



TPL Questions & Answers – Compiled by HCA

The following is a compilation of “Questions & Answers” regarding the New York State Office of the Medicaid Inspector General’s (OMIG) decision to move back to the traditional Medicare appeals process in light of the expiration of the Third Party Liability (TPL) Demonstration Project for dual eligible Medicaid/Medicare beneficiaries in New York.

What happened to the TPL Demonstration Project?

In 2003, the U.S. Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (DOH) signed an agreement to participate in a demonstration project to help settle Medicare/Medicaid payment responsibilities for dually eligible home health care patients. HCA and New York State strongly support the TPL Demonstration Project because it is significantly less burdensome for providers and clearly determines payment responsibility for these dually eligible patients by analyzing a sampling of paid Medicaid claims for a given fiscal year, rather than through a case-by-case adjudication of **all** paid Medicaid claims.

The original TPL Demonstration Project contract between CMS and DOH covered federal fiscal years (FFYs) 2000-2004. Since then, however, CMS and DOH agreed to extend this contract to include FFYs 2005-2007. The current TPL Demonstration Project ended on **September 30, 2007**, and earlier this year CMS rejected the OMIG’s request to extend the Demo through FFY 2008.

CMS’s reluctance to extend the TPL Demo has caused the OMIG to move back to its traditional Medicare appeals process for paid Medicaid claims submitted by providers on behalf of dually eligible beneficiaries in FFY 2008 (October 1, 2007 to September 30, 2008). This process must be completed by December 31, 2009.

What is HCA doing to get the TPL Demonstration extended?

HCA, along with DOH and the OMIG, have advocated over the past several years for CMS to extend the TPL for claims beyond the September 30, 2007 close of the Demo. CMS has resisted, indicating that the TPL is a “demonstration” and that the requisite collection of data and experience under the program have been fulfilled.

As a result of HCA’s advocacy, members of New York’s Congressional Delegation, including House Ways and Means Chairman Charlie Rangel (D-Harlem) and Senator Charles Schumer (D-NY), have both urged CMS to reconsider its decision on the TPL. HCA President Joanne Cunningham has met with several New York Congressional representatives to press for continuation of the Demo. HCA, working with both the OMIG and the Congressional Delegation, will continue our aggressive push to secure an expeditious positive response from CMS to continue this important payment reconciliation program. We have also worked with our federal partners at the National Association for Home Care and Hospice (NAHC) on legislative language to reinstate the Demo and are working on collaborative advocacy with home care associations in other states that are similarly affected by the expiration of the Demo.

Does the state have the right to request providers to submit demand bills to Medicare?

Yes. In order to ensure regulatory compliance for dual eligible Medicaid/Medicare beneficiaries, New York's OMIG has the right to require that providers seek reimbursement from Medicare and all other third parties before submitting a claim to Medicaid (Section 540.6(e)(1) of Title 18 NYCRR).

Where can I obtain additional information on submitting demand bills to Medicare?

On August 6 and 7, 2009, National Government Services (NGS), New York's principal regional home health intermediary, conducted a conference call specifically for New York's Medicare Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs) on the process of submitting a demand bill to Medicare. HCA has attached NGS's 42-page presentation to our website at www.hca-nys.org/tpl.cfm.

Providers should have also received a separate handout from NGS on the TPL demand billing process with their August letters from the OMIG.

What are the requirements for submitting a demand bill to Medicare and do providers first need to submit a Request for Anticipated Payment (RAP)?

Yes – prior to submitting the TPL demand bill, the 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 home health agency (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 home health 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 is possible that a final claim may not cover a full 60-day episode if the patient was discharged prior to the end of the 60-day episode.

Can providers get an extension past the December 31, 2009 requirement to submit their demand bills?

No. The OMIG had requested an extension from CMS beyond the December 31 due date for providers to submit their demand bills to Medicare; however, CMS rejected the OMIG's request, meaning that the December 31 deadline remains in effect.

