Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-02-018 **Date: FEBRUARY 26, 2002**

This Program Memorandum re-issues Program Memorandum A-01-05, Change Request 1467 dated January 16, 2001. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 1467

THIS PROGRAM MEMORANDUM REPLACES PROGRAM MEMORANDA A-99-52 & A-99-54 PREVIOUSLY SENT ON 12/8/99 & 12/15/99, RESPECTIVELY. THIS INSTRUCTION APPLIES TO REGIONAL HOME HEALTH INTERMEDIARIES (RHHIs) ONLY.

SUBJECT: Advance Beneficiary Notices Must Be Given To Beneficiaries and Demand Bills Must Be Submitted By Home Health Agencies (HHAs)--ACTION

This Program Memorandum (PM) provides instructions, consistent with home health prospective payment processes, regarding: (1) the notices that HHAs must provide to home health beneficiaries in advance of furnishing what HHAs believe to be noncovered care or of reducing or terminating ongoing care; and (2) the process required for submitting demand bills. These instructions apply to beneficiaries covered under Part A & B, but are not applicable to Part C managed care enrollees. Part I of this PM instructs HHAs with respect to their responsibility for giving proper Home Health Advance Beneficiary Notices (HHABNs) and for submitting demand bills to the Regional Home Health Intermediaries (RHHIs) when requested to do so by a beneficiary or by a person acting on the beneficiary's behalf. Additionally, Part I includes an attachment, Exhibit 1, HHABN, for use with the Home Health Prospective Payment System – Form HCFA-R-296, which must be used by HHAs to provide notice as of March 1, 2001. (For the precise approved format of the HCFA-R-296, see the PDF file of this form posted on HCFA's website at http://www.hcfa.gov/regs/prdact95.htm or http://www.hcfa.gov/medlearn/refhha.htm and also available via an e-mail request sent to Paperwork@hcfa.gov.) HHA providers must be in compliance with these requirements no later than March 1, 2001. Part II of this PM provides specific instructions to you regarding your functions as a RHHI with respect to HHABNs and demand bills claims processing, and requires you to process demand bills taking into account the requirements enunciated in Part I.

On September 26, 2000, HCFA published a ***Federal Register*** notice seeking emergency OMB clearance, pursuant to the Paperwork Reduction Act, of a proposed uniform mandatory HHABN. HCFA revised the proposed HHABN in response to comments from the public. On December 2, 2000, OMB issued an emergency clearance of the proposed uniform HHABN as revised. The use of that revised HHABN is mandatory effective March 1, 2001. (See the Supporting Statement for HCFA-R-0296.) HCFA strongly advises that HHAs use the new notice now that it is approved, rather than waiting until its use becomes mandatory.

As of March 1, 2001, the effective date of the HHABN and these instructions, these instructions will supersede the current instructions in Medicare Intermediary Manual, Part 3 (MIM) §3730.2 and in HHA Manual §270 as well as the obsolete instructions in PMs A-99-52 & A-99-54. Until each HHA transitions to the use of the new HHA PPS HHABN, it is required to comply with the instructions in PMs A-99-52 and A-99-54.

Within 2 weeks after receipt of these instructions, you should post this information on your web site and provide information to your customer service representatives who deal with providers and relevant provider associations. Also, take immediate steps to include a notice or article in your next bulletin regarding these instructions.

Part I - Home Health Agency Instructions for the Provision of Home Health Advance Beneficiary Notices and for Mandatory Claims Submission (Demand Bills)

You are responsible for providing proper HHABNs and for submitting demand bills to the RHHIs when requested to do so by a beneficiary or by a person acting on the beneficiary's behalf. Section I-1 of these instructions addresses your responsibility for providing notices to home health beneficiaries prior to furnishing care, or to reducing or terminating ongoing care, that you expect Medicare will not pay for. Section 1 also discusses the notice form, HCFA-R-296, set forth in Exhibit 1, use of which is mandatory effective March 1, 2001. Section II-2 of these instructions addresses your responsibility to submit demand bills. Section II-3 of these instructions addresses the consequences of noncompliance with these instructions. Section II-4 of these instructions addresses your responsibility for providing notices to home health beneficiaries prior to reducing or terminating ongoing care in accordance with a physician's order. These instructions apply to beneficiaries covered under Part A & B, but are not applicable to Part C managed care enrollees.

In instances where care has not yet been initiated and you believe services ordered by the physician do not meet Medicare coverage criteria, you must also provide a proper HHABN. HCFA has obtained OMB approval of a revised uniform notice (HHA PPS HHABN, Form HCFA-R-296). The demand bill process remains in effect, and must be used now to ensure continuation of beneficiary rights to obtain an official Medicare initial determination.

Section I-1. Basic Requirements for HHABNs.--A HHABN is a written notice you give to a Medicare beneficiary before home health care is furnished when you believe that Medicare will not pay* for some or all of the home health care a physician ordered for the beneficiary. You must give a Medicare beneficiary a HHABN before reducing or terminating home health care the beneficiary already is receiving if the physician's order for such care would still continue the care, but you expect payment for the home health services to be denied by Medicare. If you expect payment for the home health services to be denied by Medicare, advise the beneficiary, orally and in writing, before home health care is initiated or continued that, in your opinion, the beneficiary will be fully and personally responsible for payment. To be "fully and personally responsible for payment" means that the beneficiary will be liable to make payment "out-of-pocket," through other insurance coverage (e.g., employer group health plan coverage), or through Medicaid. You must provide HHABNs according to the instructions in Section I-1 where a reduction or termination of services is to occur, or where services are to be denied before being initiated, if there is a physician's order for such care but you believe payment will be denied by Medicare. (For situations in which a physician concurs in the reduction, termination, or denial of services, see Section I-4.) You must issue a HHABN each time, and as soon as, you make the assessment that you believe Medicare payment will not be made. If you fail to provide a proper HHABN in situations where a physician has ordered the care, you may be held liable under the provisions on LOL (see Section I-3), where such provisions apply. You may also be sanctioned for violating the conditions of participation regarding beneficiary rights.

***NOTE:** We use the terminology "Medicare will not pay" here and in the HHABN because it is a concept understandable to beneficiaries. Understand, however, that a Medicare official determination in favor of the beneficiary will not necessarily result in additional Medicare payments being made to you under HHA PPS.

