CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2362	**Date: December 1, 2011**
	Change Request 7323

NOTE: Transmittal 1025, CR 5009 dated August 11, 2006, is rescinded and replaced by Transmittal 2362 to further clarify and simplify provider understanding of the previously released information regarding HHABN issuance and policy in Chapter 30, Section 60 of the Medicare Claims Processing Manual. All other information remains the same

SUBJECT: Home Health Advance Beneficiary Notice, (HHABN), Form CMS-R-296

I. SUMMARY OF CHANGES: This transmittal implements the revised HHABN and instructions. Chapter 30, section 60 and its subsections are being revised, incorporating edits to simplify presentation of previously released information in section 60. This revises previous information from CR 5009, transmittal 1025, dated August 11, 2006.

EFFECTIVE DATE: February 3, 2012
IMPLEMENTATION February 3, 2012

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	30/Table of Contents
R	30/60/60 Form CMS-R-296 Home Health Advance Beneficiary Notice (HHABN)
R	30/60/60.1/Background on the HHABN
R	30/60/60.2/Scope of the HHABN
R	30/60/60.3/Triggering Events for HHABN/ Written Notice
R	30/60/60.4/Completing the HHABN
R	30/60/60.5/HHABN Delivery
R	30/60/60.6 Effective HHABNs
D	30/60/60.6.1/Defective HHABNs
R	30/60/60.7/Collection of Funds and Liability Related to the HHABN
R	30/60/60.8/Special Issues Associated with the HHABN

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2362	Date: December 1, 2011	Change Request: 7323

SUBJECT: Home Health Advance Beneficiary Notice, (HHABN), Form CMS-R-296

NOTE: Transmittal 1025, CR 5009 dated August 11, 2006, is rescinded and replaced by Transmittal 2362 to further clarify and simplify provider understanding of the previously released information regarding HHABN issuance and policy in Chapter 30, Section 60 of the Medicare Claims Processing Manual. All other information remains the same.

Effective Date: **February 3, 2012**

Implementation Date: February 3, 2012

I. GENERAL INFORMATION

A. Background: HHABNs have been required since 2002 to inform beneficiaries in Fee-for-Service Medicare about possible non-covered charges when limitation of liability applies. In 2006, CMS revised the notice and its instructions in response to a Federal court decision so that the notice could 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 that beneficiaries receive written notification of changes in care.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7323.1	Regional Home Health Intermediaries (RHHIs) shall take any actions necessary to implement the attached instructions; primarily by assisting HHAs in understanding their responsibilities and communicating the availability of the revised, clarified instructions.					X					
7323.2	RHHIs shall remove the former HHABN instructions from their websites and replace that information with information from this instruction when implemented.					X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7323.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN 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 one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					X					

IV. SUPPORTING INFORMATION:

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
7323.1	The HHABN is an existing requirement executed by HHAs. The release of these clarified manual instructions should have no impact on the RHHI workload beyond short term educational demands.

Section B: For all other recommendations and supporting information, use this space: NA

V. CONTACTS

Pre-Implementation Contact(s): Evelyn Blaemire, evelyn.blaemire@cms.hhs.gov, 410-786-1803;
Janet Miller; janet.miller3@cms.hhs.gov, 404-562-1799

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 30 - Financial Liability Protections

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(Rev.2362, 12-01-11)

60 - Form CMS-R-296 Home Health Advance Beneficiary Notice (HHABN)

(Rev. 2362, Issued: 12-01-11, Effective: 02-03-12, Implementation: 02-03-12)

This section provides the standards for use by home health agencies (HHAs) in implementing the Home Health Advance Beneficiary Notice (HHABN) requirements. *The HHABN is issued* to Original Medicare beneficiaries in advance of furnishing what HHAs believe to be noncovered care, *and it also is issued before* reducing or terminating *most* ongoing care *provided by the HHA. In addition to the standards set forth in this section, HHAs must complete and deliver HHABNs according to the Advance Beneficiary Notice Standards in §40.3 of this chapter.*

HHABN - Quick Glance Guide[1]

Notice Name: *Home Health Beneficiary Notice of Noncoverage (HHABN)*
Notice Number: *Form CMS-296*
Issued by: *Home Health Agency (HHA) provider*
Recipient: *Original Medicare (fee for service) beneficiary receiving home health care*
Pertinent Information: *There are 3 different "Option Box" formats for the HHABN notice; so, the provider must choose one HHABN format to use according to the situation.*

Format:	***Type of notice:***	***Must be issued:***	***Timing of notice:***	***Optional use?***
Option Box 1	*Financial liability notice*	*Prior to the HHA providing an item or service that Medicare usually covers but may not pay for in this instance because of one of the following reasons:* • *The item or service is not medically reasonable and necessary ;* • *The beneficiary is not confined to his/her home;* • *The beneficiary does not need skilled nursing care on an intermittent basis; or* • *The beneficiary is receiving custodial care only.*	*Prior to delivery of noncovered items or services.* *If possible, provide enough time for the beneficiary to make an informed decision on whether or not to receive the service or item in question and accept potential financial liability.*	*Yes. Prior to the HHA providing an item or service that Medicare never covers and that will be charged to the beneficiary, the HHA may issue the HHABN #1 as a voluntary notice of noncoverage. HHABN #1 is optional for this type of notification.*
Option Box 2	*change of care notice (because of agency reasons)*	*Prior to the HHA reducing or discontinuing care listed in the beneficiary's plan of care (POC) for reasons specific to the HHA on that occasion*	*Immediately on determination, or if possible, provide enough time for the beneficiary to arrange to obtain the reduced or discontinued home health care service(s) from a different HHA.*	*No.*
Option Box 3	*change of care notice (because of MD's orders)*	*Prior to the HHA reducing or discontinuing Medicare covered care listed in the POC because of a physician ordered change in the plan of care or a lack of orders to continue the care*	*Notify the beneficiary before the actual reduction or discontinuation, if possible.*	*No.*

