

Review Choice Demonstration (RCD) for Home Health (HH) Services Frequently Asked Questions (FAQs)

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General RCD Questions:

1. What does the Review Choice Demonstration do?

This demonstration establishes the review choice process for home health services to assist in developing improved procedures to identify and prevent fraud, protect beneficiaries from harm, and safeguard taxpayer dollars to empower patients while minimizing unnecessary provider burden. The demonstration helps ensure that the right payments are made at the right time for home health service through either pre-claim or postpayment review, protects Medicare funding from improper payments, reduces the number of Medicare appeals, and improves provider compliance with Medicare program requirements. Additionally, in response to public comments, the demonstration incorporates more flexibility and choice for providers, as well as risk-based changes to reduce burden on providers demonstrating compliance with Medicare home health policies.

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

No, the demonstration should have minimal effect on beneficiaries. Under the pre-claim review choice, services can begin prior to the submission of the pre-claim review request and continue while the decision is being made. The pre-claim review request must be submitted and reviewed before the final claim is submitted for payment. In addition, the provider may submit a pre-claim review request with more than one billing period requested for a beneficiary. Under the remaining choices, providers will provide services and submit claims for payment following their normal processes. The Medicare Administrative Contractor (MAC) will send the provider an Additional Documentation Request (ADR) for those claims eligible for review under the selected choice.

3. What date is recognized as the start date of the Home Health (HH) Review Choice Demonstration (RCD) for the purpose of calculating the 5-year end date?

The start date of the demonstration is recognized as June 1, 2019.

4. Since the Review Choice Demonstration (RCD) officially started June 1, 2019, does this mean the end date was extended to May 31, 2024?

Yes, the demonstration was initially going to end in all states on May 31, 2024, but CMS extended the demonstration for an additional 5 years. The extended demonstration will begin on June 1, 2024, and the demonstration end date is now May 31, 2029.

5. Will providers receive a 60-day notification prior to the implementation date in their state?

CMS announced the approval to implement the Review Choice Demonstration (RCD) on April 3, 2019. At least 60 days prior to the implementation date in your state, CMS will announce the date the demonstration will begin. At that time, providers will be advised of the date that the 30-day choice selection period will open in Palmetto's eServices portal as well as the deadline when it will close. These activities will occur within the 60-day notification period.

6. What states does this demonstration impact?

This Review Choice Demonstration impacts the states of Illinois, Ohio, North Carolina, Florida Texas, and Oklahoma. It includes only Home Health Agencies (HHAs) in those states that bill to Palmetto GBA, the Jurisdiction M Medicare Administrative Contract (MAC). To limit the burden and confusion for providers, the demonstration will include rendering providers who are located in the demonstration states. The National Provider Identifier (NPI), CMS Certification Number (CCN), name, and address of the rendering provider should be placed on the claim.

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 if you bill using a Provider Transaction Access Number (PTAN) for a demonstration state.

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. Branch offices located outside the demonstration states that bill under their own NPI and PTAN would not need to be included. However, if a branch office bills under your (the parent company) NPI and PTAN, they would be included in the demonstration.

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 are included in the demonstration for services provided to beneficiaries in the demonstration state as well as services provided in the neighboring non- demonstration state.

I am a Home Health Agency located in a demonstration state, but Palmetto GBA is not my Medicare Administrative Contractor (MAC).

You would not be included in the demonstration.

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.

7. Does the demonstration apply to beneficiaries already receiving home health services before the demonstration's start dates?

Billing periods that begin prior to the start date of the demonstration in each state are not subject to the demonstration. However, all billing periods, including both initial and recertification, beginning on or after the start date of the demonstration in each state will be subject to pre-claim or postpayment review depending on the choice selected.

8. What are the initial review choices?

The initial review choices are:

Choice 1: Pre-claim Review

- All billing periods are subject to pre-claim review.
- Unlimited resubmissions are allowed for non-affirmed decision prior to submission of the final claim for payment.
- More than one billing period of care may be requested on one pre-claim review request for a beneficiary.
- Claims associated with a provisionally affirmed request will not undergo

further medical review, except in limited circumstances.

Choice 2: Postpayment Review

- 100 percent of claims are reviewed after final claim submission. Default selection if no initial review choice made.
- Once the claim is submitted, Palmetto GBA will process the claim for payment then ask via an Additional Documentation Request (ADR) for the HHA to submit medical records. If a response to the ADR is not received, an overpayment notification will be issued. After each six-month period a claim approval rate will be calculated and communicated to the HHA.

9. What are the subsequent review choices?

Every six months, HHA's may select from one of the three subsequent review choices if the pre-claim review affirmation rate or postpayment review approval rate is 90 percent or greater.

The subsequent review choices are:

Choice 1: Pre-claim Review

Choice 3: Selective Postpayment Review

- A random sample of claims will be chosen for review every six months.
- Default selection if no subsequent review choice made.
- Note: Providers who select this option will remain in this option for the duration of the demonstration.

