Palmetto GBA & Review Choice Demonstration

PALMETTO GBA®

A CELERIAN GROUP COMPANY

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)

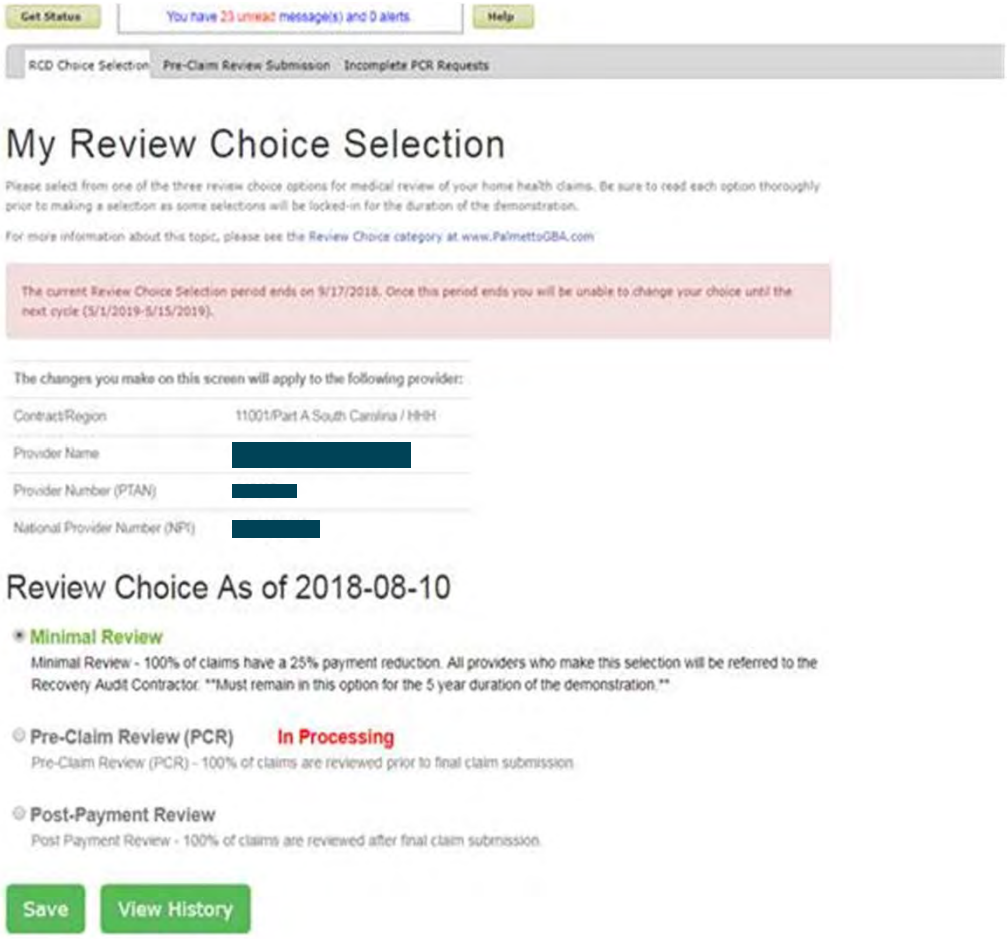
- RCD **does not** create new documentation requirements
- Home Health Agencies (HHAs) will submit the same information they are currently required to maintain for payment
- Medicare Beneficiary eligibility and benefits remain the same with this demonstration

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)
- 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


Get Status
You have 23 unread message(s) and 0 alerts
Help
RCD Choice Selection
Pre-Claim Review Submission
Incomplete PCR Requests
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
11001/Part A South Carolina / HHH
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

- 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	TBD	TBD
Ohio	TBD	TBD
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

THREE SUBSEQUENT REVIEW CHOICE OPTIONS

Pre-Claim Review	Selective Postpayment Review	**Spot Check** of 5% of Their Claims to Ensure Continued Compliance

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 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

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

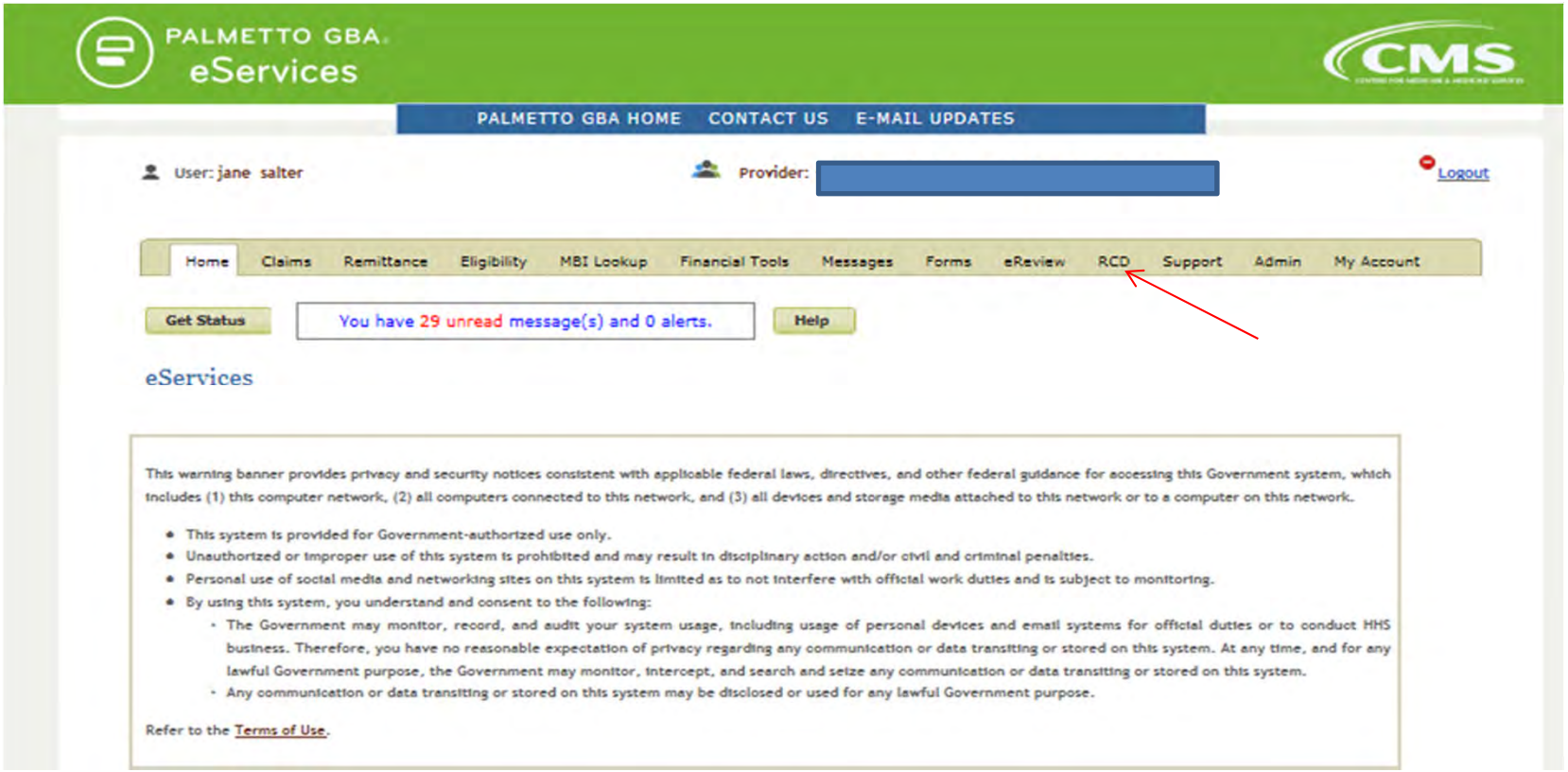
- A free Internet-based, provider self-service secure application – www.palmettogba.com/eservices
  - It is the easiest way to submit a PCR request!
  - It is the surest way to know it has been received!
  - It is the fastest way to receive the decision!
  - 97% of PCR requests in the PCR demonstration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

