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Medicare Home Health Payment Update: Florida and Other States are Required to Submit Their Home Health Claims for Pre-Claim Review

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The Centers for Medicare and Medicaid Services ("CMS") is implementing a new pre-claim review process for home health claims in five (5) states, including Florida. Other affected states are Illinois, Texas, Michigan, and Massachusetts. CMS' stated goal is to make sure home health services are medically necessary without delaying or disrupting patient care or access. The pre-claim review will begin in Florida no earlier than October 1, 2016 and the other states will be phased in during 2016 and 2017.

CMS claims this is necessary to help home health agencies avoid errors and to protect tax payer funds from fraud and abuse. In 2015, home health claims had an improper payment rate of 59%, mostly because of insufficient documentation. CMS also cites significant amounts of fraud in the home health industry in Florida and other states. CMS states that they would like to get away from their "pay and chase" approach where claims are paid and then recouped for fraud or error. This pre-claim review approach would focus on preventing fraud and mistakes before the claims are paid. In a parallel effort to fight fraud, on July 29, 2016, CMS announced that it is extending for six (6) months the temporary provider enrollment moratoria for home health agencies in Florida, Texas, Illinois, and Michigan and expanding the moratorium statewide in each of those states.

Under this process, once home health services are ordered by Medicare physicians, patients can receive home health services immediately. However, home health agencies will be required to submit supporting documentation while beneficiaries are receiving care before a formal claim for payment is submitted to CMS. Generally, home health agencies will be required to submit all of the documentation normally required for payment, but do so earlier in the process. If the documentation is sufficient, CMS will issue a positive decision and CMS will timely pay the claim according to the normal CMS claims process for home health services. Generally, a pre-claim review decision will be made within ten (10) days. If the documentation is not sufficient, then the home health agency may submit additional documentation to support the claim as many times as necessary in order to meet the billing requirements. Home health agencies will still be able to appeal final claim denials under the normal CMS appeals process. The pre-claim review process will apply to home health providers who provide services in Florida and other affected states, regardless of where the claims are submitted from.

A *de minimis* exception exists. If four (4) or fewer home health services are required by a beneficiary, the pre-claim review process is not required.

Beginning three (3) months after commencement of the pre-claim review process in each state, a penalty will be imposed on those home health providers who must use the pre-claim review process but fail to do so. Their claims will be automatically reduced by 25% if approved for payment. This payment reduction cannot be passed on to beneficiaries and is not subject to appeal.

Further, home health agencies cannot use advanced beneficiary notices ("ABN") to pass costs on to Medicare beneficiaries if denials occur under this pre-claim review process for lack of documentation or for a technical reason, such as the requirement for a face-to-face encounter. ABNs are only appropriate where the services are not medically reasonable or necessary; 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 these instances, if an ABN is timely provided at the beginning of the services, the home health provider may charge the Medicare beneficiary for uncovered costs.

Home health agencies in Florida and other affected states need to plan now for the pre-claim review process. Those who submit bills to Medicare for home health agencies should know the documentation requirements and obtain it immediately for submission with the pre-claim review process. Physicians and all those who interact with patients and their families need to be trained on proper documentation and timely submission to those responsible for billing. Providers should have a written ABN policy that all are educated on and follow. Finally, home health agencies should consider and plan for cash flow issues, such as by acquiring a line of credit. Even though CMS contends there should be no interruption in cash flow, the documentation requirements and timing of the pre-claim review process may still slow down payments.