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Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA) – Manual Instructions

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Provider Types Affected

This MLN Matters Article is for Home Health Agencies (HHAs) who submit bills to Home Health & Hospice Medicare Administrative Contractors (HH&H MACs) for services they provide to Medicare patients.

Provider Action Needed

This article tells you about updates to Chapter 10 of the Medicare Claims Processing Manual to include instructions for submitting Home Health (HH) NOAs instead of RAPs on and after January 1, 2022. Please make sure your billing staffs are aware of these manual updates.

Background

Today, Original Medicare requires HHAs to submit a RAP for every 30-day HH Period of Care (POC), using Type of Bill (TOB) 322. The 30-day POC is the unit of payment under the HH Prospective Payment System (PPS). Then, you submit a claim using TOB 329 for each 30-day POC. The TOB 329 processes as an adjustment to the TOB 322. In the last 2 years, Medicare has been phasing out RAP payments. Starting January 1, 2022, Medicare will require to submit a one-time NOA, instead of RAPs.

You will send NOAs using TOB 32A. Then, you will use TOB 329 for POCs following submission of the NOA. The National Uniform Billing Committee (NUBC) has redefined TOB 329 to represent an original claim, rather than an adjustment, for all claims with From dates on or after January 1, 2022.

You must send the NOA to your MAC by mail, Electronic Data Interchange (EDI), or Direct Data Entry (DDE). EDI submissions require additional data that the NOA doesn't require to satisfy transaction standards. CMS describes this data in a companion guide. You may voluntarily agree to use this companion guide to submit EDI NOAs at any time.

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To submit an NOA, you must have a verbal or written order from the physician that contains the services required for the initial visit. You must have conducted an initial visit at the start of care.

For all patients receiving HH services in 2021 whose services will continue in 2022, you should submit an NOA with a one-time, artificial "admission" date corresponding to the "From" date of the first period of continuing care in 2022.

CMS only requires 1 NOA for any series of HH POCs beginning with admission to home care and ending with discharge. Once you report a discharge to Medicare, you must send a new NOA before you submit any additional claims.

CR 12256 updates Chapter 10 of the Medicare Claims Processing Manual to describe these changes and to give you detailed NOA submission instructions and revised billing instructions. It also updates the manual to remove references to 60-day HH PPS episodes and RAPs.

HHAs must submit an NOA to their MAC within 5 calendar days from the start of care date. The NOA is a one-time submission that establishes the HH POC and covers contiguous 30-day POCs until you discharge the individual from Medicare HH services.

There will be a non-timely submission reduction in payment amount tied to any late NOA submissions when the you don't submit the NOA withing 5 calendar days from the start of care. The reduction in payment amount would be equal to a 1/30th reduction to the wage adjusted, 30-day period payment amount for each day from the HH start of care date until the date you submit the NOA.

If you fail to send the NOA timely, you may request an exception, which, if approved, waives the consequences of late filing. The 4 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 we or your MAC determines to be beyond your control

Your MAC won't grant exceptions if:

- You can correct the NOA without waiting for Medicare systems actions
- You submit a partial NOA to fulfill the timely-filing requirement
- You have multiple provider identifiers and submit the identifier of a location that didn't actually provide the service

Medicare won't make Low-Utilization Payment Adjustment (LUPA) per-visit payments for visits that occurred on days that fall within the period of care prior to an NOA submission.

Note: CR 12256 includes the revised Chapter 10 of the Medicare Claims Processing Manual so you can review the revisions and additions to the relevant Manual sections.

More Information

CR 12256 is the official instruction we issued to your MAC regarding this change.

For more information, contact your MAC.

Document History

Date of Change	Description
May 11, 2021	Initial article released.