

Medicare Demand Bill (TPL)

Prepared for

myUnity Essentials Financial



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Overview

To generate demand claims, charges must be transferred from Medicaid to the Medicare PPS insurance and a new Medicare Demand option set used for claim creation. All charges included on the demand claim need a Medicare Revenue Code type assigned under File > File Maintenance > Charge Code, Revenue-Codes tab and an OASIS with HIPPS must be present on the Patient file Certify tab. The Medicare PPS insurance effective dates must cover the claim period.

These instructions can be used for Third Party Liability (TPL) billing if your Medicaid payer requires you to bill Medicare for services previously paid by Medicaid.

Medicare allows entry of Demand bills via DDE if preferred.

Setup

Demand Bill RAP Option Set

This step is no longer needed for periods starting after 1/1/2022. Use the Medicare NOA Option Set to submit a one-time Notice of Admission for the patient instead.

Go to **Billing > Electronic Claims** and select the **Medicare Electronic Claims** Option Set.

Click **Options**, then **Copy**. Select an unused Destination ID # and enter the Description as **Medicare Demand RAP**.

Close and reopen Electronic Claims.

Select the new **Medicare Demand RAP** option set. Click **Options** and change the following locators:

1000.20 NM1*40 03 Receiver Name: set to 'Constant Value (Entered)' and type **Medicare PPS**

2300.05 CLM*05 Type of Bill: set to **322**

9000.30 Bill Processing Type: set to **PPS Secondary**

9000.50 Include Pat-Ins Bill Data: set to 'Bypass this Data Element'

Demand Bill Final Option Set

Go to **Billing > Electronic Claims** and select the **Medicare Electronic Claims** Option Set.

Click **Options**, then **Copy**. Select an unused Destination ID # and enter the Description as **Medicare Demand Final**.

Close and reopen Electronic Claims.

Select the new **Medicare Demand Final** option set. Click **Options** and change the following locators:

1000.20 NM1*40 03 Receiver Name: set to 'Constant Value (Entered)' and type **Medicare PPS**

2300.05 CLM*05 Type of Bill: set to **329**

2300.70 HI*BG Condition Code 1: set to 'Constant Value Entered' and type **20**

2390.15 Charge Itemizations: check 'Non-Covered' for all non-covered modalities. Use the scroll bar to make sure all applicable modalities are marked.

2400.07 SV2*07 Non-Covered Charges: set to Charge Amount (Non-Covered for Selected Modalities)

9000.30 Bill Processing Type: set to PPS Secondary

Demand Billing Process

Patient Record

Confirm the Medicare PPS insurance is listed as an active insurance in the Clinical Patient Profile. The effective dates of the payer must cover the claim period Bill Date(s).

The patient must have an OASIS with HIPPS present for the claim period.

Transfer charges from Primary to Medicare

Go to **AR > Payments/Transfers**. Select the primary insurance claim record for which charges need to be transferred (you will be transferring based on Medicare period start/end dates so this step may need to be repeated for multiple claim records).

On the **Detail** tab, check **Show Transfer** and **Allow Transfer**. Leave today's date as the **To Bill Date**. Set the **To Insurance** to Medicare PPS. If the Medicare insurance isn't shown, add it to the Clinical Patient Profile and confirm proper effective dates.

In the **Transfer** column, enter zero dollars as the amount to be transferred to Medicare. Do *not* transfer an amount for visits that fall outside the period start/end dates.

If creating Demand bills for more than one period for a patient, you must use a unique transfer 'To Bill Date' for each period so that you have separate claims per period.

The screenshot shows the 'Payment Entry' window for a Medicaid patient. The 'Transfer' section is highlighted with an orange box, showing 'Allow Transfer' checked, 'To Bill Date' set to 4/7/2021, and 'To Insurance' set to Medicare. The 'Show Transfer' checkbox is also checked. Below this is a table of charges with columns for Chg-Date, Chg-Description, Start-Time, Employee, Gross, Net, Paid, Transfer, Pay, Hold, and Deny. The 'Transfer' column for the first two rows is highlighted with an orange box and contains the value '0'.

Chg-Date	Chg-Description	Start-Time	Employee	Gross	Net	Paid	Transfer	Pay	Hold	Deny
3/3/2021	T1003: SNVT: SN Visit	08:00 AM	Alexander, Brandy	200.00	200.00	200.00	0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3/18/2021	T1003: SNVT: SN Visit	08:00 AM	Alexander, Brandy	200.00	200.00			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Create Demand Bill Electronic Claims

Go to **Billing > Electronic Claims**. Select the **Medicare Demand Bill** Option set and follow the normal process for creating claims. **Note, for periods starting after 1/1/2022. Use the Medicare NOA Option Set to submit a one-time Notice of Admission for the patient prior to sending a Demand final claim.**

Bill Date Selection: use the To Bill Date specified during the transfer process (typically the date the transfer was done).

PPS Claim Type: Final

Include Paid Bills: must be checked.

If you receive a "Contract Code missing" message, confirm the Medicare PPS insurance effective date range in the patient file spans the claim bill date.

Atypical Setup

If any modality being submitted includes *both* covered and non-covered charges, then a new Non-Covered revenue code combination must be created (the existing code will be used for the covered charges). For example, if the existing HHA revenue code is "571" then create a new code "0571NC". The new code must have "N/C" set up in the Other Code field of **File > File Maintenance > Category > Revenue Code**.

Example:

The screenshot shows a software dialog box titled "Category Maintenance: Revenue Code - Browse". It contains several input fields and a list of category types. The "Code" field is set to "0571NC" and "Active" is checked. The "Description" field contains "HHA Visit", "CPT/HCPCS" is "G0156", and "Other Code" is "N/C". A "Change Type" button is visible. The "Category Type" list includes options like Acuity, County, Denial Reason, etc., with "Revenue Code" selected. The bottom of the dialog has a toolbar with icons for End, Save, Cancel, Print, Add, Delete, and a help icon.

The non-covered revenue code also needs to be linked to the non-covered charges in **File>File Maintenance>Charge Code>Revenue-Codes** tab for the Medicare Revenue Type. Change the Start Date to cover the dates of service being billed on the demand claim.

Charge: HHAH - HHA Visit Hourly Rate - Browse					
Charge	Bill-Rate	Pay-Rate	Revenue-Codes		
Type	Code	Description	Start-Date	End-Date	GL-Account
Medicare Rev Type	0571NC	HHA Visit	1/1/2000	12/31/2099	
Commercial Rev Type	0571G0156	Home Health Aide	1/1/2000	12/31/2099	
S Code Rev Type	0571S9122	HHA VISIT	1/1/2000	12/31/2099	
Medicare Hospice Rev	0570G0156	Aide/home Health	1/1/2000	12/31/2099	

In the Demand Bill Option Set, change Locator 2400.07 SV2*07 Non-Covered Charges to “Charge Amount (Only if Revenue Other Code is N/C).