PDGM Billing 2021

FAQ

Prepared for

myUnity Essentials Financial

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Overview

This document highlights the billing changes in myUnity Essentials for Medicare and Medicare Advantage payers for billing periods beginning on or after 1/1/2021.

What to Know

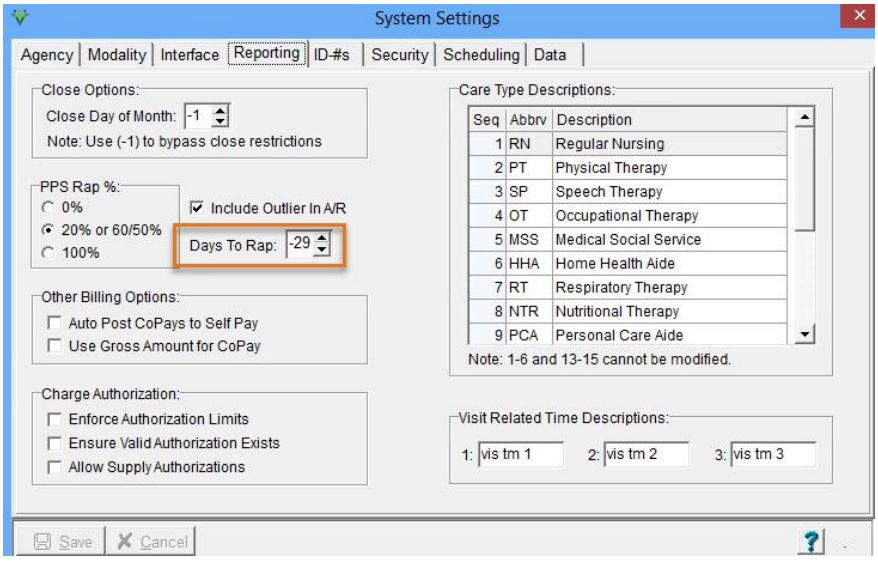
- For billing Periods starting 1/1/2021 or later, RAPs not submitted/accepted within 5 calendar days after the start of each 30-day period of care will incur a payment reduction equal to 1/30th of the payment amount for each day from the period start date until the date the RAP was accepted. This applies to MSP RAPs as well.
- RAPs pay 0% of final payment for all 30-day periods of care beginning on or after 1/1/2021 (applies to all Home Health agencies).
- Medicare allows RAPs for the second 30-day billing period within a certification period to be submitted on the certification start date. myUnity Essentials Financial allows billing it as early as day 2 of the cert period to ensure unique Bill Dates are used.
- For LUPA periods in which the RAP isn't submitted timely, 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.
- HIPPS code submitted on RAP and Final claim must still match.
- RAPs for 2021 will not auto cancel in DDE (since no payment received).
- MACs will be implementing these changes on Monday, 1/4/2021.
- If the 485 and/or OASIS are not present when the RAP is dropped, a default HIPPS code of 1AA11 will be billed on the RAP and Final claim for that period.
- The Billing Pre-Audit/Audit posting process will automatically regroup the HIPPS for periods billed with 1AA11 once the 485 and OASIS are present. The HIPPS gets regrouped for accurate reporting (A/R, revenue and LUPAs); a new RAP does not need to be generated or submitted to Medicare for this situation.
- Medicare Advantage payers are not required to follow PDGM billing rules. Contact your payers for guidance on their billing requirements for CY 2021. You can move the payer's PDGM start forward to 1/1/2022 via the Insurance tab of File > File Maintenance > Entity.

Days to RAP

The **Days to RAP** setting in **File > File Maintenance > System Settings** on the **Reporting** tab has been repurposed to allow for entering the number of days prior to the Period 2 Start Date that a RAP can be generated. A value of 0 up to -29 (negative 29) can be entered. For example, to bill a Period 2 RAP 29 days prior to the period start date, enter -29 (negative 29). To bill a Period 2 RAP 1 day prior to the period start date, enter -1 (negative 1).

Note: If value is kept at 0, RAP requirements will remain as in prior years and a 485 (not a Verbal Order), a locked OASIS and a verified billable visit will be required to allow the creation of the RAP and is NOT recommended as this can lead to late RAP penalties.

For PDGM prior to 2021, this field was used to enter the number of days into the billing period before auto-generation of the RAP with no billable visit was allowed. The Periods of Care with No Visits Expected section of this FAQ provides detailed on how to bill them.



Billing Process

These changes apply only to billing periods starting 1/1/2021 and later, regardless of the certification start date. Verbal Orders referenced below are generated from the Clinical RAP Notice Verbal Order form in Clinical.

