Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-02-045 **Date: MAY 23, 2002**

This Program Memorandum re-issues Program Memorandum A-01-70, Change Request 1698 dated May 25, 2001. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 1698

THIS PROGRAM MEMORANDUM (PM) ISSUES INSTRUCTIONS CLARIFYING TRANSMITTAL A-01-05 AND CHANGE REQUEST 1467. THESE INSTRUCTIONS APPLY TO REGIONAL HOME HEALTH INTERMEDIARIES (RHHIs) ONLY.

SUBJECT: Frequently Asked Questions (FAQs) About Home Health Advance Beneficiary Notice (HHABN, Form CMS-R-296)

This is to advise you of the posting of Frequently Asked Questions (FAQs) about the Home Health Advance Beneficiary Notice (HHABN, Form CMS-R-296) on the CMS.HHS.GOV Web site. We plan to post the FAQs attached to this letter at http://www.cms.hhs.gov/medlearn/qaprovhh.htm in the immediate future. This is a new page, so it will not be online until the FAQs are actually posted. It will be entitled "Home Health Advance Beneficiary Notice Providers Questions & Answers" and will link off the Medlearn HHA PPS page under the headings "Frequently Asked ABN Questions/ Providers."

These are not new instructions to RHHIs nor to HHAs; they are consistent with the existing instructions in PM A-01-05 and PM A-01-30. They are in reference to the OMB-approved HHABN form CMS-R-296 that is currently in effect. It would be helpful if you would advise the HHAs which you serve of the existence and location of these FAQs.

With respect to the HHABN form itself, the agency is proceeding to work within the Paperwork Reduction Act public comment and clearance process to develop a final form, taking into account the input received about the currently approved form and its implementation.

Home Health Advance Beneficiary Notice (HHABN)

FAQs / Providers

Q. What and where are the CMS Web sites where HHAs and other interested parties can find the most current information on HHABNs and Demand Billing for home health care?

A. There are several pertinent websites. Following are descriptions and URLs.

- **Home Health Prospective Payment System Quick Reference Guide (the Medlearn HHA PPS page) – includes HHABN forms and instructions.**
  http://www.hcfa.gov/medlearn/refhha.htm

- **Home Health Advance Beneficiary Notice Providers Questions & Answers (This page links off the Medlearn HHA PPS page under the headings "Frequently Asked ABN Questions / Providers.") This is where FAQs for HHAs are posted.**
- **http://www.hcfa.gov/medlearn/qaprovhh.htm**

- **Home Health Prospective Payment System Beneficiary Questions & Answers (This page links off the Medlearn HHA PPS page under the headings "Frequently Asked Questions / Beneficiary.") This is where FAQs for beneficiaries are posted.**
  http://www.hcfa.gov/medlearn/qabenhh.htm

- **The Home Health Prospective Payment System – Plans & Providers page for HHA PPS.**
  http://www.hcfa.gov/medicare/hhmain.htm

- **Medicare & Medicaid 2001 Program Memos – Listed by PM number, e.g., "A-01-30".**
  http://www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm

- **Paperwork Reduction Act of 1995 – Temporary postings of published PRA packages. Posted only while in PRA clearance. HHABN related postings are under "CMS-R-296".**
  http://www.hcfa.gov/regs/prdact95.htm

Q. Can the HHABN be on two separate pages or does the form have to be front to back? May we reformat the HHABN for our local use?

A. The current HHABN may be produced front and back or on the fronts of two pieces of paper. NCR paper printing is permitted. Forms may be printed, copied, or electronically generated. The requirement is that, however produced, the first page must replicate the first page of the standard government form, and the second page must replicate the second page of the standard government form. Reformatting the form minimally to make it possible to print on different papers or to generate electronically, etc., is permissible, but the substance of the form may not be changed, nor may the layout be changed in certain ways. Changing the form by revising the content, moving anything from one page to the other, by decreasing font size to less than 12 point font, or changing the fonts from the Arial and Arial Narrow fonts used in the standard government form, is prohibited.

Q. Will the HHABN be available in an official Spanish version?

A. Yes, we plan to publish a Spanish version of the final HHABN that is approved for use by OMB through our Paperwork Reduction Act process.

Q. In the HHABN PM (A-01-05), section I-2, B, Beneficiary Billing and Refunds, states that the provider may bill the beneficiary or third party payer pending Medicare's decision "if that is permissible under applicable State and/or Federal law." We are unaware of any specific Federal law that might prevent this. Was this sentence written about a particular Federal law that could apply?

A. The subject clause is a general caveat and no particular State or Federal law is contemplated by it.

Q. In providing the estimate of the cost of non-covered services, can the home health agency refer to the discipline specific per visit costs or must the reference be to the total anticipated costs of care?

A. The HHA must respond to the patient's request for a cost estimate in terms which the patient can understand. The HHA is not required by Medicare rules to express the cost estimate in any specific format.

