Pre-claim Review Demonstration for Home Health Services
Frequently Asked Questions
(Update: 06/08/ 2016)

1. **Congress expressed concern about this demonstration. Why is CMS moving forward with this demonstration? Has CMS addressed Congress' concerns?**

The pre-claim review demonstration will test improved methods for identifying, investigating, and prosecuting Medicare fraud occurring in Home Health Agencies (HHAs) while maintaining or improving the quality of care provided to Medicare beneficiaries. We appreciate the feedback we received from Congress and believe the demonstration announced on June 8, 2016 addresses those concerns. We will continue to work with Congress and other stakeholders to educate them on the details of the pre-claim review demonstration.

2. **What is pre-claim review?**

Pre-claim review is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. Pre-claim review helps make sure that applicable coverage, payment, and coding rules are met before the final claim is submitted.

3. **How is pre-claim review different than prior authorization?**

A pre-claim review is different than a prior authorization due to the timing of the review and when services may begin. For prior authorization, a request must be submitted prior to services beginning and providers should wait until they have a decision before they begin providing services. With a pre-claim review, services have already begun and the request is submitted after all of the initial assessments and intake procedures are completed and services have begun. The pre-claim review occurs after services start but prior to the final claim being submitted.

4. **Does pre-claim review create new documentation requirements?**

Pre-claim review does not create new documentation requirements. Home Health Agencies will submit the same information they currently submit for payment, but will do so earlier in the process.

5. **What does the pre-claim review demonstration do?**

The demonstration establishes a pre-claim review process for home health services to assist in developing improved procedures for the investigation and prosecution of Medicare fraud occurring among Home Health Agencies providing services to Medicare beneficiaries.

6. **When does the pre-claim review demonstration for home health services begin?**

The demonstration will begin no earlier than August 1, 2016 in Illinois, no earlier than October 1, 2016 in Florida, and no earlier than December 1, 2016 in Texas. The demonstration will begin in Michigan and Massachusetts no earlier than January 1, 2017. Start dates for Florida, Texas, Michigan, and Massachusetts will be determined in the coming months.

7. Will this demonstration delay beneficiaries from getting access to services?

No, the demonstration should have minimal effect on beneficiaries, as the pre-claim review occurs after services start – within 30 days of the first treatment. The pre-claim review request should be submitted after a Request for Anticipated Payment (RAP) is submitted and before the final claim is submitted for payment. If the pre-claim review request is non-affirmed, and the claim is still submitted by the HHA, the claim will be denied in full, but the HHA and beneficiary will continue to have all normal appeal rights.

8. What states does this demonstration impact?

This pre-claim review demonstration impacts Home Health Agencies in the states of Illinois, Florida, Texas, Michigan, and Massachusetts and is based on where the service is rendered.

9. Why did CMS choose these five states?

Previous CMS experience, Office of Inspection General reports, Government Accountability Office reports, and Medicare Payment Advisory Commission reports show extensive evidence of fraud and abuse in the Medicare home health benefit for treatment performed in these states.

10. Under pre-claim review, how long will Medicare have to provisionally affirm or non-affirm a pre-claim review request?

Medicare will make every effort to issue a decision on a pre-claim review request within 10 business days for an initial request and 20 business days for a resubmitted request following a non-affirmative decision.

11. What is a resubmitted request?

If the initial pre-claim review request was non-affirmed due to an error(s), then a Home Health Agency may resubmit the request with additional documentation as many times as necessary. Medicare will work closely with the Home Health Agency during the pre-claim review process to explain what documentation is needed and why a prior submission was insufficient.

12. Will there be a tracking number for each pre-claim review decision?

Yes, Medicare Administrative Contractors will list the pre-claim review tracking number on the decision notice. This tracking number must be submitted on the claim.

13. Will these claims still be subject to additional prepayment or post-payment review?

Generally, the claims that have a provisional affirmation pre-claim review decision will not be subject to additional review. However, CMS contractors, including Zone Program Integrity Contractors and Medicare Administrative Contractors, may conduct targeted prepayment and post-payment reviews to ensure that claims are accompanied by documentation not required or available during the pre-claim review process. In addition, the CMS Comprehensive Error Rate Testing (CERT) program reviews a stratified, random sample of claims annually to identify and measure improper payments. It is possible for a home health claim that is subject to pre-claim

review to fall within the sample. In this situation, the subject claim would not be protected from the CERT audit.

14. For pre-claim review, who will make the decision on the pre-claim review request?

Medicare Administrative Contractors will make these decisions using existing applicable regulations, National Coverage Determination and Local Coverage Determination requirements, and other CMS policies.

15. How will CMS administer pre-claim review? Is there specialized staff devoted to the program?

The pre-claim review is administered by the Medicare Administrative Contractors (MACs), the same contractors that currently process claims and conduct medical review on home health services. Clinical staff are assigned to medical review and trained to ensure consistency. In addition, we will employ private sector standards in our pre-claim review program, such as responding to pre-claim review requests within 10 business days of receipt of an initial pre-claim review request, providing responses that are specific about missing information, and giving providers an opportunity to resubmit the pre-claim review request an unlimited number of times for re-review. During resubmission, the MAC will make every effort to issue a decision within 20 business days.