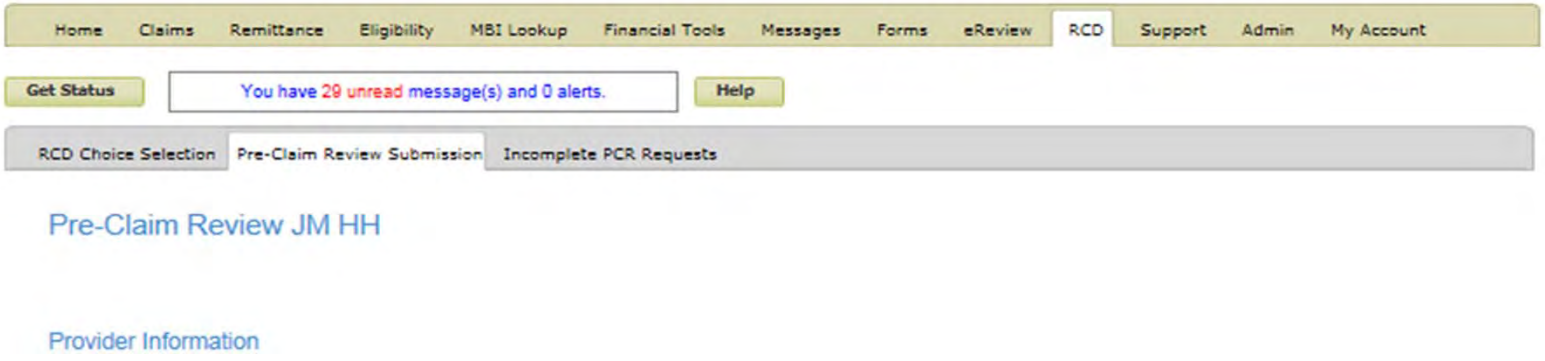
PALMETTO GBA'S ESERVICES

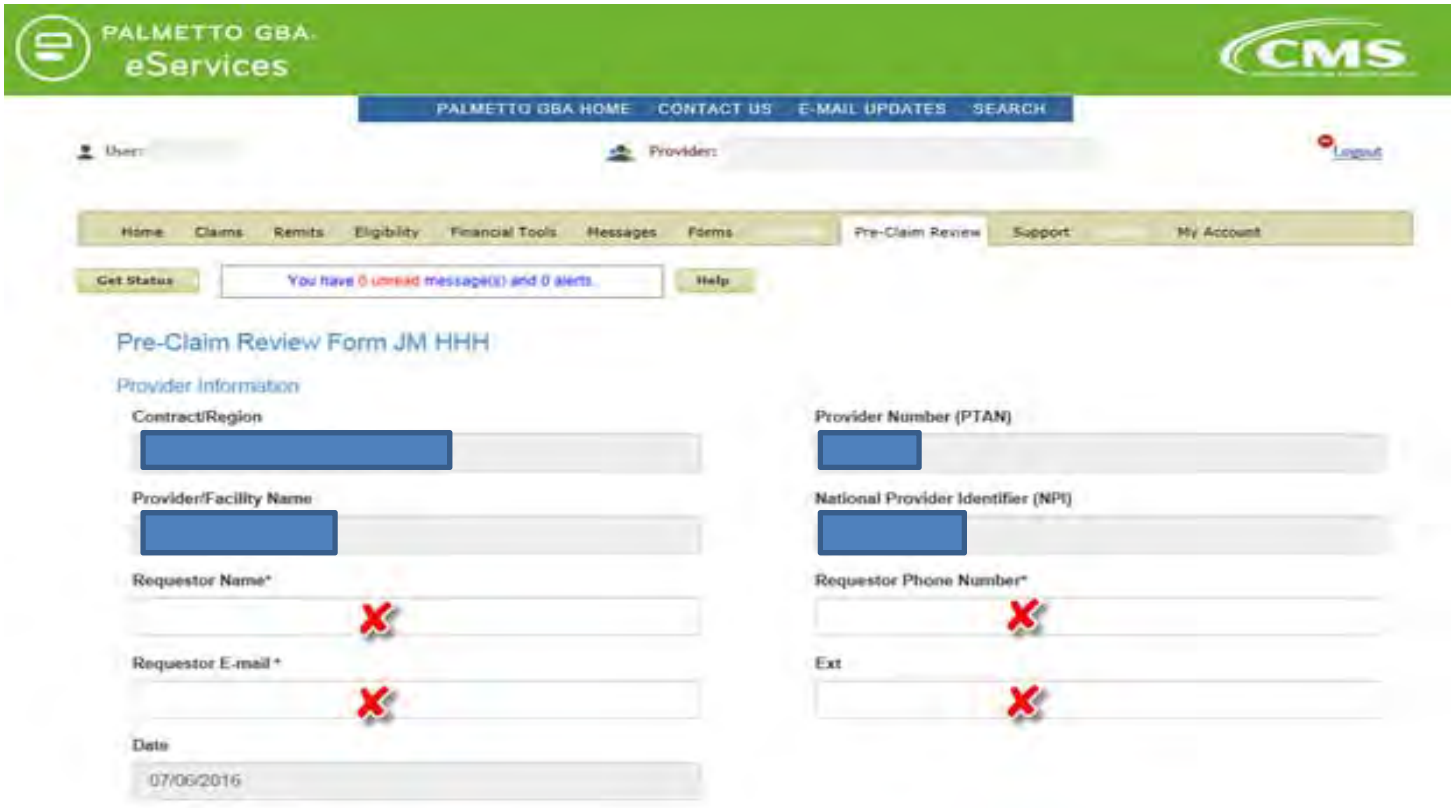
- HHAs complete an online **submittal request**, which prepopulates some provider information to help reduce errors and save time
- HHAs scan supporting documentation and attach it to the request (attachments must be in ".pdf" format)
- Once a request has been accepted into our system, the received date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

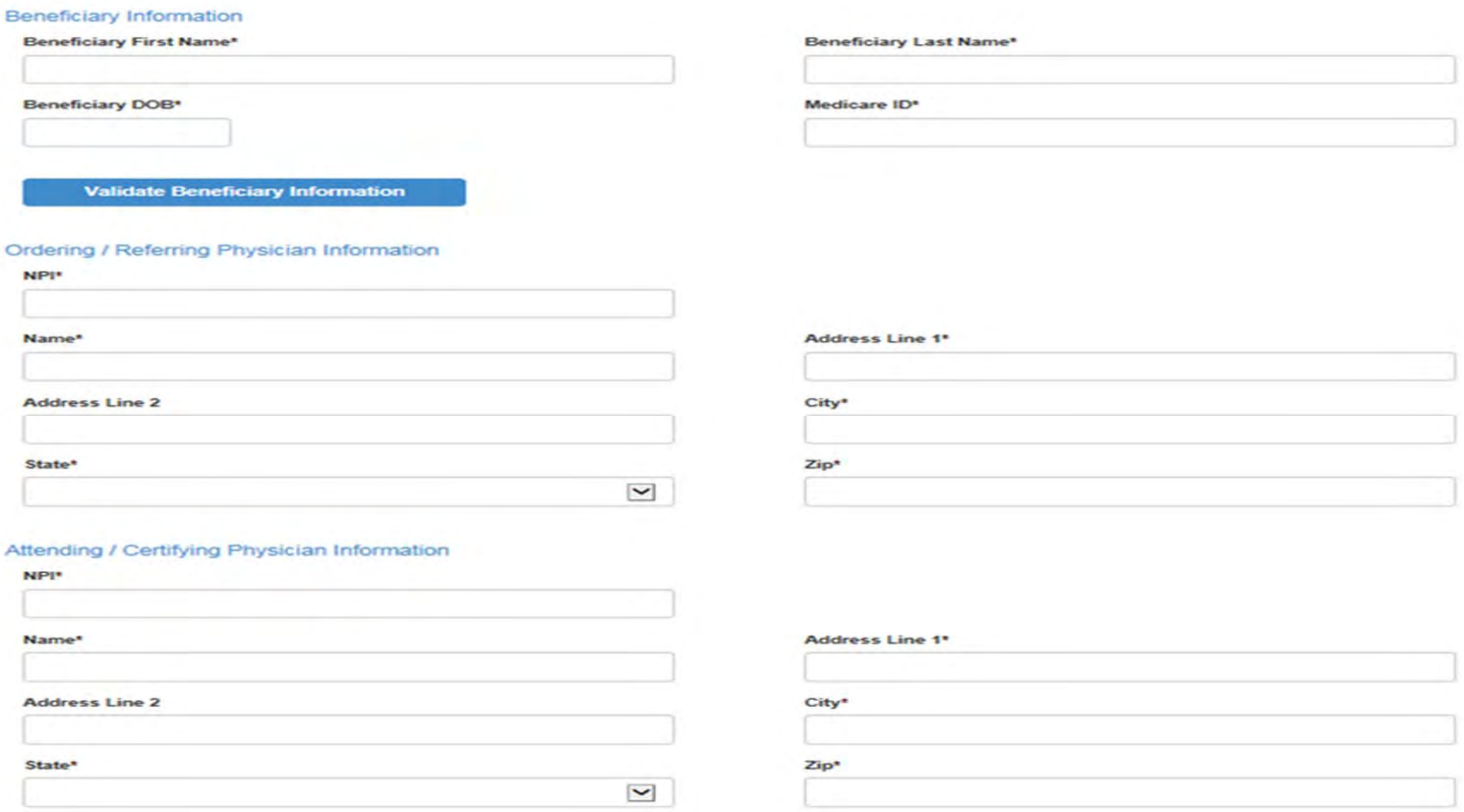
PALMETTO GBA'S ESERVICES

- 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


PALMETTO GBA
eServices
CMS
PALMETTO GBA HOME
CONTACT US
E-MAIL UPDATES
User: jane salter
Provider:
Logout
Home
Claims
Remittance
Eligibility
MBI Lookup
Financial Tools
Messages
Forms
eReview
RCD
Support
Admin
My Account
Get Status
You have 29 unread message(s) and 0 alerts.
Help
eServices
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 as 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 transiting or stored on this system. At any time, and for any lawful Government purpose, the Government may monitor, intercept, and search and seize any communication or data transiting or stored on this system.
Any communication or data transiting or stored on this system may be disclosed or used for any lawful Government purpose.
Refer to the Terms of Use.

