national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Home Health Billing Part One: The Notice of Admission

1/21/2025

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Today's Presenter

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

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Recording

Attendees/providers are never permitted to record (tape record or any other method) our educational events. This applies to webinars, teleconferences, live events and any other type of National Government Services educational events.

Objective

Attendees will understand the information needed prior to billing Medicare and how the Home Health Prospective Payment System (HH PPS) affects billing and reimbursement. We will also review the billing requirements for the NOA.

Agenda

- What to Know Before Billing Medicare
- Verifying Eligibility
  - HH PPS overview
- Submitting the NOA
- Resources
- Q&A

What to Know Before Billing Medicare

Getting Ready to Bill

- Information to know before billing Medicare
  - Tools/Resources
    - CWF
    - FISS
    - IVR
    - NGSConnex
    - HETS
- General regulations
  - Patient registration
  - Identifying primary payers

CWF

- Assists in verifying patient's eligibility
  - Providers access through online system(s)
- Maintains national beneficiary records
  - Entitlement, date of birth, date of death
  - Recent benefit periods (including any deductibles due)
  - Claim history
  - Home Health admission periods
  - Hospice enrollment
  - MSP information
  - MAO information

FISS

- All Part A MACs (including HH+H) use FISS to process claims and maintain records
  - FISS DDE Provider Online Guide - NGSMEDICARE
- Providers access through online computer system
  - Claim status
    - Processing (“in suspense”)
    - Paid, rejected, denied
    - Returned to provider for correction

NGSConnex

- Self-service applications
  - Obtain beneficiary eligibility information
  - Query for your claims status
  - Initiate and check the status of redetermination and reopening requests
  - View your provider demographic information
  - Query for your financial data
  - Submit documents for an additional documentation request
  - Submit Credit Balance Reports

IVR

- IVR uses natural language and text-to-speech technology that responds to your voice. Touch tone is also available throughout the application, as needed.
- You can obtain information such as patient eligibility, claim status, check and remittance information, and some general information.
- The IVR is available 24-hours a day, seven days a week for general questions.
- Menu options that require system access (e.g., the CWF) are limited to that system's availability. The hours are
  - Monday–Friday: 6:00 a.m.–7:00 p.m. ET
  - Saturday: 7:00 a.m.–3:00 p.m. ET

HETS

- CMS' healthcare eligibility benefit inquiry system
  - Eligibility data accessed by Medicare providers, suppliers or authorized billing agents for the purpose of preparing an accurate Medicare claim, determining beneficiary liability or determining eligibility for specific services

Home Health Eligibility

- In order to be considered eligible to utilize the home health benefit, an individual must
  - Be entitled to either Medicare Part A or Part B coverage
  - Receive services from a Medicare-certified agency
  - Be confined to the home (homebound)
  - Have a face-to-face encounter with a physician or NPP
  - Be under a doctor's care and receiving services under a plan of care established and regularly reviewed by the doctor or allowed practitioner
  - Have a doctor certify the need for
    - Intermittent skilled nursing care
    - Physical therapy
    - Speech-language pathology
    - Continued occupational therapy

Verifying Eligibility

Eligibility Search

- Required Information
  - HHA NPI
  - Beneficiary MBI
  - Beneficiary first and last name
  - Beneficiary date of birth
  - Date of service

Basic Coverage

- Verify date of Part A entitlement – still active?
- Verify date of Part B entitlement – still active?
- Verify patient is not enrolled in a MAO plan
  - Option ‘C’ – send claim(s) to MAO plan
- Verify patient has not elected Hospice
  - Services not related to patient’s terminal illness sent to Medicare with condition code ‘07’
- Verify whether Medicare is primary or secondary
  - Complete MSP questionnaire

Home Health Certification Period

- Certification valid up to 60 days
- Physician or allowed practitioner establishes plan of care which includes services needed for the certification period
- HHA provides services to eligible beneficiary
  - Services covered and billed under two 30-day periods of care
- Physician or allowed practitioner must recertify patient's eligibility and need for continued care and subsequent services beyond the initial 60-day certification

