RAP – Request for Anticipated Payment 2021

Beginning 1/1/2021 the Request for Anticipated Payment (RAP) will no longer have a 20% payment associated with its processing. The RAP will continue to be a requirement for payment, but will be associated with a penalty if it is not accepted at the Medicare Administrative Contractor (MAC) by Day 5, the begin date of the payment period being Day 0.

What is Required Prior to Filing a RAP?

You are required to have TWO documented prior to submitting a RAP in 2021:

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 home health care [84 FR 60548].

Excerpt from MLN Matters: MM11855 – "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 [in 2020 and prior], 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 an exception applies. ***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."

What is Required Content on the RAP?

CGS Medicare has a detail list of the Line Item requirements for billing a RAP.

Following is a list of the key things to note for 2021:

• Value Codes – ***BOTH OF THESE ARE OPTIONAL IN 2021*** 61-CBSA Code & 85 – FIPS code

• HCPCs – HIPPS Code – ***this should be a standard HIPPS code that the EMR will generate – there will be NO payment associated with this HIPPS code***.

• Service Date – ***January 2021 and later the agency may submit the FIRST DAY of the period of care as the Service Date on the 0023 revenue code line.***

• Diagnosis Code – ***one single diagnosis is required January 2021 and later with secondary diagnoses being completely optional.***

Accepted vs. Sent

The date that the Medicare MAC marks the RAP as received is the ONLY date that matters. The RAP will not be marked received on the same day that you send if you are sending an 837 electronic claims file. This means that you will need to allow a minimum of 24 hours for it to be marked received in the MAC system. Also, understand that this is 5 calendar days – NOT 5 business days. Agencies should prevent transmitting on the 5th day and instead directly key the RAP into DDE so that it will be marked received on the same day.

Penalty Application

If the RAP is not received within 5 days of the beginning of the 30-day period the penalty will apply to all days from the start date to the day before the RAP is received. Remembering, as stated earlier, the first calendar day of the period is Day 0 in the count.

30-DAY PAYMENT PERIOD 01/03/21 – 02/01/21

RAP accepted at MAC on 01/20/21 – HIPPS Code value $2,800 – When final is paid the agency will receive the following payment:

- 1. $2,800 divided by 30 = $93.33 per day
  2. $93.33 X 17 days = **$1,586.67 = Penalty**
  3. $2,800 – $1,586.67 = **$1,213.33 = Adjusted Payment**

Filing Multiple RAPs at the Same Time

In cases where the plan of care dictates that multiple 30-day periods of care will be required to effectively treat the patient, agencies will be allowed to submit RAPs for both the first and second 30-day periods of care at the same time to help further reduce provider administrative burden. Ensure that in the case of recertification's there is an order to recertify the patient prior to the submission of the RAPs.

RAPs and LUPAs For Low Utilization Payment Adjustment (LUPA) 30-day periods of care in which an agency 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.

Requesting Exception for Late RAP

There are four circumstances that may qualify the agency for an exception to the payment penalty for RAPs accepted more than five calendar days after the home health period of care.

They are:

1. Fires, floods, earthquakes or other unusual events that inflict extensive damage to the agency's ability to operate

2. An event that produces a data-filing problem due to a CMS or MAC system issue that is beyond the control of the agencies A newly
3. Medicare-certified agency 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 agency

Under these exceptions, the MACs will accept the “KX” modifier when reported with the HIPPS code on the revenue code “0023 line” of the FINAL CLAIM as an indicator that an agency requests an exception to the late RAP penalty. In addition, the agency should provide sufficient information in the remarks section of its claim to allow the MAC to apply the exception request. If adequate information is not provided the MAC will request the additional information through a NON-Medical ADR.