The How and When of Medicare’s ABN, HHCCN, & NOMNC (Home Care’s Alphabet Soup)

Coleen M. Schmidt
November 2015
Objectives

• To understand the purpose of each notification form.
• To identify requirements for issuing the required notification at the time of discharge and reduction of care.
• To be able to describe to patients, their rights to an expedited review.
The Conditions of Participation

§484.10(e) Standard: Patient Liability for Payment

G113

(1) The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient.

G114

Before the care is initiated, the HHA must inform the patient, orally and in writing, of--

(i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA;

(ii) The charges for services that will not be covered by Medicare; and

(iii) The charges that the individual may have to pay.
No Surprises!

Interpretive Guidelines §484.10(e)

During home visits, ask the patient whether the HHA has notified him or her of covered and noncovered services. Also, discuss whether the HHA has described any services for which the patient might have to pay and how payment sources might change (or have changed) during the course of care. Again, consider the patient’s ability to understand and retain payment information. The subject of payment for home care services is often complex and confusing, particularly early in the course of treatment when the patient’s illness or limitations appears to be the more pressing problem.

Look for a written statement in the home that might serve as a resource or reminder to the patient about the information the HHA has presented. Also, note whether there are subsequent written statements about payments for items or services of which the HHA has become aware.

In your evaluation of compliance with this standard, consider whether the HHA is making a reasonable attempt to help the patient understand how the charges for HHA services will be covered or not covered over the course of treatment. Based on the information provided by the HHA, do you believe that the patient has a reasonable understanding of how payment for home care services will likely occur and can make reasonable, informed decisions about financial matters related to the HHA’s care and treatment of him or her.

Do NOT try to advise the patient about financial, coverage, or payment issues.

Probes §484.10(e)

1. What process is followed by the HHA to inform the patient of home care charges and probable payment sources, patient’s payment liability (if any), and of changes in payment sources and patient liabilities?

2. What documentation in the clinical record indicates that the HHA informed the patient of Federally-funded or aided covered and noncovered services?
Test your understanding...

- Home Care Goals obtained
  - ABN
  - HHCCN
  - NOMNC

- Nursing discontinues services while physical therapy continues
  - ABN
  - HHCCN
  - NOMNC
Triggering Events...

- Initiation of Care
  - ABN
- Reduction of Services after the plan of care is established
  - HCCN
- Discharged from Care
  - NOMNC
Advance Beneficiary Notice (ABN)

"Advance Beneficiary Notice of Noncoverage" (ABN)

When the home health agency believes that Medicare may not pay for certain home health items and services or all of your home health care, the agency should give you an ABN.

Home health agencies are required to give you an ABN before you get any items or services that Medicare may not pay for because of any of these reasons:

- They're not considered medically reasonable and necessary.
- The care is custodial care.
- You aren't confined to your home.
- You don't need intermittent skilled nursing care.

Note

“The Home Health Advance Beneficiary Notice” (HHABN) has been discontinued. It was replaced by the HHCCN and the ABN in 2013.
# Purpose

<table>
<thead>
<tr>
<th>HHAs must provide notice:</th>
<th>Use:</th>
<th>Instead of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>prior to providing an item or service that is usually paid for by Medicare but may not be paid for in this particular case because:</td>
<td><strong>ABN</strong> (CMS-R-131)</td>
<td>HHABN Option Box 1</td>
</tr>
<tr>
<td>• it is not considered medically reasonable and necessary;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• the care is custodial;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• the individual is not confined to the home; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• the individual does not need intermittent skilled nursing care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prior to the HHA reducing or discontinuing care listed in the beneficiary’s plan of care (POC) for reasons specific to the HHA on that occasion.</td>
<td><strong>HHCCN</strong> (CMS-10280)</td>
<td>HHABN Option Box 2</td>
</tr>
<tr>
<td>prior to the HHA reducing or discontinuing Medicare covered care listed in the POC because of a physician ordered change in the plan of care or a lack of orders to continue the care.</td>
<td><strong>HHCCN</strong> (CMS-10280)</td>
<td>HHABN Option Box 3</td>
</tr>
</tbody>
</table>
## ABN vs. HHCCN

