



PRE-CLAIM REVIEW LESSONS LEARNED: **SUCCESS IS IN THE DETAILS**



SPEAKERS

DeAnn Briscoe

Senior Director for Clinical Education
MAC Legacy






David Hoover

Vice President of Revenue Cycle Management
Axxess



Why Review Choice is Happening

The Review Choice Demonstration would help make sure that payments for home health services are appropriate through either pre-claim or post-payment review.

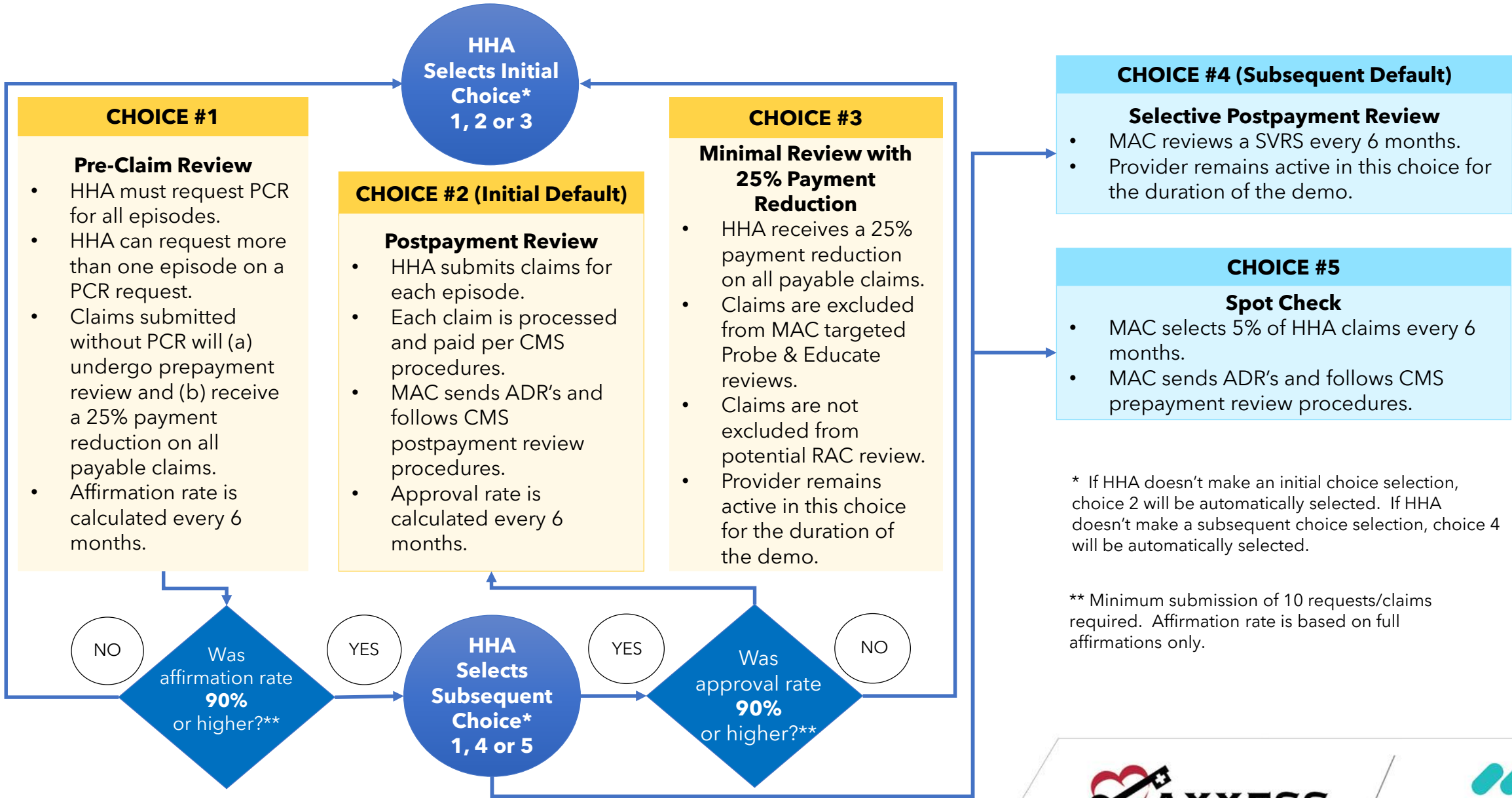
-  Prevent and identify potential fraud, waste, and abuse
-  Protect Medicare Trust Fund from improper payments
-  Reduce Medicare appeals

Key RCD Dates

- 4/3/2019** CMS receives approval for RCD
- 4/17/2019** Illinois selection period
- 6/1/2019** Illinois begins RCD
- 8/16/2019** Ohio selection period
- 9/30/2019** Ohio begins RCD
- 10/21/2019** CMS delays Texas due to PDGM until 3/2/2020
- 3/31/2020** CMS pauses all RCD activities
- 7/7/2020** CMS announces resumption of RCD
- 8/21/2020** CMS announces phased approach for 60 days
- 10/29/2020** CMS extends phased approach until 1/1/2021



Review Choice Demonstration for Home Health Services



* If HHA doesn't make an initial choice selection, choice 2 will be automatically selected. If HHA doesn't make a subsequent choice selection, choice 4 will be automatically selected.

