



Part I: Overview of the Home Health Review Choice Demonstration (RCD)

Presented by Palmetto GBA Provider Outreach and Education



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Disclaimer

- The information provided in this presentation is accurate as of today. This information reflects how Palmetto GBA expects to implement these processes based on CMS guidance, but everything is pending Paperwork Reduction Act (PRA) approval.
- The information enclosed was current at the time it was presented. Medicare policy changes frequently; links to the source documents have been provided within the document for your reference. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations.
- Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- This presentation is a general summary that explains certain aspects of the Medicare program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.



Background

- Pre-Claim Review (PCR):
 - On April 1, 2017, CMS paused the PCR Demonstration for Home Health Services while CMS considered a number of changes
 - CMS revised the demonstration to incorporate more flexibility and choices for providers, as well as risk-based changes to reward providers who show compliance with Medicare home health policies

Review Choice Demonstration (RCD)

- This Review Choice program is for home health services in the states of Illinois, Ohio, North Carolina, Florida and Texas
- During this 5-year intervention period, CMS will test the use of review options for home health services covered under Part A of the Medicare Fee-for-Service program

Review Choice Demonstration (RCD)

- The Demonstration furthers CMS's efforts to protect the Medicare Trust Funds from improper payments and to reduce Medicare appeals
- The demonstration would help make sure that payments for home health services are appropriate through either pre-claim, prepayment or postpayment review; thereby working towards the prevention and identification of potential fraud, waste, and abuse, the protection of Medicare Trust Funds from improper payments, and the reduction of Medicare appeals
- CMS expects that creating a review choice process will ensure that Medicare coverage and documentation requirements are likely met

Review Choice Demonstration (RCD)

- RCD does not create new documentation requirements
- Home Health Agencies (HHAs) will submit the same information they are currently required to maintain for payment
- Medicare Beneficiary eligibility and benefits remain the same with this demonstration

Review Choice Demonstration (RCD)

- Each home health 60-day benefit period episode of care will be reviewed under the review option chosen by the HHA
- Home health services for less than 60-days will still require review under the demonstration with the exception of a Low Utilization Payment Adjustment (LUPA) claims with four or fewer visits, however, all other episodes that include five or more visits are eligible for review
- Each claim for a 60-day episode where the PCR option was chosen but a PCR request was not submitted, is subject to prepayment medical review and if payable, a 25% payment reduction

Review Choice Selection Method

- You will make your selection through the eServices online provider portal: www.palmettogba.com/eservices
- You will be asked to select from one of the three initial review choice options for medical review of your home health claims
- Be sure to read each option thoroughly prior to making a selection as some review choice selections require you to remain in that choice for the duration of the 5 year demonstration

My Review Choice Selection

Please select from one of the three review choice options for medical review of your home health claims. Be sure to read each option thoroughly prior to making a selection as some selections will be locked-in for the duration of the demonstration.

For more information about this topic, please see the Review Choice category at www.PalmettoGBA.com

The current Review Choice Selection period ends on 9/17/2018. Once this period ends you will be unable to change your choice until the next cycle (5/1/2019-5/15/2019).

The changes you make on this screen will apply to the following provider:

Contract/Region 11001Part A South Carolina / HHRH

Provider Name

Provider Number (PTAN)

National Provider Number (NPI)

Review Choice As of 2018-08-10

Minimal Review

Minimal Review - 100% of claims have a 25% payment reduction. All providers who make this selection will be referred to the Recovery Audit Contractor. **Must remain in this option for the 5 year duration of the demonstration.**

Pre-Claim Review (PCR) **In Processing**

Pre-Claim Review (PCR) - 100% of claims are reviewed prior to final claim submission.

Post-Payment Review

Post Payment Review - 100% of claims are reviewed after final claim submission.

Save

View History

Review Choice Demonstration (RCD)

- Providers will choose their initial review choice selection prior to implementation in each state
- HHAs who do not actively choose one of the initial three review options will be automatically assigned to participate in the option for postpayment review of all their claims



Selection & Implementation Dates Per State

State	Choice Selection Dates	Implementation Date
Illinois	4/17/2019 – 5/16/2019	6/1/2019
Ohio	8/16/2019 – 9/15/2019	9/30/2019
North Carolina	TBD	TBD
Texas	TBD	TBD
Florida	TBD	TBD

Three Initial Review Choice Options

Pre-Claim Review (PCR)	Postpayment Review of ALL Claims	Minimal Review – 25% Payment Reduction on ALL Payable Claims
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Three Subsequent Review Choice Options

Pre-Claim Review	Selective Postpayment Review	Spot Check of 5% of Their Claims to Ensure Continued Compliance
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Threshold and Affirmation Rate

