



## Home Health Demand Billing for TPL Claims

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# Acronyms

ADR	Additional Development Request
CMS	Centers for Medicare & Medicaid Services
CWF	Common Working File
DDE	Direct Data Entry
FISS	Fiscal Intermediary Standard System
HHA	Home Health Agency
HH PPS	Home Health Prospective Payment System
HIPPS	Health Insurance Prospective Payment System
OASIS	Outcome and Assessment Information Set

# Acronyms

RAP	Request for Anticipated Payment
TPL	Third Party Liability

# Objective

Assist Home Health providers better understand the Home Health Demand Billing process post-TPL Demonstration Project and what is required on the bills submitted to Medicare so the appropriate denials are made. This presentation will review how demand claims should be billed now that the demonstration project is over.

# Agenda

## TPL Demand billing under HH PPS

- Define demand billing
- Criteria for submission
- How to submit claims
  - Examples

# Did You Know...?

TPL demand billing is a procedure through which a state agency is requesting Medicare to review services that the HHA has determined, based on certain criteria, Medicare would not reimburse if billed.

# What Drives Demand Billing?

## HHA issues beneficiary an HHABN

- HHA determines:
  - Services not medically reasonable and necessary; or
  - Beneficiary failed to meet homebound, intermittent or non-custodial care requirements

State requires denial from Medicare before making payment

# What is the Beneficiary's Responsibility?

Sign HHABN

Pay out-of-pocket for services indicated on HHABN

Note: Third party payers (supplemental insurers) may cover services until Medicare determination is made.

# What is the Provider's Responsibility?

Required to bill disputed services to Medicare

- Beneficiary must be under a physician plan of care
- At least one service must have been provided to the beneficiary

Submit RAP

- Establish episode

Submit one claim

- 60-day episode
- Admit to discharge

# Question #1

The HHABN must inform the beneficiary of non-covered services.

1. True
2. False

# Request for Anticipated Payment (RAP)

# RAP

RAP must be submitted to establish the HH episode in the Common Working File (CWF)

- Not a claim
- Not subject to payment floor

Should be formatted the same as any other RAP for HH patients

- No special billing requirements in TPL demand situations

# Entering RAP

MAP1701

NATIONAL GOVERNMENT SERVICES, INC.

MAIN MENU FOR REGION A62CPOH1

01 INQUIRIES

02 CLAIMS/ATTACHMENTS

03 CLAIMS CORRECTION

04 ONLINE REPORTS VIEW

ENTER MENU SELECTION: 02

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

# Claims Entry – 26

MAP1703

NATIONAL GOVERNMENT SERVICES, INC.  
CLAIM AND ATTACHMENTS ENTRY MENU  
CLAIMS ENTRY

INPATIENT	20
OUTPATIENT	22
SNF	24
HOME HEALTH	26
HOSPICE	28
NOE/NOA	49
ROSTER BILL ENTRY	87

ATTACHMENT ENTRY

HOME HEALTH	41
DME HISTORY	54
ESRD CMS-382 FORM	57

ENTER MENU SELECTION: 26

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

MAP1711 M E D I C A R E A O N L I N E S Y S T E M CLAIM PAGE 01

SC INST CLAIM ENRTY SV:

HIC 123456789A TOB 322 S/LOC S B0100 OSCAR XX7XXX UB-FORM

NPI XXXXXXXXXXXX TRANS HOSP PROV PROCESS NEW HIC

PAT.CNTL#: XXXXXXXX TAX#/SUB: 39XXXXXXXX TAXO.CD:

STMT DATES FROM 052708 TO 052708 DAYS COV N-C CO LTR

LAST DAVISON FIRST JOHN MI DOB 12091929

ADDR 1 12345 HOPE LANE 2 LOS ANGELES CA

3 4

5 6

ZIP 92885 SEX M MS ADMIT DATE 052708 HR 00 TYPE 9 SRC 5 D HM STAT 30

COND CODES 01 02 03 04 05 06 07 08 09 10

OCC CDS/DATE 01 02 03 04 05

06 07 08 09 10

SPAN CODES/DATES 01 02 03

04 05 06 07

08 09 10 FAC.ZIP 98765 4321

DCN XXXXXXXXXXXXXXXX

VALUE CODES - AMOUNTS - ANS I MSP APP IND

01 61 66780.00 02 03

04 05 06

07 08 09

37185 <== REASON CODES

PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF8-NEXT

MAP1712 M E D I C A R E A O N L I N E S Y S T E M CLAIM PAGE 02  
SC INST CLAIM ENTRY REV CD PAGE 01

HIC 123456789A TOB 322 S/LOC S B0100 PROVIDER XX7XXX

CL	REV	HCPC	MODIFS	TOT	UNIT	COV	UNIT	TOT CHARGE	NCOV	CHARGE	SERV DT
1	0023	1AFKS			00001	00001					052708
2	0001										

37185

<== REASON CODES

PRESS PF2-171D PF3-EXIT PF5-UP PF6 DOWN PF7-PREV PF8-NEXT PF11-RIGHT

MAP1713 M E D I C A R E A O N L I N E S Y S T E M CLAIM PAGE 03

SC INST CLAIM ENTRY

HIC 123456789A TOB 322 S/LOC S B0100 PROVIDER XX7XXX

OFFSITE ZIPCD:

CD	ID	PAYER	OSCAR	RI	AB	PRIOR	PAY	EST	AMT	DUE
A	Z	MEDICARE	XX7XXX	Y	Y			0.00		0.00
B								0.00		0.00
C								0.00		0.00

DUE FROM PATIENT 0.00 0.00

MEDICAL RECORD NBR 000XXXXX COST RPT DAYS NON COST RPT DAYS

DIAGNOSIS CODES 1 V571 2 7812 3 V5271 4 78199 5 V5883

6	7	8	9
ADMITTING DIAGNOSIS	V571	E CODE	HOSPICE TERM ILL IND

IDE

PROCEDURE CODES AND DATES 1 2

3 4 5 6

ESRD HOURS 00 ADJUSTMENT REASON CODE FC REJECT CODE NONPAY CODE

ATT PHYS NPI XXXXXXXXXXXX LN SMITH FN ROBERT MI S

OPR PHYS NPI 0000000000 LN FN MI

OTH PHYS NPI 0000000000 LN FN MI

37185

<== REASON CODES

PRESS PF3-EXIT PF7-PREV PAGE PF8-NEXT PAGE

MAP1715 M E D I C A R E A O N L I N E S Y S T E M CLAIM PAGE 05

SC INST CLAIM ENTRY

HIC 123456789A TOB 322 S/LOC S B0100 PROVIDER XX7XXX

INSURED NAME REL CERT-SSN-HIC SEX GROUP NAME DOB INS GROUP NUMBER

A DAVISON JOHN M 12091929  
123456789A

B

C

TREAT. AUTH. CODE  
07JK08AA41GBMDCDLG

TREAT. AUTH. CODE

TREAT. AUTH. CODE

37185

<== REASON CODES

PRESS PF3-EXIT PF7-PREV PAGE PF8-NEXT PAGE

## Question #2

There are special billing requirements when submitting a RAP for demand situations.

1. True
2. False

# Demand Claim Requirements

Submit one claim per HH episode

- 60 days or admit to discharge

May contain covered and non-covered charges

- Covered charges reflect any services rendered that meet Medicare coverage criteria
- Non-covered charges reflect services in dispute (claim may have all non-covered charges)

Condition Code 20

- Assures medical review

# What is Condition Code 20?

Beneficiary-requested billing\*

Provider realizes services are non-covered level of care or excluded, but beneficiary (or other insurance) requests Medicare determination

\*This is the CMS definition of condition code 20 – this is the code that must be used to denote TPL Demand Billing

# Did You Know...

Medical records are not to be submitted along with the claim. Medical records are not reviewed during the claims process and will cause an unnecessary expense for the facility. You should only send records once your facility receives an ADR.

# Demand Claim Example

# Entering Claim

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06 07 08 09 10

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08 09 10 FAC.ZIP 98765 4321

DCN XXXXXXXXXXXXXXXX

V A L U E C O D E S - A M O U N T S - A N S I MSP APP IND

01 61 66780.00 02 03

04 05 06

07 08 09

<== REASON CODES

PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF8-NEXT

MAP1712  
SC

M E D I C A R E A O N L I N E S Y S T E M  
INST CLAIM ENTRY

CLAIM PAGE 02  
REV CD PAGE 01

HIC 123456789A TOB 329 S/LOC S B0100 PROVIDER XX7XXX

CL	REV	HCPC	MODIFS	TOT RATE	UNIT	COV UNIT	TOT CHARGE	NCOV	CHARGE	SERV DT
1	0023	1AFKS		00060		00060				052708
2	0551	G0154		00005		00005	150.00			052708
3	0551	G0154		00004		00004	150.00			071208
4	0551	G0154		00004		00004	150.00	150.00		072508
5	0571	G0156		00002		00002	75.00			061508
6	0571	G0156		00002		00002	75.00	75.00		061608
7	0571	G0156		00003		00003	100.00	100.00		062108
8	0571	G0156		00002		00002	75.00	75.00		062308
9	0571	G0156		00003		00003	100.00	100.00		062108
10	0571	G0156		00003		00003	100.00			070408
11	0571	G0156		00003		00003	100.00	100.00		072008
12	0571	G0156		00002		00002	75.00			072308
13	0571	G0156		00003		00003	100.00	100.00		072508
14	0001						1250.00	700.00		

<== REASON CODES

PRESS PF2-171D PF3-EXIT PF5-UP PF6 DOWN PF7-PREV PF8-NEXT PF11-RIGHT

# What Happens Next?

Claim goes to S B6001 status location

System-generated letter requesting medical records

Provider sends records to Medicare for review for the episode in which records were requested

Intermediary reviews medical records

Determination is made

# Types of Determinations

## Intermediary agrees

- HHA keeps beneficiary payment

## Intermediary disagrees

- HHA refunds beneficiary

## Question #4

A RAP does not need to be submitted to establish an episode since there are non-covered charges on the claim.

1. True
2. False

# What You Should Do Now...

Submit claims timely

Respond timely to all medical documentation requests

Share this information with others

# References & Resources

## CMS Claims Processing Internet Only Manual (IOM), Pub. 100-04:

- Chapter 1, Section 70 (Timely filing)
- Chapter 10, Section 40 (General HHA billing on the UB-04)
- Chapter 10, Section 50 (Demand billing)
- Chapter 30, Sections 60-60.8 (Scope and description of HHABN)

Thank You for Your Attendance!

Questions?



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