Pre-Claim Review Demonstration for Home Health Services

Operational Guide

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Purpose

The purpose of this Operational Guide is to interpret and clarify the pre-claim review process for Medicare participating home health agencies (HHAs) when rendering home health services for Medicare beneficiaries. This guide will advise providers on the process for submitting documents in support of the final claim.

Chapter 1: Home Health Benefit

For any service to be covered by Medicare it must:

1. Be eligible for a defined Medicare benefit category;
2. Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; and
3. Meet all other applicable Medicare statutory and regulatory requirements.

To qualify for the Medicare home health benefit, under 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act, a Medicare beneficiary must:

1. Be confined to the home;
   - Medicare considers the person homebound if:
     a) There exist a normal inability to leave the home and
     b) Leaving home requires a considerable and taxing effort.
   - Additionally, one of the following must also be true:
     a) Because of illness or injury, the person needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence; or
     b) The person has a condition such that leaving his or her home is medically contraindicated.
2. Be under the care of a physician;
3. Be receiving services under a plan of care established and periodically reviewed by a physician;
4. Be in need of skilled services;
5. Had a face-to-face encounter with an approved provider type. 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 an approved provider type.
   - The certifying physician must also document the date of the encounter.

For additional information on the home health face-to-face encounter requirements, see 42 CFR 424.22(a)(1)(v)(A). See Chapter 7 of the Medicare Benefit Policy for more information on the coverage criteria for home health services.

Chapter 2: Pre-Claim Review Demonstration of Home Health Services Overview

Per-claim review requests may be submitted by Home Health Agencies (HHAs) that: provide home health services, and are enrolled in the Medicare FFS program; and beneficiaries. The term submitter will be used throughout this document to describe the person or entity that submits the pre-claim review request.

The Pre-Claim Review Demonstration will be conducted in: Illinois, Florida, Texas, Michigan and Massachusetts.

- Submitters may submit a pre-claim review request for each 60 day home health episode.
- Submitters are encouraged to utilize the pre-claim review process for home health benefit periods with a *from* date on or after:
  - **August 1, 2016 for HHAs located in Illinois**
  - **TBD, but no earlier than October 1, 2016 for HHAs located in Florida**
  - **TBD, but no earlier than December 1, 2016 for HHAs located in Texas**
  - **TBD, but no earlier than January 1, 2017 for HHAs located in Michigan and Massachusetts**
- Final claims submitted without a pre-claim review request decision will be stopped for pre-pay review.
- After the first three months of the demonstration in each state, if the claim is found payable, it will be subject to a 25 percent payment reduction.
- Providers will be able to begin submitting pre-claim requests two weeks preceding their implementation date.
- It is important to note that submitting a pre-claim review request is voluntary. HHAs should place the unique tracking number (UTN) provided in the pre-claim review decision letter on the final claim. If a non-affirmed pre-claim review decision is on file, Medicare will deny payment for the final claim submitted for those services. This denial will constitute an initial payment decision and the standard claims appeals process will apply. Final claims submitted without a pre-claim review request decision will be stopped for pre-pay review.
- After the first three months of the start of the demonstration in each individual state, if the claim is found 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. While the claims will be stopped for pre-pay review, the 25 percent reduction will not apply during the initial three months of the demonstration in each individual state.
- The 25 percent payment reduction is not subject to appeal and not transferable to the beneficiary.

Chapter 3: Home Health Type of Bills (TOBs) and Healthcare Common Procedure Coding System (HCPCS) Codes Subject to the Pre-Claim Review Demonstration

The following type of bills (TOBs) and healthcare common procedure coding system (HCPCS) codes are subject to complex medical review for the demonstration:

- Type of Bills (TOBs) –
  - 327
  - 329
  - 32F
  - 32G
  - 32H
  - 32I
  - 32J
  - 32K
  - 32M
  - 32P
  - 32Q

- HCPCS Codes:
  - G0151
  - G0152
  - G0153
  - G0155
  - G0156
  - G0157
  - G0158
  - G0159
  - G0160
  - G0161
  - G0162
  - G0163
  - G0164
  - G0299
  - G0300

Important: No pre-claim review decisions will be made on a request for anticipated payment (RAP). If a MAC receives a pre-claim review request for a RAP, the MAC will not review the request and will not issue a decision letter.