- If the HHA's full affirmation rate or claim approval rate is 90 percent or greater for a minimum of 10 claims or requests for the 6-month period, they may choose one of the subsequent review options:
 - Start or continue participating in PCR for another 6-month period
 - Selective postpayment review of a statistically valid random sample (SVRS) of claims every 6-months, for the remainder of the demonstration; or
 - No review, other than a spot check of 5% of their claims every 6-months to ensure continued compliance



Initial Review Option – Pre Claim Review (PCR)



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PCR Process Applies to TOBs:

- 327
 - 329
 - 32F
 - 32G
 - 32H
 - 32I
- 32J
 - 32K
 - 32M
 - 32P
 - 32Q

PCR Process Applies to HCPCS Codes:

- G0151
- G0152
- G0153
- G0155
- G0156
- G0157
- G0158
- G0159
- G0160
- G0161
- G0162
- G0299
- G0300
- G0493
- G0494
- G0495
- G0496

Request for Anticipated Payment (RAP)

- RAPs are NOT included in this demonstration
- No changes in the RAP submission process
- RAP can be submitted as usual
- No changes in the processing and payment of a RAP
- Note: The auto cancellation of a RAP when the final has not been submitted timely will also not change under the PCR process
 - Providers 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

Episodes of Care

- Under the PCR option, a request may be submitted for more than one 60-day episode for a beneficiary
- The PCR decision will indicate the number, if any, of provisionally affirmed episodes
- A provisional affirmative PCR decision, justified by the beneficiary's condition, may apply to some or all of the number of episodes requested
- For any additional episodes that are requested, a Plan of Care must be submitted with the request

Episodes of Care

- Only one HHA is allowed to request PCR 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 PCR request is not needed unless a separate claim will be filed

Medicare Secondary Payer (MSP)

- PCR is not required for claims billed with the GY modifier – Item or Service statutorily excluded or does not meet the definition of any Medicare benefit
- PCR is required for claims billed with the GA modifier – Waiver of liability statement on file

Medicare Secondary Payer (MSP)

- If providers wish to use PCR for a denial, they would follow the normal process and submit the request and the documentation
- If the claim is non-affirmed, the provider would then submit the non-affirmed UTN on the claim for a denial
- The provider may then submit the denied claim to their secondary insurance

Submitting for MSP with PCR

- Submit the PCR request and documentation
- Submit the claim to the primary insurance for payment consideration
- Next, submit the MSP claim to Medicare with the UTN for processing

MSP When You Don't Seek PCR

- Submit the claim to the primary insurance to make payment consideration
- Next, submit the MSP claim to Medicare for payment consideration and the claim will stop for pre-payment review

Submitting PCR Requests to Palmetto GBA

- eServices
 - IMPORTANT: This is our preferred method of submission
 - View the [eServices User Manual](#) for more information
 - eService User Guide for the Decision Tree and Checklist
 - Note: Batch submissions are not available at this time
- Electronic Submission of Medical Documentation (esMD)
 - Go to www.cms.gov/esMD for more information
 - Note: Multiple episode submissions are not allowed through esMD at this time
 - Note: Batch submissions are not available through esMD at this time
- Mail
 - Palmetto GBA – JM HH Pre-Claim Review
 - PO Box 100131
 - Columbia, SC 29202-3131
- Fax
 - 803-419-3263

Palmetto GBA's eServices

- A free Internet-based, provider self-service secure application – www.palmettogba.com/eservices
 - It is the easiest way to submit a PCR request!
 - It is the surest way to know it has been received!
 - It is the fastest way to receive the decision!
 - 97% of PCR requests in the PCR demonstration were submitted using eServices

Palmetto GBA's eServices

- HHAs complete an online submittal request, which prepopulates some provider information to help reduce errors and save time
- HHAs scan supporting documentation and attach it to the request (attachments must be in “.pdf” format)
- Once a request has been accepted into our system, the received date will be assigned and an additional user message will be generated with the Document Control Number (DCN) letting you know it is in process



Palmetto GBA's eServices

- Submission TIPS
 - You may attach individual attachments for each Task or you may attach one document with all attachments and refer to that attachment for each subsequent task
 - eServices will give an error message if an attachment with the same name is attached to a different Task



User: jane salter

Provider:

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Get Status

You have 29 unread message(s) and 0 alerts.

