Claims Billing Policy

Policy No: **Approved by:**
Effective Date:

I. Policy
To ensure that all patients receiving services are billed through the billing system and the appropriate payments are posted.

II. Scope
This policy applies to all sites performing services.

III. Procedure
Following are detailed procedures to be followed when performing the billing function:

1. Once the charges have been entered and a charge audit has been performed, the insurance claims and/or patient statements are ready to be generated.

2. Depending on the billing system, insurance claims are sent electronically (Medicare, Blue Shield, Medicaid). No less than once per week should your claims be electronically submitted. Patient statements are normally set up to print once per month. Each statement should be reviewed prior to mailing to verify that the appropriate charge and/or payment information has been posted accurately.

3. The claims will go through a sequence of edit checks (billing scrubbers and local medical review policy edits). An error report is generated that provides details as to why the claim has not passed the processing function. The error report is used to make the necessary changes to the claim. It is imperative that the billing department works closely with the cancer center, as the information from the cancer center is crucial to the billing process.

4. Once the claim passes all edits, the claim is then submitted to the insurance company for payment.

5. Once the payer reviews the claim, payment is made via an explanation of benefits (EOB) directly to the hospital for the services rendered. The payment clerk will post the appropriate payments to the patient accounts. The payment clerk will post all the checks, print a copy of the transactions entered into the system, and review that list against the adding machine tape and EOBs to validate that all payments have been entered accordingly. The EOBs, a copy of all checks, and the adding machine tape will be filed in a day file for that day's payments.

6. A review of the EOB happens at the time of payment posting. If the claim is denied, the EOB is passed along to the denial and follow-up representative. If the insurance carrier pays the claim, and there is a balance left, the patient will receive a statement when the appropriate patient statements are printed.

7. If the primary insurance company has paid the claim appropriately, and the patient has a secondary insurance company, the claim is processed to the secondary insurance. A copy of the EOB from the primary insurance is attached to the claim for verification to the secondary insurance carrier.