

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1025	Date: AUGUST 11, 2006
	Change Request 5009

Subject: Revised Home Health Advance Beneficiary Notice

I. SUMMARY OF CHANGES: This transmittal implements the revised HHABN and instructions. Chapter 30, section 60 and its subsections are being revised, incorporating previously released information from section 60 with new information.

New/Revised Material

Effective Date: September 1, 2006

Implementation Date: September 1, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/50/Beneficiary-Driven Demand Billing HH PPS
R	10/60/No Payment Billing
R	30/50/50.8.2/ABNs for Part B Services Furnished in a Skilled Nursing Facility (SNF)
D	30/50/50.8.3/ABNs for Part B Services Furnished in a Skilled Nursing Facility (SNF)
R	30/60/60.1/Background on the HHABN
D	30/60/60.1.1/Approved Standard Forms
D	30/60/60.1.2/User-Customizable Sections
D	30/60/60.1.3/Where to Obtain the HHABN Forms
D	30/60/60.1.4/OMB Burden Notice for Form CMS-R-296
R	30/60/60.2/Scope of the HHABN
D	30/60/60.2.1/Expectation of Denial
D	30/60/60.2.2/Situations In Which HHABN Is Not Given

D	30/60/60.2.2.1/Categorical Exclusions
D	30/60/60.2.2.2/Technical Exclusions
D	30/60/60.2.2.3/Services Not Under HHA PPS
D	30/60/60.2.2.4/When Home Health Services Will Not Be Furnished
D	30/60/60.2.2.5/M+C Enrollees and Non-Medicare Patients
D	30/60/60.2.3/Situations in Which HHABN Should Be Given
D	30/60/60.2.3.1/Triggering Events
D	30/60/60.2.3.2/Dual-Eligibles
D	30/60/60.2.3.3/Medicare as Sole Payer
D	30/60/60.2.4/Routine HHABN Prohibition
D	30/60/60.2.5/To Whom an HHABN Should Be Given
R	30/60/60.3/HHABN Triggering Events
D	30/60/60.3.1/Delivery Must Meet Advance Beneficiary Notice Standards
D	30/60/60.3.2/HHABN Specific Delivery Issues
D	30/60/60.3.3/Timely Delivery
D	30/60/60.3.4/Actual Receipt of Notice Required
D	30/60/60.3.5/Understandability and Comprehensibility of Notice
R	30/60/60.4/Completing the HHABN
D	30/60/60.4.1/General Rules
D	30/60/60.4.2/Header of HHABN
D	30/60/60.4.3/Body of HHABN
D	30/60/60.4.4/Option Boxes
R	30/60/60.5/Special Issues Associated with the HHABN
R	30/60/60.6/Effective Delivery/Effective HHABNs
R	30/60/60.6.1/Defective HHABNs
D	30/60/60.6.2/Acceptance of Rejection of the HHABN
D	30/60/60.6.3/Effective of HHABN on Beneficiary
D	30/60/60.6.4/Financial Liability
D	30/60/60.6.5/Limitation on Liability
D	30/60/60.6.6/Home Care Not Ordered by Physicians
D	30/60/60.6.7/Regulatory Requirements
D	30/60/60.6.8/Standards

D	30/60/60.6.9/Effect of Furnishing HHABNs and Collections From Beneficiary
D	30/60/60.6.9.1/Effective Notice
D	30/60/60.6.9.2/Defective Notice
D	30/60/60.6.9.3/Collection From Beneficiary
D	30/60/60.6.9.4/Unbundling Prohibition
N	30/60/60.7/Collection of Funds and Liability Related to the HHABN
N	30/60/60.8/Revision, Re-issuance and Retention of the HHABN
R	30/90/Form CMS-20007 - Notice of Exclusions From Medicare Benefits (NEMBs)
R	30/90/90.1.1/Using NEMBs With Categorical Denials
R	30/90/90.1.2/Using NEMBs With Technical Denials

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1025	Date: August 11, 2006	Change Request 5009
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SUBJECT: Revised Home Health Advance Beneficiary Notice (HHABN)

I. GENERAL INFORMATION

A. Background: HHABNs have been required since 2002 to inform beneficiaries in Original Medicare about possible noncovered charges when limitation of liability applies. CMS was directed, however, by a Federal court decision to revise this notice and its instructions to encompass broader notification requirements codified under the Conditions of Participation (COPs) for Home Health Agencies (HHAs).

B. Policy: Section 1879 of the Social Security Act (the Act) protects beneficiaries from payment liability in certain situations unless they are notified of their potential liability in advance. The COPs for HHAs at §1891 of the Act require general notification of changes in charges and care.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F	R	C	D	Shared System Maintainers				Other
						F	M	V	C	
I	H	A	M	I	C	M	W	S		
5009.1	Regional Home Health Intermediaries (RHHIs) shall take any actions necessary to implement the attached instructions, primarily by assisting HHAs in understanding their responsibilities. [Note this instruction updates policy previously implemented by Joint Signature Memorandum, JSM-06299, Revised Home health Advance Beneficiary Notice and Instructions for Immediate Release, dated February 17, 2006].		X							
5009.1.1	RHHIs shall remove the JSM instructions mentioned above from their Web sites on the HHABN that are dated once this CR is effective.		X							

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5009.2	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.		X							

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: The HHABN is an existing requirement primarily executed by HHAs. Though expanded in scope with this instruction, HHABN policy is simplified in other ways and should not have any impact on RHHI workload beyond short-term educational demands. Note the most recent year of data available shows that less than 4 percent of home health claims are linked to HHABNs.

E. Dependencies: None.

F. Testing Considerations: None, this is a non-systems instruction.

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: September 1, 2006</p> <p>Implementation Date: September 1, 2006</p> <p>Pre-Implementation Contact(s): Elizabeth Carmody, elizabeth.carmody@cms.hhs.gov, 410-786-7533</p> <p>Post-Implementation Contact(s): Appropriate Regional Office</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.</p>
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***Unless otherwise specified, the effective date is the date of service.**

50 - Beneficiary-Driven Demand Billing Under HH PPS

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

Demand billing is a procedure through which beneficiaries can request Medicare payment for services that: (1) their HHAs advised them were not medically reasonable and necessary, or that (2) they failed to meet the homebound, intermittent or noncustodial care requirements, and therefore would not be reimbursed if billed. The HHA must inform the beneficiary of this assessment in a Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, which also must be signed by the beneficiary or appropriate representative. *Instructions for the HHABN are found in Chapter 30 of this manual, §60.*

Beneficiaries pay out of pocket or third party payers cover the services in question, but HHAs in return, upon request of the beneficiary, are required to bill Medicare for the disputed services. If, after its review, Medicare decides some or all the disputed services received on the “demand bill” are covered and pays for them, the HHA would refund the previously collected funds for these services. If the Medicare determination upholds the HHA’s judgment that the services were not medically reasonable and necessary, or that the beneficiary failed to meet the homebound or intermittent care requirements, the HHA keeps the funds collected, unless the Regional Home Health Intermediary (RHHI) determines the HHABN notification was not properly executed, or some other factor changed liability for payment of the disputed services back to the HHA.

*The Medicare payment unit for home care under the home health prospective payment system (HH PPS) is an episode of care, usually 60 days in length. In order to be eligible for episode payment, Medicare beneficiaries must be: (1) under a physician plan of care, and (2) at least one service must have been provided to the beneficiary, so that a request for anticipated payment (RAP) can be sent to Medicare and create a record of an episode in Medicare claims processing systems. Therefore, demand billing *under HH PPS* must conform to ALL of the following criteria:*

- Situations in which disputed services are called for under a plan of care, but the HHA believes the services do not meet Medicare criteria for coverage;
- Claims sent to Medicare with TOB 32X and 33X; and
- Episodes on record in Medicare claims processing systems (at least one service in episode).

A - Interval of Billing

Under HH PPS, the interval of billing *is* standard. At most, a RAP and a claim *are* billed for each episode. Providers may submit a RAP after the delivery of the first service in the 60-day episode, and they must submit a claim either after discharge or after the end of the 60-day episode. This *does* not change in demand bill situations, so that only the claim at the end of the episode is the demand bill.

B - Timeliness of Billing

The CMS requests that HHAs submit demand bills promptly. Timely filing requirements were not changed by HH PPS (see Chapter 1 for information on timely filing). CMS has defined “promptly” for HH PPS to mean submission at the end of the episode in question. The beneficiary must also be given either a copy of the claim or a written statement of the date the claim was submitted. HH PPS provides a new incentive to be prompt in filing claims, since RAP payments *are* automatically recouped against other payments if the claim for a given episode does not follow the RAP in the later of: (1) 120 days from the start of the episode; or (2) 60 days from the payment date of the RAP. The RAP must be re-billed once payment has been recouped if the claim is to be billed unless the claim is a no-RAP LUPA as described in §40.3.

C - Claim Requirements

Original HH PPS claims are submitted with TOB 329 in form locator (FL) 4, and provide all other information required on that claim for the HH PPS episode, including all visit-specific detail for the entire episode (the HHA must NOT use 3X0). When such claims also serve as demand bills, the following information must **also** be provided: condition code “20” in FL 24-30; and the services in dispute shown as noncovered (FL 48) line items. Demand Bills may be submitted with all noncovered charges. Provision of this additional information assures medical review of the demand bill. HH PPS adjustment bills, TOB 327, may also be submitted but must have been preceded by the submission of a 329 claim for the same episode. RAPs are not submitted as demand bills, but must be submitted for any episode for which a demand bill will be submitted. Such RAPs should not use condition code 20, only the claim of the episode uses this code.

Cases may arise in which the services in dispute are visits for which an HHA has physician’s orders, but the duration of the visits exceeds Medicare coverage limits. However, the portion of these visits that is not covered by Medicare may be covered by another payer (e.g., an 8 hour home health aide visit in which the first 2 hours may be covered by Medicare and the remaining 6 hours may be covered by other insurance). In such cases, HHAs must submit these visits on demand bills as a single line item, representing the portion potentially covered by Medicare with a covered charge amount and the portion to be submitted for consideration by other insurance with a noncovered charge amount on the same line. Units reported on this line item should represent the entire elapsed time of the visit (the sum of the covered and noncovered portions), represented in 15 minute increments.

D - Favorable Determinations and Medicare Payment

Results of Medicare determinations favorable to the party requesting the demand bill will not necessarily result in increased Medicare payment. In such cases, and even if a favorable determination is made but payment does not change, HHAs will still refund any monies collected from beneficiaries or other payers for services previously thought not

medically necessary under Medicare. Medicare payment will change only with the addition of covered visits if one or more of the following conditions apply:

- An increase in the number of therapy visits results in meeting the therapy threshold for an episode in which the therapy threshold was not previously met - in such cases, the payment group of the episode would be changed by the RHHI in medical review;
- An increase in the number of overall visits that either:
 1. Changes payment from a low-utilization payment adjustment to a full episode; or
 2. Results in the episode meeting the threshold for outlier payment (it is highly unlikely both things occur for the same episode).
- A favorable ruling on a demand bill adds days to:
 3. An episode that received a partial episode payment (PEP) adjustment, or
 4. A period within an episode that received a significant change in condition (SCIC) adjustment.

If a favorable determination is made, RHHIs will assure pricing of the claim occurs after medical review so that claims also serving as demand bills receive appropriate payment.

E - Appeals

Appeal of Medicare determinations made on HH PPS claims also serving as demand bills is accomplished by appealing the HH PPS claim. Such appeals are done in accordance with regulations stipulating appeals rights for Medicare home health claims. HH PPS RAPs do not have appeal rights; rather, appeals rights are tied to the claims that represent all services delivered for the entire episode unit of payment.

F – Specific Demand Billing Scenarios

1. Independent Assessment. Billing questions relative to the HHABN and home health assessments have persisted. With regard to payment liability for the assessment itself, the assessment is a non-covered service that is not a Medicare benefit and is never separately payable by Medicare. In all *such* cases, a choice remains: The provider may or may not decide to hold the beneficiary liable, and Medicare cannot specify which is appropriate because the service at issue is outside Medicare's scope.

If a decision is made to hold a beneficiary liable for just the assessment, CMS believes providers must be in compliance with the home health Conditions of Participation (COPs), as follows:

484.10.e (1) The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. Before care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual has to pay.

Therefore, while no notice may be required if the provider chooses to be liable, the conditions state a notice is required if the beneficiary is to be held liable, and must be delivered prior to the service in question. HHABNs *can* be used for this purpose.

2. Billing in Excess of the Benefit. In some states, the Medicaid program will cover more hours of care in a week than the Medicare benefit. Therefore, *an* HHA may be billing hours/visits in excess of the benefit during a Medicare home health episode for a dually eligible beneficiary. Since the care delivered in excess of the benefit is not part of the benefit, and does not affect the amount of Medicare's prospectively set payment, there is no dispute as to liability, and *an* HHABN is not required unless a triggering event occurs; that is, care in excess of the benefit is not a triggering event in and of itself requiring an HHABN. Billing services in excess of the benefit is discussed in C in this section.

3. One-Visit Episodes. Since intermittent skilled nursing care is a requirement of the Medicare home health benefit, questions often arise as to the billing of one-visit episodes. Medicare claims systems will process such billings, but these billings should only be done when some factor potentially justifies the medical necessity of the service relative to the benefit.

Many of these cases do not even need to be demand billed, because coverage is not in doubt, since physician orders called for delivery of the benefit. When the beneficiary dies after only one visit is a clear-cut example. When physician orders called for additional services, but the beneficiary died before more services could be delivered, the delivery of only one visit is covered. The death is clearly indicated on the claim with use of patient status code 20. Other cases in which orders clearly called for additional services, but circumstances prevented delivery of more than one service by the HHA, are also appropriately billed to Medicare in the same fashion.

There may be rare cases where, even though orders do not clearly indicate the need for additional services, the HHA feels delivery of the service is medically justified by Medicare's standard, and should be covered. In such situations, when doubt exists, *an* HHA should still give the beneficiary *an* HHABN if a triggering event has occurred, explaining Medicare may not cover the service, and then demand bill the service in question.

No billing is required when there is no dispute that the one service called for on the order does not meet the requirements for the Medicare home health benefit, or is not medically necessary. However, there are options for billing these non-covered services as discussed in Chapter 1 of this manual, Section 60. Note the COPs may require notification in this situation if the beneficiary is to be held liable, as discussed in 1. immediately above.

60 - No Payment Billing

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

No-Payment Billing and Receipt of Denial Notices Under HH PPS

Claims for homebound Medicare beneficiaries under a physician plan of care and electing fee-for-service coverage are reimbursed under HH PPS. *Under HH PPS*, home health agencies may continue to seek denials for entire claims from Medicare in cases where a provider knows all services will not be covered by Medicare. Such denials are usually sought because of the requirements of other payers for providers to obtain Medicare denial notices before they will consider providing additional payment. Such claims are often referred to as no-payment or no-pay bills, or denial notices.

A - Submission and Processing

In order to submit a no-payment bill to Medicare under HH PPS, providers must use TOB 3x0 in Form Locator (FL) 4, and condition code 21 in FL 24-30 of the Form CMS-1450 claim form. The statement dates on the claim, FL 6, should conform to the billing period they plan to submit to the other payer, insuring that no future date is reported. Providers must also key in the charge for each line item on the claim as a non-covered charge in FL 48 of each line. In order for these claims to process through the subsequent HH PPS edits in the system, providers are instructed to submit a 0023 revenue line and OASIS Matching Key on the claim. If no OASIS assessment was done, report the lowest weighted HIPPS code (HAEJ1) as a proxy, *an* 18-digit string of the number 1, "111111111111111111", for the OASIS Claim-Matching-Key in FL 63, and meet other minimum Medicare requirements for processing RAPs. If an OASIS assessment was done, the actual HIPPS code and Matching-Key output should be used. Medicare standard systems will bypass the edit that requires a matching RAP on history for these claims, then continue to process them as no-pay bills. Standard systems also ensure that a matching RAP has not been paid for that billing period. FL 20, source of admission, and treatment authorization codes, FL 63, *are* unprotected for non-pay bills.

B - Simultaneous Covered and Non-Covered Services

In some cases, providers may need to obtain a Medicare denial notice for non-covered services delivered in the same period as covered services that are part of an HH PPS episode. In such cases, the provider should submit a non-payment bill according to the instructions above for the non-covered services alone, AND submit the appropriate HH PPS RAP and claim for the episode. If the episode billed through the RAP and claim is 60 days in length, the period billed under the non-payment bill should be the same.

Medicare standard systems and the CWF will allow such duplicate claims to process when all services on the claim are non-covered.

C - Custodial Care under HH PPS, or Termination of the Benefit during an Episode Period

In certain cases, CMS allows the use of no payment claims in association with *an* HHABN involving custodial care and termination of a benefit during an episode period. This does not apply to cases in which a determination is being requested as to the beneficiary's homebound status at the beginning of an episode; there *an* HHABN must be used *assuming* a triggering event occurs (*i.e., the initiation of completely noncovered care*). However, in cases where the HH plan of care prescribes only custodial care, or if the benefit has terminated during a *previous* episode period, and the physician, beneficiary, and provider are all in agreement the benefit has terminated or does not apply, home health agencies (HHAs) can use:

1. The HHABN for notification of the beneficiary, *using* Option *Box 1 language, with the beneficiary selecting the third checkbox indicating both services and billing is desired, and then also the following checkbox for Medicare billing* on that *notice*, and,
2. A condition code 21 no-payment claim to bill all subsequent services.

NOTE: Providers can never pre-select *HHABN* options for beneficiaries, in accordance with existing *liability notice* policy. In each case, the beneficiary must be consulted as to the option they want to select. The *HHABN* options presented relative to specific billing scenarios above, and in the rest of the document, are only illustrations and in no way authorization for pre-empting a beneficiary's right to choose a specific option.

Medicare Claims Processing Manual

Chapter 30 - Financial Liability Protections

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(Rev. 1025, 08-11-06)

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50.8.2 - ABNs for Part B Services Furnished in a Skilled Nursing Facility (SNF)

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

Insofar as payment may be made under Part B for certain items and services when furnished by a participating SNF (either directly or under arrangements) to an inpatient of the SNF, if payment for these services cannot be made under Part A (e.g., the beneficiary has exhausted his/her allowed days of inpatient SNF coverage under Part A in his/her current spell of illness or was determined to be receiving a noncovered level of care, or the 3-day prior hospitalization or the transfer requirement is not met), the instructions in §50.1 - §50.7 and §150 are applicable with respect to such Part B claims.

60.1 - Background on the HHABN

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

Since 2002, home health agencies (HHAs) have issued one-page HHABNs related to the absence or cessation of Medicare coverage when a beneficiary had liability protection under §1879 of the Social Security Act (the Act; see 60.2 H. below). This section also takes into account not only notification responsibilities under §1879, but also those under §1891 of the Act, the Conditions of Participation (COPs) for HHAs, in accordance with the 2nd Circuit's decision in LUTWIN v. THOMPSON. In particular, HHABNs are required more frequently for reductions and terminations. For example:

- HHABNs are required more frequently for changes in noncovered home care;*
- HHABNs are now required in some situations where qualifying requirements for Medicare benefits are not being met, such as when there is a lack of physician orders for further home care; and*
- HHABNs are required in a larger number of circumstances where covered care is reduced or terminated.*

These HHABN instructions also take into account expedited determination notice requirements, which were implemented in 2005. As detailed below (see 60.2 B), the HHABN and expedited determination notices are now the only two types of notices an HHA will need to use to convey liability to beneficiaries.

60.2 - Scope of the HHABN

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

A. Statutory Authorization for HHABN

The requirement to give an HHABN is based on §1879 of the Act with its financial liability protections, and §1891, the COPs for HHAs (the COPs are further implemented through Title 42 of the Code of Federal Regulations (CFR), Part 484.) In particular, relative to written notification, §1891(a)(1)(E) stipulates that beneficiaries have:

‘The right to be fully informed orally and in writing (in advance of coming under the care of the [home health] agency) of--

- (i) all items and services furnished by (or under arrangement with) the agency for which payment may be made under this title,*
- (ii) the coverage available for such items and services under this title, title XIX or any other Federal program of which the agency is reasonably aware,*

(iii) any charges for items and services not covered under this title and any charges the individual may have to pay with respect to items and services furnished by (or under arrangement with) the agency, and

(iv) any changes in the charges or items and services described in clause (i), (ii) or (iii).”

The following chart summarizes the notice requirements under §1879 and §1891, which can also vary based on whether the home health benefit is at issue or if other care delivered by HHAs is involved (see 60.2 E below). Note CMS has designated the HHABN as the standard notification vehicle in all these cases:

Overview of HHABN Statutory Authorization

HHABN Requirement	HH Benefit	HHA Services “Outside the HH Benefit*”
§1891 Notification of Plan of Care (POC) Reductions and Terminations	<i>Required</i>	<i>Not Required</i>
§1879 Liability Notification for a Defined Medicare Benefit	<i>Required</i>	<i>Required</i>
Liability Notification for Care that is Not a Defined Medicare Benefit	<i>Not Applicable</i>	<i>Voluntary</i>

* For definition, see 60.2 E below

B. HHABNs and Other Liability Notices

Since 2006, the HHABN has a broader scope that makes some other liability-related notices formerly used by HHAs unnecessary. Subsequently, HHAs no longer use:

- The general ABN (CMS-R-131) for Part B non-covered items/services outside the home health benefit-- HHAs use the HHABN for all benefits.
- The voluntary notices, Notice of Exclusion from Medicare Benefits (NEMB) or the NEMB-Home Health Agency (NEMB-HHA), for noncovered care outside the definition of a Medicare benefit -- HHAs use the HHABN for voluntary as well as mandatory liability notification.

Along with the HHABN, HHAs must use expedited determinations notices when required. [In short, expedited determination notices are given to beneficiaries before the termination of all Medicare covered services, so they are alerted to their right to obtain an independent, immediate review by a Quality Improvement Organization (QIO) of the decision to end coverage. For Original (Fee-For-Service, “FFS”) Medicare, the first or Generic Expedited Determination Notice is entitled, “Notice of Medicare Provider Non-Coverage,” Form Number CMS-10123, and the second or detailed notice is called the

“Detailed Explanation of Non-Coverage,” Form Number CMS-1024.] Links for “FFS HHABN” and “FFS ED Notices” are links found on CMS Web site at:

<http://www.cms.hhs.gov/BNI/>

Instructions for the expedited notices, like the HHABN, will ultimately be placed in this chapter (a new and independent section), since this chapter is the primary source of guidance on all such notices used in Original Medicare.

C. HHABN Issuers and Recipients

Only HHAs, no other types of Medicare providers, issue the HHABN. *HHAs issue HHABNs only for services that they bill or furnish, not for items or services that beneficiaries under their care may permissibly obtain from other sources (note this policy generally applies to all financial liability protection notices that are used to meet the requirements of §1879 of the Act).*

An example is when durable medical equipment (DME) suppliers, and not HHAs, are providing equipment to beneficiaries receiving home care. In such cases, it is the supplier’s responsibility, as the entity billing the equipment, not the HHA’s, to notify the beneficiary of potentially noncovered items they may deliver. Suppliers use the general ABN and follow the instructions for this notice found elsewhere in this chapter. Another example is when an HHA has an intravenous infusion division, but a pharmacy provides medications to be infused and bills the patient’s drug benefit directly. Here the pharmacy does the billing, and therefore would have any applicable notification responsibility. (Note there is no ABN-type notification requirement for Medicare Part D, only potentially for drugs provided under Part B (of Original Medicare)).

*Regarding beneficiaries receiving the HHABN, §1879 financial liability protection notices like the HHABN continue to be used solely for beneficiaries enrolled in Original Medicare, as §1879 of the Act applies only to Parts A and/or B of the Program. **HHABNs are not used in Medicare managed care.** When a beneficiary transitions to Medicare managed care from Original Medicare during a home health episode, no HHABN is required assuming there is no potential liability for payment or need to provide notification of changes in care. In this case, the beneficiary is still receiving the same basic Medicare covered care, just the type of Medicare “plan” is changing from Original Medicare to managed care (i.e., Medicare Advantage).*

NOTE: *In the instructions in this section, the term “beneficiary” is used either to mean the beneficiary or the beneficiary’s authorized representative, as applicable. Therefore, these instructions apply whether the HHA gives the HHABN to a beneficiary or an authorized representative. For more information on authorized representatives, see this chapter, §40.3.5 and §40.3.4.3. Note an authorized representative can sign and date an HHABN without further annotation when properly designated.*

HHAs should contact their Regional Home Intermediary (RHHI) if they have questions on the HHABN or related instructions, since RHHIs administer home health benefits for Original Medicare. Beneficiaries may be directed to call 1-800-MEDICARE.

D. Effect of Other Insurers/Payers

If a beneficiary is eligible for both Original Medicare and Medicaid (a “dual eligible”), or if Original Medicare and another insurance program or payer, HHABN requirements are modified when a triggering event occurs (see 60.3 below for discussion of triggering events). For example, when a beneficiary is a dual eligible, and is receiving services that are covered only under Medicaid-- so that from Medicare’s perspective, all care is noncovered-- an HHABN has to be issued only at the initiation of this noncovered care. Therefore, there would be no need for delivery of other HHABNs at subsequent triggering events, such as reductions in care, as long as coverage remained the same and the HHABN given at initiation was still effective. No additional HHABN would need to be given, unless: (1) the beneficiary again became eligible for Medicare coverage and a triggering event occurred, or (2) continuous treatment lasted for more than a year.

The same principle applies for beneficiaries who have Medicare and additional health insurance or payers other than Medicaid, when the other insurance or payer provides coverage and Medicare does not. Other payers can include: waiver programs, Office on Aging funds, community agencies (e.g., Easter Seals) and grants. However, if there is secondary or any subsequent Medicare coverage, HHABNs must again be issued at all triggering events.

