CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2781	**Date: September 6, 2013**
	Change Request 8403

SUBJECT: Home Health Change of Care Notice (HHCCN), Form CMS-10280, Manual Instructions - This CR rescinds and fully replaces CR 7323.

I. SUMMARY OF CHANGES: This transmittal introduces and implements the Home Health Change of Care Notice (HHCCN) and instructions. The previously used Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296 (CR 7323), will be discontinued. The HHCCN will replace the HHABN formatted with Option Box 2 or Option Box 3 for change of care notifications. Option Box 1 formatting of the HHABN for beneficiary liability notification will be replaced with the existing Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, and will be the subject of a separate CR (CR 8404). Chapter 30, section 60 and its subsections are being revised in accordance with these notice changes. CR 8403 rescinds and replaces CR 7323, transmittal 2362 dated December 1, 2011.

EFFECTIVE DATE: December 9, 2013
IMPLEMENTATION DATE: December 9, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	30/Table of Contents
R	30/60/60 Home Health Change of Care Notice (HHCCN), Form CMS-10280
R	30/60/60.1/Background on the HHCCN
R	30/60/60.2/Scope of the HHCCN
R	30/60/60.3/Triggering Events for HHCCN/ Written Notice
R	30/60/60.4/Completing the HHCCN
R	30/60/60.5/HHCCN Delivery
D	30/60/60.6 Effective HHABNs
D	30/60/60.7/Collection of Funds and Liability Related to the HHABN
D	30/60/60.8/Special Issues Associated with the HHABN

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2781	Date: September 6, 2013	Change Request: 8403

SUBJECT: Home Health Change of Care Notice (HHCCN), Form CMS-10280, Manual Instructions - This CR rescinds and fully replaces CR 7323.

EFFECTIVE DATE: December 9, 2013
IMPLEMENTATION DATE: December 9, 2013

I. GENERAL INFORMATION

A. Background: Home Health Advance Beneficiary Notices (HHABNs) have been required since 2002 to inform beneficiaries in Original Medicare about possible noncovered charges when limitation of liability applies. In 2006, CMS revised the notice and its instructions in response to a Federal court decision so that the notice could encompass broader notification requirements codified under the Conditions of Participation (COPs) for Home Health Agencies (HHAs). In an effort to streamline, reduce, and simplify notices issued to Medicare beneficiaries, the HHABN will be discontinued. The liability format of the HHABN (Option Box 1) will be replaced with the existing Advance Beneficiary Notice of Noncoverage (ABN). The change of care formats of the HHABN will be rescinded replaced by the Home Health Change of Care Notice (HHCCN).

B. Policy: The COPs for HHAs at §1891 of the Act require that beneficiaries receive written notification of changes in care.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8403.1	Regional Home Health Intermediaries (RHHIs) shall take any actions necessary to implement the attached instructions; primarily by assisting HHAs in understanding their responsibilities and communicating the implementation of the HHCCN for change of care notifications and discontinuation of the HHABN.							X					
8403.2	RHHIs shall remove the former HHABN instructions, CR 7323, dated December 1, 2011, Transmittal 2362, from their websites once this CR is effective.							X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8403.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.							X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	The HHCCN is a simplified, single-formatted notice replacing the multi-formatted HHABN that is an existing requirement executed by HHAs. The release of these modified manual instructions to accommodate HHCCN implementation should have no impact on the RHHI workload beyond short term educational demands.

Section B: All other recommendations and supporting information: ATTACHMENTS (2)

1. HHCCN Form

2. HHCCN Form Instructions

V. CONTACTS

Pre-Implementation Contact(s): Evelyn Blaemire, 410-786-1803 or evelyn.blaemire@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 2

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.

Items/services:	**Reason for change:**

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:

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 "(rep)" or "(representative)" next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed.

