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	Workers' Compensation Billing Practices	<i>Revised</i>	12/4/08

POLICY

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

PURPOSE

To establish a consistent and uniform method for submitting insurance claims to Workers' Compensation 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 form which will be submitted to Workers' Compensation payers is the UB04. All claims will be submitted as a paper claim to Workers' Compensation payers with the medical record attached.

For ORF, the standard bill form which will be submitted to Workers' Compensation payers is the 1500 form. All such claims will be submitted as a paper claim to Workers' Compensation payers with the medical record attached.

Interim and Late-Charge Billing

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

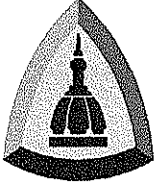
Concurrent Patient Billing

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

Linked Bills

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

Accountability for Patient Data

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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.

RESPONSIBILITIES

Admitting Representatives

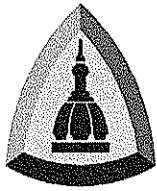
- The employer information is **not** the acceptable billing information. *The actual Workers' Compensation carrier information* is needed to appropriately bill these claims.
- If the Workers' Compensation carrier information is not available, the claim will be registered as a self-pay account. *The Workers' Compensation carrier should be the sole and primary carrier for all work-related treatment.*
- The standard-of-care information should be recorded in the notes for each account, in case treatment is not the responsibility of the Workers' Compensation carrier.
- *For all out-of-state Workers' Compensation claims*—the form on page 14 of Policy FIN045 (Verification of Insurance Benefits-Inpatient) should be completed to ensure that we are reimbursed according to Maryland fee-for-service rates.

Patient Account Representatives

- Review all claims generated by the billing system and research and correct any missing or erroneous information.
- Submit clean paper claims in accordance with the payer's requirements, with the medical records attached.
- 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 service that is not deemed to be the result of a work-related injury, according to Maryland law.
- Generate allowance required for balances that cannot be billed to patients.
- Ensure that claims are paid according to the fee-for-service Maryland rates—with the exception of accounts for which the fee-for-service rate does not apply (e.g., out-of-state claims without signed Workers' Compensation form).

Supervisor

- Monitor the billing process for accuracy.

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- 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 manual submission. Bill the Workers' Compensation payer. Bill the patient/responsible party for any verified self-pay portion concurrently with the third-party billing.
- Review all bills for completeness.
- 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 through paper submission in accordance with payer guidelines within one to two days of receipt.
- Check status of unpaid 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 Workers' Compensation carriers' remittance and correspondence within five business days of receipt.
- Change financial class as appropriate.
- Generate allowance-adjustment transactions as appropriate.

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- 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

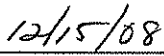
REVIEW CYCLE

Three (3) years

APPROVAL



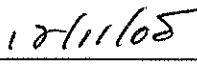
Senior Director, JHHS



Date



Director, PFS Systems JHHS



Date