

Review Choice Demonstration is coming to Ohio September 30th, 2019 and hot on its heels is PDGM. The more prepared you are for all of the changes that come, the better poised your agency will be in the coming months and years.

The purpose of RCD is not to create any new documentation requirements, but more so to protect against the prevalent evidence of fraud and abuse identified by CMS in home health care. Medicare coverage polices are not changing, neither are the ABN policies, Claim appeal rights, and RAP processes (with the exception of PDGM changes effective 1/1/2020).

- There should be no delay in beneficiaries receiving services as services can begin prior to the submission of the pre-claim review request and continue while the decision is made.
- The pre-claim review request can be submitted for more than one episode for any single beneficiary and at any time during services.
- The claim must be submitted and reviewed with a correlating Unique Tracking Number (UTN) prior to submission of the final claim.
- A pre-claim review is not applicable for Resumptions of Care, only Start of Care and Recertification beginning the date of implementation for your State.

Have you Chosen your Path Yet?

HHAs will have until two weeks prior to the start of the demonstration in their State to make a choice selection. Your account administrator will be responsible for logging into the Palmetto GMA eServices portal to make your choice. If you do not proactively make a decision for your agency and appropriately register you will automatically be defaulted into Choice 2, you have until the night before the selection period ends to make the initial decision or changes to your Agency selection.

https://www.onlineproviderservices.com/ecx improvev2/initLogin.do

All agencies have three options to choose from, and they are Titled Option 1, 2 and 3.

- Pre-claim review of all claims
- Follows process implemented under the initial Pre-Claim Review Demonstration
- Allows for multiple episodes to be requested in one preclaim review request for a beneficiary
- Allows unlimited resubmissions for nonaffirmed requests

- Post payment review of all
- Follows current post payment medical review processes
- Default option is no selection is made

- Minimal review with payment reduction
- All home health claims receive a 25% payment reduction
- Claims are excluded from MAC targeted probe and educate review, but may be selected for Recovery Audit Contractor (RAC) review

Every 6 months the HHAs pre-claim affirmation rate or post payment review approval rate will be re-calculated and the Agency's compliance determines their next steps. If your agency score is less than 90%, or you have not submitted at least 10 request/ claims the HHA must again select from one of the three initial choices.

If your agency's rate is 90% or greater (based on a 10 request/claim minimum), you may select from one of the three subsequent review choices below; Choice 1, 4 or 5. Agencies that do not actively choose one of the subsequent options will be assigned to participate in Choice 4 and will remain there for the duration of the demonstration.

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- Selective post payment review
- Follows standard intake, service, and billing procedures, and the claims will pay according to normal claim process
- After 6 months, the MAC will select a statistically valid random samples (SVRS) from post payment review
- The MAC will send an ADR letter and follow CMS post payment review procedures
- The HHA will stay in this option for the remainder of the demonstration and will not have an opportunity to select a different choice later

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- Spot check review
- Follows the standard intake, service, and billing procedures
- The MAC will randomly select 5% of the submitted claims for prepayment review every 6 months
- The HHA may remain with this choice for the remainder of the demonstration as long as the spot check shows the HHA is compliant with Medicare rules
- If the HHA is not in compliance, the HHA must select again from one of the initial three review choices.

Providers in states where RCD is active will not be under TPE review and RCD at the same time. Providers currently under TPE review will be removed prior to CMS implementing RCD in that State.

<u>CMS has provided us with a Demonstration Process Flow Sheet.</u> as well as a <u>Review</u> <u>Decision Flowchart for reference</u>

RCD Best Practices

Expediting the processing time from referral to submission is going to be key with RCD. While there is no specific form required to submit, you are encouraged to use a checklist to ensure accuracy of each individual submission. CMS is encouraging providers to submit the RAP and allow it to process before submitting the pre-claim review request: this will allow the beneficiary record to open in the Common Working File and will ensure you have all of the required documentation to submit with the request.

- Timely initiation of care by the home health agency
- Timely referrals to therapy
- Completion of all discipline assessments within 48 hours of admission
- Supporting documentation that add on disciplines have contacted and scheduled with the patient within 48 hours from admission.
 - Any assessments outside of the 48 hours must be documented and for patient –driven reasons
- Timely completion of documentation by all clinical and office staff



HealthPRO® Heritage at Home's focus is in providing resources, education, and support to home health agencies preparing for RCD and PDGM, like this <u>RCD Checklist.</u>

Our experts are here to help you prepare, execute, and succeed. Contact us with your questions. Reach out to us for perspective: <u>homehealth@healthpro-heritage.com</u>

