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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), Bayview Medical Center (JHBMC), and Howard County General Hospital (HCGH).

PURPOSE

To establish a consistent and uniform method for submitting bills to Blue Cross for all patients who receive services at JHHS hospitals.

REFERENCE

JHHS Finance Policies and Procedures Manual

- Policy FIN041 – Estimating Inpatient Payment Requirements
- Policy FIN045 – Verification of Insurance Benefits
- Policy FIN065 – Payment Denials
- Policy PFS006 – Secondary Billing Practices
- Policy PFS016 – Late-Charge Billing Policy
- Policy BIL005 – Accounts Receivable Follow-Up: Keane, Meditech & RAM

RESPONSIBILITIES

Billing Format


Claims are billed on the UB-04 or HIPAA 837 bill forms. For CORF billing at Greenspring and Community Psychiatry, we also use the HCFA 1500 as the standard form.

Interim Billing Specifics

If applicable, each affiliate will generate an interim bill every 30 days. Interim bills must be submitted sequentially as Blue Cross requires. Interim claims include the ICN (Initial Claim Number) for the previously paid interim. The ICN must appear in Field Locator 64 of the UB04.

Late-Charge Specifics

Late charges will be billed via automated late-charge processing. When PFS Representatives receive claims for late charges they will submit them in accordance with the Late Charge Billing Policy for PFS (PFS016).

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Concurrent Patient Billing

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

Linked Bills

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

Patient Financial Services Coordinators

Review all claims generated by the hospitals' billing systems and research and correct any missing or erroneous information. Return or report Registration errors to their sources for correction.

For primary and secondary insurers, submit claims electronically or on paper in accordance with Blue Cross requirements. Include all necessary attachments in accordance with payment requirements.


Perform routine follow-up on unpaid claims to resolve them, and resubmit claims as appropriate.

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

PFS Coordinator

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

Manager, Director of Business Office (JHMSC)

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PROCEDURE

Patient Financial Services Coordinator

Prepare claims from affiliate's PFS system for electronic or manual submission to Blue Cross. Bill patient or 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 or incorrect information. Report bill-form errors and omissions (using copies of these errors) to the appropriate registration area for correction in the registration system.

Except for claims that require additional information, submit clean claims via electronic or paper submission in accordance with payer guidelines *within one to two days of receipt*.

Each month, review Aged Trial Balance and/or collector assignments, and research and resolve claims that remain unpaid beyond dollar/aging standards. (Unpaid claims will queue for follow-up every 30 days within each hospital system.)


Review high-dollar accounts.

Once you have received payment from the primary payer, review secondary insurers to make sure the secondary claim has been billed. If it has not, complete the billing of the secondary claim.

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

To bill patient or responsible party for any non-covered services, change insurance to any remaining insurances until all payers are exhausted.

Generate allowance-adjustment transactions as appropriate if the affiliate's contractual agreement with the payer stipulates that the patient cannot be

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billed under certain circumstances (such as no authorization obtained, acute-care services not required, beyond billing statute, etc.).

Submit an appeals request for both administrative and medical necessity to the appropriate department (PIUM) for follow-up.

**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.


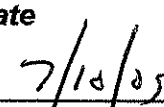
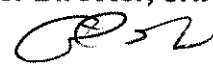
SPONSOR

Senior Director, Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years

APPROVAL

 <hr/> Senior Director, JHHS	<hr/> Date 
 <hr/> Director, PFS Operations, JHHS	<hr/> Date