

Home Health: Submitting a Pre-Claim Review Request

Hello, I am Charles Canaan, senior provider education consultant at Palmetto GBA.

Today we are going to give you the nuts and bolts on submitting the pre-claim review request for Home Health.

You've already seen the video on the background of the pre-claim review – why we have it and the basics of the claims processing side. Today we're going to give you the inside track on making sure you have the right documentation to tell your story.

So we are going to walk through how to put this together. Now there are various ways to do it. You can do it electronically, fax, mail. That's not going to matter. As long as all the pieces in there, as long as you get it to us, and give us the right information, you will have an affirmed claim.

Beneficiary Information

You have to have the right beneficiary information. That kind of sounds like a given, but make sure we have the right beneficiary information.

- Beneficiary's name
- Beneficiary's Medicare number (HICN)
- Date of birth

There are a lot of John Smiths out there in Medicare. So just putting John Smith's name on there, without the date of birth or Medicare number, we're not going to know which patient that is.

Certifying Physician/Practitioner Information

We have to have the Certifying Physician/Practitioner Information:

- Physician/Practitioner's name
- Physician/Practitioner's National Provider Identifier (NPI)
- Physician/Practitioner PTAN (optional)
- Physician/Practitioner's Address

Home Health Agency information

We also need your Home Health Agency information:

- Agency Name
- Agency National Provider Identifier (NPI)
- CMS Certification Number/PTAN
- Agency address

We do need your PTAN, your provider number. The reason is, only certain states are allowed to bill these pre-claim review requests. So your PTAN, that six digit number that goes on your claim – those first two digits tell which state you're in. So if you're from a state that's not part of this pre-claim

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review process, it will not go through. So your PTAN is very important, as well as your agency address.

Submitter Information

- Contact name
- Telephone Number

It is very important to have a contact name and a telephone number in the event there is a processing issue, something that does not go as planned. We need to know who to contact to resolve something. So please put a specific person's phone number. The operator is not very helpful if don't know who to ask for if that's the only number you give us. So a specific name and a specific phone number that goes to a specific person is what we need.

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
- State where the service is rendered

Other Information that must be part of the process or the claim will not go through, has to reference the episode, the date, from beginning to end, or the two-and-from date.

The submission date is the date you submit the request. And we also need to know if this is an initial or a resubmission. A resubmission means you submitted it one time, there were some pieces missing, or some element that did not pass first review, and you're resubmitting it.

And once again, you have to have the state.

Now, again just a quick review of the Medicare requirements. Because what you're doing with this pre-claim review, is you are showing the reviewer at Palmetto GBA that this patient meets the Home Health guidelines.

Additional Required Documentation

- Confined to the home at the time of services
- Medicare considers the person homebound if:
 - There exists a normal inability to leave the home, and
 - Leaving the home requires a considerable and taxing effort
- Additionally, one of the following must also be true:
 - Because of illness or injury the person needs the aid of supportive devices such as crutches, canes, wheelchairs and walkers; the use of a special transportation; or the assistance of another person in order to leave their place of residence; or

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- The person has a condition that leaving his or her home is medically coordinated
- You have to demonstrate that they are under the care of a physician
- Receiving services under a plan of care (POC) 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 a physician or non-physician practitioner (NPP)

First, the person must be homebound, or confined to the home. We're going to talk about ways to make sure your documentation tells that story.

Do you see that bullet that says, "due to illness or injury?" Your documentation has to explain something different from the person's baseline. You don't want to present a chronically ill person that's just getting older and is slowing down because they're just getting older. There has to be a medical reason why this person needs Home health services.

You have to demonstrate they're under the care of a physician, so we're going to talk about the plan of care part of this submission and the need for skilled services.

Now just remember, a simple order, physician ordering physical therapy, is not justification by itself. You have to provide documentation of the person's need. And we'll tell you how to do all of that in a few minutes.

You also have to make sure you submit the face-to-face information. We have a separate video that goes deep into the face-to-face information. It was targeted to the certifying physicians, but is also excellent for the Home Health agencies to look at also, so I recommend your staff watches that.

You have to make sure of the time frame—90 days before the start of care, or 30 days after. Make sure your encounter is in that window, and make sure that the date is clear so we can tell it's in that window and it has to be related to why the person needs those services.

