

Review Choice Demonstration (RCD) for Home Health Services Frequently Asked Questions (FAQs)

General RCD Questions:

1. What does the Review Choice Demonstration do?

This demonstration establishes the review choice process for home health services to assist in developing improved procedures to identify and prevent fraud, protect beneficiaries from harm, and safeguard taxpayer dollars to empower patients while minimizing unnecessary provider burden. The demonstration helps ensure that the right payments are made at the right time for home health service through either pre-claim or postpayment review, protects Medicare funding from improper payments, reduces the number of Medicare appeals, and improves provider compliance with Medicare program requirements. Additionally, in response to public comments, the demonstration incorporates more flexibility and choice for providers, as well as risk-based changes to reduce burden on providers demonstrating compliance with Medicare home health policies.

2. How is the revised Review Choice Demonstration different from the initial Pre-claim Review Demonstration?

CMS revised the demonstration to incorporate more flexibility and choice for providers, as well as risk-based changes to reduce burden on providers who demonstrate compliance with Medicare home health policies. Under the Pre-Claim Review Demonstration, a provider was required to participate in pre-claim review for the whole of the demonstration. Based on stakeholder feedback, the Review Choice Demonstration offers multiple choices for providers to demonstrate their compliance with CMS's home health policies. Providers in the demonstration states may choose to initially participate in pre-claim review or postpayment review. A provider's compliance determines their next step. Every 6 months, the HHA's pre-claim review affirmation rate or postpayment review approval rate will be calculated. If the HHA's rate is 90 percent or greater (based on a 10 request/claim minimum), the HHA may select from additional subsequent review choices, including relief from most reviews, except for a small number of claims. Even if a provider has not reached the target review threshold, it may select a different choice. Providers who do not wish to undergo such reviews have the option to furnish home health services and submit the associated claim for payment; however, they will receive a 25 percent payment reduction on all claims submitted for home health services. In addition, unlike the initial demonstration, providers under the pre-claim review choice may request more than one episode for a beneficiary on a pre-claim review request.

3. Why did CMS pause the initial Pre-Claim Review Demonstration for Home Health Services?

On April 1, 2017, CMS paused the Pre-Claim Review Demonstration for Home Health Services to consider a number of changes in response to stakeholder feedback. During the pause, CMS revised the demonstration to incorporate more flexibility and choice for providers, as well as risk-based changes to reward providers who show compliance with Medicare home health policies.

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

No, the demonstration should have minimal effect on beneficiaries. Under the pre-claim review choice, services can begin prior to the submission of the pre-claim review request and continue while the decision is being made. The pre-claim review request must be submitted and reviewed before the final claim is submitted for payment. In addition, the provider may submit a pre-claim review request with more than one episode requested for a beneficiary. Under the remaining choices, providers will provide services and submit claims for payment following their normal processes. The Medicare Administrative Contractor (MAC) will send the provider an Additional Documentation Request (ADR) for those claims eligible for review under the selected choice.

5. What states does this demonstration impact?

This Review Choice Demonstration impacts the states of Illinois, Ohio, North Carolina, Florida and Texas. It includes only Home Health Agencies (HHAs) in those states that bill to Palmetto GBA, the Jurisdiction M Medicare Administrative Contract (MAC). To limit the burden and confusion for providers, the demonstration will include rendering providers who are located in the demonstration states. The National Provider Identifier (NPI), CMS Certification Number (CCN), name, and address of the rendering provider should be placed on the claim.

Examples:

I am a branch office located and providing services in a demonstration state, but my parent corporation is located in a non-demonstration state.

You are included in the demonstration if you bill using a PTAN for a demonstration state.

I am a parent corporation located and providing services in a demonstration state, but some of my branch offices are located in non-demonstration states.

You and your branch offices providing services in the demonstration states would be included in the demonstration. Branch offices located outside the demonstration states that bill under their own National Provider Identifier (NPI) would not need to be included. However, if a branch office bills under your (the parent company) NPI and PTAN, they would be included in the demonstration.

I am a Home Health Agency located and providing services in a demonstration state, but also provide services to beneficiaries in a neighboring non-demonstration state.

You are included in the demonstration for services provided to beneficiaries in the demonstration state as well as services provided in the neighboring non- demonstration state.

I am a Home Health Agency located in a demonstration state, but Palmetto GBA is not my Medicare Administrative Contractor (MAC).

You would not be included in the demonstration.

I am a Home Health Agency located in a non-demonstration state. I provide services to beneficiaries in both demonstration and non-demonstration states.

You would not be included in the demonstration.

I am a Home Health Agency located in a non-demonstration state that provides services only to beneficiaries that live in a demonstration state.

You would not be included in the demonstration.

6. When does the Review Choice Demonstration for home health services begin?

The choice selection period will begin on April 17, 2019, and end on May 16, 2019 in Illinois. Following the close of the choice selection period, the demonstration will begin on June 1, 2019, and all episodes of care, both initial and recertifications starting on or after this date will be subject to the requirements of the choice selected. Ohio, Texas, North Carolina, and Florida will be included in the demonstration in the future. CMS and Palmetto GBA will provide at least 60 days' notice prior to the demonstration starting in each additional state.

7. Does the demonstration apply to beneficiaries already receiving home health services before the demonstration's start dates?

Episodes of care that begin prior to the start date of the demonstration in each state are not subject to the demonstration. However, all episodes of care, including both initial and recertifications, beginning on or after the start date of the demonstration in each state will be subject to pre-claim or postpayment review depending on the choice selected.

8. What are the initial review choices?

The initial review choices are:

- **Choice 1: Pre-claim Review**
 - All episodes of care are subject to pre-claim review.
 - Unlimited resubmissions are allowed for non-affirmed decision 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.

- **Choice 2: Postpayment Review**
 - 100 percent of claims are reviewed after final claim submission.
 - Default selection if no initial review choice 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.

- **Choice 3: Minimal review with a 25 percent payment reduction (HHAs remain in this option for the duration of the demonstration)**
 - 100 percent of claims have a 25 percent 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 5 year duration of the demonstration.

9. What are the subsequent review choices?

Every six months, HHA's may select from one of the three subsequent review choices if the pre-claim review affirmation rate or postpayment review approval rate is 90 percent or greater.

The subsequent review choices are:

- **Choice 1: Pre-claim Review**

- **Choice 4: Selective Postpayment Review**
 - A random sample of claims will be chosen for review every six months.
 - Default selection if no subsequent review choice made.
 - Note: Providers who select this option will remain in this option for the duration of the demonstration.
- **Choice 5: Spot Check Review**
 - Every six months, 5 percent of a provider's claims are randomly chosen for review.
 - Providers may remain in this option as long as they continue to show compliance with Medicare coverage rules and guidelines.

10. Will providers in Illinois be required to participate in this demonstration if they had at least a 90 percent or higher Pre-Claim Review (PCR) affirmation rate?

All applicable providers must participate in the demonstration. Illinois providers who previously participated in PCR and reached a full affirmation rate of 90 percent or higher for at least 10 pre-claim review requests from the dates of August 2016 through March 2017 may select from the subsequent review choices as opposed to starting in one of the initial review choices.

11. Is there an appeals process under the demonstration for non-affirmative pre-claim or postpayment review requests?

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

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

12. What happens if I do not select Pre-Claim Review (PCR) and select another choice?

Providers are not required to participate in PCR and can select from any of three initial choices. The other choices are:

- Choice 2: Postpayment Review
- Choice 3: Minimal Review with a 25 percent payment reduction

13. When can an HHA select another review choice?

HHAs who select either Choice 1: Pre-claim Review or Choice 2: Postpayment Review will be evaluated over a 6-month review cycle. At the end of each 6-month period, and within 30 days, the MAC will communicate to the HHA their pre-claim review affirmation or postpayment claim approval rate, and if they have met the review threshold. If the HHA's full affirmation rate or claim approval for that 6-month cycle is 90 percent or greater (based on a minimum of 10 submitted pre-claim review requests or claims), the HHA may select one of the three subsequent review choices. HHAs who select Choice 3: Minimal Review with 25 percent Payment Reduction will remain in this choice for the duration of the demonstration. The review cycle and threshold do not apply to this choice.

14. What if a HHA does not meet the threshold or affirmation/claim approval rate?

If the HHA's affirmation or claim approval rate is less than 90 percent or they have not submitted at least 10 requests/claims, the HHA must again choose from one of the initial three options.

15. Does the Review Choice Demonstration create new documentation requirements?

RCD does not create new documentation requirements; rather, it would only require submission of the same information currently required to be maintained. Home Health Agencies will have increased flexibility as they are able to choose their path to demonstrate compliance with the applicable Medicare rules and policy requirements.

16. Will there be a specific form to use for the demonstration?

There will not be a required form for the demonstration. The Medicare Administrative Contractor, Palmetto GBA developed a checklist to help submitters with the pre-claim or postpayment review requests. Submitters are encouraged to use the checklist, but it is not required. Refer to Palmetto GBA's website for more information.

17. Under the demonstration, who will make the review decisions?

The same contractor that currently processes claims and conducts medical review on home health services, Palmetto GBA, will make these decisions using existing applicable regulations, National Coverage Determination and Local Coverage Determination requirements, and other CMS policies. Clinical staff are assigned to medical review and trained to ensure consistency.

18. Are beneficiaries covered under a Medicare Advantage Plan included in the RCD?

No, the RCD demonstration only applies to Medicare beneficiaries covered under Fee-for-Service (FFS) Medicare.

19. How will Partial Episode Payment (PEP) claims process when a transfer occurs under the Home Health RCD process?

PEP claims will process as they have always processed, no change will occur under RCD.

20. If I am under a Unified Program Integrity Contractor (UPIC) review, do I need to make a RCD selection?

Providers under UPIC review are not eligible to make a Review Choice selection and will not participate in the demonstration while under review. If a provider is removed from UPIC review, the MAC will be notified. The provider will then be informed of their inclusion in RCD and will need to make a review choice selection at the next selection period. Questions regarding UPIC review should be directed to the UPIC.

21. Are any claims exempt from the Review Choice Demonstration process?

Home health claims for Veteran Affairs, Indian Health Services, Part A/B rebilling, demand bills submitted with condition code 20, no-pay bills submitted with condition code 21, and RAPs are not subject to the demonstration.

