

HHABNS AND BILLING PROCESSES FOR DENIAL

The HHABN (CMS-R-296) is required when

Initiation of Care (for each episode)	Reduction of Care (some services continue)	Termination of Care
Services not ordered by physician	Services reduced for HHA financial or other HHA reasons	All covered services ending, but noncovered services continue. When all Medicare covered services are terminated, the generic Expedited Review form (CMS10123) should be completed.
Care provided and no beneficiary need for intermittent skilled nursing care, PT, SLP or continuing OT	Some previously covered services reduced because beneficiary no longer meets coverage criteria	
Care provided and beneficiary not homebound	Reduction of services (includes duration of visits) not planned/anticipated in POC; not communicated in advance with beneficiary. This includes reductions within ordered ranges.	
Care provided and services not reasonable and necessary	Reduction of services (not the beneficiary's choice)	
Care provided and services custodial in nature (housekeeping)		
Item or service not a Medicare benefit under Title XVIII		
A noncovered item or service delivered one time		
Beneficiary charged for assessment, but no admission to home care		

The HHABN (CMS-R-296) is not required when

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



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Determining Whether A Demand Or No-Pay Bill Is Submitted To Medicare And Appropriate Billing Procedures

When is a demand bill submitted?

- If HHABN was required (except for custodial care) **and** beneficiary authorizes HHA to bill Medicare **and** a denial is needed.
- If HHABN was not required **and** services exceed Medicare limits **and** denial is needed.

How is a demand bill submitted?

- Bill RAP (unless LUPA) as usual
 - Note: RAP **should not** contain condition code 20
- Bill all claim data elements as usual, except:
 - Include condition code 20
 - Include both covered and noncovered charges
 - Non-Medicare payable services entered as noncovered
 - Include “Remarks” detailing why services are noncovered

When is a no-pay bill submitted?

- If HHABN was not required **and** denial needed.
- If HHABN was required for custodial care **and** beneficiary authorizes HHA to bill Medicare **and** a denial is needed.
- If HHABN was required **and** items or services do not meet Medicare covered benefit definition in Title XVIII **and** beneficiary authorizes HHA to bill Medicare **and** a denial is needed.

How is a no-pay bill submitted?

- No RAP required
- Bill all claim data elements as usual, except:
 - Type of Bill is 320
 - Dates of service entered as required by other payer
 - Include condition code 21
 - Patient status code is 01
 - If no OASIS completed, use HIPPS code HAEJ1
 - Include **only** noncovered charges
 - Include “Remarks” detailing why services are noncovered
 - If no OASIS completed, use Treatment Authorization Code “11111111111111111111”

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

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