[1] *This is an abbreviated reference tool and is not meant to replace or supersede any of the directives contained in Section 60.*

60.1 - Background on the HHABN

(Rev. 2362, Issued: 12-01-11, Effective: 02-03-12, Implementation: 02-03-12)

Since 2002, HHAs have issued 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). The HHABN gained *additional* notification capabilities in 2006 following the *U.S. Court of Appeals (2nd Circuit)* decision in LUTWIN V. THOMPSON, *361 F.3d 146; 2004 U.S. App. LEXIS 3774*. *Following Lutwin*, the HHABN was modified so that it could also be used by HHAs to notify beneficiaries receiving home health services of *any care changes* in accordance with the HHA conditions of participation (COPs) in *§1891* of the Act.

To account for this expanded use, the HHABN was revised to contain three interchangeable Option Boxes within the body of the notice designated as Option Box 1, Option Box 2, and Option Box 3. Option Box 1 language is applicable to situations involving potential beneficiary liability for HHA services as directed by §1879 of the Act. Option Box 2 or Option Box 3 is inserted into the HHABN form to notify beneficiaries of changes in a home health plan of care that are subject to the requirements of § 1891 of the Act.

60.2 - Scope of the HHABN

(Rev. 2362, Issued: 12-01-11, Effective: 02-03-12, Implementation: 02-03-12)

A. Statutory Authorization for HHABN

The requirement to give an HHABN is based on *the financial liability protections in §1879 of the Act and the HHA COPs in §1891 of the Act.* The COPs are further implemented through Title 42 of the Code of Federal Regulations (CFR), Part 484.

CMS requires HHAs to issue an HHABN in those specific situations where "limitation on liability" (LOL) protection is afforded under §1879 of the Act for items and/or services ordered by physicians that the HHA believes Medicare will not cover (see Table 1). In these circumstances, if the beneficiary chooses to receive the items/services in question and Medicare does not cover the home care, HHAs may use the HHABN to shift liability for the non-covered home care to the beneficiary. The Option Box 1 format is required when the HHABN is used for this purpose.

The following chart summarizes the statutory provisions related to HHABN issuance for LOL purposes:

Table 1.

Application of LOL for the HH Benefit

Citation from the Act	***Brief Description of Situation***	***Recommended Explanation for Header Section of the Option Box 1 HHABN***
§1862(a)(1)(A)	*Care is not reasonable and necessary*	*Medicare does not pay for care that is not medically reasonable and necessary.*
§1862(a)(9)	*Custodial care is the only care delivered*	*Medicare does not usually pay for custodial care, except for some hospice services.*
§1879(g)(1)(A)	*Beneficiary is not homebound*	*Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit*
§1879(g)(1)(B)	*Beneficiary does not need skilled nursing care on an intermittent basis*	*Medicare requires part-time or intermittent need for skilled nursing care in order to cover services under the home health benefit*

In addition to liability 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)."

HHAs are required to use the HHABN to notify the beneficiary of reductions and terminations in health care in accordance with Medicare COPs. When the HHABN is being used to inform of a change in care, it is formatted with either Option Box 2 or Option Box 3.

B. HHAs and Other *CMS* Notices

HHAs do not use the Advanced Beneficiary Notice (ABN), Form CMS-R-131. Prior to the HHABN, HHAs used the ABN notice for Part B noncovered items/services outside of the home health benefit. HHAs currently use the HHABN Option Box 1 for this type of notification.

HHAs may voluntarily use the HHABN for noncovered care outside the definition of the Medicare home health benefit. The former voluntary notice forms, the Notice of Exclusion from Medicare Benefits (NEMB) and the NEMB-Home Health Agency (NEMB-HHA) have been discontinued.

The HHA must issue an expedited determination notice called the Notice of Medicare Provider Non-Coverage, (NOMNC), CMS-10123, when all covered services are being terminated. Please see the "FFS ED Notices" link at: *http://www.cms.gov/BNI/* for information on the delivery of expedited determination notices. *The HHABN cannot be used in place of the NOMNC.*

C. HHABN Issuers and Recipients

HHAs are the only type of Medicare provider that issue the HHABN to give the beneficiary notice regarding potential liability or to notify the beneficiary of care changes. When a DME supplier, separate from the HHA, is providing equipment to a beneficiary receiving home care, it is the DME supplier's responsibility, as the entity billing for the equipment, to notify the beneficiary of potentially noncovered items. *DME suppliers use the general ABN, Form CMS-R-131, and follow the instructions for this notice which are found in Section 50 of this chapter. Similarly,* when an HHA has an intravenous infusion division but a pharmacy provides medications to be infused and bills the patient's drug benefit directly, the pharmacy *is responsible for issuing any applicable liability notification for the medications.*

The recipients of the HHABN are beneficiaries enrolled in Original Medicare only. HHABNs are not used in Medicare managed care. When a beneficiary transitions to Medicare managed care from Original Medicare during a home health episode, *HHABN issuance is required only if there is potential liability for charges to the beneficiary or a need to provide notification of changes in care.*

Subcontractors may deliver HHABNs under the direction of a primary HHA; however, notification responsibility, including effective delivery, always rests with the primary HHA. HHAs are always responsible for providing HHABNs associated with the care that they provide. HHABNs are non-transferrable in cases in which the beneficiary receives care from more than one HHA.

