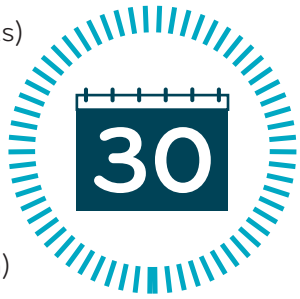
Submitting a Request for Anticipated Payment Under the Home Health Patient-Driven Groupings Model

The home health Patient-Driven Groupings Model (PDGM) was effective for requests for anticipated payment (RAPs) with a "from" date on or after January 1, 2020 (CMS-1689-FC). This changed the payment from 60-day episodes of care to 30-day periods of care. This job aid provides guidance on submitting a RAP under HH PDGM and information on additional changes to RAPs in 2021.

When to Submit a RAP

RAPs are submitted at the beginning of each 30-day period. Home health agencies (HHAs) newly enrolled in Medicare on or after January 1, 2019, must submit a no-pay RAP at the beginning of each 30-day period.



Starting in 2021, all HHAs (newly enrolled and existing) will be required to submit a RAP at the beginning of each 30-day period of care. When multiple 30-day periods of care are ordered based on the plan of care, HHAs may submit both the RAP for the first 30-day period of care and the RAP for the second 30-day period of care (for a 60-day certification) at the same time.

RAPs are submitted when:

- Appropriate physician's written or verbal order, that sets out the services required for the initial visit, has been received and documented as required
- Initial visit within the 60-day certification period has been made and individual is admitted to home health care

When No Visits Are Expected

If no visits are expected during a 30-day period of care, you must submit a RAP for all 30-day periods with the first day of the period of care as the service date on the revenue code 0023 line. This ensures the HHA is shown in the Common Working File (CWF) as the primary HHA for the beneficiary and ensures that home health consolidated billing is enforced (MLN Matters® Number: MM11527).

Inpatient Stays Spanning the End of a 30-day Period

Discharging the beneficiary is not required if they had an inpatient stay that spans the end of the first 30-day period of care in a certification period. You must submit the RAP and claim for the period following the inpatient discharge as if the 30-day periods were contiguous – submit a "from" date of day 31, even though it falls during the inpatient stay and the first visit date that occurs after the hospital discharge (MLN Matters® Number: MM11527).

Split Percentage Payment

For RAPs with "from" dates on or after January 1, 2020, a split percentage payment is made for the initial and subsequent periods of care. The first payment in response to the RAP is 20 percent. The second payment in response to the final claim is 80 percent. HHAs newly enrolled in Medicare on or after January 1, 2019, will not receive split percentage payments beginning in 2020 (SE19005).

For RAPs with "from" dates on or after January 1, 2021, the up-front split percentage payment for all 30-day periods of care will be lowered to zero for all HHAs (newly enrolled and existing).

Canceled RAP Payment

For RAPs with a "from" date prior to 2021, the RAP payment will be canceled automatically by Medicare if the final claim is not submitted 60 days after the calculated end date of the period of care (day 90) or 60 days after the paid date of the RAP (whichever is greater). RAPs with a "from" date on or after January 1, 2021 will not auto-cancel. The RAP for the second 30-day billing period would not need to be canceled by the HHA because the RAP-only record remaining in the Common Working File (CWF) will not trigger consolidated billing edits.

In addition, in cases when no visits are made during a 30-day period of care, the RAP will be auto-canceled to recover the payment (MLN Matters® Number: MM11527).

Untimely Submission of RAPs (Effective January 1, 2021)

Starting in 2021, a payment reduction will apply when the HHA does not submit the RAP within five calendar days from the start of care date ("admission date" and "from date" on claim will match start of care date) for the first 30-day period of care in a 60-day certification period, and within five calendar days of the "from date" for the second 30-day period of care in the 60-day certification period.

The payment reduction will be equal to a 1/30th reduction to the 30-day period payment amount for each day from the home health start of care date/admission date, or "from date" for subsequent 30-day periods, until the date the HHA submits the RAP.

Low Utilization Payment Adjustment (LUPA)

An HHA may decide not to submit a RAP if they know in advance that the period of care will result in a no-RAP low utilization payment adjustment (LUPA). However, under PDGM, LUPA thresholds range between two and six visits. Therefore, it is more challenging to predict when a period of care results in a LUPA.

Effective January 1, 2021, if a RAP is submitted and is untimely, no LUPA per-visit payments would be made for visits that occurred on days that fall within the time period of care prior to RAP submission. However, if a RAP is not submitted, and your claim is processed as a no-RAP LUPA, no penalty will apply. The payment reduction cannot exceed the total claim payment.

Requesting an Exception for an Untimely RAP Submission

An HHA may request an exception if the RAP is filed more than five calendar days after the period of care. There are four circumstances that may qualify for an exception:

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

To request an exception, enter information supporting the circumstance (listed above) that applies to the RAP in the REMARKS field on the claim (FISS claim page 04). Do not request an exception on the RAP. For example, if the RAP to a claim was originally received timely, but the RAP was canceled and resubmitted to correct an error, enter "Timely RAP, cancel and rebill" in the REMARKS field. Add modifier KX to the Health Insurance Prospective Payment System (HIPPS) code reported on the revenue code 0023 line. HHAs should resubmit corrected RAPs promptly (generally within two business days of canceling the original RAP).

If the information provided in the REMARKS field is not clear, Palmetto GBA will request documentation by generating a non-medical review additional development request (non-MR ADR). HHAs will need to submit documentation supporting the exception request. When a non-MR ADR is generated, the claim will be moved to status/location S B6001.