

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Pre-Claim Review Demonstration for Home Health Services
Tuesday, June 28, 2016
2:00pm – 3:00pm Eastern Time
Moderator: Jill Darling

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

All lines have been placed on mute to prevent any background noise. After the speakers' 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 withdraw your questions, please press the pound key. Thank you.

Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Jessa). Good morning and good afternoon everyone. Thanks for joining us today for today's Special Open Door Forum. I'm in the CMS Office of Communications. We do appreciate your patience in waiting. We do have a lot of folks on the line, and I know we do ask for many pieces of information from you, so we thank you, again, for your patience.

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 CMS at press@cms.hhs.gov. Thank you.

And now, I'll hand the call over to Jeane Nitsch.

Jeane Nitsch: Thanks, Jill. Again, hi. I'm Jeane Nitsch. I'm with Centers for Medicare and Medicaid Services. I'm the director of the Division of Compliance Projects and Demonstrations. I want to welcome you all today. This is our second Special Open Door Forum Call to talk about the Pre-claim Review Demonstration for Home Health Services.

Our first call was back on June 14th, and we had over 2,600 participants that day. It seems like we're going to have a lot today, too. So, thank you all, and we had a great call the first time with a lot of great questions, and expect we'll have a lot of questions today, too. Let me just give you a little bit of background of how we're going to go through the call today. We are going to walk through some background information about what's going to happen.

We're going to run through a short presentation to give some background information and then we'll turn it over and open to this to follow up for questions. For some of you who are on the first call, it may seem like a similar presentation. What we'll point out – we'll point out some different questions and answers that have come in since the last call, but we'll walk-through for those who weren't on the first call, a brief introduction about the program so that we're all on the same page when we open it up for Q's and A's.

I just want to point out that we have a lot of information on our Web site and we'll give that information. It was also on the Open Door Forum announcement, the link to our Web site, so please go there to look for that. We have some frequently asked questions that we updated just this last Friday. So, if you had an earlier version, you may want to go back to our Web site and pull up the updated frequently asked questions. We've recently posted our operational guide. There's a lot of information in there and we had requests for some basic slides so we put up a slideshow presentation that you can download. This gives an overview of the demonstration. So, that's also posted on our Web site and there's a fact sheet there as well.

We have gotten a lot of questions that have come in through our mailbox and we thank you all for using our mailbox and we've had a few that came in on voicemail. We are working through those questions. Please be patient with

us. We do get a lot of questions but I want to thank you for sending in questions. What we did is for some of the ones that were repeat questions, we actually added them to our frequently asked questions document or FAQ document. So, hopefully a lot of people will see some of the answers to things they submitted.

Also, we know that the first transcript from the first Open Door Forum Call will probably be released soon, so you'll be able to look at the Web site for the Open Door Forum Call for that information. We did get some questions about when that would be released. I also want to mention that there's a lot of education efforts going on in addition to the materials that we have published on our Web site. We had this, again, is our second Open Door Forum Call and our contractors will be holding some individual education efforts.

We really want to reach out to providers and also to physicians. We are looking to do some more education with physicians out there which I think will help the home health provider community as well as they're collecting documentation that will be submitted with the pre-claim review.

I just want to start with a couple of questions before we go into our presentation. They're just some things that have come up frequently since our last call. A lot of people have asked if someone has already begun home health services; do I need to submit a pre-claim review? And this is actually a frequently asked question, you can refer to question number 39. You would need to – for all episodes of care that began, for example, before August 1st for those in Illinois, you would not submit a pre-claim review request, but for any new home health patient or a patient with a new episode of care that starts on or after August 1st, you would submit a pre-claim review request.

Another question that we've received is, "does the plan of care need to be signed dated by the physician submitted with the pre-claim review request?" We just want to clarify and make that clear from the last call, but yes, you do need to have the plan of care signed and dated by the physicians and submit it with the pre-claim review. We've gotten a lot of questions about the unique tracking number. That will be discussed during the presentation. I want to refer you to our operational guide if you have questions about the unique

tracking number, the UTN, please see the operational guide for more information. And there was a question about if a claim is denied, will the RAP be recouped and I just want to make that clear because it was not as clear on the first call, but yes, the RAP would be recouped just as it normally would with normal processes. OK.

OK. And so, let's go ahead and get started. I'm going to run through and I have here with me Jennifer McMullen, and she's going to help me with the presentation. So, we'll just start. So, really what is this pre-claim review - ~~and~~ this is just a process where we're requesting that you submit a request for provisional affirmation of coverage and you submit with that request documentation that supports medical necessity. Really with this review, I'm just making sure that all the applicable coverage and payment rules are met before the final claim comes in.

