

Review Choice Demonstration for Home Health Services

Operational Guide

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Purpose

Previous CMS experience, Office of Inspector General reports, Government Accountability Office reports, and Medicare Payment Advisory Commission reports show there is extensive evidence of fraud and abuse in Medicare's home health benefit. The Review Choice Demonstration establishes a review choice process for home health services to test whether such a process improves methods for the investigation and prosecution of fraud.

The purpose of this Operational Guide is to interpret and clarify the review process for Medicare participating home health agencies (HHAs) when rendering home health services for Medicare beneficiaries during the Review Choice Demonstration. This guide will advise HHAs 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)¹. See Chapter 7 of the Medicare Benefit Policy² for more information on the coverage criteria for home health services.

¹ <https://www.govinfo.gov/content/pkg/CFR-2002-title42-vol2/pdf/CFR-2002-title42-vol2-sec424-22.pdf>

² <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf>

Chapter 2: Overview of the Review Choice Demonstration for Home Health Services

This demonstration will include 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 claims, documentation and/or pre-claim review request under the different choices.

The Review Choice Demonstration will be conducted in: Illinois, Ohio, North Carolina, Florida, and Texas. It will apply only to those HHAs located in the states who submit claims to the Palmetto GBA Medicare Administrative Contractor (MAC).

The demonstration will apply to home health benefit periods with a *from* date on or after:

- **June 1, 2019 for HHAs located in Illinois**
- **September 30, 2019 for HHAs located in Ohio**
- **March 2, 2019 for HHAs located in Texas**
- ***Anticipated: May 4, 2020 for HHAs located in North Carolina and Florida***

HHAs will have the option to initially select between three review choices:

- Choice 1: Pre-Claim Review,
- Choice 2: Postpayment Review, or
- Choice 3: Minimal review with a 25% payment reduction. (HHAs that select this choice will remain in this choice for the duration of the demonstration regardless of their claim approval rate).

An HHA's compliance determines their next step. Every 6 months, the HHA's pre-claim review affirmation rate or postpayment review approval rate will be calculated. If the HHA's rate is 90% or greater (based on a 10 request/claim minimum), the HHA may select from one of the three subsequent review choices:

- Choice 1: Pre-Claim Review,
- Choice 4: Selective Postpayment Review (HHAs that select this choice will remain in this choice for the duration of the demonstration regardless of their claim approval rate), or
- Choice 5: Spot Check Review.

If the HHA's rate is less than 90% or they have not submitted at least 10 requests/claims, the HHA must again select from one of the initial three choices.

A HHA under Unified Program Integrity Contractor (UPIC) review is not eligible for participation in this demonstration. **However, all HHAs are encouraged to make a choice selection. Questions regarding UPIC review should be directed to the UPIC.**

HHA Telephone Inquiries:

HHAs who have questions about the demonstration review process should call Palmetto GBA at 855-696-0705.

See Appendix A: Review Choice Demonstration Flowchart

Chapter 3: Home Health Type of Bills (TOBs) and Healthcare Common Procedure Coding System (HCPCS) Codes Subject to the 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
- G0299
- G0300
- G0493
- G0494
- G0495
- G0496

Important: Request for Anticipated Payments (RAPs) are not included in this demonstration. There is no change in the RAP submission or payment process; a RAP should be submitted as usual to the MAC. HHAs who choose Choice 1: Pre-Claim Review, are encouraged to submit the RAP prior to submitting a pre-claim review request. The auto cancellation of a RAP when the final has not been submitted timely will also not change under the PCR process. HHAs are given the greater of 120 days after the start of the episode or 60 days after the paid date of the RAP to submit the final claim. Also, home health claims for Veteran Affairs, Indian Health Services, Part A/B rebilling, demand bills submitted with condition code 20, and no-pay bills submitted with condition code 21 are not part of this demonstration.

Note: Above codes are subject to change.

Chapter 4: Episodes of Care & Payment Periods

Beginning on January 1, 2020, the unit of payment under the Home Health Prospective Payment System (HH PPS) is a 30-day period of care.

While the unit of payment is a 30-day period, recertifications, completion of the OASIS, and updates to the plan of care remain as a 60-day episode. The HH PPS permits continuous episode recertifications for patients who continue to be eligible for the home health benefit. Medicare does not limit the number of continuous episode recertifications for patients who continue to be eligible for the home health benefit.

Each home health 30-day period of care will be eligible for review. The number of episodes selected for review will depend on the review choice selected by the HHA.

Home health services for less than 30 days will also be eligible for review under the demonstration, with the exception of claims with four or fewer visits.

- For HHAs participating in Choice 1: Pre-Claim Review:
 - A request may be submitted for more than one 30-day period of care for a beneficiary. The pre-claim review decision will indicate the number, if any, of provisionally affirmed episodes. A provisional affirmative pre-claim review decision, justified by the beneficiary's condition, may apply to some or all of the number of episodes requested. For any additional episodes included in the request, a valid plan of care must be included with the documentation for that request.
 - Each claim for a 30-day period of care where a pre-claim review request was not submitted, is subject to prepayment review and if payable, a 25% 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 10³ for further information on what constitutes discharge for billing and payment purposes.

³ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf>

Chapter 5: Overview of Choices

HHAs will initially select between three review choices:

- Choice 1: Pre-Claim Review,
- Choice 2: Postpayment Review, or
- Choice 3: Minimal review with a 25% payment reduction. (HHAs that select this choice will remain in this choice for the duration of the demonstration regardless of their claim approval rate).

HHAs who do not actively select one of the initial three review choices will be automatically assigned to participate in Choice 2: Postpayment Review.

HHA will have until two weeks prior to the start of the demonstration in their state to make their choice selection. HHAs can make their selection by utilizing the Palmetto GBA eServices online provider portal at [eServices portal](#). HHAs may select from one of the three review choices available to them. HHAs should be sure to read each choice thoroughly prior to making a selection as some selections will be locked-in for the duration of the demonstration.

HHAs who select either Choice 1 or Choice 2 will be evaluated for 6 months. If the HHA's full affirmation rate or claim approval for those 6 months is 90% or greater (based on a minimum of 10 submitted pre-claim review requests or claims), the HHA may select one of the three subsequent review choices:

- Choice 1: Pre-Claim Review,
- Choice 4: Selective Postpayment Review, or
- Choice 5: Spot Check Review.

HHA's that do not actively choose one of the subsequent review options will automatically be assigned to participate in Choice 4: Selective Postpayment Review, and will remain there for the duration of the demonstration.

If the HHA's rate is less than 90% or they have not submitted at least 10 requests/claims, the HHA must again choose from one of the initial three options.