A. Form of HHABNs.--You must use the approved Form HCFA-R-296 (see Exhibit 1). You may create HHABNs electronically so long as they meet all of the format requirements of the approved standard Form HCFA-R-296 (e.g., 12 point minimum font size, no italics). Print used to fill in blank spaces on the forms also must meet these standards. The HHABN must be no more than 1 page, front and back, and the page break must occur exactly as indicated in Exhibit 1.

B. Delivery of HHABN.--Delivery of a HHABN occurs when the beneficiary (or authorized representative, viz., the person acting on the beneficiary's behalf) has received the notice and can comprehend its contents. All notices must be written in lay language with a detailed explanation as to why services either are no longer medically necessary, or why you believe the services will

otherwise be noncovered. Notices must be in a readable format and meet HCFA=s standards for cultural competency. An incomprehensible notice, or a notice which the individual beneficiary or his or her authorized representative is incapable of understanding due to the particular circumstances (even if others may understand), is not sufficient notice (see Section I-1, B, iii for applicable situations). Notices must convey that the beneficiary has the right to seek an official Medicare determination regarding the proposed discontinuation of Medicare covered services, and must specify the date that services will be discontinued.

i. Giving notice timely means that your assessment regarding Medicare coverage that requires beneficiary notification should be communicated to the beneficiary immediately. In practice, you are expected to notify beneficiaries no later than the end of the business day following the day on which you made an assessment. You must be able to justify any longer delay in notification.

ii. You should hand-deliver the HHABN to the beneficiary or authorized representative. Delivery is your responsibility and non-receipt of notice probably will protect the beneficiary from liability and may result in your being held liable under the LOL provisions. For this reason, it is in your own best interest (as well as being in the beneficiary's best interest) for you to hand-deliver HHABNs to beneficiaries. In case of compelling circumstances (e.g., in a blizzard) a telephone notice to a beneficiary, or authorized representative, may be given but will not constitute sufficient evidence of proper notice for purposes of limiting any potential liability because the content of the telephone contact usually cannot be verified. A telephone notice must be followed up immediately with a mailed notice or a personal visit at which written notice is delivered in person.

iii. A requirement for delivery of a notice is that the beneficiary, or authorized representative, must be able to comprehend the notice (viz., they must be capable of receiving notice). A comatose person, a confused person (for example, someone who is experiencing confusion due to senility, dementia, Alzheimer's disease), a legally incompetent person, a person under great duress (for example, in a medical emergency) is not able to understand and act on his or her rights, therefore necessitating the presence of an authorized representative for purposes of notice. A person who does not read the language in which the notice is written, a person who is not able to read at all or who is functionally illiterate to read any notice, a blind person or otherwise visually impaired person who cannot see the words on the printed page, or a deaf person who cannot hear an oral notice being given by phone, or could not ask questions about the printed word without aid of a translator, is a person for whom receipt of the usual written notice in English may not constitute having received notice at all (*this is not an exclusive list*). This may be remedied when an authorized representative has no such barrier to receiving notice. However, in the absence of an authorized representative, other steps must be taken to overcome the difficulty of notification. These may include providing notice in the language of the beneficiary (or authorized representative), in Braille, in extra large print, or by getting an interpreter to translate the notice, in accordance with the needs of the beneficiary or authorized representative to act in an informed manner. If the beneficiary is not capable of receiving the notice, then the beneficiary has not received proper notice and cannot be held liable where the LOL provisions apply and you may be held liable. Failure to provide a comprehensible notice is also a violation of the conditions of participation and may result in enforcement action.

iv. You also must timely answer inquiries from a beneficiary, or authorized representative, who requests further information and/or assistance in understanding and responding to the notice. You must answer inquiries from a beneficiary, or authorized representative, regarding the basis for your assessment that services may not be covered and, if requested by the beneficiary, or authorized representative, you must provide the beneficiary, or authorized representative, access to medical record information or other documents upon which you base your assessment, to the extent permissible or required under applicable State law. Where State law prohibits such direct disclosure, you must advise a beneficiary, or authorized representative, who has requested access

to such information how to obtain that information from the RHHI once a demand bill has been submitted. You must respond timely, accurately, and completely to a beneficiary, or authorized representative, who requests information about the extent of the beneficiary's personal financial liability for home health care for which you expect that Medicare may not, or may no longer, pay.

If a beneficiary, or authorized representative, or a physician, provides additional evidence with respect to Medicare coverage of the subject home health services, you must timely submit that additional evidence to the RHHI.

C. Signature of Beneficiary.--

i. The generally applicable rules of the Medicare program with respect to who may sign for a beneficiary apply to signing notices, including HHABNs. Whenever you furnish services to a beneficiary who is incapable of signing a notice, his or her representative who signs for other matters in accordance with Medicare rules also may sign a notice.

ii. You must obtain the signed HHABN from the beneficiary, either in person, or where this is not possible, via return mail from the beneficiary or person acting on the beneficiary's behalf, as soon as possible after it is signed. The HHABN should be annotated with the date of your receipt from the beneficiary. Return a copy of the HHABN, including the date of your receipt, within 30 calendar days to the beneficiary for his or her records. You must also retain a copy of the HHABN. These copies will be relevant in the case of any future appeal.

iii. If the beneficiary or the person acting on the beneficiary's behalf refuses to sign the HHABN annotate your copy of the HHABN, indicating the circumstances and persons involved. If this occurs, you may decide not to furnish services to the beneficiary because the beneficiary has not agreed to be fully and personally responsible for payment for services that are not covered by Medicare.

D. Effect of HHABN on Beneficiary.--Under the statutory provision on LOL, a beneficiary who has received a proper HHABN and who has agreed to pay for the specified services will be fully and personally responsible for payment to you for those services in the case that Medicare denies payment for them on the grounds specified in the HHABN. To be "fully and personally responsible for payment" means that the beneficiary will be liable to make payment "out-of-pocket," through other insurance coverage (e.g., employer group health plan coverage), or through Medicaid. A beneficiary who does not receive a HHABN, or who receives a defective HHABN (i.e., one which does not meet the requirements of these instructions), generally may not be held liable when the LOL provisions apply. Subject to the requirements specified in B. iii, you may use a proper HHABN to meet the requirements of the HHA Manual §266, Establishing When Beneficiary is on Notice of Noncoverage.