Help

eServices

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RCD Choice Selection Pre-Claim Review Submission Incomplete PCR Requests

Pre-Claim Review JM HH

[Provider Information](#)



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Pre-Claim Review Form JM HHH

Provider Information

Contract/Region

Provider Number (PTAN)

Provider/Facility Name

National Provider Identifier (NPI)

Requestor Name*

 X

Requestor Phone Number*

 X

Requestor E-mail *

 X

Ext

 X

Date



Beneficiary Information

Beneficiary First Name*

Beneficiary DOB*

Validate Beneficiary Information

Beneficiary Last Name*

Medicare ID*

Ordering / Referring Physician Information

NPI*

Name*

Address Line 2

State*

Address Line 1*

City*

Zip*

Attending / Certifying Physician Information

NPI*

Name*

Address Line 2

State*

Address Line 1*

City*

Zip*



Claim Information

Pre-Claim Review Episode Start Date*

08/08/2016 ✓

Pre-Claim Review Episode End Date*

10/07/2016 ✓

Type of Bill (TOB)*

329 ✓

HCPCS Code(s)*

G0153 X G0158 X G0162 X |

G0151

G0152

G0153 ✓

G0155

G0156

G0157

G0158 ✓

G0159

G0160

G0161

Dynamic Tree

Q1: Was the beneficiary admitted to your home health agency directly from an acute o

Attached Files

File Name

File Size (in bytes)

No data available in this

Validate Beneficiary Information

Claim Information

Pre-Claim Review Episode Start Date*

07/06/2016

Pre-Claim Review Episode Start Date can not be before 08/01/2016



Pre-Claim Review Episode End Date*

07/05/2016

Pre-Claim Review Episode End Date can not be same as or greater than 60 days of Episode Start Date



Type of Bill (TOB)*

329

HCPCS Code(s)*

G0153 X G0158 X G0162 X

Dynamic Tree

Q1: Was the beneficiary admitted to your home health agency directly from an acute or post-acute facility?*

Yes No

Select the facility from the following choices*

Acute Care Facility

Q2: Was the home health certification and face-to-face (F2F) encounter performed by the same physician?*

Yes No

Task 1: Upload the actual F2F clinical encounter note used by the certifying physician to justify the referral for Medicare home health services.*

Dynamic Tree

Q1: Was the beneficiary admitted to your home health agency directly from an acute or post-acute facility?*

Yes No

Select the facility from the following choices*

- Acute Care Facility
- Inpatient Rehabilitation Facility (IRF)
- Long-term Care Hospital (LTCH)
- Skilled Nursing Facility (SNF)

Confined to the Home: First Criteria

Q4: Does the beneficiary, because of illness or injury, need *
The aid of supportive devices such as crutches, canes, wheelchairs, and walkers? OR
The use of special transportation? OR
The assistance of another person to leave their place of residence?
Yes to one or more of the above No to all of the above

Task 5: Upload medical documentation that meets the First Criteria for Confined to the Home*

Confined to the Home: Second Criteria

Q6: Is there a normal inability to leave the home? * Yes No

Task 6: Upload the documentation to support the normal inability to leave the home?*


ERRORS:

File eServices Test Attachment_Home Bound 1.pdf is already attached. Please attach another file

Q3: Do you have any home health agency (HHA) generated records (for example patient's comprehensive assessment) that have been signed, dated, and incorporated into the certifying physician's medical records? * Yes No

Task 2: Upload the HHA generated records that have been signed, dated, and incorporated into the certifying physician's medical records*

Or

Refer to another Task For Task2 Attachment* 

Task 2 Information Reference Page #

Confined to the Home: Second Criteria

Q6: Is there a normal inability to leave the home? * Yes No

Task 6: Upload the documentation to support the normal inability to leave the home?*

Q7: Does leaving the home require a considerable and taxing effort? * Yes No

Task 7: Upload the documentation to support the considerable and taxing effort*

Q8: Is there a structural impairment? * Yes No

Please specify which domains this structural impairment affects* 

- Structures of the nervous system
- Eye, ear, and related structures
- Structures involved in voice and speech
- Structures of the cardiovascular system
- Structures of the immunological system
- Structures of the respiratory system
- Structures related to the digestive system
- Structures related to the metabolic and endocrine systems
- Structures related to the genitourinary system
- Structures related to movement

Attached Files	
File Name	File Description
eServices Test Attachment_Cor Assessment.pdf	Task 2: The HHA generated rec that have been signed, dated, a incorporated into the certifying physician's medical records
eServices Test Attachment_F2F Clinical Encounter Note.pdf	Task 1: The actual F2F clinical encounter note used by the cert physician to justify the referral

Attached Files

File Name	File Size (in bytes)	File Type	File Description	
eServices Test Attachment_Comprehensive Assessment.pdf ✓	2098	application/pdf	Task 2: The HHA generated records that have been signed, dated, and incorporated into the certifying physician's medical records	- Remove
eServices Test Attachment_F2F Clinical Encounter Note.pdf ✓	2104	application/pdf	Task 1: The actual F2F clinical encounter note used by the certifying physician to justify the referral for Medicare home health services	- Remove
eServices Test Attachment_Home Bound 1 ✓	2107	application/pdf	Task 5: Upload medical documentation that meets the First Criteria for Confined to the Home	- Remove
eServices Test Attachment_Physicians Certification.pdf ✓	2124	application/pdf	Task 4: The signed and dated physician's certification of patient eligibility	- Remove
eServices Test Attachment_Plan of Care.pdf ✓	2096	application/pdf	Task 3: The plan of care established and periodically reviewed by an authorized physician	- Remove
Total File Size: 10 KB Max Allowed: 150MB				

