December 20, 2021

The Notice of Admission Are you Prepared!

Presenter: Melinda A. Gaboury, COS-C

FREE Webinar

1

Intake

- Medicare eligibility verified – Part A or B (& at recertification)
- Inpatient discharge – outpatient – emergency – physician office
- Payment period timing – early vs. late – ONLY Early SOC

Clinical Assessment

- Medicare eligibility validated by start of care/recert assessment
- Clinical grouping established by Primary diagnosis
- Functional payment score established by OASIS data

Order Management

- Receipt of physician signed & dated F2F & home health certifications, orders, & F2F encounter notes

Billing, collecting & payment posting

- RAP & Final Claim filed
- Final Claims validated against OASIS
- Final claim payment adjusted based on multiple adjustment factors

Revenue Cycle

2

Billing and Collections

NOA – Notice of Admission filed at the Start of Care

Finals - end of every 30-day payment period

Remittance Advice Issued – Cash Posting Occurs

Reconciliation between what you are paid and what EMR calculated that you would get paid

3

NO- PAY RAP 2021

RAP in 2021 has no monetary value.

- In 2021 RAPs must be filed and ACCEPTED at the MAC within 5 days of the beginning of the 30-day payment period.
- If it is not accepted within 5 days, the agency will be penalized for every day up until it is accepted at the MAC
  - Estimated HIPPS amount divided by 30 for a daily amount and the daily amount multiplied by the number of allowable days based on the accepted date.
- RAPs will NOT have the same criteria for filing as they have previously
- RAPs for both 30-day payment periods can be filed at the beginning of the 60-day period

4

NO- PAY RAP 2021

With ANY 30-day period that has a start date of 12/31/2021 and EARLIER the No-Pay RAP requirement is still in effect!

5

RAPs 2021 - EXAMPLE

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:

- $2,800 divided by 30 = $93.33 per day
- $93.33 X 17 days = $1,586.67
- $2,800 - $1,586.67 = **$1,213.33**

6

Tips to Remember - NOA

- An NOA is required for any period of care that starts on or after 01.01.22
- HHAs must submit the NOA when they have received the appropriate physician's written or verbal order that contains the services required for an initial visit, and the HHA has conducted the initial visit at the start of care
- NOA must be submitted within five calendar days from the start of care. A payment reduction applies if an HHA does not submit the NOA within this time frame.
  - » Reduction in payment amount would be equal to a 1/30th reduction to the wage-adjusted 30-day period payment amount for each day from the home health start of care date until the date the HHA submitted the NOA
    - Reduction would include any outlier payment
    - Reduction amount will be displayed with value code "QF" on claim

7

Notice of Admission

For all patients receiving HH services in 2021 whose services will continue in 2022, you should submit an NOA with a one-time, artificial "admission" date corresponding to the "From" date of the first period of continuing care in 2022.

Example: Start of Care 12/15/2021

- First 30-day Period 12/15/21 – 01/14/22 (NO PAY RAP)
- Second 30-day Period 01/15/22 – 02/17/22 (NOA)

In the example above the "artificial admission date" would be 1/15/22 and would need to be used on all final claims going forward until the patient is discharged.

8

NOAs 2022 - EXAMPLE

Start of Care 60-DAY Episode with 30-day PAYMENT PERIODS

01/03/22 – 02/01/22 & 02/02/22 – 03/04/22

NOA filed and accepted at MAC on 02/20/22

HIPPS Code value $2,800 for 1st Period and $1,800 for 2nd Period

When 1st final is paid the agency will receive the following payment:
- $0 due to NOA be accepted after the first 30-day period is over.

When 2nd final is paid the agency will receive the following payment:
- $1,800 divided by 30 = $60 per day
- $60 X 18 days (2/2 – 2/19) = $1,080
- $1,800 - $1,080 = **$720**

9

Example
Low Utilization Payment Adjustments (LUPA)

If the claim reflects visit counts that are below the LUPA threshold the NOA is filed, but is accepted LATE – the agency will not be paid per visit for the visits that are in the penalty window.

Patient admitted January 15, 2022 (1/15 – 02/13)

HIPPS code calculated reflects a 5 visit LUPA threshold – visits were provided on 1/15, 1/22, 1/29 & 2/10

Agency does file a NOA, but it is not received until 1/23.

Due to the Final Claim payment resulting in a LUPA, the agency will be penalized for the visits in the non-covered days range. So, NON-covered is 1/15 & 1/22.

10

Is Your EMR Ready for CrossOver Periods?

One of the largest Home Health EMR systems has announced that their system WILL NOT be ready for the crossover periods and agencies will be required to key those NOAs directly into the DDE system!

Is your EMR Ready???