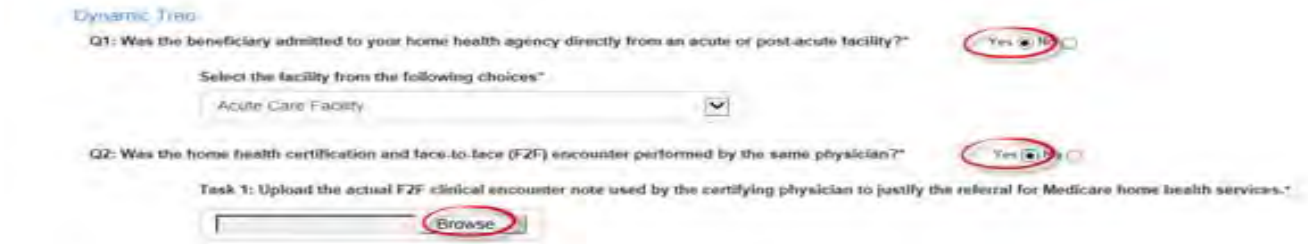

Home
Claims
Remittance
Eligibility
MBI Lookup
Financial Tools
Messages
Forms
eReview
RCD
Support
Admin
My Account
Get Status
You have 29 unread message(s) and 0 alerts.
Help
RCD Choice Selection
Pre-Claim Review Submission
Incomplete PCR Requests
Pre-Claim Review JM HH
Provider Information

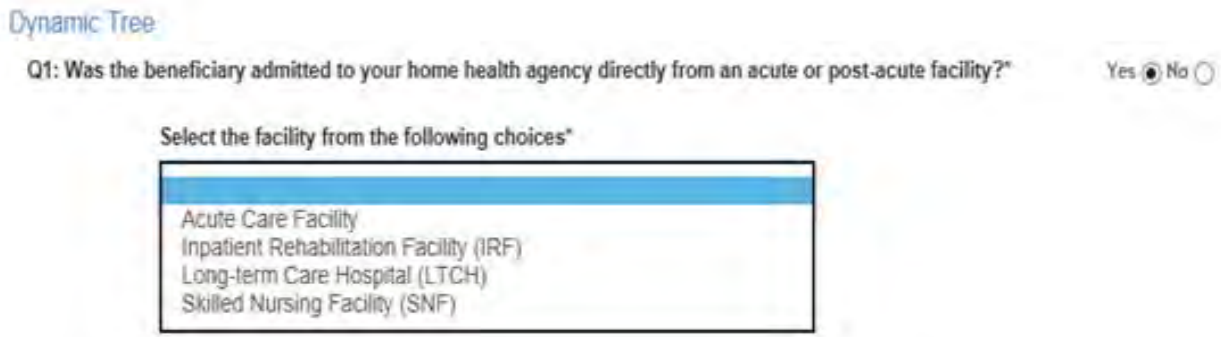

PALMETTO GBA
eServices
CMS
PALMETTO GBA HOME
CONTACT US
E-MAIL UPDATES
SEARCH
User:
Provider:
Logout
Home
Claims
Remits
Eligibility
Financial Tools
Messages
Forms
Pre-Claim Review
Support
My Account
Get Status
You have 0 unread message(s) and 0 alerts.
Help
Pre-Claim Review Form JM HHH
Provider Information
Contract/Region
Provider Number (PTAN)
Provider/Facility Name
National Provider Identifier (NPI)
Requestor Name*
Requestor Phone Number*
Requestor E-mail *
Ext
Date
07/06/2016


Beneficiary Information
Beneficiary First Name*
Beneficiary Last Name*
Beneficiary DOB*
Medicare ID*
Validate Beneficiary Information
Ordering / Referring Physician Information
NPI*
Name*
Address Line 1*
Address Line 2
City*
State*
Zip*
Attending / Certifying Physician Information
NPI*
Name*
Address Line 1*
Address Line 2
City*
State*
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
G0158
G0162
G0151
G0152
G0155
G0156
G0157
G0159
G0160
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 t


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
G0158
G0162


Dynamic Tree
Q1: Was the beneficiary admitted to your home health agency directly from an acute or post-acute facility?*
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?*
Task 1: Upload the actual F2F clinical encounter note used by the certifying physician to justify the referral for Medicare home health services.*
Browse


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*

Browse...

Confined to the Home: Second Criteria

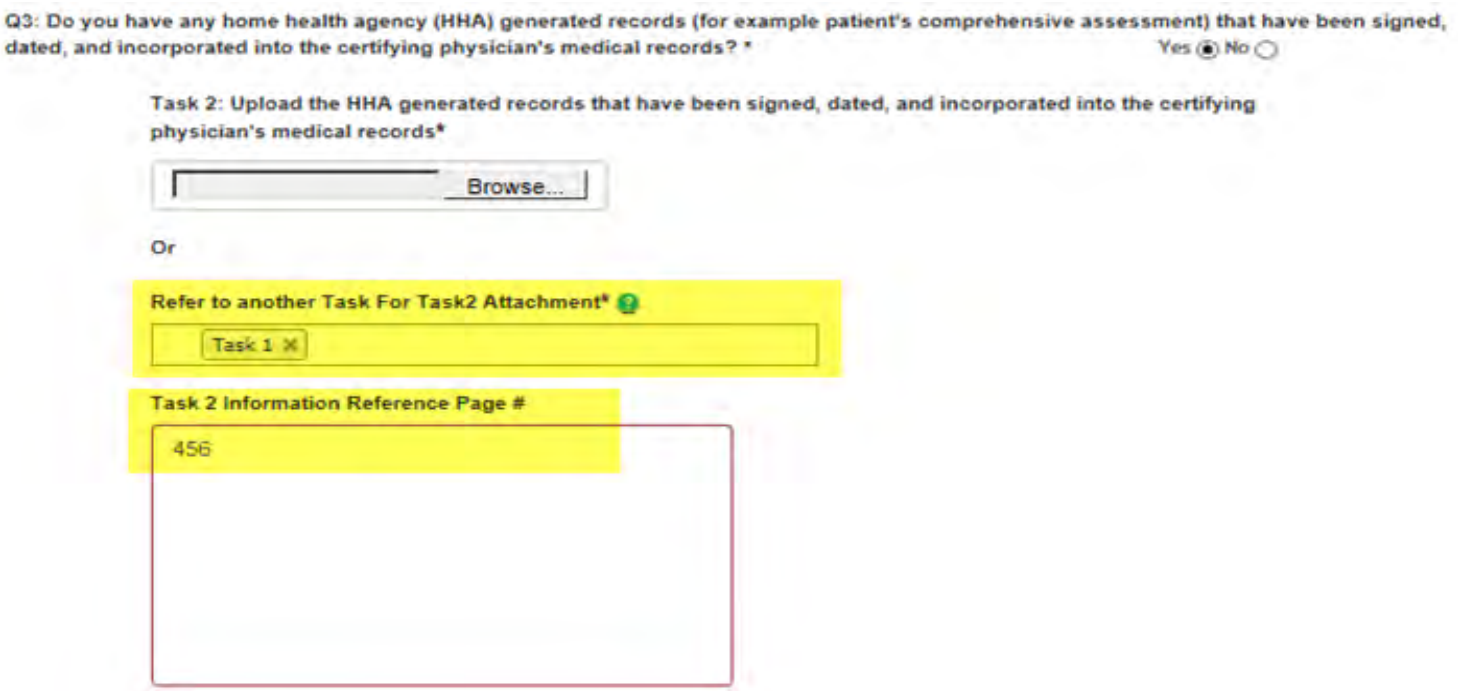
Q6: Is there a normal inability to leave the home? * Yes ◉ No ◯

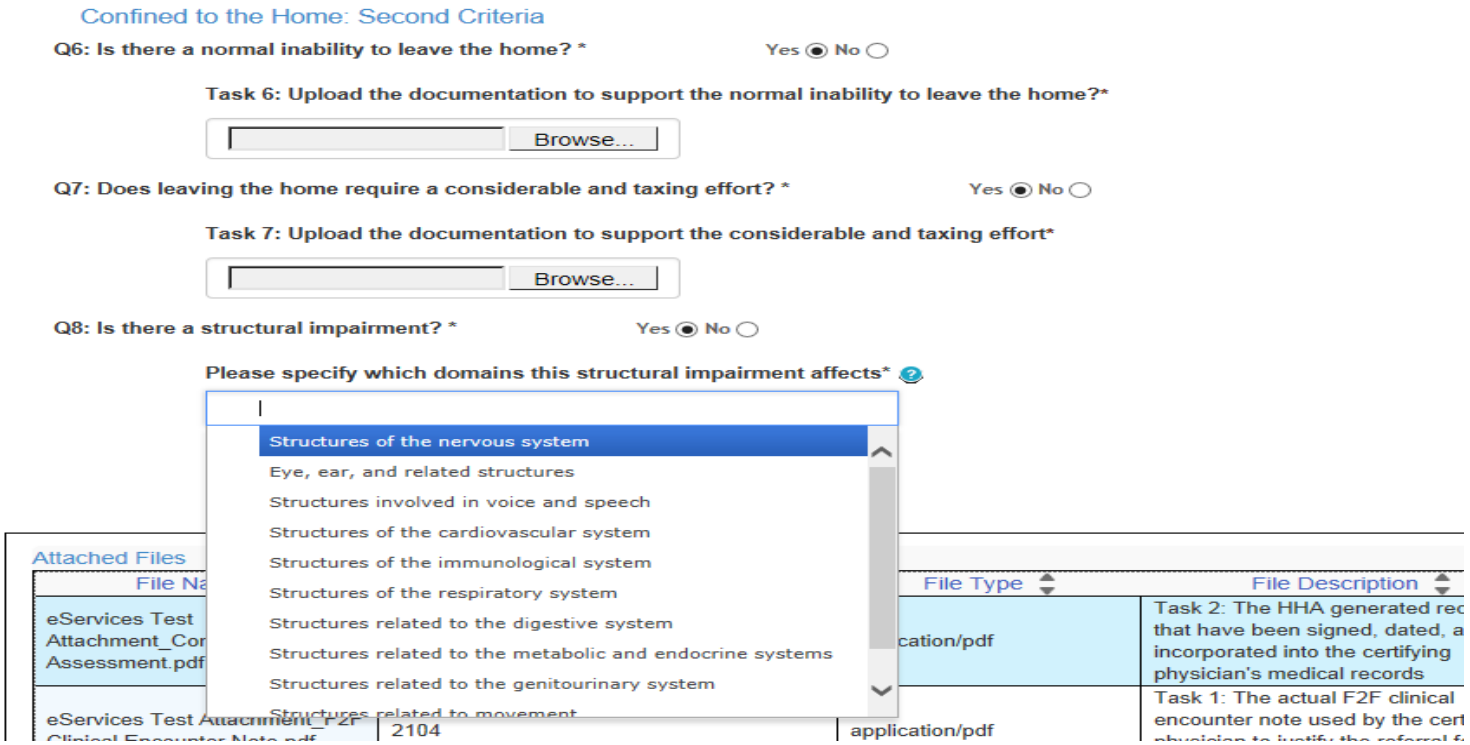
Task 6: Upload the documentation to support the normal inability to leave the home?*

