KanTime
Healthcare Software

HOW
BETTER
HAPPENS.

KanTime Healthcare Software

HOW BETTER HAPPENS.

Overview: Home Health Notice of Admission (NOA)

Kim Spence, RN
Customer Success Division Leader

Why the change?

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- Establishes the Home Health Period of Care in the CWF
- Triggers consolidated billing edits

What's the Same?

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- Submission deadline of 5 calendar days from SOC, with the SOC date counted as day zero.
- Penalty for late submission calculations same as the No Pay RAP
- Scenarios and accepted reasons for requesting an exception same as the No Pay RAP
- Minimum requirements for submission:
  - Receipt of initial order and
  - Assessment visit (not documentation) completed
  - Primary diagnosis or placeholder
    (CWF requirement, not RAP or NOA regulation requirement).
- Ability to apply a valid diagnosis code for timely submission when the Assessment/POC are not yet locked.

What's the Same?

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- LUPA visits completed prior to a non-timely NOA submission will not be reimbursed.
- Medicare Secondary Payers (MSP) actions and processing.
- 60 day care periods
- Two 30-day payment periods within each 60-day care period.
- Claim submitted at end of each 30-day payment period
- Claim TOB (0329) remains the same

What's Changing?

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- Beginning January 1, 2022:
- No more RAP's throughout the care episode.
- NOA is submitted only once, at SOC and is valid until discharge. If a new SOC is done for any reason, a new NOA must be submitted.
- Subsequent payment periods do not require further submissions.
- Once a discharge has been submitted to Medicare a new NOA must be submitted before any additional claims
- Medicare Advantage payors will continue to have to be monitored and actively communicated with to determine changes they may choose to make.

What's Changing?

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- There will be a transitional process for patients that are receiving services in 30-day episodes that begin in 2021 and end in 2022 that will require a one time NOA submission with an "artificial" admission date
    - SOC Dec 15, 2021
    - RAP is submitted within 5 days of Dec 15, 2021 SOC for the 1st 30-day payment period.
    - 1st 30-day payment period ends January 13, 2022.
    - Claim for the 1st 30-day period is submitted.
    - NOA is submitted within 5 days of January 14, 2022 with the artificial SOC date of January 14, 2022 ---(FROM DATE) of FIRST 30-day payment episode in 2022.
    - 2nd 30-day payment period ends 2/12/22
    - Claim is submitted for 2nd 30-day period with the same artificial admission date as the NOA
    - All subsequent claims until discharge will utilize this same artificial admission date

What's Changing?

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- If the NOA is submitted late, any visits **prior to the submission of the NOA** will **not** count toward the LUPA threshold so……failure to submit a NOA in a timely manner can result in what have would have been a full payment episode becoming a LUPA

- NOA will be submitted on TOB 032A (even though technically is not a billing)

- TOB 032D will be used to cancel a NOA

- NOA can be submitted by EDI (most are done this way), DDE or mail

What's Changing?

- Special Handling of Patient Discharge Status Code
    - In cases where a HHA provides care in a 30-day period of care and then discharges the patient in the next 30-day period of care, but does not provide any billable visits in the next 30-day period, special handling of the patient status code will be needed
    - Normally, the patient status code for the 30-day period before the discharge would be 30, since the patient has not yet been discharged.
    - However, since there will not be a claim for the period in which the discharge occurred, this would result in the HH admission period remaining open in Medicare systems and prevent billing for any later HH services.

What's Changing?

- Special Handling of Patient Discharge Status Code
  - In order to close the HH admission period in these cases, the HHA should **report patient status 01** on the final claim *for the last 30-day period in which billable visits occurred.*
  - This will trigger Medicare systems to close the HH admission period. I*f 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.**
  - If the cause of the discharge in the next 30-day period is a transfer to another HHA before any visits were provided, the HHA should take care not to report patient status 06 on the claim. **This would result in an incorrect partial period payment adjustment.**
  - If the cause of the discharge in the next 30-day period is the beneficiary's death, the HHA should take care not to report patient status 20 on the claim. **This would result in an incorrect date of death being recorded in Medicare systems and potentially affect claims from other providers.**

What Are The KanTime Solutions?

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- Special Handling of Patient Discharge Status Code
  - If a period of care becomes the LAST Billable 30-day period of care for a patient, with the discharge happening in its next subsequent period of care that has no-billable visits, then the LAST period of care's final claim **will be created** with the discharge status code as 01 as opposed to status code 30.
  - The system will automate and add code 01 to the final claim of the eligible period of care & will also alert staff on such in OASIS or period of care tab on certain backward transactions

What Are The KanTime Solutions?

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- Special Handling of Patient Discharge Status Code
  - If the final claim is **already created** for a 30-day period with status code = 30 and then a discharge occurs in the next 30-day period (with no billable visits in the 2nd period), then during the discharge assessment submission and locking, the system will alert the staff of the situation with a message:
    - Final claim for is created with patient status code as 30, you may need to create an adjustment claim to change the patient status to 01 and submit.
    - A similar message will also be shown on the respective Period of Care tab to alert for timely review and action.
    - The system will allow to lock the discharge assessment with this warning, but ***it's the responsibility of the staff to communicate with the biller*** to notify them of the need for the Final claim adjustment with accurate status code.