Showing 1 to 5 of 5 entries

[« First](#)
[« Prev](#)
[1](#)
[Next »](#)
[Last »](#)



15 MINUTE BREAK



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Q10: Is there an activity limitation? * Yes No

Episode 2 Information

Is there a subsequent episode?* Yes No

Episode 2 Information

Is there a subsequent episode?* Yes No

Pre-Claim Review Episode Start Date*

Pre-Claim Review Episode End Date*

Type of Bill (TOB)*

HCPCS Code(s)* 

Task 3: Upload the plan of care established and periodically reviewed by an authorized physician*

Or

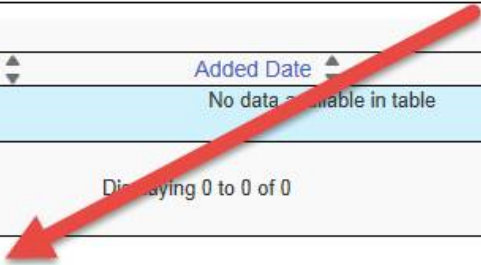
Refer to another Task For task3 Attachment* 

Task 3 Information Reference Page #

Files			
File Name	File Size (in bytes)	File Type	File Description
No data available in table			
File Size: Maximum: 150MB			
Displaying 0 to 0 of 0		« First « Prev Next »	

Attached Files			
File Name	UTN	Added Date	File Description
No data available in table			
Displaying 0 to 0 of 0		« First « Prev Next »	

Field



Your information contains 11 errors

- **Beneficiary First Name is a required field.**
- **Beneficiary Last Name is a required field.**
- **Beneficiary DOB is a required field**
- **HCPCS Code(s) is a required field.**
- **HIC Number is a required field.**
- **Requestor Name is a required field.**
- **Pre-Claim Review Episode End Date is a required field**
- **Pre-Claim Review Episode Start Date is a required field**
- **Requestor E-mail is a required field.**
- **Requestor Phone Number is a required field.**
- **Type of Bill (TOB) is a required field**



User: Frances Hul

Provider:

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Get Status You have 14 unread message(s) and 0 alerts. Help

RCD Choice Selection Pre-Claim Review Submission **Incomplete PCR Requests**

Incomplete PCR List

Show entries

Search:

Date	User id	Medicare ID	Action
2018-09-11 14:41:44.784	0m07911	82	Edit Delete

Showing 1 to 1 of 1 entries

Previous Next



Message ✕

Subject: HH Pre-Claim Review Received

Message: Hello, Your Home Health Pre-Claim Review request was submitted successfully. You will receive a second message containing the Document Control Number (DCN) once processing to the workflow management system is complete

Message ID: 36745

Beneficiary Name: JANE DOE

Beneficiary DOB: 01/01/1930

Beneficiary HIC Number: 000000000A

Episode Start Date: 08/30/2016

Episode End Date: 08/31/2016

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INBOX ARCHIVE

Filter Inbox

DCN

Form Type All

Filter

Search with DCN

Click on the subject links to view messages. Bold links indicate new unread messages. Delete Selected

Show 10 entries

Select All	Date	Subject	DCN	Archive
<input type="checkbox"/>	Tue May 28 11:31:17 EDT 2019	HH Pre-Claim Review Decision		
<input type="checkbox"/>	Wed May 22 12:12:05 EDT 2019	HH Pre-Claim Review Decision Letter eLetter		
<input type="checkbox"/>	Tue May 14 15:16:07 EDT 2019	HH Pre-Claim Review UTN		
<input type="checkbox"/>	Fri May 3 14:08:18 EDT 2019	HH Pre-Claim Review Confirmation		
<input type="checkbox"/>	Fri May 3 14:06:26 EDT 2019	HH Pre-Claim Review Received		

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INBOX ARCHIVE

Filter Inbox

DCN

Form Type **HH Pre-Claim Review**

Episode Start Date

Medicare ID

UTN

Filter

Search with Form Type and Medicare ID

Click on the subject links to view messages. Bold links indicate new unread messages. Delete Selected

Show 10 entries

Select All	Date	Subject	DCN	Archive
<input type="checkbox"/>	Tue May 28 11:01:01 EDT 2019	HH Pre-Claim Review Decision		<input type="checkbox"/>
<input type="checkbox"/>	Wed May 22 12:12:04 EDT 2019	HH Pre-Claim Review Decision Letter eLetter		<input type="checkbox"/>
<input type="checkbox"/>	Wed May 15 09:26:02 EDT 2019	HH Pre-Claim Review UTN		<input type="checkbox"/>
<input type="checkbox"/>	Thu May 9 14:23:29 EDT 2019	HH Pre-Claim Review Confirmation		<input type="checkbox"/>
<input type="checkbox"/>	Thu May 9 14:18:22 EDT 2019	HH Pre-Claim Review Received		<input type="checkbox"/>

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INBOX ARCHIVE

Filter Inbox:

DCN

Form Type **HH Pre-Claim Review**

Episode Start Date **06/01/2019**

Medicare ID

UTN

[Filter](#)

Search with Form Type and Episode Start Date

Click on the subject links to view messages. Bold links indicate new unread messages.

