CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2583	**Date: November 2, 2012**
	Change Request 7865

SUBJECT: Erroneous Partial Episode Payment Adjustments on Certain Home Health Dual-Eligible Claims

I. SUMMARY OF CHANGES: In TPL demand bill situations, overlapping HH episodes sometime cause Medicare claims to be paid partial episode payments (PEPs) in error. This CR will correct this by creating adjustments to restore full payment when the fully denied demand bill is processed.

EFFECTIVE DATE: HH PPS episodes ending on or after January 1, 2010
IMPLEMENTATION DATE: April 1, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/50/Beneficiary-Driven Demand Billing Under HH PPS

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction
Unless otherwise specified, the effective date is the date of service.

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2583	Date: November 2, 2012	Change Request: 7865

SUBJECT: Erroneous Partial Episode Payment Adjustments on Certain Home Health Dual-Eligible Claims

Effective Date: HH PPS episodes ending on or after January 1, 2010
Implementation Date: April 1, 2013

I. GENERAL INFORMATION

A. Background: In some cases, a dually-eligible beneficiary (eligible for both original Medicare and Medicaid) is admitted to home health care as a Medicare patient but later ceases to meet Medicare coverage requirements. This beneficiary is then discharged from their Medicare home health episode but continues to receive home health services which are billed to Medicaid. The home health agency (HHA) conducts a new OASIS assessment when the beneficiary's payer source changes and is likely to bill their services to Medicaid using a claim "From" date that immediately follows the date of discharge from Medicare.

The State Medicaid program may later request the HHA submit demand bills on the beneficiary's behalf regarding services which have been billed to Medicaid. In these cases, the episode period corresponding to the new OASIS assessment is likely to overlap the 60-day period associated with the last Medicare-covered home health episode. When the request for anticipated payment (RAP) for the demand billed episode is processed, it will cause a partial episode payment (PEP) adjustment to apply to the prior episode. This is correct, because Medicare cannot presume that the demand billed episode will or will not be covered based on the RAP.

When the final claim for the demand billed episode is received and reviewed, it is often found to be entirely non-covered. At this point, Medicare has established that the PEP adjustment to the prior claim is no longer correct. However, Medicare systems do not have a mechanism to restore the full payment and the HHA cannot submit an adjustment to correct their payment. The requirements below create a mechanism to restore full episode payment when appropriate.

B. Policy: This Change Request contains no new policy. It revises Medicare systems to apply existing payment adjustment policies more accurately.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7865.1	Medicare contractors shall auto-adjust any claim paid as a PEP adjustment to restore full episode payment if the final claim for the overlapping episode is a fully denied						X			X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	demand bill (condition code 20 and all charges are non-covered).										
7865.2	Medicare contractors shall create an informational unsolicited response identifying the prior episode for adjustment when a final claim with condition code 20 episode and all non-covered charges processes against an episode record with a transfer/readmission indicator of 'B' or 'C'.									X	
7865.2.1	Medicare contractors shall return the following information with the informational unsolicited response: • Identifying information for the claim to be adjusted and • A unique indicator to identify an adjustment from a PEP to full payment.									X	
7865.2.2	Medicare contractors shall update the episode record for the final claim that triggers the informational unsolicited response with an indicator that will allow the prior episode's adjustment claim to process with overlapping dates.									X	
7865.2.2.1	Medicare contractors shall exclude episode records with the indicator created by requirement 7865.2.2 from HH PPS episode sequence editing.									X	
7865.3	Medicare contractors shall create an adjustment claim for the episode identified by the informational unsolicited response.						X				
7865.3.1	Medicare contractors shall create the adjustment with type of bill 3XG.						X				
7865.3.2	Medicare contractors shall replace the patient status code '06' created by the earlier PEP adjustment with patient status code '01'.						X				
7865.3.3	Medicare contractors shall change any visit lines that were non-covered by the earlier PEP adjustment back to covered charges.						X				
7865.3.4	Medicare contractors shall return the adjustment to the HH Pricer to restore full payment for the episode.						X				
7865.4	Medicare contractors shall allow the end date of one HH episode to overlap the start date of a subsequent episode only if the indicator created by requirement 7865.2.2 is present.									X	
7865.5	Medicare contractors shall ensure HH consolidated									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	billing alerts are not sent when the indicator created by requirement 7865.2.2 is present.										
7865.6	Medicare contractors shall adjust any claims after the effective date that received PEP adjustments in error when brought to their attention by the HHA.	X				X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7865.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
7865.5	HH consolidated billing edits are not affected by these changes since they are not set when the Date of Earliest Billing Activity (DOEBA) and Date of Latest Billing Activity (DOLBA) are blank.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov, 410-786-6148

