Demand Billing Information Sheet for Home Health Providers

Please use the tips below to help ensure your home health demand bill processes successfully in the Fiscal Intermediary Standard System (FISS).

• NOA/final claims must be submitted timely to Medicare.

<table>
<thead>
<tr>
<th>Dates of service on Medicare claim</th>
<th>Must be filed</th>
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<tr>
<td>On/after January 1, 2010.</td>
<td>Within one calendar year after the date of service.</td>
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- When a Notice of Admission (NOA) or claim is stopped for an error (RTP), it will be given a new received date (REC DT) when resubmitted (F9). This new date must also adhere to the timely filing standards.
- Timely filing requirements also apply to claim adjustments and cancels (type of bills 3X7 and 3X8).
- See the Timely Claim Filing Requirements Web page (http://www.cgsmedicare.com/hhh/education/materials/timely_claim_filing_req.html) for additional information.

• Review beneficiary’s home health episode/period of care history posted to Common Working File (CWF).

- To review provider eligibility inquiry options, see the CGS Web page, “Checking Beneficiary Eligibility” at http://www.cgsmedicare.com/hhh/claims/checking_bene_eligibility.html. This page also contains links to educational materials to access and use the different options to inquire about a beneficiary’s Medicare eligibility.
- HHAs should review beneficiary eligibility information prior to submitting all NOAs or claims (including demand bills) to Medicare.

• NOAs are required in demand billing situations.

- A NOA must be submitted and processed (FISS status/location P B9997) prior to sending a demand bill to Medicare.

• “TO” date on claims should be Day 60 under the Home Health Prospective Payment System (HH PPS) or Day 30 under the Home Health Patient-Driven Groupings Model (PDGM).

- Ensure that 60/30-day episodes/period of care are billed in form locator (FL) 6 of the CMS-1450 claim form.
- Episodes are less than 60/30-day days only when an intervening event occurs (beneficiary discharge, transfer, or enrollment in a Medicare Advantage (MA) plan) prior to the 60th/30th-calendar day.

• Ensure type of bill (TOB) is correct.

- Enter 32A in FL 4 for NOAs.
- Enter 329 in FL 4 for final claims (including demand bills).

• Demand bills require condition code “20.”

- Condition codes are entered in FL 18-28.
- NOAs (TOB 32A) should never contain condition code “20.”
• Use Medicare revenue codes in FL 42 and HCPCS codes in FL 44.
  - Medicaid codes are not acceptable on Medicare claims.

• Verify required revenue code line information is included.
  - Revenue code 0023 (entered in FL 42) is required along with the HIPPS code (entered in FL 44) and first Medicare covered, billable visit (entered in FL 45) on all home health final claims, including demand bills.

• Include all services reflected in the patient’s record on the demand bill.
  - In addition, ensure all services are billed with the appropriate revenue code (i.e. 0420 is used for physical therapy, 0551 is used for skilled nursing services, 0571 is used for aide services, etc.)

• Demand bills must contain non-covered charges.
  - Services for which Medicare is not liable must be entered as non-covered in FL 48 on demand bills.

• Medicare claims (including demand bills) that are rejected (FISS status code R) cannot be appealed.

FISS Screen Prints for Completing Home Health Demand Bills

NOA
• Bill NOA as usual.

CLAIM
• Bill all claim data elements as usual, except:
  - Include condition code 20 (FL 18-28) found on FISS Page 01. In addition, the STAT field (FL 17) needs to reflect the patient’s status as of the last day of the home health episode/period of care. For services on or after January 1, 2020, refer to the Submitting a Final Claim under the Home Health Patient-Driven Groupings Model Web page at https://www.cgsmedicare.com/hhh/education/materials/final_claim.html for additional billing information.


- Include both covered and noncovered charges on FISS Page 02

  - Non-Medicare payable services entered as noncovered in the NCOV CHARGE field (FL 48)

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- Include “Remarks” (FL 80) detailing why services are noncovered on FISS Page 04

  | REMARKS |
  | ABN GIVEN TO BENEFICIARY. BENEFICIARY NOT HMEBOUND AFTER 0513; YOUR INTIALS/DATE |

PLEASE NOTE: FISS Page 03 and 05 are submitted as usual for demand billing situations. The above screenprints are provided to highlight how FISS Pages 01, 02, and 04 should appear when appropriately submitting demand bills to Medicare.