CMS-6069-N
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-6069-N]

Medicare Program; Pre-Claim Review Demonstration for Home Health Services

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces a 3-year Medicare pre-claim review demonstration for home health services in the states of Illinois, Florida, Texas, Michigan, and Massachusetts where there have been high incidences of fraud and improper payments for these services.

DATES: This demonstration will begin in Illinois no earlier than August 1, 2016, in Florida no earlier than October 1, 2016, and in Texas no earlier than December 1, 2016. The demonstration will begin in Michigan and Massachusetts no earlier than January 1, 2017.

FOR FURTHER INFORMATION CONTACT:

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Questions regarding the Medicare Pre-Claim Review Demonstration for Home Health Services should be sent to HHPreClaimDemo@cms.hhs.gov.

SUPPLEMENTARY INFORMATION:

I. Background and Legislative Authority

Section 402(a)(1)(J) of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1(a)(1)(J)) authorizes the Secretary to develop demonstration projects that

"develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act" (the Act). According to this authority, we will implement a Medicare demonstration that establishes a pre-claim review process for home health agencies (HHAs) to assist in developing improved procedures for the identification, investigation, and prosecution of Medicare fraud occurring among HHAs providing services to Medicare beneficiaries. The proposed demonstration will begin in Illinois not earlier than August 1, 2016, will begin in Florida not earlier than October 1, 2016, and will begin in Texas not earlier than December 1, 2016. The demonstration will begin in Michigan and Massachusetts not earlier than January 1, 2017. Providers in each state will be notified by the appropriate Medicare Administrative Contractor prior to the start of the demonstration in the state. Additionally, CMS will utilize other educational efforts to announce the program to stakeholders.

This demonstration will evaluate an additional method that may assist with the investigation and prosecution of fraud in order to protect the Medicare Trust Funds from fraudulent actions and improper payments. We believe this demonstration will bolster the efforts that CMS and its partners have taken in implementing a series of anti-fraud initiatives in these states and will provide valuable data that CMS working with its law enforcement partners, can use to combat the submission of fraudulent claims to the Medicare program. One such anti-fraud initiative is the use of temporary moratoria on the enrollment of new home health providers that were put in place in the Miami and Chicago that and were subsequently expanded to the Fort Lauderdale, Detroit, Dallas, and Houston metropolitan areas. These temporary moratoria prohibit the new enrollment

of home health providers to help CMS prevent and combat fraud, waste, and abuse in these locations.

We also believe the data collected from this demonstration will assist with a second initiative, the Health Care Fraud Prevention and Enforcement Action Team (HEAT) Task Force, created by the Department of Health and Human Services and the Department of Justice (DOJ), and the Heat Task Force's ongoing fight against Medicare fraud. The HEAT Task Force uses resources across the government to help prevent and stop fraud, waste, and abuse in the Medicare and Medicaid programs. Since 2007, the HEAT Task Force of the DOJ has charged more than 2,300 defendants with defrauding Medicare of more than $7 billion and convicted approximately 1,800 defendants of felony health care fraud offenses. In addition, the data resulting from this demonstration could provide investigators and law enforcement with important information to determine how to focus their investigation activities to identify and combat home health fraud, and in so doing, protect the Medicare Trust Funds from fraudulent actions and improper payments.

This demonstration may also help prevent improper payments in geographic areas where HHA providers are known to have a high incidence of fraud. The improper payment rate for HHA claims has been increasing over the past several years, and fraud is one factor contributing to the increase. It is important to note that while all payments made as a result of fraud are considered "improper payments," not all improper payments constitute fraud. CMS' Comprehensive Error Rate Testing (CERT) program, which measures Medicare's improper payment rate, estimates the payments that did not meet Medicare coverage, coding, and billing rules. The fiscal year (FY) 2015 Department of

Health and Human Services Agency Financial Report reported that the CERT program's calculated 2015 improper payment rate for HHA claims increased to 59.0 percent from the 2014 rate of 51.4 percent and the 2013 rate of 17.3 percent. The increase in the 2015 improper payment rate was primarily due to "insufficient documentation" errors, specifically, insufficient documentation to support the medical necessity of the services. Similar documentation errors have also occurred in previous years. For example, the 2014 CERT report found that the majority of home health payment errors occurred when the narrative portion of the face-to-face encounter documentation did not sufficiently describe how the clinical findings from the encounter supported the beneficiary's homebound status and need for skilled services.

