Revised Home Health Advanced Beneficiary Notice

Presented by:

Professional Home Health Care Agency, Inc.

General Information

- www.cms.hhs.gov/BNI/
  - FFS HHABN
- www.cms.hhs.gov/BNI/03_HHABN.asp
  - Official forms and detailed instructions
- On-line Medicare Claims Processing Manual, Chapter 30, on Financial Liability Protection
- www.cms.hhs.gov/medlearn/matters
  - SE0538 (June 7, 2005)
- www.cms.hhs.gov/manuals/transmittals
  - R577CP (June 3, 2005)

General Information

- This is in direct relation to the Patient Bill of Rights"
  - (42 CFR 484.10)

- A Patient Advocate to answer questions regarding the Home Health Advance Beneficiary Notice (HHABN) can be contacted at (606) 877-1135 or E-mailed questions to (effective 8/1/05):
  - patientadvocate@healthdirectionsinc.com

General Overview of Medicare Coverage

- Qualifying Criteria has not changed
- The following rules apply, in general, however each beneficiary's circumstance is different. Because of this, other Medicare rules may apply.
- Applicable Medicare Rule(s): CMS Manual Pub 100-01, Chapter 1:10.2 Home Health Services

General Overview of Medicare Coverage

- **Under either Medicare Part A or Part B of the program, to qualify for home health benefits, a beneficiary must:**
  - **1. Be confined to his/her home**
  - **2. Be under the care of a physician**
  - **3. On an intermittent basis, need:**
    - **skilled nursing services**
    - **physical therapy**
    - **or speech therapy**

- **A beneficiary requiring one or more of these services and who qualifies for home health benefits is eligible to have those services reimbursed by Medicare.**

- **This is additionally true for other home health services specified in the law, and may include:**
    - **occupational therapy**
    - **home health aides**
    - **medical social services**
    - **medical supplies**
    - **medical appliances**

General Overview of Medicare Coverage

- On the other hand…neither Medicare Part A beneficiaries, nor Part B beneficiaries can expect Medicare reimbursement for home health benefits if the services desired are not required in the treatment of his/her illness or injury.

General Overview of Medicare Coverage, continued

- CMS Manual Pub 100-01, Chapter 1:20.3: Providers and suppliers have an obligation under law, to conform to the requirements of the Medicare program.
  - Fraud and abuse committed against the program may be prosecuted under various provisions of the United States Code.
- CMS Manual Pub 100-02, Chapter 7:30-Conditions Patients Must Meet to Qualify for Coverage of Home Health Services

Medicare Coverage Definitions

Remember that Medicare defines

- Intermittent
  - skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).
- Confined to home (Homebound)
  - There exists a normal inability to leave the home or leaving requires a considerable and taxing effort. It does not mean the patient can never leave his/her home, for any reason, or by any method.

Advance Beneficiary Notice Background

Prior to this revision, HHA's have issued HHABN's when Medicare coverage was not initiated or when it was about to end only when the beneficiary had liability protection under §1879 of the Social Security Act (the Act).

Agency Must use the new form beginning June 1, 2006 and follow instructions for issuing the new form at 1) initiation, 2) reduction and 3) termination… some exceptions apply…

Exceptions to HHABN Notification Requirements

Exception	Application	Comment
Increases in Care	General	Any increases whether under the original plan of care (POC) or subsequent orders.
Transfers	General	Transfers to other covered care, i.e., another HHA or another type MCA provider.
Shortening the Duration of Care	Reductions	Any change in the duration of services included in the POC and communicated to the beneficiary, i.e., shorter therapy sessions, perhaps going from an hour to 45 min., as health status improves.
Planned Reductions in the Number of Services	Reductions	Only applicable when reductions anticipated in the POC are communicated to the beneficiary in advance/at admission, i.e., physical therapy provided 3 x wkly for the first 2 wks, then reduced to 2 x wkly.
Patient goals met	Termination	All care ending with patient goals met and/or physician orders completed. (Note that an expedited determination notice must be given in this case.

Exceptions to HHABN Notification Requirements (Cont)

Exception	Application	Comment
Beneficiary choice	Reduction or Termination	Changes in care that are the beneficiary's decision and are documented in the medical record.
Emergency or unplanned situations	General	Emergencies or unplanned situations beyond the HHA's control, i.e., natural disasters or transportation failures.
Changes in caregiver or personnel	General	Any changes in HHA caregivers or personnel
Changes in arrival or departure time of the HH staff	General	Any changes in expected arrival or departure time for HHA staff.
Changes in Brand	General	Any changes in brand of product, i.e., the same item produced by a different manufacturer.