Note: Above codes are subject to change.

Chapter 4: Episodes of Care

- A provisional affirmative pre-claim review decision, justified by the beneficiary's condition, will apply to one home health 60-day benefit period episode of care.

- Home health services for less than 60-days will still require a pre-claim review with the exception of a Low Utilization Payment Adjustment (LUPA).

- A pre-claim review request must be submitted for each 60 day episode. Each claim for a 60 day episode where a pre-claim review request was not submitted, is subject to pre-payment review and after the first three months in each individual state if payable, a 25 percent payment reduction.

- Only one HHA is allowed to request pre-claim review per beneficiary per episode of care. In a situation where a patient is discharged and readmitted to the same HHA during the 60 day episode, a new pre-claim review request is not needed unless a separate claim will be filed.
    - See CMS IOM 100-02, Chapter 7, Section 10 for further information on what constitutes discharge for billing and payment purposes.

Chapter 5: Submitting a Home Health Pre-Claim Review Request

Submitters may submit a pre-claim review request at any time prior to the submission of the final claim.
Submitters Should Include the Following Data Elements in a Home Health Pre-Claim Review Request Package:

Beneficiary Information

- Beneficiary's Name;
- Beneficiary's Medicare Number (also known as HICN or MBI); and
- Beneficiary's Date of Birth.

Certifying Physician/Practitioner Information

- Physician/Practitioner's Name;
- Physician/Practitioner's National Provider Identifier (NPI);
- Physician/Practitioner PTAN (optional); and
- Physician/Practitioner's Address.

Home Health Agency Information

- Agency Name;
- Agency National Provider Identifier (NPI);
- CMS Certification Number;
- Agency PTAN (optional); and
- Agency Address.

Submitter Information

- Contact Name; and
- Telephone Number.

Other Information

- Benefit period requested (initial or subsequent);
- Submission Date;
- From and Through Date of the 60-day episode of care;
- Indicate if the request is an initial or resubmission review; and
- State where service is rendered.

Additional Required Documentation

Documentation from the medical record that supports the beneficiary is:

- Confined to the home at the time of services;
    - Medicare considers the person homebound if:
      1) There exist a normal inability to leave the home and
      2) Leaving home requires a considerable and taxing effort. Additionally, one of the following must also be true:
        a) Because of illness or injury, the person needs the aid of supportive devices such as crutches, canes, wheelchairs,

and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence; or
b) The person has a condition such that leaving his or her home is medically contraindicated

- Under the care of a physician;
- Receiving services under a plan of care established and periodically reviewed by a physician;
- In need of skilled services;
- Had a face-to-face encounter with a medical provider 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 an approved provider type.

Submitters should note that the start date for the home health episode covered by the pre-claim review is the start date requested on the pre- claim review request. Submitters are encouraged to use their respective MAC's checklist specifically designed for pre- claim review requests. The checklist assists submitters with ensuring requests are complete.

Submitters have four options for submitting pre-claim review requests to the MACs: 1) The preferred and most expeditious method of submission: MAC Online Portal (where available), 2) Electronic submission of medical documentation (esMD) (when available), 3) Fax, or4) Mail. Please note the response will be sent to the submitters using the same method as the request was sent if available.

Home Health Agencies should send requests to their appropriate MAC.

