TO: Home Health Providers

RE: Change to Current Medicare Cost Avoidance Requirements for Home Health Claims

Through communications from the Centers for Medicare & Medicaid Services (CMS), the Department of Social Services (DSS) has been made aware that the Home Health Advance Beneficiary Notice (HHABN) will no longer be valid for dates of service **December 9, 2013** and forward. Home Health Agencies must use the ABN, Form CMS-R-131, when Option box 1 of the HHABN, Form CMS-R-296 would have been selected, to indicate that a dual eligible client's care does not meet Medicare coverage criteria.

The ABN and instructions for completion can be downloaded from the CMS Web site at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html.

HHABNs issued **prior** to December 9, 2013 for ongoing, repetitive services will remain in effect for the time period indicated on the notice, up to one calendar year from the date of issuance. The ABN, like the HHABN, is effective for up to one year and must be issued annually for ongoing, repetitive services when notice is required.

As a reminder Home Health providers are required to submit their Medicaid claims for dually eligible clients to HP indicating the reason an ABN or HHABN was issued to the client, using one of the HIPAA Adjustment Reason Codes indicated in the table below. In addition, providers are required to indicate the date the ABN or HHABN was issued. The ABN or HHABN issue date must be within one year of the date of service.

If a client's care does not meet Medicare's coverage criteria, and the claim does not contain one of the indicated Adjustment Reason Codes and corresponding ABN or HHABN issue date, the claim will post Explanation of Benefit (EOB) code 2522 "Bill Medicare First or Provide Appropriate Adjustment Reason Code and Date of ABN, HHABN or NOMNC".

Claim Submission Instructions

There are no changes to the existing claim submission instructions for clients that do not meet Medicare's coverage criteria and an ABN, HHABN or NOMNC has been completed.

For current claim submission instructions, providers should refer to Chapter 11 "Other Insurance and Medicare Billing Guides," located at www.ctdssmap.com. From the home page, click Publications, Provider Manuals, and Chapter 11 then select **"Institutional Other Insurance/Medicare Billing Guide"** from the drop down menu and click View Chapter 11. Refer to section 11.9 Billing Instructions – Medicare Denial.

Claim Auditing

As a reminder, claims submitted with a HIPAA Adjustment Reason Code of 150, 151 or 152 will be included in an Other Insurance

Audit. The audit will be based upon a monthly random sample of claims that contain one of the three Adjustment Reason Codes. Audited Home Health providers will be required to submit a copy of the original signed and dated ABN or HHABN associated with the selected claim under review. Failure to provide the appropriate ABN or HHABN issued contemporaneously with the date of the selected claim will result in the claim being recouped. Providing an ABN or HHABN with a different signature date than the ABN or HHABN date of issue indicated on the claim will also result in recoupment of the claim.

Home Health Agency Reasons to Issue Advanced Beneficiary Notice	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Code Description
Client determined to be not homebound; either at the start of care or after Medicare-covered services has been provided.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.
Client not receiving part-time or intermittent services from start of care or following the delivery of Medicare-covered services.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.
Client receiving thirty-five (35) hours per week of Medicare-covered skilled nursing and/or home health aide services combined. Medicaid being billed for additional skilled nursing and home health aide services over 35 hours/week.	151	Payment adjusted because the payer deems the information submitted does not support this many services.
Nursing, therapy and/or dependent services being provided do not meet Medicare coverage requirements, e.g. nursing visits are for medication pre-pours or the home health aide is not primarily performing hands-on personal care.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.
Client's continued care determined to not be Medicare-coverable. CMS required Annual HHABN issued.	152	Payment adjusted because the payer deems the information submitted does not support this length of service.