Choice 4: Spot Check Review

- Every six months, 5 percent of a provider's claims are randomly chosen for review.
- Providers may remain in this option as long as they continue to show compliance with Medicare coverage rules and guidelines.

10. Is there an appeals process under the demonstration for non-affirmative pre-claim or postpayment review requests?

All existing claims appeal rights remain unchanged under the demonstration. Claims that are denied under the demonstration are appealable. Non-affirmed 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.

Note: Affirmation/claim approval rates are based on submissions during the applicable cycle dates that had decisions rendered. Appeals data is not included in affirmation/claim approval rates.

11. What happens if I do not initially select Pre-Claim Review (PCR) and select another choice? Providers are not required to participate in PCR and can instead select Choice 2: Postpayment Review.

12. When can an HHA select another review choice?

HHAs will be evaluated over a 6-month review cycle. At the end of each 6-month period, and within 30 days, the MAC will communicate to the HHA their pre-claim review affirmation or postpayment claim approval rate, and if they have met the review threshold. If the HHA's full affirmation rate or claim approval for that 6-month cycle is 90 percent or greater (based on a minimum of 10 submitted pre-claim review requests or claims), the HHA may select one of the three subsequent review choices.

13. What if a HHA does not meet the threshold or affirmation/claim approval rate?

If the HHA's affirmation or claim approval rate is less than 90 percent or they have not submitted at least 10 requests/claims, the HHA must again choose from one of the initial **two** options.

14. Does the Review Choice Demonstration create new documentation requirements?

RCD does not create new documentation requirements; rather, it would only require submission of the same information currently required to be maintained. Home Health Agencies will have increased flexibility as they are able to choose their path to demonstrate compliance with the applicable Medicare rules and policy requirements.

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

There will not be a required form for the demonstration. The Medicare Administrative Contractor, Palmetto GBA, developed checklists to help submitters with the pre-claim or postpayment review requests. Submitters are encouraged to use the PCR checklist ([early](#) and [late](#)) and the [ADR checklist](#) but they are not required. Refer to Palmetto GBA's website for more information.

16. Under the demonstration, who will make the review decisions?

The same contractor that currently processes claims and conducts medical review on home health services, Palmetto GBA, will make these decisions using existing applicable regulations, National Coverage Determination and Local Coverage Determination requirements, and other CMS policies. Clinical staff are assigned to medical review and trained to ensure consistency.

17. Are beneficiaries covered under a Medicare Advantage Plan included in the RCD? No, the RCD demonstration only applies to Medicare beneficiaries covered under Fee-for-Service (FFS) Medicare.

18. How will Partial Episode Payment (PEP) claims process when a transfer occurs under the Home Health RCD process?

PEP claims will process as they have always processed, no change will occur under RCD.

19. If I am currently under a Unified Program Integrity Contractor (UPIC) review during the RCD selection period, do I need to make an RCD selection?

Yes. All providers should make an RCD selection during the choice selection period, although providers under UPIC review will not participate in the demonstration while under review. If the UPIC review ends prior to the next cycle start date in your state, the review choice selection will become active for the upcoming cycle. If a provider is removed from UPIC review after the start date for the six-month review cycle, the provider will make a review choice selection and begin participating in the demonstration in the next cycle. Questions regarding UPIC review should be directed to the UPIC.

20. What do I do if I am selected for UPIC review during an active RCD cycle?

- Providers under choice 1 should continue to submit PCR requests and affix the UTN to the claim when it is submitted.
- Once Palmetto GBA receives notification from the UPIC to exclude a provider, Palmetto GBA will begin rejecting PCR requests. At that time, the provider should discontinue submitting PCR requests and should not include a UTN on any claims submitted while under UPIC review. Claims received with a UTN will return to the provider (RTP) to remove the UTN and resubmit.
- However, if a provider is under UPIC review and UPIC review ends during the current cycle, the provider will remain excluded from the RCD for the duration of that cycle.
- The provider should make an RCD selection every cycle regardless of their UPIC review status, to ensure their RCD selection is accepted.

21. Are any claims exempt from the Review Choice Demonstration process?

Home health claims for Veteran Affairs, Indian Health Services, Part A/B rebilling, demand bills submitted with condition code 20, no-pay bills submitted with condition code 21, and Request for Anticipated Payment (RAP)/Notice of Admission (NOA) are not subject to the demonstration. Additionally, claims for beneficiaries in another Medicare demonstration, such as an Accountable Care Organization (ACO), are excluded from this demonstration.

Note: The home health agency (HHA) and beneficiary must both be part of the ACO for the claims to be excluded from RCD. If both the beneficiary and the provider are part of the ACO and the HHA submits a Unique Tracking Number (UTN) on a claim, the claim will be returned with reason code 39621. The HHA should remove the UTN from the claim and resubmit.

22. Are both certification home health billing periods and recertification home health billing periods subject to the demonstration?

Yes. The demonstration applies to both home health certification billing periods and recertification billing periods that begin after the start date in each state. A billing period initiated with the completion of a Start of Care OASIS is considered a certification.