Must an HHABN have been given to a beneficiary in order for providers to submit a demand bill to Medicare?

NGS states in a recent handout that a Home Health Advance Beneficiary Notices (HHABNs) is required in order to process a demand bill. Yet, HCA has confirmed that the entering of condition code 20 by providers on the demand

bill is what triggers the Additional Development Request (ADR) for medical review, even if an HHABN **is not** present.

The review by Medicare (NGS) of the records the provider submits with the ADR will determine payment and potential liability. If NGS's medical review finds the services demand billed to be medically reasonable and necessary, Medicare will pay the demand bill, even if the HHA did not issue an HHABN. If NGS's medical review determines the demand bill should be denied (in cases where it is determined that Medicare is not the correct payor but rather Medicaid), the beneficiary would be liable if there is a valid HHABN on file. The provider would be held liable for the charges if no HHABN was issued to the beneficiary. However, the OMIG has verbally indicated that it has no plans to recoup Medicaid dollars if NGS's Medical Review denies the demand bill and the provider failed to issue an HHABN.

What start of care date should be used on the demand bill?

Representatives from the University of Massachusetts (UMass), the OMIG's contractor for the post-TPL audit, will be discussing this issue with NGS and will provide guidance as to how providers should determine start of care for demand billing. Providers should start billing Medicare beginning with the first date of service listed for each beneficiary in the same manner as a regular Medicare claim in 60-day episodes. However, the dates of services should start with services on or after October 1, 2007.

Do I need to include non-covered Medicare services like Meals on Wheels or PCA services on my demand bill to Medicare?

No. Providers should only include services that Medicare would normally cover in the demand bill.

What if Medicare already made payment on a claim for which the OMIG is requesting a demand bill?

If a provider determines that Medicare already made payment on a claim for which the OMIG is requesting a demand bill, providers should contact the state's contractor, UMass, at: (866) 626-7594. The claim will then not be subject to the demand bill requirement after UMass confirms that Medicare payment was made on the claim.

What happens if Medicare makes payment on a demand bill?

If Medicare's final determination is that payment should be made, NGS will issue payment per normal payment procedures, with the original RAP payment being recovered and the full PPS episode being paid. Once Medicare payment is made, providers have 10 business days to submit a copy of the Medicare remittance advice to the OMIG's contractor, UMass. However, to date, the OMIG is still considering the process to then recoup Medicaid payments made on services that have since been covered by Medicare. See HCA's September 11, 2009 ASAP for additional information on this issue at www.hca-nys.org/documents/asap091109.pdf.

What happens if Medicare denies payment on a demand bill (determines Medicaid was the appropriate payor)?

If Medicare's initial determination is that payment should be denied and that Medicaid was the appropriate payor, providers will still be required to submit the following documentation to UMass within 10 business days of this Medicare determination:

- A copy of the final remittance advice showing Medicare's denial;
- A copy of each medical record submitted to NGS; and

- A copy of the original claim/demand bill submitted to NGS.

The OMIG and its contractor (UMass) have the right to appeal NGS's decision to deny Medicare payment but providers can expect minimal further contact from the OMIG or NGS once the required documentation listed above has been submitted to UMass.

Will there be additional educational sessions on this OMIG initiative?

To date, HCA has sponsored two education sessions in Albany and Rochester to prepare CHHAs and LTHHCPs for the OMIG's decision to move to a traditional Medicare appeals process in a post TPL Demonstration world.

The final in-person education will be on **September 24** at the Bulova Corporate Center in East Elmhurst outside of New York City from 10 a.m. to 1 p.m. Because registration is sold out for this session, HCA and the OMIG will be conducting another education program via conference call during the week of September 28 through October 2. HCA will notify the members as soon as a date and time for the conference call has been confirmed.

Who can I contact regarding questions with the OMIG's letter?

For specific questions regarding the OMIG letter, contact Barbara Kerr of UMass at (866) 626-7594.