Palmetto:

- **eServices**
    - www.onlineproviderservices.com
    - *Palmetto GBA's preferred method of submission
- **esMD:** (where available)
    - For more information about esMD, see www.cms.gov/esMD or contact your MAC.
- **Fax Number:** 803-419-3263
- Palmetto GBA – JM MAC Home Health Pre-Claim Review Mailing Address:
    - PO Box 100234
    - Columbia, SC, 29202-3234

NGS:

- **eServices**
    - NGS Connex
- **esMD:** (where available)
    - For more information about esMD, see www.cms.gov/esMD or contact your MAC.

- **Fax Number:** MAC J6**:** 1-717-565-3840 or 315-442-4178
  MAC JK: 1-315-442-4390

- **Mailing Address**: MAC J6: National Government Services
  PO BOX 6474
  Indianapolis, IN 46206-6474

  MAC JK: National Government Services, Inc.
  P.O. Box 7108
  Indianapolis, IN 46207-7108

CGS:

- **Online Portal:** when available
- **esMD:** (where available)
  For more information about esMD, see www.cms.gov/esMD or contact your MAC.
- **Fax Number:** 615-664-5950
- **Mailing Address:** CGS Administrators
  PO Box 20203
  Nashville, TN 37202

Cases Where Services Are Not Covered Under the Medicare Benefit, Medicare is Primary, and Another Insurance Company is Secondary:

Home Health providers or beneficiaries may submit the claim without a pre-claim review decision if the claim is non-covered (GY modifier). A pre-claim review is not needed and the claim will not be developed due to the pre-claim review demonstration. Services billed as not medically necessary (GA modifier) will be developed and reviewed under the pre-claim review demonstration.

If a home health provider or beneficiary chooses to use the pre-claim review for a denial then the following process is to be followed:

- The submitter may submit the pre-claim review request with complete documentation as appropriate. If all relevant Medicare coverage requirements are **not** met for the home health benefit period, then a non-Affirmed pre-claim review decision will be sent to the provider and to the beneficiary advising them that Medicare will not pay for the service.
- A claim with a non-affirmed decision submitted to the MAC for payment will be denied. The claim must include the UTN provided in the decision letter.
- The submitter may forward the denied claim to his/her secondary insurance payee as appropriate to determine payment for the home health benefit period.

Cases Where Another Insurance Company is Primary and Medicare is Secondary:

If a HHA plans to bill another insurance first and bill Medicare second, the submitter and beneficiary have two options:

1. Seek Pre-Claim Review:

- The submitter submits the pre-claim review request with complete documentation as appropriate. If all relevant Medicare coverage requirements **are** met for the home health benefit period, then a provisional affirmative pre-claim review decision will be sent to the provider and to the beneficiary advising them that Medicare **will** pay for the home health benefit period as long as all other r requirements are met.
- The provider renders the service and submits a claim to the other insurance company.
- If the other insurance company denies payment on the claim, the provider or beneficiary can submit a claim in accordance with Medicare Secondary Payer (MSP) provisions, to the MAC (listing the pre-claim review unique tracking number (UTN) on the claim). The MAC will process the claim according to the MSP provisions.

2. Skip Pre-Claim Review:

- The provider renders the service and submits a claim to the primary payer for a payment determination as appropriate.

- If the other insurance company denies payment on the claim, the provider or beneficiary can submit a claim to the MAC in accordance with the MSP provisions. The MAC will stop the claim for pre-payment review and will send an Additional Documentation Request (ADR) letter. The provider should respond to the ADR.

Timeframe for Decisions:

- The MAC will make every effort to send notification of the decision to the submitter and the beneficiary within 10 business days (excluding federal holidays) for an initial request.

- A resubmitted request is a request submitted with additional documentation after the initial pre-claim review request receives a non-affirmed decision. The MAC will make every effort to send notification of the decision of these requests to the provider and the beneficiary within 20 business days (excluding federal holidays).

Provider Telephone Inquiries:

Providers who have questions about the pre-claim review process should call the appropriate MAC. The numbers for Customer Service Representatives at the MACs are as follows:

- For Palmetto GBA at 855-696-0705.