Form Instructions
for the Home Health Change of Care Notice* (HHCCN), CMS-10280
(*Formerly the Home Health Advance Beneficiary Notice of Noncoverage, Option Box 2 & 3)

OMB Approval Number: 0938-1196

Overview

The HHCCN replaces 2 notice formats of the Home Health Advance Beneficiary Notice of Noncoverage (HHABN). The HHABN will be discontinued.

Medicare currently requires home health agencies (HHAs) to issue the HHABN to original, also called fee for service (FFS), Medicare beneficiaries prior to the following situations:

- providing care that Medicare usually covers but may not pay for in this instance because the care -
    - is not medically reasonable and necessary,
    - is considered custodial care, or
    - is not covered because the beneficiary is not homebound;
- changing care for HHA reasons; and/or
- changing care because of physician's or provider's orders.

These notification requirements stem from the beneficiary liability protections under §1879 of the Social Security Act (the Act) and responsibilities under the Medicare conditions of participation (COPs) for HHAs cited in §1891 of the Act. The HHABN has (3) different notice formats called "Option Boxes" to satisfy the different issuance purposes.

In order to simplify and streamline beneficiary protections notices, the HHABN will be discontinued. The HHCCN will replace the Option Box 2 and Option Box 3 formats of the HHABN. The Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, will replace the HHABN Option Box 1 format. (For information on the ABN, please see the ABN webpage: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html)

These abbreviated instructions explain when and how the HHCCN must be delivered. Please also refer to the Medicare Claims Processing Manual, Chapter 30, Section 60 for detailed information on the HHCCN.

Notices

The HHCCN is a newly approved notice that replaces the HHABN Option Box 2 and the HHABN Option Box 3. These instructions apply when the HHCCN is given to a beneficiary or an authorized representative. The term "beneficiary" used throughout these instructions can be substituted with "authorized representative" when applicable. For more information on authorized representatives, see Medicare Claims Processing Manual, Chapter 30, §40.3.5

Transition to the HHCCN

HHAs may begin using the HHCCN as soon as possible. There will be a transition period during which HHAs may issue either the HHCCN or the HHABN. The date for mandatory and exclusive use of the HHCCN is forthcoming and will be posted on the CMS website at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html

Applicability

HHCCNs are issued to beneficiaries receiving the home health care benefit for notification of plan of care changes.

Consistent with the Medicare COPs and the 2nd Circuit Court's decision in *Lutwin v. Thompson* regarding notification procedures, home health agencies must provide the HHCCN whenever they reduce or terminate a beneficiary's home health services due to physician/provider orders or limitations of the HHA in providing the specific service. Notification is required for covered and non-covered services listed in the plan of care (POC).

Triggering Events

HHAs are required to issue the HHCCN when a triggering event changes the beneficiary's 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.

Examples of HHCCN triggering events due to HHA reasons:

- Reduction = PT services are ordered 4 times per week in the POC. The HHA has an unexpected staffing shortage and can only provide PT services 2 times per week.
- Termination = PT services are ordered 4 times per week in the POC. The HHA has lost PT staff and can no longer provide any PT services.

If a termination involves the end of all Medicare covered care and no further care is being delivered, the only notice issued would be a Notice of Medicare Non-coverage (NOMNC), Form CMS-10123.

HHCCN Preparation

The following are the general instructions for HHCCN preparation:

Number of Copies: A minimum of two copies, including the original, must be made so that the beneficiary and HHA each have one.

Electronic Issuance: 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.

Reproduction: HHAs may reproduce the HHCCN by using self-carbonizing paper, photocopying the HHCCN, or other methods. All reproductions must conform to CMS instructions.

Length and Page Size: The HHCCN must NOT exceed one page in length. The HHCCN is designed as a letter-sized form. If necessary, it may be expanded to a legal-sized page to accommodate information HHAs insert in the notice, such as the HHA's contact information or a list of multiple changes to the plan of care.

Contrast of Paper and Print: A visually high-contrast combination of dark ink on a pale background must be used. Do not use reversed print such as white on black or block-shaded (highlighted) text.

