OMB Control Number: 0938-1311

Expiration Date: XX/XX/2021

Pre-Claim Review Demonstration for Home Health Services

HHAs will initially choose between three options:

- Pre-claim review,
- Postpayment review of all home health claims, or
- Minimal postpayment review of a smaller portion of the provider's home health claims, with a 25% reduction of payment on all home health claims.

If either of the first two options are selected, pre-claim or postpayment review will be required for every episode of care, although multiple episodes may be requested on a pre-claim review request. A HHA's compliance with Medicare billing, coding, and coverage requirements determines that provider's next steps under the demonstration.

A Home Health Agency (HHA) who chooses the pre-claim review option must submit a pre-claim review request prior to the submission of the final claim for payment. Each pre-claim review request may include multiple episodes of care for a beneficiary. HHAs must submit the Plan of Care for any additional affirmed episodes, prior to submission of the final claim for each episode. HHAs have an unlimited number of resubmissions of the pre-claim review request following a non-affirmation (request not approved) prior to the final claim being submitted for payment.

Submitters should, at a minimum, include the following data elements in a home health pre-claim review request:

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
- Indicate the number of episodes being requested if more than one; 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.

HHAs with claims undergoing prepayment or postpayment review should follow the normal review processes.