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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), Johns Hopkins Bayview Medical Center, Inc. (JHBMC) and Howard County General Hospital (HCGH).**

**Purpose**

The purpose of this policy is to define the responsibilities for and criteria which constitute insurance verification.

The Admitting Department is responsible for verifying a patient's insurance coverage and, as necessary, obtaining any required pre-certifications and authorizations from the patient's insurance carrier. It is the goal of JHHS Admitting Department to streamline the financial clearance and insurance verification process and thereby 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, Admitting 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 Admitting (or affiliate equivalent).


**General Conditions**

Admitting will verify all patient's insurance benefits to determine the availability and extent of third party reimbursement. Admitting will inform patients that verified insurance coverage and benefit limitations does not absolve them of financial responsibility for services they receive to the extent that the costs of such services are not paid by third party payors.

For all payors, the following steps must be taken as part of the standard insurance verification process:

- Verify coverage eligibility on dates of services, availability of benefits and if sufficient benefits are available for the pending service.
- Verify that services are covered under the plan or contract.
- Coordinate benefits among multiple payors.
- Obtain required authorizations and pre-certifications from the plan or review agent.
- Verify that the payor will honor assignment of benefits to the applicable affiliate.
- Check for any bad debt history that the patient may have had before approving a pending elective admission or procedure.

Appendix A provides a complete listing of verification requirements by payor.

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### Exceptions

- Any deviations from this policy must be reviewed and approved by the Director of Admitting (or designee) (or affiliate equivalent) before confirming arrangement with the patient/guarantor. A written explanation for the exception and written approval by the Director of Patient Financial Services (or affiliate equivalent) for granting the exception must be included in the patient's financial record.
- If insurance cannot be verified in accordance with the requirements described in this policy, the patient is liable for any uninsured balance, subject to the payment requirements described in JHHS Finance Policy No. FIN044 - Inpatient Admission and Financial Responsibility, and Policy No. FIN041 - Estimating Inpatient Payment Requirements.
- If patient elects not to utilize their insurance benefits, patient should be registered according to the "voluntary self pay" procedure.

### REFERENCES

#### **JHHS Finance Policies and Procedures Manual**

Policy No. FIN041 - Estimating Inpatient Payment Requirements

Policy No. FIN044 - Inpatient Admission and Financial Responsibility

### RESPONSIBILITIES - JHH & JHBMC

#### Admissions/PSC

Verify insurance coverage eligibility for the DOS and availability of benefits. Obtain any necessary forms or consents.

Verify that anticipated services are covered under the plan or contract.

Coordinate benefits among multiple payors.

Obtain required authorizations and pre-certifications *from* the plan or review agent within the payer specific guidelines.

Verify the payor's agreement to honor assignment of benefits to the hospital.


Check patient's prior payment history before approving any pending admission or procedure.

#### Admissions/PSC/Core Services

Determine that the services are medically justified and rendered in an appropriate setting, in conjunction with PI/UM.

Obtain any necessary insurance forms or consents.

Work with Financial Counselors to secure appropriate authorizations from third party payors and/or their review rights.

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Initiate the appeals process for denials from third party payers, in conjunction with PFS and PI/UM.

**SPONSOR**

Senior Director of Patient Financial Services (JHH, JHHS, JHBMC)  
 Director of Patient Accounts (HCGH)


**REVIEW CYCLE**

Three (3) years

**APPROVAL**

\_\_\_\_\_  
 President, JHHS/JHH


\_\_\_\_\_  
 Date

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## **PROCEDURES - JHH**

### A. Elective Admissions

1. Admissions/PSC
  - a. Receive event notice and review patient's record for prior insurance information and bad debt history, if available.
  - b. Contact insurer(s) indicated on the event notice to verify coverage (refer to Appendix A for payor-specific instructions on verifying insurance).
  - c. Call to verify secondary insurance benefits and obtain Pre-certification requirements, if applicable, and determine proper payor sequencing for coordination of benefits.
  - d. If unable to verify insurance coverage, contact the patient to verify that insurance information provided is accurate. For elective, guarantee of payment must be obtained from the insurance carrier or patient prior to admission.
  - e. If Pre-certification is needed, initiate the Pre-certification process with assistance from PI/UM.
  - f. Complete or update information in computer system regarding the verified coverages.
  - g. Return the account folder to the(In-House) Financial Counselor.
  - h. Notify patient of any balances not expected to be covered by insurance.
  