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*
Browse...
Or
Refer to another Task For Task2 Attachment*
Task 1
Task 2 Information Reference Page #
456


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...
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*
Browse...
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
Attached Files
File Type
File Description
eServices Test Attachment_Cor Assessment.pdf
cation/pdf
Task 2: The HHA generated rec that have been signed, dated, a incorporated into the certifying physician's medical records
2104
application/pdf
Task 1: The actual F2F clinical encounter note used by the cert

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.p	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

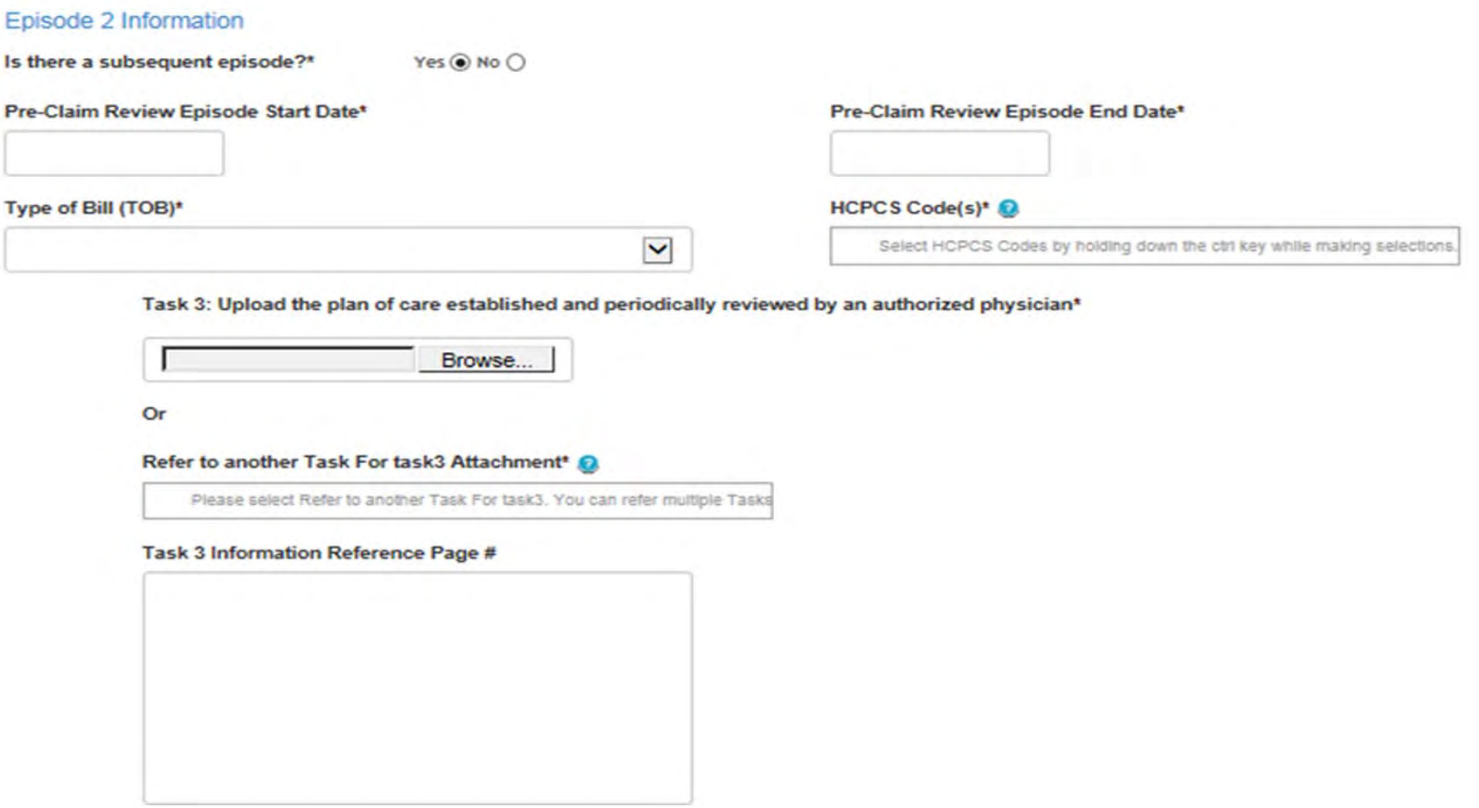
Showing 1 to 5 of 5 entries

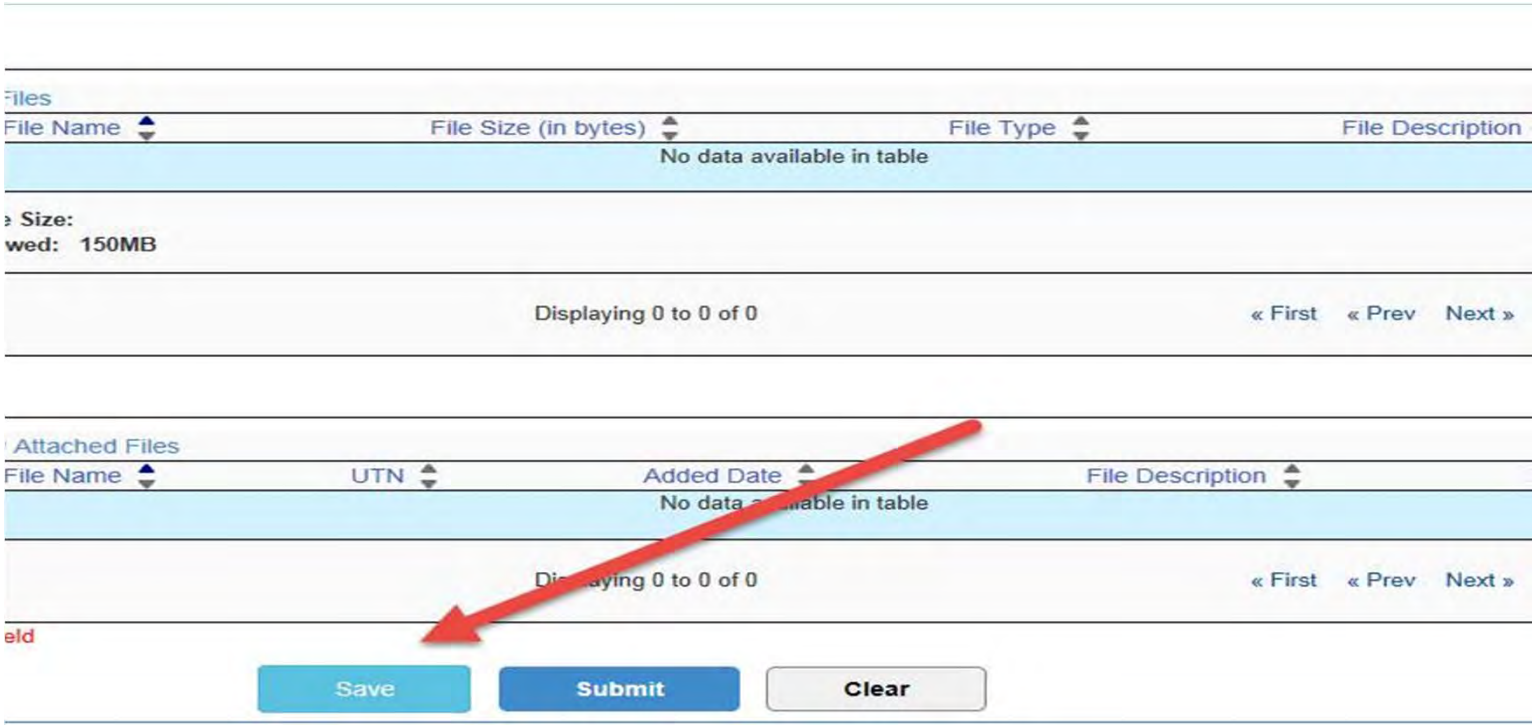
« First « Prev 1 Next » Last »