** Minimum submission of 10 requests/claims required. Affirmation rate is based on full affirmations only.



Initial Review Choices

Choice 1: Pre-claim review

All episodes of care are subject to pre-claim review.

Unlimited resubmissions are allowed for non-affirmed decisions prior to submission of the final claim for payment.

More than one episode of care may be requested on one pre-claim review request for a beneficiary.

Claims associated with a provisionally affirmed request will not undergo further medical review, except in limited circumstances.



Initial Review Choices

Choice 2: Post-payment review

100% of claims are reviewed after final claim submission.

Updated 01/06/20 this is the default selection if no initial review choice is made

Once the claim is submitted, Palmetto GBA will process the claim for payment then ask via an Additional Documentation Request (ADR) for the HHA to submit medical records.

If a response to the ADR is not received, an overpayment notification will be issued. After each six-month period, a claim approval rate will be calculated and communicated to the HHA.



Initial Review Choices

Choice 3: Minimal review

A 25% payment reduction (HHAs remain in this option for the duration of the demonstration)

All claims have a 25% payment reduction.

Providers who make this selection will be excluded from regular MAC targeted probe and educate reviews but may be subject to potential Recovery Audit Contractor (RAC) review.

Note: Providers who select this option will remain in this option for the five-year duration of the demonstration.



Subsequent Review Choices

Choice 4: Selective Post-payment Review

MAC reviews random sample every six months

Provider remains in this choice for the duration of RCD



Subsequent Review Choices

Choice 5: Spot Check

MAC selects 5% of HHA claims every six months

MAC sends ADRs and follows CMS prepayment review procedures



Partial & Non-Affirmation Issues



Signature Problems

- Stamped (not allowed except in rare, specific situations)
- Lacks notation of electronic signature
- Lacks full date of signature or credentials
- Often difficult to decipher validity of signature
 - MLN Matters Number: MM6698
 - Info on signature logs, and attestation statements
 - *Medicare Medical Records: Signature Requirements, Acceptable and Unacceptable Practices* (find on Palmetto GBA's website)
 - *Signature Requirements: Acceptable Examples* (find on Palmetto GBA's website)



Signature Strategies

- Affects face-to-face encounters (F2F), plans of care, and other orders and requires careful examination
- Examine documents carefully when they arrive
- Educate your referring practitioners
- Have practitioner sign next to invalid signature such as stamped or illegible signature
- Use signature logs as needed
- Provide documentation of practitioner's credentials (NPI registry)

Face-to-Face Encounter (F2F) Problems

- Encounter documentation does not relate to primary focus of home healthcare
 - Diagnosis does not have to match exactly
 - Required to relate only on initial episode of care
 - Primary diagnosis on plan of care must be addressed or inferred in F2F
- F2F is not performed within allowed timeframes



F2F Strategies

- Examine F2F as soon as it is received
 - Suggest clinician knowledgeable in F2F regulations
- Ensure clinical and coding personnel have access to F2F
- Diagnoses don't relate
 - Change primary diagnosis of plan of care
 - Seek alternate F2F encounter performed in the 90 days prior to start of care
 - New F2F encounter within 30 days of start of care
 - Note: Coding guidance may affect order of diagnoses; Palmetto reviewer should be aware, or documentation may be sent with submission



Test Your Knowledge

- HH plan of care primary diagnosis:
 - Z45.2 Encounter for adjustment and management of VAD
- F2F documentation
 - Patient seen for:
 - Stage 4 breast cancer and complications of chemotherapy
 - Hypertension
 - Depression
 - Other current conditions documentation included: patient receiving TPN at home, use of wheelchair for mobility, and history of falls
- Does this patient need a different F2F Encounter?

Test Your Knowledge Answer

- TPN (Total Parenteral Nutrition) may only be given intravenously
 - Non-clinician would most likely be unaware of this
- F2F mentions patient is receiving TPN at home
- Initial POC primary diagnosis refers to venous access device

- Conclusion: F2F should be approved by reviewer as valid in relation to POC
 - Inferred relationship between F2F and initial POC

F2F Certification Attestation

- Required when practitioner who performed F2F is different than practitioner signing plan of care
- Common problems
 - No F2F certification statement on supplemental order or plan of care
 - Date of F2F does not match recorded F2F certification date



F2F Certification Attestation Strategies

- When possible, include attestation statement on plan of care

Orders of Discipline and Treatments:

I CERTIFY THAT A F2F ENCOUNTER WAS CONDUCTED ON 09/02/2020 AND MEETS THE CMS ELIGIBILITY REQUIREMENTS.

