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CMS Starts New Home Health Claims Review Demo With Three Options

By Nina Youngstrom

On Dec. 10, CMS is taking another shot at a home health pre-claim review demonstration, although calling it that would be a misnomer. Home health agencies (HHAs) will have three choices—pre-claim reviews, post-claim reviews or virtually no review in exchange for a 25% pay cut. There's also a reward of sorts for more compliant providers.

CMS on Nov. 27 unveiled the details of its five-year Review Choice Demonstration for Home Health Services, which was developed in response to mounting evidence of fraud and abuse in home health care and the persistence of inadequate documentation to support certification of home health eligibility, according to slides on the CMS website.

Palmetto GBA, a Medicare administrative contractor (MAC), will run the demonstration, which starts in Illinois. Sometime soon, CMS will implement the demonstration in four other states—Florida, Ohio, North Carolina and Texas—but HHAs there will have 60 days' warning. It could eventually hit additional states. The previous version of the demo began in 2016 but was suspended last year because of glitches.

'Another Preauthorization Process'

The demonstration amounts to another preauthorization process in Medicare, says Patrick Kennedy, compliance officer for UNC Hospitals in Chapel Hill, North Carolina. There are already prior authorization demonstrations for non-emergent hyperbaric oxygen therapy, repetitive non-emergent ambulance transport and power mobility devices. While preauthorization is mostly used on the commercial side, not in Medicare, it seems to be going in that direction, he notes. Hospitals also have related experience because MACs are reviewing a sample of claims before paying them under Targeted Probe and Educate (TPE), CMS's national medical review strategy, although the home health demonstration calls for 100% claims review, Kennedy says. "We know we have to do this right on the front end—not provide services and then get the documentation. I don't know that private home health agencies have been as involved in Medicare's pre-claim review processes, so that may be where the greater challenge exists," he says. HHAs that are part of a larger system "are accustomed to" TPE and recovery audit contractor (RAC) audits, so there is more infrastructure in place to manage them.

In the demonstration, Palmetto will review home health claims for compliance with Medicare's home health benefit. Patients must be confined to their home, be under the care of a physician, receive services under a physician's plan of care, require skilled services, and have a face-to-face encounter with a physician or non-physician practitioner that's related to the main reason the patient needs home health care no more than 90 days before home health care starts or 30 days after.

HHAs can take their pick of three choices in the demonstration:

- Pre-payment review of all claims: HHAs submit a request for a pre-claim review, including their documentation, and it can encompass more than one episode of care. After reviewing the HHA's claim

information, the MAC will send a decision letter provisionally "affirming" or "non-affirming" the request for a pre-claim review, which appears to be CMS lingo for an approval/denial. If they're affirmed, Palmetto will pay the claim. If they're not affirmed, HHAs have another choice to make: (1) submit the claim, which will be denied but can be appealed, or (2) continue to address the reasons the claim was non-affirmed as many times as they want before they submit the claim, but if they're still rebuffed, "pre-claim review submissions can't be appealed."

CMS said decision letters will explain exactly why claims were not affirmed and include a pre-claim review unique tracking number. There's a penalty for dropping the ball: If HHAs select the prepayment review option but fail to submit a pre-claim review request before submitting the final claim, Medicare will chop 25% from their payment.

- Post-payment review of all claims: This is the post-payment review familiar to providers. Life will proceed normally, but MACs will do complex medical reviews on claims submitted at six-month intervals. MACs will send HHAs additional documentation requests after they get claims.

  If HHAs don't make a selection in the demonstration, they will automatically land in post-payment review.

- Minimal review with payment reduction: Claims will be paid the usual way, but "HHAs will receive an automatic 25% reduction on all payable home health claims," CMS said. With this option, claims are free from TPE, but they could be subject to review by RACs. Denied claims will retain appeal rights. If HHAs select door number three, they are stuck with it for all five years of the demo.