Q10: Is there an activity limitation? * Yes ○ No ◉

Episode 2 Information

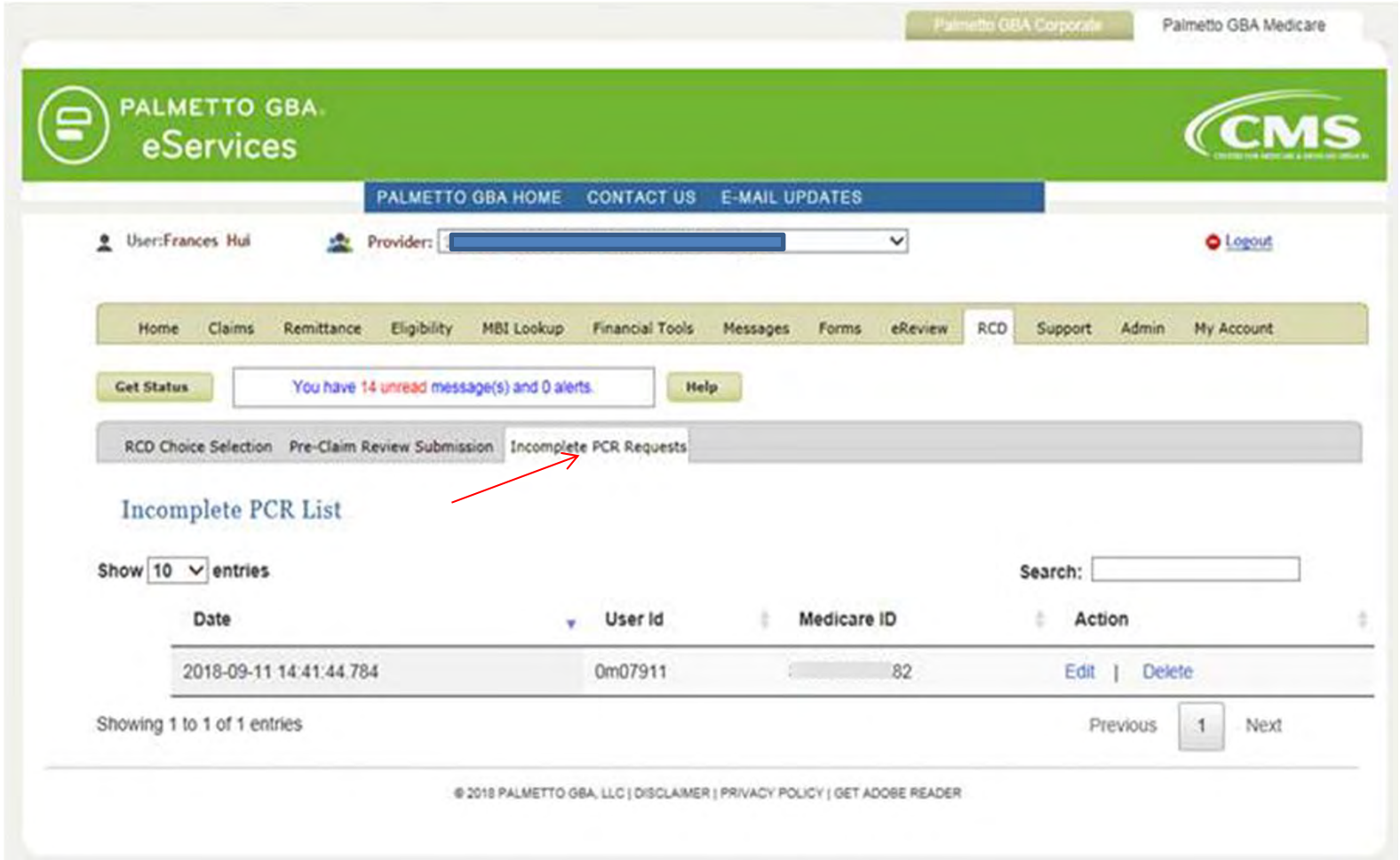
Is there a subsequent episode?* Yes ○ No ○

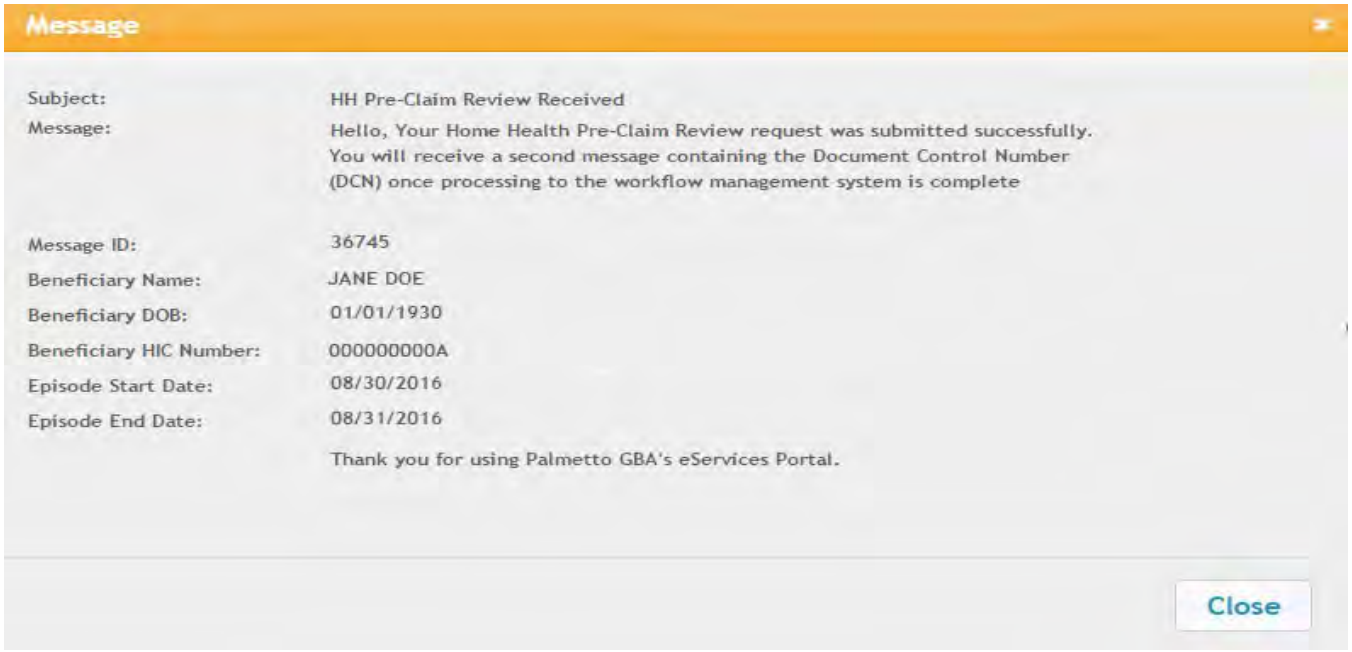

Episode 2 Information
Is there a subsequent episode?*
Yes
No
Pre-Claim Review Episode Start Date*
Pre-Claim Review Episode End Date*
Type of Bill (TOB)*
HCPCS Code(s)*
Select HCPCS Codes by holding down the ctrl key while making selections.
Task 3: Upload the plan of care established and periodically reviewed by an authorized physician*
Browse...
Or
Refer to another Task For task3 Attachment*
Please select Refer to another Task For task3. You can refer multiple Tasks
Task 3 Information Reference Page #


Files
File Name
File Size (in bytes)
File Type
File Description
No data available in table
Size:
wed: 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 »
eld
Save
Submit
Clear

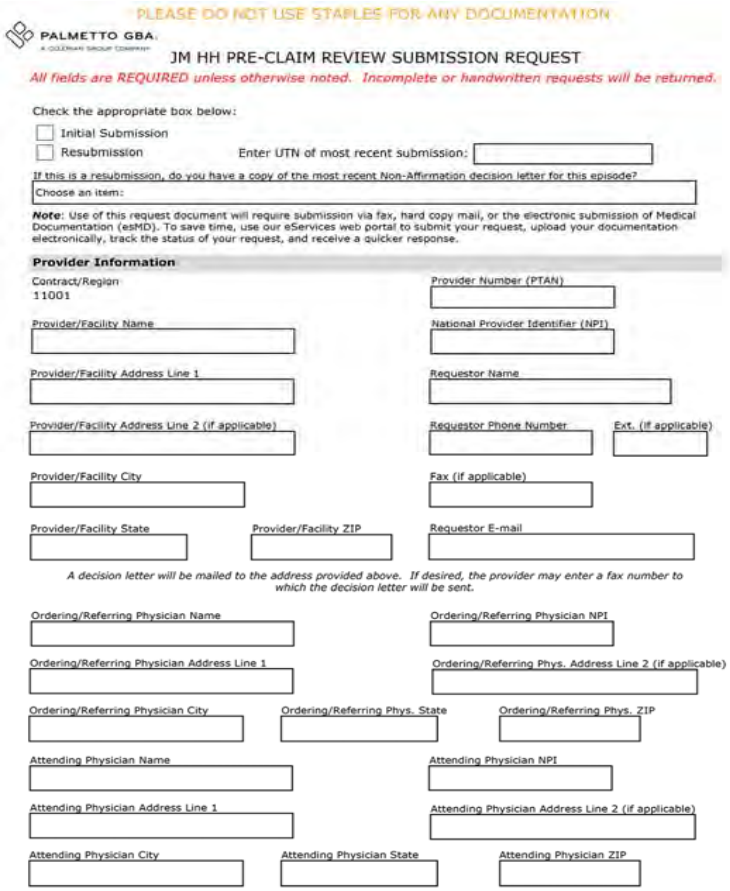
Your information contains 11 errors

- 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


Palmetto GBA Corporate
Palmetto GBA Medicare
PALMETTO GBA
eServices
CMS
PALMETTO GBA HOME
CONTACT US
E-MAIL UPDATES
User:Frances Hui
Provider:
Logout
Home
Claims
Remittance
Eligibility
MBI Lookup
Financial Tools
Messages
Forms
eReview
RCD
Support
Admin
My Account
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 10 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
1
Next
© 2018 PALMETTO GBA, LLC | DISCLAIMER | PRIVACY POLICY | GET ADOBE READER


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
Thank you for using Palmetto GBA's eServices Portal.
Close

PALMETTO GBA SUBMITTAL REQUEST



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

PALMETTO GBA

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)

Provider/Facility Name

National Provider Identifier (NPI)

Provider/Facility Address Line 1

Requestor Name

Provider/Facility Address Line 2 (if applicable)

