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PRE-CLAIM REVIEW: Preparing for the Who, What, When, Where, Why & How

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Simione HEALTHCARE CONSULTANTS

INTRODUCTION

- Team of home care and hospice experts with focus on solutions
  - Organizational
    - Operational Assessment, Strategic Planning, Compliance, Clinical Operations
  - Financial
    - Cost Reporting, Compliance, Revenue Cycle
  - Sales & Marketing
    - Assessment & Analysis, Referral Management, Training Resources, "Sales Boot Camp"
  - Technology
    - Assessment & Analysis, Guided System Search, Implementation Support, Process Engineering
  - Mergers & Acquisitions
    - Due Diligence, Business Valuation, Market Assessment
  - Simione Financial Monitor ™
    - Benchmarking

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WHAT, WHEN & WHO PRE-CLAIM REVIEW

CMS is implementing a pre-claim review process in selected areas of the country.

- States identified as high fraud areas
- Three year demonstration project
- The intent is to eliminate the "Pay and Chase" method used now

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WHAT, WHEN & WHO PRE-CLAIM REVIEW

- The demonstration implementation schedule is:
  - →August 3, 2016 in Illinois
  - →** Currently delayed in FL, TX, MI and MA
  - →No earlier than
    - October 1, 2016 in Florida
    - December 1, 2016 in Texas
  - →Michigan and Massachusetts no earlier than January 1, 2017

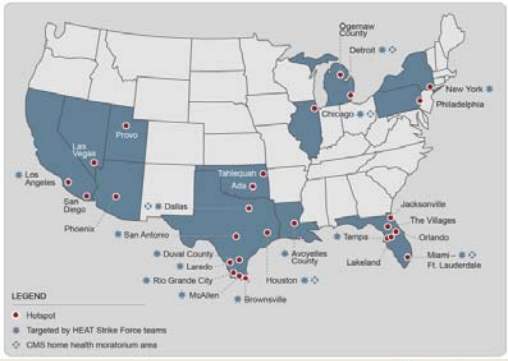
PRECLAIM REVIEW

- Home Health is a significant part of the Medicare program with $18.4 Billion paid to over 11,000 home health agencies in CY 2015.
- Over 2015 Medicare reports that 59% of claims had an improper payment rates due to insufficient documentation.
- Since 2010 over $1 billion in improper payments and fraud have been identified with the home health benefit

THE PRECLAIM REVIEW

- OIG home health investigations have resulted in more than 350 criminal and civil actions and $975 million in receivables for fiscal years (FYs) 2011–2015.

OIG IDENTIFIED FRAUD HOTSPOTS



OIG ANALYSIS OF OUTLIERS

Table 2: National Medians and Outlier Thresholds for HHAs and Physicians

Characteristic	Provider Type	National Median	Threshold for Outliers	Number of Outliers	Outliers as a Percentage of Total
No recent visit with the supervising physician	HHAs	22.6%	62.5%	470	3.9%
	Physicians	11.8%	54.6%	16,789	4.9%
No hospital or nursing home stay	HHAs	49.5%	-	-	-
	Physicians	35.7%	97.1%	1,751	0.5%
Diabetes or hypertension diagnosis	HHAs	10.1%	45.1%	483	4.0%
	Physicians	5.3%	28.8%	7,937	2.3%
Beneficiaries with claims from multiple HHAs	HHAs	6.3%	25.9%	770	6.5%
	Physicians	0.0%	13.9%	7,510	2.2%
Readmission shortly after discharge	HHAs	5.6%	19.3%	778	6.5%
	Physicians	3.6%	19.1%	3,822	1.1%

Source: OIG analysis of Medicare claims data, 2016.

MEDICARE PRE-CLAIM REVIEW

- What is the PCR?
  - →The Pre-Claim Review (PCR) is a process to request a provisional affirmation of coverage by submitting documentation and other information for review after services begin but before the final claim is submitted
- The PCR helps make sure applicable coverage payment, and coding rules are met before the final claim is submitted

PRE-CLAIM REVIEW

- CMS is using the pre-claim review demonstration to:
  - →determine if it is effective in reducing fee for service expenditures by reducing improper payments
  - →while also maintaining or improving the quality of care

THE PRE-CLAIM REVIEW

- Difference of prior authorization versus Pre-Claim Review
  - →Prior auth = occurs prior to services being provided
  - →Pre-Claim Review (PCR) = occurs AFTER services have begun
    - Intent that providers will begin services to beneficiaries
    - Submit pre-claim review documentation prior to final claim