This demonstration is for beneficiaries who are receiving fee-for-service Medicare home health services in the demonstration states and those home health agencies who are providing services in those demonstration states. We sometimes get that question as well - is it where the home health agency is located or where the services are provided. It's where the service is provided. And what is covered by a pre-claim review decision? A Pre-claim review decision is for a 60-day episode of care. It pertains to the final claim and the not the RAP.

So, let's talk about those demonstration states. We are looking to start in Illinois on August 1st. We will then move into Florida no earlier than October 1st, Texas no earlier than December 1st, and Michigan and Massachusetts no earlier than January 1, 2017. When we talk about the pre-claim review, we're often talking about the applicable coverage and payment requirements and making sure those applicable coverage and payment requirements are met. So, very familiar to everyone probably on the phone but let's just check through them, the requirements we're looking for.

We'll have some additional information what they want to see provided. What we're really wanting to make sure is that the patient receiving home health services meets the Medicare coverage requirements. So, the

beneficiary must be confined to home at the time of service. They must be under the care of a physician. They must be receiving services under plan of care established and periodically reviewed by a physician. There needs to be a need of a skilled services and they have to have had a face-to-face encounter with the medical provider and the encounter must occur no more than 90 days prior to the start of care or within 30 days after the start of care and it must be related to the reason the patient requires home health services.

So, people have asked – have the coverage and documentation requirements changed and no, they haven't. Medicare coverage policies are unchanged. The documentation requirements are unchanged. We're not creating any new documentation requirements with this demonstration and some of the other things that are unchanged is that the MAC will still be conducting these reviews. All the policies related to Advanced Beneficiary Notice, the ABN policies, they are all in place.

Claim appeal rights are still in place and also unchanged or dual eligible coverage and private insurance coverage. Those things – those policies did not change. So, what has changed? And for this, it's really that the home health agency will know before the final claim is submitted whether Medicare will pay for the services as long as all other Medicare coverage and claims processing requirements are met. This is really a benefit to home health agencies as well. It will help with their cash flow as they will know that before they get to a final claim. And before they'd have to submit a final claim, and if that claim got denied, have to go through the appeals process. This way through this process, they will be able to submit all the documentation and get a provisionally affirm decision telling them that this claim looks like it will be paid if all the other coverage requirements and claims processing requirements are met.

So, I'm going to turn it over to Jennifer McMullen. She'll talk a little bit more about the process.

Jennifer McMullen: Thank you. And now I'm going to go through an overview of the process and we'll start with the request. The pre-claim review request should identify the beneficiary name, Medicare number, origin, beneficiary date of birth and

gender. It will also identify the certifying physician or practitioner's name, National Provider Identifier, NPI and address and the home health agency's name, National Provider Identifier, NPI and address. You should also have the requestor's contact name and telephone number.

Other information should include beneficiary requested whether it's initial or subsequent, the submission date from and through date of the episode. Indicate if the request is initial or resubmission review and state – the state where the service is rendered. Request also needs to include documentation from the medical record that supports medical necessity. You can find more information in the operational guide on our demonstration Web site. In addition, you can check with your MAC through their Web site or educational opportunities to get state-specific information.

The home health agency or beneficiary may submit the request. Your request can be mailed, faxed, submitted through the MAC's provider portal where available and submitted through the Electronic Submission of Medical Documentation, or the esMD system where available. You can find more information on ways to submit the request in our FAQ specifically number 16, 21, 22 and in the operational guide. Initial requests are considered the first pre-claim review request for any episode.

The MAC will make every effort to review those initial requests and postmark decision letters within 10 business days. Submitted request or request submitted with additional documentation after the initial pre-claim review request was not affirmed. The MAC will make every effort to review the request and postmark decision letters within 20 business days. It should be noted that the first pre-claim review request or an additional episode of care is considered an initial request. More information on the review time frame can be found in our FAQ. Read the questions 10, 11 and 15.

Decision letters will be sent to the home health agencies and the beneficiaries, both if the beneficiary is the requestor or just to be notified of the decision sent to the home health agency. Decision letters will include the pre-claim review Unique Tracking Number, or (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 which specific policy requirements were not met. Please see, FAQs number 12 and 18 for more information on the decision letter.

A Unique Tracking Number will be provided for each pre-claim review request whether affirmed or non-affirmed. The MAC will list the pre-claim review Unique Tracking Number on the decision letter. Unique Tracking Number may be slightly different for each MAC. More information on the Unique Tracking Number can be found in our frequently asked questions numbers 12 and 38. The operational guide on pages 14 and 18 also give more detail on placement of this Unique Tracking Number on the claim. You can also check with your MAC for more information on state-specific information.

If a pre-claim review request is non-affirmed, the submitter may resolve the non-affirmed reasons described in the decision letter and resubmit the pre-claim review request. Unlimited resubmissions are allowed prior to the submission of the final claim. Pre-claim review decisions cannot be appealed or the submitter can submit the claim, and the claim will be denied but all appeal rights will be available. Please see frequently asked questions 18 and 29 for further information.

