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Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA)

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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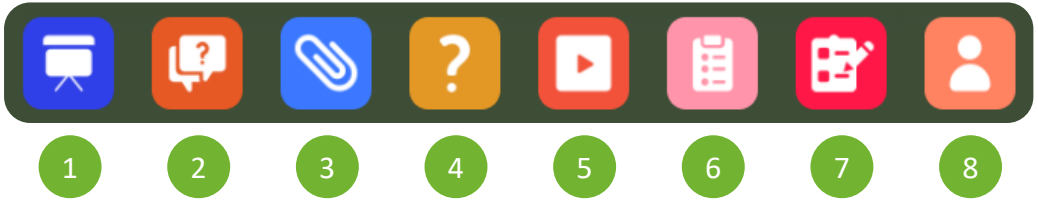

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Disclaimer

The information provided in this handout was current as of December 6, 2021. Any changes or new information superseding the information in this handout will be provided in articles and publications with publication dates December 6, 2021, posted at www.palmettogba.com/hhh.

Agenda

- Elimination of the Requests for Anticipated Payment (RAPs)
- Notice of Admission (NOA)
- Patients Receiving Home Health Services in 2021 and Continuing Services in 2022
- Timely Submission of the NOA
  - **Penalty for Late NOAs**
    - Late NOA Exception Process and examples
- Questions and Answers
- Resources

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Elimination of the Requests for Anticipated Payment (RAPs)

Requests for Anticipated Payment (RAPs)

Starting in CY 2022, RAPs will be eliminated and replaced by submission of a one-time NOA for all home health agencies (HHAs).

- Over the past two years, Medicare has been phasing out RAPs

RAPs

HHAs shall no longer submit RAPs, Type of Bill (TOB) 0322, for any HH periods of care (POC) with a “From” date on or after January 1, 2022.

- RAPs with a “From” date on or before December 31, 2021, will continue to be accepted
- RAPs with a “From” date on or after January 1, 2022, will be returned to the provider after the implementation of the January 2022 Release
  - Late NOAs that occur because a RAP was submitted in error will not receive a late NOA exception

RAPs

RAPs will be rejected if the POC “From” date is between 12/1/2021 and 12/31/2021 if the calculated 30-day end date falls within an existing HH admission period with an Admission Period Start Date and the CMS certification number (CCN) does not match.

- The HHA should contact the other provider and request they cancel and resubmit their NOA with condition code 47
  - An NOA timeliness exception applies to the resubmitted NOA in this case
  - A RAP timeliness exception may apply if it meets one of the exception reasons for late RAPs

Example

- Medicare receives an NOA from HHA 123 with a POC “From” date 1/5/2022. It is accepted.
- A RAP is received after the acceptance of the NOA from HHA XYZ with POC “From” date 12/21/2021
  - **The RAP will reject because the calculated 30-day end date falls within the existing HH admission period of HHA 123’s start of care and the CCN does not match**
  - **HHA XYZ will need to contact HHA 123 and request they cancel and resubmit their NOA with condition code 47**

Notice of Admission (NOA)

NOA

- NOAs will only be accepted for admission dates on or after January 1, 2022
  - **Return Reason Code 31193 will assign on 32A and 32D TOBs when the admission date, “From” and “Through” dates is prior to January 1, 2022**
- CMS only requires one NOA for any series of HH POCs beginning with admission to home care and ending with discharge
- Once a discharge is reported to Medicare, a new NOA is required before any additional claims are submitted
- Return Reason Code 31000 will assign on NOAs that contain a future “Admission,” “From” or “Through” date

NOA Submission Criteria

- NOA submission criteria will require that
  - **The HHA has obtained a verbal or written order from the physician that contains the services required for the initial visit; and**
  - **The HHA has conducted an initial visit at the start of care**
- As with RAPs in CY 2021, the below requirements **do not** have to be met to submit the NOA
  - **The OASIS assessment is complete, locked or export ready, or there is an agency-wide internal policy establishing the OASIS data is finalized for transmission to the national assessment system; and**
  - **A plan of care has been established and sent to the physician**

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NOA Billing Information

Billing the Home Health Notice of Admission Job Aid

Request for Anticipated Payment Versus Notice of Admission Job Aid

NOA Billing Information

- NOA TOBs
  - 032A – Admission/Election Notice
  - 032D – Cancellation of Admission/Election Notice
    - Examples of errors that would require the NOA to be canceled and resubmitted
      - Incorrect SOC/admission/"From" date reported
      - Incorrect initial attending physician or allowed practitioner reported. On the NOA, the HHA is required to enter the name and provider identifier of the attending physician that has established the plan of care with verbal orders.
- TOBs 032B, 032C or 032E will be returned to provider with Reason Code 19961
  - HH PPS does not require revocations, transfers within POCs or changes of ownership within POCs

