

**Pre-claim Review Demonstration for Home
Health Services Frequently Asked Questions
(Update: 10/27/2016)**

1. Some have expressed concern about this demonstration. Why is CMS moving forward with this demonstration? Has CMS addressed stakeholder concerns?

The pre-claim review demonstration will test improved methods for identifying, investigating, and prosecuting Medicare fraud occurring in Home Health Agencies (HHAs) while maintaining or improving the quality of care provided to Medicare beneficiaries. We appreciate the feedback we received from stakeholders and believe the demonstration announced on June 8, 2016 addresses many of those concerns. We will continue to work with stakeholders to educate them on the details of the pre-claim review demonstration.

2. What is pre-claim review?

Pre-claim review is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. Pre-claim review helps make sure that applicable coverage, payment, and coding rules are met before the final claim is submitted.

3. How is pre-claim review different than prior authorization?

A pre-claim review is different than a prior authorization due to the timing of the review and when services may begin. For prior authorization, a request must be submitted prior to services beginning and providers should wait until they have a decision before they begin providing services. With a pre-claim review, services have already begun and the request is submitted after all of the initial assessments and intake procedures are completed and services have begun. The pre-claim review occurs after services start but prior to the final claim being submitted.

4. Does pre-claim review create new documentation requirements?

Pre-claim review does not create new documentation requirements. Home Health Agencies will submit the same information they currently submit for payment, but will do so earlier in the process.

5. What does the pre-claim review demonstration do?

The demonstration establishes a pre-claim review process for home health services to assist in developing improved procedures for the investigation and prosecution of Medicare fraud occurring among Home Health Agencies providing services to Medicare beneficiaries.

6. When does the pre-claim review demonstration for home health services begin?

The demonstration began on August 3, 2016 in Illinois. It will begin 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.

7. Will this demonstration delay beneficiaries from getting access to services?

No, the demonstration should have minimal effect on beneficiaries, as the pre-claim review can occur after home health services have started. The pre-claim review request must be submitted and reviewed before the final claim is submitted for payment.

8. What states does this demonstration impact?

This pre-claim review demonstration impacts the states of Illinois, Florida, Texas, Michigan, and Massachusetts. To limit the burden and confusion for providers, the demonstration will include rendering providers who are located in the demonstration states regardless of from where they bill. The National Provider Identifier (NPI), CMS Certification Number (CCN), name, and address of the rendering provider should be placed on the claim. (Please see question 46). Examples:

- I am a branch office located and providing services in a demonstration state, but my parent corporation is located in a non-demonstration state.
 - You are included in the demonstration.
- I am a parent corporation located and providing services in a demonstration state, but some of my branch offices are located in non-demonstration states.
 - You and your branch offices providing services in the demonstration states would be included in the demonstration, but the branch offices located outside the demonstration states would not need to request pre-claim review.
- I am a Home Health Agency located and providing services in a demonstration state, but also provide services to beneficiaries in a neighboring non-demonstration state.
 - You would be included in the demonstration only for services provided to beneficiaries in the demonstration state. You would not need to request pre-claim review for services provided to beneficiaries in non-demonstration states.
- I am a Home Health Agency located in a non-demonstration state. I provide services to beneficiaries in both demonstration and non-demonstration states.
 - You would not be included in the demonstration.
- I am a Home Health Agency located in a non-demonstration state that provides services only to beneficiaries that live in a demonstration state.
 - You would not be included in the demonstration.

9. Why did CMS choose these five states?

Previous CMS experience, Office of Inspection General reports, Government Accountability Office reports, and Medicare Payment Advisory Commission reports show extensive evidence of fraud and abuse in the Medicare home health benefit for treatment performed in these states.

10. Under pre-claim review, how long will Medicare have to provisionally affirm or non-affirm a pre-claim review request?

Medicare will make every effort to issue a decision on a pre-claim review request within 10 business days for an initial request and 20 business days for a resubmitted request following a non-affirmative decision.

11. What is a resubmitted request?

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.

12. Will there be a tracking number for each pre-claim review decision?

Yes, Medicare Administrative Contractors will list the pre-claim review tracking number on the decision notice. This tracking number must be submitted on the claim.

