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FAQ tip sheet

Home health revenue cycle changes: Notice of Admission

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Significant home health revenue cycle regulatory changes have gone into effect in 2022, putting added pressure on agencies that already face operational challenges with negative impacts on cash flow. In order to maintain a healthy revenue cycle, agencies must have a strong understanding of the new Notice of Admission (NOA) and submission process.

In accordance with CMS guidelines, and effective January 1, 2022, the five-day Notice of Admission replaced the no-pay Request for Anticipated Payment (RAP). The new NOA has a one-time submission instead of a RAP every 30 days.

In this new tip sheet, industry experts Cindy Campbell and Karen Kelly provide answers to frequently asked questions about the new NOA and help agencies with best practices for achieving and sustaining revenue cycle efficiency.

Q: Can you go through a scenario explaining the Notice of Admission (NOA) submission process when the period of care crosses over into January 2022? Does the final submission have the same "from" date as the NOA or the original start of care in December 2021?

A: For all beneficiaries who received home health services that started in 2021 and continue in 2022, the agency shall submit an NOA with a one-time, "artificial admission" date corresponding to the "from" date of the first period of continuing care in 2022. For example, if a period of care begins in 2021 and ends on January 10, 2022, the agency submits an NOA with an admission date of January 11, 2022, and then submits a claim when the 30-day period of care is over. *The agency should submit the January 11, 2022, admission date on all subsequent claims until the beneficiary is discharged and readmitted with a new Start of Care. If the patient is readmitted, then a new NOA is required.*

Q: In the following scenario, which documents should we submit at the time of Pre-Claim Review (PCR) submission? A patient was seen by Primary Care Physician A (PCP-A) at a skilled nursing facility, and the plan of care for home health services is signed by the same PCP-A. The patient did not have a face-to-face (F2F) visit with the PCP 90 days from the start of care date, but the patient had a F2F visit with another Primary Care Physician B (PCP-B). The OASIS was transmitted under PCP-A to Medicare.

A: It appears that PCP-A is the Certifying Physician who initiated care and is signing the plan of care. PCP-A must sign the certification statement attesting to the patient's eligibility – including a F2F encounter

by a qualified provider in the appropriate timeframe. If PCP-B provided care to the patient in the facility and performed the F2F encounter, the date of this encounter would be included in that certification statement to indicate that the certifying MD has considered the encounter in determining eligibility.

When submitting for PCR, all requested documents must be provided, including the signed POC with the complete certification statement, the F2F visit encounter by PCP-B, and the comprehensive assessments and evaluations. Checklists for documents to include may be found here.

Q: What happens with the NOA in the case of a discharge and a readmission? Do we initiate a new NOA?

A: Yes. If you discharge a Medicare patient and readmit them, you will need to submit a new NOA.

Q: Does the patient need to sign anything that billing should submit for the NOA?

A: No. For billing purposes, there is nothing that needs to be signed. The patient needs to have signed all agency documents prior to services being rendered.

Q: If an agency is billing both episodes at one time, will they need to cancel the Request for Anticipated Payment (RAP) that crosses over into January 2022 and submit an NOA?

A: Yes. The agency cannot bill a RAP for January 2022 services. There needs to be an "artificial" NOA sent. The RAP will need to be cancelled if it was already sent.

Q: I've heard that "payment reduction cannot exceed the total payment of the claim." What does this mean?

A: CMS cannot penalize you more than the total amount of the Home Health Resource Group (HHRG) for that 30-day payment period. The reduction in payment will be equal to a 1/30th decrease to the wage and case-mix adjusted 30-day period payment amount for each day from the home health "from date" until the date the agency submits the NOA. The penalty applies to outlier claims and low utilization payments adjustment (LUPA) claims. For LUPA 30-day periods of care in which an agency fails to submit a timely NOA, no LUPA per-visit payments would be made for visits that occurred on days that fall within the period of care before submitting the NOA. The payment reduction cannot exceed the total payment of the claim.

Q: On the NOA crossover, is the "artificial period" "from date" the first 30-day period or the certification period?

A: Starting in 2022, home health agencies will submit a one-time NOA that establishes the home health period of care and covers all contiguous **30-day periods** of care until the individual is discharged from Medicare home health services.

Q: For patients continuing into 2022 on the NOA, is the "artificial admission date" the first day of the first subsequent 30-day period of care OR the first day of the next 60-day episode?

A: The NOA for the artificial admission needs to be the first day of the subsequent 30-day period that started in January of 2022.

Q: Is 01/22/22 the "artificial" admission for the 12/22/21 to 1/21/22 claim or is it the "artificial" admission for the subsequent claim of 01/22/22 to 2/21/22?

A: The "artificial" admission of 1/22/22 will need to be used for the claim of 1/22/22 to 2/21/22 in this example. The true admission date will need to be on the 12/22/21 to 1/21/22 claim.

Q: For patients that bridge 2021 to 2022, do they need an NOA for the first episode (the one that starts in 2021), or just the second 30-day episode that starts in 2022?

A: For "crossover" patients (seen in 2021 and 2022), the "artificial" NOA needs to be for the period that starts in 2022.

About the authors

Cindy Campbell is a nationally recognized home health leader and management consultant. She supports home health providers across the country, guiding them toward best practice structure, clinical modeling, and revenue cycle process efficiencies. She is a passionate advocate for shifting advanced levels of care to the home – the least restrictive setting, with the lowest cost, that yields the greatest patient satisfaction. Cindy's focus is grounded in patient experience and outcomes, with an emphasis on integrating and leveraging innovative technology into advancing clinical models to better manage patients where they live.

Karen Kelly has 3 decades of experience in home health and hospice billing. At WellSky, she continues her role as educator and trainer for U.S.-based and international revenue cycle teams that she oversees.

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