No-Pay RAP Management

Rule summary

With the removal of the upfront RAP payment for CY 2021, the required information for submitting the RAP for CY 2021 has been relaxed to only require:

- The appropriate physician's written or verbal order that sets out the services required.
- The initial visit within the 60-day certification period must have been made, and the individual admitted to home health care.

CMS finalized lowering of the up-front payment for a RAP to 0% for all 30-day periods of care beginning on or after January 1, 2021. If the HHA does not submit the RAP within five calendar days from the start of care, the reduction in payment will be equal to a 1/30th reduction of the 30-day period payment amount each day from the home health start of care date until the date the HHA submitted the RAP.

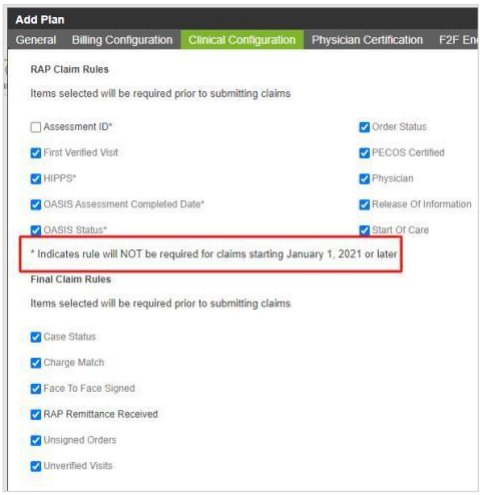
Application changes

Updates only apply where Payer-Plan Type is Medicare – traditional fee for service and the Reimbursement Type is PDGM (in billing configuration).

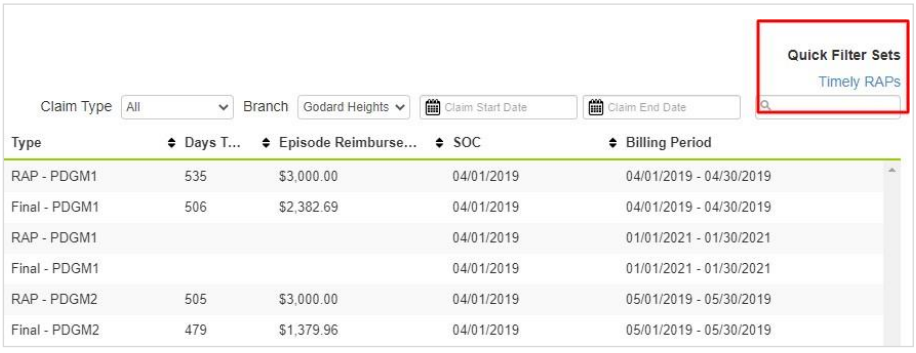
- Both RAP claims will be created at the point of first reviewed appointment.
- Clinical rules for RAP claims will require Release of Information, Start of Care Date, and a PECOS certified Physician.
- Clinical rules for OASIS and Plan of Care Order Status will be applied to Final claims. The Claims Console and Agency Billing queue will display these rules with the Final claims.
- Claim details if an OASIS is not completed:
    - HIPPS and Revenue codes will have default values of 1AA11 and 0023
    - FIPS and CBSA codes will be blank, as they are not required
    - Primary Diagnosis will be pulled from the patient chart
    - Reimbursement amount will be $0
- Rejection rules for no OASIS and missing/invalid FIPS code will not be applied to RAPs.
- Electronic and paper claim forms have been updated to accommodate rule changes.

- Late payment penalty for RAPs submitted after 5 days will NOT be calculated.
- Agencies that were formed after 2020 do not receive RAP payments. Since Home Health Care is already handling no-pay RAPs for these agencies, no changes were required for the payment/remit process.
- New No-pay RAP dashboard to track RAPs that need to be submitted or created. Criteria will include patients that have:
    - Case record in Open or Intake that requires Orders
    - Traditional Medicare Payer-Plan
    - A 2021 PDGM RAP claim that has been created but not submitted (this can be the 1st or 2nd RAP in an episode) OR
    - No PDGM RAP claim in the last 25 days OR
    - No PDGM RAP claim in the next 30 days

  Dashboard will include Patient, Start of Care Date, signed date of Admission Order, Primary Diagnosis, RAP Start date and Branch.
- New Claim rules on payer/plan setup to support rule changes



- A new filter on the Claims console allows users to filter for Timely RAPs (shows Days to Bill >= 3 days)



Type	Days T...	Episode Reimburse...	SOC	Billing Period
RAP - PDGM1	535	$3,000.00	04/01/2019	04/01/2019 - 04/30/2019
Final - PDGM1	506	$2,382.69	04/01/2019	04/01/2019 - 04/30/2019
RAP - PDGM1			04/01/2019	01/01/2021 - 01/30/2021
Final - PDGM1			04/01/2019	01/01/2021 - 01/30/2021
RAP - PDGM2	505	$3,000.00	04/01/2019	05/01/2019 - 05/30/2019
Final - PDGM2	479	$1,379.96	04/01/2019	05/01/2019 - 05/30/2019

Suggested process

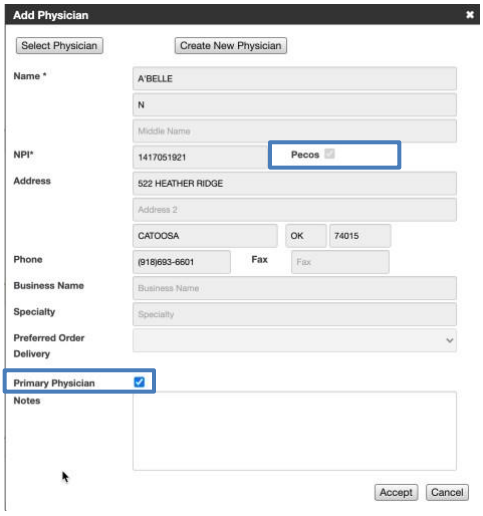
To avoid payment reductions, agencies should monitor RAP completion to ensure RAPs are submitted within five calendar days from the start of care. This section covers tips for monitoring your RAPs for timely submission.

Important Tips

- We recommend that the first signature on SOC or Recert documentation be completed as soon as possible so that your agency can submit the RAP in a timely way.
- When the first visit is verified, the system generates both RAPs (for both 30-day billing periods) with the autogenerated HIPPS code (as recommended by CMS). If your agency cannot verify the first visit within five days of SOC, you will need to generate RAPs manually to submit them in a timely way. See Manually generating a RAP.
- If your agency has trouble completing the Start of Care and QA process within the required 5-day period, you might consider deactivating the Hold on Incomplete Documentation option for services. This may help speed up the process for completion of the First Verified Visit. See Deactivate Hold Appointment on Incomplete Document option on SOC service section, below.

Procedure

1. While entering Intake information, be sure to enter the payer and the primary physician. Check that the physician is Pecos certified and checked as Primary Physician.



2. After Intake, go to the patient's chart and enter the primary diagnosis as received from the referring provider. Entering a primary diagnosis at intake ensures the RAP will not be rejected. (Navigate to the patient's chart and go to Case Details > Diagnosis. Select Edit and click Add to enter the diagnosis.)

3. Create an Admission Order using the procedure in Appendix A.

4. Check the **Release of Information** box in the patient chart as soon as your agency's procedures allow.

5. Monitor the **No-Pay RAPs dashboard** and **Claims Console** for completion of RAP requirements.

Items to track on No-Pay RAPS dashboard

	If information is missing
Start of Care	Verify that the clinician has completed the SOC visit, then go to Case Details > Case Details and select Edit. Enter the SOC date. To enter the Cert Period, go to Case Details > Cert Period. Click Add to enter the Cert Period.
Admission Order Date	Create admission order using procedure in Appendix.
Primary Diagnosis	Case Details > Diagnosis. Select Edit and click Add to enter the diagnosis.
RAP Start date	Manually generate the RAP. See Manually generating a RAP.

Tips:

- When a RAP is submitted, the patient is removed from the dashboard.
- The dashboard displays 2021 PDGM RAP claims that has been created but not submitted (this can be the 1st for 2nd RAP in an episode). For example, RAP 1 might have been submitted in 2020, and RAP 2 starts in 2021. In this case, the patient appears on the dashboard even though the episode started in 2020.

Items to track on Claims Console

	If information is missing
First Verified Visit	If the First Verified Visit is red on the claims console, verify a visit already occurred, or will be occurring, in the 30-day period. **Tip:** CMS requires you to verify a first visit before submitting a RAP, but if the Home Health Care system does not indicate the first visit is complete, and you are aware a clinician completed the first visit, you can manually generate RAPs. See **If your agency cannot finish RAP requirements on time**.
Physician	Information may be in the chart but not yet indicated on the Claims console. If the Claims Console indicates the information is missing (⚠), go to Client Details > Medical Professionals and confirm the MD is entered and Primary has a green checkmark. **Tip**: Physician and Pecos information generally do not appear as a green check until the Assessment is through QA and is signed. Best

	practice is to use Client Details > Medical Professionals information for verification.
PECOS Certified	Information may be in the chart but not yet indicated on the Claims console. If the Claims Console indicates the information is missing (⚠), go to Client Details > Medical Professionals and select Edit. Verify Pecos is checked. **Tip**: Physician and Pecos information generally do not appear as a green check until the Assessment is through QA and is signed. Best practice is to use Client Details > Medical Professionals information for verification.
Start of Care	Verify that the clinician has completed the SOC visit, then go to Case Details > Case Details and select Edit. Enter the SOC date. To enter the Cert Period, go to Case Details > Cert Period. Click Add to enter the Cert Period.
Release of Information	Go to the Case Details tab and check the Release of Information box.

6. When RAP requirements are complete, notify your agency biller that the RAP is ready for submission.

   Tip: You can submit RAPs for both billing periods simultaneously (per CSM recommendations).

If your agency cannot finish RAP requirements on time

For some agencies, it may be challenging for some agencies to review the first appointment within the required five-day window for submission. It may be necessary to generate RAPs manually or adjust documentation completion rules.

Manually generating a RAP

RAPs are autogenerated after the first appointment is reviewed. Use the following procedure to manually generate a RAP if you have not reviewed the first appointment within the required 5-day period.

Note: You will need to generate RAPs for both PDGM 1 and PDGM 2.

Procedure

1. From the Billing queue, click **Add New Claim**.
2. Select the patient.

3. Specify the RAP for the **Claim Type** and select the **Certification Period**.

4. Click **Accept**.

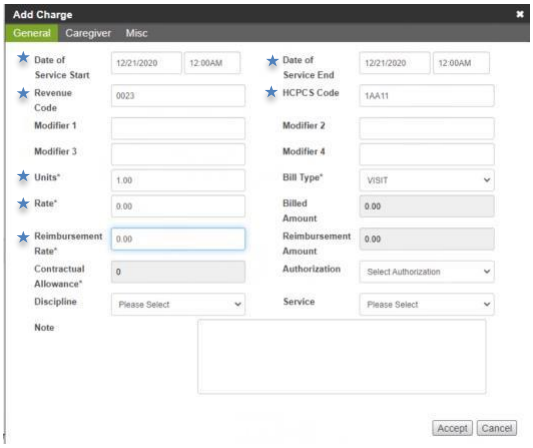
5. Review the generated RAP. Note that the system DOES NOT place the default HIPPS code on the generated RAP. You must add the generic HIPPS code to the manually created RAP.

