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POLICY

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

Purpose

The purpose of this policy is to establish procedures for the accurate assessment of patient financial responsibility, and criteria for financial clearance for inpatient admissions. It is a goal of JHHS Patient Financial Services to streamline the financial clearance process and improve patient financial services. In the course of achieving this goal, the procedures outlined in this policy are under continuous improvement and will be updated as required. In general, Patient Financial Services shall coordinate activities with other functional areas involved in the admissions process whenever possible, and strive to improve overall service to patients. Service improvement goals will be established by each affiliate as appropriate and monitored by the Director of Patient Financial Services (or affiliate equivalent).


General Conditions

The obligation for payment for health care services becomes effective when a course of treatment is initiated or at the time services are rendered. All patients receiving treatment at JHHS affiliates are responsible for paying in full all charges for such treatment, less any amounts determined to be eligible for financial assistance consideration, verified as eligible for insurance coverage or for which patients are "held harmless" according to their verified insurance or medical coverage benefits.

Admission Priorities

Priorities of admission are directly related to the degree of medical urgency of the patient's condition:

- Patients will be admitted promptly upon verification of the medical need for non-elective admissions, either as emergency admissions through the emergency departments at JHHS affiliates, or as other emergency admissions including emergency transfers from other facilities. In no event will a patient be denied treatment in the Emergency Department or as an emergency transfer at any affiliate because of financial or payment issues. JHH, JHBMC and HCGH shall follow the EMTALA law.
- For elective admissions:
 1. Physician offices and affiliate clinics will notify Admitting/Patient Financial Services Departments in accordance with the affiliate's established admissions process.
 2. Admissions may be delayed for patients whose insurance coverage requires pre-certification.
 3. Admissions may be postponed if the patient is unable or unwilling to satisfy his expected financial liability regarding the admission (See "Determination of Patient Liability" section, below), if the admitting physician agrees to the postponement.

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Verification of Insurance Benefits

- Admission intake personnel should obtain all essential insurance-related information from physician offices, affiliate clinics, emergency departments, other institutions, or patients in as expedited a manner as possible.
- Admissions' Patient Service Coordinators acting as Account Managers are responsible for contacting the insurance company to verify a patient's eligibility and coverage.
- All acceptable, verified insurance benefits will be assigned to the JHHS affiliate. The contract holder will be requested to sign an Assignment of Benefits form as confirmation of assignment.

Determination of Patient Liability

(See JHHS Finance Policy No. FIN041 – Estimating Inpatient Payment Requirements)

Admissions' Patient Service Coordinators are responsible for calculating the patient's liability (subject to any "hold harmless" provisions as applicable) after insurance benefits have been certified and coverage verified.

1. Elective Admission Patients

- Patient Service Coordinators will contact the patient to explain the estimated balance due and request payment by the time of admission.
- If verified insurance benefits will not cover at least 80% of the expected charges and the patient is either unwilling or unable to qualify for any of the special payment programs so described, the Patient Service Coordinators shall contact the applicable Admitting Physician to determine if the admission can be postponed until the patient can satisfy the financial obligation.


The Admitting Physician's decision shall be final regarding whether or not the patient's medical condition warrants postponement of services.

2. Non-elective Admission Patients

- Patient Service Coordinators are responsible for interviewing patients with no insurance coverage during the course of the patient's stay and referring candidates to the Medical Assistance Team.
- Patients will be asked to arrange for payment of the self-pay balance by the time of discharge. If patient cannot meet their financial obligations, payment alternatives will be considered.

3. All Patients

- The Patient Service Coordinators will offer the payment alternatives described in the "Payment Alternatives" section below to patients unable to pay their expected liability in full.
- Calls to, or contacts with, patients should be made only if required information is not already available to Admitting or Patient Financial Services personnel. Calls or contacts made to patients should be well planned in advance and organized to streamline the financial clearance process and minimize disturbance to patients.