E. Instructions for Completion of HHABN Form HCFA-R-296.--HHABNs, Exhibit 1, serve as notice to the beneficiary that you believe that home health services, which have been ordered by a physician, are not covered in different situations. A HHABN with the first block checked ("We expect Medicare will not pay for any home health services for you") is used when you expect that Medicare will not pay, even before services have been initiated. A HHABN with the second block checked ("We expect Medicare will stop paying for some of your home health services") is used when ongoing home health services will be reduced (e.g., reduced in number, frequency, or for a particular subset of services, or otherwise) because you expect that Medicare will not pay. A HHABN with the third block checked ("We expect Medicare will stop paying for all home health services for you") is used when all home health services will be terminated because you expect that Medicare will not pay. The HHABN should not be used in situations where a physician has not ordered care, or has changed or ended the care plan. For any particular HHABN, you should make an original and two copies. (If your RHHI requires a copy, make one more.) Give the original to the beneficiary (or the person acting on the beneficiary's behalf), send the first copy to the beneficiary's physician, and keep the second. When you give the beneficiary (or person acting on the beneficiary's behalf) a copy, instruct him or her to return it to you with his or her signature and the date he or she signed the notice. If the beneficiary or the person acting on the beneficiary's behalf refused to sign the HHABN, annotate your copy accordingly, indicating the circumstances and persons involved.

i. Page 1 - Heading of HHABN--

a. "Home Health Agency Letterhead"--Put your (HHA's) name, address and phone number at the top of the front page of the notice; include your logo (if any).

b. "Date of Notice"--Enter the date you delivered the HHABN, i.e., gave it personally to the beneficiary or to the person acting on the beneficiary's behalf. Where personal delivery is not possible, enter both the date you notified the beneficiary by telephone and the date you mailed the notice.

c. "Beneficiary name" Line--Enter the name of the beneficiary; do not substitute the name of an authorized representative.

d. "Medicare # (HICN)" Line--Enter the beneficiary's health insurance claim number.

e. "Attending physician" Line--Enter the attending physician's name.

f. "Physician's telephone number" Line--Enter the attending physician's telephone number.

ii. Page 1 - Body of HHABN--

a. Check the appropriate box for the reason why you expect that Medicare will not pay. Check the first box in the case of initiation of services; check the second box in the case of reduction of services; check the third box in the case of termination of services.

b. In the paragraph entitled "Why Won't Medicare Pay for Your Services", in the first blank ("We, _____, have looked …"), enter your agency's name. In the second blank ("We expect Medicare will not pay for _____"), specify the particular home health care services about which notice is being given and the effective date, i.e., the date on which services are scheduled to end or be reduced. The services at issue must be described in sufficient detail so that the beneficiary can understand precisely what services may not be furnished (e.g., "physical therapy services 4 times weekly"). In the third blank ("because _____"), give the specific reason why you expect Medicare to deny payment. The reason(s) cited must be sufficiently specific to allow the beneficiary to understand the basis for your expectation that Medicare will deny payment, and, if necessary, to gather evidence to the contrary from a physician and/or others in support of the coverage of such services (e.g., "our clinical assessment of your condition indicates that you can benefit from physical therapy services twice weekly, but that additional physical therapy services each week would not be effective").

c. In the paragraph entitled "What Does this Mean for You?", in the blank "We estimate that all of those services will cost about: $_____", enter the estimated cost of the services.

d. "If you do not hear from Medicare …" Lines--Enter the name and telephone number of the servicing RHHI on the first line. Enter the RHHI's TTY/TDD telephone number for the hearing and speech impaired on the second line.

e. "If you have questions, please call us at:____" Lines--Enter your agency's telephone number on the first line. Enter your agency's TTY/TDD telephone number on the second line.

iii. Page 2 - HHABN Signature Page--

a. "What Do You Do Right Now?" section "1. Choose an option…"--A, B, & C check boxes - The beneficiary must select an option by checking one of the three boxes. Before delivering the notice to the beneficiary, you fill in any appropriate additional insurance coverage(s)

that the beneficiary has in the line within the sentence "Please bill my other insurance: (____) if necessary."

b. Section "2. Sign and date …"--In the "On: ___" blank, the beneficiary enters the date that he or she, or the person acting on his or her behalf, received the HHABN. In the "Date of signature" blank, the beneficiary, or person acting on his or her behalf, enters the date on which he or she signed the HHABN. In the "Signature of beneficiary . . .", blank, the beneficiary, or person acting on his or her behalf, must sign his or her name.

c. Section "3. Return the form …"--Put your (HHA's) name and mailing address in the space provided.

iv. Obtaining the Signed HHABN.--Obtain the entire (both pages) signed HHABN, containing the signature of the beneficiary or person acting on the beneficiary's behalf, and with option A, B, or C checked as to the action the beneficiary wants to take, from the beneficiary, either in person, or where this is not possible, via return mail from the beneficiary or person acting on his or her behalf, as soon as possible after it is signed. Annotate the HHABN with the date of your receipt from the beneficiary. Return a copy of the HHABN, including the date of your receipt, within 30 calendar days to the beneficiary for his or her records. Retain your own copy of the HHABN. These copies will be relevant in the case of any future appeal. If a beneficiary who chose option C later requests that a claim be submitted to Medicare, consistent with option A, annotate your copy of the HHABN with the date of your receipt of the new request, and return a copy of the annotated HHABN within 30 calendar days to the beneficiary for his or her records. If the beneficiary or the person acting on his or her behalf refuses to sign the HHABN and/or refuses to choose option A, B, or C, annotate your copy of the HHABN, indicating the circumstances and persons involved. If this occurs, you may decide not to furnish services to the beneficiary because the beneficiary has not agreed to be fully and personally responsible for payment for services that are not covered by Medicare.

v. Provision of Home Health Advance Beneficiary Notices (HHABNs).--Provide a HHABN to beneficiaries, according to the following instructions, whenever Medicare payment denial is expected on any one of the following statutory bases: not medically necessary and reasonable (under §1862(a)(1) of the Act); custodial care exclusion (under §1862(a)(9) of the Act); and failure to meet the HHA services homebound and intermittent care requirements (under §1879(g)(1) of the Act). Do not pre-select any option on the form.