Q. What telephone numbers do I enter on the HHABN? What is the TTY/TDD number of the RHHI?

A. There are three places on the HHABN where telephone numbers are to be entered. A TTY/TDD number is a special number for the hearing impaired and/or speech impaired, which can only be accessed with special TTY equipment.

At the top of the HHABN, enter the office telephone number of the attending physician who ordered the home care for the patient.

At the third to the last sentence and next to the last sentence on the first page, after "If you do not hear from Medicare within 90 days…", enter the local RHHI's office telephone number and its telephone number for the hearing and/or speech impaired in the first and second blanks or directions for using its other telecommunication system for individuals with impaired speech or hearing.

At the bottom of the first page, after "If you have questions, please call us at:" enter the HHA's office telephone number in the first blank and the HHA's telephone number for the hearing and/or speech impaired in the second blank after "TTY/TDD:" or directions for using the HHA's other telecommunication system for individuals with impaired speech or hearing.

Here are the RHHIs' current numbers:

RHHI	Office Number	TTY/TDD No.
Assoc. Hosp. Svcs. of Maine	(888) 896-4997	(207) 822-4646 or (877) 476-5600
UGS (West Coast, Pacific)	(877) 602-7904	(866) 879-0235
UGS (Midwest, East, Puerto Rico)	(800) 531-9695	(866) 879-0234
Medicare Customer Svcs. Ctr.	(800) 444-4606	(800) 516-6684
Palmetto Government Benefits	(800) 583-2236	(800) 223-1296
Cahaba	(877) 910-8139	No TTY/TDD

Q. What are the triggering events that necessitate issuing an HHABN?

A. An HHABN is given to a Medicare beneficiary when a triggering event occurs and the care is physician-ordered but the HHA believes that Medicare will not pay. There are three triggering events for which an HHABN must be given:

Initiation of Services – Triggering Event 1 = In the situation in which an HHA advises a beneficiary that it will not accept the beneficiary as a Medicare patient because it expects that Medicare will not pay for the services, the HHA must provide an HHABN to the beneficiary before it furnishes home health services to the beneficiary.

Reduction of Services - Triggering Event 2 = In the situation in which an HHA proposes to reduce a beneficiary's home health services because it expects that Medicare will not pay for a subset of home health services, or for any services at the current level and/or frequency of care, the HHA must provide an HHABN to the beneficiary before it reduces services to the beneficiary.

Termination of Services - Triggering Event 3 = In the situation in which an HHA proposes to stop furnishing all home health services to a beneficiary, because it expects that Medicare will not continue to pay for the services, the HHA must provide an HHABN to the beneficiary before it terminates such home health services.

Q. Is an HHA required to provide an HHABN when physician prescribed services continue without interruption or reduction where there is a change in payer eligibility, in the opinion of the HHA, from Medicare to another third party payer such as Medicaid?

A. Yes. When the HHA predicts that Medicare will not pay for the services ordered by the physician and the physician continues his/her prescription for those services, this means that the HHA would reduce or terminate services to the beneficiary if Medicare were the sole payer for the services. On this basis, we characterize such situations as "triggering events," as described above. When, in describing "triggering events," we say "an HHA proposes to reduce a beneficiary's home health services because it expects that Medicare will not pay" and "an HHA proposes to stop furnishing all home health services to a beneficiary, because it expects that Medicare will not continue to pay", our premise is that Medicare is the sole payer for the services, and must be since we are not promulgating instructions for other insurers. The premise of this question is that "physician prescribed services continue without interruption or reduction" when a patient changes "payer eligibility" from Medicare to Medicaid. It is true that, on a practical basis, "physician prescribed services continue without interruption or reduction" in this situation. From a Medicare coverage vantage point, however, there is a reduction or termination when Medicare, which has been paying, stops paying. In other words, there is a triggering event which underlies the change in "payer eligibility."

Q. Is a home health agency required to issue an HHABN even in circumstances where the individual is not enrolled in the Medicare program, e.g., under age 18; insufficient qualifying earning quarters; within disability waiting period?

A. No. The HHABN is to be used solely for individuals enrolled in the Medicare Fee-For-Service (FFS) program (Parts A & B). Do not use the HHABN for non-Medicare enrollees. Do not use the HHABN for Medicare M+C (Part C) enrollees.

Q. Some home health agencies provide care to individuals on an outpatient basis within their offices or a clinic. Is the HHABN required where a home health agency provides services to an individual outside of the home?

A. No. HHABNs (CMS-R-296) are for use with home health care. For Part B services furnished on an outpatient basis, an CMS-R-131 ABN may be used, as appropriate.

Q. Must home health agencies issue an HHABN to an ongoing patient every 60 days?

A. No, an HHABN remains effective for the predicted denial it communicates to the beneficiary, without periodic reissuance, for an indefinite period as long as no triggering event occurs. If a triggering event does occur, then an HHABN must be given immediately. The beneficiary may request a demand bill at any point in his/her care.

