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POLICY

This policy applies to the Johns Hopkins Health System (JHHS) Patient Financial Services (PFS) Division and the following entities: The Johns Hopkins Bayview Medical Center (JHBMC) and Howard County General Hospital (HCGH).

PURPOSE

To describe the process for filing late charges with all payers—on the Meditech systems.

PROCEDURE

Additional charges or credits that are posted to a patient account after the final bill date are called “late charges.” *With the exception of Medicare and certain Blue Cross lines of business*, the Meditech systems automatically re-bill and/or adjust late charges according to the following guidelines:

The Billing Representative will:

1. Verify that the date of service for the late charge falls *within the dates of service* for the account.
2. Verify that the late charge corresponds to the initial service rendered.
Note: dates of service may be the same, but that does not mean the late charge belongs to the account.
3. When the account has generated a final bill and the initial claim has been submitted to the third-party payer, the following action is required:
 - a) Per departmental policy for late-charge allowances, if the late-charge balance meets the amount to be adjusted, the Meditech systems will automatically adjust the late charge(s).


JHBMC: *The amounts allowed for late-charge adjustment are:*

Bayview Inpatient	\$199.99
Bayview Outpatient	\$49.99
Medicare Outpatient	\$99.99

HCGH: *The amounts allowed for late-charge adjustment are:*

HCGH Inpatient	\$74.99
HCGH Outpatient	\$24.99

- b) All other late charges that exceed these adjustment amounts are billed to the appropriate third-party payer—*unless the late charge is outside the timely filing period.*
4. **For late credits**, verify that the credit amount is the same as the original charged amount. Verify the date of the credit: *it should be the same as the original charge date.* If the credit amount or date is different from the original charge date, follow up with the department where the charge originated.

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All third-party payers have specific requirements regarding the types of bills that must be submitted. For example: late-charge only bill, or all-inclusive bill (detailing all charges—the initial ones as well as any additional charges). For “Late Charge Only” claims, the Meditech systems will automatically generate late-charge billing according to the specific requirements of each third-party payer:

All Payers

All accounts—regardless of the third-party payer—must be documented in the Meditech systems. Each account should be statused and set to queue to the library of the appropriate PFS Representative for follow-up on a future date. This date has been established within each department’s requirements.

Medicare—JHBMC

1. If a payment has been received on the account, the PFS Representative will automatically receive a re-bill for “Late Charge All Inclusive Bill” via the Meditech systems.

Upon receipt of the claims the PFS Rep will review accounts via the Meditech systems for accuracy and verify that the types of bills are appropriate:
117 inpatient; 137 outpatient.


2. Claims with bill types **117** or **137** will pend in CareMedic and be listed under the “**HD**” (hold bill) status code for review and special handling.

If a claim contains only a change to charges, the PFS Rep will submit the late-charge adjustment electronically through CareMedic.

3. *If multiple updates are required on the late-charge bill* (such as date changes, diagnosis additions, etc.), the Rep will access the Medicare Florida Shared System (FSS) to submit an adjustment for the late charge(s). To adjust a claim according to Medicare specifications, select “**Claims Correction**” in FSS and enter the amount. **Note:** when you enter information for a claim correction in FSS, the system automatically establishes the type of bill; therefore, the PFS Rep does **not** need to enter the bill type.
4. *If it has been 45 days since the final bill and no payment has been received on the initial claim*, auto rule for Medicare late-charge processing will automatically produce a late-charge bill for review.

Medicare—HCGH

1. The PFS Rep will automatically receive a late bill for “**Late Charge Only**” via the Meditech systems.
2. The **115 inpatient** and **135 outpatient** late bills will pend in CareMedic.
3. Process the claim in CareMedic, adding late charges to the final bill claim and adjusting the total of the bill and the ICN.
4. Secondary claims automatically drop to queue.

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5. Claims with bill types **115** or **135** will pend in CareMedic and be listed under the “**HD**” (hold bill) status code for manual review and special handling.
6. The PFS Rep will access the Medicare Florida Shared System (FSS) to submit an adjustment for the late charge(s). To adjust a claim according to Medicare specifications, select “**Claims Correction**” in FSS and enter the amount. **Note:** when you enter information for a claim correction in FSS, the system automatically establishes the type of bill; therefore, the PRS Rep does **not** need to enter the bill type.
7. *If it has been 45 days since the final bill and no payment has been received on the initial claim, auto rule for Medicare late-charge processing will automatically produce a late-charge bill for review.*

Medicaid

1. Medical Assistance allows only one late-charge claim to be submitted per encounter. For any additional late charges you must submit an Adjustment Request Form (DHMH 4518A).
2. The PFS Rep will receive a re-bill for **Late Charge Only** via the Meditech systems.

When you receive the late charge, review the claim via the Meditech systems to determine the date of the payment for the initial claim and verify that the claim is complete—including the appropriate type of bill: **115 inpatient; 135 outpatient.**

3. Medicaid requires an Adjustment Request Form (DHMH 4518A) for any additional late charges billed after the first late-charge bill. The PFS Rep must pull the payment voucher, photocopy it, and attach the copy to UB04. In the remarks section, note: “**Billing for late charge, payment listing attached.**”

Blue Cross

1. If payment has been received, the PFS Rep will receive a re-bill via the Meditech systems.

Maryland Blue Cross, Blue Card, and FEP require that late charges be submitted as Late Charge Adjustments. An all-inclusive bill is produced and the ICN (Initial Claim Number) is placed in Field Locator 64 of the UB04.

For Blue Cross of the National Capital Area (including Blue Choice, an HMO product), late charges must be submitted as “**late charge only**” claims, and they do **not** require an ICN.


2. Blue Cross late-charge claims are submitted electronically, and the re-bill will download to the electronic billing system. **Note:** NASCO claims are an exception to this rule: they must be submitted on paper, but they are also submitted electronically for tracking.

When you receive the re-bill, review the claim for accuracy and verify that the type of bill is appropriate: **115 inpatient; 135 outpatient.**

Commercial/HMO/MCO/MSA/Work Comp/Grants/Other

1. The PFS Rep will receive a re-bill for **Late Charge(s)** via the Meditech systems.

These payers require a “**Late Charge Only**” claim.

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2. When you receive the re-bill request (UB04 electronic or hard copy), review the claim for accuracy and verify that the type of bill is appropriate:
115 or 117 inpatient; 135 or 137 outpatient.
3. Follow each payer's specific guidelines and submit the claim via electronic billing or mail to the appropriate insurance address.
4. JHHC requires that "Late Charge Only" claims be sent on paper.

Exceptions to auto rules for write-off or re-bill

1. In cases where accounts should **not** be selected for the adjustment or re-bill auto rule (for example: charge audits, Medicare reviews, customer-service calls, etc.), *the following procedure must be followed:*
 - a) Select "**Process an Account**" function and enter the account number
 - b) Select "**Edit Account**"
 - c) Select "**CDS BAPAGENERIC**"
 - d) Enter "**Y**" in the "**Late Charge Override**" field

These steps must be followed before you forward a charge reversal sheet to data entry.

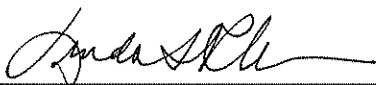
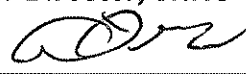
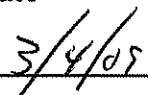
SPONSOR

Senior Director, Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years

APPROVAL

	
Senior Director, JHHS	Date
	
Director, PFS Financial Support, JHHS	Date