

Centers for Medicare & Medicaid Services  
Special Open Door Forum:  
Pre-Claim Review Demonstration for Home Health Services  
Tuesday, June 14, 2016  
2:00pm – 3:00pm Eastern Time  
Conference Call Only  
Moderator: Jill Darling

Operator: Good afternoon. My name is (Lindsey) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Pre-claim Review Demonstration for Home Health Services Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you. Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Lindsey). Good morning and good afternoon, everyone. Thanks for joining us today. My name is Jill Darling in the CMS Office of Communications. Welcome to the Pre-claim Review Demonstration for Home Health Services Special Open Door Forum.

I do have one brief announcement. This special open door forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have inquiries, please contact us at [press@cms.hhs.gov](mailto:press@cms.hhs.gov). Thank you.

Now I will hand the call over to Jeane Nitsch.

Jeane Nitsch: Thanks, Jill.

Again, my name is Jeane Nitsch and I'm the director of the Division of Compliance Projects and Demonstrations here at CMS. We are really excited to have this call with you today. We've been very anxious to speak to you about this demonstration so we can explain it in a little better detail, answer some questions, and most importantly, we really want to hear from you. So this will be a great opportunity for us to hear from all of you. There's been a lot of speculation about this demonstration and many of you have expressed concern for a variety of reasons. Hopefully, by the end of today's call, we'll have helped alleviate some of these concerns and answered your questions and we'll be able to move forward with this demonstration.

Let me just review how today's call is going to go. I'm going to start by answering just a couple questions that have been raised since the announcement of the program last week. We'll then run through some salient points of the demonstration and then we will open it up for questions.

Let me just assure you that this is not your only opportunity to ask questions. We will have another open door forum call on June 28, and you'll see an announcement go out about that and be another special open door forum call. We also have a mailbox that you can email your questions to and I'll give you that information a minute. And also I just want to remind you to check out our website. We have some background information about the demonstration and also on the website or some I think a fact sheet, a frequently asked questions are also on that website.

So if you want to jot down now, but you'll be hearing this throughout today. If you want to send email questions in, you can email them to [HHPreClaimDemo@cms.hhs.gov](mailto:HHPreClaimDemo@cms.hhs.gov), and all that's truncated together, [HHPreClaimDemo@cms.hhs.gov](mailto:HHPreClaimDemo@cms.hhs.gov).

If you haven't been able to find the website, the website address was on the special open door forum announcement, I would suggest you look there to (look) it up. And, you know, you can always – and if you kind of have comments, you can always do everyone's backup plan which is Google, CMS

pre-claim review demonstration and you will find it as well. Go to the announcement for the link to our website.

I'm going to, as I said, start with a few questions that we've gotten in and then we'll go through some of the program I'm going to be working.

Jennifer McMullan is also going to be presenting today, and she's been working on this demonstration. We have others in the room who are part of the team and so we'll get started.

One of the questions that had come in is how is this pre-claim review demonstration different from prior authorization from what was discussed in the federal registry notice that went out on February 5th, 2016?

A lot of you probably noticed that on February 5th, we had that PRA or Paperwork Reduction Act notice and it discussed the potential CMS program and talk about how CMS was interested in conducting possibly a prior authorization demonstration for home health services. That notice stirred up a lot of concern. The notice was not an announcement of a prior authorization program for home health services and as such it lacked a lot of the detail information about the demonstration.

And this led a lot of stakeholders to assume, very understandably so, how the demonstration might be implemented. And a lot of people drew the conclusion that the home health agencies would have to submit a request and receive approval before providing patient services. And let's just be clear, we want to make sure the beneficiary has access to care. It's just very important to CMS and we would not design the program that would delay medically needed care.

So, because of that, we really thought that we needed to change the name of the program to kind of dispel some of that fear, which we do not want people to think that you would have to get your pre-claim review and get it affirmed before the start of care. So that's why we changed it from prior authorization to pre-claim review demonstration. We heard your concerns.

So, how will this demonstration fight fraud? We've gotten that questioning quite a bit as well. This is to test the demonstration in accordance to Section 402(a)(1)(J) of the Social Security Act. And that gives the Secretary authorization to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services, under the health programs established by the Social Security Act. So that's the provision we're using to start this demonstration.

And under the pre-claim review process, this demonstration will really help to assure that all relevant clinical and/or medical documentation requirements for the appropriate level of services are met before the home health agency provider's submit the claim. It will really discourage any providers from submitting improper claims, and we hope to have fewer fraudulent claims for these services thereby reducing the Medicare program's current reliance on the practice of kind of "pay and chase" for inappropriate billing. So it's one of the tools. It's a powerful tool in our antifraud toolkit and we're really looking forward to seeing how this does in helping us reduce fraud and abuse in the program.

So a lot of people have also asked why there wasn't a more targeted approach applied to the demonstration and by targeting I mean, why aren't you just going after the bad actors? Based on our previous experience, also based on the Office of Inspector General reports, the Government Accountability Office reports, the Medicare Payment Advisory Commission reports, they all showed extensive evidence of fraud and abuse in the Medicare home health benefit for treatment performed in the states which are in the demonstration.