NOTE: *When Medicare beneficiaries have no coverage in addition to Medicare, HHAs must provide HHABNs at all triggering events, whether care is covered or noncovered.*

Regarding timing of notification in cases when periods of Medicare covered and other payer/insurer covered care overlap, there is some flexibility. A common example is “split billing” nursing hours paid by Medicaid above those allowed by Medicare in keeping with its coverage policy on intermittent need. If an HHABN was given prior to/at the beginning of the period, such as a recertification period, where split billing was to be done, and explicitly described the care only Medicaid covers, another HHABN would not have to be given just because Medicare coverage ended after that point, assuming the previously given HHABN was still effective (see 60.6). However, the HHA could instead choose to wait to issue the HHABN for the ongoing noncovered care until Medicare coverage was ending-- HHAs can determine which approach will lead to the most effective communication with each individual beneficiary they serve. Note, however, expedited determination notices must be issued when termination of Medicare coverage occurs, in accordance with requirements for this distinct appeal right.

E. Use of HHABNs for All Home Health Services

Since 2006, HHABNs are used both within and outside of the Medicare home health benefit. If HHAs are administering home health plans of care, related items and services are considered delivered under the home health benefit. Examples of services outside the home health benefit include equipment delivered when HHAs are acting as durable medical equipment suppliers, or possibly when administering therapy to non-homebound beneficiaries under a therapy, not home health, plan of care.

In terms of billing, this distinction is drawn by the type of bill: care that is part of the home health benefit is billed with either a 32X or 33X, care outside the home health benefit is billed with 34X. For the HHABN, items or services within and outside of the home health benefit are defined in the same way as they are in billing. Note that:

- *Any Medicare benefit can be either covered or noncovered, depending on individual circumstances involved; and*
- *Generally the term “care outside the benefit” includes: (1) benefits other than the one under consideration (in this section, home health), and (2) items or services that are never-covered as Medicare benefits (see F. immediately below for more on noncovered care).*

NOTE: *There are differences in when the HHABN has to be issued based on whether care is, or is not, provided under the home health benefit (see 60.3 below).*

F. Noncovered Services

Generally, coverage equates with payment. Covered services are those which Medicare pays in accordance with its established policies, and in Medicare manuals the term “covered” most often means usually or potentially covered under Medicare policy.

Conversely, if a service is “noncovered” in Medicare, this usually means Medicare normally is not expected to or will not pay. Lack of eligibility for a benefit, such as failure to meet the homebound criterion for Medicare to cover home care, is an example of noncoverage due to coverage/payment policy. (Note that while such policy is often the reason payment is not expected, there are other reasons, such as a beneficiary’s lack of eligibility for a Part of Medicare, that are different from lack of eligibility for a specific benefit like home health).

There are two basic types of noncovered services under policy as described above:

- ***Never-Covered Care.*** *Items or services that Medicare never covers, such as: (1) defined exclusions like routine foot care cited under §1862(a)(13)(C) of the Act, or (2) care that is not described as covered either in broad categories under Title 18 of the Act (the authorizing statute for Medicare), or in more specific national or local Medicare coverage decisions. Examples of such services which HHAs*

deliver include: telemonitoring of health status, geriatric alcohol prevention programs.

- **Usually Covered Care.** *Items or services that Medicare usually covers, but are denied in individual cases for specific reasons, such as when the service in question is considered not reasonable and necessary in a particular case.*

Never-Covered Care -- Home Health Benefit. *Preliminary guidance on the HHABN in 2006 stated that “never-covered” services, when included on the home health plan of care, must be treated like other on the plan in terms of HHABN notification. However, this instruction clarifies that the COPs for HHAs do not require notification for such never-covered care, even when described on home health care plans, as long as there are no charges to the beneficiary. That is, consistent with §1891(a)(1)(E)(iii)-(iv), which focus on charges: notice only has to be given when items and services never-covered under this title are provided to beneficiaries AND the beneficiary is charged for that care. If there are no charges, there is no notification requirement.*

Never-Covered Care -- Outside the Home Health Benefit. *Never-covered services that are either benefits other than home health or cannot be categorized as a Medicare benefit at all are not subject to HHABN notification requirements as discussed above relative to the home health benefit. Such care is not required to be administered under home health plans of care, and is not necessarily concurrent with Medicare covered home care. The HHABN may not be required even if HHAs charge for this care, as long as there is no beneficiary liability as recognized under §1879 of the Act (see H. immediately below). If §1879 does not apply to care outside the benefit, use of the HHABN is voluntary.*

Usually Covered Care (Noncovered in an Individual Case). *In contrast to never-covered services, note that §1891(a)(1)(E)(i)-(ii) require notification for “all items and services furnished... for which payment may be made under this title.” These sections do not reference charges, and set a higher notification standard when care “may” be covered (paid) by Medicare (i.e., this care is not “never-covered” because it can be covered in certain cases). HHABN notification is required when such noncovered items or services are on home health plans of care and reduced or terminated, whether or not there are charges. Again, there is no parallel notification requirement for care outside the home health benefit not administered under home health care plans.*

G. Bundled Payment

For home health, the primary example of bundled payment is the 60-day episode under the home health prospective payment system. This is a global payment for all Medicare covered home care needed in the 60 day episode; it is not based on individual items and services. (Note there are a few exceptions, since separate payment is made for DME osteoporosis drugs provided under the benefit during the episode.)

NOTE: *Items and services that Medicare never covers, as opposed to service Medicare usually covers but may not in an individual case (for reasons such as a lack of*

medical necessity, see F. immediately above), are not considered part of the bundled home health prospective payment. Never-covered care is not within the definition of any Medicare benefit. Examples of never-covered care specific to the home health benefit include: care provided to beneficiaries who are not homebound, telemonitoring, and full-time skilled nursing care.

Initiation. *HHABNs are not required at initiation of bundled care since the related payment is for any related services that are potentially covered as part of the home health benefit. This is consistent with ongoing financial liability protection policy, which states such notices cannot be used, in effect, to double charge by collecting funds from a beneficiary for care Medicare has already covered in a bundle (see 50.7.7.6 in this chapter on bundled payment; and note Chapter 7 in Pub.100-02, the Medicare Benefit Policy Manual, describes the home health benefit in detail--this manual is 100-04 in the same series).*

NOTE: *If an HHABN was not given at admission/start of care because an HHA was delivering covered and noncovered care in the same bundled payment, and subsequently care continued and became completely noncovered, then an HHABN would have to be issued (see F. above, and 60.3 C. below).*

Reductions. *After initiation, for care considered within a bundle, HHAs must issue HHABNs if during the 60-day episode reductions occur in care that Medicare usually covers. This assures that the beneficiary is aware of these changes as required under the COPs. Such notification is required even if there is no additional liability for the beneficiary (i.e., because the 60-day payment remains the same despite the change, or the payment group changes but the beneficiary still has no liability).*

Terminations. *For terminations of bundled care under the home health benefit, HHABNs are not required, since expedited determination notices fulfill notification requirements. An HHABN is only required if: (1) expedited determination notification requirements do not apply; and/or (2) completely noncovered care continues after coverage ends (see 60.3 below).*

H. Limitation of Liability

Home Health Benefit. *Historically, CMS has required HHABNs only in those specific situations where “limitation on liability” (LOL) protection was afforded under §1879 of the Act for item(s) and/or service(s) ordered by physicians that HHAs believed Medicare would not cover. Prior to 2006, CMS also only required that HHABNs be issued for care that was part of the home health benefit.*

Under these instructions, HHAs continue to use the HHABN in these circumstances, that is, in order to charge beneficiaries for home care presumed to be noncovered, assuming beneficiaries make choices to receive such care and accept liability. The chart below lists anticipated denial reasons where §1879 protections apply.

Application of LOL for the HH Benefit

Citation from the Act	Brief Description of Situation	Explanation
<i>§1862(a)(1)(A)</i>	<i>Care is not reasonable and necessary</i>	<i>Medicare does not pay for such care</i>
<i>§1862(a)(9)</i>	<i>Custodial care is the only care delivered</i>	<i>Medicare does not usually pay for such care, except for some hospice services</i>
<i>§1879(g)(1)(A)</i>	<i>Beneficiary is not homebound</i>	<i>Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit</i>
<i>§1879(g)(1)(B)</i>	<i>Beneficiary does not need full time skilled nursing care</i>	<i>Medicare requires an intermittent need in order to cover such services under the home health benefit</i>

Another change in HHABN policy is that HHABNs are not only required in situations where LOL protection is available regardless of financial liability. This is necessary to meet HHA notification requirements under §1891 of the Act (see A. immediately above).

Outside the Home Health Benefit. With HHABNs given for care outside the home health benefit, the usual reason for presumed noncoverage will be under §1862(a)(1)(A) of the Act, namely that care is not reasonable and necessary. Note that the required frequency of notification for such care has not changed, only the particular notice employed (see 60.2 above, particularly B. and E.).

60.3 - HHABN Triggering Events

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

Generally, HHAs are required to issue HHABNs whenever they believe they are about to deliver noncovered item(s) and/or service(s) at three points in time, called “triggering events”:

Definition of Triggering Events

EVENT	DESCRIPTION
A. Initiation	<i>When an HHA expects that Medicare will not cover any item(s) and/or service(s) delivered under a planned course of treatment from the start of a spell of illness, OR before the delivery of one-time item(s) and/or service(s) that Medicare is not expected to cover.</i>
B. Reduction	<i>When an HHA reduces or stops some item(s) and/or service(s) during a spell of illness, while continuing others, including when one home</i>

	<i>health discipline ends but others continue, independent of Medicare coverage.</i>
C. Termination	<i>When an HHA ends delivery of either all Medicare-covered care, or all care in total.</i>

NOTE:

- *See A., B. and C. immediately below for more information on each triggering event.*
- *See D. below for certain limited exceptions for the home health benefit when an HHABN is not required even though a triggering event may have occurred.*

Home Health Benefit. *HHAs must issue HHABNs at triggering events when either §1879 or §1891 of the Act apply (see 60.2 A. and H. above), as summarized in the following charts:*

TABLE A - Triggering Events For the HH Benefit: §1879 or §1891 Applies

Application:	Medicare COVERED CARE	
Population:	All Beneficiaries	
Initiations	<i>Not Required</i>	
Reductions	<i>HHABN</i>	
Terminations for Coverage Reasons*	<i>Generic Expedited Determination Notice**</i>	
Terminations not based on Coverage*	<i>HHABN</i>	

** For definition, see C. below.*

***HHABNs are also given ONLY if noncovered care continues after coverage ends. See C. below on terminations.*

TABLE B - Triggering Events For the HH Benefit: §1879 or §1891 Applies

Application:	Medicare NONCOVERED CARE	
Population:	Beneficiaries with other coverage (i.e., Medicaid)	Beneficiaries with no other coverage
Initiations*	<i>HHABN</i>	<i>HHABN</i>
Reductions	<i>Not Required</i>	<i>HHABN</i>
Terminations**	<i>Not Required</i>	<i>HHABN</i>

** Of completely noncovered care, see C. below.*

*** In contrast to Table A above, there are no expedited determination requirements when care is noncovered.*

Outside the Home Health Benefit. *HHAs must issue HHABNs for triggering events only when required under §1879 (see 60.2 H. above), summarized as follows:*

TABLE A - Triggering Events Outside the HH Benefit - §1879 Applies

Application:	Medicare COVERED CARE
Population:	All Beneficiaries
Initiations	<i>Not Required</i>
Reductions	<i>HHABN</i>
Terminations for Coverage Reasons*	<i>Generic Expedited Determination Notice** and/or HHABN</i>
Terminations not based on Coverage*	<i>Not Required</i>

* For definition see discussion in C. below on terminations.

** Expedited determinations are only required at the end of a planned course of covered treatment usually delivered over the course of time, such as when administering a therapy plan of care, and are not used for one-time or sporadic item(s) or service(s). (Note one-time items or services are classified as initiations, not terminations (see A. below).) HHABNs are also given ONLY if noncovered care continues after coverage ends. When expedited determination notices are not required, the HHABN is required only if LOL applies (see 60.2 H).

TABLE B - Triggering Events Outside the HH Benefit - §1879 Applies

Application:	Medicare NONCOVERED CARE	
Population:	Beneficiaries with other coverage (i.e., Medicaid)	Beneficiaries with no other coverage
Initiations*	<i>HHABN</i>	<i>HHABN</i>
Reductions	<i>Not Required</i>	<i>Not Required</i>
Terminations **	<i>Not Required</i>	<i>Not Required</i>

* Of completely noncovered care, see C. below.

** In contrast to Table A above, there are no expedited determination requirements when care is noncovered.

NOTE:

- *When §1879 does not apply and care is outside the home health benefit, such as care that is part of another Medicare benefit, notification of liability with the HHABN is voluntary, not required.*
- *These notice delivery rules are unique for HHAs. HHAs that also operate as hospices or other types of Medicare providers or suppliers (under separate provider or supplier identification numbers), should NOT assume these requirements are applicable to other types of providers.*
- *For ongoing continuous (long-term) noncovered care exceeding a year in duration, another HHABN must be given as each new year begins, assuming coverage remains the same and therefore HHABN requirements still apply. This is in keeping with standing Medicare liability notice practices that serve to confirm both beneficiary retention of coverage information and that coverage status is in fact unchanged (see 50.7.1 in this chapter).*

- See 60.4 G.2.b below for a summary of triggering events further broken down by which option box language is used on the HHABN.

