Sullivan County Department of Public Health

Title: Advanced Beneficiary Notice of Non-Coverage (ABN) **Number**: AG-01 **Page Number:** 1 of 6	Original Approval: 7/01 Reviewed/ revised: 9/02, 8/05, 5/06, 8/06, 9/06, 6/15, 3/24

Statement/ Purpose:
To establish guidelines to provide appropriate advanced notices of non-coverage to beneficiaries and authorized representatives when services are initiated, reduced or terminated.

Authority:
CoP 484.10 (e); ABN CMS Manual Instructions, 50.15.4 - Home Health Agency use of the ABN (Rev. 2878, Issued: 02-14-14 Effective: 05-15-14 Implementation: 05-15-14); Form CMS-R-131 (03/11) Advanced Beneficiary Notice of Noncoverage; Form CMS-10280 Instructions for the HHCCN; Form CMS-10123- Notice of Medicare Non-coverage (NOMNC); Form CMS-10095 - Form Instructions for the NOMNC; 42 CFR 405.1204(a),(c)(3) & (6), (f) Expedited reconsiderations

Application:
SCDPH RN, PT, OT, ST

Terminology:

Responsible Party:
Director of Patient Services

Cross-Reference:
Discharge Process from Agency

Procedure:

I. ABNs: Advanced Beneficiary Notice

The Agency is required to issue an ABN to Original Medicare beneficiaries in specific situations where "limitation on liability" (LOL) protection is afforded under §1879 of the Act for items and/or services that the HHA believes Medicare will not cover (see Table 1 below). In these circumstances, if the beneficiary chooses to receive the items/services in question and Medicare does not cover the home care, the agency may use the ABN to shift liability for the non-covered home care to the beneficiary. A healthcare provider who fails to comply with the ABN instructions risks financial liability and/or sanctions.

ABNs are not used in managed care; however, when a beneficiary transitions to Medicare managed care from Original Medicare during a home health episode, ABN issuance is required when there are potential charges to the beneficiary that fall under the LOL protections. The agency should contact their Regional Home Health Intermediary (RHHI) if they have questions on the ABN or related instructions, since RHHIs process home health claims for Original Medicare. The following chart summarizes the statutory provisions related to ABN issuance for LOL purposes:

Table 1.

Application of LOL for the Home Health Benefit Citation from the Act	Brief Description of Situation	Recommended Explanation for "Reason Medicare May not Pay" section of ABN
§1862(a)(1)(A)	Care is not reasonable and necessary	Medicare does not pay for care that is not medically reasonable and necessary.
§1862(a)(9)	Custodial care is the only care delivered.	Medicare does not usually pay for custodial care, except for some hospice services.
§1879(g)(1)(A)	Beneficiary is not homebound.	Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit.
§1879(g)(1)(B)	Beneficiary does not need skilled nursing care on an intermittent basis.	Medicare requires part-time or intermittent need for skilled nursing care in order to cover services under the home health benefit.

The ABN must be prepared with an original and at least one copy. The beneficiary is given his/her copy of the signed and dated ABN immediately, and the agency should retain the original ABN in the beneficiary's record.

If after completing and signing the ABN, a beneficiary changes his/her mind, the provider should present the previously completed ABN to the beneficiary and request that the beneficiary annotate the original ABN. The annotation must include a clear indication of his/her new option selection along with the beneficiary's signature and date of annotation.

If the beneficiary refuses to choose an option and/or refuses to sign the ABN when required, the provider should annotate the original copy of the ABN indicating the refusal to sign or choose an option and may list witness(es) to the refusal on the notice although this is not required. If a beneficiary refuses to sign a properly delivered ABN, the provider should consider not furnishing the item/service, unless the consequences (health and safety of the patient, or civil liability in case of harm) are such that this is not an option.

ABN delivery is considered to be effective when the notice is:

1. Delivered by a suitable provider to a capable recipient and comprehended by that recipient.
2. Provided using the correct OMB approved notice with all required blanks completed.
   Failure to use the correct notice may lead to the provider being found liable since the burden of proof is on the provider to show that knowledge was conveyed to the beneficiary according to CMS instructions.
3. Delivered to the beneficiary in person if possible.
4. Provided far enough in advance of delivering potentially noncovered items or services to allow sufficient time for the beneficiary to consider all available options.
5. Explained in its entirety, and all of the beneficiary's related questions are answered timely, accurately, and completely to the best of the provider's ability.
   The provider should direct the beneficiary to call 1-800-MEDICARE if the beneficiary has questions s/he cannot answer. If a Medicare contractor finds that the provider refused to answer a beneficiary's inquiries or direct them to 1-800-MEDICARE, the notice delivery will be considered defective, and the provider will be held financially liable for noncovered care.

6. Signed by the beneficiary or his/her representative.

An ABN can remain effective for up to one year. A new ABN is required when the specified treatment extends beyond one year.