And in addition, the improper payment error rate for home health services increased from 17.3 percent in 2013 to 51.4 percent in 2014. What a whopping increase we saw there. And then based on the Fiscal Year 2015, HHS Agency Financial Report, it further showed the increase in the improper payment rate, the error rate went to 59 percent in 2015. So due to the extent of the problem, we chose to go with a much broader statewide approach.

So I just wanted to hit a couple of those items. When we chose the states, we were looking at the information we got from the reports I mentioned about

fraud. Additionally, we looked at what states where active home health moratorium were in place. We looked at claim volume, we looked at improper payment rates, and any states that were identified as high risk for fraud.

So with that, I'm going to start, I just wanted to get those out of the way, because I know those questions were going to come up later. I'm going to start going over a little bit of the program, the new demonstration. And then, turn it over to Jennifer who will go into a little more detail into some of the process pieces of the demonstration and then we'll open up for questions.

This is establishes a three-year pre-claim review demonstration for home health services. We really think this demonstration will help CMS test the method for combating fraud, waste and abuse in the Medicare home health program. What it is a process for which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment? And with that, we think that the pre-claim review will help make sure that the applicable coverage payment and coding rules are met before the final claims are submitted and really help in that regard.

This demonstration will affect home health agencies providing services in the selected demonstration states. What is covered by the pre-claim review decision is it will cover a 60-day home health service episode, so that pre-claim review decision pertains to the final claim and not the RAP. So I just want to be clear, we'll mention this again later, that you're not submitting it with the RAP. The pre-claim review decision affects the final claim.

So where are we going to be having this demonstration? We are starting in Illinois and we believe we will be able to start on August 1st. And on, well, the documentation it says no earlier than August 1st, but that really is our target date for right now. We are then hoping to start In Florida no earlier than October 1st, Texas no earlier than December 1st, Michigan and Massachusetts no earlier than January 1st.

So what are we looking for with this pre-claim review? What we're really looking for is to make sure that the medical necessity requirements are met.

And I'm just going to kick through them because I know the home health folks on the line probably know this like the back of their hand. But we really want to make sure that to be qualified for the Medicare home health benefit that the beneficiary must meet the following requirements; that they have to be confined to home at the time of services. They must be under the care of a physician. They must be receiving services under a plan of care established and periodically reviewed by the physician. They must be in need of skilled services. And they have to have a face-to-face encounter with the medical provider (who's mandated) under the Affordable Care Act. And that face-to-face must occur no more than 90 days prior to the home health start of care or within 30 days of the start of home health care. And it must be related to the primary reason the patient requires home health services by the physician or the non-physician practitioner.

So what's going to be required for this demonstration is the documentation – so I may be very clear about this, the demonstration does not create any new documentation requirements. They're all the same. So the same things you've been collecting all along will be needed now. We want to make sure that Medicare coverage policies, they have not changed, the documentation requirements have not changed. And all those documentation requirements you can find on the CMS and the Medicare Administrative Contractor, MAC websites.

Also, unchanged with this demonstration is that the MACs will conduct the reviews. The Advance Beneficiary Notice policies are still in effect. The claim appeal rights have not changed. The dual eligible coverage requirements have not changed and any private insurance coverage (also) have not changed as well.

So really what has changed? What has changed for this demonstration is that the home health agency will know before the final claim is submitted, whether Medicare will pay for the service as well the other Medicare coverage and claims process and requirements are met.

And we really believe with this demonstration that this will really help the home health agencies with cash flow, because they're really seeing that they'll

know that this claim looks like it's going to be paid. We'll know up front. You won't have to wait until the end for that information for after the claim is submitted.

So I'm going to actually turn it over to (Jennifer McMullan). She's going to talk a little more about the process pieces of the demonstration in a little more detail. (Jennifer).

(Jennifer McMullan): Well, thank you. Now, I'm going to walk you through a little bit of the process, and we'll start with the request.

The pre-claim review request should at a minimum identify the beneficiary name, Medicare number, date of birth and gender. The certifying physician and practitioner name, national provider identifier, NPI and address, the home health agency name, national provider identifier and address, the requester's contact name and telephone number, and it should also include the benefit period requested, the submission date, the from and through date of the episode, and it must indicate if the request is an initial or resubmission review, and the state where the service is rendered.

The pre-claim review request should also include any documentation from the medical records that would support medical necessity. We'll make sure everything is included that you currently need to have to report the medical necessity, and more information will be available soon in the operational guide.

The home health agency or beneficiary may submit a pre-claim review request. The request can be mailed, (passed), submitted through the MAC provider portal or submitted through the Electronic Submission of Medical Documentation, esMD system.

Initial requests are considered the first pre-claim review request for any episode. It should be noted that any – the first request for any additional episodes are still considered an initial request, and the MAC will make every effort to review initial request and postmark decision letters within 10 business days. Resubmitted requests are submitted with additional documentation after an initial pre-claim review request was non-affirmed.

The MAC will make every effort to review the request and postmark decision letters within 20 business days.

Decision letters will be sent to the home health agency and the beneficiary both; if the beneficiary is the requester or if they are just being notified of the decision sent to the home health agency. Decision letters will include the pre-claim review, Unique Tracking Number, UTN, 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 what policy requirements were not met.

The unique tracking number will be provided for each pre-claim review request, whether it's affirmed or non-affirmed. And the MAC will list the pre-claim review, unique tracking number on the decision letter. This number must be submitted on the claims.