Illinois HHAs who previously participated in the initial pre-claim review demonstration and met the 90% target full provisional affirmation rate (based on a minimum 10 requests submitted) can also select from the three subsequent review choices above, and do not need to start in one of the initial three review choices.

Choice selection is made at the PTAN level.

Chapter 6: Choice 1: Pre-Claim Review; Submitting a Pre-Claim Review Request

Submitters may submit a pre-claim review request at any time prior to the submission of the final claim. An individual request may include multiple episodes for a beneficiary. The request must be submitted prior to the final claim being submitted for the first episode on the request. For any additional episodes included in the request, a valid plan of care must be included with the documentation for that request.

For claims with dates of service of 1/1/2020 and after, HHAs will need to submit a PCR for each 30-day billing period. When requesting more than 30 days of services, the HHA can select the multiple episode/billing period option and submit two or more 30-day billing periods at the same time. In eServices, HHAs can select multiple episode(s)/billing periods once all tasks are completed for episode/billing period 1. For multiple episodes/billing periods, HHAs should enter the episode/billing period start and end dates, type of bill, HCPCS codes, and upload the POC, if changed, or refer back to the POC (Task 3) for episode/billing period 1. Each 30-day request will generate a separate UTN.

When submitting the 30-day billing periods separately, all documentation for the episode must be submitted regardless if it is the first 30 days in the episode or the second 30 days in the episode.

Submitter's should at a minimum 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; 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 30-day billing period;
- 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/**billing periods** 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.

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. For any additional affirmed episodes from one request the start date for the home health episode will start after the initial episode ends. Submitters are encouraged to use the MAC's checklist specifically designed for pre-claim review requests located on their provider portal. The checklist assists submitters with ensuring requests are complete.

Submitters have four options for submitting pre-claim review requests to Palmetto GBA:

- Palmetto GBA Online Portal: www.onlineproviderservices.com
 - the preferred and most expeditious method of submission
- Electronic submission of medical documentation (esMD)
 - see www.cms.gov/esMD or contact Palmetto GBA at 855-696-0705.
- Fax: 803-419-3263
- Mail:
 - Palmetto GBA – JM MAC Home Health Pre-Claim Review
 - PO Box 100131
 - Columbia, SC 29202-3131

Please note the response will be sent to the submitters using the same method as the request was sent if available. However, if the submission is via fax, a response is only sent via fax if a return fax number is included in the request. Otherwise the response will be sent via mail.

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

HHA's 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 HHA 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 HHA 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 Unique Tracking Number (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 HHA and to the beneficiary advising them that Medicare **will** pay for the home health benefit period as long as all other requirements are met.
- The HHA renders the service and submits a claim to the other insurance company.
- If the other insurance company denies payment on the claim, the HHA or beneficiary can submit a claim in accordance with Medicare Secondary Payer (MSP) provisions, to the MAC (listing the pre-claim review UTN on the claim). The MAC will process the claim according to the MSP provisions.

2. Skip Pre-Claim Review:

- The HHA 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 HHA or beneficiary can submit a claim to the MAC in accordance with the MSP provisions. The MAC will stop the claim for prepayment review and will send an Additional Documentation Request (ADR) letter. The HHA should respond to the ADR. If the claim is found payable, it will be subject to a 25% payment reduction. The 25% payment reduction is non-transferable to the beneficiary and is not subject to appeal.

Timeframe for Decisions:

- The MAC will 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 send notification of the decision of these requests to the HHA and the beneficiary within 20 business days (excluding federal holidays).

See Appendix B: Choice 1 Pre-Claim Review (Submission Process for Home Health Services)

Chapter 7: Pre-Claim Review: A 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. The provisional affirmation may be for all or some of the episodes requested on the pre-claim review request, as well as for all or some of the HCPCS codes requested for each episode.

Decision Letter(s):

Palmetto GBA will make every effort to send decision letters with the provisional pre-claim review decision with a UTN to the submitter via the Palmetto GBA provider portal, mail, or fax postmarked within 10 business days for initial requests and 20 business days for resubmitted requests. HHAs submitting via esMD will receive their decision letter via the MAC provider portal, if enrolled to receive greenmail, as decision letters sent via esMD are not available at this time. Decision letters will be mailed to HHAs that do not receive mail via the MAC provider portal. A copy of the decision letter(s) 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 if they change HHAs.
- Only one HHA 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 10⁴ for further information on what constitutes discharge for billing and payment purposes.
- A subsequent HHA 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. A new pre-claim review request must be provided regardless if multiple episodes have been affirmed for the previous HHA.

HHA'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) 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

4 <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf>

(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 absent evidence of possible fraud or gaming, and be excluded from future medical review.
- While claims falling under this option will be excluded from regular MAC targeted probe and educate reviews, they may be subject to UPIC review if fraud is suspected. Also, claims may be selected as part of the CERT sample.

Chapter 8: Pre-Claim Review: A Non-Affirmed Decision

Incomplete Requests:

An incomplete request will result in a non-affirmed decision.

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 through a detailed decision letter sent within 10 business days for initial requests and 20 business days for resubmitted requests.
- The submitter may resubmit another complete package with all documentation required as noted in the decision letter. See Chapter 9 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.

Non-Affirmed Decisions Following Review:

The pre-claim review package does not show requirements for coverage under the Medicare home health benefit were met.

When a review results in a non-affirmed decision:

- The MAC will send a decision letter to the HHA that includes all of the reasons a non-affirmed decision was reached. The beneficiary will also receive a copy of the decision letter.
- For non-affirmed decisions due to documentation errors where the beneficiary seems to have otherwise met Medicare coverage criteria, the MAC will also reach out to the HHA via phone to provide individualized education on the reasons for the non-affirmed decision and encourage the HHA to resubmit the request as soon as possible.
- The submitter may resubmit another complete package with all documentation required as noted in the decision letter. See Chapter 9 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.

HHA's Action for All Non-Affirmed Decisions:

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

Chapter 9: Pre-Claim Review: 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-claimreview package and follow the resubmission procedures.
- The MAC will provide notification of the decision through a decision letter sent within 20 business days of the review to the HHA and the beneficiary.

Chapter 10: Pre-Claim Review: Claim Submission Where Pre-Claim Review was Requested

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 NPI of the rendering provider on the claim.
 - Should be submitted to the applicable MAC for adjudication.
 - If the HHA 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 HHA is required to submit all medical documentation to support the services billed.
- Each episode will receive a unique UTN, even if multiple episodes were submitted in one request.

