

Centers for Medicare and Medicaid Services
Review Choice Demonstrations for Home Health Services
Special Open Door Forum
Moderator: Jill Darling
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1:30 p.m. ET

Operator: Good afternoon. My name is (Amy), 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 Review Choice Demonstrations for Home Health Services Special Open Door Forum.

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 to withdraw your question, please press the pound key. I would now like to turn the call over to Ms. Jill Darling. Please go ahead.

Jill Darling: Great. Thank you, (Amy). Good morning and good afternoon everyone. I am Jill Darling in the CMS Office of Communications. And thank you for joining us today for the Special Open Door Forum. And, as always, thank you for your patience at the beginning of the call as we try to get more folks in.

So, before we get into today's presentation, I 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 any enquiries, please contact CMS at press@cms.hhs.gov. And I will now hand the call off to Amy Cinquegrani.

Amy Cinquegrani: Thanks, Jill, and thanks to all of you for joining the call today. My name is Amy Cinquegrani, and I am the director for the Division of Payment Methods and Strategies in the Center for Program Integrity at CMS. I hope you found

the slides for our presentation. They went up on our website about an hour or so ago.

They are on the website listed on the open door forum announcement. But, if you need help finding the slides, I'll go ahead and give the website now. It's go.cms.gov/homehealthrcd. That's all one word – go.cms.gov/homehealthrcd. And the slides are the first document in the Downloads section at the bottom of the page.

On slide two, we have some acronyms that will be used in the presentation materials in case someone is not familiar with them. Probably everyone is familiar with the alphabet soup we use here at CMS.

Moving on to slide three. I hope you are all here to learn more about the new Review Choice Demonstration for Home Health Services. I do want to note the disclaimer that's on this slide. We are still pending our full Paperwork Reduction Act approval for this demonstration. And, so, some of the information and details are still subject to change.

But, we wanted to take the opportunity to provide an overview of the demonstration as it stands now and how we think we will implement the demonstration with Palmetto and especially to get your feedback and questions as we finalize some of these details and develop our supporting documents such as our frequently-asked questions and an operational guide.

We will provide more information on the Paperwork Reduction Act approval when it comes through, including any dates and how those dates will be affected by the approval. But, we did just want to let you know as we go through this presentation that some of these things are still in flux. But, we wanted to educate and hear from you and let you hear from us as we work through this process.

So, moving on to slide four. Based on previous experience in Medicare, the OIG, the GAO and MPAC have all noted that there is extensive evidence of fraud and abuse in the Medicare home health program, including in the

demonstration states. There is also evidence of improper payments that are not related to fraud in the demonstration states.

Insufficient documentation continues to be one of the major reasons for these improper payments despite a decrease in the improper payment rate. And the primary reason is that documentation to support certification of home health eligibility was not there or was insufficient.

So, to back up a little bit, CMS implemented a Pre-Claim Review Demonstration for Home Health Services in August of 2016 in Illinois, which was paused in April of 2017 and not expanded to the other demonstration states. We received a lot of feedback about the original demonstration.

And, so, over the past year or so, we have worked to make changes in order to address that feedback and, specifically, implement some of the suggestions in the feedback that we heard from stakeholders. So, we are excited about the new choice concept and some of the other changes that we have included.

And Jennifer McMullen will go into more details about those choices in a few slides. But, overall, CMS has revised the demonstration to offer more flexibility and choice for providers, as well as more risk-based changes to reward providers who show compliance with our home health policies.

And on slide five, the goal of the demonstration – we want to test improved methods for identifying, investigation and prosecuting Medicare fraud occurring in home health while maintaining quality of care provided to our beneficiaries.

On slide six, we have some information about who is involved in the demonstration and who has to participate. Home health agencies that operate in and render services to Medicare fee-for-service beneficiaries in Illinois, Ohio, North Carolina, Florida and Texas and submit claims to Palmetto GBA, the MAC in Jurisdiction M, are included in the demonstration.

So, if you're a home health provider that operates in one of those states but you submit your claims to a different MAC, you will not be part of this

demonstration. And CMS does have the option to expand the demonstration to other states in the Palmetto JM jurisdiction if there is increased evidence of fraud.

In the event that we do choose to expand beyond the initial five states, we'll certainly give plenty of notice. But, we will implement our first initial five states first.

Next, on slide seven, we have some information on the timing of the demonstration. As I mentioned before, we won't proceed until we have our full PRA approval. For Illinois, we are planning to begin on December 10. And that is our target date for providers to begin their choice selection. So, when we have our PRA approval, we'll announce that date that providers can begin that selection process and the date that reviews will start under the demonstration.

We want to make sure that providers have plenty of time to make their choice selection and that Palmetto has the time that they need to update their systems with the choice selections. So, we will push back our start date, if necessary, to ensure that there is ample time for everything to work smoothly. The demonstration will be phased into the other states with at least 60 days notice before implementing in that state, and it will run for five years.

Now, on slide eight, we have some information on the requirements for the home health benefit under Medicare. And as part of this demonstration, just like in any other medical review program, coverage requirements and documentation requirements are not changing. These are the regular home health payment policies that claims need to meet when being submitted for payment.

So, essentially, the beneficiary needs to be confined to the home, needs to be under the care of a physician, receiving services under a plan of care, be in need of skilled care and have a face-to-face encounter that meets our criteria for that. Again, these are the same home health policies as in any medical review that claims need to meet. And, now, to talk more about the demonstration process, I will turn the call over to Jennifer McMullen.

Jennifer McMullen: Thank you, Amy. I am now going to talk through a little bit about how the demonstration is going to work. On slide 10, we talk about the three initial choices a home health agency can make.

The first choice is pre-claim review of all claims that will follow the process implemented under the initial Pre-Claim Review Demonstration. However, it will allow for unlimited resubmissions of non-affirmed requests and will allow for multiple episodes to be requested on one pre-claim review request for a beneficiary.

The second choice is post-payment review of all claims with all the current post-payment medical review process. And this will be the default option if no selection is made for these initial choices.

For choice three, it will be a minimal review with a payment reduction. All home health claims will receive a 25-percent reduction. Claims will be excluded from MAC targeted probe and educate review but may be selected for Recovery Audit Contractor, RAC, review.

On slide 11, we begin to talk about the pre-claim review options. The home health agency or beneficiary will submit a request for pre-claim review. It may contain more than one episodes for a beneficiary. The MAC will then review the request and any supporting documentation, make a decision using existing applicable regulations, National Coverage Determination and Local Coverage Determination requirements and any other applicable CMS policies. The MAC will then send a decision letter provisionally affirming or not affirming the pre-claim review request.

On slide 12, we talk about the decision. A provisional affirmed decision means a claim will be paid as long as all other Medicare requirements are met. A non-affirmed decision means the request did not demonstrate Medicare home health coverage requirements were met.

