	The Johns Hopkins Health System PFS Policies and Procedures Manual	<i>Policy Number</i>	BIL009
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		<i>Revised</i>	12/12/08

POLICY

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

PURPOSE

To establish a consistent and uniform method for submitting insurance claims to commercial third-party payers for all patients receiving such payable services at JHHS affiliates.

DOCUMENTATION

Each affiliate will establish guidelines that define the documentation required to generate a complete bill.

Billing Format

The standard bill forms which will be submitted to commercial insurance payers are the UB04 (paper) and the ANSI 837 (EDI format).

All claims will be submitted electronically to commercial insurance payers that can accept the standard ANSI 837 format. All other claims will be manually billed via a paper claim.

Interim and Late-Charge Billing

Interim and late-charge billings will be submitted in accordance with commercial insurance payers' requirements.

Concurrent Patient Billing

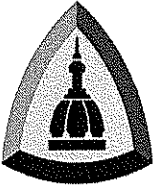
Patients will be billed for their expected liabilities concurrently with the commercial insurance payers whenever a patient liability has been identified through the insurance verification process.

Linked Bills

PFS will comply with all commercial insurance payers' requirements for linking re-admission services to the inpatient bill.

Accountability for Patient Data

All intake areas are accountable for collecting and validating accurate patient data as required to generate a correct bill form. PFS will verify and update systems with newer or more accurate validated patient data as required to generate a correct bill form.

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RESPONSIBILITIES

Patient Account Representatives

- Review all claims generated by the billing system and research and correct any missing or erroneous information.
- Submit clean paper claims or clean electronic claims in accordance with the payer's requirements.
- Perform periodic follow-up on unpaid claims and re-submit claims as appropriate.
- Review remittance advice for rejected or denied claims and bill patients for any non-covered service(s) as appropriate.
- Generate allowance required for balances that cannot be billed to patients.

Supervisor

- Monitor the billing process for accuracy.
- Maintain appropriate files and logs on billing volume, timeliness of payment, aging, errors, number of re-bills, and reasons and denial rates.


Manager

- Monitor billing effectiveness through review of system reports, aging directories, and rejection rates.
- Review current rules and regulations—both code and administrative—to ensure compliance with all applicable regulations.

PROCEDURES

Patient Account Representatives

- Prepare claims from the billing system for electronic or manual (or equivalent) submission. Bill the commercial insurance payer. Bill the patient/responsible party for any verified self-pay portion concurrently with the third-party billing.
- Review all hard-copy and electronic bills for completeness.

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- Research and correct missing or incorrect information on the bill form. Report all bill-form errors and omissions with copies of the same bill form to Supervisor, and maintain appropriate logs or databases of omissions and errors.
- Submit clean claims either through paper or electronic submission in accordance with payer guidelines within one to two days of receipt.
- Check status of electronic claims within two days of submission. Correct any errors and re-submit claim.
- Check status of unpaid paper claims within 30 to 45 days of submission. Correct any errors and re-submit claims.
- Review Aged Trial Balance (ATB) monthly and research and resolve claims that remain unpaid beyond aging/dollar standard.
- Process and act upon commercial insurance carriers' remittance and correspondence within five business days of receipt.
- Change financial class as appropriate.
- Generate allowance-adjustment transactions as appropriate.
- Transfer accounts from active A/R to inactive by allowance codes as appropriate (with management approval).

Supervisor

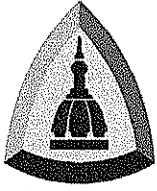
- Maintain appropriate databases—either paper or electronic—to monitor productivity, error ratio, rejected/denied claims, and aging of claims.

Manager

- Review system reports for productivity and efficiency, rejection directories, and denial rates.
- Ensure compliance with all applicable rules and regulations.
- Monitor effectiveness through ATB and cash reports.

SPONSOR

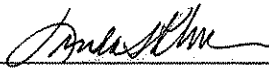
Senior Director, Patient Financial Services, JHHS

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REVIEW CYCLE

Three (3) years

APPROVAL



 Senior Director, JHHS

1/2/09

 Date



 Director, PFS Operations, JHHS

12/18/08

 Date