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Payment Alternatives

- If the Admissions' Patient Service Coordinator determines that the patient's financial/medical situation may qualify the patient for special funding or any government-sponsored insurance program, the applicable application process will be initiated (refer to JHHS Finance Policy No. FIN054 - Special Entitlement Advocacy Program).
- When appropriate, an onsite Eligibility Technician will interview and assist patients who may be eligible for Maryland Medical Assistance coverage (refer to JHHS Finance Policy No. FIN054 - Special Entitlement Advocacy Program).
- The Patient Service Coordinator will discuss installment payment arrangements to provide the patient with extended periods of time to satisfy financial obligations (refer to JHHS Finance Policy No. FIN033 - Installment Payments - Inpatient).
- A JHHS Financial Assistance Application may also be completed for any patients whose financial circumstances may meet the program's criteria, pending a final determination of the patient's eligibility for Medical Assistance (refer to JHHS Finance Policy No. FIN034 - JHHS Financial Assistance Program).
- Other financial alternatives as developed by JHHS or its affiliates.

Additional Financial Requirements


- The Patient Service Coordinator will require that the contract holder sign any other financial-related statements or forms required by his or her insurer (e.g., Authorization to Use Life-Time Reserve Days, Coordination of Benefits Questionnaire, etc.) for insurance benefits to be assigned.
- In order for insurance benefits to be properly assigned, each patient will also be asked to sign a Release of Medical Record Information at time of service permitting the JHHS affiliate to release medical information requested by the patient's insurer(s) as part of the claims adjudication process. Additionally, the responsible party (the individual who accepts the legal obligation to pay for the medical services) will also be required to sign the Statement of Financial Responsibility at the time services are rendered.

A patient will be registered as a private pay or self-pay patient, subject to the financial clearance process just described, if:

1. The contract holder for the primary insurance coverage refuses to sign an Assignment of Benefits; or,
2. The patient refuses to sign a Release of Medical Record Information; or,
3. The responsible party refuses to sign the Statement of Financial Responsibility; or
4. Insurance coverage cannot be verified.

Exceptions

All exceptions to this policy must be approved in writing by an officer-level employee (i.e., Vice President or higher) of either an affiliate or JHHS (as applicable) and must be made available to the Director of Patient Financial Services.

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REFERENCE

JHHS Finance Policies and Procedures Manual


- Policy No. FIN033 - Installment Payments - Inpatient
- Policy No. FIN034 - JHHS Financial Assistance Program
- Policy No. FIN041 - Estimating Inpatient Payment Requirements
- Policy No. FIN045 - Verification of Insurance Benefits - Inpatient and JHCP Services
- Policy No. FIN054 - Special Entitlements Advocacy Program
- Policy No. FIN055 - Discharge Clearance
- Policy No. FIN056 - Financially Clearing Hospital Transfers and Other Direct Source Admissions
- Policy No. FIN062 - Granting Financial Clearance for Transplant Patients

Annotated Code of Maryland, Health-General - Section 4-301; Section 19 -355; Section 19 -708

RESPONSIBILITIES - JHH

A. Elective Admissions

Admitting Patient Service Coordinator	Input patient reservation, automatically generating an event notice and assign account to Pre-admit Financial Counselor based on payer.
Admitting Patient Service Coordinator Account Manager	Review reservation printout; check hospital databases regarding patient's prior admission, bad debt history, or payer problems. Conduct pre-admit phone interview; advise patient of amount due at admission; enter patient demographic and financial data; document relevant information when completed. Review claim history, data entry for accuracy; prepare account for billing; ensure payments received and signatures obtained at admission. Approve admission or refer problems to team leader. Review and reconcile daily the Lead Time Count Down Report.
Leadership	Assure that all accounts are worked by staff; determine appropriate courses of action for problematic admissions. Distribute the Lead Time Count Down Report; review completed reports.

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B. Urgent Admissions (Hopkins Admissions [HEAL] Team)


Admitting	<p>Receive admission notice; document encounter, travel to patient's location for interview; obtain signatures through patient interview; obtain information about insurance & pre-certification requirements; communicate status to patient & physician; attempt to collect co-payment; arrange for escort to room; complete data entry.</p> <p>Check for patient's prior insurance/clinical information; initiate pre-certification form; call insurance and or pre-certification agency; calculate co-payment; attempt to collect payment via check and/or credit card; communicate insurance, pre-certification and co-pay status to Insurance Verifier; complete required information and enter data.</p> <p>Receive notice of admission; document encounter on HEAL form; contact shift coordinator; obtain floor/bed assignment; notify physician's office, Clinic Coordinator and Patient Service Coordinator Account Manager of status; send plates and bracelet to nursing unit; complete data entry and documentation.</p>
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C. Emergent Admissions - Emergency Department (ED)

ED Admission Facilitator	Without delaying any screening examination and stabilization required by EMTALA, initiate patient interview to obtain demographic and financial information; check for prior admission of patient; initiate payer notification procedures; copy insurance card; obtain signature on necessary forms; produce patient plates; document relevant actions taken and information on patient's admission folder and in comments section of automated billing system.
Patient Service Coordinator Account Manager	Within 24 hours of admission, ensure that insurance/financial information has been obtained/verified and pre-certed. Notify patient of any balances not covered by verified insurance benefits. Request payment by time of discharge.