22. Are both certification home health episodes and recertification home health episodes subject to the demonstration?

Yes. The demonstration applies to both home health certification episodes and recertification episodes that begin after the start date in each state. An episode of care initiated with the completion of a Start of Care OASIS is considered a certification.

23. What if a beneficiary only requires a few home health visits? Will the claim still be subject to the demonstration?

Low-Utilization Payment Adjustment (LUPA) claims with four or fewer visits are excluded from the Review Choice Demonstration for Home Health Services; however, all other episodes that

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include five or more visits are eligible for review if applicable under the choice selected.

24. Will claims reviewed under the demonstration still be subject to additional review?

Absent evidence of potential fraud or gaming, the claims that have a provisional affirmation pre-claim review decision or where approved under medical review will not be subject to additional review. However, CMS contractors, including Unified Program Integrity Contactors and Medicare Administrative Contractors, may conduct targeted prepayment and postpayment 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 or postpayment review to fall within the sample. In this situation, the subject claim would not be protected from the CERT audit.

25. Will Home Health Agencies in the demonstration states be allowed to require that beneficiaries sign an Advanced Beneficiary Notice (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).

26. Will providers be required to participate in Targeted Probe & Education (TPE) and RCD at the same time?

No. Providers will not be under TPE review and RCD at the same time. Providers currently on TPE review will be removed prior to CMS implementing RCD in that particular state.

27. Will CMS consider having targeted pre-claim or postpayment reviews in the future?

During the course of the demonstration, as well as when it concludes, CMS will monitor and analyze data to evaluate the impact of the demonstration on fraud and other improper payments in the demonstration states, and may consider if a more focused risk-based approach is warranted in the future.

28. Where can I send additional questions?

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

29. Where can I find more information related to the Review Choice Demonstration?

More information can be found <https://go.cms.gov/homehealthRCD>.

Choice Selection Questions:

30. How do we make a RCD selection?

Providers can make a choice selection during their specific states timeframe in the [eServices portal](#). CMS and Palmetto GBA will ensure adequate notice for the choice selection period is given in each state.

31. Is eServices the only way to make my RCD selection?

Yes, providers need to make their selection in the [eServices portal](#).

32. What if I do not make a selection?

If a HHA does not make a selection prior to the end of the choice selection period, the HHA will automatically be put in Choice 3: Postpayment Review if they are in the initial options stage or Choice 4: Selective Postpayment Review option if they are in the subsequent option stage.

33. Who can make a selection in eServices?

The account administrator selected in the [eServices portal](#) is the only one that can make a selection for RCD.

34. Can I change my selection after one has been made?

Yes, providers can make and change their review choice selections until the night the selection period ends.

35. How can I check to see what selection my HHA made?

If you are an account administrator with eServices, you can check on the [eServices portal](#). If you are not an administrator, you can utilize the Review Choice Demonstration Look Up Tool at www.palmettogba.com.

36. How do I know if I am in the initial or subsequent choice stage?

Except for some providers in Illinois, all providers will begin in the initial review choice stage. HHAs who select either Choice 1: Pre-claim Review or Choice 2: Postpayment Review will be evaluated over a 6-month review cycle. At the end of the 6-month period, and within 30 days, the MAC will communicate to the HHA their pre-claim review affirmation or postpayment claim approval rate, and if they have met the review threshold. If the HHA's full affirmation rate or claim approval for that 6-month cycle is 90 percent or greater (based on a minimum of 10 submitted pre-claim review requests or claims), the HHA may select one of the three subsequent review choices. HHAs who select Choice 3: Minimal Review with 25 percent Payment Reduction will remain in this choice for the duration of the demonstration. The review cycle and threshold do not apply to this choice.

37. Do all locations that fall under the same Provider number have the same affirmation rate and RCD selection choices?

It is possible to have different affirmation rates if you have more than one PTAN and NPI combination. The affirmation rate is calculated on the combination of the PTAN and NPI. If the PTAN is linked to more than one NPI or an NPI is linked to more than one PTAN, then the data is separated accordingly.

38. What stage will Illinois HHAs begin with?

HHAs in Illinois who participated in the initial Pre-Claim Review Demonstration and had 90 percent full affirmation rate with at least 10 pre-claim review submissions may select from the subsequent review choices. Palmetto GBA will notify HHAs in Illinois which choices they may select from.

39. How is the Pre Claim Review (PCR) affirmation rate being determined for Illinois providers who participated in PCR? Is it an average from the entire length of PCR or is it based on the affirmation rate the agency had at the end of PCR?

The initial affirmation rate given in the letter that was mailed to all Illinois providers dated April 8, 2019 was calculated based on the aggregate of all completed PCR submissions during the previously implemented PCR demonstration.

40. When and how will I receive the results of my 6 month review period?

Results letters will be sent to providers within the 7th month (30 calendar days or 20 business days) from the end of the review cycle. If a provider selects eDelivery in their preferences in eServices, all PCR responses will be sent via eDelivery regardless of what method the PCR request was submitted to Palmetto GBA. Providers that do not select eDelivery will receive the PCR response via mail.

41. Does the Pre-Claim Review (PCR) affirmation rate calculation include appeals?

The PCR affirmation rate is based on your PCR submissions during the active demonstration dates that had a decision rendered. Because PCR submissions are not subject to appeal, appeals data is not included in the affirmation rate. Providers have the ability to make as many resubmissions as needed to get a full affirmation prior to submitting the claim. The number of resubmissions is not counted against the affirmation rate.