13. Will these claims still be subject to additional prepayment or post-payment review?

Absence of evidence of potential fraud or gaming, 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. It is possible for a homehealth claim that is subject to pre-claim review to fall within the sample. In this situation, the subject claim would not be protected from the CERT audit.

14. For pre-claim review, who will make the decision on the pre-claim review request?

Medicare Administrative Contractors will make these decisions using existing applicable regulations, National Coverage Determination and Local Coverage Determination requirements, and other CMS policies.

15. How will CMS administer pre-claim review? Is there specialized staff devoted to the program?

The pre-claim review is administered by the Medicare Administrative Contractors (MACs), the same contractors that currently process claims and conduct medical review on home health services. Clinical staff are assigned to medical review and trained to ensure consistency. In addition, we will employ private sector standards in our pre-claim review program, such as making every effort to respond to pre-claim review requests within 10 business days of receipt of an initial pre-claim review request, providing responses that are specific about missing information, and giving providers an opportunity to resubmit the pre-claim review request an unlimited number of times for re-review as long as the final claim has not been submitted. During resubmission, the MAC will make every effort to issue a decision within 20 business days.

16. Will pre-claim review allow for electronic submission of pre-claim review requests?

Submitters who choose to utilize the pre-claim review process may send pre-claim review requests to the Medicare Administrative Contractors (MACs) via mail, fax, providerportal (where available), or through the Electronic Submission of Medical Documentation (esMD) system (where available). Submitters should check their MAC's website for available submission methods. The method used to submit the request is the same method that will be used to send the decision. More information on esMD and availability can be found at <http://www.cms.gov/esMD>.

17. Is pre-claim review needed for beneficiaries in the states already receiving home health services before the demonstration's start dates?

Home health services provided to beneficiaries after the start date of the demonstration in their state will be subject to pre-claim review.

18. What are a Home Health Agency's options if it receives a non-affirmed decision?

The decision letter will specify why a Home Health Agency's (HHA's) pre-claim review request was non-affirmed. The agency can correct the deficiencies and resubmit the request with a new coversheet and relevant documentation. If the agency does not wish to resubmit the request, it can submit claims with the unique tracking number identified on the non-affirmed decision letter. The claims will be denied, and the HHA can appeal the denial. Please refer to question 25 as well.

19. What documents are required for the pre-claim review request?

The pre-claim review request should include all documents and information that support medical necessity for the beneficiary needing the applicable level of Home Health Services. The Medicare Administrative Contractor websites provide more specific information for each state.

20. When should the home health pre-claim review request be submitted?

The pre-claim review request may be submitted at any time before the final claim is submitted. The pre-claim review should be submitted when the Home Health Agency has obtained all required documentation from the medical record to support medical necessity and demonstrate eligibility requirements are met. The pre-claim review process, including submission of the request and receiving the Unique Tracking Number (UTN), must occur before the final claim is submitted for payment. This includes resubmissions after receiving a non-affirmed decision. Pre-claim review must be requested for each episode of care.

21. How many times may a pre-claim review request be submitted?

A submitter is allowed an unlimited number of resubmissions for pre-claim review requests that have not been affirmed.

22. What if a beneficiary only requires a few home health visits? Should a pre-claim review request still be submitted?

Low-Utilization Payment Adjustment (LUPA) claims with four or fewer visits are excluded from the Pre-Claim Review Demonstration for Home Health Services; however, all other episodes home health care that include five or more visits must submit a pre-claim review

request.

23. If a home health claim is denied after receiving a non-affirmative pre-claim review decision, will the Request for Anticipated Payment (RAP) be recouped as an overpayment?

The Medicare Administrative Contractors will follow their standard procedures to recoup a RAP for any denied claims.

24. Does the pre-claim review demonstration delay care to people with Medicare benefits?

Access to care and services should not be delayed for people with Medicare's home health benefit. The pre-claim review process, including submission of the request and receipt of the decision and UTN, must occur before the final claim is submitted for payment.

25. Will beneficiaries have to pay for services if a Home Health Agency provides care but ultimately does not obtain a provisional affirmed decision?

