UNIVERSITY OF KANSAS
WATKINS HEALTH SERVICES
BUSINESS OFFICE

NUMBER:	ISSUE DATE:
BO-101	**04/01/2001**
TITLE:	**REVISED:**
Insurance Billing	**7/16/13; 10/05/2018**
TITLE OF OWNER:	**APPROVED:**
Business Operations Manager	**Director**

PURPOSE: To have a process in place to submit patient charges to an insurance company if the patient chooses.

POLICY: The patient is ultimately responsible for all charges whether they are sent to insurance or not. Charges will be submitted to an insurance company as a convenience to the patient and if the patient so elects. Electronic and paper claims are processed weekly.

PROCEDURES:

1. Insurance can be billed once the following forms are completed by the patient:
   1.1. Consent for Use and Disclosure of Health Information (AD-309-1).
   1.2. Treatment Agreement (AD-410-1).
   1.3. A copy of the insurance card (front/back) and Insurance Information to include:
      - Insurance company name and claims address.
      - Policyholder name, address, date of birth and relationship to patient.
      - Front and back of insurance card will be scanned into Point and Click.

2. Steps for the input of insurance information and transferring of charges to the insurance company are as follow:
   2.1. From Open Registration:
      - Click “Insurance”.
      - Click on either “Add” or “Edit”
      - Choose correct insurance plan from dictionary.
      - If the insurance company is not listed in the dictionary, the insurance clerk will input the new insurance company per PnC guidelines.
      - Enter policy eligibility dates
      - Enter Policy ID number and group number.
      - Select patient’s relationship to the Subscriber.
      - Select or enter the subscriber name, date of birth and address.
      - Click Insurance verification, as appropriate.

   2.2. The insurance clerk will check the account to see if there are charges to be transferred to the insurance.

3. Insurance claim printing and processing.
    3.1. Claim forms (HCFA 1500) are printed twice weekly:
        - Got to Open Billing
        - Organizational view
        - Browse tickets
        - Service date is 1/1/13 (or 5 years back)
        - Any errors are corrected.
        - Print claims.

4. Electronic filing of claims filing process
    4.1. Electronic claims are processed twice weekly: See BO-101-2 Insurance Billing procedure.

5. Denied insurance claims and non-payments (e.g. applied to deductible) are processed as follows:
    5.1. Use the appropriate transaction code to indicate reason for non-payment or denial from insurance.
    5.2. Add detailed note to claim, providing explanation of denial if needed.
    5.3. The amount is transferred back to the patient to be billed.
    5.4. Terminate insurance if claim denied for “no coverage at the time of service”.
    5.5. Follow-up when needed, collaborating with coder and insurance specialist.

6. Amounts that have been pending insurance for 45 days or more, with no reply from the insurance company are refiled once and then transferred to the patient if no response after 60 days or more.
    6.1. Denial code “OTP” is used stating “no reply from insurance”.
    6.2. The amount is transferred back to the patient to be billed.

7. Insurance payments are processed and any unpaid balance is transferred back to the patient for the next invoice cycle.
    7.1. Balanced batches and checks are entered in register for deposit at the end of the day per Daily Balancing & Deposit policy (BO-208).

REFERENCES:
BO-208 Daily Balancing & Deposit
AD-410 Treatment Agreement
AD-309 Consent for Use & Disclosure of Health Information
KU Policy Library, http://policy.ku.edu/

This document is on file with the KU Policy Library.