16. Will pre-claim review allow for electronic submission of pre-claim review requests?

Submitters who choose to utilize the pre-claim review process may send pre-claim review requests to the Medicare Administrative Contractors (MACs) via mail, fax, or through the Electronic Submission of Medical Documentation (esMD) system. The method used to submit the request is the same method that will be used to send the decision. More information on esMD and availability can be found at http://www.cms.gov/esMD.

17. Is pre-claim review needed for beneficiaries in the states already receiving home health services before the demonstration's start dates?

Home health services provided to beneficiaries after the start date of the demonstration in their state will be subject to pre-claim review.

18. What are a Home Health Agency's options if it receives a non-affirmed decision?

The decision letter will specify why a Home Health Agency's (HHA's) pre-claim review request was non-affirmed. The agency can correct the deficiencies and resubmit the request with a new coversheet and relevant documentation. If the agency does not wish to resubmit the request, it can submit claims with the unique tracking number identified on the non-affirmed decision letter. The claims will be denied, and the HHA can appeal the denial.

19. What documents are required for the pre-claim review request?

The pre-claim review request should include all documents and information that support medical necessity for the beneficiary needing the applicable level of Home Health Services. The Medicare Administrative Contractor websites provide more specific information for each state.

20. When should the home health pre-claim review request be submitted?

The pre-claim review request should be submitted after the Request for Anticipated Payment (RAP) is processed and within 30 days of the first treatment provided to the beneficiary. The pre-claim review process must occur before the final claim is submitted for payment. Pre-claim review must be requested for each episode of care.

21. How many times may a pre-claim review request be submitted?

A submitter is allowed an unlimited number of resubmissions for pre-claim review requests that have not been affirmed.

22. What if a beneficiary only requires a few home health visits? Should a pre-claim review request still be submitted?

Yes. A pre-claim review request should be submitted regardless of the number of visits required.

23. If a home health claim is denied after receiving a non-affirmation pre-claim review decision, will the Request for Anticipated Payment (RAP) be recouped as an overpayment?

The Medicare Administrative Contractors will follow their standard procedures to recoup a RAP for any denied claims.

24. Does the pre-claim review demonstration delay care to people with Medicare benefits?

Access to care and services should not be delayed for people with Medicare's home health benefit. The Home Health Agency should submit a Request for Anticipated Payment (RAP) and begin providing home health services before submitting a pre-claim review request. The pre-claim review process must occur before the final claim is submitted for payment.

25. Will beneficiaries have to pay for services if a Home Health Agency provides care but ultimately does not obtain a provisional affirmed decision?

Generally, no. If the Home Health Agency does not obtain a provisional affirmation of coverage and the claim is denied, the beneficiary is only responsible for payment of services of denied claims if he has been presented with and signed an Advanced Beneficiary Notice (ABN) at the start of the home health services.

If a provider submits a claim for payment without a pre-claim review request being submitted, the home health claim will undergo pre-payment review. If the claim is determined to be

payable, it will be paid with a 25 percent reduction of the full claim amount. The 25 percent payment reduction is non-transferrable to the beneficiary.

26. Will Home Health Agencies in the demonstration states be allowed to require that beneficiaries sign an ABN?

No. Home Health Agencies will not be allowed to require that beneficiaries sign an ABN. A beneficiary has the right to refuse to sign an ABN. Beneficiaries who feel as though they are being inappropriately asked to sign an ABN should contact the Medicare program at 1-800-MEDICARE (1-800-633-4227).

27. How many home health providers can request pre-claim review for one beneficiary for one time period?

Under this demonstration, CMS allows one Home Health Agency provider to request pre-claim review per beneficiary per episode of care. If the initial provider cannot complete the home health service, the initial provider's request is cancelled. In this situation, a subsequent provider may submit a pre-claim review request to provide services for the same beneficiary and must include the required documentation in the submission.

28. What happens if an applicable claim in the demonstration area does not go through pre-claim review?

If a provider submits a claim for payment without a pre-claim review request being submitted, the home health claim will undergo pre-payment review. If the claim is determined to be payable, it will be paid with a 25 percent reduction of the full claim amount. The 25 percent payment reduction, which applies for failure to receive a pre-claim review decision, is non-transferrable to the beneficiary. Beneficiaries are not liable for more than they would otherwise be if the demonstration were not in place. This payment reduction, which will not apply during the first three months of the demonstration in a particular state, is not subject to appeal. After a claim is submitted and processed, appeal rights on the claim determination are available as they normally are.

29. Is there an appeals process for non-affirmative pre-claim review requests?

All existing claims appeal rights remain unchanged. Claims that are denied under the demonstration are appealable. Non-affirmative pre-claim review determinations are not appealable; however, providers have the option of:

i. Resubmitting the pre-claim review request before filing a claim; or
ii. Submitting a claim which, will be denied, and then submitting an appeal.

30. Where can I find more information related to pre-claim review?

More information can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Overview.html and click on the tab titled, "Pre-Claim Review Initiatives."

31. Where can I send additional questions?

Additional questions on the pre-claim review model may be sent to CMS at HHPreClaimDemo@cms.hhs.gov.