Start of Care RAPs

The Billing Pre-Audit now allows the Start of Care Period 1 RAP to be generated for admitted patients with the following:

- Verbal Order (marked Complete) or 485 with primary diagnosis present in the Billing Module.
- Billable visit on file in the Billing Module (does not have to be marked complete/verified).
- Note, the OASIS does not have to be present in Billing in order to RAP the period.

Recertification RAPs

RAPs for re-certification Period 1 can be billed with the following:

- Verbal Order (marked Complete), 485 or Change Order with primary diagnosis code present in Billing.
- Recert Period 1 RAPs can be billed starting on the Period 1 start date (the Certification Start Date), but not prior to that.
- Note, the OASIS does not have to be present in Billing in order to RAP the period.

Period 2 RAPs

- Period 2 RAPs can be billed prior to the period Start Date. Medicare allows RAPs for the *second* 30-day billing period within a certification period to be submitted as early as the certification start date. myUnity Essentials Financial allows billing it as early as day 2 of the cert period to ensure unique Bill Dates are used. Agencies can set how many days in advance they want to generate the RAP for the second 30-day billing period in **File > File Maintenance > System Settings** via the **Reporting** tab (-29 **Days to RAP** is the max days allowed). Do not change the setting until 1/4/2021 or later as MACs are not updating their systems until that date!

Note: You must use a report To Date up to 29 days into the future when running the Billing Pre-Audit for RAPs in order to capture Period 2 RAPs that can be generated early.

MSP RAPs

MSP RAPs must also be submitted with 5 calendar days after the start of each 30-day period or a payment reduction will be incurred. Review the MSP FAQ for updated instructions, which includes running the Patient > Patient List report daily to identify MSP patients who may need a RAP billed. It is highly recommended to submit these RAPs via DDE to avoid a late penalty.

Late RAP Exceptions

Per CMS, "For purposes of determining if a 'no-pay' RAP is timely-filed, the 'no-pay' RAP must be submitted within 5 calendar days after the start of each 30-day period of care. For example, if the start of care for the first 30-day period is January 1, 2021, the 'no-pay' RAP would be considered timely-filed if it is submitted on or before January 6, 2021.

Example:

1/1/2021 = Day 0 (start of the first 30-day period of care)
1/6/2021 = Day 5 (A 'no-pay' RAP submitted on or before this date would be considered 'timely-filed'.)
1/7/2021 and after = Day 6 and beyond (A 'no-pay' RAP submitted on and after this date will trigger the penalty.)"

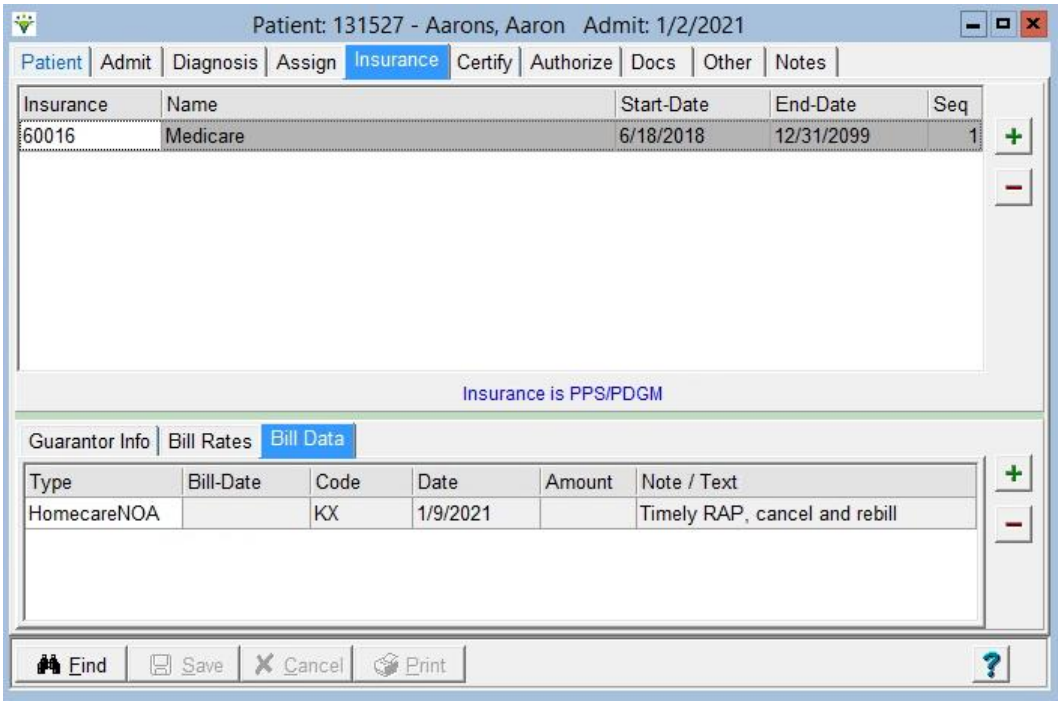
Late RAP exception reasons are listed at https://www.cms.gov/files/document/mm11855.pdf.

