Note: 12/2/2022

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484.50 Rights- Patient Notices

Home Health Change of Care Notice- HHCCN
Advanced Beneficiary Notice- ABN
Notice of Medicare Non-coverage –NOMNC

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HHCCN
Home Health Change of Care Notice-
HHCCN

Issue HHCCN when a “Triggering Event” changes services
CMS defines—“Triggering Event”:
Any reductions/terminations in
• Plan of Care
• Service/item

Form CMS-10280 (Exp. 04/30/2022)
Home Health Change of Care Notice-
HHCCN

Provide HHCCN:
1. HHA reason
   • Limited Availability of staff
   • Closure of HHA
   • Safety concerns in beneficiary’s home
   • Patient has not had the required F2F visit with the certifying physician
     • Does not shift financial liability to the patient (Don't use ABN)
2. Physician Order - Reduce or terminate a home health items/service due to physician/provider order
Home Health Agency:

Patient Name:

Address:

Patient Identification:

Phone:

Home Health Change of Care Notice (HHCCN)

Your home health care is going to change. Starting on ____________, your home health agency will change the following items and/or services for the reasons listed below:

Item/Serviced: Reason for change:

Read the information next to the checked box below. Your home health agency is giving you this information because:

☐ Your doctor’s order for your home care has changed. The home health agency must follow physician orders to give you care. If you don’t agree with this change, discuss it with your home health agency or the doctor who orders your care.

☐ Your home health agency has decided to stop giving you the care listed above. If you have a valid order for home care and still think you need home care, you need to contact your doctor to order care. If the doctor orders care, the agency must give you care. If you get care from a different home health agency, you can ask it to bill Medicare.

If you have questions about these changes, you can contact your home health agency or your doctor who orders your home care.

Please sign and date below to show that you received and understand this notice. Return this signed notice to your home health agency in person or by mailing it to them at the address listed at the top of this notice.

Signature of the Receiver of the Notice of Change

Date

*If a representative signs for the home health agency, write “(proxy)” or “(representative)” next to the signature. If the representative’s signature is not legible, this representative’s information must be provided.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call 1-800-638-4298 or email: AdditionalLanguages@cms.hhs.gov.

Form CMS-10155 (Rev. 04-20-08)

CAG Approval No.: 2010-1144

5
Exceptions to HHCCN Notification

The HHCCN is NOT required when changes in care involve:

- Increase in care
- Changes in HHA caregiver or personnel
- Changes in visit time for HHA staff
- Change in brand of product (same item produced by a different manufacture)
- Change in length of visit
  - (shorter PT session as health status improves, such as reduction from 1 hour to 45 minutes)
- Reductions outlined in the POC (PT 3-5 times a wk)
- Change in mix of services delivered by a specific discipline with no decrease in frequency (blood draw d/c but wound care remains 3x/wk)
- Change in care that are the beneficiary decision
Patient Refuses to Sign

• “If the beneficiary refuses to sign the notice, the HHA must write that the beneficiary refused to sign on the notice itself and provide a copy of the annotated form to the beneficiary.”

• CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 30, Section 60.4G.4.
Note: 12/2/2022

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**Advance Beneficiary Notice (ABN)**

- Always used for potential financial liability, signed-prior to providing care
- Used when services are usually covered by Medicare but in this instance may not be covered.
- Must review with the patient and if there are any questions raised they must be answered before the form is signed.
- Form CMS-R-131 (Exp. 06/30/2023)

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Reasons HH is Not Covered

Description of Situation

- Care is not reasonable and necessary
- Custodial care is the only care delivered
- Beneficiary is not homebound
- Beneficiary does not need skilled nursing care on an intermittent basis

Explanation for Reason Medicare May Not Pay

- Medicare does not pay for care that is not medically reasonable and necessary
- Medicare does not usually pay for custodial care, except for some hospice services
- Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit
- Medicare requires part-time or intermittent need for skilled nursing care in order to cover services under the home health benefit

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Option 1: Indicates the Choice to Bill Medicare

☐ OPTION 1. I want the _______ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles

- Beneficiaries select Option 1 on the ABN when a Medicare claim denial is necessary to facilitate payment by a secondary insurer or if the patient wants “Demand Billing”.
- HHAs may also use the “Additional Information” on the ABN to include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information.
- “We will submit a claim for this care to your other insurance,”

- Agencies can pre-print language in the “Additional Information” section of the notice.

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Option 2

- ☐ OPTION 2. I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

- This option allows the beneficiary to receive the non-covered items and/or services and pay for them out of pocket.
- No claim will be filed, and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

- MA Medicaid office does NOT want a claim filed with Medicare prior to filing a claim with Medicaid, therefore the patient should choose Option 2.

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Option 2

- HHAs may direct dual eligible on choosing the correct option box according to State directives. HHAs are permitted to pre-type information in the “Additional Information” area for ABNs issued to dual eligible to help them understand that Medicaid will pay for the service.

- the HHA must add a statement in the “Additional Information” box such as:

“Medicaid will pay for these services. Sometimes, Medicaid asks us to file a claim with Medicare. We will file a claim with Medicare if requested by your Medicaid plan.”

