HOME HEALTH

Revenue round-up: Eliminate revenue loss from No-pay RAP and beyond.

Expert tips for effective revenue cycle management.

HEALTHCARE *first* by ResMed

Describing 2020 as a challenging year for home health agencies is an understatement. With the transition to the patient-driven groupings model and then a pandemic, this industry has experienced some of the biggest changes in decades.

Some of the more significant changes have affected the delivery of care, which has resulted in increased use of telecommunications technology. The increased use of telehealth is helpful and may offset some labor costs while promoting a consistent care plan. But without reimbursement for these technologies, it is still a delicate balancing act for home health providers.

Additional trends and payment changes that may impact agencies include the national increase in LUPA over the past year and wage index changes based on patient's residence. The latter could be so significant, that the Centers for Medicare and Medicaid (CMS) has capped any reduction at five percent.

But the No-pay RAP—perhaps the most substantial change of all—has garnered the attention of many agencies, as it can have significant effects on revenue cycle management.

In this eBook, industry experts weigh in on these transitions with tips on how to prevent revenue leakage in 2021 and beyond.

Notable No-pay RAP requirements to consider.

In CY 2021, home health agencies are required to submit a No-pay RAP at the beginning of every 30-day period of care, as the RAP serves an operational role for the Medicare program by notifying the common working file system that a beneficiary is under a home health period of care. Since payment is no longer associated with RAP submission, the Centers for Medicare and Medicaid Services (CMS) has relaxed the documentation requirements for submission, which means agencies can submit as soon as they have the order for the initial visit, the initial visit has been made, and the patient is admitted to care.

Agencies are no longer required to wait for comprehensive assessments, nor for the care plan to be completed, to drop their RAPs. Both the first- and second-period RAPs can be submitted at the same time, further promoting reduced administrative burden and timely submission.

More No-pay RAP requirements to consider:

- Only the primary diagnosis is required on the RAP—while it doesn't need to match the final, it needs to be a valid diagnosis that generates the clinical grouping under PDGM (other diagnoses are optional).
- Any valid PDGM HIPPS code can be submitted on the RAP, however, the HIPPS code MUST match on both the RAP and final claim.
- Adoption of PDGM is optional for Medicare Advantage plans, and some MA plans may still utilize a PPS-like payer model.

Along with the five-day RAP submission requirement, there's also a non-timely submission payment reduction when the RAP is not submitted and accepted within five calendar days.

Notable No-pay RAP requirements to consider

One day late or a submission on day six would equate to a 20% reduction in your 30-day period payment—a significant impact to revenue.

Brandy Shifteh, RN, BHSA, MBA
HEALTHCARE*first*, Regulations Compliance Manager

Exceptional circumstances

The payment reduction for a late RAP submission can be waived for exceptional circumstances outside the agency's control.

The Medicare Administrative Contractors (MACs) will accept the KX modifier when reported with the HIPPS code on the claim as an indicator that the agency requests an exception to the late penalty.

Agencies should provide sufficient information in the Remarks section of the claim to allow the MAC to research the exception request, otherwise additional documentation will be requested.

Assumptions for 2021 and beyond.

It's important for agencies to consider future industry regulations. Here is a list of what we might see in 2021 and beyond.

Sequential billing requirements

CMS might propose to implement sequential billing requirements with the implementation of the Notice of Admission (NOA) that will replace RAPs in CY 2022. If this happens, it would need to be considered in your revenue cycle management workflow.

Behavioral adjustment and functional impairment level changes

CMS will likely make changes to the current behavioral adjustment, as well as recalibrate the current functional impairment thresholds to promote an even distribution across the three levels.

Case-mix weights and LUPA thresholds

By 2022, we anticipate a recalibration of the current case-mix weights, as well as changes to the current LUPA thresholds.

Workflows are vital to revenue management.

No-pay RAP can have significant financial consequences if not submitted in a timely manner—which is precisely why the workflow from intake to back office must be effectively structured. These steps are vital to driving claims accuracy and achieving effective revenue cycle management.

Intake

Insurance verification and eligibility checks

Critical to intake function, these checks identify the primary payor and Medicare secondary payors. Getting this wrong at intake will cause denials and billing delays downstream.

Completion of face-to-face encounters

Completion of the face-to-face encounter should be confirmed up front, in addition to the certifying physician responsible to oversee the plan of care. The intake function should ensure there is an order for the initial assessment visit—a prerequisite for the RAP submission.

Workflows are vital to revenue management.