HCPCS Codes Subject to the Pre-Claim Review Demonstration

You have to put the HCPCS codes for your disciplines on the claim. So, your nursing services, your physical therapist, your OT, your aids, your physical therapy assistants, social workers, all of those go on there.

And remember, when you put these codes on there, your documentation has to support a need for these services. If you put the need for speech language pathology on there by putting the HCPCS Code on there, but none of your documentation supports why you need a speech pathologist, that's not going to be affirmed, and you are going to have to resubmit.

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And those are the rest of the codes.

Flow Chart

This slide here is a critical pathway. Now if you are using the electronic portal, it is on there. It is also on our website under the tools for the PCR checklist and the links will be at the very end of the presentation.

This walks you through your logic on how to put your documentation together. Like I said, it's on the eServices portal, but whether you mail or fax it, use Pony Express or walk with it, the documentation requirement is going to be exactly the same. This gives you a perfect roadmap to make sure you have all the pieces.

Checklists

We also have two checklists that are on our website. And we're going to walk through this as we talk through this session on the subsequent and initial submission. The documentation for start of care is slightly different from a later episode, so we will highlight those. But these documents are great checklists to make sure you have everything, so you want to make sure the staff has put the right pieces in there, and you don't have to go through the resubmission process.

Required Documentation – In This Order by Task

The documentation will go under task, and regardless of what methodology you use – these same tasks will be there.

TASK 1 — The actual face-to-face (F2F) clinical encounter note used by the certifying physician to justify the referral for HH services

The first task is the face-to-face encounter documentation. So this is the document that originates from the physician. So either the outpatient, visit notes, an evaluation and management note, or something that came from the facility, either the discharge summary from the hospital or a progress note from the hospital, nursing facility, or wherever they happen to come from.

Now, remember that this document is supposed to support eligibility and need for services. So you're looking at something written in a problem-oriented format. It has a history of the problem, exam or physical assessment findings, and some type of plan that relates to this person's needs – nursing, physical therapy, they need something that Home Healthcare can provide. Remember, this task has to be there, you cannot skip this one even if you're talking about a later episode, you must put the face-to-face documentation in there regardless of the episode.

TASK 2 — The HH-generated records that have been signed, dated, and incorporated into the certifying physician's medical records

Task 2 is information generated by the Home Health agency to support what's in Task 1. Your Home Health agency has a lot of good information that they can actually obtain. Your comprehensive

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assessment has great pieces of documentation that looks at how the person can groom themselves, feed themselves, bathe themselves, ambulate, fall risk – all these things are natural pieces of your documentation. If the face-to-face information in Task 1 does not quite cover all of the needs, you can submit your documentation to the physician, have him sign off on that and include that with Task 2.

Other things can be your physical therapy assessment, that's going to contain natural things like the person's ability to ambulate, strength, issues with balance, coordination. All these things are going to point to a person needing skilled services, a person being homebound.

So, you can submit these and have the physician sign off on them and put them in Task 2.

Now the question is always asked: Does the physician always has to sign the comprehensive assessment, do they always have to sign a therapy evaluation?

If you want them counted as part of the face-to-face documentation, yes, they need to be cosigned.

If you feel the information in Task 1 supports itself, and you don't need any additional documentation to support the face-to-face, these do not have to be signed.

But my recommendation: if you're already getting all of that good information anyway because it's a requirement you have to do, why not go ahead and have the physician sign it and just put more evidence?

Now if you're using a face-to-face form still, that's fine. But the face-to-face form goes under this task, not under Task 1, because that is not something that originates from the physician. So your face-to-face form, if you're still using it, goes under this task.

TASK 3 — The plan of care (POC) signed and dated by the certifying physician

Task 3: the plan of care. A lot of people still using the good old CMS 485, or some facsimile of it. You need to put that under task three, that's the plan of care for the current episode, in the event this is a later episode, and the start of care plan. You have to have both of them. So if you leave out some of the other, you're going to run into a non-affirmation. It has to be signed, so make sure you have a signed version, and make sure you have a legible version. A lot of times, these get faxed, back and forth, back and forth, back and forth, to the doctor's office, and after that fourth fax everything gets blurry. So make sure you have a legible copy where the words can be read, the signature can be seen, and the date. Be careful of the margins when you're faxing and scanning.

