	<b>The Johns Hopkins Health System</b> <b>Policy &amp; Procedure</b>	<i>Policy Number</i>	<b>BIL007</b>
	<i>Subject</i>	<i>Effective Date</i>	<b>6/15/01</b>
	<b>Managed Care Billing Procedures</b>	<i>Page</i>	<b>1 of 2</b>
		<i>Revised</i>	<b>9/1/09</b>

## **POLICY**

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

## **PURPOSE**

To establish a consistent and uniform method for submitting bills to Managed Care payers for all patients receiving services at JHHS affiliates.

## **REFERENCES**

### **NUBC Guidelines**

### **JHHS Financial Policies and Procedures Manual**

Policy FIN034 – JHHS Financial Assistance Program

Policy FIN041 – Estimating Inpatient Payment Requirements

Policy FIN045 – Verification of Insurance Benefits—Inpatients and JHMSC Services

## **RESPONSIBILITIES**

Patient Financial Services  
Representatives

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

Submit claims electronically or on paper in accordance with each payer's requirements for primary, secondary, etc., insurers. Include all necessary attachments in accordance with payment requirements.

## **PROCEDURE**

### **Billing Format**


For JHH, JHBMC and HCGH hospital billing, the UB04 is the standard bill form for third-party payers. The CMS 1500 is the standard bill form for off-site, unregulated programs (such as Community Psychiatry). Affiliates will submit claims on paper and in EDI format, depending on the specifications of each payer.

### **Managed Care Electronic Claims**

1. Every day, 1500 and UB04 claims are reviewed and edited for accuracy and then submitted to the Managed Care payer.
2. Each account is set up for review within 30 days after the final bill date.

### **Managed Care Paper Claims**

1. Claims are printed on a local printer or sent to an off-site billing company.

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2. Accounts requiring special date range and itemized bills to accompany the UB04 are:
  - JAI \$35,000 and greater “stop-loss” accounts
  - Kaiser and USFHP \$50,000 and greater accounts
3. Managed Care secondary claims are submitted upon receipt of primary payment and then set up for review within 30 days.

**Follow-Up**

1. Accounts are reviewed and followed up through Keane and/or Meditech follow-up collector queues, auto-rejection reports, ATBs, and monthly high-dollar reports.
2. Appropriate follow-up includes a review of the payer’s EOB and/or auto-reject coding to determine the cause of the rejection and to resolve the error.
3. To resolve some billing-related issues, it may be necessary to make an online inquiry or phone call or to send a fax to the payer.
4. Every week the PFS Rep will receive a report of high-dollar accounts; the Rep will follow up each account, and management will review all high-dollar accounts for payer status.
5. Reconciliations are performed for payers with large outstanding receivables.

**SPONSOR**

Senior Director, Patient Financial Services, JHHS

**REVIEW CYCLE**

Three (3) years

**APPROVAL**

  
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**Senior Director, JHHS**

11/16/09  
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**Date**

  
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**Director, PFS Financial Support, JHHS**

11/18/09  
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**Date**