Pre-Claim Review Resource Kit

Home Health

a product of the Home Health Section of the American Physical Therapy Association

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Introduction

The Centers for Medicare & Medicaid Services (CMS) began several initiatives to prevent or identify improper payments before CMS processes a claim, and to identify and recover improper payments after paying a claim. Per CMS, "The Federal government estimates that about 12.1 percent of all Medicare Fee-For-Service (FFS) claim payments are improper across all settings. According to the Comprehensive Error Report Testing, the error rate for home health is upwards of 62% claims with errors.[1,2] The overall goal is to reduce improper payments by identifying and addressing coverage and coding billing errors for all provider types."

As a result of CMS error testing and initiatives, CMS developed Pre-Claim Review (PCR). Since implementing PCR however, there have been some bumps in the road. The National Association for Home Care and Hospice (NAHC) has highlighted a few:[3]

- For the first 11 of the PCR demonstration, the "best week" outcome translates to weekly $4.2 million in losses and an annualized loss of $217 million in unreimbursed care for home health agencies (HHAs). HHAs cannot survive for much longer with such ongoing losses.

- Medicare beneficiaries cannot withstand a 22% rejection rate. PCR is a direct barrier to care access. HHAs with any PCR rejections restrict patient admission and delay the start of care until an affirmation is received.

- The rejection rate is also higher than the reported 22%. CMS continues the flaw in its 10/5 data release by not disclosing the specific level of partial affirmations.

- CMS does not offer any analysis or explanation regarding the significantly diverse performance outcomes of the HHAs. However, and more importantly, CMS does not reveal that the data only represents 30% of the HHAs in the state. Currently, there are 772 Medicare participating HHAs in Illinois. The CMS data reflects only 229 of them. The absence of 70% of the HHAs from the PCR data is a strong indication that the patient and HHA risk already exposed in the first 11 weeks of the project is only the tip of the iceberg.

Even though the PCR has been paused in Illinois and halted in Florida, the resources provided here provide Home Health Agencies with tools to be well prepared to handle PCR, *if and when it is restarted.* If PCR is not resumed, the tools provide processes to assist with efficient claim submission.

This resource has been created to enhance your knowledge of PCR and the claim process in an attempt to provide you the tools necessary to initiate organizational process development so that your organization can achieve success while adapting to this new change. The World Health Organization has created the International Classification of Functioning, Disability and Health and the American Physical Therapy Association has resources to improve documentation standards that support CMS claim submission requirements.[4, 5]

This resource kit includes:

1. Key Terms
2. Checklist for Claim Submission/Pre-Claim Review

Other recommended resources include a CMS workflow available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Pre-Claim-Review-Initiatives/Downloads/Review-Decision-Flowchart.pdf. Additional resources are available at CMS.gov.

Key Terms

Activity Limitations – Difficulty performing daily activities as a result of body structure and function impairments, and **Participation Restrictions** – Problems an individual may encounter with involvement in life situations as a result of body structure and function impairments

- Communication
- Mobility and Movement
- Self-care
- Domestic life
- Interpersonal interactions and relationships
- Safety at home
- Medication Management
- Learning and applying knowledge
- Swallowing and nutritional intake
- Obtaining necessary medical care or services
- Obtaining necessary goods and supplies
- Caring for a loved one
- Recreation and leisure activities
- Participation in routine community and life activities

ADR – Additional Documentation Request

CCN – CMS Certification Number

CERT – CMS Comprehensive Error Rate Testing

CMS – Centers for Medicare & Medicaid Services

Environmental Factors – the physical, social and attitudinal environment in which one lives. The effect of people or things that interact with the individual

- Cluttered environment
- Inadequate sitting surfaces
- Obstacles blocking pathways
- Unavailable/damaged DME
- Family support
- Structural barriers

Face-to-Face – occurs 90 days before through 30 days after start of care, approved practitioner, must be related to primary reason for home health services – this documentation must include justification for referral to home health services

FFS – Fee-For-Service

Functional Impairment – A significant deviation of loss in physiological function of body systems (including psychological)

Mental functions
Sensory functions and pain
Voice and speech functions
Functions of the cardiovascular system
Functions of the hematological and immunological systems
Functions of the respiratory system
Functions of the digestive system
Functions of the metabolic and endocrine systems
Genitourinary functions
Neuromusculoskeletal and movement-related functions
Functions of the skin and related structures