A. Initiations

With respect to the initial assessment of a beneficiary, prior to admission (i.e., start of care), no notification is required if the HHA only assessed the beneficiary, did not admit him/her, and did not charge for the assessment. However, if an HHA charges for an assessment, the HHA must provide notice to the beneficiary before charging for the service as cited in Chapter 10 of this manual (50 F).

In their admission processes for home care, HHAs provide information on covered and noncovered charges as required under the COPs for HHAs. CMS does not mandate that a standardized notice format, like the HHABN, be used in the admission process when covered care is to be delivered. The HHABN is only issued to a beneficiary at initiation when care is completely noncovered by Medicare. If there is delivery of some noncovered care from initiation, such as when there is a noncovered part of bundled care that is covered as a whole (see 60.2 G. above), an HHABN is not required. Another example of HHABNs not being required at initiation is when Medicare covered nursing hours will be provided up to the Medicare limit, and hours beyond that limit will also be provided and paid by Medicaid for a dually eligible beneficiary.

Initiation of completely noncovered care is usually a triggering event for all beneficiaries for all benefits (the exception is care outside the home health benefit when LOL does not apply, see 60.2 H above). Relative to the home health benefit, if another payer or insurer provides coverage after that point while that beneficiary remains ineligible for coverage under Medicare, HHAs do not need to issue HHABNs for subsequent triggering events for up to a year (see 60.2 D. above). For other benefits, HHAs are not required to issue HHABNs for other triggering events after initiation when care remains completely noncovered.

One-Time Items/Services. *Neither HHABNs nor expedited determination notices are necessary for one-time treatments not covered by Medicare where there is no beneficiary liability. If, however, the beneficiary is charged, the HHABN may be required. Any one-time care (that which is provided and completed in a single encounter) is considered an initiation in terms of triggering events, since such care cannot be reduced or terminated over time.*

Under the home health benefit, one-time services are uncommon, such as episodes that are truncated to one visit because of a beneficiary's death. In such cases, HHABNs would not have been required since services at delivery would have been presumed to be covered. If an HHA knowingly plans to provide a potentially noncovered one-time service or item, under the home health benefit (including related assessments), an HHABN must be issued unless: (1) there are no charges to the beneficiary, or (2) a recognized exception applies (see D below). If a one-time service is provided under another Medicare benefit, such as when HHAs provide DME as suppliers under Part B,

HHABNs are only required when the item supplied is not believed to be reasonable or necessary for treatment (LOL applies, see 60.2 H. above).

B. Reductions

Reductions and terminations are sometimes confused, but in the case of reductions, HHAs must be discontinuing some, but not all, care. For example, reductions may include cases where one type of care ends but other type(s) continue, such as the end of one discipline under the home health benefit (skilled nursing) while another (physical therapy) continues.

For most beneficiaries receiving the home health benefit, HHABNs are required for reductions whether or not the care that is ending (the reduction) or the care that continues afterward is covered by Medicare, unless an explicit exception applies (see D. below). Only beneficiaries that are receiving completely noncovered care under Medicare that is covered through another payer or insurer are excepted (see 60.2 D above and the 2 Table Bs at the beginning of this section, as well as D. below). Outside the home health benefit, HHAs are only required to issue HHABNs when Medicare covered care is being reduced and LOL applies (see 60.2 H. above).

C. Terminations

Termination is the complete cessation of all item(s) and/or service(s) at the end of a course of treatment, as opposed to reductions, where only some care ends. Particularly because of expedited determination notice requirements effective July 2005, HHABNs are not always required at termination of home care.

The HHABN and generic expedited notices address different things: the generic notice gives information on the right to a quick decision from a QIO affirming or disputing the end of all covered care. The right to an expedited determination only applies when coverage for a course of treatment under certain Medicare benefits is terminated for Medicare coverage reasons (see "Reasons for Termination" below). Instructions for expedited determinations are in Transmittal 594, CR 3903 dated June 24, 2005 (which will be added to this chapter in the future). Home health and therapy (i.e., administered under a therapy, not home health, plan of care) would likely be the only benefits HHAs provide to which the expedited right applies. In contrast to expedited determination notices, the HHABN provides information on potential liability for care that would be delivered after coverage ends, and on claim-related appeal rights.

Beneficiaries must receive notice for ANY terminations of home care. For the purposes of the COPs for HHAs, either an expedited determination notice or an HHABN can fulfill this requirement. If §1879 requirements also apply (i.e., noncovered care for which the beneficiary may be liable will continue after termination of coverage), the HHABN must also be provided. A generic expedited determination notice must be issued at termination if: (1) the reason care is ending is related to Medicare coverage policy, and (2) noncovered care will not continue after coverage ends.

Reasons for Termination. Regarding (1) in the paragraph above, common examples of care ending for Medicare coverage reasons for the home health benefit are lack of a physician order or a beneficiary no longer being homebound. Outside the home health benefit, lack of orders is also a common reason for noncoverage of other benefits.

Expedited determination notices are required in these situations. Terminations not related to coverage policy are likely when HHAs decide to stop providing some or all care for their own financial and/or other reasons, regardless of Medicare policy or coverage. For example, this could occur due to the availability of staffing, closure of the HHA or concerns for staff safety in a beneficiary home. It could also be a situation such as a termination of an HHA's provider agreement with Medicare, which though not necessarily the HHA's choice, still does not affect a given beneficiary's eligibility for Medicare covered home care, nor is such a termination based on Medicare coverage policy.

NOTE: As with other triggering events, exceptions to HHABN notification requirements may apply (see D. immediately below).

Dual Eligible Example. If a dually eligible beneficiary who has been receiving home care services under Medicare ceases to be homebound, the payer/insurer becomes Medicaid. Since triggering event definitions are written in the context of Medicare coverage, an expedited determination notice is given because Medicare coverage is terminating, but since Medicare noncovered (Medicaid covered) care will be continuing from that point forward, an HHABN is issued too because of the initiation of noncovered care from Medicare's perspective. Medicare requires that its beneficiaries be informed of potential liability in advance of actually incurring that liability (i.e., receiving the noncovered care), when LOL applies (see 60.2 H. above), even if another payer/insurer exists and is likely to provide coverage (see 60.2 D above and D. below).

D. Exceptions to HHABN Notification Requirements

HHABN notification requirements for care outside the home health benefit are much smaller in scope than requirements than when the home health benefit is being delivered (see the tables at the beginning of this section for illustration of this point). **Therefore, the following exceptions in the table below were developed to apply only to the home health benefit.** (Note that for services "outside the home health benefit" (see 60.2 E. for definition), HHABNs would not be required in any of the cases listed below, with the possible exception of meeting patient goals if noncovered care continued thereafter and LOL applied (see 60.2 H above and 14. in the table below)).

Table of Exceptions to HHABN Notification Requirements - HH Benefit

#	EXCEPTION	APPLICATION	DESCRIPTION
1	<i>Increases in Care</i>	<i>General</i>	<i>Any increases whether under the original plan of care (POC) or subsequent orders (includes noncovered care simultaneous to but exceeding Medicare coverage, i.e., private duty nurses, other payer/insurer coverage).</i>
2	<i>Transfers</i>	<i>General</i>	<i>Transfers to other covered care, i.e., another home health agency or another type of Medicare provider (includes worsening patients needing hospitalization, until such time as the patient returns to the HHA's care).</i>
3	<i>Emergency or Unplanned Situations</i>	<i>General</i>	<i>Emergencies or unplanned situations beyond the HHA's control (i.e., natural disasters, staff member illnesses or transportation failures).</i>
4	<i>Changes in Caregiver or Personnel</i>	<i>General</i>	<i>Any changes in HHA caregivers or personnel as decided by the HHA.</i>
5	<i>Changes in Arrival or Departure Time</i>	<i>General</i>	<i>Any changes in expected arrival or departure time for HHA staff as determined by the HHA.</i>
6	<i>Changes in Brand</i>	<i>General</i>	<i>Any changes in brand of product, i.e., the same item produced by a different manufacturer as determined by the HHA.</i>
7	<i>Free Care Never-covered by Medicare*</i>	<i>General</i>	<i>Care that is never-covered by Medicare under any circumstances and for which the HHA will not charge the beneficiary.</i>
8	<i>Free Initial Assessment (never-covered by Medicare)**</i>	<i>Initiation</i>	<i>Initial assessments (in cases where beneficiaries are not admitted) for which HHAs do not charge.</i>
9	<i>Noncovered Parts of a Covered Bundled Payment***</i>	<i>Initiation</i>	<i>Noncovered item(s)/service(s) that are part of care covered in total under a Medicare bundled payment (i.e., HH PPS episode payment).</i>
10	<i>Length of Visit/Care</i>	<i>Reductions</i>	<i>Any change in the duration of services included in the POC and communicated to the beneficiary by the HHA, i.e., shorter therapy sessions as health status improves, perhaps going from an hour to 45 minutes.</i>

#	EXCEPTION	APPLICATION	DESCRIPTION
11	<i>Lessening the Number of Items or Services</i>	<i>Reductions</i>	<i>Only applicable to reductions anticipated in the POC and communicated by the HHA to the beneficiary (see 1. and 2. below table for further discussion).</i>
12	<i>Changes in Services within a Discipline</i>	<i>Reduction</i>	<i>Changes in the mix of services delivered in a specific discipline (i.e., skilled nursing) with no decrease in frequency with which that discipline is delivered (see 3. below table for examples).</i>
13	<i>Changes in Modality of Care Resulting in Use of Different Supplies</i>	<i>Reduction</i>	<i>Changes in the modality affecting supplies employed as part of specific treatment (i.e., wound care) with no decrease in the frequency with which those supplies are provided (see 4. below table for examples).</i>
14	<i>Patient Goals Met</i>	<i>Terminations</i>	<i>All care (every discipline) ending with all patient goals met and/or physician orders completed (note an expedited determination notice must still be given in this case).</i>
15	<i>Beneficiary Choice</i>	<i>Reduction or Termination</i>	<i>Changes in care that are the beneficiary's decision and are documented in the medical record.</i>
16	<i>Exclusive Coverage under Other Payer/Insurer****</i>	<i>Reduction or Termination</i>	<i>When there is no applicable Medicare coverage but another payer/insurer will cover the beneficiary's care.</i>

* See 60.2 F (above).

** See A. immediately above.

*** See 60.2 G.

**** See 60.2 D.

1. Ranges in Orders (“11” in chart above)

Section 30.2.2 of Chapter 7 of Pub. 100-02, Medicare Benefit Policy Manual, allows the use of ranges when physicians write home health care orders. An example of orders given in ranges is: “therapy 2–3 times per week for 3 weeks”, as opposed to more prescriptive orders allowing HHAs less flexibility in judging patient progress (as well as making revisions in orders more likely): “3 visits a week for 2 weeks, 2 visits the final week”. Since the purpose of the HHABN is to keep the beneficiary informed of specific changes in the POC, the use of ranges on HHABNs is not permitted. That is, language on the HHABN cannot be open-ended as to when a specific change described would occur, particularly if listing a number of potential future changes in a range that is not projected to occur at specific points in time or with the achievement of specific goals (see 2. immediately below).

2. Advance Notification (“11” in chart above)

*Some HHAs do not believe they can accurately inform beneficiaries of specific timeframes based on the POC developed from physician orders, because they cannot guarantee that patient’s progress will conform to such plans. Other HHAs do feel comfortable advising their beneficiaries in advance, perhaps as part of reviewing the plan of care for the upcoming 60-day episode. **If an HHA is comfortable giving advance notice of all triggering events anticipated in the POC, such notice can be given before the period begins or prior to the first triggering event.** Another HHABN would then not have to be given in that period as long as treatment did in fact conform to expectations. However, if patient progress was not what was anticipated, or if a change in orders occurred, or for any other reason the previous HHABN no longer captured all reductions/terminations for the period, another HHABN would be required. Alternatively, an HHABN could be provided in advance of each triggering event. There is no mandate to take one approach over the other.*

NOTE:

- *When a certain type of service/home health discipline is close to ending, HHAs can use an endpoint describing when specific goals are met. This assumes the HHA either describes the actual goal on the HHABN (“you can transfer from bed to a chair independently”) or fully explains verbally what the term “goals met” (if used on the HHABN) means to the affected beneficiary-- the medical record would also make clear the goal at issue had been discussed with the beneficiary. However, if physician orders exist for specific frequencies of care, this approach cannot be used as an alternative to what is specified in the order.*
- *Sometimes the statement is made that any change in a physician order, and subsequently, the home health POC, requires an HHABN be provided. Given the nature of the home health benefit, services are usually decreasing as a patient improves; thus, subsequent orders would likely be for a reduced number of services. However, new orders can still have one of four possible results: stopping care altogether, reducing care (the most common by far), maintaining care at the same level, or increasing care. Of these possibilities, it is only when reductions or terminations occur that HHABNs may be required.*

3. Use of the HHABN within Home Health Disciplines (“12” in chart above)

Regarding item(s) or service(s) provided within the scope of a single one of the six home health disciplines (see Chapter 7 of Pub. 100-02, Medicare Benefit Policy Manual for basic information on this benefit), an HHABN is only required when the frequency of that discipline is reduced, such as from 3 to 2 visits a week.