a. Providing HHABNs at Initiation of Services.--In the situation in which you advise a beneficiary that you will not accept the beneficiary as a Medicare patient because you expect that Medicare will not pay for the services, for one of the reasons listed above, provide a HHABN to the beneficiary before you furnish home health services to the beneficiary. Check the first block ("We expect Medicare will not pay for any home health services for you") on the first page.

b. Providing HHABNs at Reduction of Services.--In the situation in which you propose to reduce a beneficiary's home health services because you expect that Medicare will not pay for a subset of home health services, or for any services at the current level and/or frequency of care, for one of the reasons listed above, provide a HHABN to the beneficiary before you reduce services to the beneficiary. Check the second block ("We expect Medicare will stop paying for some of your home health services") on the first page.

c. Providing HHABNs at Termination of Services.--In the situation in which you propose to stop furnishing all home health services to a beneficiary, because you expect that Medicare will not continue to pay for the services, for one of the reasons listed above, provide a HHABN to the beneficiary before you terminate such home health services. Check the third block ("We expect Medicare will stop paying for all home health services for you") on the first page.

F. Effectuating Beneficiary Choice.--Effectuate timely the beneficiary's choice of option A, B, or C. Do not pre-select any option on the form.

i. Option A.--If the beneficiary chooses option A, promptly submit a claim to Medicare, following the demand bill instructions in Section I-2 of these instructions. The phrase "promptly submit a claim" means that you should submit a demand bill in accordance with your normal billing cycle and not delay longer (see Section I-2.A. for more complete instructions). When a beneficiary chooses option A, the beneficiary's demand for submission of a claim and for an initial determination has been made; do not require of the beneficiary any further demand.

ii. Option B.--If the beneficiary chooses option B, the beneficiary chooses not to receive the home health care services which were the subject of the notice. Accordingly, in each such case, you should not initiate any new services and/or you should terminate, or reduce, services in accordance with the specifications in the notice which was given to the beneficiary. Any termination or reduction of services should take place on the effective date that was specified in the notice given to the beneficiary and should be limited to those services specified in that notice. If the beneficiary chooses option B after the effective date of a notice and you have continued services after that effective date, you may immediately effectuate termination or reduction of services.

iii. Option C.--Although you may be bound by mandatory claims submission requirements, you can be prevented from submitting a claim if the beneficiary refuses to allow you to send medical information to Medicare for purposes of payment. This is an unusual circumstance, which arises from time to time when a beneficiary, for reasons of his or her own, would rather pay privately for services than share information about the services with the Federal Government (Medicare) in order to obtain the benefits for which he or she may be eligible. When the beneficiary checks option C, do not submit a claim and the beneficiary will be fully and personally responsible to you for payment. In such cases, Medicare will not take any punitive action against you for your having been prevented from complying with mandatory claims submission requirements (unless it is found that you coerced the beneficiary into selecting option C). Do not suggest to any beneficiary that he or she select option C; however, answering a beneficiary's questions about option C is, of course, permissible.

a. Advise the beneficiary of the extent of his or her personal financial liability for that care and for any additional home health care he or she wishes to receive. When a beneficiary chooses option C, refusing to allow you to send medical information to Medicare for purposes of payment, you may bill the beneficiary for charges for those services specified in the HHABN.

b. When a beneficiary has chosen option C, he or she may later change his or her mind and request you to submit a claim to Medicare, consistent with option A, above. So long as such a request is made within the applicable claims filing time limit, as provided in HHA Manual §235, you must promptly effectuate the beneficiary's choice in accordance with the above instructions for option A.

Section I-2. Basic Requirements for Mandatory Claims Submission (Demand Bills).--

A. Claim Submission.--When a beneficiary agrees to be fully and personally responsible for payment for the services if Medicare does not pay and has requested that a claim be submitted to Medicare, the beneficiary's "demand" for submission of a claim and for an initial determination has been made; no further demand is required of the beneficiary. Any time a beneficiary receives home health care services for which you expect Medicare will deny payment, and agrees to be fully and personally responsible for payment if Medicare does not pay, and requests that a claim be submitted to Medicare, you must promptly* submit a claim to the RHHI and report, on the claim submitted, condition code 20 (demand-beneficiary requested billing) to indicate the beneficiary believes the services are covered. You must give the beneficiary, or person acting on the beneficiary's behalf, a copy of the claim or a written statement that you have submitted it and the date on which it was submitted. You must timely furnish any additional evidence the RHHI requires and you must give the beneficiary a reasonable amount of time to provide additional documentation for the adjudication of the claim, which you must forward, with the RHHI-requested information and proper identifying information, to the RHHI. However, all documentation must be received by the RHHI within 30 days of the date of the additional documentation request (ADR).

***NOTE:** The requirement in Section I-2.A. to "promptly" submit a demand bill is that you must submit a demand bill in accordance with your normal billing cycle and not delay longer. The meaning of "prompt" submission under HHA PPS, specifically, is as follows: Under HHA PPS, you may submit only one claim for payment at the end of each episode of care. See 65 FR 41,128 (July 3, 2000) (Medicare Program; Prospective Payment System for Home Health Agencies, Final Rule). Thus, under HHA PPS, "prompt submission" of a claim with the demand bill code requires that the claim (i.e., the demand bill) be submitted at the end of the episode in question, at the time that you submit your claim for final payment for the episode. See 65 FR at 41,141. Pursuant to the HHA PPS Final Rule, where you have received a "request for anticipated payment" (RAP) for an episode, the RAP will be canceled and recovered unless the claim for the episode (with the condition code 20 to indicate that the claim is a demand bill when requested by the beneficiary in the circumstances described in this PM) is submitted within the greater of 60 days from the end of the episode or 60 days from the issuance of the anticipated payment.

B. Beneficiary Billing & Refunds.--You may bill the beneficiary or other third-party payers for charges for services you believe are not covered by Medicare and for which you have submitted a demand bill, pending Medicare's decision, if that is permissible under applicable State and/or Federal law. Should the RHHI decide that the services are covered, you will be required to refund any amounts which were collected from the beneficiary or from third-party payers (public or private) that paid on the beneficiary's behalf, even though Medicare may not necessarily make any additional payments to you.