42. If I select Choice 1: PCR the first 6 month review cycle, then change to Choice 5: spot check for the second 6 month review cycle, will the claims with affirmed UTNs that I submit during the second 6 months be exempt from spot check review?

Claims with affirmed UTNs will not be selected for the spot check review.

43. What happens if I qualify for a subsequent review choice, but do not make a selection?

HHA's with a full affirmation rate or claim approval rate of 90 percent or greater that do not actively select one of the subsequent review choices by the deadline indicated in their letter will automatically be assigned to participate in Choice 4: Selective Postpayment Review. The HHA will remain in this choice for the remainder of the demonstration and will not have an opportunity to select a different choice.

44. If we undergo a change of ownership, will my HHA be able to select a new review option.

No. The new owner will continue with the previous owner's selection. As long as the previous owner did not select Choice 3: Minimal Review with a 25 percent Payment Reduction or the Choice 4 Selective Postpayment Review option, the new owner may select a different option at the end of the 6 month review period.

Submission Questions:

45. Will the Palmetto GBA eServices provider portal allow you to add more than one attachment per PCR task?

Yes, just assure the attachment is named something different than the other attachments previously added as the system will prevent you from adding two attachments with the same name.

46. What happens if the provider does not have any documentation for PCR Task #2: *Attach the Home Health Agency (HHA) generated records that have been signed, dated, and incorporated into the certifying physician's medical records?*

Task #2 is requesting that the HHA generated records, if any, that have been provided to the physician, signed and dated and incorporated in to the physician's medical record be attached. If the HHA answers yes, the documentation should be uploaded or referred to if the

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documentation was already uploaded in the documentation under Task #1. If the agency answers no, they will proceed to Task #3.

Reference: [MLN Matters SE1436](#)

47. If a provider selects an incorrect response to the PCR questions in Task # 5 and the documents attached do not match the item(s) selected, will this result in an error?

- Task #5 – Q4/Q5: *Attach medical documentation that meets the First Criteria for Confined to the Home*
- Task #5 – Q6: *Attach medical documentation that meets the Second Criteria for Confined to the Home*
- Task #5 – Q7: *Attach medical documentation that meets the Second Criteria for Confined to the Home*

Yes, an error will be displayed in this scenario – “Form cannot be submitted. The response(s) do not support the requirements for Home Health Services.”

48. If a Home Health Agency (HHA) submitting a PCR request does not have any documents for Task #5 will this will this result in a denial?

- Task #5 – Q4/Q5: *Attach medical documentation that meets the First Criteria for Confined to the Home*
- Task #5 – Q6: *Attach medical documentation that meets the Second Criteria for Confined to the Home*
- Task #5 – Q7: *Attach medical documentation that meets the Second Criteria for Confined to the Home*

The review determination will be made based on the entirety of the documentation submitted. However, please keep in mind the documentation submitted must demonstrate that the beneficiary meets the first and second criteria for confined to home.

Reference: [MLN Matters SE1436, Page 2](#)

49. How should we submit PCR documentation in the eService portal?

For efficiency of review, providers are encouraged to separately attach the documentation by task if the documentation is captured separately as opposed to scanning and attaching one attachment with all the documentation included. If the documentation for several tasks is captured in one document, providers are able to attach the document under one task and then refer to it under each subsequent task. We suggest providers reference the page number(s) in the text box under the subsequent task(s).

50. How should providers submit a resubmission through the eService portal?

Providers that submit a PCR request through the eService portal and receive a non-affirmed or partially-affirmed decision can send a resubmission with additional or updated information in eServices. Once in the eService portal, enter the Unique Tracking Number (UTN) and the portal will pre-populate much of the information that was already submitted. Providers will not need to resubmit attachments that were previously submitted with the original PCR request.

Once the resubmission is in process, providers will receive a message with a new UTN. A separate resubmission is needed for each episode if multiple episodes were submitted and they

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were not all fully affirmed (i.e., one or more episodes received a non-affirmed or partially-affirmed decision.

Note: *There must be at least one change to successfully resubmit the request.*

51. Can I submit a resubmission through esMD?

Yes. Providers resubmitting through esMD should note on the medical documentation that the submission is a resubmission.

52. Can I submit multiple episodes through esMD?

At this time esMD will only accept single episode PCR submissions. For multiple episode submissions, please choose the eService portal, mail or fax.

53. We have multiple PTANs and I submitted my PCR request under the wrong one. Do I need to correct this?

Yes, it is important that the PCR request is submitted with the correct PTAN. This will have to be manually changed in the system. Please contact Palmetto GBA's Provider Contact Center at 1-855-696-0705 and let them know you need to have that PCR request deleted.

54. If I submit a PCR request and get an incomplete submission response and resubmit with corrections, is it considered an initial or a resubmission?

This would be considered an initial submission because the original submission was incomplete.

Important: You can avoid incomplete submissions by submitting a PCR request through the Palmetto GBA eService portal at no charge. The eService portal will not allow a provider to submit for PCR with incomplete information and thus avoiding this denial.