Confirming admissions source and timing

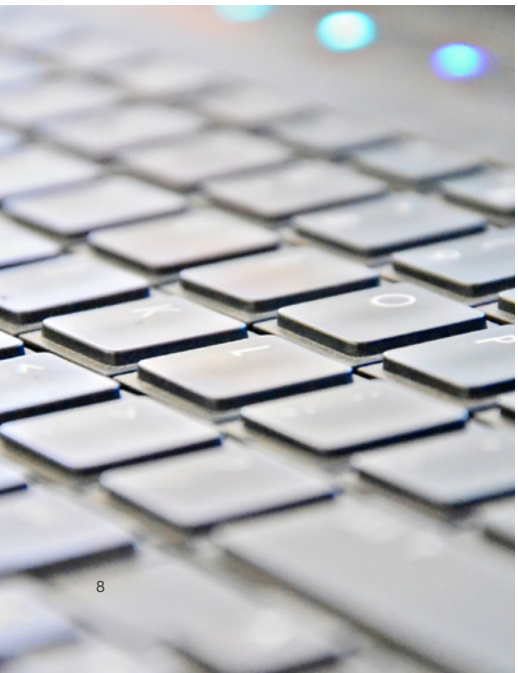
There must be a gap of at least 60 days between the end of one 30-day period and the start of a new one for the submission to be classified as early. This is why it's important to validate the dates of previous periods from other home health agencies (or the same agency) at intake.

Supporting clinical documentation requested and received

Ensuring completion of this intake function will support accurate assessments by admitting clinicians and identifying valid PDGM primary diagnoses, as required for the RAP.

Best practice tip!

All intake staff should request a copy of the discharge summary as part of the referral intake process, which helps validate the facility type and discharge date.



Comprehensive assessment

The initial billable visit, meaning that skilled care was provided, is necessary to establish the start of care. During this part of the workflow, most agencies also complete the comprehensive assessment with OASIS items.

As part of the comprehensive assessment, the admitting clinican identifies and validates the primary diagnosis, cormorbidites, and all other pertinent data to be included on the plan of care.

Best practice tip!

Agencies should have policies in place for clinical assessments and routine visit documentation to be completed in a timely manner.

Workflows are vital to revenue management.

Plan of care development

The plan of care is developed based on the comprehensive assessment, which identifies the patient's specific needs, interventions, and goals for care. This must be completed, reviewed by the physician, and signed and dated prior to submitting the final claim.

Best practice tip!

Establish a well-structured quality review and coding system as part of the clinical workflow. This is critical under PDGM for accurate final claims and OASIS accuracy.

Changes in the patient's condition

Any changes to the patient's condition that occurred mid-episode and prior to the start of the second payment period are important to capture—as these status changes may impact case-mix and payment for the subsequent period of care.

It's important for home health agencies to have a structured process to identify when there are significant changes to functional status, diagnoses, or transfers to inpatient facilities that occur between initial and subsequent periods.

Agencies should also develop a closed-loop communications process with their quality review and coding system and back-office billing functions to ensure claims are updated when mid-episode status changes occur.

Workflows are vital to revenue management.

By the time [inaccuracies] are identified by billing, it's too late. Clinical and quality review systems should always drive claims accuracy. This focus on accuracy up front will prevent later issues with billing and revenue.

Angela Urban, RN, BSN, HCS-D, COS-C, Manager of QA and OASIS Review Operations, HEALTHCARE*first*

Best practice tip!

Consider making mid-episode case conferences a standardized process, particularly if there are patient status changes mid-episode that will impact the plan of care, case-mix, and payment for the second 30-day period of care.

Financial success is a process.

The Healthcare Financial Management Association defines the revenue cycle as all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.

The home health industry has weathered the challenges of PDGM, No-pay RAP, and a pandemic—and revenue cycle challenges are no exception. Starting with intake, everything flows to billing. So to truly review revenue success, we have to look at the entire process.

Payor verification authorization

This has a large impact on financial success for agencies caring for both new and ongoing patients. By using a scheduled verification tool through your EHR, you can set automated checks weekly or monthly. This approach provides an audit trail that includes the date and timestamp needed for proof of results in a request for an exception of the No-pay RAP penalty.

- Authorization requirements should be met before performing services, such as pre-certifications or pre-authorizations.
- Expiring authorizations should be tracked and reviewed weekly.

Financial success is a process.

It's important that process is solid so you're not leaving hard-earned dollars on the table. This is why our reviewers hold certifications in coding and OASIS and hospice, just to name a few.

Rachael Feeback, Services Customer Advocate, HEALTHCARE*first*

Scheduling

Think of schedulers as your gatekeepers. Whether they're centralized or self-schedulers in the field, the key is to make them a part of the process. They act as an important link between your agency, your patients, your caregivers, and your payors.

