

HHABN is Retiring... Now what forms?

Colleen Bayard PT, MPA, COS-C
Director of Regulatory & Clinical Affairs
Home Care Alliance of Massachusetts, Inc.



November 21, 2013

1

Disclaimer

- Home Care Alliance of MA has produced this material as an informational reference for home health providers . HCA makes no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the Centers for Medicare & Medicaid Services' (CMS) Web site at <http://www.cms.gov>

2

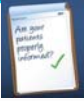
Agenda

- Background: Discuss history and necessity of patient notices (including COPs)
- Triggering events for HHCCN
- Exceptions
- Completion and Delivery of HHCCN
- Use of the ABN- Triggering Events
- Completion and Delivery of ABN

3

History- Patient Notices


484.10 Patients Rights-



- HHABN required since 2002 to notify beneficiary of non-covered charges when limitation of liability applies
 - 484.10 (e) *Standard: Patient liability for payment.*
 - Patient has the right to be advised, before care is initiated, of payment for services may be expected from Medicare/other insurances
- 2006- CMS revised notice in response to Federal Court Decision to broaden notification requirements under COPS-To inform patient in change of care plan
 - 484.10 (c) *The patient has the right to be informed, in advance, about the care to be furnished and of any changes in the care to be furnished*

4

HHABN Being Replaced Effective 12/9/2013



1. **Advanced Beneficiary Notice (ABN)**
 - Existing Form CMS-R-131
 - Option Box 1- **Liability**
2. **Home Health Change of Care Notice (HHCCN)**
 - New CMS 10280
 - Option Box 2 or Option Box 3 (**change in POC**)

**Medicare Claims Processing Manual-Chapter 30
Section 60 and subsections are being revised in
accordance with the notice**

5

HHCCN and the ABN

- Only used for Medicare fee-for-service
- May begin using forms immediately
- Not needed for Medicare Advantage Plans

6

Home Health Change of Care Notice


NEW form CMS 10280

7

HHCCN- Change Request 8403

HHA must provide HHCCN whenever:


1. **HHA reason** (Former Option Box 2)
 - Availability of staff
 - Closure of HHA
 - Safety concerns in beneficiary's home
 - Patient has not had the required F2F visit with the certifying physician
 - Does not shift financial liability to the patient
2. **Physician Order** -Reduce or terminate a home health items/service due to physician/provider order (Former Option Box 3)



8

Timing of Notice

- No exact time frames for delivery
- Far enough in advance so beneficiary may pursue alternatives
- However may occur immediately when HHA find change in POC is warranted:
 - Safety issue arises
 - Unforeseen staffing shortage



9

HHCCN Triggering Events

- CMS defines-*“Triggering Event”*: any reductions or terminations in care/service/item
- HHA are required to issue the HHCCN when a *“Triggering Event”* changes the beneficiaries POC



10

Examples-

- **Triggering Event Due to Physician Order**
 - Reduction: POC lists wound care as daily, new order for every other day
 - Termination: POC- wound care 2x wk provider writes new order to discharge wound care and SN (PT still involved in case)
- **Triggering Event Due to HHA Reasons**
 - Reduction: PT ordered 4x wk- unexpected PT shortage only can provide PT 2x wk
 - Termination: PT ordered 4x wk- HHA lost PT staff can no longer provide PT services

11

Multiple Changes

When multiple care changes occur due to simultaneous order and agency specific change- The HHA must give the beneficiary 2 separate HHCCN so they can identify the reasons that correspond to each change.

Only one check box indicating the change can be marked on the HHCCN

12

Patient Decides to Reduce or Change Services



- If a patient decides to discontinue or reduce the services he or she is receiving, no notice is required.
- The medical record should include information about the patient's decision.

13

Exceptions to HHCCN Notification

The HHCCN is NOT required when changes in care involve:

- Increase in care
- Changes in HHA caregiver or personnel
- Changes in visit time for HHA staff
- Change in brand of product (same item produced by a different manufacture)
- Change in length of visit
 - (shorter PT session as health status improves, such as reduction from 1 hour to 45 minutes)
- Reductions outlined in the POC (PT 3-5 times a wk)
- Change in mix of services delivered by a specific discipline with no decrease in frequency (blood draw d/c but wound care remains 3x/wk)
- Change in care that are the beneficiary decision



14

Instructions for Completion



15

Completing the Form

Form has 3 sections

- Header
- Body
- Signature/Date

16

Header

- Agency name
- Agency address
- Agency phone number and TTY number when necessary
- Patient's full name
- Patient identification-**Optional field**
 - Medical record number, electronic bar code
 - **Do not use Medicare number or SS#**