If a pre-claim review request is non-affirmed, the submitter can (resolve) the non-affirmative reason described in the decision letter and resubmit the pre-claim review request. An unlimited number of resubmissions are allowed prior to the submission of the claim. And pre-claim review decisions cannot be appealed. The submitter can also submit the claim, the claim will be denied and all appeal rights are available for the claim.

If a home health agency has not requested pre-claim review before submitting the claim, the claim will be stopped for prepayment review. After the first three months of the demonstration, if the claim is determined to be payable, it will be paid with the 25 percent reduction of the full claim amount. The 25 percent reduction amount is not transferable to the beneficiary and not subject to appeal. The three-month grace period will be applied from the start day of the demonstration in each demonstration state.

I'm now going to go through some of the scenarios again. The first – in the first scenario, a pre-claim review request is submitted, the MAC decision is affirmed, and the home health agency submits the claim. The claim will be paid as long as all other requirements are met. In the second scenario, the pre-claim review request is submitted and the MAC decision is non-affirmative.

The home health agency can submit a claim and a claim will be denied, or the submitter can fix and resubmit the request. In the third scenario, a pre-claim review request is not submitted and there is no MAC decision. The home health agency will submit the claim and the claim will be stopped for prepayment review, and if payable, reduced by 25 percent after the grace period.

Resources such as background information, a fact sheet, and frequently asked questions can be found on the demonstration website. Please refer to the special open door forum announcement for the website address, or you can Google CMS pre-claim review to find the website.

For more information, you can look on the website where you'll find information and frequently asked question or you can send in questions through email to [HHPreClaimDemo@CMS.hhs.gov](mailto:HHPreClaimDemo@CMS.hhs.gov). And that is H-H-P-r-e-C-l-a-i-m-D-e-m-o@CMS.hhs.gov.

I will now turn it back over to Jill to open for question.

Jill Darling: Thank you, ladies. And (Lindsey), we'll have our Q&A, please.

Operator: And to remind you ladies and gentlemen, if you would like to ask a question, please press the star and the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Please limit your questions to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may press star one again to rejoin the queue.

Your first question comes from the line of (Laura Wolf) from Kindred at Home. Your line is now open.

(Laura Wolf), your line is open.

(Laura Wolf): Hello. Can you hear me now? Hello?

Jeane Nitsch: Yes, go ahead.

(Laura Wolf): OK. Yes. I just set it on mute.

I'm the first time listening. To be honest, I'm just kind of listening and take it all in. I'm sure next time I'll have some questions but right now I'm just absorbing so no questions here. Thank you very much.

Jeane Nitsch: Thank you.

Operator: And your next question comes from the line of (Christine Bentley) from Desert Star Home Health. Your line is now open.

(Christine Bentley): Yes. Hello. Thank you for taking my question. I thought that the point of the face-to-face in the OASIS was to prove medical necessity, and in order to complete now this new administrative function that we've added, and yes, you're right, it is documentation that we already collect, that is correct, but to complete the function for the agency to submit the documentation for CMS to review it or the MAC to review it, I mean, that is going to require some additional staff. And I mean, it seems like all the changes that are coming in and many of them seemed good that the point is to decrease healthcare cost.

So my questions is, where does the money come from to pay for this additional staff not only for the agency but for CMS, because it seems it either increases healthcare dollars or we take it away from the healthcare dollars that we have for patient care for the beneficiary?

Jeane Nitsch: Thank you. And I think it's (Christine)?

(Christine Bentley): Yes.

(Off-mike)

Jeane Nitsch: Yes. Thank you for the call. And there will not be any money added to the home health – for the home health demonstration for home health agencies. And we understand there's a lot of concern from home health agencies who are worried about any added time that will take to collect this information. But we've recognized also that for providers this should be information they

already have and are collecting to make sure that they are meeting the Medicare criteria and the medical necessity criteria.

The face-to-face encounter is just one of those pieces that in the Medicare criteria. So, it's important that they'd be collecting more information than just the face-to-face encounter. But since this is information, this is not new documentation. This is information that the home health agency should already have. We're confident that you'll be able to pull it together to send it with their pre-claim review. Thank you for your question.

Operator: Your next question comes from the line of (Mary Anne Laverne) from Options Home Health. Your line is now open.

(Mary Anne Laverne): Yes. Thank you. How long is this demonstration going to last?

Jeane Nitsch: It's a three-year demonstration.

(Mary Anne Laverne): Now, well, if a provider – excuse me. If a provider is – has a large percentage of approval rate, will they be taking off the demonstration earlier than the three-year timeframe?

Jeane Nitsch: Right now, the demonstration is set up for to be statewide. We will always love to see if later there is a need to alter the demonstration, but we are not looking to do that at this point.

(Mary Anne Laverne): OK. Thank you.

Operator: Your next question comes from the line of (Kimberly McKeith) from MEDITECH. Your line is now open.

(Kimberly McKeith): Hello. I was just wondering if we know where on the claim this tracking number should appear.

Jeane Nitsch: Yes, we do. It's going to be submitted – if they're submitting a home health claim on the 1450 form or the, sometimes it's called the CMS UB-04 claim form that will be in Field Locator 63. And then for electronic claims that would be submitted in positions 19 through 32 of Loop 2300.

