Pre-Claim Review Demonstration for Home Health Services in IL

Implementation Workshop Series
Disclaimer

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.

Palmetto GBA and CGS employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

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.
Agenda

- Pre-Claim Review (PCR) for Home Health (HH) Services Demonstration Overview
- Home Health Type of Bills (TOBs) and Healthcare Common Procedural Coding System (HCPCS) Codes Subject to the PCR for HH Demonstration
- Number of HH Benefit 60-day Episodes of Care
- Submitting a HH Pre-Claim Review (PCR) Request
- A Provisional Affirmative Documentation Decision
- A Non-Affirmation Decision and Incomplete Requests
Agenda Continued

- Resubmitting a HH PCR Request
- Claim Submission Where HH PCR Was Sought
- Claim Submission Where HH PCR Was Not Sought: The Prepayment Review Process
- Claim Appeals
- Resources
Pre-Claim (PCR) Review for Home Health Services Demonstration Overview
PCR Overview

- The PCR demonstration is being implemented as a result of findings that show extensive evidence of fraud and abuse in the Medicare home health program.
- Most demonstration states have also been identified as high-risk states that select cities and counties under the temporary moratoria on home health provider enrollment authorized under the Affordable Care Act.
- The Medicare improper payment rate for home health services increased from 17.3 percent in 2013 to 51.4 percent in 2014 and is projected to increase to 59 percent for 2015.
Program Goal

The goal of this demonstration is to assess PCR as a means of reducing Medicare FFS expenditures for home health services by reducing improper payments while maintaining or improving the quality of care experienced by the beneficiary.
PCR vs. Prior Authorization

• PCR is different than prior authorization due to timing of review and when services begin
• Prior authorization requests must be submitted prior to services beginning and providers should wait until they have a decision before they begin providing services
• PCR requests are submitted after initial assessments and intake procedures are completed, services have begun, and before a final claim is submitted
What is the PCR?

- PCR is a process to request a provisional affirmation of coverage by submitting documentation and other information for review after services begin but before the final claim is submitted.

- The PCR helps make sure applicable coverage, payment, and coding rules are met before the final claim is submitted.
Who is Involved?

- Home Health Agencies (HHAs) who provide services in the selected states in the demonstration
- Beneficiaries receiving home health care services under the Medicare fee-for-service benefit
Where and When Does the PCR Take Place?

- The demonstration will begin no earlier than:
  - August 1, 2016 in Illinois
  - October 1, 2016 in Florida
  - December 1, 2016 in Texas
  - Michigan and Massachusetts no earlier than January 1, 2017
Where and When Does the PCR Take Place?

- Illinois providers may begin submitting PCR requests to Palmetto GBA beginning July 15, 2016
- Palmetto GBA will begin reviewing those requests August 1, 2016
- Note: These requests should be for home health benefit periods with a \textit{from} date on or after August 1, 2016
Home Health Type of Bills (TOBs) and Healthcare Common Procedural Coding System (HCPCS) Codes
Subject to the PCR for HH Services Demonstration
TOBs

- The PCR process applies to the following TOBs:
  - 327
  - 329
  - 32F
  - 32G
  - 32H
  - 32I
  - 32J
  - 32K
  - 32M
  - 32P
  - 32Q
HCPCS Codes

- The PCR process applies to HCPCS Codes:
  - G0151
  - G0152
  - G0153
  - G0155
  - G0156
  - G0157
  - G0158
  - G0159
  - G0160
  - G0161
  - G0162
  - G0163
  - G0164
  - G0299
  - G0300

Note: Codes are subject to change
Request for Anticipated Payment (RAP)

- RAP is not subject to the PCR process
- 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
Low Utilization Payment Adjustments (LUPAs)

- HH services for less than 60-days will still require a pre-claim review with one exception
  - LUPAs are not subject to the PCR process
  - LUPAs occur when four or fewer visits are provided in a 60-day episode
Number of Home Health Benefit
60-day Episodes of Care
Episodes Subject to the PCR Process