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

- The submission of the home health claim must include the non-affirmed 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 NPI 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: Pre-Claim Review (Claim line process if PCR was requested)

Chapter 11: Pre-Claim Review: Claim Submission Where Pre-Claim Review was NOT Requested

If an applicable claim is submitted without a pre-claim review request being submitted, it will be stopped for prepayment 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 Review Choice Demonstration.

Prior to the start of the demonstration, HHA's 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 NPI for the rendering provider on the claim.

Once the demonstration is live in a state, final claims submitted under the pre-claim review Choice without a pre-claim review request decision on file will be stopped for prepayment review. If the claim is found payable, it will be subject to a 25% payment reduction. The 25% payment reduction is non-transferable to the beneficiary and is not subject to appeal.

Stopping a Claim for Prepayment Review:

- The MAC will stop the claim and send an Additional Documentation Request (ADR) through the US Postal Service or Online Provider Portal.
- The HHA will have 45 days to respond to the ADR with all requested documentation.
- The HHA can send the documentation via:
 - Palmetto GBA Online Portal (www.onlineproviderservices.com)
 - Fax (803-419-3263)
 - Mail (PO Box 100131 Columbia, SC, 29202-3131)
 - esMD (if available, for more information see: www.cms.gov/esMD)

See Appendix D: Pre-Claim Review (Claim line process if PCR was not requested)

Chapter 12: Choice 2: Postpayment Review

Under this choice all claims submitted during the cycle will be pulled for postpayment review. The postpayment review process will follow the procedures and rules in place under the home health benefit. This demonstration does not alter the process or create new rules.

Claim Submission

- HHA collects all necessary paperwork such as the Plan of Care
- HHA provides home health services
- HHA submits the claim to the MAC

Additional Documentation Request

Once the claim is received the MAC will process for payment and send the HHA an additional documentation request (ADR). The HHA will submit all medical documentation and other documents and records that are necessary in order to conduct a review and reach a conclusion about the eligibility of the beneficiary and medical necessity.

Records may include documents such as:

- Plan of Care
- Home Health Agency Records
- Progress Notes
- Nursing Visit Notes

Timing

The HHA will have 45 days to respond to the ADR. The MAC will then have 60-days to review the documentation and make a decision. If no response is received, an overpayment will be initiated.

Review

Reviewers shall consider documentation in accordance with Medicare coverage rules and conditions. The postpayment review under this choice will follow the same review standards as are in place absent the demonstration.

Decision

The MAC will communicate the claim review decision to the HHA. If a claim is denied, the MAC will follow the standard payment recoupment procedures already in place. The HHA retains all appeal rights for denied claims.

See Appendix E: Choice 2- Postpayment Review for Home Health Services (Initial Default)

Chapter 13: Choice 3: Minimal Review with 25% Payment Reduction

Under this choice, HHAs will submit claims according to the normal claims process. HHAs will remain in this choice for the duration of the demonstration and will not have an opportunity to select a different option later.

Claim submission

- HHA collects all necessary paperwork such as the Plan of Care
- HHA provides home health services
- HHA submits the claim to the MAC

Payment Reduction

All claims submitted during the course of the demonstration will be subject to an automatic 25% payment reduction. The reduction will be made on all payable claims.

The 25% payment reduction is not appealable. The reduction may not be transferred to the beneficiary.

Claim Review Selection

Claims falling under this option will be excluded from regular MAC targeted probe and educate reviews, but may be subject to potential RAC review, in accordance with their regular review processes. The claims may also be subject to UPIC review if fraud is suspected.

The HHA will retain all appeal rights for denied claims.

Appendix F: Choice 3- Minimal Review with 25% Payment Reduction

Chapter 14: Review Cycle and Compliance Threshold

HHAs who select either Choice 1 or Choice 2 will be evaluated over a 6-month review cycle. Within 30 days of the end of the cycle, the MAC will communicate to the HHA their pre-claim review affirmation or postpayment claim approval rate, and if they have met the review threshold.

If the HHA's full affirmation rate or claim approval for those 6 months is 90% or greater (based on a minimum of 10 submitted pre-claim review requests or claims), the HHA may select one of the three subsequent review choices:

- Choice 1: Pre-Claim Review,
- Choice 4: Selective Postpayment Review, or
- Choice 5: Spot Check Review.

If the HHA's affirmation or claim approval rate is less than 90% or they have not submitted at least 10 requests/claims, the HHA must again choose from one of the initial three options. In Choice 1: Pre-Claim Review, only fully affirmed decisions will be factored into a HHA's affirmation rate.

Illinois HHAs who previously participated in the initial pre-claim review demonstration and met the 90% target full provisional affirmation rate (based on a minimum 10 requests submitted) can also select from the three subsequent review choices above, and do not need to start in one of the initial three review choices.

HHAs who select Choice 3: Minimal Review with 25% Payment Reduction will remain in this choice for the duration of the demonstration. The review cycle and threshold do not apply to this choice.

Chapter 15: Subsequent Review Choices (Choices 1, 4, and 5)

Once a HHA reaches the 90% threshold, they may choose one of three subsequent review choices:

- **Choice 1: Pre-Claim Review:** The HHA may begin or continue participating in pre-claim review for a 6-month period. If their provisional full affirmation rate remains at or above 90%, the HHA may choose to continue to participate in pre-claim review or may choose another subsequent review choice. If the HHA falls below the 90% threshold, the HHA must select from one of the initial review choices.
- **Choice 4: Selective Postpayment Review:** Under this choice the HHA will render services and submit claims according to their normal process. Every 6 months, the MAC will select for postpayment review a statistically valid random sample of claims. The HHA will remain in this choice for the remainder of the demonstration and will not have an opportunity to select a different choice.
- **Choice 5: Spot Check Review:** Under this choice, the MAC will select a random sample of 5% of a HHA's submitted claims, based on their previous 6 months' claim volume, for pre-payment review, to ensure continued compliance. The HHA must maintain the 90% claim approval review threshold to continue participation in this review choice. If the spot check shows the HHA is no longer compliant with Medicare coverage rules, and their claim approval rate falls below 90%, the HHA must again select from one of the initial three review choices.

Illinois HHAs who previously participated in pre-claim review and have already reached the 90% target provisional full affirmation rate (based on a minimum 10 requests submitted) can also choose from the three choices above, and do not need to start in one of the initial three review choices.

HHAs with a full affirmation rate of 90% or greater that do not actively select one of the subsequent review choices by their selection deadline (typically 2 weeks prior to the start of the new six month review cycle) will automatically be assigned to participate in Choice 4: Selective Postpayment Review, and will remain here for the duration of the demonstration.