C. Medical Review of Demand Bills.--All demand bills (100%) you submit involving medical issues shall be subject to complex medical review by RHHIs. Your RHHI will inform you of the requirements relevant to complex medical review.

D. Payment Action on Demand Bill.--When your RHHI receives a demand bill, that claim will receive an initial determination with respect to coverage and, if the services are in fact denied payment, a determination under LOL when such provision applies. In such a denial case, the RHHI will advise you and the beneficiary of its decision.

Section I-3. Consequences of Noncompliance.--If you fail to comply with these instructions, you may risk financial liability and/or sanctions. LOL shall apply as required by law, regulations, rulings and program instructions thereunder. Sanctions under the conditions of participation (COPs) may be imposed for violations.

A. Limitation on Liability.--Failure to provide notice, or provision of a defective notice, to a beneficiary in a particular case, to which the LOL provision (§1879 of the Act) applies, * may cause you to be held liable under the LOL provision, unless you can demonstrate that you did not know, and could not reasonably have been expected to know, or there is clear and obvious evidence that the beneficiary knew, that Medicare would not make payment. If you advise a beneficiary that, in your view, Medicare probably will not pay, but you do so in a defective manner such that the beneficiary cannot fully exercise his or her rights and protections (e.g., when you did not execute and deliver a notice properly), that constitutes prima facie evidence that you knew that Medicare would not make payment and will not be sufficient to shift liability to the beneficiary. When you are held liable under the LOL provision, you cannot collect from either the Medicare program or the beneficiary.

***NOTE:** The LOL provision applies whenever Medicare payment is denied on any one of the following statutory bases: not medically necessary and reasonable (under §1862(a)(1) of the Act); custodial care exclusion (under §1862(a)(9) of the Act); and failure to meet the HHA services homebound and intermittent care requirements (under §1879(g)(1) of the Act). Other applicable statutory bases for denial (e.g., for hospice care) are not relevant to these instructions.

B. Failure to Promptly Submit Demand Bills.--When a beneficiary requests that a claim be submitted to Medicare, you must promptly* submit such a demand bill to Medicare. If you fail to do so, you will be prohibited from charging the beneficiary or other third-party payers that might otherwise make payment on behalf of the beneficiary. You must submit a demand bill in response to a beneficiary's request because this is a prerequisite for an initial determination by Medicare on that claim, from which the beneficiary's appeal rights under §1869 of the Act arise.

***NOTE:** The requirement in Section I-3.B. to "promptly" submit a demand bill is that you must submit a demand bill in accordance with your normal billing cycle and not delay longer (see Section I-2.A. for more complete instructions).

C. Sanctions Under the Conditions of Participation.--Sanctions under the COP may be imposed for violations.

Section I-4. Requirements for Notice When Home Health Care Is Not Ordered By a Physician.--Medicare never pays for home health care that is not ordered by a physician. The instructions in this Section I-4 apply to situations where care is reduced or terminated in accordance with a physician's order; that is, where the services at issue are not ordered by a physician or where the physician agrees with your assessment that the services are not or are no longer reasonable and necessary. Where the physician concurs with a reduction or termination of care, you must record such concurrence, along with any verbal or written orders by the physician, in the patient's medical and clinical records. The provisions on LOL (addressed in Section I-3 of these instructions) do not apply in these situations, but certain beneficiary protections under the COP do apply.

A. Regulatory Requirements.--

i. Under 42 CFR §484.10(c) COP: Patient rights; Standard: Right to be informed and to participate in planning care and treatment: the patient has the right to be informed, in advance, about the care to be furnished, and of any changes in the care to be furnished.

ii. Under 42 CFR §484.10(e) COP: Patient rights; Standard: Patient liability for payment: (1) the patient has the right to be advised, orally and in writing, before care is initiated, of the extent to which payment may be expected from Medicare or other sources, and of the extent to which payment may be required from the patient; and (2) the patient has the right to be advised, orally and in writing, of any changes in the information provided pursuant to subsection (1).

B. Standards.--These instructions make no changes in these requirements. In order to fulfill the requirements or 42 CFR §484.10(c), the beneficiary must be informed in a meaningful way, in advance, about the care to be furnished, and of any changes in the care to be furnished, even where the physician concurs in the proposed change(s). In order to fulfill the requirements of 42 CFR §484.10(e), you must give a notice to the beneficiary before care is initiated; and the notice must be in writing and also be orally explained to the beneficiary, and must specify the care to be furnished or any changes in the care to be furnished, as may be applicable, and the extent of the beneficiary's financial liability if he or she receives the proposed home health care. If you do not notify beneficiaries, or are not timely with such notices, or give defective notices, you may be found to be in violation of the COPs.

If you have questions about these instructions, you may contact Raymond Boyd at RBoyd@hcfa.gov, telephone number (410) 786-4544.

Attachment: Exhibit 1 - HHABN for use with the Home Health Prospective Payment System – Form HCFA-R-296. For the precise format, see the PDF file of this form posted on HCFA's website at http://www.hcfa.gov/regs/prdact95.htm or http://www.hcfa.gov/medlearn/refhha.htm and also available via an e-mail request sent to Paperwork@hcfa.gov.

HHA Letterhead

Exhibit 1

Date of Notice:

Beneficiary name: _____ Medicare # (HICN):_____

Attending physician: _____ Physician's telephone number: _____

HOME HEALTH ADVANCE BENEFICIARY NOTICE (HHABN)

- ☐ We expect Medicare will not pay for **any** home health services for you.
- ☐ We expect Medicare will stop paying for **some** of your home health services.
- ☐ We expect Medicare will stop paying for **all** home health services for you.

Why Won't Medicare Pay For Your Services?

Medicare only pays for your home health services if you qualify under Medicare program rules. You must be homebound, under the care of a physician, and require intermittent skilled nursing care or therapy, or continue to need occupational therapy. All home health services must be medically necessary for the care of your condition and be ordered by a physician. We, _____, have looked at your medical records and condition. We expect Medicare **will not pay for:** _____ _____ _____ because:_____ _____.

This is our opinion based on our understanding of Medicare's home health coverage rules. Talk to your doctor, family, and us about your need for those specified services.

What Does This Mean for You?

