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Penalty for Delayed Request for Anticipated Payment (RAP) Submission -- Implementation

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Implementation Date: January 4, 2021

Note: We revised this article to reflect the revised CR 11855. The revised CR changed the principal diagnosis code reporting instructions in Chapter 10, Section 40.1 and the service date reporting instructions in Chapter 10, Section 40.2 of the Medicare Claims Processing Manual. These changes make sure claims successfully match their corresponding RAP. We show these changes in red print on page 4. We also changed the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for Home Health Agencies (HHAs) who wish to bill Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article informs you about the implementation of the Calendar Year (CY) 2021 Home Health (HH) Request for Anticipated Payment (RAP) payment policies. Please be sure your billing staffs are aware of these changes.

BACKGROUND

Section 1895(b)(2) of the Social Security Act (the Act), as amended by Section 51001(a) of the Bipartisan Budget Act of 2018 (BBA of 2018), requires Medicare to change the unit of payment under the Home Health Prospective Payment System (HH PPS) from 60 days to 30 days.

- Under the HH PPS, Medicare makes a split-percentage payment for most 60-day episodes/30-day periods of care.
- The first payment is made in response to a RAP submitted at the beginning of the episode/period of care and a second payment is made in response to a final claim submitted at the end of the 60-day episode/30-day period of care.
- Added together, the first and second payment equal 100 percent of the permissible payment for the episode/30-day period.

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The RAP also serves a greater operational role for the Medicare program by establishing the beneficiary's primary HHA in the Common Working File (CWF), so that the claims processing system can reject claims from providers or suppliers, other than the primary HHA, for the services and items subject to consolidated billing.

In the CY 2019 HH PPS final rule with comment period, the Centers for Medicare & Medicaid Services (CMS) finalized that HHAs certified for participation in Medicare effective on or after January 1, 2019 (newly enrolled), will not receive split-percentage payments beginning in CY 2020 (83 FR 56463). Those HHAs are still required to submit a RAP at the beginning of a period of care in order to establish the HH period of care, as well as every 30 days thereafter, but no payment will be associated with the RAP submission.

In the CY 2020 HH PPS final rule with comment period, CMS finalized that HHAs that were certified for participation in Medicare with effective dates prior to January 1, 2019 (existing HHAs), would continue to receive split-percentage payments upon implementation of the Patient-Driven Groupings Model (PDGM) and the change to a 30-day unit of payment in CY 2020, but the up-front payment would be decreased from 60/50 percent to 20 percent (84 FR 60548).

Starting in CY 2021, the split-percentage payment would be lowered to 0 percent for all HHAs (newly enrolled and existing). However, all HHAs would still be required to submit a RAP at the beginning of each 30-day period of care (84 FR 60548). Since no payment will be associated with the submission of the RAP in CY 2021, HHAs are to submit the RAP when:

1. The appropriate physician’s written or verbal order that sets out the services required for the initial visit has been received and documented as required at 42 Code of Federal Regulations (CFR) Sections 484.60(b) and 409.43(d); and
2. The initial visit within the 60-day certification period has been made and the individual is admitted to HH care (84 FR 60548)

The information needed for submission of the RAP in CY 2021 will mirror the one-time Notice of Admission (NOA) process, also finalized in the CY 2020 HH PPS final rule with comment period, starting in CY 2022 (84 FR 60549).

In instances where the plan of care dictates multiple 30-day periods of care will be required to effectively treat the beneficiary, HHAs will be allowed to submit RAPs for both the first and second 30-day periods of care (for a 60-day certification) at the same time to help further reduce provider administrative burden (84 FR 60549).

Also for CY 2021, there will be a non-timely submission payment reduction when the HHA does not submit the RAP within 5 calendar days from the start of care date (“admission date” and “from date” on the claim will match the start of care date) for the first 30-day period of care in a 60-day certification period and within 5 calendar days of the “from date” for the second 30-day period of care in the 60-day certification period.

This reduction in payment will be equal to a 1/30th reduction to the wage and case-mix adjusted 30-day period payment amount for each day from the HH start of care date/admission date, or “from date” for subsequent 30-day periods, until the date the HHA submits the RAP. The 1/30th reduction would be to the 30-day period payment amount, including any outlier payment, that

the HHA otherwise would have received absent any reduction.

For Low Utilization Payment Adjustment (LUPA) 30-day periods of care in which an HHA fails to submit a timely RAP, no LUPA per-visit payments would be made for visits that occurred on days that fall within the period of care prior to the submission of the RAP. The payment reduction cannot exceed the total payment of the claim. The payment reduction for the late submission of a RAP can be waived for exceptional circumstances as outlined in regulations at 42 CFR 484.205(i)(3).