In the instructions in this section, the term "beneficiary" is used to mean the beneficiary or the beneficiary's representative, as applicable. For more information on representatives, see this chapter, §40.3.5 and §40.3.4.3.

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

60.3 - Triggering Events *for HHABN/Written Notice*

(Rev. 2362, Issued: 12-01-11, Effective: 02-03-12, Implementation: 02-03-12)

HHAs *may be* required to *provide a written notice to an Original Medicare beneficiary at three points in time, called "triggering events":*

Table 2

Triggering Events

EVENT	*DESCRIPTION*
Initiation *of a* ***non-covered*** *service*	*When an HHA expects that Medicare will not cover an item and/or service delivered under a planned course of treatment from the start of a spell of illness, OR before the delivery of a one-time item and/or service that Medicare is not expected to cover.*
Reduction *of a service*	*When an HHA reduces or stops an item and/or service during a spell of illness while continuing others, including when one home health discipline ends but others continue.*
Termination *of a service or all services*	*When an HHA ends delivery of either all Medicare-covered care, or all care in total.*

A. Initiations

Initiations occur at the start of home health care and may also occur when a service is added to the existing HH plan of care (POC). The Option Box 1 format of the HHABN must be issued to the beneficiary prior to receiving care that *is usually covered by Medicare, but in this particular instance, it is not covered or may not be covered by Medicare because:*

- *the care is not medically reasonable and necessary,*
- *the beneficiary is not confined to his/her home,*
- *the beneficiary does not need skilled nursing care on an intermittent basis, or*
- *the beneficiary is receiving custodial care only.*

If the HHA believes that Medicare will not or may not pay for care for a reason other than one listed directly above, issuance of the HHABN Option Box 1 is not required. Since Medicare has specific requirements for payment of home health services, there may be occasions where a payment requirement is not met, and therefore, the HHA expects that Medicare will not pay for the services. The HHA cannot use the HHABN Option Box 1 to transfer liability to the beneficiary when a billing requirement is not met. (For example, if a home health agency initiates care for a beneficiary, but chooses to end care because of the lack of a provider face to face encounter, the beneficiary must receive written notice of this change in care in the form of an HHABN with Option Box 2. The HHABN formatted with Option Box 2 has no bearing on

financial liability and is a change of care notice only. Issuance of the HHABN with Option Box 2 does not exempt home health agencies from ensuring that Medicare program requirements are met, including but not limited to the face to face encounter. This is described under "C. Terminations" below.)

An HHABN is required at initiation only when there is potential for the beneficiary or his/her secondary insurance to incur a charge. If the HHA provides a noncovered service that is considered part of the HHAs bundled episodic care charge, with no charges to the beneficiary or a secondary insurance plan, issuance of the HHABN is not required.

An HHABN must be issued prior to providing the care that is usually covered by Medicare but is not covered in a particular case so that the beneficiary is made aware of the charges and can make an informed decision regarding whether or not s/he wants to receive the care not paid for by Medicare. An HHABN signed at initiation of home health care for items and/or services not covered by Medicare is effective for up to a year, as long as the care being given remains unchanged from the care listed on the notice.

> ***Example**: Option Box 1 for initiation – MANDATORY use*
>
> *A beneficiary requires skilled nursing wound care 3 times weekly; however, she is no longer confined to the home. She wants the care done at her home by the HHA.*
>
> *HHABN Option Box 1 must be issued to this beneficiary before providing home care that will not be paid for by Medicare. This allows the beneficiary to make an informed decision on whether or not to receive the noncovered care and accept the financial obligation.*

When an HHA performs an initial assessment of a beneficiary prior to admission but does not admit the beneficiary, an HHABN is not required if there is no charge for the assessment. However, if an HHA charges for an assessment, the HHA must provide notice to the beneficiary before *performing and* charging for *this* service.

Any item or service which Medicare considers to be experimental (e.g., a "Research Use Only" or "Investigational Use Only" laboratory test) is denied as not reasonable and necessary under §1862(a)(1) of the Act because Medicare has determined that it is not proven to be safe and effective. In this circumstance, the beneficiary must be given an HHABN Option Box 1 that lists the reason for expecting denial as: "Medicare does not pay for services which it considers to be experimental/for research use."

Any one-time care that is provided and completed in a single encounter is considered an initiation in terms of triggering events and is subject to the applicable HHABN Option Box 1 issuance requirements as explained above. (HHABN Option Box 2 or 3 regarding reductions and terminations in care are never required for one time services.)

