National Government Services

MEDICARE

Home Health Demand Billing

Background

Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the fee for service (FFS) Medicare Program. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers.

When a home health agency (HHA) feels that Medicare will not cover a service for a specific beneficiary, the provider issues an advance beneficiary notice of noncoverage (ABN), Form CMS-R-131. The ABN provides the beneficiary with the option to have a demand denial submitted to Medicare for review of the coverage determination.

What is a Demand Bill?

The Centers for Medicare and Medicaid Services (CMS) defines a demand bill as a request by a beneficiary or his/her representative that a claim be submitted to Medicare in order to obtain a determination for services which the provider believes are noncovered by Medicare. The beneficiary agrees to be fully and personally responsible for payment in the event that Medicare does not pay.

A demand bill is submitted by the provider when a beneficiary requests Medicare payment for services that the HHA deems not to be medically reasonable and necessary, or when the HHA determines that the beneficiary failed to meet the homebound, intermittent or noncustodial care requirements, and therefore would not be reimbursed if billed.

Beneficiaries may pay out of pocket or third party payers may 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 of 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 from the beneficiary or third party payer, unless the MAC determines the ABN notification was not properly executed, or some other factor changed liability for payment of the disputed services back to the HHA.

Requirements for Submission

Prior to submitting the demand bill, the request for anticipated payment (RAP) for the episode must first be submitted. The beneficiary must be under a plan of care established by a physician and at least one service must have been provided to the beneficiary in order for the HHA to submit a RAP. The RAP will establish that the beneficiary is under home health care and will create the record of an episode in the Medicare system. In order to submit a demand bill the HHA must meet all of the following criteria:

1. The HHA must have determined that the services under the plan of care for which the demand bill is being requested (i.e., services in dispute) do not meet Medicare's coverage criteria;
2. A RAP must be sent on 322 type of bill to establish a HH episode and the final claim for the episode must be sent on a 32X type of bill (typically 329, or 327 if an adjustment bill); and
3. There must have been at least one service provided to the patient for the established episode.

If there are successive episodes in dispute, a RAP and final claim must be billed for each episode. The RAP should be submitted after the first service in the episode is provided to the patient and the final claim for the episode should be submitted either after discharge or at the end of the 60-day episode. It's possible that the final claim may not cover a full 60-day episode if the patient was discharged prior to the end of the 60-day episode.

How to Submit a Demand Bill

First the RAP must be submitted to establish the home health episode. The RAP should be formatted as any other RAP for home health patients, i.e., all billing requirements are still in place. There are no special billing requirements for RAPs when billing in a demand situation. Once the RAP for the episode has processed, submit the final claim for the episode. There should only be one claim submitted per home health episode. Keep the following points in mind when submitting the home health demand bill:

- A signed ABN* must be on file to submit a demand claim.
- Claims should be billed for 60 days (if a full episode) or admit to discharge.

- Reflect covered charges for services that meet Medicare coverage criteria and non-covered charges for services in dispute (it's possible that the demand claim may contain all non-covered charges).
- Condition Code 20 must be on the claim to indicate there are services for which the beneficiary has requested billing. **The presence of condition code 20 assures medical review of the demand bill.**
- All other billing requirements apply to demand claims as to any other episode claim (see *Billing the Home Health Final Episode Claim* job aid)

* There must be an appropriate reason for the lack of a signature recorded on the ABN (such as a properly annotated signature refusal) if it is not signed by the beneficiary.

Note: The claim payment/reconciliation process for demand claims is the same as any other home health billing situation. The initial split percentage payment from the RAP is adjusted based on the information submitted on the final claim. If the MAC determines that the provider's determination of non-coverage is correct, no payment will be made on the final claim for the episode.

The following screen shots serve as an example of how to submit a home health third party liability (TPL) demand claim. The required fields are in highlighted with field descriptions in the tables below.