[Delete Selected](#)


Show **10** entries

<input type="checkbox"/> Select All	Date	Subject	DCN	Archive
<input type="checkbox"/>	Tue May 28 12:01:12 EDT 2019	HH Pre-Claim Review Decision		
<input type="checkbox"/>	Tue May 28 11:01:01 EDT 2019	HH Pre-Claim Review Decision		
<input type="checkbox"/>	Wed May 22 12:12:07 EDT 2019	HH Pre-Claim Review Decision Letter eLetter		
<input type="checkbox"/>	Wed May 22 12:12:04 EDT 2019	HH Pre-Claim Review Decision Letter eLetter		
<input type="checkbox"/>	Wed May 15 17:36:00 EDT 2019	HH Pre-Claim Review UTN		
<input type="checkbox"/>	Wed May 15 13:57:12 EDT 2019	HH Pre-Claim Review Confirmation		
<input type="checkbox"/>	Wed May 15 13:49:31 EDT 2019	HH Pre-Claim Review Received	No DCN Available	
<input type="checkbox"/>	Wed May 15 09:26:02 EDT 2019	HH Pre-Claim Review UTN		
<input type="checkbox"/>	Thu May 9 14:23:29 EDT 2019	HH Pre-Claim Review Confirmation		
<input type="checkbox"/>	Thu May 9 14:18:22 EDT 2019	HH Pre-Claim Review Received		

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INBOX ARCHIVE

Filter Inbox

DCN

Form Type **HH Pre-Claim Review**

Episode Start Date

Medicare ID






UTN

Filter

Search with Form Type and UTN

Click on the subject links to view messages. Bold links indicate new unread messages. **Delete Selected**

Show 10 entries

Select All	Date	Subject	DCN	Archive
<input type="checkbox"/>	Tue May 28 11:01:01 EDT 2019	HH Pre-Claim Review Decision		
<input type="checkbox"/>	Wed May 22 12:12:04 EDT 2019	HH Pre-Claim Review Decision Letter eLetter		
<input type="checkbox"/>	Wed May 15 09:26:02 EDT 2019	HH Pre-Claim Review UTN		
<input type="checkbox"/>	Thu May 9 14:23:29 EDT 2019	HH Pre-Claim Review Confirmation		
<input type="checkbox"/>	Thu May 9 14:18:22 EDT 2019	HH Pre-Claim Review Received		

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Palmetto GBA Submittal Request

PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

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JM HH PRE-CLAIM REVIEW SUBMISSION REQUEST

All fields are REQUIRED unless otherwise noted. Incomplete or handwritten requests will be returned.

Check the appropriate box below:

Initial Submission
 Resubmission Enter UTN of most recent submission:

If this is a resubmission, do you have a copy of the most recent Non-Affirmation decision letter for this episode?
 Choose an item:

Note: Use of this request document will require submission via fax, hard copy mail, or the electronic submission of Medical Documentation (esMD). To save time, use our eServices web portal to submit your request, upload your documentation electronically, track the status of your request, and receive a quicker response.

Provider Information

Contract/Region 11001	Provider Number (PTAN) <input type="text"/>
Provider/Facility Name <input type="text"/>	National Provider Identifier (NPI) <input type="text"/>
Provider/Facility Address Line 1 <input type="text"/>	Requestor Name <input type="text"/>
Provider/Facility Address Line 2 (if applicable) <input type="text"/>	Requestor Phone Number Ext. (if applicable) <input type="text"/> <input type="text"/>
Provider/Facility City <input type="text"/>	Fax (if applicable) <input type="text"/>
Provider/Facility State Provider/Facility ZIP <input type="text"/> <input type="text"/>	Requestor E-mail <input type="text"/>

A decision letter will be mailed to the address provided above. If desired, the provider may enter a fax number to which the decision letter will be sent.