55. Which physician information do we enter as the certifying in the PCR request if one physician signed the face-to face (F2F) and another the POC?

The name and NPI of the physician signing the Certification should be entered on the PCR request. This may or may not be the physician who conducted the F2F encounter.

Reference: [MLN Matters SE1219, Page 2](#)

Billing and Claims Questions:

56. If I use a billing company or have a corporate parent company, whose information should I put on the claim?

You should put the National Provider Identifier (NPI), CMS Certification Number (CCN), name, and address of the rendering provider on the claim. If you do not have a separate NPI, you should put the NPI and CCN of the corporate parent company and the name and address of the rendering provider.

57. Will the claim form be changed to include a field to report the pre-claim or postpayment review action? If not, where can we key the UTN on the final claim?

No, the claim form will not be changed. The operational guide will provide instructions on how to report the unique tracking number that will be issued with the pre-claim review decision on an existing field. For Electronic Claims on the UB04, the UTN will follow the treatment authorization code in positions 1 through 18. You will key the UTN in positions 19 through 32.

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Note: Do not put a space between the Treatment Authorization Code and the UTN.

If you are using Direct Data Entry, enter the Treatment Authorization Code on Page 5 and the cursor will automatically go to the field to enter the UTN.

58. If we included a HCPCS code on the Pre-Claim Review (PCR) request but don't end up providing that service during the episode of care, do we still need to include it on the final claim? Will the final claim still process without the code?

Yes, the final claim will process if you need to leave off a provisionally affirmed HCPCS code.

59. Are adjustment claims subject to Pre-Claim Review (PCR)?

Yes, adjustment claims are subject to HH PCR. Whether the adjustment was provider initiated or MAC initiated, if the UTN was on the original claim, it must remain on the claim upon adjustment.

60. What will happen if I mis-key the UTN or accidentally leave it off the final claim?

The claim will Return-to-Provider (RTP) for correction if the UTN is missing or mis-keyed.

Note: If there is no pre-claim review decision on file for a claim submitted by a provider who has chosen Choice 1:Pre-Claim review, the claim will be stopped for prepayment review.

Choice 1: Pre Claim Review (PCR) Questions:

61. What is the pre-claim review option?

Pre-claim 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.

62. 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 and all eligibility requirements for the beneficiary needing the applicable level of home health services. We do not anticipate the entire record will need to be submitted to support medical necessity (e.g., not every PT note, wound care treatment, etc. may be needed.)The MAC website will provide more specific information for each state.

63. Should documentation supporting the face-to-face encounter be submitted with the pre- claim review request? If so, is it required for each additional episode?

Yes, documentation supporting the face-to-face encounter must be submitted with the pre-claim review request. You may submit the pre-claim review request at any time prior to the final claim submission to allow time to collect this documentation. Medicare does not require a new face-to- face encounter for additional episodes where the patient has not been discharged from home health care. However, documentation supporting the face-to-face encounter from the start of care should be submitted with the pre-claim review request for subsequent episodes of care.

64. What if I have a patient who began receiving home health services prior to the requirement of the Face-to-Face Encounter and has continued to receive services with no break in service?

In this case, instead of providing the Face-to-Face Encounter documentation, you would provide an explanation of why you do not need it for that particular beneficiary.

65. When submitting the pre-claim review request, does the plan of care need to be signed by the physician?

Yes, the plan of care needs to include the physician's signature and date when it is submitted with the pre-claim review request.

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

The pre-claim review request may be submitted at any time before the final claim is submitted. The pre-claim review process, including submission of the request and receiving the Unique Tracking Number (UTN), must occur before the final claim is submitted for payment. This includes resubmissions after receiving a non-affirmed decision. The pre-claim review request should be submitted when the HHA has obtained all required documentation from the medical record to support medical necessity and demonstrate eligibility requirements are met. Pre-claim review must be requested for each episode of care; however, more than one episode can be submitted on one request for a beneficiary.

67. Do I need to submit a pre-claim review request before I submit the Request for Anticipated Payment (RAP)?

Providers are encouraged to submit the Request for Anticipated Payment (RAP) and allow it to process before submitting the pre-claim review request. This will allow the beneficiary record to open on the Common Working File and will ensure you have all of the required documentation to submit with the request.

68. Can providers request more than one episode of care for a beneficiary on one pre-claim review request?

Yes, an initial PCR request may include more than one episode of care for a beneficiary as long as the documentation supports the need for multiple episodes. Providers will receive a separate decision (affirmed/non-affirmed) and UTN for each episode included on the request. Providers requesting more than one episode of care on an initial PCR submission may use the eService portal or by submitting the hardcopy form via mail or fax. At this time, providers that submit through esMD may only request a single episode.

Resubmitted PCR requests can only include a single episode of care. Providers should include the UTN for the episode being resubmitted. Providers can resubmit PCR requests through the eService portal, mail, fax, or esMD. Providers resubmitting through esMD should note on the medical documentation that the request is a resubmission.

69. If an episode concludes before the MAC has completed pre-claim review, does the HHA need to wait to submit its final claim?

Yes. The Home Health Agency needs to wait until they receive the pre-claim review decision letter. The decision letter will contain a unique tracking number that will need to be submitted on the claim.

