E-Alliance Extra

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The following summary of the CMS Pre-Claim Review Demonstration for Home Health Services was provided by legal counsel for the Pennsylvania Home Care Association. I think you will find it interesting. Glad MO is not one of the pilot states!

Mary Schantz

Pre-claim Review Demonstration for Home Health Services

Summary:

On June 14, 2016, CMS held a conference call to provide information on the pre-claim review demonstration (previously referred to as prior authorization) for Home Health Services in the Medicare Fee-for-Service program. The demonstration does not apply to Medicare HMOs.

Preclaim review does not change beneficiary eligibility standards or Medicare's documentation requirements for home health care.

The demonstration will last 3 years and will begin on or about, but not before, **August 1, 2016** in Illinois, no earlier than October 1, 2016 in Florida, and no earlier than December 1, 2016 in Texas. The demonstration will begin in Michigan and Massachusetts no earlier than January 1, 2017. Start dates for Florida, Texas, Michigan, and Massachusetts will be determined in the coming months.

The pre-claim review process seeks to ensure that medical necessity requirements are met, including that the beneficiary: is homebound; is under the care of a physician; is receiving services under a plan of care set and reviewed by a physician; has a demonstrated need for skilled services; and has had a face-to-face (F2F) encounter with a medical provider within 90 days pre- or 30 days post-start of home health care, which is directly related to the reason the applicable beneficiary needs home health services.

Program Requirements:

The pre-claim review request should be submitted after the Request for Anticipated Payment (RAP) is processed and within 30 days of the first treatment provided to the beneficiary. The pre-claim review process must occur before the final claim is submitted for payment. Pre-claim review must be requested for each episode of care. CMS also suggested that MACs may provide forms or other guidance regarding the format and content of pre-claim review document requests.

The pre-claim review must: identify the beneficiary's name, Medicare number, date of birth, and gender; identify the certifying practitioner's name, NPI, and address; identify the HHA's name, NPI, and address; identify the requestor's contact name and telephone number; outline the benefit period requested; provide the submission date; provide the from and through dates for the episode; identify whether the submission is an initial submission or a resubmission; and identify the state where services will be or are being rendered. The pre-claim review request should also include all documents and information that support medical necessity for the beneficiary needing the applicable level of Home Health Services. The pre-claim process will consist of an "initial request," and in some cases a "resubmitted request". Initial requests are the first pre-claim review request for a given episode. MACs will respond to these within 10 business days. Resubmitted requests are those submitted following an initial request, but which include additional documentation. MACs work to respond to resubmissions within 20 business days. A MACs decision to affirm or non-affirm the review will be sent to the HHA and the beneficiary and will include a pre-claim review unique tracking number (UTN). The UTN must be submitted on the final claim. Pre-claim review requests that are not affirmed will also include an explanation.
If the initial pre-claim review request was non-affirmed due to an error(s), then a Home Health Agency may resubmit the request with additional documentation as many times as necessary. Medicare will work closely with the Home Health Agency during the pre-claim review process to explain what documentation is needed and why a prior submission was insufficient. Generally, the claims that have a provisional affirmation pre-claim review decision will not be subject to additional review. However, CMS contractors, including Zone Program Integrity Contractors and Medicare Administrative Contractors, may conduct targeted prepayment and post-payment reviews to ensure that claims are accompanied by documentation not required or available during the pre-claim review process. In addition, the CMS Comprehensive Error Rate Testing (CERT) program reviews a stratified, random sample of claims annually to identify and measure improper payments.

If a provider submits a claim for payment without a pre-claim review request being submitted, the home health claim will undergo pre-payment review. If the claim is determined to be payable, it will be paid with a 25 percent reduction of the full claim amount. The reduction is not appealable. The 25 percent payment reduction, which applies for failure to receive a pre claim review decision, is non-transferrable to the beneficiary. Beneficiaries are not liable for more than they would otherwise be if the demonstration were not in place. This payment reduction, which will not apply during the first three months of the demonstration in a particular state, is not subject to appeal. After a claim is submitted and processed, appeal rights on the claim determination are available as they normally are.

All existing claims appeal rights remain unchanged. Claims that are denied under the demonstration are appealable. Non-affirmative pre-claim review determinations are not appealable; however, providers have the option of: resubmitting the pre-claim review request before filing a claim; or submitting a claim which, will be denied, and then submitting an appeal.

HHAs or beneficiaries may submit pre-claim review by mail, fax, through the MAC provider portal, or through the Electronic Submission of Medical Documentation System (esMD). Questions regarding the demonstration may be sent to: HHPreClaimDemo@cms.hhs.gov.

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