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Policy

This policy/procedure applies to The Johns Hopkins Health System Corporation (JHHS) and the following affiliated entities: The Johns Hopkins Bayview Medical Center (JHBMC), and Howard County General Hospital (HCGH).

Additional charges that are posted to a patient account after the final bill date are called "late charges". The Meditech System automatically rebills and/or adjusts late charges in accordance with policy for "Late Charge Only" claims with the exception of Medicare and select Blue Cross lines of business.

The Billing Representative will:

- 1) Verify that the date of service for the late charge coincides with the initial date of service.
- 2) Verify that the late charge coincides with the initial service rendered. The date of service may be the same; however the late charge may not belong 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) If balance of late charge meets the amount to be adjusted per Departmental Policy for late charge allowances, the Meditech System will automatically adjustment (weekly) the late charge(s).
 1. The amounts allowed for Late Charge adjustment at JHBMC is:


Bayview Inpatient	\$199.99
Bayview Outpatient	\$49.99
Medicare Outpatient	\$99.99
 2. The amounts allowed for Late Charge adjustments at HCGH is:

HCGH Inpatient	\$74.99
HCGH Outpatient	\$24.99
 - b) All other late charges, which exceed the established late charge adjustment amounts, are to billed to the appropriate third party payers.
- 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 charged date. If the credit amount or date is different from the original charge, call or forward it to the specific department.

All Third Party Payers have specific requirements regarding the type of bill, which must be submitted, i.e., late charge only bill vs. all inclusive bill (detailing all charges, initial bill charges as well as any additional charges). For this reason the Meditech System will produce automatic late charge billing(s) in accordance with the specific third party payer for "Late Charge Only" claims.

Medicare- JHBMC

- 1) PFS Rep will automatically receive a rebill for "Late Charge all Inclusive Bill" via the Meditech System if a payment has been received on the account. Upon receipt of the claims, the PFS Rep will review the accounts via the Meditech System for accuracy and verify that the types of bills is appropriate (**117 Inpatient; 137 Outpatient**).
- 2) Claims with type of bill 117 or 137 will pend in Caremedic and be listed under the "HD" (hold bill) status code for review and special handling. If the claim contains only a change to charges, PFS rep will submit late charge adjustment electronically through Caremedic.

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- 3) If multiple updates are required on late charge bill (date changes, diagnosis additions), Rep will access the Medicare Florida Shared System to submit an adjustment for the late charge(s). The Rep will select "Claims Correction" in the FSS Medicare system and enter the amounts to adjust the claim according to medicare adjustment specifications. (Note: when information is entered for a claim correction into FSS, the system will automatically establish the bill type (117/137), therefore, the PFS Rep is not required to enter the bill type within the Medicare system for the adjustment.
- 4) Auto rule for Medicare late charge processing will automatically produce a late charge bill for review if it has been 45 days from the final bill and no payment has been received on the initial claim.


Medicare- HCGH

- 1) Billing Rep will automatically receive a late bill for "Late Charge Only" via the Meditech System.
- 2) The 115 inpatient and 135 outpatient late bills will pend in CareMedic.
- 3) Process the claim in CareMedic adding late charges to final bill claim and adjusting total of bill and ICN number.
- 4) Secondary claims automatically drop to Queue.
- 5) Claims with type of Bill 115 or 135 will pend in CareMedic and be listed under the "HD" [hold bill] status code for manual review and handling.
- 6) The Billing Rep will access the Medicare Florida Shared System to submit an adjustment for the late charge[s]. The Rep will select "Claims Correction" in the FSS Medicare system and enter the amounts to adjust the claim according to the Medicare adjustment specifications. [Note: when information is entered for a claim correction in the FSS the system automatically established the type of Bill [115/135], therefore, the Billing Rep is not required to enter the Bill type within the Medicare system for the adjustment.
- 7) Auto rule for Medicare late charge processing will automatically produce a late charge bill for review if it has been 45 days from the final bill and no payment has been received on the initial claim.

Medicaid:

- 1) Medical Assistance only allows one late charge claim to be submitted per encounter. Any additional late charges will require a "gold adjustment" form to be submitted.
- 2) The PFS Rep will receive a rebill for Late Charge only via the Meditech System via collection rules. Upon receipt of the late charge the PFS Rep reviews the claim via the Meditech System 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 a hard copy claim to be submitted for the first late charge bill. Medicaid requires a "gold adjustment" form for any additional late charge(s) billed. PFS Rep must pull payment voucher, photocopy and attach copy to UB04. Under remark section, notate "billing for late charge, payment listing attached."

Blue Cross:

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- 1) PFS Rep will receive a rebill (if payment has been received) via the Meditech System. Maryland Blue Cross, Blue Card, and FEP requires that late charges be submitted for Late Charge Adjustments, and billed as an all inclusive Claims and require the ICN# in UB04 form locator 64. For Blue Cross of the National Capital Area including Blue Choice (HMO product), late charges must be submitted as "late charge only" claims, and do not require an ICN#.
- 2) Blue Cross late charge claims are submitted electronically (with the exception of NASCO claims which must be submitted via paper), therefore the rebill will download to the electronic billing system. NASCO claims are also submitted electronically for tracking. Upon receipt of the rebill, the PFS Rep will review the claim for accuracy and verify that the type of bill is appropriate **(115 Inpatient: 135 Outpatient)**.

Commercial/HMO/MCO/MSC/Work Comp/Grants/Other:


- 1) PFS Rep will receive a rebill for Late Charge(s) via the Meditech System collection rules. These payors require a "Late Charge Only" claim.
- 2) Upon receipt of the rebill request (UB04 electronic or hard copy) the PFS Rep will review the claim for accuracy and verify that the type of bill is appropriate **(115 Inpatient: 135 Outpatient)**.
- 3) Follow guidelines according to payor specifications, and submit claim via electronic billing or mail to the appropriate insurance address.
- 4) JHHC requires "Late Charge Only" claims be sent via paper.

All Payors:

All accounts regardless of the Third Party Payor, must be documented in the Meditech System. The (account(s) should be statused and set to queue to the library of the appropriate PFS Rep for follow up at a future date. This date has been established with in each department's requirements.

Exceptions to auto rules for write off or rebill:

- 1) In cases where accounts should not be selected for the adjustment or rebill auto rule, the following procedure must be Followed (ex; Charge audits, Medicare reviews, customer service calls, etc.):
 - a. Select "Process an Account" function, enter account number
 - b. Select "Edit Account"
 - c. Select "CDS BAPAGERNIC"
 - d. Enter "Y" in the "late charge override" field
 - e. This process must be followed prior to forwarding a charge reversal sheet to data entry.

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SPONSOR

Senior Director, Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years

APPROVAL

Senior Director, JHHS

Date

Director, PFS Financial Support, JHHS

Date