Ordering/Referring Physician Name <input type="text"/>	Ordering/Referring Physician NPI <input type="text"/>
Ordering/Referring Physician Address Line 1 <input type="text"/>	Ordering/Referring Phys. Address Line 2 (if applicable) <input type="text"/>
Ordering/Referring Physician City <input type="text"/>	Ordering/Referring Phys. State Ordering/Referring Phys. ZIP <input type="text"/> <input type="text"/>
Attending Physician Name <input type="text"/>	Attending Physician NPI <input type="text"/>
Attending Physician Address Line 1 <input type="text"/>	Attending Physician Address Line 2 (if applicable) <input type="text"/>
Attending Physician City <input type="text"/>	Attending Physician State Attending Physician ZIP <input type="text"/> <input type="text"/>

Review Time Requirements

- For the initial submission of the PCR request, MACs are required to make the decision and notify each submitter within ten (10) business days (excluding Federal holidays) of receipt of the request
- The submitter will be notified if the decision is incomplete, provisionally affirmative or non-affirmed
- The Decision notification will contain a Unique Tracking Number (UTN)
- The decision notification will be sent to the submitter based on how it was received
 - Note: To protect PII/PHI, we will only fax back the response if you have clearly identified in the fax field on the submittal request the fax number you want us to use

Provisional Affirmative Decision

- A provisional affirmation 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 decision applies only to the episode for which the PCR was submitted
 - The notification will include:
 - UTN
 - Which HCPCS were affirmed

Provisional Affirmative Decision

- A provisionally affirmative decision is not transferable and does not follow the beneficiary
- If a beneficiary with an provisionally affirmed decision transfers to another HHA during that 60-day episode of care, the receiving HHA must submit their own HH PCR request

Non-Affirmation Decision

- A non-affirmation decision is rendered when:
 - The documentation submitted does not meet one or more Medicare requirements
 - The notification will include:
 - Non-affirmed UTN
 - Which HCPCS were non-affirmed
 - A detailed explanation of which requirements have not been met to affirm the HCPCS

Resubmitting PCR Request to Palmetto GBA

- Resubmission of a PCR request can be done for non-affirmation decisions
- The submission process is the same as for initial requests except it will be identified as a resubmission
- There is no limit to the number of times the PCR can be resubmitted
- The submitter should select “Resubmission” on the submission request
- The submitter should also provide the UTN of the most recent non-affirmation decision letter
- Note: At this time, providers submitting through esMD MUST notate on the documentation that it is a resubmission for it to process correctly

Resubmission Review Time Requirement

- MACs have 20 business days (excluding Federal holidays) from the date received to conduct the medical review, make the decision(s), and notify the requester(s) of the decision(s)
- A notification will be sent to the submitter for each request received that provides a provisional affirmative or a non-affirmation decision
- A notification will also be sent to the beneficiary for each request received that provides a provisional affirmative or a non-affirmation decision

Submitting the Final Claim

- Normal data submitted on the claim is required
- The services on the claim should represent the actual services provided
- TOB is 329 for HH Final Claim
- Enter the 14 byte UTN provided in the PCR notification
 - Electronic claim:
 - In Positions 19 through 32 of loop 2300 REF02 (REF01=G1)
 - It will follow the OASIS assessment data which will remain in positions 1 through 18
 - UB-04 Claim Form:
 - Positions 19 through 32 of field locator 63

Impact of the PCR Decision

- Claims are subject to all processing edits
- If all requirements are met, and a provisionally affirmative decision was issued, payment will be made on the claim
- If a non-affirmed decision was made, Medicare will deny payment on the claim
- A denied claim based on a non-affirmation decision will constitute an initial payment decision and the standard claims appeals process will apply

PCR and the Appeals Process

- The standard appeals process applies to the final claim
- There is no appeal process for a non-affirmation PCR decision
- In order to access appeal rights, the final claim should be submitted with the non-affirmed UTN which will result in a denial of the claim with the ability to appeal
- Note: If the final claim is submitted after the PCR without the UTN it will RTP advising that the UTN is needed on the claim



Initial Review Option – Postpayment Review



Presented by Palmetto GBA Provider Outreach and Education



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Postpayment Review Option

- 100% of claims are reviewed upon submission of the final claim
- Once the claim is received, an ADR will be sent
- 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



Initial Review Option – Minimal Review



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Minimal Review Option

- 25% payment reduction on all payable claims
- Claims are excluded from MAC targeted Probe and Educate reviews (TPE)
- Providers who make this selection may be subject to Recovery Audit Contractor (RAC) review
- **NOTE:** Must remain in this option for the 5 year duration of the demonstration



Subsequent Review Option – Pre Claim Review (PCR)

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PCR Option

- The HHA may begin or continue participating in PCR for a 6-month period
- If provisional full affirmation rate remains at or above 90% for at least 10 requests
 - HHA may choose to continue to participate in PCR or may choose another subsequent review option
- If the HHA falls below the 90% threshold or 10 requests
 - HHA must select from one of the initial review options



Subsequent Review Option – Selective Postpayment Review



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Selective Postpayment Review Option

- Under this option a selective postpayment review of a statistically valid random sample of claims will be pulled every 6-months
- Once chosen the HHA will remain here for duration of the demonstration