HHABN Option Box 1 is not required prior to delivery of statutorily excluded items, but the HHA may choose to issue HHABN Option Box 1 as a voluntary notice. For example, HHABN Option

Box 1 issuance is not required before a beneficiary receives and is charged for an item and/or service that Medicare never covers such as routine foot care. However, the HHA could voluntarily issue the HHABN before providing routine foot care to assure that the beneficiary is aware of the impending liability. Exclusions from Medicare coverage are set out in §1862(a) of the Act.

B. Reductions

Reductions involve any decrease in an aspect of care (such as frequency, amount, or level of care) provided by the HHA and/or care that is part of the POC. When care that is listed on the POC or provided by the HHA is reduced, the beneficiary must receive the HHABN (with the Option Box 2 or Option Box 3 format) listing the items/services being reduced and the reason for the reduction, regardless of who is responsible for paying for that service.

If a reduction occurs because the HHA decides to stop providing the service for administrative reasons Option Box 2 is used on the HHABN. If the reduction is based on a physician's order, Option Box 3 is used on the HHABN. When there is a reduction in services that is not part of the home health benefit or is not part of the POC, an HHABN is not required.

***Example 1 –** Option Box 2 for reduction*

Because of a temporary staffing shortage, an HHA reduces daily physical therapy (PT) to PT 3 times weekly for 2 weeks.

The HHABN Option Box 2 must be issued to the beneficiary prior to this care reduction that is due to an agency issue.

***Example 2** – Option Box 3 for reduction*

The beneficiary met PT goals sooner than expected, and the physician writes an order to discontinue home PT. Physical therapy services are discontinued with no change in existing skilled nursing orders.

The HHABN Option Box 3 must be issued to the beneficiary prior to this care reduction that is a change to the existing POC because of a doctor's order. Reductions include cases, such as this, where one type of care ends, but the beneficiary continues to receive another type of home health service.

If a reduction occurs for an item or service that will no longer be covered by Medicare but the beneficiary wants to continue to receive the care and assume the financial charges, the HHA must issue HHABN Option Box 1 prior to providing the noncovered items or services. Technically, this is an initiation of noncovered services following a reduction of services.

***Example 3 –** Option Box 1 for reduction with subsequent initiation*

The beneficiary's POC lists "PT for gait retraining 5x per week for 2 weeks, then reduce to 3x weekly x 2 weeks". After 2 weeks of PT, the beneficiary wants to continue therapy 5x a week even though this amount of therapy is no longer medically reasonable and

necessary. The HHA would issue an HHABN Option Box 1 to alert the beneficiary that he will be financially responsible for the PT not covered by Medicare if he wishes to receive them.

C. Terminations

A termination is the cessation of all services provided by the HHA and can include Medicare covered and noncovered care. When all home health care is ending for reasons not related to Medicare coverage, the HHA issues the HHABN with formatting appropriate to the specific situation. As with reductions, the HHA chooses the HHABN Option Box formatting based on the reason for the change in care.

If care termination is due to agency reasons *(such as staffing, closure of the HHA, concerns for staff safety),* not related to the need for covered care, Option Box 2 is used.

***Example 1** – Option Box 2 for termination*

An HHA decides to stop providing care because guard dogs at the home have posed safety issues for staff.

Because termination is due to an HHA administrative decision, HHABN Option Box 2 must be given to the beneficiary prior to discontinuation of services.

***Example 2** – Option Box 2 for termination*

An HHA has initiated care for a beneficiary, and the beneficiary has not yet had the required face to face encounter with the certifying physician or an allowed non-physician practitioner (NPP). The HHA believes that the face to face encounter requirement will not be met in the allowed time frame and decides to stop providing care.

*This termination is due to an HHA administrative decision; thus, HHABN Option Box 2 must be given to the beneficiary prior to discontinuation of services. HHABN Option Box 2 issuance does **not** affect financial liability but serves as a written change of care notice as required by the HHA COPs.*

If care termination is due to a physician's orders to discontinue care or a lack of orders to continue care, the HHA may issue Option Box 3.

***Example 3** – Option Box 3 for termination*

A physician orders discontinuation of all home health services or fails to order continued home health services.

HHABN Option Box 3 may be issued to the beneficiary since all services are ending based on the physician's orders.

When all Medicare covered home health care is terminated, HHAs may sometimes be required to deliver the Notice of Medicare Provider Non-Coverage, (NOMNC), CMS-10123. The NOMNC

informs beneficiaries of the right to an expedited determination by a Quality Improvement Organization (QIO) if they feel that termination of home health services is not appropriate. Detailed information and instructions for issuing the NOMNC can be found on the *CMS website under the link for "FFS ED Notices" at:* *http://www.cms.gov/BNI/* . *When all care is being terminated based on physician's orders, HHAs have the option of issuing the NOMNC alone or both the NOMNC and the HHABN Option Box 3. Since the NOMNC provides written notification of the forthcoming termination of all home health care, it satisfies the regulatory requirement for change of care advisement.*

If a beneficiary requests a QIO review upon receiving a NOMNC, the QIO will make a fast decision on whether covered services should end. The QIO decision will affect the necessity of subsequent HHABN deliveries. If covered care continues following a favorable QIO decision, the HHA would resume issuance of HHABNs as warranted for the remainder of this home health episode. If the QIO decides that Medicare covered care should end and the patient wishes to continue receiving care from the HHA even though Medicare will not pay, an HHABN with Option Box 1 must be issued to the beneficiary since this would be an initiation of noncovered care.