- The PCR process for IL providers applies to all 60-day episodes of care that begin on or after August 1, 2016
  - Initial
  - Recertification
- Discharge and readmit to the same agency within same 60-day episode of care
  - If a new admission (start of care OASIS) is required, a new PCR request must be submitted
- Transfer during a 60-day episode of care
  - The receiving HHA submits a PCR request
Submitting a HH Pre-Claim Review (PCR) Request
PCR Submission Requirements

• Submitting a PCR request will be voluntary

• However, after the first three months of the demonstration in a state, if an HHA provides services to a beneficiary and submits the claim to the Contractor for payment without submitting a PCR request,
  ▪ Claim will be subjected to prepayment medical review and
  ▪ If approved for payment, the claim will be subject to a 25% payment reduction
  ▪ Note: This payment reduction is not appealable and cannot be billed to the beneficiary
PCR Request Required Elements

- Under the demonstration, a HHA or a beneficiary may submit a request for PCR for the applicable services.
- The request must contain certain elements to be considered complete:
  - Beneficiary Information
  - Certifying Physician/Practitioner Information
  - Home Health Agency Information
  - Submitter Information
  - Other Information
  - Required Documentation
Beneficiary Information Required

- Beneficiary Name
- Beneficiary Medicare Number
- Beneficiary’s Date of Birth
Certifying Physician/Practitioner Information

- Certifying Physician/Practitioner Name
- Certifying Physician/Practitioner National Provider Identifier (NPI)
- Certifying Physician/Practitioner PTAN (optional)
- Certifying Physician/Practitioner Address
Home Health Agency Information

- Agency Name
- Agency National Provider Identifier (NPI)
- CMS Certification Number
- Agency PTAN (optional)
- Agency Address
Submitter/Requester Information

- Contact Name
- Telephone Number
Other Information

• Benefit period requested (initial or recertification)
• Submission Date
• From and Through Date of the 60-day episode of care
• Indicate if the request is an initial or resubmission review
• State where service is rendered
Medicare Home Health Documentation Requirements

- Documentation from the medical record that supports the beneficiary is:
  - Confined to the home at the time of services;
  - Medicare considers the person homebound if:
    a) There exist a normal inability to leave the home and
    b) Leaving home requires a considerable and taxing effort
Medicare Home Health Documentation Requirements

• Additionally, one of the following must also be true;

  a) Because of illness or injury, the person needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence; or

  b) The person has a condition such that leaving his or her home is medically contraindicated
Medicare Home Health Documentation Requirements

- Under the care of a physician;
- Receiving services under a plan of care established and periodically reviewed by a physician;
- In need of skilled services;
  - Nursing care on an intermittent basis, or
  - Physical therapy or speech-language pathology; or
  - Have a continuing need for occupational therapy
Medicare Home Health Documentation Requirements

- Had a face-to-face (F2F) encounter with a medical provider as mandated by the Affordable Care Act. This encounter must:
  - Occur no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care; and
  - Be related to the primary reason the patient requires home health services; and was performed by a physician or non-physician practitioner.
Required Documentation - In This Order by Task

- *Only for resubmissions* - Most Recent Non-Affirmation Letter for This Episode
- **Task #1** - The actual F2F clinical encounter note used by the certifying physician to justify the referral for HH services
- **Task #2** - The HH generated records that have been signed, dated and incorporated into the certifying physician’s medical records
- **Task #3** - The Plan of Care (POC) signed and dated by the certifying physician
- **Task #4** - The signed and dated physician’s certification of patient eligibility
Required Documentation - In This Order by Task

- **Task #5** - Medical records that meet each HH requirement for **Confined to the Home**

  - **Criteria 1:**
    - Does the beneficiary, because of illness or injury, need:
      - The aid of supportive devices such as crutches, canes, wheelchairs, and walkers?
      - The use of special transportation?
      - The assistance of another person to leave their place of residence?
    - Does the beneficiary have a condition such that leaving the home is medically contraindicated?
Required Documentation - In This Order by Task

• **Task #5** - Medical records that meet each HH requirement for **Confined to the Home**
  
  ▪ **Criteria 2:**
  
  • **Component 1** - Is there a normal inability to leave the home?
  
  • **Component 2** - Does leaving the home require a considerable and taxing effort?
    