EXAMPLES:

- *A beneficiary is receiving several skilled nursing services during visits that are*

scheduled 3 times a week. One service within that discipline, a Protimed draw 1 time a week, is discontinued. Other skilled nursing services (wound care and education) continue, such that skilled nursing visits continue to occur 3 times per week. No HHABN is required when the Protimed draws are discontinued, only when skilled nursing is reduced in frequency.

- *A beneficiary is receiving physical therapy 3 times a week. The therapist changes the beneficiary from a walker to a cane while continuing to visit at the same frequency. No HHABN is required.*

4. Use of the HHABN when Changes in Modality Affect Supplies (“13” in chart above)

When an HHA is providing multiple supplies for complex treatments such as wound care, HHABNs are not required if there is a change in the modality of this treatment, only when supplies are reduced.

EXAMPLES:

- *Specific wound care products like Mesalt and Alldress are stopped, and a Hydrogel pad is started. Since this represents a change in the modality (or intervention), not a reduction, no HHABN is necessary. However, if the frequency of the provision of wound care supplies was reduced, such as from 3 to 2 times a week, an HHABN would be required.*
- *A beneficiary is receiving just skilled nursing care and supplies for wound care. Once the beneficiary learns to do his own wound care, the frequency of skilled nursing visits decreases, and an HHABN is required for this service reduction (although the provision of wound care supplies may stay the same for a time). As the wound continues to heal and the beneficiary is performing wound care less often, at the point fewer supplies are needed, an HHABN is required for that subsequent reduction in the frequency of supplies.*

60.4 - Completing the HHABN

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

A. Notices

HHABNs are available at:

<http://www.cms.hhs.gov/BNI/>

The notice is available in English and Spanish, and in PDF and Word formats, under a dedicated link on the top left-hand margin: “FFS HHABN”.

The HHABN is the Office of Management and Budget (OMB) approved standard notice for use by Medicare HHAs to: (1) advise Medicare beneficiaries of potential liability for noncovered item(s) and/or service(s) they deliver, allowing such HHAs to collect payment up-front from beneficiaries in such cases, and (2) inform beneficiaries of changes in the POC when required by the COPs for HHAs. HHAs are strongly advised to use the approved standard notice, as failure to use this notice could result in improper notification (see 60.6 below).

B. Choosing the Correct Language Version

HHAs should choose the appropriate version of the HHABN based on the language the beneficiary best understands. When Spanish-language HHABNs are used, the HHA should make insertions on the notice in Spanish. If this is impossible, additional steps need to be taken to ensure that the beneficiary comprehends the content of the notice.

C. Compliance with Paperwork Reduction Act of 1995

Consistent with the Paperwork Reduction Act of 1995, the valid OMB control number for this information collection appearing on the HHABN is 0938-0781. The estimated time required to complete this information collection ranges from 4 to 18 minutes for a single notice, depending on the option box language used (see F. 2 immediately below). This includes the time to prepare the notice, review it with the beneficiary and obtain beneficiary choices and signature.

Commenters may send comments concerning the accuracy of the time estimate(s) or suggestions for improving this notice to:

*Centers for Medicare & Medicaid Services
Attn: Reports Clearance Officer
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850*

D. Effective Dates

HHABNs are effective as of the OMB approval date given at the bottom of each notice. The routine approval is for 3-year use. HHAs are expected to exclusively employ the effective version of the HHABN.

E. Ongoing Care Situations

Generally, the HHABN version that should be used is the one effective when the triggering event requiring notification occurs, such as a reduction or termination in care. For prior admissions, specifically noncovered admissions when HHABNs are required at initiation of care, there is no need to re-notify beneficiaries who have received prior HHABN versions just because a new version has become effective.

F. General Notice Requirements

The following are the general instructions HHAs must follow in preparing an HHABN:

- 1. Number of Copies:*** *A minimum of two copies, including the original, must be made so the beneficiary and HHA each have one.*
- 2. Reproduction:*** *HHAs may reproduce the HHABN by using self-carbonizing paper, photocopying the HHABN, or using another appropriate method. All reproductions must conform to applicable instructions.*
- 3. Length and Page Size:*** *The HHABN must NOT exceed one page in length. The HHABN is designed as a letter-sized form. If necessary, it may be expanded to a legal-sized page to accommodate information HHAs insert in the notice, such as the HHA's name, list of item(s) and/or service(s) that will no longer be provided, and cost information.*
- 4. Contrast of Paper and Print:*** *A visually high-contrast combination of dark ink on a pale background must be used. Do not use reversed print (e.g., white on black), or block-shade (highlight) notice text.*
- 5. Modification:*** *The HHABN may not be modified, except as specifically allowed by these instructions.*
- 6. Font:*** *The HHABN must meet the following requirements in order to facilitate beneficiary understanding:*
 - a. Font Type:*** *To the greatest extent practicable, the fonts as they appear in the HHABN downloaded from either RHHI or CMS Web site should be used. Any changes in the font type should be based solely on software and/or hardware limitations of the HHA. Examples of easily readable alternative fonts include: Arial, Arial Narrow, Times New Roman, and Courier.*
 - b. Font Effect/Style:*** *Any changes to the font, such as italics, embossing, bold, etc., should not be used since they can make the HHABN more difficult to read.*
 - c. Font Size:*** *The font size generally should be 12 point. Titles should be 18 point, but insertions in blanks of the HHABN can be as small as 10 point if needed.*
 - d. Insertions in Blanks:*** *Information inserted by HHAs in the blank spaces on the HHABN may be typed or legibly hand-written.*
- 7. Customization:*** *HHAs are permitted to do some customization of HHABNs, such as pre-printing agency-specific information to promote efficiency and to ensure clarity for beneficiaries. Guidelines for customization are:*

- a. HHAs may have multiple versions of the HHABN specialized to common treatment scenarios, using all the required language and formatting of the HHABN, but with pre-printed language in its blanks.*
- b. HHAs may print different versions of HHABNs on different color paper to easily differentiate the versions, but in all cases high-contrast combinations of light paper and dark font color should be used.*
- c. HHAs may also differentiate versions of their HHABNs by adding letters or numbers in the header area.*
- d. Maintaining underlining in the blank spaces is not required.*
- e. Information in blanks that is constant can be pre-printed, such as the HHA's name, or Medicare's telephone (1-800-MEDICARE or 1-800-633-4227) and/or TTY (1-877-486-2048) numbers. Note the TTY phone number only needs to be entered when appropriate and based on the needs of beneficiaries.*
- f. If pre-printed multiple options are used describing the items or services and reasons for noncoverage, the beneficiary should only see information applicable to his/her case clearly indicated in each blank or checked off in a checkbox.*
- g. Checkboxes for disciplines, if used to describe item(s) and/or service(s), must still allow for explanation of what is changing; for example: " Physical Therapy: Reduced to 2 times per week." Just checking off a discipline without an explanation could render the notice invalid.*
- h. HHAs should have available HHABNs without pre-printed information on hand for staff to use in unusual cases that do not conform to pre-printed language for items or services or reasons for noncoverage.*

NOTE:

- *HHAs must exercise caution before adding any customizations beyond these guidelines, since changing HHABNs too much could result in invalid notice and provider liability for noncovered charges. Medicare's liability notice policy generally bases validity determination on two factors: effective delivery and beneficiary comprehension (see 60.6 below).*
- *Medicare does not validate adaptations of the HHABN made by individual HHAs. Validity judgments are generally made by RHHIs, usually when reviewing HHABN-related claims.*

G. Completing Sections of the HHABN

The new HHABN continues to be a one-page notice, composed of four sections:

- *Header Section*
- *Body Section*
- *Option Boxes*
- *Signature/Date Section*

The HHABN file contains four pages. The first page is instructional and never distributed to beneficiaries-- it is marked "SAMPLE" in the bottom right corner. It has instructions for filling in the blanks and boxes in the notice. To differentiate the instructions from the actual notice text, the instructions are printed in a different font in the appropriate blanks.

The next three pages are "ready to use" HHABNs. The second page is an HHABN with Option Box 1 text placed into the boxed area of the notice-- it is marked "OPTION BOX 1" in the bottom right corner. The third page is an HHABN with Option Box 2 text in the boxed area-- it is marked "OPTION BOX 2" in the bottom right corner. The last page is also a blank HHABN, with Option Box 3 text in the boxed area -- it is marked "OPTION BOX 3" in the bottom right corner. See section 2.b below on which option box to use.

1. The Header Section

HHAs are permitted to customize the header section of the HHABN. The header section is above the title of the notice, "Home Health Advance Beneficiary Notice," which appears in larger point font size at the top of the page.

After downloading the notice from a RHHI/CMS Web site, HHAs may add identifying information, including the HHA's name, logo, and billing address. At a minimum, information allowing the beneficiary to contact the HHA must appear, including the provider's name and address (telephone number is given elsewhere on the notice).

2. The Body Section and Option Boxes

a. Instructions for the Body Section

The body section of the HHABN is below the header and above the option boxes. The HHA starts by inserting standard information into the following two blanks in this section:

Step 1: *The HHA inserts its name in the blank space provided in the sentence beginning: "WE, _____, YOUR HOME HEALTH AGENCY, . . .". Since the entry in the "Step 1" blank is the same no matter what option box is used, the name can be pre-printed in the notice.*

Step 2: In the next blank beginning: “ARE LETTING YOU KNOW THAT WE _____”, the HHA inserts the appropriate phrase, depending on which option box is used (see b. immediately below).

Step 3: The HHA must describe on the blank lines immediately after: “WITH THE FOLLOWING ITEMS AND/OR SERVICES: _____...” the item(s) and/or service(s) anticipated to be noncovered that are the reason for issuing the HHABN.

Regarding Step 3:

- *The HHA should describe either the items or services that: (1) Medicare will no longer cover but may still be provided by the HHA (this applies only when Option Box 1 is used, see b. immediately below), (2) the applicable reduction in items or services, or (3) the termination of all Medicare-covered care.*
- *General descriptions of multi-faceted services or supplies are permitted. For example, “wound care supplies” would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is not required.*
- *The HHABN should be used to describe reductions in either supplies or services. This is even true for care, like wound care, where delivery of supplies and services is highly integrated. Thus, notice would still be required if frequency of services was reduced although level of supplies remained constant. The converse would also be true, i.e., services remain constant and the level of supplies is decreased.*
- *When a reduction occurs, enough additional information must be included so that the beneficiary understands the nature of the reduction. For example, entering “wound care supplies weekly (now to be provided monthly)” would be appropriate to describe a decrease in frequency for this category of supplies, whereas just writing “wound care supplies” would not be sufficient in this particular case.*
- *Changes in the modality or interventions that are part of a service like wound care are not considered reductions. Again, if the frequency of the service is reduced, an HHABN would be required. (See 60.3, D.4 above.)*
- *AN HHA may add date information in the blank where items and/or services are described on the HHABN to help a beneficiary better understand when noncoverage begins. Note however that policy on timely HHABN delivery remains the same: **the HHABN has to be issued before the care in question is provided, so that the beneficiary can make an informed choice on accepting responsibility for payment when payment is at issue.** The time frame for how far before giving the notice is flexible, though notification must occur with enough advance that the beneficiary has time to make an informed choice.*

Step 4: After the word: "BECAUSE: _____..." the HHA must describe why the item(s) and/or service(s) listed are expected not to be covered by Medicare, or will no longer be provided by the HHA.

Regarding Step 4:

- The reasons provided must be in plain language that allows the beneficiary to understand why the notice is being given and enables the beneficiary to make an informed choice about accepting financial liability (when applicable). The information must convey more than simply that care is "not reasonable or necessary." A large amount of text is not required, nor is a citation to an actual policy document.
- The level of detail in the reason given should at a minimum be similar to that found in a Medicare Summary Notice (MSN) message. For example, a Step 4 entry could be: "you are no longer homebound" or, even more consistent with the related MSN message: "you can now leave your home unaided." Both phrases are simply worded examples of concise yet complete explanations of a common yet specific reason why, according to Medicare policy, the home health benefit may not be covered for an improving individual. If needed, supplemental explanations should be provided verbally when delivering the notice.
- If multiple item(s) and/or service(s) are listed by the HHA in Step 3, and different reasons exist for including each item or service on the HHABN, the HHA is responsible for providing sufficient information in Step 4 to allow the beneficiary to understand each reason specifically associated with each item or service listed.