NOA Billing Information

- Statement Covers Period “From” and “To” Date
  - Report date of the first visit provided in the admission as the “From” date. The “To” or “Through” date on the NOA must always match the “From” and admission date.
- Admission Date
  - This is the first Medicare billable visit and the Medicare start of care date. The admission date on the NOA must always match the “From” and “Through” dates.
    - Return Reason Code 31191 will assign if all dates do not match
- Patient Status Code
  - Not required unless submitting 837I format (electronic)
    - Default value “30”

NOA Billing Information

- Condition Code (CC)
  - If the NOA is for a patient transferred from another HHA, the HHA enters condition code 47
  - Condition code 47 may be used when the beneficiary has been discharged from another HHA, but the final claim has not been submitted or processed at the time of the new admission
  - Return Reason Code 19960 to assign when a CC other than 47 is present on TOB 32A and 32D
- Value Code (VC) & Amount
  - Not Required

NOA Billing Information

- Revenue Code
  - Submit revenue code 0023 (Home Health PPS)
- Health Insurance Prospective Payment System (HIPPS) code
  - Not required on the NOA unless submitting via the 837I format (electronic)
    - Use place holder HIPPS code “1AA11” for 837I format submissions
  - There is not a matching field requirement for the NOA and POC claim
  - Subsequent final claims should be submitted with either a Grouper produced HIPPS code or any valid HIPPS under the HH Patient-Driven Groupings Model (PDGM)

NOA Billing Information

- Service Date
  - Not required unless submitting 837I format
    - Enter same date as admission date (electronic)
- Payer Name
  - Required – Always submit as Medicare primary
- Principal Diagnosis Code
  - Required – Submit any valid HH diagnosis code
    - The principal diagnosis reported on the POC claim is what drives the clinical grouping under PDGM for the POC

NOA Billing Information

When a patient is discharged from an HHA and readmits later to the same HHA, but no discharge has processed, the HHA may submit the NOA for new admission.

- No special coding is necessary (i.e., CC 47)
- If it is the same CCN, the NOA will process
  - **This is the current process with RAPs**

NOA Billing Questions and Answers

Q: An HHA is getting a new referral. But Medicare’ s eligibility systems shows the beneficiary has an open admission with another HHA that has discharged and hasn't submitted their final claim. Would the HHA use 47 even though it is a new admission and not necessarily a transfer from the other agency?

A: Yes, if the admitting HHA has confirmed the beneficiary was discharged from the open admission on file, they should submit condition code 47 in that case. This will create a new admission period for their billing.

NOA Billing Questions and Answers

Q: How will Medicare Secondary Payer (MSP) affect timely submission of NOAs?

A: MSP billing is not required on NOAs. The HHA shall submit the NOA as Medicare primary and it will process without MSP editing. The period of care claim must be billed as MSP.

MSP NOAs shall also be submitted within 5 calendar days from the start of care (SOC)/admission date to be considered timely.

NOA Billing Questions and Answers

Q: Does the principal diagnosis code reported on the NOA need to match the principal diagnosis on the initial POC claim?

A: No, the principal diagnosis code reported on the NOA does not need to match the principal diagnosis reported on the initial POC claim. This information will not be stored on HH admission periods or compared to claims.

Questions and Answers

Q: Does the primary diagnosis code reported on the NOA need to be changed if the clinician changes the primary diagnosis after the NOA has been sent?

A: No, the NOA does not have to be canceled and resubmitted if the primary diagnosis is changed after the NOA was sent and processed. Keep in mind, the principal diagnosis reported on the POC claim is what drives the clinical grouping under PDGM for the POC.

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Patients Receiving Home Health Services in 2021 and Continuing Services in 2022

Services Continuing in 2022

For all patients receiving HH services in 2021 and will continue services in 2022, HHAs 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.