If requesting an exception for late submission/acceptance, the KX modifier and Bill Note should be added to that period's Final claim. The information can be added at any time prior to generating the Electronic Final Claim.

To do this, go to the **Patient** file **Insurance** tab and click on the **Bill Data** tab. Press **+** to add a new row (a separate row can be added for each RAP submitted late, if more than one).

Type: HomecareNOA

Bill-Date: leave blank
Code: enter KX (must be in all caps)
Date: enter a date within the billing period
Amount: leave blank
Note: enter the reason for requesting a late exception



Sample Electronic Claim Submission Report for claim with Late NOA with an exception:

12/21/2020 10:27:09 AM
0150 - Medicare Elec Claims - 5010

Electronic Claim Submission
Finals Billed From: 1/31/2021 - 1/31/2021
Final2021.x12

Institutional Page 1
Home Health Care Services

Patient #	Patient Name	Admit Date	Bill Date	Bill Type	Payor
131527	Aarons, Aaron	1/2/2021	1/2/2021	Final: 1/31/2021	Medicare

Adm-Src: 1 Status: 30 Period-1 From: 01/02/2021 To: 01/31/2021 Contract: 1E64TE4MK72
TOB: 329 Unit: 01 Statement From: 01/02/2021 To: 01/31/2021
Diagnosis: 1:I11.0 2:R53.1 3:R50.81
Values: 1:41740 2:85*06073.00 Occurrences: 1:50:01/02/2021
Order-Doctor: Jason Alexander 1234567890 Refer-Doctor: Aaron Aarons 1234567890
Bill-Notes: Timely RAP, cancel and rebill

Rev	Description	Code	Date	Units	Hours	Amount	Other
0023	Home Health Services	1AA11	01/02/21	1		0.00	KX
0551G0299	Sn Admission	Snadm	01/02/21	4	1.00	200.00	G0299
0551G0299	Sn Admission	Q5001	01/02/21	1	0.00	0.01	Q5001
0001	Total Charges			5		200.01	

Grand Totals:
Patients: 1 **Claims:** 1 **Charges:** 200.01 **Errors:** 0

LUPAs

Billing reports for LUPA thresholds will not reflect an accurate threshold until the 485 and OASIS are present and the period has been automatically regrouped during a Billing Pre-Audit/Audit post process.

For LUPA periods in which the RAP isn't submitted timely, 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.

HIPPS Scoring & Reports

If no 485 or OASIS are present in Billing when a RAP is ready to be billed, a default HIPPS code of 1AA11 will be used instead. The HIPPS will subsequently be automatically regrouped by the Billing Pre-Audit/Audit post routine once both items (485 and OASIS) have been completed and posted from Clinical. Periods meeting the criteria will not be shown in the run, but the regrouped HIPPS will be reflected on PPS reports at that point. The original billed HIPPS will continue to pull to RAP and Final claims so that they match in order to meet claim billing requirements.

Billing reports for LUPA thresholds will not reflect an accurate threshold until the 485 and OASIS are present and the period has been automatically regrouped by the Billing Pre-Audit/Audit posting process. This is because the information needed to generate the true HIPPS and EEP amounts are not available until that point.

The **PPS Revenue Report** will not begin earning days until the period is regrouped with a valid HIPPS via the Billing Pre-Audit/Audit posting process or the Period Start Date has begun (whichever is later).

PPS Activity Report

When the PPS Activity Report is run for Days to RAP, patients who have a period 2 RAP billed but do not have a discharge date or a subsequent certification period on file will show in red. If these patients are continuing service, they need a Diagnosis Export done from Clinical as soon as possible to avoid a penalty for late RAP submission/acceptance. If they have been discharged, their discharge date and reason need to be sent from Clinical.

If running the report for RAPs not Done to see what hasn't been RAP-billed for period 2, you will need to run the report using a To Date up to 29 days into the future to capture those periods.