See Appendix G: Choice 4- Selective Postpayment Review (Subsequent Default)

See Appendix H: Choice 5- Spot Check Review

Chapter 16: Claim Appeals

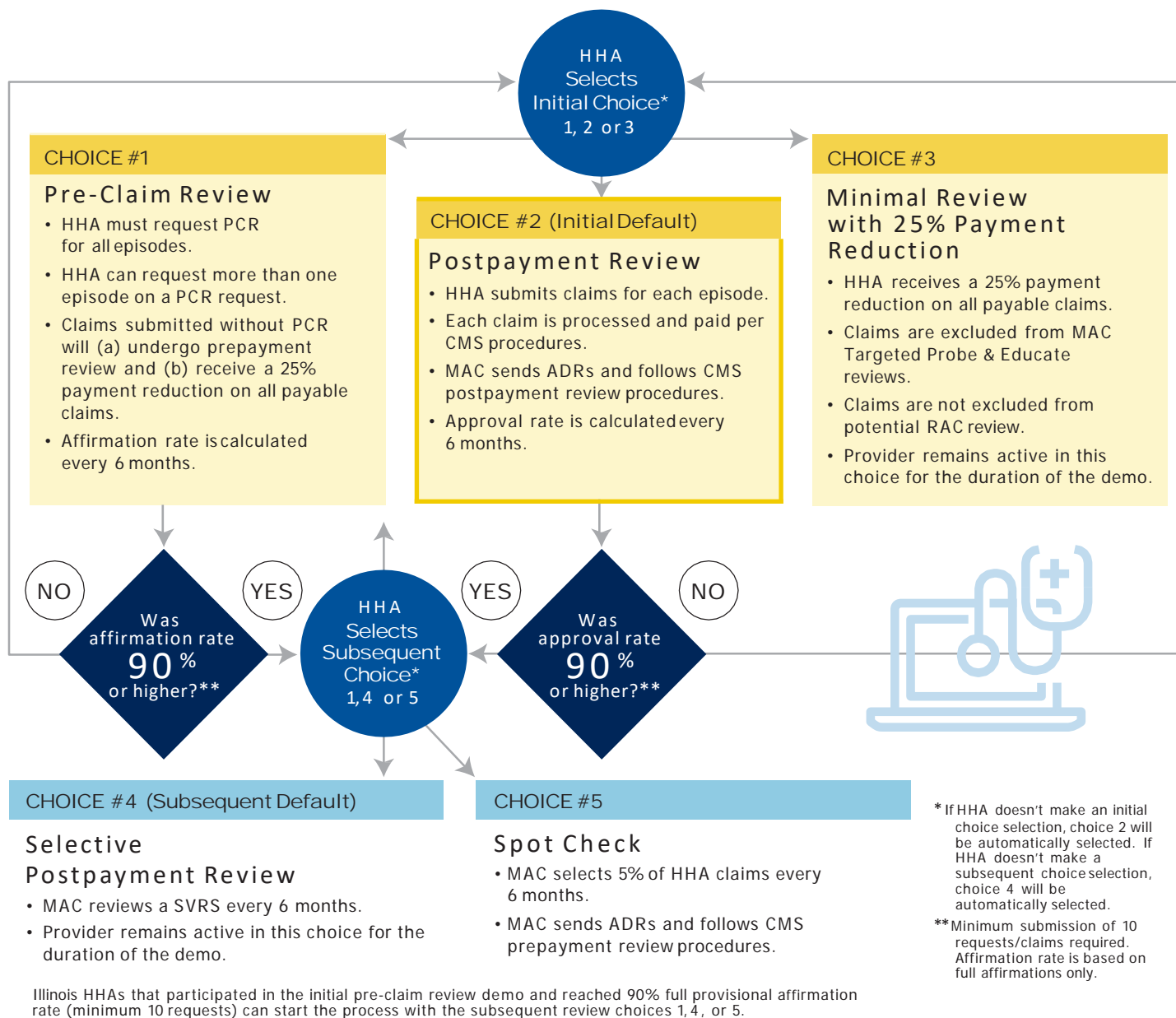
The Review Choice Demonstration does not include a separate appeal process for a non-affirmed pre-claim review decision. However, a non-affirmed pre-claim review decision does not prevent the HHA from submitting a final claim. A submission of a final claim with a non-affirmed UTN and resulting denial by the MAC would constitute an initial determination on the claim that would make the appeals process available for disputes by beneficiaries and HHAs.

Appeals will follow all current procedures no matter which choice a HHA selects. For further information consult the CMS IOM 100-04, Chapter 29⁵, Appeals of Claims Decision.

5 <https://www.cms.gov/RegulationsandGuidance/Guidance/Manuals/downloads/clm104c29.pdf>

Appendix A:

Review Choice Demonstration for Home Health Services



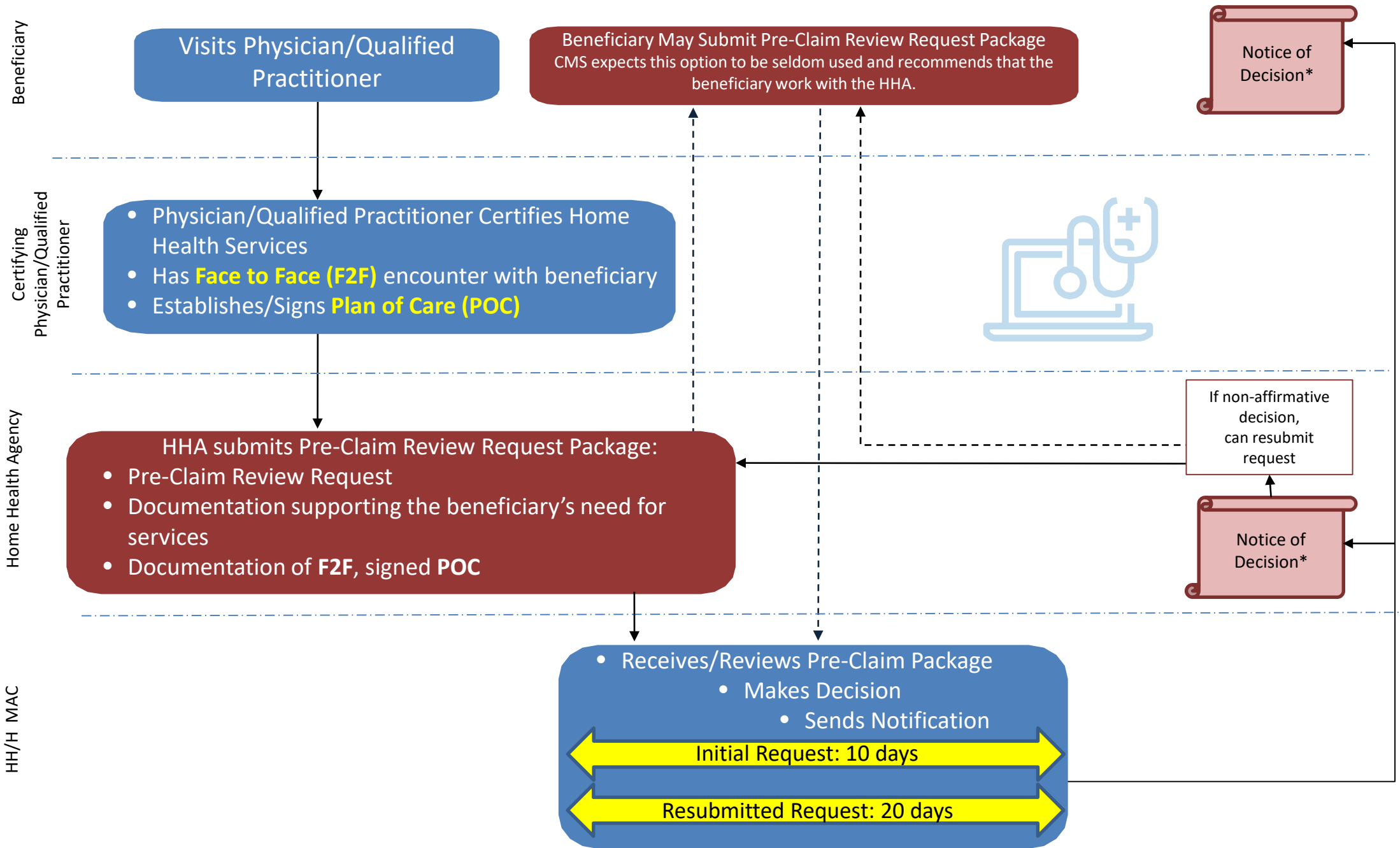
GLOSSARY

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

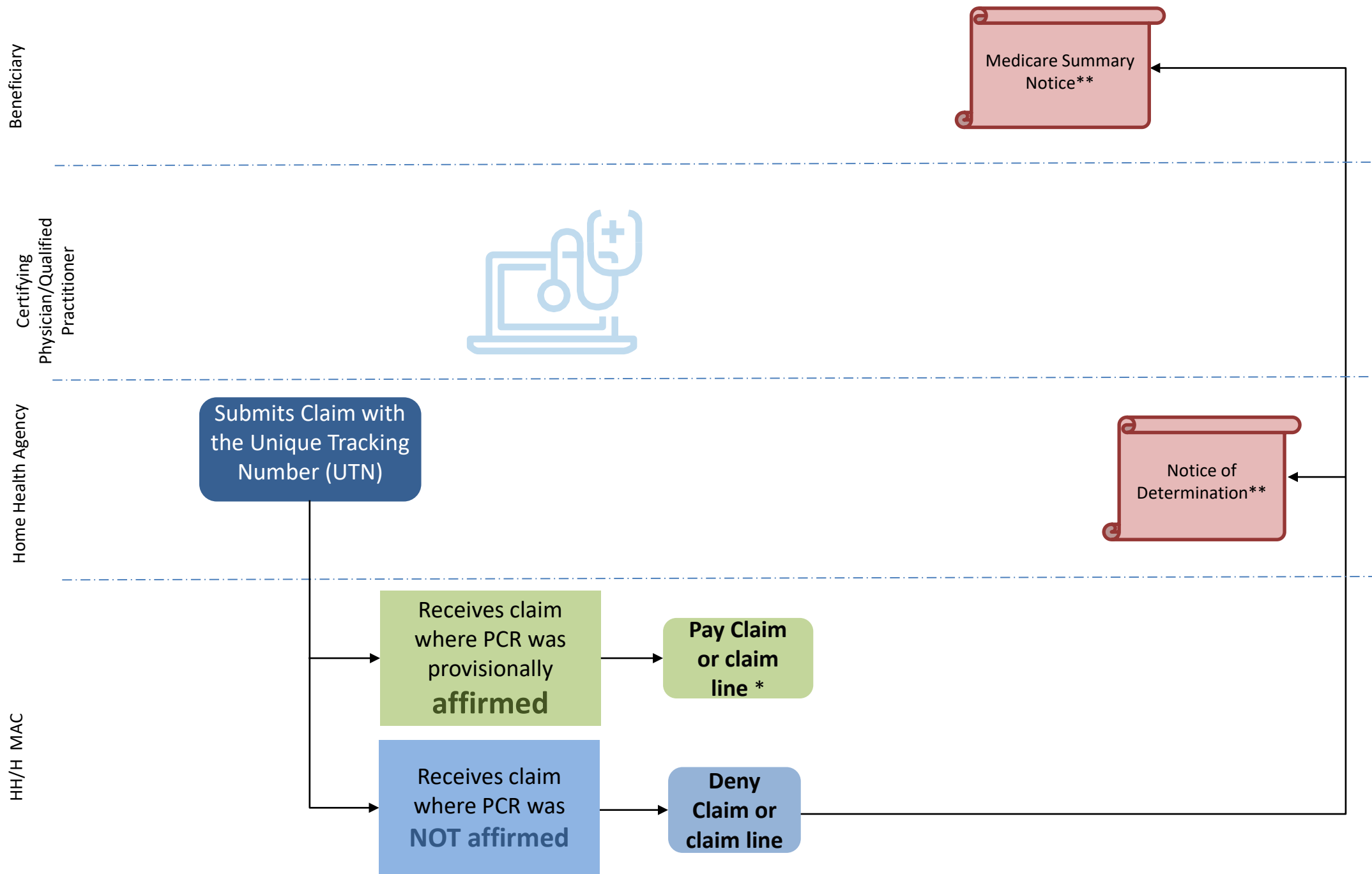


Appendix B: Choice #1 Pre-Claim Review Submission Process for Home Health Services



* If the decision is non-affirmative, the notification will contain detailed reasoning.