- For NGS: MAC J6: 877-702-0990 TTY: 888-897-7523
  MAC JK: 888-855-4356 TTY: 866-786-7155

- For CGS: will be updated shortly

Chapter 6: A Provisional Affirmative Decision

Provisional Affirmative Decision
A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the service likely meets Medicare's coverage, coding, and payment requirements.

Decision Letter(s):
The MAC will make every effort to send decision letters with the provisional affirmative pre-claim review decision with a UTN number to the submitter via the MAC provider portal postmarked within 10 business days for initial requests and 20 business days for resubmitted requests. Decision letters sent via esMD are not available at this time. A copy of the decision letter will also be mailed to the beneficiary.

Non-Transferability of a Provisional Affirmative Pre-Claim Request Decision:

- A provisional affirmative pre-claim review decision does not follow the beneficiary.
- Only one home health provider is allowed to request pre-claim review per beneficiary per benefit period. In a situation where a patient is discharged and readmitted to the same HHA during the 60 day episode, a new pre-claim review request is not needed unless a separate claim will be filed.
  - See CMS IOM 100-02, Chapter 7, Section 10 for further information on what constitutes discharge for billing and payment purposes.
- A subsequent home health provider may submit a pre-claim review request to provide home health services for the same beneficiary and must include the required documentation in the submission.

Provider's Actions:

- Render/deliver service/item.
- Submit pre-claim review request for an eligible service/item.
- Submit the claim with the unique tracking number (UTN) and the CMS Certification Number (CCN) of the rendering provider on the claim.
  - The submission of the pre-reviewed claim is to have the 14 byte UTN that is located on the decision letter. For submission of a claim on a UB04 Claim Form, the UTN is submitted in positions 19 through 30 in field locator 63. The last two characters of the UTN should be written outside the lines next to position 30. For submission of electronic claims, FISS shall accept the UTN following the OASIS assessment data (Positions 1-18) in positions 19 through 32 of loop 2300 REF02 (REF01=G1) on type of bill 032x.
- If all requirements are met the claim will be paid.
- The pre-claim review demonstration has specific parameters for pre-payment review; however other contractors (CERT, ZPICs, etc.) may have parameters outside of the Pre-Claim Review Demonstration that will suspend the same claim for another type of

review. If your claim is selected for review, guidance and directions will be provided on the Additional Documentation Request (ADR) Letter from the requesting contractor.

Chapter 7: A Non-Affirmed Decision for Incomplete Requests

An Incomplete Request is Considered a Non-Affirmed.

When an Incomplete Request is Submitted:

- The MAC will make every effort to provide notification of what is missing with the pre-claim review request to the submitter via fax, mail, or the MAC provider portal (when available) through a detailed decision letter sent within 10 business days for initial requests and 20 business days for resubmitted requests. A copy of the decision letter will also be mailed to the beneficiary.
- The submitter may resubmit another complete package with all documentation required as noted in the decision letter. See Chapter 8 for instructions on resubmitting a pre-claim review request.
- If the claim is submitted to the MAC for payment with a non-affirmed pre-claim review decision, it will be denied.
    - All ordinary claim appeal rights will then apply.
    - The claim could then be submitted to secondary insurance.

Providers Action:

- Resubmit a pre-claim review request, if appropriate.
- Use the home health pre-claim review request checklist/tool to ensure that the request package complies with all requirements.

Chapter 8: Resubmitting a Pre-Claim Review Request

- The submitter should review the decision letter that was provided.

- The submitter should make whatever modifications are needed to the pre-claim review package and follow the submission procedures.

- The MAC will make every effort to provide notification of the decision through a decision letter sent within 20 business days of the review to the home health provider and the beneficiary.

