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CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier/OMB Control Number CMS-10599
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: CMS-10599 Review Choice Demonstration for Home Health Services

Dear CMS Office of Strategic Operations and Regulatory Affairs Staff,

The Association of Home Care Coding and Compliance (AHCC), the national membership organization for home health coding and compliance professionals, together with the Board of Medical Specialty Coding and Compliance (BMSC), the credentialing arm of AHCC, appreciate the opportunity to comment on the Review Choice Demonstration Project.

The original Pre-Claim Review Demonstration Project caused many problems in Illinois due to operational issues. Reimbursement claims for legitimately necessary and compliantly supplied services were delayed and denied. There was a huge backlog of claims needing review that further delayed payment. As agencies worked to make corrections to their claims and processes, reviewers gave varying answers to the same questions. Overall, in the early weeks and months of the project, home health agencies struggled to receive payment for legitimate claims due to “technical” documentation errors that did not alter the patient's eligibility or medical need for the services. How will the new project address these issues?

In the end, it isn’t clear that the original project prevented the problem it was supposed to prevent – fraud. How will this project be different?

We understand that the new project will move agencies from 100% review to a “spot check” of their claims once they reach the target pre-claim review affirmation or post-payment review claim approval rate. What is the target affirmation or approval rate? We assume that it will be less than 100%, because 100% compliance is extremely difficult to achieve and, as noted above, many mistakes that would prevent a provider from achieving 100% compliance are technical issues that do not alter the eligibility or medical necessity for care. (Similar to the recently discontinued physician estimate of the need for continued care.). We suggest that 85% approval would be an appropriate and achievable goal.

Unfortunately, the publication provided few details regarding the mechanics of this process. One issue that will have a significant impact is the sample size or number of records that must be reviewed before the error rate can be determined. The larger this initial sample, the more burdensome this process will

be for providers who are not engaged in fraud, but simply trying to provide high quality care and comply with Medicare requirements.

Once a provider has completed the "initial assessment," it will be important to define the follow-up "spot check" to balance the burden on providers and the program's goals. If the spot checks are too frequent, the program will be functionally no different from the previous pre-claim review demonstration. It will also be important to carefully define the scope of records reviewed during the follow-up. We suggest an annual follow up of no more than 20 records will be a sufficient frequent probe to verify ongoing compliance.

When deciding whether to deny a claim, we believe the review should focus on core payment issues such as Medicare eligibility. If the goal is to avoid paying erroneous claims and/or identifying fraudulent claims, review should not focus on technical documentation issues, but on substantive issues that would call into question the legitimacy of the claim. For example, if there is no 485, that claim would not demonstrate the patient's eligibility and a denial would be appropriate. Or if there was a statement that therapy goals had been met, but therapy continued there would be a problem with the claim. Or if the description of the patient's home bound status was obviously deficient, there would be reason for questioning the claim. But if the issue is instead technically deficient face to face documentation for a patient who clearly had a face to face encounter with the physician, the claim should not be denied.

Finally, we hope that CMS will take into account the likelihood that this project will result in an increase in appeals. Given the already over-burdened Medicare appeals process, we hope the agency will examine the current appeals processes and make adjustments to accommodate increased requests. Providers should not have their rights to due process further burdened by additional appeals generated by a poorly conceived or implemented process.

Sincerely,
The Association of Home Care Coding and Compliance

Jan Milliman
Chief Executive Officer
Association of Home Care Coding and Compliance