The information included in this paper is provided as general information only. This information should not be considered complete or dispositive guidance for legal or regulatory compliance. The specific application of laws and regulations to an organization requires a careful consideration of all the relevant facts and circumstances and may require assistance of competent legal counsel.

The Following are 24 Questions and Answers provided by CMS in response to inquiries from The National Association for Home Care & Hospice (NAHC). These Q&As provide guidance to hospices on situations when they are required to provide the notice.

**Question** If a patient is being discharged home from a care center (inpatient general/inpatient respite) or taken off continuous care (short-term management), is it be appropriate to issue an ABN?

**Answer** When there is a change in the level of care, an ABN is not required since there is no beneficiary liability.

**Question** In a situation where the patient/family want to continue the higher level of care but the hospice disagrees, would the hospice have to issue an ABN?

**Answer** The level of care is based upon patient need, not patient preference. Hospices should ensure that prior to the election of the benefit, individuals understand the nature of the levels of care and how they are determined. If a patient wishes to remain in a facility, he/she may receive an ABN explaining that he/she is responsible for room and board and that the care rendered by the hospice will be at the routine level of care. The room and board payment by the beneficiary should NOT be the difference in the amount paid by Medicare to the hospice for the higher level of care -- the payment is for room and board ONLY.

**Question** If the above answer is yes -- that is, an ABN is issued -- the concern is that if the notice is given at the time of decreasing the level of care services, the patient/family may feel they have the option of continuing with the higher level of care, even though the care would be considered outside of the hospice plan of care and the patient/family may have to pay for it. There are times when the patient/family decide they like the comfort of having the 24-hour care and do not want to go back to the routine home care level of care.

**Answer** As indicated above.

**Question** Would it be alright for a hospice to refer a patient to the services of another provider for this additional care because the hospice does not provide private service?

**Answer** The hospice could assist the beneficiary in finding services that Medicare does not pay for, e.g., private care, so that beneficiaries and their families have the opportunity to choose among options. A notice of exclusion from Medicare benefits (NEMB) could be provided. The NEMB is not based on beneficiary liability protections established by section 1879 of the Social Security Act but may be used to fulfill other notice requirements. NEMBs alert Medicare beneficiaries in advance that Medicare does not cover a certain item(s) and/or service(s) because the item(s) or service(s) do not meet the definition of a benefit or are specifically excluded by law.

**Question** If the above answer is yes, must the hospice then document in the patient's record the receipt of the ABN and the decision the patient/family makes, and then continue the "routine home care" level of services?
**Answer** Documentation should support the care and services provided. This would include when an ABN was given and the reasons for doing so.

**Question** If a Medicare hospice benefit patient/family wants a diagnostic test that the hospice interdisciplinary group (IDG) does not consider "medically reasonable and necessary" for providing care related to the patient's terminal illness, should the hospice provide an ABN?
**Answer** The hospice is responsible for all medically reasonable and necessary services pertaining to the terminal and related conditions. Diagnostic tests are included. If the medical director and/or physician member of the IDG orders the test, it is covered under the daily per-diem rate. It would not be appropriate to have the test ordered by a physician other than the hospice physician in order to defer payment. If there is no medical necessity and the patient/family insists, the hospice would not be liable. If the test is related to the patient's terminal and related conditions, it will not be covered under Medicare Parts A or B. CMS believes that an ABN would be required if these circumstances are met.

**Question** Orders are for three skilled nursing visits per week for nine weeks ("SN 3 wk 9") for wound care. The wound improves after three weeks and the patient requires only two skilled nursing visits per week for the remaining six weeks, so the physician orders the decrease. Would an HHABN be delivered, and if yes, which "option box" would be used?
**Answer** Yes. An HHABN would be delivered using "Option Box 3" since the reduction is related to physician's orders.

**Question** Orders are for two skilled nursing visits per week for nine weeks ("SN 2 wk 9") for wound care, and a Foley catheter change is also being done monthly. At the end of the recertification period, the wound has healed and the new recertification sets care at "1 mo 2" for catheter changes (continuing catheter changes each month for two months). Would an HHABN be delivered, and if yes, which "option box" would be used?
**Answer** Yes. An HHABN would be delivered using "Option Box 3" since the reduction is related to physician's orders.

**Question** There is a scheduling error and a patient visit is missed and not made up that week. Is an HHABN needed, and if yes, which "option box" would be used?
**Answer** An HHABN would not be delivered, since this is an unplanned event and not a true reduction in the patient's plan of care (POC).

**Question** Upon initiation of care, the patient requires Medicare-covered skilled nursing and aide care. The patient is incontinent and needs appropriate supplies, which will be provided during the course of the skilled nursing or aide visits but not left with the patient for use in between visits because they are not Medicare-covered. The patient does not have another insurance to pay for incontinence supplies. Is an HHABN needed?
**Answer** An HHABN would not be necessary unless the patient wishes to pay for additional supplies out of his or her pocket and has physician's orders for them. In that case, an HHABN would be required at all triggering events.
**Question** A patient requires a Medicare-covered skilled nursing service on a monthly basis and also needs her medication box pre-filled each week. The visits in which only the medication pre-fills are performed will be billed to Medicaid. Is an HHABN needed, and if yes, which "option box" would be used?

**Answer** Since Medicare is paying for some of the care, an HHABN will need to be issued for Medicaid-covered services at all triggering points until Medicare coverage ends.

**Question** It is determined at the initial evaluation that the only service a patient requires is personal care, which will be billed to the home and community-based waiver program (a Medicaid program). Is an HHABN needed, and if yes, which "option box" would be used?

**Answer** Yes. An HHABN would be delivered using "Option Box 1" and would be required upon initiation of services and annually afterward.