Your typical 485 the signature is at the very bottom of the page. A lot of times that gets cut off when people are scanning and faxing. So make sure you get the entire document.

TASK 4 — The signed and dated physician's certification of patient eligibility

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Now Task 4 is the certification. If you're doing a traditional 485, most of the time that is going to be on the plan of care itself. In the event you have it written somewhere else, you would put it under this tab.

You also need to include the recertification statement when you're talking about a later episode. So, you have to have that statement from the physician that his patient will need skilled services for x amount of days, or x amount of weeks. Remember, you have to have a quantifier with time.

The question I know somebody has: "I have a patient, a diabetic, who is going to be here forever. What do I do about that person?"

You still have to go through this process. You can put a time longer than 60 days if you want to, but you have to do this every 60 days regardless of what time you put in there.

You have to put a time that's quantifiable: until discharge, until death do us part, some phrase like that is not acceptable. You have to have a timeframe where you can look on the calendar, and figure out exactly what you're talking about.

And if you have a long-term person, again, pick a date, and reassess at that time.

TASK 5 — Medical records that meet each HH requirement for "Confined to the Home"

Task 5 is going to be the most interesting task because there are so many things you can do with it. Task 5 is when you're supporting your person being homebound and you're supporting medical necessity.

So for homebound documentation, the words on the screen are referencing information from the manual. But you want to make sure your documentation includes it.

Now your comprehensive assessment should have a lot of information in it. So if you did not do this under Task 2, you can include it here. It would be the perfect place to do it. Your comprehensive assessment naturally talks about ambulation, if they have crutches, if they have a cane, things like that.

Your therapy assessment. If the person has a therapy order, you need to submit that. So put that here with Task 5. And also, your evaluation and assessment both go here. So the person has been on service and comfort of episodes, and you need the current assessment plus the previous one. So make sure you put all your therapy information here.

You also have to show that there's a medical reason the person can't leave home. As I said earlier, you don't want to take a picture of a little old person that's just winding down and can't leave the house because they're just getting old. So there are three little checklists that can help you do this.

Structural impairment is checklist one. Functional impairment is checklist two. Activity limitation is checklist three.

Checklist 1 — Structural Impairment

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Here is checklist one. It reverences structural impairment, so basically your visual inspection of your documentation. If this person has some type of visual anomaly, and that's what structural impairment is, is an anatomical change – that's where you want to put this. Now most of your patients may not have a structural impairment. Wound care would be an exception, or if they had a broken bone, or they had injuries from a fall, there you might see a structural change. But do not be concerned of your person does not have structural impairment. Your person may not have one.

Checklists two and three your person should definitely have.

Checklist 2 — Functional Impairment

Now checklist two is the physiological or functional part. So basically your physical assessment should identify a structural impairment. You're treating the person for a medical problem, so it should line up with one of the items on this checklist. If your person has out of control high blood pressure you would check functions of the cardiovascular system, and put in there your blood pressure record that shows the person's blood pressure is very high, very low, or fluctuations to or fro.

If the person has diabetes, you see functions of the metabolic and endocrine system.

Hyperglycemia versus hypoglycemia, fainting, dizziness, or the side-effects of that, will be your documentation. So whatever the reason you're admitting them, what symptoms go with that diagnosis naturally. You check that box and make sure you put that information in.

Checklist 3 — Activity limitation

Your activity limitations. You're looking at therapy. Therapy has to be working on something. What are they working on? If physical therapy is working on that person's ambulation and transferring, you would check "mobility."

If occupational therapy is helping them dress themselves, you have "self care." You also have speech-language pathology helping with communication, or domestic life, helping them with feeding themselves. Whatever your therapist is signed up to do, there is something on this list you can match it to. So your therapy assessments, your therapy evaluation, if you want to stick in some of your therapy individual visit notes, that would be helpful.

You also want to make sure your therapy goals are in this section, what your therapist is working on. Measurable goals. A person will walk from the bedroom to the bathroom, which is 30 feet, in six weeks. You have to have something that is quantifiable. You don't want to have a \$6 million dollar man, though: a person will get better, stronger, faster. That's not going to cut it. You have to have something that is measurable and has action started / action finished.