The Limitation on Liability protections of §1879 of the Social Security Act (the Act) will apply to this demonstration. The Limitation on Liability provisions require a provider to notify a beneficiary in advance of furnishing an item or service when such item or service is considered not medically reasonable and necessary, or when a beneficiary is not considered homebound, or when the beneficiary does not need physical therapy, speech-language pathology, skilled nursing care on an intermittent basis, or have a continuing need for occupational therapy, in order to shift financial liability for non-covered care to the beneficiary. In accordance with CMS policies, if an ABN was not issued when required at the start of care and the pre-claim review is non-affirmative, the beneficiary is not financially liable for the care that the HHA provided while awaiting the pre-claim review decision. If the HHA believes that the pre-claim review will be non-affirmative for any of the reasons listed, the provider may issue an ABN in accordance with CMS policy which would allow the beneficiary to choose to receive the service and accept financial liability. The ABN would be effective for denied services furnished after receipt of the ABN. If the HHA expects Medicare to cover the services, an ABN should not be issued. Blanket or routine issuance of ABNs is prohibited under Medicare policy.

Other requirements to qualify for the Medicare home health benefit, such as the face-to-face encounter, are considered technical in nature and are not part of the Limitation on Liability provisions and do not trigger an 1879 of the Act determination. If this documentation is missing then it would be a technical denial, and the provider would be held liable (i.e., not be able to charge the beneficiary) based on 1866(a)(1) of the Act.

When a pre-claim review is non-affirmed, the decision letter will include a detailed written explanation outlining which specific policy requirements were not met. If then on-affirmation is due to one of the reasons listed above that trigger application of the limitation on liability provision, the HHA may issue an ABN and the beneficiary will be held financially liable for denied services received following issuance of a valid ABN. If the non-affirmation was due to documentation errors, the HHA can correct the deficiencies and resubmit the request with all relevant documentation. In this situation it would not be appropriate to issue an ABN. Also, if the pre-claim review decision is non-affirmed for a reason for which the HHA would otherwise be financially liable (that is, the reason for denial is not one that triggers the limitation on liability provision), the HHA should not issue an ABN following a non-affirmative pre-claim

review decision in an attempt to shift liability.

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 but beginning three months after the start of the pre-claim review program in a particular state, there will be a 25 percent reduction to the full claim amount. The 25 percent payment reduction is non-transferrable to the beneficiary.

26. Will Home Health Agencies in the demonstration states be allowed to require that beneficiaries sign an Advanced Beneficiary Notice (ABN)?

No. Home Health Agencies will not be allowed to require that beneficiaries sign an ABN. A beneficiary has the right to refuse to sign an ABN. Beneficiaries who feel as though they are being inappropriately asked to sign an ABN should contact the Medicare program at 1-800-MEDICARE (1-800-633-4227).

27. How many home health providers can request pre-claim review for one beneficiary for one time period?

Under this demonstration, CMS allows one Home Health Agency (HHA) provider to request pre-claim review per beneficiary per episode of care. If the initial provider cannot complete the home health service, the initial HHA's request is cancelled. In this situation, a subsequent provider may submit a pre-claim review request to provide services for the same beneficiary and must include the required documentation in the submission.

28. What happens if an applicable claim in the demonstration area does not go through pre-claim review?

If an HHA submits a claim without a pre-claim review request being submitted, the MAC will stop the claim for pre-payment review. If the claim is payable, it will be paid with a 25 percent reduction of the full claim amount. 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.

29. Is there an appeals process for non-affirmative pre-claim review requests?

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:

- i. Resubmitting the pre-claim review request before filing a claim; or
- ii. Submitting a claim which, will be denied, and then submitting an appeal.

30. Where can I find more information related to pre-claim review?

More information can be found at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Overview.html> and click on the tab titled, "Pre-Claim Review Initiatives."

31. Where can I send additional questions?

Additional questions on the pre-claim review model may be sent to CMS at HHPreClaimDemo@cms.hhs.gov.

32. When submitting the pre-claim review request, does the plan of care need to be signed by the physician?

Yes, the plan of care needs to include the physician's signature and date when it is submitted with the pre-claim review request.