2. Admissions/PI/UM
  - a. Review any cases forwarded that require clinical information for Pre-certification.
  - b. Contact the payor and/or the designated review agent to obtain the necessary certification.
  - c. Obtain certification document and/or number to the (In-House) Financial Counselor.
  - d. On scheduled day of admission, review verification and Pre-certification information gathered by (Pre-Admission) Financial Counselor and Pre-certification Nurse.
  - e. Re-verify eligibility of HMO and Medical Assistance patients with the payor if the pre-admission review occurred more than two days in advance of the actual admission date. Verify authorization for procedure.

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f. Collect any balances due from the patient.

B. Urgent/Emergency Admissions

1. Admissions/PSC


- a. Receive event notice and review patient's record for prior insurance information and bad debt history, if available.
- b. Contact insurer(s) indicated on the event notice to verify coverage (refer to Appendix A for payor-specific instructions on verifying insurance).
- c. Call to verify secondary insurance benefits and obtain Pre-certification requirements, if applicable, and determine proper payor sequencing for coordination of benefits.
- d. If unable to verify insurance coverage, contact the patient or family member to verify that insurance information provided is accurate.
- e. Obtain Pre-certification if needed, route the account to PI/UM.
- f. Complete or update information in computer system regarding the verified coverages.
- g. Retains the account folder.
- h. Notify patient of any balances not expected to be covered by insurance.

2. PI/UM

- a. Review any cases forwarded that require Pre-certification or special attention (pre op days, OP Procauth for inpatient).
- b. Contact the payor and/or the designated review agent to obtain the necessary certification.
- c. Obtain certification document and/or number.


3. Onsite Cashier/PSC

- a. Collect any balances due from the patient prior to discharge.

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C. Same Day Admission


1. Admissions Services/PSC
  - a. Copy patient's insurance card(s).
  - b. Route information to the (In-House) Financial Counselor/Account Management Team.
  
2. Financial Counselor/PSC
  - a. Review patient's record for prior insurance information and bad debt history, if available.
  - b. Contact insurer(s) indicated on the event notice to verify coverage and obtain authorization.[Refer to Appendix A for payor-specific instructions on verifying insurance.]
  - c. Call to verify secondary insurance benefits and obtain Pre-certification requirements, if applicable, and determine proper payor sequencing for coordination of benefits.
  - d. If unable to contact the patient or family member to verify that insurance information provided is accurate, *make the patient responsible*.
  - e. If Pre-certification is needed, initiate the process with PI/UM.
  - f. Complete or update information in computer system regarding the verified coverages.
  - g. Notify patient of any balances not expected to be covered by insurance.
  - h. Collect any balances due from patient.
  
3. Pre-certification Nurse/PIUM
  - a. Review any cases forwarded that require clinical information for pre-certification.
  - b. Contact the payor and/or the designated review agent to obtain the necessary certification.
  - c. Obtain certification document and/or number.

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**PROCEDURES - JHBMC**

A. Elective Admissions and Same Day Admissions


1. Admitting Officer
  - a. Receive Bed Reservation Form from admitting physician's office.
  - b. Verify that all information is completed regarding patient demographics and course of treatment. Contact the admitting physician and/or Operating Room to obtain additional information.
  - c. Generate a pre-registration record in the automated billing system,
  - d. Place a routing sticker on one copy of the bed reservation form and route to the Pre-Admission Financial Counselor. Retain the original bed reservation form in the Pending Admission area, filed by scheduled admission date.
  - e. Verify that all updated information has been entered into the online pre-admission record.
  - f. Match the routed bed reservation form with the copy retained in the pre-admission area.
  
2. Pre-Admission Financial Counselor
  - a. Receive bed reservation form from Admitting Officer.
  - b. Review patient's record, if available.
  - c. Contact insurer(s) indicated on the bed reservation form to verify coverage. [Refer to Appendix A for payor-specific instructions on verifying insurance.]
  - d. Call to verify secondary insurance benefits and obtain precertification requirements, if applicable, and determine proper payor sequencing for coordination of benefits.
  - e. If unable to verify insurance coverage, contact the patient or family member to verify that insurance information provided is accurate. For elective, guarantee of payment must be obtained from the insurance carrier or patient prior to admission.
  - f. Obtain precertification number from appropriate payor(s). If unable to obtain precertification, note on routing sticker and ask for intervention by Utilization Review Coordinator.
  - g. Complete/update information in computer system regarding the verified coverages.