Now, if they're submitting claims on the 1500 claim form, the unique tracking number is submitted in the first 14 positions of item 23. And for electronic claims, the unique tracking number is submitted in either the 2300 line.

So – but you don't have to. If you're (sitting on the call), you're thinking I didn't write down all those numbers, just know that all that information will be in the operational guide that will be coming out and we have to get that out in the next few weeks. So that will be...

(Kimberly McKeith): OK.

Jeane Nitsch: ... listed on our website.

(Kimberly McKeith): I do just want to point out that currently FL 63 holds the OASIS Claim Matching Key. So will they just both appear in that field?

Jeane Nitsch: I'll have to check with our system folks from that one.

(Kimberly McKeith): OK. Thank you.

Jeane Nitsch: Thanks for your question.

Operator: Your next question comes from the line of (Minda Mile) from...

(Off-mike)

Operator: Your line is now open.

(Minda Mile): Hi. My question was answered. Thank you.

Jeane Nitsch: OK. Thanks.

Operator: Your next question comes from the line of (Liz Carroll) from Able Palm Home & Healthcare. Your line is now open.

(Liz Carroll): Thank you. Will we have a form to fill out this information, or is everyone going to be submitting the information ad hoc?

Jeane Nitsch: Right now we haven't created a form. That information usually comes out from the MAC as they kind of provide information out to the providers, and sometimes they will say this item has to be in request and the MACs might create a form for people to use, but that information will be coming out from the MAC and you'll be able to check their website.

(Liz Carroll): OK. And when you give the loop number for the UB-04 19 through 32, you spoke a little quickly. What loop number was that in?

Jeane Nitsch: Let me see. Was that for the – it was in Loop 2300.

(Liz Carroll): Thank you.

Operator: Your next question comes from the line of (Christine Bunch) with Health First Home Care. Your line is now open.

(Christine Bunch): Yes. My question is, I understand this is for the Medicare beneficiaries for the three years. Is there a chance that Medicare HMOs will be added to that three-year time period or just traditional Medicare patient?

Jeane Nitsch: This is just for traditional Fee-for-Service Medicare.

(Christine Bunch): Thank you.

Operator: Your next question comes from the line of (Josephine Madden) with Accessible Home Care. Your line is open.

(Josephine Madden): Hi. I have a question about the timeline of getting the reply from CMS Palmetto. In Florida alone, there were approximately 1,300 Medicare agencies. If each agency receives one (we follow) a day, and a 10-day period that's 13,000 pre-claim audits. Can you tell me where the money come in to hire these people that as a little audit it? Can you do 13,000 in 10 days and that's only one per day from each agency? So what's the timeframe for our reply?

Jeane Nitsch: Yes, we ran all those numbers ourselves to see how many claims we would anticipate. And we have modified the contracts for the MACs involved and give them additional funding. They'll be hiring staff to work just on this

demonstration. So we're very confident that they'll be able to handle the influx of request.

(Josephine Madden): So what's our turnaround time?

Jeane Nitsch: They have 10 days for an initial request and 20 days for a resubmission.

(Josephine Madden): Thank you.

Operator: Your next question comes from the line of (Tracy Schoonover) with (B&D) Healthcare. Your line is now open.

(Tracy Schoonover): I was wondering; if you could tell me how is this going to affect our RAP payment?

Jeane Nitsch: It's – the RAP payment won't change. So you'll still submit the RAP and you'll get your 60 percent of the claim page that has not changed at all. If for some – and the same process will apply that if any RAP needed to be recouped, it's an automatic recovery. None of that has changed.

(Tracy Schoonover): So if we submit the information and you don't approve it, you'll take the RAP money back at that time or you'll give it to the...

(Crosstalk)

Jeane Nitsch: No.

(Tracy Schoonover): ... day episode?

Jeane Nitsch: No. This program is based on the final claim, not on the RAP.

(Tracy Schoonover): OK. But, yes, one second.

Jeane Nitsch: Do you want to clarify your question?

(Tracy Schoonover): Yes. No. I also want to know, so if we – I mean, because most of the ADRs that a lot of people have gotten have been denied and they're on the way to ALJ. So what is the process? Do we discharge the patient if you deny our claim?

Jeane Nitsch: The process for claim denial is the same. We're really hoping now that this demonstration is really going to have a big impact or reducing appeals. Because you're going to know upfront what information wasn't provided and be able to correct that information and resubmit so that you'll have the claim right at the time you're submitting your final claim. And we really think this is going to really help home health agencies reduce their appeals.

(Tracy Schoonover): But if you deny in the 10 days, it can...

Jeane Nitsch: No. It's not a denial.

(Tracy Schoonover): (OK).

Jeane Nitsch: The pre-claim review is affirmed or non-affirmed. Only the claim can be denied and your appeal rights only are based on the claim. If your claim is denied, then you have the traditional appeal rights you would normally have. If it's affirmed or non-affirmed, that's what the pre-claim review decision will be for the affirmed or non-affirmed decision. If it's affirmed, you know, you're pretty much good to go when you submit your final claim. If it's non-affirmed, you have that opportunity to resubmit it in unlimited amount of times before you submit your final claim. So that really gives you a great opportunity to correct any (errors) you have.

