HHABNs (CMS-R-296) And Billing Processes For Denial

The Home Health Advance Beneficiary Notice (HHABN) is required when . . .		
Initiation of Care Start of home health care/service added to existing home health plan of care (POC)	**Reduction of Care** Any decrease in an aspect of care provided by HHA and/or care that is part of the POC	**Termination of Care** Cessation of all services provided by HHA – can include covered and non-covered care
Services not ordered by physician	Services reduced for HHA financial or other HHA reasons	Lack of face-to-face encounter
Care provided and beneficiary not homebound	Some previously covered services reduced because beneficiary no longer meets coverage criteria	When all Medicare covered services are terminated, the Expedited Determination Notices (Notice of Medicare Non-Coverage and Detailed Explanation of Non-Coverage) should be completed. Additional information regarding the Expedited Review form is available at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html
Care provided and no beneficiary need for intermittent skilled nursing care, PT, SLP or continuing OT	Reduction of services (includes duration of visits) not planned/anticipated in POC; not communicated in advance with beneficiary. This includes reductions within ordered ranges	
Care provided and services not reasonable and necessary	Reduction of services (not the beneficiary's choice)	
Care provided and services custodial in nature (housekeeping)		
A non-covered item or service delivered one time		
Beneficiary charged for assessment, but no admission to home care		
Lack of face-to-face encounter		

Please review Medicare Learning Network (MLN) Matters® article, MM7323 for updated instructions on the HHABN: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7323.pdf

The HHABN is not required when . . .			
Initiation of Care	**Reduction of Care**	**Termination of Care**	**Other Reasons**
Beneficiary meets all home health coverage criteria	Reduction in number, duration of services, or length of visits that are anticipated in the POC, which were communicated in advance to the beneficiary	Beneficiary chooses to terminate all services (must document in medical record)	Increases in care/services
			Emergency or other unplanned situations (natural disasters, etc.)
HHA not providing care	Visits decreased within ranges as expected and was clearly communicated to beneficiary	Transfers to other covered care (another HHA or other Medicare provider)	Changes in personnel/caregiver
	Beneficiary chooses to reduce services (must document in medical record)	Care ends due to patient goals met/physician's orders completed (Expedited Review)	Changes in arrival/departure times
			Changes in brand (supplies, etc.)
	Non-covered services reduced and HHABN had been given upon initiation of these services	Non-covered services terminated and HHABN had been given upon initiation of non-covered care	

Source of Information: Medicare Claims Processing Manual (Pub. 100-04, Ch. 30, § 60)
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf

© 2012 Copyright, CGS Administrators, LLC.
Disclaimer: This resource is not a legal document. Reproduction of this material for profit is prohibited.

Appropriate Procedures For Submitting Demand Denials Or No-Pay Bills To Medicare

How is a demand bill submitted?

- Bill RAP as usual. RAPs are required to be submitted for every episode for which a demand bill will be submitted. (CMS Pub. 100-04, Ch. 10, §50.C)
  - **Note:** RAP **should not** contain condition code 20
- Bill all claim data elements as usual, except:
  - Include condition code 20
  - Include both covered and non-covered charges
    - Non-Medicare payable services entered as non-covered
  - Include "Remarks" detailing why services are non-covered
  - **Note:** Home health agencies use the OASIS Claim-Matching-Key output, along with the HIPPS code generated through the Grouper software from the OASIS assessment for the 60-day episode when submitting a demand bill to Medicare.

See the *Medicare Claims Processing Manual* (Pub. 100-04, Ch. 10, § 50) for the full instructions for submitting home health demand bills to Medicare: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf Additional information is also available in Medicare Learning Network (MLN) Matters® article, MM7660: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7660.pdf and MLN Matters® article, MM7865: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7865.pdf

How is a no-pay bill submitted?

- No RAP required
- Bill all claim data elements as usual, except:
  - Type of bill is 320
  - Dates of service entered as required by other payer
  - Include condition code 21
  - Patient status code is 01
  - If no OASIS completed, use HIPPS code 1AFKS
  - Include **only** non-covered charges
  - Include "Remarks" detailing why services are non-covered
  - If no OASIS completed, use 11AA11AA11AAAAAAAA as the Treatment Authorization Code

How do I bill when there are simultaneously covered and non-covered services on a no-pay bill?

In the event that a no-pay bill is appropriate, you will need to submit two claims to Medicare.
Please note: it is never appropriate to submit services payable by Medicare on a no-pay bill.
The no-pay bill will contain the non-covered services and you will bill a RAP/claim or NO-RAP LUPA for any covered services payable by Medicare. The "FROM" and "TO" dates on the no-pay bill must either match or fall within those billed on the claim for covered services.

See the *Medicare Claims Processing Manual* (Pub. 100-04, Ch. 10, § 60) for the full instructions for submitting home health no-pay bills to Medicare. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf

© 2012 Copyright, CGS Administrators, LLC.
Disclaimer: This resource is not a legal document. Reproduction of this material for profit is prohibited.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES