Review Choice Demonstration Model

FAQ

Prepared for

myUnity Essentials Financial

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Background

After suspending the Pre-Claim Review for Illinois in 2017, CMS has now mandated the Review Choice Demonstration Model. HHAs will select from three initial choices:

• Pre-claim review

• Post-payment review

• Minimal post-payment review with a 25% payment reduction.

If a selection is not made during the choice selection period, agencies will be automatically placed in Choice 2: Post-payment. After a 6-month period, HHAs demonstrating compliance with Medicare rules through pre-claim review or post-payment review will have additional choices, including relief from most reviews except for a review of a small sample of claims.

Review Choice requirements were updated in August 2020 due to the COVID-19 Public Health Emergency. Refer to the following sites for details:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Choice-Demonstration/Review-Choice-Demonstration-for-Home-Health-Services

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Choice-Demonstration/Downloads/RCD-Operational-Guide.pdf

Claim Setup

Go to **Billing > Electronic Claims**.

In the **Option Set** dropdown, choose the **Medicare PPS** option set. Click the **Options** button to access the Billing Option Wizard. Click **Copy**. In the **Destination ID** field, enter an unused ID number. In the **Description** field, add phrase to differentiate it from original set, for example “with UTN.” Click **OK**.

Follow the above steps for any other option sets that may require the UTN (example MSP, Medicare Demand, etc.).

Close and reopen Electronic Claims.

Select the newly created **Medicare UTN** option set in the Option Set dropdown.

Click **Options** button to access the Billing Option Wizard and using the Locator dropdown, make the following selections:

2300.50 REF*G1 Treatment Authorization Codes: Authorization (Non-PPS Auth or PPS UTN)

2300.51 REF*G1 Treatment Authorization Edit: Error (No Claim) When Treatment Authorization Missing (Default).

Press **Save** when done.

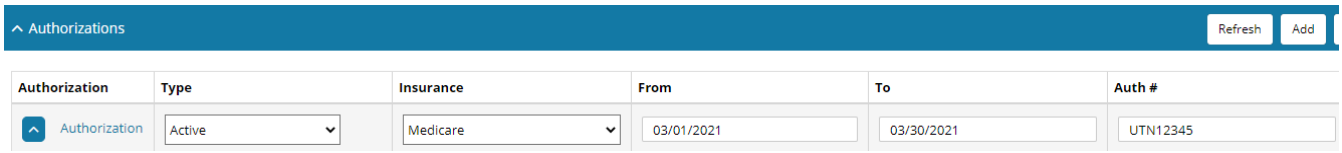
Repeat these steps all other newly created Medicare UTN option sets (i.e. MSP UTN, Medicare Demand UTN, etc.).

When using these new option sets, PPS Final claims generated without a valid UTN will show as failures on the Electronic Submission Report and these claims will not pull to the claim file. If it is determined the claim does not require the UTN (for example the claim is prior to the review choice period or is a LUPA for a billing period that begins prior to 4/1/2020), use the original non-UTN option set to generate the claim.

Entering the UTN

In the Clinical Patient Schedule, add an Authorization for the patient for the Medicare insurance. Enter the 30-day period with that period's UTN from Medicare.

If your agency has decided to always select RCD Choice #1 and Authorization Required has been set in the Insurance library for Medicare, the Insurance must be set to Medicare when entering the authorization.

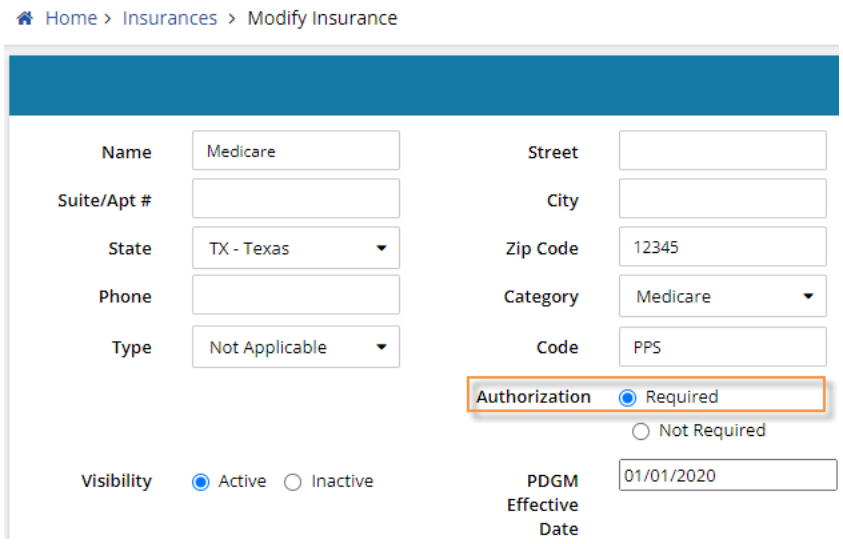


Note, for PPS periods prior to 2020, in the Authorization-# field enter "POC" followed by the UTN assigned by Medicare. Entering "POC" is *not* required for PDGM claims, but if entered it will not have adverse effects on claim output.