33. Will there be a specific form to use for the demonstration?

There will not be a required form for the demonstration. The Medicare Administrative Contractors participating in the demonstration may develop a checklist to help submitters with the pre-claim review requests. Submitters are encouraged to use the checklist, but it is not required. Refer to your Medicare Administrative Contractor's website for more information.

34. Will the claim form be changed to include a field to report the pre-claim review action?

No, the claim form will not be changed. The operational guide will provide instructions on how to report the unique tracking number that will be issued with the pre-claim review decision on an existing field.

35. If an episode concludes before the Medicare Administrative Contractors has completed pre-claim review, does the Home Health Agency need to wait to submit its final claim?

Yes. The Home Health Agency needs to wait until they receive the decision letter. The decision letter will contain a unique tracking number that will need to be submitted on the claim.

36. The FAQ indicates that only one Home Health Agency (HHA) is allowed to request pre-claim review per beneficiary per episode of care. In a situation where a patient is discharged and readmitted to the same HHA during the 60 day episode, is the HHA required to submit a second pre-claim review?

A pre-claim review decision is based on each episode of care. If a separate claim will be filed, a new pre-claim decision must be requested. For more information on Partial Episode Payment Adjustments, please refer to the Medicare Benefit Policy Manual, Chapter 7, Section 10.8.

37. Will agencies be expected to submit the whole record as with the ADR process?

The pre-claim review request should include all documents from the medical record that supports medical necessity and all eligibility requirements for the beneficiary needing the applicable level of home health services. We do not anticipate the entire record will need to be submitted to support medical necessity (e.g., not every PT note, wound care treatment, etc. may be needed.)

38. Will we receive a different Unique Tracking Number (UTN) for each attempt to obtain affirmation or will each episode of care have the same UTN for all attempts? For example, a pre-claim review request is submitted for an episode of care beginning August 1st. The first submission was non-affirmed and had UTN- 1234 and the second submission was affirmed. Would the second submission have UTN- 1234 or a different UTN?

A unique tracking number will be provided for each pre-claim review request, whether it's provisionally affirmed or non-affirmed. The Medicare Administrative Contractor will list the pre-claim review UTN on each decision letter.

39. Do I need to submit a pre-claim review request for a beneficiary whose 60-day episode began prior to the start date of the demonstration in their state?

No. The demonstration only applies to those episodes of care that begin on or after the start date of the demonstration in the state where the service will or is being rendered.

40. Should documentation supporting the face-to-face encounter be submitted with the pre-claim review request? If so, is it required for each additional episode?

Yes, documentation supporting the face-to-face encounter must be submitted with the pre-claim review request. You may submit the pre-claim review request at any time prior to the final claim submission to allow time to collect this documentation. Medicare does not require a new face-to-face encounter for additional episodes where the patient has not been discharged from home health care. However, documentation supporting the face-to-face encounter from the start of care should be submitted with the pre-claim review request for subsequent episodes of care.

41. Given that a home health episode is 60 days, with a 30-day standard for submitting pre-claim review, what impact do days 31-60 have in the final claim determination if the Medicare Review Contractor has issued an affirmative decision on a pre-claim review request?

You are correct that a pre-claim review decision is for an episode of care. Absent evidence of potential fraud or gaming, claims that have a provisional affirmative decision 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 (for example, records to verify treatments completed as billed) during the pre-claim review process if fraud or gaming is suspected.

CMS' evaluation contractor will monitor for fraud and incidents where the Home Health Agency intentionally delayed services until after the receipt of a provisionally affirmed pre-claim review decision. These cases will be referred to the appropriate Zone Program Integrity Contractor or other enforcement agency as appropriate. Please refer to question 13 as well.

42. Do I need to submit a pre-claim review request for both certification home health episodes and recertification home health episodes?

Yes. The demonstration applies to both home health certification episodes and recertification episodes that begin after the start date in each state. An episode of care initiated with the

completion of a Start of Care OASIS is considered a certification.

43. Do I need to submit a pre-claim review request before I submit the Request for Anticipated Payment (RAP)?

Providers are encouraged to submit the Request for Anticipated Payment (RAP) and allow it to process before submitting the pre-claim review request. This will allow the beneficiary record to open on the Common Working File and will assure you have all of the required documentation to submit with the request.