Modification: Don't modify the HHCCN, except as specifically allowed by these instructions.

Font: The lettering on the HHCCN must meet the following requirements to facilitate beneficiary understanding:

- Font Type: Use the fonts as they appear on the documents downloaded from the CMS website. Any changes in the font type should be based solely on software and/or hardware limitations of the HHA. Examples of easily readable alternative fonts include Arial, Arial Narrow, Times Roman, and Courier.

- Font Effect/Style: Don't make style changes to the font, such as italics, embossing, bold, etc., since this could make the HHCCN more difficult to read.

- Font Size: The font size generally should be 12 point. Titles should be 14-16 point. Words inserted in the blanks on the HHCCN can be as small as 10 point if needed.

- Insertions in Blanks: Information inserted by HHAs in the blank spaces on the HHCCN may be typed or legibly hand-written.

Customization: HHAs are permitted to do limited customization of HHCCNs, such as pre-printing agency-specific information to promote efficiency and to ensure clarity for beneficiaries. Guidelines for customization are:

- HHAs may pre-print descriptions of common change of care scenarios. For example, an HHA could pre-print, "Beginning on _____, we will decrease the frequency of your wound care to ___ times per _____."

- HHAs may print distinct versions of their pre-printed HHCCNS on different colored paper so that they are easily identified, but the notice must appear as a high-contrast combination of dark-colored font on light-shaded paper.

- HHAs may label different pre-printed versions of their HHCCNs by adding letters or numbers in the header area.

- Information in blanks that is constant can also be pre-printed, such as the HHA name, address, and phone number.

- Pre-printed information inserted on the notice should be at least 12-point font size if possible, and 10-point minimum. 10 point should only be used if a smaller font is needed to include all applicable information in the blank space provided.

- HHAs may list multiple change-of-care scenarios on a pre-printed HHCCN. If multiple scenarios are listed, the beneficiary should be able to clearly identify the information that pertains to his/her case. HHAs may use checkboxes to indicate information applicable to the beneficiary. Alternatively, applicable items can be circled, or items that do not apply can be crossed out.

- The printed blank lines in the change of care description area of the notice may be removed if needed for customization.

- The HHA may pre-print specific HHA disciplines with corresponding checkboxes on the HHCCN. However, an explanation of what is changing must be included on the notice. For example, if Physical Therapy is checked, text such as “reduced to 2 times per week” must be inserted. Just checking off a discipline without an explanation could render the notice invalid.

- HHCCNs without pre-printed information should be available for HHA staff to use in cases that don’t conform to pre-printed language.

HHCCN Completion and Delivery

The HHCCN is a one-page notice composed of three sections:

- Header
- Body
- Signature/Date

The Header Section

HHAs are permitted to customize the header section of the HHCCN that sits above the “Home Health Change of Care Notice” title at the top of the page. HHAs may add identifying information such as a logo, web address, or an email address.

The blanks in the header section are completed as follows:

- **Home Health Agency:** The name of the HHA must be listed.
- **Address:** The correspondence address of the HHA must be listed.
- **Phone:** A phone contact must be included and a TTY number must be included when necessary.
- **Patient’s Name:** The beneficiary's full name must be inserted in the blank. (A pre-printed name label is permitted.)
- **Patient Identification:** Completion of this blank is optional and serves for HHA identification purposes. A birth date or medical record number may be inserted. HHAs must not include the beneficiary’s Medicare health insurance claim number (HICN) or Social Security number on the notice. Electronic bar codes are permitted.

The Body Section

The body section of the HHCCN is below the header and above the signature area.

The body includes (5) components for completion by the HHA:

- Date
- Items/services description
- Reason for the change
- Check boxes - General reason for change
- Additional Information

Date

Directly under the title of the notice there is a blank line for insertion of a date. The HHA must insert the date that the changes listed on the notice will start.