   To enter the generic HIPPS code:

   a. Scroll down and click **Add Charge**.

   b. Enter the following:

Date of Service Start and End	For RAP 1, enter the first day of the 30 day pay period (time 12:00 am); for RAP 2, enter the first day of the second billing period (time 12:00 am).
Revenue code	OO23
Generic HCPCS code	1AA11
Units	1.00
Rate	0.00
Reimbursement Rate	0.00



   c. Click **Accept**. Note that the RAP now includes the generic HIPPS code (HCPCS)

6. Repeat the same process for RAP 2, being sure to include the first date of service for the second billing period.

Deactivate Hold Appointment on Incomplete Document option on SOC service

If your agency has trouble completing the Start of Care documentation and QA process within the required 5-day period, you might consider deactivating the **Hold Appointment on Incomplete Documentation** rule for the start of care service.

Procedure

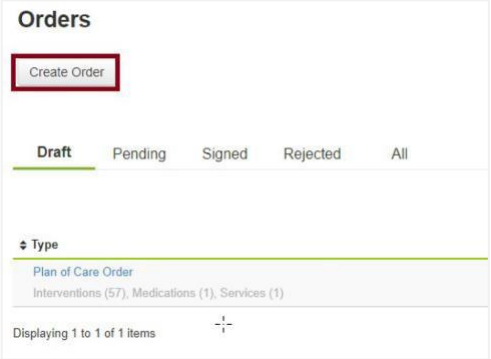
1. With Admin user privileges, go to **Administration > Services**.
2. For your start of care document, click **Edit**.
3. On the Billing tab, uncheck **Hold Appointment on Incomplete Documentation**. This allows you to review the appointment so that the RAP can be generated.
4. Click **Accept**.

Appendix A: Creating an Admission Order

Use the following procedure to create and manage an Admission order.

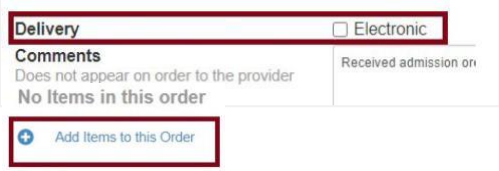
Procedure

1. Enter the admission items into the patient's record. (Medications, Interventions or Services)
2. From the Orders tab, select **Create Order**.



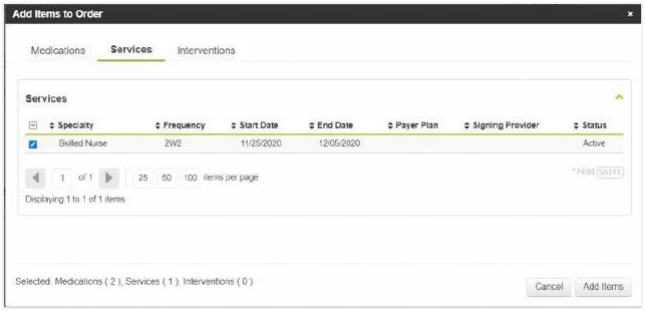
3. Select **Order Type: Admission.**

4. Uncheck the option to **Deliver Electronic**. Note: this will prevent the order from going to Forcura.



5. Select **Add Items to this Order**.

6. Select the admission items and click **Add Items**.

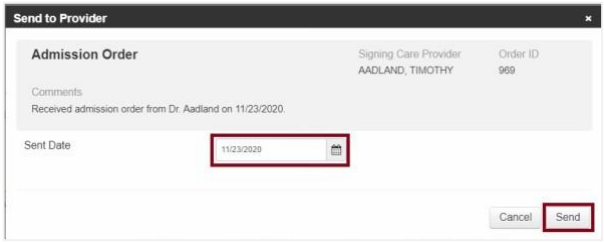


7. Sign the Admission Order.

8. Go to the Pending Order List.

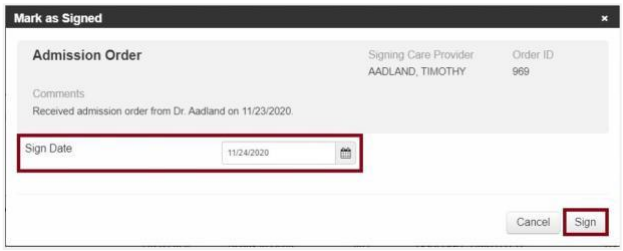
9. Set the Admission Order to **Send to Provider**.