Claim Page 1:

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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 ENTRY                        SV:
  HIC              TOB      S/LOC            OSCAR                UB-FORM
 NPI            TRANS HOSP PROV                  PROCESS NEW HIC
 PAT.CNTL#:                       TAX#/SUB:                  TAXO.CD:
  STMT DATES FROM          TO         DAYS COV      N-C       CO      LTR
  LAST                               FIRST                MI    DOB
  ADDR 1                                    2
       3                                    4
       5                                    6
 ZIP           SEX    MS   ADMIT DATE         HR    TYPE   SRC     HM     STAT
    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
   DCN
       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                       02                       03
 04                       05                       06
 07                       08                       09
      PLEASE ENTER DATA
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Field	Description/Notes
HIC	Beneficiary's Medicare Health Insurance Claim Number
TOB	Type of Bill – 329
NPI	National Provider Identifier Number
PAT. CNTL#	Patient Control Number – enter the number assigned to the patient's medical/health record.
STMT DATES FROM and TO (Statement Covers Period "From and "Through")	Enter the beginning and ending date of the period covered by the claim. The "From" date must match the date submitted on the RAP for the same episode. MMDDYY format. For continuous care episodes, the "To" date must be 59 days after the "From" date. MMDDYY format.
LAST, FIRST, MI, ADDR, DOB, SEX	Patient's last name, first name, and middle initial (if applicable), full address, date of birth (MMDDYYYY) and sex code (M/F)
ADMIT DATE	The HHA enters the same date of admission that was submitted on the RAP for the episode (MMDDYY).
TYPE	Enter the appropriate NUBC code for the admission type.
SRC (Source of Admission)	Enter the appropriate NUBC code for the source of admission.
STAT	Patient Status – Enter the code that most accurately describes the patient's status as of the "To" date of the billing period. Any applicable NUBC approved code may be used.
FAC. ZIP	Facility Zip Code of the provider or subpart (9 digit code).
COND CODES	Condition Code 20 must be present on the claim requesting demand billing. Enter any other codes appropriate to describe conditions that apply to the billing period.
VALUE CODES	Enter Value Code 61 with the appropriate Core Based Statistical Area (CBSA) Code. The five-digit CBSA code must be entered with two trailing zeroes.

Claim Page 2:

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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                TOB      S/LOC          PROVIDER

                                        TOT     COV
  CL  REV  HCPC MODIFS          RATE  UNIT    UNIT   TOT CHARGE NCOV CHARGE SERV DT
   1 0023 1AFKS                       00060  00060         0.00              0601XX
   2 0551 G0154                       00005  00005       150.00              0601XX
   3 0551 Q5001                       00001  00004         0.01              0601XX
   4 0551 G0154                       00004  00004       150.00              0712XX
   5 0551 G0154                       00004               150.00    150.00    0726XX
   6 0571 G0156                       00002  00002        75.00              0615XX
   7 0571 G0156                       00002                75.00     75.00    0616XX
   8 0571 G0156                       00003               100.00    100.00    0621XX
   9 0571 G0156                       00002                75.00     75.00    0623XX
  10 0571 G0156                       00003               100.00    100.00    0625XX
  11 0571 G0156                       00003  00003       100.00              0704XX
  12 0571 G0156                       00003               100.00    100.00    0721XX
  13 0571 G0156                       00002  00002        75.00              0724XX
  14 0001                                                1150.01    600.00


         PROCESS COMPLETED  ---  PLEASE CONTINUE
    PRESS PF2-171D  PF3-EXIT  PF5-UP  PF6-DOWN  PF7-PREV  PF8-NEXT  PF11-RIGHT
```

Field	Description/Notes
REV	Revenue Codes – Claims must report a Revenue Code line **0023** matching the one submitted on the RAP for the episode. Claims must also report all services provided to the patient within the episode.
HCPC	Enter the HIPPS code for the 0023 revenue line. For all other revenue lines, report CPT/HCPCS codes as appropriate for each revenue code.
TOT UNITS	Total service units – No units of service are required on the 0023 revenue line. Units of service for other Revenue Codes are reported as appropriate.
TOT CHARGE	Total Charges – The total charge for the 0023 revenue line must be zero. Total charges for other Revenue Codes are reported as appropriate.
NCOV CHARGE	The total non-covered charges for services in dispute are entered in this field.

Field	Description/Notes
SERV DT	Service Date – Report the date of the first service provided under the HIPPS code reported on the 0023 revenue line (same as the RAP). Report all other service dates for additional revenue codes as appropriate. MMDDYY format.

There are no special instructions for claim pages 3 and 5 – the information entered on these pages should match the RAP for the same episode and follow the same billing requirements for any other final episode claim. You may enter remarks on claim page 4 to explain the reason for demand billing, though it is not required.

Related Content

- A copy of the ABN and instructions on its use can be found on the CMS website: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html
- CMS Internet-Only Manual (IOM) Publication 100-04, *Medicare Claims Processing Manual*:
  - 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 40-50 (Scope and description of ABN)
- A job aid specific to TPL demand billing as well as job aids on billing the home health RAP and billing the home health claim can be found here.