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Notice of Admission

Home Health

What is an NOA

NOA is **a one-time submission that alerts CMS when a patient has been admitted to home health.** An NOA also covers contiguous 3-day plans of care until the patient is discharged.

The NOA is a type of claim and should be included in most home health software solutions.

Started 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.

What's Needed Prior to Submit an NOA

(1) A verbal or written order from the physician that contains the services required from the initial visit.

(2) You must have conducted an initial visit at the start of care.

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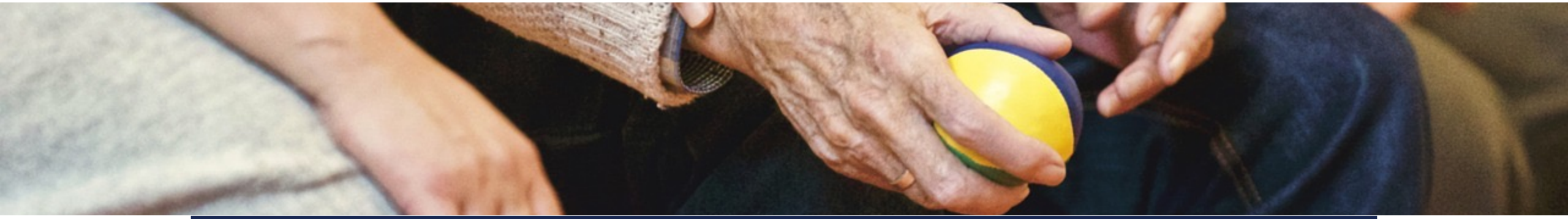
Principal Diagnosis Code on the NOA



The principal diagnosis code reported on the NOA does NOT need to match the principal diagnosis reported on the initial period of care claim.

Secondary diagnoses are not required on an NOA.

The NOA does NOT have to be canceled and resubmitted if the primary diagnosis is changed after the NOA was sent and processed.

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Penalty for Late NOA's

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.

The reduction in payment amount would be equal to a 1/20th 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.

"Accepted" is defined as processing and approving after the NOA is received. The date an NOA completes processing and approves in not used in calculating the NOA's timeliness, only the date the NOA was received by the MAC.

NOTE:

Some of the EMR's will delay the NOA reaching DDE by 1 day. For example – If you submit after 3 pm today it might not show up in the DDE until tomorrow. Don't delay submitting until the last day.

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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.

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 can NOA submission.

Exception request, if applicable, are required on each period of care claim for which the NOA was late.

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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:

01 Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate.

02 An event that produces a data filing problem due to a CMS or MAC systems issue that is beyond your control.

03 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 form its MAC.

04 Other circumstances that we or your MAC determines to be beyond your control.

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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.

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

Any codes within this job aid indicate common codes for required fields on Home Health NOAs. The National Uniform Billing Committee (NUBC) maintains the coding information for Medicare billing, including the UB-04 data elements. For an all-inclusive listing of codes appropriate for all claims fields used for Medicare billing, visit https://www.nubc.org to subscribe to the official UB-04 Data Specifications manual.

The bolded fields on the claims screens shots provided are the fields required when billing the Home Health NOA via the 8371 format (electronically). The tables below the screen shots include field title descriptions and the associated valid values.