D. Transfers from Other Facilities and Other Direct Source Admissions

Refer to JHHS Finance Policy No. FIN056 - Financially Clearing Hospital Transfers and Other Direct Source Admissions.

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RESPONSIBILITIES - JHBMC

A. Elective Admissions

Patient Registrar

Schedule admissions; pre-register elective admissions; notify Financial Counseling and Utilization Review personnel of all Admissions; enter patient demographic, financial and admission information into the computer system.

Contact patient's insurer(s) and verify insurance coverage; request payment from patients for any portion of their billings not covered by insurance, unless patient is held harmless by insurance for that portion of their charges; obtain authorization numbers from appropriate review agents for Commercial, Blue Cross, and HMO patients; contact Admitting Physicians to recommend deferral of any elective admissions whenever adequate payment arrangements cannot be made.

Admitting Medical Staff

Review any cases wherein inadequate payment arrangements are made or are determined to not meet payer requirements for acute-care services; determine whether the patient's medical condition warrants admission, regardless of the financial circumstances; communicate this decision to the *Admissions* Department.

B. Urgent Admissions

Patient Registrar

Enter patient demographic, financial and admission information into the computer system; generate an inpatient admission; notify the Admissions and Utilization Review functions of all urgent admissions within 24 hours - except weekends.


Contact patient's insurer(s) and verify insurance coverage; request payments from patient for any portions of their billings not covered by insurance, unless patient is held harmless by insurance for that portion of their charges; obtain authorization numbers from appropriate review agents for Commercial, Blue Cross and HMO patients.

Utilization Review Staff

Determine if the admission is medically justified; obtain pre-approval numbers from any non-emergency Maryland Medical Assistance admissions from DelMarVa; notify Admitting Physician if the admission is determined to not be medically necessary or authorized by the payer.

Onsite Cashier

Collect balances due from patients prior to the patient's discharge.

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C. Emergency Admissions

ED Patient Registrar	<p>Enter the patient demographic, financial and admission information into the computer system, the gathering of such information shall not delay any screening examination or stabilization required by EMTALA; generate an inpatient admission; link the ED visit to the inpatient stay; notify the Admitting Office and Utilization Review functions of all admissions within 24 hours - except weekends.</p> <p>Verify that proper bed assignments are made and entered into the system; monitor admission information for completeness.</p> <p>Contact patient's insurer(s) and verify insurance coverage; request payments from patients for any portions of their billings not covered by insurance, unless patient is held harmless by insurance for that portion of their charges; obtain authorization numbers from appropriate review agents for Commercial, Blue Cross and HMO patients.</p>
Utilization Review Staff	<p>Determine if the admission is medically justified; notify Admitting Physician if the admission is determined to be medically necessary or authorized by the payer.</p>
Onsite Cashier	<p>Collect patient due balances prior to the patient's discharge.</p>


D. Transfers from Other Facilities and Other Direct Source Admissions

Refer to JHHS Finance Policy No. FIN056 - Financially Clearing Hospital Transfers and Other Direct Source Admissions.

RESPONSIBILITIES – HCGH

A. Elective Admissions

Admitting Officer	<p>Schedule admissions; pre-register elective admissions; notify Financial Counseling and Utilization Review personnel of all Admissions; enter patient demographic, financial and admission information into the computer system.</p>
Designated Authorization Group	<p>Contact patient's insurer(s) and verify insurance coverage; request payment from patients for any portion of their billings not covered by insurance, unless patient is held harmless by insurance for that portion of their charges; obtain authorization numbers from appropriate review agents for Commercial, Blue Cross and HMO</p>

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patients; contact Admitting Physicians to recommend deferral of any elective admissions whenever adequate payment arrangements cannot be made.