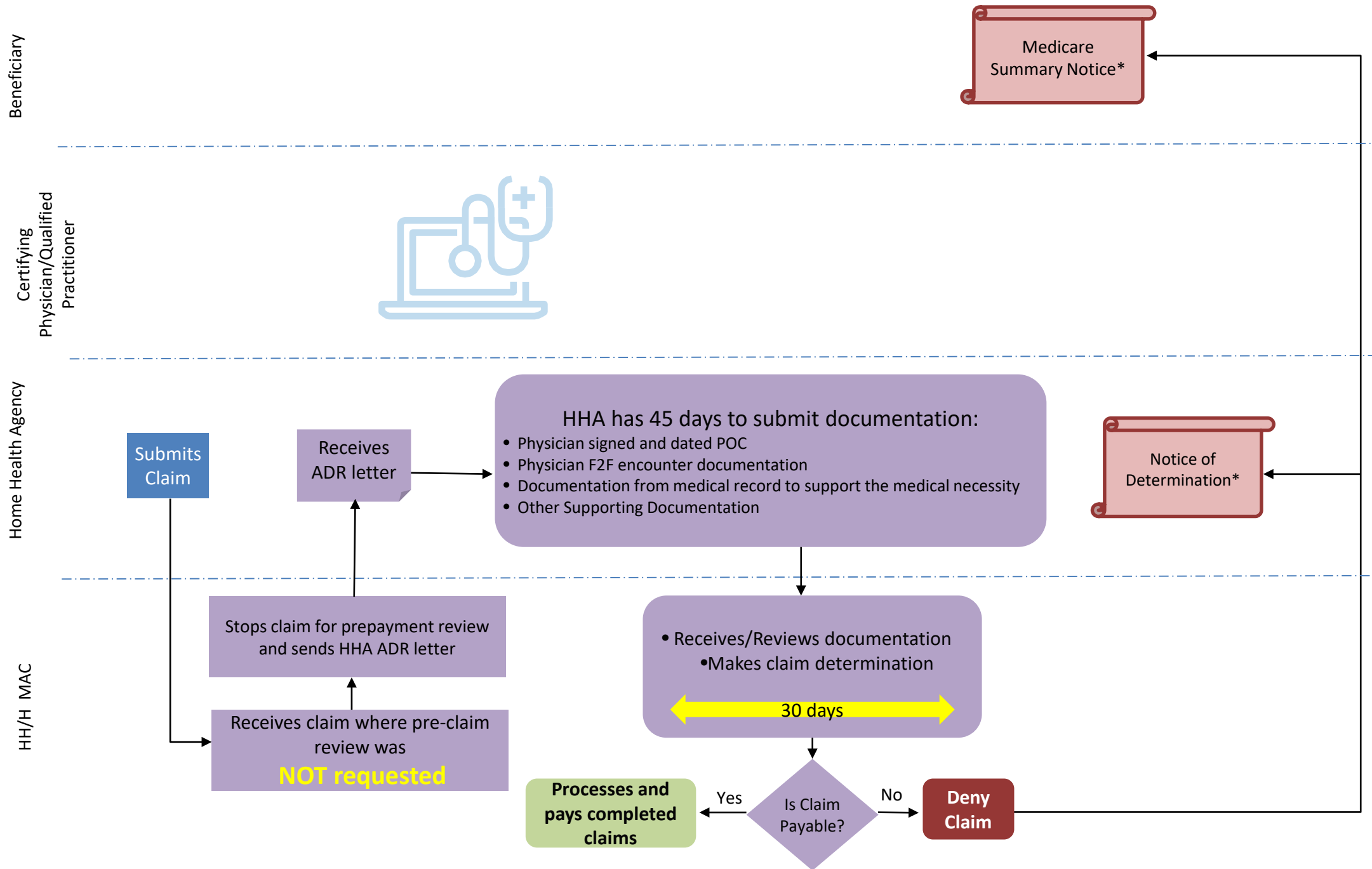
Appendix C: Choice #1 Pre-Claim Review for Home Health Services Claim Line Process (if PCR was requested)



* If all Medicare coding, billing, and coverage requirements are met.

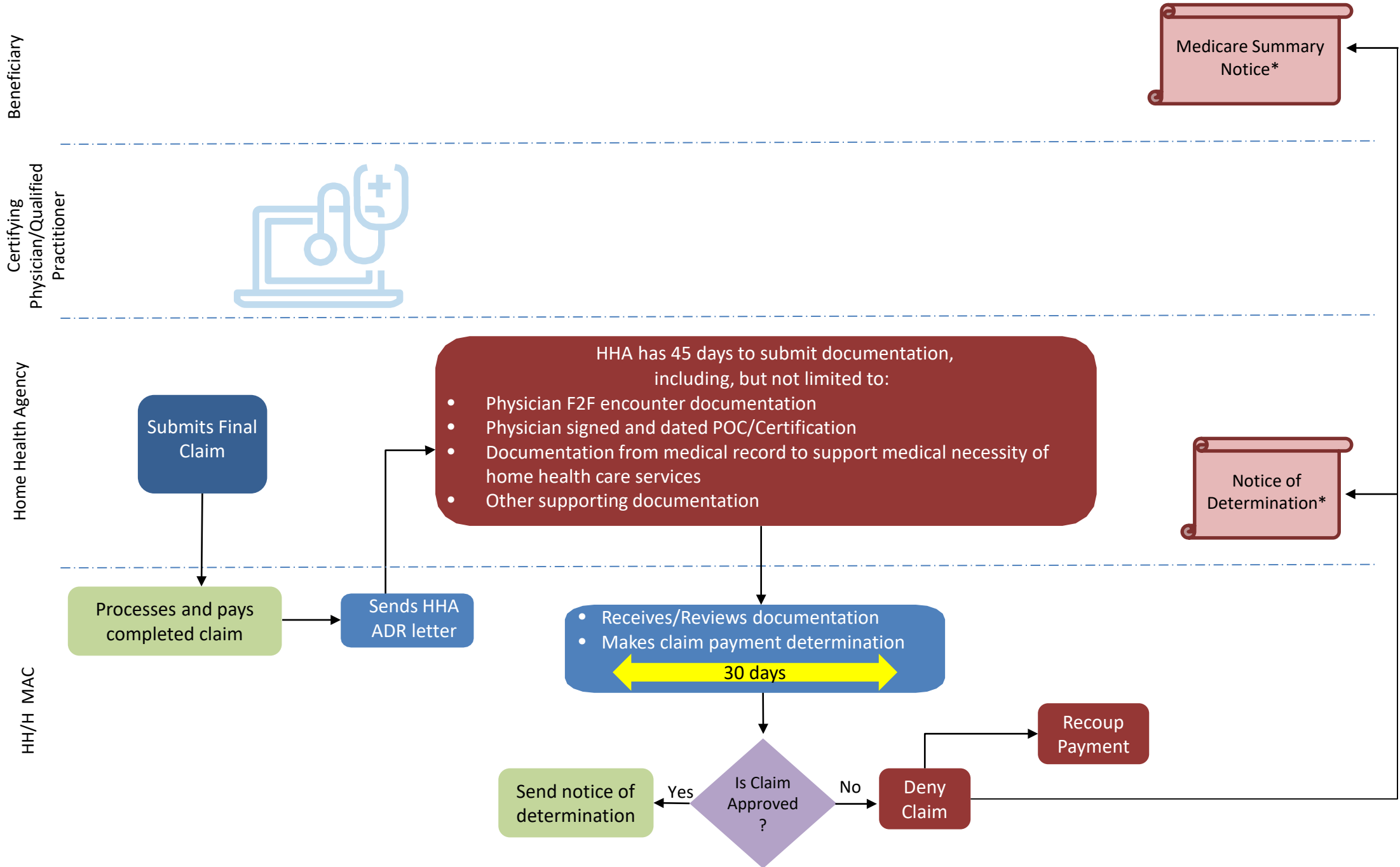
** If the claim is denied, the notification will contain detailed reasoning. Appeal rights are available.