You still can get the specified home health services if you think that you need them. We expect that you will have to pay for those services yourself or through any other insurance that you may have. We estimate that all of those services will cost about $_____.
Only Medicare can make the official decision about Medicare payment.
You can ask Medicare for an official decision if you:

- Request that we provide the specified services pending Medicare's decision.
- Instruct us to submit a claim to Medicare so that Medicare can decide if it will pay for those services. You may give us additional evidence to submit with the claim supporting your need for those services, like a letter from your doctor.
- Choose **Option A** on the next page.

If your home health services are paid for by Medicare and/or by your other insurance, you will be refunded any amounts that you are due.

If you do not hear from Medicare within 90 days you can call Medicare at : (__)_____.
Medicare TTY/TDD for the hearing and speech impaired: (___)_____.

If you have questions, please call us at: (___)_____. **TTY/TDD:** (___)_____.

OMB Approval No. 0938-0781. Form No. HCFA-R-296

What Can You Do If Medicare Decides Not to Pay for Your Services?

You have the right to appeal Medicare's decision not to pay for your home health services. Medicare will send you notice of its official decision not to pay that explains its decision in your case. That notice will explain how you can appeal Medicare's decision not to pay.

What Do You Do Right Now?

1. Choose an option (check only **one** box below).

☐ **A. I want to receive the specified home health services and obtain a Medicare official decision.** Please submit a claim, with any supporting evidence that I include, to Medicare for its official decision. Please bill my other health insurance (_____ _____) if necessary. I understand that, if I have no insurance other than Medicare, I might have to pay for these services while Medicare is making its decision. If Medicare or another insurer does decide to pay and I have made any payments, I will be refunded any amounts that I am due. I agree to be fully and personally responsible for payment of any amount for which Medicare and my other insurance will not pay.

☐ **B. I do not want to receive the specified home health services.**

☐ **C. I want to receive the specified home health services.** I do not want you to submit a claim or any health information to Medicare for an official decision. I know that I will be fully responsible for payment.

---

2. Sign and date the form, to authorize the option you chose.

On (date)_____, I received this notice explaining to me that Medicare may not pay for some or all of my home health services.

_____ _____

Date of signature Signature of beneficiary or person acting on beneficiary's behalf

3. Return the form to us at our address below.

HHA Address Block

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept with your personal medical records at our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

This is a Medicare Approved Notice.

OMB Approval No. 0938-0781. Form No. HCFA-R-296

Part II - RHHI Instructions with Respect to Home Health Advance Beneficiary Notices and Mandatory Claims Submission

Section II-1 Basic Requirements for Home Health Advance Beneficiary Notices (HHABNs). A HHABN is a written notice given by a provider to a Medicare beneficiary before home health care is furnished when the provider believes that Medicare will not pay for some or all of the home health care a physician ordered for the beneficiary. A provider must give a Medicare beneficiary a HHABN before reducing or terminating home health care the beneficiary already is receiving if the physician's order for such care would still continue the care, but the provider expects payment for the home health services to be denied by Medicare. If the provider expects that Medicare will not pay for the care, the provider must advise the beneficiary, orally and in writing, before home health care is initiated or continued that, in the provider's opinion, the beneficiary will be fully and personally responsible for payment. To be "fully and personally responsible for payment" means that the beneficiary will be liable to make payment "out-of-pocket," through other insurance coverage (e.g., employer group health plan coverage), or through Medicaid or other Federal or non-Federal payment sources. The provider must provide HHABNs in every case where a reduction or termination of services is to occur, or where services are to be denied before being initiated, if there is a physician's order for such care. (For situations in which a physician concurs in the reduction, termination, or denial of services, see Section II-4). The provider must issue notices each time, and as soon as, the provider makes the assessment that it believes that Medicare payment will not be made. Failure to provide a proper HHABN in situations where a physician has ordered the care may result in the HHA being held liable under the provisions on LOL, where such provisions apply. (See MIM, Part 3, §3440, Establishing When Beneficiary is on Notice of Noncoverage.) Providers may also be sanctioned for violating the conditions of participation regarding beneficiary rights.

A. Acceptance or Rejection of HHABNs.--Reject a defective HHABN, that is, a HHABN that was not properly executed (i.e., not properly delivered and effectuated). If you reject a HHABN, unless you have clear and obvious evidence that the beneficiary knew, or you determine that the beneficiary could reasonably have been expected to know that Medicare would not make payment (in which case the beneficiary must be held liable), hold the beneficiary not liable and hold the provider liable in cases where the LOL provisions apply. This PM does not require you to obtain and examine all HHABNs issued by providers. Providers are not required to routinely submit to you a copy of every HHABN they issue; however, you may require your providers to do so. These instructions will assist you in advising providers with respect to their responsibilities, in advising beneficiaries with respect to their rights and protections, and in dealing with complaints from beneficiaries about the lack of notice or defective notice.

i. Use of the approved HHABN Form HCFA-R-296 (see Exhibit 1) will be mandatory, effective March 1, 2001. A provider's self-produced HHABN (i.e., electronically generated HHABNs) which adheres to the format of the approved form is acceptable. No print used to fill in the blank spaces on a form may use a font size less than 12-point font. Italics or any typeface that is difficult to read may not be used. It must be clear and obvious to the beneficiary that the HHABN is issued by the provider rather than by the Medicare program. Reject a HHABN that does not meet these standards.

ii. Delivery of a HHABN occurs when the beneficiary (or authorized representative, viz., the person acting on the beneficiary's behalf) both has received the notice and can comprehend its contents. All notices must be written in lay language with a detailed explanation as to why services either are no longer medically necessary, or why the provider believes the services will otherwise be noncovered. Notices must be in the approved format and meet HCFA's standards for cultural competency. An incomprehensible notice, or a notice which the individual beneficiary or his or her authorized representative is incapable of understanding due to the particular circumstances (even if others may understand), is not sufficient notice, and does not provide protection for purposes of the LOL provisions, where such provisions apply. Notices also must convey that the beneficiary has the right to seek an official Medicare determination regarding the proposed discontinuation of Medicare covered services, and must specify the date that services will be

discontinued. A HHABN should be hand-delivered to the beneficiary or authorized representative. Delivery is the provider's responsibility. Reject a telephone notice as insufficient evidence of proper notice for purposes of limiting the provider's liability, because the content of the telephone contact usually cannot be verified, unless the provider shows that the beneficiary does not dispute the content of the telephone notice. The HHA must immediately follow up a telephone notice with a mailed notice or a personal visit at which written notice is delivered in person. Reject a notice that was not given timely. Expect HHAs to notify beneficiaries no later than the end of the business day following the day on which an assessment was made by the HHA. Ask the HHA to justify any longer delays in notification. Reject a HHABN that does not meet these standards.