If a home health agency has not requested a pre-claim review before submitting the final claim, the claim will be stopped for pre-payment review. After the first three months of the demonstration, if a final claim is submitted without first going through the pre-claim review process, and the claim is determined to be payable, it will be paid with a 25 percent reduction off the full claim amount. The 25 percent payment reduction is non-transferable to beneficiaries and is not subject to appeal. The three month grace period will be applied from the start date in each demonstration state. Please review Frequently Asked Question number 28 for more information on prepayment review.

And now I'm going to go through some scenarios, again. For the first scenario, a pre-claim review request is submitted and is affirmed. The home health agency submits the final claim and the final claim will be paid as long as all other requirements are met. In the second scenario, the pre-claim review request is submitted but not affirmed. The home health agency can submit the final claim and the claim will be denied or the request – excuse me, the pre-claim review request can be fixed and resubmitted. In the third scenario, the pre-claim review request is not submitted and there is no decision. The home health agency submits the final claim which (will be sought) for prepayment review. After the first three months-in each demonstration state, if the claim is found payable, it will be reduced by 25 percent.

Information and resources such as background information, fact sheet, frequently asked questions and the operational guide can be found on the demonstration Web site. The Web site link can be found in the special Open Door Forum announcement or using Google CMS Pre-Claim Review. For more information, you can go to the demonstration Web site or you can also send us questions through e-mail to hhpreclaimdemo@cms.hhs.gov that's hhpreclaimdemo@cms.hhs.gov.

I will now turn back to Jill to open for questions.

Jill Darling: Thank you, ladies. (Jessa), we'll go ahead and begin our Q&A, please.

Operator: As a reminder, ladies and gentlemen, if you'd like to ask a question, please press star followed by the number one on your telephone keypad, and if you would like to withdraw your questions, please press the pound key. Please limit your question to one question and one follow up question 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 (Alice Yuhas) from Divinity Home Care. Please, go ahead.

(Alice Yuhas): Hello.

Female: (I'm on mute).

(Alice Yuhas): We have a question about – we have a lot of referrals that come through Allscripts, electronic referrals from the hospital, and we're wondering if those – if the information that we get through the Allscripts referral which is usually CBC from the hospitals and H&P information and the referral from the hospital, if that will suffice as our initial order without an actual physician's signature on it? It's an electronic document.

Jeane Nitsch: It might be a question we need to refer to the MAC to see what they're expecting. I'm not sure that that would suffice, but we will get that answer – if you want to send that question into our mailbox, we will surely get back to you, and for others, we can post something on our Web site to answer that question. I don't want to steer you in the wrong direction.

(Alice Yuhas): OK. And one more thing, the plan of care on the last call, we understood that the plan of care did not need to be signed and dated yet when we sent it through for the pre-claim review because sometimes there's a delay in the physician signing that. So, now we do have to have it signed and dated before we can even send the information and for the pre-claim review, and it will be week into the episode.

Jeane Nitsch: That's correct, you will need the plan of care signed and dated by the physician.

(Alice Yuhas): So, we can't control the physician.

Jeane Nitsch: That's why we're going to help ...

(Alice Yuhas): So, we – so where ...

Jeane Nitsch: Go ahead. I'm sorry.

(Alice Yuhas): Well, it's just – it's frustrating because we can't control the physicians and we use a lot of man hours to – as I'm sure other agencies do as well to obtain physician's signatures and I can even I can't even imagine trying to obtain the signature within just a couple of days so that we can go ahead and submit for

the pre-claim review before we're knee-deep into the episode and we provided all the care. That's the problem.

Jeane Nitsch: We agree. Sometimes getting physician's signature has been a problem for providers and we want to help support you in any way. So, we're planning to do some education efforts out to providers to help encourage them and tell them what's the requirements are and make sure that they're working with the home health agencies to make sure they have the documentation they need to be able to submit with the pre-claim review request.

Tatjana Savich: My name is Tatjana Savich and I'm the administrator, and I work with (Alice) and have for several years, and my concern is the patients -- the patients that are postop all kinds of things whether it's a postoperative or whether they're just getting discharged and they're going back to home, the patients are in need of medically necessary nursing and therapy services and we're concerned that patients are going to get a delay in service which could lead to Medicare paying for more money, for your infections and different types of things that happened when the start of care is postponed due to administrative burden.

Jeane Nitsch: We have -- we were worried about that as well and designed this program to make sure that beneficiaries will be able to receive care while the pre-claim review process is going forward. So, we anticipate that the home health agency like normal, will go in, initiate their assessment, begin care; continue with that as they collect the documents they will need for the review.

