AXXESS

LIVE Q&A ON
HOME HEALTH MEDICARE BILLING

SPEAKERS

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Axxess Support and Resources

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Agenda

- Frequently Asked Questions
- Billing Scenarios
- Issues
- Audience Question-and-Answer

Frequently Asked Questions

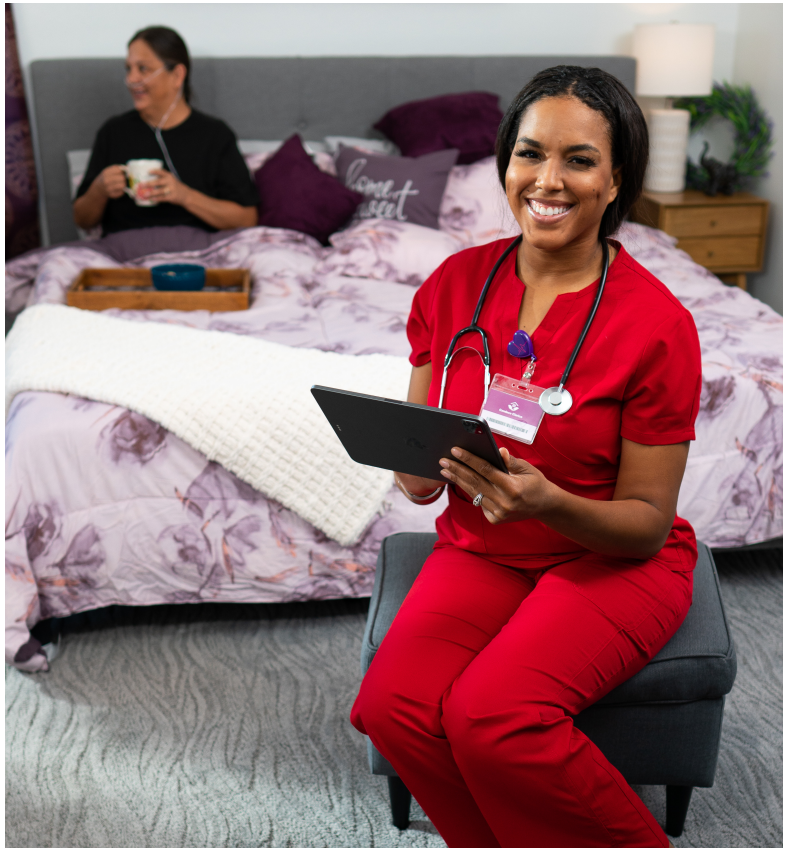
Question:

Does the OASIS need to be completed by the clinician, coded, finished with quality assurance and fully submitted for the Notice of Admission (NOA) to be billed within the five-day window?

Answer:

No, an OASIS assessment does not need to be completed to bill an NOA but a billable start of care visit must be completed and a verbal or written physician's order that contains the services required must be in place prior to submitting the NOA.

For current patients' NOA submissions, organizations can use the start date of the billing period to serve as the service line date to submit the NOA.



Frequently Asked Questions

Question:

Do we need to put in the actual primary diagnosis when submitting an NOA or does it just have to be a placeholder?

Answer:

The NOA only needs to contain a primary diagnosis which can be generic. The principal diagnosis on the OASIS drives the clinical grouping under PDGM (Patient-Driven Groupings Model) for the HIPPS code. A HIPPS code is not required for the NOA submission, and a generic HIPPS code can be used to submit an NOA if the OASIS is not available.

Note that in Axxess Home Health, the generic HIPPS code 1AA11 will only be used to submit the NOA and not for reporting purposes. The final claim will store and report the HIPPS/claim amount from the assessment.

Frequently Asked Questions

Question:

If Medicare is not the primary payer, should an NOA still be submitted?

Answer:

Yes. Even if Medicare is not the patient's primary insurance payer, submitting an NOA is recommended. Submitting an NOA ensures that one is on file with Medicare in case the payer changes. The NOA will establish care with Medicare so that the final claim can be released.

It is important for an organization to review the billing and claim requirements of each managed care payer to ensure proper and timely claim submission and to minimize denials.

Frequently Asked Questions

Question:

Are there any Medicare Advantage payers requiring NOA submissions?