Items/services description

When there are changes in care that require written beneficiary notification, the HHA lists the change or changes in the blank area under “Items/services:” The HHA must also explain whether the item/service is being reduced or terminated.

The description should be informative, in language understandable to the beneficiary. Common abbreviations such as “PT” for physical therapy may be used only if the beneficiary is familiar with the term.

Example 1: “On Dec.17, 2012, we will stop all of your occupational therapy services.”
Example 2: “On Dec 21, 2012, the frequency of your wound care will decrease to 3 days per week.”

Reason for change

In the blank area under “Reason for change”, the HHA must insert the specific reason that the care change is occurring. For doctor’s order changes, an example of language that can be used is: “Your doctor has changed your order for this care.”

For agency related changes, more specific information may be provided in accordance with the situation. For example, “Your dog has repeatedly threatened our staff, and we are unable to safely enter your home,” could be a possible reason cited.

Check Boxes
The HHA must identify the general reason for the change or changes that are listed in the table above. The HHA must check one of the 2 checkboxes in the section under “Read the information next to the checked box below.”

“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.

- **Signature:** The beneficiary or representative must sign the HHCCN.

- **Date:** The beneficiary or representative must enter the date that the HHCCN was signed. The HHA may insert the date if the beneficiary is having difficulty and requests assistance.

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.

HHCCN Delivery

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

Retention of the HHABN

The HHA keeps one copy of the completed, signed or annotated HHCCN in the beneficiary's record, and the beneficiary receives a copy. Electronic retention of electronically issued or scanned HHCCNs is permitted.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1196. The time required to complete this information collection is estimated to average 4 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Medicare Claims Processing Manual
Chapter 30 - Financial Liability Protections

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(*Rev. 2781, 09-06-13*)

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60 - Home Health *Change of Care Notice (HHCCN), Form CMS-10280*

(Rev. 2781, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

This section provides the standards for use by home health agencies (HHAs) in implementing the Home Health *Change of Care* Notice (HH*CC*N), *Form CMS-10280,* requirements. The *HHCCN* is issued to Original Medicare beneficiaries before reducing or terminating most ongoing care provided by the HHA.

HH*CC*N - Quick Glance Guide[1]

Notice Name: Home Health *Change of Care* Notice (HH*CC*N)
Notice Number: Form CMS-*10280*
Issued by: Home Health Agency (HHA) provider
Recipient: Original Medicare (fee for service) beneficiary receiving home health care

Pertinent Information: *The HHCCN replaces HHABN Option Box 2 and Option Box 3. The Advance Beneficiary Notice of Noncoverage (ABN), CMS-R-131, replaces HHABN Option Box 1. See Section 50 for ABN information and instructions.*

Type of notice:	Must be issued:	Timing of notice:	Optional use?
*C*hange of care notice	Prior to the HHA reducing or discontinuing care listed in the beneficiary's plan of care (POC) for *administrative* reasons specific to the HHA on that occasion	Immediately on determination, or if possible, provide enough time for the beneficiary to arrange to obtain the reduced or discontinued home health care service(s) from a different HHA.	No.
	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	Notify the beneficiary before the actual reduction or discontinuation, if possible.	No.

The HHCCN replaces the Home Health Advance Beneficiary Notice (HHABN), CMS-R-296, Option Box 2 and Option Box 3. Option Box 1 of the HHABN is replaced by the existing Advance Beneficiary Notice of Noncoverage (ABN),CMS-R-131, which is detailed in Section 50 of this chapter. HHAs should begin using the ABN and HHCCN in place of the HHABN as soon as possible since the HHABN will be discontinued. The date for mandatory use of the HHCCN and ABN in place of the HHABN will be posted on the web link for home health notices at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

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[1] *This is an abbreviated reference tool and is not meant to replace or supersede any of the directives contained in Section 60.*

Table 1 HHA Notice Changes

Instead of:	***Use:***
HHABN Option Box 1	*ABN (CMS-R-131)*
HHABN Option Box 2	*HHCCN*
HHABN Option Box 3	*HHCCN*