If a pre-claim review request was non-affirmed, the submitter can resolve the non-affirmative reasons, which will be described in the letter, and resubmit

the pre-claim review request. They can resubmit an unlimited number of times prior to the submission of the claim for payment. Pre-claim review decisions cannot be appealed. The other option is a submitter can submit the claim, the claim will be denied and all appeal rights will be available.

On slide 13, we continue to talk about the pre-claim review option. A pre-claim review request may be submitted for more than one episode for a beneficiary as long as the documentation supports the need for multiple episodes. The pre-claim review decision can, justified by the beneficiary's condition, affirm some or all of the episodes requested.

For any additional provisionally affirmed episodes included in the request, a valid plan of care must be submitted prior to claim submission. And a pre-claim review request can be resubmitted for any additional episodes not provisionally affirmed prior to the episode's final claim being submitted for payment.

On slide 14, we talk about the requests. An initial request is the first pre-claim review request for any episode. The MAC will make every effort to review the request and postmark decision letters within 10 business days.

A resubmitted request is a request submitted with additional documentation after the initial pre-claim review request was non-affirmed. In this case, the MAC makes every effort to review the request and postmark the decision letter within 20 business days.

On slide 15, we talk about the decision letters. These letters will be sent to the home health agency and the beneficiary. 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 include detailed written explanation outlining which specific policy requirements were not met.

If a home health agency chooses choices option one pre-claim review and does not submit a pre-claim review request before submitting the final claim, the subsequent claim will be stopped for prepayment review. If the claim is

determined to be payable, it will be subject to a 25-percent payment reduction. The 25-percent payment reduction is non-transferable to the beneficiary and is not subject to appeal.

On slide 17, we talk about choice two, post-payment review. The home health agency will follow the standard intake, service and billing procedures, and the claims will pay according to normal claim processes. The MAC will conduct complex medical review on the claims submitted during a six-month interval.

The MAC will send the home health agency an Additional Documentation Request, or ADR, letter following receipt of the claim for payment. Home health agencies who do not select an initial choice will default to this option.

On slide 18, we talk about choice three, minimal review with a 25-percent payment reduction. The home health agency will follow the standard intake, service and billing procedures, and the claims will pay according to normal claim processes. Home health agencies will receive an automatic 25-percent reduction on all payable home health claims.

Claims falling under this choice will be excluded from regular MAC Targeted Probe and Educate TPE reviews but may be subject to potential RAC review. Any denied claims will retain all normal appeal rights. Home health agencies will remain in this option for the duration of the demonstration and will not have an opportunity to select a different choice later.

On slide 19, we talk about compliance. For choices one and two, an affirmation rate or claim approval rate will be calculated every six months. If the rate is 90 percent or greater based on a 10 request or claim minimum, home health agencies can select a subsequent review choice.

These review choices are pre-claim review, selective post-payment review or a spot check. Illinois home health agencies who participated in the initial pre-claim review demonstration and reached the 90-percent provisional full affirmation rate with a minimum of 10 requests can start the process with the subsequent review choices.

On slide 20, we talk about the selective post-payment review option. The home health agency will follow the standard intake, service and billing procedures, and the claims will pay according to normal claim processes. After six months, the MAC will select a statistically valid random sample for post-payment review.

The MAC will send the home health agency an ADR letter and follow CMS post-payment review procedures. The home health agency will stay in this option for the remainder of the demonstration and will not have an opportunity to select a different review choice later. And home health agencies who do not select a subsequent choice will default to this option.

On slide 21, we talk about the spot check review option. The home health agencies will follow the standard intake, service and billing procedures. The MAC will randomly select 5 percent of the submitted claims for pre-payment review every six months.

The home health agency may remain with this choice for the remainder of the demonstration as long as the spot check shows the home health agency is compliant with Medicare rules. If the home health agency is not in compliance, they must select again from one of the initial three review choices.

On slide 22, we talk about the choice selection procedure. Once the selection period begins in their state, home health agencies will have until two weeks prior to the start of the demonstration to select an initial review choice. Home health agencies will make their choice selection through the eServices online provider portal at www.palmettogba.com/eservices. And this link will be in the presentation slides as well. Illinois home health agencies who participated in the initial demonstration and reached the 90-percent provisional full affirmation rate with a minimum of 10 requests may select a subsequent review choice.

On slide 23, we have a flowchart of the demonstration process. On slide 24, we discuss what is not changing under this demonstration. Medicare coverage

policies will not be changing under the demonstration, and the demonstration does not create any new documentation requirement.

Home health agencies will still be able to submit their Request for Anticipated Payment, RAP, in the same manner and subject to the same rules as they currently would without the demonstration being in place. Also unchanged are all Advanced Beneficiary Notice policies, claim appeal rights, dual eligible coverage and private insurance coverage. Access to care and services should not be delayed for people with Medicare's home health benefit.

On slide 25, we talk about CMS oversight. CMS will regularly assess pre-claim affirmation and claim approval rates, will review a sample of MAC decisions to ensure review accuracy, and contract with an independent evaluator to review the demonstration.

On slide 26, we have places where more information can be found. Information, including the slides for today's presentation, can be found at the Review Choice Demonstration website. And, again, that website is go.cms.gov/homehealthrcd. Questions can be sent to the home health mailbox at homehealthrcd@cms.hhs.gov. And, again, that too is listed in the slide. And CMS and Palmetto will continue to provide educational opportunities. I will now turn the presentation back over to Jill for questions.

Jill Darling: Great. Thank you, Jennifer and Amy. Now, to our operator, (Amy), please open up the lines for Q&A, please.

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

Please limit your question 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 today comes from the line of Patrick Kennedy of UNC Health Care. Your line is open.

Patrick Kennedy: Yes. Thank you. Choice three mentions exclusion from the targeted probe and educate. Is that also the case with choice one and two?

Jennifer McMullen: This is Jennifer. Yes, they will also be excluded from targeted probe and educate.

Patrick Kennedy: OK. Thank you.

Operator: Your next question comes from the line of (Carrie Capilano) of Northwest Home Health. Your line is open.

(Carrie Capilano): Hi. Good afternoon. I am calling from an agency in Illinois and wondering when the letters from Palmetto will be mailed to the agencies so we know what our affirmation rate was for the first PCR.

Jennifer McMullen: They should be coming to you shortly. As Amy mentioned earlier, we are waiting on our final PRA approval before we can start sending them out. But, you should be getting them shortly.

(Carrie Capilano): So, we should expect to see them before December 10, I would think. Does that sound right?

Amy Cinquegrani:Hi. This is Amy. We will – we are hoping that you will see them December 10. In any event, we – you won't see the letters until after we have our PRA approval.

(Carrie Capilano): Yes.

Amy Cinquegrani:So, if we are able to get those letters out and we have approval before the December 10 timeframe that we're targeting, then that would be our preference. If it – if we don't have our approval in time to be able to send those letters prior to December 10, then we will adjust our timeframes from there.

(Carrie Capilano): Okey doke. Thank you.