Answer:

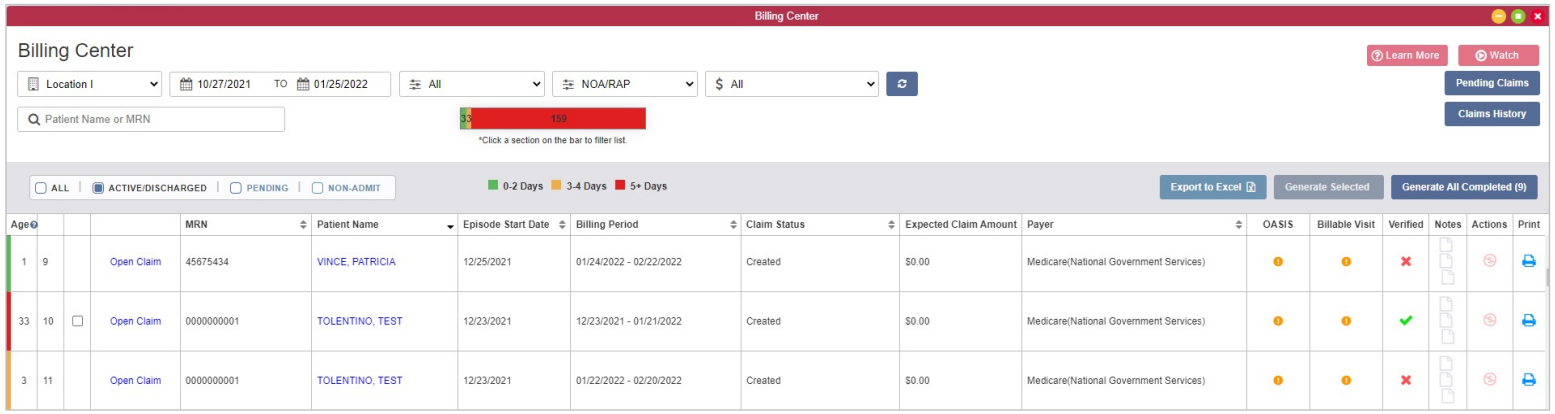
Yes, there are Medicare Advantage payers that require NOAs to be submitted. It is recommended that organizations contact their contracted Medicare Advantage plans and inquire about changes in 2022 that may include the NOA. Please review the payer set up in your electronic medical records (EMR) system and update where necessary. Axxess Home Health can accommodate each payer's requirements and be modified to fit the payer's effective date, should their onset differ from the Medicare date of January 1, 2022.
In addition to Medicare, these payers have modified claims submission requirements for 2022:

- MyNexus – NOA required
- Triwest – No NOA, Final only
- Molina – No NOA, Final only
- Humana – No NOA, Final only

Frequently Asked Questions

Question:

Does Axxess Home Health provide reports to determine what NOAs are at risk for being untimely?



Answer:

Yes. The Billing Center in Axxess Home Health includes a RAP/NOA Aging column that enables users to filter results by age for interactive, hands-on management of internal processes. This tool displays the ages of NOAs that have not yet been submitted.

- The green portion represents NOAs that are 0-2 days old.
- The orange represents NOAs in their third or fourth day.
- The red portion shows NOAs that are five or more days old.

Clicking on any portion of the bar will filter the results for those patients.

Frequently Asked Questions

Question:

What should be done with an NOA that is in returned to provider (RTP) status? Should the original be corrected or cancelled?

Answer:

When an NOA is in RTP status, it can be corrected and resubmitted directly in Axxess DDE or the Medicare direct data entry (DDE) black screen system without being cancelled.

Frequently Asked Questions

Question:

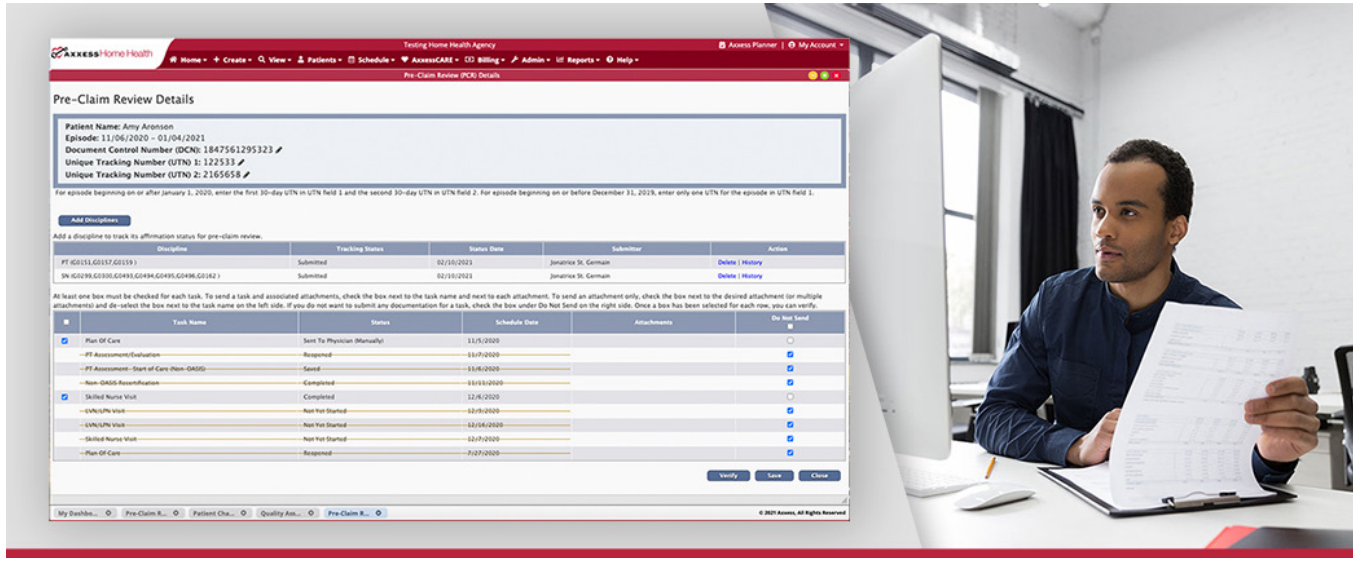
With the recent changes with NOAs, do I still need to obtain the unique tracking number (UTN) for my final claims if my state is under Review Choice Demonstration (RCD)?

Answer:

RCD requirements and processes are separate from the NOA submission.

If the organization has opted for Pre-Claim Review (PCR), the finals need to be submitted with the UTN number.

The one-time NOA should still be submitted within five calendar days at the onset of the admission.



Frequently Asked Questions

Question:

If our organization submits the NOA timely but needs to cancel it because of an error, can we file an exception on the initial claim?

Answer:

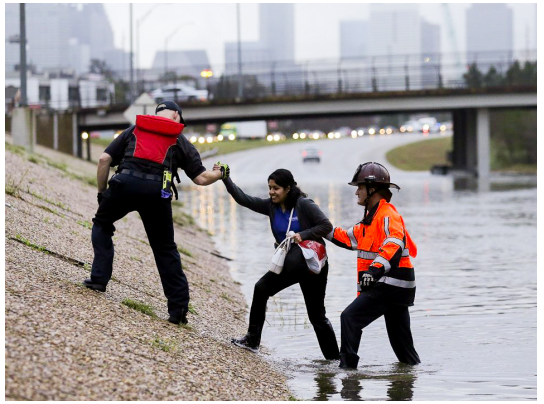
Yes. If the NOA was originally received timely but was canceled with TOB 032D (Cancellation of Admission) and resubmitted to correct an error, enter Remarks to indicate this is the case, i.e., “Timely NOA, cancel and rebill.”

Append modifier KX to the HIPPS code on the 0023 revenue line of the period of care claim. Agencies should resubmit the corrected NOA promptly–generally within two business days of canceling the incorrect NOA.

Billing Scenarios

Scenario:

A home health organization had to submit an NOA past the five-day window due to a tornado. What do they do?



Response:

The organization should submit the NOA as soon as possible.
If the NOA was submitted beyond five days, the final claim should be submitted with the KX modifier and with the Remark indicating the reason for the delay to request an exception to help avoid potential penalties.

The four circumstances that may qualify for an exception are:

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 your MAC determines to be beyond your control.

Billing Scenarios

Scenario:

Patient Diana began services on 1/05/2022 and the home health organization submitted an NOA that was accepted. Diana had a medical event and was transferred to the hospital and discharged from the home health organization on 1/14/2022. On 1/21/2022, Diana was readmitted to the same organization. Does the organization's biller need to submit another NOA?

Response:

The organization would need to submit two NOAs for this patient: one on 1/05/2022 for the initial admission to the organization and one on 1/21/2022 for the readmission from the hospital.

If the patient had been transferred but not discharged and a new billing period had begun when the Resumption of Care was completed, then an NOA would not be needed. Only a final claim for the subsequent billing periods is needed in this situation.

Billing Scenarios

Scenario:

Best Care Home Health's biller is not sure if he should only use condition code (CC) 47 in transfer situations. Does he enter CC 47 on an NOA if the previous home health organization Compassion Home Healthcare has discharged but not processed their final claim, or would this result in a late NOA?