Tatjana Savich: Well, we're very concerned about this because our experience with ADR reviews is that oftentimes the claims are denied for kind of arbitrary reasons and we wonder sometimes that the claims have even been reviewed by an actual person? And so we're very concerned that we're going to be providing all those care which we want to provide care to our patients and we always do and then we're going to end up providing care without getting payment.

Jeane Nitsch: Well, that's the great thing about this demonstration that is different than just going forward submitting a claim and having it denied and having to go through the appeals process which is very costly for everyone involved. With

pre-claim review decision, it's a – it's a decision, it's an affirmed or non-affirmed. And what comes back to you in the decision letter is that affirmed or non-affirmed and if it's non-affirmed, it will give you a detailed description of what is missing in the documentation.

The home health agency can resubmit any number of times they want -- before the final claim is submitted and this gives them numerous opportunities to correct any errors in the submission. So, they'll know upfront that their claim is going to be paid, as long all as the other coverage and coding requirements are met. So, this program is actually a benefit to home health agencies instead of going all the way to the end, providing all the services and then finding out a piece of documentation is missing.

Jill Darling: We'll go to next question, please. Thank you.

Operator: Your next question comes from the line of (Rusty Smith) from (Grace Jone Health). Please, go ahead.

(Rusty Smith): Yes, hello. Hold it. Thank you, guys for having number 37 to the frequently asked questions by adding that language which stipulated you may not be required to send every document in record. You're at least signaling that you might know the range of possibilities to some point in the future.

So, my question really leads toward when will that be – when will you indicate what documents are going to be required as shown that – and (it was at the) – for the therapy or nursing services being provided? For example, will therapy only need to send the initial eval or are you going to require the initial eval plus the first two visit notes? Do you know when you're going to be far enough along to provide specific guidance?

Jeane Nitsch: Well, first, you need to submit all documentation that is necessary to prove medical necessity. So, the face-to-face encounter, the physician order, all those things that were mentioned earlier need to be provided with the pre-claim review. For any specific, if you're looking for very specific what – documentation the MACs may be looking for, I would go to their Web site and listen in as they're going to have some education calls. I know the first

call, I believe that's happening maybe this week for people who – in Illinois who used Palmetto.

(Rusty Smith): OK. So, let me make sure I'm understanding your answer correctly. What I'm hearing is that you guys at CMS aren't really going to specifically be dictating. You're going to leave to the individual MACs to make that determination and put out a checklist that we should follow. Is that correct?

Jeane Nitsch: Well, you know, what needs to be submitted in the sense of it must meet all the documentation requirements, whatever you feel supports medical necessity that's what need to be submitted. But if you're looking for any specific other information, that would – I would point you to the MAC.

(Rusty Smith): Well, yes, so that was kind of what I was getting to is what – that was kind of at the heart of my question is, you know, how much of the documentation plus what's that you're providing therapy services? Are you going to want to see the therapy eval in order to show medical necessity?

Jeane Nitsch: I think that's partly for the home health agency to determine what is proving skilled need and if that's what you need to submit to show that this person has a skilled need then I would say, "Yes, submit that documentation." But whatever documentation you have that supports the Medicare criteria, that's what you would want to submit.

Jill Darling: Next question, please. Thank you.

Operator: Your next question comes from the line of (Andrew Kochie) from Home Care Association. Please, go ahead.

(Andrew Kochie): Hi. I'm with the Home Care Association and we would take issue that was then it was a benefit to home health agencies and we think that's requiring physician orders to be signed as part of the pre-claim requirement. It's really a hard burden for agencies. We have lots of problems getting all this despite your education efforts. The (physicians) many times don't cooperate. I don't think they have skin in the game, and right now, (it can take up) to a year to get a physician order and for a final and to build on a final claim.

So, making them to have get this physician order signed in time to submit a pre-claim review is a real hardship and has really caused a lot of problems in getting claim submitted that are successfully, you know, determined under the pre-claim. That's with my statements and then I had one of the – I had a question.

I was trying to compare the FAQs and I noticed that FAQ 7 was revised where originally it said, I think the pre-claim review had to be submitted within 30 days of the start of services, and I'm curious – that language was then changed then taken out. So, is that not the case anymore?

Jeane Nitsch: That's correct. The pre-claim review request can be submitted at any time once you have all the documentation you need to support medical necessity and some people were asking, "Well, I might have that before I submit the RAP, you know, can I submit a pre-claim review?" So, we wanted to make that clear that you can submit it at any time before the final claim.

(Andrew Kochie): OK. Thank you. And then one last comment again going back to the documentation, you know, we would hope that CMS has learned from the face-to-face requirements and the probe and educates activity that's going on right now. How hard is it for agencies to, you know, leave this face-to-face requirements and the fact that this now has to be met as part of the pre-claim requirements, again, we think is a very high, you know, burden for agencies. Thank you.

