Part I: Overview of the Home Health Review Choice Demonstration (RCD)
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.
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 on this topic, please see the Review Choice category at www.PalmettoGBA.com.

The current Review Choice Selection period ends on 9/1/2018. 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**: 1000 North Carolina / NH
- **Provider Name**
- **Provider Number (PTIN)**
- **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.
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

<table>
<thead>
<tr>
<th>State</th>
<th>Choice Selection Dates</th>
<th>Implementation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ohio</td>
<td>8/16/2019 – 9/15/2019</td>
<td>9/30/2019</td>
</tr>
<tr>
<td>North Carolina</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Texas</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Florida</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>
Three Initial Review Choice Options

<table>
<thead>
<tr>
<th>Pre-Claim Review (PCR)</th>
<th>Postpayment Review of ALL Claims</th>
<th>Minimal Review – 25% Payment Reduction on ALL Payable Claims</th>
</tr>
</thead>
</table>
## Three Subsequent Review Choice Options

<table>
<thead>
<tr>
<th>Pre-Claim Review</th>
<th>Selective Postpayment Review</th>
<th>Spot Check of 5% of Their Claims to Ensure Continued Compliance</th>
</tr>
</thead>
</table>
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)
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](http://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.palmettagba.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.
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.
This warning banner provides privacy and security notices consistent with applicable federal laws, directives, and other federal guidance for accessing this Government system, which includes (1) this computer network, (2) all computers connected to this network, and (3) all devices and storage media attached to this network or to a computer on this network.

- This system is provided for Government-authorized use only.
- Unauthorized or improper use of this system is prohibited and may result in disciplinary action and/or civil and criminal penalties.
- Personal use of social media and networking sites on this system is limited to not interfere with official work duties and is subject to monitoring.
- By using this system, you understand and consent to the following:
  - The Government may monitor, record, and audit your system usage, including usage of personal devices and email systems for official duties or to conduct HHS business. Therefore, you have no reasonable expectation of privacy regarding any communication or data transmitting or stored on this system. At any time, and for any lawful Government purpose, the Government may monitor, intercept, and search any communication or data transmitting or stored on this system.
  - Any communication or data transmitting or stored on this system may be disclosed or used for any lawful Government purpose.

Refer to the Terms of Use.
Pre-Claim Review JM HH

Provider Information
**Validate Beneficiary Information**

**Claim Information**

**Pre-Claim Review Episode Start Date**

07/06/2016

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

**Pre-Claim Review Episode End Date**

07/05/2016

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

**Type of Bill (TOB)**

329

**HCPCS Code(s)**

- G0153
- G0158
- G0162

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34 August 2019
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

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

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

Browse
Confined to the Home: First Criteria
Q4: Does the beneficiary, because of illness or injury, need any 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*
Browse...

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?*
Browse...

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 1 X

Task 2 Information Reference Page #  

456
Confined to the Home: Second Criteria

Q6: Is there a normal inability to leave the home? *

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? *

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

Q8: Is there a structural impairment? *

Please specify which domains this structural impairment affects*
<table>
<thead>
<tr>
<th>File Name</th>
<th>File Size (in bytes)</th>
<th>File Type</th>
<th>File Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>eServices Test Attachment_Comprehensive Assessment.pdf</td>
<td>2098</td>
<td>application/pdf</td>
<td>Task 2: The HHA generated records that have been signed, dated, and incorporated into the certifying physician’s medical records</td>
</tr>
<tr>
<td>eServices Test Attachment_F2F Clinical Encounter Note.pdf</td>
<td>2104</td>
<td>application/pdf</td>
<td>Task 1: The actual F2F clinical encounter note used by the certifying physician to justify the referral for Medicare home health services</td>
</tr>
<tr>
<td>eServices Test Attachment_Home Bound 1.pdf</td>
<td>2107</td>
<td>application/pdf</td>
<td>Task 5: Upload medical documentation that meets the First Criteria for Confined to the Home</td>
</tr>
<tr>
<td>eServices Test Attachment_Photographers Certification.pdf</td>
<td>2124</td>
<td>application/pdf</td>
<td>Task 4: The signed and dated physician’s certification of patient eligibility</td>
</tr>
<tr>
<td>eServices Test Attachment_Plan of Care.pdf</td>
<td>2096</td>
<td>application/pdf</td>
<td>Task 3: The plan of care established and periodically reviewed by an authorized physician</td>
</tr>
</tbody>
</table>

Total File Size: 10 KB  
Max Allowed: 150MB
15 MINUTE BREAK

Presented by Palmetto GBA Provider Outreach and Education
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*

[File selection field]

Browse...

Or

Refer to another Task For task3 Attachment*

[Link or button]

Please select Refer to another Task For task3. You can refer multiple Tasks

Task 3 Information Reference Page #
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.
**Incomplete PCR List**

<table>
<thead>
<tr>
<th>Date</th>
<th>User Id</th>
<th>Medicare ID</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018-09-11 14:41:44.784</td>
<td>0m07911</td>
<td>82</td>
<td></td>
</tr>
</tbody>
</table>

Showing 1 to 1 of 1 entries
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

Thank you for using Palmetto GBA’s eServices Portal.
Inbox Filter Search
Palmetto GBA
Submittal Request
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
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
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
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)
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

Presented by Palmetto GBA Provider Outreach and Education
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
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
RCD Status Tool
PCR Status Tool
Pre-Claim Review Determination

Unique Tracking Number (UTN): 0MH00000000023

Beneficiary Name:

Partial MID: 3958A

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

G00300, G00399

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.
CMS RCD Resources


Palmetto GBA RCD Webpage

- www.palmettogba.com/RCD
THREE WAYS TO STAY CONNECTED

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• Follow us on Twitter to view and post short messages.
Questions?