

## PRE-CLAIM REVIEW DEMONSTRATION FOR HOME HEALTH SERVICES: MAKING PROVIDERS MORE PROACTIVE

On June 8, the Centers for Medicare & Medicaid Services (“CMS”) announced its plan to implement a three-year Medicare pre-claim review demonstration for home health services in the states of Illinois, Florida, Texas, Michigan and Massachusetts (the “Demonstration”). These states were selected based on high incidences of fraud and improper payments for home health services. The purpose behind implementing a pre-claim review demonstration for home health agencies (“HHAs”) is to assist in developing improved procedures for the identification, investigation and prosecution of Medicare fraud. Illinois will be the first state in which CMS implements the pre-claim review process, beginning on August 1, 2016. Given the short time frame until implementation, it is important for the HHA and Medicare beneficiaries in the Demonstration states to understand how these new requirements will impact their billing procedures in order to ensure that payments are received for services rendered. For providers outside of the Demonstration, it is important to understand that this Demonstration, like many Demonstrations we have seen recently, will almost certainly become a nationwide home health program practice.

### BACKGROUND

CMS states that the Demonstration is part of an effort to implement a series of anti-fraud initiatives in select states designed to collect data on how to combat Medicare fraud occurring among Medicare HHAs. It also falls within CMS’s stated desire to move away from a “pay and chase” model and towards a model in which potentially improper payments are made *before* any money is paid. CMS believes pre-payment review will be a useful project because it will identify improper documentation before claims are paid. CMS feels that this is important because in FY 2015, 59 percent of payments to home health agencies were considered improper. This is a dramatic increase from 17.3 percent of payments being improper in 2013 and 51.4 percent in 2014.

Not surprisingly, this exceptionally high error rate is due to agencies’ documentation being insufficient to support the medical necessity of services provided. Of course, CMS noted in the proposed CY 2015 PPS Final Rule that this dramatic increase in error rates was due, in large part, to the ongoing issues with the face-to-face rule. Despite this fact, CMS proposes to address this error rate by requiring home health agencies to submit the supporting documentation for pre-payment review. The demonstration does not change beneficiary eligibility standards or Medicare’s documentation requirements for home health care. Instead of waiting until after care is provided, the demonstration requires the HHA to provide the necessary documentation that will support the conclusion that Medicare beneficiaries are eligible for payments while Medicare beneficiaries are receiving care.

### PRE-CLAIM REVIEW

The Demonstration will require the HHA to submit a request for pre-claim review and all relevant documentation supporting the claim for reimbursement to their Medicare Administrative Contractor (“MAC”). The process will work as follows: (i) after admission, the HHA will submit the request for anticipated payment (“RAP”); (ii) the HHA will then submit its pre-claim review request for the care; and (iii) the MAC will review the pre-claim review request and determine whether the documentation comports with applicable Medicare coverage and clinical documentation requirements.

While the claim is under pre-payment review, the RAP will be paid. The HHA is expected to admit the patient and begin providing services as they would do in any case. This is an important point. Although initially described as a prior authorization process, this is not a prior authorization. The Demonstration is implementing a 100 percent pre-payment review of all claims. This means HHAs will be providing care for some period of time without knowing whether or not the claim will be paid. The MAC is required to review the documentation and issue a pre-claim review decision “generally within 10 days.”<sup>1</sup> If the MAC determines the claim is appropriate, the HHA will then submit a claim for payment to the MAC after the delivery of home health services as they would currently. This claim will include a tracking number that signifies that the services have been affirmed for pre-claim review and will be paid so long as all Medicare coverage requirements are met.

If the payment request is denied, the HHA may amend and resubmit the pre-claim review request an unlimited number of times. After a pre-claim review is resubmitted, the MAC will conduct a complex medical review and will “make all reasonable efforts” to notify the home health agency within 20 business days with a decision. The HHA may appeal any claim denial if they believe that the MAC denied the claim

inappropriately or was incorrectly determined to be not medically necessary or not sufficiently documented.

## GETTING READY FOR THE DEMONSTRATION

Providers in the demonstration states need to start planning now because they have little time to prepare for 100 percent pre-payment review. Preparation and education for the Demonstration will be very important, in order to avoid improper documentation of claims and losing potential payments. Some key steps providers should take to be prepared include:

- *Review your process for obtaining all of the claims documentation required.* Determine how many days it takes the agency to assemble all of the necessary documentation. The ideal turnaround time for assembling all documentation should ideally be less than one week. An HHA cannot submit the pre-payment review request until it has all of the documentation. This means the 10-day clock cannot start until you have all of this documentation.
- *Educate physicians on the importance of returning documentation timely.*
- *Review your face-to-face compliance.* Are you receiving the documents you need from the physician in a timely fashion? Have you implemented a process to supplement the physician's clinical record to provide the supporting information you need? If not, you need to consider it.
- *Consider your cash flow and begin planning.* Despite CMS stating that the pre-payment review process would improve agency cash flow, agency experience with pre-payment review in other contexts leads to the conclusion that this will reduce cash flow. At a minimum, it is likely there will be delays in submitting claims if an agency is not approved on the first submission. If the agency does not receive a favorable response and is forced to appeal, the agency will not be paid until the appeal is resolved. It is not clear at what level this will impact cash flow, but this must be a consideration.
- *Educate your staff.* Your clinical staff, especially therapists and nurses, and billing staff must have a thorough understanding of what is required for a claim to be approved. Agencies have some time before the Demonstration goes live and should use this time to educate staff on the documentation requirements.
- *Implement new processes.* Agencies should begin identifying the new procedures that will be needed for this process, for example, auditing documentation as it comes in to identify shortcomings and have them corrected. In an effort to reduce turnaround times, additional procedures related to obtaining documentation from physicians and educating physicians and staff should be implemented. This could be implementing steps related to supplementing physician documentation for face-to-face and other similar matters.

Agencies may also consider whether the three-month grace period is a time to ease into pre-payment review. Submitting some, but not all, claims may provide a way to measure denial rates, turnaround times, etc. It may also help agencies to identify changes to documentation processes needed to ensure success once the three-month deadline has passed. Providers who consider this option need to be very careful to submit 100 percent of claims for pre-payment review before the grace period ends or they will lose 25 percent of the claims that were not submitted.

This Demonstration appears to be extremely problematic for providers as it will likely lead to delays in payment and a significant percentage of claims not being paid. Providers in the demonstration states need to be working very diligently now to prepare in order to minimize the impact once the Demonstration goes live.

If you have any questions regarding this article, please contact Robert Markette at (317) 977-1454 or [rmarkette@hallrender.com](mailto:rmarkette@hallrender.com) or your regular Hall Render attorney.

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<sup>1</sup> Press Release, Centers for Medicare & Medicaid Services, Pre-Claim Review Demonstration of Home Health Services (CMS-6069-N) (June 8, 2016) available [here](#).