Amy Cinquegrani:Sure.

Operator: Your next question comes from the line of (Jillian Gwen) of Quality Care Health. Your line is open.

(Jillian Gwen): Thank you. It's Comprehensive Quality Care. Thank you very much. My question is – I'm also from Illinois – is regarding the two-week prep time for the December 10. Will we get a notice because we are waiting on the PRA approval that may push that date back?

Amy Cinquegrani:Hi. This is Amy. Home health agencies won't get a specific letter mailed to them in the event that we push back the December 10 timeframe. We will update our website and Palmetto will update materials as well. So, the letter that will be coming specifically to the individual agencies will be when we have our PRA approval and when we are able to begin the choice selection process.

(Jillian Gwen): Thank you.

Amy Cinquegrani:Sure.

Operator: And, again, ladies and gentlemen, if you would like to ask a question, please go ahead and press star, then the number one on your telephone keypad.

Your next question comes from the line of Alicia Hipps of Home Health – sorry – Homecare Homebase. Your line is open. Caller, are you there? Your line is open.

Alicia Hipps: How long do they have to have for the letters to be reviewed or how far in advance will that be? In other words – I mean we're already like two weeks out right now and they haven't been sent out yet. So, to me, that would seem like maybe that's not enough notice. What – is there a – is there a set amount of time that you have to give for the letters to be reviewed?

Amy Cinquegrani:Hi. This is Amy. You are right. We are – there is not a lot of time before that December 10 timeframe. So, we are hoping to receive our PRA approval anytime now. And, then, we will proceed with sending the letters. So, that is

something that we are expecting that we can get started with in the next few days. If it seems like it's going beyond that timeframe, then we will likely need to adjust our targeted start date.

Alicia Hipps: OK. So, I can expect that something will be posted on your website probably by the end of the month if either that it's been approved or maybe that it's been delayed.

Amy Cinquegrani: Right. We will be giving a communication in we need to adjust our timeframe.

Alicia Hipps: OK. Thank you.

Operator: And your next question comes from the line of (Amy Blair) of Good Samaritan Society. Your line is open.

(Amy Blair): Yes. Hi. I'm curious if choice one, the pre-claim review, is chosen and we receive an affirmed decision – is there an expected turnaround time for payment on that?

Jennifer McMullen: The payment – if the decision is affirmed, then the payment will be following the normal payment procedures – so, whatever your normal timeframe is.

(Amy Blair): OK. Perfect. Thank you so much.

Jennifer McMullen: Yes.

Operator: Your next question comes from the line of (Tiffany Medina) of Quality Care Home Health. Your line is open.

(Tiffany Medina): Hi. Yes. Good afternoon. I have two questions. The first is in the initial three-choice selection, are we tied in to the choice that we make for the duration, or can we – can we change back and forth if we decide to? And what's the timeframe on that if it's allowed?

Jennifer McMullen: For choice one, pre-claim review, and choice two, post-payment review of all claims, you will be able to choose a different option. It will be on a six-month cycle. So, you can select another option after that six-month cycle. For choice three, minimal review with payment reduction – for that choice, if you select that one, you will be in that for the duration of the demonstration.

(Tiffany Medina): OK. Which is five years?

Jennifer McMullen: Yes.

(Tiffany Medina): OK. And, then, my second question is these letters with choice one and two – once we get an affirmed notice, would they be available via a portal of some sort or we are going to be expecting to get a letter in the mail?

Jennifer McMullen: For choice one, the pre-claim review, your decision letter will be sent back in the same method as you submitted the request in.

(Tiffany Medina): OK. And there will be a request option available to submit electronically?

Jennifer McMullen: Yes. You should be able to do that through the provider portal or through eSMD.

(Tiffany Medina): OK. Thank you.

Operator: Your next question comes from the line of Beverly Thompson of Wichita Home Health. Your line is open.

Beverly Thompson: Yes. My question is the five-year time period – is that one five-year time period for everything or is it sequential as you come on to the program?

Amy Cinquegrani: Hi. This is Amy. That's five years from the start of the demonstration in Illinois.

Beverly Thompson: OK. Thank you.

Amy Cinquegrani: Sure.

Operator: Your next question comes from the line of Eddie Muniz of Advantis Home Care. Your line is open.

Eddie Muniz: Yes. Hi, there. Good afternoon. I guess I have two questions. The first part I'd like to ask is in the MAC, who is it that will be reviewing these claims under the – I guess under choice one, when we send them in, who is it that's actually reviewing these? Are these nursing or administrative-type personnel at the – at the MACs?

Amy Cinquegrani:Hi. This is Amy. Palmetto will be using nurse reviewers for the requests and the post-payment reviews.

Eddie Muniz: OK. And the follow up to this is under choice one – and I know it says they'll try to answer within 10 business days – if the claim is not affirmed – or the pre-claim review is not affirmed and we're subject now to this reduction of payment, is it still the agency's responsibility to still continue providing service to a patient that wasn't affirmed for whatever the reason?

Because I'm sure there will be some disagreements here and I need to know what, is our responsibility; in a case where we're heading down the line 10, 15 days in and you basically told us, "Well, no, this is not affirmed episode." What is the agency's responsibility at that point?

Amy Cinquegrani:Hi. This is Amy. I'm not sure that I understood your question. So, the 10 days is for the initial pre-claim review decision. And, then, there is unlimited resubmissions if you feel that you're providing services that meet Medicare criteria. You can continue to resubmit if you think that you'll get to that affirmed decision. And Palmetto will be proactively reaching out to providers that have documentation errors to assist them with their documentation and encourage you to resubmit. But, you can then submit your claim if you would like and go through that pre-claim review process and follow up with an appeal, if necessary.

Eddie Muniz: I mean (inaudible) realize that you answered well with that. But, you know, this process could take time. If we – what is the agency's responsibility as far

as maintaining a patient if we say, well – you know, a couple of levels in and you're still saying it's not affirmed.

Again, you're putting us in a situation where we're disagreeing and we still have to maintain service and provider care into our cost. You know, there is a little bit of a – I'm a little unsure there as to what CMS is expecting from us at that point. Are you telling us it's not – I know that it's a little bit of an open-ended question?

You're basically telling us in that case, it's not an affirmed case. We have a disagreement. We provided care. So, is it – the determination is not an affirmed case even after a few resubmission – does that mean we discharge this case because – and we tell the patient they are not – their services are not covered? Is that what we do?

Amy Cinquegrani: If you feel that the services won't be – won't be covered by Medicare, you can let the patient if they want to continue receiving care. I think at that point, that's where the ABN would come into play. But, that is for services that won't be covered by Medicare.

Eddie Muniz: OK. If I – if I can add possibly one quick – is the – an affirmed episode or review is guarantee of payment after the – after the services have been provided?

Amy Cinquegrani: Yes. So long as the information on the claim matches what was in your pre-claim review request, then that – then that claim will be paid. If you submit your – if you follow up and submit a claim with a different information that was on your pre-claim review request, then that might cause some issues for the payment. But, it is – it is saying that that claim will be covered.