Jeane Nitsch: Thank you, (inaudible). So, I just want to say that, again, our documentation requirements have not changed. So, you would have needed that documentation for that claims previously as well. Next question?

Operator: Your next question comes from the line of (Maryann Lavere) from Absent Home Health. Go ahead.

(Maryann Lavere): Yes. Thank you for taking my call. My question is related to the actual review process. I was curious as to specifically for PGBA. How many reviewers are they planning on adding on and what are the qualifications going to be for these reviewers? Are they going to be licensed clinicians or

they are going to be just like high school graduates or – and is there a place where we can actually see what type of training they will have?

The reason why I'm asking this is because I realized that there can be some inconsistency and subjective opinions when doing a clinical review. And since it is in the Q&A that we have to submit the face-to-face with each episode and every third episode it's considered an initial episode, if we submit the face-to-face with the start of the care episode and it passes, there is a possibility that submitting that face-to-face with subsequent episodes within a given length of stay that that different reviewer could possibly have a different opinion.

So, that's my concern with submitting same information and that will be reviewed by two different people. Thank you.

Jeane Nitsch: Thank you for your comments. For the MACs, we modified the contracts and added money so that they would be able to hire the additional staff needed and have time to train those staffs to make sure that they're able to handle these additional reviews. So, we're confident that the MACs will be doing that. If you have specific questions about their training, I would suggest you refer those questions to the MAC.

And for the face-to-face requirement, we have put that out, I think, in a Q&A to show that if it's a second 60-day episode, an initial request for that episode but the continuation of home health services has not been broken, you can submit that first face-to-face encounter documentation. We'll make sure the MACs know that. So, thank you.

Operator: Your next question comes from the line of (Alice Pivaworski). Please go ahead.

(Alice Pivaworski): Hi. Actually, they did answer the question, but I'm going to add to it. The qualifications for the person you're going to be hiring, you said you're going to train them. Are there going to be clinicians in there? Will there be nurses or will they be people that have a high school diploma and you are going to show them what the should be doing and looking at?

Jeane Nitsch: I believe they're all nurses, but I can double check that. Yes. All the MAC reviewers are nurses.

(Alice Pivaworski): OK. That answers my question. Thank you.

Operator: Your next question comes from the line (Mary Kris). Please go ahead.

(Mary Kris): Yes. My question is when you're talking about Medicare PPS patients, are you talking primary and secondary patients who have Medicare PPS or just the primary Medicare PPS patients?

Jeane Nitsch: This is for Medicare fee for service.

(Mary Kris): Yes. Because some patients have – they have Medicare PPS as a secondary.

Jeane Nitsch: So, yes, you would have to submit a pre-claim review request ...

(Mary Kris): For both of them then, OK. Thank you.

Operator: Your next question comes from the line of (Victoria Vanuso). Please go ahead.

(Victoria Vanuso): Hi. This is (Victoria Vanuso). I'm representing (Rain Management, Argan) Home Healthcare. My question is we have these previous experiences before about having a hard time with our 485s, doctor orders, and physical therapy evaluation form, and we needed this doctors to sign them because, you know, we have – we were already given a deadline for submission.

And what happened is we have some doctors sometimes that they go on vacation. Let's say – I'll give you a scenario like if I admit the patient within like the first week of the month and suddenly this doctor goes on vacation the following week. And some – also the doctors actually that we deal with their – from – actually from Middle East or India and when they go on vacation they really take their time. They stay there for like weeks, like – it could be like from four weeks to five weeks.

And what happened then is if we cannot comply with the deadline that they're giving us because the doctor is away and no one can sign, you know, on his

behalf, what's going to happen then with our, you know, pre-claim review?
Are we going to be, you know, able to – as we're noncompliant because the
doctor is away, no one can sign for the documents?

Jeane Nitsch: Well, every doctor who goes away should be putting someone else in charge
of their patients. So, if they have assigned some other physician to cover their
service, that doctor should be able to sign the documentation needed.

(Victoria Vanuso): But the problem is that we are finding out that not a lot of doctors now are
being covered by someone else. They just, you know, they wait – we have to
wait for them. That's the previous experiences that we have had that, you
know, no one is able to sign for him. So – and because this other doctor
would give this reason, "Oh, I haven't seen that patient. I didn't do like first,
you know – I haven't evaluated the patient, so how can I sign your care plan?
How can I sign your documents when I don't know these patients?" And we
are already in our deadline for like submission. How are we going – or how
CMS is going to deal with us, you know, when it comes to those kinds of
situations?

Jeane Nitsch: Medicare requires for home health services that a patient be under the care of
a physician. That's the bottom line. You would need to make sure that all
patients are under the care of a physician.

(Victoria Vanuso): I know. But like what I said, the question is what if this physician
happens to be like on his way for vacation when we have admitted the patient?

