or erroneous information. Forward registration errors to appropriate registration area.

Submit claims electronically or on paper in accordance with the payers requirements for primary, secondary, etc insurers. Attach all necessary attachments in accordance with payers requirements.

PROCEDURES


Billing Format: For JHH, JHBMC, HCGH hospital billing, the UB04 is the standard bill form, which will be submitted to payors. The 1500 is the standard bill form for O/P unregulated offsite clinics. Both paper and EDI format are used for claim submission.

Managed Care Electronic Claims:

1. 1500 and UB04 claims are reviewed and edited for accuracy and submitted to the Managed Care payor on a daily basis.
2. The account is set-up for review within 30-45 days after final bill date.

Managed Care Paper Claims:

1. Claims are printed on a local printer or sent to offsite billing company.

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2. Accounts requiring itemized bills to accompany the UB04 are:
 - a) JAI greater than \$35,000
 - b) Amerigroup late charges
3. Managed Care secondary claims are submitted upon receipt of primary payment and set up for review within 30-45 days.

Follow-up:

1. Accounts are reviewed and followed up through Keane and/or Meditech follow up collector queues, auto rejection reports, ATB's and monthly high dollar reports.
2. Appropriate follow-up includes a review of the payors EOB and/or auto reject coding to determine the cause of the rejection and a resolution for the error.
3. An on-line inquiry, phone call and/or fax to the payor will be necessary to billing related issues.
4. A weekly report is received for High dollar accounts. These accounts are followed up by the PFS Rep and receive additional review by management for payor status.
5. Reconciliations are performed for payors with large outstanding receivables.

SPONSOR

Senior Director, Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years

APPROVAL

 Senior Director, JHHS

 Date

 Director, PFS Financial Support, JHHS

 Date