Medicare Claims Processing Manual

Chapter 10 - Home Health Agency Billing

Table of Contents

I

50 - Beneficiary-Driven Demand Billing Under HH PPS

(Rev.25, 10-31-03)

A3-3638.30, PM-A-01-05

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 noncustodial care requirements, and therefore would not be reimbursed if billed. The HHA must inform the beneficiary of this assessment in a Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, which also must be signed by the beneficiary or appropriate representative.

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 judgment 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 HHABN 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 days 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 claims processing 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 TOB 32X and 33X; and
- Episodes on record in Medicare claims processing 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

CMS requests that HHAs submit demand bills promptly. Timely filing requirements were not changed by HH PPS (see Chapter 1 for information on timely filing). The CMS has defined "promptly" for HH PPS to mean submission at the end of the episode in question. The beneficiary, must also be given either a copy of the claim or a written statement of the date the claim was submitted. 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 §40.3.

C - Claim Requirements

Original HH PPS claims are submitted with 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 (the HHA must 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 noncovered (FL 48) line items. Demand Bills may be submitted with all noncovered charges. 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 as demand bills, but must be submitted for any episode for which a demand bill will be submitted. Such RAPs should not use condition code 20, only the claim of the episode uses this code.

Cases may arise in which the services in dispute are visits for which an HHA has physician's orders, but the duration of the visits exceeds Medicare coverage limits. However, the portion of these visits that is not covered by Medicare may be covered by another payer (e.g. an eight hour home health aide visit in which the first two hours may be covered by Medicare and the remaining six hours may be covered by other insurance). In such cases, HHAs must submit these visits on demand bills as a single line item, representing the portion potentially covered by Medicare with a covered charge amount and the portion to be submitted for consideration by other insurance with a noncovered charge amount on the same line. Units reported on this line item should represent the entire elapsed time of the visit (the sum of the covered and noncovered portions), represented in 15 minute increments.

D - Favorable Determinations and Medicare Payment

Results of Medicare determinations favorable to the party requesting the demand bill will not necessarily result in increased Medicare payment. 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 change only 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;

- 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);

- 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.

If a favorable determination is made, RHHIs will assure pricing of the claim occurs after medical review so that claims also serving as demand bills receive appropriate payment.

E - Appeals

Appeal of Medicare determinations made on HH PPS claims also serving as demand bills is accomplished by appealing the HH PPS claim. Such appeals are done in accordance with regulations stipulating appeals rights for Medicare home health claims. HH PPS RAPs do not have appeal rights; rather, appeals rights are tied to the claims that represent all services delivered for the entire episode unit of payment.

F – Specific Demand Billing Scenarios

HHABN policy has continued to change, but documentation of this policy can be found at:

- *The ABN Web site; and*
- *Chapter 30 (Financial Liability Protections), §60, of this Manual.*

The Notice of Exclusions from Medicare Benefits (NEMB) can also be referenced on the ABN Web site.

1. Independent Assessment. *Billing questions relative to the HHABN and home health assessments have persisted. With regard to payment liability for the assessment itself, the assessment is a non-covered service that is not a Medicare benefit and is never separately payable by Medicare. In all cases of statutory exclusions, a choice remains: The provider may or may not decide to hold the beneficiary liable, and Medicare cannot specify which is appropriate because the service at issue is outside Medicare's scope.*

If a decision is made to hold a beneficiary liable for just the assessment, CMS believes providers must be in compliance with the home health Conditions of Participation (COPs), as follows:

484.10.e (1) The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. Before care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual has to pay.

Therefore, while no notice may be required if the provider chooses to be liable, the conditions state a notice is required if the beneficiary is to be held liable, and must be delivered prior to the service in question. Since the HHABN is not appropriate in these cases, the provider is free to develop their own written notice, but Medicare does have a voluntary form, the NEMB, could be used for this purpose.

2. Termination of the Benefit During the Episode Period. The HHABN is likely to be warranted in cases when only non-skilled, not medically necessary or non-covered services remain to be delivered under the plan of care, or when the beneficiary is no longer homebound, during the 60 days of the original episode period. These situations can be triggering events under existing HHABN policy (i.e., termination of the benefit), since the close of the episode, or the end of the benefit, occurs at this point, and a Medicare "paper" discharge can be done (i.e., the final claim for the episode prepared and submitted). At this point two billing options exist:

a. If there is no doubt the benefit has been completed, meaning the ordering physician, beneficiary and provider agree Medicare coverage has ended, the HHA has the option of billing the balance of the 60 day period remaining after the benefit has ended on a no payment claim as described in section 60 below. As with other statutory exclusions or services not part of a recognized Medicare benefit, notification of the beneficiary as to his/her liability prior to delivery of the service if the provider intends to charge may still be required by the HH COPs. A form such as the NEMB can be used in these cases.

b. If there is doubt/dispute as to the benefit is continuing, the whole 60-day episode period must be billed on a single HH PPS demand bill, and HHABNs must be given when triggering event(s) occur.