    ▪ Checklist 1 - Structural Impairment
    ▪ Checklist 2 - Functional Impairment
    ▪ Checklist 3 - Activity Limitation
Methods of Submitting a PCR Request to Palmetto GBA

- eServices
  - **IMPORTANT**: This is our preferred method of submission
  - View the eServices User Manual for more information
- Electronic Submission of Medical Documentation (esMD)
  - Go to www.cms.gov/esMD for more information
- Mail
  - Palmetto GBA - JM HH Pre-Claim Review
    PO Box 100234
    Columbia, SC 29202-3234
- Fax
  - 803-419-3263
Methods of Submitting to CGS

- **myCGS**
  - View the [myCGS User Manual](#) for more information

- **Electronic Submission of Medical Documentation (esMD)**
  - Go to [www.cms.gov/esMD](http://www.cms.gov/esMD) for more information

- **Mail**
  - CGS Administrators
    - PO Box 20203
    - Nashville, TN 37202

- **Fax**
  - 615-664-5950
Palmetto GBA’s eServices

- A free Internet-based, provider self-service secure application - www.onlineproviderservices.com
  - 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!
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
  - Attach individual attachments for each Task instead of one attachment including all documents for the submission
  - eServices will give an error message if an attachment with the same name is attached to a different Task
Palmetto GBA eServices Submittal Request

You are accessing a U.S. Government information system, which includes: (1) this computer, (2) this computer network, (3) all computers connected to this network, and (4) all devices and storage media attached to this network or to a computer on this network. This information system is provided for U.S. Government-authorized use only. Unauthorized or improper use of this system may result in disciplinary action, as well as civil and criminal penalties. By using this information system, you understand and consent to the following:

- You have no reasonable expectation of privacy regarding any communication or data transiting or stored on this information 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 information system.
- Any communication or data transiting or stored on this information system may be disclosed or used for any lawful Government purpose.

Refer to the Terms of Use.
Palmetto GBA eServices Submittal Request

Welcome to the eAuthentication section where you can submit your prior authorization request. Resubmissions are available if you originally used the eServices portal to submit your request and have the UTN available. Get started by selecting your form below.

Select a Type: Pre-Claim Review, Home Health

Pre-Claim Review Form: PA-HHH-A 5001
Palmetto GBA eServices Submittal Request

Pre-Claim Review Form JM HHH

Provider Information

Contract/Region
11001/Part A South Carolina / HHH

Provider/Facility Name
HHH Test Provider 1

Requestor Name*
[Blank]

Requestor E-mail *
[Blank]

Date
07/05/2016

Provider Number (PTAN)
747770

National Provider Identifier (NPI)
1447427125

Requestor Phone Number*
[Blank]

Ext
[Blank]
Palmetto GBA eServices Submittal Request

Beneficiary Information
- Beneficiary First Name*
- Beneficiary DOB*
- Validate Beneficiary Information

Claim Information
- Pre-Claim Review Episode Start Date*
- Type of Bill (TOB)*

Beneficiary Last Name*
- HIC Number*
- Pre-Claim Review Episode End Date*
- HCPCS Code(s)*
  - Select HCPCS Codes by holding down the Ctrl key and choosing directions.
Palmetto GBA eServices Submittal Request
Palmetto GBA eServices Submittal Request

Validate Beneficiary Information

Claim Information
Pre-Claim Review Episode Start Date*
07/06/2016

Pre-Claim Review Episode Start Date cannot be before 06/01/2016

Type of Bill (TOB)*
329

Pre-Claim Review Episode End Date*
07/05/2016

Pre-Claim Review Episode End Date cannot be same as or greater than 40 days of Episode Start Date

HCPCS Code(s)*
G0153 X
G0158 X
G0162 X
Palmetto GBA eServices Submittal Request

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
- 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
Palmetto GBA eServices Submittal Request

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:

- Long-term Care Hospital (LTCH)

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.*

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? *

Attached Files

<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_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>
</tbody>
</table>

Total File Size: 2 KB
Max Allowed: 150MB
Palmetto GBA eServices Submittal Request

