HEALTHCARE *first*

patients before paperwork

April 2017

A GUIDE TO THE PRE-CLAIM REVIEW PROCESS

BACKGROUND

In 2012, The Office of Inspector General (OIG) found that 98% of medical records document Medicare coverage requirements for home health services. However, home health agencies (HHAs) submitted 22% inaccurate claims because services were unnecessary or claims were inaccurately coded, resulting in $432 million in improper payments. While the Centers for Medicare and Medicaid Services (CMS) has implemented numerous tactics to reduce fraud (whether intended or unintended), suggestions have been made that additional monitoring, edits, and restrictions should be placed on HHAs for further reduction.

OVERVIEW & TIMELINE

OVERVIEW

The Centers for Medicare & Medicaid Services (CMS) is implementing a three-year Medicare pre-claim review demonstration for home health services in Illinois, Florida, Texa, Michigan, and Massachusetts. The purpose behind this demonstration is to determine if a pre-claim review process would ensure medical necessity of home health services, without delaying or disrupting patient care or access. It is also intended to determine if pre-claim review would reduce expenditures while maintaining or improving care quality.

If HHAs in the demonstration states do not submit claims to the pre-claim review process, those claims will be stopped for pre-payment review. CMS states that after the first three months of the demonstration in a participating state, payments will be reduced by 25% for claims that were found to be payable but were not submitted for pre-claim review.

TIMELINE

The Pre-Claim Review Demonstration is scheduled take place in Illinois, Florida, Texas, Michigan, and Massachusetts. The demonstration began in Illinois on August 3, 2016, however on March 31, 2017, CMS announced that as of April 1, 2017, the Pre-Claim Review demonstration would be suspended for at least 30 days in Illinois. They also stated that the demonstration would not expand to Florida on April 1, 2017 as planned.

Beginning April 1, 2017, and continuing throughout the pause, the Medicare Administrative Contractors will not accept or process any Home Health Pre-Claim Review requests, regardless of date of service listed on the pre-claim review request. Home health claims should continue to be submitted for payment and will be paid under normal claim processing rules.

CMS said they will notify providers at least 30 days in advance via an update to their website of further developments related to the demonstration.

Further clarification on the status of the Pre-Claim Review Demonstration status can be found on the Home Health Pre-Claim Review (PCR) Demonstration Pause Questions and Answers document provided by CMS.

PRE-CLAIM REQUEST PROCESS

PRE-CLAIM REQUEST PROCESS

Submit Pre-Claim Review Package

Be sure to include:
F2F Encounter Documentation
Signed/dated POC/Certification
Medical Necessity Documentation
Other Supporting Documentation

MAC reviews the package and notifies the HHA of decision.

Notification of decision will be sent approximately **10 days** following the initial submission.

If affirmed, HHA is notified by MAC and HHA submits final claim with UTN.

When MAC receives the final claim **with an affirmed pre-claim review**, the claim will be paid as long as all other Medicare requirements are met.

If non-affirmed, HHA resubmits pre-claim review request to MAC.

If a decision is non-affirmed, the notification to the HHA will explain why. The HHA should **re-submit the request and include the requested missing information**. Following resubmission, a new notification of decision will be made in approximately 20 days.

FREQUENTLY ASKED QUESTIONS

FREQUENTLY ASKED QUESTIONS

Q. What is the pre-claim review?
A. Pre-claim review is a process by which a request for coverage is submitted for review before a final claim is submitted for payment. Pre-claim review requests are made any time after initial assessments and intake procedures are complete, but before the final claim is submitted.

Q. What additional documentation is required for pre-claim review?
A. No additional documentation is required. HHAs submit the same information they would normally submit for payment, but submission occurs before submitting the final claim.

Q. What is the timeline for Medicare to affirm or non-affirm pre-claim review requests?
A. CMS has stated that pre-claim review requests will be affirmed within or around ten business days following an initial request and 20 business days following a resubmitted request initiated as a result of a non-affirmed decision.

Q. What documents should be submitted in a pre-claim review request?
A. HHAs should submit all documentation that supports medical necessity for the level of home health services being provided. HHAs should contact their MACs for guidance on required documentation.

Q. How are pre-claim review requests submitted?
A. There are four ways to submit pre-claim review requests to the MACs:

- MAC Online Portal (where available) – this is the fastest, preferred method of submission
- Electronic submission of medical documentation (esMD) (if available)
- Fax
- Mail

Q. How are pre-claim review decisions received?
A. A decision letter, with a corresponding unique tracking number (UTN) number from the MAC will be sent to the HHA using the same method as the request sent, when possible. Additionally, a copy of the decision letter will be sent to the beneficiary. The UTN number will then be included in the final claim to indicate that a pre-claim review occurred.

