Medicare Home Health Pre-Claim Review (PCR) Beneficiary Decision Letter

JOB AID

This resource illustrates the Medicare Home Health Pre-Claim Review (PCR) decision letter sent to the beneficiary receiving services from a home health provider in a PCR demonstration state. Refer to the Pre-Claim review Demonstration for Home Health Services web page at http://www.cgsmedicare.com/hhh/medreview/pre_claim_review_demo.html for additional information.

September 19, 2016

Provider's Name
Address Line 1
Address Line 2

MEDICARE Pre-Claim Review DECISION

UTN:	Medicare Beneficiary:	Dates of Service:	
12345678912345	XXXXXXXXXA	**From:** MMDDCCYY	**To:** MMDDCCYY

Dear Beneficiary's Name:

This letter is to inform you of the decision on a Home Health services Pre-Claim Review request submitted by your home health agency on your behalf. A pre-claim review request is information submitted by your home health agency for review to make sure coverage requirements are met for the services provided to you. You are receiving this letter because your home health agency submitted a pre-claim review request for the service (s) noted below in the Decision Summary section.

The pre-claim review decision is (Select one item from Table 1)

Table 1	
Affirmed.	Medicare coverage requirements were met for the services requested.
Non-Affirmed.	Medicare coverage requirements were not met for the services requested.

More information on the decision is provided below. If your request was not approved/ non-affirmed, and you or your home health agency have additional information to support your need for home health services, you or your home health agency may submit another pre-claim review request with the necessary documents for review.

Decision Summary

HCPCS Code	Decision	Rationale
HCPCS Code is selected from Table 2	**Decision is selected from Table 3**	**Rationale is selected from Table 4**

Table 2 - HCPCS Codes	
G0151	Physical therapist
G0152	Occupational therapist
G0153	Speech-therapist
G0155	Medical social services
G0156	Home health aide
G0157	Physical therapist assistant
G0158	Occupational therapist assistant
G0159	Physical therapy maintenance
G0160	Occupational therapy maintenance
G0161	Speech therapy maintenance
G0162	Skilled nursing; management and evaluation
G0163	RN, LPN; observation and assessment
G0164	RN, LPN; training/education
G0299	Skilled nurse
G0300	Licensed Practical Nurse

Table 3 - Decision
Provisionally Affirmed
Non-Affirmed

Table 4 - Rationale	
5HC01	The physician certification was invalid since the required face-to-face encounter was missing. Refer to CMS IOM Publication 100-02. Chapter 7. Section 30.5.1
5HC01	The physician certification was invalid since the required face-to-face encounter was untimely. Refer to CMS IOM Publication 100-02. Chapter 7. Section 30.5.1
5HC01	The physician certification was invalid since the required face-to-face encounter did not support homebound status. Refer to CMS IOM Publication 100-02. Chapter 7. Section 30.5.1 and 30.5.1.2 and 100-08, Chapter 6, Section 6.2.3