17

Body of the Form

5 components for completion by HHA

- Date
- Items/service
- Reason for the change
- Check boxes-General reason for the change (1 of 2)
- Additional Information

18

Body of the Form

- Date: date changes begin
- Items/Services: description of specific reduction or termination
 - Example:
 - On November 23, 2013, the frequency of your wound care will decrease to 3 days per week
 - On November 22, 2013, we will stop all your Occupational therapy services
 - On November 22, 2013 daily wound supplies will be decreased to 3 days a week

19

Body of the Form

- Reason for Change
- Example:
 - Your doctor has changed your order for nursing visits
 - Your doctor has ordered occupational therapy be discontinued
- Example:
 - Your dog has been threatening to our staff and we are unable to safely enter your home
 - You did not have a Face to Face encounter to meet payment eligibility; we will no longer be able to provide home health services.

20

Body-Check Boxes

Determine which of 2 reasons listed applies in this situation and check it:

- Physician orders for home care have changed
- HHA has decided to stop providing HH services

21

Body-Additional Information

“Additional information”

- Optional area
- May include any other information that could be helpful
- Physician's name and phone number
- Language assistance used

22

Signature and Date

- Beneficiary or representative must sign and date
 - HHA may insert date if beneficiary is having difficulty and requests assistance (annotation)
- Representative's signature-must be indicated as “rep” or “representative” next to the signature
 - If signature is not clearly legible the name must be printed next to the signature



23

More on Signatures

- Patient physically unable to sign
 - Can't physically sign but capable of understanding the notice a representative is not required to sign
 - Patient allows HHA to annotate the form on their behalf regarding the circumstances
 - E.g. - 2 broken arms- HHA staff signs and dates in presence of the patient, inserting beneficiary name along side with his/her name
 - Colleen Bayard PT, Home Health Agency, signed for Jane Doe
 - Should be witnessed by a second person if possible
 - Further the medical record must support the patient's inability to sign



24

Patient Refuses to Sign



- “If the beneficiary refuses to sign the notice, the HHA must write that the beneficiary refused to sign on the notice itself, and provide a copy of the annotated form to the beneficiary.”
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual, Chapter 30, Section 60.4G.4.*

25

Instructions



- **Delivery-**
 - HHA are required to explain the entire notice and answer all questions; make every effort to make sure patient understands the HHCCN
 - Abbreviations should be avoided, unless the abbreviation is spelled out elsewhere and the HHA should explain the meaning
 - If verbal assistance in other language provided, HHA should document the type of translation assistance in the “additional information” section of the notice
 - In-person delivery of the HHCCN is preferable, it is not required

26

Advanced Beneficiary Notice ABN- Liability Issues




27

ABN

Always used for potential financial liability, and signed prior to providing care

- Used when services are usually covered by Medicare but in this instance may not be covered.
 - 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.



Reasons HH is Not Covered

Description of Situation	Recommended Explanation for Reason Medicare May Not Pay
<ul style="list-style-type: none"> • Care is not reasonable and necessary • Custodial care is the only care delivered • Beneficiary is not homebound 	<ul style="list-style-type: none"> • Medicare does not pay for care that is not medically reasonable and necessary • Medicare does not usually pay for custodial care, except for some hospice services • Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit
<ul style="list-style-type: none"> • Beneficiary does not need skilled nursing care on an intermittent basis 	<ul style="list-style-type: none"> • Medicare requires part-time or intermittent need for skilled nursing care in order to cover services under the home health benefit

29

Triggering Events for ABN Issuance by HHA

Event	Description
<ul style="list-style-type: none"> • Initiation 	<ul style="list-style-type: none"> • 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.
<ul style="list-style-type: none"> • Reduction 	<ul style="list-style-type: none"> • When an HHA expects that Medicare coverage of an item or service will be reduced or stopped during a spell of illness while continuing others, including when one home health discipline ends but others continue.
<ul style="list-style-type: none"> • Termination 	<ul style="list-style-type: none"> • When an HHA expects that Medicare coverage will end for all items and services in total.

30

Example of Reduction:

- A homebound patient received nursing visits 3x/wk for the first two weeks and then was reduced to 2x/wk according to the plan of care. The patient wishes to continue receiving the visits 3x/wk. The additional visits are not medically necessary. The patient must be notified that these visits would not be covered by Medicare and he/she would be financially liable.



