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POLICY

This policy applies to the Johns Hopkins Health System (JHHS) Patient Financial Services (PFS) Department and to the following entities – The Johns Hopkins Hospital (JHH), Bayview Medical Center (JHBMC), and Howard County General Hospital (HCGH).

DEFINITION

The purpose of this policy is to establish a consistent and uniform method of bill submission to Medicaid for all patients receiving services at JHHS hospitals.

REFERENCE

JHHS Finance Policies and Procedures Manual
 Policy No. FIN034 - JHHS Financial Hardship
 Policy No. FIN041 - Estimating Inpatient Payment Requirements
 Policy No. FIN045 - Verification of Insurance Benefits

RESPONSIBILITIES

Patient Financial Services
 Representatives

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

Submit claims electronically or on paper in accordance with the payers requirements for primary, secondary, etc insurers. Attach all necessary attachments in accordance with payers requirements.


PROCEDURES

Medicaid Billing Procedures

The billing format for JHH, HCGH and BMC is the UB04 claim form or the 837 electronic file. The HCFA 1500 claim form is used for billing offsite psychiatric services for JHH and for BMC. The primary billing is performed through an EDI format to the payor.

Medicaid Electronic Claims

Claims are received through the Electronic billing system daily.

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- UB04 and HCFA 1500 claims are reviewed and edited for accuracy and submitted to the DHMH on a daily basis.
- The account is set-up for review within 30 days, after final billing.

Medicaid Paper Claims

- Claims are system generated, printed on a local printer or printed to offsite billing company.
- Claims are submitted on paper if they require an attachment or the billing date is greater than 9 months from admission date.
- Claims are reviewed for accuracy and the necessary documentation is attached and forwarded by courier to the DHMH on a daily basis, (attached forms include: 216, sterilization or hysterectomy).
- Medicaid secondary claims are submitted on paper with the primary payors EOB.
- The account is set-up for review within 30 days after submission.

Follow-up

- Accounts are reviewed and followed up through collector follow up work queues or an ATB. Resubmission of paper claims is done every 60 days to keep statute. A receipt is attached to be stamped by DHMH and returned as proof of submission.
- Appropriate follow-up includes a review of the payors EOB to determine the cause of rejection and a resolution for the error.
- In some cases a phone call to the payor will be necessary to resolve issues, which delay or prevent payment.
- A weekly report is received for high dollar accounts; these accounts are followed up on by the PFS Rep and receive additional review by management for payment status.

SPONSOR

Senior Director, Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years

APPROVAL

Senior Director, JHHS

Date

Director, PFS Financial Support, JHHS

Date



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