10. Enter the **Sent Date** as the date the admission order was received and click **Send**.



11. Set the Admission Order to **Signed by Provider**.

12. Set the **Signed Date** and click **Sign**.



Appendix B: Frequently Asked Questions

The following Frequently Asked Questions were presented by BlackTree HealthCare Consulting during our PointClickCare No-Pay RAP User Group and Webinar sessions. With the permission of BlackTree Consulting, we are presenting them here for your reference.

Q: Do you need just one RAP for each admission?

A: No, you need a RAP for each payment period.

Q: Do the new RAP rules apply to patients admitted prior to 2021 who cross over into the new year?

A: Yes. The new RAP rule applies to all periods starting on or after January 1, 2021, including those subsequent periods for patients admitted in 2020 or before.

Q: Is the new submission rule five calendar days or five business days?

A: Five **calendar** days, including weekends and holidays. Keep in mind January 1, 2021 is a Friday so Monday, January 4 will be day 3 for those 1/1/21 payment periods.

Q: Does the OASIS need to be completed and locked in order to submit the RAP?

A: No, the OASIS does not need to be locked in order to bill the RAP. BlackTree recommends billing all RAPs and final claims with the same generic HIPPS code.

Q: If you bill with a generic HIPPS code, how will Medicare know what HIPPS code the claim should pay at?

A: Medicare's payment grouper is based on the diagnosis codes on the claim (for Clinical Grouping and Comorbidity Adjustment), the OASIS answers from OASIS submitted to iQIES (for Functional Impairment Score), and Common Working File (for Source and Timing) to generate the appropriate paid HIPPS code

Q: Do I need a first billable visit to bill the 2nd RAP?

A: No. You do not need a billable visit to bill the 2nd RAP – just bill the 0023 HIPPS line date equal to the period start date

Q: How do I bill the 0023 HIPPS line for 2nd period final claims?

A: 2nd period final claims will still have the first billable visit as the 0023 HIPPS line date (in some instances it may not match the RAP HIPPS line which is allowed)

Q: Do I need to cancel the 2nd RAP if the patient is discharged prior to the subsequent 30-day period?

A: No, you do not. RAPs auto-cancel rules will no longer apply since there is no money to recover (CR 11855)

Q: Do the no-RAP LUPA rules still apply?

A: You do not need to bill a RAP for LUPAs. However, this approach is not recommended. Predicting LUPAs is often difficult and even if you are anticipating a LUPA and enough visits are performed to make a full HIPPS payment you face significant payment penalties.

If a RAP is submitted late and the claim is a LUPA, 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.

Q: How are Saturday/Sunday submissions handled in determining timeliness?

A: Electronic claims received on a weekend or holiday are marked as received on the actual calendar date of receipt.

Q: Is the new RAP rule the same as the Notice Of Admission (NOA) rule?

A: No, the NOA rule doesn't begin until January 1, 2022. The NOA is a one-time submission that establishes the home health period of care and covers all contiguous 30-day periods of care until discharge.

Q: Do I need a timely RAP if I'm billing MSP?

A: Yes. If your EMR doesn't allow for billing of RAPs in MSP situations, BlackTree recommends to key the RAP directly into DDE.

Q: What if I don't have an acceptable primary diagnosis code at intake?

A: It is BlackTree's recommendation to use the same generic, valid primary diagnosis code in the rare instance a valid primary diagnosis code is not available at intake.

Q: How long will the RAPs take to process and "pay"?

A: According to CMS, the RAPs should be processed "immediately in an on-line session in DDE, the following day for batch submissions". This would be much shorter than the typical 5-7 days processing time for today's RAPs.

Q: Can I submit subsequent RAP today for subsequent periods starting in January?

A: No. MACs will be able to accept new RAPs starting on January 4, 2021.

Q: How do I file an exception?