All Services Discharged

If termination involves the end of all Medicare covered services and no further care is being delivered; the only notice would be the

Notice of Medicare Non-coverage-Form CMS-10123

A separate HHCCN does not need to be issued

- However: When a HHA ends delivery of all Medicare-covered care, but expects to continue delivering non-covered care, **an ABN is needed as well as the notice of non-coverage**
 - ✓ Services will be continued under another payer such as Medicaid or self-pay

32

Instructions for Completing the ABN



33

Completing the form

- 10 blanks labeled (A) through (J) Labels should be removed prior to use
- Blanks A-F and H may be completed prior to delivering notice
- Blanks G,I, J completed by the patient
- Entries may be typed or handwritten

34

Completing the Form

- Blank A: HHA - name, address, phone number of HHA
- Blank B: Patient name - first and last name of beneficiary receiving notice (If Medicare card has a middle initial, include it)
- Blank C: Identification number- Optional field
 - ✓ Medical record number may be used
 - ✓ **Do not use Medicare number**

35

Blank D Sections

- Blank D: (7 blanks for D)
 - "NOTE" section above table (2)
 - In header of table (1)
 - "What you need to know section" (1)
 - Under Options (3)
- General descriptors can be
 - Item
 - Service
 - Care

36

Blank D

- Blank D: Beneath header
- Specific services that may not be covered with frequency and duration if repetitive or continuous non-covered care
 - Home health aide visits 3 times per week for 1 year
 - Nursing visits weekly for 1 year
 - Physical therapy visits twice a week for 4 weeks
 - Occupational therapy visits weekly for 8 weeks
 - Wound care supplies monthly for 3 months

37

Blank E

Blank E: Reason Medicare May Not Pay

- Must have at least one reason applicable to each item or service listed in D
- Same reason may apply to multiple items
- Suggest using CMS reasons provided on slide # 29

38

Blank F

- Blank F: Estimated cost of each service at issue
“Cost estimate must be a good faith estimate based on agencies charges and the expected frequency and duration of each service”.
- Cost estimates per visit, per hour or per number of visits weekly are acceptable, including information on the time period involved when appropriate
- Cost Estimate Examples (Claims Processing Manual Ch. 30- 50.14.4)
 - \$440 for 4 weekly nursing visits in 1/13
 - Nursing visits daily for one year at \$125 each
 - \$260 for 3 physical therapy visits 1/3-1/7/13
 - \$50 for right arm split
- Estimate must be within \$100 or 25% of actual cost
- Allows patient to determine out of pocket cost

39

Blank G

- Blank G: Options - Beneficiary or representative selects choice of 3 Options
- If multiple services are listed in blank D but beneficiary wants only some of them, multiple ABNs must be used
- If beneficiary will not select a choice, mark on form "beneficiary refused to choose an option"
 - HHA may enter beneficiary's selection if patient is physically unable to do so
 - Must annotate notice appropriately

40

Option 1: Indicates the Choice to Bill Medicare

- Beneficiaries select Option 1 on the ABN when a Medicare claim denial is necessary to facilitate payment by a secondary insurer or if the patient wants "Demand Billing".
- If there is a secondary Insurance:
HHAs may also use the "Additional Information" on the ABN to include specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information.
- Agencies can pre-print language in the "Additional Information" section of the notice.
 - *"We will submit a claim for this care to your other insurance"*

41

Option 2: MassHealth's Clarification on the ABN for Dually eligible (published November 18, 2013)

- *The new ABN form does not allow a dual-eligible beneficiary to choose the option to bill Medicaid. Therefore, you should direct the beneficiary to choose Option 2. Under Section H, you should pre-print the following language: "We will bill your Medicaid plan. We will bill Medicare only if your Medicaid plan instructs us to do so."*
- *This allows MassHealth, as payer of last resort, the right to exercise any appeals to Medicare.*

42

Option 2

- **OPTION 2. I want the ____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.**
- This option allows the beneficiary to receive the non-covered items and/or services and pay for them out of pocket.
- No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

43

Option 2

- *MA Medicaid office does NOT want a claim filed with Medicare prior to filing a claim with Medicaid, therefore the patient should choose Option 2.*
- *HHAs may direct dual eligibles on choosing the correct option box according to State directives. HHAs are permitted to pre-type information in the "Additional Information" area for ABNs issued to dual eligibles to help them understand that Medicaid will pay for the service.*

44

Option 3

- **OPTION 3. I don't want the ____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.**
- This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided and thus, there are no appeal rights associated with this option.

