

Information partners can use on:

Medicare Fee-for-Service: Pre-Claim Review Demonstration for Home Health Services

Medicare is conducting a pre-claim review demonstration for home health services. The purpose of this demonstration is to make sure that people with Medicare continue to get timely, medically necessary care while addressing fraud and reducing improper payments. Also, people will know before a claim is submitted if Medicare is likely to cover the services. **The person's access to services shouldn't be delayed by the pre-claim review demonstration.**

This demonstration will take place over a 3-year period in Illinois, Florida, Texas, Massachusetts, and Michigan. The demonstration began on August 3, 2016 in Illinois. Start dates for Florida, Texas, Michigan, and Massachusetts will be determined in the coming months. For more information, visit www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Pre-Claim-Review-Initiatives/Overview.html.

What happens during a pre-claim review?

Either the Home Health Agency (HHA), or the person with Medicare sends a request for a pre-claim review along with supporting documentation to Medicare. Medicare will review the information to make sure the person meets the eligibility requirements and that the services they get meet the coverage requirements for home health benefits. Medicare covers home health services only when the services are medically necessary and all other home health services coverage requirements, like being homebound, are met. Individuals can continue to get services while this review occurs.

Note: The Medicare home health benefit isn't changing and pre-claim review doesn't create new documentation requirements. The demonstration requires the same information that's currently necessary to support Medicare payment, but earlier in the process.

What does a person with Medicare need to do?

The person with Medicare doesn't need to do anything. In most cases, the HHA providing care will submit a pre-claim review request and all documentation to Medicare on the person's behalf.

What happens if a person gets a favorable pre-claim review result?

The HHA and the person with Medicare will get a letter informing them that their request was provisionally affirmed, meaning approved. A provisional affirmed decision means the claim will be paid as long as all other Medicare requirements are met.

What happens if a person gets a non-favorable pre-claim review result?

The HHA and the person with Medicare will get a letter informing them that their request was non-affirmed, meaning not approved. In some cases the request may be partially affirmed and partially non-affirmed. The decision letter will explain the reason for the decision. If the request is non-affirmed and there's additional information that supports the need for home health services, either the person or their HHA may submit another pre-claim review request to Medicare with the additional information. Medicare will re-review information as many times as needed. The person can continue to get services while this review occurs. It's important to note that a non-affirmed decision of a pre-claim review isn't a denial of a claim. The claim is submitted later after exhausting the pre-claim review process.

In some cases, if the person's pre-claim review request is non-affirmed by Medicare, and they continue to get home health services, they won't have to pay for a subsequently denied claim. However, the HHA may give them an Advance Beneficiary Notice of Non-coverage (ABN) to tell them the services they're getting may not be covered by Medicare. If they agree to get the services and agree to pay if Medicare doesn't pay, the HHA may bill them for all denied charges. They can contact Medicare to check if they have to pay even if they received an ABN. The person or the HHA may appeal any denied claims.

HHAs can't require people with Medicare to sign an ABN. People have the right to refuse to sign an ABN. If a person believes they're being inappropriately asked to sign an ABN, they should call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Where can people with Medicare get more information?

People with Medicare can visit [Medicare.gov/coverage/home-health-services.html](https://www.medicare.gov/coverage/home-health-services.html) or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Where can other stakeholders get more information?

For more information, visit www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Pre-Claim-Review-Initiatives/Overview.html. If you still have questions, email HHPreClaimDemo@cms.hhs.gov.

