

Easy as A..B..N..

By Lisa A. Woolery, Senior Consultant – lwoolery@simioneconsultants.com

Is your supervisory, clinical and billing staff compliant with Home Health Advanced Beneficiary Notice (HHABN) requirements? If not, improper documentation can cost your agency thousands of dollars in third party reimbursement and incur sanctions for non-compliance with Medicare regulations.

The 2-page HHABN form has been effective since March 2001 and a new 1-page form has been approved by OMB and will be effective October 1, 2002. Agencies are free to use the new form immediately if they wish. The current 2-page form will be obsolete on October 1, 2002. The new 1-page form CMS-R-296 and related instructions can be found at www.cms.gov/medicare/bni.

HHABN compliance begins at intake and the need for an ABN must be evaluated upon initiation, reduction and termination of Medicare covered services. Payer changes may also trigger the need for an ABN, even when ordered care is not reduced or terminated.

At each trigger point, ask yourself the following questions:

Is the patient an eligible Medicare beneficiary ?

The HHABN applies only to Medicare beneficiaries. If the patient has Medicare coverage, an HHABN is not required.

Is the patient's Medicare under an HMO/Managed Care?

The HHABN applies only to Medicare fee-for-service beneficiaries. HHABN's do not apply to patients whose Medicare coverage is managed by an HMO.

Has the MD ordered the services in question?

All services require a physician's order to be eligible for Medicare payment. An HHABN is not required when the physician has NOT ordered the services requested or when the physician agrees with and orders the service reduction or termination.

Has the MD ordered SKILLED services (RN, PT, SLP)?

If the physician does not order a qualifying skilled service, the HHABN is NOT required as the care does not qualify for Medicare payment.

Will Medicare be billed for ALL of the services ordered?

If the agency believes the care qualifies and Medicare will be billed for all services provided, an HHABN is not required. HHABNs are only used when care that is ordered by a Medicare beneficiary's physician is **NOT** going to be billed to Medicare.

Will Medicare be billed for SOME of the services ordered?

If some of the services ordered qualify for Medicare payment and some services do not (such as Aide services in excess of part-time or intermittent criteria) an HHABN is required for those services that do NOT qualify.

When it is determined that an HHABN is required, the form must be properly completed. The writing must be legible and it is critical that consistent procedures are implemented to ensure compliance.



1. Prepare the header of the form to include the agency's identifying information, the date the patient was notified, the patient's name and HIC number, and the physician's name and telephone number.

2. Identify the specific services you expect not to be covered and why they will not be covered (i.e. not homebound, not a skilled service, not medically necessary, etc.). The cost of the services in question must be noted on the form. These descriptions should be in a form that the patient can easily understand. It is acceptable to list the per visit or per hour cost of services.

3. Explain each option to the patient (*descriptions below are based on the new form CMS-R-296*):

OPTION A: The patient wants you to "Demand" bill Medicare for their determination. This is used when the patient believes Medicare would cover the services and they want an official determination rather than the agency's "opinion". Indicate any other health insurance the patient may have. The patient wants to continue to receive the services while awaiting Medicare's decision. The patient agrees to be responsible for the payments or other payers may be billed while waiting for Medicare's decision. If the patient refuses to take responsibility, the agency may discontinue service while awaiting Medicare's decision. Check your State's Medicaid Guidelines, as some states want all

dually eligible patients to receive an official determination. *Option A must be immediately processed and a "Demand" bill sent to Medicare.*

OPTION B: The patient accepts your coverage determination and does not request a "demand" bill. Other existing payers may be billed unless they require claim submission to Medicare. This greatly reduces the agency's paperwork burden, but because of the wording on the current 2-page form, many patients have been reluctant to choose this option. The new form is clearer in describing this option. The beneficiary must instruct the agency to bill another insurance, or to not bill any insurance for the services.

OPTION C: The patient declines services; the Agency may omit, reduce or discontinue services.

4. The patient must sign the original form and keep a copy. The agency representative must date the receipt of the signed HHABN. If it is returned through the mail, a copy with the date of receipt must be sent to the patient. If a competent patient or his representative refuses to sign the ABN, indicate the circumstances on your copy of the form. The agency may decide not to provide services to a beneficiary who refuses to sign the HHABN.

Telephone numbers are to be entered (or pre-printed) in three places on the HHABN:

1. The physician's phone number.
2. The telephone numbers for your Regional Home Health Intermediary (RHHI).
3. The agency's telephone and TTY/ TDD numbers.

The HHABN process does not end with the patient's signature. If the patient chooses option A, the billing department must begin to process the demand claim. The claim must be coded (condition code 20) and billed to Medicare before billing any other payment source.

- The MD may be notified by receiving a copy of the signed (option A) HHABN.
- The Patient must be notified by the agency when the claim is sent.
- The intermediary will notify the agency and the patient of the determination.

The HHABN will remain in effect until another qualifying event occurs.