

**HHABN Questions and Answers
October 2006**

The answers to questions in bold type have been changed from the original set of Q&As posted in September. NAHC has received clarification from CMS on Medicare secondary payer issues and when care is to be added to a completed duration of visits within the episode.

Q. Orders for SN 3 wk 9 for wound care. Wound improves after 3 weeks and patient only needs SN 2 times a week for the remaining 6 weeks, so MD orders the decrease. HHABN? If yes, which option?

A. HHABN, Option Box 3 would be issued since the reduction is related to physician's orders.

Q. Orders for SN 2 wk 9 for wound care. Also doing Foley catheter change monthly. At end of the recertification period, wound heals. The new recertification only has 1 mo 2 for catheter changes. HHABN? If yes, which option?

A. An HHABN, Option Box 3 will be required since the reduction is related to physician orders.

Q. There is a scheduling error and a visit is missed and not made up that week. HHABN needed? If yes, which option?

A. No HHABN, this is an unplanned event and not a true reduction in the POC.

Q. At initiation of care, the patient needs Medicare covered skilled nursing and aides. The patient is incontinent and needs incontinent supplies. These will be provided during the course of the SN or aide visits, but not left for use in between visits because they are not Medicare covered. The patient does not have another insurance to pay for them. HHABN needed? If so, what Option?

A. No, not unless the patient wants to pay for additional supplies out-of-pocket and has a physician's order for them. Then an HHABN would be required at all the triggering events.

Q. Patient needs a Medicare covered SN service monthly. Also needs medication box pre-filled weekly. The visits only to per-fill will be billed to Medicaid. HHABN needed? If yes, which Option?

A. Since Medicare is paying for some of the care you will have to issue an HHABN for the Medicaid covered services at all the triggering time points until Medicare coverage ends.

Q. At initial evaluation, it is determined the only service the patient needs is personal care which will be billed to the home and community based waiver program (Medicaid program). HHABN needed? If yes, which option?

A. An HHABN, Option Box 1, would be required at initiation and annually thereafter.

Q. Orders are for 3 wk 9 SN for wound care and physical therapy. After 6 weeks the wound heals, so the MD discontinues the SN visits. The patient is still receiving PT. HHABN needed? If yes, which Option?

A. HHABN Option Box 3 since the decrease in visits is related to physician orders.

Q. Orders are for SN 2 wk 4, 1 wk 4. At next recertification new orders are written for care but for 2 wk 4. The frequency has increased from prior orders, but the duration is less (4 weeks as opposed to 8). HHABN needed? If so, which Option?

A. No HHABN is required. An Expedited Determination would be issued at the end of 4 weeks.

Q. Orders for SN 2 wk 3. Ordered completed but something else comes up with patient requiring additional orders to be written for 1 wk 3. HHABN? If so, which option?

A. An HHABN, Option Box 3, will be required. Even though an additional week of care has been ordered, the visit frequency will be decreasing. The beneficiary will have to be notified, in this example, that care is being reduced from 2xw to 1xw.

Q. The patient is discharged from the agency because outpatient therapy services are starting. This is a multiple discipline case. The SN is discharging today, prior to the end of the visit schedule so she will issue an Option Box 3. PT will discharge with goals met and perform the agency discharge next week prior to the start up of outpatient services. From what I understand, the agency discharge with goals met will result in no HHABN and just the Medicare discharge notice. Is this correct?

A. That is correct, since all Medicare covered services are ending the Expedited Determination notice will be sufficient notice.

Q. If a patient is receiving Medicare services, goes to the physician and is discharged to outpatient services do we just send the Expedited Determination Notice (EDN) to the home? Or do they need an Option Box 3 HHABN?

A. Only the EDN is required since all Medicare covered services will be ending.

Q. PT is the last service and wants to discharge before the 9th week because goals were met (on 485 PT orders are for 1-3w 9 Does PT have to issue both the Expedited Notice and the HHABN?

A. Only the Expedited Determination notice is required since all Medicare covered services are ending. In your example, the PT discharge will end all Medicare covered care.

Q. If an LPN receives a physician order to decrease visits can she have the HHABN signed?

A. Who in the agency is to furnish the HHABN is not specifically stated in CMS policy. The main issue is to be sure the LPN is able to adequately explain the HHABN and answer any questions the beneficiary may have.