A: To request an exception, enter information supporting the circumstance that applies to the RAP in the REMARKS field on the Claim (page 4). For example, if the RAP to a claim was originally received timely but the RAP was canceled and resubmitted to correct an error, enter in the REMARKS field "Timely RAP, cancel and rebill". Add 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).*

*Source: CGS website

Q. Is the "from" date on the RAP counted as day 1 or day 0?

A. The count for the 5-day time frame begins with the "from" date on the RAP as day 0. In the Medicare Claims Processing Manual, chapter 10, 40.1, CMS states "… within 5 calendar days **after** the "from" date of a HH period of care." *CMS has confirmed this information for NAHC.*

Q. If the OASIS assessment is not completed prior to the submitting the RAP, how will the HHA determine which HIPPS code is assigned to revenue code 0023?

A. If the OASIS assessment is not completed in time to establish a HIPPS code for the RAP/claim, HHAs may report any valid HIPPS code on the RAP and claim. The amount paid on the claim will be based on inputs from the Medicare system and not the HIPPS code reported on the claim. *CMS confirmed for NAHC that HHAs may use any default HIPPS code for the RAP/claim.*

Q. I understand that the HIPPS code on the RAP and claim must match.

A. Correct, the HIPPS code on the RAP and the claim must match in order to facilitate matching that claim to the corresponding RAP. However, as noted in the previous answer, any valid HIPPS code may be reported on the RAP and claim.

Q. Agencies may not be able to file the RAP timely if there is not a visit scheduled within the first 5 days of the "from" date of the subsequent period or recertification episode. How are agencies able to comply with the timely submission criteria.

A. CMS will permit the "from" date on the RAP to be the service date associated with revenue code 0023. This will prevent delaying the submission of the RAP for subsequent periods, including recertification episodes, when the first visit in that period would be beyond the 5-day timeframe.

Q. Will there be a problem with claims processing if the first service date on the RAP is different than the first services date on the claim.

A. CMS is removing the edit to allow the first service date on the RAP to not have to match the first service date on the claim.

Q. How does the No RAP LUPA policy fit in with No Pay RAP policy?

A. Per CMS, it is unchanged. If the claim is a LUPA and there is no corresponding RAP, the claim will pay normally, and no penalty will be applied. But, if the agency bills the RAP, it will still be held to the 5-day RAP rules and penalty, even if the episode turned out to be a LUPA.

Q. What happens to the RAP penalty if you do not learn about an insurance change from another plan to Medicare until weeks or months afterward?

A. Delays related to an insurance change that could not be known in time should be an exception to the penalty. However, the burden of proof will be on the agency.

Q. If the hospitalist does the initial referral for the first admission visit, but another physician certifies the Plan of Care – can the physician differ between the RAP and the Final?

A. There should not be any processing issues if the physician does not match on the RAP/final. However, the general rule should be to include the certifying physician on the RAP where possible. The one issue we've seen is if the physician is changed following an initial PECOS denial. In some of these cases, the final claim has been rejected upon resubmission.

Q. If there is a penalty for late submissions of RAPs – how will that be reflected on the remit? Is there a special adjustment code? Also, could you clarify whether a RAP must be submitted or admitted to avoid incurring a penalty?

MLN article 11855 (https://www.cms.gov/files/document/MM11855.pdf - also attached) provides some detail on these issues.

On the top of page 3, there is guidance on how late payments will appear in the ERA. We reviewed both this MLN article and the final rule language, and both indicate the penalty is on submission of the RAP. That said, our recommendation is still for agencies to approach this as submitted and accepted.

Note: We base our recommendations on approaching this rule as submitted and accepted on our experience with hospice NOEs. We have encountered scenarios where NOEs are submitted on day 5 but not accepted until day 6, and the final claim is initially short paid due to the penalty. In most scenarios, agencies can submit exceptions to receive the full payment, but this results in delays in cash flow and extra follow-up needed from billers. Also, we've had cases where Medicare stuck to their denials and never issued payment.