Q. Does the requirement in PM A-01-05 that HHAs should furnish an HHABN "when you believe that Medicare will not pay for some or all of the home health care a physician ordered for the beneficiary," imply that HHAs must provide HHABNs to all dually eligible beneficiaries, even though Medicaid, rather than the beneficiary, will be liable for the non-Medicare covered service?

A. HHAs are required to give an HHABN to Medicare beneficiaries (including dual eligibles) when the HHA believes that Medicare will not continue to pay for some or all of the home health care a physician has ordered for the beneficiary. The HHA must give the Medicare beneficiary an HHABN before reducing or terminating home health care that the beneficiary already is receiving, and that Medicare has been paying for, if the physician's order for such care would still continue care, but the HHA expects payment for the home health services will be denied by Medicare.

Q1. With respect to chronic long-term dually eligible patients, are HHAs required to give an HHABN every 60 days even where no Medicare covered services have been provided?

Q2. Is an HHABN required where the patient has been receiving full-time, private duty skilled nursing services?

A1 & 2. If there are and have been no triggering events, there would be no need to provide an HHABN. Of course, a State Medicaid Agency could insist that a Medicare claim be submitted, but our instructions do not require an HHABN for a patient in a stable, long term Medicaid care plan.

Q. Do I have to give an HHABN to my Medicaid-only patients?

A. No. Give HHABNs to Medicare beneficiaries, only. However, if the patient is a dual-eligible and a triggering event occurs, you need to give an HHABN.

Q. Does the HHA have to give a beneficiary an HHABN for non-covered services?

A. HHAs do not need to give an HHABN for statutorily excluded services, e.g., personal comfort items, routine screening tests, routine foot care, and immunizations.

Q. Is an HHABN required when the patient is receiving no services from skilled care personnel and is receiving only personal care services?

A. No. Do not use the HHABN in such circumstances because the complete absence of any Medicare-qualifying skilled service negates any possibility of coverage under the Medicare program.

Q. If Option C is marked, can the HHA bill Medicaid or other insurance?

A. Yes, the HHA usually may bill Medicaid or other insurance, unless the beneficiary indicates that he or she does not want a claim sent to anyone. When the beneficiary simply selects Option C, the beneficiary is requesting that no claim be sent to Medicare, however, a claim may be sent to any other insurer. PM A-01-05, Section I-1.F.iii. provides: "When the beneficiary checks option C, do not submit a claim and the beneficiary will be fully and personally responsible to you for payment." Section I-1. provides: "To be 'fully and personally responsible for payment' means that the beneficiary will be liable to make payment 'out-of-pocket,' through other insurance coverage (e.g., employer group health plan coverage), or through Medicaid." However, if the beneficiary indicates that he or she does not want a claim sent to <u>any</u> insurer, you must honor that decision. In that case, the beneficiary will be personally responsible for payment on a private-pay basis.

Q. What are the OASIS responsibilities when the payer shifts from Medicare to another payer, such as Medicaid? Are these different from when the payer source shifts from non-Medicare such as Medicaid to Medicare? Finally, how should this all be reflected in the OASIS question regarding payer source?

A. M0150 of the OASIS data set asks for all current payment sources for home care. As such, it is informational, and not designed for billing purposes. However, in light of PPS, in the OASIS User's Manual on page 8.6, there is guidance relative to OASIS data collection that considers payment source changes. The User's Manual describes the situation where the patient's primary payment source changes from Medicare to an alternative payment source as well as the situation where the patient's primary payment source changes from an alternative payment source to Medicare.

<u>Patient's primary payment sources from skilled home care changes during the episode of care from Medicare to an alternative payment source.</u>

Appropriate Agency Action: There are 2 possibilities for this situation:

1. **If the original start of care (SOC) date is maintained, continue assessments and OASIS data collection/reporting according to that date. Report any new payment source (or**

delete any that no longer pertain) in M0150 - Current Payment Sources for Home Care at the next regular assessment.

2. **If the SOC date changes to coincide with the payment source change, the patient must be discharged (discharge date to coincide with last visit of "old" payment source). A new comprehensive assessment must occur with the new SOC date.**

Patient's primary payment source for home care changes during the episode of care from other-than-Medicare to Medicare.

Appropriate Agency Action: This situation parallels response 2 (above). Follow the actions described there (i.e., discharge patient on last visit of "old" payment source, conduct new comprehensive assessment at new SOC date). A SOC comprehensive assessment and OASIS data collection is required when Medicare becomes the payer source.

The *effective date* for this PM is May 25, 2001.

The *implementation date* for this PM is May 25, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after May 25, 2003.

If you have any questions, contact Raymond Boyd at RBoyd@cms.hhs.gov, telephone number (410) 786-4544.