Eddie Muniz: Yes. So, subject to post-claim review or just a random spot check? Am I correct with that?

Amy Cinquegrani: You are asking if a claim that was submitted that had an affirmative pre-claim review decision is submit to a random spot check?

Eddie Muniz: Correct.

Amy Cinquegrani: Is that your question? No, it wouldn't be. Only if there is suspicion that there's some sort of gaming going on in your claim submission. But, it would not be part of any sort of random review.

Eddie Muniz: Thank you. And I apologize for the additional questions. Thank you for your – for your time.

Amy Cinquegrani: Thank you.

Operator: Your next question comes from the line of (Nica Ofrein) of World First Class. Your line is open.

(Nica Ofrein): Yes. Good afternoon. I'd like to know when, is Florida's turn. What date should we expect for Florida?

Amy Cinquegrani: Hi. We don't have a date for Florida. After we've implemented Illinois, then we will consider when to roll out Florida. And we will give at least 60 days notice.

(Nica Ofrein): Thank you.

Amy Cinquegrani: Sure.

Operator: Your next question comes from the line of (John Taylor) of Gateway Home Health. Your line is open.

(John Taylor): Hello. I'm sorry I got disconnected earlier so this may have been answered already. But, this is related to choice five. It's actually a two-part question. But, on choice five, if they are electing the spot check after the initial six-month review, you are saying that they are not found in compliance, then basically they go backwards.

Under that spot check, what is considered compliance? Is it the 90 percent or if they submit 100 episodes under that spot check or requested and only one of

100 – is that 90 percent or they're back into it or they ask for six – if they get one wrong, are they back into the pre-claim?

Jennifer McMullen: It will be the 90 percent of the 5 percent that are reviewed.

(John Taylor): OK. It will be 90 percent of the 5 percent for that one. OK.

Jennifer McMullen: Yes.

(John Taylor): And, then, my second-part question for you is going back to pre-claim on the first choice, the initial six months. I know that the pre-claim option is not subject to a TPE review after an affirmation is made. What other type of reviews are that – or is that episode susceptible to after affirmation of payment? Are there any other (inaudible) ...?

Jennifer McMullen: It would ...

(John Taylor): ... could request that episode for review?

Jennifer McMullen: It would be just like with any other claims (inaudible). It could be that UPIC review and it also could be part of a CERT statistics.

(John Taylor): OK.

Jennifer McMullen: It would not be part of just standard medical review.

(John Taylor): OK. So, basically, pretty much through any choice through the first portion of this is the remainder of the five years after six months. All claims are still subject to some type of review regardless of affirmation of payment. Would that be a correct statement?

Jennifer McMullen: I believe – are you asking if they will go through some type of (review), whether it's pre-claim or post-payment review?

(John Taylor): In addition. I'm asking is in addition to this program here regardless of affirmation of payment or election of what type of review you want, at any

time there could be some other Medicare contractor that could request that particular episode regardless.

Jennifer McMullen: There could be if there were signs of potential fraud of abuse. But, there wouldn't be just for general review.

(John Taylor): OK. Perfect. Thank you very much. You answered both my questions.

Operator: Your next question comes from the line of (Lorie Kale) of Quality in Real Time. Your line is open.

(Lorie Kale): Hi. I have a question regarding choice four. When you are talking about the statistically valid random sample. Will that – those claims be subject to – be it an extrapolation for all the claims in the period?

Jennifer McMullen: No, they won't.

(Lorie Kale): OK. And, then, I have a follow-up question. So, if an agency like in Illinois – if they pick choice four, will that go – will they start getting – let me see – will it result in a further six-month period from the start of the review claim? Does – or is it a determination of the total agency claims in the six months and then issuance of this statistically valid sample request in month seven? Like do they get the six months and then on month seven you're going to start doing the ADRs? Or is it starting right at the beginning if they choose choice four?

Jennifer McMullen: Palmetto, please correct me if this is – if I'm not explaining correctly. But, I believe this will be after the six-month period the ADRs will be sent.

(Lorie Kale): So, starting month seven is when they will start getting the ADRs?

Female: (Inaudible).

Female: Hi. This is (Inaudible). This is going to be Jason Rhodes with their medical review. He does the statistics. So, he is going to explain the way that that process is going to work.

(Lorie Kale): OK.

Jason Rhodes: So, that process will be based on the previous six months prior to the start date of RCD, meaning we will evaluate ...

(Lorie Kale): OK.

Jason Rhodes: ... the six months prior to starting and, then, use that sample size for what happens in the first six months of RCD.

(Lorie Kale): OK. So, it will start right away. OK. Thank you.

Operator: Your next question comes from the line of (Leila Brielo) of LHC Group. Your line is open.

(Leila Brielo): Hi. Good afternoon. We know that the demonstration will be phased into the other states with at least 60 days notice before implementation. Is that between each state will be the 60 days or do we know – can you indicate on how long the notice will be given between each state?

Amy Cinquegrani: Hi. This is Amy. Yes. It will be at least 60 days between each.

(Leila Brielo): OK. Thank you.

Operator: Your next question comes from the line of (Frances Alcasar) of Majestic Care Providers. Your line is open.

(Frances Alcasar): Hi. Thank you so much. I was wondering about patients that sometimes change agencies in the middle of all this excitement. So, I'm not really sure. Do we start the whole submission all over again if they were in the middle of an episode with another provider and the agency has been affirmed and they get out of the hospital and they select a different agency? Do we start that process all over again or does the affirmation follow them to the next agency? It's a little bit confusing for us here.

Jennifer McMullen: Sure. The affirmation does not follow the beneficiary. It would stay with the home health agency. So, you would need to send in the pre-claim review request for that beneficiary.

(Frances Alcasar): So, the review is really on the agency. It has nothing to do with the patient.
Right? The beneficiary has nothing to do with it.

Jennifer McMullen: it does follow the home health agency. Yes.

(Frances Alcasar): OK. All right. Got it. Thank you.

Operator: Your next question comes from the line of (Conrad Ginger) of Reliance Home Health. Your line is open.

(Conrad Ginger): Yes. Hi. So, if we received a letter from Palmetto GBA basically saying that we were excluded from medical review back in 2017, would we still be – how does that work for us? Would I have to call in to Palmetto and basically coordinate with them? Or – otherwise, is there any exemptions to the pre-claim?

Amy Cinquegrani: Hi. This is Amy. If you did not participate in the pre-claim review demonstration initially, then when you get your – a new letter from Palmetto offering a choice selection, you could then make that – make that selection then. There – it is possible that there could be some exemptions from the demonstration. And that would be based on written notice from CMS or Palmetto as well.

(Conrad Ginger): Thank you very much.

Amy Cinquegrani: Sure.

Operator: Your next question comes from the line of Michele Brooks of Advanced Home Care. Your line is open.

Michele Brooks: Hi. Thank you so much. I have a question regarding choice four on the subsequent review choice. It looks like from – if you choose this choice, you go through the first six months, you get a pass into choice four. You can choose that. Do you stay in that choice, then? Or if something happens with the random samples and there is an issue with that, can you get kicked back out of that back into the initial three choices? Just checking on that.

Jennifer McMullen: For choice four, you will remain (for) demonstration once you're in that one.

Michele Brooks: OK. Thank you so much. And just a follow up on that, is that – the statistically valid random sample after six months – my question with that is is that done on a monthly basis or is that going to be every six months throughout the remainder of the five years?

Jennifer McMullen: That should be every six months.

Michele Brooks: OK. Thank you so much. Have a great afternoon.

Operator: Your next question comes from the line of (Tiffany Medina) of Quality Home Health. Your line is open.

(Tiffany Medina): Hi. Yes. I had a question. In the first three choices, assuming that we went with choice number for the pre-claim review, sometimes we have patients that may have addendum or interim orders that bring about change in services or different types of service or frequency.

How does that work at the end when – if we would have gotten a letter affirming the pre-claim review with choice number one and then when we go to submit our final claim there is discrepancies, obviously, in maybe the services that we're submitting for payment in comparison to what we were initially approved for?

Amy Cinquegrani: Hi. This is Amy. We understand that there could be some changes and orders. And in those cases, it would be appropriate to submit those orders on the claim for payment. Palmetto, is there anything that you would add to that answer?

Tammy Tucci: Hi. Yes. This is Tammy Tucci, the manager of provider outreach and education with Palmetto. If they have not had a change as far as the OASIS, they haven't had to do a new OASIS, if they have additional services – say, for instance, maybe they had – a therapeutic got added.

(Tiffany Medina): Yes.

Tammy Tucci: That's perfectly fine for them to submit the claim with the (UTN) that was affirmed. But, when they go to do the next period, they do need to make sure they include the services that were added and the additional information and documentation that goes with them.

The only time that would be a problem is if they had submitted something on the claim or on the pre-claim review and that particular code got non-affirmed. Maybe it was a partial affirmation. Then you can't add something additional in the claim. But, this is something where they never have even asked for it. It was never turned down because they didn't even have the service orders. They don't have to do another PCR until it's time for the next period – benefit period.

(Tiffany Medina): OK. Thank you.

Operator: And, again, ladies and gentlemen, if you do have any more questions, please go ahead and press star, then the number one on your telephone keypad. Your next question comes from the line of (Robbins Devola) of Little Company. Your line is open.

(Robbins Devola):Hi. Can you clarify for me if Illinois will receive the 60 days notice as in other states? And if not, what is the logic behind that?

Amy Cinquegrani:Hi. This is Amy. We have given the December 10 targeted start date and we provided that with more than 60 days notice and have been providing outreach and education mostly through Palmetto since then. So, there won't be an additional 60-day period for Illinois.

(Robbins Devola):OK. Thanks.

Amy Cinquegrani:Yes.

Operator: Your next question will come from the line of Jean Walker of UnityPoint at Home. Your line is open.

Jean Walker: Good morning. We have an Illinois agency, but we do all our billing through CGS. And we've been on a pre-claim already. And I'm wondering who the contact is at CGS for this project.

Jennifer McMullen: If you do all of your – if you do all of your billing through CGS, then you will not be part of this demonstration.

Jean Walker: But, we were a part of the initial demonstration.

Jennifer McMullen: Yes. We have revised the demonstration to just include those who billed to Palmetto.

Jean Walker: So, if we bill to CGS, we will not be included in this demonstration? That's what they said the last time as well. And, then, we didn't get started and then we got kind of in a scramble. So, I just – will that be in the transcript saying that so we don't have to go back and correct like we did the last time?

Jennifer McMullen: Yes. That should be in the transcript and it should also be in our documentation on the website.

Jean Walker: Excellent. Thank you very much.

Operator: Your next question comes from the line of (Kristen Housen) of Centra Home Care. Your line is open.

(Kristen Housen): Hello. I just have a question about partial affirmation. I heard somebody say partial affirmation. And could you give an example of what a partial affirmation might be?

Jennifer McMullen: Sure. Partial affirmation would be where some of the services are affirmed but not all. If you included something for nursing services and therapy, the nursing services were affirmed but the therapy was not. So, that would be a partial affirmation because part of it was affirmed but not all.

(Kristen Housen): OK. Thank you.

Operator: Your next question comes from the line of (Vicky Rafhousen) of Access Technology. Your line is open. (Vicky), your line is open.

(Vicky Rafhousen): I have (inaudible) question to the partial affirmation. So, in your example, if we were to bill, were we – are we only allowed to bill just the affirmed in the (inaudible) items (on the RAP) on the final claim? Or if we do include non-affirmed visit items on the final claim, will the whole claim get denied or partially denied?

Female: Palmetto, would you like to answer that question about the claim?

Female: Hi. Yes. I believe the question was with regard to if – obviously, with pre-claim review, they are submitting their request in and there are individual HCPCS codes on the claim that are being requested for affirmation. And if you had some that were not affirmed and others that were affirmed, if that UTN comes in on the claim, it is – correct – there – the ones that should not be on there are going to edit out of the system not – they're still be not paid by the claim processing system because that UTN is not going to let it go through (down to the plan).

(Vicky Rafhousen): So, basically, we'll get the – our reimbursement will be reduced in that case?

Female: Yes. Those items will be not covered based off of the claim processing. But, because they had the UTN on the claim, for instance, you would be able to appeal if you – because you would have submitted the claim at that point. So, for those non-covered lines, if – you would only have the appeals process at that point to go through if you submitted them. We would much prefer that if you had a partially affirmed that you try to resubmit those services.

And, again, with regard to the resubmission process, that would be – you would be getting feedback. It's probably something where you just need additional documentation to be submitted. I would not automatically jump to assuming not that patient is not coverable under Medicare. It's simply look at the feedback that's being given with regard to the documentation.

(Vicky Rafhousen): Thank you.

Female: You're welcome.

Operator: Your next question comes from the line of (Leslie Rhodes) of Trilogy Home Health. Your line is open.

(Leslie Rhodes): Hi. I just have a question between the difference between choice one and choice two. I noticed on choice one there is a 25-percent payment reduction on all claims that could be payable. But, on choice two, if we get the automatic ADR, then we do not get a 25-percent reduction. Is that correct?

Jennifer McMullen: Are you talking about choice one or choice three?

(Leslie Rhodes): Choice one. On choice one, it does say a 25-percent reduction ...

Jennifer McMullen: Yes.

(Leslie Rhodes): ... for pre-claims reviews. But, on choice two ...

Jennifer McMullen: This is ...

(Leslie Rhodes): Go ahead.

