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Attention Home Health Agencies!

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Revised Home Health Advance Beneficiary Notice (HHABN)

Provider Types Affected

Home Health Agencies (HHAs) who bill Medicare regional home health intermediaries (RHHIs) for their services

Key Points

- Since 2002, HHABNs (currently Form CMS-R-296) have been used by Medicare home health agencies (HHAs) to inform Medicare beneficiaries in Original Medicare about possible noncovered items and/or services provided by the HHA and to alert beneficiaries that they may be liable for payment. The HHABN allows HHAs to collect payment for these services from Medicare beneficiaries based on section 1879 of the Social Security Act (SSA).
- The Centers for Medicare & Medicaid Services (CMS) revised the HHABN form to encompass broader notification requirements. HHABNs are now required:
  - To be issued more often for changes in noncovered home care;
  - In some situations where qualifying requirements for Medicare benefits are not met, such as when there is a lack of physician orders for further home care;
  - In a larger number of circumstances where covered care is reduced or terminated; and

  - To use three different sets of language in the Option Box in the middle of the form (called Option Box 1, 2 and 3) depending on the reason that either noncovered care is being initiated, or care is generally being reduced or terminated.

- Please refer to the instructions found in the manual revision attachment to Change Request (CR) 5009, *Medicare Claims Processing Manual*, Chapter 30, Financial Liability Protections, section 60 and its subsections for specific HHABN and Form CMS-R-296-related information and requirements. CR5009 is available at *http://www.cms.hhs.gov/Transmittals/Downloads/R1025CP.pdf* on the CMS website.
- Please note also that minimal conforming changes are being made to the *Medicare Claims Processing Manual*, Chapter 10, to reflect the revisions to HHABN policy. Those changes are also reflected in the attachment to CR5009.
- HHABN Forms are available in English and Spanish at *http://www.cms.hhs.gov/BNI/* on the CMS website. They can be found under a dedicated link on the top left-hand margin: FFS HHABN.
- Please contact your RHHI regarding questions on the HHABN or related instructions since RHHIs administer home health benefits for Original Medicare.

Background

Medicare beneficiaries are protected from payment liability in certain situations unless those beneficiaries are notified of their potential liability in advance. The home health Conditions of Participation (COPs) require general notification of reductions and terminations of care.

Consequently, the HHABN is provided to Medicare beneficiaries prior to certain kinds of changes in their home health coverage to meet both of these requirements. The notification provides specific information about the beneficiary's payment liability for home health services (§1879 of the Social Security Act) when Option Box 1 language is applicable. Option Box 2 is generally used for reductions or terminations HHAs have made for their own business reasons. Option Box 3 is used when physicians order reductions in care.

This article is based on CR5009, which revises the current HHABN form and instructions in accordance with a court decision, Lutwin vs. Thompson. The revised manual section (Chapter 30, Financial Liability Protections, section 60 and its subsections) completely overlays the previous section 60. The new section

60.1-.5 contain a lot of new material, and from 60.6 to the end of the section 60 the material is largely the same as that which existed previously.

Revised Manual Highlights

Highlights of the revised manual include the following:

- Section 60.2 B clarifies that the new HHABN completely replaces other liability notices, including the general ABN and voluntary Notice of Exclusion from Medicare Benefits or "NEMB." HHAs can now use the HHABN for mandatory or voluntary liability notices, and the only other related forms required for a very specific use are the expedited determination notices.
- Section 60.2 D discusses the effect other payers or insurers have on notification requirements for beneficiaries with other coverage in addition to Medicare. This includes beneficiaries called dual eligibles who have both Medicare and Medicaid. Most notably, when other insurance is providing payment and there is no Medicare coverage, the HHABN generally is needed only at initiation of care.
- Section 60.2 F on noncovered services distinguishes between noncoverage care that is sometimes covered and that which is never covered by Medicare. Note that if beneficiaries are not charged for never-covered care, there is no mandatory notice requirement-- this is a new policy clarification.
- There is a discussion of bundled payments in Section 60.2 G that builds on Section 60.2 F. Essentially, when an entire bundle of services is paid in full by Medicare, there is no notification requirement solely because an individual piece of that bundle is thought to be noncovered.
- Section 60.3 on triggering events, which are still initiation, reduction and termination, defines these events more specifically depending on whether care is covered or noncovered, and whether the home health benefit is being delivered or some other type of care.
- Note that while some HHAs only provide the home health benefit, others provide different services as well, such as therapy under a therapy plan of care rather than a home health plan of care. Also, in this section there is discussion of one-time services, which are classified under initiations.
- Section 60.3 D provides an updated table of exceptions to notification. There are new entries in this table. In addition to topics already mentioned, there are exceptions for changes in the mix of services provided within a home health discipline, which assumes that there is no reduction in the overall frequency of delivery of that discipline, and a similar exception for changes in the modality of care affecting the use of supplies.

- This section also touches on how ranges of visits when given in orders should be handled on the HHABN, as well as flexibility under certain circumstances for giving notice in advance of triggering events.
- Section 60.4 gives instructions for using Option Boxes 1, 2, or 3, distinguishing when one option box is used instead of the others. In short, Option Box 2 and 3 have very specific defined uses and are much shorter forms with a lot less information to be completed, while Option Box 1 is most like the previous HHABN and used when a beneficiary faces financial liability.
- In any case, where Option Box 2 or 3 is not appropriate, Option Box 1 would be used. These final instructions provide some new options for filling out blanks related to use of Option Box 1 or 3, based on very good comments received from HHAs.
- Section 60.5 has two new sections, one on beneficiary choices made on the HHABN when the beneficiary is a dual eligible and the Medicaid program in question has some specific requirements - this is not the case in all states. Second, there is a new section on how expedited determinations can affect and change liability as described on the HHABN.

Remember, as of September 1, all HHAs must be using the new HHABN exclusively. As of that date, the CMS webpage where the HHABN notices are posted will be updated, so that only this version of the HHABN will appear.

Additional Information

CR5009 is the official instruction issued to your RHHI regarding changes mentioned in this article. CR5009 may be found by going to http://www.cms.hhs.gov/Transmittals/downloads/R1025CP.pdf on the CMS website.

Please refer to your local RHHI if you have questions about this issue. To find their toll free phone number, go to *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.