44. Which Medicare Administrative Contractor should I send my pre-claim review to?

You should send your pre-claim review request to the same Medicare Administrative Contractor where you submit your home health claims.

45. If I received a provisionally affirmed decision and UTN for a beneficiary for a 60 day episode and later in the episode the beneficiary's condition supports adding additional services (e.g. therapy), will I need to submit a new pre-claim review request?

The pre-claim review initial request should be submitted after you have had enough time to evaluate the beneficiary's condition to determine the services (HCPCS) that will be required for the episode. (Please see question 20). However, if later in the episode the beneficiary's condition supports additional services that were not on the initial provisionally affirmed pre-claim review request, you would not need to submit an additional pre-claim review request for that episode.

CMS contractors (including Zone Program Integrity Contractors, Recovery Audit Contractors, and Medicare Administrative Contractors) may conduct targeted prepayment and post-payment reviews to ensure there is no evidence of fraud or gaming. (Please see question 41).

46. If I use a billing company or have a corporate parent company, whose information should I put on the claim?

You should put the National Provider Identifier (NPI), CMS Certification Number (CCN), name, and address of the rendering provider on the claim. If you do not have a separate NPI, you should put the NPI and CCN of the corporate parent company and the name and address of the rendering provider.

47. What if I have a patient who began receiving home health services prior to the requirement of the Face-to-Face Encounter and has continued to receive services with no break in service?

In this case, instead of providing the Face-to-Face Encounter documentation, you would provide an explanation of why you do not need it for that particular beneficiary.

48. Where on the claim should I put the Unique Tracking Number (UTN)?

For submission of a claim on a UB04 Claim Form, you should put the UTN in positions 19 through 30 in field locator 63. The last two characters of the UTN should be written outside the lines next to position 30. For submission of electronic claims, FISS shall accept the UTN following the OASIS assessment data (Positions 1-18) in positions 19 through 32 of loop 2300 REF02 (REF01=G1) on type of bill 032x.

49. What will happen if a Home Health Agency in Illinois submits a request for episodes of care that began prior to August 3, 2016?

CMS is instructing Home Health Agencies (HHAs) in Illinois not to submit pre-claim review requests for episodes of care that began prior to August 3, 2016; however, if such a request is submitted, the Medicare Administrative Contractor (MAC) will work directly with the HHA that submitted the request and allow them to either have the request withdrawn or processed as a test request.

50. Will the August 3, 2016 start in Illinois affect other dates for the demonstration (e.g., such as the end date of the demonstration or the application of the 25% payment reduction for not submitting a pre-claim review request)?

No. The change in the start date will not impact other dates in the demonstration. For Illinois, HHAs that do not submit a pre-claim review request and submit the claim for payment will have their claim stopped for pre-payment review, and beginning November 1st, if those claims are deemed payable, the claims will be paid with a 25 percent payment reduction, which is non-transferable to the beneficiary.

51. In Illinois, how many pre-claim review requests were received for episodes of care that began on August 1 or August 2, 2016 before HHAs received this instruction not to submit requests for those dates?

As of August 4th, only two requests for pre-claim review were received by the Medicare Administrative Contractor (MAC) for episodes of care that began on August 1 or August 2. The MAC worked directly with the HHAs that submitted the requests and allow them to either have the requests withdrawn or processed as test requests.

52. Are any claims exempt from the pre-claim review process?

Home health claims for Veteran Affairs, Indian Health Services, and Part A/B rebilling, demand bills submitted with condition code 20, no-pay bills submitted with condition code 21, and RAPs do not require pre-claim review.

53. Will CMS consider having targeted pre-claim reviews in the future?

During the course of the demonstration, as well as when it concludes, CMS will monitor and analyze data to evaluate the impact of the demonstration on fraud and other improper payments in the demonstration states, and may consider if a more focused risk-based approach to pre-claim review is warranted in the future.