23. What if a beneficiary only requires a few home health visits? Will the claim still be subject to the demonstration?

Initially claims with 4 or fewer visits were excluded, but as of April 1, 2020, all billing periods are subjected to the Review Choice Demonstration regardless of the number of

visits.

24. Will claims reviewed under the demonstration still be subject to additional review?

Absent evidence of potential fraud or gaming, the claims that have a provisional affirmation pre-claim review decision or were approved under medical review will not be subject to additional review. However, CMS contractors, including Unified Program Integrity Contactors and Medicare Administrative Contractors, may conduct targeted prepayment and postpayment 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 home health claim that is subject to pre-claim or postpayment review to fall within the sample. In this situation, the subject claim would not be protected from the CERT audit.

25. 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).

26. Will providers be required to participate in Targeted Probe & Education (TPE) and RCD at the same time?

No. Providers will not be under TPE review and RCD at the same time. Providers currently on TPE review will be removed prior to CMS implementing RCD in that particular state.

27. Will CMS consider having targeted pre-claim or postpayment 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 is warranted in the future.

28. Where can I send additional questions?

Additional questions on the Review Choice Demonstration may be sent to CMS at HomeHealthRCD@cms.hhs.gov.

29. Where can I find more information related to the Review Choice Demonstration?

More information can be found <https://go.cms.gov/homehealthRCD>.

Choice Selection Questions:

30. How do we make an RCD selection?

Providers can make a choice selection during their specific states timeframe in the [eServices portal](#). CMS and Palmetto GBA will ensure adequate notice for the choice selection period is given in each state.

31. Is eServices the only way to make my RCD selection?

Yes, providers need to make their selection in the [eServices portal](#).

32. What if I do not make a selection?

If an HHA does not make a selection prior to the end of the choice selection period, the HHA will automatically be put in Choice 2: Postpayment Review if they are in the initial options stage, or Choice 3: Selective Postpayment Review option if they are in the subsequent option stage.

33. Who can make a selection in eServices?

The account administrator selected in the [eServices portal](#) is the only one that can make a selection for RCD.

34. Can I change my selection after one has been made?

Yes, providers can make and change their review choice selections until the night the selection period ends.

35. How can I check to see what selection my HHA made?

If you are an account administrator with eServices, you can check on the [eServices portal](#). If you are not an administrator, you can utilize the Review Choice Demonstration Look Up Tool at www.palmettogba.com.

36. How do I know if I am in the initial or subsequent choice stage?

Except for some providers in Illinois, all providers will begin in the initial review choice stage. HHAs will be evaluated over a 6-month review cycle. At the end of the 6-month period, and within 30 days, the MAC will communicate to the HHA their pre-claim review affirmation or postpayment claim approval rate, and if they have met the review threshold. If the HHA's full affirmation rate or claim approval for that 6-month cycle is 90 percent or greater (based on a minimum of 10 submitted pre-claim review requests or claims), the HHA may select one of the three subsequent review choices.

37. Do we need to make a Review Choice Demonstration Selection for each NPI and PTAN combination we use?

No. Providers participating in the Home Health Review Choice Demonstration (RCD) in the demonstration states will need to make a selection at the PTAN level only. If multiple NPIs are associated with a single PTAN, the selection for that PTAN will be assigned to all the associated NPIs. If you have multiple PTANs, you will need to make a selection for each. The results will also be determined at the PTAN level. All claims/PCR request results for a PTAN

will be combined to determine the final outcome, as well as the next set of options available to the PTAN.

38. When and how will I receive the results of my 6-month review period?

Results letters will be sent to providers within the one month (30 calendar days or 20 business days) from the end of the review cycle. If a provider selects eDelivery in their preferences in eServices, all PCR responses will be sent via eDelivery regardless of what method the PCR request was submitted to Palmetto GBA. Providers that do not select eDelivery will receive the PCR response via mail.

39. Does the Pre-Claim Review (PCR) affirmation rate calculation include appeals? The PCR affirmation rate is based on your PCR submissions during the active demonstration dates that had a decision rendered. Because PCR submissions are not subject to appeal, appeals data is not included in the affirmation rate. Providers have the ability to make as many resubmissions as needed to get a full affirmation prior to submitting the claim. The number of resubmissions is not counted against the affirmation rate.

40. If I select Choice 1: PCR the first 6-month review cycle, then change to Choice 4: spot check for the second 6 month review cycle, will the claims with affirmed UTNs that I submit during the second 6 months be exempt from spot check review?

Claims with affirmed UTNs will not be selected for the spot check review.

41. What happens if I qualify for a subsequent review choice, but do not make a selection?

HHA's with a full affirmation rate or claim approval rate of 90 percent or greater that do not actively select one of the subsequent review choices by the deadline indicated in their letter will automatically be assigned to participate in Choice 3: Selective Postpayment Review. The HHA will remain in this choice for the remainder of the demonstration and will not have an opportunity to select a different choice.

42. If we undergo a change of ownership, will my HHA be able to select a new review option.

No. The new owner will continue with the previous owner's selection. As long as the previous owner did not select the Choice 3 Selective Postpayment Review option, the new owner may select a different option at the end of the 6-month review period.