Chapter 9: Claim Submission Where Pre-Claim Review was Sought

Cases Where a Pre-Claim Review Request was Submitted and Received a Provisional Affirmative Decision:

- The submission of the home health claim is to have the UTN that is located on the decision letter. For submission of a claim on a CMS-UB04 Claim Form, the UTN is submitted in positions 19 through 30 in field locator 63. The last two characters of the UTN should be written outside the lines next to position 30. For submission of electronic claims, the UTN must be submitted following the OASIS assessment data (Positions 1-18) in positions 19 through 32 of loop 2300 REF02 (REF01=G1) on type of bill 032x.
- Final Claim:
  - Should be submitted with the pre-claim review UTN on the claim.
  - Should include the CCN of the rendering provider on the claim.
  - Should be submitted to the applicable MAC for adjudication.
  - If the provider changes during the home health benefit period, and the receiving HHA did not submit a pre-claim review request, the claim will undergo a complex medical review. The new home health provider is required to submit all medical documentation to support the services billed.

Cases Where a Pre-Claim Review Request was Submitted and Received a Non-Affirmed Decision:

- The submission of the home health claim pre-reviewed must include the UTN that is located on the decision letter. For submission of a claim on a CMS-UB04 Claim Form, the UTN is submitted in positions 19 through 30 in field locator 63. The last two characters of the UTN should be written outside the lines next to position 30. For submission of electronic claims, the UTN must be submitted following the OASIS assessment data (Positions 1-18) in positions 19 through 32 of loop 2300 REF02 (REF01=G1) on type of bill 032x.
- Final Claim:
  - Should be submitted with the pre-claim review UTN on the claim.
  - Should include the CCN of the rendering provider on the claim.
  - Should be submitted to the applicable MAC for adjudication.
- If the claim is submitted to the MAC for payment with a non-affirmed pre-claim review decision, it will be denied.
  - The standard claims appeals process will apply.
  - This claim could then be submitted to secondary insurance.

See Appendix C - Claim Process When Pre-Claim Review Was Sought

Chapter 10: Claim Submission Where Pre-Claim Review was NOT Sought: The Prepayment Review Process

If an applicable claim is submitted without a pre-claim review request being submitted, it will be stopped for pre-payment review. Home health final claims for benefit periods with a *from* date prior to the start date in each state are not applicable for the Pre-Claim Review Demonstration.

At this time, providers do not need to do anything differently when submitting a claim without a UTN. They do not need to put any information in the remarks field. They do not need to submit any unsolicited documentation. They should include the CCN for the rendering provider on the claim.

Stopping a Claim for Pre-Payment Review:

- The MAC will stop the claim and send an Additional Documentation Request (ADR) through the US Postal Service or Online Provider Portal (if available).
- The HHA will have 45 days to respond to the ADR with all requested documentation.
- The HHA can send the documentation via:
    - Online Portal (if available)
    - Fax
    - Mail
    - esMD (if available, for more information see: www.cms.gov/esMD)
- The MAC will have 30 days to review the documentation and make a payment determination.