**Question** Orders are for three skilled nursing visits per week for nine weeks ("SN 3 wk 9") for wound care and physical therapy. After six weeks the wound has healed, so the physician discontinues the skilled nursing visits. The patient is still receiving physical therapy. Is an HHABN needed, and if yes, which "option box" would be used?

**Answer** Yes. An HHABN would be delivered using "Option Box 3" since the decrease in visits is related to physician's orders.

**Question** Orders are for two skilled nursing visits per week for four weeks and then one visit per week for four weeks ("SN 2 wk 4, 1 wk 4"). New orders are written for care at the next recertification -- but for two visits per week for four weeks ("2 wk 4"). The frequency of visits has actually increased from the prior orders, but the duration is less (i.e., for a total of four weeks as opposed to a previous total of eight). Is an HHABN needed, and if so, which "option box" would be used?

**Answer** An HHABN would not be required. An expedited determination notice would be issued at the end of four weeks.

**Question** Orders are for two skilled nursing visits per week for three weeks ("SN 2 wk 3"). The services ordered are completed, but something else comes up and the patient requires additional orders to be written for one visit per week for three weeks ("1 wk 3"). Is an HHABN needed, and if so, which "option box" would be used?

**Answer** An HHABN would not be required since the additional order is an increase in care.

**Question** A patient is discharged from the agency because outpatient therapy services are starting; this is a multiple discipline case. The patient will be discharged from skilled nursing first, prior to the end of the visit schedule, so the nurse will issue an HHABN using "Option Box 3." The patient will be discharged from physical therapy with goals met and the agency will perform the discharge the next week, prior to the start of outpatient services. The agency discharge with goals met therefore will not require an HHABN to be issued, just a Medicare discharge notice. Is this correct?

**Answer** Yes. All Medicare-covered services are ending in this case and an expedited determination notice will be sufficient.
**Question** If a patient is receiving Medicare services and is discharged by his or her physician to outpatient services, would the agency just send the expedited determination notice to the home or would it need to issue an HHABN using "Option Box 3"?

**Answer** Only an expedited determination notice is required since all Medicare-covered services will be ending.

**Question** The physical therapist is providing the last service to a patient and wants to discharge before the ninth week because goals have been met (on the plan of care [POC], physical therapy orders are for one to three visits per week for nine weeks, "1-3 wk 9"). Does the physical therapist have to issue both an expedited determination notice and an HHABN?

**Answer** Only the expedited determination notice is required since all Medicare-covered services are ending. In this example, the physical therapy discharge will end all Medicare-covered care.

**Question** If a licensed practical nurse (LPN) receives physician's orders to decrease visits, can he or she have the HHABN signed?

**Answer** CMS is not specific regarding who in the agency must issue the HHABN. The primary concern is that the LPN is able to explain the HHABN adequately and answer any questions the beneficiary may have.

**Question** Why is an HHABN required for recertification when there is a decrease in visit frequency? A recertification is a new plan of care (POC), so why wouldn't the process start over? Technically, the original POC ended when the 60-day episode ended; please explain why an HHABN would have to be issued upon resumption of care.

**Answer** CMS's position is that upon recertification and at resumption of care (ROC), patients will expect care to continue at the level of the original plan unless they are notified otherwise. Therefore, if visits are reduced at these points (recertification and ROC), the agency must provide written notice in the form of an HHABN.

**Question** If a patient is a Medicare beneficiary but skilled nursing will be billed to Medicaid and aide services to a waiver program (e.g., because the patient is not homebound or it is not a Medicare "skill"), would an HHABN be needed, and if so, which "option box" would be used and how often would the notice be required?

**Answer** Yes. An HHABN would be delivered using "Option Box 1" upon initiation of services and renewed annually for medical services provided where a third party other than Medicare (Medicaid included) is the payer.

**Question** I understand that an HHABN is required if goals are met early for one discipline but another discipline continues care. However, if skilled nursing and physical therapy are being provided but the physical therapist decides the patient is no longer progressing -- and the physician agrees -- is an HHABN required, and if so, which "option box" would be used? What about if the family does not agree with the physical therapist and feels that the patient is progressing?

**Answer** If the physical therapist ends services earlier than is written on the POC, the
physician agrees, and other covered services are continuing (e.g., skilled nursing), an HHABN would be delivered using "Option Box 3" since the change is related to physician's orders. If the family insists the therapy continue and the physician agrees to write orders for continued therapy, an HHABN would have to be issued using "Option Box 1" since the agency would be providing care that Medicare may not cover (i.e., services are determined to be not "reasonable and necessary").

**Question** Visit frequency for covered care is reduced from five times per week to three times per week, and an HHABN is provided to the patient. Visit frequency is reduced again from three times per week to once per week. Since the decrease is another change, another HHABN would be required, correct?

**Answer** Yes. Another HHABN would be delivered using "Option Box 3" since there is a reduction in care related to physician's orders from the most recent HHABN.

**Question** Under HHABN "Option Box 1," if the patient selects choice three ("I want the items and/or services listed above, and I agree to pay for the items and/or services myself if Medicare or my other insurance doesn't pay") the **note section below** applies. The note states that if a claim is submitted to Medicare, the patient will receive a summary notice indicating Medicare's official payment decision and can choose to appeal the decision if Medicare will not pay. If it takes 30 to 60 days for the patient to receive the Medicare summary notice, is the home health agency obliged to continue care? What are the agency's obligations in this case?

**Answer** Part of that note section reads: "You may have to pay the full cost at the time you get the items and/or services." This informs the patient that the agency might bill the patient until the fiscal intermediary renders a decision. If the intermediary rules that Medicare will pay for the "items and/or services," any money the agency has collected from the beneficiary must be refunded.