PROVISIONAL AFFIRMATION

- Provisional Affirmation
  - →CMS will 'affirm' that the coverage, payment and coding rules have been followed prior to the submission of the final claim
  - →The Provisional affirmation will provide the agency with a UTN (Unique Tracking Number) for each episode submitted

PRE CLAIM REVIEW

Episodes Subject to the PCR Process

→ Initial

→ Recertification

- Pre-claim review is required for all episodes

→ Discharge and readmit to the same agency within same 60-day episode of care

- Transfer during a 60-day episode of care

→The receiving HHA submits a PCR request

PRE CLAIM REVIEW

Request for Anticipated Payment (RAP)

- RAP is not impacted

→No changes in the RAP submission process

→No changes in the processing and payment of a RAP

→Encouraged to submit a RAP and allow it to process before submitting a pre-claim review

- RAPs will continue to automatically be cancelled when the final has not been submitted within the time limits which are the greater of 120 days after the start of the episode or 60 days after the paid date of the RAP to submit the final claim

PRE CLAIM REVIEW

HH services for less than 60-days will still require a pre-claim review with one exception

→LUPAs are not subject to the PCR process

- LUPAs occur when four or fewer visits are provided in a 60-day episode

OTHER TYPES OF CLAIMS

- The following types of claims are not subject to pre-claim review
  - →Veteran Affairs
  - → Indian Health Services
  - →Part A/B rebilling
  - →Demand bills submitted with condition code 20
  - →No-pay bills submitted with condition code 21
  - →RAPs

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SUBMISSION REQUIREMENTS

Submitting a PCR request will be voluntary

- Submitting a claim without a PCR request
  - → Claim will be subjected to prepayment medical review
  - →After the first three months of the demonstration in a state, the claim will be subject to a 25% payment reduction

*Note: This payment reduction is not appealable and cannot be billed to the beneficiary

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REQUIRED ELEMENTS

To be considered complete the following are required:

- Patient (beneficiary) Information
- Certifying Physician/Practitioner Information
- Home Health Agency Information
- Submitter Information
- Other Information
- Required Documentation

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REQUIRED INFORMATION

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Patient Information

→ Name

→Medicare Number

→Date of Birth

Certifying Physician/Practitioner Information

→Name

→National Provider Identifier (NPI)

→Transaction Access Number (PTAN)(optional)

→Address

REQUIRED INFORMATION

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Agency Information

→Name

→Agency National Provider Identifier (NPI)

→Agency PTAN

→Agency Address

Submitter Information

→Name of contact

→Telephone #

OTHER REQUIRED INFORMATION

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- Benefit period requested (initial or recertification)
- Submission Date
- From and Through Date of the 60-day episode of care
- Indicate if the request is an initial or resubmission review
- State where service is rendered

REQUIRED DOCUMENTATION

In Order by Task

- *Only for resubmissions - Most Recent Non-Affirmation Letter for This Episode
- Task #1 - The actual F2F clinical encounter note used by the certifying physician to justify the referral for HH services
- Task #2 - The HH generated records that have been signed, dated and incorporated into the certifying physician's medical records

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REQUIRED DOCUMENTATION

- Task #3 - The Plan of Care (POC) signed and dated by the certifying physician
- Task #4 - The signed and dated physician's certification of patient eligibility

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REQUIRED DOCUMENTATION

Task #5 - Medical records that meet each HH requirement for Confined to the Home

→Medical records that meet each HH requirement for Confined to the Home

- Criteria 1: Does the beneficiary, because of illness or injury, need: The aid of supportive devices such as crutches, canes, wheelchairs, and walkers? The use of special transportation? The assistance of another person to leave their place of residence? Does the beneficiary have a condition such that leaving the home is medically contraindicated?