Submission Questions

Palmetto's eServices Portal Submissions:

43. Will the Palmetto GBA eServices provider portal allow you to add more than one attachment per PCR task?

Yes, just assure the attachment is named something different than the other attachments previously added as the system will prevent you from adding two attachments with the same name.

44. What happens if the provider does not have any documentation for PCR Task #2: Attach the Home Health Agency (HHA) generated records that have been signed, dated, and incorporated into the certifying physician's medical records?

Task #2 is requesting that the HHA generated records, if any, that have been provided to the physician, signed and dated, and incorporated into the physician's medical record be attached. If the HHA answers yes, the documentation should be uploaded or referred to if the documentation was already uploaded in the documentation under Task #1. If the agency answers no, they will proceed to Task #3.

Reference: Please refer the [Medicare Benefit Policy Manual Chapter 7](#), 30.5.1.2 – Supporting Documentation Requirements

45. If a provider selects an incorrect response to the PCR questions in Task # 5 and the documents attached do not match the item(s) selected, will this result in an error?

- Task #5 – Q4/Q5: *Attach medical documentation that meets the First Criteria for Confined to the Home*
- Task #5 – Q6: *Attach medical documentation that meets the Second Criteria for Confined to the Home*
- Task #5 – Q7: *Attach medical documentation that meets the Second Criteria for Confined to the Home*

Yes, an error will be displayed in this scenario – “Form cannot be submitted. The response(s) do not support the requirements for Home Health Services.”

46. If a Home Health Agency (HHA) submitting a PCR request does not have any documents for Task #5 will this result in a denial?

- Task #5 – Q4/Q5: *Attach medical documentation that meets the First Criteria for Confined to the Home*
- Task #5 – Q6: *Attach medical documentation that meets the Second Criteria for Confined to the Home*
- Task #5 – Q7: *Attach medical documentation that meets the Second Criteria for Confined to the Home*

The review determination will be made based on the entirety of the documentation submitted. However, please keep in mind the documentation submitted must demonstrate that the beneficiary meets the first and second criteria for confined to home.

Reference: Please refer the [Medicare Benefit Policy Manual Chapter 7, 30.1.1](#) – Patient Confined

to the Home

47. How should we submit PCR documentation in the eService portal?

For efficiency of review, providers are encouraged to separately attach the documentation by task if the documentation is captured separately as opposed to scanning and attaching one attachment with all the documentation included. If the documentation for several tasks is captured in one document, providers are able to attach the document under one task and then refer to it under each subsequent task. We suggest providers reference the page number(s) in the text box under the subsequent task(s).

48. How should providers submit a resubmission through the eService portal?

Providers that submit a PCR request through the eService portal and receive a non-affirmed or partially-affirmed decision can send a resubmission with additional or updated information in eServices. Once in the eService portal, enter the Unique Tracking Number (UTN) and the portal will pre-populate much of the information that was already submitted. Providers will not need to resubmit attachments that were previously submitted with the original PCR request. Once the resubmission is in process, providers will receive a message with a new UTN. A separate resubmission is needed for each billing period if multiple billing periods were submitted and they were not all fully affirmed (i.e., one or more billing periods received a non-affirmed or partially-affirmed decision).

Note: There must be at least one change to successfully resubmit the request.

esMD Submissions:

49. Can I submit a resubmission through esMD?

Yes. Providers resubmitting through esMD should note on the medical documentation that the submission is a resubmission.

50. Can I submit multiple billing period requests through esMD?

At this time esMD will only accept single billing period PCR submissions. For multiple billing period submissions, please choose the eService portal, mail, or fax.

General Submissions:

51. We have multiple PTANs and I submitted my PCR request under the wrong one. Do I need to correct this?

Yes, the provider should submit a new initial PCR submission (not a resubmission) with the correct PTAN. Both PCR requests will be included in the affirmation rate.

52. If I submit a PCR request and get an incomplete submission response and resubmit with corrections, is it considered an initial or are submission?

This would be considered an initial submission because the original submission was incomplete.

Important: You can avoid incomplete submissions by submitting a PCR request

through the Palmetto GBA eService portal at no charge. The eService portal will not allow a provider to submit for PCR with incomplete information and thus avoiding this denial.

53. Which physician information do we enter as the certifying in the PCR request if one physician signed the face-to face (F2F) and another the POC?

The name and NPI of the physician signing the Certification should be entered on the PCR request. This may or may not be the physician who conducted the F2F encounter.

Reference: Please refer to the [Medicare Benefit Policy Manual, Chapter 7](#), Section 30.5.1

Billing and Claims Questions:

54. 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.

55. Will the claim form be changed to include a field to report the pre-claim or postpayment review action? If not, where can we key the UTN on the final claim?

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. For Electronic Claims on the UB04, the UTN will follow the treatment authorization code in positions 1 through 18. You will key the UTN in positions 19 through 32.

Note: Do not put a space between the Treatment Authorization Code and the UTN.