Regardless of whether or not a QIO review is requested, when a beneficiary wants to continue receiving care that has been terminated and will not be covered by Medicare, the HHA must treat this as an initiation of a noncovered service and issue the HHABN with Option Box 1 as described in Section A. above.

D. Effect of Other Insurers/Payers

If a beneficiary is eligible for both Original Medicare and Medicaid (dually eligible) or is covered by Original Medicare and another insurance program or payer, HHABN requirements still apply. Other payers can include waiver programs, Office on Aging funds, community agencies (e.g., Easter Seals) or grants.

For example, when a beneficiary is a dual eligible and receives services that are covered only under Medicaid but are noncovered by Medicare, an HHABN must be issued at the initiation of this care to inform the beneficiary that Medicare will likely deny the services.

E. Exceptions to HHABN Notification Requirements

The HHABN formatted with Option Box 1 is NOT required in the following situations:

- *initial assessments (in cases where beneficiaries are not admitted) for which HHAs do not charge;*
- *transfers to other covered care including another HHA or another type of setting such as inpatient hospitalization;*
- *emergencies or unplanned situations beyond the HHA's control (i.e., natural disasters, staff member illnesses or transportation failures);*
- *care that is never covered by Medicare under any circumstances (i.e., an HHA offers complimentary hearing aid cleaning and maintenance);*

- *telehealth monitoring used as an adjunct to regular covered HH care; or*
- *noncovered items/services that are part of care covered in total under a Medicare bundled payment (e.g., HH PPS episode payment).*

The HHABN formatted with Option Box 2 and 3 is NOT required when changes in care involve:

- *increase in care;*
- *changes in HHA caregivers or personnel as decided by the HHA;*
- *changes in expected arrival or departure time for HHA staff as determined by the HHA;*
- *changes in brand of product, (i.e., the same item produced by a different manufacturer) as determined by the HHA;*
- *change in the duration of services that has been included in the POC and communicated to the beneficiary by the HHA, (i.e., shorter therapy sessions as health status improves, such as a reduction from an hour to 45 minutes);*
- *lessening the number of items or services in cases where a range of services is included in the POC;*

  ***Example:** The POC order states: PT 3-5x per week as needed for gait training. The therapist begins therapy at 5 times per week, and as the patient progresses, therapy is reduced to 3 times per week. No HHABN would be needed in this case.*

- *changes in the mix of services delivered in a specific discipline (e.g., skilled nursing) with no decrease in frequency with which that discipline is delivered;*

  Example: A beneficiary is receiving several skilled nursing services during visits that are scheduled 3 times a week. One service within that discipline, a *blood* 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 *blood* draws are discontinued, only when skilled nursing is reduced in frequency.

- *changes in the modality affecting supplies employed as part of specific treatment (e.g., wound care) with no decrease in the frequency with which those supplies are provided; or*

  ***Example:** A specific* wound care *product* like *Alldress is stopped, and a Hydrogel pad is started.* Since this represents a change in the modality (or intervention) *and* not a reduction, no HHABN is necessary.

- *changes in care that are the beneficiary's decision and are documented in the medical record.*

F. Voluntary uses of the HHABN

As mentioned above, HHAs have the option of issuing the HHABN voluntarily to beneficiaries when no notice is required. So, in any of the situations listed in section E. above, an HHA may choose to issue an HHABN. In general, issuance of the HHABN when it is not required may be impractical and unneeded; however, there are situations in which the HHA and the beneficiary may find voluntary notification useful, especially if liability is involved.

Example: A beneficiary is receiving home health services, and his physician orders telehealth monitoring as an adjunct to the regular home health visits. The HHA elects to issue HHABN Option Box 1 before telehealth monitoring begins as a courtesy to the beneficiary and to prepare him for future billing statements. Per §1895(e) of the SSA, telehealth services are outside of the scope of HHA services covered by the prospective payment system. Thus, HHAs providing telehealth as an addition to covered Medicare services are not required to issue an HHABN for the never covered telehealth services.

When the HHABN is being issued as a voluntary notice, the beneficiary does not need to choose an option box (HHABN Option Box 1 format only) or provide a signature.

60.4 - Completing the HHABN

(Rev. 2362, Issued: 12-01-11, Effective: 02-03-12, Implementation: 02-03-12)

A. Notices

HHABNs are available at: *http://www.cms. gov/BNI/*

The notice is available in English and Spanish, and in PDF and Word formats, under a dedicated link "FFS HHABN".

The form and instructions were updated in 2009 with minimal changes to assure accessibility in compliance with Section 508 of the Rehabilitation Act of 1973, as amended in 1998, and by removing the requirement for beneficiaries to list their health insurance claim number (HICN) on the form. Aside from theses minor changes to the form, the HHABN continues to include an interchangeable Option Box with flexibility to insert Option Box 1, 2, or 3 on the form that is delivered to the beneficiary. The Option Box language remains unchanged and consistent with the HHABN in current use.

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 items and/or services they deliver *or* (2) inform beneficiaries of changes in the POC when required by the COPs for HHAs. HHAs *must* use the *OMB* approved standard notice. *HHAs must not add any customizations beyond these guidelines. Section 60.6 provides additional guidance on effective notice delivery.*

B. Choosing the Correct Language Version

HHAs should choose the appropriate version of the HHABN based on the language the beneficiary best understands. When a Spanish-language HHABN is used, the HHA should make

insertions on the notice in Spanish. If this is impossible, the HHA must take additional steps needed to assure beneficiary comprehension and document this on the HHABN.

