Form Instructions
for the Home Health Change of Care Notice (HHCCN)
CMS-10280
OMB Approval Number: 0938-1196

Overview

Medicare currently requires home health agencies (HHAs) to issue HHCCNs to Medicare beneficiaries receiving the home health care benefits for notification of plan of care changes.

Consistent with the Medicare Condition of Participation and the 2nd Circuit Court's decision in *Lutwin v. Thompson* regarding notification procedures, home health agencies must provide the HHCCN whenever they reduce or terminate a beneficiary's home health services due to physician/provider orders or limitations of the HHA in providing the specific service. Notification is required for covered and non-covered services listed in the plan of care (POC). More information on the HHCCN may be found in the Medicare Claims Processing Manual, Chapter 30, Section 60.

The Advance Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131, must be used in order to transfer potential financial liability to the beneficiary in the following situations:

- providing care that Medicare usually covers but may not pay for in this instance because the care,
- is not medically reasonable and necessary,
- is considered custodial care, or
- is not covered because the beneficiary is not

homebound. (For information on the ABN, please see the ABN

webpage)

Changes to the HHCCN

There were no substantive changes made to the HHCCN form or the form instructions. We did make plain language and information design changes to the form according to our Office of Communications (OC) recommendations. These OC recommendations are soundly based on research-based best practices in plain language and information design.

Preparation

The following are the general instructions for HHCCN preparation:

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

- **Electronic Issuance:** Electronic issuance of HHCCNs is permitted. If a doctor/provider elects to issue an HHCCN that is viewed on an electronic screen before signing, the patient must be given the option of requesting paper issuance over electronic if that is what the patient prefers. Also, regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the patient should be given a copy of the signed HHCCN to keep

for his/her own records.

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

- **Length and Page Size:** The HHCCN must NOT exceed one page in length. The HHCCN 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 contact information or a list of multiple changes to the plan of care.

- **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- shaded (highlighted) text.

- **Modification:** Don't modify the HHCCN, except as specifically allowed by these instructions.

- **Font:** The lettering on the HHCCN must meet the following requirements to facilitate patient understanding:

    - **Font Type:** Use the fonts as they appear on the documents downloaded from the CMS website. 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:** Don't make style changes to the font, such as italics, embossing, bold, etc., since this could make the HHCCN more difficult to read.

    - **Font Size:** The font size generally should be 12 point. Titles should be 14-16 point. Words inserted in the blanks on the HHCCN can be as small as 10 point if needed.

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

- **Customization:** HHAs are permitted to do limited customization of HHCCNs, such as pre-printing agency-specific information to promote efficiency and to ensure clarity for patients. Guidelines for customization are:

    - HHAs may pre-print descriptions of common change of care scenarios.

    - Information in blanks that is constant can also be pre-printed, such as the HHA name, address, and phone number.

    - Pre-printed information inserted on the notice should be at least 12-point font size if possible, and 10-point minimum. 10 point should only be used if a smaller font is needed to include all applicable information in the blank space provided.

    - HHAs may list multiple change-of-care scenarios on a pre-printed HHCCN. If multiple scenarios are listed, the patient should be able to clearly identify the information that pertains to his/her case. HHAs may use checkboxes to indicate information applicable to the patient. Alternatively, applicable items can be circled, or items that do not apply can be crossed out.

- The HHA may pre-print specific HHA disciplines with corresponding checkboxes on the HHCCN. However, an explanation of what is changing must be included on the notice. For example, if Physical Therapy is checked, 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.

- HHCCNs without pre-printed information should be available for HHA staff to use in cases that don't conform to pre-printed language.

HHCCN Completion and Delivery

The Header Section

HHAs are permitted to customize the header section of the HHCCN that sits above the "Home Health Change of Care Notice" title at the top of the page. HHAs may add identifying information such as a logo, web address, or an email address.

The blanks in the header section are completed as follows:

- **Home Health Agency:** The name of the HHA must be listed.

- **Address:** The correspondence address of the HHA must be listed.

- **Phone:** A phone contact must be included and a TTY number must be included when necessary.

- **Patient's Name:** The patient's full name must be inserted in the blank. (A pre- printed name label is permitted.)

- **Patient Identification Number:** Completion of this blank is optional and serves for HHA identification purposes. A birth date or medical record number may be inserted. HHAs must not include the patient's Medicare health insurance claim number (HICN), Medicare Beneficiary Identifier (MBI) or Social Security number on the notice. Electronic bar codes are permitted.

The Body Section

The body section of the HHCCN is below the header and above the signature area. The body includes 4 components for completion by the HHA:

- Your home health care is changing
- Why are you getting this notice?
- Get help or more information
- Signature

Your home health care is changing

Directly under the title of the notice there is a blank line for insertion of a date after "Starting on…….,". The HHA must insert the date that the changes listed on the notice will start.

When there are changes in care that require written patient notification, the HHA lists the

change or changes in the blank area under "What items/services are changing". The HHA must also explain whether the item/service is being reduced or terminated.

The description should be informative, in language understandable to the patient. Common abbreviations such as "PT" for physical therapy may be used only if the patient is familiar with the term.

> **Example 1:** "We will stop all of your occupational therapy services."
>
> **Example 2:** "The frequency of your wound care will decrease to 3 days per week."

In the blank area under "Reason for change", the HHA must insert the specific reason that the care change is occurring. For doctor/provider's order changes, an example of language that can be used is: "Your doctor/provider has changed your order for this care."

For agency related changes, more specific information may be provided in accordance with the situation. For example, "Your dog has repeatedly threatened our staff, and we are unable to safely enter your home," could be a possible reason cited.

Why are you getting this notice?

The HHA must identify the general reason for the change or changes that are listed in the table above. The HHA must check one of the 2 checkboxes in the section under "Why are you getting this notice?."

> "**Your doctor/provider changed (or didn't renew) the order for your home care."**
> The HHA checks the first circle when care will be reduced or stopped because of an order change or the lack of an order to renew care.
>
> "**Your home health agency decided to stop giving you the items/services for the reasons listed above."**
> The HHA checks the second circle 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 patient's home.

When multiple care changes occur due to simultaneous order changes and agency specific reasons for change, the HHA must give the patient 2 separate HHCCN's so that s/he can identify the reason that corresponds to each change. Only one check box indicating the reason for change can be marked on each HHCCN.

Get help or more information

An entry in this area is optional. HHAs should use this area to include information that may be helpful to the patient's specific case. For example, the ordering doctor/provider's name and phone number could be inserted here if the patient has questions on an order change that the HHA can't answer.

Signature

This section contains 2 boxed and labeled blanks for completion. The patient or authorized representative is required to sign and date the HHCCN confirming his/her review and understanding of the notice. The HHA may insert the date if the patient is having difficulty and requests assistance.

If an authorized representative is signing on behalf of the patient, the circle "Check here if you're signing as an Authorized Representative and make sure your name is legible or print your name, if not legible" must be checked.

If the patient refuses to sign the HHCCN, the HHA must note on the HHCCN that the patient refused to sign and provide a copy of the annotated HHCCN to the patient.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1196. This information collection is for the Home Health Agencies to notify original Medicare beneficiaries receiving home health care benefits of plan of care changes. The time required to complete this information collection is estimated to average less than 4 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under 42 U.S.C. 1395(bbb) and 42 CFR 484.10(c). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.