Patient-Driven Groupings Model

- Payment model for HH PPS
- Reimbursement calculated based on clinical characteristics and other patient information across payment categories
- Plan of care and certification/recertification based on 60 days
  - Billed under two 30-day payment periods
- Reimbursement driven by the resource grouping assigned

PDGM Payment Groupings

- Admission Source
  - Institutional
  - Community
- Timing
  - Early period
  - Late period
- Clinical Grouping
  - Primary reason for home care
  - Principal diagnosis
  - 12 total clinical groups
- Functional Impairment
  - Low/Medium/High
- Comorbidity Adjustment
  - None/Low/High

Notice of Admission

Background

- Billing requests for anticipated payment (RAPs) at the beginning of every period of care was phased out to make way for the NOA
- NOAs required for every period of care beginning on or after 1/1/2022
- NOAs only required for new admissions
  - Admission period remains open until patient is either discharged or transferred out of home health care

NOA Submission – Claim Page 1

Field	Description/Notes
MID: Medicare ID Number	Enter the Medicare Beneficiary Identifier.
TOB: Type of Bill	32A – Notice of Admission 32D – Cancellation of Admission
NPI: National Provider Identifier Number	Enter your home health agency's NPI number.
STMT DATES FROM and TO (Statement Covers Period "From and "Through")	Report the 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" date.
LAST, FIRST, MI, ADDR, DOB, SEX	Patient's last name, first name, and middle initial (if applicable), full address, date of birth (MMDDYYYY) and sex code (M/F).
ADMIT DATE	Enter the effective date of admission, which is the first Medicare billable visit and the Medicare start of care date (MMDDYY). The Admission date on the NOA must always match the From date.
SRC (837I ONLY): Source of Admission	Submit a default value of "1."
STAT (837I ONLY): Patient Status	Submit default value of "30."
COND CODES: Condition Codes	Enter condition code 47 for a patient transferred from another HHA. HHAs can also use cc 47 when the patient has been discharged from another HHA, but the discharge claim has not been submitted or processed at the time of the new admission.
FAC. ZIP	Facility ZIP Code of the provider or subpart (9-digit code).

NOA Submission – Claim Page 2

Field	Description/Notes
REV (837I ONLY): Revenue Codes	Enter Revenue Code 0023, which indicates billing under HH PPS.
HCPC (837I ONLY): Healthcare Common Procedure Code	Submit HIPPS code 1AA11 as a placeholder value, since differing HIPPS codes may apply over the course of an HH admission.
TOT UNITS (837I ONLY): Total Services Units	Enter 1 unit
TOT CHARGE (837I ONLY): Total Charge	The total charge for the 0023 revenue line must be zero.
SERV DT (837I ONLY): Service Date	Must not be a future date. The admission date may be duplicated to satisfy this requirement.

NOA Submission – Claim Page 3

Field	Description/Notes
PAYER (837I ONLY) Payer Identification	Enter “Medicare” on line A with payer code “Z.”
RI (837I ONLY) Release of Information	Enter “Y”, “R” or “N.” “Y” – Indicates the HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims “R” – Indicates the release is limited or restricted “N” – Indicates no release is on file
DIAGNOSIS CODES (837I ONLY)	Enter the appropriate ICD code for the principal diagnosis code or submit any valid diagnosis code.
ATT PHYS (837I ONLY) Attending Physician	Enter the NPI and name (last name, first name, middle initial) of the attending physician who established the plan of care with verbal orders — this must be the individual physician’s NPI, not a group NPI.

NOA Submission – Claim Page 4

Field	Description/Notes
REMARKS	Remarks are not required on the NOA; however, remarks are recommended when canceling the NOA to indicate the reason for cancellation.

NOA Submission – Claim Page 5

Field	Description/Notes
INSURED NAME (837I ONLY)	Enter the patient's name as shown on the Medicare card.
CERT/SSN/HIC (837I ONLY)	Enter the beneficiary's Medicare number as it appears on the Medicare card if it does not automatically populate.