3. Billing in Excess of the Benefit. In some states, the Medicaid program will cover more hours of care in a week than the Medicare benefit. Therefore, a HHA may be billing hours/visits in excess of the benefit during a Medicare home health episode for a dually eligible beneficiary. Since the care delivered in excess of the benefit is not part of the benefit, and does not affect the amount of Medicare's prospectively set payment, there is no dispute as to liability, and a HHABN is not required unless a triggering event occurs; that is, care in excess of the benefit is not a triggering event in and of itself requiring an HHABN. Billing services in excess of the benefit is discussed in C in this section.

4. One-Visit Episodes. *Since intermittent care is a requirement of the Medicare home health benefit, questions often arise as to the billing of one-visit episodes. Medicare claims systems will process such billings, but these billings should only be done when some factor potentially justifies the medical necessity of the service relative to the benefit.*

Many of these cases do not even need to be demand billed, because coverage is not in doubt, since physician orders called for delivery of the benefit. When the beneficiary dies after only one visit is a clear-cut example. When physician orders called for additional services, but the beneficiary died before more services could be delivered, the delivery of only one visit is covered. The death is clearly indicated on the claim with use of patient status code 20. Other cases in which orders clearly called for additional services, but circumstances prevented delivery of more than one service by the HHA, are also appropriately billed to Medicare in the same fashion.

There may be rare cases where, even though orders do not clearly indicate the need for additional services, the HHA feels delivery of the service is medically justified by Medicare's standard, and should be covered. In such situations, when doubt exists, a HHA should still give the beneficiary a HHABN if a triggering event has occurred, explaining Medicare may not cover the service, and then demand bill the service in question.

No billing is required when there is no dispute that the one service called for on the order does not meet the requirements for the Medicare home health benefit, or is not medically necessary. However, there are options for billing these non-covered services as discussed in Chapter 1 of this Manual, Section 60, Note the COPs may require notification in this situation if the beneficiary is to be held liable, as discussed in 1. immediately above.

60 - No Payment Billing

(Rev 25, 10-31-03)

No-Payment Billing and Receipt of Denial Notices Under HH PPS

Claims for homebound Medicare beneficiaries under a physician plan of care and electing fee-for-service coverage are reimbursed under HH PPS as of October 1, 2000. After the advent of this payment system, home health agencies (HHAs) may continue to seek denials for entire claims from Medicare in cases where a provider knows all services will not be covered by Medicare. Such denials are usually sought because of the requirements of other payers for providers to obtain Medicare denial notices before they will consider providing additional payment. Such claims are often referred to as no-payment or no-pay bills, or denial notices.

A - Submission and Processing

In order to submit a no-payment bill to Medicare under HH PPS, providers must use TOB 3x0 in Form Locator (FL) 4, and condition code 21 in FL 24-30 of the Form CMS-1450 claim form. The statement dates on the claim, FL 6, should conform to the billing period they plan to submit to the other payer, insuring that no future date is reported. Providers must also key in the charge for each line item on the claim as a non-covered charge in FL 48 of each line. In order for these claims to process through the subsequent HH PPS edits in the system, providers are instructed to submit a 0023 revenue line and OASIS Matching Key on the claim. If no OASIS assessment was done, report the lowest weighted HIPPS code (HAEJ1) as a proxy, a 18-digit string of the number 1, "111111111111111111", for the OASIS Claim-Matching-Key in FL 63, and meet other minimum Medicare requirements for processing RAPs. If an OASIS assessment was done, the actual HIPPS code and Matching-Key output should be used. Medicare standard systems will bypass the edit that requires a matching RAP on history for these claims, then continue to process them as no-pay bills. Standard systems must also ensure that a matching RAP has not been paid for that billing period. FL 20, source of admission, and treatment authorization codes, FL 63, should be unprotected for non-pay bills.

B - Simultaneous Covered and Non-Covered Services

In some cases, providers may need to obtain a Medicare denial notice for non-covered services delivered in the same period as covered services that are part of an HH PPS episode. In such cases, the provider should submit a non-payment bill according to the instructions above for the non-covered services alone, AND submit the appropriate HH PPS RAP and claim for the episode. If the episode billed through the RAP and claim is 60 days in length, the period billed under the non-payment bill should be the same. Medicare standard systems and the CWF will allow such duplicate claims to process when all services on the claim are non-covered.

C - Custodial Care under HH PPS, or Termination of the Benefit during an Episode Period

In certain cases, CMS allows the use of no payment claims in association with an HHABN involving custodial care and termination of a benefit during an episode period. This does not apply to cases in which a determination is being requested as to the beneficiary's homebound status at the beginning of an episode; there an ABN must be used if a triggering event occurs. However, in cases where the HH plan of care prescribes only custodial care, or if the benefit has terminated during an episode period, and the physician, beneficiary, and provider are all in agreement the benefit has terminated or does not apply, home health agencies (HHAs) can use:

1. *The HHABN for notification of the beneficiary, selecting Option A on that form, and,*
2. *A condition code 21 no-payment claim to bill all subsequent services.*

NOTE: *Providers can never pre-select ABN options for beneficiaries, in accordance with existing ABN policy. In each case, the beneficiary must be consulted as to the option they want to select. The ABN options presented relative to specific billing scenarios above, and in the rest of the document, are only illustrations and in no way authorization for pre-empting a beneficiary's right to choose a specific option.*

Termination of the benefit during the episode is discussed in Section 50 F, above.