FREQUENTLY ASKED QUESTIONS

Q. What is a Provisional Affirmative decision?
A. This indicates that a future claim submitted to Medicare for the service likely meets Medicare's coverage, coding, and payment requirements.

Q. What is a Non-Affirmed Decision?
A. When an incomplete request for pre-claim review is received, the MAC will notify the provider of what information is missing. A copy of the decision letter will also be issued to the beneficiary. The provider will submit the pre-claim review request again, with all required documentation noted in the decision letter. If a final claim is submitted to the MAC for payment with a non-affirmed pre-claim review decision, the claim will be denied. HHAs cannot appeal non-affirmed pre-claim review decisions.

Q. What are the penalties for non-compliance?
After the first three months of demonstration in a particular state, a 25% payment reduction will be applied for claims that, after such pre-payment review, are found to be payable, but did not first receive a pre-claim review decision prior to final claim submission. This 25% reduction cannot be recouped nor can it be charged to the beneficiary.

PREPARATION TIPS

SIX KEY PREPARATION TIPS

Pre-claim review requirements will almost definitely require changes to your claims and documentation processes. You will need to develop new procedures to ensure that pre-claim review requests follow every RAP and that they are regularly monitored and tracked to avoid potential interruption in your cash flow. Following are some important tips on how to prepare.

1. You must work with your physicians to ensure that you get the signed plan of care back as soon as possible. Inform your physicians of this new Medicare requirement and ask for their cooperation in completing the necessary documentation in a timely manner. This will allow you to submit to pre-claim review as soon as possible and avoid payment delays or RAP takebacks.
2. It is essential that you ensure you have a solid document management process in place to track the status of your pre-claim review requests. You should know which episodes you have submitted and when they were submitted. Additionally, you should have the means to efficiently collect and resubmit missing documentation on "non-affirmed" requests.
3. Monitor your days to RAP and days to final to determine what sort of impact the pre-claim review demonstration has had on your cash flow. If you aren't able to efficiently track this data, companies such as HEALTHCARE*first* have tools available to enable you to do so quickly and easily.
4. Keep abreast of updates to the demonstration through CMS and your MAC. Be sure to reach out to your MAC if you have any questions before problems could occur.
5. Evaluate your clinical documentation process. You will want to ensure your documentation is accurate, complete, and compliant in order to receive affirmative pre-claim review decisions the first time.
6. Ask your EHR software vendor how they are helping you succeed during Pre-Claim Review Demonstration. Some vendors, like HEALTHCARE*first* have enhanced functionality such as guided care planning and pre-claim billing warnings to help HHAs manage the pre-claim review process.

HEALTHCAREFIRST HAS YOU COVERED

HEALTHCAREFIRST HAS YOU COVERED

HEALTHCARE*first* is dedicated to your agency's success. From scheduling and clinical documentation, to billing and reporting, we are changing the way HHAs manage operations. Our integrated EHR and business intelligence software enables you to streamline the pre-claim review process, ensuring accuracy and timely reimbursement.

SIMPLIFY OPERATIONAL TASKS

- HEALTHCARE*first* makes everything you do easier and faster. Our Web-based system streamlines workflows and tasks, saving your agency valuable time that can be better spent focusing on patients.

ENSURE COMPLIANCE

- Automated care planning guidance and built-in regulatory compliance checks ensures that your clinical documentation is accurate, complete, and compliant before your claims are submitted for review.

ACCELERATE REIMBURSEMENT

- We help improve the efficiency and accuracy of your billing processes so you quickly get paid for the services you provide. With pre-claim billing warnings, you can rest assured that your claims will pass review the first time.

GAIN INSIGHT INTO YOUR OPERATIONS

- Easily monitor your days to RAP and days to final to ascertain the impact of the pre-claim review demonstration on your cash flow. Get daily updates of your Medicare claims so you can reconcile your billing and fix problems before they cost you money.

REDUCE COSTS

- Automating tasks such as intake and admissions, scheduling, billing, and payroll will save time and drastically reduce overhead costs. Our software streamlines workflows and ensures that these tasks are accomplished quickly and easily.

CONTACT US at 800.841.6095 or connect@healthcarefirst.com to learn more!

HEALTHCARE *first*
patients before paperwork