60.1 - Background on the *HHCCN*

(Rev. 2781, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

HHAs have issued HHABNs related to the absence or cessation of Medicare coverage when a beneficiary had liability protection under §1879 of the Social Security Act (the Act) *since 2002*. The HHABN gained additional notification capabilities in 2006 following the U.S. Court of Appeals (2nd Circuit) decision in LUTWIN V. THOMPSON, 361 F.3d 146; 2004 U.S. App. LEXIS 3774. Following Lutwin, the HHABN was modified so that it could also be used by HHAs to notify beneficiaries receiving home health services of any care changes in accordance with the HHA conditions of participation (COPs) in §1891 of the Act.

To account for this expanded use, the HHABN was revised to contain three interchangeable Option Boxes within the body of the notice designated as Option Box 1, Option Box 2, and Option Box 3. Option Box 1 language *was* applicable to situations involving potential beneficiary liability for HHA services as directed by §1879 of the Act. Option Box 2 or Option Box 3 *was* inserted into the HHABN form to notify beneficiaries of changes in a home health plan of care that are subject to the requirements of § 1891 of the Act.

In order to streamline, reduce, and simplify notices issued to Medicare beneficiaries, the HHABN is being discontinued. HHABN, Option Box 1, which is the liability portion of the notice, is replaced by the existing Advance Beneficiary Notice of Noncoverage (ABN), CMS-R-131. The change of care notification portions of the HHABN, Option Box 2 and Option Box 3, is replaced by the newly approved HHCCN.

60.2 - Scope of the *HHCCN*

(Rev. 2781, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Statutory Authorization for *HHCCN*

The requirement to give an HH*CC*N is based on the HHA COPs in §1891 of the Act. The COPs are further implemented through Title 42 of the Code of Federal Regulations (CFR), Part 484.

§1891(a)(1)(E) stipulates that beneficiaries have:

"The right to be fully informed orally and in writing (in advance of coming under the care of the [home health] agency) of --

> all items and services furnished by (or under arrangement with) the agency for which payment may be made under this title,
>
> the coverage available for such items and services under this title, title XIX or any other Federal program of which the agency is reasonably aware,
>
> any charges for items and services not covered under this title and any charges the individual may have to pay with respect to items and services furnished by (or under arrangement with) the agency, and
>
> any changes in the charges or items and services described in clause (i), (ii) or (iii)."

HHAs are required to use the *HHCCN* to notify the beneficiary of reductions and terminations in health care in accordance with Medicare COPs.

B. HHAs and Other CMS Notices

HHAs *will now* use the Advanced Beneficiary Notice (ABN), Form CMS-R-131 for *liability notification instead of* the HHABN Option Box 1. *The ABN and form instructions can be downloaded from the CMS website at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html*

HHA*s* must *continue to* issue an expedited determination notice called the Notice of Medicare Provider Non-Coverage, (NOMNC), CMS-10123, *if applicable,* when all covered services are being terminated. Please see the "FFS ED Notices" link at: *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html* for information on the delivery of expedited determination notices.

C. *HHCCN* Issuers and Recipients

HHAs are the only type of Medicare provider that issues the HH*CC*N to notify the beneficiary of care changes *involving reductions or terminations of items and/or services*. The recipients of the *HHCCN* are beneficiaries enrolled in Original Medicare only. HH*CC*Ns are not used in Medicare managed care. When a beneficiary transitions to Medicare managed care from Original Medicare during a home health episode, HH*CC*N issuance is required only if there is a *specific* need to provide notification of changes in care *as the transfer occurs*.

Subcontractors may deliver *HHCCNs* under the direction of a primary HHA; however, notification responsibility, including effective delivery, always rests with the primary HHA. HHAs are always responsible for providing *HHCCNs* associated with the care that they provide. In the *form* instructions *and instructions* in this section, the term "beneficiary" is used to mean the beneficiary or the beneficiary's representative, as applicable. For more information on representatives, see §40.3.5 and §40.3.4.3 *of this chapter*.