Authorization detail (Discipline, Billing Code, Authorized #, etc.) should *not* be entered.

Tracking Missing UTNs

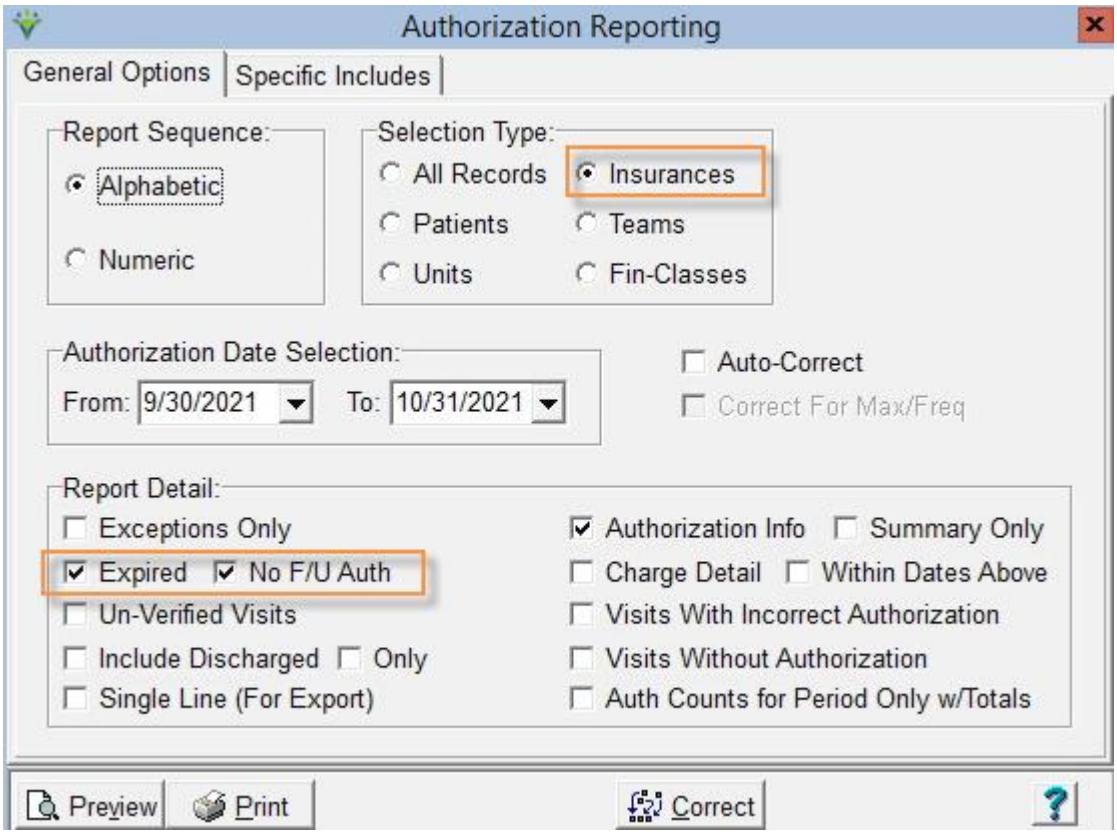
Agencies that chose Choice 1 (the pre-claim review) and plan to *always* obtain the UTN for all their Medicare patients should have Medicare configured as Authorization Required in Clinical.



The **Billing Pre-Audit** for Finals will fail for “Required authorization UTN has not been entered” when Medicare is configured to require authorizations and an authorization record is not present for the billing period. If an agency has Authorization Required selected for Medicare and they have a claim they wish to submit without the UTN, they must enter “**No Auth Req**” as the authorization number to bypass the Billing Pre-Audit edits.

Agencies that have *not* selected Choice 1 for perpetuity can set Medicare Authorization to ‘Not Required’. These agencies have the option of entering “**UTN REQ**” as a placeholder in the Authorization Number field to keep track of periods where the UTN has not yet been obtained. The **Billing Pre-Audit** for Finals will fail for “Required authorization UTN has not been entered” when this entry is found in the Authorization Number field. This failure will not occur if the authorization is missing.

The **Authorizations Report** can be run selecting the Medicare insurance to track patients with expiring/expired UTN authorization records:



Sample Authorizations Report:

11/1/2021 1:06:01 PM
Alphabetic Sequence
Select Insurances

Authorizations Report

Expiring/No-F/U From:9/30/2021 To:10/31/2021

Page 1
Home & Hospice Care Services

Start/End	Type	Freq	Basis	Period	Duration	Authorized	Actual	(O)ver/(U)nder	Charge
Abbington, Abigail - 131753			Admit: 8/7/2020				Prim-Ins: Medicare		
9/1/2021	**9/30/2021**		#: 1548798797987987						
							0.00	0.00	
				Admit Totals:		0.00	0.00	0.00	
Activity, Tess - 224			Admit: 5/18/2021				Prim-Ins: Medicare		
9/15/2021	**10/14/2021**		#: utn45555666						
							0.00	0.00	
				Admit Totals:		0.00	0.00	0.00	

Grand Totals: **Authorized:** 0.00 **Actual:** 0.00 **Over/Under:** 0.00