(Tracy Schoonover): On affirmed, this is providing services to the patients?

Jeane Nitsch: Well, but you'll be told what is missing. So if you already know and you feel comfortable that they are meeting the Medicare criteria, you might just find out you're missing a piece of documentation that you just need to resubmit.

(Tracy Schoonover): What if we feel that this process is going to go on forever and it's not business (world) then you continue providing services to the patient. Can we see providing services to the patient?

Jeane Nitsch: I can't comment on your business on your business practice, but I would hope that we've heard from some health agencies that patient care is very important

to them and they would not want to stop patient care if it's something that they could correct.

(Tracy Schoonover): OK, that's it. Thank you.

Jeane Nitsch: Thank you.

Operator: Your next question comes from the line of (Nicki Courgette) with (Fresher) Home Health. Your line is open.

(Nicki Courgette): Hi. I just want to know. So after you submit the RAP, you do get the payment. Now, how – when do you submit the (EUA)? Do you have to do the review first, make sure everything is approved, then submit the (EUA) or submit it with it?

Jeane Nitsch: What is the (EUA)?

(Nicki Courgette): I'm sorry, the final claim.

Jeane Nitsch: I'm sorry. So...

(Nicki Courgette): The final claim.

Jeane Nitsch: Could you repeat your...

(Nicki Courgette): So the last – the final claim once before you discharge a patient. So when – does that get submitted the same time that's with the forms that are required or does that, you know, forms get submitted, then the final gets built?

Jeane Nitsch: So kind of the process of how it works. So, you can submit your pre-claim review with the documentation that shows that medical necessity is met. And once you have that, you can submit that pre-claim review right up until you submit your final claim.

(Nicki Courgette): OK. So, now, why is there – OK, so everything is approved? And, say, you – I mean, if you – if something is not approved and then you have the appeals. Why are they taking 25 percent off if by the time you're done with appeal and it's approved? Why are you losing 25 percent?

Jeane Nitsch: The 25 percent reduction is to encourage home health agencies to go through their pre-claim review process. The 25 percent reduction occurs if you did not seek a pre-claim review decision prior to submitting your claim. For the first three months of the demonstration, and this will be true in each state, they'll be three months from the start in each state will give a grace period. But if after that grace period you submit claims that if not – that should have gone through the pre-claim review process and you did not go through that process, you would receive a 25 percent reduction on the final payment.

(Nicki Courgette): OK. And so, and then we will be notified (up) what you said what forms and everything, how to submit it and what needs to be done for this process?

Jeane Nitsch: Yes.

(Nicki Courgette): OK.

Jeane Nitsch: Absolutely.

(Nicki Courgette): OK. OK. Thank you.

Jeane Nitsch: Thank you. These are great questions.

Operator: Your next question comes from the line of (Sandra Philipson) with (Ingalls) Home Care. Your line is open.

(Patricia): Yes. My name is (Patricia). I was just wondering, when it comes down to your new all Start of Care as well as our research. Do they all fall under these criteria?

Jeane Nitsch: I'm sorry, I had trouble understanding. Could you repeat that?

(Patricia): Yes. When it comes down to the, your Start of Care as well as your research, this situation also apply to them – to all of them?

(Crosstalk)

(Patricia): To all research and all...

(Crosstalk)

Jeane Nitsch: I'm sorry. Yes. So if you have a second episode, you would need...

(Patricia): Yes.

Jeane Nitsch: ... to submit a second pre-claim review. And that is considered an initial pre-claim. It's the considered initial for each episode of care.

(Patricia): OK.

(Off-mike)

(Patricia): So everyone then?

(Off-mike)

Jeane Nitsch: Each episode, yes.

(Patricia): Each episode. OK. OK. Thank you.

Jeane Nitsch: With that 60-day period.

(Patricia): (With that) 60-day period. OK. Thank you.

Operator: Your next question comes from the line of (Robin Stavola) from (Palmetto) Hospital Home. Your line is now open.

(Robin Stavola): Hi. I had a couple of questions. We admit 300 patients a month. So that gets us down roughly to about 10 per day. Can you really assure us that Palmetto, that I think was referenced earlier in the conversation, will have the additional staff who are trained in home healthcare and know the home healthcare coverage rules will be able to process this information timely enough so that we don't lose a lot of money on the episode?

You know, secondly, if Palmetto is going to mail (in) snail mail, our approval or our affirmation back, mail gets lost and with the volume that it sounds like Palmetto will have to be absorbing. I'm concerned about mailing back and continuing to provide services when we have all these additional

documentation request from Palmetto. Hence, I would again emphasize the need for training of whoever Palmetto hires to process these documents.

Jeane Nitsch: Absolutely. And we agree with you. We've been working with our contractors for several months. So they've known this demonstration was coming and they are planning to hire and train people to do these reviews. We hope – also want to remind people that it's not just through snail mail that this can be submitted by fax, and also electronic or through the MAC portal. I know Palmetto has a portal but they often encourage people to use to submit these kinds of requests.

(Crosstalk)

(Robin Stavola): So Palmetto's response then – can Palmetto's respond to us electronically?

Jeane Nitsch: Yes. If you submit it electronically, they'll respond electronically. If you fax in they will fax back.