Requestor Phone Number Ext. (if applicable)

Provider/Facility City

Fax (if applicable)

Provider/Facility State Provider/Facility ZIP

Requestor E-mail

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

Ordering/Referring Physician NPI

Ordering/Referring Physician Address Line 1

Ordering/Referring Phys. Address Line 2 (if applicable)

Ordering/Referring Physician City Ordering/Referring Phys. State Ordering/Referring Phys. ZIP

Attending Physician Name

Attending Physician NPI

Attending Physician Address Line 1

Attending Physician Address Line 2 (if applicable)

Attending Physician City Attending Physician State Attending Physician ZIP

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
  - **UB04 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

Postpayment Review

INITIAL REVIEW CHOICE:

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

Minimal Review

INITIAL REVIEW OPTION

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**

PCR

SUBSEQUENT REVIEW OPTION

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

Selective Postpayment Review

SUBSEQUENT REVIEW OPTION

SELECTIVE POSTPAYMENT REVIEW OPTION

- Under this option a selective postpayment review of a statistically valid random sample of at least 30 claims will be pulled every 6-months
- Once chosen the HHA will remain here for duration of the demonstration

Spot Check

SUBSEQUENT REVIEW OPTION

SPOT CHECK OPTION

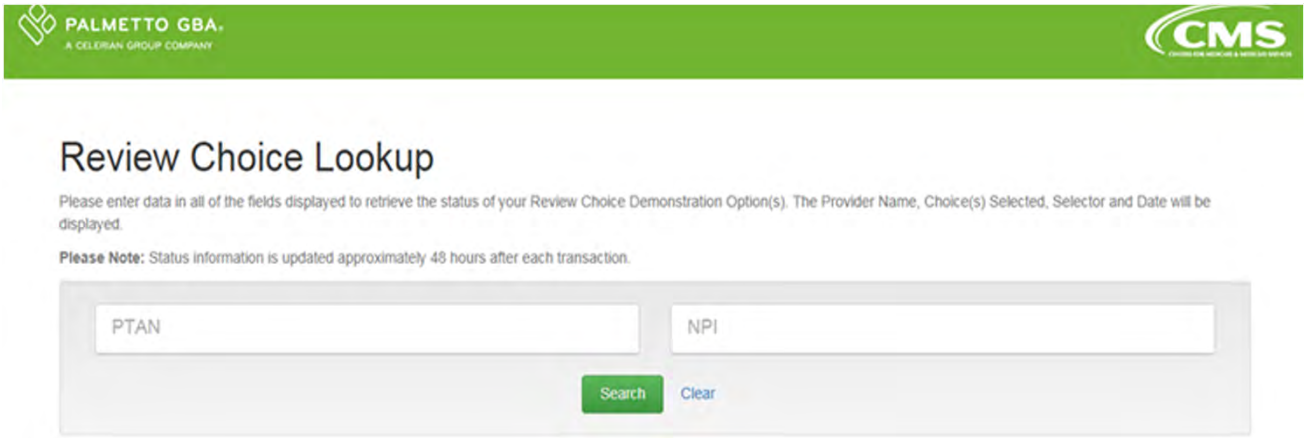
- No reviews conducted other than a spot check of 5% of a HHA's claims during a 6-month period to ensure continued compliance
- Continued compliance will be monitored through the selection of those 5% of claims for prepayment review
- The HHA can continue to select this option each 6-month period unless 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