- For example, if a patient began care on 12/13/2021, and the new POC will begin on 1/12/2022, the NOA should use the same date as the “From” date of the new billing period, i.e., 1/12/2022, as the artificial “admission” date

Services Continuing in 2022

- HHAs are to use the artificial “admission” date on all subsequent claims until the beneficiary is discharged and another NOA is required
- NOA must be submitted timely

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Payment Reduction for Late NOAs

Timely NOA Submission

- HHAs must submit an NOA to their MAC within 5 calendar days from the start of care (SOC)/admission date
  - **The SOC of date is counted as day zero**
    - Count five calendar days starting the day after the SOC/admission date to determine timely NOA submission
- All NOAs, including for all patients receiving HH services in 2021 whose services will continue in 2022, must be submitted timely

Timely NOA Submission Question and Answer

Q: Is it sufficient for the NOA to be submitted within 5-calendar days to meet the timely filing requirement or does it need to be submitted and processed?

A: An NOA is considered timely to meet the 5-calendar day requirement when it is submitted and accepted by the MAC within 5 calendar days of the SOC/admission date. “Accepted” is defined as processing and approving after an NOA was received. The date a NOA completes processing and approves is not used in calculating the NOA’s timeliness, only the received date of the NOA is used.

- **NOTE**: If the NOA is RTP for correction, it will be given a new received date when it is returned for processing after correction

Payment Reduction for Late NOAs

The 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 HH start of care date until the date the NOA was received by the MAC.

- The payment reduction may span multiple POCs, if applicable
- No low utilization payment adjustment (LUPA) per-visit payments shall be made for visits that occurred on days that fall within the POC prior to the submission of the NOA
- includes outlier payments
- This reduction shall be a provider liability, and the provider shall not bill the beneficiary for it
- MAC applied value code QF will show the dollar amount that the claim payment was reduced due to the NOA being filed more than 5 days after the HH From date

Exception to Late NOA Payment Reduction

If the HHA fails to send the NOA timely, they may request an exception.

- The four circumstances that may qualify for an exception are the same as a late 2021 RAP
  1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate
  2. An event that produces a data filing problem due to a CMS or MAC systems issue that is beyond your control
  3. You are a newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC
  4. Other circumstances that we or your MAC determines to be beyond your control

Late NOA Exception Process

- HHA may request an exception on the final claim that corresponds with the late NOA
  - MACs will accept the KX modifier when reported with the HIPPS code on the revenue code 0023 line of TOB 0329 (other than 032A, 032D and 0320) as an indicator that an HHA requests an exception to the late NOA penalty
- The HHA should provide sufficient information in the **Remarks section** of the claim to allow the MAC to research the exception request
  - The claim may be returned to provider if the remarks do not provide enough information

Late NOA Exception Process

The MAC will not grant exceptions if the HHA.

- Can correct the NOA without waiting for Medicare systems actions
- Submit a partial NOA to fulfill the timely-filing requirement
- Has multiple provider identifiers and submit the identifier of a location that didn’t actually provide the service

NOA Exception Questions and Answers

Q: If an HHA submits a NOA timely, but needs to cancel it for an error, can we file an exception on the corresponding claim(s)?

A: Yes. If the NOA that corresponds to a claim was originally received timely, but the NOA was canceled and resubmitted to correct an error, enter remarks to indicate this condition, (for example, “Timely NOA, cancel and rebill”). Append modifier KX to the HIPPS code reported on the revenue code 0023 line. HHAs should resubmit corrected NOAs promptly (generally within 2 business days of canceling the original NOA).

NOA Exception Questions and Answers

Q: Can an HHA appeal a late NOA penalty?

A: Appeals are only requested on denied claims; however, an HHA may request an exception on the final claim that corresponds with the late NOA. MACs will accept the KX modifier when reported with the HIPPS code on the revenue code 0023 line of TOB 032x (other than 032A, 032D and 0320) as an indicator that an HHA requests an exception to the late NOA penalty. I the exception is denied, an appeal may be filed.

Exception Example

- Scenario
  - NOA was late due to a beneficiary was disenrolled from a Medicare Advantage (MA) plan and Medicare's eligibility systems were not updated timely to show the termination
- Remarks
  - In this scenario, the HHA should apply "CR12256 disenroll MA XX/XX/XXXX" to the exception remarks. Please ensure to add the MA termination date in the remark, i.e., "CR12256 disenroll MA 12/31/2021".

Exception Example

- Scenario
  - NOA was returned due to an overlap of a hospice election

- Remarks
  - Timely submitted NOA was returned with reason code C7010, overlap of a hospice election. Hospice election is now closed.
    - Exception may be denied if CC 07 (not related to hospice) is later added by the HHA

Exception Example

- Scenario
  - NOA was late due to natural disaster

- Remarks
  - NOA date 2/14/22. NOA was late due to power outage and state of emergency declared on 2/12/22 due to severe winter weather that is impacting (input county and state)

Exception Example

- Scenario
  - NOA was returned due to an overlap with a different HHA

- Remark
  - NOA was submitted timely, but rejected due to an overlapping POC with a different HHA
    - This exception would be denied if Medicare's eligibility systems showed beneficiary was on service on with another HHA prior to the NOA's submission date and the admission would overlap. CC 47 is applicable.