Jennifer McMullen: I apologize. For choice one, the 25-percent reduction is only if you choose choice one – so, you choose the pre-claim review option but you submit a claim without having first submitted a request for that claim. Then it will be subject to 25-percent reduction. If you submit a pre-claim review request first and get your decision before you submit the claim, it won't have the 25-percent reduction.

(Leslie Rhodes): OK. Thank you.

Jennifer McMullen: You're welcome.

Operator: Your next question comes from the line of (Lorie Kale) of Quality in Real Time. Your line is open.

(Lorie Kale): Hi. I do have a question on is the approval rate for choice two based on fully-paid claims or is it on the charge denial rate? Hello.

Jennifer McMullen: Palmetto, would you like to explain that part?

Tammy Tucci: Yes. Hi. This is Tammy Tucci again. And it's based on the charge denial rate.

(Lorie Kale): OK. So, partially denied claims are going to be counted against the approval rate?

Tammy Tucci: Yes, ma'am. That is correct.

(Lorie Kale): OK. And I have a follow-up question. I do – I was just wondering when are you guys going to update the frequently-asked questions on the websites?

Tammy Tucci: We will – once the approval has come through and CMS will notify us – and then we'll be able to post all of the frequently-asked questions onto the website.

(Lorie Kale): OK. Thank you.

Operator: And your next question comes from the line of (Stephanie Burton) of Blessing Home Care. Your line is open.

(Stephanie Burton): My question is for Palmetto. I checked last Friday and I didn't see the RCD in the e-service. Do you know when that's going to be updated?

Tammy Tucci: This is Tammy Tucci with Palmetto. And you are talking about the tab which would be visible in eServices. And you're correct. Once we get the approval, that tab will appear to your administrator. Now, that's important. You may see the tab and it may be grayed out for you if your eServices administrator doesn't grant you as the user the option to have access to that tab. But, you are right. You are not able to see that at this time. It will be available once at start.

(Stephanie Burton): OK. Thank you.

Tammy Tucci: Sure.

Operator: And your next question comes from the line of (Vicky Rafhousen) of Access Technology. Your line is open.

(Vicky Rafhousen): Hello. I have a question regarding the – sending the PCR documents through mail or fax. Do we have any guidance or templates on how those documents should look like specifically covering the cover letter which we need to send additional to the actual documents?

Jennifer McMullen: Palmetto, would you like to answer this one?

Tammy Tucci: Yes. We will have – with regard to if you're submitting it in to us in that method, we will have out there the cover sheet that have the separator pages that will go in front of the documentation to sort of prompt you. Of course, our preferred methodology for submission would be through the eServices portal. It walks you through the different pieces that we need. But, if you are sending it in that way, we are going to have the cover sheet and the Web form and the separator pages for you to use to prompt you as well.

(Vicky Rafhousen): All right. And that sounds great. One more question is that what – when we send the document to ESMD, what – how does the document look like then? Would we still need to have a cover letter similar to the fax and mail as well?

Tammy Tucci: Yes, sir. You can use that for all of those methods of submission. You can utilize the form as well as the separator pages when you send it through ESMD. And that will be very beneficial to us for your submission.

(Vicky Rafhousen): And one more question. On the ESMD – on the eServices portal, you noted the fact that whenever you have a question (inaudible) and all that, you attach a document. And in – when we're doing the letter and – a letter or the fax method, we don't have that capability. So, would you – would we have to just attach the documents or do we have to specify where the information is located in the document?

Tammy Tucci: That's – the separator pages that are included with that form are sort of what take the place of those steps that are in eServices. So, for instance, it will have a separate page that says "Plan of Care" in there to prompt you to make sure that you've included that with your documentation.

(Vicky Rafhousen): Yes.

Tammy Tucci: If – in eServices, if you have your documentation, you can submit it to us and upload it individually as an attachment. Or, if you have it as one attachment, that's OK as well in eServices. We'll take it and you can put it at the first prompt for an attachment.

And, then, at each additional prompt, you can just refer back to that initial attachment. And that was – that was actually an improvement at the request of providers when we went through pre-claim review to make it simpler for you. So, if you have your documentation in one large document, that's OK as well and you can do that.

(Vicky Rafhousen): Thank you.

Tammy Tucci: You're welcome.

Operator: Your next question comes from the line of Eddie Muniz of Advantis Home Care. Your line is open.

Eddie Muniz: Yes. Hi, there. I'm a little bit concerned about these timeframes with the initial and the subsequent request. I understand there's probably going to be a documentation issued especially at first. You know, we are trying to take these post-acute care type cases, provide them with the appropriate levels of care and discharge them to the community in as short a timeframe as possible.

And you guys are telling us 10 days maybe for the first round and then 20 days maybe for the next round. I mean, we're all for this – the pre-claim review process. But, I feel like it's the provider that's kind of be hung out here a little bit while we're doing our work and just kind of sitting on these timeframes.

And I'm even concerned about the 10 and the 20-day being realistic with the amount of volume that you guys are probably going to expect at first. I mean I'm not asking for a definitive answer here of any kind. But, I'm asking for a little feedback as to how you see this.

Amy Cinquegrani: Hi. This is Amy. And that's great feedback. And we understand the concern. We are confident that the 10- and 20-day timeframes will be met by the contractor. We are confident that volume is not a concern and that they will be appropriately staffed for the states in question when we – when we roll out.

Eddie Muniz: OK. I appreciate that. And just kind of following up, is there going to be – I understand there's going to be clinical analysis of these cases for authorization or not. But, is there a certain type of protocol that's going to be followed? Or are we going to fall into a process of a little bit of a – you know, the trivial or depends who sees the case may see it different than someone else.

And if the cases – (that you do have to have some protocol), providers are going to be (inaudible) to this to understand – you know, I mean (we've been doing) home care for a long time. It's not that we don't understand. But, we want to know what you guys are looking for. You know, a lot of times, things get – are subject interpretation, especially clinical when you are reading a written documentation from one nurse to the other. I hope you understand the question. And you probably do.

Amy Cinquegrani: Yes. Thank you for that. We do understand that concern. And Palmetto has implemented comprehensive training for the nurse reviewers and they go through interrater reliability as part of that training. And, so, we are hopeful that we will not get into differences between reviewers. All policies are available for all providers to follow. And those are the same things that Palmetto will use when they are reviewing as well.

There are templates available that help providers if they choose to use them. And as the folks from Palmetto were saying earlier, their eServices portal pretty much walks you through, you know, what documentation to submit to try to reduce any of those documentation issues. And in addition to that, CMS will be providing oversight of those decisions. And, so, we are confident that

we won't get into some of those issues that you mentioned. So, we appreciate that concern.

Eddie Muniz: All right. Thank you. And I appreciate you understanding the concern and being aware of them. Thank you very much.

Operator: Your next question comes from the line of (Frances Alcasar) of Majestic Care Provider. Your line is open.

(Frances Alcasar): Hi. Another caller earlier mentioned something about ESMD. We're having a little bit of difficulty trying to set up with that service to submit paperwork. Do you happen to have a phone number or a contact that you can give me?

Amy Cinquegrani: Hi. This is Amy. If you want to send an email to our Home Health RCD mailbox – that's homehealthrhd@cms.hhs.gov – and just make sure you put "ESMD" in that subject heading, we can route it to the correct folks.

(Frances Alcasar): I appreciate it. Thank you.

Amy Cinquegrani: Thanks.

Operator: Your next question comes from the line of (Elaine McCollum) of Community Therapy. Your line is open.

(Elaine McCollum): Hi. I was just wondering how this will affect when they change the episodes to the 30-day period. Are you going to have to request a pre-claim review every 30 days?

Jennifer McMullen: As part of the revised demonstration, we do allow for more than one episode to be requested on one pre-claim review request. So, if the documentation shows that the beneficiary would need multiple episodes, you can send it one request with those multiple episodes. But, we will also be making sure that the demonstration will work with all the new changes and requirements that are coming up.

(Elaine McCollum): OK. Thank you.

Operator: Your next question comes from the line of (Jillian Gwen) of Quality Care Health. Your line is open.

(Jillian Gwen): Hi. Thank you. I had a follow up regarding the comprehensive training for the nurses. I was wondering (inaudible). Is there a website that we can lead us to that we can review and just kind of hone in on some of the documentation (scale) to be proactive?

Amy Cinquegrani: Hi. The home health policies are available on the Medicare Coverage Database. And as well as I'm sure, Palmetto, you have links to the coverage requirements on your website as well. Is that something you want to speak to? And any templates you have?

Tammy Tucci: We do have the regulations out there. And as CMS mentioned, the coverage regulations aren't changing with regard to this. So, our nurse are still being taught on all of the regulations that are outlined in the code, the federal regulations and the Internet-only manual with CMS. And she is correct about the Local Coverage Determinations that are posted on our website. But we will have all the same regulations that we've had previously. And that is what they will be using to review these claims.

(Jillian Gwen): Thank you.

Operator: Your next question comes from the line of Norma Figueroa of American Home Care. Your line is open.

Norma Figueroa: Yes. Hi, there. We have a quick question. Would there be training to be conducted to the physicians or with the medical groups in regards to the demo – this demonstration?

Jennifer McMullen: We do have a letter that will be going to the physician to explain the demonstration and have the (inaudible) with their role in it will be to – so, there will be that training provided.

Norma Figueroa: OK. Thank you.

Operator: And your next question comes from the line of Eddie Muniz of Advantis Home Care. Your line is open.

Eddie Muniz: I hope I'm not reaching my quota, but I've got to ask the question. Is there any other than before the claim is sent in, is there a timeframe as to when the pre-claim review can be requested from the – from the start of care, I guess.

Jennifer McMullen: It can be requested at any time you feel you have all your documentation up until that claim is submitted. So, there is – there is no timeframe there.

Eddie Muniz: OK. All right. Thank you.

Operator: Your next question comes from the line of (Vicky Rafhousen) of Access Technology. Your line is open.

(Vicky Rafhousen): Hi. I have one more question. So, what is the benefit of doing a pre-claim review versus post-claim review?

Jennifer McMullen: The advance is, for pre-claim review, if you receive a non-affirmed decision, you will have the opportunity to fix whatever documentation errors or whatever issues there are and then resubmit again and ask for a decision for sending in your claim. For the post-payment review, if your claim is denied, you'd have to go through the appeal process. So, it just makes it a little bit easier.

(Vicky Rafhousen): But, for an organization that is confident about their processes and the documentation and then they wouldn't have to really worry about their criteria not meeting and so on – so, wouldn't it be beneficial to just go with the post-claim review at that point?

Jennifer McMullen: It may be for your home health agency. We provided flexible – flexibility by different options to choose for home health agencies which one they thought would be best for them based on their resources and their claims and things. So, you definitely have that option.

(Vicky Rafhousen): OK. Thank you.

Operator: And your next question comes from the line of Deb Louchart of Five Points Healthcare. Your line is open.

Deb Louchart: Hi. To follow up on Mr. Muniz' last question, are you saying that we have to choose the option, choice one, two or three, with every claim that is submitted? Or we initially make an option of choice one, two or three and, then, we stick with that either for six months or throughout the demonstration project?

Jennifer McMullen: You would make that choice at the beginning of the six months for options one or two. And, then, with the – in those two options for the whole of the six months. For option three, you would take one and then stay for the demonstration – duration of the demonstration. But, you would not have to choose it for each claim. It would just be one choice for each cycle.

Deb Louchart: OK. So, if you chose option – or choice one or choice two, which can be changed every six months, do you have to resubmit that option choice in every six months? Or is that choice carried out throughout the demonstration project as long as that is what the provider wants?

Jennifer McMullen: No. Each six months, you would need to go back into the selection portal and just – and reselect that option.

Deb Louchart: OK. Thank you.

Operator: Your next question comes from the line of (Nathan Johnson) of RHS Home Health. Your line is open.

(Nathan Johnson): Hi. Yes. My question is for choice five with the – essentially the spot check, I just wanted to clarify the episode dates that would be a part of that spot check and generally the timing that those would begin. So, if it's a – if it's 5 percent over a six-month period, is that for claims with start of episode dates after the RCD start or December 10, whatever that is?

And do those – are those triggered – is that 5 percent triggered based on the first claims during RCB? And is that triggered by the final bill that will start

compiling those? And I guess, finally, do – are those grouped into kind of an ADR package with the number of claims that would equal that 5-percent sample? And are they all do it the same time or is it spread out?

Jennifer McMullen: Palmetto, could you please provide a response?

Jason Rhodes: All right. This is Jason with Palmetto. Just kind of a long question, so I think I'll hit – try to hit all the points at once (inaudible). The first question about the data service, it will be episodes that start on or after the implementation of RCD for that state.

You asked about the packet. No, these are triggered randomly. So, we looked at the previous six months prior to you going into this option and we do a percentage based upon that billing pattern for those six months. We use that to put into shared systems to grab claims at random and each one will get an ADR much like the normal medical review process that we have in place now. But if you have that, whatever your 5 percent total is for your (agency).

(Nathan Johnson): So, the claims would be captured at random. And I'm assuming that's based on the final bill.

Jason Rhodes: Correct.

(Nathan Johnson): OK. And we'd be submitting a normal-sized kind of ADR response with complete documentation for the chart. And, then, those – we'd be getting those just throughout the first six-month period or is it – and, then, the results are analyzed at that sixth month? And when do we get a report on our compliance rate at the – you know, at that point? Is that month seven, month eight, or what does that feedback process look like?

Jason Rhodes: Well, due to the timeline it takes for an ADR to develop, get to the provider and provider to respond and then for the review option to happen, it won't be throughout the entire six months. We will try to condense that down to the first four months of the six-month period to give time for response and for a review decision to be made.