Case Management Staff

Determine if the admission is medically justified; obtain pre-approval numbers for all non-emergency Maryland Medical Assistance admissions from DelMarVa; notify Admitting Physician if the admission is determined to not be medically necessary or authorized by the payer.

B. Urgent Admissions

Admitting Officer

Enter patient demographic, financial and admission information into the computer system; generate an inpatient admission; notify the Financial Counseling and Utilization Review functions of all urgent admissions.

Utilization Review Staff

Determine if the admission is medically justified; obtain pre-approval numbers from any non-emergency Maryland Medical Assistance admissions from DelMarVa; notify Admitting Physician if the admission is determined to not be medically necessary or authorized by the payor.

C. Emergency Admissions

Registrar

Enter the patient demographic, financial and admission information into the computer system; generate an inpatient admission; link the ED visit to the inpatient stay; Financial Counseling and Utilization Review functions of all admissions.

Admitting Officer

Verify that proper bed assignments are made and entered into the system; monitor admission information for completeness.

Financial Counseling Staff


Contact patient's insurer(s) and verify insurance coverage; request payments from patients for any portions of their billings not covered by insurance, unless patient is held harmless by insurance for that portion of their charges; obtain authorization numbers from appropriate review agents for Commercial, Blue Cross and HMO patients.

Case Management

Determine if the admission is medically justified; notify Admitting Physician if the admission is determined to be medically necessary or authorized by the payor.

D. Transfers from Other Facilities and Other Direct Source Admissions

Refer to JHHS Finance Policy No. FIN056 - Financially Clearing Hospital Transfers and Other Direct Source Admissions.

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SPONSOR

Vice President of Finance/Chief Financial Officer and Treasurer, JHHS
Director of Patient Accounts (HCGH)


REVIEW CYCLE

Three (3) years

APPROVAL

President, JHHS/JHH

Date

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PROCEDURES - JHH


Inpatients gain access to JHH in one of four ways:

- A. Elective/Pre-admission
- B. Urgent Admission
- C. Emergent Admission
- D. Transfer from another institution.

This policy covers the first three types of admissions. Transfer policies and procedures are discussed in JHHS Finance Policy No. FIN056 - Financially Clearing Hospital Transfers and Other Direct Source Admissions.


A. Elective/Pre-admission

1. Admitting Patient Service Coordinator Account Manager
 - a. Receive reservation for the admission from referring physician's office - via fax or event notice from areas that enter reservations direct to on-line systems.
 - b. Complete reservation information and enter into the automated ADT system. The Event Notice will print automatically and serve as the initial documentation of the admission folder.
 - c. Maintains file to track pre-admit and pre-certification activity.
 - d. Review the reservation printout and conduct an inquiry via patient information systems, physician referral form, etc., in order to determine whether the patient is known to any hospital computer database. Also, review the automated billing system for bad debt or any specific payer problem. If a patient has a previous bad debt, refer account to team leader for review.
 - e. Estimate the portion of the bill for which the patient is responsible in accordance with JHHS Finance Policy No. FIN041 - Estimating Inpatient Payment Requirements. (The admission may need to be pre-certified and insurance verified- see JHHS Finance Policy No. FIN045 - Verification of Insurance Benefits.)
 - f. Conduct a Pre-admission telephone interview in accordance with the Pre-admission Telephone Interview Guidelines (see Appendix A) and other established Pre-admission procedures and update the patient's data. Follow the question format on the Pre-admit screen and enter the patient's responses directly on-line as the interview is conducted - any updates will replace prior information.
 - g. Inform the patient during the interview of the signatures required and any amounts due at admission (deductibles, co-payments, etc.). Determine patient's ability to pay. As appropriate, inform patient of payment options available.

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Based on patient's circumstances, recommendation may be made to defer the admission.