45

Blank H

- Additional Information:
- May add information to help the dually eligible patient understand the payment situation
 - *"We will bill your Medicaid plan. We will bill Medicare only if your Medicaid plan instructs us to do so."*
 - *May also add secondary insurance information*


46

Blank I and J

- Blank I: Signature-must be signed by beneficiary or authorized representative
 - If the beneficiary refuses to choose an option and/or refuses to sign the ABN when required, the HHA should annotate the original copy of the ABN indicating the refusal to sign or choose an option and may list witness(es) to the refusal on the notice although this is not required.
 - *If a beneficiary refuses to sign a properly delivered ABN, the HHA should consider not furnishing the item/service, unless the consequences (health and safety of the patient, or civil liability in case of harm) are such that this is not an option.*
 - In any case, the HHA must provide a copy of the annotated ABN to the beneficiary, and keep the original version of the annotated notice in the patient's file.
- Blank J: Date form is signed
 - If beneficiary has difficulty writing, HHA may ass date if assistance is requested

47

Period of Effectiveness



- "A signed ABN 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 there is a change in the POC a new ABN is required
- Dually eligible patient receiving care only covered by Medicaid. At the end of the year, a new ABN must be provided to the patient.
- **An ABN given November 30, 2012, would be effective through November 29, 2013, assuming no other changes**

, Medicare Claims Processing Manual, Chapter 30, Section 60.4E.

48

Period of Effectiveness



If you have been providing one non-covered service and another is being added, give the patient an ABN with only the additional service.

- EXAMPLE:
The patient has been receiving only nursing services that have been covered by Medicaid. An ABN was signed three months ago when that service was initiated. Now the patient will also be receiving Home Health Aide services that are also not covered as the patient is not homebound. Give the patient an additional ABN to notify the patient about the cost of only the home health aide services
- If both nursing and home health services continue to be provided as non-covered services for the remaining nine months, the updated ABN can include both nursing and aide

49

More on ABN...



- Cannot back date the ABN
- Incomplete ABN-
 - improper or incomplete ABN notice-
provider is liable
- The ABN does not have to necessarily be issued to the patient by a nurse or a therapist.
 - The person has to be someone the home health agency has appointed to issue the ABNs.

50

Option Boxes

- The beneficiary or his or her representative must choose only one of the three options listed in Blank (G).
- Under no circumstances can the HHA staff decide for the beneficiary which of the 3 checkboxes to select.
- Pre-selection of an option by the HHA invalidates the notice.
- However, at the beneficiary's request, HHA may enter the beneficiary's selection if he or she is physically unable to do so. In such cases, HHA must annotate the notice accordingly.



51

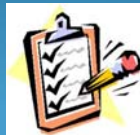
Delivery Requirements

ABN delivery is considered to be effective when the notice is:

1. Delivered by HHA to a capable recipient and comprehended by that recipient.
2. Provided using the correct notice with all required blanks completed.
3. Delivered to the beneficiary in person if possible.
4. Provided far enough in advance of delivering potentially non-covered items or services to allow sufficient time for the beneficiary to consider all available options.
5. Explained in its entirety, and all of the beneficiary's related questions are answered timely, accurately, and completely to the best of the HHA ability.
6. Signed by the beneficiary or his/her representative.

52

Instructions that Pertain to HHCCN and ABN



53

Instructions for Customization

- HHA are permitted to do limited customization, such as pre-printing agency specific information
- Pre-printed forms can be on different colored paper as long as visually high contrast combination
 - Dark ink on light background
 - May label pre-printed versions by adding letters or numbers in the header area
- HHA may pre-print descriptions of common change of care scenarios
 - E.g.: "Beginning on _____, we will decrease the frequency of your wound care to _____ times per _____"


54

Instructions for Customization

- Pre-printed information inserted on the notice should be 12 font
 - 10 font should only be used if smaller font needed to include all applicable info in the blank space provided
- Permitted to list multiple change of care scenarios
 - May use check boxes to identify information applicable to the scenario
 - Alternatively applicable items may be circled or items that do not apply can be crossed out
- *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.*

55

More Instructions



- **Copies:** minimum of 2 copies
 - Beneficiary and HHA each have one
- **Electronic Issuance- permitted**
 - May be viewed on an electronic screen and signed if the patient is agreeable. The patient must be given the option of paper issuance
 - Signature may be digitally captured
 - A paper copy of the signed form must be given to the patient

56

Instructions

- **Length and Page Size-**
 - Must not exceed one page in length
 - Designed as letter-size form; May be expanded to legal size to accommodate HHA's information address, telephone #, etc.
- **Contrast of Paper-**
 - Visually high contrast combination
 - Dark ink on light background
 - Do not reverse print

57

Instructions for Font

- **Font Type-**
 - Use font on document downloaded from CMS website
 - Alternative fonts allowed because of software limitations
 - i.e. -Arial, Arial narrow, Times Roman, Courier
- **Font Effect/Style-**
 - Do Not Change style of font- No Italics, embossing, bold
 - Makes HHCCN more difficult to read
- **Font Size**
 - Size should generally be 12 point
 - Titles 14-16 point
- **Insertion in Blanks:** may be typed or legibly hand-written


58

Resources

- Beneficiary Notices- HHCCN and ABN
<http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html>
- Conditions of Participation-
<http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/homehealth.html>

59

Questions



60
