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|  | The Johns Hopkins Health System Policy & Procedure | <i>Policy Number</i> | BIL011 |
| | | <i>Effective Date</i> | 6/30/99 |
| | <i>Subject</i> Medicaid Billing Specifics | <i>Page</i> | 1 of 3 |
| | | <i>Revised</i> | 9/1/09 |

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 Medicaid for all patients who receive services at JHHS hospitals.

REFERENCE

NUBC Guidelines
 JHHS Finance Policies and Procedures Manual
 Policy FIN034 – JHHS Financial Hardship
 Policy FIN041 – Estimating Inpatient Payment Requirements
 Policy FIN045 – Verification of Insurance Benefits

RESPONSIBILITIES

Patient Financial Services Representatives

Review all claims generated by the hospital billing system.
 Research and correct any missing or erroneous information.
 Return or report Registration errors to their sources for correction.

Submit claims electronically or on paper in accordance with the payer requirements for primary, secondary, tertiary.

Include all necessary attachments in accordance with payer requirements.


PROCEDURE

Medicaid Billing Procedures

The billing format for JHH, HCGH and JHBMC is the UB04 claim form or the 837 electronic file. For JHH and JHBMC, the HCFA 1500 claim form is used for billing off-site psychiatric services. [sentence deleted]

Medicaid Electronic Claims

- Claims are received each day through the electronic billing system; this system automatically edits bills to ensure that all required information is included and accurate.
- All missing or incorrect information from an exception report is reviewed and edited daily for accuracy, and claims are submitted to the DHMH.
- The account is set up to review within 30 days of final billing.

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Medicaid Paper Claims


- Claims are submitted on paper if they require an attachment *or* if the billing date is more than twelve (12) months from the admission date.
- Claims are system-generated and printed on a local printer.
- Claims are reviewed for accuracy and any necessary documentation is attached (attached forms may include 216, sterilization or hysterectomy, etc.); claims are then forwarded to DHMH by courier every day.
- Medicaid secondary claims are submitted on paper with the primary payor's EOB.
- The account is set up to review within 30 days of submission.

Medicaid Inpatient Claims

- Claims are matched with the patient's billing folder. (Billing folders are forwarded from the MAT Team once a 3808 [authorization] is completed by a Kepro agent via the online iExchange system).
- The Resource amount is entered into the hospital systems and recorded on the UB04.
- Claims are matched with the 3808 information and updates and adjustments are made to the claims.

Follow-up

- Accounts are reviewed and follow-up is done through the collector work queues or an ATB. Re-submission of paper claims is done every 60 days to maintain statute. A receipt is attached which is stamped by DHMH and returned as proof of submission.
- Follow-up includes a review of the weekly Medicaid remittance to determine the cause of rejection and resolution of the error.
- Some cases may require a phone call to Medicaid to resolve issues that delay or prevent payment.
- A high-dollar-account report is received weekly. These accounts are reviewed by PFS representatives as well as managers to monitor payment status.

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SPONSOR

Senior Director, Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years

APPROVAL



 Senior Director, JHHS

11/16/09

 Date



 Director, PFS Financial Support, JHHS

11/24/09

 Date