See Appendix D. - Claim Process When Pre-Claim Review Was Not Sought

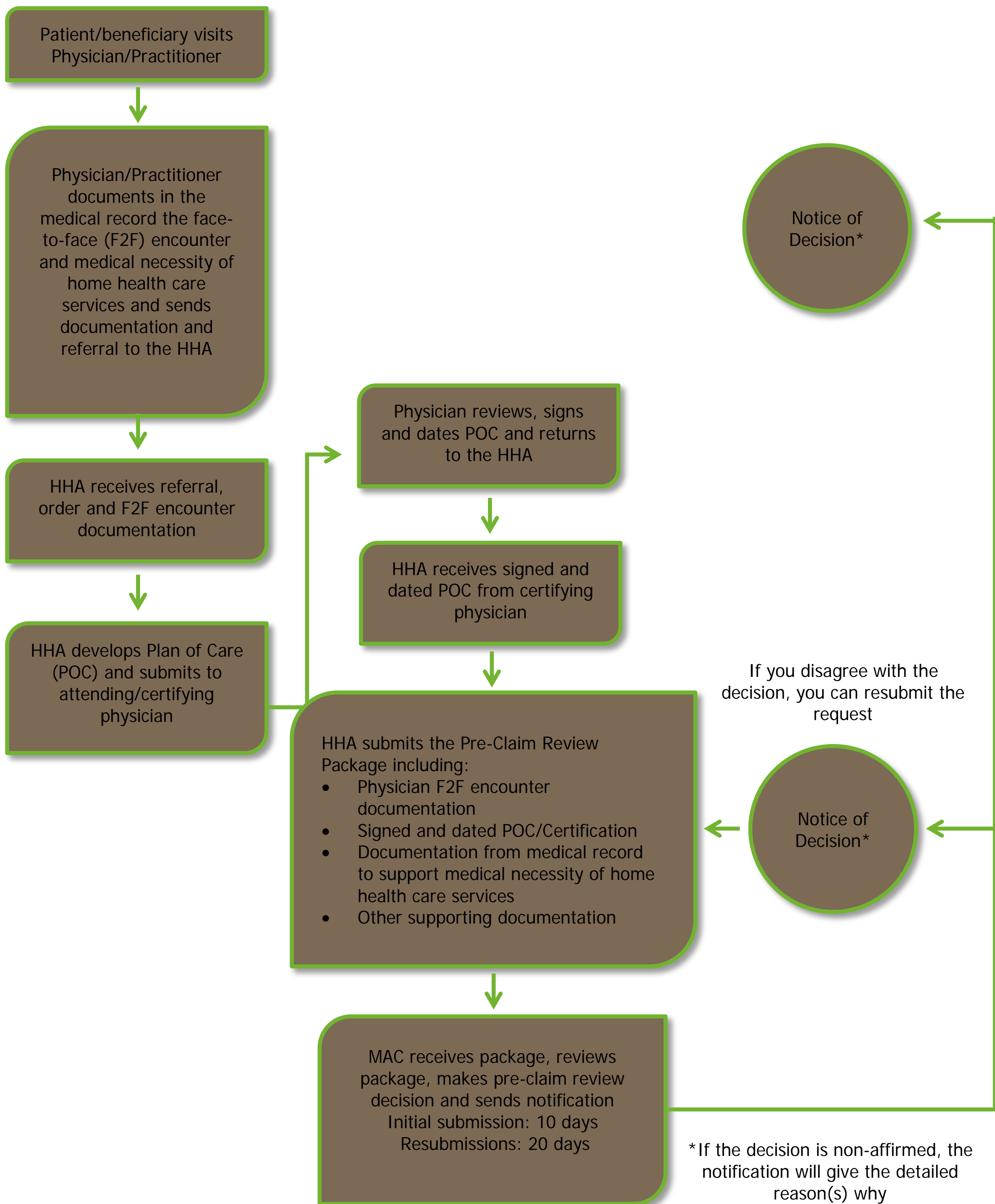
Chapter 11: Claim Appeals

Appeals follow all current procedures. For further information consult the Centers for Medicare & Medicaid Services' Medicare Claims Processing Manual publication 100-04, Chapter 29 Appeals of Claims Decision.

