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Medicare Pre-Claim Review Demonstration for Home Health Services

Beginning Aug. 1, 2016, the Centers for Medicare & Medicaid Services (CMS or Agency) will implement a three-year pre-claim demonstration for home health services in Illinois, followed by Florida, Texas, Michigan, and Massachusetts. The demonstration will begin in Florida no earlier than Oct 1, 2016; in Texas, it will begin no earlier than Dec. 1, 2016. In Michigan and Massachusetts, it will begin no earlier than Jan. 1, 2017.

The Agency initiated this demonstration project under the Social Security Amendments of 1968, 42 U.S.C. § 1395b-1(a)(1)(J), that purportedly permits the Secretary to develop demonstration projects to improve methods for the investigation and prosecution of fraud. The goal of this demonstration in establishing a pre-claim review is to develop improved procedures for the detection of fraud among Home Health Agencies (HHAs) providing services to Medicare patients. Providers in each of the five-states will be notified by the Medicare Administrative Contractors (MACs) prior to the start of the demonstration and CMS will use other educational efforts to announce the program.

Purpose of the Demonstration Program

The demonstration is intended to bolster the existing efforts of CMS, such as the temporary moratoria on enrollment of new providers and other efforts outlined in the Notice. Data collected will also assist with the Health Care Fraud Prevention and Enforcement Action Team (HEAT).

This demonstration may also help prevent improper payments in geographic areas where HHA providers are known to have a high incidence of fraud. The HHS Comprehensive Error Rate Testing (CERT) program calculated that the 2015 improper payment rate for HHA claims increased to 59 percent from the 2014 rate of 51.4 percent and 2013 rate of 17.3 percent. A majority of the errors occurred in the narrative portion of the face-to-face encounter documentation. Medicare did make a policy change to simplify these face-to-face regulations; however, CMS still has cases in which the medical record does not support the eligibility for the benefit, which constitutes “insufficient documentation” errors. Therefore, this requirement will ensure all coverage and clinical document requirements are met before claims are submitted for final payment.

The demonstration will also: 1) determine the level of resources necessary to implement a permanent pre-claim review program; 2) determine the feasibility of a pre-claim review to prevent payment for services with a high incidence of fraud; and 3) determine the return on investment of pre-claim review for home health claims. CMS will analyze data to determine the impact on fraud in the demonstration states that will help in developing improved fraud detection procedures.

This demonstration does not create new documentation requirements; it merely requires documentation be provided earlier in the claims payment process.

Educational materials will be posed for providers and through the MACs. Questions should be submitted to HHPreClaimDemo@cms.hhs.gov.

Provider Pre-Claim Submission Requirements

An HHA provider or the beneficiary will be encouraged to submit to the relevant MAC a request for pre-claim review with all relevant documentation. After receipt, the MAC will review whether it meets all the coverage and clinical documentation requirements. The HHA should submit the Request for Anticipated Payment (RAP) before submitting the pre-claim review request and begin providing services while waiting for the decision. The MAC will communicate a decision provisionally approving or disapproving payment and make all reasonable efforts to make a determination and issue a notice of decision within 10 business days.

If declined, the submitter may amend and resubmit an unlimited number of times. For subsequent pre-claim review requests, CMS or its agents will conduct a complex medical review and make all reasonable efforts to postmark and notify its decision within 20 business days.

If a claim is submitted without a pre-claim review decision, it will be stopped for prepayment review and documentation will be requested. After the first three months of the demonstration in a state, CMS will apply a payment reduction of 25percent for claims that, after the review, are deemed payable, but did not first receive a pre-claim review decision. This 25 percent payment reduction may not be recouped or charged to the beneficiary, and is not subject to appeal.

Three specific scenarios are outlined:

1. Pre-claim review documentation is submitted and Medicare coverage and documentation requirements are met, the MAC will send a provisional affirmative pre-claim decision to the HHA and Medicare beneficiary. When the HHS submits the claim for payment after delivery the level of service, the claim will include a unique tracking number indicating it was cleared during pre-claim review and if it meets coverage and document requirements, the claim will be paid.
2. If a pre-claim review documentation does not meet all Medicare coverage and clinical requirements, notification of a non-affirmative decision will be sent to the HHA and Medicare beneficiary. The submitter may resubmit additional documentation. Alternatively, the HHA could submit the claim to the MAC, the MAC would deny for lack of a provisional affirmative pre-claim review and recoup the payment made on the RAP. The HHA or the beneficiary would have the opportunity to appeal, if denied inappropriately. Beneficiaries will have the option of signing an Advance Beneficiary Notice of Noncoverage (ABN) in order to receive the services and be liable for payment.
3. If a pre-claim review request is submitted with incomplete documentation, the request, along with a note of what is missing, will be sent to the submitter. Both the HHA and the beneficiary are notified and the submitter can resubmit the additional documentation.
4. When the HHA provides treatment to the beneficiary and submits the claim without submitting a pre-claim review, the home health claim will be stopped for prepayment review with documentation. If the claim is determined to be not medically necessary or not sufficiently documented, the claim will be denied. The claim may be appealed and if determined to be payable, it will be paid. After the first three months, CMS will reduce payment by 25 percent for claims deemed payable that did not first receive a pre-payment review. The 25

percent reduction is not subject to appeal. The beneficiary would not be liable for more than he or she would otherwise be if the demonstration were not in place.

For more information access the Fee-For-Service webpage.

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