PUBLICATION

CMS Transmittal Instructions Issued to MACs to Prevent Misuse of RAP Requests

December 13, 2018

On October 26, 2018, CMS published Transmittal 839 (Change Request 10789) in the Medicare Program Integrity Manual (Pub. 100-08, Chapter 4/4.5 – 4/4.5.5). This Transmittal is meant to convey instructions to Medicare Administrative Contractors (MACs) on claims payment and monitoring obligations to detect and prevent misuse of Requests for Anticipated Payments (RAPs).

The Government Accountability Office published a report in February 2009 addressing improper payments in home health. In recent years, CMS and contractor initiatives have been implemented to review claims payments, and to ferret out improper payments and protect the integrity of Program funds. This is one of those initiatives. It provides steps for education, warnings, corrective action, RAP suppression and referral to the Unified Program Integrity Contractor (UPIC) when there is a misuse by a home health agency.

This Transmittal rescinds Transmittal 817 and replaces it with new instructions for home health agency misuse of RAPs. RAPs were implemented in October 2000 when payment moved to the Prospective Payment Model. While a RAP is not considered a claim for purposes of Medicare regulations, it is submitted using the same format as Medicare claims. CMS is always concerned with the accuracy of claims payments.

Under the Home Health Prospective Payment System (HH PPS), a RAP and a final claim are submitted for each 60-day episode period. See, 42 C.F.R. 484.205. Medicare makes a split percentage payment for most HH PPS episode periods. The first payment is in response to a processed RAP, and the last is in response to a processed final claim. If the final claim is not received 120 days after the start date of the episode or 60 days after the paid date of the RAP (whichever is greater), the RAP payment will be canceled automatically by the Fiscal Intermediary Standard System (FISS).

It is instructive to home health agencies seeking guidance as to use of RAP payments implemented in October 2000 and designed to ensure home health agencies have sufficient cash flow. This provides instruction for the regulations 42 C.F.R. 484.205 and 42 C.F.R. 409.43(c)(2) (regarding authority to reduce or disapprove a RAP) and Pub 100-02 Medicare Benefit Policy Manual, Chapter 7 Section 10.6 authority to reduce or disapprove RAPs.

Home health agencies can be proactive in conducting internal pre-claim submission reviews to identify errors in RAP claim submissions. For assistance, please contact any member of Baker Donelson's Reimbursement Team.