(Robin Stavola): And then at what point and – I mean, we're six weeks away from this August 1st. At what point will Palmetto start to let us know how to process these if there is in fact the template or some sort of form that Palmetto is going to use? When do you anticipate that Palmetto will start educating Illinois providers before...

(Crosstalk)

Jeane Nitsch: I will have to get back to you. But we'll have another open door forum in two weeks and I'll see if I can get an answer to that question for you.

Melanie Combs-Dyer: This is Melanie Combs-Dyer. I also wanted to just put in a plug for electronic submission of medical documentation. The esMD system is another way that you can submit a pre-claim review request and receive a response electronically as well.

Jeane Nitsch: Next question?

Operator: Your next question comes from the line of (Steven Merley) from Intrepid USA. Your line is now open.

(Steven Merley): Hi. How are you doing? First off, I would just like to make a comment that this really sound like 100 percent probe audit. What we're doing here because you're going to be looking at every single page in. My question is, will the patient be (sent) a determination at the medical necessity, whether it was met or not met?

Jeane Nitsch: Both the – if – in almost all situations we expect that the submitter will be the home health agency. But there – if the patient is the requester, they would also get the decision back. But even if they're not the requester and the home health agency requested the pre-claim review, the decision might go back to the home health agency and to the beneficiary.

(Steven Merley): So the beneficiary will get notification that they do not, from your review do not qualify as being medical necessity?

Jeane Nitsch: Well, they will also – they will say that the decision was not affirmed and they will get – see the reasons why it was not affirmed. So they might see that the plan of care was maybe needed or there wasn't documentation of the face-to-face requirement.

(Steven Merley): OK. OK. (That) answered my question.

Melanie Combs-Dyer: This is Melanie Combs-Dyer. You said this is like 100 percent prepayment review, and you're right, but there's one big difference that I just wanted to point out and that has to do with the appeals process. You know, 100 percent prepayment review, when you get a denial, your only option is to enter the appeals process, which can be expensive for you and for the – your contractors.

Under pre-claim review, you'll be able to resubmit your pre-claim review request. And you can submit that a second time or third time or fourth time, however may...

(Crosstalk)

(Steven Merley): Right. But I would think you'll find a lot more discrepancy on the front end and the back end and given the numbers is what I would believe.

Jeane Nitsch: And I think what we've found in other demonstrations that are similar is there is a learning curve and we know that. But what will happen is the home health agencies will get up to speed and they'll probably understand what needs to be submitted. We've seen this with our other providers. And we noticed that even our MACs do a lot to educate providers who were still having struggling to get it right. And now they reach out to them...

(Steven Merley): Right.

Jeane Nitsch: ... So they're educated, so that we really are trying to help but there will be a learning curve.

(Steven Merley): And I understand that. I guess where I feel our hands are tied is we're relying on the physician, the provider on that face-to-face piece and it becomes very difficult.

Jeane Nitsch: Right. But that is a requirement and I'm sure that that's been collected all along from the home health agencies. We do understand that there is a burden sometimes in getting that information from physicians. And we will do our part to help educate physicians the best we can to help support you and able to get in your efforts to get that documentation.

(Steven Merley): OK. Thank you.

Operator: Your next question comes from the line of (Adam Marconi) from Doctor Home Choice Care. Your line is now open.

(Adam Marconi): All right. Thanks for taking my question. The question is...

(Off-mike)

(Adam Marconi): ... pre-claim audit and approve for services. What...

(Off-mike)

(Adam Marconi): ... reevaluations plan do you have for it if you add more services on after you've been affirmed?

Jeane Nitsch: What really matters because you just need to show that there's a need for skilled services. So any additional services that are added will change the pre-claim review decision.

(Adam Marconi): OK. Thank you.

Operator: Your next question comes from the line of (Amy Bodley) from Residential Home Health. Your line is now open.

(Amy Bodley): Hi. I was just curious to know if there's a certain percentage of claims that are going to be included in the demonstration for each agency, or is it just on occasional sampling, or hopefully not our entire population.

Jeane Nitsch: All Medicare beneficiaries who are receiving Medicare home health benefits, it's for them. So, depending on what percentage of your clients are Medicare, that's the percentage that it would be.

(Amy Bodley): OK. Thank you.

Operator: Your next question comes from the line of (Angel Lamont) with Louisiana Healthcare. Your line is now open.

(Angel Lamont): Thank you. My question is already been answered, when going into field locator for the Unique Tracking Number. Thank you.

Jeane Nitsch: OK. And look for that operational guide. They'll be coming out the next few weeks.

(Lindsey), we'll take the next question.

Operator: Your next question comes from the line of (Jeff Aalberg) with (Greenberg Chart). Your line is now open.

(Jeff Aalberg): Hi. Please disregard my question. Thank you.

Operator: Your next question comes from the line of (Verneigen Dullard) with MSA Home Health. Your line is open.

(Verneigen Dullard): Thank you. My question is, will a signed 485 be required for the initial pre-claim review?

Jeane Nitsch: Well, that 485 hasn't – it was retired back in 2003. So that's form is not used.

(Verneigen Dullard): OK, the plan of care.

Jeane Nitsch: OK. I just want to make sure. So your question again then is...

(Crosstalk)

Jeane Nitsch: ... (far enough) by the 485...