Due to the substantial increase in improper payments and concerns raised by the home health industry, relating to implementation of the face-to-face encounter documentation requirement, we made Medicare HHA payment policy changes in an effort to simplify the face-to-face encounter regulations. Specifically, as of January 1, 2015, a separate narrative is no longer required as part of the face-to-face documentation. Rather, the certifying physician's or the acute/post-acute care facility's medical record(s) for the patient must contain sufficient documentation to substantiate eligibility for home health services.

Despite these recent changes, we continue to see cases in which the medical record does not support eligibility for the home health benefit, which constitute "insufficient documentation" errors. Moreover, we note that the recent regulatory changes do not address HHA errors in home health billing other than those related to the face-to-face narrative requirement. Therefore, we also plan to use this demonstration to

help make sure that all coverage and clinical documentation requirements are met before claims are submitted for final payment.

We also believe that this demonstration will enable us to-- (1) test the level of resources needed to implement a permanent pre-claim review program for home health services; (2) determine the feasibility of performing pre-claim reviews to prevent payment for services that have historically had a high incidence of fraud; and (3) determine the return on investment of pre-claim review for home health claims. This demonstration will support our program integrity strategy of moving beyond a reactive "pay and chase" method toward a more effective, proactive strategy that identifies potential improper payments before payments are made. We will analyze data from the home health services pre-claim review demonstration to evaluate the impact on fraud in the demonstration states, which we believe will help assist in developing improved procedures for the identification, investigation, and prosecution of Medicare fraud occurring among HHAs providing services to Medicare beneficiaries and may consider if a more focused, risk based approach to pre-claim review is warranted in the future.

The pre-claim review demonstration does not create new documentation requirements, but simply requires currently mandated documentation earlier in the claims payment process. In addition, there are no changes to the home health service benefit for Medicare fee-for service beneficiaries.

II. Provisions of the Notice

This demonstration will implement a 3-year pre-claim review process for home health services in Illinois, Florida, Texas, Michigan, and Massachusetts. Prior to and during the demonstration, we will conduct outreach to and education of home health

providers and Medicare beneficiaries using media such as webinars, open door forums, frequently asked questions pages on our website, other website postings, and educational materials issued by the Medicare Administrative Contractors (MACs) to provide guidance on the pre-claim review process. Additional information about the implementation of the pre-claim review demonstration will be available on the CMS website at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Overview.html. Questions regarding the Medicare Pre-Claim Review Demonstration for Home Health Services should be sent to HHPreClaimDemo@cms.hhs.gov. Under this demonstration, a HHA provider, the entity billing on behalf of the HHA, or the beneficiary (known as the "submitter") will be encouraged to submit to the relevant MAC a request for pre-claim review, along with all relevant documentation to support Medicare coverage of the applicable home health level of service. After receipt of all relevant documentation, the MAC will review the pre-claim review request to determine whether the service level complies with applicable Medicare coverage and clinical documentation requirements. The HHA provider should submit the Request for Anticipated Payment (RAP) before submitting the pre-claim review request and begin providing services while waiting for the decision from the MAC.

The MAC will communicate to the HHA and beneficiary a decision provisionally approving (or disapproving) payment after a submission of a request for pre-claim review. For the initial submission of a pre-claim review request, the MAC will make all reasonable efforts to make a determination and issue a notice of the decision within 10 business days.

If the MAC declines payment after review, the submitter may amend and resubmit it. A pre-claim review request may be resubmitted an unlimited number of times. For subsequent pre-claim review requests, CMS or its agents will conduct a complex medical review and make all reasonable efforts to postmark and notify the HHA and the beneficiary of its decision within 20 business days. These timeframes are consistent with the Prior Authorization of Power Mobility Devices (PMDs) Demonstration. Meeting these timeframes will be part of the contract performance metrics for the MACs that are involved in this demonstration at the time their contracts are modified to incorporate the demonstration's work requirements (as well as the necessary funding).

