Medicare Intermediary Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 1821 **Date: DECEMBER 21, 2000**

CHANGE REQUEST 1469

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3638.30 - 3638.30 (Cont.)	6-190.5 - 6-190.6 (2 pp.)	6-190.5 - 6-190.6 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: 10/01/00*
IMPLEMENTATION DATE: 10/01/00

Section 3638.30, Beneficiary-Driven Demand Billing Under HH PPS, has been revised to clarify demand billing under HH PPS.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

3638.25 HH PPS Claims When No RAP Was Submitted.--A RAP and a claim must be submitted for all episodes for which payment based on HIPPS codes will be made. However, there may be circumstances in which an HHA is aware prior to billing Medicare at four or fewer visits will be supplied in the episode. In these cases, since the HHA is aware that the episode will be paid a low utilization payment adjustment (LUPA) based on national standardized per visit rates, the HHA is permitted to submit only a claim for the episode. These claims will be referred to as "No-RAP LUPA" claims.

HHAs may submit both a RAP and a claim in these instances if they choose, but only the claim is required. HHAs should be aware that submission of a RAP in these instances will result in recoupment of funds when the claim is submitted. HHAs should also be aware that the receipt of the RAP or a "no-RAP LUPA" claim cause the creation of an episode record in CWF and establishes an agency as the primary HHA which can bill for the episode. If submission of a "No-RAP LUPA" delays submission of the claim significantly, the agency is at risk for that period of not being established as the primary HHA.

If the agency chooses to submit this "No-RAP LUPA" claim, the claim form should be coded like other claims as described in §3638.24.

3638.30 Beneficiary-Driven Demand Billing Under HH PPS.--Demand billing is a procedure through which beneficiaries can request Medicare payment for services that (1) their HHAs advised them were not medically reasonable and necessary, or that (2) they failed to meet the homebound, intermittent or non-custodial care requirements, and therefore would not be reimbursed if billed. The HHA must inform the beneficiary of this assessment in an Advance Beneficiary Notice (ABN), which also must be signed by the beneficiary or appropriate representative. In short, beneficiaries pay out of pocket or third party payers cover the services in question, but HHAs in return, upon request of the beneficiary, are required to bill Medicare for the disputed services. If, after its review, Medicare decides some or all the disputed services received on the "demand bill" are covered and pays for them, the HHA would refund the previously collected funds for these services. If the Medicare determination upholds the HHA's judgement that the services were not medically reasonable and necessary, or that the beneficiary failed to meet the homebound or intermittent care requirements, the HHA keeps the funds collected, unless the Regional Home Health Intermediary (RHHI) determines the ABN notification was not properly executed, or some other factor changed liability for payment of the disputed services back to the HHA.

With the advent of HH PPS, the Medicare payment unit for home care changes from visits to episodes, usually 60 day in length. In order to be eligible for episode payment, Medicare beneficiaries must be: (1) under a physician plan of care, and (2) at least one service must have been provided to the beneficiary, so that a request for anticipated payment (RAP) can be sent to Medicare and create a record of an episode in Medicare systems. Therefore, initially under HH PPS, demand billing must conform to ALL of the following criteria:

- Situations in which disputed services are called for under a plan of care, but the HHA believes the services do not meet Medicare criteria for coverage;
- Claims sent to Medicare with type of bill 32x and 33x; and,
- Episodes on record in Medicare systems (at least one service in episode).

A. Interval of Billing.--Under HH PPS, the interval of billing will change and become standard. At most, a RAP and a claim will be billed for each episode. Providers may submit a RAP after the delivery of the first service in the 60-day episode, and they must submit a claim either after

discharge or after the end of the 60-day episode. This will not change in demand bill situations, so that only the claim at the end of the episode is the demand bill.

B. Timeliness of Billing.--Several HCFA memoranda to HHAs serving Medicare beneficiaries since 1998 request prompt filing of demand bills. This request should be met to the greatest degree possible, even though the HH PPS billing interval is fixed (A. above), and timely filing requirements for claims remain the same as under the cost reimbursement system. HH PPS provides a new incentive to be prompt in filing claims, since RAP payments will be automatically recouped against other payments if the claim for a given episode does not follow the RAP in the later of: (1) 120 days from the start of the episode; or (2) 60 from the payment date of the RAP. The RAP must be re-billed once payment has been recouped if the claim is to be billed unless the claim is a no-RAP LUPA as described in §3638.25.

C. Overlap with Cost Reimbursement System Billing.--Note that statute on timely filing for Medicare claims allows a period of several months after October 1, 2000 in which home health claims can be submitted under both under the interim payment system (IPS) and the prospective payment system. This is also true of demand bills, but like these other claims, demand bills must cover a discrete period in time under one or the other payment system, not spanning both systems. IPS claims must be limited to services on or before September 30, 2000; HH PPS claims for services on or after October 1, 2000.

D. Claim Requirements.--Original HH PPS claims are submitted with type of bill (TOB) 329 in form locator (FL) 4, and provide all other information required on that claim for HH PPS episode, including all visit-specific detail for the entire episode (do NOT use 3X0). When such claims also serve as demand bills, the following information must also be provided: condition code "20" in FL 24-30; and the services in dispute shown as non-covered (FL 48) line items. Provision of this additional information assures medical review of the demand bill. HH PPS adjustment bills, TOB 327, may also be submitted but must have been preceded by the submission of a 329 claim for the same episode. RAPs are not submitted with indication of demand billing.

E. Favorable Determinations and Medicare Payment.--Results of Medicare determinations favorable to the party requesting the demand bill will not necessarily result in increased Medicare reimbursement. In such cases, and even if a favorable determination is made but payment does not change, HHAs will still refund any monies collected from beneficiaries or other payers for services previously thought not medically necessary under Medicare. Medicare payment will only change with the addition of covered visits if one or more of the following conditions apply:

? An increase in the number of therapy visits results in meeting the therapy threshold for an episode in which the therapy threshold was not previously met-- in such cases, the payment group of the episode would be changed by the RHHI in medical review;

o An increase in the number of overall visits that either: (1) changes payment from a low-utilization payment adjustment to a full episode, or (2) results in the episode meeting the threshold for outlier payment (it is highly unlikely both things occur for the same episode);

o A favorable ruling on a demand bill adds days to: (1) an episode that received a partial episode payment (PEP) adjustment, or (2) a period within an episode that received a significant change in condition (SCIC) adjustment.