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. This includes the time to prepare the notice, review it with the beneficiary, and obtain beneficiary's choice and signature.

D. Effective Dates

HHABNs are effective *per* the OMB *assigned* date given at the bottom of each notice *unless CMS instructs HHAs otherwise.* The routine approval is for 3-year use. HHAs are expected to exclusively use the effective version of the HHABN *per CMS directives*.

When a new version of the HHABN notice becomes effective, it is not necessary to re-notify beneficiaries who have already received an HHABN for noncovered care that they are currently receiving. The notice that was effective upon issuance remains valid regardless of the release of a newer version.

E. Extended Notices

A signed HHABN for services not covered by Medicare is effective for up to a year as long as the care that is being delivered remains unchanged from what is listed on the notice. If this care is ongoing, a new HHABN must be provided on a yearly basis.

A single HHABN covering an extended course of treatment is acceptable provided that the HHABN identifies every item and/or service the HHA believes Medicare will not cover. Items and/or services that are provided on a regularly scheduled basis may be considered an extended course of treatment. If additional items or services that may not be covered by Medicare are to be furnished as the extended course of treatment progresses, the HHA must separately notify the beneficiary by issuing another HHABN.

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 items and/or services 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 such as white on black or block-shade (highlight) notice text.

5. Modification: The HHABN may not be modified, except as specifically allowed by these applicable instructions.

6. Font: The HHABN must meet the following requirements in order to facilitate beneficiary understanding:

- **a. Font Type:** The fonts as they appear in the HHABN downloaded from *the 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 *14-16* 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.** 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.
- **f.** *Pre-printed information in the blanks should be in 12-point font size wherever possible, with a minimum of 10-point in smaller blanks, if necessary.*
- ***g.*** 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.
- ***h.*** *If checkboxes are used to identify change pertaining to a specific discipline within the HHA, an explanation of what is changing must be included. For example, if a*

check box next to Physical Therapy is marked, text such as "reduced to 2 times per week" must be inserted. Just checking off a discipline without an explanation could render the notice invalid.

i. HHA staff should have HHABNs without pre-printed information on hand to allow for unusual cases that do not conform to pre-printed language for items or services or reasons for noncoverage.

G. Completing Sections of the HHABN

The 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 *should not be* distributed to beneficiaries. *It* is marked "SAMPLE" under the form title *and includes instructions* for filling in the blanks and boxes. To differentiate the instructions from the notice text, the instructions are printed within brackets in the appropriate blanks.

The next three pages *in the HHABN file* are "ready to use" HHABNs. The second page is marked "Option Box 1 Sample" and contains Option Box 1 text in the boxed area of the notice. The third and fourth pages, labeled as "Option Box 2 Sample" and "Option Box 3 Sample" *respectively,* contain Option Box 2 text and Option Box 3 text Section *G.3* below outlines *when each* option box *should be used*.

1. The Header Section

HHAs are permitted to customize the header section of the HHABN *that is* above the "Home Health Advance Beneficiary Notice" title at the top of the page.

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 *on the notice.*

2. The Body Section

The body section of the HHABN is *the area of the notice that is* below the header and above the option boxes.

Step 1: The HHA inserts its name in the first blank in the first sentence. The HHA name can be pre-printed on the notice *if desired.*

Step 2*: In the second blank, the HHA inserts the appropriate phrase, depending on which option box is used.*

If Option Box 1 is used, appropriate phrases would include "believe Medicare will no longer provide you", "believe Medicare will not provide you", or "believe Medicare will not pay for";
If Option Box 2 is used, HHAs should insert the phrase "will no longer provide you"; or
If Option Box 3 is used, HHAs should insert the phrase "will no longer provide you"

Step 3: *In the third blank the HHA lists items and/or services that are the subject of the notice.*

- The HHA must describe the items *and*/or services that Medicare will no longer cover but may still be provided by the HHA *(Option Box 1 only)*, the *specific* reduction in items or services, or the termination of some or all Medicare-covered care.

- General descriptions of multi-faceted services or supplies are permitted. For example, "wound care supplies" is an appropriate description for a group of items used to provide *wound* care. An itemized list is not required.

When a reduction occurs, *HHAs must provide* enough additional information 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 *reduction* in *the* frequency *that wound care supplies are delivered to the beneficiary.*

Step 4: *In the blank area following the word "Because:"* the HHA must describe why *it expects* the items and/or services to be *noncovered* by Medicare, or *why they* will no longer be provided by the HHA.

- The reasons provided must be in plain language that *is understandable to the* beneficiary and enables the beneficiary to make an informed choice about accepting financial liability when applicable. The *notice* must convey more than *a statement* that care is not reasonable or necessary. The level of detail given should be similar to that found in a Medicare Summary Notice (MSN) message. For example, *in the "Because" section*, a *HHA* could *enter* "you are no longer homebound" or "you can now leave your home unaided." Both phrases are examples of concise yet complete explanations of a common reason why the home health benefit may not be covered for an individual. If needed, *additional* explanation should be provided verbally when delivering the notice.