Canceling a Timely NOA to Correct an Error

- 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, e.g., “Timely NOA, cancel and rebill”
- Append modifier KX to the HIPPS code on the 0023 revenue code line of the period of care claim
- HHAs should resubmit the corrected NOA promptly within two business days of canceling the incorrect NOA

Canceling a Timely NOA to Correct an Error – Claims Submitted for Admission Period

- If the NOA needs to be cancelled and resubmitted to correct an error after claims were processed, the HHA must cancel all claims associated with the admission period set up by the NOA prior to cancelling that NOA.
- Resubmit claims for admission period after correct NOA processes

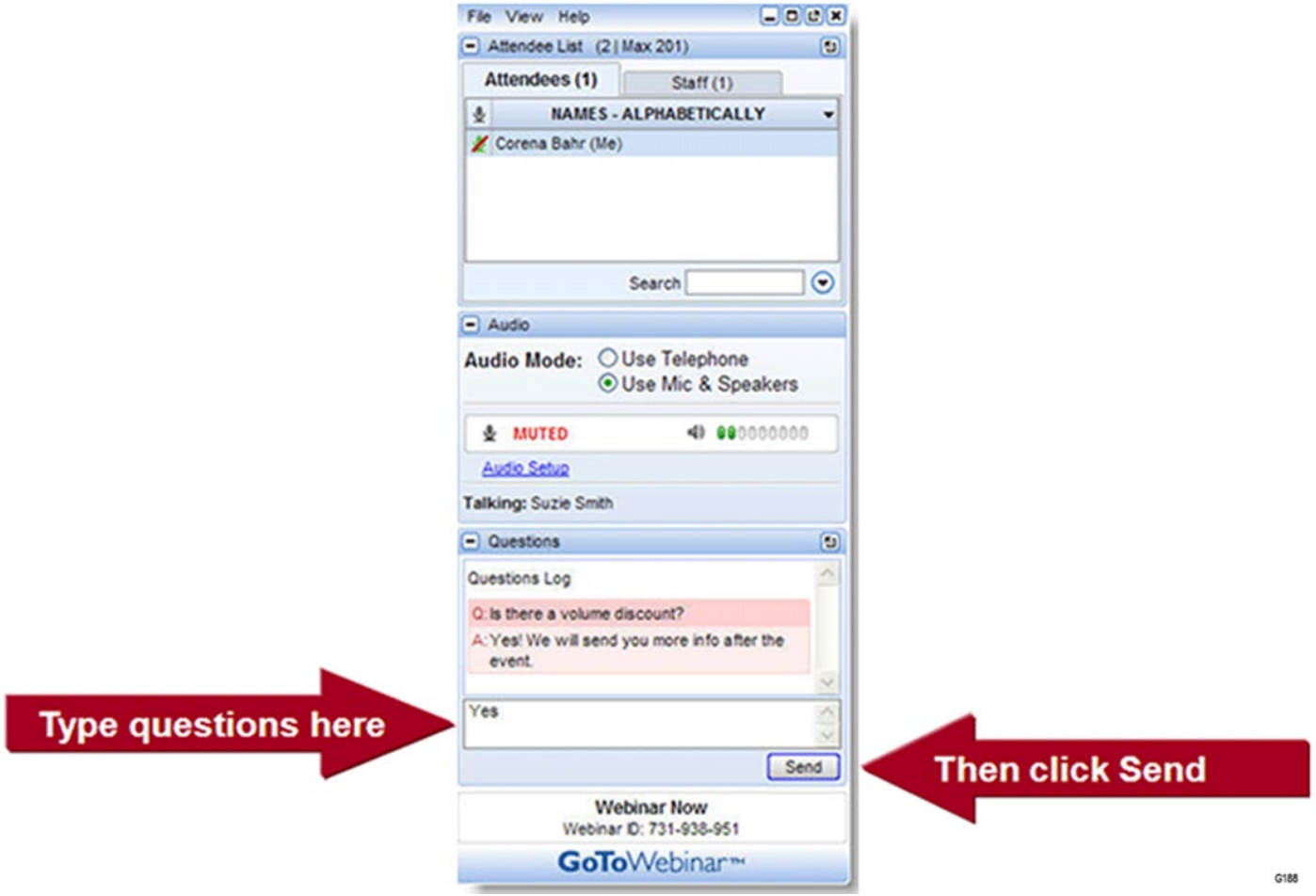
NOA Cancel and Resubmission

- Examples of errors that require NOA cancel and resubmission:
  - Incorrect Admission, From or Through date
  - Incorrect beneficiary