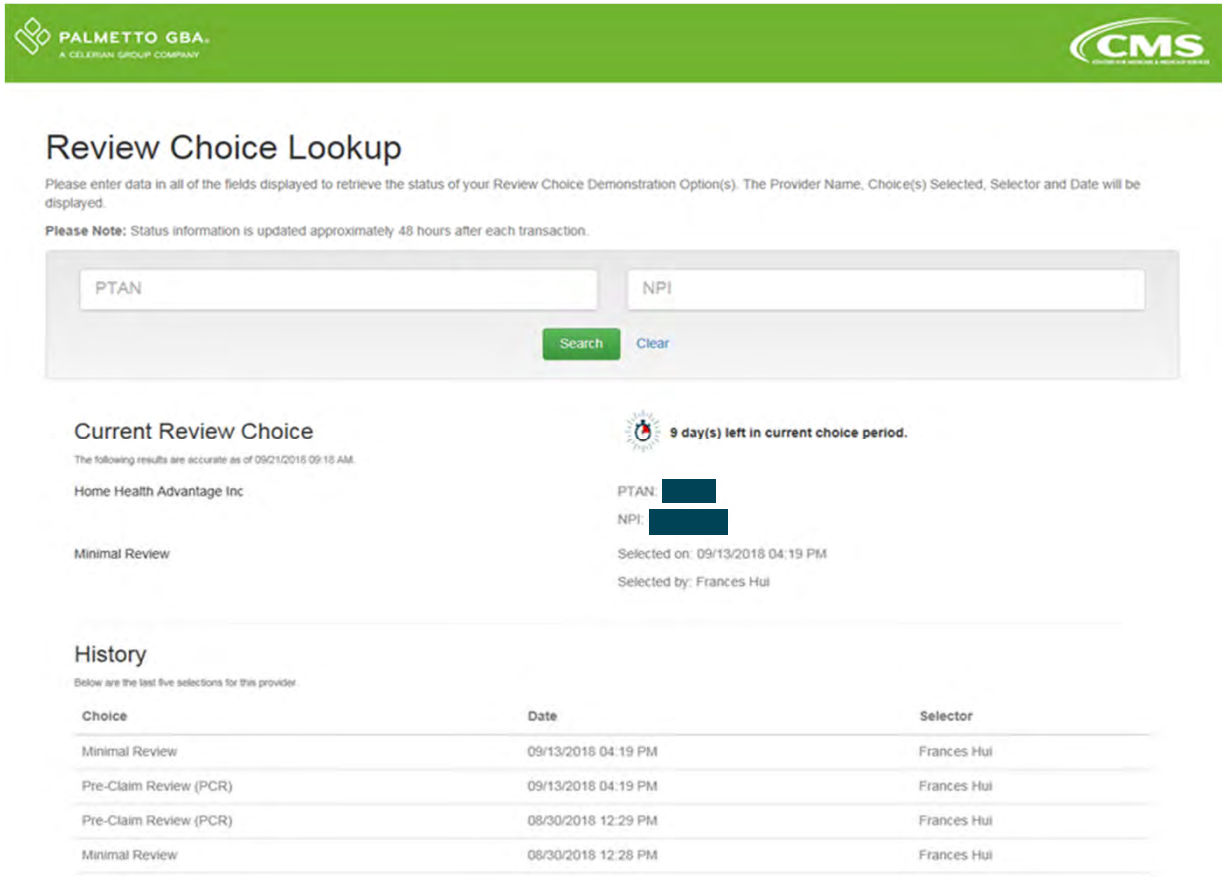
SIX MONTH REVIEW PERIOD OVERVIEW

- 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

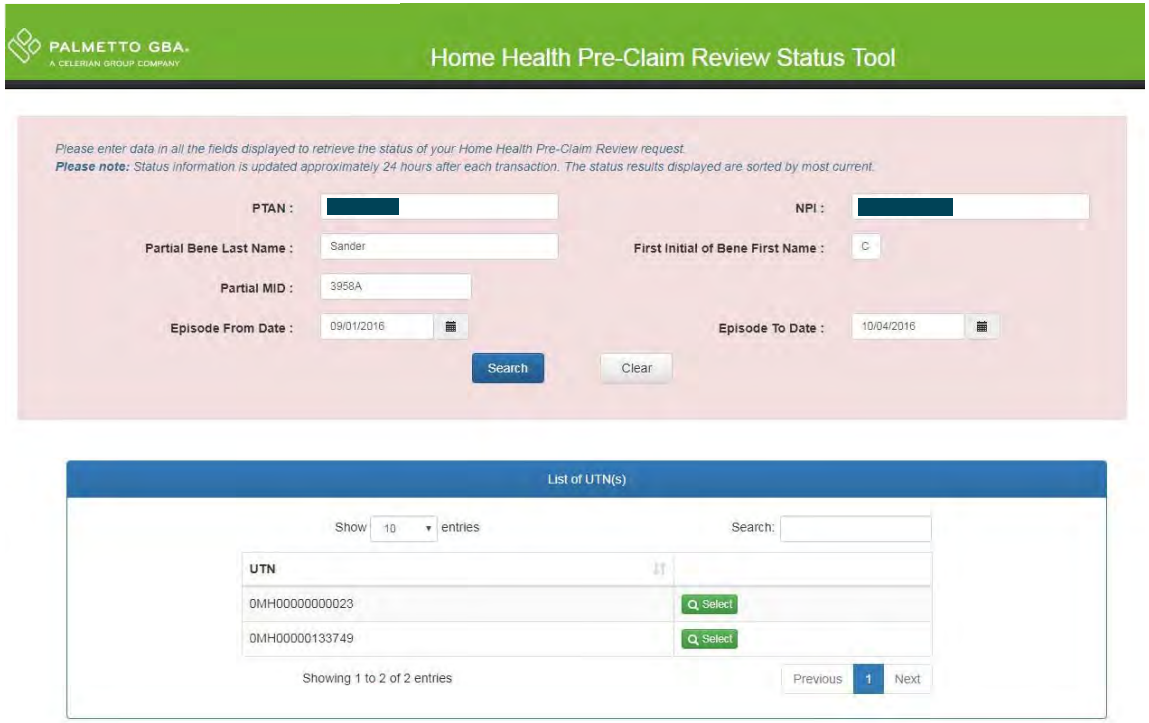
SELF SERVICE TOOLS AND RESOURCES

RCD STATUS TOOL

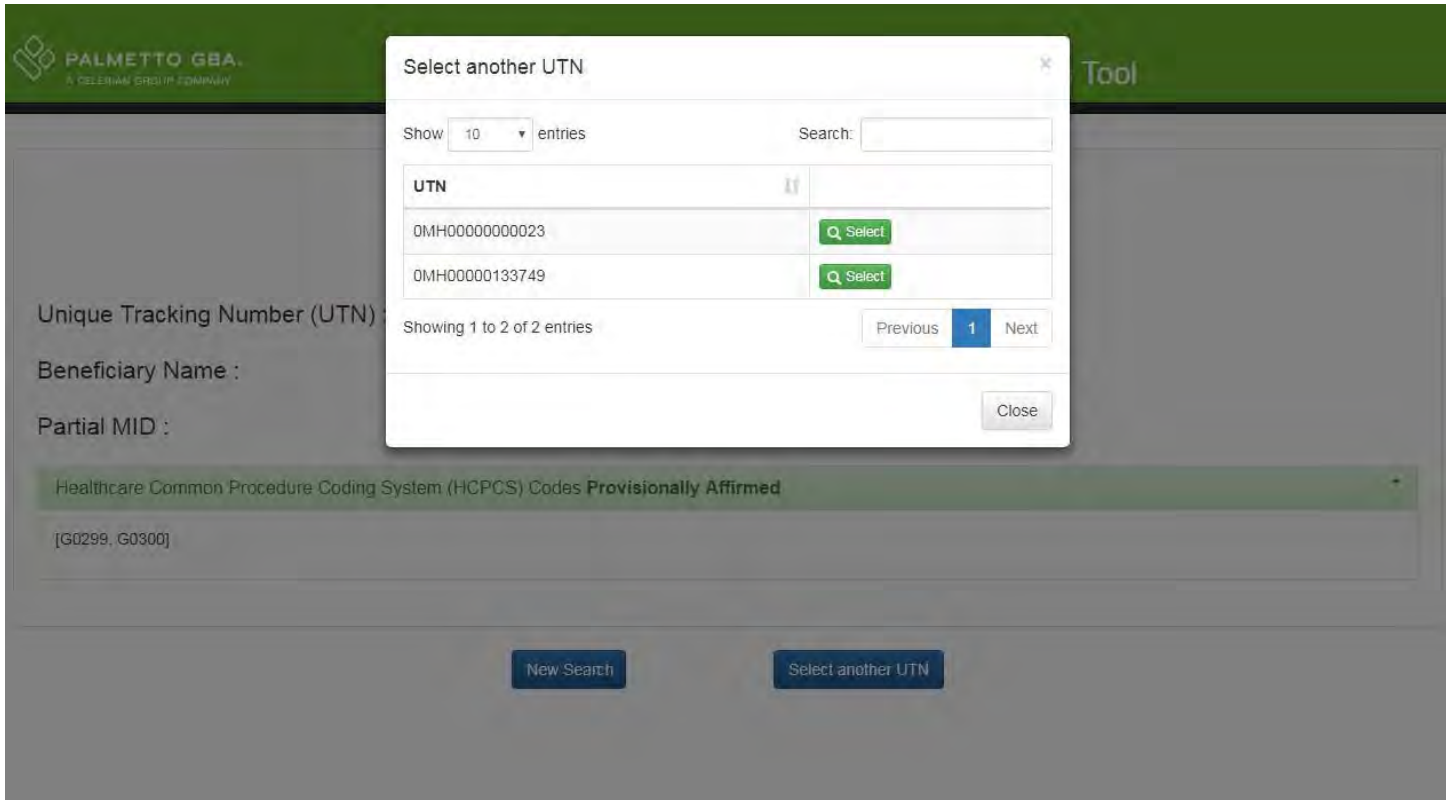



PALMETTO GBA.
A CELERIAN GROUP COMPANY
CMS
Review Choice Lookup
Please enter data in all of the fields displayed to retrieve the status of your Review Choice Demonstration Option(s). The Provider Name, Choice(s) Selected, Selector and Date will be displayed.
Please Note: Status information is updated approximately 48 hours after each transaction.
PTAN
NPI
Search
Clear
Current Review Choice
The following results are accurate as of 09/21/2018 09:18 AM.
9 day(s) left in current choice period.
Home Health Advantage Inc
PTAN: [redacted]
NPI: [redacted]
Minimal Review
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




PALMETTO GBA.
A CELERIAN GROUP COMPANY
Home Health Pre-Claim Review Status Tool
Pre-Claim Review Determination
Unique Tracking Number (UTN) :
0MH00000133749
Beneficiary Name :
[redacted]
Partial MID :
3958A
Healthcare Common Procedure Coding System (HCPCS) Codes Provisionally Affirmed
[G0299, G0300]
New Search
Select another UTN


PALMETTO GBA
Tool
Select another UTN
Show 10 entries
Search:
UTN
0MH00000000023
Select
0MH00000133749
Select
Showing 1 to 2 of 2 entries
Previous
1
Next
Close
Unique Tracking Number (UTN) :
Beneficiary Name :
Partial MID :
Healthcare Common Procedure Coding System (HCPCS) Codes Provisionally Affirmed
[G0299, G0300]
New Search
Select another UTN

Pre-Claim Review Determination

Unique Tracking Number (UTN) : 0MH00000000023

Beneficiary Name : CHARLES SANDERS

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.

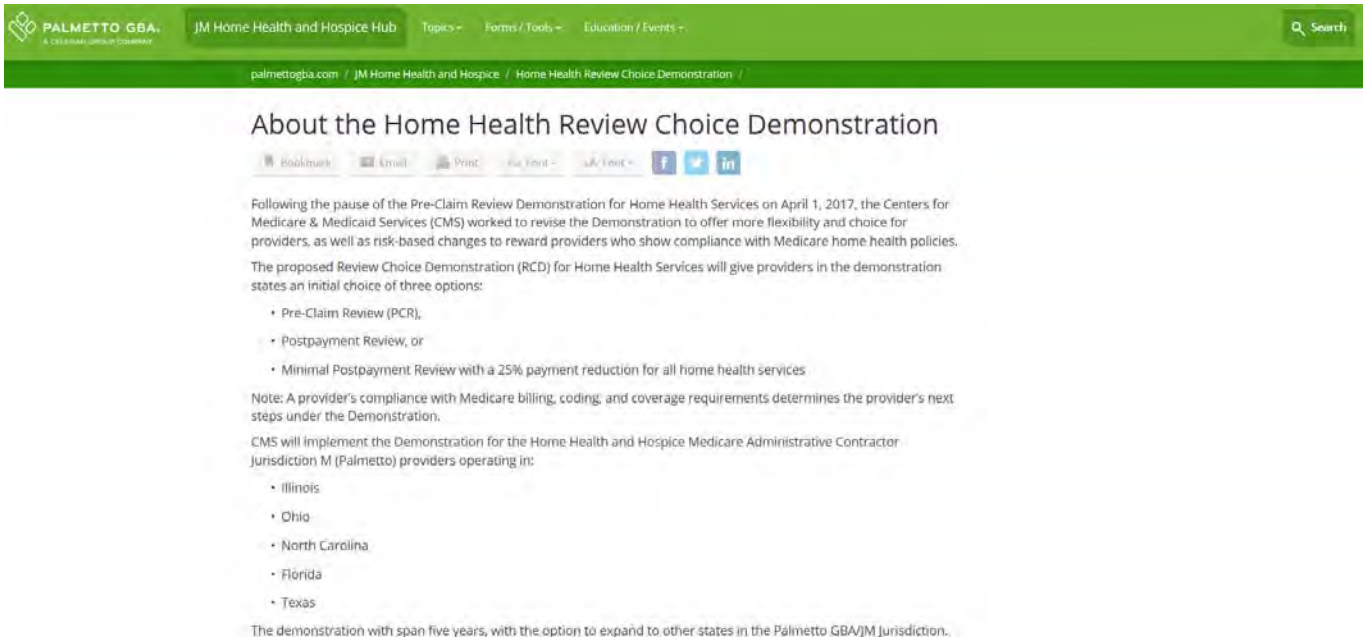
New Search Select another UTN

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



Four ways to stay connected to Palmetto GBA

Sign up for our listserv

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

Listservs

Subscribe to our RSS Feed

- When you subscribe to a feed, it is added to the Common Feed List. Updated information from the feed is automatically downloaded to your computer and can be viewed in Internet Explorer and other programs.

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.

