

# Home Health Third Party Liability (TPL) Demand Billing

## Background

---

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

There are times when a beneficiary may be eligible for traditional Medicare and Medicaid (dually-eligible). 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. Depending on a state's requirements, a demand bill may be submitted only after a third party payer requests Medicare payment determination on a claim.

## 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 TPL demand bill is submitted by the provider when a state agency requests Medicare review 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 non-custodial care requirements, and therefore would not be reimbursed if billed.

For dually-eligible patients, third party payers may cover the services in question, but HHAs in return, upon request of the state agency, 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 state agency 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 (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 TPL 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 a 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 TPL 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 TPL 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 state agency is requesting 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 TPL demand claim. The required fields are in highlighted with field descriptions in the tables below.

### Claim Page 1:

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:
<b>HIC</b>	<b>TOB</b>	S/LOC		OSCAR				UB-FORM			
<b>NPI</b>	TRANS HOSP PROV			PROCESS NEW HIC							
<b>PAT.CNTL#:</b>	TAX#/SUB:				TAXO.CD:						
<b>STMT DATES FROM</b>	<b>TO</b>	DAYS COV		N-C		CO		LTR			
<b>LAST</b>	<b>FIRST</b>			<b>MI</b>		<b>DOB</b>					
<b>ADDR</b>	1	2									
	3	4									
	5	6									
<b>ZIP</b>	<b>SEX</b>	MS	<b>ADMIT DATE</b>	HR	<b>TYPE</b>	<b>SRC</b>	HM	<b>STAT</b>			
<b>COND CODES</b>	01	02	03	04	05	06	07	08	09	10	
OCC CDS/DATE	01	02	03	04	05	06	07	08	09	10	
	06	07	08	09	10						
SPAN CODES/DATES		01	02		03						
04	05		06		07						
08	09		10		<b>FAC.ZIP</b>						
DCN											
<b>VALUE CODES - AMOUNTS - ANS I MSP APP IND</b>											
01	02		03								
04	05		06								
07	08		09								

PLEASE ENTER DATA  
 PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-EXIT

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:

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						
CL	REV	HCPC	MODIFS	RATE	TOT UNIT	COV 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 <b>0023</b> 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.
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).

Field	Description/Notes
	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 home health episode claim. You may enter remarks on claim page 4 to explain the reason for demand billing, though it is not required.

## Resources

---

- 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 separate job aid on regular demand billing as well as job aids on billing the home health RAP and billing the home health claim can be found [here](#).

**Disclaimer:** This job aid was prepared as a service to the public and is not intended to grant rights or impose obligations. This job aid may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2006 American Medical Association. All rights reserved.