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- h. Notify patient and/or family member of any balances not expected to be covered by insurance.
    - i. Note the date and time verification activities were completed on the bed reservation form's routing sticker before forwarding to the Utilization Review Coordinator.
  - 3. Utilization Review Coordinator
    - a. Review information on bed reservation form to determine appropriateness of admission/service. Contact the admitting physician if further clarification is required.
    - b. Review any forwarded cases that require precertification assistance.
    - c. Contact the payor and/or the designated review agent to obtain the necessary certification.
    - d. Enter certification number into the automated billing system and attach any written documentation received from the payor and/or review agent to the bed reservation form.
    - e. Note date and time review is completed on the bed reservation form's routing sticker before forwarding back to Admitting Officer.
  - 4. In-House Financial Counselor
    - a. On the scheduled day of admission, review the verification and precertification information gathered by the Pre-Admission Financial Counselor and Utilization Review Coordinator.
    - b. Re-verify eligibility of HMO and Medical Assistance patients with the payor if the pre-admission review occurred more than two days in advance of the actual admission date.
    - c. Collect any balances due from the patient

**B. Urgent/Emergency Admissions**

- 1. In-House Financial Counselor
  - a. Receive admission folder with completed registration sheet.
  - b. Review patient's record for prior insurance information and bad debt history, if available.
  - c. Contact insurer(s) indicated on the event notice to verify coverage. [Refer to Appendix A for payor-specific instructions on verifying insurance].
  - d. Call to verify secondary insurance benefits and obtain precertification requirements, if applicable, and determine proper payor sequencing for coordination of benefits.

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- e. If unable to verify insurance coverage, contact the patient or family member to verify that insurance information provided is accurate. *If insurance is not verified, make patient responsible.*
  - f. If precertification is needed, contact the payor and/or designated review agent to obtain. Refer any cases for which payor and/or review agent will not provide authorization to the Utilization Review Coordinator.
  - g. Complete or update information in computer system regarding the verified coverages.
  - h. Notify patient of any balances not expected to be covered by insurance.
2. Utilization Review Coordinator
- a. Review any forwarded cases that require precertification intervention.
  - b. Contact the payor and/or the designated review agent to obtain the necessary certification.
  - c. Update the automated billing system with the certification number and forward written confirmation to the In-House Financial Counselor.
3. Onsite Cashier
- a. Collect any balances due from the patient prior to discharge.



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**APPENDIX A**

**PAYOR-SPECIFIC INSURANCE VERIFICATION REQUIREMENTS**

Insurance benefits will be considered “verified” when the following conditions are met:

<p>1. Medicare</p>	<ul style="list-style-type: none"> <li>a. Beneficiary is eligible for coverage on the date of service.</li> <li>b. Benefits are not exhausted.</li> <li>c. A Medicare Secondary Payor (MSP) Questionnaire has been completed to correctly identify and sequence payor liability.</li> <li>d. The service is a covered service under the Medicare program.</li> <li>e. If the patient will need to use Life Time Reserve (LTR) days, a signed authorization form is on file.</li> <li>f. The service is determined to be medically justified and rendered in an approved setting.</li> </ul>
<p>2. Maryland Medical Assistance</p>	<ul style="list-style-type: none"> <li>a. Verify that patient is eligible for MA federal coverage on the date of service.</li> <li>b. The service is a covered service under the Medicaid program.</li> <li>c. Necessary authorizations have been obtained from the designated review organization and/or the patient's primary care provider.</li> <li>d. Any necessary forms and consents (voluntary sterilization, medical justification for therapeutic abortion, etc.) have been obtained in accordance with State regulations and time frames.</li> <li>e. A coordination of benefit inquiry has been performed to correctly identify and sequence payor liability.</li> <li>f. The service is determined to be medically justified and rendered in an approved setting.</li> </ul>
<p>3. Out-of-State Medical Assistance</p>	<ul style="list-style-type: none"> <li>a. Out-of-State Medical Assistance coverage that does not pay at least 80% of expected charges will not be accepted for elective services; only patients being treated on an emergency basis will be accepted unless an override is obtained.</li> <li>b. Patient is eligible for coverage on the date of service.</li> <li>c. The service is covered service under the particular state's Medicaid program.</li> <li>d. The JHHS affiliate has a provider number on file with that state's Medical Assistance program.</li> <li>e. Necessary authorizations have been obtained from the designated review organization and/or the patient's primary care provider.</li> <li>f. Any necessary forms and consents (voluntary sterilization, medical justification for therapeutic abortion, etc.) have been obtained in accordance with State regulations and time frames.</li> <li>g. A coordination of benefit inquiry has been performed to correctly identify and sequence payor liability.</li> <li>h. The service is determined to be medically justified and rendered in an approved setting.</li> </ul>
<p>4. Blue Cross</p>	<ul style="list-style-type: none"> <li>a. Patient is eligible for coverage on the date of service – i.e., the premiums are paid up-to-date and the subscriber is still employed (group plans only).</li> <li>b. The service is covered under the subscriber's contract.</li> <li>c. Any necessary second surgical opinion forms have been obtained in accordance with payor requirements.</li> <li>d. A coordination of benefit inquiry has been performed to correctly sequence payor liability.</li> <li>e. Necessary authorizations and notifications have been obtained from the designated review organization and/or the patient's primary care provider.</li> <li>f. The service is determined to be medically justified and rendered in an approved setting.</li> </ul>