### ABN/HHCCN Triggering Events

<table>
<thead>
<tr>
<th>Initiation of Care (for each episode)</th>
<th>Reduction of Care (some services continue)</th>
<th>Termination of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services not ordered by physician</td>
<td>Reduction of services due to physician orders (not the beneficiary’s choice)</td>
<td>All services ending</td>
</tr>
<tr>
<td>Complete the ABN</td>
<td>Complete the HHCCN</td>
<td>*GED Only</td>
</tr>
<tr>
<td>No beneficiary need for intermittent skilled nursing care, PT, SLP or continuing OT Complete the ABN</td>
<td>Covered/noncovered services reduced for HHA financial or other HHA reasons Complete the HHCCN</td>
<td>Covered/noncovered services ending for HHA financial or other HHA reasons Complete the HHCCN</td>
</tr>
<tr>
<td>Beneficiary not homebound Complete the ABN</td>
<td>Some previously covered services reduced because beneficiary no longer meets coverage criteria Complete the HHCCN</td>
<td>All covered services ending, but noncovered services continue Complete the HHCCN and ABN</td>
</tr>
<tr>
<td>Services not reasonable and necessary Complete the ABN</td>
<td>Reduction of services (includes duration of visits) not planned/anticipated in POC, not communicated in advance with beneficiary Complete the HHCCN</td>
<td></td>
</tr>
<tr>
<td>Item or service not a Medicare benefit under Title XVIII Complete the ABN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services custodial in nature (housekeeping) Complete the ABN</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*GED – Generic Expedited Determination

### The ABN/HHCCN is not required when

<table>
<thead>
<tr>
<th>Initiation of Care</th>
<th>Reduction of Care</th>
<th>Termination of Care</th>
<th>Other Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary meets all home health coverage criteria</td>
<td>Reduction in number, duration of services, or length of visits that are anticipated in the POC, which were communicated in advance to the beneficiary</td>
<td>Beneficiary chooses to terminate all services</td>
<td>Increases in care/services</td>
</tr>
<tr>
<td>Beneficiary chooses to reduce services</td>
<td></td>
<td>Transfers to other covered care (another HHA or other Medicare agency)</td>
<td>Emergency or other unplanned situations (natural disasters, etc.)</td>
</tr>
<tr>
<td>Missed Visit due to: Pt. choice, emergency or unplanned situation, transfer (e.g. hospital) and within ranges ordered</td>
<td></td>
<td>Care ends due to patient goals met/physician’s orders completed (expedited review)</td>
<td>Changes in personnel/caregiver</td>
</tr>
</tbody>
</table>
ABN (Policy)

- Horizon Hospice staff will complete and deliver an ABN form to Medicare beneficiaries or their representatives when it is likely that Medicare will not provide coverage in specific cases.

- The ABN form will be verbally reviewed with the beneficiary or representative and all questions raised during the review will be answered before it is signed.

- The ABN form will be reviewed and delivered far enough in advance that the beneficiary or representative has time to consider their options and make an informed choice.

- An ABN form may be used to provide voluntary notification of actual or potential financial liability.

- An ABN form will not be required in emergencies or urgent care situations.

- In all cases, the use of the ABN form and the conversation reviewing it will be documented in the patient’s record.
Form Completion

Patient Name: B.  
C. Medical Record Number:  

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn’t pay for D.  

Medicare does not pay for everything, even some care that you or your health care provider have 
good reason to think you need. We expect Medicare may not pay for the D.  

<table>
<thead>
<tr>
<th>D.</th>
<th>E. Reason Medicare May Not Pay:</th>
<th>F. Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D.  

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D.  

☐ OPTION 2. I want the D.  

☐ OPTION 3. I don’t want the D.  