iii. A requirement for delivery of a notice, and for the LOL provision's protections from liability to be available to the provider, is that the beneficiary, or authorized representative, must be able to comprehend the notice (viz., they must be capable of receiving notice). A comatose person, a confused person (for example, someone who is experiencing confusion due to senility, dementia, Alzheimer's disease), a legally incompetent person, a person under great duress (for example, in a medical emergency) is not able to understand and act on his or her rights, therefore necessitating the presence of an authorized representative for purposes of notice. A person who does not read the language in which the notice is written, a person who is not able to read at all or who is functionally illiterate to read any notice, a blind person or otherwise visually impaired person who cannot see the words on the printed page, or a deaf person who cannot hear an oral notice being given by phone, or could not ask questions about the printed word without aid of a translator, is a person for whom receipt of the usual written notice in English may not constitute having received notice at all (*this is not an exclusive list*). This may be remedied when an authorized representative has no such barrier to receiving notice. However, in the absence of an authorized representative, providers must take special steps to remedy the difficulty of notification. These may include providing notice in the language of the beneficiary (or authorized representative), in Braille, in extra large print, or by getting an interpreter to translate the notice, in accordance with the needs of the beneficiary or authorized representative to act in an informed manner. If the beneficiary is not capable of receiving the notice, then the beneficiary has not received proper notice and cannot be held liable where the LOL provisions apply and the provider may be held liable. It is the provider's responsibility to ensure that the beneficiary (or the authorized representative) actually can comprehend the notice. Reject a HHABN that does not meet these standards. Failure to provide a comprehensible notice is also a violation of the conditions of participation and may result in enforcement action.

iv. The provider must timely answer inquiries from a beneficiary, or authorized representative, who requests further information and/or assistance in understanding and responding to the notice. The provider must answer inquiries from a beneficiary, or authorized representative, regarding the basis for the provider's assessment that services may not be covered and, if requested by the beneficiary, or authorized representative, the provider must give the beneficiary, or authorized representative, access to medical record information or other documents upon which it based its assessment, to the extent permissible or required under applicable State law. Where State law prohibits such direct disclosure, the provider must advise a beneficiary, or authorized representative, who has requested access to such information how to obtain that information from you once a demand bill has been submitted to you. The provider must respond timely, accurately, and completely to a beneficiary, or authorized representative, who requests information about the extent of the beneficiary's personal financial liability for home health care for which the provider expects that Medicare may not, or may no longer, pay. If a beneficiary, or authorized representative, or a physician, provides additional information with respect to Medicare coverage of the subject services, the provider must timely submit that additional information to you. Reject a HHABN in a case in which the provider does not meet these requirements.

v. The generally applicable rules of the Medicare program with respect to who may sign for a beneficiary apply to signing notices, including HHABNs. Whenever a provider furnishes services to a beneficiary who is incapable of signing a notice, his or her representative who signs for other matters in accordance with Medicare rules also may sign a notice. (See the regulations, 42 CFR §424.36(b) "Who may sign when the beneficiary is incapable." See also MIM §3302.5 "Signature on the Request for Payment by Someone Other Than the Patient.")

B. Effect of HHABN on Beneficiary.--Under the statutory provision on LOL, a beneficiary who has received a proper HHABN and who has agreed to pay for the specified services will be fully and personally responsible for payment to the provider if Medicare denies payment. These instructions, when referring to the beneficiary being "fully and personally responsible for payment," mean that the beneficiary will be liable to make payment "out-of-pocket," through other insurance coverage (e.g., employer group health plan coverage), or through Medicaid. Do not hold a beneficiary who does not receive an HHABN, or who receives a defective HHABN (i.e., one that does not meet the requirements of these instructions, or one on which an option was pre-selected by the HHA), liable under the LOL provisions, unless you have clear and obvious evidence that the beneficiary knew or could reasonably have been expected to know that Medicare would not make payment (in which case, hold the beneficiary liable).

Section II-2. Basic Requirements for Mandatory Claims Submission (Demand Bills).--

A. Claim Submission.--A provider that submits a claim to you as a demand bill will report, on the claim submitted, condition code 20 (demand-beneficiary requested billing) to indicate the beneficiary believes the services are covered. The provider must furnish any additional evidence you require and should give the beneficiary a reasonable amount of time to provide additional documentation to the provider for the adjudication of the claim. Expect to receive all documentation within 30 days of the date of the additional documentation request (ADR), in accordance with §234.6 of the HHA Manual.

B. Beneficiary Refunds.--With respect to charges for services for which the HHA has submitted a demand bill, if you decide that the services are covered, require the provider to refund to the beneficiary, or to the appropriate third-party payer, any amounts which were collected from the beneficiary or from a third-party insurer on the beneficiary's behalf. Require a refund of any amounts collected even though Medicare may not necessarily make additional payments to the HHA. (See MIM §3401.) Further, if you decide that the services are not covered, but that the provider did not provide the beneficiary with adequate notice, require the provider to refund any amounts that were collected from the beneficiary or from a third-party payer on the beneficiary's behalf.

C. Medical Review of Demand Bills.--Subject all demand bills (100%) submitted by an HHA to complex medical review in a timely manner. You must inform your HHAs of the following information:

i. All demand bills submitted by an HHA will be subject to complex medical review.

ii. Specify the medical documentation that is typically required by the ADR.

iii. HHAs should wait to receive the ADR, then submit the requested medical documentation and any documentation provided by the beneficiary within 30 days of the date of the ADR, in accordance with §234.6 of the HHA Manual. RHHIs should expedite medical review of demand bills submitted by a provider at the request of the beneficiary or someone acting on the beneficiary's behalf to the extent possible.