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

50 - Beneficiary-Driven Demand Billing Under HH PPS

(Rev.2583, Issued: 11-2-12, Effective: HH PPS episodes ending on or after 01-0-10, Implementation: 04-01-13)

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), which also must be signed by the beneficiary or appropriate representative. Instructions for the HHABN are found in chapter 30 of this manual, §60.

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 Medicare contractor determines the HHABN notification was not properly executed, or some other factor changed liability for payment of the disputed services back to the HHA.

The Medicare payment unit for home care under the home health prospective payment system (HH PPS) is an episode of care, 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, demand billing under HH PPS 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
- 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 is standard. At most, a RAP and a claim are 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 does 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

The 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). 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 are 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 days 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 Type of Bill *(*TOB) 329, and provide all other information required on that claim for the HH PPS episode, including all visit-specific detail for the entire episode (the HHA must NOT use TOB 3X0). When such claims also serve as demand bills, the following information must **also** be provided: condition code "20" and the services in dispute shown as noncovered 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 TOB 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 8 hour home health aide visit in which the first 2 hours may be covered by Medicare and the remaining 6 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.

Cases may also arise in which a State Medicaid program requests the demand bill on the beneficiary's behalf regarding services which have been billed to Medicaid. In these cases, the dates of service for which the State requests the demand bill may not correspond exactly to the episode periods billed to Medicare. These cases require special instructions:

Request begins during non-Medicare episode:

A Medicare-Medicaid dually-eligible patient may be admitted to home care with the expectation that no services will be billed to Medicare. Later, the State may request demand bills beginning during the course of that episode. This may occur when requests correspond to a calendar year. For example, the patient may be admitted in December and the request for demand bills is effective January 1. In this case, the HHA should submit a demand bill to Medicare with episode dates corresponding to the OASIS assessment that began in December. All services in the episode should be submitted as non-covered line items. As with any demand bill, condition code 20 should be reported on this claim.

Request applies to services immediately following Medicare discharge:

A dually-eligible patient may be discharged from Medicare home health services before the end of a 60-day episode due to the patient meeting their treatment goals. The patient may remain under the care of the HHA receiving services billed to Medicaid. *States may vary in their requirements for a new Start of Care OASIS assessment in these cases.*

If the State *requesting* a demand bill for the services within the original Medicare 60-day episode *does not require a new OASIS assessment*, the HHA should submit an adjustment to their previously paid Medicare claim, using TOB 3x7. The HHA should add condition code 20 to the adjustment claim, change the statement "Through" date to reflect the full 60-day period and add the services provided during the demand bill request period as non-covered line items. The HHA should then submit claims with condition code 20 and all non-covered line items for any episodes of continuous care within the demand bill request period.

If the State requesting a demand bill for the services within the original Medicare 60-day episode requires a new OASIS assessment, the HHA should submit RAPs and submit claims with condition code 20 as they would for any other demand bill situation. When Medicare receives the RAP for the demand billed episode it will cause a partial episode payment (PEP) adjustment to apply to the prior episode. Medicare cannot presume that the demand billed episode will or will not be covered based on the RAP. If the final claim for the demand billed episode is later reviewed and found to be entirely non-covered, Medicare systems will automatically adjust the prior episode to restore the appropriate full episode payment.

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 a change in the payment group for the episode - in such cases, the payment group of the episode would be changed by the contractor 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 an episode that received a partial episode payment (PEP) adjustment.

If a favorable determination is made, contractors 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

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 such cases, 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:

> *42 CFR* 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. HHABNs can be used for this purpose.

2. 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, an 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 an 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.

3. One-Visit Episodes. Since intermittent skilled nursing 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, an HHA should still give the beneficiary an 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 number 1, immediately above.