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? *  

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

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

Task 4: Upload the signed and dated physician’s certification of patient eligibility*
Palmetto GBA eServices Submittal Request

<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...</td>
<td>2038</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...</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</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_Physicians...</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  
Showing 1 to 5 of 5 entries
Palmetto GBA eServices Submittal Request

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
Palmetto GBA eServices Submittal Request

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*
Palmetto GBA eServices Submittal Request

Q8: Is there a structural impairment? * Yes ☐ No ☐

Please specify which domains this structural impairment affects*
- Structures involved in voice and speech ☑
- Structures of the cardiovascular system ☑
- Structures related to the digestive system ☑

Q9: Is there functional impairment? * Yes ☐ No ☐

Please specify which domains this functional impairment affects*
- Functions of the cardiovascular system ☑
- Functions of the digestive system ☑
- Voice and speech functions ☑

Q10: Is there an activity limitation? * Yes ☐ No ☐

Please specify which domains this activity limitation affects*
- Communication ☑
- Mobility ☑

Please submit form
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
Other Ways to Submit to Palmetto GBA

- To submit the request using one of the methods below, do the following:
  - Complete the JM HH Pre-Claim Review Submittal Request
  - Ensure all fields are completed
  - Print the request and place it in front of the required documentation
  - Ensure that the required documentation is pre-ceded by the separator pages

- Electronic Submission of Medical Documentation (esMD)
  - Go to www.cms.gov/esMD for more information

- Mail
  - Palmetto GBA - JM HH Pre-Claim Review
    - PO Box 100234
    - Columbia, SC 29202-3234

- Fax
  - 803-419-3263
Palmetto GBA Website Submittal Request
# Palmetto GBA Website Submittal Request

**JM HH PRE-CLAIM REVIEW SUBMISSION REQUEST**

All fields are **REQUIRED**. Incomplete or handwritten requests will be returned.

Check the appropriate box below:

- Initial Submission
- Resubmission

Do you have a copy of the most recent Non-Affirmation decision letter for this episode?

Choose an item: □ Enter UTN of most recent Non-Affirmation

Note: Use of this request document will require submission via fax, hard copy mail, or the electronic submission of Medical Documentation (eMD). 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

<table>
<thead>
<tr>
<th>Contract/Region</th>
<th>Provider Number (PTAN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11001</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider/Facility Name</th>
<th>National Provider Identifier (NPI)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider/Facility Address Line 1</th>
<th>Requestor Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider/Facility Address Line 2 (if applicable)</th>
<th>Requestor Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider/Facility City</th>
<th>Ext (if applicable)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider/Facility State</th>
<th>Provider/Facility ZIP</th>
<th>Requestor Email</th>
</tr>
</thead>
</table>

A decision letter will be mailed to the address provided above.

### Beneficiary/Patient Information

- **Beneficiary/Patient First Name**
- **Beneficiary/Patient Last Name**
- **Beneficiary Gender**
- **Beneficiary/Patient Date of Birth**
- **Beneficiary/Patient HIC Number**

Choose an Item: □
Palmetto GBA Website Submittal Request
### Criteria 1: Confined to the Home

Q4: Does the beneficiary, because of illness or injury, need (check all that apply):

- [ ] The aid of supportive devices such as crutches, canes, wheelchairs, and walkers?
- [ ] The use of special transportation?
- [ ] The assistance of another person to leave their place of residence?

If one or more of the above apply, proceed to Task 5.
If none of the above applies, proceed to Q5.

Q5: Does the beneficiary have a condition such that leaving the home is medically contraindicated? Choose an item:

- [ ]

### Task #5 – Q4/Q5: Attach medical documentation that meets the First Criteria for Confined to the Home

### Criteria 2: Confined to the Home

Q6: Component 1: Is there a normal inability to leave the home? Choose an item:

- [ ]

### Task #5 – Q6: Attach medical documentation that meets the Second Criteria for Confined to the Home

Q7: Component 2: Does leaving the home require a considerable and taxing effort? Choose an item:

- [ ]