H. Additional Information:
Home Health Change of Care Notice (HHCCN)

“Home Health Change of Care Notice” (HHCCN)

The HHCCN is a written notice that your home health agency should give you when your home health plan of care is changing because of one of these:

- The home health agency makes a business decision to reduce or stop giving you some or all of your home health services or supplies.
- Your doctor changed your orders to reduce or stop giving you certain home health services or supplies that Medicare covers.

The HHCCN lists the services or supplies that will be reduced or stopped, and it gives you instructions on what you can do if you don't agree with the change.

The home health agency isn’t required to give you a HHCCN when the “Notice of Medicare Non-coverage” (NOMNC) is issued.

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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 [date], your home health agency will change the following items and/or services for the reasons listed below:

<table>
<thead>
<tr>
<th>Item/services</th>
<th>Reason for change</th>
</tr>
</thead>
</table>

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

- Your doctor’s orders for your home care have changed.
  - The home health agency must follow physician orders to give you care.
  - The home health agency can’t give you home care without a physician’s order.
  - You may not agree with this change. Discuss it with your home health agency or the doctor who orders your home care.

- Your home health agency has decided to stop giving you the home care listed above.
  - You can look for care from a different home health agency if you have a valid order for home care and still think you need home care.
  - You may need help finding a different home health agency to give you this care. Contact the doctor who ordered your home 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 and/or the doctor who orders your home care.

You cannot appeal to Medicare about payment for the items/services listed above unless you both receive them and a Medicare claim is filed.

Additional Information:

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 Patient or of the Authorized Representative*: ___________________________
Date: ___________________________

*If a representative signs for the beneficiary, write “(representative)” next to the signature. If the representative’s signature is not clearly legible, the representative’s name must be printed.

Form CMS-10289 (Approved 06/2013)  OMB Approval No. 0938-1196
HHCCN (Policy)

- Horizon Home Care staff are required to use the HHCCN to notify the Medicare Beneficiary of reductions and terminations in health care in accordance with the Medicare conditions of participation (Part 484.1891(a)(1)(E)).

- Horizon Home Care will use the Advance Beneficiary Notice (ABN) for liability notification (see policy 7.15 Advance Beneficiary Notice of Non-Coverage). An ABN is issued (not the HHCCN) if a reduction occurs for an item or service that will no longer be covered by Medicare but the beneficiary wants to continue to receive the care and assumes the financial charges.

- Horizon Home Care will issue an expedited determination notice called the Notice of Medicare Provider Non-Coverage, if applicable, when all covered services are being terminated (see policy 2.247 Generic and Detailed Notice).

- HHCCNs are not used for beneficiaries enrolled in Medicare Managed Care.
Form Completion

Home Health Change of Care Notice (HHCCN)

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

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

- Your doctor’s orders for your home care have changed.
  - The home health agency must follow physician orders to give you care.
  - The home health agency can’t give you home care without a physician’s order.
  - If you don’t agree with this change, discuss it with your home health agency or the doctor who orders your home care.

- Your home health agency has decided to stop giving you the home care listed above.
  - You can look for care from a different home health agency if you have a valid order for home care and still think you need home care.
  - If you need help finding a different home health agency to give you this care, contact the doctor who ordered your home 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 and/or the doctor who orders your home care.

You cannot appeal to Medicare about payment for the items/services listed above unless you both receive them and a Medicare claim is filed.

Additional Information:

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*If a representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the representative’s signature is not clearly legible, the representative’s name must be printed.

Form CMS-10280 (Approved 06/2013) OMB Approval No. 0938-1196
Notice of Medicare Non-Coverage (NOMNC)

"Notice of Medicare Non-Coverage" (NOMNC)

Your home health agency will give you a NOMNC when all of your Medicare-covered services are ending. This notice will tell you when the services will end and how to appeal if you think the services are ending too soon. The NOMNC tells you how to contact your Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) to ask for a fast appeal. If you don’t get this notice, ask for it.

If you decide to ask for a fast appeal, you should call the BFCC-QIO within the timeframe listed on the notice. After you request a fast appeal, you’ll get a second notice with more information about why your care is ending. The BFCC-QIO may ask you questions about your case. To help your case, ask your doctor for information, which you can submit to the BFCC-QIO.