- If multiple items or services are listed in Step 3 *and there are* different reasons associated with each, the HHA *must include information in this blank that explains, in plain language, the link between each reason and the corresponding item/service.*

Step 5: *In the blanks for telephone numbers provided just below the "Because:" section,* the HHA must enter its own telephone number *and* provide a TTY number for speech or hearing impaired beneficiaries when appropriate.

3. The Option Boxes

As presented in the sample forms, HHAs must choose one Option Box per HHABN issued.

When there is a termination of all Medicare covered home health services, the Notice of Medicare Provider Non-Coverage (NOMNC), CMS-10123, must be issued and may be obtained from the CMS website http://http://www.cms.gov/BNI . If the beneficiary chooses to receive care that will no longer be covered by Medicare, the HHA should also issue an HHABN with Option Box 1.

Instructions *for Using and Completing* Option Box 1:

Option Box 1 is used to notify the beneficiary of potential financial liability that may be associated with a particular usually covered item or service. The item or service may or may not be a home health benefit for which Medicare payment is not expected.

Cost Estimate: The HHA must provide an estimate of the total cost of the items and/or services listed *on the HHABN* in the first blank in this option box. Since one or *more* items and/*or* services could be at issue, the HHA must enter separate total costs for each item or service as clearly as possible, including information on the period of time involved when appropriate. *The cost estimate must give the beneficiary an idea of what his/her out of pocket costs might be if s/he chooses to receive the care listed at the top of the HHABN*.

For example:

- $440 for 4 weekly nursing visits in 1/09.
- $260 for 3 physical therapy visits 1/3-1/7/09.
- *$50 for spare right arm splint.*

When applicable, an 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.

If the beneficiary chooses to receive only certain items or services of those listed on the HHABN instead of everything originally listed on the notice, the HHA must annotate the notice to clearly state the amount the beneficiary may have to pay for those items and/or services.

Check Boxes and the Related Insurance Blank: *The check boxes within the Option Box are NEVER completed in advance. Only the beneficiary or his/her representative can make a selection.*

The beneficiary or representative must check only one of the 3 numbered check boxes. If the number 3 box is checked, the beneficiary or representative must then indicate whether the claim should be sent to Medicare and/or another insurance.

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."

Instructions for *Using and Completing* Option Box 2:

Option Box 2 *is a change of care notice* used when the HHA decides to stop providing some or all care for its own financial or other reasons, *such as:* the availability of staffing, closure of the HHA or safety concerns in a *beneficiary's* home, *regardless of Medicare policy or coverage*.

Notification using this Option Box is limited to home health benefits only. There is no information to complete in Option Box 2 itself.

Option Box 2 Text

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.

Instructions for *Using and Completing* Option Box 3:

Option Box 3 *is a change of care notice* used when the HHA *reduces or* stops providing certain items and/or services because *there is a new or changed* physician order *or no active physician's order to continue the care.* There is no information to complete in Option Box 3 itself; *however, it is recommended that the HHA enter the ordering physician's name and telephone number so that the beneficiary can readily contact the ordering provider if s/he questions the cessation of care. This information should be inserted in the blank area below the Option Box 3 text.*

Option Box 3 Text

***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.*

4. **The Signature and Date Section**

This section contains 4 boxed and labeled blanks for completion. The HHA or the beneficiary may complete the patient's name and identification blanks. However, the beneficiary or representative must sign and date the HHABN confirming his/her receipt and understanding of the notice.

- **Patient's Name:** The beneficiary's full name should be inserted in the blank.
- ***Patient Identification:*** *Completion of this blank is optional and serves for HHA identification purposes. A birth date or medical record number may be inserted. HHAs are not permitted to insert the beneficiary's Medicare health insurance claim number (HICN) or Social Security number into this blank.*
- **Signature:** The beneficiary or representative must personally sign the HHABN.
- **Date:** The beneficiary or representative must personally enter the date that the HHABN was signed.

If the beneficiary refuses to sign the HHABN, the HHA must write that the beneficiary refused to sign on the HHABN itself, and provide a copy of the annotated HHABN to the beneficiary.

60.5 - *HHABN Delivery*

(Rev. 2362, Issued: 12-01-11, Effective: 02-03-12, Implementation: 02-03-12)

HHAs must make every effort to ensure beneficiaries understand the entire HHABN prior to signing it. When delivering HHABNs, HHAs are required to explain the *entire notice and its content, and answer all* beneficiary *questions to the best of their ability. If abbreviations are used, the HHA should explain their meaning to the beneficiary. If the beneficiary* requests additional information *while completing the HHABN*, the HHA must respond timely, accurately, and completely to the information request.

While in-person delivery of the HHABN is preferable, it is not required consistent with general ABN requirements, see Medicare Claims Processing Manual, Chapter 30, §40.3.4.1.

If a mode other than in person delivery is used, the HHA must adhere to the requirements under the Health Insurance Portability and Accountability Act (HIPAA). Instructions on ABN telephone notice found in §40.3.4.2 of this chapter are also applicable to HHABNs.

Delivery with Option Box 1

While reviewing this option box, the HHA must review cost estimates and instruct the beneficiary to select only one of the 3 numbered check boxes. The HHA must advise the beneficiary that if the third check box is chosen, a box must be checked to indicate whether a claim should be submitted to Medicare, the beneficiary's other listed insurer, or both.