Jeane Nitsch: That physician should have signed their patient over to some other physician.
The patient should always be under the care of a physician. I'm sorry I can't
give you a better answer than that.

(Victoria Vanuso): I know. Because what the other – what these doctors are telling is – OK.
Then there should someone who is covering because if what about if the
patient gets sick then the reception that's always given to us, "Well, if there's
something going on to the patient and I'm not around, you can send them to
the hospital. (There's a hospital there)." That has been now our experience.
You know, that's why now I don't know whether there are some other – some
other agencies can identify, you know, with us that most of these doctors are

doing that now. I mean they will not sign unless, you know, unless it is their own patients.

Jeane Nitsch: We'll just tell you as we go through the education of physicians we will keep your comments in mind, but you need to make sure that all patients are under a care of a physician. We will be putting some information on our Web site that can be used to get the physician to explain the pre-claim review demonstration and the requirements that they are under in providing the documentation needed. So, we will make sure we have that information. We need to go on to the next question.

Operator: Your next question comes from the line of (Kathy Beedy) from New Home Healthcare. Please go ahead.

(Kathy Beedy): Hi, yes. Actually, it was basically regarding the time plan of care that we also heard on the last call did not need to be signed. So, I guess my question is then what occurred since this last call for this to be changed because like the prior call we have the same scenarios, same situations of trying to get this signed. So, I guess, what occurred since that last call?

And also, in regard to the education of the physicians, we've been doing face-to-face for how long now and we still – it is an ongoing battle to educate them what's required in the face-to-face. So, how is this going to be different from that?

Jeane Nitsch: Let me just say I misspoke and that's why we clarified it at the start of this call that the care plan needs to be signed and dated by the physician. I would also point people to our Frequently Asked Questions. We've added one to the Frequently Asked Questions so people would have that information handy.

We, again, are – we are hearing your concerns about needing to educate physicians. It is a priority here that we want to make sure that we're rolling out this demonstration to the physician community as well. If you have suggestions on how we could better educate the physicians, please submit that to our e-mail box at [hhpreclaimdemo@cms.hhs.gov](mailto:hhpreamdemo@cms.hhs.gov) – let me try to have it right – [hhpreclaimdemo@cms.hhs.gov](mailto:hhpreamdemo@cms.hhs.gov). We'd love to hear your suggestions for educating physicians. Thank you.

Operator: Your next question comes from the line of (Alyana Rumble) from Anchor Home Health. Please go ahead.

(Alyana Rumble): Hi. Thank you for taking my question. I'm from Anchor Home Health. And my question was if we had other services, other skills to – after we get the pre-claim review back, let's say we add – we – the patient is not performing and we have to add more physical therapist visits, do we have to send another pre-claim review?

Jeane Nitsch: No. And we've actually addressed this in our FAQs number 41 that if additional services are added we're not asking for an additional pre-claim review, but absent any fraud or gaming, if we notice fraud or gaming, we will do reviews of those claims to make sure that that is not going on and make adjustments to the demonstration as need be.

(Alyana Rumble): Thank you very much.

Operator: Your next question comes from the line of (Boris Metlovski) from Well Care Health – Home Health. Please go ahead.

(Boris Metlovski): Hi. I have a question. In regard of requirements and if CMS does not have, as I understand, unified requirements to be submitted for the claim, how home health should determine on their own? Every one has his own judgment I understand. So, it's from objective point of view, we're moving to the subjective point of view of individuals.

Jeane Nitsch: Medicare criteria has not changed. So, whatever documentation you have that supports Medicare – the Medicare requirements - that need to submit.

(Boris Metlovski): I have this sense that requirements have not changed, but I would like to know if it's possible to create unified requirements?

Jeane Nitsch: Look at the MAC's Web site. They're going to be putting up a checklist of things that they would like to see submitted that will help you and guide you in your submission of documentation.

Male: And we also have another question. As far as (vis-a-vis the RAP), is there going to be an extension between, you know, the RAP and the final so that the RAP isn't pulled while we're in pre-claim review?

Jeane Nitsch: I'm sorry. I'm having trouble hearing you. Could you move closer to the mic?

Male: Right. So, the issue is from when the RAP there is a limited amount of time from the RAP is submitted until we have to submit the EOE, the final claim, right? Ninety days? Is there going to be an extension provided on that timeline to accommodate for this pre-claim review, which could take some time?

Jeane Nitsch: No. There isn't. No extension on the RAP. And since you brought up the RAP, the same process would occur. The RAP would be paid 60 percent upfront and then the rest would be with final claim.

Male: No. But it's auto-canceled after 90 days. So, my question is will that feature be deactivated while Medicare provide additional time to submit the EOE to accommodate for the time being taken by the pre-claim review before the RAP is auto-canceled and taken back?

