NEW YORK STATE OF OPPORTUNITY. Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

August 19, 2019

Provider Name
Provider Address
City, State Zip code

RE: Demand Bill Notification

Dear Home Health Provider:

To ensure regulatory compliance with Title 18 of the Official Compilation of Codes, Rules and Regulations (18 NYCRR) for dual eligible Medicaid/Medicare beneficiaries, the State of New York Office of the Medicaid Inspector General (OMIG) has contracted with the University of Massachusetts Medical School (UMass) to perform a Medicare Home Health Appeals Initiative. This process is to ensure providers seek reimbursement from Medicare and all other third parties before submitting a claim to Medicaid and to seek reimbursement of Medicaid payments for which a third party is legally responsible.

Please be advised that a provider of medical assistance who reasonably should have, or becomes, aware of available health insurance that can be claimed from a liable third party for a recipient, the provider must submit a claim for such payment to the liable third party. If a provider fails to submit such a claim as required, reimbursement for such claim will not be made by the medical assistance program. **Any reimbursement received in violation of these provisions must be repaid to the medical assistance program by such provider.** No repayment will be required if the provider can produce documentation acceptable to the department that the provider reasonably attempted to satisfy any conditions of claiming requirements of liable third-party payors. Please refer to 18 NYCRR 540.6(e)(6-7) for further information.

This letter serves to notify your agency of claims for dual eligible Medicare/Medicaid beneficiaries that you are required to submit to Medicare for a coverage determination. **Providers who fail to demonstrate good faith efforts to collect Medicare revenues (18 NYCRR 505.23(c) (2) (ii) and to provide documentation of these efforts to the OMIG (18 NYCRR 540.6 (e) (6)) may be subject to audit for recovery of the Medicaid payment**.

The amount of Medicaid payment that may be subject to audit for recovery on the enclosed Case Selection Report is $_____.

As subrogee for dually eligible beneficiaries, the OMIG is requesting that you demand bill Medicare for each beneficiary for the period of time listed on the enclosed Federal Fiscal Year (FFY) 2019-Semiannual Case Selection Report. This Case Selection Report provides you with a listing of all cases

that need to be submitted for the **first half of FFY 2019 only**. If your agency is selected for future initiatives, you will receive a separate Demand Bill Notification Letter and Case Selection Report at that time.

Important Next Steps:

1. **Review Case Selection Report**
   Review the enclosed Case Selection Report for beneficiaries whose home health services were paid by the State of New York Medicaid Program during the first half of FFY 2019. Dates of service for this report include MONTH X, XXXX thru MONTH X, XXXX or the end of the episodic period billed to Medicaid.

2. **Submit Evidence for Beneficiary Exclusion**
   Exclusions may be considered if a beneficiary on your Case Selection Report is not eligible for Medicare or if you have received a previous Medicare payment for the given time periods. In order for these cases to be excluded, your agency must submit evidence showing ineligibility or proof of prior Medicare payment. You will be asked to provide screen prints from the Fiscal Intermediary Standard System (FISS) to confirm ineligibility or a copy of the original claim and the final remittance advice to prove prior Medicare payment. This documentation is required for an exclusion to be reviewed for this project. Please contact UMass customer service at the phone number listed on the following page for more information.

3. **Submit Demand Bills**
   Prepare and submit demand bills for the beneficiaries included on the attached Case Selection Report to your Medicare Administrative Contractor (MAC). Under the Patient Protection and Affordable Care Act (PPACA), claims for services must be filed within one calendar year (12 months) after the date of service. In order to comply with this requirement, **all demand bills must be submitted within one calendar year from the end date of the certification period identified in the attached Case Selection Report.** We request that you only bill Medicare for the period of time listed. If the certification period extends past MONTH X, XXXX, include all Medicaid claims billed for that beneficiary until the completion of that certification period. Please do not continue to demand bill for certification periods which begin after MONTH X, XXXX.

   Please note, if your agency has already submitted a demand bill for the second half of FFY 2018, which overlaps with dates on the attached Case Selection Report, please do not resubmit the claim to Medicare.

4. **Monitor Demand Bills**
   Continue to monitor the status of your claims. Your agency is required to correct any claims that are rejected or suspended by the MAC. In addition, you will need to timely submit a complete medical record to Medicare once the Additional Development Requests (ADR) is issued. **Failure to submit a valid or timely claim to Medicare may result in an overpayment, equal to the amount reimbursed by the medical assistance program, plus interest.**

If you have questions regarding submitting demand bills to Medicare, including information on timely filing requirements, ADR requests, or claim submission errors, please contact your local Medicare Administrative Contractor**.**

5. **Submit Required Project Documents**
   A final remittance advice for each episode billed will be issued within 60 days of the final bill submission to Medicare. **Upon receipt of the final remittance advice from Medicare, you must send copies of the following documents to our contractor, UMass within 20 business days**:

   - A copy of the original claim submitted to the MAC for each 60-day episode billed.
   - A copy of the final claim remittance advice sent to you from the MAC.
   - A copy of each medical record your agency submitted to the MAC upon the ADR request.

All of the above documentation must be sent to UMass at the following address within **20 business days** of receipt of the final remittance advice from your MAC:

Third Party Appeals NY
University of Massachusetts Medical School
333 South Street
Shrewsbury, MA 01545-4169

Thank you for your assistance in completing the requirements of the Medicare Home Health Appeals Initiative. As always, your cooperation is greatly appreciated. Please feel free to contact **Laurie Burns of UMass at (866) 626-7594** if you have any questions.

Sincerely,

Debra L. Hathaway, Director
Bureau of Third Party and Payment Oversight
Office of the Medicaid Inspector General