Claim submission

For the final claim submission, ensure all visits are completed in a timely manner—this is a component that really drives cash flow.

Reporting

Simply put: if you can't measure it, you can't improve it.

Areas of RCM that delay cash flow.

One of the best ways to improve cash flow is to have a schedule that prevents penalties. Starting with a daily schedule, ensure claims are submitted electronically for all payors—including RAPs and finals. Electronic submission is key, as that lessens the manual burden and reduces costly typos.

The following are common areas of RCM that delay cash flow along with recommendations to prevent revenue loss.

RAPs on day five

While we recommend electronic submission, day five is the exception. This is because many submissions go through a clearinghouse, which results in a one-day lag—something you can't afford if you're sitting on day five. Instead of submitting electronically, our recommendation is direct data entry into Medicare or a payor portal for Medicare Advantages.

iQIES submissions

Since OASIS must be submitted and accepted before Medicare will pay your final claim, this should be a part of your process to prevent issues with cash flow. Monitor RTPs (Return to Provider) with screen prints, which will act as proof of timeliness.

Areas of RCM that delay cash flow.

Monitor orders

Claims are most commonly held due to unsigned orders or incomplete face-to-face documentation, which is why you need a daily process to monitor these tasks as well as rejections. If you receive a rejection indicating that the payor cannot accept claims for future dates, you have two actions:

1. Immediately submit on the period start date if this payor enforces No-pay RAP penalties.
2. Change your process moving forward so you don't end up in a cycle of continual rejections.

Unbilled A/R

When reviewing unbilled accounts receivable, identify and quantify trending issues as part of a daily process. Weekly A/R processes should also include:

- Reviewing RAPs that will hit timely filing over the weekend
- Creating a collections plan reviewed by timely filing days, A/R balance, and payor-specific trends
- Reconciling cash postings to bank statements to ensure accuracy and timeliness

One of the biggest things we did to prepare for CMS changes in 2020 was invest in and have a relationship with a strong coding team. We never have to worry about being short staffed, and we always have the same coders who know our team. We've been very fortunate.

Deb Wesley, CEO, Addison County Home Health & Hospice

A deeper dive into accounts receivable.

For unbilled accounts receivable, identify and quantify trending problems and leverage technology. Here's a breakdown of how to use A/R to your advantage.

Aged orders
Review these by physician. If half of your orders are outstanding for the same physician, then you know where to start.

Outstanding visits
Review these by clinician so you can coach those who are struggling to complete visits in a timely manner.

Authorizations
Don't skip measuring this, as it will allow you to meet or exceed your agency's expectations.

OASIS
Submit OASIS daily to help with billing and cash flow—but remember that it must be accepted.

The key to A/R is to continuously measure and improve. Trend the claim denials, track productivity, and leverage technology (clearinghouse, EHR, etc.) to your advantage.

Unbilled A/R: Measure to improve

Unbilled A/R is recognized revenue that does not have a claim submitted and accepted. Simply put, it delays cash flow. That's why it's important to trend your unbilled A/R to ensure that it's within your agency's best practice guidelines. But how do you measure it? Here are two ways:

- Divide A/R over 30 days, which can be an indicator of where your agency met goals, exceeded expectations, or needs improvement.
- Review the average number of days it takes to collect payment—the lower the number, the faster your agency is at collecting payment. As accounts age, they're at higher risk for timely filing denials.

Face the unknown with a trusted partner.

While home health agencies have faced some of the largest regulation changes in decades along with a pandemic, they are still faced with the unknown. Regulation will continue to evolve and cash flow will always be top of mind. We strive to be a strong partner so you not only survive these changes, but also thrive through them.

Request a demo of HEALTHCARE*first* RCM services to learn the immediate benefits we can provide your agency.

More about HEALTHCARE*first*

HEALTHCARE*first* has one mission: to deliver innovative, easy-to-use, and affordable solutions. For 25 years, HEALTHCARE*first* has been the premiere provider of revenue cycle management services (OASIS review, coding, and billing), CAHPS surveys, and advanced analytics for out-of-hospital (or post-acute care) organizations. Serving thousands of organizations across the United States, HEALTHCARE*first* has been the single source for organizations to enhance patient care, create operational efficiencies, improve reimbursement, and simplify CMS compliance. With HEALTHCARE*first*, providers can focus on patients instead of paperwork.

HEALTHCARE*first* by ResMed

HEALTHCARE*first* is a wholly owned subsidiary of ResMed (NYSE: RMD, ASX: RMD), visit **www.healthcarefirst.com** or call **1.800.841.6095** for more information.