Jeane Nitsch: No. The answer is no.

Operator: Your next question comes from the line of (Theresa Gates) from Beyond Home Health. Please go ahead.

(Theresa Gates): Hi. Thank you for taking my call. I just wanted to confirm in Florida at a minimum we're starting October 1st with pre-claim review. So, am I to understand that start of care's new home health admissions that start October 1st and on are subject to pre-claim review or these final claims after October 1st?

Jeane Nitsch: No. New episodes of care that would begin October 1st or after would need a pre-claim review.

(Theresa Gates): OK. And then my second question is in my history of getting ADRs from Palmetto, there may be one reason that we were denied. And when I send the second letter of reconsider – or the first letter of reconsideration that initial denial has now been approved but yet they find something else that wasn't found in the initial review. My question – my question to you about this in relation to pre-claim review is am I to be guaranteed that when we submit our pre-claim review that the entire requirements are reviewed and then when we are not affirmed that the entire list of non-affirmed documents are given to us so that I don't have to continue to re-send things?

Jeane Nitsch: We might need to check on the MAC on how they're going to want that documentation to come through, whether they want the entire package sent back through with the second pre-claim review request. We can check on that and we can post the FAQ to our Web site.

(Theresa Gates): I guess – well, just to clarify my question, if I submit – if I was denied because my homebound status, for example, was not sufficient and I then turn in the first letter of reconsideration for the homebound status. I was then given a denial letter for the face-to-face when I was under the impression when I sent in my ADR that all the record that I sent in was reviewed. But yet, now, I'm finding out I'm denied on something they could have reviewed the first go around.

So, my question about the pre-claim review is you have all these documents that are needed to justify medical necessity. I want to make sure that everything that's going to be looked at and affirmed or not affirmed is in one (inaudible).

Jeane Nitsch: When you get a non-affirm decision and you re-submit, you're going to need to re-submit the entire package so that everything comes in with that pre-claim review.

(Theresa Gates): I understand. So, if I receive a non-affirmed because my face-to-face didn't meet the requirement, am I to understand that everything else did meet the requirements?

- Jeane Nitsch: They'll be dictating in your decision letter what was missing from the documentation.
- Connie Leonard: It will be all inclusive. So, you're not going to get (inaudible) or face-to-face and then fix that and then get a denial for something else and then something else. When you get that first denial information, it shouldn't say denial. It will include everything that needs to be fixed so that you can fix it all and re-submit and get an affirmation.
- (Theresa Gates): OK. That answers my question because that's not how it works right now for ADR. So, I just want to confirm that that is going to be different for pre-claim review.
- Connie Leonard: It is going to be different, yes. And thank you for that comment. We'll take a look at that on the – on the pre-pay. Thank you.
- Operator: Your next question comes from the line of Nicole Daniels from St. Louis Home Care. Please go ahead.
- Nicole Daniels: Hi. I just want to clarify something that I think I heard early on. We are a provider based in Missouri. We provide services for patients who reside in Illinois. We do not submit to the Illinois MAC Palmetto. We submit to Cahaba. Will our patients that live in Illinois be a part of this initial pre-claim demonstration? Hello?
- Jeane Nitsch: Sorry. We were on mute.
- Nicole Daniels: OK.
- Jeane Nitsch: We are working with the other MACs and it is based on where the services provided, but I'm not sure Cahaba is part and I will double check that to make sure, but we are working with the additional MACs that do have some providers in those states. We know that there are – not just Palmetto working in Illinois.
- Female: And if she is not – but if their agency is not located in Illinois, they would not (inaudible). We'll make sure we get that question clarified in our Web site.

Nicole Daniels: OK. Thank you.

Operator: Your next question comes from the line of Elizabeth Buckley from Trinity Home Health. Please go ahead.

Elizabeth Buckley: Hi. I have a question about the re-submitting documents for a subsequent episode if we've already got a pre-claim authorization that's been affirmed for the first episode then re-submit that same documentation for the second episode. Are we put – can we be confident that that same documentation, face-to-face documentation especially, is going to work the second time if it worked the first time?

Jeane Nitsch: As long as you still continue to meet medical necessity, the documentation should work.

Elizabeth Buckley: Right. But I mean they won't deny it on face-to-face this time if they are non-affirmed for face-to-face the second episode if they've already affirmed the face-to-face for the first episode.

Jeane Nitsch: So I think we have a Q&A on that, but I will check that it talks about as long as there is no break in service to that – home health service to that patient then a second episode of care you could use that documentation from the face-to-face encounter.

Elizabeth Buckley: OK. And then to follow up on the RAP question that a gentleman had asked previously. So, there's no change in the status of the RAP being taken back if a final claim is not submitted within a certain length of time. So, if I get – if I submit everything for my pre-claim authorization and it gets the denial the first time and it's within, you know, say maybe 30 days, just because it gets the denial that first time they're not going to take the RAP out?