Exception Example

- Scenario
  - Data filing problem due to a CMS or MAC systems

- Remarks
  - Timely submitted NOA was returned on 1/15/22 for CPIL issue with reason code XXXXX before MAC suspended and bypassed issue on 1/27/22
    - Make sure you include the reason code and/or name of the issue on Palmetto GBA's Claims Payment Issues Log (CPIL)

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Questions and Answers

Questions and Answers

Q: What if an HHA provides care in a 30-day period of care and then discharges the beneficiary in the next 30-day period of care, but does not provide any billable visits in the next 30-day period?

A: In order to close the HH admission period in these cases, the HHA should report patient status 01 on the claim for the last 30-day period in which visits occurred. If the claim has been submitted with patient status 30 before the discharge occurred, the HHA should adjust the claim to change the patient status to 01. Adjustment CC E0 is the appropriate condition code when adjusting a claim's patient status.

Questions and Answers

Q: What if an HHA provides care in a 30-day period of care and then the beneficiary is discharged deceased in the next 30-day period of care, but no billable visits were provided in the next 30-day period?

A: If the cause of the discharge in the next 30-day period is the beneficiary's death, the HHA should not report patient status 20 (expired) on the claim. This would result in an incorrect date of death being recorded in Medicare systems and potentially affect claims from other providers. The HHA should report patient status 01 on the claim for the last 30-day period in which visits occurred. Use adjustment CC E0 for the adjustment.

Questions and Answers

Q: What if the patient is admitted to an inpatient facility in the first 30-day POC, the HHA expecting the patient to come back to HH, but eventually does not? The HHA realize this on the third 30-day period. What does the HHA need to do with the new NOA implementation?

A: Once the HHA is aware of the discharge situation, they should adjust their last claim with billable visits to replace patient status 30 with the appropriate discharge status code. Use adjustment CC E0 for the adjustment.

Questions and Answers

Q: How will POCs with No Visits Expected would work in 2022 and beyond? In 2021, they would submit the RAP to open the period and that would show the patient was under HH.

A: Since the NOA creates the admission period, there is no need to submit anything for the POCs in which no services are expected. If, at the end of the 30-day period, no visits were provided there would be no claim for that POC.

Questions and Answers

Q: If there is an error on the NOA that will cause it to return to the provider, does the HHA have to wait until the NOA is returned to correct and resubmit it?

A: No. When a NOA is set to return (T B9900 status/location), the HHA may immediately submit a new, corrected NOA to avoid or reduce the penalty. The new NOA will not edit as a duplicate since the initial NOA did not process.

Questions and Answers

Q: Will there be a requirement to send a notice of discharge as well, like we do in hospice?

A: A HH discharge is determined by the POC claim billed with a discharge patient status code. There is no separate billing requirement for a discharge.

Questions and Answers

Q: Will we continue to bill final claims on a 30-day POC basis?

A: Yes. Billing the 30-day POC claims under PDGM is not changing. HHAs will continue to be required to submit a 30-day period of care claim when there are services provided for that POC.

Questions and Answers

Q: How will this affect the HH Review Choice Demonstration (RCD) states?

A: The changes will not impact RCD states. HHAs are still encouraged to submit the NOA and allow it to process before submitting the initial pre-claim review request. This will allow the beneficiary record to open on the Common Working File and will ensure the HHA has all of the required documentation to submit with the request.

Questions and Answers

Q: Do you know which other payers will require NOAs? Which payers will "copy" the Medicare NOA rules?

A: The billing guidelines for the NOA apply to Original Medicare. HHAs will need to contact any MA plans or other insurance plans to which you submit claims to find out the details of their billing requirements.

Resources

- MLN Matters Number MM12256 — NOA – Manual Instructions
- Change Request 12227 — Replacing Home Health RAPs with a NOA – Implementation
- MLN Matters Number MM12424 — HH NOA – Additional Manual Instructions
- NOA Companion Guide Transaction Information
- Billing the Home Health Notice of Admission Job Aid
- Request for Anticipated Payment Versus Notice of Admission Job Aid
- NOA FAQ – Coming Soon!

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