January 2006 Revised Home Health Beneficiary Notice (HHABN)

- HHABN's will be issued more frequently.
- HHABN's will be given when Medicare coverage is not at issue.
  - Different language will be used in the HHABN based on whether coverage is at issue.
- HHABN's will now be required more broadly for noncovered care
  - such as in situations where qualifying requirements for Medicare home health care benefits may not be met, such as having physician orders or being homebound.
- HHABN's will be the single liability notice used for beneficiaries under Original or Fee For Service Medicare
  - HHA's no longer to use other comparable notices.

HHA's will no longer use:

- The general ABN (CMS-R-131) for Part B non-covered items/services outside the HH benefit
- The voluntary notices, Notice of Exclusion from Medicare Benefits (NEMB) or the NEMB-Home Health Agency (NEMB-HHA), for non-covered care outside the definition of a Medicare benefit.

Applicability

- Part A Medicare beneficiaries or their authorized representative
- Part B Medicare beneficiaries or their authorized representative

In Addition, HHABN’s must also be given when…

- LOL protection is not available when a triggering event occurs, and
- There is not any liability and a triggering event occurs.

Application of Limitation of Liability (LOL)for the Home Health Benefit

HHABN is still required for these anticipated denial reasons

Citations from the Act	Brief Description of Situation	Explanation
§1862(a)(1)(A)	Care is not reasonable and necessary	Medicare does not pay for such care
§1862(a)(9)	Custodial care is the only care delivered	Medicare does not usually pay for such care, except for some hospice services
§1879(g)(1)(A)	Beneficiary is not homebound	Medicare requires that a beneficiary cannot leave home in order to cover services under the home health benefit.
§1879(g)(1)(B)	Beneficiary does not need intermittent skilled care	Medicare requires this need in order to cover services under the home health benefit.

HHABN Notices must also be given when…

- The beneficiary will not be charged, and
- There is no liability because non-covered charges are part of an otherwise covered bundled payment.

More on Triggering Events

Formerly, HHABN's were given only when triggering events occurred, either when only non-covered care started at admission, or when some or all covered care ended.

Now, HHA's are required to issue the HHABN more frequently, especially when the HHA believes Medicare will not cover services (regardless of whether the care is "necessary" in the HHA's or beneficiary's view).

Definition of HHABN 3 Triggering Events

Event	Description
A. Initiation	When a HHA expects that Medicare will not cover any item(s) and/or services(s) from the start of a spell of illness, or before the delivery of an one-time item or service that Medicare is not expected to cover.
B. Reduction	When a HHA reduces or stops some item(s) and/or service(s) during a spell of illness, while continuing others, whether or not the discontinued care had been covered by Medicare.
C. Termination	When a HHA ends delivery of all care, whether covered by Medicare or not.

Relation of Triggering Events to Notice Delivery

Triggering Event	Non-covered Care	Covered Care
A. Initiation	HHABN	N/A
B. Reduction	HHABN	HHABN
C. Termination	HHABN	Notice of Medicare Non-Coverage (and sometimes HHABN*)

*The HHABN is given with the Notice of Medicare Non-coverage when non-covered care will continue after the termination of covered care.

This aspect of the notice delivery rule is unique to home health. HHA's that also operate hospices, other types of Medicare providers or suppliers should NOT assume these notice requirements are identical for triggering events when other types of care are involved.

Triggering Event #1: Initiation

Under MCA CoPs, HHA's have always had to provide info on covered and non-covered charges at admission. CMS has no standardized notice format for this purpose. The HHABN is given when initiating non-covered care that fits one of the following scenarios:

1. **Not a MCA benefit.** The HHA has concluded that the item or service does not meet definition of a MCA covered benefit defined in Title XVIII of the Act. LOL protection never applies.
2. **Excluded from Coverage under §1862.** The HHA has concluded the item and/or service falls within specific statutory exclusions listed in §1862(a)(2)-(8) or (10)-(22) of the Act, e.g., the item or services is a personal comfort item or routine foot care. LOL protection never applies.
3. **Excluded from Coverage and Subject to Limitation of Liability (LOL) under §1879**. The HHA has concluded that one of the situation listed in the table "Application of LOL for the Home Health Benefit"

For Triggering Event #1: Initiations, also note:

- If HHAs plan to charge beneficiaries for an assessment, not followed up by an admission, the HHABN should be used. (The NEMB and NEMB-HHA are now replaced by the HHABN.)
- Notice must be given for termination of covered care before the initiation of solely non-covered care.

Example: A referral is received and upon assessment the nurse determines there is no skilled services to be performed. Therefore, the nurse issues the HHABN and the patient is not admitted to the agency’s service without prior knowledge that the patient is responsible for services and/or supplies.

Triggering Event #2: Reductions

Reduction means

- the HHA is discontinuing some, but not all care (whether or not remaining care is covered by Medicare.)
- one type of care ends but another will continue (perhaps nursing is ending, but PT will continue)

Triggering Event #2: Reductions

Just as in Triggering Event #1, there are three levels of care to consider for this event.