If you are using Direct Data Entry, enter the Treatment Authorization Code on Page 5 and the cursor will automatically go to the field to enter the UTN.

56. If we included a HCPCS code on the Pre-Claim Review (PCR) request but don't end up providing that service during the billing period, do we still need to include it on the final claim? Will the final claim still process without the code?

Yes, the final claim will process if you need to leave off a provisionally affirmed HCPCS code.

57. Are adjustment claims subject to Pre-Claim Review (PCR)?

Yes, adjustment claims are subject to HH PCR. Whether the adjustment was provider initiated or MAC initiated, if the UTN was on the original claim, it must remain on the claim upon adjustment.

58. What will happen if I mis-key the UTN or accidentally leave it off the final claim?

Normally, the claim will Return-to-Provider (RTP) for correction if the UTN was created for the period, but was omitted on the claim, or if the UTN does not match a UTN for the beneficiary, regardless of the period. However, CMS is experiencing system issues that are causing claims to ADR instead of returning them to the provider for correction. If a valid UTN for a different period is entered on the wrong claim, this will result in an ADR. To avoid having to respond to an ADR, providers should place the correct UTN on the corresponding 30-day billing period. CMS is working to resolve these issues as quickly as possible.

Choice 1: Pre Claim Review (PCR) Questions:

59. What is the pre-claim review option?

Pre-claim 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.

60. 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 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.) The MAC website will provide more specific information for each state.

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

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 billing periods 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 billing periods.

For more information on face-to-face encounter documentation requirements please see the Medicare Program Integrity Manual, Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf>.

62. 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.

63. 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.

64. 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 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. The pre-claim review request should be submitted when the HHA has obtained

all required documentation from the medical record to support medical necessity and demonstrate eligibility requirements are met. Pre-claim review must be requested for each billing period of care; however, more than one billing period can be submitted on one request for a beneficiary.

65. Do I need to submit a pre-claim review request before I submit the Request for Anticipated Payment (RAP)/ Notice of Admission (NOA)?

Providers are encouraged to submit the Request for Anticipated Payment (RAP)/Notice of Admission (NOA) 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 ensure you have all of the required documentation to submit with the request.

66. Can providers request more than one billing period for a beneficiary on one pre-claim review request?

Yes, an initial PCR request may include more than one billing period for a beneficiary as long as the documentation supports the need for multiple billing periods. Providers will receive a separate decision (affirmed/non-affirmed) and UTN for each billing period included on the request. Providers requesting more than one billing period of care on an initial PCR submission may use the eService portal or by submitting the hardcopy form via mail or fax. At this time, providers who submit through esMD may only request a single billing period.

Resubmitted PCR requests can only include a single billing period of care. Providers should include the UTN for the billing period being resubmitted. Providers can resubmit PCR requests through the eService portal, mail, fax, or esMD. Providers resubmitting through esMD should note on the medical documentation that the request is a resubmission.

67. If a billing period concludes before the MAC has completed pre-claim review, does the HHA need to wait to submit its final claim?

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

68. How many home health providers can request pre-claim review for one beneficiary for one-time period? In a situation where a patient is discharged and readmitted to the same HHA during the 30-day billing period, is the HHA required to submit a second pre-claim review request?

Under this demonstration, CMS allows one HHA provider to request pre-claim review per beneficiary per billing period. 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.

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.

69. If we undergo a change of ownership, will the affirmation decision transfer to the new owner?

Yes, the affirmation decision will transfer to the new owner.

70. Will the demonstration allow for the electronic submission of pre-claim review requests?

Submitters who choose to utilize the pre-claim review process may send pre-claim review requests to Palmetto GBA via mail, fax, provider portal, or through the Electronic Submission of Medical Documentation (esMD) system (where available). Providers resubmitting through esMD should notate on the medical documentation that the submission is a resubmission.

Submitters should check Palmetto GBA'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>

71. Will the MAC 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.
 - **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
 - Decision letters are sent via US postal mail in addition to the MAC sending the pre-claim review response via esMD.
- Fax
 - Decision letters are faxed if a return fax number is clearly identified in the request submitted.
 - Rejection and exclusion notification letters may be faxed as well, as long as a return fax number is clearly identified in the request.
- Mail
 - Decision letters are sent via US postal mail.

72. Under the Review Choice Demonstration, 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 10 business days for a resubmitted request following a non-affirmative decision.

73. 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. A resubmitted request may be for non-affirmed services or for additional billing periods that were non-affirmed.

74. Will we receive a different Unique Tracking Number (UTN) for each attempt to obtain affirmation or will each billing period have the same UTN for all attempts? For example, a pre-claim review request is submitted for a billing period 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 submission, whether it's provisionally affirmed or non-affirmed. The Medicare Administrative Contractor will list the pre- claim review UTN on each decision letter.

75. If I request more than one billing period on a pre-claim review request, will each affirmed billing period get a tracking number?

Yes, each affirmed billing period will receive its own tracking number. The tracking numbers should be submitted on the individual claims.

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

The decision letter will specify why a 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.

77. How many times may a pre-claim review request be resubmitted?

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

78. 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 the non-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.

- 79. 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.
- 80. If I received a provisionally affirmed decision and UTN for a beneficiary for a 30-day billing period and later in the billing period 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 billing period. However, if later in the billing period 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 billing period.
- 81. What happens if an applicable claim in the demonstration area does not go through pre-claim review?** If an HHA has selected Choice 1: Pre-Claim Review and 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 is not subject to appeal. After a claim is submitted and processed, appeal rights on the claim determination are available as they normally are.

82. Do I have to participate in 100 percent review?

Yes, initially providers must select from either 100 percent pre-claim or postpayment review. If the HHA's full affirmation rate or claim approval for that 6- month cycle is 90 percent or greater (based on a minimum of 10 submitted pre-claim review requests or claims), the HHA may then select from one of the three subsequent review choices.

83. If I submit a pre-claim review request with more than one billing period, does that count as one PCR decision or multiple decisions in regards to threshold?

If a PCR request is submitted with multiple billing periods, each billing period is counted individually towards your threshold. For example, if you submit a PCR request with three additional billing periods, then this would be counted as four individual PCR decisions towards your threshold.

84. Do we have to submit a new PCR request if we have a resumption of care in a billing period that already has an affirmed decision?

No, a new PCR request will not be required for a resumption of care.

85. Do we have to submit a new PCR request if we receive supplemental orders for additional services in the billing period after the PCR request has already been completed?

No, a new PCR request will not be required if additional services are added after the PCR has been processed. The provider would reflect the HCPCS for those added services on their final claim and assure that the documentation, including the order for those services, is maintained in the medical record.

86. Do we have to submit a new PCR request if we complete a new Start of Care (SOC) OASIS?

Yes, a new PCR request will be required with a new SOC.

87. What is the response time for PCR decisions?

Palmetto GBA has 10 business days to make a decision and respond to the initial request. For resubmissions, Palmetto GBA again has 10 business days to respond. The most efficient way to submit and receive a response is via [eServices](#).

Note: If a provider selects eDelivery in their preferences in eServices, all PCR responses will be sent via eDelivery regardless of what method the PCR request was submitted to Palmetto GBA. Providers that do not select eDelivery will receive the PCR response via the same method the PCR request was submitted.

88. What should a provider do when the dates on the PCR submission are mis-keyed and the request is non-affirmed? The system will not allow the request to be resubmitted because the dates are different from the original submission. How will this impact the affirmation rate?

The provider should submit an initial PCR request with the correct dates. It cannot be assumed that the new request replaces the previous request because the dates of service are different; therefore, both requests will be included in the affirmation rate.

89. Is an initial PCR submission only for the start of care and resubmissions for recertification?

An initial submission is not the same as the start of care. An initial submission is the first time a pre-claim review request is submitted. It can be for any billing period. A resubmission is not the same as a recertification. A resubmission is performed when the previous submission was non-affirmed or partially affirmed and the provider is requesting an additional review.

90. Is a subsequent billing period request the same as a recertification?

A subsequent billing period in the eServices portal is not the same as a recertification. The subsequent billing period option in eServices was designed to submit multiple billing periods for a pre-claim review request at one time. It should not be selected merely because the request is for a billing period that occurs after the start of care billing period.

91. If the RN completes the OASIS assessment/comprehensive assessment and there is not a need for nursing services on the plan of care, does HCPCS code G0299 need to go on the PCR request.

In this instance, the nurse visit would be submitted on the claim as non-covered. Services that are required to be submitted as non-covered on the claim should not be submitted on the PCR request. Examples of non-covered charges not to be submitted on a PCR request may include:

- Visits provided exclusively to perform OASIS assessments
- Visits provided exclusively for supervisory or administrative purposes
- Therapy visits provided prior to the required re-assessments
- Services that the HHA has issued an Advance Beneficiary Notice of Noncoverage (ABN) for, such as demand billing when beneficiaries can request Medicare payment for services that: (1) their HHAs advised them were not medically reasonable and necessary, or that (2) they failed to meet the homebound, intermittent or noncustodial care requirements, and therefore would not be reimbursed if billed.

Questions on Additional Choices:

92. What documents are required for the review choices other than pre-claim review?

The HHA should submit all documentation and information that are currently required for medical review of home health claims. The documentation should support the eligibility and need for the level of services indicated on the claim.

93. When should the information for those options be submitted?

The HHA should conduct all standard intake procedures, provide the necessary services, and submit the claim. Once the claim is received, the MAC will send the HHA an ADR. The HHA should submit the documentation following receipt of the ADR.

94. If I select the postpayment review choice, will I be under this choice for the duration of the demonstration?

No. Providers who select the Postpayment Initial Review choice will have 100 percent of their final claims reviewed for a 6-month review cycle. At the end of each 6-month period, and within 30 days, the MAC will communicate to the HHA their pre-claim review affirmation or postpayment claim approval rate, and if they have met the review threshold. If the HHA's full affirmation rate or claim approval for that 6-month cycle is 90 percent or greater (based on a minimum of 10 submitted pre-claim review requests or claims), the HHA may select one of the three subsequent review choices.

95. How long may I remain in the spot check choice?

A HHA may remain in Choice 4: Spot Check review for the duration of the demonstration as long as they show continued compliance with Medicare requirements.

96. Will all states be able to select the "spot check" Choice 4?

Yes. In all states at the end of each 6-month period, and within 30 days, the MAC will communicate to the HHA their pre-claim review affirmation or postpayment claim approval rate, and if they have met the review threshold. If the HHA's full affirmation rate or claim approval for that 6-month cycle is 90 percent or greater (based on a minimum of 10 submitted pre-claim review requests or claims), the HHA may select one of the three subsequent review choices which includes Choice 4: Spot Check Review.

NOTE: In order to remain in Choice 4: Spot Check Review, the HHA must maintain the review threshold in each subsequent 6-month review cycle.

97. Will a provider that does not have the minimum 10 claims submitted be able to select Choice 4: Spot Check Review?

No. Providers that meet the compliance threshold for the subsequent review choices must have at least 10 claims submitted to be able to select this choice.

98. Under Choice 4: Spot Check Review, will a provider receive the 5% list of claims subject to review after the 6 months has ended? If so, would it be pre or postpayment review? How would Palmetto GBA know how many to choose until after the 6 months?

Palmetto GBA will suspend 5% of claims over a 6-month period for prepayment review. The 5% is based upon a provider's claim submission average from the previous 6 months.

99. If a provider chooses Choice 4: Spot Check Review, for what time period will Palmetto GBA select claims to review?

Claims selected for all review options will have a start of care date on or after each state's implementation date. For choices #3 and #4, Palmetto GBA will use the previous 6 months claim volumes to determine the sample size for both options. All claims selected will be within the dates of the demonstration start dates for the state in question.

100. If I choose Choice 4: Spot Check Review in a subsequent 6-month period, will the ADRs sent be from that same subsequent period, or will some be selected with billing period start dates from a previous period?

Claims selected for all review options will have a start of care date on or after the state's implementation date. For both the initial 6-month review cycle and subsequent 6-month review cycles, Palmetto GBA will be selecting claims for review based on the date of receipt. Claims billed later in a review cycle will be reviewed based on the RCD selection choice that is in place at the time the claim is submitted. It is possible for a claim with the date of service on or after the implementation date to be selected for review at any point in the demonstration, based on date of receipt.

101. Some of the review choices reference submitting documentation in response to an ADR, but Pre-Claim Review (PCR) only requires enough documentation to complete the Task. What documentation should be submitted for these review options?

The documentation required for other review options in response to an ADR is all records associated with the billing period and is the standard documentation required for regular medical review. For information on what documentation is required for PCR, please see the [PCR Early/Start of Care Checklist](#) and the [PCR Late Period Checklist](#).

102. How is the 90% approval rate calculated for Spot Check if only a service (i.e. PT) is denied on the claim and not the whole claim?

Partially paid claims do not count toward the 90% approval rate. A claim must be fully paid to be considered for this calculation.

Patient-Driven Groupings Model (PDGM) Questions:

103. For claims with dates of service of 1/1/2020 and after, my claims will be subjected to PDGM billing rules. Will I need to submit a PCR for each 30-day billing period and what documentation is required?

Yes, each 30-day billing period needs a PCR and may be submitted as an initial PCR request. If a provider is requesting more than 30 days of services, the provider can select the multiple billing periods option and submit two or more 30-day billing periods at the same time.

In eServices, you can select multiple billing periods once you complete all the tasks for billing period 1. For multiple billing periods, you will need to enter the billing period start and end dates, the type of bill, HCPCS codes and upload the POC, if changed, or refer back to the POC (Task 3) for billing period 1. Each 30-day request will generate a separate UTN.

When submitting the 30-day billing periods separately, all documentation for the episode must be submitted regardless if it is the first 30 days in the episode or the second 30 days in the episode.

104. After PDGM starts, do I put the same UTN on both 30-day period claims?

No. When the multiple billing period option is used, two or more UTNs will be generated; one for each 30-day period. Providers should place the correct UTN on the corresponding 30-day billing period claim to avoid an RTP or ADR.

105. Is it possible that the first 30-day billing period in an episode be affirmed, and the second non-affirmed?

It is unlikely that this will occur. Generally, Home Health episodes of care are for a 60-day period. If all requirements are met for the entire episode of care, the second 30-day billing period would also be affirmed. If the plan of care only covers the first 30-days of the episode, then the second 30-day billing period within the 60-day episode would be non-affirmed.

106. If I only submit a PCR for the first 30-day billing period, then later submit a PCR for the second 30-day billing period AND the diagnosis changes from the first to the second billing periods, will the documentation provided with the first 30-day billing period suffice?

There are many times that a diagnosis changes in the middle of the 60-day episode. This should be reflected in the skilled notes from the HHA. When recertification occurs, the new diagnosis is reflected on the POC and any relevant information such as updated evaluations, skilled visit notes, orders, goals, etc., are all updated to accommodate the change in diagnosis. A new face-to-face is NOT required, as this is only a start of care certification requirement.