Following is a link to a job aid that provides details of keying the NOA into DDE, developed by CGS, NGS & Palmetto GBA:

https://cgsmedicare.com/hhh/education/materials/pdf/billing_noa.pdf

11

Notice of Admission

Type of Bill Required - 032x - Home Health Services under a Plan of Treatment

- 4th Digit Definition
  - A - Admission/Election Notice
  - D - Cancellation of Admission/Election Notice Statement Covers Period (From-Through) Required
  - The HHA reports the date of the first visit provided in the admission as the From date. The Through date on the NOA must always match the From date.

Patient Name/Identifier Required –

- Patient's last name, first name, and middle initial.

Patient Address Required - Patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

Patient Birth Date Required - Month, day, and year of birth of patient. **Left blank if the full correct date is not known.**

12

Patient Sex Required - "M" for male or "F" for female must be present. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.

Admission/Start of Care Date Required - The Admission date on the NOA must always match the From date.

Condition Codes Conditional. - If the NOA is for a patient transferred from another HHA, the HHA enters condition code 47. Note: No line item service information is required by the Medicare program to complete a Notice of Admission via DDE. However, certain line information is required to meet the requirements of the 837I claim format. See the NOA Companion Guide for details on meeting these requirements.

Release of Information Certification Indicator Required - A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

Notice of Admission

13

National Provider Identifier – Billing Provider Required –

- The HHA enters their provider identifier.

Insured's Name Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown, record the patient's name as shown on the patient's HI card or other Medicare notice.

Insured's Unique Identifier Required – Identification # with the insurance (MBI for Medicare patients)

Principal Diagnosis Code Required to meet the requirements of the 837I claim format. See the NOA Companion Guide

Attending Provider Name and Identifiers Required - The HHA enters the name and provider identifier of the attending physician that has established the plan of care with verbal orders.

Notice of Admission

14

Final Claims – Billing Requirements

All payment periods

- OASIS assessment(s) transmitted to & accepted at database
  - SOC, recertification, ROC or other follow-up, *if applicable*
- Compliant F2F encounter documentation obtained
- All physician orders signed & dated
  - POC & all other interim orders applicable to payment period
- All billable visit & NRS documentation completed
- Compliant therapy reassessment documentation completed

15

HIPPS Code

Position #1		Position #2		Position #3		Position #4		Position #5
Source & Timing		Clinical Group		Functional Level		Co-Morbidity		Placeholder
Community Early	1	MMTA_OTHER	A	Low	A	None	1	1
Institutional Early	2	Neuro Rehab	B	Medium	B	Low	2	
Community Late	3	Wounds	C	High	C	High	3	
Institutional Late	4	Complex Nursing	D					
		MS Rehab	E					
		Behavioral Health	F					
		MMTA - Surgical Aftercare	G					
		MMTA - Cardiac	H					
		MMTA - Endocrine	I					
		MMTA - GI/GU	J					
		MMTA - Infectious	K					
		MMTA - Respiratory	L					

16

Payment Pricing

Claim payments subject to pricing

- OASIS Validation is the first step – the Claim will RTP if the OASIS data and the claim do not match.
- Payment period timing
  - Claim payments to be automatically repriced for early or late status based on paid claims history on Medicare CWF (Start of Care ONLY)
- Admission source
  - **Occurrence codes 61 & 62** will now be used to trigger payment calculation for Institutional vs. Community. Claims data will be utilized to reconcile periodically with the Institutional credit given.

17

Payment Pricing

Claim payments subject to pricing

- Clinical Grouping & Comorbidities
  - The primary & all secondary diagnoses are taken from the CLAIM to determine the Clinical Grouping and Comorbidity level.
- Functional Scores
  - OASIS Responses will be extracted from the OASIS-D1 and used to calculate the HIPPS code

The final HIPPS code calculated by the Medicare MAC is the one that your final claim payment will be based on regardless of the HIPPS code that you sent in on the claim.

18

Requesting an Exception for Late RAP or NOA

An HHA may request an exception if the RAP is filed more than 5 calendar days after the period of care. The four circumstances that may qualify for an exception are:

- 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 MAC 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 MAC.
- Other circumstances determined by CMS or MAC to be beyond the control of the HHA.

19

Requesting an Exception for Late NOA

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). For example, if the RAP to a claim was originally received timely but the RAP was canceled and resubmitted to correct an error, enter in the REMARKS field "Timely RAP, cancel and rebill". Add modifier KX to the HIPPS Code reported on the revenue code 0023 line of the Final Claim.

If the information provided in the REMARKS field is not clear, MAC 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.

20

Thank You For Participating!

info@healthcareprovidersolutions.com

21