Review Choice Demonstration for Home Health Services

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• ABN: Advanced Beneficiary Notice
• ADR: Additional Documentation Request
• HHA: Home Health Agency
• MAC: Medicare Administrative Contractor
• PCR: Pre-Claim Review
• RAC: Recovery Audit Contractor
• RAP: Request for Anticipated Payment
• SVRS: Statistically Valid Random Sample
• TPE: Targeted Probe and Educate
To invite home health agencies and Medicare practitioners to discuss the Review Choice Demonstration (RCD) for Home Health Services

**Disclaimer: The information provided in this presentation reflects current understanding of how CMS and Palmetto GBA expect to implement the demonstration, pending full Paperwork Reduction Act approval.**
Why is CMS Conducting this Demonstration?

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

• Insufficient documentation for home health claims continues to be prevalent, despite a decrease in the improper payment rate. The primary reason for these errors was that documentation to support certification of home health eligibility requirements was missing or insufficient.

• CMS implemented a Pre-Claim Review Demonstration for Home Health Services in Illinois on August 3, 2016, which was paused April 1, 2017 and was not expanded to other states.

• CMS has revised the demonstration to offer more flexibility and choice for providers, as well as risk-based changes to reward providers who show compliance with Medicare home health policies.
What is the Goal of this Demonstration?

This demonstration will:

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

- Home Health Agencies (HHAs) who:
  - 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 Medicare Administrative Contractor (MAC) in Jurisdiction M
  - CMS has the option to expand the demonstration to other states in the Palmetto/JM Jurisdiction if there is increased evidence of fraud.
When Does the Demonstration Begin?

- Targeted start dates:
  - Illinois – No earlier than December 10, 2018
  - Demonstration will be phased into the other states with at least 60 days’ notice before implementation

- Duration: Five years
What are the Requirements for the Medicare Home Health Benefit?

• Be confined to the home at the time of services;

• Under the care of a physician;

• Receiving services under a plan of care established and periodically reviewed by a physician;

• Be in need of skilled services;

• Have a face-to-face encounter with an allowed provider type as mandated by the Affordable Care Act. This encounter must:
  • occur no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care; and
  • be related to the primary reason the patient requires home health services and was performed by a physician or non-physician practitioner.
The Review Choice Demonstration Process
How Does the Demonstration Work?

- HHAs can choose between three initial choices:
  - Choice I:
    - Pre-claim review of all claims
    - Follows process implemented under the initial Pre-Claim Review Demonstration
    - Allows unlimited resubmissions of non-affirmed requests
    - Allows for multiple episodes to be requested on one pre-claim review request for a beneficiary
  - Choice II:
    - Postpayment review of all claims
    - Follows current postpayment medical review processes
    - Default option if no selection made
  - Choice III:
    - Minimal review with payment reduction
    - All home health claims receive a 25% payment reduction
    - Claims are excluded from MAC targeted probe and educate review, but may be selected for Recovery Audit Contractor (RAC) review
Choice I: Pre-Claim Review

- The HHA (or beneficiary) will submit a request for pre-claim review
  - May contain more than one episode for a beneficiary

- The MAC will:
  - Review the request and supporting documentation,
  - Make a decision using existing applicable regulations, National Coverage Determination and Local Coverage Determination requirements, and other CMS policies, and
  - Send back a decision letter provisionally affirming or non-affirming the pre-claim review request
Choice I: Pre-Claim Review

- A provisional affirmed decision- the claim will be paid as long as all other Medicare requirements are met

- A non-affirmed decision- the request did not demonstrate Medicare home health coverage requirements were met

- If a pre-claim review request is non-affirmed:
  1. The submitter can resolve the non-affirmative reasons described in the decision letter and resubmit the pre-claim review request
     - Unlimited resubmissions are allowed prior to the submission of the claim
     - Pre-claim review decisions cannot be appealed
   or
  2. The submitter can submit the claim:
     - The claim will be denied
     - All appeal rights are available
Choice I: Pre-Claim Review

- 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.

- 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.
Choice I: Pre-Claim Review

Initial Requests

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

Resubmitted Requests

• The request submitted with additional documentation after the initial pre-claim review request was non-affirmed
• The MAC makes every effort to review the request and postmark decision letters within 20 business days
Choice I: Pre-Claim Review

• Decision letters are sent to the:
  - Home Health Agency
  - The beneficiary

• Decision letters include the pre-claim review Unique Tracking Number (UTN) that must be submitted on the claim

• Decision letters that do not affirm the pre-claim review request will:
  - Provide a detailed written explanation outlining which specific policy requirement(s) was/were not met
Choice I: Pre-Claim Review

If a HHA chooses choice I: Pre-Claim Review and does not submit a pre-claim review request before submitting the final claim:

1. The subsequent claim will be stopped for prepayment review

2. If the claim is determined to be payable, it will be subject to a 25% payment reduction
   - The 25% payment reduction is non-transferable to the beneficiary
   - The 25% payment reduction is not subject to appeal
Choice II: Postpayment Review

- The HHA 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 6-month interval.