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NOA Claim Page 1

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MAP1711          M E D I C A R E   A   O N L I N E   S Y S T E M        CLAIM PAGE 01
  SC                                INST CLAIM ENTRY                          SV:
  MID                    TOB        S/LOC                OSCAR                UB-FORM
 NPI                  TRANS HOSP PROV P                    ROCESS NEW HIC
 PAT.CNTL#:                              TAX#/SUB:                        TAXO.CD:
  STMT DATES FROM              TO              DAYS COV       N-C          CO          LTR
  LAST                                  FIRST                      MI     DOB
  ADDR  1                                          2
        3                                          4
        5                                          6
 ZIP              SEX     MS    ADMIT DATE          HR     TYPE    SRC      HM        STAT
    COND CODES 01      02     03      04     05    06     07     08     09       10
  OCC CDS/DATE 01              02               03              04              05
               06              07               08              09              10
    SPAN CODES/DATES  01                        02                      03
 04                   05                        06                      07
 08                   09                        10                      FAC.ZIP
   DCN
          V A L U E   C O D E S   -   A M O U N T S   -   A N S I   MSP APP IND
 01                          02                        03
 04                          05                        06
 07                          08                        09
        PLEASE ENTER DATEA
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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 (HHA"s) NPI number.
STMT DATES FROM and **TO** - Statement Covers Period "From" and "To"	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, ZIP, 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 - Source of Admission	Submit a default value of "1."
STAT - 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 Claim Page 3

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MAP1713          M E D I C A R E   A   O N L I N E   S Y S T E M       CLAIM PAGE 03
  SC                              INST CLAIM ENTRY
  MID                  TOB        S/LOC              PROVIDER
                                                          OFFSITE ZIPCD:
   CD    ID     PAYER                        OSCAR        RI AB PRIOR PAY   EST AMT DUE
  A
  B
  C
  DUE FROM PATIENT

  MEDICAL RECORD NBR                          COST RPT DAYS       NON COST RPT DAYS
  DIAGNOSIS CODES  1            2             3             4             5
                   6            7             8             9
  ADMITTING DIAGNOSIS               E CODE              HOSPICE TERM ILL IND
  IDE
  PROCEDURE CODES AND DATES   1                     2
   3                    4                     5                     6

  ESRD HOURS 00  ADJUSTMENT REASON CODE FC    REJECT CODE          NONPAY CODE
  ATT PHYS         NPI                  L                        F              M     SC
  OPR PHYS         NPI                  L                        F              M     SC
  OTH PHYS         NPI                  L                        F              M     SC
  REN PHYS         NPI                  L                        F              M     SC
  REF PHYS         NPI                  L                        F              M     SC

            PROCESS COMPLETED ---  PLEASE CONTINUE
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FIELD	DESCRIPTION/NOTES
PAYER - Payer Identification	Enter "Medicare" on line A with payer code "Z".
RI - Release of Information	Enter "Y," "R," or "N." • "Y" indicates HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims • "R" indicates release is limited or restricted • "N" indicates no release is on file

FIELD	DESCRIPTION/NOTES
DIAGNOSIS CODES	Enter the appropriate ICD code for the principal diagnosis code or submit any valid diagnosis code.
ATT PHYS - 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 Claim Page 4

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MAP1714        M E D I C A R E   A   O N L I N E   S Y S T E M      CLAIM PAGE 04
  SC                          INST CLAIM ENTRY          REMARK PAGE 01

  MID                  TOB       S/LOC            PROVIDER


REMARKS




   47 PACEMAKER   48   AMBULANCE   40  THERAPY   41  HOME HEALTH
   58 HBP CLAIMS (MED B)           E1  ESRD ATTACH
   ANSI CODES - GROUP:    ADJ REASONS:    APPEALS:

            PROCESS COMPLETED ---  PLEASE CONTINUE
                 PF3-EXIT  PF7-PREV  PF8-NEXT  PF11-RIGHT
```

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.

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NOA Claim Page 5

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MAP1715          M E D I C A R E   A   O N L I N E   S Y S T E M       CLAIM PAGE 05
  SC                              INST CLAIM ENTRY
  MID                  TOB        S/LOC              PROVIDER
INSURED NAME REL   CERT-SSN-HIC   SEX   GROUP   NAME   DOB    INS GROUP NUMBER
  A
  B
  C

  TREAT. AUTH. CODE


  TREAT. AUTH. CODE


  TREAT. AUTH. CODE


            PROCESS COMPLETED  ---   PLEASE CONTINUE
                 PF3-EXIT   PF7-PREV   PF8-NEXT   PF11-RIGHT
```

FIELD	DESCRIPTION/NOTES
INSURED NAME	Enter the patient"s name as shown on the Medicare card.
CERT/SSN/HIC	Enter the beneficiary"s Medicare number as it appears on the Medicare card if it does not automatically populate.

