



Update to Chapter 7, “Home Health Services”, of the Medicare Benefit Policy Manual (Pub 100-02)

MLN Matters Number: MM12615 **Revised**

Related Change Request (CR) Number: 12615

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Note: We revised this Article due to a revised CR 12615. CMS removed information on the the definition of an allowed practitioner from the CR. We removed that information from the Article. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.

Provider Types Affected

This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

In this Article, you'll learn about:

- Updates to chapter 7 of the Medicare Benefit Policy Manual (Pub. 100-02) to incorporate Calendar Year (CY) 2022's Policy Implementation of the Notice of Admission (NOA)
- The elimination of the Request for Anticipated Payment (RAP) policy

Make sure your billing staff knows about these changes.

Background

[Section 1895\(b\)\(2\)](#) of the Social Security Act (the Act), as amended by section 51001(a) of the Bipartisan Budget Act of 2018 (BBA of 2018), required Medicare to change the unit of payment under the Home Health Prospective Payment System (HH PPS) from 60 days to 30 days. The statutorily required provisions in the BBA of 2018 resulted in the Patient-Driven Groupings Model (PDGM). Beginning January 1, 2020, HH agencies (HHAs) are paid a national, standardized 30-day period payment rate if a period of care meets a certain threshold of HH visits. This payment rate is adjusted for case-mix and geographic differences in wages. Thirty-day periods of care that don't meet the visit threshold are paid a per-visit payment rate for the discipline providing care.

We finalized a phased-out approach of the split-percentage payment due to a change in the unit of payment to a 30-day period.

In the CY 2020 HH PPS final rule with comment period ([84 FR 60478](#)), we finalized additional changes to the split-percentage payment approach.

- 1) HHAs will no longer submit RAPs for any HH period of care with a from date on or after January 1, 2022.
- 2) Instead, for each admission to HH, the HHA notifies Medicare systems via submission of a one-time Notice of Admission (NOA). There's no upfront payment with the NOA submission. Payment for each 30-day period of care will be paid with the submission of a final claim.

Notice of Admission (NOA)

Beginning on or after January 1, 2022, RAPs will be replaced with the one-time NOA, which must be submitted timely. NOAs must be submitted within 5 calendar days from the start of care date to establish that the patient is under a Medicare HH period of care and to trigger HH Consolidated Billing (CB) edits required under [section 1842\(b\)\(6\)\(F\)](#) of the Act.

Only 1 NOA is required for any series of HH periods of care beginning with admission to home care and ending with discharge. After a discharge has been reported to Medicare, a new NOA is required before the HHA submits any additional claims for that patient.

NOA submission can occur when the following criteria have been met:

1. The appropriate physician's written or verbal order that sets out the services required for the initial visit has been received and documented, as required in regulation at [42 CFR 484.60\(b\)](#) and [42 CFR 409.43\(d\)](#)
2. The initial visit within the 60-day certification period must have been made and the individual admitted to HH care.

When an NOA isn't filed timely, Medicare will reduce payment for a period of care, including outlier payment, by the number of days from the HH admission date to the date the NOA is submitted to and accepted by the Part A/B MAC (HHH), divided by 30. No Low Utilization Payment Adjustment (LUPA) per-visit payments will be made for visits that occurred on days that fall within the period of care prior to the submission of the NOA. This reduction will be a provider liability, and the provider won't bill the patient for it.

We may waive the failure to submit a timely-filed NOA if it's decided that a circumstance met by a HHA is exceptional and qualifies for a waiver. The HHA must fully document and provide any requested documentation to their MAC for a decision of the exception.

An exceptional circumstance may be due to, but isn't limited, to the following:

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 A/B MAC (HHH) systems issue that's beyond the HHA's control
3. A newly Medicare-certified HHA that's notified of that certification after the Medicare certification date, or which is awaiting its user ID from its A/B MAC (HHH)
4. Other circumstances decided by the A/B MAC (HHH) or CMS to be beyond the HHA's control

For more information on claims processing for NOA, read [MLN Matters Article MM12256](#) (Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA) – Manual Instructions).

More Information

We issued [CR 12615](#) to your MAC as the official instruction for this change. The relevant manual updates are attached to the CR.

For more information, [find your MAC's website](#).

Document History

Date of Change	Description
June 7, 2022	We revised this Article due to a revised CR 12615. CMS removed information on the definition of an allowed practitioner from the CR. We removed that information from the Article. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.
April 28, 2022	We revised the Article due to a revised CR 12615. The CR revision changed the background and policy sections of the CR's business requirements and manual attachment. You'll find substantive content updates on pages 2 and 3. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.
March 28, 2022	Initial article released.

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