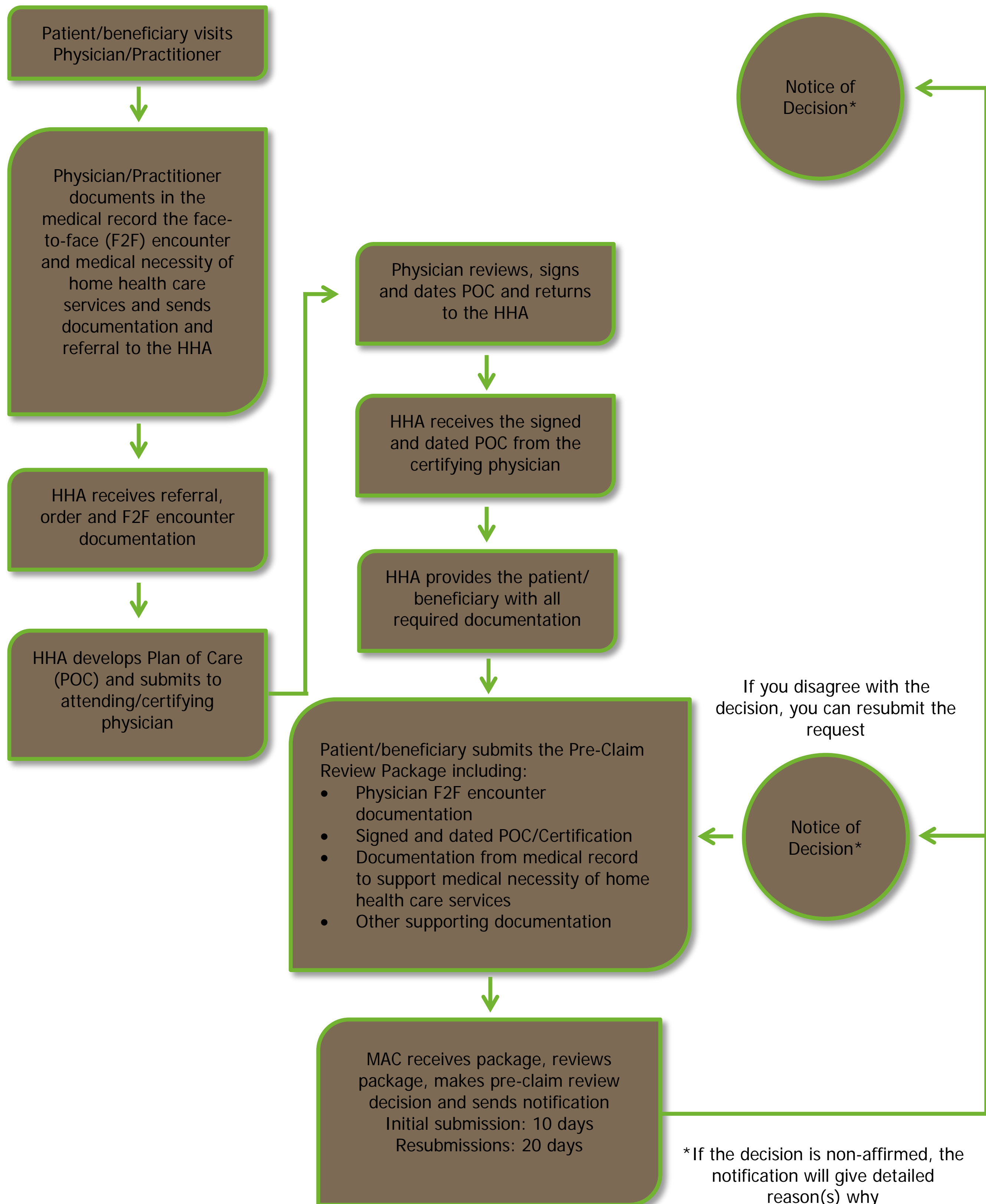
This Pre-Claim Review Demonstration does not include a separate appeal process for a non-affirmed pre-claim review decision.

However, a non-affirmed pre-claim review decision does not prevent the provider from submitting a final claim. Such a submission of a final claim with the UTN and resulting denial by the MAC would constitute an initial determination on the claim that would make the appeals process available for disputes by beneficiaries and HHAs.