If a beneficiary is receiving repetitive non-covered care, but the provider or supplier failed to issue an ABN before the first or the first few episodes of care were provided, the ABN may be issued at any time during the course of treatment. However, if the ABN is issued after repetitive treatment has been initiated, the ABN cannot be retroactively dated or used to shift liability to the beneficiary for care that had been provided before ABN issuance. In cases such as this, care that was provided before ABN delivery would be the financial responsibility of the supplier/provider.

Electronic issuance of ABNs is permitted.

ABNs should be delivered in-person and prior to the delivery of medical care which is presumed to be noncovered. In circumstances when in-person delivery is not possible, providers may deliver an ABN through one of the following means: direct telephone contact, mail, secure fax machine; or internet e-mail. The provider must receive a response from the beneficiary or his/her representative in order to validate delivery. When delivery is not in-person, the provider must verify that contact was made in his/her records. In order to be considered effective, the beneficiary should not dispute such contact. Telephone contacts must be followed immediately by either a hand-delivered, mailed, emailed, or faxed notice. The beneficiary or representative must sign and retain the notice and send a copy of this signed notice to the provider for retention in the patient's record. The provider must keep a copy of the unsigned notice on file while awaiting receipt of the signed notice. If the beneficiary does not return a signed copy, the provider must document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the notice itself.

II. HHCCNs: Home Health Change of Care Notice

The agency is required to issue the HHCCN when a triggering event changes the beneficiary's Plan Of Care (POC). Triggering events are reductions or terminations in care. Examples of HHCCN triggering events due to physician or provider orders:

- Reduction = The POC lists wound care every day. The provider writes a new order to decrease wound care to every other day.
- Termination = The POC lists wound care 2x week. The provider writes a new order to discontinue all wound care.

HHCCN Procedures:

"Your doctor's or provider's orders for your home care have changed." The HHA checks the first box when care will be reduced or stopped because of an order change or the lack of an order to renew care.

"Your home health agency has decided to stop giving you the home care listed." The HHA checks the second box when the HHA decides to stop providing some or all care for its own financial and/or other reasons, regardless of Medicare policy or coverage, such as the availability of staffing, closure of the HHA, or safety concerns in a beneficiary's home.

When multiple care changes occur due to simultaneous order changes and agency specific reasons for change, the HHA must give the beneficiary (2) separate HHCCN's so that s/he can identify the reason that corresponds to each change. Only one check box indicating the reason for change can be marked on each HHCCN.

Additional Information: An entry in this area is optional. HHAs should use this area to include information that may be helpful to the beneficiary's specific case. For example, the ordering provider's name and phone number could be inserted here if the beneficiary has questions on an order change that the HHA can't answer.

The Signature and Date Section: This section contains 2 boxed and labeled blanks for completion. The beneficiary or representative is required to sign and date the HHCCN confirming his/her review and understanding of the notice.

If a representative is signing on behalf of the beneficiary, this must be indicated by either the representative or the HHA writing "(rep)" or "(representative)" next to the representative's signature. If the representative's signature is not clearly legible, the name must be printed near the signature.

If the beneficiary refuses to sign the HHCCN, the HHA must note on the HHCCN that the beneficiary refused to sign, and provide a copy of the annotated HHCCN to the beneficiary.

When delivering HHCCNs, agency staff (providers) are required to explain the entire notice and its content and answer all beneficiary questions to the best of their ability. Staff must make every effort to ensure beneficiaries understand the HHCCN prior to signing it. If common abbreviations are used, the provider should explain their meanings to the beneficiary. While in-person delivery of the HHCCN is preferable, it is not required.

A minimum of two copies, including the original, must be made so that the beneficiary and agency each have one. The HHA keeps one copy of the completed, signed or annotated HHCCN in the beneficiary's record, and the beneficiary receives a copy.

Electronic issuance of HHCCNs is permitted. If a provider elects to issue an HHCCN that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what the beneficiary prefers. Also, regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a copy of the signed HHCCN to keep for his/her own records.

III. NOMNC : Terminations of Services.

A termination is the cessation of all Medicare covered services provided by the agency. If the patient wants to continue receiving care from the agency that will not be covered by Medicare for any of the statutory reasons listed in Table 1 and a physician orders the services, an ABN must be issued to the beneficiary in order for the agency to charge the beneficiary or secondary insurer. If the beneficiary won't be getting any further home care after discharge, there is no need for ABN issuance.

When all Medicare covered home health care is terminated, the agency may sometimes be required to deliver the Notice of Medicare Provider Non-Coverage, (NOMNC), CMS-10123. The NOMNC informs beneficiaries of the right to an expedited determination by a Quality Improvement Organization (QIO) if they feel that termination of home health services is not appropriate. If a beneficiary requests a QIO review upon receiving a NOMNC, the QIO will make a fast decision on whether covered services should end. If the QIO decides that Medicare covered care should end and the patient wishes to continue receiving care from the HHA even though Medicare will not pay, an ABN must be issued to the beneficiary since this would be an initiation of non-covered care.