54. May I submit my pre-claim review request through fax?

Yes, you may fax your pre-claim review request to the Medicare Administrative Contractors. The fax numbers are as follows:

- Palmetto: 803-419-3263,
- CGS: 615-664-5950,
- NGS J6: 1-717-565-3840 or 315-442-4178, and
- NGS JK: 1-315-442-4390.

55. Will the MACs send responses to pre-claim requests via the same mechanism by which they are received? For instance, if I send my request via a fax, will the response be sent back via a fax?

The MACs accept and respond to pre-claim review requests via the following mechanisms:

- Online Portal
 - Palmetto GBA accepts requests through their portal and sends decision letters via greenmail delivery within their portal.
 - CGS currently accepts requests through their portal, but sends responses via fax or mail.
Note: If a provider is set up for greenmail delivery but then submits through another mechanism, the decision letters will continue to be delivered via greenmail
- esMD (available October 12, 2016)
 - Decision letters are sent via US postal mail.
- Fax
 - Decision letters are faxed if a return fax number is clearly identified in the request submitted, decision letters are.
 - Rejection and exclusion notification letters are sent via US postal mail to the provider. Changes are in development to send these letters via fax as well, as long as a return fax number is clearly identified in the request.
- Mail
 - Decision letters are sent via US postal mail.

56. What should Home Health Agencies do if the certifying physician will not provide documentation?

CMS created an informational letter directed towards physicians that will be available for download on the Pre-Claim Review Demonstration for Home Health Services website. Home Health Agencies can give the letter to physicians reminding them of their responsibility to provide the documentation.

If the physician and/or facility will still not provide the documentation, Home Health Agencies should notify their MAC or CMS (at HHPreClaimDemo@cms.hhs.gov) of the uncooperative physicians and/or facilities. Physicians and/or facilities who show patterns of non-compliance with this requirement, including those physicians and/or facilities whose records are inadequate or incomplete, may be subject to increased reviews, such as through provider-specific probe reviews.

57. If I receive a partial affirmed decision for some of the services on my pre-claim review request, do I need to resubmit a new request with just the affirmed services?

No, you do not need to resubmit a new request with just the affirmed services. These services will be paid once the claim is submitted as long as all other Medicare requirements are met. CMS will monitor the pre-claim review requests to look for those requests where only the affirmed services of a previous request are resubmitted.

58. If I resubmit my pre-claim request following a non-affirmed or partially non-affirmed decision, do I need to resubmit the whole request?

Yes. When resubmitting a pre-claim review request following a non-affirmed or partially non-affirmed decision, you do need to resubmit the whole request. The resubmitted request will be reviewed and linked to a new UTN.

59. The Program Integrity Manual (section 6.2.1.1) states that Medicare reviewers will consider Home Health Agency (HHA) documentation when determining patient eligibility for home health services if it is incorporated into the patient’s medical record held by the certifying physician and/or the acute/post-acute care facility’s medical records (if the patient was directly admitted to home health) and signed off by the certifying physician.” What does “signed off” mean?

“Signed off” by the certifying physician means that the certifying physician has signed AND DATED the note by the HHA.

60. If the HHA sends the physician a 4 page nurse’s note, is the physician required to sign and date EVERY PAGE or just sign and date once at the end?

If it is clear that the document being incorporated is one continuous note, the certifying physician need only sign and date at the end of the note. If the 4 pages are not a single continuous note, the certifying physician must sign and date each page he wishes to incorporate.

61. What demonstrates that a document supporting Medicare home health certification requirements (i.e. the actual clinical note for the face-to-face encounter note or home health agency generated information) has been acknowledged and incorporated in the medical record?

Documentation in the certifying physician’s medical records and/or the acute care facility’s medical records (if the patient was directly admitted to home health) is the basis for certification of home health eligibility. The certifying physician must sign and date any home health agency generated information incorporated into the certifying physician’s and/or the acute/post-acute care facility’s medical record for the patient and used to support their certification of patient eligibility. When the face-to-face encounter is not performed by the certifying physician, the certifying physician must also document the date of the face-to-face encounter as part of the certification process, but need not sign and date the face-to-face encounter note.

62. How can the Medicare reviewer consider HHA documentation in conjunction with the certifying physician's and/or acute care or post- acute care facility's documentation (if the patient was admitted to home health from such setting) when determining a beneficiary's eligibility for home health services?