Delivery with Option Box 2

The HHA must review the text in the box and verbally explain to the beneficiary that he/she may be able to obtain the same or similar care from another HHA, since coverage through Medicare is not affected. HHAs are encouraged to do as much as possible to offer ideas to beneficiaries for contacting other HHAs and must inform ordering physicians of reductions/terminations consistent with the COPs for HHAs.

Delivery with Option Box 3

The HHA must review the text in the box, and inform the beneficiary that the HHA will no longer provide certain care because the physician order has changed. When requested, the HHA may facilitate contact and understanding between the physician and beneficiary. The beneficiary may also seek to contact the physician directly.

Retention of the HHABN

The HHA keeps a copy of the completed, signed or annotated HHABN in the beneficiary's record, and the beneficiary receives a copy. HHA's may retain a scanned copy of the paper copy or "wet" document in an electronic medical record if desired. The primary HHA must retain the HHABN if a subcontractor is used.

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.

Other Considerations During Completion

1. Beneficiary Unable to Sign

If the beneficiary is physically unable to sign the HHABN and is fully capable of understanding the notice an authorized representative is not required for signature. 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.

2. **Beneficiary Changes His/Her Mind.**

If a beneficiary chooses a particular option and later changes his/her mind, the HHA should present the previously completed HHABN to the beneficiary if possible. *The HHA should then instruct the beneficiary to annotate the form by documenting his/her current choice, the date of the annotation, and his/her initials or signature.*

In situations where the HHA is unable to present the *existing* 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.

3. Timely Notice

There are no exact time frames for HHABN delivery. However, the beneficiary should receive the HHABN far enough in advance so that s/he can make an informed choice regarding whether or not s/he will receive the service in question when the HHABN with Option Box 1 is delivered. With HHABN Option Box 2 or 3, delivery timing of the notice may sometimes occur immediately upon the HHA finding that a change in care is warranted. However, in general, HHABN with Option Box 2 or 3 should be delivered far enough in advance of the care change so that the beneficiary may pursue avenues to continue receiving the care noted on the HHABN. When plans for issuance of the notice are known in advance, the HHABN should not be issued so far in advance as to cause confusion regarding the information it conveys.

Some allowance is made for "immediate" delivery prior to furnishing the care at issue when unforeseen circumstances arise *such as an impending, unforeseen agency staffing shortage.* This should be avoided whenever possible, but is permissible as long as the beneficiary *has a fair opportunity to* make an informed choice.

60.6 - Effective HHABNs

(Rev. 2362, Issued: 12-01-11, Effective: 02-03-12, Implementation: 02-03-12)

In order for the HHA to assign liability to a beneficiary, the HHABN with Option Box 1 must be considered a valid notice that was effectively delivered in accordance with CMS guidelines. HHAs must 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 may be considered an invalid notification by reviewing entities.

The HHABN must convey the HHA's genuine doubt regarding the likelihood that Medicare may not pay for the listed items and/or services, the reason 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 cost estimate must be a good faith estimate made by the HHA, and a difference in the cost estimate and actual cost will not automatically invalidate the HHABN.*

To be considered valid, the HHABN must be signed by the beneficiary, unless appropriate documentation for the lack of signature is recorded on the HHABN. *Delivery of a defective HHABN for this or any other reason may result in the HHA being financially liable.*

An HHABN delivered when the beneficiary cannot give appropriate informed consent, such as during a medical emergency or health care crisis, may be ruled defective. Similarly, if the HHA issues an HHABN under coercive circumstances, such as forcing the beneficiary to mark a certain checkbox, or by marking a check box before issuing the notice to the beneficiary, the notice may be found defective. The only exception to the HHA marking the check box on the Option 1 HHABN is in cases of State instituted directives for dual eligibles which is further explained below.

HHAs are prohibited from routinely issuing to beneficiaries HHABNs or "blanket" HHABNs describing a broad range of services. The HHABN must provide sufficient specificity for the beneficiary to make an informed decision on how to proceed regarding the care in question.

HHAs should never seek a beneficiary's signature on a blank HHABN that does not contain the necessary information regarding the care in question.

60.7 - Collection of Funds and Liability Related to the HHABN

(Rev. 2362, Issued: 12-01-11, Effective: 02-03-12, Implementation: 02-03-12)

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 items and/or services 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.

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 items and/or service 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 must refund any previously collected amounts to the beneficiary consistent with the other insurer's payment.

B. Financial Liability for Providers

HHAs may be held financially liable for the cost of items and/or services in situations where the HHA fails to issue an HHABN when required or issues a defective HHABN. 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 *to the beneficiary.*

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. 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 items and/or services 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 promptly refund the appropriate amount to the beneficiary.

60.8 - *Special Issues Associated with the HHABN*

(Rev. 2362, Issued: 12-01-11, Effective: 02-03-12, Implementation: 02-03-12)

State Authority for Option Selection for Dual Eligibles

Some States have specific rules established regarding the completion of an HHABN Option Box 1 in situations where "dual eligibles" (Medicaid recipients who are also Medicare beneficiaries) may need to accept liability for Medicare noncovered care that will, in fact, be covered by Medicaid. Certain States direct HHAs to select the third checkbox in Option Box 1 language so that the choice to bill Medicare is 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.

HHAs serving dual eligibles need to comply with HHABN State policy within their jurisdiction.

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, statutory 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.