Form Instructions
Instructions for the Home Health Advance Beneficiary Notice (HHABN)
OMB Approval Number: 0938-0781

Overview

Home health agencies (HHAs) issue HHABNs to original or fee for service (FFS) Medicare beneficiaries for reasons related to the absence or cessation of Medicare coverage when a beneficiary has liability protection under §1879 of the Social Security Act (the Act) and/or in conjunction with their responsibilities under Medicare conditions of participation (COPs) for HHAs. These instructions explain how to complete this form and how and when the form should be delivered. We have updated the form and instructions in 2009 by making minimal formative 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.

Notices

Aside from the minor changes to the form addressed above, 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, approved under the Paperwork Reduction Act of 1995 (PRA). These instructions apply whether the HHA gives the HHABN to a beneficiary or an authorized representative. For more information on authorized representatives, see Medicare Claims Processing Manual, Chapter 30, §40.3.5

Transition to the Reformatted HHABN

HHAs may begin using the reformatted HHABN as soon as possible. Continued use of either form remains acceptable through a transitional period that is dependent on OMB approval of the reformatted version. The date for mandatory use of the reformatted HHABN is forthcoming pending this approval.

Applicability

HHABNs are issued to beneficiaries receiving the home health care benefit for notification of potential financial liability and/or notification of plan of care changes.

HHAs are required to issue HHABNs to FFS Medicare beneficiaries in situations where items and/or services are ordered that the HHA believes Medicare might not cover. The following are HHA situations which would require HHABN issuance applicable to limitation of liability (LOL) along with the corresponding reasons why Medicare might not pay:

- Care that is not reasonable and necessary because Medicare does not pay for such care;

- Custodial care that is the only care delivered because Medicare does not usually pay for such care, except for some hospice services;
- Care delivered to a beneficiary who is not homebound because Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit;

For care provided by HHAs that is outside the Medicare home health benefit, the only LOL requirement that will apply is section 1862(a)(1)(A) of the Act, involving care that is not reasonable and necessary.

Consistent with the Medicare COPs and the 2nd Circuit Court's decision in *Lutwin v. Thompson* regarding notification procedures, home health agencies must provide the HHABN whenever they reduce or terminate a beneficiary's home health services in relation to changes in physician/provider orders or due to limitations of the HHA in providing the specific service.

Triggering Events

HHAs are required to issue HHABNs whenever a triggering event takes place. Triggering events may occur as initiations, reductions, or terminations in care and, under the home health benefit, may apply for purposes of either covered or noncovered care.

HHABN triggering events include the following:

- Initiation = When a HHA expects that Medicare will not cover any planned items and/or services from the start of a course of treatment given over a spell of illness, OR before the delivery of one-time items or services that Medicare is not expected to cover.
- Reduction = When a HHA reduces or stops some items and/or services during a spell of illness, while continuing others, including when one home health discipline ends but others continue.
- Termination = When a HHA ends delivery of all Medicare-covered care, but expects to continue delivering noncovered care.

If a termination involves the end of all Medicare covered care and no further care is being delivered, the only notice issued would be an Expedited Determination Notice (CMS-10123).

If an HHABN is issued for ongoing, continuous, noncovered care that exceeds a year in duration, a new HHABN must be issued on a yearly basis.

HHABN Preparation

The following are the general instructions for HHABN preparation:

Number of Copies: A minimum of two copies, including the original, must be made so the beneficiary and HHA each have one.

Reproduction: HHAs may reproduce the HHABN by using self-carbonizing paper, photocopying the HHABN, or other appropriate methods. All reproductions must conform to applicable instructions.

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 HHAs name, list of items and/or services that will no longer be provided, or cost information.

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.

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

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

- **Font Type:** The fonts as they appear in the HHABN downloaded from the CMS website 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 Roman, and Courier.

- **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.

- **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.

- **Insertions in Blanks:** Information inserted by HHAs in the blank spaces on the HHABN may be typed or legibly hand-written.

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:

- 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.

- HHAs may print different versions of HHABNs on different color paper to easily differentiate the versions, but in all cases a high-contrast combination of light paper and a dark font color should be used.

- HHAs may also differentiate versions of their HHAs by adding letters or numbers in the header area.

- Underlining in the blank spaces is not required.

- Information in blanks that is constant can be pre-printed, such as the HHA name.

- 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.

- 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.

- 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.

- 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.

HHAs must exercise caution before adding any customizations beyond these guidelines, since changing HHABNs too much could result in invalid notice and provider liability for noncovered charges. CMS liability notice policy generally bases validity determination on two factors: effective delivery and beneficiary comprehension as described in the Medicare Claims Processing Manual, Chapter 30. CMS does not validate adaptations of the HHABN made by individual HHAs. Validity judgments are generally made by Regional Home Health Intermediaries (RHHIs), usually when reviewing HHABN-related claims.