- The MAC will send the HHA an Additional Documentation Request (ADR) letter following receipt of the claim for payment.

- HHAs who do not select an initial choice will default to this option.
Choice III: Minimal Review with 25% Payment Reduction

• The HHA will follow the standard intake, service, and billing procedures, and the claims will pay according to normal claim processes.

• HHAs will receive an automatic 25% 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.

• HHAs will remain in this option for the duration of the demonstration and will not have an opportunity to select a different choice later.
Compliance with Pre-Claim and Postpayment Review

- For choices I and II, an affirmation rate/claim approval rate will be calculated every 6 months.

- If the rate is 90% or greater (based on a 10 request/claim minimum), HHAs can select a subsequent review choice:
  - Pre-Claim Review
  - Selective Postpayment Review
  - Spot Check

- IL HHAs who participated in the initial PCR demonstration and reached the 90% provisional full affirmation rate (minimum of 10 requests) can start the process with the subsequent review choices.
Subsequent Review Choices: Choice IV: Selective Postpayment Review

- The HHA will follow the standard intake, service, and billing procedures, and the claims will pay according to normal claim processes.

- After 6 months, the MAC will select a statistically valid random sample (SVRS) for postpayment review.

- The MAC will send the HHA an ADR letter and follow CMS postpayment review procedures.

- The HHA will stay in this option for the remainder of the demonstration and will not have an opportunity to select a different review choice later.

- HHAs who do not select a subsequent choice will default to this option.
Choice V: Spot Check Review

- The HHA will follow the standard intake, service, and billing procedures.
- The MAC will randomly select 5% of the submitted claims for prepayment review every 6 months.
- The HHA may remain with this choice for the remainder of the demonstration as long as the spot check shows the HHA is compliant with Medicare rules.
- If the HHA is not in compliance, the HHA must select again from one of the initial three review choices.
Once the selection period begins in their state, HHAs will have until two weeks prior to the start of the demonstration to select an initial review choice.

HHAs will make their choice selection through the eServices online provider portal: www.palmettogba.com/eservices.

IL HHAs who participated in the initial demonstration and reached the 90% provisional full affirmation rate (minimum of 10 requests) may select a subsequent review choice.
Review Choice Demonstration for Home Health Services

**CHOICE #1**
Pre-Claim Review
- HHA must request PCR for all episodes.
- HHA can request more than one episode on a PCR request.
- Claims submitted without PCR will (a) undergo prepayment review and (b) receive a 25% payment reduction on all payable claims.
- Affirmation rate is calculated every 6 months.

**CHOICE #2 (Initial Default)**
Postpayment Review
- HHA submits claims for each episode.
- Each claim is processed and paid per CMS procedures.
- MAC sends ADRs and follows CMS postpayment review procedures.
- Approval rate is calculated every 6 months.

**CHOICE #3**
Minimal Review with 25% Payment Reduction
- HHA receives a 25% payment reduction on all payable claims.
- Claims are excluded from MAC targeted Probe & Educate reviews.
- Claims are not excluded from potential RAC review.
- Provider remains active in this choice for the duration of the demo.

**CHOICE #4 (Subsequent Default)**
Selective Postpayment Review
- MAC reviews a SVRS every 6 months.
- Provider remains active in this choice for the duration of the demo.

**CHOICE #5**
Spot Check
- MAC selects 5% of HHA claims every 6 months.
- MAC sends ADRs and follows CMS postpayment review procedures.

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*If HHA doesn’t make an initial choice selection, choice 2 will be automatically selected. If HHA doesn’t make a subsequent choice selection, choice 4 will be automatically selected.*

**Minimum submission of 10 requests/claims required. Affirmation rate is based on full affirmations only.**

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**GLOSSARY**
- **HHA:** Home Health Agency
- **MAC:** Medicare Administrative Contractor
- **ADR:** Additional Documentation Request
- **RAC:** Recovery Audit Contractor
- **PCR:** Pre-Claim Review
- **SVRS:** Statistically Valid Random Sample
Medicare coverage policies are not changed under the demonstration

The demonstration does **not** create any new documentation requirements

HHAs will still be able to submit their Request for Anticipated Payment (RAP) in the same manner and subject to the same rules as they currently would without the demonstration being in place

Also unchanged are:
- All Advanced Beneficiary Notice (ABN) policies
- Claim appeal rights
- Dual eligible coverage
- Private insurance coverage

Access to care and services should not be delayed for people with Medicare’s home health benefit
CMS Oversight

- CMS will:
  - Regularly assess pre-claim affirmation and claim approval rates
  - Review a sample of MAC decisions to ensure review accuracy
  - Contract with an independent evaluator to review the demonstration
For More Information

- Review Choice Demonstration [website](#)

- Questions should be sent to [homehealthRCD@cms.hhs.gov](mailto:homehealthRCD@cms.hhs.gov)

- CMS and Palmetto will continue to provide educational opportunities
Questions?