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	Secondary Billing and Cross-Over Billing	<i>Revised</i>	11/29/07

POLICY

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

PURPOSE

The purpose of this policy is to establish a consistent and timely process for initial secondary claims submission and outline how to handle electronic cross-over claims that do not cross.

RESPONSIBILITIES

Secondary Billing Team (JHHS)

Processing of all initial PFS secondary claims. This includes accelerated Medicare secondary claims.

PROCEDURES

- 1) Medicare billing representative will print all secondary bills and EOBs from CareMedic and deliver to the Secondary Billing Team for JHHS.
- 2) Daily report will be generated to list accounts where primary payments were received for accounts that have secondary insurance for JHH and BMC. For HCGH, these are processed when primary voucher is worked.
- 3) PFS Reps will print EOB from document imaging.
- 4) PFS Reps will print Keane and/or Meditech on demand bills to match the EOBs.
- 5) PFS Reps will validate UB04 with hospital system prior to billing, (i.e. Financial Class, balance due, etc.) and document claim submission.
- 6) If Medicare is secondary, refer to Medicare billing representative, for electronic submission to Medicare.

JHHS

Refer back to Primary Team when:


****Invalid/incomplete secondary insurance information

****Late charges posted and not billed to primary carrier.

Exceptions:

Accounts which crossover from Medicare, i.e. Blue Cross and Medicaid.

Accounts which have secondary insurance updated after patients have received data mailers for self pay portions will be billed by team responsible for secondary insurance. Rebill will be requested for the secondary insurance team by the individual updating the secondary insurance.

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Secondary claims as designated by Third Party Managers which must be returned for individual team to complete billing (i.e. Medicaid, Special, etc.), as well as accounts missing insurance information, i.e. insurance addresses. PFS will return and update Keane and/or Meditech with activity code "Returned by Secondary Billing Team". The billing is completed by the individual teams and Keane and/or Meditech is updated accordingly.

Final Processing:

- Review secondary UB04 for completeness and accuracy
- Attach copy or EOB
- Update hospital system
- Send to secondary insurance carrier

Crossover Billing:

Medicare Secondary claims for Blue Cross and Medicaid electronically "cross-over" from the Medicare Program to Blue Cross or to Medical Assistance. However, there are occasions where the cross-over transaction fails.

Systems Support - Produce the weekly Non-Cross Report by Hospital by payer and deliver to appropriate billing team.

Billing Representative – Follow above procedures to reprint claim and Medicare EOB to resubmit to secondary payer.

1. Notes: Secondary Payers are matching on HIC# and the correct Medicare number may not be in the secondary payer database requiring a manual claim.
2. When looking at a Medicare remittance, a claim status of '1' indicates the claim did not cross-over.


SPONSOR

Senior Director, Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years

APPROVAL

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Senior Director, JHHS

Date

Director, PFS Financial Support, JHHS

Date