

Home Health Notice of Admission (NOA) Frequently Asked Questions (FAQ)

Starting January 1, 2022, Medicare will require Home Health Agencies (HHAs) to submit a one-time Notice of Admission (NOA) instead of Requests for Anticipated Payment (RAPs). HHAs shall no longer submit RAPs, Type of Bill (TOB) 0322, for any Home Health (HH) periods of care 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.

NOA Information

- 1. Is the NOA only required to be submitted at the time of admission (or artificial admission) or for every 30-day period of care?**

Answer: Medicare only requires one NOA (TOB 032A) for any series of HH periods of care beginning with admission to home care and ending with discharge. HHAs shall not submit an NOA for subsequent 30-day periods of care with the exception of the one-time NOA submission for beneficiaries receiving HH services in 2021 and continuing services in 2022 (see FAQ 15–18).

- 2. May the NOA be submitted early?**

Answer: No. NOAs that contain a future “Admission,” “From” or “Through” date will be returned to the provider. For new admissions, the NOA cannot be submitted until the HHA has obtained a verbal or written order from the physician/practitioner and conducted an initial visit at the start of care (SOC), which is the admission date.

- 3. Would an HHA only use condition code (CC) 47 in transfer situations? Can an HHA enter CC 47 on an NOA if the previous HHA has discharged, but not processed their final claim, or would this result in a late NOA?**

Answer: In home health, a transfer is when a HH beneficiary transfers from one HHA to another HHA within a 30-day period. In transfers from one agency to another, the receiving agency submits the NOA with condition code 47. This will close the prior admission period from the previous agency.

CC 47 may also be used when the beneficiary has been discharged from another HHA, 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 HHA and readmits later to the same HHA, but the discharge claim has not been submitted or processed, the HHA may submit the NOA without CC 47 for the new admission. If it is the same CMS certification number (CCN) for the HHA, the NOA will process without CC 47.

- 4. Besides CC 47, are there other CCs an HHA should submit on an NOA?**

Answer: No. The NOA will be returned to the provider if any other CC than 47 is applied to the NOA. Unlike RAPs, NOAs will not edit for hospice elections and CC 07 (unrelated to the terminal condition) shall not be applied to the NOA. Period of care claims will continue to edit for hospice elections and CC 07 should only be applied to the claim in situations that the HH services are completely unrelated to the termination condition.

5. Will the NOA require a Health Insurance Prospective Payment System (HIPPS) code like RAPs?

Answer: A HIPPS code is only required on the NOA when billing via the 837I format (electronically). When billing electronically, use a placeholder HIPPS of "1AA11."

6. In 2021 we get a rejection if we put a different HIPPS on the final claim compared to the RAP. After NOA implementation, will we still get rejections if the final claim HIPPS for the first 30-day period doesn't match the HIPPS on the NOA? What about the subsequent final claims submitted after the first 30-day period?

Answer: The HIPPS is not required on the NOA unless submitting via the 837I format, in which case HIPPS code "1AA11" is used. Since the field where the HIPPS code is submitted is not a required field on the NOA, there is **not** a matching field requirement for the NOA/period of care claim. Subsequent period of care claims may be submitted with either a Grouper produced HIPPS code or any valid HIPPS under the Patient-Driven Groupings Model (PDGM).

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

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

8. Does the principal diagnosis code reported on the NOA need to match the principal diagnosis on the initial period of care claim?

Answer: No, the principal diagnosis code reported on the NOA does not need to match the principal diagnosis reported on the initial period of care claim. Also, secondary diagnoses are not required on an NOA.

Please remember, the principal diagnosis reported on a period of care claim is what drives the clinical grouping under PDGM for the HIPPS.

9. 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?

Answer: No, the NOA does not have to be canceled and resubmitted if the primary diagnosis is changed after the NOA was sent and processed.

10. If the NOA is manually entered in DDE, do the HHA choose Home Health (option 26) or NOA/NOE (option 49) from the Claims Entry screen?

Answer: Either option will bring the HHA to claims entry where they can enter the appropriate NOA information. Be sure to change the bill type to 032A.

11. Does the NOA apply to Medicare Secondary Payer (MSP) as well?

Answer: MSP billing is not required on NOAs. HHAs shall submit the NOA as Medicare primary and it will process without MSP editing.

Remember that beneficiaries who have Medicare as a secondary payer are still Medicare beneficiaries, and therefore all Medicare billing requirements must be met. The NOA is required for Medicare billing,

regardless of whether Medicare is primary or secondary (or tertiary). The HHA will input the necessary MSP information on their final claims.

12. Which other payers will require NOAs? Which payers will "copy" the Medicare NOA rules?

Answer: The billing guidelines for the NOA apply to Original Medicare. The HHA will need to contact any Medicare Advantage (MA) plans or other insurance plans to which the HHA submits claims to find out the details of their billing requirements.