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

- Incorrect ‘admission,’ ‘from’ or ‘through’ date
- Incorrect beneficiary

NOA – With LUPAS, transfers to another agency, discharge from another agency

- 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.
- 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 claims has not been submitted or processed at the time of the new admission to discharge the beneficiary.
- When a beneficiary is discharged from a 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.
- A HIPPS code only required on the NOA when billing via the 8371 format (electronically). When billing electronically, use a placeholder HIPPS of ”1AA11.”

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Canceling a NOA Due to 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 line of the period of care claim. HHAs should resubmit the corrected NOA promptly – generally within two business days of canceling the incorrect NOA.

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Switching from Medicare Advantage to Original Medicare

Medicare begins as the first visit after the MA (Medicare Advantage) 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 disenrolled 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.”

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Billing the Home Health Notice of Admission (NOA)

Field	Description/Notes
SRC Source of Admission	Not required unless submitting via the 837I format. Submit default value of "1."
STAT Patient Status	Not required unless submitting via the 837I format. Submit default value of "30."
COND CODES Condition Codes	If the NOA is for a patient transferred from another HHA, enter condition code "47."
FAC.ZIP	Facility ZIP Code of provider or subpart (nine-digit code)

Field	Description/Notes
PAYER Payer Identification	Enter "Medicare" on line A with payer code "Z" • Always submit the NOA as Medicare primary. Palmetto GBA will accept and process a TOB 032A if the "From" date overlaps a Medicare Secondary Payer period.
RI Release of Information	Enter "Y," "R" or "N" • "Y" indicates HHA has a signed statement on file permitting it to release data to other organizations in order to adjudicate claims • "R" indicates release is limited or restricted • "N" indicates no release is on file
DIAGNOSIS CODES	Enter appropriate ICD code for principal diagnosis or submit any valid diagnosis code
ATT PHYS Attending Physician	Enter NPI and name (last name, first name, middle initial) of attending physician who established the plan of care with verbal orders. This must be the individual physician's NPI – not a group NPI.

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

What information on the NOA has to match on the OASIS or the initial final claim?

Medicare published fields does not indicate that anything has to match. The information that Medicare is going to take away from an agency's final claim is the diagnosis codes and the OASIS transmission to get the HIPSS codes and clinical data.

Can a NOA be submitted early?

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 and written order from the physician/practitioner and conducted an initial visit at the start of care (SOC), which is the admission date.

Other Notes:

- Final claims for every 30-day period are still required for payment.
- Agencies should be aware of the potential penalties NOT being capped at thirty days.
- NOA is not required for Pro-bono patients since they will not be billed.
- A qualified home health billing service company is able to submit NOA's for an agency.

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Tips to Remember

- An NOA is required for any period of care that starts on or after 01.01.22.
- HHAs must submit the NOA when they have received the appropriate physician's written or verbal order that contains the services required for an initial visit, and the HHA has conducted the initial visit at the start of care.
- NOA must be submitted within five calendar days from the start of care. A payment reduction applies if a HHA does not submit the NOA within this time frame.
  - 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 home health start of care date until the date the HHA submitted the NOA.
    - Reduction would include any outlier payment.
    - Reduction amount will be displayed with value code "QF" on claim.

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Thank You

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References

Billing the Home Health Notice of Admission (NOA) vis DDE (Home Health & Hospice) (cgsmedicare.com)

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

MM12256 (cms.gov)

https://www.ngsmedicare.com/documents/20124/2731544/2263_090821_billing_noa.pdf/73023d98-1083-df5b-e76a-066bdff58bce?t=1631797821272&download=true

Billing the Home Health Notice of Admission (Home Health & Hospice) (cgsmedicare.com)

Billing the Home Health Notice of Admission (NOA) Electronically (Home Health & Hospice (cgsmedicare.com)