HCPCS – Healthcare Common Procedure Coding System

HHAs – Home Health Agencies

Homebound Status

Confined to the home – there exists a normal inability to leave the home and leaving home requires a considerable and taxing effort
Additional criteria – because of illness or injury, the person needs the aid of supportive devices or the use of special transportation or the assistance of another person in order to leave their place of residence or the person has a condition such that leaving his or her home is medically contraindicated

ICF – International Classification of Functioning, Disability and Health – A framework for organizing and documenting information on functioning and disability

LUPA – Low Utilization Payment Adjustment – claims with four or fewer visits – excluded from pre-claim review at this time

MACs – Medicare Administrative Contractors

NAHC – National Association for Home Care and Hospice

Non-Affirmed Decision – incomplete request

NPI – National Provider Identifier

Order Components – contains type of services to be provided, the professional who will provide the services and the frequency of the services

Overpayment -- A payment a provider receives over the amount due for services furnished under Medicare statutes and regulations. Common reasons for overpayment are:

- Billing for excessive or non-covered services
- Duplicate submission and subsequent payment of the same service or claim
- Payment for excluded or medically unnecessary services

- Payment for services that were furnished in a setting that was not appropriate to the patient's medical needs and condition
- Payment to an incorrect payee

Partially Affirmed Decision – indicates at least one, if not more, service(s) was provisionally affirmed since pre-claim review requests may include one or more home health services

Patient Eligibility – documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records support skilled need

Personal Factors – the influences on functioning particular to the individual

Age
Race
Gender
Dietary preferences
Psychological assets
Fitness
Lifestyle habits
Upbringing
Coping styles
Education
Social background
Religion

Physician Certification – can include history and physical, progress notes, discharge summary – this documentation must include specific components, including satisfaction of homebound criteria and demonstration of skilled need.

POC – Plan of Care (at times referred to as the "485") – for detailed information on components of the POC, please refer to: Guidelines: Physical Therapy Documentation of Patient/Client Management BOD G03-05-16-41.

Postpayment Review – Review of claims after payment. Postpayment reviews may result in either no change to the initial determination or a revised determination, indicating an underpayment or overpayment.

Pre-Claim Review – process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment.

Prepayment Review – Review of claims prior to payment. Prepayment reviews result in an initial determination.

Provisionally Affirmed Decision – preliminary finding that a future claim submitted to Medicare for the service likely meets Medicare's coverage, coding and payment requirements.

RAP – Request for Anticipated Payment – split percentage payment approach to ensure adequate cash flow to Home Health Agencies.

Reasonable and Necessary – documentation supports services are required at a level of complexity which require the skills of a qualified clinician.

Structural Impairment – A significant deviation or loss in body structure (anatomical parts of the body such as an organ, limb or their components):

Structures of the nervous system
Eye, ear and related structures
Structures involved in voice and speech
Structures of the cardiovascular system
Structures of the immunological system
Structures of the respiratory system
Structures related to the digestive system
Structures related to the metabolic and endocrine systems
Structures related to the genitourinary system
Structures related to movement
Skin and related structures

TOBs – Type of Bills

Underpayment – A payment a provider receives under the amount due for services furnished under Medicare statute and regulations.

UTN – Unique Tracking Number

CLAIM/PRE-CLAIM REVIEW CHECK LIST

1. Face to Face and physician's progress note from the encounter. In some cases, this could be the same document.

2. Any HHA-generated records (OASIS, SN Assessment, Therapy Evaluations and other required documentation that may be determined by the local Medicare Administrative Contractor (MAC)) that have been signed, dated, and incorporated into the certifying physician's medical records.

3. Established Plan of Care – If using the "485" form, it will cover item 4 if the form is signed and dated by the physician.

4. The signed and dated physician's certification of patient eligibility.

    Criteria 1 – Confined to the home
        Uses an AD for ambulation
        Requires special transportation
        Requires the assistance of another person
    OR
    The patient has a condition that makes leaving the home contraindicated.
        State the condition specified by MD that is contraindicated to leave.

    Criteria 2 – A normal inability to leave the home
        The patient has a condition that makes leaving the home contraindicated
        Leaving the home requires a considerable and taxing effort
            A structural impairment?
            A physical impairment?
            A functional impairment?
            An activity limitation?

References

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5. American Physical Therapy Association – Guidelines: Physical Therapy Documentation of Patient/Client Management BOD G03-05-16-41, https://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/BOD/Practice/DocumentationPatientCareMgmt.pdf