13. The NOA job aid states the NPI entered with the name in the Attending Physician field must be an individual NPI, not a group NPI. How do we determine if the physician's NPI is an individual NPI rather than a group NPI?

Answer: Please visit the NPI registry to verify this information, <https://npiregistry.cms.hhs.gov/>.

14. Is the end of the HH Admission Period when the beneficiary is discharged? For example, there would not be a new admission when a beneficiary is transferred to a hospital but remains on service, or at the end of a recertification period?

Answer: An HHA has the option to discharge a beneficiary when admitted to a hospital during a 30-day period, so if the HHA keeps the beneficiary on service without discharging them, there would not be a new admission when the beneficiary is back with the HHA. The NOA is only required for new admissions, so a beneficiary remaining on service with the same HHA for multiple recertifications would not require an NOA for the recertification periods.

In most cases, if a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been a subsequent 60-day recertification, a new HH certification begins with the new start of care date after inpatient discharge. Please refer to Section 10.9 — Discharge Issues, of the HH [Medicare Benefit Policy Manual](#) for more information on discharges associated with inpatient admission overlapping into subsequent 60-day recertifications.

15. What happens if a beneficiary is transferred within the 1st 30-day period and resumes care with the HHA in the 2nd 30-day period, but is coming in from a SNF? Guidance tells us to do a new start of care. What do we need to do with the new NOA implementation?

Answer: An HHA has the option whether or not to discharge a beneficiary when transferred to another facility for inpatient care. If the HHA chooses not to discharge the beneficiary, there is no need to submit an NOA when the beneficiary returns to the HHA. The NOA is only required for new admissions, so a beneficiary remaining on service with the same HHA for multiple recertifications would not require an NOA for the recertification periods.

Beneficiaries Receiving HH Services in 2021 and Continuing Services in 2022

16. What do HHAs do for beneficiaries receiving HH services in 2021 and who will continue services in 2022?

Answer: For all beneficiaries receiving HH services in 2021 who will be continuing services in 2022, HHAs are required to submit an NOA with a one-time, artificial “admission” date corresponding to the “From” date of the first period of continuing care in 2022. Unlike a new admission, there is no requirement to perform a visit on the artificial “admission” date.

17. For artificial admission NOAs, what admission date do we use on our claims?

Answer: The admission date on the NOA for services that carry over into 2022 should use the date that corresponds to the “From” date of the new period of care. For example, if a beneficiary began care on 12/15/2021, and the new period of care will begin on 1/16/2022, the NOA should use the same date as the “From” date of the new billing period, e.g., 1/16/2022. The period of care claim starting on 1/16/2022 will also use the new artificial admission date, which will carry over to all subsequent claims for that beneficiary until discharge.

18. Does the five-day NOA submission requirement apply to the artificial NOA for periods spanning 2021-2022?

Answer: Yes, the five-day submission requirement applies to all NOAs, including those billed with an artificial admission date when a period of care carries over into 2022 from 2021.

19. When using an artificial admit date on periods of care that continue into 2022 from 2021, will the artificial admit date be the admit date on all claims going forward rather than the real admit date?

Answer: Yes. Since an admission in 2022 is required for the NOA, the guidance to bill an artificial admission date that corresponds to the “From” date of the period of care in 2022 in essence changes the admit date for the periods of care going forward. For example, a new period of care beginning on 1/16/2022 requires an NOA with that date. The next period of care begins 2/15/2022 and care continues until the beneficiary is discharged on 5/2/2022. The claims would be billed as follows:

- Admit date 1/16/2022; “From” and “Through” dates 1/16/2022 – 2/14/2022
- Admit date 1/16/2022; “From” and “Through” dates 2/15/2022 – 3/16/2022
- Admit date 1/16/2022; “From” and “Through” dates 3/17/2022 – 4/15/2022
- Admit date 1/16/2022; “From” and “Through” dates 4/16/2022 – 5/2/2022

Payment Reduction for Late NOAs

20. Is there a penalty for late NOAs?

Answer: Yes, there is non-timely submission payment reduction when the HHA does not submit the NOA within five calendar days from the SOC date. A timely-filed NOA is submitted to the HH & Hospice Medicare Administrative Contractor (MAC) within five calendar days from the admission date and accepted. “Accepted” is defined as processing and approving after the NOA is received. The date an NOA completes processing and approves is not used in calculating the NOA’s timeliness, only the date the NOA was received by the MAC.

21. Will the exception process for a late NOA be the same as they are with the 2021 RAPs?

Answer: Yes, MLN Matters [MM12256](#) explains the non-timely payment reduction and exceptions for failure to submit the NOA timely.