1. Non-covered Care
2. Covered or Non-covered Care
3. Covered Care

Example: A patient has been receiving skilled nursing care for weekly wound assessment and physical therapy for gait training and strengthening. The patient's wound has now healed and his/her skilled nursing services are being discharged but they will continue to receive PT services.

Triggering Event #2: Reduction of Covered or Non-covered Care

An HHABN is also given when some care, either covered or non-covered, ends because of:

A. Financial or other HHA reasons.
   - The HHA has reasons individual to its business and independent of the beneficiary's MCA coverage for discontinuing some item(s) and/or service(s). Note that LOL protection does not apply in this case.
     - HHABNs should be given at initiation if all subsequent care was non-covered.

Triggering Event #2: Reduction Non-covered Care, continued

- The most likely reason that non-covered care would be reduced is that it's no longer reasonable or necessary. There's no LOL protection in this case because it is already considered "non-covered".
- The HHABN would have been given at initiation, if all care from initiation was non-covered.

Triggering Event #3: 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.

Just as in the case of Triggering Event #1 (Initiation) and Event #2 (Reduction), we have three levels of care to consider for this event.

1. Non-covered Care
2. Covered or Non-covered Care
3. Covered Care

Triggering Event #3: Terminations; Non-covered care

For terminations, as with reductions:

- The most likely reason non-covered care would be terminated is that it is no longer reasonable or necessary. There is no LOL protection in this case, as the care is already considered non-covered.
- When HHABN's are given for such terminations, a HHABN should have been given at the initiation of the non-covered care.

Example: A patient's wound has healed and no longer meets the definition of skilled services under the Medicare Guidelines.

Triggering Event #3:
Terminations; Covered or Non-covered Care

For terminations unrelated to Medicare coverage, of either covered or non-covered care, a HHABN must be issued for:

- Financial/Other HHA Reasons
  - Reasons may include the end of services due to staffing requirements, safety issues in the beneficiary's home, closure of the HHA…in short, where the beneficiary's coverage is not changed by the HHA decision to end care.
  - As is done with reductions, LOL protection does not apply, and HHABN should have been given at initiation if all subsequent care was non-covered.

Triggering Event #3:
Terminations; Covered Care

For terminations for reasons related to coverage: Remember that Expedited Determination Notice is required when all Medicare coverage is terminating.

- Reasons for terminating coverage include when care is Excluded from Coverage and Subject to Limitation of Liability (LOL) under §1879
  - **Note: There is only one case where both the HHABN and the generic expedited notice must be given, and that is ONLY if non-covered services will be continuing after covered services are ending.** That is because the notices address different things: the expedited notice gives information on the right to a quick decision for a QIP affirming or disputing the end of all covered care. The HHABN provides information on potential liability for care that would be delivered after coverage ends, and on claim-related appeal rights.

General HHABN Requirements

1. A minimum of 2 copies, including the original, must be made so the beneficiary and HHA each have one.
2. An additional copy may be obtained, for beneficiary's authorized representative, if applicable.
3. The HHA will keep the original version of the completed HHABN, whether annotated or signed, in the beneficiary's medical record.
4. The beneficiary receives a copy of the completed HHABN.

PHHCA Responsibility

- HHA staff are required to explain the notice, its contents, and answer all questions orally to the best of their ability.
- HHA's must make every effort to ensure beneficiaries understand the entire HHABN prior to signing it.
- In-person delivery is not required; however the HHA must maintain documentation that notice was actually received.
- Telephone notice must be followed-up immediately with mailed notice or personal visit; in order to obtain beneficiaries signature. If this occurs, the date of the telephoned notice will be accepted as the time of HHABN delivery.
- If the patient refuses to sign
  - The nurse documents on the notice of the refusal.
  - Contacts the office for a witness of the refusal.
  - The witness can sign the notice at a later date.
  - A completed notice indicated the refusal and with the nurses and witness' signatures is to be mailed to the beneficiary, certified mail.

PHHCA Staff must….

- Ensure the completion of all four* “blanks” in the boxed Signature and Date Section at the bottom of the HHABN. They are:
  1. Patient’s name: Use the beneficiary’s full name
  2. Medicare HICN: The beneficiary’s Medicare health insurance claim number should be included in the blank.
  3. Signature: The beneficiary must personally sign the HHABN.
  4. Date: The beneficiary must personally enter the date on which the HHABN was received and completed.

*The HHA may assist the beneficiary by completing the first 2 blanks.

Conclusion

- Be Present for the Entire Session.
- Sign the Roster.
- Please contact your Branch Manager, for any questions regarding this HHABN
- Update Your Key Ring Reference with BOTH the card and sticker ***and*** Sign and turn in the Acknowledgement Form
- Questions and Answers/Brief Review