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DOCUMENTATION REQUIREMENTS (CONT'D)

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Home Bound Cont'd

→ Criteria 2:

- Component 1 - Is there a normal inability to leave the home?
- Component 2 – Does leaving the home require a considerable and taxing effort?
  - Checklist 1 – Structural Impairment
  - Checklist 2 – Functional Impairment
  - Checklist 3 – Activity Limitation

SUBMISSIONS

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- Online – eService's (Preferred Method)
  - →Faster/more efficient
  - →PCR Decision is sent via greenmail delivery
- esMD (if available)
  - →PCR Decision letters via US postal mail.
- Fax
  - →PCR Decisions are faxed if a return # is clearly identified in the request.
  - →Currently rejection and exclusions are sent via mail. Palmetto is working on changing this
- Mail – responses are via Mail

SUBMISSION TURNAROUND

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- Initial submission are to be turned around within ten (10) business days (excluding Federal holidays) from receipt
  - →You will be notified if the decision is provisionally affirmative or non-affirmed
  - →The Decision notification will contain a Unique Tracking Number (UTN)* which will be required on the claim
  - →The decision will be sent to the submitter based on how it was received*

PROVISIONAL AFFIRMATION DECISION

"Preliminary finding that a future claim submitted to Medicare for the service **likely** meets Medicare's coverage, coding, and payment requirements"

→***Will ONLY apply to the episode submitted*** and includes:

- The UTN
- Which HCPCS (services) were affirmed
- A detailed explanation of which requirements have not been met
- * DOES NOT follow beneficiary – transfers require their own decision submitted by the receiving agency

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CHANGES TO THE PLAN OF CARE

- Adding services to the plan of care (additional HCPCS codes)
  - →Instructions to add these to final claim
- Partial Provisional Affirmation Decision
  - →May approve some services (HCPCS) and not others
  - →Resubmit or submit final claim bill with appeal rights

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INCOMPLETE DECISIONS

For incomplete decisions (required information was missing)

The notification will include:

→An explanation of what information was missing

→**Note: An incomplete decision does not count as a submission. If an initial submission is deemed incomplete, the next time the same episode is submitted for PCR, it will be considered the initial.

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RESUBMISSIONS

Resubmitting a Pre Claim Review request can be done when not affirmed

- →Same process as for the initial requests
  - The re-submission will be identified as a resubmission = option to select on the submission request
  - Provide the UTN of the most recent non-affirmation decision letter
- →There is no limit set on re-submissions
- →MACs have 20 business days to respond
- →Decisions are also sent to the beneficiary (for both affirmed and not affirmed)

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FINAL CLAIM SUBMISSION

- Must include the UTN
- Provisionally Affirmed claims will be paid
- Non-provisionally affirmed claims will be denied
  - →May appeal after the final claim
- Claims that have not been submitted for affirmation will be denied and medical review will occur
  - →Subject to 25% reduction (not appealable/cannot bill beneficiary)
  - →* after three months in demonstration

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OPERATIONAL IMPACT

- Significant issues in IL
  - →Reported high denial rates
  - →Submission of documentation taking up to an hour per claim
  - →Requiring increased staff time (Clerical & Clinical)
    - Focus on timeliness of obtaining documentation
    - Clinical review of documentation
    - Tracking sent doc, UTN #s, missing documentation, re-submissions, denials etc.

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OPERATIONAL IMPACT

- Reality
  - →Not similar to ADR Processes
  - →Documentation needs to stand on its own
    - Must be adequate
    - Support skill
    - Homebound clear
    - Face to face
      - – MD documentation
      - – Agency documentation incorporated into the MD documents

OPERATIONAL IMPACT

Documentation Processes

- →Refine to ensure efficiency
  - Optimizing accuracy
  - Ensuring correct and complete
- →Benchmark days
  - To RAP - Target < 15 days
  - To End of Episode (EOE) – Target < 28 days
- →If submitting documentation to MD to support skill and Homebound
  - Return with MD signature

OPERATIONAL IMPACT

- MD Signatures & Dates
  - →Ensure correct MD
    - Referring MD versus following MD
  - →Face to face tracking
    - Actual MD encounter note included
  - →POC tracking (don't forget the re-cert language)

OPERATIONAL IMPACT

- Troublesome MDs
  - →CMS has a letter to MDs on the pre-claim review website for agencies to use
  - →Asking that uncooperative MD's be reported to CMS HHPreClaimDemo@cms.hhs.gov
    - May be subjected to increased reviews
    - Provider specific reviews

OPERATIONS – SOME THOUGHTS CONTINUED

- Tracking systems
  - →Excel
  - →IS systems?
- Medical records working with billing – UTN #
- How do you currently manage pre-auth with managed care?
  - →Can you duplicate any of these procedures?

RESOURCES

- CMS Resources
  - →https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Pre-Claim-Review-Initiatives/Overview.html
  - →Updated Q & A; other updates
- Video – time to submit
  - →https://vimeo.com/181136878
- Provider Operations Manual
  - →http://www.onlineproviderservices.com/

Questions????

Thank you!!

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