If an applicable claim is submitted for payment without a pre-claim review decision, it will be stopped for prepayment review and documentation will be requested. After the first 3 months of the demonstration in a particular state, we will apply a payment reduction for claims that, after such prepayment review, are deemed payable, but did not first receive a pre-claim review decision. As evidence of compliance, the HHA must submit the pre-claim review number on the claim in order to avoid a 25-percent payment reduction. The 25-percent payment reduction cannot be recouped from or otherwise charged to the beneficiary, and is not subject to appeal. The beneficiary would not be liable for more than he or she would otherwise be if the demonstration were not in place.

The following explains the various pre-claim review scenarios:

In each of the following scenarios, the HHA would conduct all required assessments, submit the RAP, and begin services for the beneficiaries.

- Scenario 1: When a submitter submits a pre-claim review request to the MAC

with appropriate documentation, and all relevant Medicare coverage and documentation requirements are met for the home health service, the MAC will send a provisional affirmative pre-claim review decision to the HHA and the Medicare beneficiary. When the HHA submits the claim for payment to the MAC after delivering the home health level of service(s), the claim will include a unique tracking number that indicates it has been affirmed for pre-claim review and, as long as all Medicare coverage and documentation requirements continue to be met, the claim is paid.

- Scenario 2: When a submitter submits a pre-claim review request with documentation that does not meet all relevant Medicare coverage and clinical documentation requirements for the home health level of service, notification of a non-affirmative decision will be sent to the HHA and the beneficiary advising them that Medicare will not pay for the service. The submitter may then resubmit the request with additional documentation to support that the Medicare requirements have been met. Alternatively, the HHA could submit the claim to the MAC, at which point the MAC would deny the claim for lack of a provisional affirmative pre-claim review decision and recoup the payment made on the RAP following their standard procedures. Upon receiving the claim denial by the MAC, the HHA or the beneficiary would have the opportunity to appeal the claim denial if they believe Medicare coverage was denied inappropriately. Beneficiaries will continue to have the option of signing an Advance Beneficiary Notice of Noncoverage (ABN) in order to receive the services and be liable for payment.

- Scenario 3: When a submitter submits a pre-claim review request with incomplete documentation, the request, along with a detailed decision letter explaining what information is missing, is sent back to the submitter for resubmission. Both the

HHA and the beneficiary are notified and the submitter can resubmit the request with appropriate supporting documentation.

- Scenario 4: When the HHA provides the treatment to the beneficiary and submits the claim to the MAC for payment without submitting a pre-claim review request, the home health claim will be stopped for prepayment review and documentation will be requested. If the claim is determined to be not medically necessary or not sufficiently documented, the claim will be denied and all current policies and procedures regarding liability for payment will apply. The HHA, the beneficiary, or both can appeal the claim denial if they believe the claim was payable. If the claim is determined to be payable on appeal, it will be paid. After the first 3 months of the demonstration, we will reduce payment by 25 percent for claims that after such prepayment review are deemed payable but did not first receive a pre-claim review decision. This payment reduction is not subject to appeal. After a claim is submitted, processed, and denied, appeal rights for the claim denial would become available in accordance with 42 CFR part 405, subpart I. The 25-percent payment reduction cannot be charged to the beneficiary. The beneficiary would not be liable for more than he or she would otherwise be if the demonstration were not in place.

Additional information is available on the CMS' website at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Overview.html.

III. Collection of Information Requirements

We announced and solicited comments for the information collection requirements associated with the Medicare Prior Authorization of Home Health Services

Demonstration in a 60-day **Federal Register** notice that published on February 5, 2016 (81 FR 6275). The information collection requirements do not take effect until they are approved by OMB and issued a valid OMB control number.

Dated: May 26, 2016.

Andrew M. Slavitt,

Acting Administrator,

Centers for Medicare & Medicaid Services.

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