(Crosstalk)

(Verneigen Dullard): Does it need to be signed as part of the initial pre-claim review documentation to be submitted? Is that going to be one of the requirements, a signed plan of care?

Jeane Nitsch: The requirement is that it be “completed and signed” I believe is the terminology that's used. So the same requirements, the Medicare requirements are the same (one is qualify).

(Verneigen Dullard): Well, OK. I guess I'm not understanding because the 485 is usually signed by the time you drop your final. But what I'm asking is if we're going to submit our pre-claim review within 10 days, which is my plan, you know, do I have to ensure that we get a 485 signed quicker to submit it, or can we sign the, excuse me, the plan of care without the signature?

(Crosstalk)

Jeane Nitsch: Right. The medical necessity requirements say that they have to be under the plan of care of a physician and receive services under that plan of care. So whatever documentation is needed to show that is what would be needed.

Melanie Combs-Dyer: (So we'll send the planning)...

(Crosstalk)

Melanie Combs-Dyer: OK. So we'll send the plan of care. When it's ready, we'll just send the plan of care.

(Verneigen Dullard): OK.

Melanie Combs-Dyer: OK. Thank you.

(Verneigen Dullard): Sure.

Operator: Your next question comes from the line of (Diana Cornetti) with (Cornettian Craft). Your line is now open.

(Diana Cornetti): Hi. Thank you for taking my call. I have a clarification based on a previous question. You'd stated that if additional services go also throughout the episode of care, that won't change the pre-claim determination, it'll stand, because it's based on – still reasonable and necessary that was established at the (start). My concern here...

Jeane Nitsch: Right.

(Diana Cornetti): ... is that there may be, and I would like your impression of this, a delay in asking for additional services, especially therapy services which could affect that ruling, and so the initial pre-claim determination we based solely on the admitting clinician, OK? And therapy will be withheld until that determination is made and what can that do to some of those patients that require that service from the start of care?

Jeane Nitsch: We expect that the home health agencies would begin providing care prior to even submitting their pre-claim review request. Because if you feel – just like you would do now that you feel that all the Medicare criteria are met then you would start services, that wouldn't change.

(Diana Cornetti): Thank you. I absolutely understand that. And what I – I believe that that's provides an opportunity for additional services to be withheld until that

signing comes back. That's just a comment based on that previous answer.  
Thank you.

Jeane Nitsch: I appreciate your comment. I'm not sure I understand or agree with that comment, because once you've established that need, that would go for the pre-claim review. You would send in the documentation to show that the person does – is in need of skilled services. So I'm not sure why you would delay anything once that established.

(Crosstalk)

Female: ... and make sure I want to make sure I'm saying this correctly. There's not a need...

(Off-mike)

Female: ... revise of affirmation because additional therapies were added.

(Diana Cornetti): No, there's not.

Female: And I thought that it might be...

(Off-mike)

Female: ... going but I could be mistaken. So there will not be a need to revise the affirmed decision if additional therapies...

(Off-mike)

Female: ... need for a delay. Once you received an affirmation, it's the (term) for the whole entire episode.

(Off-mike)

Operator: And your next question comes from the line of...

(Crosstalk)

Jeane Nitsch: Go ahead, (Lindsey).

Operator: Your next question comes from the line of (Sharon Shalt) with (AirClean).  
Your line is now open.

(Sharon Shalt): Hi. And good afternoon, thanks for taking my question. Actually, I have two questions. Since the – in the states where we're going with 100 percent pre-claim review. How was that going to impact your post-payment ADR volume for medical necessity? Do we anticipate that going away?

Melanie Combs-Dyer: This is Melanie Combs-Dyer. So if you go through the pre-claim review process, then that claim will be marked as "off limits" for most post-pay review. That is normal post-pay review by the MAC, post-pay review by the Recovery Audit Contractor. It'll be off limits and it will not be selected for review. There are a couple of exceptions (report) that detect the fraud-fighting contractor, can review any time they want, the OIG or GAO, of course could review any time they want, and the CERT contractor, the Comprehensive Error Rate Testing contractor that pull the random sample to measure for the national error rates. They, of course, would be not affected by this. But the normal post-pay review that you're talking about will go away.

Jeane Nitsch: And you'll see that the frequently asked questions that are part of our website, I believe its number 13.

(Sharon Shalt): Great. Thanks. And just like the Michigan and Massachusetts start date, I believe you said was January 2017 but I wasn't sure.

Jeane Nitsch: Yes. No earlier than January 1st, 2017.

(Sharon Shalt): Thank you.

Operator: Your next question comes from the line of Angie Begnaud with LHC Group.  
Your line is now open.

Angie Begnaud: Thank you. My question has to do with the timing of the prepaid claim being (set). We're saying that it's going to be after the RAP process and within 30 days or the first treatment provided, and if our face-to-face is required to be sent, we have 30 days (post), the patient starting with home care to get that

done. So, how is that going to affect the timing of that 30 days post-start of care?

Jeane Nitsch: Angie, I'm so glad you ask that question. Because let everyone know that we'll be revising one of our Q&As on our website, because it does talk about the Pre-Claim request needing to occur after the RAP and before its 30 days after treatment.