The HHA documentation can be used to support the beneficiary's eligibility for home health services if the HHA documentation is signed off by certifying physician and the information from the HHA is corroborated by the certifying physician's generated documentation and/or acute care or post-acute care facility's generated documentation. CMS has developed a flow chart to help in determining when and how the HHA documentation can be appropriately used to support Medicare home health services. To see a copy of the flowchart, click on "Review Decision Flow Chart" in the Downloads section of the CMS HH pre-claim review website.

63. Do HHAs need to get the OASIS signed by the physician?

The certifying physician does not need to sign an OASIS if it is being used to determine medical necessity. However, if the OASIS is being incorporated into the physician record to show eligibility, it would need to be signed by the physician.

64. I received a call from the review contractor about my request being non-affirmed prior to receiving my decision letter. During the call it was determined that the request was incorrectly non-affirmed and should have been affirmed. Can the decision be changed without me needing to resubmit the request?

Yes. If during a call with review contractor about a non-affirmed request prior to receiving your decision letter, it is determined the request was incorrectly non-affirmed, you do not need to resubmit your request. The review contractor can make the change to an affirmed decision and your decision letter should reflect that. However, if it was determined during that call that the request was non-affirmed because something was missing or incorrect with the documentation, you would need to resubmit the request.

65. An HHA reported the following scenario and question:

We admitted a patient from a rehab hospital. The face-to-face was done at the rehab hospital and visit note was included. We sent both the face to face form and visit note to the community physician to sign and he refused stating he cannot sign as he has not seen the patient. Any guidance on this?

There is no requirement for a "face-face form" nor is there a requirement for the certifying physician to write a narrative about the face-to-face encounter. The requirements for the certifying physician are simple in that the certifying physician must attest to five elements for home health certification:

- 1. The patient is homebound;*
- 2. The patient is in need of skilled services on an intermittent basis;*
- 3. A plan of care has been established and is periodically reviewed by a physician;*
- 4. The patient is under the care of a physician;*
- 5. A face-to-face encounter occurred within 90 prior or 30 days after the start of care, was conducted by an allowed provider type, was for the primary reason the patient is in need of home health services, and the date of the encounter.*

These elements listed above can be included on the old CMS' form 485 (the home health plan of care), which many HHAs continue to use, though it is not a Medicare requirement. HHAs have

the discretion to provide the certification in any manner they so choose as long as all of the elements are included. In the downloads section is an example of how one HHA incorporated all five elements of the plan of care and even though the certifying physician did not conduct the face-to-face encounter, he attests that one occurred and documents the date of the encounter (see field #26 on the plan of care). This example is a valid certification for home health eligibility. If the certifying physician did not conduct the actual face-to-face encounter, he does not have to write a face-to-face narrative and he is not required to co-sign the actual face-to-face encounter note. He only must attest to the five elements above as part of the home health certification. He is, however, required to sign the certification and the home health plan of care. If he does not sign the certification or plan of care, the HHA cannot bill for any services rendered as the eligibility requirements have not been met.

66. An HHA reported the following scenario and question:

A physician has signed the plan of care and has been overseeing the care, but does not want to incorporate the rehab hospital physician's notes into his record as the basis for certifying the patient for care. This is a very common scenario that we hear about--hospitalists don't want to certify the patient for home care and the community physician is worried because he hasn't seen the patient since the inpatient care was provided. Should the certifying physician incorporate the note?

If the physician has certified the patient for home health services, but did not conduct the face-to-face encounter, which was related to the primary reason the patient requires home health services, it is questionable as to why he would not want to incorporate that note into the patient's medical record. It would seem that the face-to-face encounter note is one way for the inpatient physician to provide information regarding the patient's course of stay that could help the certifying physician substantiate his patient's need for home health services. It is not uncommon clinical practice for clinical notes to be sent from the inpatient facility physician to the patient's community physician to help facilitate continuity and coordination of care. If the physician does not feel the face-to-face encounter note provides him with adequate information regarding the patient's need for home health services, it is questionable as to why he would then certify the patient for those services and sign the home health plan of care.