"Detailed Explanation of Non-Coverage" (DENC)

Your home health agency will give you a DENC when it's informed by the BFCC-QIO that you've requested a BFCC-QIO review of your case. The DENC will explain why your home health agency believes that Medicare will no longer pay for your home health care.
NOMNC (Policy)

• In compliance with Medicare regulations, Horizon Home Care & Hospice, Inc. will provide a NOMNC to all Medicare patients or his/her representative no later than two days prior to the termination/discharge of the patient’s home care or hospice services. If services are expected to last fewer than two days, the NOMNC should be delivered upon admission. If there is more than a two day span between services, the NOMNC should be issued the next to last time services are provided.

• If the patient does not agree that coverage should end, the patient may request an expedited review of the termination/discharge decision by the Quality Improvement Organization (QIO) for the state of Wisconsin. The Agency then must furnish the patient/representative with the Detailed Explanation of Non-Coverage explaining why services are no longer covered.

• The Director, Performance Improvement will be the Agency contact for the QIO. The Vice President, Clinical Operations or Manager on-call will be the Agency contact for the QIO when the Director, Performance Improvement is not available and on weekends and holidays.
Form Completion

Notice of Medicare Non-Coverage

Patient name: ___________________________ Patient number: ___________

The Effective Date Coverage of Your Current Services Will End: ___________

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current 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 also will look at your medical records and/or other relevant information. You do not have 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, and the independent reviewer agrees services should no longer be covered after the effective date indicated above:
  - Neither Medicare nor your plan will pay for these services after that date.
- 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 noon of the day before 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 this 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: (KEPRO, 1-855-408-8557) to appeal, or if you have questions.

See page 2 of this notice for more information.
Medicare

Appeal Rights in Original Medicare

- File an appeal if
  - A service or item isn’t covered
    - And you think it should’ve been
  - Payment for a service or item is denied
    - And you think Medicare should’ve paid for it
  - You question the amount Medicare paid for a service
Rights in Home Health and Hospice

All persons with Medicare, have certain guaranteed rights and protections regardless of setting. With Home Health and Hospice, you also have the following rights:

- Discharge appeal rights
- Home Health and Hospice providers must give you a written copy of your rights and obligations before care begins, to include your right to
  - Choose your agency
  - Have your property treated with respect
  - Participate in and receive a copy of your plan of care
  - Have your family or guardian act for you if you're unable
  - Receive a copy of the “Home Health Agency Outcome and Assessment Information Set (OASIS) Statement of Patients Privacy Rights” when getting in-home health care
Patient Appeal Process

• KEPRO will contact the Agency representative to request a copy of the NOMNC.
  • Same day response

• KEPRO will verify the appropriate form was used and that it was completed properly.
  • Invalid if not completed correctly
  • New form will need to be competed (discharge dates are changed)

• KEPRO will inform the patient they must contact their MD and request them to fax a “certification letter” to them (KEPRO).
  • MD has 60 days to complete
Patient Appeal Process

• If KEPRO does not receive a certification letter from MD within a few days the case is ‘closed’ and the agency can move forward with discharge.
  • If the MD does send the certification within the 60 days, the case can be re-opened.

• Once KEPRO receives the certification letter, KEPRO will request a copy of the Detailed Explanation.
  • Note: Detailed form is completed when the Agency is notified of the appeal.

• KEPRO will request specific pieces of the Medical Record.
Appeal Decision

• “Unfavorable” to the patient. Agencies decision to discharge is upheld.

• “Favorable” to the patient. Agencies decision to discharge is overturned.
  • Services are re-instated.

• Agency will receive a copy of the letter with the decision outlined.
Let’s Summarize
Review

Next Steps:

- Review your orientation information specific to the ABN, HHCCN, & NOMNC
- Compliance Audit (obtain base line information)
- Educate (recommend annually)
- Review every discharge/ensure proper notification is occurring