Step 5: In the paragraph beginning: "IF YOU HAVE QUESTIONS . . .", the HHA must enter its own telephone number, and/or provide a TTY number, or directions for using another telecommunication system for speech or hearing impaired beneficiaries when appropriate.

b. Use of the Option Boxes

There are three choices of option box language, and each can be linked to specific statutory authority:

Authority Supporting HHABN Option Boxes

Application	HH Benefit	Outside HH Benefit*
§1879 Liability Notice given prior to care to alert the beneficiary of potential liability for Medicare benefit	HHABN – Option Box 1	HHABN – Option Box 1
§1891 COP-Required Notice alerting beneficiaries to changes in care, specifically occurring because the HHA will no longer provide services for their own business or financial reasons	HHABN – Option Box 2	None Required

<i>Application</i>	<i>HH Benefit</i>	<i>Outside HH Benefit*</i>
<i>§1891 COP-Required Notice alerting beneficiaries of changes in the POC based on physician orders</i>	<i>HHABN – Option Box 3</i>	<i>None Required</i>
<i>Voluntary Notice alerting beneficiaries of potential financial liability for care that is not part of a defined Medicare benefit** or when not otherwise required by LOL policy (i.e., formerly NEMB or NEMB-HHA was used)</i>	<i>Not Applicable</i>	<i>Voluntary use of HHABN - Option Box 1</i>

** See 60.2 E. above for definition.*

*** See 60.2 E. and F.*

The appropriate option box is placed in the middle of the HHABN between the Body and Signature and Date sections. An overview of option box use is provided in the following chart based on context of use (rather than supporting authority).

General Summary of Option Box Use

<i>Option Box</i>	<i>Possible Beneficiary Liability</i>	<i>Assessments without Admission</i>	<i>Home Health Benefit Use</i>	<i>Other Medicare Benefit Use*</i>	<i>Care Not a Medicare Benefit*</i>	<i>Contains Billing Information</i>
<i>1</i>	<i>Must use</i>	<i>Use if charging beneficiary</i>	<i>Yes</i>	<i>Yes</i>	<i>Voluntary use</i>	<i>Yes</i>
<i>2</i>	<i>Can't use</i>	<i>Voluntary use if not charging</i>	<i>Yes</i>	<i>No</i>	<i>No</i>	<i>No</i>
<i>3</i>	<i>Can't use</i>	<i>Can't use</i>	<i>Yes</i>	<i>No</i>	<i>No</i>	<i>No</i>

** See 60.2 E. and F.*

Note with regard to triggering events and the option boxes:

- *Only Option Box 1 HHABNs are given with generic expedited determination notices when potential liability for noncovered care exists after coverage.*
- *Multiple instances of a single triggering event may be described on a single HHABN, assuming that HHABN is appropriate to each event.*

EXAMPLES:

- *Two reductions happening simultaneously both due to changes in the physician order can both be described on a single Option Box 3 HHABN (i.e., goals being met for one discipline -- physical therapy -- and a reduction in skilled nursing care).*
- *Less common cases where multiple different triggering events occur simultaneously may require separate HHABNs, such as with an initiation of completely new noncovered care (and for which the beneficiary may be liable), and a reduction in ongoing covered care due to physician orders (with*

no liability). **Option Box 1 must be used any time there is liability**, Option Box 3 could be used for the reduction related to orders. If such events were combined on a single Option Box 1 HHABN, the HHA would still have to assure the beneficiary understood which event entailed potential liability (and which did not).

The following chart summarizes the circumstances in which each option box should be used.

Triggering Event	Option Box 1	Option Box 2	Option Box 3
INITIATIONS			
<i>Initiations of Entirely Noncovered Treatment, Any Medicare Benefit, when §1879 LOL* Applies</i>	Yes	<i>No</i>	<i>No</i>
<i>One-time Noncovered Items/Services, Beneficiary Liable, Any Medicare Benefit, §1879 LOL* Applies</i>	Yes	<i>No</i>	<i>No</i>
<i>One-time Noncovered Items/Services, §1879 LOL* Does Not Apply and/or Not a Medicare Benefit</i>	<i>Voluntary</i>	<i>No</i>	<i>No</i>
REDUCTIONS			
<i>Any Reduction for HHA Reasons (Unrelated to Coverage)**, No Beneficiary Liability, HH Benefit</i>	<i>No</i>	Yes	<i>No</i>
<i>Any Reduction by Physician Order, No Beneficiary Liability, HH Benefit</i>	<i>No</i>	<i>No</i>	Yes
<i>Any Other Reductions, HH Benefit</i>	Yes	<i>No</i>	<i>No</i>
<i>Other Covered Care Reductions, Other Medicare Benefits, §1879 LOL* Applies</i>	Yes	<i>No</i>	<i>No</i>
<i>Any Other Reductions (Outside HH Benefit)***</i>	<i>Voluntary</i>	<i>No</i>	<i>No</i>
TERMINATIONS			
<i>Any Termination for HHA Reasons (Unrelated to Coverage)**, No Beneficiary Liability, HH Benefit</i>	<i>No</i>	Yes	<i>No</i>
<i>Covered Care Termination for Coverage Reasons (Including Physician Orders), HH Benefit</i>	Yes****	<i>No</i>	<i>No</i>
<i>Covered Care Termination for Coverage Reasons (Including Physician Orders), Any Medicare Benefit Subject to Expedited Determinations (i.e., therapy delivered by HHAs under a therapy plan of care)</i>	Yes****	<i>No</i>	<i>No</i>

<i>Any Other Terminations (services not subject to Expedited Determinations or §1879 LOL)</i>	<i>Not Required</i>	<i>No</i>	<i>No</i>
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** See 60.2 H for definition.*

*** See 60.3 C for definition.*

**** See 60.2 E for definition.*

***** Expedited Determination Notice MUST be given, and HHABN is also needed **only** when noncovered care continues after coverage ends.*

Instructions specific to each option box follow.

i. Instructions for Option Box 1

Option Box 1 is used in any of the following situations (see the charts earlier in this section for guidance on when to use this option box for different triggering events.):

- A beneficiary faces potential liability/will be receiving noncovered care/will be charged.*
- A beneficiary wants a claim filed for potentially noncovered care the HHA provides.*
- The care at issue is outside the Medicare home health benefit.*
- A beneficiary will be charged for an assessment although not admitted to care.*
- Any circumstance that may arise for which neither Option Box 2 nor 3 is appropriate.*

If Option Box 1 is being used, HHAs should insert the most appropriate of the following phrases in the Step 2 blank in the body of the HHABN:

- “will not provide you (if choosing Box 1 below)”*
- “will no longer provide you (if choosing Box 1 below)”*
- “believe Medicare will not provide you”*
- “believe Medicare will no longer provide you”*

The text insertion for Option Box 1 is in quotation marks below:

Option Box 1 Text

*“The estimated cost of the items and/or services listed above is \$ _____
 _____ . If you have other insurance, please see #3 below.*

You have three options available to you. You must choose only one of these options by checking the box next to the option and then signing below:

- 1. *I don't want the items and/or services listed above. I understand that I won't be billed and that I have no appeal rights since I will not receive those items and/or services.*
- 2. *I want the items and/or services listed above, and I agree to pay myself since I don't want a claim submitted to Medicare or any other insurance I have. I understand that I have no appeal rights since a claim won't be submitted to Medicare.*
- 3. *I want the items and/or services listed above, and I agree to pay for the items and/or services myself if Medicare or my other insurance doesn't pay. Send the claim to:*

(Please check one or both boxes):

Medicare

My other insurance. _____

Please note: *If you select option 3 and a claim is submitted to Medicare, you will get a Medicare Summary Notice (MSN) showing Medicare's official payment decision. If the MSN indicates that Medicare won't pay all or part of your claim, you may appeal Medicare's decision by following the appeal procedures in the MSN. If you don't receive an MSN for your claim, you can call Medicare at: (____) _____. TTY: (____) _____. You may have to pay the full cost at the time you get the items and/or services. If Medicare or your other insurance decides to pay for all or part of the items and/or services that you have already paid for, you should receive a refund for the appropriate amount.*

By signing below, I understand that I received this notice because this Home Health Agency believes Medicare will not pay for the items/services listed, and so I chose the option checked above."

Step 1: *The HHA must provide an estimate of the total cost of the items and/or services listed in the first blank in this option box. Since one or multiple items and services could be at issue, the HHA must enter a total cost that reflects each item or service as clearly as possible, including information on the period of time involved when appropriate (i.e., not a one-time service). For example:*

- *"\$400 in total for 4 weekly nursing visits in 1/06"*
- *"\$210 in total for 3 physical therapy visits 1/3-17/06, \$50 for medical equipment" (Specific pieces of durable medical equipment [DME] should be identified as space allows.)*

NOTE:

- *The cost estimate is meant to give the beneficiary an idea of what costs would be if he/she paid out of pocket, not what the beneficiary may actually have to pay given other coverage. The fact that other insurance might pay appears next in the*

HHABN after the cost estimate; thus, HHAs will inform beneficiaries of cases where other insurance will cover costs.

- The HHA must provide a reasonably good faith estimate of the total cost sufficient to assist the beneficiary in making a decision to accept or decline potential financial responsibility.*
- The estimated cost reported on the HHABN may be \$0 if, for example, an HHA chooses not to charge a beneficiary, or if bundled payments with no beneficiary liability are involved.*
- Since it may not be possible for HHAs to project all possible costs for future periods into one blank, a proxy like average daily cost can be given. For example, if an average day involves a skilled nursing visit, an average visit charge or private fee charge master amount for this service could be used to give a daily cost, noting when possible the duration over which continuing care could be expected. The use of “posted charges” is also acceptable in making an estimate.*
- If an HHA bills for the administration of drugs in cases where it believes that this service will not be covered, although it is usually Medicare covered, the HHA would have to give an HHABN for that specific service if the HHA planned to charge for it, but would not have to include the actual drug in estimated costs if supplied and billed by another entity (i.e., a pharmacy).*
- The HHA must annotate the amount the beneficiary may have to pay if he/she later chooses to receive only certain items or services of those listed on the HHABN instead of everything originally listed.*
- Abbreviations can be used due to the limited space available for cost estimates. Abbreviations generally should still be avoided, but are permitted in this space and overall are more acceptable if spelled out elsewhere on the notice (such as where the care at issue is described). If used, abbreviations would be part of what an HHA must cover verbally to assure the beneficiary comprehends the HHABN.*

Step 2: (Check Boxes and the Related Insurance Blank): *The two sets of check boxes--the first concerning the beneficiary’s desire to get the items or services at issue and numbered 1-3, and the second under Check Box 3 indicating whether Medicare and/or another insurer, i.e., Medicaid for dual eligibles and Medigap insurance for those with such policies, should be billed--are NEVER completed in advance (see 60.6). However, the HHA may fill in the blank naming the other insurance in advance when it is familiar with the coverage of a beneficiary, such as for an established patient. At a minimum, HHAs must identify all Federal government-funded insurance they are aware the beneficiary may have that could provide coverage.*

Step 3: In the space provided in the "PLEASE NOTE:" section of Option Box 1, the HHA must provide the Medicare phone number and the TTY telephone. The phone number is 1-800-MEDICARE (or 1-800-633-4227), and the TTY number is: 1-877-486-2048. These numbers may be pre-printed when the HHA prepares the HHABN.

ii. Instructions for Option Box 2

Option Box 2 is used when an HHA decides to stop providing some or all care for its own financial and/or other reasons, regardless of Medicare policy or coverage.

Examples of such reasons include: the lack of availability of staffing, closure of the HHA or safety concerns in a beneficiary home. (See the charts earlier in this section for guidance on when to use this option box for different triggering events.) Generally, this language can be used only when:

- There is no beneficiary liability.
- There is no further delivery of the care described in the body of the HHA (that is, a reduction or termination with no ensuing care of the type described, not a change from covered to noncovered care, such as when Medicare stops paying but care continues).
- There is no related claim (that is, there is no ensuing care described that could be billed later).

Option Box 2 could seem appropriate in similar cases when benefits other than home health are involved. However, notification is not required in these cases, and additionally, the wording of this option box references home care. Note that an HHA may issue HHABNs with Option Box 2 language voluntarily to provide notice that it will not charge nor admit a beneficiary after an assessment is done.

Steps for Completion. If Option Box 2 is used, HHAs should insert the following phrase in the Step 2 blank in the body of the HHABN:

“will no longer provide you”

The HHA would fill out the rest of the body of the HHABN as described above. Unlike for Option Box 1, however, there is no information to complete in Option Box 2 itself, as shown below:

Option Box 2

“By signing below, I understand that I received this notice because this Home Health Agency decided to stop providing the items and/or services listed above. The Agency’s decision doesn’t change my Medicare coverage or other health insurance coverage. I can’t appeal to Medicare since this Home Health Agency won’t provide me with any more items and/or services; however, I can try to get the items and/or services from another Home Health Agency.