Q. Why is a HHABN required for recertification when there is a decrease in the frequency? A recertification is a new plan of care, why wouldn't the process start over. Technically, the original POC ended when the 60 day episode ended. Subsequently, please explain why we would need to issue a HHABN upon resumption of care.

A. CMS's position is patients at recertification and at resumption of care will expect care to continue at the level of the original plan unless notified. If visits are reduced at these time points (recertification /ROC) then the agency must give written notice in the form of an HHABN.

Q. If a patient is a Medicare beneficiary but we will be billing Medicaid for SN and Waiver for aide services, because he/she is not homebound or it is not a Medicare "skill", would an HHABN be required and if so how often?

A. An Option Box 1 will be required at initiation, and renewed annually for medical services provided where a third party, other than Medicare, even Medicaid is the payer.

Q. I understand that a HHABN is required if goals are met early for one discipline but the other discipline continues care. However, if SN and PT are in, PT is no longer progressing and the physician agrees. Is a HHABN required? What If the family does not agree with the PT and feels the patient is progressing? Please explain the reason.

A. If the PT ends earlier than written on the POC, the MD agrees, and other covered services are continuing (i.e. SN) then an HHABN, Option Box 3, would be required. If the family insists the therapy continue and the MD agrees to write orders for continued therapy, an HHABN Option Box 1 will have be issued since you would be providing care that Medicare may not cover (not reasonable and necessary).

Q. If frequencies for covered care reduced from 5xw to 3xw and a HHABN was given. Now frequencies are being reduced again from 3xw to 1xw. I was thinking that another HHABN would be required. This decrease is another change. Please explain.

A. Yes, you would issue another HHABN, Option Box 3 since there is a reduction in care from the most recent HHABN.

Q. HHABN Option Box 1- if box #3 is chosen then under the note section. it is stated that a claim will be submitted to Medicare and the patient will get a Medicare Summary Notice showing Medicare's official payment decision. Then, they may also appeal if Medicare will not pay. Question: If it takes 30-60days for a MSN to be received by the patient then is the HHA obligated to continue care? What is the Home Health Agencies obligation?

A. Part of that statement also reads: "You may have to pay the full cost at the time you get the items and /or services." This statement is informing the patient that the agency may bill them until the FI renders a decision. If the FI rules that Medicare will pay for the service, any money the agency has collected from the beneficiary must be refunded.

Q. Physician discharges the patient even if the patient still has skilled needs. All services end. Then would we be required to give Expedited Determination Notice only or Option Box 3 (lack of physician order) or both?

A. An Expedited determination would be issued since Medicare covered care ends when there are no physician orders for care.

Q. Re-certification has new orders that will be on the POT. However, we are still required to give an HHABN. Correct? What Option Box?

A. If the visit frequency on the recertification is less than the original POC or the latest HHABN, this would be considered a reduction in care and an HHABN is to be issued. Option Box 3 will be used since the change in the POC is related to physician orders.

Q. If this is not discussed, please tell me if a range is ordered on the plan of care. For example 1-3 times per week and the clinician goes three times one week and then the next 2 weeks goes at one time per week, does this count as a reduction of service? Can you order a range on the plan of care anymore or would you need to order a specific frequency for each individual week care is provided to actually determine a specific reduction of services.

A. Ranges may be used on the POC, and if followed as written an HHABN would not be required when planned reductions occur. The expectation is that agencies are explaining to the patients how the visit frequency will be plotted out when a range is written.

Q. Could you please give an example of when an HHABN is required on initiation of Medicare non-covered items or services?

A. An HHABN would be required on initiation of care that is provided for which you know or believe Medicare will cover, such as personal care services provided by the agency and paid for by Medicaid or any other third payer.

Q. If Medicare is the secondary payer does the patient need an HHABN?

A. If Medicare is paying for any of the services then the HHABN will apply at all triggering events for those services for which Medicare is paying. If a patient has

Medicare as a secondary insurance, yet another insurance is primary and paying for all care, then the HHABN, Option Box 1, would be required at initiation only.

