The "No Pay RAP" Fact Sheet and Frequently Asked Questions

What is the No pay RAP: Beginning January 1, 2021 home health agencies (HHAs) will be required to submit a request for anticipated payment (RAP) that will be paid at 0%, prior to each claim.

Purpose: The No-Pay RAP will be used to update the Medicare Common Working File to enforce the home health consolidated billing rules. The No Pay RAP will be replaced with the Notice of Admission (NOA) in 2022.

Criteria for submission: 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 in regulation at 42 CFR 484.60(b) and 42 CFR 409.43(d);

(2) the initial visit within the 60-day certification period must have been made and the individual admitted to home health care.

With the implementation of the No pay Rap HHAs will longer be required to complete the following processes prior to submitting the RAP.
• An OASIS assessment that is complete, locked or export ready,
• A plan of care has been established and sent to the physician

Contents of the No Pay RAP: The only changes to the information required on the RAP in 2021 are that two value codes (61 and 85) and other diagnosis codes are now optional.

Penalty: The No Pay RAP must be submitted and accepted into the system within 5 calendar days after the start of care date for the first 30-day period of care in a 60-day certification period and within 5 calendar days after the "from date" for the second 30-day period of care in the 60-day certification period.

Penalty rate: 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 home health "from date" until the date the HHA submits the RAP.

- Applies to outlier payments
- Applies to Low Utilization Payments Adjustments (LUPAs)
    - 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
    - The LUPA payment reduction cannot exceed the total payment of the claim

Exceptions to the penalty: HHAs may request an exception which, if approved, waives the consequences of late filing. The following four circumstances meet the criteria for a late submission penalty.

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 A/B MAC (HHH) 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 A/B MAC (HHH).
4. Other circumstances determined by the A/B MAC (HHH) or CMS to be beyond the control of the HHA.

To request an exception:

- Enter in the "remarks" section of the claim the condition for the exception
- Append modifier KX to the HIPPS code reported on the revenue code 0023 line
- The Medicare Administrative Contractors (MACs) may request documentation from the HHA to support its request for an exception to waive of the consequences of late filing of a RAP when the KX modifier on the revenue code 0023 line is reported on the claim.

Working with your vendor:

The following question may be helpful when working with your vendors.

1. Has the vendor modified the workflow within the EHR to permit the RAP to be submitted in accord with the new criteria and within 5 days beginning on January1, 2021
2. If your vendor has not completed the updates when will they be completed?
3. How will the agency's operations need to be altered?
4. Will the agency have access to reports for compliance analytics and management?
5. What is the anticipated learning curve for staff to work with the changes in the HER and operations?

FAQs

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? Also, 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. And, the OASIS assessment might not be completed in time to establish a HIPPS code for the RAP/claim. However, 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 any default HIPPS code may be used for the RAP/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 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. What happens if timely submitted RAP is later canceled and resubmitted. How does this impact a timely RAP submission?

A . The RAP will still be considered timely, but since the original receipt date is lost when the original RAP was cancelled, the corresponding claim would need to be submitted requesting an exception. This was in the recent correction to CR 11855:

> 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, (e.g., "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).

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 afterwards?

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. See below from the 2020 CY HHPPS rate update final rule.

> Comment: A commenter stated their concerns regarding the how the NOA policy would apply in situations where beneficiaries have a Medicare Advantage Plan but changes coverage to traditional Medicare during open enrollment or when the patient qualifies for a special enrollment while receiving home health services under an existing plan of care.
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> Response: In this scenario, the HHA would likely fall into one of the established timely filing exceptions for NOAs. To pursue this potential exception, the HHA would file for an exception with their MAC to request a waiver of the timely filing requirement associated with submitting the NOA. If the MAC determines that the circumstance meets the criteria for an exception, the HHA would receive the full 30-day payment amount despite filing the NOA more than 5 calendar days after the start of care:

References:

Medicare Claims Processing Manual, Chapter 10, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf .

Change Request 11855 https://www.cms.gov/files/document/r10369cp.pdf

Medicare and Medicaid Programs; CY 2020 Home Health Prospective Payment System Rate Update, Final rule. https://www.govinfo.gov/content/pkg/FR-2019-11-08/pdf/2019-24026.pdf