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Insurance benefits will be considered “verified” when the following conditions are met:

<p>5. Commercial Insurance</p>	<ul style="list-style-type: none"> <li>a. The patient is eligible for coverage on the date of service – i.e., the premiums are paid up-to-date and the contract holder is still an employee (for group coverage).</li> <li>b. The service is covered service under the patient’s contract.</li> <li>c. The service is not excluded as a pre-existing condition (elective only).</li> <li>d. Any necessary second surgical opinion forms have been obtained in accordance with payor requirements.</li> <li>e. A coordination of benefit inquiry has been performed to correctly identify and sequence payor liability.</li> <li>f. Necessary authorizations and notifications have been obtained from the designated review of organization(s).</li> <li>g. The service is determined to be medically justified and rendered in an approved setting.</li> <li>h. The plan will honor assignment of benefits.</li> </ul>
<p>6. HMO/PPO (USFHP)</p>	<ul style="list-style-type: none"> <li>a. The patient is eligible for coverage on the date of service – i.e., is still an employee and premiums (for group coverage) are paid up to date.</li> <li>b. The service is a covered service under the enrollee’s contract.</li> <li>c. Necessary authorizations and notifications have been obtained from the designated review organization(s).</li> <li>d. A coordination of benefit inquiry has been performed to correctly identify and sequence payor liability.</li> <li>e. The service is determined to be medically justified and rendered in an approved setting.</li> <li>f. The plan will honor assignment of benefits.</li> </ul>
<p>7. Workers’ Compensation</p>	<ul style="list-style-type: none"> <li>a. The service is related to the patient’s workers’ compensation claim.</li> <li>b. The claims adjuster for the employer’s compensation carrier has provided written authorization of payment.</li> <li>c. Verified health insurance coverage for any services to be provided that are not related to the employee’s claim.</li> <li>d. Necessary authorizations have been obtained from the patient’s health insurer for services not related to the employee’s claim or for which the workers’ compensation carrier may not pay.</li> <li>e. A coordination of benefit inquiry has been performed to correctly identify and sequence payor liability.</li> <li>f. The service is determined to be medically justified and rendered in an approved setting.</li> <li>g. The carrier will honor assignment of benefits.</li> <li>h. Out of state payors must guarantee payment in writing at HSCRC rates “fee for service.” Form should be completed and signed by payor before admission. (See attached form)</li> </ul>



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Insurance benefits will be considered “verified” when the following conditions are met:

8. Auto Liability	<ul style="list-style-type: none"> <li>a. The claims adjuster for the at-fault liability carrier has provided a written authorization of payment.</li> <li>b. The applicable coverage limit is greater than the expected charges.</li> <li>c. Verified health insurance coverage (see above).</li> <li>d. Necessary authorization(s) have been obtained from the patient’s health insurer for service not related to the accident claim or which the auto liability carrier may not pay.</li> <li>e. A coordination of benefit inquiry has been performed to correctly identify and sequence payor liability.</li> <li>f. The service is determined to be medically justified and rendered in an approved setting.</li> <li>g. The carrier will honor assignment of benefits.</li> </ul>
9. Union Plans	<ul style="list-style-type: none"> <li>a. The patient is eligible for coverage on the date of service – i.e., the premiums are paid up-to-date and the contract holder still meets the required minimum employment hours required for coverage.</li> <li>b. The service is a covered service under the patient’s contract.</li> <li>c. Necessary authorizations and notifications have been obtained from any designated review organization(s).</li> <li>d. A coordination of benefit inquiry has been performed to correctly identify and sequence payor liability.</li> <li>e. The service is not excluded as a pre-existing condition (elective only).</li> <li>f. Any necessary second surgical opinion forms have been obtained in accordance with payor requirements.</li> <li>g. The service is determined to be medically justified and rendered in an approved setting.</li> <li>h. The plan will honor assignment of benefits.</li> </ul>
10. CHAMPUS	<ul style="list-style-type: none"> <li>a. The patient is eligible for coverage on the date of service.</li> <li>b. The service is a covered service under the CHAMPUS contract.</li> <li>c. Necessary authorizations and notifications have been obtained from any designated review organizations.</li> <li>d. Statement of Non-Availability is provided for any elective services.</li> <li>e. The service is determined to be medically justified and rendered in an approved setting.</li> <li>f. The plan will honor our assignment of benefits.</li> <li>g. A coordination of benefit inquiry has been performed to correctly identify and sequence payor liability.</li> </ul>
11. Grant Programs	<ul style="list-style-type: none"> <li>a. The patient is eligible for grant coverage on the date of service.</li> <li>b. The Grant Administrator has provided a written authorization of payment, specifying what services are to be covered.</li> <li>c. Verified health insurance coverage for any services to be provided that are not covered by the Grant Program.</li> <li>d. The services are determined to be medically justified and rendered in an approved setting.</li> </ul>

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<b>PAYOR-SPECIFIC INSURANCE VERIFICATION REQUIREMENTS</b>	
Insurance benefits will be considered “verified” when the following conditions are met:	
12. State Managed Care Organizations	<ul style="list-style-type: none"> <li>a. Verify that the patient is eligible through EVS or Managed Care Company.</li> <li>b. The service is covered under the Maryland Medical Assistance.</li> <li>c. Obtain the necessary authorization/referral from the MCO.</li> <li>d. A coordination of benefits inquiry has been performed to correctly identify and sequence payor liability.</li> <li>e. The service is determined to be medically justified and rendered in an approved setting.</li> </ul>

**JOHNS HOPKINS HEALTH SYSTEM  
WORKERS' COMPENSATION FORM**  
(TO BE COMPLETED FOR INPATIENT AND OUTPATIENT VISITS)

PATIENT: \_\_\_\_\_

PAT COM #: \_\_\_\_\_ MEDICAL RECORD #: \_\_\_\_\_

DATE OF ADMISSION: \_\_\_\_\_

WORKERS' COMPENSATION INSURANCE CARRIER (NAME, ADDRESS & PHONE):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EMPLOYER (NAME, ADDRESS & PHONE):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WORKERS COMPENSATION CLAIM NUMBER: \_\_\_\_\_

CLAIMS ADJUSTER (INCLUDE PHONE): \_\_\_\_\_

STATE WHERE CLAIM IS FILED: \_\_\_\_\_

In consideration for the treatment of the above named patient, the Workers' Compensation Insurance Carrier and/or Employer named herein agrees to reimburse THE JOHNS HOPKINS HEALTH SYSTEM for services rendered to the above mentioned patient at the rates set forth and approved by the Maryland Health Services Cost Review Commission and to comply with Maryland law concerning this admission. Maryland rates shall apply to all services rendered to the patient.

\_\_\_\_\_  
Workers' Compensation Insurance Carrier

DATE: \_\_\_\_\_

\_\_\_\_\_  
Employer

DATE: \_\_\_\_\_

**THIS FORM MUST BE COMPLETED FOR ALL WORKERS' COMPENSATION CLAIMS AND MUST BE RETURNED TO THE PATIENT FINANCIAL SERVICES DEPARTMENT PRIOR TO PATIENT'S ADMISSION OR TREATMENT.**

(NOTE: ADMISSION MAY BE DENIED FOR ALL NON EMERGENT SERVICES UNLESS FORM IS COMPLETED AND SIGNED)