70. How many home health providers can request pre-claim review for one beneficiary for one time period? In a situation where a patient is discharged and readmitted to the same HHA during the 60-day episode, is the HHA required to submit a second pre-claim review request?

Under this demonstration, CMS allows one HHA provider to request pre-claim review per beneficiary per episode of care. If the initial provider cannot complete the Home health service, the initial HHA'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.

If a separate claim will be filed, a new pre-claim decision must be requested. For more information on Partial Episode Payment Adjustments, please refer to the Medicare Benefit Policy Manual, Chapter 7, Section 10.8.

71. If we undergo a change of ownership, will the affirmation decision transfer to the new owner?

Yes, the affirmation decision will transfer to the new owner.

72. Will the demonstration allow for the electronic submission of pre-claim review requests?

Submitters who choose to utilize the pre-claim review process may send pre-claim review requests to Palmetto GBA via mail, fax, provider portal, or through the Electronic Submission of Medical Documentation (esMD) system (where available). Providers resubmitting through esMD should notate on the medical documentation that the submission is a resubmission. Submitters should check Palmetto GBA's website for available submission methods. 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>.

73. Will the MAC send responses to pre-claim requests via the same mechanism by which they are received? For instance, if I send my request via a fax, will the response be sent back via a fax?

The MACs accept and respond to pre-claim review requests via the following mechanisms:

- Online Portal
 - Palmetto GBA accepts requests through their portal and sends decision letters via greenmail delivery within their portal.

Note: If a provider is set up for greenmail delivery but then submits through another mechanism, the decision letters will continue to be delivered via greenmail

- esMD
 - Decision letters are sent via US postal mail in addition to the MAC sending the pre-claim review response via esMD.
- Fax
 - Decision letters are faxed if a return fax number is clearly identified in the request submitted.
 - Rejection and exclusion notification letters may be faxed as well, as long as a return fax number is clearly identified in the request.

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- Mail
 - Decision letters are sent via US postal mail.

74. Under the Review Choice Demonstration, 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.

75. 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. A resubmitted request may be for non-affirmed services or for additional episodes that were non-affirmed.

76. Will we receive a different Unique Tracking Number (UTN) for each attempt to obtain affirmation or will each episode of care have the same UTN for all attempts? For example, a pre-claim review request is submitted for an episode of care beginning August 1st. The first submission was non-affirmed and had UTN- 1234 and the second submission was affirmed. Would the second submission have UTN- 1234 or a different UTN?

A unique tracking number will be provided for each pre-claim review request, whether it's provisionally affirmed or non-affirmed. The Medicare Administrative Contractor will list the pre-claim review UTN on each decision letter.

77. If I request more than one episode on a pre-claim review request, will each affirmed episode get a tracking number?

Yes, each affirmed episode will receive its own tracking number. The tracking numbers should be submitted on the individual claims.

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

The decision letter will specify why a 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.

79. How many times may a pre-claim review request be resubmitted?

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

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

The MAC will follow their standard procedures to recoup a RAP for any denied claims.

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

The Limitation on Liability protections of §1879 of the Social Security Act (the Act) will apply to this demonstration. The Limitation on Liability provisions require a provider to notify a beneficiary in advance of furnishing an item or service when such item or service is considered not medically reasonable and necessary, or when a beneficiary is not considered homebound, or when the beneficiary does not need physical therapy, speech-language pathology, skilled nursing care on an intermittent basis, or have a continuing need for occupational therapy, in order to shift financial liability for non-covered care to the beneficiary. In accordance with CMS policies, if an ABN was not issued when required at the start of care and the pre-claim review is non-affirmative, the beneficiary is not financially liable for the care that the HHA provided while awaiting the pre-claim review decision. If the HHA believes that the pre-claim review will be non-affirmative for any of the reasons listed, the provider may issue an ABN in accordance with CMS policy which would allow the beneficiary to choose to receive the service and accept financial liability. The ABN would be effective for denied services furnished after receipt of the ABN. If the HHA expects Medicare to cover the services, an ABN should not be issued. Blanket or routine issuance of ABNs is prohibited under Medicare policy.

Other requirements to qualify for the Medicare home health benefit, such as the face-to-face encounter, are considered technical in nature and are not part of the Limitation on Liability provisions and do not trigger an 1879 of the Act determination. If this documentation is missing then it would be a technical denial, and the provider would be held liable (i.e., not be able to charge the beneficiary) based on 1866(a)(1) of the Act.

When a pre-claim review is non-affirmed, the decision letter will include a detailed written explanation outlining which specific policy requirements were not met. If the non-affirmation is due to one of the reasons listed above that trigger application of the limitation on liability provision, the HHA may issue an ABN and the beneficiary will be held financially liable for denied services received following issuance of a valid ABN. If the non-affirmation was due to documentation errors, the HHA can correct the deficiencies and resubmit the request with all relevant documentation. In this situation it would not be appropriate to issue an ABN. Also, if the pre-claim review decision is non-affirmed for a reason for which the HHA would otherwise be financially liable (that is, the reason for denial is not one that triggers the limitation on liability provision), the HHA should not issue an ABN following a non-affirmative pre-claim review decision in an attempt to shift liability.

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 but beginning three months after the start of the pre-claim review program in a particular state, there will be a 25 percent reduction to the full claim amount. The 25 percent payment reduction is non-transferrable to the beneficiary.