Q. Is it necessary to give HHABNs when a patient is admitted as a liability case? They fell at a restaurant. The restaurant's insurance is primary. Medicare is secondary.

A. If a patient has Medicare as a secondary insurance, yet another insurance is primary and paying for all care, then an HHABN, Option Box 1, would be required at initiation only.

Q. Does "unplanned situation" include the physician making the decision to discharge services at a physician visit?

A. A patient unexpectedly discharge by the physician is not considered an unplanned occurrence for the purpose of the notice requirement. In this case, since all Medicare covered care would be ending, the Expedited Determination Notice would be required. If some non-covered care were to continue then an HHABN, Option Box 1, would also have to be provided.

Q. If PRN orders are ordered on a 485 and they are not used during the episode of care, will an HHABN be required?

A. PRN orders are orders for additional care and would not be subject to the HHABN whether they are used or not.

Q. Are both notices: an Expedited Determination and an HHABN necessary in all unplanned discharges?

A. The Expedited Determination Notice and the HHABN are provided together only when all Medicare covered services are ending but some non-covered care will be provided/continue. For example, all skilled nursing care will end and the home care aide will also have to end. The patient, however, wants the HCA to continue and will pay out of pocket for the services. The Expedited Determination Notice is provided to allow the beneficiary an appeal process for ending Medicare covered services and the HHABN is provided to inform the beneficiary that Medicare will not cover the home care aide, and what the charges will be. This allows the beneficiary to make an informed decision regarding whether to receive the non-covered care. If there is no other non-covered care continuing the Expedited Determination Notice is the only notice required when all Medicare covered services are ending regardless of whether the discharge is planned or not.

Q. If at the initiation of services Physical Therapy writes for 2x/a week for 4 weeks, and nursing writes for 3x/week for 9 weeks. When therapy completes their services at the 4 week mark as planned. Do they still need to issue a HHABN even though they made it clear they would discontinue their service at 4 weeks?

A. If the Pt writes 2xw for 4 weeks and discharges at the end of the 4 weeks, while another service is continuing; an HHABN will not be required.

Q. If the patient is transferred to hospital, there is no need to deliver HHABN (exception). When the patient returns to agency 2 weeks later, the ROC SN frequency is the same as original plan of care, therefore no need for HHABN. However, if ROC SN frequency is reduced from the original plan of care is an HHABN is required.

A. Yes, an HHABN would be required if the ROC frequency was less than the original POC. An option Box 3 would be provided since the reduction is related to physician orders.

Q. We have a DME company that is part of our Home Health company that has a different provider number for Medicare. Would we be required to deliver HHABN to Medicare DME pts?

A. If the DME division is billing on their supplier number, the HHA is not billing for the DME, the HHABN would no apply. The DME company would be required to provide any advance beneficiary notice related to Medicare non-coverage.

Q. The original POC says "provide wound care supplies per procedure until drainage ends". Is an HHABN needed when supplies stop because drainage stops?

A. Using broad statements to indicate an end point for items and /or services, such as, "when the wound heals", may be too vague for patients to fully understand when supplies will be discontinued. Agencies could write something that implies healing such as "when the drainage stops"., This is so the beneficiary has something tangible they can observe and relate to. We believe a statement such as the one you suggest would not require an HHABN when supplies will no longer be provided.

Q. Since we do not charge the beneficiary for wound supplies is an HHABN required?

A. An HHABN will have to be given for supplies, even if there is no charge. Supplies are part of "home health services "that are subject to the HHABN requirements at all triggering events, regardless of charges.

Q. If you are terminating services due to patient non-compliance would you still need to issue HHABN even though ALL services are being discontinued? Would you not instead issue the Expedited Determination Notice?

A. Since the discharge of a non-compliant patient is an agency decision, and the patient may still be in need of skilled care, an HHABN Option Box 2 would be issued. The patient has the option of choosing another agency and to comply with a treatment plan.

Q. If a patient is placed on hold for therapy per doctor's order, would you issue a HHABN option 3? The visit frequency is not reduced but the patient is no longer participating in therapy per doctor's order due to a temporary inability to participate.

A. Yes, an HHABN, Option Box 3, would be required since services will be reduced from what was envisioned on the original POC.