Pre-Claim Review Demonstration for Home Health Services

Demonstration Overview

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Why is CMS conducting this demonstration?

- Based on our previous experience, Department of Health and Human Services Office of Inspector General reports, Government Accountability Office reports, and Medicare Payment Advisory Commission findings, there is extensive evidence fraud and abuse in the Medicare home health program, in particular, in the chosen demonstration states.

- Most of the demonstration states have also been identified as high-risk states that have select cities and counties under the temporary moratoria on home health provider enrollment authorized under the Affordable Care Act.

- The Medicare improper payment rate for home health services increased from 17.3 percent in 2013 to 51.4 percent in 2014. The Fiscal Year 2015 HHS Agency Financial Report reported a further increase to 59 percent in 2015.

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What is the goal of this demonstration?

This demonstration will:

- Test improved methods for identifying, investigating, and prosecuting Medicare fraud occurring in the home health program while maintaining or improving the quality of care provided to Medicare beneficiaries.

- Help make sure that applicable coverage and coding rules are met before the final claim is submitted.

- Reduce the current program's reliance on the practice of "pay and chase" for inappropriate billing.

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Who is involved?

- Demonstration States: Illinois, Florida, Texas, Michigan and Massachusetts.
- Home Health Agencies who are located in and render services to Medicare fee-for-service beneficiaries in the demonstration states.
- Beneficiaries using the Medicare fee-for-service benefit to receive home health services in the demonstration states.

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How long is the demonstration and when does it start?

Duration of the demonstration:

- Three years.

Targeted start dates:

- Illinois - August 1, 2016
- Florida - no earlier than October 1, 2016
- Texas - no earlier than December 1, 2016
- Michigan and Massachusetts - no earlier than January 1, 2017.

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What is a 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.

What are the requirements for the Medicare home health benefit?

To qualify for the Medicare Home Health benefit, under 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act, a Medicare beneficiary must meet the following requirements:

- Be confined to the home at the time of services;
  - Medicare considers the person homebound if : 1) There exist a normal inability to leave the home, and 2) Leaving home requires a considerable and taxing effort. Additionally, one of the following must also be true: 1) Because of illness or injury, the person needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence; or 2) The person has a condition such that leaving his or her home is medically contraindicated.
- Under the care of a physician;
- Receiving services under a plan of care established and periodically reviewed by a physician;
- Be in need of skilled services;
- Have a face-to-face encounter with an allowed provider type as mandated by the Affordable Care Act. This encounter must:
  - occur no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care; and
  - be related to the primary reason the patient requires home health services and was performed by a physician or non-physician practitioner.

How does the demonstration work?

- The Home Health Agency (or beneficiary) will submit to the Medicare Review Contractor a request for a pre-claim review for each episode of care.

- Along with the request the submitter will include documentation from the medical record that supports medical necessity and demonstrates that the Medicare home health coverage requirements are met.

- The pre-claim review request may be submitted at any time before the final claim is submitted. The pre-claim review process must occur before the final claim is submitted for payment. Pre-claim review must be requested for each episode of care; however, Low-Utilization Payment Adjustment (LUPA) claims with four or fewer visits are excluded from the Demonstration.

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How does the demonstration work?

- Medicare Administrative Contractors will review the request and supporting documentation and make a decision using existing applicable regulations, National Coverage Determination and Local Coverage Determination requirements, and other CMS policies.
- The Medicare Administrative Contractors are the same contractors that currently process claims and conduct medical review on home health services.
- The Medicare Administrative Contractors will send back a decision letter affirming or non-affirming the pre-claim review request.

What does affirm and non-affirm mean?

- A provisional affirmed decision means the claim will be paid as long as all other Medicare requirements are met.
- A non-affirmed decision means the request did not demonstrate that Medicare home health coverage requirements were met.

What does the decision letter include?

- Decision letters are sent to the Home Health Agency and the beneficiary, both if the beneficiary is the requestor or just as notification of the decision sent to the Home Health Agency.
- Decision letters include the pre-claim review Unique Tracking Number that must be submitted on the claim.
- Decision letters that do not affirm the pre-claim review request will provide a detailed written explanation outlining which specific policy requirement(s) was/were not met.

What happened if the decision is non-affirmed?

If a pre-claim review request is non-affirmed:

1. The submitter can resolve the non-affirmative reasons described in the decision letter and resubmit the pre-claim review request.

    - Unlimited resubmissions are allowed prior to the submission of the claim
    - Pre-claim review decisions cannot be appealed

or

2. The submitter can provide the service and submit a claim:

    - The claim will be denied
    - All appeal rights are available

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What if a pre-claim review request is not submitted?

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

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What are the review timeframes?

Initial Requests

- The first pre-claim review request for any episode
- The MAC will make every effort to review the request and postmark decision letters within **10 business days**

Resubmitted Requests

- The request submitted with additional documentation after the initial pre-claim review request was non-affirmed
- The MAC makes every effort to review request and postmark decision letters within **20 business days**

(Note: A request for a second episode of care is still considered an initial request.)

Does the demonstration change coverage requirements?

- Medicare coverage policies are unchanged.
- The demonstration does NOT create any new documentation requirements. It simply requires the information be submitted earlier in the claims process.
- HHAs will still be able to submit their Request for Anticipated Payment (RAP) in the same manner and subject to the same rules as they would without the demonstration being in place.

What else is unchanged?

- All Advanced Beneficiary Notice (ABN) policies.
- Claim appeal rights.
- Dual eligible coverage.
- Private insurance coverage.

What has changed?

- The Home Health Agency will know before the final claim is submitted whether Medicare will pay for the service as long as all other Medicare coverage and claims processing requirements are met.

- Absence of evidence of potential fraud or gaming, the claims that have a provisionally affirmed pre-claim review decision will not be subject to additional review. There are a few exceptions.

Will this demonstration delay beneficiaries from receiving home health services?

- Access to care and services should not be delayed for people with Medicare's home health benefit.

Where can I get more information?

- Model Web Site: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Pre-Claim-Review-Initiatives/Overview.html
  - Background Information
  - Fact Sheet
  - Frequently Asked Questions
- Questions can be sent to: HHPreClaimDemo@cms.hhs.gov

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