Appendix D: Choice #1 Pre-Claim Review for Home Health Services Claim Line Process (if PCR was not requested)



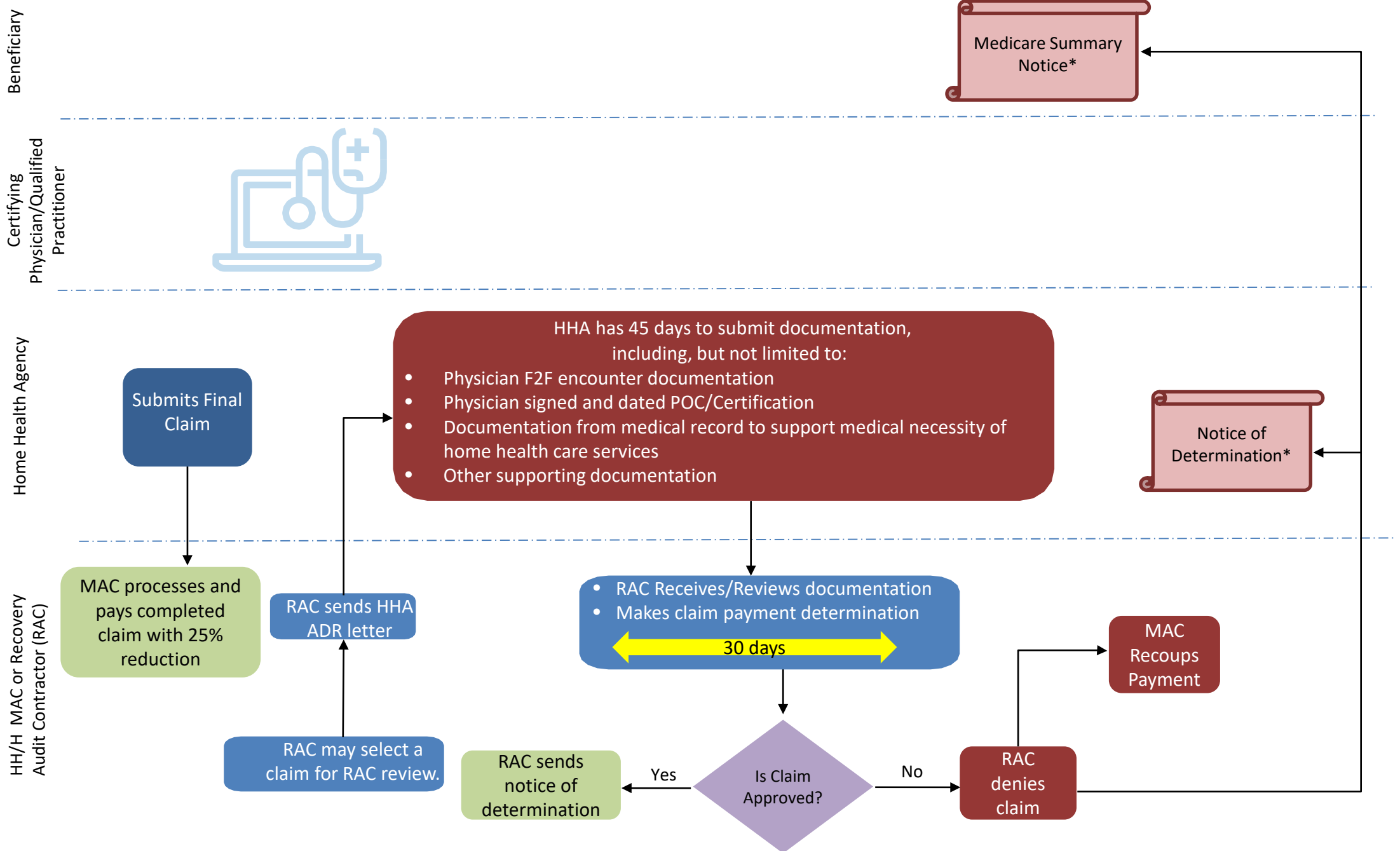
* If the claim is denied, the notification will contain detailed reasoning. Appeal rights are available.

Appendix E: Choice #2 Postpayment Review for HomeHealth Services (Initial Default)



