BILLING
OPERATIONAL PROCEDURE

April, 1989 (rv 7/93, r 6/96, rv 4/99, 9/02, rv 9/05, 3/08, 10/12, 11/13) (rv 3/14) **Policy Ref**: 110-06
Reviewed/Revised: May, 2017 **Procedure**: 705-04

A. PURPOSE:

To provide a mechanism whereby all accounts are billed according to financial classification, to either the individual or applicable third party, in a timely and accurate manner.

B. PROCEDURE:

I. For each individual discharged a final posting of applicable charges shall be made and a preliminary, itemized statement mailed within seven (7) days.

II. The Finance/Billing Dept. shall review each individual account file prior to billing to ensure accuracy and completeness. Omissions, unbilled charges, unbalanced totals or other incongruity in the account file shall be brought to the attention of the Chief Financial Officer.

III. Where there is applicable third party coverage the Finance/Billing Office shall compare the final billing to the UB-04 and HCFA-1500 forms to confirm charges and ensure that all data fields are complete. Claims are transmitted via electronic submission or on paper and mailed. Documents needed for billing include; a detailed bill, UB-04, HCFA-1500 and signed individual signature forms. Optional documents include; copies of insurance cards, insurance claim forms and medical records.

IV. When the UB-04 and HCFA-1500 are complete and accurate i.e. constitutes a "clean claim" based on the carriers' requirements, the biller shall initial the form in the appropriate field.

V. Individual diagnoses shall be given the appropriate ICD-10-CM coding and noted on all insurance claims. Procedure codes shall be verified and coded on the UB-04 and HCFA-1500 forms.

VI. Billings shall be submitted to secondary and tertiary insurance carriers based on coordination of benefit (COB) requirements, along with copies of remittances from primary carriers, copies of insurance cards or detailed bills.

VII. All outstanding third party billings are to be placed in the "pending insurance" file until payment is received or other follow up action is taken. Applicable late charges shall be billed to the carrier.

VIII All Medicaid claims shall be reviewed by the Billing Supervisor for appropriateness of billing. Hospital Services are not eligible for Medicaid reimbursement unless it is a Medicaid HMO.

IX. For individuals with no third party coverage, final billing shall be made within thirty (30) days of the preliminary billing. Where a repayment plan has been negotiated with the individual the first payment shall be due thirty (30) days after discharge.

PROCEDURE APPROVED:

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QI/RM Director

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Date