Response:

In home health, a transfer is when a beneficiary transfers from one organization to another within a 30-day period. The receiving organization, Best Care Home Health, should submit the NOA with condition code 47 to close the prior admission period from the previous organization, Compassion Home Healthcare.

Billing Scenarios

Response (continued):

CC 47 may also be used when the beneficiary has been discharged from another organization, but the period of care claim has not been submitted or processed at the time of the new admission to discharge the beneficiary.

When a beneficiary is discharged from an organization and readmits later to the same organization, but the discharge claim has not been submitted or processed, the organization may submit the NOA without CC 47 for the new admission. If it is the same Medicare certification number (CCN) for organization, the NOA will process without CC 47.

Billing Scenarios

Scenario:

Patient Ian is a Medicare beneficiary that switched from a Medicare Advantage (MA) plan to Medicare, but the home health organization was notified after the fact. How should the home health organization revenue cycle team proceed?

Response:

Since the home health organization did not find out that Ian had disenrolled from a MA plan until they received a denial, the team should submit an NOA as soon as possible.

The corresponding final should be submitted with a KX modifier and a statement in the remarks indicating the date the beneficiary disenrolled from the MA.

Issues

NOA RTP Reason Code 32114

- Your organization may be impacted by a CMS oversight that is currently causing NOAs to be rejected for missing ZIP codes (reason code 32114). CMS is aware of this issue and is actively working toward a resolution.
- To rectify this error:
  - Step 1: Verify that your DDE (black screen) logins are active by clicking the blue DDE Black Screen button in the top-right corner of Axxess DDE.
  - Step 2: Access the claim in the Claim Center, enter the 9-digit ZIP code and resubmit the claim (F9).
- Since this issue is only affecting batch claims, you can manually enter NOAs into DDE (black screen) to ensure pending acceptance.
- If an NOA is late due to this issue, enter the following text in the Remarks section of your final claim: "Jan 2022 Issue RE 32114."

Issues

NOA RTP Reason Code 19960

NOAs were returned to provider (RTP) with reason code 19960 in status/location TB9900 and had condition code 15 (not entered by agency).

Palmetto is working to resolve the issue. For most NOAs that were affected, Palmetto removed the condition code 15 and removed the 19960 code prior to returning to the provider. This allowed many NOAs to process.

Some NOAs may still return to provider and be in status/location TB9997. Palmetto is reviewing these NOAs for resolution. No provider action is required at this time.

Update: Providers will need to request a late NOA exception on the corresponding claim if it was late due to this issue. In the remarks for these exception requests, provider shall enter "Late due to CC 15 release."

Claims Payment Issues Logs

To track the latest claims issues identified by the Centers for Medicare and Medicaid Services (CMS), visit the following links:

- Palmetto GBA
- CGS/NGS

For more information, CGS Medicare has provided a job aid document with additional details on billing the home health NOA.

Recap: NOA Overview and Process

- A Notice of Admission (NOA) is a one-time submission that establishes the home health plan of care (POC). The NOA began January 1, 2022. This new process **eliminates the need for any type of RAP**.
- There is **required submission at the start of care only**. **If a patient is discharged and readmitted, a new NOA is required at the start of care**.
- **For all patients who are on service on January 1, 2022, organizations will need to submit a one-time NOA at the start of their first 30-day period in 2022**. This establishes a new artificial "admission" date within the Common Working File (CWF) without requiring an actual discharge or readmission on the part of the provider.
- Organizations must submit an NOA to their Medicare Administrative Contractor (MAC) within five calendar days from the start of care date. This covers contiguous 30-day POCs until you discharge the patient from Medicare home health services.
- **Untimely submissions of NOAs will result in a daily penalty equal to 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 you submit the NOA.** This payment reduction also applies to outlier payments.
- You **must have a verbal or written order from the physician that contains the services required for the initial visit and you must have conducted an initial visit at the start of care**. The NOA only needs to contain **a primary diagnosis which can be generic**.

References and Resources

- Axxess Help Center NOA Updates and Resources
- Centers for Medicare and Medicaid Services NOA Companion Guide
- Office of the Federal Register, Current Public Inspection Issues
- Centers for Medicare and Medicaid Services, Final Rule, 9 November 2021
- CMS Manual System, Pub 100-04 Medicare Claims Processing, 9 June 2021
- MLN Matters, Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA) – Manual Instructions, 9 June 2021
- Centers for Medicare and Medicaid Services, Medicare Administrative Contractors Page
- CGS, The New 2022 Home Health Notice of Admission (NOA), 28 September 2021

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