82. If I receive a partial affirmed decision for some of the services on my pre-claim review request, do I need to resubmit a new request with just the affirmed services?

No, you do not need to resubmit a new request with just the affirmed services. These services will be paid once the claim is submitted as long as all other Medicare requirements are met. CMS will monitor the pre-claim review requests to look for those requests where only the affirmed services of a previous request are resubmitted.

83. If I received a provisionally affirmed decision and UTN for a beneficiary for a 60-day episode and later in the episode the beneficiary's condition supports adding additional services (e.g. therapy), will I need to submit a new pre-claim review request?

The pre-claim review initial request should be submitted after you have had enough time to evaluate the beneficiary's condition to determine the services (HCPCS) that will be required for the episode. However, if later in the episode the beneficiary's condition supports additional services that were not on the initial provisionally affirmed pre-claim review request, you would not need to submit an additional pre-claim review request for that episode.

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

If an HHA has selected Choice 1: Pre-Claim Review and submits a claim without a pre-claim review request being submitted, the MAC will stop the claim for pre-payment review. If the claim is 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 is not subject to appeal. After a claim is submitted and processed, appeal rights on the claim determination are available as they normally are.

85. Do I have to participate in 100 percent review?

No, providers who do not wish to participate in either 100 percent pre-claim or postpayment reviews have the option to furnish home health services and submit the associated claim for payment without undergoing such reviews; however, they will receive a 25 percent payment reduction on all claims submitted for home health services and could be subject to potential Recovery Audit Contractor (RAC) review. Providers who select this option will remain under it for the duration of the demonstration and may not select another choice. This will allow for operational consistency among the review and payment of the provider's claims.

86. If I submit a pre-claim review request with more than one episode, does that count as one PCR decision or multiple decisions in regards to threshold?

If a PCR request is submitted with multiple episodes, each episode is counted individually towards your threshold. For example, if you submit a PCR request with three additional episodes, then this would be counted as four individual PCR decisions towards your threshold.

87. Do we have to submit a new PCR request if we have a resumption of care in an episode of care that already has an affirmed decision?

No, a new PCR request will not be required for a resumption of care.

88. Do we have to submit a new PCR request if we receive supplemental orders for additional services in the episode of care after the PCR request has already been completed?

No, a new PCR request will not be required if additional services are added after the PCR has been processed. The provider would reflect the HCPCS for those added services on their final claim and assure that the documentation, including the order for those services is maintained in the medical record.

89. Do we have to submit a new PCR request if we complete a new Start of Care (SOC) OASIS?

Yes, a new PCR request will be required with a new SOC.

90. If we select PCR, do we need to submit our Request for Anticipated Payment (RAP) and allow it to process before submitting our documentation for PCR?

Providers are encouraged to submit the RAP and allow it to process prior to submitting the PCR Request. This will allow the beneficiary record to open on the Common Working File and will ensure you have all of the required documentation to submit with the request.

91. What is the response time for PCR decisions?

Palmetto GBA has 10 business days to make a decision and respond to the initial request. For resubmissions, Palmetto GBA has 20 business days to respond. The most efficient way to submit and receive a response is via [eServices](#).

Note: If a provider selects eDelivery in their preferences in eServices, all PCR responses will be sent via eDelivery regardless of what method the PCR request was submitted to Palmetto GBA. Providers that do not select eDelivery will receive the PCR response via the same method the PCR request was submitted.

Questions on Additional Choices:

92. What documents are required for the review choices other than pre-claim review?

The HHA should submit all documentation and information that are currently required for medical review of home health claims. The documentation should support the eligibility and need for the level of services indicated on the claim.

93. When should the information for those options be submitted?

The HHA should conduct all standard intake procedures, provide the necessary services, and submit the claim. Once the claim is received, the MAC will send the HHA an ADR. The HHA should submit the documentation following receipt of the ADR.

94. If I select the postpayment review choice, will I be under this choice for the duration of the demonstration?

No. Providers who select the Postpayment Initial Review choice will have 100 percent of their final claims reviewed for a 6-month review cycle. At the end of each 6-month period, and within 30 days, the MAC will communicate to the HHA their pre-claim review affirmation or postpayment claim approval rate, and if they have met the review threshold. If the HHA's full affirmation rate or claim approval for that 6-month cycle is 90 percent or greater (based on a minimum of 10 submitted pre-claim review requests or claims), the HHA may select one of the three subsequent review choices. HHAs who select Choice 3: Minimal Review with 25 percent Payment Reduction will remain in this choice for the duration of the demonstration. The review cycle and threshold do not apply to this choice.

95. If I select the Minimal Review choice, is the 25 percent reduction appealable?

No, the 25 percent payment reduction is not appealable and may not be transferred to the beneficiary.

96. How long may I remain in the spot check choice?

A HHA may remain in Choice 5: Spot Check review for the duration of the demonstration as long as they show continued compliance with Medicare requirements.