Subsequent Review Option – Spot Check



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Spot Check Option

- No reviews conducted other than a spot check of 5% of a HHA's claims during a 6-month period to ensure continued compliance
- Continued compliance will be monitored through the selection of those 5% of claims for prepayment review
- The HHA can continue to select this option each 6-month period unless the spot check indicates the HHA is not compliant with Medicare coverage rules and policy, in which case the HHA must again choose one of the initial three review options

Six Month Review Period Overview

- For those options that are evaluated every six months, the claims or PCR requests reviewed during the six month period will determine the providers results
- Providers will continue in their selected option during the evaluation and selection period
- The evaluation period occurs during month seven
- At the end of month seven, providers will be able to select their option during a two week window



RCD Self Service Tools and Resources



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RCD Status Tool

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CMS
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Review Choice Lookup

Please enter data in all of the fields displayed to retrieve the status of your Review Choice Demonstration Option(s). The Provider Name, Choice(s) Selected, Selector and Date will be displayed.

Please Note: Status information is updated approximately 48 hours after each transaction.

PTAN

NPI

Review Choice Lookup

Please enter data in all of the fields displayed to retrieve the status of your Review Choice Demonstration Option(s). The Provider Name, Choice(s) Selected, Selector and Date will be displayed.

Please Note: Status information is updated approximately 48 hours after each transaction.

<input type="text" value="PTAN"/>	<input type="text" value="NPI"/>
<input type="button" value="Search"/>	<input type="button" value="Clear"/>

Current Review Choice

The following results are accurate as of 09/21/2018 09:19 AM.

Home Health Advantage Inc

Minimal Review



9 day(s) left in current choice period.

PTAN:

NPI:

Selected on: 09/13/2018 04:19 PM


Selected by: Frances Hui

History

Below are the last five selections for this provider.

Choice	Date	Selector
Minimal Review	09/13/2018 04:19 PM	Frances Hui
Pre-Claim Review (PCR)	09/13/2018 04:19 PM	Frances Hui
Pre-Claim Review (PCR)	08/30/2018 12:29 PM	Frances Hui
Minimal Review	08/30/2018 12:28 PM	Frances Hui

PCR Status Tool

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Home Health Pre-Claim Review Status Tool

Please enter data in all the fields displayed to retrieve the status of your Home Health Pre-Claim Review request.
Please note: Status information is updated approximately 24 hours after each transaction. The status results displayed are sorted by most current.

PTAN :

Partial Bene Last Name :

Partial MID :

Episode From Date :

NPI :

First Initial of Bene First Name :

Episode To Date :

List of UTN(s)

Show entries

Search:

UTN	
0MH00000000023	<input type="button" value="Select"/>
0MH00000133749	<input type="button" value="Select"/>

Showing 1 to 2 of 2 entries

Pre-Claim Review Determination

Unique Tracking Number (UTN) : 0MH00000133749

Beneficiary Name :

Partial MID : 3958A

Healthcare Common Procedure Coding System (HCPCS) Codes **Provisionally Affirmed**

[G0299, G0300]

New Search

Select another UTN

Select another UTN ✕

Show entries Search:

UTN	
0MH00000000023	<input type="button" value="Q Select"/>
0MH00000133749	<input type="button" value="Q Select"/>

Showing 1 to 2 of 2 entries

Unique Tracking Number (UTN) :

Beneficiary Name :

Partial MID :

Healthcare Common Procedure Coding System (HCPCS) Codes **Provisionally Affirmed**

[G0299, G0300]

Pre-Claim Review Determination

Unique Tracking Number (UTN) : 0MH00000000023

Beneficiary Name :

Partial MID : 3958A

Healthcare Common Procedure Coding System (HCPCS) Codes **Non-Affirmed**

[G0300, G0299]

Pre-Claim Review Determination Education

- Documentation submitted does not support a normal inability to leave the home. Refer to CMS IOM Publication 100-02, Chapter (7), Section (30.1.1).
- Documentation submitted does not support skilled nursing services are reasonable and necessary. Refer to CMS IOM Publication 100-02, Chapter 7, Section (40.1).
- The initial plan of care was not submitted or was invalid, therefore services on the subsequent episode may not be allowed. Refer to CMS IOM Publication 100-02, Chapter 7, Section 6.2.1.
- The physician certification for a subsequent episode was invalid since the required face-to-face encounter was missing/incomplete/untimely. Refer to CMS IOM Publication 100-08, Chapter 6.2.1.
- The physician certification was invalid since the required face-to-face encounter was not related to the primary reason for home health services. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.1.2.
- The physician certification was invalid since the required face-to-face encounter was untimely and/or the certifying physician did not document the date of the encounter. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.1.
- The physician certification was not valid as the certification documentation submitted does not support homebound status. Refer to CMS IOM Publication 100-02, Chapter 7, Section (30.5).
- The physician certification was not valid as the certification/recertification documentation submitted does not support skilled need. Refer to CMS IOM Publication 100-02, Chapter 7, Section (30.5).
- The physician recertification estimate of how much longer skilled services are required is missing/incomplete/invalid. Refer to CMS IOM Publication 100-02, Chapter 7, Section (30.5.2).
- There was no valid initial physician's certification of patient eligibility, therefore services on the subsequent episode may not be allowed. Refer to CMS IOM Publication 100-08, Chapter 6.2.1.