D. Payment Action on Demand Bill.--When you make your initial determination with respect to a demand bill, do not assume that the services are noncovered solely on the basis of the HHA's opinion, reflected by the condition code 20. Give all such claims a genuine initial determination with respect to coverage and, if the services are in fact denied payment, make a determination under LOL in cases where it applies. In a case where payment is denied and LOL applies, where the beneficiary received a proper HHABN and agreed to be fully and personally responsible for payment, hold the beneficiary liable under LOL. Advise the HHA and the beneficiary of your decision and include the usual explanation of appeal rights with the denial notification to the beneficiary.

Section II-3. Consequences of Noncompliance.--An HHA that fails to comply with these instructions may risk financial liability and/or sanctions. LOL shall apply as required by law, regulations, rulings and program instructions thereunder. Additionally, sanctions under the Conditions of Participation (COPs), when authorized by law and regulations, may be imposed.

A. Limitation on Liability.--Hold liable, under LOL, an HHA that failed to provide notice, or provided a defective notice, to a beneficiary in a particular case, to which the LOL provision (§1879 of the Act) applies*, unless the HHA can demonstrate that it did not know, and could not reasonably have been expected to know, that Medicare would not make payment, or there is clear and obvious evidence that the beneficiary knew that Medicare would not make payment. If an HHA advises a beneficiary that, in its view, Medicare probably will not pay, but does so in a defective manner such that the beneficiary cannot fully exercise his or her rights and protections (which you must assume to be the case when a notice was not executed and delivered properly by the HHA), consider that to be prima facie evidence that the HHA knew that Medicare would not make payment and not sufficient evidence to shift liability to the beneficiary. If a liable HHA collects from a beneficiary, implement the beneficiary protections under MIM §3446 Indemnification Procedures for Claims Falling Within the Limitation of Liability Provision.

***NOTE:** The LOL provision applies whenever Medicare payment is denied on any one of the following statutory bases: not medically necessary and reasonable (under §1862(a)(1) of the Act); custodial care exclusion (under §1862(a)(9) of the Act); and failure to meet the HHA services homebound and intermittent care requirements (under §1879(g)(1) of the Act). Other applicable statutory bases for denial (e.g., for hospice care) are not relevant to these instructions.

B. Failure to Promptly Submit Demand Bills.--Pursuant to 42 CFR §489.21(b), when a beneficiary agrees to be fully and personally responsible for payment, receives the services, and requests that a claim be submitted to Medicare, the HHA must promptly* submit a demand bill to Medicare and, if the HHA fails to do so, it shall be prohibited from charging the beneficiary. An HHA must submit a demand bill in response to a beneficiary's request because this is a prerequisite for an initial determination by Medicare on that claim, from which the beneficiary's appeal rights under §1869 of the Act arise. If the HHA does not submit a demand bill, you must contact the HHA. If there is continued non-compliance by the HHA, you must send a written letter describing the circumstances to the responsible regional office for appropriate action.

***NOTE:** The requirement in Section II-3.B. to "promptly" submit a demand bill is that the HHA must submit a demand bill in accordance with its normal billing cycle and not delay longer. The meaning of "prompt" submission under HHA PPS, specifically, is as follows: Under HHA PPS, the HHA may submit only one claim for payment at the end of each episode of care. See 65 FR 41,128 (July 3, 2000) (Medicare Program; Prospective Payment System for Home Health Agencies, Final Rule). Thus, under HHA PPS, "prompt submission" of a claim with the demand bill code requires that the claim (i.e., the demand bill) be submitted at the end of the episode in question, at the time that the HHA submits its claim for final payment for the episode. See 65 FR at 41,141. Pursuant to the HHA PPS Final Rule, where the HHA has received a "request for anticipated payment" (RAP) for an episode, the RAP will be canceled and recovered unless the claim for the episode (with the condition code 20 to indicate that the claim is a demand bill when requested by the beneficiary in the circumstances described in this PM) is submitted by the HHA within the greater of 60 days from the end of the episode or 60 days from the issuance of the anticipated payment.

Section II-4. Requirements for Notice When Home Health Care Is Not Ordered By a Physician.--Medicare never pays for home health care that is not ordered by a physician. The instructions in this Section II-4 and in Section I-4, above, apply to situations where care is reduced or terminated in accordance with a physician's order; that is, where the services at issue are not ordered by a physician or where the physician agrees with the provider's assessment that the services are not necessary. The provisions on LOL (addressed in Sections I-3 and II-3 of these instructions) do not apply in these situations, but certain beneficiary protections under the COP do apply.

A. Regulatory Requirements.--

i. Under 42 CFR §484.10(c) Condition of Participation: Patient rights; Standard: Right to be informed and to participate in planning care and treatment: the patient has the right to be informed, in advance, about the care to be furnished, and of any changes in the care to be furnished.

ii. Under 42 CFR §484.10(e) Condition of participation: Patient rights; Standard: Patient liability for payment: (1) the patient has the right to be advised, orally and in writing, before care is initiated, of the extent to which payment may be expected from Medicare or other sources, and of the extent to which payment may required from the patient; and (2) the patient has the right to be advised, orally and in writing, of any changes in the information provided pursuant to subsection (1).

B. Standards.--These instructions make no changes in these requirements. In order to fulfill the requirements of 42 CFR §484.10 (c), the beneficiary must be informed in a meaningful way, in advance about the care to be furnished and of any changes in the care to be furnished, even where the physician concurs in the proposed change(s). In order to fulfill the requirements of 42 CFR Section 484.10(e), an HHA must give a notice to the beneficiary before care is initiated; and the notice must be in writing and also be orally explained to the beneficiary, and must specify the care to be furnished or any changes in the care to be furnished, as may be applicable, and the extent of the beneficiary's potential financial liability if he or she receives the proposed home health care. An HHA that does not notify beneficiaries, or is not timely with such notices, or gives defective notices, is in violation of the COPs. Refer violations of the COPs under 42 CFR §484.10(c) and/or under §484.10(e) to the responsible regional office.

The *effective date* of this PM is March 1, 2001.

The RHHIs' *implementation date* of this PM is March 1, 2001.

The *implementation date* for HHA providers to be in compliance with the requirements of this PM is March 1, 2001.

These instructions should be implemented within your current operating budget.

Contractors should contact the appropriate regional office with any questions.

This PM may be discarded by March 1, 2003.

For further information, contact Raymond Boyd at RBoyd@hcfa.gov, telephone number (410) 786-4544.