- h. If verified insurance benefits will not cover at least 80% of the expected charges and the patient is either unwilling or unable to qualify for any of the special payment programs so described, contact the Admitting Physician to determine if deferral of admission is permissible given the patient's medical condition. The decision of the Admitting Physician regarding patient admission is final.
- i. If the Admitting Physician determines that the patient will be seen regardless of financial circumstances, refer to override Matrix to proceed with request for admission override. If override is granted, contact patient to determine if patient may be eligible for Maryland Medical Assistance or other alternative payment or assistance options.
- j. If the patient has not had a prior visit or encounter at JHH or cannot be reached by phone, contact the referring physician's office in order to obtain information regarding other telephone numbers for the patient, representative, family member, or employer, and any information pertaining to the patient's medical coverage. Request that the referring physician advise the patient to contact the Patient Service Coordinator Account Manager in order to provide the needed information.
- k. Answer all questions in the Pre-admit registration and document any other useful information in the *Comments* section of the Pre-admit screen.
- l. Note "Completed" status in the *Comments* section if the Pre-admission is complete to the extent that the patient's insurance can be verified or if the patient is being admitted as a self-pay.
- m. Return the reservation account to the team leader, if unable to obtain information from the patient or other sources.
- n. Contact the Office of International Patient Affairs if the patient is not a U.S. citizen and inquire whether they are aware of the patient. If the International Office will represent the patient, request that patient information be faxed, document the conversation in the Comments screen, and code the admission accordingly. If the International Office is not aware of or will not represent the patient, contact the Admitting Physician's office to obtain satisfactory information. If sufficient information is not available, refer the account to the team leader in order to determine the appropriate course of action. The admission of an international patient with prior bad debts shall be deferred until previous obligations are satisfied, unless it is an emergency admission. Document all information in the


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comments screen.

- o. Request deposit for the estimated charges if a patient or representative refuses to cooperate by providing necessary information in the Pre-admission interview and cannot be persuaded to do so.
- p. Document a completed Pre-admission in the comments section of the Pre-admit screen as "OK to admit." Update the Pend code appropriately. Document all relevant information in SMS/PHS computer systems.
- q. Verify at date of admission that the Admitting Office has collected any required deposits, made legible copies of all insurance cards, and obtained required signatures on all forms.
- r. Review and reconcile daily the Lead Time Count Down Report to ensure that all accounts are processed in a timely manner.

2. Leadership


- a. Assure that all accounts are worked by the staff.
- b. Determine appropriate courses of action for problematic admissions referred from Patient Service Coordinators.
- c. Distribute daily the Lead Time Count Down Report; respond to questions/problems encountered by staff regarding the reconciliation's.

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B. Urgent Admissions (HEAL Team)

The HEAL Team provides an express admission service for patients being admitted from a clinic or physician's office on the JHH campus. A telephone call to HEAL will summon a Patient Service Coordinator Account Manager to the patient's location, eliminating the need for the patient to come to the Admitting Office. The HEAL Team is notified of an urgent/emergent admission from a clinic or on-campus physician's office. After notification, the following procedures take place:


1. Insurance Verification	2. Pre-certification*	3. Admissions
a. Document the encounter on the work sheet, completing all data elements.	a. Obtain clinical information from physician or clinic.	a. Document the encounter on the HEAL Team reservation form.
b. Travel to the clinic or physician's office.	b. Initiate and complete the Pre-certification/Insurance form.	b. Contact the shift coordinator for the appropriate service.
c. Interview patient or family member using the Pre-admission/admission form.	c. Call the insurance company and/or Pre-certification agency to verify insurance and Pre-certify the admission.	c. Obtain unit location for patient's admission. Continue to follow up until floor is assigned.
d. Obtain signatures on forms; copy insurance cards.	d. Record pre-cert number on insurance form.	d. Call unit; obtain bed assignment; continue to follow up until bed is assigned.
e. Check EPIC, SMS & PHS for previous insurance and clinical information.	e. Enter Pre-certification and insurance information into <i>Keane</i> after all data has been entered into SMS.	e. Call attending MD's office and advise of bed placement.
f. Verify insurance benefits. Co-payment amounts, and OK if JHH treated as in/out of network.	* With assistance of PI/UM Nursing Staff	f. Place patient on Quick Admit in SMS.
g. Communicate status of same to patient, family member, physician and/or nurse		g. Send plates and armband to nursing unit.
h. Follow up until reference or authorization is obtained and bed is assigned.		h. Follow up with the nursing unit until bed is ready.
i. Attempt to collect co-payment and make telephone service arrangement as appropriate.		i. Complete entry of admission in SMS after all information has been obtained.
j. Arrange for Escort to take patient to the inpatient unit.		
k. Transfer work sheet information to HEAL Team reservation form.		
l. Complete entry of admission in SMS after all information has been obtained.		