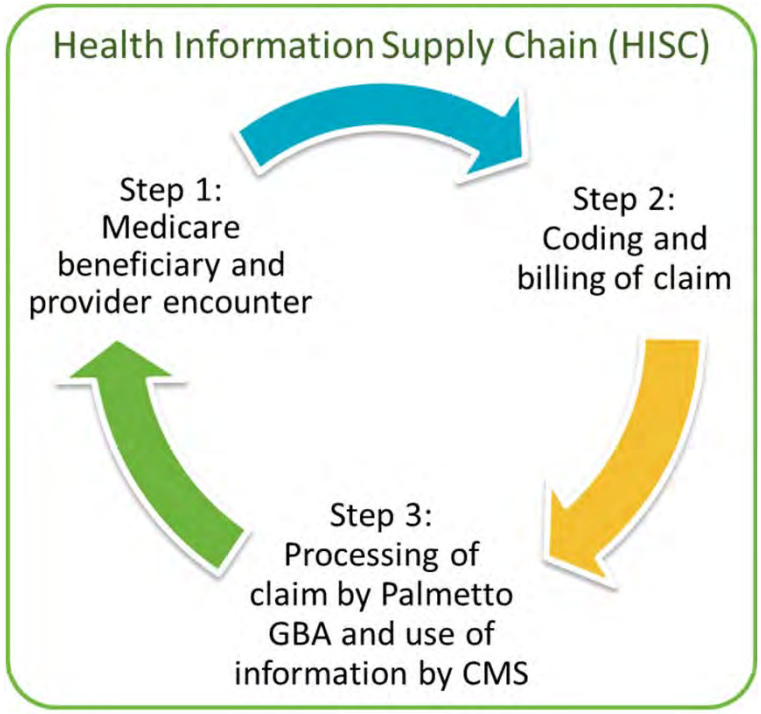
MEDICARE DOCUMENTATION REQUIREMENTS FOR HOME HEALTH CERTIFYING OR REFERRING PHYSICIANS

AGENDA/OBJECTIVES

- Health Information Supply Chain[sm]
- Physician's Role in Establishing Medicare Home Health (HH) Eligibility
- Required Elements of the HH Certification
- HH Face-to-Face (F2F) Encounter Requirement
- HH Documentation
- HH Resources
- Questions

HEALTH INFORMATION SUPPLY CHAIN[SM]

HEALTH INFORMATION SUPPLY CHAIN℠



HEALTH INFORMATION SUPPLY CHAIN℠

All of these providers are a vital link in the HH Benefit's Health Information Supply Chain℠:

- Home Health Agencies (HHAs)
- HH Certifying or Referring Physicians:
  - Hospitalist
  - Community Physician
  - Nursing Facility Medical Director

PHYSICIAN'S ROLE IN ESTABLISHING MEDICARE HOME HEALTH ELIGIBILITY

PHYSICIAN'S ROLE IN ESTABLISHING MEDICARE HOME HEALTH ELIGIBILITY

- Documentation in the certifying, referring or community physician's medical record and/or is included in the acute/post-acute care facility's medical record (if patient was directly admitted to HHA)
  - Will be used as the **basis upon which patient eligibility for the Medicare HH benefit will be determined**

PHYSICIAN'S ROLE IN ESTABLISHING MEDICARE HOME HEALTH ELIGIBILITY

- In **compliance with the Medicare provider enrollment agreement**
  - The certifying or referring physicians and/or the community physician **must provide**, upon request, the medical record documentation that supports the certification of patient eligibility for the Medicare HH benefit to the HHA, review entities, and/or CMS

PHYSICIAN'S ROLE IN ESTABLISHING MEDICARE HOME HEALTH ELIGIBILITY

- The HHA's generated medical record documentation for the patient, by itself, is not sufficient in demonstrating the patient's eligibility for Medicare HH services
- It is the patient's medical record held by the certifying or referring physician that must support the patient's eligibility for HH services

PHYSICIAN'S ROLE IN ESTABLISHING MEDICARE HOME HEALTH ELIGIBILITY

- Information from the HHA can be incorporated into the certifying or referring physician's medical record for the patient
- Information from the HHA must be corroborated by other medical record entries and align with the time period in which services were rendered
- The HHA documentation should also be shared with the certifying or referring physician, as it compliments & supports documentation in the certifying or referring physicians records

PHYSICIAN'S ROLE IN ESTABLISHING MEDICARE HOME HEALTH ELIGIBILITY

- The certifying physician **must review and sign off** on anything incorporated into the patient's medical record that is used to support the certification of patient eligibility
  - The physician's sign-off indicates the physician reviewed, accepted and incorporated the HHA generated documents into the patient's medical record held by the certifying physician (and/or the acute/post acute care facility)
- If this documentation is to be used for verification of the eligibility criteria, **it must be dated prior to submission of the claim**

REQUIRED ELEMENTS OF THE HOME HEALTH CERTIFICATION

REQUIRED ELEMENTS OF THE CERTIFICATION

The certifying physician must certify that:

1. The patient needs intermittent SN care, PT, and/or SLP services.
2. The patient is confined to the home (that is, homebound)
3. A plan of care (POC) has been established and will be periodically reviewed by a physician
4. Services will be furnished while the individual was or is under the care of a physician
5. A **F2F encounter** occurred no more than 90 days prior to the HH start of care (SOC) date or within 30 days of the start of the HH care, was related to the primary reason the patient requires HH services, and was performed by a physician or allowed non-physician practitioner

HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT

HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT

- A F2F encounter with the patient by the certifying or referring physician or allowed NPP must occur before they can certify the need for HH services
- The F2F must be related to the primary reason for the HH admission
- The **certifying or referring physician must**:
  - Certify (attest) that a F2F patient encounter occurred and
  - Document the date of the encounter which must have been within:
    - 90 days prior to SOC, or
    - 30 days after SOC
- Currently, there are no mandatory forms for the F2F encounter

HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT

2014 F2F Encounter Required Elements

- Narrative mandatory regarding:
  - Need for skilled services, and
  - Homebound status

2015 F2F Encounter Required Elements

- Documentation from the patient's medical record providing proof that a visit occurred (example: discharge summary or office progress note)
- Narrative required when skilled oversight of unskilled care is ordered
- The F2F documentation must support that the encounter was related to the primary reason for skilled services

HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT

Two most common F2F creation scenarios:

Scenario #1

- Patient is discharged from the acute/post-acute facility directly to HH services
- The **hospitalist** is seeing the patient while in the hospital

Scenario #2

- Patient is admitted to HH, not following a discharge from a acute/post-acute facility
- The **community physician** is seeing the patient in physician's office with no hospitalization

HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT

Scenario #1 (A): Patient discharged from acute/post-acute facility directly to HH services

- Hospitalist sees patient & performs F2F encounter
- Community physician will follow patient after discharge and certifies HH services
  - HH criteria requires patient to be under care of physician
  - Certifying physician must document the date of the F2F encounter

HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT

Scenario #1 (B): Patient discharged from acute/post-acute facility directly to HH services

- Hospitalist sees patient & performs F2F encounter
- Hospitalist certifies HH services
- Hospitalist identifies the community physician who will follow the patient
- The community physician will follow the patient after discharge
  - HH criteria requires patient to be under care of physician

HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT

Scenario #2: Patient admitted to HH, not following a discharge from a acute/post-acute facility

- Community physician has in-person visit/F2F encounter with the patient 90 days before or 30 days after the 1st HHA visit
  - Note: The F2F visit must be related to the primary reason for HH services
- The community physician will document the F2F encounter in the medical record, and will certify the patient's eligibility for HH

PHYSICIAN BILLING FOR HOME HEALTH CERTIFICATION AND RECERTIFICATION

Physicians can bill for the certification and recertification of patient eligibility for Medicare-covered HH services under a HH POC (patient not present), including contacts with the HHA and review of reports of patient status required by physicians to affirm the initial implementation of the POC that meets patients' needs, per certification period

- **HCPCS G0180 (Certification)**
- **HCPCS G0179 (Recertification)**

PHYSICIAN BILLING FOR HOME HEALTH CERTIFICATION AND RECERTIFICATION

Note: If there are no covered services, these codes should not be billed or paid. As such, these claims will not be covered if the HHA claim itself was non-covered due to certification/recertification ineligibility or because there was insufficient documentation to support that the patient was eligible

HOME HEALTH DOCUMENTATION

HOME HEALTH DOCUMENTATION

- Documentation in the certifying or referring physician's medical records and/or the acute /post-acute care facility's medical records (if patient was directly admitted to HH) will be used as the basis upon which patient eligibility for the Medicare HH benefit will be determined
- Certifying physicians and acute/post-acute care facilities must provide, upon request, the medical record documentation that supports the certification of patient eligibility for the Medicare HH benefit to the HHA, review entities, and/or CMS

HOME HEALTH DOCUMENTATION

Examples of Medical Records HHAs obtain from the certifying or referring physician and/or the acute/post acute care facility include but is not limited to:

- Referral/Order for HHA Services identifying the physician that will be monitoring the POC with the HHA
- Discharge Plan
- F2F encounter documentation
- HHA created POC (signed and dated)
- HHA created SOC assessment (signed and dated)

HOME HEALTH DOCUMENTATION CONTINUED

- Certification/recertification statement
  - Effective January 1, 2019: Recertification statement no longer required (MLN Matters® SE1436)
- Acute/Post-acute care discharge summaries
- History and physical examination (H&P)
- Physician progress notes
- Documentation (anywhere in the medical record) supporting the need for skilled service & homebound status

SE1436

HOME HEALTH DOCUMENTATION

Four questions physicians should answer in their documentation in order to effectively communicate the clinical rationale for determining if an individual is **homebound** and **in need of skilled services**:

1. What is the structural impairment of the patient?
2. What is the functional impairment of the patient?
3. What is the activity limitation of the patient?
4. How do the skills of a nurse or therapists address the specific structural and functional limitations and activity limitations identified when answering the first three questions?

HOME HEALTH RESOURCES

HOME HEALTH RESOURCES

- The Centers for Medicare and Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual, Chapter. 7, Section 30.5.1.1: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
- Change Request (CR) 9119 – Transmittal 29 - Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R92GI.pdf

HOME HEALTH RESOURCES

- Change Request (CR) 9119 – Transmittal 208 - Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R208BP.pdf
- MLN Matters® MM9119: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/mm9119.pdf

HOME HEALTH RESOURCES

- MLN Matters® MM9112: Transmittal 587 - Clarification of Ordering and Certifying Documentation Maintenance Requirements: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R587PI.pdf
- MLN Matters® SE1436: Certifying Patients for the Medicare Home Health Benefit: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1436.pdf

THANK YOU FOR ATTENDING!

Questions?