Homebound Documentation

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For homebound—don't take for granted that you write down that somebody had a fall that makes them homebound. Make sure that you are giving the symptoms. The person has a cane, they have crutches. If the person is new to this device you want to make sure that's brought out. A person with a walker for one week versus a person with a walker for six years, that tells a different story.

Medical symptoms that make the person homebound: shortness of breath. A very powerful thing in documentation. How far can that person walk without shortness of breath?

The person cannot bear weight. They have a gaping wound on their leg, so they can't put weight on that leg. Those are powerful examples of things to talk about.

State the issue. If your person has a psychiatric issue, or some type of dementia is the reason they're homebound, make sure that's clearly documented. Sometimes the providers don't do that, and the functional part shows they can walk fine, so we don't know why that person is homebound.

Pain is something you want to make sure you're documenting. Don't just say pain, yes or no. This patient's pain is normally a 2, now it's a 9. You'll want to make sure that you are showing something different.

Four Questions

So these four questions that you've been in Palmetto GBA sessions should look familiar to you. If you can answer these four questions in your documentation you should have told that person's story for field services and for homebound.

Four questions:

- Structural impairments
- Functional impairments
- Activity limitations
- What's a nurse or therapist going to do about it.

That fourth bullet is probably the most important, because that defines why the person is in Home Health. Nursing and therapy are going to be what gets you paid. So you have to justify why they are there.

Structures and Functions

And those are just definitions on the screen about structures and functions. We've already discussed that.

Activity Limitations

Activity limitations – look at those ATLS they should do every day: feeding themselves, bathing themselves, brushing their teeth, combing their hair. They can't do that because of their illness, how's the therapist, how's the nurse going to help them over that hump.

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So remember your chronically ill person has to have an acute problem, an acute symptom. That's what the Home Health agency is doing. The person is going to have high blood pressure the rest of their life, so you're not going to make that part go away. You're getting them stable, that's what you're doing: stabilizing an exacerbation of a chronic condition

Now to help yourself out with medical necessity you want to make sure you that you're choosing the proper diagnosis. You want to avoid integral part codes as principle diagnosis.

You have to make sure you are coding the diagnosis, not the symptom. For example, my person has gastroenteritis. And you know what that is: you have a stomach bug. A natural symptom of that is nausea, another natural symptom is vomiting.

You do not want to say I'm admitting this person because they have nausea and vomiting when you know they have gastroenteritis. Those are natural symptoms of that disease. So the gastroenteritis would be your admission. That's just an example.

Other things you want to be documenting: looking at the body systems, deviations from normal.

Functions of the Cardiovascular System

So again, you're looking at the cardiac system. What's different? I can't walk as far as I used to walk. I can't transfer like I used to. I used to sit up, now I'm stuck in the bed.

What is different? They have some type of condition where they wear themselves out. That's what you want to do—think of that before and after: before I had this exacerbation, I could do this; since I've had it, this is what my limitation is.

Functions of the Respiratory System

Respiratory, same type thing – shortness of breath at rest, inability to talk, I can't yell at TV during the football game. Something that's different.

Talking is something that people just overrate, but if you're on the phone and used to talk for five minutes, now you only talk one minute before you run out of breath, .that's a significant finding, so don't overlook something like that.

Functions of the Musculoskeletal System

Muscle/skeletal changes just really will help your homebound. How far can a person walk? What do they need to get from point A to point B? Do they need crutches? Do they need a ramp now? Do they lean against a wall? They can't bear weight? What's different about them trying to get from point A to point B?

I referenced a diabetic patient already. What symptoms make them need Home Health? Their blood sugar is high, low, they're having confusion, they're having confusion, they're having those kinds of symptoms. What is different?

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If you're admitting them because they cannot give their own insulin, make sure that it is documented why the person cannot use their hands for whatever reason. They can't see because they have diabetic retinopathy. Your rationale is, make sure that's clearly documented.

Activity Limitations

And make sure your activities are just there so we know why therapy is there. Based on that physical symptom, it should tie to an inability to do something to take care of myself. Going back to these four questions, if you can answer all four of those questions, you should be in very good shape.

Now here are a few extra-special golden nuggets to help put you over the top.

Looking at your nursing services, those G-Codes that we referenced earlier.