Really, the request could come in at any time. Once you feel like you have met all the requirements and have all that documentation to send in, you can send your pre-claim review request. So if it's on 30th day, the 35th, the 45th, that's fine.

Angie Begnaud: So if any time...

(Crosstalk)

Angie Begnaud: If any time before the final gets submitted?

Jeane Nitsch: (That's correct).

Angie Begnaud: OK.

Jeane Nitsch: Once you've met all the criteria and have all the information to send in, but before the final claim.

(Crosstalk)

Angie Begnaud: OK. Thank you.

Melanie Combs-Dyer: This is Melanie. Let me make sure that I'm also understanding this correctly.

(Off-mike)

Melanie Combs-Dyer: ...So the Home Health agency would send in their pre-claim review request any time before the final claim is submitted even before services are rendered, so long as they've got the order in the plan of care, the face-to-face

evaluation documentation. They've got all the documentation together even before their first visit they could submit their pre-claim review request. Is that correct?

Jeane Nitsch: They can. It may be very hard to show that they've met all those criteria. It does seem that it'd be naturally occurring order that a lot of – all that would happen before you even submit the pre-claim review request, but you're not precluded. If you have all that documentation and you've made other criteria and you can establish that, you can send it in.

(Off-mike)

Female: ... right there.

Female: Right.

Operator: And your next question comes from the line of (Edward Castro) with (MS) Healthcare. Your line is now open.

(Edward Castro): Thank you. Most of my questions been answered...

(Off-mike)

(Edward Castro): ... timeline. So we have until three months before we get to the 25 percent deduction from the initial start of care date?

Jeane Nitsch: From the start of the program. So if we start in Illinois on August 1st, we would not do a 25 percent reduction for not providing going through the pre-claim review demonstration until three months later. We would give everybody that grace period.

(Edward Castro): OK.

(Crosstalk)

(Edward Castro): (Actually), we are providing the information but how much time do we have after the start of care date to provide that information? Let's say if it's – we

don't have, let's say, for example, the document has been certain documents, face-to-face or whatever, until after the end of episode, or (the end of day)?

Jeane Nitsch: Until you submit your final claim.

(Edward Castro): OK. Great. Thank you so much.

Jeane Nitsch: Sure.

Operator: Your next question comes from the line of (Mendy Pasivon) with (All Country) Healthcare. Your line is now open.

(Mendy Pasivon): Hi. Thanks for taking my question. I want to ask you about recertifications. We usually get an order from the doctor and to recertify because there's a clinical need to continue. Will that be all that's necessary?

Jeane Nitsch: Now, when you're saying recertification, are you talking about the second 60-day episode of care?

(Mendy Pasivon): Yes.

Jeane Nitsch: You would need to submit a pre-claim review request for that second episode of care, and all the supporting documentation that would be needed. It's still considered an initial request even if it's for a second episode of care.

(Mendy Pasivon): Does that mean a visit to the physician?

Jeane Nitsch: If you have that documentation that shows that face-to-face encounter occurred, that documentation would just fall through on that next submission.

Melanie Combs-Dyer: So this is Melanie, just to clarify. In their initial pre-claim review requests were the second episode. They would include the original order which by now it's probably 70 days old, their original face-to-face examination which could be 70 days old, and the plan of care which perhaps has been modified since the first time that the plan of care came in, and any other documentation that demonstrates the patient still required skilled services. Is that correct?

Jeane Nitsch: That's correct. Because the face-to-face requirement is 90 days before 30 days after the start of care, and the start of care really would have gone back prior to that second 60-day episode.

(Mendy Pasivon): OK. That's pretty clear. And would that be the same for a resumption of care?

Jeane Nitsch: I don't know what a resumption of care. Could you clarify?

(Mendy Pasivon): It's when a patient comes out of a facility and we're resuming services.

Jeane Nitsch: So are you talking like a past?

(Mendy Pasivon): No.

Jeane Nitsch: No? OK. So just – if it's a new episode of care, you have to submit a pre-claim review request. So if you have a final claim for that first period...

(Crosstalk)

Jeane Nitsch: ... then you would need to submit. But if it's still within that same episode of care, the pre-claim review request you've submitted with follow through to your final claim as long as your claim hasn't changed.

(Mendy Pasivon): OK.

(Crosstalk)

(Mendy Pasivon): (Now I ask), is there notification of this going out to physicians and hospitals also?

Jeane Nitsch: Yes. We are doing education. We wanted to do as much as we can to help you get that documentation that's required from both physicians, or anyone else who may be helping to provide input on the medical record. So, we are going to be doing education out for those folks as well.

(Mendy Pasivon): OK. And I ask that because the homebound status is one of the biggest challenges that we can't seem to get the doctors or the hospitalists to write on

the orders or in the documentation. So we, you know, we are educating the doctors' offices, because that's one of the medical necessitates to meet the criteria. So, you're educating them would be most helpful.

(Off-mike)

Jeane Nitsch: And if you have any feedback for us on how – what we can do more to help educate physicians or how we can help you better with this as you implement the program, please let us know. And I think we have to – that will be our final question for the day. I'll turn it back over to Jill.

(Mendy Pasivon): Thank you.

Jill Darling: Thanks everyone for joining today's call. And I will turn the call over to (Lindsey).

Operator: This concludes today's conference call. You may now disconnect.

END