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C. Emergent Admissions - ED

1. ED Admission Facilitator
 - a. Receive information from attending physician or designee that patient will be admitted without delaying any screening examination and stabilization required by EMTALA... initiate interview to obtain demographic and financial information from patient or family member. Check for patient identification data.
 - b. Place appropriate forms in patient's account jacket at conclusion of interview. If patient or family member is not available, gather all admission data from other sources - PID, ADT previous admission, EPIC, Sending Institution, etc. Document source on the admission folder, Admission checklist and comments section in ADT.
 - c. Contact *designate* agency to *authorize* the admission; facilitate the gathering of all necessary information for authorization. Document actions taken in comments section of ADT, along with dates, times of calls to insurance company and Pre-certification agency. Complete facilitator worksheet.
 - d. Copy insurance card and assure that all required forms and signatures are obtained for the admission.
 - e. Produce patient plates for delivery to the nursing unit with the patient.
 - f. Inform attending physician and/or charge nurse of any problems or concerns.

2. Patient Service Coordinator
Account Manager
 - a. Visit patient on floor within first working day of admission (as appropriate regarding patient's condition) to obtain needed information or answer patient's questions. In order to determine medical necessity, refer cases requiring clinical information as part of the pre-certification process to PI/UM staff for intervention and completion of authorization from the payer.
 - b. Contact Department of Social Work if patient is unable to communicate in order to coordinate meeting with family members or other responsible person in order to resolve insurance and financial issues.
 - c. Complete all billing system screens.
 - d. Contact the patient as appropriate to discuss any balances not covered by verified insurance and arrange payment by the time of discharge. Discuss financial options available if patient is unable to satisfy his expected liability.

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3. Leadership
- a. Assure that all accounts are worked by the staff. Respond to questions or problems encountered by staff regarding report reconciliation.

PROCEDURES - JHBMC


Inpatients gain access to JHBMC in one of four ways:

- A. Elective/Pre-admission
- B. Urgent Admission
- C. Emergent Admission
- D. Transfer from another institution.

This policy covers the first three types of admissions. Transfer policies and procedures are discussed in JHHS Finance Policy No. FIN056 - Financially Clearing Hospital Transfers and Other Direct Source Admissions.

A. Elective Admissions

1. Patient Registrar
- a. Obtain reservation form for admission from physician's office or Operating Room scheduler.
 - b. Preregister patient and route reservation form to Insurance Verification and Quality Assurance (QA) Office.
 - c. Review reservation form and preregistration information. Contact all listed insurers to determine eligibility and coverage.
 - d. Verify insurance coverage and obtain any necessary Pre-admission approvals from all payers except Maryland Medical Assistance.
 - e. Approve for admission if verified coverage equals 100% of expected charges and refer to QA Office for medical justification review.
 - f. If verified coverage is equal to less than 100% of expected charges:
 - 1) Complete a deposit worksheet.
 - 2) Contact the patient and request payment of deposit by admission date.
 - 3) If the patient states that he or she cannot pay the deposit amount, offer the following payment options, as appropriate:
 - a) Installment Payment Arrangements


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- b) JHHS Financial Assistance Program
 - c) Other JHHS financial alternatives
 - 4) Contact the admitting physician if less than 80% of the balance is secured through insurance and/or patient payment arrangements, and recommend postponement of the planned admission until financial issues can be resolved.

- 2. Admitting Physician
 - a. Review the clinical aspects of the intended admission.
 - 1) Contact the Patient Registrar if the admission is determined to be medically urgent (requiring the admission of the patient as initially scheduled) and override the deferral recommendation.
 - 2) Contact the Patient Registrar if the admission can be postponed without jeopardizing the patient's condition and approve the deferral recommendation.

- 3. Patient Registrar
 - a. Review the Admitting Physician's decision regarding deferral. If the Admitting Physician overrides the deferral recommendation:
 - 1) Notify the patient of the physician's decision.
 - 2) Track the override by admitting physician.
 - 3) Refer the admission to QA Office for medical justification review.
 - b. If the Admitting Physician concurs with the deferral recommendation:
 - 1) Notify the patient of the postponement
 - 2) Assist the patient in applying for financial assistance as appropriate (Medical Assistance, JHHS Financial Assistance, etc.)
 - 3) Notify the Admitting Office of the postponement.

- 4. Quality Assurance (QA) Reviewer
 - a. Review the reservation form and determine if the admission is medically justified:
 - 1) Obtain necessary authorization numbers from DelMarVa (if Maryland Medical Assistance recipient) or payer-designated Utilization Review agent, if Financial Counselor was unable to obtain pre-authorization.
 - 2) Contact Admitting Physician for clarification, as needed.