- Check carefully to ensure date recorded meets F2F you will use for submission
 - Decide which practitioner encounter you will use for F2F encounter if you have more than one
- Do you need an attestation?
 - Agencies are getting an attestation when not needed—increased burden on agency and practitioner
 - If plan of care practitioner co-signed F2F, attestation not required



Test Your Knowledge

- SOC: 04/16/20
- Period 1: 08/14/20 – 09/12/20 SN, ST
- Period 2: 09/13/20 – 10/12/20 SN, ST
- POC doctor: Ran, MD
- F2F practitioner: Pitt, NP performed in office on 04/25/20

- Does this require a F2F certification attestation?



Test Your Knowledge Answer

- What do we know?
 - This is a recertification--a new F2F is not needed
 - You WILL be examining the F2F and need for F2F certification statement for the initial episode and submitting it with your recert periods
 - Never assume a previously accepted F2F and F2F certification will be accepted with newly submitted documents
- Is a F2F Certification Statement/Attestation required for submission? **Yes**
 - F2F was performed by a NP
 - Certifying physician who signed POC is a different practitioner



Test Your Knowledge

- SOC: 04/11/20
- Period 1: 08/09/20 – 09/07/20 SN, OT
- Period 2: 09/08/20 – 10/07/20 SN, OT
- POC doctor on 04/11/20: Blane, MD
- POC doctor on 08/09/20: Kruger, MD
- F2F practitioner: Blane, MD performed in an acute care hospital on 04/07/20

- Does this require a F2F certification attestation?

Test Your Knowledge Answer

- What do we know?
 - Recertification
 - Initial SOC certifying physician: Dr. Blane
 - F2F encounter performed by Dr. Blane
 - Current POC certifying physician: Dr. Kruger
- Do we need a F2F certification statement/attestation? **No**
- We **WILL** submit F2F documentation with this submission



Plan of Care

- Must contain all required elements (§484.60)
- Reviewers primarily look at:
 - Diagnoses to support services ordered
 - Primary diagnosis as it relates to F2F encounter
 - Services, frequency, and duration
 - Examine if the services will be included in both payment periods
 - Presence of interventions and goals for every service ordered
 - Therapy goals need to have short- and long-term goals; must show complexity of care required by qualified therapist
 - Signature of practitioner with credentials and date



Plan of Care Strategies

- Careful examination to ensure all elements are present
- Practitioner who does not include credentials
 - Provide supporting documentation from NPI registry
- Suggestions:
 - Include F2F supporting documentation on POC—narrative of patient status and current problems to be addressed by HH
 - Include statement that physician/practitioner will include agency generated supporting documentation in their medical records



Clinical Summary Template Sample

PRIMARY PROBLEM (What is the change from the patient's baseline; e.g. exacerbation of disease, new medication, knowledge deficit, etc.)

HOMEBOUND STATUS (describe functional limitations resulting from the structural impairment(s))

ASSISTANCE NEEDED for ADLs/IADLs and WHO IS ABLE TO HELP?

OTHER PERTINENT INFORMATION



Applying ICF to PCR Submission

- ICF: International Classification of Function
- Describes how the patient's activity limitations relate to their disease, injury, or illness causing need for services and inability to easily leave their home
- Body structure: Changes in normal structure of body
 - Examples: Supplemental oxygen usage, joint replacements, urinary catheter
- Body function: Changes in function of body from norm
 - Examples: CHF, diabetes, anxiety, incontinence

Body Function	Body Structure
Mental functions	Structure of the nervous system
Sensory functions and pain	Eye, ear and related structures
Voice and speech functions	Structures involved in voice and speech
Functions of the cardiovascular system	Structures of the cardiovascular system
Functions of the hematological and immunological systems	Structures of the immunological system
Functions of the respiratory system	Structures of the respiratory system
Functions of the digestive system	Structures related to the digestive system
Functions of the metabolic and endocrine systems	Structures related to the metabolic and endocrine systems
Genitourinary functions	Structures related to the genitourinary systems
Neuromusculoskeletal and movement-related functions	Structures related to movement
Functions of the skin and related structures	Skin and related structures

Submission Tips from the Real World

- Keep notes on each submission
 - SOC date
 - Periods to be submitted
 - Services ordered in each period
 - F2F info—date performed, practitioner who performed F2F, office or facility
 - Additional info needed such as:
 - Orders with added orders and goals
 - Resumption of care orders
 - Credential info, etc.



Sample Note Format

eServices login #

<Patient Initials>
7/30 - 8/28 SN, PT
8/29 - 9/27 SN

SOC: 7/30/20

Pending cert order
signature sent on 10/21

F2F: Rodr NP 7/28/20 office; Rav MD cert doc on supp
order

<Patient Initials>
8/25 - 9/23 SN, OT, ST
8/29 - 9/23 SN, ST

SOC: 10/30/19

Submitted 2 periods

F2F: Wor MD rehab

→
cert doctor

More Tips

- Notes will help you during submission
- Make sure you can read your own handwriting
- Use the visit calendar in your EMR to see when scheduled visits end for an ordered service—some 5-week durations will only be included in period 1
- Services starting after SOE but prior to submission need to have orders and goals for reviewers
- On eServices, NEVER submit before checking your entries!