HHAs should note that MACs will

- Report the following remittance advice messages for the late submission payment reduction in the Claim Level CAS segment (loop 2100) on Home Health Claims on the 835 ERA
    - Group Code: CO
    - Claim Adjustment Reason Code (CARC): 95 ("Plan procedures not followed")
- Report the following remittance advice messages for the late submission payment reduction in the Claim Level CAS segment (Loop 2320) on Home Health Claims to the 837I COB
    - Group Code: CO
    - CARC: 95 ("Plan procedures not followed")

MACs will accept the KX modifier when reported with the Health Insurance Prospective Payment System (HIPPS) code on the revenue code 0023 line of Type of Bill (TOB) 032x (other than 0322 and 0320) as an indicator that an HHA requests an exception to the late RAP penalty. The HHA should provide sufficient information in the Remarks section of its claim to allow the MAC to research the exception request. If the remarks are not sufficient, the MAC will request documentation from the HHA.

The four circumstances that may qualify the HHA for an exception to the consequences of filing the RAP more than 5 calendar days after the HH period of care From date are as follows:

1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate
2. An event that produces a data filing problem due to a CMS or MAC systems issue that is beyond the control of the HHA
3. A newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC
4. Other circumstances determined by the MAC or CMS to be beyond the control of the HHA.

Other items of note for HHAs are:

- Value codes 61 and 85 are optional for RAPs with "From" dates on and after January 1, 2021
- Other Diagnosis Codes are optional for RAPs with "From" dates on and after January 1, 2021

Principal Diagnosis Code Reporting
For "From" dates on or after January 1, 2021, the RAP may contain any valid diagnosis code, in order to facilitate timely submission. Since these RAPs aren't paid, the accurate principal diagnosis code that supports payment is needed only on the claim for the period of care.

Service Date Reporting
For initial episodes/periods of care, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode/period. For subsequent episodes, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode/period, regardless of whether the visit was covered or non-covered, unless the HHA submitted the corresponding RAP using the first day of the period of care as the service date on the 0023 line. In that case, the HHA reports a service date on the 0023 revenue code line that matches the date submitted on the RAP. This is necessary to make sure Medicare systems can correctly match the claim to the RAP during processing.

A new exception applies when submitting RAPs for all subsequent periods of care in calendar year 2021. The HHA may submit these RAPs with the first day of the period of care as the service date on the 0023 line. This will allow for the submission of RAPs for two 30-day periods of care immediately after the start of a 60-day certification period. It will also prevent delaying the submission of the RAP for subsequent periods when the first visit in that period would be beyond the 5-day timeframe for a timely-filed RAP.

Remarks
Conditional – If the RAP that corresponds to a claim was filed late and the HHA is requesting an exception to the late-filing penalty (see section 40.1 of the manual revision of CR 11855), enter information supporting the exception category that applied to the RAP.

If the RAP that corresponds to a claim was originally received timely but the RAP was canceled and resubmitted to correct an error, enter remarks to indicate this condition, (for example, "Timely RAP, cancel and rebill"). Append modifier KX to the HIPPS code reported on the revenue code 0023 line. HHAs should resubmit corrected RAPs promptly (generally within 2 business days of canceling the original RAP).

Remarks are otherwise required only in cases where the claim is cancelled or adjusted.

ADDITIONAL INFORMATION

The official instruction, CR 11855, issued to your MAC regarding this change, is available at https://www.cms.gov/files/document/r10696CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
April 1, 2021	We revised this article to reflect the revised CR 11855. The revised CR changed the principal diagnosis code reporting instructions in Chapter 10, Section 40.1 and the service date reporting instructions in Chapter 10, Section 40.2 of the Medicare Claims Processing Manual. These changes make sure claims successfully match their corresponding RAP. We show these changes in red print on page 4. We also changed the CR release date, transmittal number, and the web address of the CR. All other information remains the same.
October 27, 2020	We revised this article to reflect the revised CR 11855 issued on October 27, 2020. The CR revision added remittance advice message information and we added that information to the article. We also changed the CR release date, transmittal number, and the web address of the CR. All other information remains the same.
September 25, 2020	We revised this article to reflect the revised CR 11855 issued on September 24, 2020. The CR revision changed Service Date reporting instructions in Chapter 10, section 40.1 and instructions for Remarks in section 40.2 of the manual attachment of the CR. We included those instructions in this article. We also changed the CR release date, transmittal number, and the web address of the CR. All other information remains the same.
July 31, 2020	Initial article released.