97. Will all states be able to select the “spot check” Choice 5?

Yes. In all states at the end of each 6-month period, and within 30 days, the MAC will communicate to the HHA their pre-claim review affirmation or postpayment claim approval rate, and if they have met the review threshold. If the HHA’s full affirmation rate or claim approval for that 6- month cycle is 90 percent or greater (based on a minimum of 10 submitted pre-claim review requests or claims), the HHA may select one of the three subsequent review choices which includes Choice 5: Spot Check Review. HHAs who select Choice 3: Minimal Review with 25 percent Payment Reduction will remain in this choice for the duration of the demonstration. The review cycle and threshold do not apply to this choice.

NOTE: In order to remain in Choice 5: Spot Check Review, the HHA must maintain the review threshold in each subsequent 6- month review cycle.

98. Will a provider that does not have the minimum 10 claims submitted be able to select Choice 5: Spot Check Review?

No. Providers that meet the compliance threshold for the subsequent review choices must have at least 10 claims submitted to be able to select this choice.

99. Under Choice 5: Spot Check Review, will a provider receive the 5% list of claims subject to review after the 6 months has ended? If so, would it be pre or postpayment review? How would Palmetto GBA know how many to choose until after the 6 months?

Palmetto GBA will suspend 5% of claims over a 6 month period for prepayment review. The 5% is based upon a provider’s claim submission average from the previous 6 months.

100. If a provider chooses Choice 5: Spot Check Review, for what time period will Palmetto GBA select claims to review?

Claims selected for all review options will have a start of care date on or after each state’s implementation date. For choices #4 and #5, Palmetto GBA will use the previous 6 months claim volumes to determine the sample size for both options. All claims selected will be within the dates of the demonstration start dates for the state in question.

101. If I choose Choice 5: Spot Check Review in a subsequent 6 month period, will the ADRs sent be from that same subsequent period, or will some be selected with episode start dates from a previous period?

Claims selected for all review options will have a start of care date on or after the state’s implementation date. For both the initial 6 month review cycle and subsequent 6 month review cycles, Palmetto GBA will be selecting claims for review based on the date of receipt. Claims billed later in a review cycle will be reviewed based on the RCD selection choice that is in place at the time the claim is submitted. It is possible for a claim with the date of service on or after the implementation date to be selected for review at any point in the demonstration, based on date of receipt.

102. Some of the review choices reference submitting documentation in response to an ADR, but Pre-Claim Review (PCR) only requires enough documentation to complete the Task. What documentation should be submitted for these review options?

The documentation required for other review options is the standard documentation required for regular medical review and is not the same as what is required under PCR. For information on what documentation is required for PCR, please see the [PCR Initial Checklist](#) and the [PCR Subsequent Episode Checklist](#).

General Medicare Home Health Policy and Coverage Questions:

103. When does the Face-to-Face (F2F) encounter need to be done?

The F2F encounter should occur no more than 90 days prior to the Home Health start of care (SOC) date or 30 days following the SOC.

Reference: Please refer to MLN Matters Number SE 1436 for written guidelines.

104. If we auto cancel our Request for Anticipated Payment (RAP) could that put us on Zero RAP pay?

Yes, CMS tracks data for both auto cancels and manual cancels and the Zero RAP pay process will still apply during the RCD demonstration.

105. What should Home Health Agencies do if the certifying physician will not provide documentation?

If the physician and/or facility will not provide the documentation, Home Health Agencies should notify their MAC or CMS (at HomeHealthRCD@cms.hhs.gov) of the uncooperative physicians and/or facilities. Physicians and/or facilities who show patterns of non-compliance with this requirement, including those physicians and/or facilities whose records are inadequate or incomplete, may be subject to increased reviews, such as through provider-specific probe reviews.

106. Some providers have long-term patients on service whose Start of Care (SOC) will be prior to when the home health face-to-face (F2F) encounter requirement was implemented. If the patient does not require a F2F encounter, how do we need to respond to Q2 *Was the home health certification and face-to-face (F2F) encounter performed by the same Physician* and then what documentation do we submit for Task #1: *Attach the actual F2F clinical encounter note used by the certifying physician to justify the referral for Medicare home health services or upload supporting documentation as to why the F2F is not applicable in eServices?*

The provider should respond “no” to Q2 and provide supporting documentation to support why the F2F is not applicable for Task #1.

107. If a patient is on home health service prior to the implementation of RCD and upon recertification they will need to submit a PCR request, what documentation from the past benefit periods will need to be submitted?

For all medical necessity reviews, the Medicare review contractors shall review the certification documentation for any episode initiated with the completion of a SOC OASIS. Therefore, if the

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subject claim is for a subsequent episode of care, the HHA must submit all certification documentation as well as recertification documentation.

Reference: [CMS IOM Publication 100-08, Chapter 6, Section 6.2.1](#)

108. Do we need to submit the face-to-face (F2F) encounter documentation for each benefit period if we already submitted it with a previous Pre-Claim Review (PCR) request and it was approved for the beneficiary?

Yes, if the PCR request is for a new episode of care, the HHA must submit all certification documentation as well as recertification documentation as each episode is reviewed independently.

Reference: [CMS IOM Publication 100-08, Chapter 6, Section 6.2.1](#)

109. When does the Plan of Care (POC) need to be signed when submitting Pre-Claim Review for additional episodes?

The POC needs to be signed prior to submitting a Pre-Claim Review (PCR) request. Timeliness of Signature Requirements can be found in the Medicare Benefit Policy Manual Publication 100-02, Ch 7, Section 30.2.4.