- Examples of errors that do not require NOA cancel and resubmission
  - Change in principal diagnosis code reported on NOA
  - Change of physician/practitioner
    - Report correct physician/practitioner on the claim(s)
  - Match the HIPPS on the NOA to the claim

Resources

Ask a Question Using the Question Box



National Government Services Web Resources

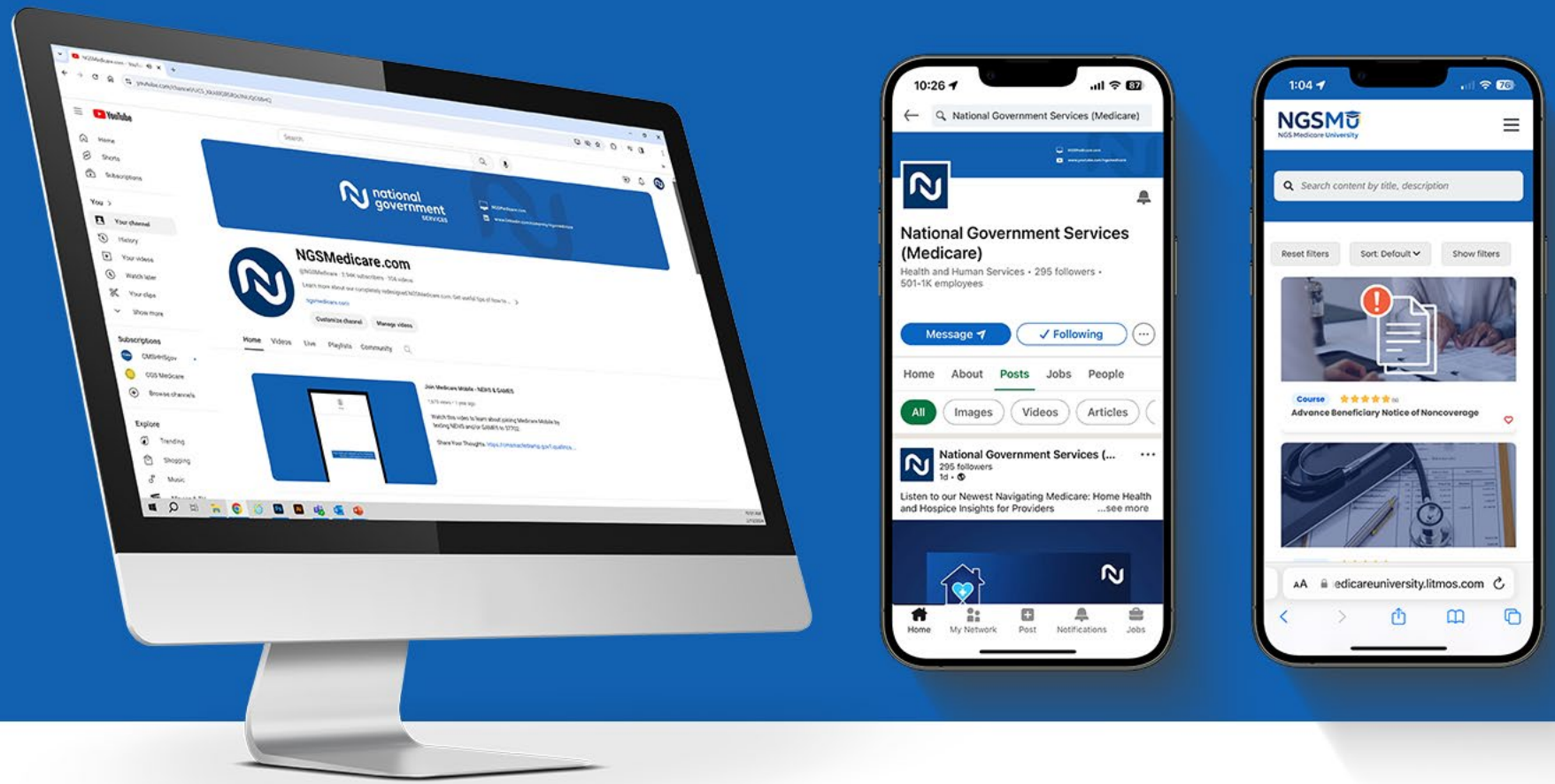
- NGS website
- Events
  - Upcoming education sessions
  - Past events material
- Education
  - Medicare topics
    - Home health billing (job aids)
- Medicare University
  - CBT courses

