 JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTH SYSTEM	The Johns Hopkins Health System Policy & Procedure	<i>Policy Number</i>	FIN064
	<i>Subject</i>	<i>Effective Date</i>	07-17-09
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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), Johns Hopkins Community Physicians (JHCP), Johns Hopkins Home Care Group (JHHCG), and Howard County General Hospital (HCGH).

Purpose

To establish a consistent and uniform method for submitting bills to third-party payers and patients for all services rendered at JHHS affiliates.

Documentation

Each affiliate will establish guidelines defining the responsibilities of documentation required to generate a complete bill.

Billing Format

For JHH, JHHCG, HCGH and JHBMC hospital/technical or HHS billing, the standard bill form (UB04) will be submitted to third-party payers. The HCFA 1500 form will be the standard form used by JHCP, offsite Rehab services, unregulated Laboratory and Psychiatric Services, DME and IV. Affiliates will submit electronic claims to all third-party payers that can accept the standard EDI format associated with these bill forms. Each affiliate will bill up to a maximum of four carriers plus the patient for each service.

Interim and Late-Charge Billing (JHH, JHBMC & HCGH)

The affiliate will generate interim bills every 30 days and late-charge billings weekly in accordance with payer requirements.

Concurrent Patient Billing (JHH, JHBMC & HCGH)


Each affiliate will bill patients for their expected liabilities concurrently with their third-party payers whenever a patient liability has been identified through the insurance verification process and the affiliate's system supports concurrent billing.

Linked Bills (JHH, JHBMC & HCGH)

All affiliates will comply with payer requirements for linking readmission services to the inpatient bill, mother-and-baby bill combinations, the 72-hour rule, and other examples of linked billing. For JHBMC Community Psychiatry, if two services are billed on the same provider number on the same day, a report is generated daily that lists the two services that need to be linked.

Accountability for Patient Data

All intake areas including but not limited to the Emergency Departments, clinics, Outpatient Center, diagnostic testing, and Admitting Departments are accountable for collecting and validating accurate patient data, as required, to generate a correct bill form.

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REFERENCES

JHHS Finance Policies and Procedures Manual

Policy No. FIN041 - Estimating Inpatient Payment Requirements

Policy No. FIN045 - Verification of Insurance Benefits - Inpatient

Policy No. FIN065 - Payment Denials

RESPONSIBILITIES

Patient Financial Services
 Patient Service Coordinator,
 Billing/Collections

Review all claims generated by the affiliate's billing system and research and correct any missing or erroneous information. Forward registration concerns to appropriate registration area. Forward system requests to management.

For primary and secondary insurers, submit claims electronically or on paper in accordance with the payer's requirements. Attach all necessary documents as stipulated by payers.

Accounts should be billed within two (2) business days.


Perform routine follow-up on unpaid claims to bring to resolution and resubmit claims, as appropriate.

Bill and collect from secondary insurer.

Generate allowance required for balances that cannot be billed to patients as a result of affiliates' contractual arrangements with payers. Process all rejected services, as appropriate.

Patient Financial Services
 Support Representatives
 Manager; Sr. Director of Business
 Office (JHCP); Community
 Psychiatry Administrative Director
 (JHBMC)

Monitor billing effectiveness through review of system reports, aging of accounts receivable, and rejections rates.

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SPONSOR

Senior Director, Patient Finance (JHH, JHHS, JHBMC, HCGH)
 Senior Director of Finance (JHCP)
 CFO (JHHCG)

REVIEW CYCLE

Three (3) years


APPROVAL


 Vice President of Finance/CFO and Treasurer, JHHS

7/17/09
 Date

PROCEDURES - JHH, JHBMC, HCGH, JHCP & JHHCG

1. Patient Financial Services, Patient Service Coordinator, Billing/Collections
 - a. Prepare claims from affiliate's Patient Financial Services system for electronic or manual submission. Bill patient/responsible party for any verified self-pay portion concurrently with any third-party billing, when applicable.
 - b. Review electronic and hard-copy bills for completeness and receipt.
 - c. Research and correct missing/incorrect information. Report bill-form errors and omissions via copies of same to management who will forward to appropriate registration leadership for review and correction.
 - d. Submit clean claims via electronic/paper submission in accordance with payer guidelines within 1-2 days of receipt.
 - e. Review Aged Trial Balance monthly and/or collector assignments and research and resolve claims that remain unpaid beyond dollar/aging standards. Unpaid claims will appear in the PFS Representative's Collector queue system for follow-up.
 - f. Check status of unpaid third-party paper claims within 30-45 days of submission. Correct any errors and resubmit claims.
 - g. Accounts placed on hold in the electronic billing system should

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be properly documented. If an account holds longer than seven (7) days, the host system should be documented to reflect "hold status." Once the account is billed, the system bill date should be updated to reflect the actual billing date.

- h. Bill secondary insurers upon receipt of primary payer remittance advice.
- i. Process and act upon third-party remittance and correspondence within five (5) business days of receipt:
 - 1) Change financial class to self-pay to bill patient/responsible party for any non-covered services as appropriate.
 - 2) Generate allowance adjustment transactions as appropriate if affiliate's contractual agreement with payer stipulates that patients cannot be billed under certain circumstances, such as: no authorization obtained, acute-care services not required, beyond billing statute, etc.
 - 3) Submit all denied adjustments for write-off.
 - 4) Monitor appeals submitted by appeal groups for appropriate follow-up.

2. Patient Financial Services Management

- a. Review system reports for billing productivity and efficiency, high-dollar and/or aged accounts, bill holds, etc. Review and approve accounts transferred to bad-debt receivables.
- b. Check status of major third-party electronic claims within 3 business days of submission. Correct any errors and resubmit claims.