HealthTrust
SOFTWARE

Notice of Admission Frequently Asked Questions

Effective on January 1, 2022, Home Health Agencies who submit bills to Home Health & Hospice Medicare Administrative Contractors (HH&H MACS) for services provided to Medicare patients will be required to submit a one-time Notice of Admission (NOA) for each Medicare patient. These Notices of Admission will take the place of No Pay Requests for Anticipated Payment (RAP), which have been phased out by the Center for Medicare and Medicaid Services.

What is a Notice of Admission (NOA)?

- A Notice of Admission is a one-time submission to establish the home health period of care and covers contiguous 30-day periods of care until the individual is discharged from Medicare home health services.

How will I handle NOAs in HealthTrust Software?

- The process for transmitting a Notice of Admission in HealthTrust Software is very similar to the current process for transmitting a RAP. For start of care episodes (and on the first episode in 2022 for patients who are already on service), on the episode screen, choose READY as the status when you are ready to create the NOA for that episode. Create your pending claim. For start of care episodes beginning on or after January 1, 2022 (and also for the first episode for any PPS patient starting in 2022), the system will automatically create a NOA claim instead of the normal RAP claim. The system will use Type of Bill "32A" and HIPPS code "1AA11". After the NOA has been billed, the system will change the episode status to RAP / NOA for you.
- For all subsequent episodes, you will not bill a NOA or RAP. You will proceed directly to the final claim at the end of each 30 day period.
- For final claims, you will change the episode status to "CONFIRMED" when you are ready to bill the Final Claim (this process has not changed from the current functionality).

When can I submit a Notice of Admission (NOA) to a MAC?

- A Notice of Admission can be submitted to Medicare once:
    - The Home Health Agency has received a verbal or written order from the physician that contains the services required for the initial visit AND;
    - The Home Health Agency has conducted an initial visit at the start of care

What is the timeline for a Notice of Admission to be submitted to a MAC?

- A Notice of Admission must be submitted to and accepted by the MAC within five (5) calendar days from the start of care.

What if a Notice of Admission is not submitted within 5 days from the start of care?

- Failure to submit a timely Notice of Admission will result in reduction in the payment amount 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 the Notice of Admission is submitted.

What if a Notice of Admission is submitted within the five-day timely filing period but contains inadvertent errors?

- Inadvertent errors may not trigger the Notice of Admission to be immediately returned to the Home Health Agency for correction.
- In these instances, the Home Health Agency must wait until the incorrect information is fully processed by Medicare systems before the Notice of Admission is returned for correction. Such delays in the Medicare systems could cause the Notice of Admission to be late. However, a delay such as this may qualify for an exception to the timely filing requirement since it is outside the control of the Home Health Agency.

What form do I use to submit a Notice of Admission?

- If you are not using HealthTrust Software to transmit your NOA, use Type of Bill 32A to submit a Notice of Admission.

How should I submit a Notice of Admission?

- A Notice of Admission must be sent by mail, Electronic Data Interchange (EDI), or Direct Data Entry (DDE). NOTE: HealthTrust Software uses EDI as its submission protocol.

Do I need to submit multiple Notices of Admission?

- No, CMS only requires one (1) Notice of Admission for any series of Home Health Periods of Care beginning with an admission to home care and ending with discharge.
- However, once a discharge has been reported to Medicare, a new Notice of Admission must be sent before any additional claims are submitted.

What if I have a patient who received service in 2021 and whose services will continue in 2022?

- Home Health Agency will submit a Notice of Admission with a one-time, artificial "admission" date corresponding to the "From" date of the first period of continuing care of 2022.
    - For example, if a period of care begins in 2021 and ends on January 10, 2022, the Home Health Agency will submit a Notice of Admission with an admission date of January 11, 2022 and then submit a claim when the 30-day period of care is over.

What if I receive a transfer patient from another Home Health Agency who has already submitted a Notice of Admission for the patient?

- Home Health Agency will submit a Notice of Admission with condition code 47 to indicate a transfer when an admission period may already be open for the same beneficiary at another Home Health Agency.
- In order for a receiving home health Agency to accept a beneficiary elected transfer, the receiving Home Health Agency must document that the beneficiary has been informed that the initial Home Health Agency:
    - Will no longer receive Medicare payment on behalf of the patient; AND
    - Will no longer provide Medicare covered services to the patient after the date of the patient's elected transfer

How should I submit a Prospective Payment System (PPS) claim?

- All claims for periods of care following the admission of a patient will be submitted using Type of Bill 329.
- Type of Bill 329 has been redefined to represent an original claim, rather than an adjustment, for all claims with "From" dates on or after January 1, 2022.
- Home Health Agencies may not submit a claim until after all services are provided for the period of care and the physician has signed the plan of care and any subsequent verbal order.
- The 30-day period of care is the unit of payment for Home Health PPS
    - The period of care payment is specific to one individual homebound beneficiary

Which form do I use to cancel or adjust a claim?

- Type of Bill 0328 is used to cancel a Home Health PPS claim
- Type of Bill 0327 is used to adjust a Home Health PPS claim

Where can I find more information about the NOA?

- CMS has published an MLM Matters document on the NOA available at https://www.cms.gov/files/document/mm12256.pdf.

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What is Required in a Notice of Admission

The following data elements are required to submit a Notice of Admission under the Home Health Prospective Payment System.

Provider Name, Address, and Telephone Number

- Minimum entry is the Agency's name, city, State, and zip code
- State may be abbreviated using standard post office abbreviations

Type of Bill

- 032x - Home Health services under a Plan of Treatment

Statement Covers Period (From-Through)

- Home Health Agency will report the date of the first visit provided in the admission as the "From" date
- The "Through" date on the Notice of Admission must always match the "From" date

Patient Name/Identifier

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

Patient's Address

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

Patient Birth Date

- Month, day and year of birth of patient
- Leave blank if the full correct date is not known

Patient Sex

- "M" for male or "F" for female must be present

Admission/Start of Care Date

- The Admission date on the Notice of Admission must always match the "From" date

Condition Codes

- Conditional - if the Notice of Admission is for a patient transferred from another Home Health Agency, the Home Health Agency enters condition code 47
- *Note* - no line item service provider 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 Notice of Admission Companion Guide for details on meeting those requirements

Release of Information Certification Indicator

- 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

National Provider Identifier

- Enter the provider identifier of the Home Health Agency

Insured’s Name

- 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 health insurance card or other Medicare notice

Insured’s Unique Identifier

- Unique number assigned by the health plan to the insured

Principal Diagnosis Code

- Required to meet the requirements of the 837I claim format

Attending Provider Name and Identifiers

- Home Health Agency enters the name and provider identifier of the attending physician that has established the plan of care with verbal orders