HHABN Completion and Delivery

The HHABN continues to be a one-page notice, composed of four sections:

- Header Section
- Body Section
- Option Boxes
- Signature/Date Section.

CMS releases this HHABN in a file that contains four pages. The first page is instructional and never distributed to beneficiaries; it is marked "SAMPLE" under the form title. This notice contains instructions for filling in the blanks and boxes. To differentiate the instructions from the actual notice text, the instructions are printed within brackets in the appropriate blanks.

The next three pages 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. Subsequently, the third and fourth pages are labeled as "Option Box 2 Sample" and "Option Box 3 Sample" and contain Option Box 2 text and Option Box 3 text in their respective boxed areas. Section B.2.b below outlines which option box to use.

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 name, logo, and billing address. At minimum, information allowing the beneficiary to contact the HHA must appear on the notice.

The Body Section

The body section of the HHABN is below the header and above the option box area. The HHA starts by inserting standard information into the following two blanks in this section:

Step 1: The HHA inserts its name in the first blank space 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 should describe either the items 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 permitted to describe a group of items used to provide this care, and an itemized list is not required.

- When a reduction occurs, HHAs should 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 decrease in frequency of this nature.

Step 4: In the blank area following the word "Because:" the HHA must describe why the items and/or services listed are expected not to be covered by Medicare, or will no longer be provided by the HHA.

- The reasons provided must be in plain language that allows the beneficiary to understand the reason for the notice and enables the beneficiary to make an informed choice about accepting financial liability when applicable. The information 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, a Step 4 entry could be "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 yet specific reason why according to Medicare policy the home health benefit may not be

covered for an improving individual. If needed, additional explanation would 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 allows the beneficiary to understand the link between each reason and its corresponding item/service.

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

The Option Boxes

The HHA must choose one Option Box per HHABN issued as presented in the sample forms.

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

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 and/or other reasons, regardless of Medicare policy or coverage, such as: the availability of staffing, closure of the HHA or safety concerns in a beneficiary home.

Option Box 3 is a change of care notice used when the HHA stops providing certain items and/or services due to lack of a physician order, but other care continues.

When there is a termination of all HHA services, an Expedited Determination Notice must be issued and may be obtained from our website http:// http://www.cms.hhs.gov/BNI . If terminated care that is now not covered by Medicare, the HHA would also issue an HHABN with Option Box 1.

Instructions for Option Box 1:

Step 1: 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 multiple items and services could be at issue, the HHA must enter a total cost that reflects each item or service as clearly as possible, including information on the period of time involved when appropriate. The cost estimate is meant to give the beneficiary an idea of what costs would be if he/she paid out of pocket, not what the beneficiary may actually have to pay given other coverage. Examples are listed below:

- $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.

- $0 for all services listed. (This would be inserted if the HHA chooses not to charge a beneficiary or if bundled payments with no beneficiary liability are involved.)

When applicable, a proxy like 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

The HHA must annotate the amount the beneficiary may have to pay if he/she later chooses to receive only certain items or services of those listed on the HHABN instead of everything originally listed on the notice.

Step 2: Check Boxes and the Related Insurance Blank. The check boxes within the Option Box are NEVER completed in advance and must be checked off by the beneficiary or his/her representative.
The HHA may fill in the blank listing the beneficiary's other insurance in advance in cases where additional coverage of an established patient are known.
The beneficiary must check only one of the 3 numbered items. If number 3 is checked, the beneficiary must then mark one or both of the boxes to indicate his/her claim submission request.

Instructions for Option Box 2:

Option Box 2 is used when the HHA decides to stop providing some or all care for its own financial and/or other reasons, regardless of Medicare policy or coverage, such as the availability of staffing, closure of the HHA or safety concerns in a beneficiary home.
Notification using this Option Box is limited to home health benefits only.

An HHA may issue notices with Option Box 2 language voluntarily to provide notice that it will not charge or admit a beneficiary after an assessment is done.

There is no information to complete in Option Box 2 itself.

Instructions for Option Box 3:

Option Box 3 is used when the HHA stops providing certain items and/or services due to lack of a physician order, but other care continues. Notification using this Option Box is limited to home health benefits only.

There is no information to complete in Option Box 3 itself.

The Signature and Date Section

This section contains 4 boxed and labeled blanks for completion. The HHA or the beneficiary may complete the name and identification blanks; however, the beneficiary or representative is required to sign and date the HHABN confirming his/her review 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.

HHABN Delivery

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. HHAs must make every effort to ensure beneficiaries understand the entire HHABN prior to signing it. If abbreviations are used, the HHA should explain their meaning to the beneficiary. 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.

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 one copy of the completed, signed or annotated HHABN in the beneficiary's record, and the beneficiary receives a copy.