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Option 1 or 2

- CMS has confirmed that option choices for dual eligible will vary depending on State Medicaid directive follow your State Medicaid office’s recommendations. If a Medicare denial is needed in order to get Medicare to pay as secondary, the patient should be instructed to choose Option 1.

- If the State Medicaid office does NOT want a claim filed with Medicare prior to filing a claim with Medicaid, the patient should choose Option 2.

- HHAs may direct dual eligible on choosing the correct option box according to State directives.

- Massachusetts is Option 2.

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Option 3

☐ OPTION 3. I don’t want the ______ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

- This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided and thus, there are no appeal rights associated with this option.

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Period of Effectiveness

- “A signed ABN for services is effective for up to a year as long as the care that is being delivered remains unchanged from what is listed on the notice.
  - If there is a change in the POC a new ABN is required
  - If care is ongoing, a new ABN must be provided on a yearly basis.”

Example:
- An ABN given November 30, 2019 would be effective through November 29, 2020-- assuming no other changes

, *Medicare Claims Processing Manual, Chapter 30, Section 60.4E.*

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More on ABN…

- Cannot back date the ABN
- Incomplete ABN-
  - improper or incomplete ABN notice- provider is liable
- The ABN does not have to necessarily be issued to the patient by a nurse or a therapist.
  - Could be another employees the HHA has appointed to issue the ABNs.

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More on ABN…

- The beneficiary or his or her representative must choose only one of the three options listed in Blank (G).
- Under no circumstances can the HHA staff decide for the beneficiary which of the 3 checkboxes to select.
- Pre-selection of an option by the HHA invalidates the notice.
- However, at the beneficiary’s request, HHA may enter the beneficiary’s selection if he or she is physically unable to do so.
  - In such cases, HHA must annotate the notice accordingly.

RESOURCE

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NOTICE OF MEDICARE NON-COVERAGE

EXPEDITED DETERMINATION NOTICE

Form has an approval date of 12/31/11
Notice of Medicare Non-coverage …NOMNC

• Written advance notice of intent to discharge patient from all HH services under Medicare and Medicare Advantage Plans
  • Notice given at least 2 calendar days before covered services end or the second to last visit if care is not being provided daily.
    • Note: The two day advance requirement is not a 48 hour requirement
  • Exception: When a home health beneficiary is found to no longer be homebound, the NOMNC should be provided to the beneficiary immediately.
When is a NOMNC Form Required?

- Complete cessation of Medicare coverage
  - Treatments are no longer medically necessary
  - Teaching has been completed
  - Medical condition has stabilized
  - Homebound requirement is no longer met
  - Physicians orders are terminated
  - Goals of care have been attained
  - **Hospice services** when a beneficiary is determined to no longer meet terminal criteria
When is a NOMNC form **Not** required?

- Beneficiary requests discontinuation of care
- Some, but not all of the Medicare services are terminated
- Unsafe patient situation (HHCCN)
- Hospitalization
- Nursing home placement
- Beneficiary relocation
- Beneficiary non-compliance (HHCCN)
- **Hospice** beneficiary chooses to revoke the hospice benefit
All Services Discharged - Do I need to complete a NOMNC and a HHCCN?

NO....if termination involves the end of all Medicare covered services and no further care is being delivered; the only notice would be

*Notice of Medicare Non-coverage*
Notice of Medicare Non-Coverage

Patient name: ___________________________  Patient number: ___________________________

The Effective Date Coverage of Your Current (Insert type) Services Will End: (Insert effective date)

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current (insert type) services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision:
- You have the right to an immediate, independent medical review (Appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer will also look at your medical records and/or other relevant information and, when necessary, may ask you to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, the independent reviewer assesses services to be covered after the effective date indicated above.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal:
- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of the notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: (Insert QIO name and toll-free number of QIO) to appeal, or if you have questions.

See page 2 of this notice for more information.
Notice of Medicare Non-Coverage

- Beneficiary (or representative) has until noon on day after notice of discharge to request expedited review by QIO.
- QIO has 72 hours from request to render a decision & notify beneficiary, provider and MD responsible for care.
- Beneficiary may request an expedited reconsideration by the Quality Improvement Contractor (QIC) if disagrees with QIO decision.
- Provider cannot bill beneficiary for services until after bene. receives decisions from QIO and/or QIC.
- If QIC does not make a decision within 72 hours, beneficiary may request case escalated to ALJ review.

RESOURCE
Medicare Provider Non-Coverage Notice DENC

- Detailed Explanation of Provider non-coverage by the close of the day after beneficiary or authorized representative requests an expedited determination from the Quality Improvement Organization (QIO) must include:
  - specific, detailed information why services are no longer considered reasonable & necessary or otherwise covered by Medicare;
  - description of applicable Medicare coverage rules;
  - any specific beneficiary applicable information relevant to the coverage determination.

RESOURCE
Medicare Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
KEPRO

• Call the KEPRO Helpline: for all appeals, complaints, case reviews, and concerns and select the appropriate menu option.
  ➢ Toll-free Telephone 888-319-8452
  ➢ Local Telephone 216-447-9604

• https://www.keproqio.com/