HHAs should contact their *CMS* Regional *Office* if they have questions on the *HHCCN* or related instructions. Beneficiaries who need assistance may be directed to call 1-800-MEDICARE.

60.3 - Triggering Events for *HHCCN*/Written Notice

(Rev. 2781, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

HHAs may be required to provide *an HHCCN* to an Original Medicare beneficiary at *two* points in time, *for reasons not related to Medicare coverage* called "triggering events":

Table 2

Triggering Events *for HHCCN Issuance*

EVENT	DESCRIPTION
Reduction of a service	When an HHA reduces or stops an item and/or service during a spell of illness while continuing others, including when one home health discipline ends but others continue.
Termination of all services	When an HHA ends delivery of all services.

A. *Reductions*

Reductions involve any decrease in items and/or services, such as frequency, amount, or level of care, provided by the HHA. When care that is listed on the POC or provided by the HHA is reduced, the beneficiary must receive the HHCCN listing the items/services being reduced and the reason for the reduction, regardless of who is responsible for paying for that service.

When a reduction occurs because the HHA decides to stop providing the service for administrative reasons or because of a physician's order, the HHCCN must be issued.

> ***Example 1 –*** *Reduction for HHA reasons:*
>
> *Because of a temporary staffing shortage, an HHA reduces daily physical therapy (PT) to PT 3 times weekly for 2 weeks.*
>
> *The HHCCN must be issued to the beneficiary prior to this care reduction that is due to an agency administration issue.*
>
> ***Example 2*** *–Reduction based on physician's orders:*
>
> *The beneficiary met PT goals sooner than expected, and the attending physician writes an order to discontinue home PT. Physical therapy services are discontinued with no change in existing skilled nursing orders.*

The HHCCN must be issued to the beneficiary prior to this care reduction that is a change to the existing POC because of a physician's order. Reductions include cases, such as this, where one type of care ends, but the beneficiary continues to receive another type of home health service.

An ABN is issued (and 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 assume the financial charges. See Section 50.15.4.

B. *Terminations*

A termination is the cessation of all services provided by the HHA and can include Medicare covered and noncovered care. When all home health care is ending for reasons not related to Medicare coverage, the HHA issues the HHCCN with information appropriate to the specific situation.

***Example 1** – care termination due to agency reasons (such as staffing, closure of the HHA, concerns for staff safety), not related to Medicare coverage*

An HHA decides to stop providing care because guard dogs at the home where the care is being furnished have posed safety issues for staff.

Because termination is due to an HHA administrative decision, the HHCCN must be given to the beneficiary prior to discontinuation of services.

***Example 2** – care termination due to agency reasons (failure to meet face to face encounter requirement)*

An HHA has initiated care for a beneficiary, and the beneficiary has not yet had the required face to face encounter with the certifying physician or an allowed non-physician practitioner (NPP). The HHA believes that the face to face encounter requirement will not be met in the allowed time frame and decides to stop providing care.

*This termination is due to an HHA administrative decision; thus, the HHCCN must be given to the beneficiary prior to discontinuation of services. Issuing the HHCCN does **not** affect financial liability but serves as a written change of care notice as required by the HHA COPs.*

***Example 3** – care termination due to a physician's orders to discontinue care or a lack of orders to continue care*

A physician orders discontinuation of all home health services or fails to order continued home health services.

The Notice of Medicare Provider Non-Coverage (NOMNC), CMS-10123 must be issued to the beneficiary when all Medicare covered services are ending based on the physician's orders. Since the NOMNC provides written notification of the forthcoming termination of all home health care, it satisfies the regulatory requirement for change of care advisement (HHCCN issuance). Thus, when the NOMNC is issued as required, the HHA doesn't have to issue a

separate HHCCN. When home health services end because of physician's orders, HHAs have the option of issuing the NOMNC alone or both the NOMNC and the HHCCN.

