	The Johns Hopkins Health System	<i>Policy Number</i>	BIL010
		<i>Effective Date</i>	2/18/00
	PFS Policy & Procedures Manual	<i>Page</i>	1 of 5
	<i>Subject</i>	<i>Revised</i>	2/22/08
	Blue Cross Billing Specifics		

POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) and the following affiliated entities: The Johns Hopkins Hospital (JHH), and Johns Hopkins Bayview Medical Center, Inc. (JHBMC) and Howard County General Hospital (HCGH).

Purpose

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

Documentation

Each affiliate will establish guidelines defining the responsibilities of documentation required to generate a complete bill.

Billing Format

For JHH, JHBMC and Howard County General hospital billing, claims are billed on the UB-04 or HIPAA 837 bill form, which will be submitted to Blue Cross payers. The HCFA 1500 form will be the standard form, we also use for CORF billing at other sites such as Greenspring, and Community Psychiatry. Affiliates will submit electronic claims to Blue Cross according to Blue Cross specifications that can accept the standard EDI format associated with these bill forms.


Interim and Late Charge Billing

Interim Billing Specifics: Each affiliate will generate an interim bill every 30 days, if applicable. Interim bills must be submitted sequentially as Blue Cross requires. Interim claims include the ICN for the previously paid interim. The ICN must be included in FL64.

Late Charge Specifics: Late charges will be billed via the automated late charge processing. Upon receipt of claims for late charges Patient Financial Services Reps will submit claim in accordance with the Late Charge Billing Policy for Patient Financial Services.

Concurrent Patient Billing

Each affiliate will bill patients for their expected liabilities concurrently with their third party payers whenever a patient liability has been identified through the insurance verification process and the affiliate's system supports concurrent billing.

	The Johns Hopkins Health System	<i>Policy Number</i>	BIL010
	PFS Policy & Procedures Manual	<i>Effective Date</i>	2/18/00
		<i>Page</i>	2 of 5
	<i>Subject</i>	<i>Revised</i>	2/22/08
	Blue Cross Billing Specifics		

Linked Bills

All affiliates will comply with payer requirements for linking readmission services to the inpatient bill, mother and baby bill combinations, 72-hour rule and other examples of linked billing.

Accountability for Patient Data

All intake areas, including but not limited to the Emergency Departments, clinics, Johns Hopkins Outpatient Center, diagnostic testing, and Admitting Departments, are accountable for collecting and validating accurate patient data as required to generate a correct bill form.

REFERENCES

JHHS Finance Policies and Procedures Manual

- Policy No. FIN045 - Verification of Insurance Benefits - Inpatient and JHMSC Services
- Policy No. FIN041 - Estimating Inpatient Payment Requirements
- Policy No. PFS016 - Late Charge Billing Policy
- Policy No. PFS006 - Secondary Billing Policies
- Policy No. FIN065 - Payment Denials
- Policy No. BIL005 - Accounts Receivable Follow Up Keane, Meditech & RAM

RESPONSIBILITIES


Patient Financial Services Coordinators

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

For primary and secondary insurers, submit claims electronically or on paper in accordance with the Blue Cross requirements. Attach all necessary documents to record with payment requirements.

Perform routine follow up on unpaid claims to bring to resolution and resubmit claims, as appropriate.

Generate allowance required for balances that cannot be billed to patients as a result of affiliate's contractual arrangements with payers. Process all rejected services as appropriate.

	The Johns Hopkins Health System	<i>Policy Number</i>	BIL010
	Policy & Procedure	<i>Effective Date</i>	2/18/00
	<i>Subject</i>	<i>Page</i>	3 of 5
	Blue Cross Billing Specifics	<i>Revised</i>	2/22/08

PFS Coordinator
 Manager, Director of Business
 Office (JHMSC)

Monitor billing and collection effectiveness through review
 of system reports, aging and rejections rates.

PROCEDURES - JHH, JHBMC & HCGH

1. Patient Financial Services
 Coordinator

Prepare claims from affiliate's Patient Financial
 Services system for electronic or manual submission to Blue
 Cross Bill patient/responsible party for any verified self-pay
 portion concurrently with any third party billing.


Review electronic and hard copy bills for completeness
 and receipt, via reconciliation reports from electronic
 vendor.

Research and correct missing/incorrect information. Report
 bill form errors and omissions via copies of same to
 appropriate registration area for correction in registration
 system.

Submit clean claims via electronic/paper submission in
 accordance with payer guidelines within 1 - 2 days of
 receipt, with exception to claims needing additional
 information.

Review Aged Trial Balance monthly and/or collector
 assignments and research and resolve claims that remain
 unpaid beyond dollar/aging standards. Unpaid claims will
 appear in the Patient Financial Service Representative
 Collector queue systems for follow-up.

Claims will queue for follow-up every 30 days within the
 hospital system. Review Aged Trial Balance monthly and
 research and resolve claims that remain unpaid beyond
 dollar/aging standards. Check status of unpaid third party
 paper claims within 30 - 45 days of submission. Correct any
 errors and resubmit claims.

	The Johns Hopkins Health System	<i>Policy Number</i>	BIL010
	PFS Policy & Procedures Manual	<i>Effective Date</i>	2/18/00
	<i>Subject</i>	<i>Page</i>	4 of 5
	Blue Cross Billing Specifics	<i>Revised</i>	2/22/08

Review High Dollars


Review secondary insurers upon receipt of primary payor, to insure that secondary claim has been billed if not complete billing of secondary claim.

Process and act upon third party remittance and correspondence within five (5) business days of receipt:

- 1) Change insurance to self-pay to bill patient/responsible party for any non-covered services as appropriate. Automated processing for Blue Cross remittances.
- 2) Generate allowance adjustment transactions as appropriate if affiliate's contractual agreement with payer stipulated that patients cannot be billed under certain circumstances, such as: no authorization obtained, acute-care services not required, beyond billing statute, etc.
- 3) Submit all denied adjustments for write-off.
- 4) Submit appeals request for both administrative and medical necessity to the appropriate department, i.e., U.M. for appropriate follow-up.

2. Patient Financial Services
System Support Manager

Review system reports for billing productivity and efficiency, high dollar and/or high age accounts, bill holds, etc. Review and approve any accounts transferred to bad debt receivables.

	The Johns Hopkins Health System	<i>Policy Number</i>	BIL010
	PFS Policy & Procedures Manual	<i>Effective Date</i>	2/18/00
	<i>Subject</i>	<i>Page</i>	5 of 5
	Blue Cross Billing Specifics	<i>Revised</i>	2/22/08

SPONSOR

Senior Director, Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years

APPROVAL

Senior Director, JHHS

Date

Director, PFS Operations, JHHS

Date