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- b. Determine whether the admission meets medical criteria of JHBMC and the payer.
- c. Notify the Admitting Office if the admission is medically approved.
- d. Notify the Admitting Physician if the admission is not medically approved and ask him or her to notify the patient. Notify the Admitting Office that the admission has been postponed, pending further notice.


5. Patient Registrar

- a. Activate the Pre-admission record on the patient's date of admission and obtain patient signatures; collect any required payments.

B. Urgent/Emergency Admissions

1. ED Patient Registrar

- a. Enter patient demographic data into ADT system without delaying any screening examination and stabilization required by EMTALA.
- b. Obtain a bed assignment when advised of admission decision.
- c. Generate an inpatient admission and link the ED visit to the inpatient stay.
- d. Ask patient and/or guardian to complete admission process.
- e. Contact the patient's primary care provider as required by payer contracts.
- f. Verify admission information input by ED personnel to ensure completeness. Follow up with patient and/or financial counselor to obtain necessary signatures if not previously obtained in the ED.
- g. Review insurance information gathered at admission. Review prior account history to identify any other possible insurance coverages. Updates within 24 hours except weekends.
- h. Contact all listed insurers to determine eligibility and coverage.
 - 1) If verified coverage equals 100% of expected charges, approve admission and refer to QA Office for medical justification review.
 - 2) If verified coverage is less than 100% of expected charges:
 - a) complete a payment worksheet to estimate the patient's expected liability

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- b) contact the patient to discuss his/her financial liability
 - c) ask for payment by time of discharge.
- 3) If the patient states that he or she cannot pay the expected liability, offer the following payment options, as appropriate:
 - a) Eligibility for Maryland Medical Assistance
 - b) Installment Payment Arrangements
 - c) JHHS Financial Assistance Program
 - d) Other JHHS financial alternatives
- 4) Gather the necessary information from the patient to facilitate his or her selected repayment option.
 - i. Communicate the discharge status of the account to the nursing unit. If a patient has satisfied all estimated liabilities, process a "courtesy" discharge notification so that the patient or family member does not have to stop at the Financial Counselor or cashier area at discharge.
- 2. Quality Review Coordinator
 - a. Review clinical information regarding the admission to ensure that the admission is medically justified. Contact admitting physician for any necessary clarification.
- 3. Onsite Cashier
 - a. Collect payments from patient and/or responsible parties prior to at discharge.

PROCEDURES - HCGH


Inpatients gain access to HCGH in one of four ways:

- A. Elective/Pre-admission
- B. Urgent Admission
- C. Emergent Admission
- D. Transfer from another institution.

This policy covers the first three types of admissions. Transfer policies and procedures are discussed in JHHS Finance Policy No. FIN056 - Financially Clearing Hospital Transfers and Other Direct Source Admissions.


A. Elective Admissions

- 1. Admitting Officer
 - a. Receive reservation form for the admission from referring physician's office.
- 2. Preadmission Counselor
 - a. Review the reservation printout and conduct an inquiry via patient information systems, physician referral form, etc., in order to determine whether the patient is known to any hospital computer data base.
- 3. Designated Authorization Group (DAG)
 - a. Conduct a preadmission telephone interview in accordance with the Preadmission Telephone Interview Guidelines (see Appendix A) and other established preadmission procedures

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and update the patient's data. Follow the question format on the preadmit screen and enter the patient's responses directly on-line as the interview is conducted – any updates will replace prior information.