Please note that there are many different ways to find another Home Health Agency, including by contacting your doctor who originally ordered home care. You may then ask the new Home Health Agency to bill Medicare or your other insurance for items and/or services you receive from them.”

iii. Instructions for Option Box 3

Option Box 3 is used when the HHA stops providing, or reduces the frequency of, certain items and/or services due to lack of a physician order, but other care continues. That is, this option box is only used with reductions. (See 60.3 regarding definition of triggering events, and clarification of the difference between a reduction and termination of all care; note the charts earlier in this section provide guidance on which option box to use with different triggering events.) Thus, Option Box 3 is appropriate when:

- *There is no beneficiary liability.*
- *There is no further delivery of the care described in the body of the HHA (that is, the reduction entails no ensuing care of the type described, as opposed to a reduction in coverage where particular items/services change from Medicare covered to noncovered, and delivery of care continues thereafter).*
- *There is no related claim (there is no ensuing care described that could be billed later).*

Option Box 3 could seem appropriate in cases when benefits other than home health are involved and affected by similar changes in physician orders. However, notification is not required in these cases, and additionally the wording of this option box references home care.

Steps for Completion. *If Option Box 3 is used, HHAs should insert the following phrase in the Step 2 blank in the body of the HHABN:*

“will no longer provide you”

The HHA would fill out the rest of the body of the HHABN as described above.

NOTE: *An HHA may substitute the phrase “will reduce” or “will stop” for this language-- and delete the following word “WITH” from the notice-- if it believes this phrasing will lead to clearer communications with beneficiaries.*

There is no information to complete in Option Box 3 itself, as shown below:

Option Box 3

“By signing below, I understand that I received this notice because my doctor has changed my orders and so my home health plan of care is changing. This home health agency has explained to me that they cannot provide home care without a doctor’s order.”

3. The Signature and Date Section

Once the beneficiary has reviewed and understands the information contained in the HHABN, the HHA must request that the beneficiary complete all four blanks in the boxed Signature and Date Section at the bottom of the HHABN. The four blanks are:

- ***Patient’s Name:*** *The beneficiary's full name should be inserted in the blank.*
- ***Medicare # (HICN):*** *The beneficiary’s Medicare health insurance claim number should be inserted in the blank.*
- ***Signature:*** *The beneficiary must personally sign the HHABN.*
- ***Date:*** *The beneficiary must personally enter the date that the HHABN was completed.*

NOTE: *The HHA may complete the first two blanks to assist the beneficiary.*

4. Other Considerations During Completion

a. Requests for Additional Information. *If while completing the HHABN the beneficiary requests additional information, the HHA must respond timely, accurately, and completely to the information request. See 60.6 for other requirements for effective delivery.*

b. Refusal to Complete or Sign. *If the beneficiary refuses to choose an option, where applicable, and/or refuses to sign the HHABN, the HHA should annotate its copy of the HHABN, indicating the refusal to sign and individuals present. The HHA must still provide a copy of the annotated HHABN to the beneficiary. The HHA must keep the original version of the annotated HHABN.*

Whether item(s) and/or service(s) will be provided or not when the beneficiary has refused to sign (or not expressly agreed to be responsible for payment) must be decided by the HHA. If under these circumstances the HHA decides to provide the care in question, the HHA should have a second person witness the provision of the HHABN and the beneficiary’s refusal to sign/select an option by making an annotation on the HHABN indicating that he/she witnessed this event. The witness must then sign and date next to his/her annotation. Where there is only one person on site, the second witness may be contacted by telephone and may sign the HHABN annotation at a later time. The unused patient signature line on the HHABN may be used for such an annotation; writing in the

margins of the notice also is permissible. An HHA is not obligated to provide noncovered care when a beneficiary refuses to accept liability (See 40.3.4.6 in this chapter).

c. Beneficiary Changes His/Her Mind. *If a beneficiary chooses a particular option and later changes his/her mind, where possible, the HHA should present the previously completed HHABN to the beneficiary and request that the beneficiary annotate the original HHABN to show and date the beneficiary's current choice. In those situations where the HHA is unable to present the HHABN to the beneficiary in person, the HHA may annotate the beneficiary's current intent on the notice and immediately forward a copy to the beneficiary. In either situation, a copy of the revised HHABN must be provided to the beneficiary within 30 calendar days.*

NOTE: *For requirements after completion, such as retention, see 60.8 below.*

60.5 - Special Issues Associated with the HHABN

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

A. Option Selection for Dual Eligibles.

As discussed above, HHAs must use Option Box 1 whenever there is potential beneficiary financial liability. Some States have also established specific HHABN rules involving situations where “dual eligibles” (Medicaid recipients who are also Medicare beneficiaries) would face liability that would be covered by Medicaid. In those cases, such States insist that HHABNs be completed to select the third checkbox in Option Box 1 language (referred to here as “Option 3”), and subsequently that the choice to bill Medicare is also indicated. (Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the “payer of last resort”, meaning other Federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid picks up any remaining charges.)

Medicare HHAs serving dual eligibles need to comply with State policy on HHABNs when it exists. (In the absence of explicit guidance from a State, dual eligibles may select whatever HHABN choice they want.) However, the State rules apply only when Medicaid will be billed. If Medicaid will not be billed (because the dual eligible makes a choice on the HHABN either not to receive any care at all, or to exercise the right to self-pay), the Medicaid requirement would not apply. (This is consistent with policy that the mandatory billing provisions of §1848(g) of the Act do not apply when a beneficiary self-pays.)*

Normally, an HHA may choose the method of billing it feels is most appropriate in association with a beneficiary's choices on a specific HHABN (though HHAs must always bill Medicare as directed by a beneficiary when he/she expresses a preference). The choices for billing related to HHABNs are: a “demand bill” if detailed review of the HHABN coverage assumption represented on the claim is sought, or a “no-payment bill” in cases where noncoverage is not in doubt and a denial is sought for reasons such as

facilitating consideration by a subsequent payer (see Chapters 1 and 10 in this manual for billing information pertinent to HHAs). However, beyond which HHABN option to choose as discussed above, some States have also specified the type of Medicare billing to be done related to the HHABN, requiring that a demand bill be filed instead of a no-payment claim. Note in such cases, if the HHABN and related demand bill do not appear to be consistent, specifically because the beneficiary has not selected Option 3 and did not specify that Medicare be billed, RHHIs will still process the associated claim, not acting to “return to provider” (RTP) as would be done with other potential administrative errors. (Note that if needed, the intermediary can confirm whether the beneficiary is dual eligible by reviewing the MDS/OASIS items that indicate payer source.)

*[*Mandatory claim submission applies when Medicare payment may be sought, and it is a requirement for providers or suppliers in such cases to file claims for services that are or may be covered under Part B (i.e., care outside the home health benefit, see 60.2 E). This includes situations where the provider or supplier believes claims might be denied due to lack of medical necessity. Generally, the only exceptions to mandatory submission are: (1) when a physician or practitioner opts out of Medicare, (2) when a beneficiary does not authorize the physician or supplier to submit the claim (i.e., is receiving a service and accepting personal responsibility for payment), and (3) when a physician or supplier provides care for free. Medicare would not make a payment in any one of these situations. Note that when a State Medicaid program insists Medicare billing be done for dually eligible beneficiaries, the beneficiary still has the right to self-pay and demand no claim be filed. In such cases, neither Medicare nor Medicaid payment would be sought.]*

B. Effect of Expedited Determinations

If a decision is made on a beneficiary request for an expedited determination (see 60.3 C) or reconsideration that contradicts the expectation on coverage made on an HHABN, the HHABN becomes moot for any period of overlap. For example, if an expedited determination finds that 3 days of care listed on an HHABN as noncovered are covered, the HHABN is moot and the Medicare program, not the beneficiary, will pay for that care. In general, decisions made under expedited review are official Medicare determinations that supersede provider projections on coverage made on HHABNs. Specifically, if an HHABN anticipated that a beneficiary would be liable, but a later decision under the expedited process found the provider liable, the provider would be liable and the HHABN moot. HHAs should annotate HHABNs that have become moot in such cases, noting the subsequent expedited determination. Note that the processing of claims related to a decision made under the expedited determination process must conform to that official Medicare decision.

60.6 - Effective Delivery/Effective HHABNs

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

As discussed earlier in this chapter, HHABNs are required in specific circumstances (see 60.3 in particular). When an HHABN is required, the delivery of an HHABN must be effective, or notification may not be deemed valid for purposes of assigning liability to a beneficiary. In order for delivery of an HHABN to be considered effective:

- *The HHABN must be delivered to the beneficiary in person whenever possible. However, Medicare’s notice policy allows for cases where this may not be possible. For example, notice may instead be given timely by telephone or email and followed up by mail. If e-mail is used, statutory privacy requirements under the Health Insurance Portability and Accountability Act (HIPAA) are met (i.e., not transmitting any personal identifiers such as social security numbers or HICNs). Instructions on ABN telephone notice are found in this chapter, 40.3.4.2 (these general instructions are also applicable to HHABNs).*
- *When delivering HHABNs to beneficiaries, HHAs are required to explain the entire notice and its content, and answer all beneficiary questions orally to the best of their ability. HHAs must make every effort to ensure that beneficiaries understand the entire HHABN prior to signing it.*
- *The HHABN must be received by the beneficiary prior to the beneficiary receiving the item(s) and/or service(s) at issue. This should be far enough in advance to give the beneficiary time to make an informed choice, but not so far in advance as to cause confusion about what care is described by the HHABN.*
 - *Some allowance is made for “immediate” delivery prior to furnishing the care at issue when unforeseen circumstances arise. This should be avoided whenever possible, but is permissible as long as the beneficiary still can make an informed choice.*
- *The HHABN must convey the HHA’s genuine doubt regarding the likelihood that Medicare may not pay for the listed item(s) and/or service(s), the reason(s) the HHA expects that Medicare may not pay for each listed item or service, the estimated cost for each item and/or service, and the beneficiary's options.*
- *The HHABN must be signed by the beneficiary, unless an appropriate reason for the lack of signature is recorded on the HHABN, such as a properly annotated signature refusal.*
 - *If the beneficiary is physically unable to sign the HHABN, but is fully capable of understanding the notice, so that there is no need for an authorized representative, the beneficiary may allow the HHA to annotate the HHABN on his/her behalf regarding this circumstance. For example, a fully cognizant beneficiary with two broken hands may allow an HHA staff person to sign and date the notice in the presence of and under the direction of the beneficiary, inserting the beneficiary’s name along with his/her own name, i.e., “John Smith, Shiny HHA, signing for Jane Doe.” Such signatures should be witnessed by a second person whenever possible. Further, the medical record should support the beneficiary’s inability to write in the applicable time period.*
- *In general, an HHABN remains effective for the predicted denial it communicates*

to the beneficiary as long as no other triggering event occurs (see 60.3 above on triggering events and exceptions, see 60.5 B and 60.7 D for conditions where HHABNs become moot). HHABNs can at most describe care given over a single year. If a new triggering event does occur, or if care stretches into another year, then another HHABN must be given.

- *Upon appeal of a related claim, a previously furnished HHABN may serve as acceptable evidence of knowledge that care would not have been covered (i.e., the HHABN cited similar or reasonably comparable item(s) and/or service(s) for which a similar denial was expected). A denial of a claim for such care received not more than 1 year previously may also be acceptable evidence of knowledge a similar denial would be likely. Still, HHAs are advised to provide an HHABN every time it is required, and not rely on a retrospective interpretation of evidence to determine liability.*

Regarding notice delivery in general, subcontractors may deliver HHABNs under the direction of a primary HHA. Note however that overall notification responsibility, including effective delivery, always rests with the primary HHA. If however a patient chooses to acquire care from another HHA following care delivered by a previous HHA, the previous HHA is never responsible for providing HHABNs for future triggering events that occur under the care of the “new” HHA. HHAs are always only responsible for providing HHABNs associated with the care that they themselves provide.

Further, if a vendor other than an HHA provides services to a beneficiary receiving home care, it is the vendor that is responsible for providing liability notification to the beneficiary, when required, for the care that vendor furnishes and bills. An example is when a supplier of DME directly supplies equipment to a beneficiary.

60.6.1 - Defective HHABNs

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

The following are examples of defective notice that may result in beneficiaries being protected from liability under §1879 of the Act. In such cases, HHAs cannot collect the cost of noncovered item(s) and/or service(s) from beneficiaries.

Failure to Use the Standard Notice. *HHAs are strongly encouraged to use the OMB-approved HHABN notice format, consistent with these instructions. HHAs should not alter the standard notice in any way not expressly permitted in these instructions. Failure to use the approved HHABN greatly increases the possibility of an invalid notification.*

Unintelligible Notice. *Notice will be considered defective if the HHABN is unreadable, illegible, incomprehensible, or it can be demonstrated that the beneficiary did not understand the notice due to particular circumstances that were within the HHA’s control, i.e., failure to use plain language.*

Unable to Give Consent. Notice may be ruled defective if given when the beneficiary cannot give informed consent, such as during a medical emergency or health crisis, especially if the notice could have been delivered by the HHA at another point in time.

Coercion. Notice may be found defective if the HHA is judged to have forced the beneficiary to complete the HHABN in a certain way, such as by forcing the selection of a given checkbox option in Option Box 1, or if the HHA intentionally misled the beneficiary during completion of the notice.

Routine Notice. Notice may be found defective if the HHA routinely gives the HHABN for all item(s) and/or service(s) the HHA provides, disregarding whether or not the HHABN is required.