### Checklist 1: Is there a structural impairment? If yes, select all that apply below:

- [ ] a. Structures of the nervous system
- [ ] b. Eye, ear, and related structures
- [ ] c. Structures involved in voice and speech
- [ ] d. Structures of the cardiovascular system
- [ ] e. Structures of the immunological system
- [ ] f. Structures of the respiratory system
- [ ] g. Structures of the digestive system
- [ ] h. Structures related to the metabolic and endocrine systems
- [ ] i. Structures of the genitourinary system
- [ ] j. Structures related to movement
- [ ] k. Skin and related structures

### Checklist 2: Is there a functional impairment? If yes, select all that apply below:

- [ ] a. Mental functions
- [ ] b. Sensory functions and pain
- [ ] c. Voice and speech functions
Task #5—Q7. Attach medical documentation that meets the Second Criteria for Confined to the Home.

Instructions for completing this request:
1. All fields are required. Requests submitted without all fields completed will be returned as an incomplete request.
2. Complete all fields online. Handwritten requests will not be processed and will be returned as an incomplete request.
3. This request may not be saved after it is completed.

Documentation Requirements:
Note: Documentation header page will print with this request: Ensure that all relevant documentation is attached behind the appropriate header page.
1. If this is a re-submission, ensure that you included the UTN and a copy of the most recent Nee-Affirmation decision letter for this episode is attached.
2. Task #1: P2P Clinical Encounter Notes.
3. Task #2: HHA generated records that have been signed, dated, and incorporated into the certifying physician’s medical records (if applicable).
4. Task #3: Plan of care signed and dated by the certifying physician.
5. Task #4: Signed and dated physician’s certification.
6. Task #5—Q4/Q5: Medical documentation that meets the criteria 1, which supports that the patient is certified to the home.
7. Task #5—Q6: Documentation to meet criteria 2, which supports the patient’s normal inability to leave the home.
8. Task #5—Q7: Documentation that meets criteria 2, which supports that it is a considerable and taxing effort for the patient to leave the home.

PRINT REQUEST
Palmetto GBA Website Submittal Request
Palmetto GBA
Website
Submittal Request
Palmetto GBA Website Submittal Request

Task #2
HHA Generated Records

PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION
Palmetto GBA Website Submittal Request
Task #4
Signed and Dated Physician’s Certification

Palmetto GBA Website Submittal Request
Task #5 – Q4/Q5
Documentation that Meets Criteria 1 –
Confined to the Home

Palmetto GBA
Website
Submittal Request
Task #5 – Q6
Documentation that meets Criteria 2 – Patient’s Inability to Leave the Home
Task #5 – Q7
Documentation that Meets Criteria 2 – Considerable and Taxing Effort to Leave the Home
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 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.
Pre-Claim Review Process When Services are Not Covered Under Medicare, Medicare is Primary and the Provider Needs a Denial to Bill the Secondary

- 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
Pre-Claim Review Process When Services are Not Covered Under Medicare, Medicare is Primary and the Provider Needs a Denial to Bill the Secondary

- 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.
Medicare Secondary Payer (MSP) and Pre-Claim Review

MSP When You Seek 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 provisionally affirmed UTN for payment
Medicare Secondary Payer (MSP) and Pre-Claim Review

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
A Provisional Affirmative Documentation Decision
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:
    ▪ The UTN
    ▪ Which HCPCS we affirmed
    ▪ A detailed explanation of which requirements have not been met
Provisional Affirmative Decision

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

- A PCR could possibly include both provisionally affirmed and non-affirmed HCPCS codes under a UTN.
- In this case the provider has two options:
  - Submit the final claim with all the HCPCS codes with the UTN and the provisionally affirmed HCPCS will approve for payment and the non-affirmed HCPCS will deny with appeals rights.
  - Resubmit the PCR for the non-affirmed HCPCS codes which would result in a new UTN based on that decision which would then need to be used on the final claim.
PCR Decisions Based on Individual HCPCS Codes

• If a beneficiary’s health changes during that same 60-day episode of care which require additional HH services with additional HCPCS codes, the PCR will need to be resubmitted