A Medicare health provider must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to enrollees receiving skilled nursing, home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services, no later than two days before the termination of services. This notice fulfills the requirement at 42 CFR 422.624(b)(1) and (2). In situations where the termination decision is not delegated to a provider, the plan must provide the service termination date to the provider not later than two days before the termination of services for timely delivery to occur.

General Information:

- Provide the Notice of Medicare Provider Non-Coverage at the time all services are due to terminate no later than two days before termination of home health services.
- Provide the Detailed Explanation of Home Health Care Non-Coverage when the beneficiary initiates an expedited determination by the QIO.
- If the beneficiary has Medicare Plus Choice or Medicare Advantage, these HMOs are responsible for providing the beneficiary and the QIO with a detailed explanation.
- Coverage of provider services continues until the date and time designated on the termination notice, unless the QIO reverses the provider's service termination decision.
- No later than 72 hours after receipt of the request for an expedited determination, the QIO must notify the beneficiary, beneficiary's physician and the provider of services of its determination.
- If the QIO's decision is delayed because the Agency did not timely supply necessary information or records, the Agency may be liable for the costs of any additional coverage, as determined by the QIO.
- If the beneficiary does not agree with the QIO's decision, they may request a reconsideration from the QIO. QIO must notify all parties of its decision no later than 72 hours after receipt of the request. The provider may not bill the beneficiary for any disputed services until the QIO makes its determination.

NOMNC Procedure:

1. If it is solely the beneficiary's decision to terminate services, a Notice of Medicare Provider Non-Coverage does not need to be given.

2. The "Notice of Medicare Provider Non-Coverage"[CMS-10123 for Medicare, CMS-10095-A for Medicare Plus Choice (M+C) and Medicare Advantage patients (MA)], must be given as soon as the termination date is known but no later than two days before the end of the services.
3. The form is to be completed by the nurse or therapist using the appropriate format of each form.
4. Fill in the date that the Home Health Services will end.
5. Provide the notice to the beneficiary or person acting on the beneficiary's behalf.
6. Assist with reading and meaning of notice.
7. Evaluate beneficiary's comprehension of the notice.
8. If a beneficiary is able to comprehend the Notice, but either is physically unable to sign it or needs assistance of an interpreter or an assistive device to read or sign it, it will still be acceptable as valid delivery of Notice. Document the use of such assistance in the patient's record.
9. The beneficiary signs and dates notice.
10. If an authorized representative is signing for the beneficiary, their relationship should be documented following their signature. If the beneficiary is unable to sign and the authorized representative is not present, they are to be notified by telephone of the content of the notice. (See attached CMS guidelines and/or refer to immediate supervisor for further instructions). The provider must then document the call and mail the notice via certified return receipt to the representative.
11. In the absence of a NYS Health Care Proxy or Power of Attorney and with the exception of an incapacitated or legally incompetent beneficiary, both the beneficiary and the representative must sign, date and complete an Appointment of Representative Form) or similar written statement.
12. The nurse's/therapist's note for that visit should state that the notice was presented and if applicable, include the reason the authorized representative is signing.
13. If the beneficiary refuses to sign the notice, the nurse/therapist will annotate its copy of the notice to indicate the refusal. The date of the refusal is considered the date of receipt of the notice.
14. The original notice will be for the client's record. A copy goes to the beneficiary or authorized representative.

Detailed Explanation of Home Health Care Non-Coverage Notice

1. If the beneficiary decides to appeal the denial of coverage, they must contact the Quality Improvement Organization (QIO) by no later than noon of the day before the services are to end.
2. The QIO will inform the provider of the request for a review:
    - If coverage is by Medicare, the provider is responsible for sending the QIO and the beneficiary a "Detailed Explanation of Home Health Care Non-Coverage" no later than close of business of the day of the QIO's notification.
    - If coverage is by a managed care organization, the managed care organization is responsible for providing the QIO and the patient with a detailed explanation of why coverage is ending.
3. The RN Case Manager or her/his immediate supervisor or designated person completes the "Detailed Explanation of Home Health Care Non-Coverage" and forwards it the patient/authorized representative and sends a copy to the QIO.
4. The QIO Point of Contact (Director of Patient Services) or her/his designee reviews the medical record and provides a copy of the medical record to the QIO upon request.
5. The beneficiary, upon request, is entitled to a copy or access to any documentation that is sent to the QIO including records of any information provided by telephone. The Agency may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The Agency must accommodate such a request by no later than close of business of the first day after the material is requested.
6. The QIO Point of Contact or designee will notify the billing office that the beneficiary will not be billed until the expedited determination has been completed.