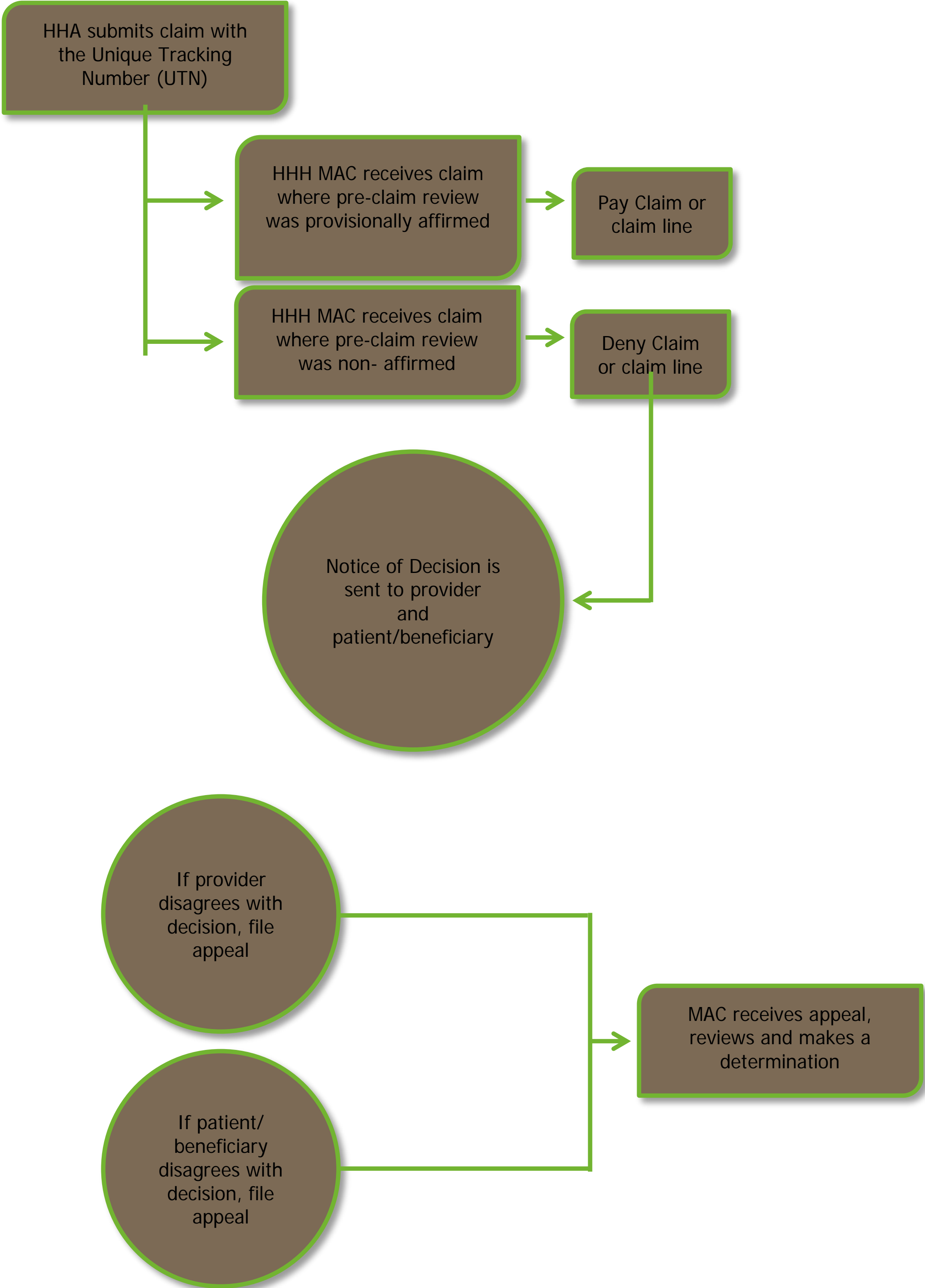
Appendix A: Example of Pre-Claim Review Request Process (Home Health Agency Submits)



Appendix B: Example of Pre-Claim Review Request Process (Beneficiary Submits)



Appendix C: Example of Claim Process (if Pre-Claim Review was sought)



Appendix D: Claim Process (if Pre-Claim Review was not sought)