New Search

Select another UTN

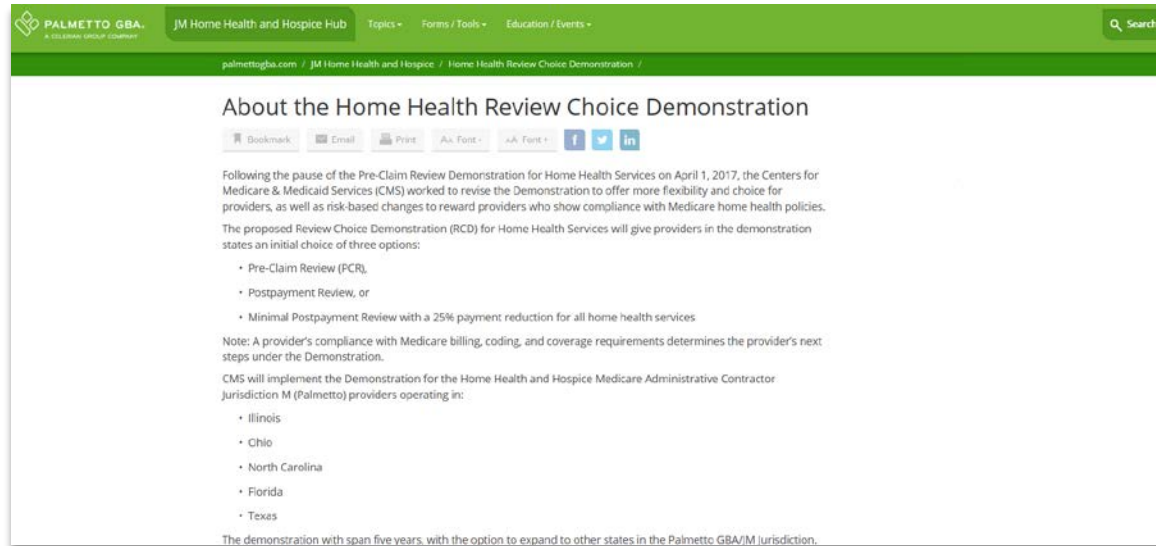


CMS RCD Resources

- <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Choice-Demonstration/Review-Choice-Demonstration-for-Home-Health-Services.html>
- <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10599.html?DLPage=1&DLEntries=100&DLSort=1&DLSortDir=descending>

Palmetto GBA RCD Webpage

- www.palmettogba.com/RCD



The screenshot shows the Palmetto GBA website interface. The header includes the Palmetto GBA logo, navigation links for 'JM Home Health and Hospice Hub', 'Topics', 'Forms / Tools', and 'Education / Events', and a search bar. The breadcrumb trail reads: 'palmettogba.com / JM Home Health and Hospice / Home Health Review Choice Demonstration /'. The main heading is 'About the Home Health Review Choice Demonstration'. Below the heading are utility links for 'Bookmark', 'Email', 'Print', 'A+ Font', and 'A- Font', along with social media icons for Facebook, Twitter, and LinkedIn. The main text explains that following the pause of the Pre-Claim Review Demonstration for Home Health Services on April 1, 2017, CMS worked to revise the Demonstration to offer more flexibility and choice for providers, as well as risk-based changes to reward compliance. It states that the proposed Review Choice Demonstration (RCD) will give providers an initial choice of three options:

- Pre-Claim Review (PCR),
- Postpayment Review, or
- Minimal Postpayment Review with a 25% payment reduction for all home health services

A note states: 'Note: A provider's compliance with Medicare billing, coding, and coverage requirements determines the provider's next steps under the Demonstration.' It also mentions that CMS will implement the Demonstration for the Home Health and Hospice Medicare Administrative Contractor Jurisdiction M (Palmetto) providers operating in:

- Illinois
- Ohio
- North Carolina
- Florida
- Texas

The bottom of the page notes: 'The demonstration will span five years, with the option to expand to other states in the Palmetto GBA/M jurisdiction.'

THREE WAYS TO STAY CONNECTED

Sign up for Our Listserv

Listservs

- Receive daily or weekly email updates via our listserv to stay up-to-date with Medicare and Palmetto GBA news.

Find Us on Facebook



- Ask simple/general questions via our Facebook page and receive a response within 24 hours.

Follow Us on Twitter



- Follow us on Twitter to view and post short messages.

Questions?