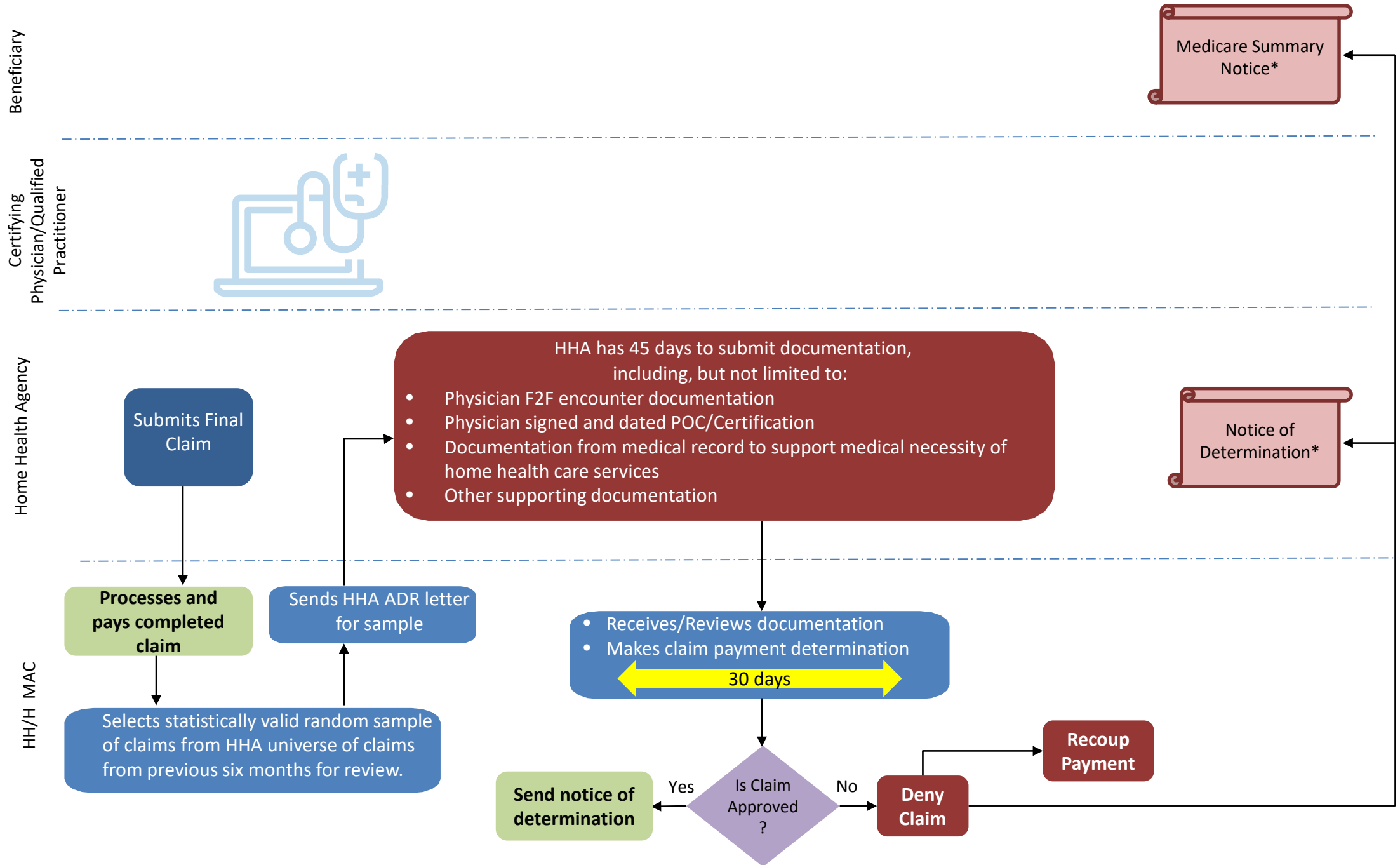
* If the claim is denied, the notification will contain detailed reasoning. Appeal rights are available.

Appendix F: Choice #3 Minimal Review for Home Health Services with 25% Payment Reduction



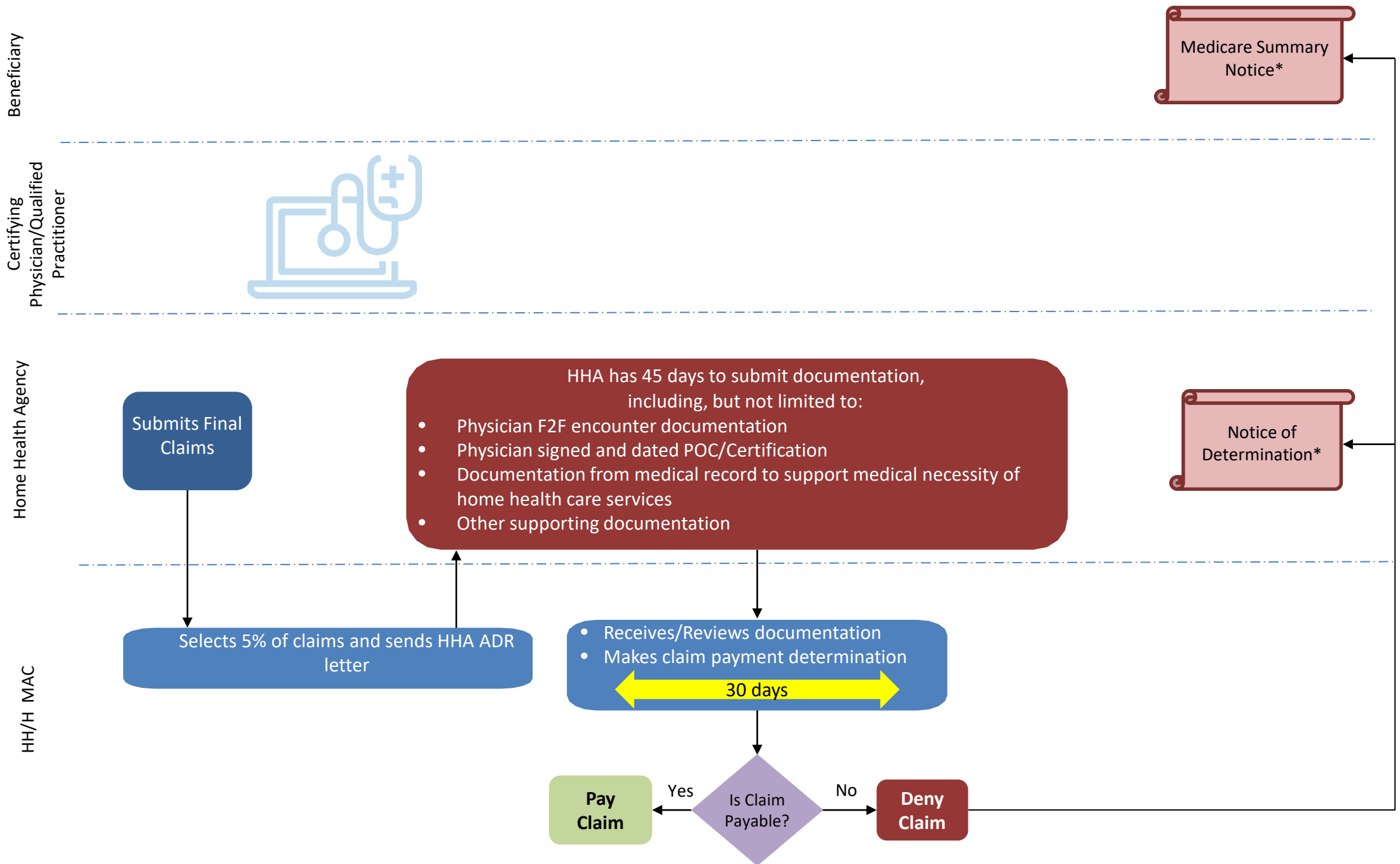
* If the claim is denied, the notification will contain detailed reasoning. Appeal rights are available.

Appendix G: Choice #4 Selective Postpayment Review for HomeHealth Services (Subsequent Default)



* If the claim is denied, the notification will contain detailed reasoning. Appeal rights are available.

Appendix H: Choice #5 Spot Check Review for Home Health Services



* If the claim is denied, the notification will contain detailed reasoning. Appeal rights are available.