The MAC won't grant exceptions if:

- The HHA can correct the NOA without waiting for Medicare systems actions
- The HHA submits a partial/incomplete NOA to fulfill the timely-filing requirement
 - CMS has clarified that a partial NOA would be a submission that is missing required fields or has invalid values in those fields
- The HHA has multiple provider identifiers and submit the identifier of a location that didn't actually provide the service

22. How do we determine the five calendar days for timely submission of the NOA? Is day one the start of care (SOC) or the day after?

Answer: Count five calendar days starting the day after the SOC/admission date to determine timely NOA submission.

23. If the HHA submits the NOA timely, but needs to cancel it for 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, e.g., "Timely NOA, cancel and rebill." Append modifier KX to the HIPPS code on the 0023 revenue line of the period of care claim. HHAs should resubmit the corrected NOA promptly – generally within two business days of canceling the incorrect NOA.

Examples of errors that would require the NOA to be canceled and resubmitted:

- Incorrect "Admission," "From" or "Through" date
- Incorrect beneficiary

24. Is the payment penalty for a late NOA only on the initial 30-day period?

Answer: The payment penalty may apply to more than one period of care claim, depending on when the NOA is submitted. For example, if an NOA is received on day 40, the penalty will be applied to the initial period of care, and the second 30-day period. Exception requests, if applicable, are required on each period of care claim for which the NOA was late.

25. If an NOA is not submitted at all, would the HHA forfeit payment for the entire admission period, not just for 30 days as currently under the No Pay RAP?

Answer: Keep in mind that billing the NOA is a requirement for billing period of care claims, including Low Utilization Payment Adjustment (LUPA) claims. If an HHA neglects to bill the NOA, they have not met the requirement to bill any period of care claims. If the NOA is late, there will be a penalty applied to the initial claim in the admission period (and any following period, depending on the NOA receipt date), so it is advisable to submit the NOA within five calendar days of the SOC/initial visit, or as soon as possible after

that timeframe, to reduce the amount of financial penalty. For LUPAs, no per-visit payments shall be made for visits that occurred on days that fall within the period of care prior to the submission of the NOA.

26. Is there any guidance about billing for an exception to the late NOA penalty when we find out the beneficiary had switched from a MA plan to Original Medicare after the fact?

Answer: Yes. Since Original Medicare begins as of the first visit after the MA enrollment period ends, the NOA will need to be billed with the date of the first visit under Original Medicare, and all visits from that point are billed to Original Medicare.

In cases where the HHA does not find out the beneficiary had disenrolled from their MA plan until well after the fact, or until the HHA gets a denial from the MA plan, the NOA should be submitted as soon as possible. The corresponding period of care claim is then billed with the KX modifier and the following statement in Remarks: "CR12256 disenroll MA XX/XX/XXXX." The XX/XX/XXXX date should be the day the MA coverage ended, e.g., "CR12256 disenroll MA 12/31/2021."

27. What should an HHA do if they have a late RAP submission reject because the period "From" date is between 12/1/2021 and 12/31/2021 and the calculated 30-day end date falls within another agency's January 2022 HH admission date (opened by an NOA)?

Answer: This scenario would be caused by a late RAP submission for a period beginning in December 2021, that was received after a January 2022 NOA was already received and processed for another agency. The HHA with the late RAP should contact the other agency 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.

Period of Care Claim Billing Updates

28. Will we continue to bill period of care claims on a 30-day period basis?

Answer: Yes. Billing the 30-day period of care 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 period.

29. What if a beneficiary transfers to inpatient facility care in the first 30-day period and we were expecting the beneficiary to come back to home health, but the beneficiary doesn't return? We realize this in the 3rd 30-day period. What do we need to do with the new NOA implementation?

Answer: Once the HHA is aware of the discharge situation, they should adjust their last claim to replace patient status 30 with the appropriate discharge status code. Please see [CR12424](#) for further instruction on reporting discharges and transfers during a period where no visits were provided. Claim change reason code (Condition Code [CC]) E0, change in patient status, would be used on the adjustment.

30. 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?

Answer: 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.

31. How will periods of care with “no visits expected” work in 2022 and beyond? In 2021, they would submit the RAP to open the period and that would show the beneficiary was under HH.

Answer: Since the NOA creates an admission period, there is no need to submit anything for the periods of care 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 period.

A PDF version of this article is available to download below.

Resources

- There are chapters that include billing instructions for specific disciplines. These are within certain Publications in the CMS Internet Only Manuals (IOM). Information on billing as it specifically relates to Home Health is in CMS IOM Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 10, “Home Health Agency Billing” <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf>
- CMS [MLN Matters MM12256](#), Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA)
- CMS [MLN Matters MM12424](#), Home Health Notices of Admission – Additional Manual Instructions