Jeane Nitsch: No. If you get a non-affirmed decision, no. It's based on the final claim. So, the same rules apply.

Elizabeth Buckley: OK. So, I could continue to re-submit and my RAP won't be taken back until we get to that time limit and I can't remember if its 90 days or 120 days, whatever it is. If we don't have – what is that?

Jeane Nitsch: I believe it might be 120.

Elizabeth Buckley: OK. So, still same rules, if I don't bill my final claim within that length of time, my RAP will be taken back, but it won't necessarily be taken back just because I get a non-affirmed decision.

Jeane Nitsch: Correct.

Elizabeth Buckley: OK.

Operator: Your next question comes from the line of (Deborah Perry). Please go ahead.

(Deborah Perry): Hi. Thank you very much for taking my call. I have a question about the plan of care. I don't mean to beat a dead horse, but you have said a few times that the coverage guidelines in the Medicare criteria has not been changed, but to require that the plan of care be signed by the physician for the pre-claim review does change the coverage deadline because currently our orders do not have to be signed until we submit the final claim. So, I'm a little bit confused about that.

Jeane Nitsch: Well, you have to be sure that the case is – the patient is under the care of the physician and the care plan has been shown to the physician and the physician agrees with that plan of care. So, in order to do that, having a signed dated plan of care would work to meet that requirement.

(Deborah Perry): Right. Then you just see how that does change the coverage guidelines because currently we have verbal (sort of) care. We communicate with the physician verbally. We get our orders. We create the plan of care and then we have until we submit the final claim to get that signed. We'd also have the face-to-face document, which is coordinating care to the physician and home health agency, which is directing our care as well. So, I mean, you can't see how that is really truly changing the coverage guideline to require us to have that signature prior to submitting the final claim and I do believe it ...

Yes. Go ahead.

Jeane Nitsch: We appreciate everyone's comments. There seems to be a lot of concern around the plan of care. We will take that back and give it more consideration. So, if we have any changes or updates, we will update our FAQs and make sure that that information is on there. But for right now, it's the signed dated plan of care.

(Deborah Perry): OK. Can I ask one more question? You know, for the pre-claimed review is submitted and change denied. I know that we have our limited ability to resubmit that. I'm curious though if the denial if the pre-claim review if there's going to be a denial percentage that factors into our overall denial rate and possible call an agency to be placed on targeted medical review based on this pre-claim review.

Jeane Nitsch: So, these are non-affirmed. They are not a claim denial.

(Deborah Perry): OK.

Jeane Nitsch: They won't be part of that percentage.

(Deborah Perry): OK. All right. Thank you very much.

Jill Darling: (Jessa), we'll take one more question please.

Operator: Certainly. Your next question comes from the line of (Evelyn Daniels). Please go ahead.

(Evelyn Daniels): Hi. I have a couple of comments. First of all, there has been a frequent reference to the fact that the beneficiary will not suffer. In most of the smaller agencies, the beneficiary will suffer because you don't necessarily have the funds to work – to send staff out if you're constantly waiting for an affirmed decision. In the past, we have those 30 days. We could work from the initial percentage that we received, 60/40 on the start of care and 50/50 on the (re-cert). Now, we don't have that.

My question is this. If in the past, we've had a whole year in which to bill, why is it all of a sudden we are now being penalized by having a shorter time for the affirmation to take place?

Jeane Nitsch: Let me correct something you said.

(Evelyn Daniels): OK.

Jeane Nitsch: You would still get your 60 percent. That hasn't changed. So, we need to submit your RAP. You're going to get your 60 percent. It's independent of the pre-claim review demonstration.

(Evelyn Daniels): That's not clear in the information. We would (need) that to be clarified.

Jeane Nitsch: Yes. I hope that eases your concern.

(Evelyn Daniels): I think that eases a lot of people's concern because I've been reading up on this and that's not clear. It is clear that you won't get it more than anything, but I like the idea that you have clarified that, and thank you very much.

Jeane Nitsch: OK. We will make sure that there's a Q&A making that very clear.

(Evelyn Daniels): Thank you.

Operator: I turn the call back over to the presenters.

Jeane Nitsch: I just want to thank everyone for participating in today's call. It was, again, a lot of great questions, a lot of great remarks. We do hear you. Again, please look to our Web site for any updates with additional Frequently Asked Questions. If you continue to have questions and you don't feel they're addressed, please send them in to our mailbox and that's hhpreclaimdemo@cms.hhs.gov. Again, be patient with us. We do have quite a few in there and we are working to get answers back to people. But again, as we see repeat questions, we're hoping to just add them to our Frequently Asked Question as well.

So, thanks, again, everyone for the call today.

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

END