Home Health Line Fact Sheet

Review Choice Demonstration basics

CMS plans to expand its Review Choice Demonstration (RCD) for home health agencies in California beginning in early 2027. This will be the seventh state participating and the first under Wellpoint Federal as the Medicare Administrative Contractor (MAC). Here are some basics to keep in mind about RCD and the popular pre-claim review option.

Initial review choices

When entering the demonstration, agencies must choose between two review pathways.

Pre-claim review: Agencies submit documentation for an affirmation for each 30-day period prior to billing. Periods that are unaffirmed can be resubmitted.

Post-payment review: Claims are billed and paid normally, then all claims are pulled for a post-payment audit. Failure to comply or respond within 45 days results in overpayment recoupment.

90% compliance after six months

After demonstrating compliance, agencies have a choice among three review pathways.

Pre-claim review: Continued 100% pre-claim submission.

Selective post-payment review: A random sample of claims is audited every six months.

Spot check review: A small percentage of claims is randomly audited every cycle

Pre-claim review

Documentation must show the patient is:

- Confined to the home at the time of services, such that:
  - There exists a normal inability to leave the home and leaving home requires a considerable and taxing effort.
  - Additionally, because of illness or injury, the patient needs the aid of supportive devices, the use or special transportation or the assistance of another person to leave their home ***OR*** the patient has a condition such that leaving the home is medically contraindicated.
- Under the care of a physician or allowed practitioner.
- Receiving services under a plan of care established and periodically reviewed by a physician or allowed practitioner.
- In need of skilled services.
- Had a face-to-face encounter with an allowed medical provider that occurred no more than 90 days prior to or 30 days after the start of care and was related to the primary reason the patient requires home health services.

If a pre-claim request is non-affirmed:

- The MAC will send a decision letter to the agency that includes all the reasons a non-affirmed decision was reached. The beneficiary will also receive a copy of the decision letter.
- For non-affirmed decisions due to documentation errors where the beneficiary seems to have otherwise met Medicare coverage criteria, the MAC will also call the agency to provide individualized education on the reasons for the non-affirmed decision and encourage the agency to resubmit the request as soon as possible.
- The submitter may resubmit another complete package with all documentation required as noted in the decision letter.
- If the claim is submitted to the MAC for payment with a non-affirmed pre-claim review decision, it will be denied.

Source: CMS, *RCD for Home Health Services Operational Guide*

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