Detailed information and instructions for issuing the NOMNC can be found on the CMS website at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html

C. *Effect of Other Insurers/Payers*

HHCCN requirements apply only when home health services are expected to be partially or fully covered by Medicare. When a beneficiary is not receiving any services that are expected to be covered under the Medicare home health benefit, the HHCCN is not required. For example, if a dual eligible beneficiary (having both Medicare and Medicaid) is not receiving any Medicare covered home health services, HHCCN issuance wouldn't be required when changes of care occur. (NOTE: HHAs are required to issue the ABN to dual eligible beneficiaries when applicable. See Section 50.15.4 C)

D. *Exceptions to HHCCN Notification Requirements*

The HHCCN is NOT required when changes in care involve:

- *increase in care;*
- *changes in HHA caregivers or personnel as decided by the HHA;*
- *changes in expected arrival or departure time for HHA staff as determined by the HHA;*
- *changes in brand of product, (i.e., the same item produced by a different manufacturer) as determined by the HHA;*
- *change in the duration of services that has been included in the POC and communicated to the beneficiary by the HHA, (i.e., shorter therapy sessions as health status improves, such as a reduction from an hour to 45 minutes);*
- *lessening the number of items or services in cases where a range of services is included in the POC;*

  > ***Example:*** *The POC order states: PT 3-5x per week as needed for gait training. The therapist begins therapy at 5 times per week, and as the patient progresses, therapy is reduced to 3 times per week. No HHCCN would be needed in this case.*

- *changes in the mix of services delivered in a specific discipline (e.g., skilled nursing) with no decrease in frequency with which that discipline is delivered;*

  > ***Example:*** *A beneficiary is receiving several skilled nursing services during visits that are scheduled 3 times a week. One service within that discipline, a blood draw 1 time a week, is discontinued. Other skilled nursing services (wound care and education) continue, such that skilled nursing visits continue to occur 3 times per week. No HHCCN is required when the blood draws are discontinued, only when skilled nursing is reduced in frequency.*

- *changes in the modality affecting supplies employed as part of specific treatment (e.g., wound care) with no decrease in the frequency with which those supplies are provided; or*

  Example: *A specific wound care product like Alldress is stopped, and a Hydrogel pad is started. Since this represents a change in the modality (or intervention) and not a reduction, no HHCCN is necessary.*

- *changes in care that are the beneficiary's decision and are documented in the medical record.*

60.4 - Completing the *HHCCN*

(Rev. 2781, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Notices *and General Notice Requirements*

The HHCCN and the general instructions for preparing the HHCCN are available for download at the home health notice link found at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

The notice is available in English and Spanish, and in PDF and Word formats. The *HHCCN* is the Office of Management and Budget (OMB) approved standard notice for use by Medicare HHAs to inform beneficiaries of changes in the POC when required by the COPs for HHAs. HHAs must use the OMB approved standard notice. HHAs must not add any customizations *to the notice* beyond *what is permitted by the accompanying HHCCN form instructions and* the guidelines *published in this section.*

B. Choosing the Correct Language Version

HHAs should choose the appropriate version of the *HHCCN* based on the language the beneficiary best understands. When a Spanish-language *HHCCN* is used, the HHA should make insertions on the notice in Spanish. If this is impossible, the HHA must take additional steps needed to assure beneficiary comprehension and document this on the *HHCCN*.

If needed, HHAs must provide verbal assistance in other languages to assist beneficiaries in understanding the document. HHAs should document any types of translation assistance used in the "Additional Information" section of the notice.

C. Compliance with Paperwork Reduction Act of 1995

Consistent with the Paperwork Reduction Act of 1995, the valid OMB control number for this information collection appearing on the *HHCCN* is 0938-*1196*. The estimated time required to complete this information collection *is 4* minutes for a single notice. This includes the time to prepare the notice, review it with the beneficiary, and obtain *the* beneficiary's signature.