And, then, in the seventh month, all of that information will be shipped back to the provider to give them (inaudible) other information, any applicable denials, how to avoid all the education material that comes with the general ADR package results.

(Nathan Johnson): And, then, at that seven-month mark – is that when essentially you may have to – if you aren't meeting that 90-percent compliance, would it be at that moment that you would have to make – you would have to go into the full pre-claim? Or would that – would there some other period of time or is that, you know, (inaudible)?

Jason Rhodes: Sorry. There's a little background noise. So, (inaudible) you were not able to reach the 90-percent affirmation rate. And, then, we'll give you the options to log back in to the portal and make another selection for the next six months.

(Nathan Johnson): OK. And then, finally, the last – and that's very helpful and that definitely clarified all that info. The last question – or just more comment that I had – you know, we're an agency in Illinois and went through a pre-claim a year and a half ago – two years ago.

I think it would be helpful if – a few other people mentioned education or some clarity on what are reviewers truly trying to focus on, what does CMS – you know, what is their overall goal? Are there education materials to support that so you could proactively educate your clinical management team, your orders face-to-face review team et cetera, et cetera?

Is there a kind of a logic path or a decision tree type document that would show the process that reviewers are using so that we can understand how as an agency to kind of do pre-bill audit pre – you know, essentially review choice audit so that we feel confident in what we're submitting?

I know most providers feel very confident in this industry. It's just a matter of the technicality here. So, if there are workflow or decision tree documents for affirmation versus denial, not just the Medicare policy that's hundreds of pages long that would be very helpful.

Tammy Tucci: This is Tammy Tucci with Provider Outreach and Education. And we agree. I can tell you that that's what we did with the eServices portal. That is a decision tree. And it's actually based off of the medical review checklist that we use when we review any home health claim. So, it will set you through and it will literally not allow you to submit without giving some information that is needed in that checklist because it lets you know that without that, we wouldn't be able to affirm it.

But, we will also have some very focused education from a clinical who is in MAC Provider Outreach and Education who will be going around doing education that's focused on the clinician. So, I promise you and make a commitment to you that we will have that.

And for the person who asked about the physician training, we also will be – we have already reached out to partner with the AB MACs in which we are not an AB MAC – the AB MAC in that state for those states that are going to be part of this demonstration. And we've reached out in our partner group to make sure that we do get education focused on the physician because we understand that it's a pain point, a concern that you guys have. And we found that that was very effective in the state of Illinois when we did PCR. It was – it proved to be beneficial. So, we will be continuing to do that.

(Nathan Johnson): Thank you.

Tammy Tucci: You're welcome.

Operator: And your next question comes from the line of (Sherry Quitario) of Nursing Plus. Your line is open.

(Sherry Quitario): Can you tell me how is this going to work with the PDGM if it's going to be going to a 30-day billing period?

Amy Cinquegrani: Hi. This is Amy. I'll take that, Jennifer. I think Jennifer mentioned earlier that with the 30-day billing period that will – obviously, that – you will need to submit your claim every 30 days. So, there will be – needing to be a pre-claim review request for every 30 days. But, we have made the change in this

demonstration to allow for multiple-episode requests if the – if the beneficiary needs multiple episodes. So, you will be able to request more than one in the information that's submitted.

(Sherry Quitario): Right. But, in episode, it is 60 days. And that's where it is a little confusing. With the 60-day episode, are you saying you can request for more than one 60-day episode? Are you saying we can request for more than a 30-day period of time?

Amy Cinquegrani: You can request for more than one episode of care.

(Sherry Quitario): OK. Thank you.

Amy Cinquegrani: Yes.

Operator: Your next question comes from the line of (Beth Whitney) of Trilogy Home Health. Your line is open.

(Beth Whitney): Hi. I'm actually questioning choice number two. If we chose to do the post-payment review, would that be subject to all claims that we submit or would it just be a random selection of whatever you guys chose?

Jennifer McMullen: For choice two, that would be for all claims submitted.

(Beth Whitney): OK. So, if we did that on all claims, would we lose the appeal right that we currently have when we receive ADRs?

Jennifer McMullen: No. There will be no changes to appeal rights. So, you'll still have the same appeal rights.

(Beth Whitney): OK. So, basically, if we do choice number two, it's exactly like we are doing now, just all of our claims instead of the few that we may get are going to be ADR. But, we won't lose any appeal rights. Now, does that still include the ALJ?

Jennifer McMullen: It will be the same process as now for appeals. We aren't making any changes at any level.

(Beth Whitney): OK. That's all I needed. Thank you.

Operator: And at this time, there are no – sorry. We do have one other question from the line of (Chinwe Oziratkyo) of Miranda Home Health. Your line is open.

(Chinwe Oziratkyo): Hi. Yes. I just wanted to reaffirm. You're saying that it's the letter for – the letter to affirm our rates if not in by December or before that time, the pre-claim will probably be extended due to the fact that we don't know our rate in order to choose the selections like if the pre-claim choice one, two, possible three being the fact that we need to our affirm rate in order to have a selection?

Amy Cinquegrani:Hi. Yes. That's correct.

(Chinwe Oziratkyo): OK. Thank you.

Amy Cinquegrani:Yes.

Operator: Your next question comes from the line of Jean Walker of UnityPoint at Home. Your line is open. Jean Walker, your line is open.

Jean Walker: Excellent. Thank you. I asked the question, but I just – I've been asked to ask another question. And that is is the agency in Illinois that bills to CGS – is that a change in your practice that you have to be billing in Palmetto and be in Illinois? Is that a change from your first demonstration project?

Amy Cinquegrani:Hi. Yes. This is Amy. That is one of the major changes that we have made from the original pre-claim review demonstration, which included all MACs that have providers in the demonstrate states. In this new demonstration, it is only for those providers – those home health agencies that bill to Palmetto.

Jean Walker: Thank you very much. I appreciate the clarification.

Amy Cinquegrani:Sure.

Jill Darling: (Amy), we'll take on more question, please.

Operator: Your last question today comes from the line of (Lorie Kale) of Quality in Real Time. Your line is open.

(Lorie Kale): Hi. Once initial choice two is made, will there be any need to obtain a UTN for these claims to like prevent or set them aside from 25-percent payment reduction? Or will all that information that you need be on the demand letter?

Jennifer McMullen: There will not be a UTN for this option. It will follow the standard post-payment review procedures that are currently in place for other medical review.

(Lorie Kale): OK. So, all of that information that you need to appeal the claim will be on the demand letter?

Jennifer McMullen: It should be. Yes.

(Lorie Kale): OK. Thank you.

Operator: And I'll now turn the call back to the presenters.

Jill Darling: All right. Thanks, (Amy). Thanks, everyone, for joining today's Special Open Door Forum. A lot of great questions. And if you would like to send in a question if you were not able to get in the queue, it's homehealthrcd@cms.hhs.gov. Thanks, everyone. Have a great day.

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

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