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Guide to the CMS Home Health Pre-Claim Review Demonstration

Remember the old saying, "one person can ruin it for everyone?" When it comes to home healthcare, the "one person" is hundreds of home healthcare agencies that are suspected of Medicare fraud. Approximately 5 percent of home health agencies share characteristics that often point to home healthcare fraud, according to a June 2016 report by the U.S. Department of Health and Human Services' Office of Inspector General. The report also noted the Centers of Medicare and Medicaid have estimated that Medicare made more than $10 billion improper payments to home healthcare agencies in 2015.

Naturally, CMS wants to do something to decrease, and hopefully eliminate, home healthcare fraud. Of course for the remaining thousands of other home health agencies who are solely focused on providing care for their patients, this can mean additional programs, regulations or documentation to adhere to. One recent program implemented to stop home healthcare fraud is the pre-claim review demonstration.

What is the pre-claim review demonstration?

The pre-claim review demonstration is a program that requests that provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. Pre-claim review helps ensure applicable coverage, payment, and coding rules are met before the final claim is submitted. Fortunately, no new documentation is required with pre-claim review. Home health agencies submit the same information they currently do for payment, just earlier in the process.

Managed by Medicare Administrative Contractors, or MACs, pre-claim review confirms that all certification and coverage requirements are met. MACs have 10 days to review and determine if a claim is affirmed, non-affirmed, or partially affirmed. Home health agencies can re-submit non-affirmed or partially-affirmed claims as many times as necessary.

The Pre-Claim Review Demonstration is ongoing in Illinois and currently slated to roll out to Florida, Texas, Michigan, and Massachusetts.

It's important to note that the pre-claim review

demonstration is not mandatory. However, non-affirmed claims that are submitted for payment will be denied by MACs, and the home health agency will be hit with a 25 percent payment rate penalty for skipping the pre-claim review process. So, while not mandatory, any agency that wants to remain profitable should comply.

Which states are impacted?

Pre-claim review began in August 2016 as a pilot program impacting home health agencies that provide services to beneficiaries in Illinois. Plans for four additional states to join the program (Florida, Texas, Michigan and Massachusetts) were delayed because of challenges and backlash with the Illinois roll out. These initial states were chosen as participants given the extensive evidence of Medicare fraud, so it's natural that CMS would target them first in an effort to decrease, or hinder, fraudulent activity.

Recently, CMS announced that the pre-claim review demonstration would roll out to Florida in April 2017. There's no word on when the program will go live in Texas, Michigan or Massachusetts, but CMS will provide at least 30 days' notice on their website, and will likely stagger roll out dates in order to provide education and further assistance to participating agencies.

How can my agency be successful?

Because the pre-claim review demonstration is a newer initiative, formal best practices are still being established, but that doesn't mean there aren't things participating agencies can do to increase their affirmation rates.

Outlining achievable workflows, understanding what documentation is needed and where it is coming from, what team members are responsible for what tasks, and how information is compiled and transmitted will keep the pre-claim review process organized and efficient.

Technology can help facilitate complete, correct documentation and assist in automating the pre-claim review process. Plus, insights delivered from technology solutions can help further streamline processes, related to pre-claim review and beyond, and help spot trend information on affirmation and non-affirmation rationale.

Having a deep understanding of what documents are required with each pre-claim review submission can help turn quicker affirmations, but more importantly, find a way to quickly and effectively communicate your patient's medical need for home health services.

While CMS is doing some outreach to physicians and other healthcare providers to educate them on pre-claim review and what information is needed on the outset, it's not enough to get providers engaged and working with home health agencies to ensure complete and accurate information is being received.

Pre-Claim Review- The Basics

Home health providers are required to obtain a pre-claim review for home health services prior to submission of a final claim.

The pre-claim review demonstration does not create new documentation requirements, according to CMS.

Affirmative decisions on pre-claim reviews will be issued a Unique Tracking Number (UTN) that must be included when submitting the final claim to be eligible for payment.

Claims submitted without a pre-claim review decision can reduce payment amounts and/or lengthen revenue cycle time.

After three months, claims submitted without a pre-claim review decision will be paid with a 25% reduction of the full claim amount. This decision cannot be appealed.

Having conversations to educate referral sources will be a pillar of success with pre-claim review.

Are you next?

If your home health agency provides services to beneficiaries in Florida, Texas, Michigan or Massachusetts, the time to prepare for pre-claim review is now. And beyond that, you never know when CMS might announce additional states that will be impacted by the program in the future. Here are some steps you can take:

1) Ensure your agency has efficient document management processes in place. You can find a full list of documents required under pre-claim review here; start planning organized workflows that enable staff to work quickly and have instant access to important documentation when they need it.

2) Educate your staff now as a precaution. Introduce the idea of pre-claim review in a lunch and learn session, for example, or as a recorded session that staff can view during down time. Once there is a complete workflow in place, invite key stakeholders to a meeting where roles and responsibilities are covered. You want to be ready and have the ability to be agile should CMS push the "go" button.

3) Think about how you could make your documentation easy for a MAC to review. The goal is to have your claim affirmed quickly, so consider including a cover with your submission so there is a clear outline of who is submitting the documents and what cases are included.

> *IT'S IMPORTANT TO NOTE THAT THE PRE-CLAIM REVIEW DEMONSTRATION IS NOT MANDATORY. HOWEVER, NON-AFFIRMED CLAIMS THAT ARE SUBMITTED FOR PAYMENT WILL BE DENIED BY MACS AND THE HOME HEALTH AGENCY WILL BE HIT WITH A 25 PERCENT PAYMENT RATE PENALTY.*

For now, the pre-claim review demonstration is a small pilot program, impacting home health agencies providing services to beneficiaries in Illinois, with Florida not far behind. The process of submitting claims for affirmation prior to submitting for payment is not mandatory, but the implications of not participating are too detrimental to ignore. Looking for ways to efficiently capture, file and retrieve necessary documentation, along with identifying clear roles and responsibilities will be pillars of success with the program. While not a nationwide initiative yet, home health agencies need to be aware of the program and understand the implications, and what can be done now to prepare.