Observation and Assessment

Observation and Assessment: that is when we have a patient that needs some observation to make sure they are going to be okay getting back to their normal life. Either with monitoring their medication because we had to change them, or they just had a heart attack so we're making sure they're not overdoing it. Whatever reasons you're observing, make sure that it's clearly documented.

What are you looking to prevent? What are you hoping doesn't happen? So you have to say this is what I'm observing for, and roughly every three weeks you have to have a summary. Is this person looking like they're doing better or they're still at risk for exacerbation and I need to continue to observe them.

So, some vague statements people have been writing for years: "monitoring disease process," that does not tell anything by itself. Good old "medication management" – I know people love that one. What are you managing specifically? Are there new medications? Did somebody change the dose? Are you looking for a side effect? Adverse reaction?

What does medication management mean as far as the Home Health benefit?

Teaching and Training

This is another one of those goodies that people use and don't explain what they are doing.

Teaching and training means tasks you are trying to teach that beneficiary: teaching them to give their own insulin; working with an Alzheimer's person to dress themselves, brush their teeth, or do some type of simple function.

So once again have a specific task what you're trying to do. You should have something listed there that has a beginning and an end so we know when that person has completed that task.

You have to have a reasonable amount of time if you're trying to teach somebody do a wound, and after a certain amount of time they're just not getting it, you need to adjust your plan and come up

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with a plan B. So you want to document those efforts, why it didn't work, and what we're going to do next.

The Therapy Documentation

We have had issues with people forgetting these documents, so I want to reiterate this. You have to include your therapy evaluation, current therapy, 30-day assessment, and the previous one if the time factor is appropriate. You have to include your goals. If those things are not included, your claim will not be affirmed.

You have to have a good baseline for therapy, and these are your basic ADLs up on the screen — eating, bathing, dressing.

You have to know what that person's baseline is so you can document if they're improving. You can't say someone walks better when you didn't document what they were walking like in the first place. Make sure you have a baseline on these actions on the screen.

There are several listed in the Medicare manual 100-2, chapter 15.

If you look at the American Physical Therapy Association's Home Health section it gives you many objective measures. I put some common ones on the slides that many of you use. The point I want to bring out is, you have to be specific when you're using these tools.

These are used to identify somebody's risk for falling. They don't all have the same exact scale. So just to simply say, my patient is a fall risk 5 with no other information, that doesn't tell me anything. Explain what tool you use and what that score means.

Medical Record Audit Tool

Definitely include that. If you have the form, include that. But definitely put the score and what tool you definitely used.

Palmetto GBA PCR Resources

This is a tool that is on the Palmetto GBA web site. We originally put it together for regular ADRs, but it's an excellent tool for pre-claim reviews.

Make sure you include this. Did I add that? Did I get this page signed? So there is the hyperlink that will help your staff with training, and also making sure you have the right pieces in there.

Our pre-claim review section has a lot of resources. It has job aids, it has videos listed under there, there are several sources, so there's the Web link on the screen, please take advantage of those.

HH PCR eServices Submittal; Request User Guide & Checklists

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Here's the User Guide I referenced earlier. It has the checklist, it has that wire diagram, so this is a must. You want to check this periodically, because as we get updates to the processes we will update this manual. This will be your holy grail, basically, for submitting your claims.

Resources

So, these are some other references we have. We will continually put updates as soon as we get information that will be helpful to you. We will definitely put that on the website so you can know the up-to-date changes. And here are other changes that we will list, like Frequently Asked Questions, or our FAQ sheet, we will update as time goes along.

So we want to make sure you have all the tools you need your pre-claim request affirmed.

Don't give up if it's not affirmed the first time, you can resubmit it over and over again until you get it right. The good thing about this is you have a chance to get something else. If you didn't get enough information from the physician, you go back and get some more. As long as you do these things before the final thing is billed you are able to go back and get that fixed.

We want to see everybody get their claims paid. We want people to get paid for the services they provide and we want the beneficiary to receive the proper services. That's our mission at Palmetto GBA. So we are going to continue to produce new tools.

So please watch the website, watch the Listserv. So whenever we find something that is going to help you, we're going to put it out there.

I'm Charles Canaan with Palmetto GBA. Thanks for watching.