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- Special Handling of Patient Discharge Status Code
  - If the final claim is **already created** with status code = 01, a discharge is occurring in the subsequent 30-day period and a staff member attempts to delete that discharge assessment, then
    - The system will alert and block the user from deleting the assessment with a message:
    - Cannot Delete the assessment, as the Final Claim for period 3 is already created with Patient status Code as 01, you may need to cancel the claim and try again. Note: After deleting this assessment, please recreate the final claim with the proper patient discharge status code (30 - Active) and bill type
    - This will be a hard stop for deleting the discharge assessment.. In order to clear this deficiency, the user will have to first cancel the final claim

What Are The KanTime Solutions?

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- Special Handling of Patient Discharge Status Code
  - If a final claim is **already created** with status code = 30 and then in the period of care tab the setting "Exclude this period of care from billing Final Claim" is enabled in the subsequent 30-day period, an alert message will be flagged in the **subsequent** period of care tab
  - EXAMPLE:
  - Final claim for P3 is already created with patient status code 30, please review its claim for proper discharge status code if you think P4 period of care is the Last 30-day period of care for this admission
  - The system will allow the user to enable the said period of care flag with this warning under Period 4, but **it's the responsibility of the staff to communicate with the biller** to handle the Period 3 final claim adjustment with accurate status code.
  - The system **always** carry Patient Status Code = 01 for the eligible LAST periods of Care Final claims regardless of the Billing reason Code recorded in the Discharge assessment.

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- Automated configuration of Medicare payor rules effective 1/1/2022.

- Ongoing configurations by payor to allow for likely variances in adoption of these requirements by non-Medicare payors who can choose when and if they will change, or how much of this they will adopt.

What Are The KanTime Solutions?

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- Existing RAP configurations in Dashboards and Reporting for Medicare will be modified to consider RAP and NOA in the overlap, then just NOA.

- Dashboard alerting for NOA will mirror that for RAP's due, grouped by timeline in days as well as overdue and associated aging reports.

What are the KanTime Solutions?

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- A late RAP/NOA agency level configuration will be available to require documentation of reason code(s)/request for exemption notes to be mandatory

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- Validation that initial order has been received and first visit completed before allowing transmission of RAP/NOA.

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- Automated inclusion of a valid HIPPS if Assessment and/or POC are not yet locked and automated inclusion of that same DX code on subsequent pay period claims.

- If a NOA has been submitted and a user attempts to change SOC start date the system will block the ability to change the date. The NOA will have to be cancelled first (TOB 32D), then a new NOA will need to be submitted with the new SOC date. (New)

- MSP & Demand Claims Filing: NOA will be required and mandated during the MSP/Demand Claim flows. (New)

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- Reporting Changes
  - Financial Reports like MER, WER & Late RAP/NOA will consider and show NOA transactions (Billing & Late Penalty calculations & applications just as No-Pay RAPs)
  - Other Reports will be enhanced to filter and list NOA
    - Episode Listing Report
    - PPS Pricer Report
    - Unbillable RAP ->>will be changed to ->> Unbillable RAP/NOA
    - Unbilled Final Claim
    - Days to RAP ->>will be changed to ->> Days to RAP/NOA

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- Reporting Changes (continued)
  - PDGM Statistics - This Report will be provided with a new counter and filter to view “Average number of days to NOA by Early and Late Status”, similar to previous RAP data.
  - KPI (Key Performance Indicator) Reports - These reports will be provided with a set of new counters to filter and view NOAs, the logic will be similar to the logic for RAPs.
    - NOA Billed
    - NOA Approved
    - Average Days to Bill NOA
  - JE Report - JE setup will utilize the existing invoice type. Hence the type will change and be renamed from "RAP" to "RAP/NOA" to support both RAP, No-Pay RAPs & NOAs hereafter

Resources:

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ttps://www.cms.gov/files/document/r10758CP.pdf

https://www.cms.gov/files/document/mm12256.pdf

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c10.pdf

https://www.cgsmedicare.com/hhh/education/materials/pdf/home_health_billing_codes.pdf

https://www.cms.gov/files/document/MM12424.pdf

https://www.cms.gov/files/document/r10987cp.pdf

Medicare Claims Processing manual 10.1.10.3

42 Code of Federal Regulations (CFR) Sections 484.60(b) and 409.43(d)
(84 FR 60548)

QUESTIONS?

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If you are a current KanTime customer, we thank you so much for being our customer. If you have any questions regarding the NOA please feel free to contact support@kanrad.com

If you aren't a customer of KanTime yet, and would like to learn more about KanTime, please reach out to us **here**. We would love to show you How Better Happens.