Table 4 - Rationale	
5HC01	The physician certification was invalid since the required face-to-face encounter did not support medical necessity. Refer to CMS IOM Publication 100-02. Chapter 7. Section 30.5.1 and 30.5.1.2 and 100-08, Chapter 6, Section 6.2.3,
5HC01	The physician certification was invalid since the required face-to-face encounter did not occur within the 90 days before or 30 days after the start of care. Refer to CMS IOM Publication 100-02. Chapter 7. Section 30.5.1.
5HC01	The physician certification was invalid since the certifying physician did not document the date of the face to face encounter. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.1
5HC01	The physician certification was invalid since the required face-to-face encounter was not performed by an allowed provider. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.1 and 30.5.1.1.
5HC01	The physician certification was invalid since the certifying physician did not identify the community physician who signed the plan of care. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.1.
5HC01	The physician certification was invalid since the required face-to-face encounter was not related to the primary reason for home care. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.1.
5HC01	The physician certification was invalid since the actual face-to-face encounter visit/clinical/progress note was not submitted. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.1 and 30.5.1.2
5HC02	Physician's plan of care and/or certification present - signed but signature dated untimely. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.2.3-30.2.4.
5HC03	Physician's plan of care and/or certification present - signed but signature is not dated. Refer to CMS IOM 100-02, Chapter 7, Section 30.2.3 -30.2.4
5HC04	Physician's plan of care and/or certification present - no signature or unable to authenticate signature. Refer to CMS IOM 100-02, Chapter 7, Section 30.2.3 -30.2.4
5HC05	Physician's plan of care and/or certification was missing or illegible. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.2
5HC06	Certification did not include all five elements of a valid certification. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.
5HC06	Certification missing. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.
5HC06	Certification invalid; acute/post-acute physician cert missing statement that plan of care was established and periodically reviewed; community MD cert missing F2F date. Refer to CMS IM Publication 100-02, Chapter 7, Section 30.5.
5HC07	Physician's Plan of Care missing one or more required contents. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.2
5HC07	Physician's Plan of Care missing. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.2
5HC08	The recertification estimate of how much longer skilled services are required is missing. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.2.
5HC08	The recertification estimate of how much longer skilled services are required defaulted to end of episode and/or was not realistic. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.2.
5HC09	The initial certification was missing, therefore the recertification episode is denied. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5, and 100-08, Chapter 6, Section 6.2.1
5HC09	The initial certification was incomplete or illegible, therefore the recertification episode is denied. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5, and 100-08, Chapter 6, Section 6.2.1
5HC09	The initial certification was untimely, therefore the recertification episode is denied. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5, and 100-08, Chapter 6, Section 6.2.1
5HC09	The initial certification was missing a required element, therefore the recertification episode is denied. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5, and 100-08, Chapter 6, Section 6.2.1
5HH01	Documentation submitted does not support homebound status. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.1

Table 4 - Rationale	
5HH02	Homebound status not met due to ineligible place of residence. Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.1.2
5HI05	Medicare will pay for daily skilled nursing care when the beneficiary needs care for a temporary, but not indefinite period. Refer to CMS IOM Publication 100-02, Chapter 7, Section 40.1.3
5HN01	Skilled observation was not needed from the start of care (SOC). Refer to CMS IOM Publication 100-02, Chapter 7, Section 40.1
5HN03	Documentation does not support why medication can't be self injected. Refer to CMS IOM Publication 100-02, Chapter 7, Section 40.1.2.4.
5HN04	Documentation does not support that Epogen administration was medically necessary. Refer to CMS IOM Publication 100-02, Chapter 7, Section 40.1.2.4.
5HN05	Documentation does not support why insulin can't be self injected. Refer to CMS IOM Publication 100-02, Chapter 7, Section 40.1.2.4.
5HN06	Vitamin B12 is not reasonable and necessary based on diagnosis. Refer to CMS IOM Publication 100-02, Chapter 7, Section 40.1.2.4.
5HN08	Documentation does not support that skilled management and evaluation (M&E) of care plan is reasonable and necessary. Refer to CMS IOM Publication 100-02, Chapter 7, Section 40.1.2.2.
5HN09	Monthly mediport flush without administration of medication is not medically necessary. Refer to CMS IOM Publication 100-02, Chapter 7, Section 40.1.2.4.
5HN10	Medicare requires that skilled observation is needed as long as there is reasonable potential for change in condition that requires skilled services. Refer to CMS IOM Publication 100-02, Chapter 7, Section 40.1.2.1.
5HN13	The Medicare program does not consider prefilling of insulin syringes to be a skilled nursing service. Refer to CMS IOM Publication 100-02, Chapter 7, Section 40.1.2.4.
5HN14	Based on the documentation submitted, the type of medication received is not accepted by Medicare as an effective treatment for the medical condition. Refer to CMS IOM Publication 100-02, Chapter 7, Section 40.1.2.4.

Who is Responsible for the Bill?

Medicare does not cover home health services unless all coverage requirements are met. This includes a requirement that such services are medically necessary. Generally, if your pre-claim review request is non- affirmed and you continue to receive home health services, you will not be financially liable for any denied claims. However, if your home care provider determines that based on Medicare's decision and the documentation they submitted that you do not meet Medicare guidelines for coverage; they may discharge you from care. If this should happen, your home care provider will provide you with information on options that are available to you.

If you have additional questions or want to report possible fraud, visit Medicare.gov or call 1.800.MEDICARE (1.800.633.4227).

Sincerely,

J15 Medical Review
CGS Administrators, LLC
A Medicare Contractor
Contractor Number-15004