Provider Contact Center

- First option when contacting National Government Services
  - Required to log and track all incoming inquires
- Tiered system to respond accurately to all provider inquiries
- Contact number and hours available on our website
  - Contact Us > Provider Contact Center

CMS Resources

- CMS website
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Section 70 (Claim Processing Timeliness)
  - Chapter 10, Sections 40.1 and 40.2 (Home Health Agency Billing)
- Medicare Learning Network®
  - Resource Materials
  - Training
  - MLN® Matters Articles
- Home Health Agency (HHA) Center



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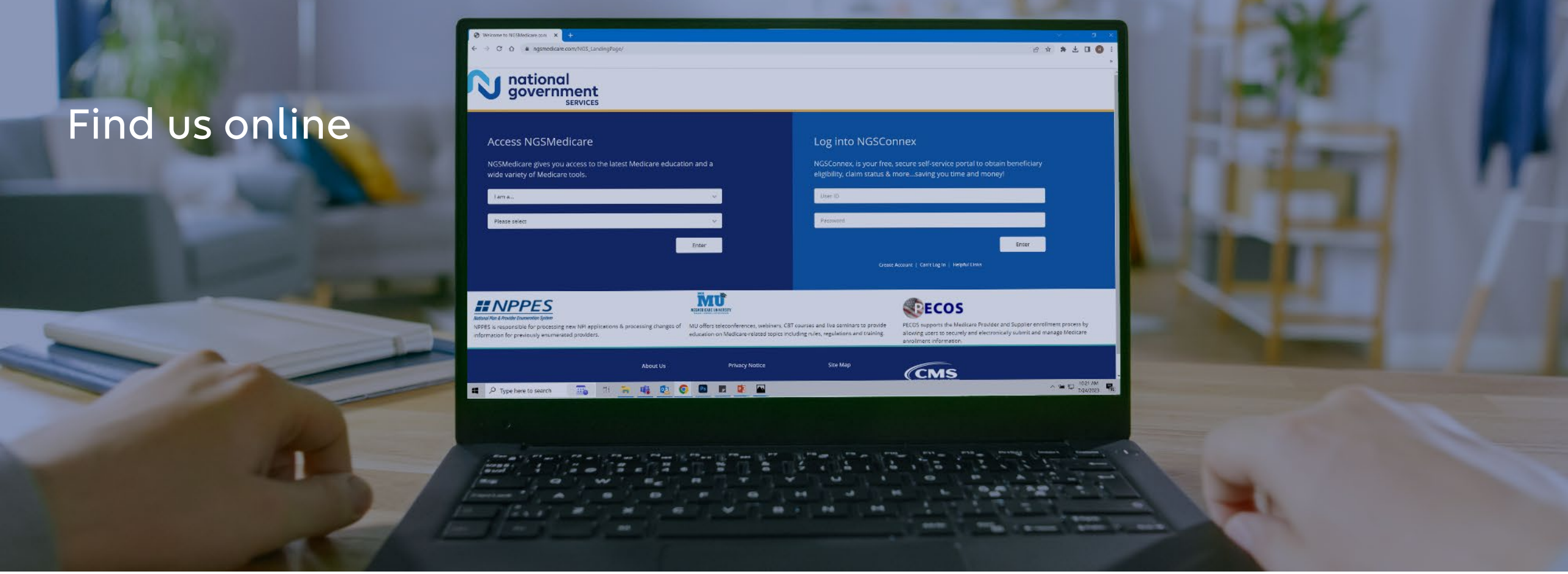

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

[IVR System](#)
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

[NGSConnex](#)
Web portal for claim information

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Questions?

Thank you!