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Invalid Home Health Advanced Beneficiary Notice (HHABN) Conditions

MassHealth will recover Medicaid payments from home health agencies (HHAs) for services delivered to dually eligible members when a Medicare contractor and the Office of Medicare Hearing and Appeals determine that

- (1) Medicare coverage criteria have not been met and the claim has been denied; and
- (2) the dually eligible member is not liable for the costs of the services claimed due to an invalid Home Health Advanced Beneficiary Notice (HHABN).

All of the criteria used to conclude the validity of an HHABN is in accordance with 42 USC 1879 et.seq; 42 USC 1891(a)(1)(E); 42 USC 1395bbb(a)(1); 42 CFR, sec. 411.406; 42 CFR 405.1200; and CMS Policy Manual Financial Liability for Providers, Ch 30, sec. 60-70. An HHABN is considered **invalid** when issued by an HHA if the HHABN meets one of the following conditions.

- (1) The HHABN is not delivered to the dually eligible member in accordance with federal statute, federal regulations, and CMS Policy Manual guidelines required and stated in the Medicare rules, regulations, policies, and statutes cited above.
- (2) The HHABN does not clearly state
 - (a) the reason that the HHA expects that Medicare may not pay for each listed item or service;
 - (b) the estimated cost for each item and/or service; and
 - (c) the beneficiary's options.
- (3) The HHABN is illegible or incomprehensible, or it can be demonstrated that the HHA did not make every effort to ensure that the member understood the entire HHABN before signing it.
- (4) The HHABN is not signed by the dually eligible member or his or her representative (unless appropriate documentation explaining the absence of signature is recorded on the HHABN in accordance with Medicare rules, regulations, policies, and statutes).

MassHealth uses these criteria after appeal efforts for Medicare coverage have been exhausted. **Note:** The list of criteria invalidating an HHABN is not exhaustive. MassHealth reserves the right to expand the list of criteria if Medicare rules, regulations, policies, or statutes change. In such instances, MassHealth will inform HHAs before changing its criteria.

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