D. Effective Dates

HHCCNs are effective *for HHA use* per the OMB assigned date given at the bottom of each notice unless CMS instructs HHAs otherwise. The routine approval is for 3-year use. HHAs are expected to exclusively use the effective version of the *HHCCN* per CMS directives.

60.5 - *HHCCN* Delivery

(Rev. 2781, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

HHAs must make every effort to ensure beneficiaries understand the entire *HHCCN* prior to signing it. When delivering *HHCCNs*, HHAs are required to explain the notice and its content, and answer beneficiary questions to the best of their ability. If abbreviations are used, the HHA should explain their meaning to the beneficiary. If the beneficiary requests additional information while completing the HH*CC*N, the HHA must respond timely, accurately, and completely to the information request.

While in-person delivery of the HH*CC*N is preferable, it is not required consistent with general ABN requirements, see Medicare Claims Processing Manual, Chapter 30, §40.3.4.1.

If a mode other than in person delivery is used, the HHA must adhere to the requirements under the Health Insurance Portability and Accountability Act (HIPAA). Instructions on ABN telephone notice found in §40.3.4.2 of this chapter are also applicable to HH*CC*Ns.

Delivery when change of care is due to agency administrative reasons

The HHA *should* review the text *associated with the* box *that was checked on the HHCCN by the HHA* and verbally explain to the beneficiary that he/she may be able to obtain the same or similar care from another HHA, since coverage through Medicare is not affected. HHAs are encouraged to do as much as possible to offer ideas to beneficiaries for contacting other HHAs and must inform ordering physicians of reductions/terminations consistent with the COPs for HHAs.

Delivery when change of care is due to physician orders

The HHA *should* review the text *associated with the box that was checked on the HHCCN by the HHA*, and inform the beneficiary that the HHA will no longer provide certain care because the physician's order has changed. When requested, the HHA may facilitate contact and understanding between the physician and beneficiary. The beneficiary may also seek to contact the physician directly.

Retention of the *HHCCN*

The HHA keeps a copy of the completed, signed or annotated HH*CC*N in the beneficiary's record, and the beneficiary receives a copy. HHA's may retain a scanned copy of the paper copy document in an electronic medical record if desired. The primary HHA must retain the *HHCCN* if a subcontractor is used.

Applicable retention periods are discussed in Chapter 1 of this manual, §110. In general, this is 5 years from discharge when there are no other applicable requirements under State law.

Other Considerations During Completion

1. Beneficiary Unable to Sign

If the beneficiary is physically unable to sign the *HHCCN* and is fully capable of understanding the notice a representative is not required for signature. The beneficiary may allow the HHA to annotate the *HHCCN* on his/her behalf regarding this circumstance. For example, a fully cognizant beneficiary with two broken hands may allow an HHA staff person to sign and date the notice in the presence of and under the direction of the beneficiary, inserting the beneficiary's name along with his/her own name, i.e., "John Smith, Shiny HHA, signing for Jane Doe." Such signatures should be witnessed by a second person whenever possible. Further, the medical record should support the beneficiary's inability to write in the applicable time period.

2. *Timely Notice*

There are no exact time frames for HHCCN delivery. Delivery timing of the notice may sometimes occur immediately upon the HHA finding that a change in care is warranted. However, in general, HHCCN should be delivered far enough in advance of the care change so that the beneficiary may pursue alternatives to continue receiving the care noted on the HHCCN. When plans for issuance of the notice are known in advance, the HHCCN should not be issued so far in advance as to cause confusion regarding the information it conveys.

Some allowance is made for "immediate" delivery prior to furnishing the care at issue when unforeseen circumstances arise such as an impending, unforeseen agency staffing shortage or a dangerous home situation. This should be avoided whenever possible, but is permissible when a situation occurs prompting an immediate determination to reduce or end services that could not have been made in advance.