Neither RCD nor PDGM change the documentation requirements. For Medical Review purposes, the contractor continues to apply the home health benefit per the Code of Federal Regulations (CFR) and Internet Only Manuals (IOMs) as it relates to a 60-day episode. The episode of care is still 60 days and the certification/recertification is viable for that length of time. If a provider submits a PCR and the diagnosis changes mid-way through the episode, a new POC or recertification would not be expected until the start

of the new 60-day episode. The same POC (as long as the dates cover the entire 60 days) and certification elements used for the first 30-day billing period would be used, as well as current skilled notes and valid orders to render a determination for the second 30-day billing period.

107. For options other than PCR (Choices 2, 3, and 4), if the second 30-day period within a 60-day episode is selected for review, what will happen if the documentation and diagnosis for the second 30-day billing period no longer exactly matches due to changes in the patient's condition?

The documentation requirements are not changing. The episode of care remains 60 days and the certification/recertification is viable for that length of time. If a diagnosis changes in the middle of the 60-day episode, the skilled notes, orders, and other documentation should reflect the change. As long as the dates cover the entire 60 days, the same POC and certification elements would be used, as well as current skilled notes and valid orders to render a determination. A new POC or recertification would not be expected until the start of the new 60-day episode. The new diagnosis should be reflected on the POC when recertification occurs, along with all relevant information that supports the shift of the diagnosis. A new face to face is NOT required, as this is only a start of care certification requirement.

108. If I submit a single PCR for the first 30-day billing period and then later submit a request for the second 30-day billing period during the same 60-day certification period, will I need to upload all of my documentation a second time?

Currently, yes, you would need to upload new documentation. Providers are encouraged to use the multiple billing period feature to avoid having to submit the same information multiple times. In eServices, you can select multiple billing periods once you complete all the tasks for episode/billing period 1. For multiple billing periods, you will need to enter the billing period start and end dates, the type of bill, HCPCS codes, and refer back to the POC (Palmetto Portal Task 3) for billing period 1. If, however, the POC has changed upload the new POC.

If the POC uploaded with the first pre-claim review request only covers the first 30-day billing period, a new POC would be needed for the second 30-day billing period. In that case, the new POC should be uploaded for Task 3.

109. For options other than PCR (Choices 2, 3, and 4), will the ADR be for the 30-day billing period or the 60-day episode?

Each ADR will cover one 30-day billing period.

General Medicare Home Health Policy and Coverage Questions:

110. When does the Face-to-Face (F2F) encounter need to be done?

The F2F encounter should occur no more than 90 days prior to the Home Health start of care (SOC) date, or within 30 days after the SOC.

Reference: Please refer to the [Medicare Benefit Manual, Chapter 7](#), Section 30.5.1.1- Face to Face Encounter

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

If the physician and/or facility will not provide the documentation, Home Health Agencies should notify their MAC or CMS (at HomeHealthRCD@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.

112. Some providers have long-term patients on service whose Start of Care (SOC) will be prior to when the home health face-to-face (F2F) encounter requirement was implemented. If the patient does not require a F2F encounter, how do we need to respond to Q2 *Was the home health certification and face-to-face (F2F) encounter performed by the same Physician* and then what documentation do we submit for Palmetto eServices Portal Task #1: *Attach the actual F2F clinical encounter note used by the certifying physician to justify the referral for Medicare home health services or upload supporting documentation as to why the F2F is not applicable* in eServices?

The provider should respond “no” to Q2 and provide supporting documentation to support why the F2F is not applicable for Task #1.

113. If a patient is on home health service prior to the implementation of RCD and upon recertification they will need to submit a PCR request, what documentation from the past benefit periods will need to be submitted?

For all medical necessity reviews, the Medicare review contractors shall review the certification documentation for any billing period initiated with the completion of a SOC OASIS. Therefore, if the subject claim is for a subsequent billing period, the HHA must submit all certification documentation as well as recertification documentation.

Reference: Please refer to [CMS IOM Publication 100-08, Chapter 6, Section 6.2.1](#), Physician Certification of Patient Eligibility for the Medicare Home Health Benefit.

114. Do we need to submit the face-to-face (F2F) encounter documentation for each benefit period if we already submitted it with a previous Pre-Claim Review (PCR) request and it was approved for the beneficiary?

Yes, if the PCR request is for a new billing period, the HHA must submit all certification documentation as well as recertification documentation as each billing period is reviewed independently.

Reference: Please refer to [CMS IOM Publication 100-08, Chapter 6, Section 6.2.1](#), Physician Certification of Patient Eligibility for the Medicare Home Health Benefit.

115. When does the Plan of Care (POC) need to be signed when submitting Pre- Claim Review for additional episodes?

The POC needs to be signed prior to submitting a Pre-Claim Review (PCR) request. Timeliness of Signature Requirements can be found in the [Medicare Benefit Policy Manual Publication 100- 02, Ch 7](#), Section 30.2.4.