- b. If verified insurance benefits will not cover at least 80% of the expected charges and the patient is either unwilling or unable to qualify for any of the special payment programs so described, contact the Financial Counselor to determine if payment arrangements or deferral of admission is permissible given the patient's medical condition. The decision of the Admitting Physician regarding patient admission is final.
 - c. If the patient has not had a prior visit or encounter at HCGH or cannot be reached by phone, contact the referring physician's office in order to obtain information regarding other telephone numbers for the patient, representative, family member, or employer, and any information pertaining to the patient's medical coverage. Request that the referring physician advise the patient to contact the HCGH Business Office in order to provide the needed information.
 - d. Answer all questions in the preadmit registration and document any other useful information in the *Comments* section of the preadmit screen.
 - e. Request deposit for the estimated charges if a patient or representative refuses to cooperate by providing necessary information in the preadmission interview and cannot be persuaded to do so.
4. Admission Counselor/
Designated Authorization
Group (DAG)
 - a. Verify at date of admission that the Admitting Office has collected any required deposits, made legible copies of all insurance cards, and obtained required signatures on all forms.
5. Admitting Manager
 - a. Assure that all accounts are worked by the staff.
 - b. Determine appropriate courses of action for problematic admissions referred from Preadmission Counselor – e.g., in instances of previous bad debts.
6. Financial Counselors
 - a. Receive account once patient is admitted from the Preadmission Counselor; review claims data entry for accuracy and prepare the account for billing to the proper financial class.
 - b. Obtain amounts due and all required signatures from patient prior to discharge if not obtained prior to or at admission.
 - c. Review daily the Admission Report to assure that insurance

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verification and precertification have been complete on all necessary patients.


B. Emergent Admissions – ED

1. Registrar
 - a. Initiate interview to obtain demographic and financial information from patient or family member. Check for patient identification data.
 - b. If patient or family member is not available, gather all admission date from other sources – previous admission, sending Institution, etc.

2. Bed Control
 - a. Receive information from attending physician or designee that patient will be admitted.
 - b. Inform attending physician and/or charge nurse of any problems.

3. Designated Authorization Group (DAG)
 - a. Contact the appropriate precertification agency to certify the admission; facilitate the gathering of all necessary information for authorization. Document actions taken in comments section along with dates, times of calls to insurance company and precertification agency.
 - b. Review daily the Admission Report to assure that insurance verification and precertification have been completed as necessary on all patients. Complete all billing system screens.
 - c. Contact the patient as appropriate to discuss any balances not covered by verified insurance and arrange payment by the time of discharge. Discuss financial options available if patient is unable to satisfy his expected liability.


4. Financial Counselor
 - a. Visit patient on floor within first working day of admission (as appropriate regarding patient's condition) to obtain needed information or answer patient's questions as necessary.

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APPENDIX A
PRE-ADMISSION TELEPHONE INTERVIEWING GUIDELINES

1. Introduce yourself:
Greeting: "Good morning (evening, or afternoon), my name is _____ from the Johns Hopkins Hospital Admitting Office. May I speak with _____?"

When the person gets on the phone, repeat the greeting. If not home, ask if it would be all right to contact the person at work and if approved, ask for work telephone number.
2. State the purpose of the call:
"Mr/Mrs/Ms _____, I am calling concerning your scheduled admission on [admission date] with Dr. _____. I would like to ask you a series of questions regarding this admission which will help us to complete your admission faster when you come in on [admission date]. This process will take us approximately 15 minutes. Is this an appropriate time?" If not, obtain a time to call back and complete the interview.
3. Use the ADT Pre-admission Screens and enter the data directly on line:
"Your last name is _____." (Always verify spelling of name. It may also be helpful to write the name phonetically on the account folder for future reference.)
4. Remember to be patient and courteous at all times, since you will be talking to somebody who was not expecting your call:
"I am sorry to interrupt you and I will try to be as brief as possible."
5. If the patient seems to be in a hurry or is getting impatient, reassure him/her that the interview will not take any longer than necessary. Ask for their indulgence.
6. Lead the interview and try not to be sidetracked. If this should happen, you may say:
"I understand; now can you tell me..." and continue with the next interview question.
7. Do not argue with the patient. You may say:
"I understand, however, we will need this information in order to complete your admission."
8. Patients may have trouble reading or accessing information for you; e.g., elderly or handicapped persons may need someone in the household to help with the needed information. You may ask:
"Is there someone there with you who can find and read the information to me?"
9. Patients need to be advised that they will be required to pay their co-pay amount at the time of admission. The estimated patient charges will be based on either the mean or median charge of similar patient population or average daily hospital charges. A copy of this will be available to all Patient Service Coordinator Account Managers. The Case Mix Information Management Department will provide access to hospital charge data to determine mean and median. Advise patients that any charges which will be due prior to the admission are payable by cash, check or credit card.
10. It is important that the patient is asked to come to the admitting office in order to sign his/her paperwork as early as possible. (OB patients are also expected to sign paperwork prior to admission.)
11. If patient refuses to provide information, indicate that you will call them back to advise them of the

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estimate.