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.**

Dates of service on Medicare claim	Must be filed
On/after January 1, 2010.	Within one calendar year after the date of service.

  - 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.
  - To assist in calculating correct episode/period of care dates, access the OASIS calendar located at https://qtso.cms.gov/news-and-updates/oasis-follow-assessment-scheduling-calendars or the Home Health Patient-Driven Groupings Model (PDGM) 30-Day Period of Care Billing Schedule at https://www.cgsmedicare.com/hhh/education/materials/pdf/pdgm_30_day.pdf.
- **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.
  - Access the *Medicare Claims Processing Manual* (Pub. 100-4, Ch. 10, §40.2, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf) for a listing of appropriate codes used on home health claims. The information begins under the header "Revenue Code and Revenue Description"
- **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.

```
MAP17711    PAGE 01      CGS J15 MAC - HHH REGION     ACPFA052 MM/DD/YY
 XXXXXXXX     SC            INST CLAIM ENTRY              C201641P HH:MM:SS
 MID XXXXXXXXXXX  TOB 329   S/LOC S B0100  OSCAR           SV:    UB-FORM
NPI XXXXXXXXXX TRANS HOSP PROV               PROCESS NEW MID
PAT.CNTL#:                    TAX#/SUB:                TAXO.CD:
 STMT DATES FROM 0505YY TO 0703YY DAYS COV     N-C       CO      LTR
 LAST DOE                      FIRST JOHN          MI    DOB 08011920
 ADDR 1 123 STREET NAME                2 ANYWHERE IA
 3                                  4                          CARR:
 5                                  6                           LOC:
ZIP 12345      SEX M  MS  ADMIT DATE 0307YY HR 09 TYPE 9 SRC 1 D HM STAT 30
COND CODES 01 20 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 12345 6789
  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 61   99916.00          02                  03
04                        05                  06
07                        08                  09
    PLEASE ENTER DATA
     PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL  FWD  PF7-PREV  PF8-NEXT
```

- **Include both covered and noncovered charges on FISS Page 02**
  - Non-Medicare payable services entered as noncovered in the NCOV CHARGE field (FL 48)

```
MAP1712     PAGE 02      CGS J15 MAC - HHH REGION       ACPFA052   MM/DD/YY
XXXXXXX      SC          INST CLAIM ENTRY               C201641P   HH:MM:SS
                                                  REV CD PAGE 01
 MID XXXXXXXXXXXX  TOB 329 S/LOC S B0100    PROVIDER
 UTN                PROG      REP PAYEE
                                 TOT      COV                                SERV   RED
CL    REV HCPC   MODIFS   RATE  UNIT     UNIT   TOT CHARGE   NCOV CHARGE    DATE   IND
   0023  1AFKS                                                               0507YY
   0270                          1        1        23.45                    0507YY
   0551  G0300                   4        4       100.00                    0507YY
   0551  G0300                   3        3       100.00                    0512YY
   0551  G0300                   2                100.00       100.00       0519YY
   0551  G0300                   3                100.00       100.00       0629YY
   0571  G0156                   3                 60.00        60.00       0524YY
   0571  G0156                   2                 60.00        60.00       0619YY
   0571  G0156                   3                 60.00        60.00       0701YY
   0001                                           603.45       380.00
```

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

```
MAP1714   PAGE 04      CGS J15 MAC - HHH REGION        ACPFA052   MM/DD/YY
 XXXXXXX   SC         INST CLAIM ENTRY                C201641P   HH:MM:SS
                                              REMARK PAGE 01
 REMARKS
 ABN GIVEN TO BENEFICIARY. BENEFICIARY NOT HMEBOUND AFTER 0513;
 YOUR INTITIALS/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.