Last Minute or Untimely Notice. Last minute notification does not allow the beneficiary time to make an informed decision regarding his/her healthcare options. HHABNs given at the last minute may be found defective. HHABNs are also ineffective if given too far in advance of item(s) and/or service(s) at issue, or after the delivery of such care.

Notice Given More than 1 Year Prior. HHABNs are considered effective for no more than 1 year. HHABNs given for services for a period of over a year will be found defective for the period of time exceeding 1 year.

Generic HHABNs. Generic HHABNs that do not provide sufficient specificity in order for the beneficiary to make an informed decision regarding his/her healthcare are considered defective. For example, HHABNs that do no more than state that Medicare denial of payment is possible, that the HHA never knows whether Medicare will deny payment, or that the HHA never knows the policy of other applicable insurers will be deemed too generic in order to properly notify the beneficiary.

Blanket HHABNs. Blanket HHABNs are given to beneficiaries for all or too broad of a range of item(s) and/or service(s). Therefore, these notices are defective because they do not provide sufficient information for the beneficiary to make an informed decision regarding his/her healthcare options.

Signed Blank HHABNs. An HHA is prohibited from obtaining beneficiary signatures on blank HHABNs, i.e., HHABNs that contain no information regarding item(s) and/or service(s) and the reasons for issuing the notice. A beneficiary's signature must not be obtained until after the HHABN is delivered.

Advance Completion of Information Completed by the Beneficiary. An HHABN may be deemed invalid if an HHA checks off boxes in Option Box 1 before delivering the HHABN to the beneficiary.

Failure to Include Valid Information. An HHABN may be deemed invalid because the HHA fails to include key information in the HHABN. The inclusion of erroneous information will also be treated in the same manner. As examples, the failure to list

significant item(s) and/or service(s) or the failure to provide an estimate of the total actual cost of each item or service may result in the HHABN being deemed defective.

NOTE: *With regard to the estimated cost, an amount that is different from the final actual cost does not invalidate the HHABN, as long as the amounts on the notice represent a good faith attempt to estimate costs for all the item(s) and/or service(s) for which the beneficiary may be liable.*

Failure to Ensure Comprehension of the HHABN. *An HHABN may be deemed defective if the HHA does not make best efforts and take appropriate steps to ensure that the beneficiary understands the information contained in the HHABN. It is not acceptable to hand the beneficiary the notice and have him/her sign it with no oral review of the notice. Failing to select a checkbox in Option Box 1 language, or selecting multiple checkboxes when a choice of one is indicated on the HHABN, will be seen as a lack of comprehension deeming the HHABN defective.*

A. Special Exceptions to Defective Notice

Services Which Are Always Denied for Medical Necessity. *In any case where a national Medicare coverage determination provides that a particular item or service is neither covered nor reasonable and necessary, an HHABN that gives as the reason for expecting denial that: “Medicare never pays for this item/service under written national policy” may be routinely given to beneficiaries, and no claim need be submitted to Medicare unless the beneficiary requests that a claim be submitted. This exception also applies codified local Medicare coverage policy.*

Experimental Items and Services. *Any item or service which Medicare considers to be experimental (e.g., “Research Use Only” and “Investigational Use Only” laboratory tests) is denied as not reasonable and necessary under §1862(a)(1) of the Act because Medicare has judged that it has not been proven to be safe and effective. The beneficiary may be given an HHABN that specifies as the reason for expecting denial as: “Medicare does not pay for services which it considers to be experimental/for research use.” Alternatively, more specific language with respect to Medicare coverage for clinical trials may be substituted as necessary as the reason for expecting that Medicare will deny the claim.*

Frequency Limited Items and Services. *Some items or services furnished have established statutory or regulatory frequency limitations on Medicare coverage, or frequency limitations on coverage on the basis of a national coverage decision or on the basis of the contractor’s local medical review policy. Since all or virtually all beneficiaries may be at risk of having their claims denied in those circumstances, the HHA may routinely give HHABNs to beneficiaries in such cases. In issuing the HHABN, the HHA must state the frequency limitation as the HHABN’s reason for expecting denial (e.g., “Medicare does not usually pay for a flu shot more than once a year”).*

Repetitive or Extended Notices. A single HHABN covering an extended course of treatment is acceptable provided that the HHABN identifies every item and/or service for which the HHA believes Medicare will not pay. Item(s) and/or service(s) that are provided on a regularly scheduled basis may be considered an extended course of treatment; and a single HHABN may suffice as long as all other applicable notification requirements are fulfilled. If, however, as the extended course of treatment progresses, and additional items or services are to be furnished, which Medicare or other applicable insurers will not cover, the HHA must separately notify the beneficiary by issuing another HHABN.

60.7 - Collection of Funds and Liability Related to the HHABN (Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

A. Collection of Funds and Beneficiary Liability

A beneficiary's agreement to be responsible for payment on an HHABN means that the beneficiary agrees to pay for expenses out-of-pocket or through any other insurance other than Medicare that the beneficiary may have. The HHA may bill and collect funds from the beneficiary for noncovered item(s) and/or service(s) at the time of delivery of such HHABNs, unless prohibited from collecting in advance of the Medicare payment determination by other applicable Medicare policy, State or local law. Note there is no general Medicare policy affecting timing of such collection by HHAs.

When delivery of an HHABN is effective and Medicare ultimately denies payment of the related claim, the HHA retains the funds collected from the beneficiary. However, if Medicare subsequently pays all or part of the claim for item(s) and/or service(s) previously paid for by the beneficiary to the HHA, the HHA must refund the beneficiary the proper amount. Medicare regulations require prompt payment of refunds to beneficiaries when Medicare provides payment.

When the beneficiary has insurance other than Medicare, and payment is subsequently received from that source, the HHA similarly should refund any previously collected amounts to the beneficiary consistent with the other insurer's payment. Note, however, that Medicare laws or regulations concerning the handling of incorrect collections do not provide for Medicare to ensure that prompt refunds occur when payment is made by another insurer or payer, referred to on the HHABN as "my other insurance." This is true even for the home health benefit and despite the incorporation of the home health COPs in HHABN requirements. Medicare would not have a claim to those monies or be able to act on behalf of the beneficiary in these cases, and Medicare may be unaware of such incorrect collections.

B. Financial Liability for Providers

HHAs may be held financially liable for the cost of item(s) and/or service(s) in situations where the HHA fails to issue an HHABN when required or issues a defective HHABN, since the beneficiary may be afforded liability protection under §1879 (see 60.2 H).

When a beneficiary does have liability protection and proper notification has not occurred, HHAs are precluded from collecting funds from the beneficiary, and will be required to make prompt refunds to the beneficiary (if funds were previously collected), or face possible sanctions for failure to do so. HHAs will be held financially liable if unable to demonstrate that they did not know or could not reasonably have been expected to know either that Medicare would not make payment, or that the care in question was noncovered and liability protection applied.

C. Unbundling Prohibition and Shifting of Financial Liability

*In issuing HHABNs, HHAs may not use these notices to shift financial liability to a beneficiary when full payment is made through bundled payments (see 60.2 G.); that is, where the beneficiary would otherwise not be financially liable for payment for the service because Medicare made full payment for a bundled group of items and/or services. **Using HHABNs to collect from beneficiaries where full payment is made on a bundled basis would constitute double billing.** An HHABN may be used, however, for any part of the cost of care that is specifically excluded from the Medicare bundled payment.*

D. Effect of Initial Payment Determinations on Liability

An HHABN informs a beneficiary of his/her HHA's expectation with regard to Medicare coverage. If the care described on the HHABN is provided, Medicare makes an actual payment determination on the item(s) and/or service(s) at issue when adjudicating the related claim. Such adjudications may uphold the provider's expectation, in which case the beneficiary will remain liable for payment if agreeing to accept this liability based on a valid HHABN. However, adjudication may not conform to the provider's expectation, in which case the decision made on the claim supersedes the expectation given on the HHABN. That is, Medicare may cover and pay for care despite the HHA's expectation, or deny the claims and find the provider liable. In such cases, if the HHA collected funds from the beneficiary, the HHA must refund promptly the beneficiary for the appropriate amount.

60.8 - Revision, Re-issuance and Retention of HHABN

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

A. Requirements for Retention after Completion

The HHA keeps the original version of the completed HHABN, whether annotated or signed, in the beneficiary's record. The primary HHA must retain the HHABN if a subcontractor is used. The beneficiary receives a copy of the completed HHABN.

An HHABN, once signed by the beneficiary, may not be modified or revised. Annotations are only made as permitted under these instructions. When a beneficiary must be notified of new information beyond the scope of the original notice with or without annotations, a new HHABN must be given.

Applicable retention periods are discussed in Chapter 1 of this manual, §110. In general, this is 5 years from discharge when there are no other applicable requirements under State law. Retention is required even if the beneficiary refused to choose an option or sign the notice, and even when no care was ultimately provided to the beneficiary.

B. Beneficiary and Related Party Requests for Copy of the HHABN

HHAs are required to provide a copy of an HHABN not only to a beneficiary but also to the beneficiary's subrogees if a copy is requested during the applicable claim timely filing period. Timely filing periods are described in this manual, Chapter 1, §70. The most common example of a subrogee is a State acting on behalf of a beneficiary with dual Medicare and Medicaid eligibility.

C. Request for Copies by RHHIs/Approved Governmental Agents

HHAs are not required to routinely submit copies of HHABNs to their Medicare RHHIs. However, copies must be supplied upon the request of an RHHI, QIO or other approved CMS administrative agent, or directly to CMS Central or Regional Offices when specified. Such requests may be made in relation to medical review of a claim, statute requirement, court case or Federal oversight agency request (i.e., Office of Inspector General). Medicare or its agents may also request HHAs to report on their HHABNs separate from providing copies (such as counting the number of HHABNs provided in a year by type of checkbox or Option Box language, in order for Medicare to meet applicable reporting requirements under statute).

90 - Form CMS-20007 - Notices of Exclusions From Medicare Benefits (NEMBs)

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

NOTE: *HHAs do not use the NEMB.*

For all expected denials of Medicare payments for items and services for which an ABN is not used because neither LOL nor RR applies, the Notice Of Exclusions From Medicare Benefits (NEMB) Form CMS-20007 may be used to advise beneficiaries, before items or services that are not Medicare benefits are furnished, that Medicare will not pay for them. NEMBs allow beneficiaries to make informed consumer decisions about receiving items or services for which they must pay out-of-pocket and to be more active participants in their own health care treatment decisions. The NEMB may be used, on an entirely voluntary basis, by physicians, practitioners, suppliers and providers to advise their Medicare patients of the services that Medicare never covers, for which it is not appropriate to use ABNs. The NEMB Form CMS-20007 is available online in English and Spanish at the CMS Beneficiary Notices Initiative (BNI) Web page at:

<http://www.cms.hhs.gov/BNI/>

Physicians, practitioners, suppliers and providers may use notices of their own design rather than the NEMB form. Some professional associations, with the assistance and approval of CMS, have developed service-specific NEMB type notices to advise Medicare beneficiaries of the limits of Medicare coverage for certain items and services. Those service-specific notices, which are not government notices but proprietary notices of the authoring associations, are also available in PDF format at the BNI and ABN links given above.

90.1.1 - Using NEMBs With Categorical Denials

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

NOTE: *HHAs do not use the NEMB.*

Physicians, practitioners, suppliers and providers prepare and deliver to Medicare beneficiaries, or people acting on their behalves, NEMBs when it is known that Medicare will not pay for, or will not continue to pay for, items or services on the basis of any categorical statutory exclusion listed in the third box on this notice. In these cases, notification is voluntary.

In these cases, insert a mark in check-off box number 2. an NEMB IS NOT used for either of the following two categorical exclusions that trigger statutory protections:

- The service may be denied as “not reasonable and necessary” (“medical necessity”) - §1862(a)(1) of the Act; or
- The service may be denied as “custodial care” - §1862(a)(9) of the Act.

90.1.2 - Using NEMBs With Technical Denials

(Rev. 1025, Issued: 08-11-06; Effective/Implementation Dates: 08-01-06)

NOTE: *HHAs do not use the NEMB.*

Physicians, practitioners, suppliers and providers may prepare and deliver to Medicare beneficiaries, or people acting on their behalves, NEMBs when it is known that Medicare will not pay for, or will not continue to pay for, items or services on the basis of any technical statutory exclusion. That is, NEMBs may be given for any failure to meet completely the statutory definition of a Medicare benefit. In these cases, notification is voluntary.

In these cases, insert a mark in check-off box number 1 in the second box on the form. **An NEMB IS NOT** used for any of the following *four* technical exclusions that trigger statutory protections:

- The patient in hospice is found not to be terminally ill – §1861(dd)(3)(A) of the Act;
- The patient received a prohibited telephone solicitation (“cold call”) in the case of medical equipment & supplies - §1834(a)(17)FIRST(B) of the Act;
- The supplier does not have a supplier number, in the case of medical equipment & supplies denials - §1834(j)(1) of the Act; or
- The supplier has not obtained a required advance coverage determination in the case of medical equipment & supplies denials – §1834(a)(15) of the Act.