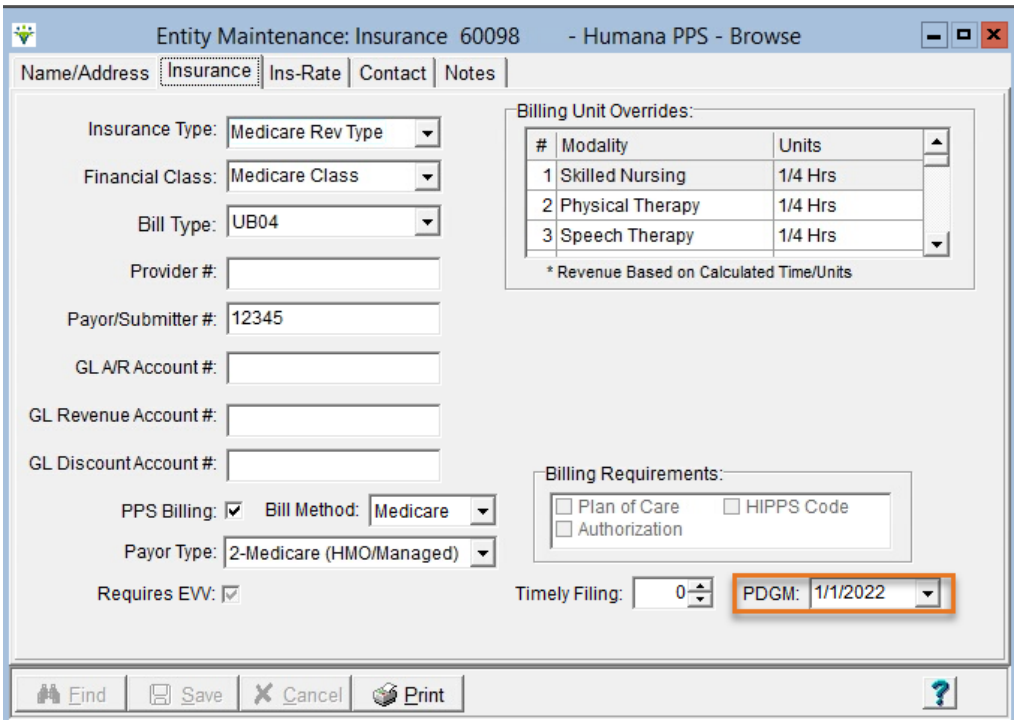
Periods of Care with No Visits Expected

The **Days to RAP** setting in **File > File Maintenance > System Settings** has been repurposed to allow early billing of period 2 RAPs for billing periods beginning 1/1/2021. If your agency has billing periods started in 2020 where no visits are expected, the RAP has not yet been generated and the current date is now 1/1/2021 or later, you will need to follow the steps below to get the RAP to generate without a billable visit:

1. Go to **Charge > Enter/Maintain** and enter a Billable Visit to prevent the Billing Pre-Audit Failure for "No valid charge found." Once the Billing Pre-Audit and Billing Audit are run and posted, the billable visit can be deleted from **Charge > Enter/Maintain**.
2. Generate the RAP under **Billing > Electronic Claims**.
3. Run and post the Final Pre-Audit and Audit as usual when the period comes to an end. The Final claim in Billing > Electronic Claims will have the exception message "Negative-Charges, No-Charges, or No-Units Found." This failure can be ignored since the Final does not get submitted to Medicare for no-visit periods.

Medicare Advantage Payers

Contact your Medicare Advantage payers to confirm their billing requirements for claim periods beginning on or after 1/1/21. Billing of PPS HIPPS codes in myUnity Essentials has been extended through 12/31/2021. If needed, change the **PDGM** start date in your insurance file under **File > File Maintenance > Entity** via the **Insurance** tab for any payers who are reimbursing using the PPS method instead of PDGM. Once PDGM billing has been posted, this date cannot be changed back to an earlier date without un-billing and inactivating all PDGM claims for that payer.



With myUnity Essentials version 1.2.8.75 and higher, for MA payers not accepting the default 1AA11 HIPPS or early RAPs, a new checkbox has been added to the Billing Pre-Audit report for "No Early Initial Claims." When checked, Period 2 RAPs will not generate prior to the period start date and no RAPs will generate until a valid 485, OASIS and verified billable visit are present. This ensures the RAP and Final are both submitted with a matching non-default HIPPS code for reimbursement. Its recommended to create a Report Group if using this setting.

Medicare Implementation Date

MACs will be implementing these changes on Monday, 1/4/2021.

Helpful Links

CMS Final Rule:

https://www.cms.gov/medicaremedicare-fee-service-paymenthomehealthppshome-health-prospective-payment-system-regulations/cms-1730-f