• Note: Palmetto GBA is in the process of clarifying this requirement with CMS
A Non-Affirmation and Incomplete Decisions
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:
  - The non-affirmed UTN
  - Which HCPCS were non-affirmed
  - A detailed explanation of which requirements have not been met to affirm the HCPCS
An Incomplete Decision

- When the PCR request is **incomplete** (required information was missing)
  - The notification will include:
    - An explanation of what information was missing

- **Note**: A PCR request is not required for a RAP or LUPA
Resubmitting a HH Pre-Claim Review Request
Resubmitting the 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
PCR Resubmission Review Time Requirement

- MACs have an additional 20 business days (excluding Federal holidays) of 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
Claim Submission Where Pre-Claim Review for Home Health Services Was Sought
Submitting the Final Claim

- Normal data submitted on the claim is required
- TOB is 329
- 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 OASSIS 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
Claim Submission Where Home Health Pre-Claim Review Was Not Sought

The Prepayment Review Process
Pre-Payment Review

• If the provider does not submit a PCR request, the claim will automatically be held for pre-payment review.

• The provider will receive an Additional Documentation Request (ADR).

• All pre-payment review regulations will apply.

• If the reviewer determines that all Medicare criteria are met for payment, the claim will be paid.

• If the reviewer determines that all Medicare criteria are not met, the claim will be denied and the provider may appeal the denial.
Payment Reduction for Non-Submission

- If no PCR request was submitted and the claim is determined to be payable in the pre-payment medical review, it will be paid with a 25 percent reduction in final payment.
- The 25 percent payment reduction, which applies for failure to receive a PCR request, is non-transferrable to the beneficiary.
- This payment reduction is not subject to appeal.
- **Note:** The payment reduction will not be applied during the first three months of the demonstration in each state.
Claim Appeals
Submitting the Appeal

- The standard appeals process applies to the final claim.
- There is no appeal process for non-affirmation PCR of HH services decisions.
- 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.
Resources
Resources

- CMS’ website
  - Pre-Claim Review Initiatives
  - Frequently Asked Questions
  - Pre-Claim Review Fact Sheet
  - Pre-Claim Review Demonstration Home Health Services Operational Guide
  - Pre-Claim Review Demonstration for Home Health Services Overview Slides
Palmetto GBA Resources

- Palmetto GBA’s website
  - Home Health Pre-Claim Review webpage
  - YouTube Video: Home Health Face-to-Face
Coming Soon to Palmetto GBA

- HH PCR Status Tools:
  - IVR
  - Website
Stay Connected to Palmetto GBA

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.

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.
Other Ways to Stay Connected to Palmetto GBA

Contact us Email
- Ask a question via email using the “contact us” feature
- *Please do not send questions with Protected Health Information (PHI)*

YouTube
- View educational videos on YouTube

LinkedIn
- Stay up-to-date with company news
- Discover new job opportunities
- See how you’re connected to employees
Key Palmetto GBA Self-Service Tools

• Claims Payment Issues Log
  ▪ Look here for issues affecting claims payment
  ▪ Sign up to receive email updates for specific issues

• EDI System Status Log
  ▪ Look here for issues affecting Electronic Remittance Advices, GPNet, Common Edit Module (CEM) edits, and 999 and 277CA’s
Claims Payment Issues Log

Click Here
Selecting Specific Issues for Updates

Click on the article that you want to view. From there you can sign up to receive regular updates.
Accessing the EDI System Status Log
Viewing the EDI System Status Log

Palmetto GBA
EDI Systems Status Log

No Open Issues

Resolved Issues

<table>
<thead>
<tr>
<th>Tracking Number:</th>
<th>Issue Opened (Date/Time):</th>
<th>Issue Resolved (Date/Time):</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLM00028</td>
<td>01/12/2015</td>
<td>01/12/2015</td>
</tr>
</tbody>
</table>

Systems Affected:

<table>
<thead>
<tr>
<th>RRB</th>
<th>J01</th>
<th>J011</th>
<th>J15</th>
</tr>
</thead>
</table>

Description of Issue:

01/12/2015: System wide power outage.

Impact:

Delays in submitters receiving their 999 and 277CA's.

Current Status:

System up and running. No back log at this time. All reports have been distributed.
Thank You for Attending!

Questions?